Medicaid Reimbursement

July 7, 2009

DSS
Strong Families - South Dakota's Foundation and Our Future

Overview

- The goal of any effective rate setting methodology is to include all allowable and reasonable costs and allow the provider to cover the cost incurred for the provision of the service.

- Rate setting methodologies should be “consistent with efficiency, economy, and quality of care” (Social Security Act)

- Not all programs and services for which rates are set are the same, therefore there is no one methodology, or formula to establish rates.

Overview

- However, there is federal regulatory guidance and uniform standards that are used when establishing reimbursement rates.

  - OMB Circular A-87
  - CMS Publications 15-1 & 15-2 Provider Reimbursement Manual
  - South Dakota's Medicaid State Plan

Overview

- Not all costs are allowable for Medicaid reimbursement. Some examples include advertising, bad debt, fund raising as examples.

- Based on the approach and service type, rates may be uniform for a specific service for all providers or may be unique to each provider for the same service.

- Rate setting cannot be done in isolation. A collaborative approach using financial workgroups is used when possible to develop rate setting models.

Overview

- These working groups include representation from provider and agency fiscal and program staff, direct care staff, facility administrators, and other key stakeholders and promote transparency and common understanding regarding reimbursement rates. Examples of financial workgroups include:

Assisted Living	Substance Abuse
Homemaker/Nursing	Community Mental Health
Community Support Providers	Long Term Care
Psychiatric Residential Treatment for Youth	

Overview

- We also work directly with various trade associations and groups to provide input into the reimbursement process. These include:

South Dakota Health Care Association

Dental Association

South Dakota Association of Community Based Service Providers

South Dakota Association of Healthcare Organizations

Assisted Living Association of South Dakota

South Dakota Council of Mental Health Centers

South Dakota Council of Substance Abuse Directors

South Dakota Medical Association

South Dakota Association Physical Therapists

Association of Residential Youth Care Providers

Basis for Reimbursement

• While specific models may vary for different services, South Dakota establishes reimbursement rates on the following basis:

- Costs Reported to the Department

- Use of Medicare or Other Fee Schedules

Cost Settlement

- Reimbursement is made on either a per diem or percent of billed usual and customary charges.

- Provider submits a cost report which reflects actual costs and units of service provided for the reporting period.

- The difference between reimbursement made and costs incurred can result in an overpayment or underpayment to the provider.

- The underpayment/overpayment is recovered through a retroactive rate adjustment.

Cost Settlement

- State institutions including the South Dakota Developmental Center at Redfield and the geriatric and adolescent units at the Human Services Center utilize this method as federal guidelines do not allow state owned facilities to be reimbursed more than actual costs.
- This method is used for specialized hospital units including neonatal and rehabilitation. An evaluation of use of a prospective rate indicates cost settlement is the most cost effective at this time.
- Children's Care Hospital and School – currently being evaluated.

Prospective Rate Based on Historical Costs

- Reimbursement rate is paid on an hourly or daily basis or a percent of billed usual and customary charges.
- Providers submit cost reports on an annual basis.
- The historical cost report data is used to develop a reimbursement model used to pay rates in a future period.
- Since there is a lag in time between the cost report period and when the cost data can be used for rate setting, costs are typically inflated forward to the period when the rates will be paid.

Prospective Rate Based on Historical Costs

- Models can include ceilings or other mechanisms to minimize the impact that outliers could have on rates and offer a tool to manage costs.
- The annual cost report data can be used to measure how well the model performed and if adjustments need to be made.
- Periodic adjustments to recognize more recent cost report data may also be incorporated into the model.

Prospective Rate Based on Historical Costs

- Pros:

-ability to incentivize certain aspects of service delivery

-cost basis that offers incentives to control costs

- Cons:

-providers that have access to other resources will report potentially higher costs than providers with limited resources, creating disparity among providers.

- Types of services reimbursed using this method include:

Nursing Home	Community Support Services
Homemaker/Nursing	Community Mental Health
Substance Abuse	Psychiatric Residential Treatment

Use of Medicare or Other Fee Schedules

- This type of approach is typically utilized where collection of cost data would not be feasible or for services provided out of state.
- Medicare Fee Schedule

  Based on data collected at the federal level – regionalized to South Dakota. Where possible, specific Medicare rates are used. In some instances, Medicare fees are used as a guide.

  Examples: Most independent practitioners including physicians, optometry, podiatry, surgery.

  Pros- Easily implemented and understood

  Cons- No control over legislative or federal program changes

Use of Medicare or Other Fee Schedules

- Percent of billed usual and customary charges

Examples: Some independent practitioners, durable medical equipment. Most out of state facilities for both inpatient and outpatient hospital services.

Pros- Easily implemented and understood
Cons- Not necessarily tied to actual cost

- Use of Other fee schedules

Examples: Commercial dental fee schedule, other states' Medicaid reimbursement rates.

Reimbursement Methods by Facility Type

- The number and type of services offered by each facility determines the reimbursement method used.

- Facilities that deliver one type of service may be reimbursed using one method. However, because certain facilities provide multiple types of services, they may be reimbursed using a variety of methods.

Hospitals

- For example, hospitals are reimbursed using cost settlement, prospective rates based on historical costs, and other fee schedules depending on the type of facility and service provided.
- For reimbursement purposes, facilities are classified as the following types:

Diagnosis-related Group (DRG)

Non - DRG (Including Access Critical)

Specialized Surgical

Out of State

Hospitals - DRG

- There are 26 DRG hospitals in South Dakota.
- DRG hospitals have over 30 Medicaid discharges in a given year.
- Annual expenditures: $71.7 million
- Numbers Served: 15,768

Hospitals - DRG

- Inpatient Services reimbursement is a prospective rate based on historical costs.
- The DRG methodology is a system developed for Medicare use to classify hospital admissions into one of over 740 groups. When a claim is submitted, it is assigned to a specific DRG based upon the diagnosis, procedures, age, sex, discharge status, and presence of complications. Each DRG has a South Dakota specific weight to account for acuity and each hospital has a specific target amount used to calculate the reimbursement of the hospital stay.

Hospitals- DRG

- Although inpatient services are reimbursed using the prospective payment, outpatient services are reimbursed through an annual cost settlement process.

- The percent of billed charges is adjusted annually based on cost report information and the cost to charge ratios for the various cost centers.

Hospitals- Non- DRG

- There are 26 Non- DRG facilities in South Dakota.
- Providers are paid at 95% of usual and customary charges for inpatient and 90% for outpatient services.
- Nine of the 26 Non-DRG facilities in South Dakota have been designated Access Critical for Medicaid reimbursement purposes and are cost settled to ensure we meet their costs.
- Annual expenditures a little over $1 million.

Hospitals- Specialized Units

- There are 10 Specialized Units (or DRG-exempt) in South Dakota. Specialized units are reimbursed using the cost settlement method.
- These include 3 neonatal, 4 rehab units.
- Providers are paid a percent of charges and then an annual cost settlement is conducted.
- There are 3 Specialized acute psychiatric units in South Dakota. They are reimbursed using a daily per-diem rate.

Hospitals- Out of State

- South Dakota utilizes 96 out of state facilities that account for 19% (down from 21% last year) of inpatient expenditures or $13.5 million.

- Out-of-state services are a result of services that can't be performed in-state, are emergency, or provided by border facilities.

- Reimbursement for inpatient and outpatient services are paid using a percent of billed usual and customary charges with the exception of North Dakota where their state DRG methodology is used.

Community Based Services

Annual Expenditures

Assisted Living	$6.9 million
Homemaker/Nursing	$2.1 million
Community Mental Health	$15.6 million
Substance Abuse	$4.8 million
Psychiatric Residential Treatment for Youth	$13.4 million

Annual Number Served:

Assisted Living	631
Homemaker/Nursing	5770
Community Mental Health	8250
Substance Abuse	1194
Assistive Daily Living Services	129
Psychiatric Residential Treatment for Youth	329

DSS
Strong Families - South Dakota's Foundation and Our Future

Community Based Services

Number of Providers:

Assisted Living	154
Homemaker/Nursing	37
Community Mental Health	11
Substance Abuse	29
Assistive Daily Living Services	6
Psychiatric Residential Treatment for Youth	9

Community Based Services

- Prospective rate based on historical cost

- Providers submit an annual cost report subject to audit. The cost report includes revenue, expense, and units of service provided during the reporting period.

- Because of the time lag between submission of the cost report and use of the information for rate setting, costs are typically inflated.

- Several categories of providers in this group have adopted a uniform timeframe for the cost report period so that all provider cost data is from the same time period.

Community Based Services

- Input from the financial workgroup is gathered and used in model development

- Review and analysis of the raw cost report data is completed to identify outliers and establish ranges and mean values for various components of the model.

  - per unit cost information by provider
  - average salary and benefits
  - relationship of personnel costs to operating

- If outliers do exist, they can be excluded from use in model development by use of standard deviation calculations.

Community Based Services

- In addition to cost report data, additional information may be collected through surveys or other tools for use in model development.

- Survey data could include time spent updating care plans, travel time for home based services, average vacation or other leave days used, etc.

Community Based Services

Example of a model where service is paid on an hourly rate and typically delivered by a single staff person:

Average Salary and Benefits	$30,015
Average Operating	$ 7,125
Total Cost	$37,140

Billable Time 80% or 1664 hours annually

Total Cost divided by Billable Time = rate per hour

$37,140 1664 = $22.32 per hour

Community Based Services

- When modeling a service where direct service delivery involves a team of staff, multiple staff salaries and either billable time or daily census data is used.

Community Support Services – Service Based Rates

Annual Expenditures: $92.6 million

Annual Number Served: 2,243

Number of Providers: 19

- Service Based Rate System developed in 1996 and implemented in 1997.

- Statistical model used to fairly and equitably distribute existing resources within the system.

Community Support Services – Service Based Rates

- The Service Based Rate system establishes an individualized rate for every person supported within the system based upon each person's needs. Those with higher needs receive a higher rate.
- A person's needs are determined through a standardized tool called the Inventory for Client and Agency Planning (ICAP).
- The ICAP is completed annually by Community Support Provider staff and reviewed and tested by state staff.

Community Support Services – Service Based Rates

SOURCES OF DATA USED IN THE SBR MODEL

- Cost reports submitted annually and subject to audit
- Activity logging data – details units of service received
- Service record – a list of services an individual receives
- ICAP – assessment tool
- Economic measures – locally adjusted

Community Support Services – Service Based Rates

- Cost reports are used to compile system-wide average costs for services such as service coordination/case management, day services, supported employment, residential services, and nursing.
- Activity logging is used to determine the number of units of service provided to each person and multiplied by the average cost to determine a cost of service for each person.
- Multiple regression is used to formulate a model which predicts the cost of services an individual needs based on the services they receive and their ICAP.
- The model generates an individualized rate for each person.

Community Support Services – Service Based Rates

- Community Support Providers play a vital and critical role in the SBR process.
- SBR modeling process is very transparent with stakeholder input through a financial workgroup.
- The SBR system has also allowed us to meet fiscal accountability and quality assurance standards as prescribed by CMS.

Community Support Services – Family Support

- Services include service coordination, specialized equipment, respite care, personal care, companion care, nutritional supplements, and supported employment.

Annual Expenditures: $3.1 million

Number served: 712

Number of programs: 24

Reimbursement for services based upon established fee schedule and actual costs of services and supports as approved in the individualized service plan.

Nursing Facility and Hospice Care

Annual Expenditures: $ 140.7 million

Annual Number Served: 3,647

Number of Providers: 107

- Prospective rate based on historical costs
- Medicaid pays for approximately 58% of nursing facility residents in South Dakota

Nursing Facility

- South Dakota's reimbursement method pays a daily rate unique to each resident. Rates for residents with special or heavy care needs are higher while those with less needs are lower.

- A resident's care needs are identified through an assessment called the Minimum Data Set (MDS). The MDS is used to collect data regarding the individual's functional capacity including basic self care activities such as health, bathing, dressing, toileting, eating, and transferring. The assessments are completed by the nursing home staff and monitored by state staff.

- Each level of care from the MDS is assigned a Case Mix Weight.

Nursing Facility

- Case mix scores range anywhere from .59 for an individual with lower care needs to 2.67 for a resident that requires extensive care.

- In addition to the individual resident assessment, a cost report is submitted annually by the facility and subject to audit annually. The cost report also includes the number of residents served during the year.

- Nursing facilities utilize a range of timeframes for cost reporting with fiscal year ends ranging from December 31 to March 31. This compounds the problem of the lag time between submission of the data and use for rate setting.

Nursing Facility

- "Ceilings" or limitations are applied to allowable costs based on a comparison of costs in each category among all facilities.

  Direct Care
  Non Direct Care
  Capital
  Occupancy
  Overall

- Ceilings are applied to all allowable costs and a facility specific direct care and non direct care rate are established.

Nursing Facility

- When facilities are reimbursed for services, the direct care component of the rate is multiplied by the resident's case mix score resulting in an individualized rate for each resident based on their specific care needs.

The total rate is calculated by:

Facility Direct Care Rate X Resident Case Mix + Facility Non Direct Care Rate = Total Rate per day

- Hospice room and board care is reimbursed at 95% of the daily rate established for the resident in care. Hospice services are reimbursed using Medicare rates.

Swing Bed

- A “swing bed” is an inpatient hospital bed for people who are determined to be nursing facility level of care and are waiting for placement in a nursing facility, or a person who is stepping down from an acute care admission and are not quite ready to be discharged home.

- Reimbursement for this service is the statewide average nursing facility rate (excluding the cost of therapy services).

Clinics

- Includes physician and dental services provided at Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

Annual Expenditures: $7.2 Million
Number of Providers: 117

- Reimbursement is cost based and inflated each calendar year by the Medicare Economic Index, for calendar year 2009 it was 1.6%.

Independent Practitioners

- Includes physician; podiatry; optometric; psychology; chiropractic; and physical, occupational, and speech therapy.

Annual Expenditures: $70.9 million

Number of Providers: 3,705

Reimbursement for services based on use of Medicare rates or other fee schedules.

- Some services, such as family practice services use Medicare rates as a guide, but may not reimburse specifically at the Medicare rate.

Indian Health Services (IHS)

- Includes services provided at 5 in-state inpatient hospitals and 32 outpatient, clinic, and specialty care facilities.

Annual Expenditures:	$41.3 million
Number Served:	Averages nearly 8,000 visits monthly

Reimbursement made according to daily rates set by the federal government. Current inpatient rate is $1,906/day and the outpatient is $268/day.

Services provided at an Indian Health Services facility are eligible for 100% federal funding. However the State does pay match for IHS contract providers.

School Districts

- Direct care services of physical therapy, speech therapy, audiology, nursing, and psychiatric.
- Reimbursement of Medicaid-related administration expenses.
- School districts provide the general fund match and DSS passes through the federal Medicaid funds.

Annual Expenditures: $7.7 million

Number of Participating School Districts: 138

Reimbursement rates established according to the actual costs incurred by the school districts.

Durable Medical Equipment/Prosthetic Devices

- DME and prosthetic devices allow individuals to remain in their home and provide a level of functioning for the individual to be active in their community. Examples of covered equipment includes wheelchairs, oxygen concentrators, and ventilators.

Annual Expenditures: $5 million

Number of Providers 237

- Reimbursement rates established using a set fee schedule based upon actual costs, Medicare, or a percentage of usual and customary billed charges.

Home Health Agencies

- Services such as skilled private duty nursing and personal care/attendant care allow individuals to remain in their homes rather than be placed in a facility or institution. Services include wound care and ventilator care.

Annual Expenditures: $1.8 million

Number of Providers 27

- Reimbursement rates established based on Medicare fee schedule or hourly nursing rates in order to be competitive in the market.

Prescription Drugs

- All drugs where the manufacturer has signed a federal rebate agreement are covered, including some OTCs.
- Some drugs require prior authorization.

Annual Expenditures: $48 million

Collected drug rebates reduce actual expenditures – $17 million

Current reimbursement is the lesser of:

- Provider's usual and customary charge;
- Average Wholesale Price (AWP) less 10.5% + $4.75;
- The payment amount established by the US Department of Health and Human Services for multi-source drugs + $4.75; or
- The payment established by the department for drugs listed on the state's Maximum Allowable Cost (MAC) list + $4.75

Dental Services

- Dental services are provided to adults/children and medically necessary orthodontic services to children.

Annual Expenditures: $12.3 million

Annual Number Served: 47,244

Number of Providers: 310

- Dental reimbursement rates established using South Dakota commercial rates as a benchmark. Current reimbursement is 70-80% of commercial rates.