

# **Top 10 Medicaid Payment Considerations**

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Overarching Federal Law 10

5 Medicaid Managed Care Premium Rates

UPL Regulations under Section (30)(A) 9

4 Supplemental Payments

Proposed "Access" Rules under Section (30)(A) 8

3 Potentially Preventable Events

Payment Levels in Acute and LTC 7

2 Stakeholders

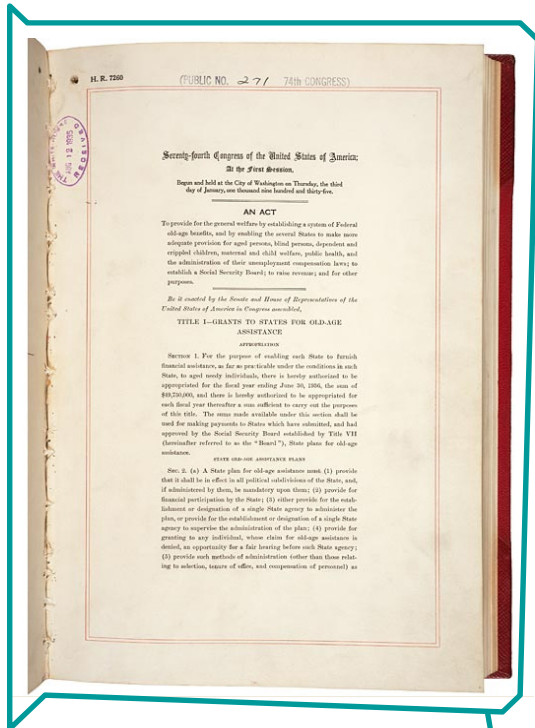
Payment Methods in Acute and LTC 6

1 State Legislature

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## 10

# Overarching Federal Law



A State plan for medical assistance must... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan.... As may be necessary to safeguard against **unnecessary utilization**... and to assure that payments are consistent with **efficiency, economy** and **quality of care** and are sufficient to enlist **enough providers** so that care and services are available under the plan at least to the extent such care and services are available to the general population in the geographic area.

**Section 1902(a)(30)(A) of the Social Security Act**

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## UPL Regulations under Sec. (30)(A)

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- No FFP for payments above UPL
  - UPL is tied to aggregate amount Medicare would pay for hospital, nursing home, ICF/MR services
  - Gross mechanism for controlling costs
  - All payment SPAs must demonstrate compliance
  - Gave rise to “UPL payments”
    - Supplemental payments above standard rates
    - Reflects difference between Medicaid and Medicare payment rates
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## 8 Proposed “Access” Rules under Section (30)(A)

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- Access review required every 5 years or whenever rates are reduced or restructured
  - Must consider input from affected stakeholders
  - Must assess:
    - Extent enrollee needs met;
    - Availability of care and providers
    - Changes in utilization
  - Must compare:
    - Medicaid payment levels to provider “charges”
    - Medicaid payment levels to Medicare, commercial or “applicable Medicaid allowable cost of service”
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# 7 Payment Levels in Acute and LTC

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- What is the benchmark?
  - Do absolute and relative payment levels advance key policy priorities?
    - Obstetrics
    - Pediatrics
    - Behavioral health
    - Inpatient v. Outpatient
    - Institution v. Community
  - How do across-the-board rate cuts affect payment reform strategy?
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# 6

## Payment Methods in Acute and LTC

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- Define goals
    - Transparency and accountability
    - Incentivize quality and efficiency
    - Recognize complexity/severity of illness
  - Don't automatically default to Medicare
  - Question
    - Per-diem, per-hour and per-visit rates
    - Institution-specific, cost-based rates
  - Mandated for FQHCs under federal law
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## 5 Medicaid Managed Care Premium Rates

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- States are increasingly embracing managed care systems
  - Both CMS and MACPAC reviewing rate setting
  - Federal law requires “actuarial soundness”
  - SPA must describe
    - Rate-setting methodology
    - Underlying data
  - GAO has raised concerns about federal oversight and quality of data
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## Supplemental Payments

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- Types
    - DSH
    - Upper Payment Limit (UPL)
    - Managed Care/Provider Directed
  - Funding
    - Provider taxes/assessments
    - Intergovernmental transfers
    - Certified Public Expenditures
  - Where do they fit in payment reform strategy?
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## Potentially Preventable Events

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- **Potentially Preventable Readmissions (PPRs)**  
*Return hospitalizations that may result from deficiencies in the process of care and treatment or lack of post discharge follow-up rather than unrelated events that occur post discharge*
  - **Potentially Preventable Complications (PPCs)**  
*Harmful events or negative outcomes that may result from the process of care and treatment rather than from a natural progression of the underlying disease*
  - **Develop payment adjustment for PPRs/PPCs by comparing risk-adjusted rates of hospitals**
    - Improves quality
    - Contains costs
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# Stakeholders

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- Providers
  - Provider Associations
  - Unions
  - Health Plans
  - Health Plan Associations
  - Consumer Advocates
  - PhRMA
  - DME Providers
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# State Legislature



And, one more....

**The State  
Budget**



# For More Information:

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