West Virginia's SFY18 Medicaid Managed Care Directed Payment Program Provider Payment Methodology

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Introduction

This document provides a methodology overview of the CMS approved changes to West Virginia's payment methods of the Directed Payment Program (DPP) for its Medicaid Managed Care populations, both Mountain Health Trust (MHT), which includes TANF and West Virginia Health Bridge (WVHB), for the time period State Fiscal Year 2018 (SFY18 July 1, 2017 through June 30, 2018).

These payments are paid through the MCOs to the providers. A summary of the changes and their methodology is below.

DPP is a program that provides qualifying providers with additional dollars as an access fee for Medicaid members utilizing their services (inpatient admissions or outpatient visits). Payments to providers will be based upon member utilization of services at each provider during the year.

This is a methodolgy change from SFY16 which was an Upper Payment Limit (UPL) reimbursement through fee-for-service which was not permitted to be transfered under Medicaid managed care. The Expansion (WVHB) population was carved into manged care in July of 2015 and SSI population carved in January 2017. CMS regulations in 2016 continued the general prohibition on pass-through payments in managed care but they also allow exceptions based on "the delivery of services, utilization, and the outcomes and quality of the delivered services." The DPP payments under the new methodolgy began for SFY17 and forward.

SFY18 Methodology

The State determines the annual funding which is then allocated into further buckets based upon the following:

1. Category of Aid (COA) – TANF, TANF Pregnant Women (PW), Expansion, and SSI
2. Category of Service (COS) – Inpatient Admissions and Outpatient Visits
3. Provider Resource Group (PRG) – Rural Non-Safety Net, Urban Non-Safety Net, and Rural Safety Net, Urban Safety Net

No additional DPP funds will be applied to the maternity kick payments. Dental and behavioral health services are excluded from the Directed Payments requirement.

See **Appendix A** for a list of qualified providers and their provider resource group.

SFY18 Annual Estimated DPP Allocation Amounts
The SFY18 capitation rate development cost base data was used to calculate the Allocation Amounts by COA and COS. The base data dollars used for the calculations are completed and blended of two base years.

Allocation Amount calculations use the distribution of inpatient and outpatient dollars combined by each COA. Using these distributions, providers' DPP dollars were allocated into

the relevant Allocation Amounts. Lastly, those buckets are further divided out into the four Provider Resource Groups based on historical payments.

Table 1 shows the estimated annual DPP Allocation Amounts for SFY18 by COA, COS, and Provider Resource Groups.

Table 1
SFY18 Quarterly Estimated DPP Allocation Amounts

Provider Resource Group	Inpatient	Outpatient	Total
TANF			
Rural Non-Safety Net	$651,716	$899,988	**$1,551,704**
Urban Non-Safety Net	$1,147,850	$1,585,126	**$2,732,976**
Rural Safety Net	$1,010,226	$1,395,075	**$2,405,301**
Urban Safety Net	$3,278,781	$4,527,840	**$7,806,621**
Total	**$6,088,573**	**$8,408,029**	**$14,496,602**
TANF Pregnant Women			
Rural Non-Safety Net	$201,147	$86,206	**$287,353**
Urban Non-Safety Net	$354,275	$151,832	**$506,107**
Rural Safety Net	$311,798	$133,628	**$445,426**
Urban Safety Net	$1,011,969	$433,701	**$1,445,671**
Total	**$1,879,189**	**$805,367**	**$2,684,556**
Expansion (WVHB)			
Rural Non-Safety Net	$925,275	$1,718,368	**$2,643,644**
Urban Non-Safety Net	$1,629,663	$3,026,518	**$4,656,181**
Rural Safety Net	$1,434,272	$2,663,648	**$4,097,920**
Urban Safety Net	$4,655,059	$8,645,110	**$13,300,170**
Total	**$8,644,270**	**$16,053,645**	**$24,697,915**
SSI			
Rural Non-Safety Net	$695,393	$568,958	**$1,264,351**
Urban Non-Safety Net	$1,224,778	$1,002,091	**$2,226,869**
Rural Safety Net	$1,077,931	$881,944	**$1,959,875**
Urban Safety Net	$3,498,523	$2,862,428	**$6,360,951**
Total	**$6,496,625**	**$5,315,421**	**$11,812,046**

Note there may be some rounding differences dividing the annual amount into four quarters.

Provider Distribution and Payment Calculations

Next, a fixed dollar amount is assigned to each service type and for each Provider Resource Group by COA using actual provider utilization. Quarterly reports from the State data warehouse were used to calculate the retrospective lump sum payments BMS will make to each MCO to be distributed to eligible providers. The reports summarize utilization of MCO paid services rendered to their Medicaid members including sub-capitation arrangements. The utilization was reported by the program COA and COS buckets by each qualified provider. There are three months of paid run-out after the end of each quarterly timeframe to ensure appropriate count of qualified rendered services.

The distribution of service utilization is calculated by eligible providers within each Provider Resource Group and by MCO. Then those service utilization distributions are applied to the Allocation Amounts to calculate the total dollars by each eligible provider and MCO.

Directed Payments to Providers
The Department will pay the MCO the annual access payment for each qualified provider that is based on utilization of inpatient admits or outpatient services. The Department's annual access payments are made as retrospective quarterly lump sum payments.

The MCO shall make payments to qualified providers based on the number of inpatient admits and/or outpatient visits. The directed access payments must be sent to qualified providers within 15 calendar days after the MCO receives the amounts from the Department. These payments are in addition to any amount the MCO is required by agreement to pay for the provision of services under the Contract.

Table 2 shows the anticipated payment schedule for SFY18 by quarter.

Table 2
Anticipated SFY18 Quarterly DPP Payment Schedule

SFY18 Quarter Utilization Experience	3 Month Paid Run-out	Data Collected, Calculations Completed, and Appropriations Released *(60-75 days)**	MCO Payments to Providers *(15 days)*
Q1	12/31/17	Mid-February 2018	Delivered: June 30, 2018
Q2	3/31/18	Mid-May 2018	Delivered: August 17, 2018
Q3	6/30/18	Mid-September 2018	Early October
Q4	9/30/18	Mid-December 2018	Early January 2019

* Calculations and payments are later compared to previously communicated due to the time required to get into State's shared data warehouse for summarization.

In SFY18, dollars were added to the program for the SSI population and the Enhanced Payment Program (EPP) for all populations.

Provider Payment Exhibit Example

Below is an example of the provider payment exhibit with a walk-through of the calculations. In this example, we will look at the Outpatient COS for "Provider ABC" who classifies as Provider Resource Group "xyz".

The final payments by MCO are highlighted in yellow in the top total section (cells D2 to D5). These dollars are a sum of the COAs sections below the total section (so $4,525 in D2 = D9 + D16

+D23). The following steps outline the calculation for all COAs (they line up with the steps in the example table):

1. Units by MCO for this COA, COS and PRG are summarized in the first column.
2. The provider's distribution of units to the total units incurred across all providers for the COA and PRG is calculated.
3. The provider's total payment is calculated using the percentage in step 2 above and the total Allocation Amount for the COA, COS, and PRG.
4. Total step 3 dollars are distributed based on MCO unit distribution in column (C).

SFY17 Provider Payments - EXAMPLE

Provider ABC

PRG: xyz

November '17 paid run-out

		OP		
	Population & MCO *(A)*	**Units** *(B)*	**Dist** *(C)*	**Dist. Dollars** *(D)*
1	**Total**			
2	MCO 1	210	22%	$ 4,525
3	MCO 2	225	23%	$ 6,063
4	MCO 3	220	23%	$ 5,550
5	MCO 4	305	32%	$ 7,850
6	**Grand Total**	**960**	*100.0%*	**$ 23,988**
7	PRG Grand Total	4,700		*$ 100,000*
8	**TANF**			
9	MCO 1	150	29%	$ 2,625
10	MCO 2	75	14%	$ 1,313
11	MCO 3	100	19%	$ 1,750
12	MCO 4	200	38%	$ 3,500
13	**Total TANF**	**525**	*100.0%*	**$ 9,188**
14	PRG Total	2,000	*26.3%*	*$ 35,000*
15	**Pregnant Women**			
16	MCO 1	10	12%	$ 1,000
17	MCO 2	25	29%	$ 2,500
18	MCO 3	20	24%	$ 2,000
19	MCO 4	30	35%	$ 3,000
20	**Total Pregnant Women**	**85**	*100.0%*	**$ 8,500**
21	PRG Total	200	*42.5%*	*$ 20,000*
22	**Expansion**			
23	MCO 1	50	14%	$ 900
24	MCO 2	125	36%	$ 2,250
25	MCO 3	100	29%	$ 1,800
26	MCO 4	75	21%	$ 1,350
27	**Total Expansion**	**350**	*100.0%*	**$ 6,300**
28	PRG Total	2,500	*14.0%*	*$ 45,000*

1. Provider ABC Total TANF OP visits are 525 across all four MCOs.

2. Those visits are 26.3% of the total visits . *(525 / 2,000)*

4. The $9,188 for the provider is allocated by the MCO's distribution. So "MCO 3" will pay $1,750. *($1,750 = 19% * $9,188)*

3. Since the provider has 26.3% of the total PRG units for OP, then 26.3% of the PRG Allocation Amount of $35,000 is distributed to them. *($9,188 = $35,000 * 26.3%)*

Note there may be small differences due to rounding. This is repeated for all COS and funding streams (traditional DPP and EPP) to calculate the final provider payments by MCO.

Appendix A – Qualified Providers and Provider Resource Groups

Urban Safety Net
Cabell-Huntington
CAMC
Ohio Valley General Hospital
St. Mary's
WVU Hospitals *(EPP dollars only)*
Wheeling Hospital

Urban Non-Safety Net
Camden-Clark Memorial Hospital
City Hospital Inc.
Monongalia General Hospital
Reynolds Memorial Hospital
St. Francis
Thomas Memorial Hospital
Weirton Medical Center

Rural Safety Net
Beckley ARH
Bluefield Regional Medical Center
Davis Memorial Hospital
Fairmont General Hospital Inc.
Greenbrier Valley Medical Center
Logan Regional Medical Center
Pleasant Valley Hospital
Stonewall Jackson Memorial Hospital
Summersville Regional Med Center
Welch Community Hospital
Wetzel County Hospital
Williamson Memorial Hospital

Rural Non-Safety Net
Princeton Community Hospital
Raleigh General Hospital
United Hospital Center