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## KCMU Medicaid Benefits Database: Definitions for Frequently Used Reimbursement Methodologies

**Fee for Service** – Payment methodology that generally refers to an established maximum payment amount for a particular component of a service or an established percentage (sometimes 100%) of the maximum applicable to the Medicare program for the service. The state then generally pays the lesser of the provider’s charge or this amount.

**Cost based payment** - Payment methodology that typically requires a year-end settlement process or some documentation of actual cost is required to justify payment. Institutional providers may be paid using this methodology.

**Prospective Payment** - Payment methodology where payment rates are generally based on historical cost, though year-end settlement or documentation of actual cost may not be required. Institutional providers may be paid using this methodology.

**Percentage of Charge** - Payment methodology that uses a “percentage of charge” to reflect cost, typically using some documentation of a provider’s historical cost to charge ratio. Institutional providers may be paid using this methodology.

**Per Diem** - Payment methodology that makes payment for each day of care. Institutional providers such as nursing facilities may be paid using this methodology.

**Per Discharge** - Payment methodology that makes a single payment for an episode of care, such as a hospitalization or a surgical procedure provided in a freestanding ambulatory surgery center or birth center. In some cases the payment includes all services and is “all-inclusive” or “global”, and in others, certain ancillary services can be billed separately.

**Diagnosis Related Groups (DRGs)** - Payment methodology often used to reimburse hospitals; the payment methodology establishes payment by the diagnosis of the patient, procedures performed and duration of stay. DRGs are the most common, but different DRG models in use across the states. Some states use the Medicare Severity DRGs (MS-DRGs); other states use All Patient DRGs (AP-DRGs) or All Patient Refined DRGs (APR-DRGs). Some states use “case-mix”, the average acuity level of a hospital’s patients compared to its peers, to adjust payment.