Maine DHHS
Rate Setting

Michelle Probert, Director
Office of MaineCare Services
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Rate Setting Overview

The Rate Setting unit:

- Is responsible for determining adequate methods of reimbursement for DHHS services that are provided by designated agencies.

- Works with Department program staff, such as MaineCare Services, to develop and implement rate methodologies for the reimbursement of services.

- Has the goal to develop rates that will be cost effective and affordable while meeting the needs of the service delivery system.

Medicaid Payment Methodologies Overview

States can establish their own Medicaid provider payment rates within federal requirements, and generally pay for services through fee-for-service or managed care arrangements.

Section 1902(a)(30)(A) of the Social Security Act requires that such payments be consistent with efficiency, economy, and quality of care, and are sufficient to provide access to the general population.

To change the way they pay Medicaid providers, states must submit a State Plan Amendment to CMS for approval. The State Plan includes individuals to be covered, services to be provided, methodologies for provider reimbursement, and administrative activities.

Types of Payment

Payment Type	Service Examples
Fee For Service (FFS)	Physician services, Physical Therapy and Occupational Therapy Services
Per diem	Adult Family Care Home Services, PRTF Services, Agency Group Homes (Section 21), IOP services.
Per Member Per Month (PMPM)	Health Home Services, Non-Emergency Transportation
Per discharge	Psych sub-units services
Encounter rates	Indian Health Services (IHS), Rural Health Centers (RHC), Federally Qualified Health Centers (FQHC)
Bundled rates (e.g. DRGs, APCs)	Maternity, non-Critical Access inpatient and outpatient services

Diagnosis Related Groupings (DRGs) and Ambulatory Payment Calculations (APCs):
Ambulatory payment classifications (APCs) are the reimbursement methodology used for outpatient services in acute care hospitals, and DRGs are reimbursement for inpatient services.

APCs and DRGs cover only the hospital fees (not the professional fees) associated with a hospital outpatient visit or inpatient stay. These do not apply to Critical Access Hospitals.

Types of Methodology

Payment Methodology	No. of MaineCare Policies	Policy examples
Based on a % of current Medicare, updated regularly	8	Hospital Services, PT/OT, Durable Medical Equipment
Based on a percent of Medicare for a static year, unless current Medicare is lower	2009: 5, 2005: 2	Laboratory Services, Physician Services, Podiatry Services
Legacy rate (not based on recent data)	15	Private Duty Nursing, Behavioral Health Services, Chiropractic Services, Day Health Services

There are several MaineCare policies that include more than one type of reimbursement methodology within a single policy.

Types of Methodology

Payment Methodology	No. of MaineCare Policies	Policy examples
Contracted entity recommends/sets/negotiates rates, with provider input or based on actuarial assessment	4	Dental Services, Non-Emergency Transportation
Recent independent rate study	1	Rehabilitative and Community Support for Children with Cognitive Impairments and Functional Limitations
Base fee adjusted by resource use/assessment/case mix/other adjustments. Includes reimbursement based off a base year or submitted budget/cost documents regularly from providers. May or may not be cost settled*.	8	Federally Qualified Health Centers, Rural Health Centers, Hospital Services

Cost Settled: *Providers are given prospective interim payments to cover the cost of care and then an audit is conducted to settle actual costs against the interim payments that were received.*

There are several MaineCare policies that include more than one type of reimbursement methodology within a single policy.

Types of Methodology

Payment Methodology, Continued	No. of MaineCare Policies	Policy Examples
Average of other states' rates when other methodologies are not available (e.g. not a Medicare-covered service)	6	Genetic testing labs, Physician Administered Drugs
Federally set rate	1	Indian Health Services
Internal rate assessment (ongoing or static), may or may not be provider specific. Based on collecting state and national data and setting more fixed rates	9	Health Homes, Behavioral Health Homes, Opioid Health Homes, Behavioral Health Services, Hospital Discharge Rates
Priced by prior authorization	5	Durable Medical Equipment, Dental Services
Various industry standards	1	Pharmacy Services

There are several MaineCare policies that include more than one type of reimbursement methodology within a single policy.

Frequency & Reasons for Rate Reviews

- Federal requirements, such as 21st Century Act, ACA's Primary Care Rate Increase, Access Monitoring Review Plan (*can* lead to rate changes)
- Legislative mandate
- Formal rate reviews, such as the FY 16/17 Burns and Associates Rate Review of Sections 13, 17, 28, 65
- Internal reviews
- Provider and stakeholder feedback

Rate Review Frequency*	Number of MaineCare Policies
Quarterly	3
Annually	27
No set schedule	21

**Rate reviews can occur without resulting in any changes to reimbursement*

Rates Established Before 2015

Within each MaineCare policy, rates for services can be changed on an individual basis, meaning that some policies have rates that have not been updated as recently as others.

Historical Snapshot	
Year of rate change	**Number of policies**
2005	2
2009	10
2010	2
2011	1
2012	3
2013	1
2014	1
Total number of policies with some rates established before 2015: 20	

Examples of Recent Legislation

LD 924, ***An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government***
Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder Section 96, Private Duty Nursing
LD 925, ***An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government***
Section 12, Consumer-Directed Attendant Services Section 13, Targeted Case Management Section 17, Community Support Services Section 23, Developmental and Behavioral Clinic Services Section 26, Day Health Services Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations Section 65, Behavioral Health Services Section 67, Nursing Facility Services Section 97, PNMIs
LD 687, Resolve, ***Regarding Reimbursement for Speech and Language Pathology Services***
Section 109, Speech and Hearing Services
LD 1776, ***An Act To Implement the Recommendations of the Commission To Study Long-term Care Facilities***
Section 67, Nursing Facility Services

Upper Payment Limit (UPL) Demonstration

Federal UPL policy prohibits federal matching funds for fee-for-service payments in excess of what would have been paid by Medicare. This ensures that MaineCare does not pay providers more than Medicare would have paid for the same or comparable services delivered by those same institutions. States must submit UPL demonstrations annually and demonstrate that they are either:

- Paying no more than Medicare (i.e., for Clinic, Physicians or DME), or

- Paying no more than the cost of providing the service (i.e., Hospitals and Residential providers).

Upper Payment Limit (UPL) Demonstration

Services Included in UPL	
Hospitals	Inpatient Services, Outpatient Services, Institutions for Mental Disease (IMDs)
Residential Providers	Nursing Facilities, Intermediate Care Facilities, Psychiatric Residential Treatment Facilities*
Other Services	Clinics (ambulatory care clinics, ambulatory surgical centers, dialysis clinics, Sections 17, 23, and 65 mental health clinics, family planning clinics, and substance abuse clinics, qualified practitioners (physicians), Durable Medical Equipment (DME)
** There are currently no enrolled PRTFs*	

Other States' Methodologies

MA: Rate determination annually for institutional providers and biennially for non-institutional providers, use of peer group cost analyses, ceilings on capital and operating costs, use of national or regional indices to measure increases or decreases in reasonable costs

NH: Quarterly (review), use of all payer claims database for benchmarking

MO: Consistent Medicare benchmark for FFS physician services (benchmark has increased over time)

Other States' Methodologies, Cont.

CO: Standard process to establish many rates for HCBS waiver services:

1. Identifies inputs for each service under review (salaries, facility overhead, administrative and capital) and uses standard principles and provider input to establish prices and assumptions (e.g. staffing ratios) in rate building

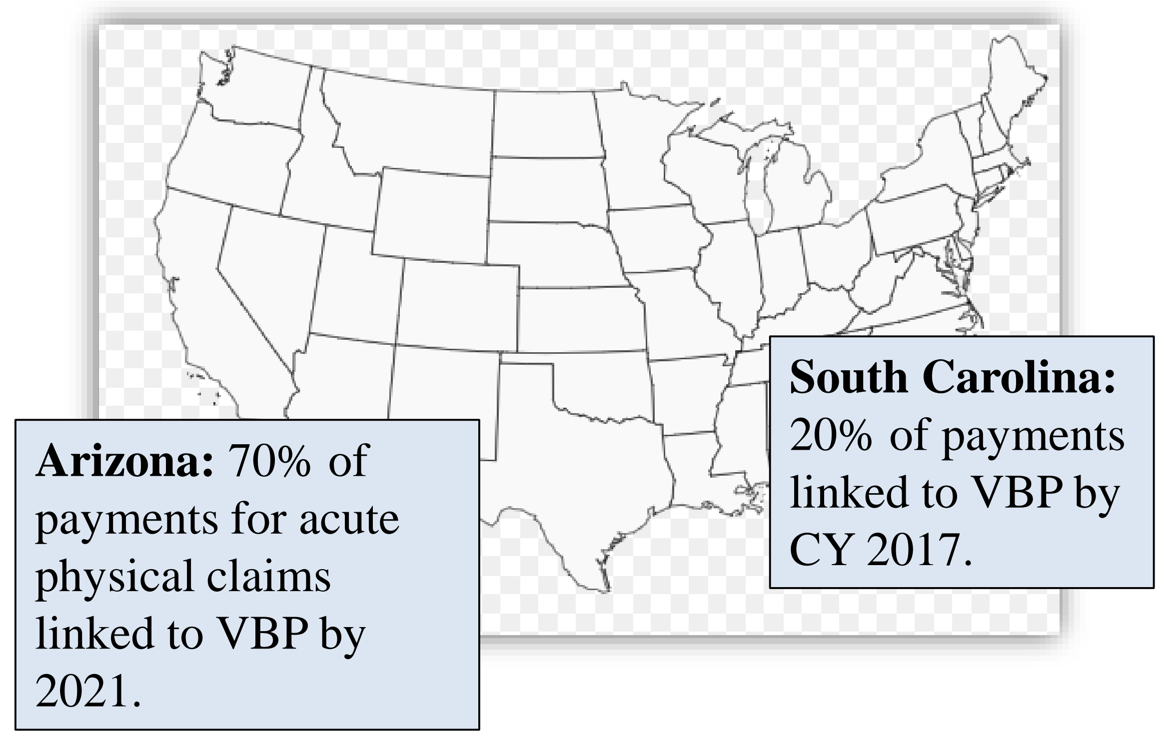
2. Compares rate across all other states offering similar services.

3. Provides stakeholders information on the current service rate, the rate according to the new methodology, and what adjustments had to be made for the rate to fit within a pre-determined budget. Stakeholders have one month to provide feedback.

4. Conducts follow-up research and incorporates validated feedback into rates.

Other States – APMs / Value-Based Purchasing

- Over 17 states have already set APM or VBP goals.
- States can provide financial (e.g. bonus payments) or non-financial incentives to increase VBP.
- States can design goals around specific services, health conditions, level of APM achieved, total dollars in APM, or even how many Medicaid or multi-payer members are included in the model.



MaineCare's APMs

CATEGORY 2 **FFS, link to quality & value** Primary Care Provider Incentive Payments	CATEGORY 3 **APMs built on FFS architecture**	CATEGORY 4 **Population-based payment**
A	A	A
Foundational payments for infrastructure & operations Primary Care Case Management and Health Homes (Section 91)	**APMs with Shared Savings** (e.g. shared savings with upside risk only) Accountable Communities	**Condition-Specific Population-Based Payment** Behavioral Health Homes (Section 92)
B	B	B
Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	**APMs with Shared Savings and Downside Risk** (e.g. episode-payments for procedures and comprehensive payments with upside and downside risk)	**Comprehensive Population-Based Payment** (e.g. global budgets of full/percent of premium payments)
C		C
Pay-for Performance (e.g. bonuses for quality performance)		**Integrated Finance & Delivery Systems** (e.g. global budgets or full/percent of premium payments in integrated systems
	N	N
	Risk based payments NOT linked to quality	Capitated payments NOT linked to quality Opioid Health Homes (Section 93)

Potential Future Payment Models

Align with national movement toward value-based payments and delivery system reform

- Engage with stakeholders to set targets for MaineCare-wide performance on cost, quality, value-based payment implementation.
- Develop a roadmap to achieve these targets (e.g. principles, activities, process, milestones).
- Pursue technical assistance and funding opportunities to assist stakeholders in transitioning to value-based care.
- Improve linkage of data across different sources to more comprehensively evaluate quality and cost.

Questions?

Michelle Probert
Director of MaineCare Services
michelle.probert@maine.gov
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