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# Medicaid Provider Rate Setting

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# Agenda

1. Fee-for-Service Rate Setting
2. Recent Final Rule Publications Impact on Provider Rate Setting
3. Medicaid Agency's Discretion to Dictate Rates

# Fee-for-Service Rate Setting

# Fee-for-Service Provider Rate Setting

- Section 1902(a)(30)(A) of the Social Security Act requires that payment rates "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 that such care and services are available to the general population in the geographic area."
- 42 CFR §430.10 states that "State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV (42 CFR §430 through 42 CFR §600), and other applicable official issuances of the Department (CMS)."
- Fee-for-Service (FFS) Rates are included in the State Plan as follows:
  - Attachment 4.19-A: Inpatient Hospital Services
  - Attachment 4.19-B: Other Types of Care or Services including Outpatient Hospital Services, Physician Services, Pharmacy Services, Clinic, Non-Institutional Services)
  - Attachment 4.19-D: Nursing Facilities and Intermediate Care Facilities

# FFS Provider Rate Setting

## Need for Provider Rate Setting Reform and Update

MaineCare Rate Reform
Overview

Presented to the Health and Human Services Committee

MaineCare Director Michelle Probert

March 23, 2023

- Rates in over 40% of MaineCare policies had no schedule for review
- Rates in almost 40% of MaineCare policies had not been updated since prior to 2015
- Rates in almost 30% of polices were “legacy rates” for which no methodology is available

# FFS Provider Rate Setting

## Components for Calculating FFS Provider Rates

- Cost Reports
  - Medicare Cost Reports
  - State Specific Medicaid Cost Reports
- Cost Studies
- Percentage of Medicare
- Comparisons to Other States
- Policy Adjustments for Specific Diagnosis
- Claims Data
- Salary Specific Information (Bureau of Labor Statistics [BLS])
- Inflation Factors

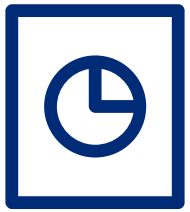
# Example of Provider Rate Setting

# Key Components of a DRG Payment Methodology

# Components of Base Rate Development

Inpatient Hospital Base Rate Calculation Using DRG Methodology

FFS Claims and/or Encounter Data from MMIS System



Cost Report Cost Per Diems and Cost-to-Charge Ratios

Develop Pools for Transfers and Outlier Payments

Funding Available for Base Rates

Determine Discharges, Case Mix, and Inflation Factors

Base Rate Development

# Recent Final Rule Publications Impact on Provider Rate Setting

# Final Rule — Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 430, 438, and 457**

**[CMS–2439–F]**

**RIN 0938–AU99**

**Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

**ACTION:** Final rule.

- Published in the Federal Register on May 10, 2024 (2024-08085.pdf (govinfo.gov)). Displayed on CMS Website on April 22, 2024
- Codify existing CMS expectations that payment levels for certain providers not exceed the average commercial rate (ACR)
  - Inpatient hospital services
  - Outpatient hospital services
  - Qualified practitioner services at an academic medical center
  - Nursing facility services
  - These proposals would require an ACR demonstration and a total payment rate comparison to the ACR annually

# Final Rule — Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

## Comparative Rate Analysis

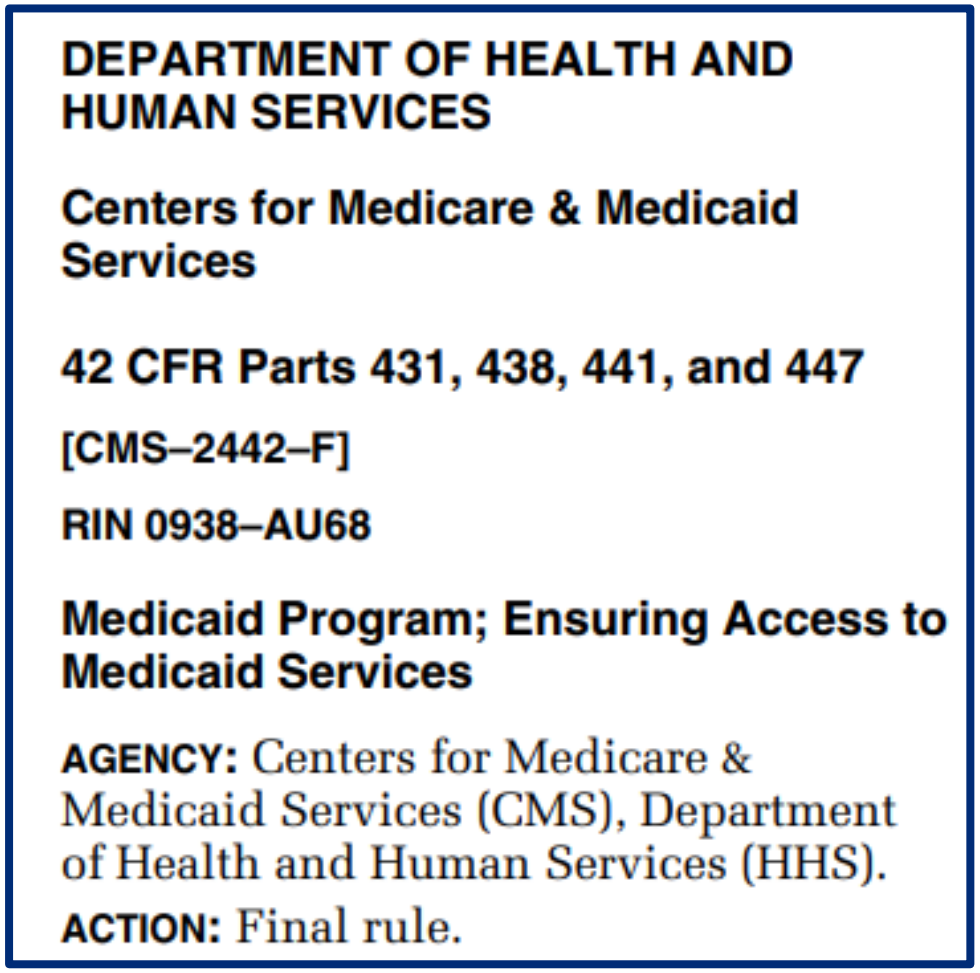
- The Final Rule requires Medicaid and CHIP MCOs to complete and states to report to CMS annual provider payment rate comparison analyses for:
  - Primary care, OB/GYN, mental health, and substance use disorder (SUD) services relative to Medicare;
  - Homemaker, home health aides, personal care services, and habilitation services relative to Medicaid fee-for-service.
- The payment rate analyses must consider adult and pediatric rates separately. Separate reports required if difference in payment levels
- The comparative rate analyses will be based on paid claims data from the immediate prior rating period
- Effective for the rating period starting two years after July 9, 2024

# Final Rule — Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

## Upcoming Timeline for Implementation

| | |
|---|---|
| State Directed Payments (SDPs) following a Medicare fee schedule no longer require a preprint | July 9, 2024 (Effective Date of Rule) |
| ACR analysis required for preprint approval | First contract/rating year period after July 9, 2024 (i.e., January 1, 2025–July 1, 2025, depending on methodologies the state-specific contract/rating year) |
| SDP cost percentage reporting | First contract/rating year period after July 9, 2024 (i.e., January 1, 2025–July 1, 2025, depending on methodologies the state-specific contract/rating year) |
| Comparative rate analysis for primary care, OB/GYN, mental health, and SUD services relative to Medicare | First contract/rating year period after July 9, 2026 (i.e., January 1, 2027–July 1, 2027, depending on state-specific contract/rating year) |
| Comparative rate analysis or homemaker, home health aides, personal care services, and habilitation relative to Medicaid FFS | First contract/rating year period after July 9, 2026 (i.e., January 1, 2027–July 1, 2027, depending on state-specific contract/rating year) |

# Final Rule — Ensuring Access to Medicaid Services



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Parts 431, 438, 441, and 447**

**[CMS–2442–F]**

**RIN 0938–AU68**

**Medicaid Program; Ensuring Access to Medicaid Services**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

**ACTION:** Final rule.

- Published in the Federal Register on May 10, 2024 (2024-08363.pdf (govinfo.gov)). Published on CMS website on April 22, 2024
- FFS Payment Rate Transparency and Comparative Rate Analyses
- HCBS and MLTSS Payment Rate Transparency and Comparative Rate Analyses

# Final Rule — Ensuring Access to Medicaid Services

## FFS Payment Rate Transparency and Comparative Rate Analyses

### Publicly Accessible Fee Schedules

States must post all FFS Medicaid fee schedules on a publicly accessible website, including when rates differ by various demographic factors.

In cases where Medicaid programs use bundled payment rates, states are required to identify each individual service included in the bundled rate and how much of the payment is allocated to each respective service.

### Comparative Rate Analysis

States must complete comparative FFS reimbursement rate analyses for primary care, OB/GYN, and outpatient behavioral health services relative to Medicare rates in the same manner as managed care organizations must complete an analysis in the Managed Care Rule.

### Payment Rate Disclosure

States must post rates for personal care, home health aides, homemaker services, and habilitation services converted into hourly rates.

# Final Rule — Ensuring Access to Medicaid Services

## FFS Payment Rate Transparency and Comparative Rate Analyses — Upcoming Timeline for Implementation

| | |
|---|---|
| Post and maintain publicly accessible Medicaid fee schedules | July 1, 2026, then updated within 30 days of a payment rate change |
| Comparative rate analysis for primary care, OB/GYN, and outpatient behavioral health services | July 1, 2026, then every two years |
| Publish the average hourly rate paid for personal care, home health aide, homemaker, and habilitation services, and publish the disclosure every two years | July 1, 2026, then every two years |
| Establish an advisory group on payment rates for direct care workers for personal care, home health aide, homemaker, and habilitation services | First meeting must occur by July 9, 2026 and then at least every two years |

# Final Rule — Ensuring Access to Medicaid Services

## HCBS and MLTSS Payment Rate Transparency and Comparative Rate Analyses

### Payment transparency and reporting

- States are required to report on hourly reimbursement rates for personal care, home health, homemaker services, and habilitative services.
- Rate information must be reported by categories of service and separated for individual direct care workers and those employed by an agency.
- Additional reporting is required on the number of paid claims and number of participants using HCBS.

### Minimum of 80% of Medicaid payment for personal care, homemaker, and home health aide services must be spent on direct care worker compensation

- The Rule defines “compensation” as salaries and wages, worker benefits (e.g., health and dental benefits, sick leave, and tuition reimbursement), and employer share of payroll taxes.
- States are also required to report on their readiness to report payment rate adequacy of direct care workers prior to when the actual reporting requirements take effect.

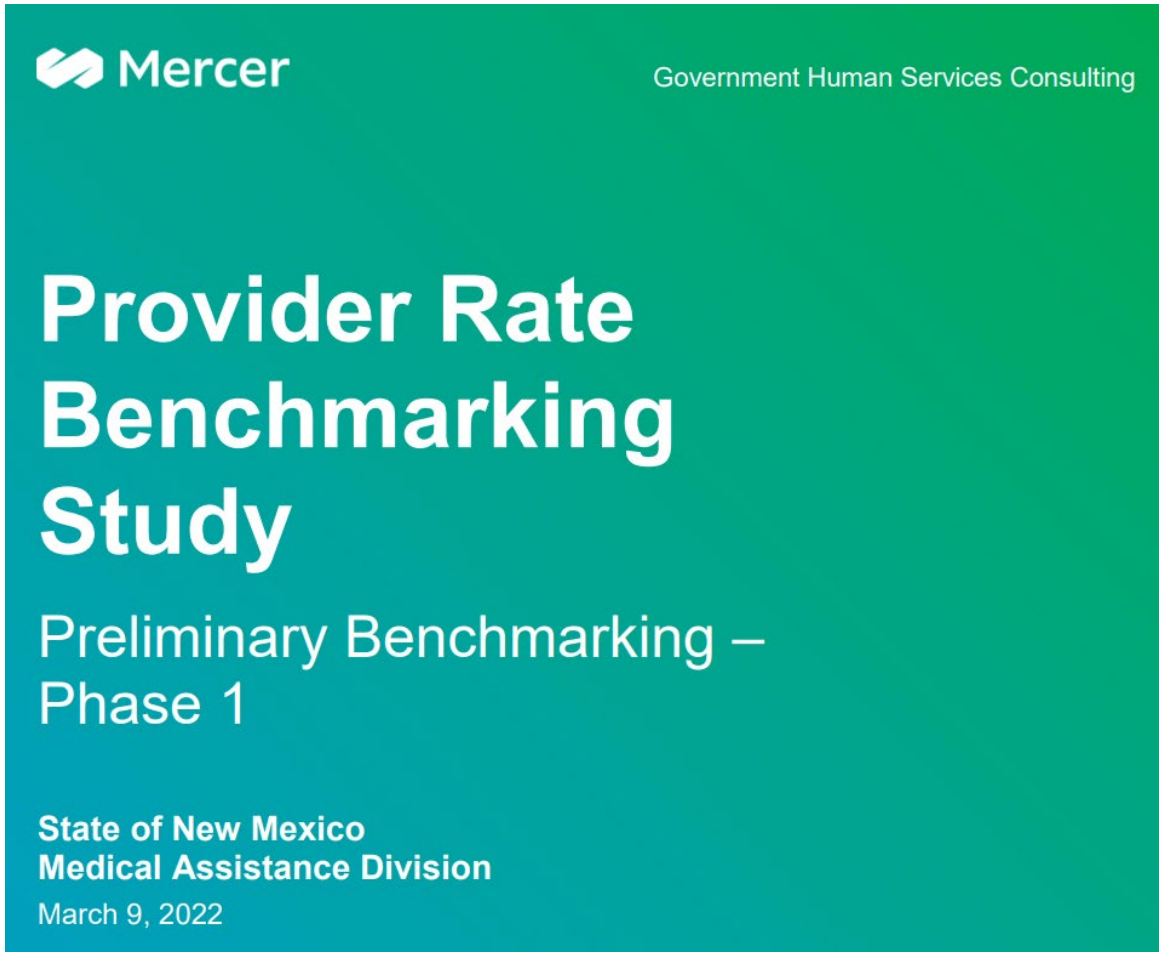
# Final Rule — Ensuring Access to Medicaid Services

## HCBS and MLTSS Payment Rate Transparency Implementation Timeline

| | |
|---|---|
| State readiness and reporting on compensation for personal care, home health care, homemaker services, and habilitation services | July 9, 2027; for MLTSS, the first rating period following this date |
| Payment rate adequacy reporting requirements for compensation for personal care, home health care, homemaker services, and habilitation services | July 9, 2028; for MLTSS, the first rating period following this date |
| 80% rule for direct care worker compensation (not including habilitation services) | July 9, 2030; for MLTSS, the first rating period following this date |

# Medicaid Agency's Discretion to Dictate Rates

# Comparing FFS Rates to MCO Rates




- Although the managed care organizations (MCOs) are not required to align with FFS fee schedules and negotiate rates with contracted providers, Mercer found that their reimbursement closely compares with FFS in many cases
- In some cases, MCOs paid below FFS, such as many services billed by physicians, BH agencies, and dentists. Some of these differences may be related to different treatment of items such as the state's Gross Receipts Tax
  - The majority of physician and other practitioner services are provided under managed care (91%) and on average, MCOs pay for physician and other practitioner services at 95% of the average FFS payment levels
  - Half of the overall physician expenditures in the managed care program (50%) are for E&M codes, and the managed care expenditures are 101% of the FFS reimbursement.

# Medicaid Agency's Discretion To Dictate Rates Under 42 CFR §438.6(c)(1)(iii)

The State may require the MCO, Pre-Paid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) to:

(A) Adopt a minimum fee schedule for network providers that provide a particular service under the contract using State plan approved rates as defined in paragraph (a) of this section.

(B) Adopt a minimum fee schedule for network providers that provide a particular service under the contract using rates other than the State plan approved rates defined in paragraph (a) of this section.

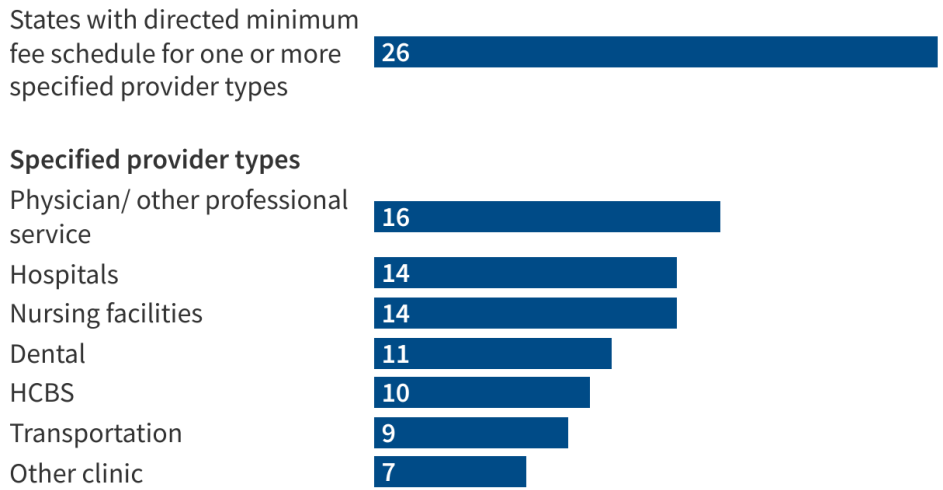
(C) Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

(D) Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

# Minimum Fee Schedules

Figure 9

**About Two-Thirds of States with MCOs and/or PHPs Have a Directed Minimum Fee Schedule For One or More Specified Provider Types.**




Note: Data are as of July 1, 2021. Data are among 40 states with MCOs and/or pre-paid health plans (PHPs). HCBS = Home and Community Based Services. DE, MN, NM, and RI did not respond to the 2021 survey.

Source: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2021. KFF

Source: 10 Things to Know About Medicaid Managed Care | KFF

- **Example #1:** Minimum fee schedule established by the state for primary care services and specialty physician services for the rating period, October 1, 2023 through September 30, 2024, incorporated into the capitation rates through a risk-based rate adjustment. *Total Spend: $300.2 Million.*
- **Example #2:** Uniform dollar increase and minimum fee schedule for home and community-based services and behavioral health outpatient services established by the state for the rating period, July 1, 2024 through June 30, 2025, incorporated into the capitation rates through a risk-based rate adjustment. *Total Spend in SDP: $374.7 Million.*
- **Example #3:** Minimum and maximum fee schedules established by the state for outpatient hospital services for the rating period, July 1, 2024 through June 30, 2025, incorporated into the capitation rates through a risk-based rate adjustment. *Total Spend in SDP: $1.268 Billion.*

# Questions?

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