Maine DHHS
MaineCare Rate System Update

Michelle Probert, Director
Office of MaineCare Services
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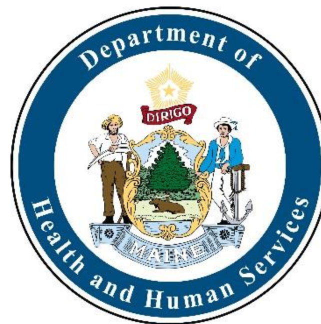


Outline

- Problems with current rate setting system
- MaineCare Comprehensive Rate System Evaluation RFP
- MaineCare Value-Based Purchasing Goals
- Upper Payment Limit (UPL) Update

Current Rate System Challenges

Federal Medicaid Payment Requirements

Section 1902(a)(30)(A) of the Social Security Act requires that states' Medicaid payment rates 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.

Why do we need to reform our current system?

- Does not incent high value care
  - Reliance on Fee for Service and cost reimbursement
  - Over 75% of MaineCare's spend does not have any tie to quality or value
- Outdated
  - Rates in over 40% of MaineCare policies have no schedule for review
  - Rates in almost 40% of MaineCare policies have not been updated since prior to 2015.
- Inconsistent
  - Rates benchmarking Medicare utilize a range of percentages and benchmarks from various different years
- Often no basis
  - Rates in almost 30% of polices are "legacy rates" for which no methodology is available

Why do we need to reform our current system?

- Complex
  - Management of myriad, inconsistent methodologies and different timelines for rebasing and adjustment is very administratively burdensome and difficult for providers and the Department to track.
- Rates increasingly mandated by legislature
  - Outsize impact of advocacy versus evidence-based assessment of sufficiency of rates by service
  - Lack of clear methodologies, in part due to lack of access to data regarding actual cost of services
  - Expectations sometimes inconsistent with timelines and requirements for obtaining state and federal authority
  - Department resources tied up in implementing legislation and cannot proactively address other priorities and system shortcomings
- Increasing CMS emphasis/ scrutiny on rate methodologies

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

Impact of Legislative Mandates: Rulemaking

The passage of LDs 924 and 925 affected 18 different chapters of MaineCare policy, requiring a total of 62 rulemakings.

As part of this rulemaking process, MaineCare received, vetted, and responded to 258 public comments, held 20 public hearings, and required over 700 signatures from state officials.

This resulted in over 6,500 pages being filed with the Secretary of State's Office and, from start to finish, took over 520 days.

MaineCare Comprehensive Rate System Evaluation RFP

Rate System Evaluation: Background & Timeline

In June, the HHS Committee requested the Department report on its efforts to make the MaineCare rate system more rational and transparent.

On January 4, 2020, the Department issued an RFP seeking proposals to perform a comprehensive evaluation of MaineCare's rate setting system and make recommendations for improvement.

TIMELINE

Rate System Evaluation: Process

Conduct Evaluation and Formulate Recommendations

- For each service, compare MaineCare's current payment rates and methods to those for other state Medicaid programs, Medicare, and private insurance.
- Identify services where MaineCare rates and/or payment methods are outliers
- Identify opportunities to introduce additional value-based Alternative Payment Models which use financial incentives to encourage high-quality and efficient services.

Rate System Evaluation: Process, Continued

Develop Plan for a Comprehensive Rate Assessment Process

- Make recommendations on how MaineCare should simplify, streamline, and rationalize its rate setting approaches.
  - Propose process and structure for ongoing rate review, adjustments and rebasing
- Propose priority list of services for rate review in the short- and long-term. This prioritization will incorporate stakeholder input.
- Estimate cost of rate review and of bringing MaineCare's "outlier rates" in line with benchmarks.
- Present recommendations

Concurrent Rate Reviews

This evaluation does not replace ongoing rate studies, nor does it foreclose interim changes.

These targeted efforts will be designed so they integrate with the larger plan once it is complete.

Concurrent Rate Reviews, Continued

Rate reviews planned and/or in process include:

- MaineCare Waiver Services
  - Section 18, Home and Community-Based Services for Adults with Brain Injury
  - Section 20, Home and Community Based Services for Adults with Other Related Conditions
  - 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

Concurrent Rate Reviews, Continued

- Section 65, Behavioral Health Services
  - Section 65, Functional Family Therapy (FFT) & Multi-Systemic Therapy (MST)
  - Section 65, new Intensive Out Patient and Partial Hospitalization services:
    - Mental Health and Co-Occurring Intensive Out Patient (MHIOP)
    - Developmental Disability and Behavioral Health Intensive Out Patient (DDBHIOP)
    - Geriatric Intensive Out Patient (GIOP)
    - Eating Disorder Partial Hospitalization Program (EDPHP)

MaineCare Value-Based Purchasing Programs and Alternative Payment Model Plans

CY2018 MaineCare Alternative Payment Model Results

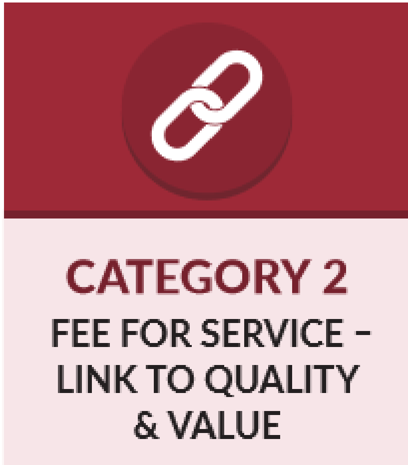
Population-Based Accountability

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment

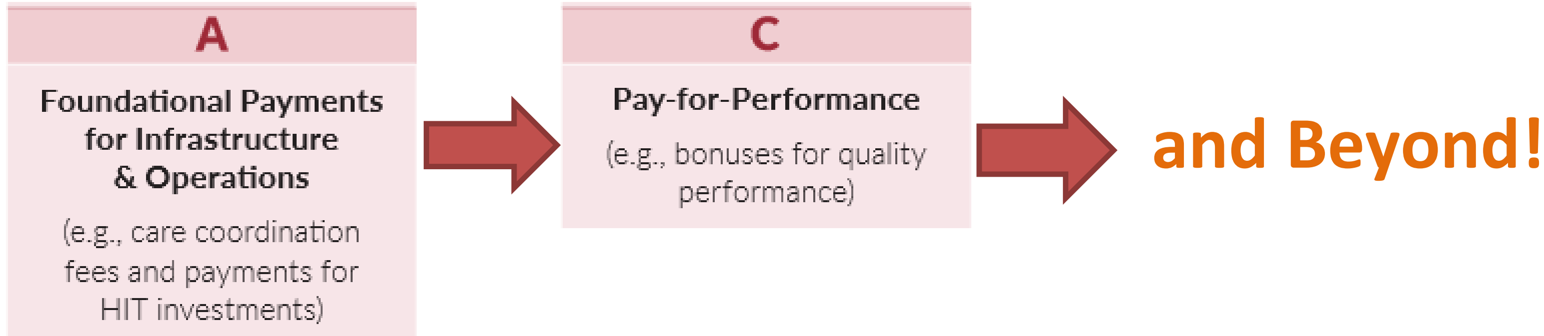
Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

Category 1	Category 2	Category 3	Category 4
	2A: Health Homes	3N: Opioid Health Homes	
	2C: Behavioral Health Homes	3A: Accountable Communities	
78%	4%	18%	0%

Primary Care: MaineCare's Next Steps



1. Grow enrollment in PCCM and Health Homes
2. Explore alignment with Center for Medicare & Medicaid Innovation (CMMI) Primary Care First Initiative
3. Simplify MaineCare's primary care initiatives into one
4. Tie payment to quality for all foundational payments
5. Explore further movement along the APM continuum



Behavioral Health Homes (BHH) Next Steps

CATEGORY 2

FEE FOR SERVICE - LINK TO QUALITY & VALUE

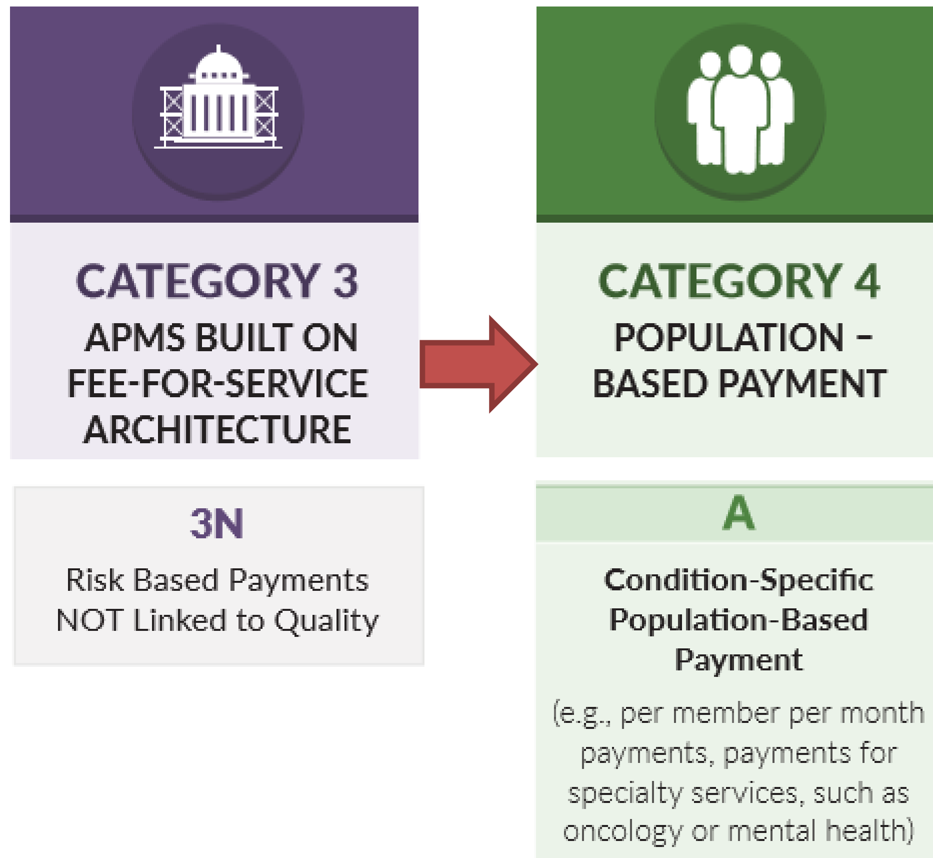
C

Pay-for-Performance

(e.g., bonuses for quality performance)

1. Evaluate BHH Model alongside comparable services (Community Integration, Targeted Case Management)
2. Move toward a more unified model of care coordination for adults with Serious Mental Illness and kids with Serious Emotional Disturbance
3. Re-visit current Pay for Performance model and metric
4. Explore potential for integration of services such as medication management into the model, or for the introduction of a higher level of service to act as a step-down for individuals reeving Assertive Community Treatment (ACT)

Opioid Health Homes (OHH) Next Steps



1. Continue to grow enrollment in program
2. Introduce pay for performance model and metrics
3. Propose additional changes to:
   - Improve access to Opioid Use Disorder treatment
   - Better integrate with primary care
   - Meet the needs of individual members in treatment

Accountable Communities (AC) Performance

First 4 Years of AC Initiative	
Shared Savings payments to 4 AC's	Over $5M
Savings to MaineCare from 4 AC's	Over $30M
Minimum # of ACs who have received shared savings each year	2
Largest shared savings payment to an AC	$1.1M
Range of quality scores for ACs receiving shared savings payments*	72% – 95%

*Includes performance by pediatric-only AC.

Accountable Communities (AC) Next Steps

CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

1. Move ACs toward assumption of downside risk
2. Promote partnership with community-based organizations to move ACs beyond accountability for "traditional" healthcare services to better serve high need members
3. Incent screening and referral for social health needs

What Else?

- MaineCare assessing opportunity for APMs
- CMMI's multi-payer Rural Health Model
- Episodes of care/ bundled payments for maternity, other services
- Provide greater flexibility through bundled payment models with links to quality for:
  - Assertive Community Treatment
  - Care Coordination Services for individuals with Long Term Services and Supports needs

Exploration of UPL Methodology Options

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, or
- Paying no more than the cost of providing the service

The proposed Medicaid Financial Accountability Regulation would change UPLs. We are assessing its implications for Maine

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*	

LD 1838/ Chapter 111

Resolve "that the Department of Health and Human Services shall examine options and methodologies to increase the federally approved upper payment limits for services provided under MaineCare."

- MaineCare contracted with a vendor this fall to examine the option of changing the UPL methodology for Nursing Facilities to a cost-based approach, which raised the maximum allowable limit for NF reimbursement
- MaineCare is engaging with a vendor to examine options for the "clinic" (behavioral health) UPL calculation.

Questions?

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