Maine DHHS
MaineCare Rate System Update

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Outline

- MaineCare's Plan for a Comprehensive Rate System Evaluation
- Problems with current rate setting system
- MaineCare Value-Based Purchasing Goals
- Proposed Medicaid Financial Accountability Regulation (MFAR)
- Upper Payment Limit (UPL) Update

Federal Medicaid Payment Requirements

Section 1902(a)(30)(A) of the Social Security Act: payment rates must be consistent with efficiency, economy, and quality of care, and 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.

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

Proposals due: January 31 , 2020 → Anticipated start date: April 1, 2020 → Anticipated completion date: November 30, 2020

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)

Current Rate System Challenges

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 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

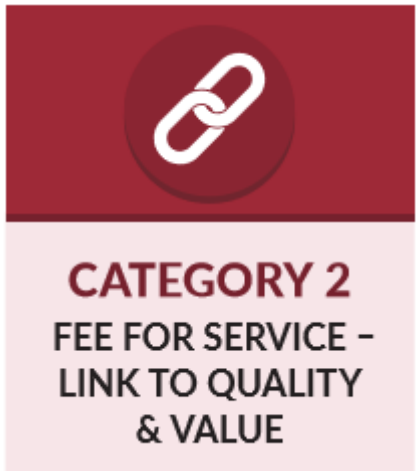
HCP LAN
Health Care Payment Learning & Action Network

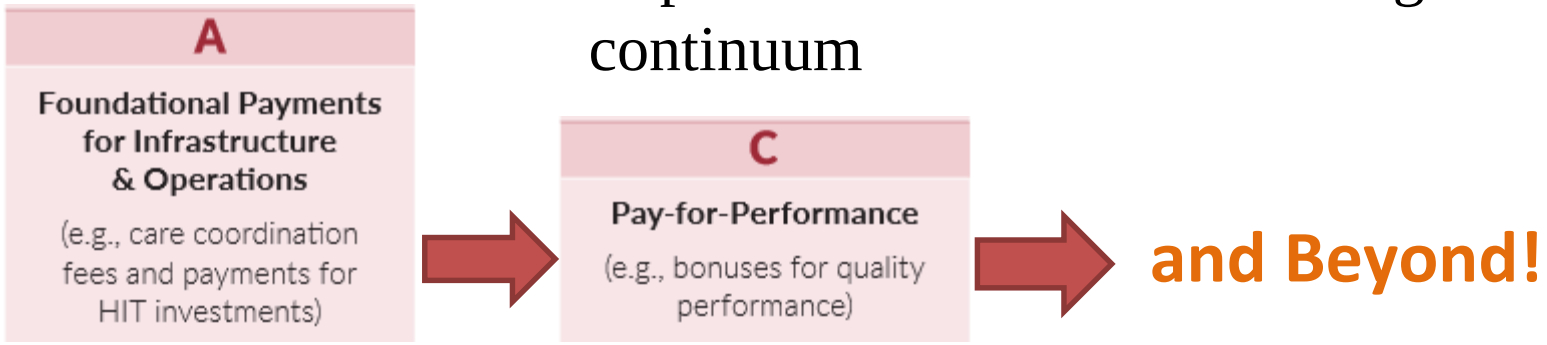
- 2A: Health Homes
- 2C: Behavioral Health Homes
- 3N: Opioid Health Homes
- 3A: Accountable Communities

78% 4% 18% 0%

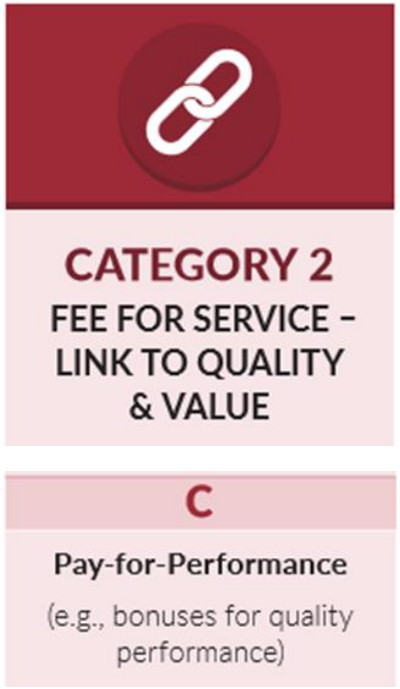
Primary Care: MaineCare's Next Steps

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



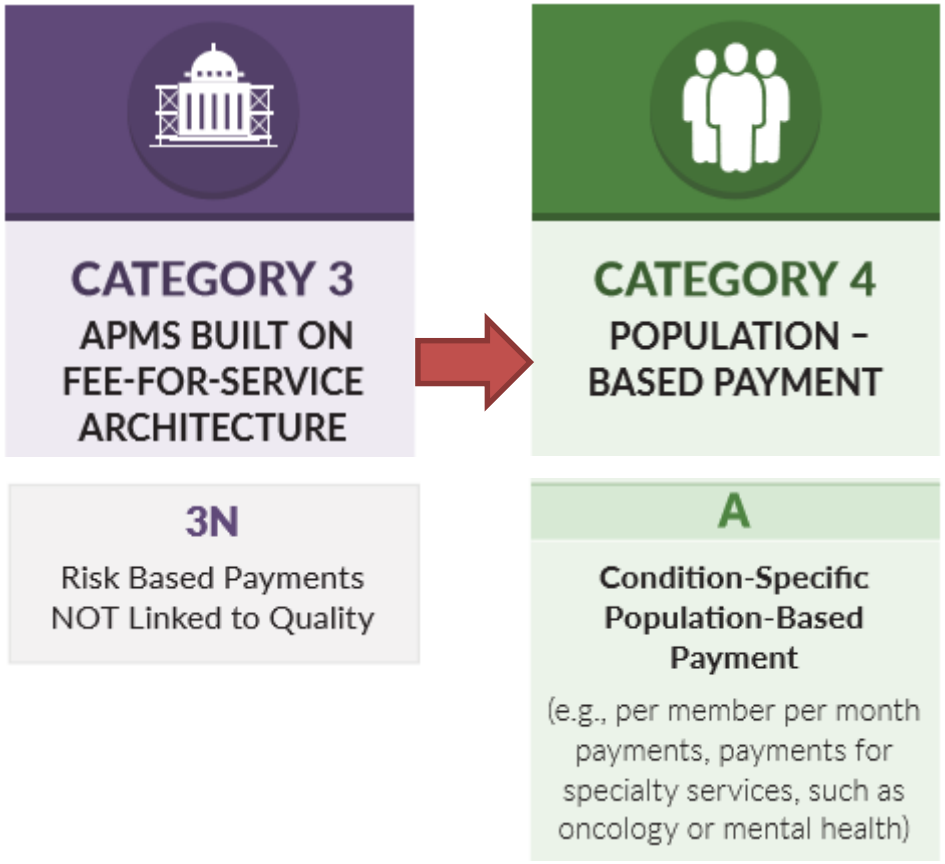


Behavioral Health Homes (BHH) Next Steps



1. Evaluate BHH Model alongside comparable services (Community Integration, Targeted Case Management) to see if a unified service model makes sense.
2. Strengthen current Pay for Performance model
3. Explore:
   - integration of services such as medication management into the model,
   - introduction of a higher level of service to act as a step-down for individuals receiving Assertive Community Treatment (ACT)

Opioid Health Homes (OHH) Next Steps



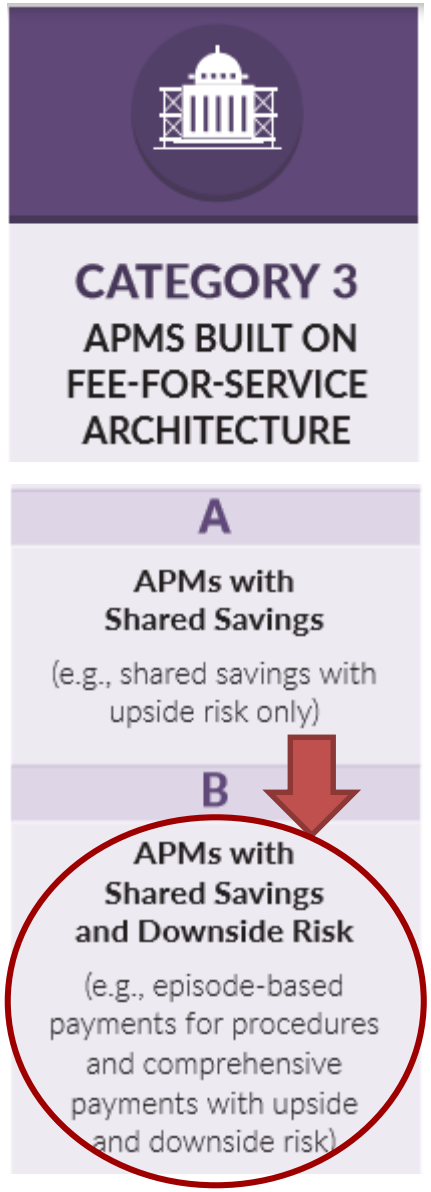
1. Continue to grow enrollment
2. Introduce pay for performance model
3. Propose additional changes:
   - Improve access to treatment
   - Better integrate with primary care
   - Meet the needs of individual members

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



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?

- **Long Term Services & Supports:**
  - Tie nursing facility payments to quality and cost
  - Transition older adult care coordination supports to APM
  - Tie employment supports under Section 21 and 29 to employment outcomes
- **CMMI's multi-payer Rural Health Model**
- **Establish an APM for maternity care**

Proposed Medicaid Fiscal Accountability Rule (MFAR)

MFAR

- **Rule Proposed by CMS November 2019**
- **Target date for finalization: not specified, goal is as early as August 2020**
- **Comments closed February 1, 2020**
- **Almost 4,000 comments received.**

MFAR: Selection of Commenters

- **Maine Department of Health & Human Services**
- **Maine Hospital Association**
- **ADvancing States** (State aging and disability agencies)
- **American Health Care Association** (Nursing Facilities)
- **American Hospital Association**
- **American Medical Association**
- **Center on Budget and Policy Priorities**
- **Children's Defense Fund**
- **National Association of Medicaid Directors**
- **National Governors Association**
- **Medicaid and CHIP Payment and Access Commission (MACPAC)**

MFAR: Common Concerns Nationally

- Elimination of long-standing, previously sanctioned state options for financing, accounting and payments
- Will result in decreased access to care
- Broadness of language makes it difficult for state to ascertain prospectively whether or not payments and policies are in compliance
- Full impact of changes unknown

MFAR: Potential Implications in Maine

- Supplemental Payments
- Health Care Taxes
- Service Provider Taxes
- Allowing taxes as costs under cost settlement and reimbursement rates
- Significant increase in state reporting requirements

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

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*	

UPLs and MFAR

- MFAR would not appear to have implications for Nursing Facility UPLs in Maine
- MFAR would no longer to require states to submit UPL demonstrations for clinics

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
- Given the potential elimination of the clinic UPL, the Department does not recommend exploring alternate calculation options at this time, given the cost of contracting with a vendor to perform the work and the burden on providers of needing to share significant cost data with the Department.

Questions?

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