MassHealth

MassHealth
Provider Rate Setting

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Agenda

Rate Development

a. Purpose & Objective
b. Types of rates and providers
c. Process
d. Data Sources
e. Methodologies and considerations
f. Stakeholders
g. Innovations

Rate Development

Purpose

- MassHealth sets rates of payment for providers that are directly contracted
- Rates are paid to providers for members in the PCC program and FFS
- MassHealth is not a party to contracts and rates of payment paid by MCEs to providers, i.e. MCO, SC, etc.

Rate Development

Objective

- MassHealth's objective is to pay reasonable rates of payment that reflect the cost of providing services by efficient and economically operated facilities and providers, *and*
- Within the financial capacity of the Commonwealth
- Ensure access to services in the communities we serve
- Focus on high quality care
- Transparency
- Comply with all federal and state regulations

Rate Development

Types of rates/providers

1. Institutional
    a. Acute hospitals
    b. Sub-acute-CDR hospitals
    c. Nursing facilities
    d. Private psychiatric hospitals

2. Professional
    a. Physicians
    b. NPs/PAs
    c. MH/SA providers

3. Ambulatory Providers, e.g
    a. CHCs
    b. Clinical Labs
    c. Home Health Services
    d. Others

Rate Development

Process-Institutional providers

- Most institutional rates set by annual contract
  - Acute hospital, Chronic Disease and Rehab RFA, Private psych hospitals (Nursing facility set through regulatory process)
  - Contract rates reviewed and updated annually by MassHealth with assistance from CHIA staff
  - Process Includes:
    - Data identified and Validated
    - Cost review and analysis
    - Methodology review to asses the need for changes
    - Assessment of any new legislative requirements
    - Assessment of budget requirements
    - Prioritization of other rate and program initiatives

Rate Development

Process – Non-institutional providers

- 36 Ambulatory and professional rates set in accordance with regulatory promulgation process- M.G.L 118E Sec. 13C, 13D

  - Multi-step process that can take up to a year from start to finish

  - Process Includes:
    - Analysis
    - Proposal
    - Budget assessment
    - Internal/executive review
    - A&F and Governors office sign-off
    - Public Hearing
    - Review of public comment
    - Re-proposal if changes are made
    - Final Approval
    - Adoption

Rate Development

Data Sources

- Current sources for data
  - Cost Report: (UFRs from the Operational Services Division, CHIA cost reports)
  - MassHealth claims data
  - External benchmarks: Industry studies, salary websites
  - Other Governmental published sources: Bureau of Labor Statistics (BLS), HUD, Medicare fee schedules, other states' Medicaid
  - All Payer Claims Database (APCD)

Rate Development

Methodology

- The statute authorizes several standards and methods which include, but are not limited to, the following:

- Peer group cost analyses
- Ceilings on capital and operating costs
- Productivity standards
- The revision of existing historical costs basis where applicable, to reflect norms of efficient service delivery
- Other means to encourage the cost-efficient delivery of services

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Methodology

- Methodology varies by provider type

- Current Methods used (examples):

  - Cost Report Based Unit Rates
  - Relative Value Based
  - Inflation Adjusted
  - Benchmark to other Payer (e.g. Medicare)
  - Model Budget

Rate Development

Cost Report – Based Unit Methodology

- Numerous provider types, including:
  Nursing Homes, Adult Day Health Programs, Home Health Agencies, Ambulance Companies, Day Habilitation, Community Health Centers, Adult Foster Care, Group Adult Foster Care

- Reports are analyzed
  - Administrative costs
  - Direct care personnel compensation
  - Non- compensation expenses

- Develop several options for consideration
  - Approval of rates by MassHealth
  - MassHealth initiates regulatory process

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Relative Value Based Methodology

- Fee for Service pricing method used primarily for physician services
- A Harvard study for CMS in the 1980s assigned numeric values called Relative Value Units (RVUs) to each service a clinician provides
- The RVUs account for the complexity and expense associated with each service.
- Types of RVUs:
  - **Work RVUs** – measures the time, technical skill and effort, mental effort and judgment, and stress
  - **Practice Expense RVUs** – measures non-physician clinical work, non-clinical work and overhead such as expenses for building space, equipment, and office supplies
  - **Malpractice RVUs** – allocates the cost of malpractice insurance premiums to each service

Payment rate = (RVU Work * GPCI Work) +
(RVU Practice Expense * GPCI Practice Expense) + • CF
(RVU Malpractice * GPCI Malpractice)]

GPCI: Geographic Pricing Index

Rate Development

Inflation Adjusted Using Cost Adjustment Factor

- Cost Adjustment Factors are used to inflate existing rates

- The CAF is calculated using CPI data (quarterly inflation indices). The formula considers the Rate Period and the Base Period of the regulation.

- Prospective CAF: Considers anticipated inflation throughout the effective period of the regulation

- Retrospective CAF: Considers both anticipated inflation throughout the effective period, and unaccounted inflation since the regulation was last reviewed.

  Rate Period: Effective period of the regulation

  Base Period: Varies depending on whether the methodology uses a cost report or inflates the current rate

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Benchmark to Medicare

- Some MassHealth rates are benchmarked to an established standard
- An example of this is professional services are set at 75% of Medicare

Rate Development

Model Budget- Program Based Method

- A program based method builds a model budget that includes all the major cost components of a program.

- The example is a service model budget for a specialty program. Rates were calculated using the following data:

    - Uniform financial reports (UFR)
    - Provider cost estimates
    - Purchaser staffing guidelines
    - Market based salary data (salary.com)

Rate Development

Model Budget- Program Based Method

		FTE	Salary
Staffing	Management	1.32	$66,232
	Medical	1.1	$101,629
	Nursing	10.08	$57,885
	Case Mgmt	8.55	$37,916
	Recovery Sp	10.08	$26,952
	Support	4.99	$28,898
	Taxes & Fringe	23.00%	
	Direct Staffing Total		**$1,873,259**
Other Program Expenses		Wtd Avg Per Unit	
	Travel	$1.58	
	Meals	$11.23	
	Occupancy	$16.31	
	Other program expenses	$2.55	
	Subtotal		**$2,286,047**
Admin	Direct Admin	$4.34	
	Admin M&G	12.00%	
	Total		**$2,607,890**
Final Rate w CAF & Utilization Factor	CAF	5.38%	**2,748,194.48**
	Utilization Factor	87.5%	**2,404,670**
	Utilization	8,384	
	Final Rate		**$286.83**

Rate Development

Considerations

- Member Access
- Data availability
- State Budget
- Big picture-priorities

Rate Development

Stakeholders

- Important part of process
- Opportunity for MassHealth to hear from the provider community
- Questions:

➢ Do you feel you have a forum to discuss questions and make suggestions about particular provider rate developments?

➢ For those rates set through the regulatory process, do you actively participate in the public hearings?

Rate Development

Innovations

1. Introduction of PCPR- Capitated primary care payment combined with a medical home load and quality improvement payments.

2. Transition to APR-DRG payments from fixed case rate methodology for acute inpatient hospitals

3. Plans to replace the Acute hospital PAPE methodology

4. Future ACO expansion to build on PCPR

Inpatient APR-DRG Methodology

- MassHealth is going live on 10/1/14 with its new inpatient PPS methodology
- The Inpatient prospective APR DRG methodology will assign DRGs based on the diagnosis codes on each claim submitted for payment
- 3M APR-DRG v.30 (ICD-10 compliant) will be used for assigning DRGs
- Inpatient DRG base rate will be derived from the current SPAD statewide standard
- New cost weights were developed for each DRG.
- Outliers will be based on costs and not on length of stay and will be covered as part of the prospective payment

Outpatient PPS Methodology

- MassHealth in conjunction with PCG, is working to replace the PAPE for the 2016 rate year
- The Outpatient PAPE replacement methodology is still under development, but may retain elements of the current time-based episode
- New methodology will use the 3M EAPG grouper to determine episode acuity
- New acuity weights will be developed
- New methodologies are being considered for the base rate that will incorporate costs differently then is currently done