MassHealth Provider Rate Setting

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Director, Purchasing Strategy
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
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 assess 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)
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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
Rate Development

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
Rate Development

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

\[
\text{Payment rate} = (\text{RVU Work} \times \text{GPCI Work}) + (\text{RVU Practice Expense} \times \text{GPCI Practice Expense}) + \text{CF} \\
(\text{RVU Malpractice} \times \text{GPCI Malpractice})
\]

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
Rate Development

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
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

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<th>Salary</th>
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<tr>
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<td>Utilization</td>
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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 than is currently done