



# Overview of FY17 Rate Changes Including the Delay in Waiver Rate Changes

July 21, 2016





# Rate Changes Implemented 7/1/16

- Inpatient Hospital
  - 1.05% (50% of inflation) (12 VAC 30-70-351 modified by Item 306.GGGG)
  - Rebasing (12 VAC 30-70-391)
- Outpatient Hospital
  - 1.05% (50% of inflation) (12 VAC 30-80-36 modified by Item 306.GGGG)
  - Rebasing (12 VAC 30-80-36.B.3)
- Nursing Facility
  - 0.9% Inflation (12 VAC 30-90-44.A.4)
  - 3rd Year of Transition from Cost-Based to Price-Based Rates (12 VAC 30-90-44.B)
- Physician Annual Budget Neutral Rebasing (12 VAC 30-80-190)
- Home Health - 1.7% Inflation (12 VAC 30-80-180)
- Outpatient Rehab Facilities - 2.1% Inflation (12 VAC 30-80-200)
- EPSDT Nursing Rates - 11.5% Increase (Item 306.KKKK)



# HCBS Waiver Rate Increases Delayed

- Any rates included in the ID/DD waiver redesign (Item 306.CCCC)
- 2% increase for Personal Care, Respite Care and Companion Care (Item 306.JJJJ)
- 11.5% increase for Private Duty Nursing in Tech Waiver (Item 306.KKKK)
- 2.5% increase for Adult Day Health Care (Item 306.LLLL)



## **ID/DD Waiver Amendment Negotiation with CMS**

- In discussion with CMS over one year
- Discussion accelerated after General Assembly approval of the waiver redesign March 2016
- Many issues have been negotiated including waiver rate methodologies for ID/DD habilitation services
- When approval of the ID/DD waivers was delayed, CMS explicitly told DMAS also not to increase any HCBS rates effective July 1, 2016
- Subsequently, CMS asked DMAS for rate methodologies for ALL services in the ID/DD waivers



# Waiver Rate Methodologies

- Beginning in 2014, CMS has insisted that the state have rate methodologies for all waiver services during its review of waiver renewals or amendments (initially affecting the ID, DD and Day Support waivers)
  - Primary CMS motivation is to ensure that rates are not excessive
  - Up to this point, CMS has not required that states fully fund “benchmark rates” using approved rate methodologies
  - CMS prefers methodologies that develop rates based on detailed assumptions that can be validated but have accepted methodologies based on comparable rates for other Medicaid services, similar commercial services or Medicaid services in other states
  - These new CMS requirements in some instances exceed expectations for State Plan rates
- DBHDS hired a contractor, Burns and Associates, to develop rate methodologies consistent with CMS expectations
  - Rate work focused on rates for new and existing habilitation services
  - Final rate methodologies did not include services in non ID/DD waivers (personal care, private duty nursing, adult day health care)



## Federal HCBS Waiver Rule

- New Federal Rule on HCBS published January 16, 2014
- New requirements for waiver amendments at 42 CFR 441.304
- "A request for an amendment that involves a substantive change as determined by CMS, may only take effect on or after the date when the amendment is approved by CMS..."
- "Substantive changes include...changes in rate methodology..."
- "The agency must provide public notice of any significant change in its methods and standards for setting payment rates for services"



## New Federal Access Rule

- New federal access rule published November 2, 2015 may also affect Medicaid rates
- Rule implements Section 1902(a)(30(A) of the Social Security Act, which requires states to:
  - “...assure that payments 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;”
- Only applies to FFS (separate access requirements are included in the new Managed Care rule)



# Access Monitoring Review Plan

- States must develop an Access Monitoring Review Plan (due October 1, 2016)
  - The plan must specify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care
  - Plan and monitoring analysis must consider:
    - The extent to which beneficiary needs are fully met;
    - Availability of care through enrolled providers in each geographic area, by provider type and site of service;
    - Changes in beneficiary utilization of covered services in each geographic area
    - Characteristics of the beneficiary population
    - Actual or estimated levels of provider payments available from other payers, including public and private payers, by provider type and site of service
  - The State must solicit and respond to beneficiary and provider input



## Required Analysis for Services

- The State must do a separate data analysis every three years for each provider type and site of service for the following:
  - Primary care services
  - Physician specialist services
  - Behavioral health services
  - Pre and post-natal OB service, including labor and delivery
  - Home health services
  - Additional services with higher volume of access complaints
- The first data analysis is due January 1, 2017
- The State must submit an access review for any State Plan Amendment that reduces or restructures provider rates (including reductions to inflation that are included in the State Plan)



## Access Rule and Rate Reductions

- Prior to submission of a SPA that proposes to reduce or restructure Medicaid service payments rates, states are required to make information available so that beneficiaries, providers and other stakeholders may provide input on beneficiary access to the affected services and the impact that the proposed payment change will have, if any, on continued service access.
- States must analyze the effect of the change in payments rates on access, and a specific analysis of the information and concerns expressed in input from stakeholders
- CMS would disapprove an SPA if
  - The state does not demonstrate adequate access
  - The state does not submit the supporting documentation
- Reduction in hospital inflation triggered the access rule and additional steps for DMAS to take
- Reductions in inflation for hospital, nursing facility, home health and rehab facility services in FY18 will also trigger the access rule