Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

July 26, 2023

The Honorable Guy J. Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2022 Joint Chairmen's Report (p. 115-116) – Report on Current Medicaid Rate Structures and Rate-Setting Studies for All Provider Types

Dear Chairs Guzzone and Barnes:

Pursuant to the requirements of the 2022 Joint Chairmen's Report (p. 115-116), the Maryland Department of Health (MDH) respectfully presents this report on current Medicaid rate structures and rate-setting studies for all provider types. MDH respectfully requests the release of funds associated with this report and apologies for the delayed submission.

If further information on this subject is needed, please contact Megan Peters, Acting Director, Office of Governmental Affairs, at megan.peters@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D, M.P.H.
Secretary

cc: Marie Grant, Assistant Secretary for Health Policy
Ryan Moran, Deputy Secretary, Health Care Financing and Medicaid
Tricia Roddy, Deputy Director, Maryland Medicaid Program
Marlana Hutchinson, Director, Office of Long-Term Services and Supports
Alyssa Brown, Director, Office of Innovation, Research and Development
Megan Peters, Acting Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

2022 Joint Chairmen's Report (p. 115-116) – Report on Current Medicaid Rate Structures and Rate-Setting Studies for All Provider Types

December 2022

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I. Introduction

The 2022 Joint Chairmen's Report[1] requires the Medical Care Program Administration of the Maryland Department of Health (MDH) in consultation with the Behavioral Health Administration (BHA) and the Developmental Disabilities Administration (DDA) to submit a report on current Medicaid rates, rate enhancements, and rate-setting studies. The report must include the following information for each provider type:

- A timeline for when the current rate structure and rates were determined
- The method for determining and establishing the current rate structure and rates, including whether a rate-setting study was conducted and if not, the reason the study was not conducted, and a discussion of how actual provider expenditures were taken into account in setting rates
- A summary of recent rate increases and enhancements
- The status of any ongoing rate-setting studies and plans for future rate-setting studies
- A description of any federal requirements affecting the rate structure, such as whether rates must be actuarially sound, must cover certain costs, or cannot differ across certain service types, geographic locations, or provider types

The following report describes the rate structure/processes for the various provider types within the Maryland Medicaid program.

II. HealthChoice Rate-Setting

Implemented in 1997, HealthChoice is Maryland's mandatory Medicaid managed care program, which currently insures 1,480,869 Maryland residents and 84 percent of the Medicaid population (as of November 2022). Nine managed care organizations (MCOs) currently participate in the program. The MCOs are at risk for the majority of medical services for their enrollees, with the exception of the following, which are covered on a fee-for-service (FFS) basis:

- Specialty mental health care and substance use disorder treatment services
- Dental care
- Health-related services and targeted case management services provided to children when the services are specified in the child's individualized education plan or individualized family service plan
- Therapy services (occupational, physical, and speech) for children

[1] *Report on the Fiscal 2023 State Operating Budget (SB 290) and the State Capital Budget (SB 291) and Related Recommendations*. Joint Chairmen's Report, 2022 Session, page 115-116. Retrieved from https://mgaleg.maryland.gov/Pubs/BudgetFiscal/2022rs-budget-docs-jcr.pdf.

- Personal assistance services offered under the Community First Choice program
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- Behavioral health drugs
- Services covered under 1915(c) home and community-based services (HCBS) waivers

The payment rates to the Medicaid MCOs are set and updated on an annual cycle, which is documented and described in a previous Joint Chairmen's Report, footnoted below.[2] The MCOs negotiate payment rates with their contracted providers.

III. Fee-for-Service Physician/Dental Fee/Emergency Service Transporter Rate Setting

Pursuant to SB 481 (Chapter 464 of the Acts of 2002), MDH established an annual process to set the FFS reimbursement rates for Maryland Medicaid and the Maryland Children's Health Insurance Program (CHIP) (together referred to as Maryland Medicaid). The law also directs MDH to submit an annual report to the Governor and various state House and Senate committees, including a comparison of Maryland Medicaid's FFS reimbursement rates with those of other states and a description of other measures of access and cost for Maryland's Medicaid program.

MDH uses the Medicare fee schedule as a point of reference when it changes physician fees. MDH's first annual report concluded that Maryland Medicaid's reimbursement rates in 2001 were, on average, approximately 36% of Medicare's rates. As of FY 2022, Maryland Medicaid's overall reimbursement rates were approximately 91% of Medicare's 2022 rates. The Maryland Medicaid reimbursement rates for all E&M codes were maintained at 93% of Medicare for FY 2021 and increased to 100% of Medicare rates effective July 1, 2022. The link to the most recent annual report is footnoted below with the next update expected to be submitted to the General Assembly on or before January 1, 2023.[3]

Effective July 1, 2022, MDH provided a one-time rate increase of 9.4 percent for 32 specific dental codes. These codes include a selection of diagnostic, preventive, and restorative services. During the 2022 legislative session, the Maryland FY 2023 Operating Budget directed $19.6 million ($9.1 million General Funds) to Medicaid to increase dental reimbursement rates, representing the largest increase since FY 2009. This 9.4 percent rate increase is a result of these efforts.

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[2] https://health.maryland.gov/mmcp/Documents/JCRs/2017/2017%20Joint%20Chairmen%27s%20Report%20on%20Managed%20Care%20Rate-Setting.pdf

[3] https://health.maryland.gov/mmcp/Documents/JCRs/2021/physicianfeeJCRfinal1-22.pdf. The 2022 report will be posted here when available, https://health.maryland.gov/mmcp/Pages/Reports-and-Publications.aspx.

Additionally, Senate Bill 295, *Maryland Medical Assistance Program – Emergency Service Transporters – Reimbursement* (Ch. 668 of the 2022 Acts) increased reimbursement rates for emergency medical services transports from $100 to $150 effective July 1, 2022.

For the Long Term Services and Supports (LTSS) administered programs, providers have received a number of rate increases since FY 2017, which will continue through FY 2026. These increases are supported by funding through the budget, HB295 *Maryland Minimum Wage Act of 2014* (Ch. 262 of the 2014 Acts); HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* Chs 10 and 11 of 2019 Acts)[4]; the Governor's Supplemental Budget, and American Rescue Plan Act (ARPA). Percentage increases and funding authority for each increase are listed below:

- FY 2017: 1.1% rate increase effective July 1, 2016
- FY 2018: 2% rate increase effective July 1, 2017
- FY 2019: 3% rate increase effective July 1, 2018
- FY 2020: 4% rate increase effective January 1, 2021 (HB 166/SB 280)[5]
- FY 2022: 5.2% rate increase effective November 1, 2021 (ARPA)[6]
- FY 2023: Effective July 1, 2022: Temporary, one time emergency 4% rate increase for FY 2023 only (ARPA); 4% rate increase (HB 166/SB 280); 4% rate increase allocated in Governor Hogan's Supplemental Budget No. 4[7] in amendment to the budget for FY 2023
- FY 2024: 4% rate increase effective July 1, 2023 (HB 166/SB 280); additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will also be effective July 1, 2023, contingent on passage of the Governor's proposed budget.

IV. Developmental Disabilities Administration Rate-Setting

Background

DDA continues to actively implement a transformation plan to align policies and funding processes to create a flexible, person-centered, and family-oriented system of support. Activities include building an advanced information technology platform to support efficient processes and transitioning from a prospective payment model to a fee-for-service (FFS) payment model. Rate setting activities for services provided through three Medicaid §1915(c) waivers have been

[4] https://mgaleg.maryland.gov/2019RS/bills/sb/sb0280E.pdf

[5] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) will go into effect January 1, 2021, rather than July 1, 2021, https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JANUARY%201%202021.pdf.

[6] For more information regarding MDH's ARPA spending plan, see the quarterly updates posted here, https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx.

[7] FY2023-Supplemental-Budget-No.-4.pdf (maryland.gov)

instrumental in establishing new FFS rates to create flexible, person-centered support so people can have full lives. DDA currently operates two systems, Provider Consumer Information System (PCIS2), which has been used historically to deliver payment to providers on a prospective basis, and LTSS*Maryland*, a new rate and FFS payment methodology that will be completed by December 2024. During this transition phase, the DDA will be actively engaging providers to support the full transition to LTSS*Maryland.*

History of the Transition from PCIS2 to LTSSMaryland

DDA transitioned all case management functionalities and eligibility to LTSS*Maryland* in 2018. During the 2020 legislative session, the General Assembly passed Senate Bill 796 (Ch. 7 of the Acts of 2021) to ensure that providers and individuals who receive DDA services are not negatively impacted when using the Long-Term Services and Supports (LTSS*Maryland*) software system or the Electronic Visit Verification (EVV) function. It obligated DDA to meet several requirements at least 90 days before requiring providers to use LTSS*Maryland* for all individuals served in addition to offering a pilot for at least 6 months.[8] DDA instituted an early-adopters group (EAG) to pilot new funding rates and processes in LTSS*Maryland*. In April 2022, the DDA began transitioning additional pilot groups into LTSS, and have transitioned approximately 45% of providers by the end of April 2023.

Rate Setting Methodology

Following legislation passed in the 2014 legislative session, DDA contracted with Johnston, Villegas-Grubbs, and Associates, LLC (JVGA) to complete a rate analysis and impact study that considered the actual cost of providing community-based services. The final report included FFS rates based on The Brick™ Method, with a summary of specific components and development processes for Maryland. The foundation of the Brick™ is the wage for the direct support professional, and it studies the relationship between cost categories to determine the components of the Brick™. Other components include Employment Related Expenses, Facility Costs, Program Support, General and Administrative, Transportation, and Training.[9] This methodology requires the collection of general ledger (GL) cost data from providers for the selected state fiscal year (FY). Providers are asked to submit total expenditures by cost account/category and by cost account line item. Initial FFS rates were established for services through this process and implementation of the Brick™ methodology. Following the work with JVGA, DDA contracted with CBIZ Optumas to do a review of GL data, cost components, and the Brick™ and to ensure ongoing fidelity to the model.

Beginning in February 2022, DDA initiated an annual rate setting cycle modeled after the established process used to set rates for the Medicaid HealthChoice managed care program. A

[8] https://mgaleg.maryland.gov/2020RS/fnotes/bil_0006/sb0796.pdf
[9] https://health.maryland.gov/dda/Documents/JVGA%20DDA%20Rate%20Setting%20Report.pdf

Rate Review Advisory Group (RRAG) was established to provide an iterative and responsive structure to the process. There are two distinct cycles of operation for the DDA rate setting cycle, dependent on whether the Department is in a review phase of selected services or identified priorities, or if operating in a rebase year review of all rates and services. Rate rebasing for home and community-based waivers typically occurs in a three-to-five-year cycle. The annual process occurs over eight months in each calendar year, with established agenda and action items for stakeholders throughout the cycle. Outcomes of the first rate-setting cycle included data driven advancement of key rate priorities and FY 2024 budget recommendations.

Current Rates, Recent Rate Increases, and Enhancements

DDA currently maintains two sets of rates for services provided and reimbursed through prospective payments in PCIS2, as well as services provided and reimbursed FFS through LTSS*Maryland*. Rates are updated based on DDA's state budget allocation, policies, cost of living adjustment, and input from the RRAG on FFS rates.[10] Current rates became effective on July 1, 2022.

Additionally, several increases have been implemented since FY 2016 and will continue into FY 2025 as detailed below. These increases are supported by funding through HB 295 *Maryland Minimum Wage Act of 2014* (Ch. 262 of the 2014 Acts); HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* Chs 10 and 11 of 2019 Acts)[11]; the Governor's Supplemental Budget, and the 10% enhanced FMAP funding available for reinvestment as a result of the American Rescue Plan Act (ARPA).[12]

- FY 2016: 3.5% rate increase effective July 1, 2015 (HB 295)
- FY 2017: 3.5% rate increase effective July 1, 2016 (HB 295)
- FY 2018: 3.5% rate increase effective July 1, 2017 (HB 295)
- FY 2019: 3.5% rate increase effective July 1, 2018 (HB 295)
- FY2020: 4% rate increase effective July 1, 2019 (HB 295)
- FY 2021: 4% rate increase effective January 1, 2021 (HB 166/SB 280)[13]; 5.5 % rate increase beginning April 1, 2021 except for targeted case management (ARPA)

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[10] https://health.maryland.gov/dda/Documents/Fiscal/Rates%20and%20Invoices/PT%2039-22%20FFS%20Rates%20for%20Medicaid%20Waiver%20Programs%20Operated%20by%20the%20DDA%20April%201%2c%202022%20%281%29.pdf

[11] https://mgaleg.maryland.gov/2019RS/bills/sb/sb0280E.pdf

[12] For more information regarding MDH's ARPA spending plan, see the quarterly updates posted here, https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx.

[13] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) will go into effect January 1, 2021, rather than July 1, 2021, https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JANUARY%201%202021.pdf.

- FY 2022: 4% rate increase effective July 1, 2021 (HB 166/SB 280); 5.5% increase for targeted case management providers effective November 1, 2021 (ARPA);
- FY 2023: 4% rate increase effective July 1, 2022 (HB 166/SB 280); additional 4% rate increase effective July 1, 2022 (Governor's Supplemental Budget)[14]; one-time temporary emergency 10% rate increase for all providers from October 1, 2022 through December 31, 2022 (ARPA)
- FY 2024: 4% rate increase effective July 1, 2023 (HB 166/SB 280); additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will also be effective July 1, 2023, contingent on the passage of the Governor's proposed budget.

Federal Requirements that Affect Rate Structures

The §1915(c) waiver instructions, Technical Guide, and Review Criteria from the Centers of Medicare and Medicaid Services and the Social Security Act both have detailed requirements for the rate setting process. Appendix I-2 of the §1915(c) waiver application addresses the waiver service and rate determination method requirements.[15] To establish a statewide rate methodology, a state must have uniform and consistently applied policies concerning the determination of waiver payment amounts or rates according to CMS. Appendix I-2 requires public notice on rate setting methodology and a public comment process. All payment rates must remain in compliance with §1902(a)(30)(A) of the Social Security Act.[16]

The rate setting methodology for each waiver service must be reviewed at a minimum every five years. The rate review process must include when the rates were initially set and last reviewed; how the state measures rate sufficiency and compliance with §1902(a)(30)(A) of the Social Security Act; the rate review method used; and the frequency of rate review activities.

Future Plans

DDA will continue with the annual rate setting cycle and RRAG stakeholder group initiated in January 2022 to support the review of rate priorities and inform the FFS rates established with the Brick™ methodology. Efforts are currently underway to pilot and establish a standardized GL data collection template for DDA providers to allow for annual data collection to support data-informed decisions for identified priorities, specific services, and rate rebase years. Additionally, DDA will continue to support providers with the transition from PCIS2 to LTSS*Maryland* and the new rate structure.

[14] FY2023-Supplemental-Budget-No.-4.pdf (maryland.gov)
[15] Instructions Technical Guide and Review Criteria (cms.gov)
[16] Social Security Act §1902 (ssa.gov)

V. Behavioral Health Provider Rates

Background

Rate setting for behavioral health providers differs from other provider types. When setting rates for somatic providers, state Medicaid programs often use Medicare reimbursement as a point of comparison. However, Medicare coverage for behavioral health services is limited. As such, Medicare cannot be used as a point of comparison for the vast majority of behavioral health services, and MDH often uses provider costs, and rates paid by neighboring states to set rates for behavioral health providers.

Per legislation, MDH must conduct an independent cost–driven, rate–setting study to set community provider rates for community–based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community–based behavioral health services. These requirements are discussed in greater detail below.

Current Rates, Recent Rate Increases, and Enhancements

Behavioral health community providers received a number of rate increases since FY 2019, which will continue through FY 2026. These increases are supported by funding through HB1329/SB967—*Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017* (Chs. 571 and 572 of the Acts of 2017), HB166/SB280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* Chs 10 and 11 of 2019 Acts); the Governor's Supplemental Budget, and the 10% enhanced FMAP funding available for reinvestment as a result of ARPA. Percentage increases and funding authority for each increase are listed below:

- FY 2019: 3.5% rate increase effective July 1, 2018 (HOPE Act)
- FY 2020: 3.5% rate increase effective July 1, 2019 (HOPE Act)
- FY 2021: 4% rate increase effective January 1, 2021 (HB 166/SB 280)[17]
- FY 2022: 3.5% rate increase effective July 1, 2021 (HB 166/SB 280); 5.4% rate increase effective November 1, 2021 (ARPA).
- FY 2023: 3.25% rate increase effective July 1, 2022 (HB 166/SB 280); 4% rate increase effective July 1, 2022, that was allocated in Governor Hogan's Supplemental Budget No. 4 in amendment to the budget for FY 2023; one-time temporary emergency 4% increase in rate from July 2022 through September 2022 for Brain Injury Waiver providers
- FY 2024: 3% rate increase effective July 1, 2023 (HB 166/SB 280); additional 8% in rate increases originally scheduled for FY 2025 and FY 2026 will also be effective July 1, 2023, contingent on the passage of the Governor's proposed budget.

[17] On December 17, 2020, Governor Larry Hogan announced that Medicaid behavioral health and long term care provider rate increases pursuant to Maryland Senate Bill 280 (2019) will go into effect January 1, 2021, rather than July 1, 2021, https://health.maryland.gov/mmcp/Documents/MEDICAID%20PROVIDER%20RATE%20CHANGES%20FROM%20JANUARY%201%202021.pdf.

Future Plans and Rate Study

MDH is currently initiating a process to examine behavioral health provider payment rates. The Heroin and Opioid Prevention Effort and Treatment (HOPE) Act[18] of 2017 (HB 1329/SB 967; Chapters 571 and 572 of the Acts of 2017) requires MDH to:

- Conduct an independent cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual costs of providing community-based behavioral health services.
- Develop and implement a payment system incorporating findings of the rate-setting study, including projected costs of implementation and recommendations to address any potential shortfalls in funding.
- Consult with stakeholders, including community providers and individuals receiving services, in conducting the rate-setting study and developing the payment system required by this Act.

MDH convened the Behavioral Health System of Care Optimization and Integration Workgroup and corollary stakeholder discussion groups in the summer of 2019 through early 2020. As part of the workgroup/discussion group deliberations, MDH obtained preliminary stakeholder feedback on requirements for the rate-setting study. The stakeholders noted that many providers would need technical assistance on collecting/reporting the cost data needed for the study. As a result, MDH determined that a two-phased process was needed to conduct the study:

- The goal of the first phase is to design a cost report template and to train the providers on how to use the template to successfully report their costs of rendering services under the publicly funded behavioral health system.
- Once the template is designed and the providers are trained, the second phase is to analyze the data, conduct the study, and make recommendations for any changes to the rates.

While there were delays in procurement due to the COVID-19 pandemic, MDH issued a request for proposals (RFP) on July 1, 2022, for a contractor to conduct phase one (developing the cost reporting template and training providers). The categories of providers to be included in the cost reports are:

- Outpatient mental health clinics
- Mobile treatment programs
- Psychiatric rehabilitation programs
- 1915(i) programs/providers

[18] https://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_571_hb1329E.pdf

- Targeted case management
- Substance use disorder American Society of Addiction Medicine (ASAM) Level 1, 2, and 3 providers
- Opioid treatment programs

Responses were due on August 19, 2022, and as of the drafting of this report, staff are currently evaluating proposals. An award is expected soon.