REPORT TO THE VERMONT LEGISLATURE

Medicaid Rate Analyses: Home Health Services and Resource-Based Relative Value Scale Fee Schedule

In Accordance with
Act 113 of 2024, Section E.306.2: An act relating to making appropriations for the support of government

Submitted to: House Committee on Health Care
House Committee on Appropriations
Senate Committee on Health and Welfare
Senate Committee on Appropriations

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Report Date: January 15, 2025

VERMONT
AGENCY OF HUMAN SERVICES

The Agency of Human Services' mission is to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

VERMONT

LEGISLATIVE REQUEST

(a) To the extent that resources allow, the Department of Vermont Health Access shall conduct the analysis set forth in subdivision (1) of this subsection first, followed by the analysis set forth in subdivision (2) of this subsection, and shall provide its findings to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare and on Appropriations on or before January 15, 2025:

(1) methodologies for comparing Medicaid rates for home health agency services to rates under the Medicare home health prospective payment system model and for comparing Medicaid pediatric palliative care rates to rates underthe Medicare home health prospective payment system model or to Medicare hospice rates, or both; and

(2) methodologies for modifying the Medicaid Resource-Based Relative Value Scale professional fee schedule by considering:

(A) maintaining alignment with relative value units used by Medicare but including a minimum on conversion factors;

(B) benchmarking one or more conversion factors in Vermont Medicaid to the Medicare conversion factor from a specific year; and

(C) determining whether Vermont Medicaid should continue to use two separate conversion factors, or transition to a single conversion factor in combination with other methods of providing enhanced support for primary care services.

EXECUTIVE SUMMARY

Part I of this report provides a comparison of Vermont Medicaid reimbursement for home health services and the Medicare Patient-Driven Groupings Model (PDGM) episodic reimbursement methodology for home health services. It is estimated that the current Vermont Medicaid fee-for-service rates pay approximately 67% of what home health providers would receive from Medicare for comparable services. This section of the report also presents a possible framework for benchmarking reimbursement rates for Pediatric Palliative Care and High Technology Nursing services to other Medicaid home health reimbursement rates. DVHA will conduct annual fiscal analyses based on these benchmarking approaches to inform future decision-making around funding allocation.

Part II of this report provides an overview of the Vermont Medicaid Resource-Based Relative Value Scale (RBRVS) fee schedule for professional services, and evaluates several methodological considerations, including continuing to align with the Relative Value Units (RVUs) updated and used by Medicare on an annual basis; options for different Conversion Factors (CFs) that could be used to keep Medicaid rates from decreasing when Medicare rates decrease; and the potential for enhancing Medicaid primary care payments using methods other than a differential CF. DVHA will continue to implement the RBRVS methodology that is currently outlined in the Vermont Medicaid State Plan, maintaining alignment with the RVUs used in the Medicare Physician Fee Schedule and maintaining different CFs for primary care and all other services. In addition, DVHA will conduct annual fiscal analyses for a variety of CF options to inform future decision-making around policy and funding allocation.

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PART I: HOME HEALTH SERVICES

INTRODUCTION AND OVERVIEW OF MEDICAID HOME HEALTH REIMBURSEMENT

Since 2022, the Department of Vermont Health Access (DVHA) has been using Medicare's Low Utilization Payment Adjustment (LUPA) fee-for-service rates as a benchmark for developing Vermont Medicaid's reimbursement for comparable home health services[1]. In State Fiscal Year 2025, the Vermont General Assembly appropriated funding to align Vermont Medicaid's reimbursement rates with 100 percent of the Medicare LUPA rates. To date, DVHA has not benchmarked Vermont Medicaid reimbursement against the Medicare Patient-Driven Groupings Model (PDGM) reimbursement.

OVERVIEW OF MEDICARE PATIENT-DRIVEN GROUPINGS MODEL (PDGM)

Medicare pays home health providers using the Patient-Driven Groupings Model (PDGM).[2] Through this reimbursement model, providers are paid for 30-day "episodes", or periods of care delivery. Depending on the home health services needed and patient information (like demographics and clinical diagnoses), the grouping model will assign a level of payment for the 30-day episode that encompasses all home health services delivered. In the event that a patient does not utilize a minimum number of services within the 30-day episode, a Low Utilization Payment Adjustment (LUPA) payment rate is used to reimburse home health providers. The LUPA reimbursement is more like traditional fee-for-service reimbursement, and the per-visit rates are lower.

COMPARING VERMONT MEDICAID HOME HEALTH RATES TO MEDICARE RATES

DVHA and representatives of the VNAs of Vermont convened monthly during the summer and fall of 2024 to consider approaches for comparing Medicaid home health reimbursement to the Medicare PDGM reimbursement model. The Medicaid program uses a fee-for-service payment model, and the Medicare program uses the episodic PDGM model so a direct comparison isn't possible. To date, DVHA has only been able to compare fee-for-service Medicaid rates to Medicare LUPA rates only, which is relatively straightforward but provides a limited comparison to the broader Medicare reimbursement structure.

For this exercise, Vermont's home health agencies provided data on the average number of Medicare visits (by type) delivered in a 30-day episode. These visit counts were multiplied by the Medicare LUPA fee-for-service reimbursement rates to develop an estimate of how much an average Vermont home health agency would be paid for the number of visits in an average episode of care. This amount was then compared to the average PDGM reimbursement, to determine the difference between the two. Using the PDGM and LUPA reimbursement

[1] 21-090-Final-GCR-HH-HT-Pediatric-Palliative-Rates-CY2022.pdf
[2] Home Health Patient-Driven Groupings Model | CMS

information from the Calendar Year 2025 Home Health Prospective Payment System (HH PPS) Final Rule[3], it was determined that using the LUPA rates would reimburse for services at approximately 67 percent of the PDGM reimbursement. By extension, the Vermont Medicaid reimbursement rates (which are presently equivalent to 100 percent of the Medicare LUPA rates) could also be benchmarked as reimbursing approximately 67 percent of the Medicare PDGM methodology.

Given the complexity of the PDGM payment model, it would be challenging to develop an exact 'apples-to-apples' comparison of the episodic payments and the fee-for-service payments. It should also be noted that there are distinct population differences between Medicare and Medicaid, and that there are differences in the home health benefit structures between the two payers (e.g., Vermont Medicaid does not require that members are homebound in order to receive home health services). However, both DVHA and the VNAs of Vermont agree with this general approach to benchmarking the LUPA rates against the PDGM rates, and believe that this analytic approach could be replicated on an annual basis to ensure that the relative comparisons continue to capture year-to-year policy or reimbursement changes that Medicare may implement.

COMPARING PEDIATRIC PALLIATIVE CARE AND HIGH TECHNOLOGY NURSING RATES TO HOME HEALTH RATES

DVHA and the VNAs of Vermont took this opportunity to holistically review rate benchmarking options for both the Pediatric Palliative Care (PPC) and the High Technology Nursing (HTN) programs, recognizing that neither program is perfectly comparable to the home health services for which Medicare pays. Although the programs and services are different, Vermont's home health agencies are the primary service providers for these programs, and for that reason it may be helpful for provider organizations to have more consistency across the programmatic rate structures.

These programs have been administered by different departments within AHS, and for that reason, there have been different opportunities to set and adjust reimbursement rates over time. This has, in some cases, led to inconsistencies in rate structures for home health agencies. For example, in the home health services that are currently benchmarked against Medicare LUPA rates, Vermont Medicaid pays $74.68 per hour of home health aide services. By contrast, in the High Technology Nursing program, for which rates do not have an external benchmark, Vermont Medicaid pays $72.04 per hour of registered nurse services. Therefore, a single home health agency that provides services for both programs may receive higher reimbursement for a home health aide under one program than it does for a registered nurse in another program.

The following tables show services in the HTN and PPC programs that may lend themselves to being benchmarked against other Medicaid rates for skilled home health services (for which there is also a Medicare benchmark) according to which type(s) of agency staff are providing those services.

[3] 2024-25441.pdf

SKILLED HOME HEALTH SERVICES (Benchmarked Against Medicare)	Revenue Code
SKILLED NURSING	550
MEDICAL SOCIAL SERVICES	560
HOME HEALTH - HOME HEALTH AIDE	570

PEDIATRIC PALLIATIVE CARE SERVICES	Revenue Code	Potential Rate Benchmark
MEDICAL SOCIAL SERVICES (GRIEF, BEREAVEMENT)	561	Could be equivalent to rate for Medical Social Services (560)
MEDICAL SOCIAL SERVICES (EXPRESSIVE THERAPY)	562	Could be equivalent to rate for Skilled Nursing (550)
RESPITE CARE, RN/LPN	660	Could be based on 25% of rate for Skilled Nursing (550) (for 15 minute increment)
RESPITE CARE, HHA/LNA	669	Could be based on 25% of rate for Home Health Aide (570) (for 15 minute increment)

HIGH TECHNOLOGY NURSING SERVICES	Procedure Code	Potential Rate Benchmark
DIRECT SKILLED NURSING SERVICES OF A REGISTERED NURSE (RN) IN THE HOME HEALTH OR HOSPICE SETTING	G0299	Could be based on 25% of rate for Skilled Nursing (550) (for 15 minute increment)
DIRECT SKILLED NURSING SERVICES OF A LICENSE PRACTICAL NURSE (LPN) IN THE HOME HEALTH OR HOSPICE	G0300	Could continue to be 85% of RN rate for High Technology Nursing program
NURSING ASSESSMENT/EVALUATION	T1001	Could be equivalent to rate for Skilled Nursing (550)

CONCLUSION

There are methodological options for benchmarking Vermont Medicaid's home health reimbursement rates to Medicare's reimbursement rates for the same services, and for increasing internal consistency among the reimbursement rates for services provided by home health agencies across different programs. DVHA will conduct annual fiscal analyses based on these benchmarking approaches to inform decision-making around funding allocation.

PART II: RESOURCE-BASED RELATIVE VALUE SCALE FEE SCHEDULE

INTRODUCTION OVERVIEW OF MEDICAID RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) FEE SCHEDULE

DVHA uses the Medicare Physician Fee Schedule (PFS) fee-for-service rates as a benchmark for developing Vermont Medicaid's reimbursement for physician services, referred to as the Resource-Based Relative Value Scale (RBRVS) professional fee schedule. DVHA pays for professional services under the RBRVS fee schedule which is the same underlying system used by Medicare in the PFS. The RBRVS fee schedule uses national cost data to estimate the resources needed to provide a particular service relative to all other services. It is maintained by the Centers for Medicare and Medicaid Services (CMS) for use in the federal Medicare program and is updated annually to reflect new data and other policy changes. Each procedure in the RBRVS fee schedule is assigned a number of relative value units (RVUs). The number of units determines the payment level for the procedure. There are three geographically adjusted components that comprise an RVU. These components are:

1. **Physician work**, including the time and clinical skill necessary to treat a patient during the encounter.
2. **Practice expense**, including labor costs as well as expenses for building space, equipment, and office supplies.
3. **Professional liability insurance expense**, including the cost of malpractice insurance premiums.

The total RVU is then multiplied by a Conversion Factor (CF), which is a value that converts the RVU into a dollar amount.

***Physician Work* + *Practice Expense* + *Liability Insurance Expense* = Relative Value Unit (RVU)**

***RVU x Conversion Factor (CF)* = Dollar amount paid for procedure**

For example, Vermont Medicaid reimbursement for the commonly billed procedure code 99214 (established patient office or outpatient visit, 30 minutes) can be calculated based on:

- An RVU (for non-facility place of service) of 3.73326
- A CF of $28.96

3.73326 *[RVU]* x $28.96 *[CF]* = $108.12 *[Reimbursement rate per unit]*

DVHA currently has two conversion factors (CFs): a primary care CF and a standard CF that applies to all other provider specialties and services. Having two CFs has enabled Vermont Medicaid to maintain higher reimbursement rates for primary care services. For many years, Vermont Medicaid maintained primary care reimbursement rates that were equal to 100% of Medicare's reimbursement rates; in SFY2024, the General Assembly appropriated additional

funds to raise Medicaid's reimbursement to be 110% of Medicare's 2023 reimbursement rates. As of January 1, 2025, Medicaid's reimbursement for primary care services is equivalent to 114% of Medicare's 2025 reimbursement rates.

It has been DVHA's practice to maintain, when possible, Medicaid CFs that are set percentages of Medicare CFs. This means that Medicaid rates may fluctuate up or down depending on how the Medicare CF changes. Due to annual reductions in the Medicare CF since 2022, providers have advocated for the Vermont Medicaid RBRVS fee schedule to be held harmless from annual Medicare CF reductions. DVHA was therefore directed to analyze several methodological considerations for the RBRVS methodology.

ANALYSIS OF PAYMENT METHODOLOGY STRUCTURES

Provider Engagement

DVHA engaged with the Vermont Medical Society and HealthFirst, advocacy groups representing providers that regularly bill professional services, throughout the process of reviewing methodological options for the Medicaid RBRVS professional fee schedule. Meetings with representatives from the Vermont Medical Society and HealthFirst occurred on August 7, 2024, October 23, 2024, November 13, 2024, and December 5, 2024, to review and solicit feedback on payment methodology considerations and scenarios.

Summary of Analysis and Provider Feedback

DVHA and provider advocates explored four payment methodology frameworks for the RBRVS fee schedule and evaluated each for potential strengths and challenges.

Consideration 1: Maintaining alignment with Medicare Relative Value Units (RVU)

The Medicare published RVUs are currently a component of the DVHA payment methodology for the RBRVS professional fee schedule. RVUs are used to assign a relative value based on the resources needed to deliver the service and are updated annually by Medicare. Continuing to utilize the RVUs in DVHA's payment methodology maintains alignment with Medicare and many other payers' reimbursement approaches for physician services. Another strength in keeping this methodology is the validity of the RVUs themselves such that they consider the time, effort, skill and stress associated with providing each service. RVUs are set via Medicare using standardized methodologies which include physician input and practice cost data from a survey. Potential challenges identified with this approach is that RVU values can change annually and either increase or decrease, which could impact specific service lines more than others. Moreover, from an operational standpoint, deviating from this approach is not feasible for Medicaid's claims processing system at this time. Both DVHA and external stakeholders agreed that continuing to use the RVUs was preferred.

Consideration 2: Maintain Medicare RVU methodology and establish conversion factor rate floors

Like Medicare, DVHA utilizes a conversion factor (CF) in the RBRVS professional fee schedule methodology. The Medicare CF is not based on a methodology but rather used as a mechanism to achieve budget neutrality at the federal level for the Medicare program. Similarly, DVHA's CF

can be used achieve budget neutrality at the Medicaid program level when necessary. In this option DVHA explored establishing both a primary care and standard CF floor rate which would establish the lowest possible DVHA CF rates within the methodology. DVHA CF rates would never drop below the floor, even if Medicare's CF was lower. This would protect against reductions to the Medicaid CF when the Medicare CF is reduced.

However, upon further review of this option, it became clear that maintaining a CF floor would not guarantee that all rates are held harmless, particularly when certain services have RVU decreases. Conversely, it could also have a significant impact on annual Medicaid spending, because the mix of services that are seen nationally for the Medicare program are different than the mix of services utilized by Vermont's Medicaid members.

This approach would also affect DVHA's and AHS' ability to meet budget targets set forth by the administration. If maintaining the CF at the floor level required additional funds, it would create a budget pressure that would, in the absence of new appropriations, require DVHA to reduce rates for other Medicaid services and providers.

Given that this approach may have unintended consequences, neither DVHA nor provider advocates prefer to specify a CF floor (or floors) going forward. Provider advocates were in favor of continuing to review how annual CF and RVU interactions might affect different providers and services and using those analyses to support holding provider reimbursement—particularly for primary care services and providers—as constant as possible if funds are not available to support increases.

Consideration 3: Maintain Medicare RVU methodology and establish a single CF in combination with other methods of providing enhanced support to primary care services

This payment methodology would move away from DVHA's current methodology that utilizes two CFs, and have a single standard CF. To account for the elimination of the primary care conversion factor, DVHA would adopt the new Medicare add-on codes established to support primary care services. Partners agreed this approach would be difficult to operationalize and there are many unknown interactions with other active or potential future Medicaid payment models (e.g., the Blueprint for Health and the States Advancing All-Payer Health Equity Approaches and Development [AHEAD] model). It was noted by provider advocates that this approach would also require additional administrative burden on provider practices to modify their billing practices. Both DVHA and provider advocates agreed this approach is not preferred.

Consideration 4: Maintain Medicare RVU methodology and incorporate additional fiscal models to be calculated annually

DVHA explored the possibility of conducting additional fiscal analyses on an annual basis to quantify various methodological options of interest. Together DVHA and external partners identified these models of interest: 1) using the proposed Medicare CF for the upcoming year, 2) using the current Vermont Medicaid CFs, 3) using CFs from prior Medicare year(s) of interest, and 4) using the Medicare Economic Index (MEI) as a measure of inflation for medical care to increase current Medicaid CFs. Looking at a variety of scenarios on an annual basis would support both DVHA and AHS in developing updates that fit within an existing Medicaid

appropriation, and these analyses could be available to inform advocacy and decision making with providers and policymakers.

CONCLUSION

DVHA will continue to implement the RBRVS methodology that is currently outlined in the Vermont Medicaid State Plan, maintaining alignment with the RVUs used in the Medicare Physician Fee Schedule and maintaining different CFs for primary care and all other services. In addition, DVHA will conduct annual fiscal analyses for a variety of CF options to inform decision-making around policy and funding allocation.