Medicaid Memorandum of Agreement (MOA)

- Defines the rate at which Michigan CHCs are paid by Medicaid.
- Negotiated as a group and signed by individual health centers.
- Differs from the Medicaid Provider Manual, that describes the process for reimbursement (the how).
- Michigan has negotiated 4 MOAs.
Legislative History of Medicaid PPS


2000: Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act (BIPA).
Rate Determination

The payment baseline was based on each health center's average cost per visit for the years of 1999 and 2000 and is unique for each health center.

PPS rates are adjusted up based on approved changes in scope and the Medicare Economic Index (MEI).

While PPS establishes the payment floor, states are not required to pay PPS and can choose an Alternative Payment Methodology (APM).

New sites’ rates are determined based on rates in Centers in the “same or adjacent areas.”
MOA Negotiation Process

- MPCA provides staff support to the MOA workgroup open to health center volunteers statewide (approx. 10)

- Workgroup meets in advance of meetings with Medicaid to discuss areas of consideration and complete research of potential impact.

- Medicaid and MPCA present areas to be negotiated and the complete process takes approx. a year.

- Medicaid representatives include those from the reimbursement and policy sections of Medicaid, ultimately approved by the Medicaid Director.

- It has been a 12 year process
The Creation of Michigan’s MOA

- First MOA workgroup formed in 2001
- Cost calculations and negotiations took several years, CMS continued to offer guidance/clarification.
- MPCA did calculating and determined health centers would fair better with an APM vs. PPS
CHANGES THAT HAVE OCCURRED OVER THE MOAS
MOAs 1 & 2 (Effective 2003)

- First was void by CMS and then had to be renegotiated.
- Rates were determined with 1999 and 2000 with sunset provision after 5 years
- Pharmaceuticals
MOA 3 (Effective 2007)

- Outreach and transportation changes - $7.79
- Family Planning Waiver addition - $7.40
- Behavioral health code additions
- Hospital visits retention
MOA 4 (Effective 2010)

- Dental Changes
- Obstetrical billing changes
- Clarity that new starts don’t come in at the cap
- Some biologics and vaccines excluded
MOA 5 (To Be Effective in 2014)

- MOA Workgroup outlined areas of consideration for further research
- Medicare and Medicaid cost report review underway
- Workgroup will likely reconvene in the fall.
Comparison to other States

- 24 states have more than one rate for medical dental and mental health.
- The vast majority of states use MEI as an adjustment factor.
- 16 states report that co-pays are deducted from FQHC payments.
- 22 states provide wrap-around payments to FQHCs treating managed care enrollees.
- PCAs in the majority of states feel that wrap around process is problematic, reporting significant delays.
- 5 states pay the managed care organizations the wrap-around who in turn pay the health centers.
- Average rates vary throughout the country, from around $90 per visit to $165 per visit.
QUESTIONS?

For further information, please contact:

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