

Bundled Payments

This guidance applies to states that develop bundled rates as a fee-for-service (FFS) payment methodology. States have developed bundled rates for:

- Multiple units of a single service, such as a daily rate for personal care services.
- Multiple services within a single benefit category, such as a daily rate for assertive community treatment rehabilitative services.
- Multiple services across benefit categories, such as a daily rate that includes personal care, targeted case management, and physical therapy.

Information states should include within the Attachment 4.19-B pages for bundled rates:

- As applicable, the state's title for the service bundle.
- A list of the covered 1905(a) services included in each service bundle. The covered services within the payment bundle must correspond to service descriptions in section 3.1-A of the state plan, which describes covered services, providers, and provider qualifications.
- The service bundle payment unit (i.e. minute increments, hourly, daily, weekly, or monthly).
- A statement identifying which provider will be billing for the bundled service, if the service is a multi-benefit category bundle.
- A statement noting that any provider delivering services through a bundle will be paid through that bundle's payment rate and cannot bill separately; and, that Medicaid providers delivering separate services outside of the bundle may bill for those separate services in accordance with the state's Medicaid billing procedures.
- A statement indicating that at least one of the services included in the bundle must be provided within the service payment unit in order for providers to bill the bundled rate. While CMS minimally expects beneficiaries to receive one service within a service payment unit, states may require more than one service to be delivered within a unit in order for providers to bill. (Please note that prepayment for service bundles is not allowed under state plan authority.)
- An assurance that the rate does not include costs related to room and board or other unallowable facility costs, if the rate is paid in residential settings.
- One of the following:
 - A) An effective date for the fee schedule that includes the bundled rate(s), language that ensures governmental and private providers are paid the same bundled rates, and a web-link to the fee schedule;
 - B) The actual amount of the bundled rate; or
 - C) The precise formula in the state plan that explains how rates are set, allowing providers to calculate their Medicaid payment.
- An assurance that the state will periodically monitor the actual provision of services paid under a bundled rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle.

Supporting information states should provide to CMS for bundled rates:

For new bundled rates, CMS requests information on how states developed the rates, including: assumptions regarding the type, quantity, intensity, and price of the component services typically provided to support the economy and efficiency of the rate. In addition, states must provide a statement indicating that the bundled payment methodology comports with the statute regarding direct payment to providers at section 1902(a)(32) of the Social Security Act. This information is maintained as part of the administrative record and is not required within the state plan methodology.

Reporting bundled rates on the CMS-64:

States can only report expenditures for which all supporting documentation is available (i.e. date of service, name of recipient, Medicaid identification number), in readily reviewable form, which has been compiled and is immediately available when the claim for expenditures is filed on the CMS-64.

When a state proposes to reimburse using a single bundled rate across multiple benefit categories, the state must develop a method for allocating the portion of the rate related to each benefit category for purposes of proper reporting on the CMS-64, by benefit category. This methodology must be provided to CMS during the review of the SPA.

Drug rebates for drugs included in bundled rate:

By including a drug in the bundled payment rate, the drug is excluded from the definition of a “covered outpatient drug” as defined in statute at section 1927(k) of the Social Security Act, due to the limiting definition in section 1927(k)(3), and in regulation at 42 C.F.R. 447.502. In order for a drug to be eligible for a rebate based on state utilization:

- The drug must not have been provided and reimbursed as part of another service (i.e., the drug must be paid as a distinct line item)
- The state must require providers to submit the claim with the National Drug Code (NDC) of the utilized drug
- The drug must be claimed on the prescribed drug line of the CMS 64 and reported to the Medicaid Drug Rebate Program in the state’s quarterly NDC reports of utilization
- The drug must be from a manufacturer that has a rebate agreement in effect
- The drug must not have been purchased through the 340B Program
- The drug must be prescribed

For additional guidance on covered outpatient drugs, please refer to [Medicaid Drug Rebate Program Notice, State Release No. 178](#) and the [Covered Outpatient Drug Final Rule with Comment \(CMS-2345-FC\)](#).