State Directed Payment Arrangements

Common Approaches Using §438.6(c) “Preprints”

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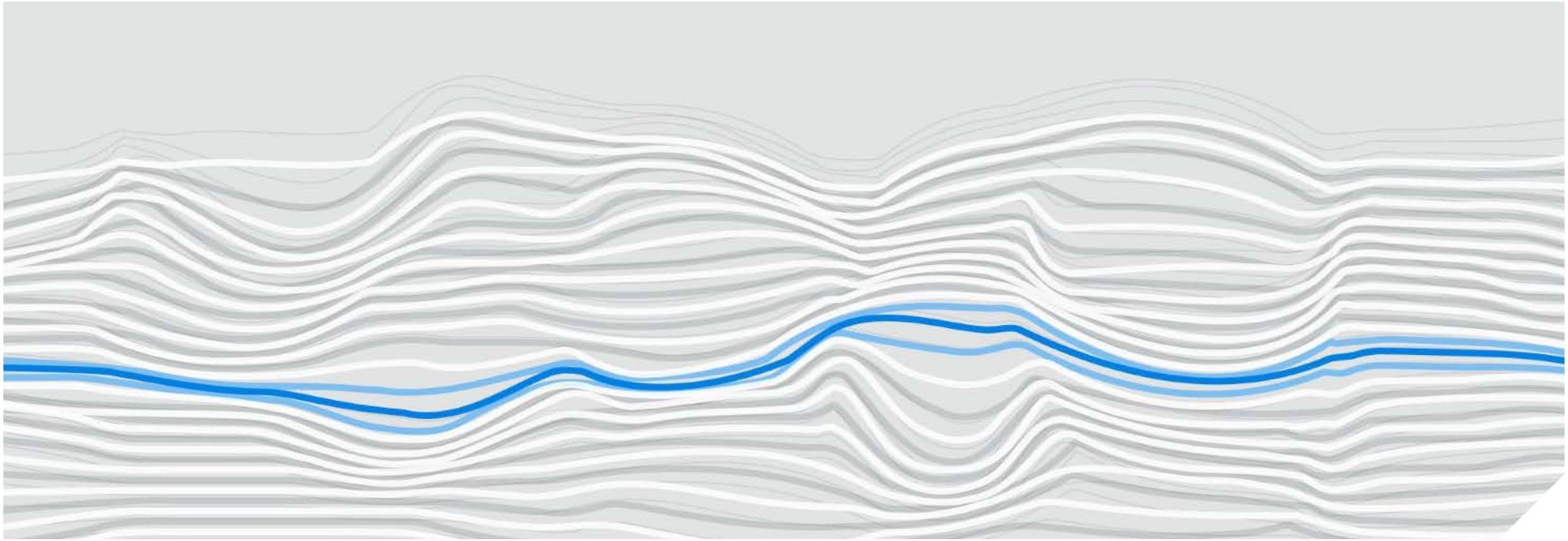


State Directed Payments overview

State Directed Payment: Introduction

In response to the Medicaid managed care final rule, many states have gained approval from the Centers for Medicare and Medicaid Services (CMS) for “state directed payment” arrangements

- Allows states to require managed care plans to make **specified payments to providers** that **support delivery system and provider payment reforms**
- Provides a permissible mechanism for making **supplemental payments** in managed care programs, as an alternative to pass-through payments (phased out in the final rule)

We have conducted a comprehensive review of **65 state directed payment arrangements** approved by CMS as of August 15, 2018.

Medicaid supplemental payment environment

Supplemental payment programs remain **a major share of Medicaid expenditures** and in many states are **partially funded by providers**

Per MACPAC's 2018 Medicaid hospital supplemental payment report[(1)]:

- **$47.2 billion**, or **27 percent** of FY 2016 total national Medicaid hospital expenditures were attributable to supplemental payments
- **75 percent** of the share of non-federal funds for FY 2016 Medicaid hospital supplemental payments (excluding Disproportional Share Hospital payments) was from hospital taxes and local governments

As states shift their Medicaid populations towards managed care, the available fee-for-service (FFS) upper payment limit (UPL) gap is decreasing, making it challenging to maintain historical supplemental payment levels.

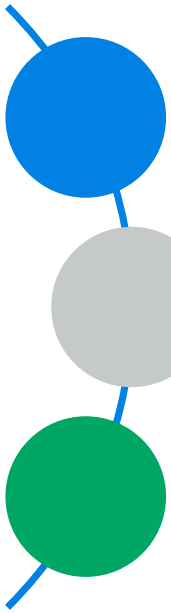
Source: 1. MACPAC, "Medicaid Base and Supplemental Payments to Hospitals" (June 2018).

Pass-through payments

To maintain supplemental payments under managed care, many states have used **pass-through payment** arrangements

- Pass-through payments are **"add-ons" to the base capitation rates** paid to Medicaid managed care plans, where the plans are required to pass the payments through to contracted providers

In its May 6, 2016 Final Rule, CMS initiated a **phase out of pass-through payments**, citing several concerns(1):



CMS viewed pass-through payments to be no different than the state making a payment outside of the contract directly to providers

CMS had difficultly linking pass-through payments to services, utilization, quality, or outcomes

CMS believed that pass-through payments limited managed care plans' ability to effectively use value-based purchasing (VBP) strategies and implement quality initiatives

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Source: CMS, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule", 81 Fed. Reg. 27498 (May 6, 2016), page 27588-27589.

State Directed Payments: Guidance

CMS provided guidance on permissible state directed payment arrangements as defined in **42 CFR §438.6(c)** in its November 2017 Informational Bulletin

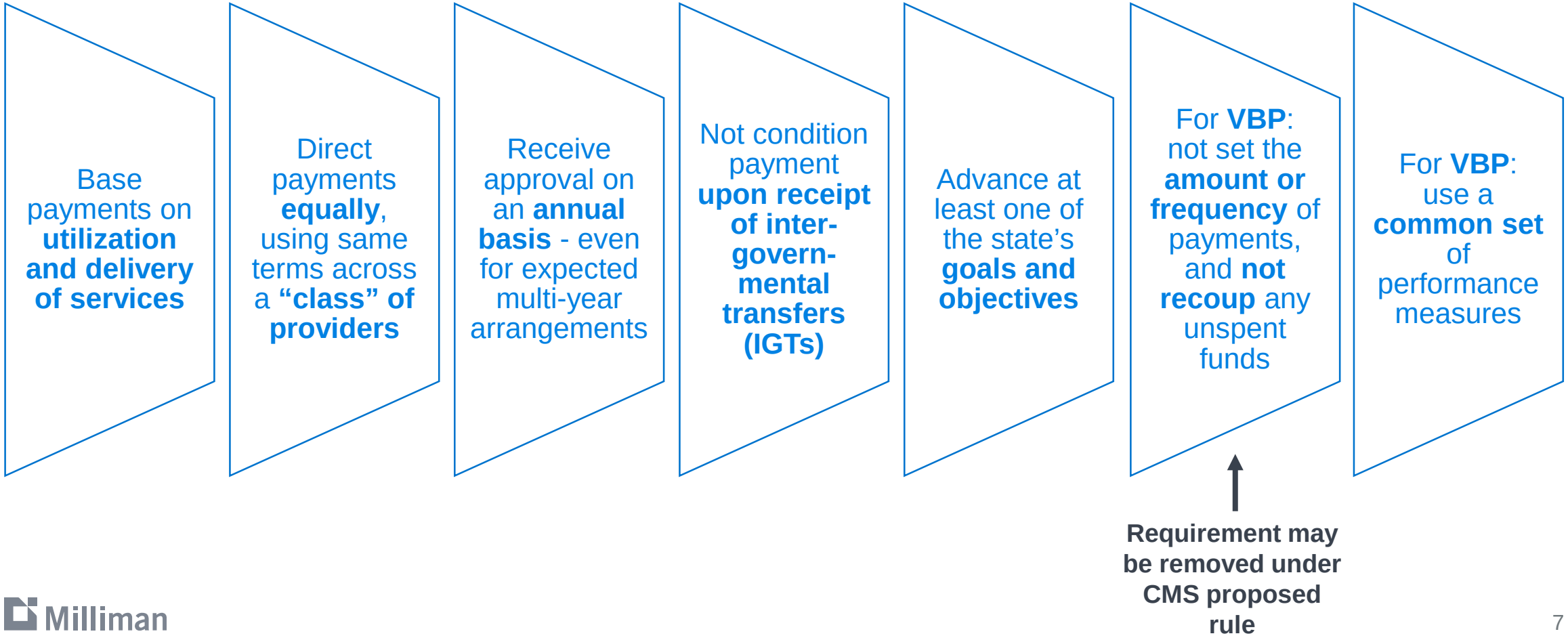
CMS defined three types of arrangements through which states may direct managed care plans to:

		Preprint Category:
1	***Implement value-based purchasing (VBP) models**:* includes bundled payments, episode-based payments, accountable care organizations (ACOs), and other models that reward providers for delivering greater value and achieving better outcomes	**VBP**
2	***Implement multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives:*** includes pay-for-performance arrangements, quality-based payments, and population-based payment models	
3	***Adopt specific types of parameters for provider payments***: includes minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules	**Directed Fee Schedule**

CMS also released the **"Section 438.6(c) Preprint" form** for states to use when applying for approval of state directed payments

Preprint approval criteria

CMS guidance regarding **Preprint form approval** requires that states must do the following in their proposed arrangements:



State Directed Payments

Capitation rate setting requirements

Guidance per the CMS 2019-2020 Medicaid Managed Care Rate Development Guide:

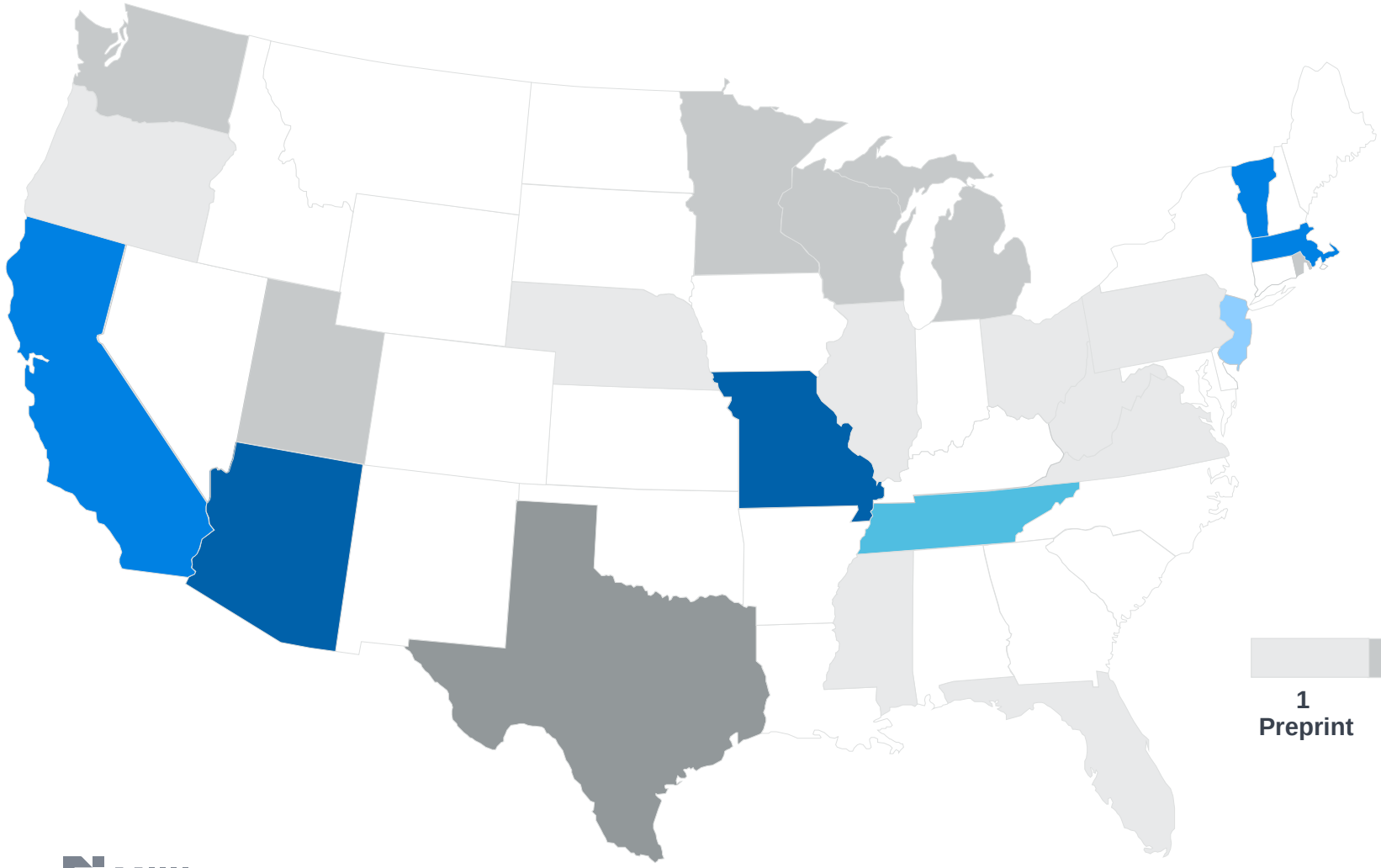
- Documentation related to the state directed payment term must be included in the initial base rate certification
- States must provide an estimate of the magnitude of the capitation rate for each rate cell related to state directed payments (if material)
- After the rating period is complete, states must submit actual state directed payments for each rate cell to CMS
- If the payment distribution or total payment amount changed from the initial base rate certification, states must submit a rate amendment and describe the magnitude of and the reason for the change

CMS §438.6 Managed Care Rule proposed changes

- Proposed **directed fee schedule** changes:
  - Permit directed payments based on a State Plan fee schedule without requiring a “Preprint”
  - Creation of new state directed fee schedule types for cost-based rates, Medicare equivalent rates, commercial rates, and other market-based rates
- Proposed directed **VBP** arrangement changes:
  - Allow multi-year approval (instead of annual approval) in certain circumstances
  - Remove the prohibition on the state specifying the amount and frequency of managed care plan payments
- Proposed **new pass-through payment** changes:
  - Transitional three year arrangement only for services or populations previously FFS with supplemental payments
  - Pass-through payment amounts **limited to historical** supplemental payment levels

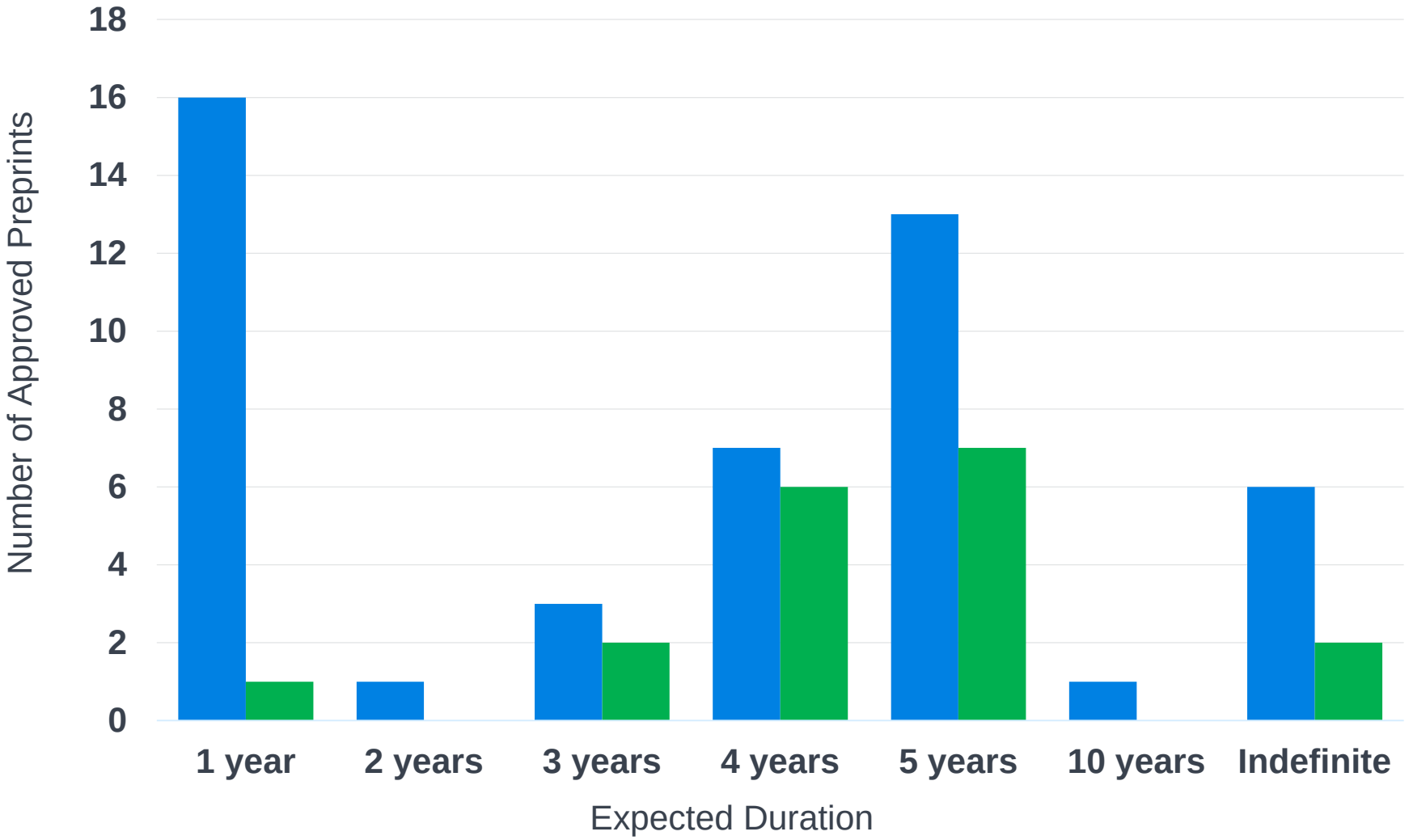
Common approaches

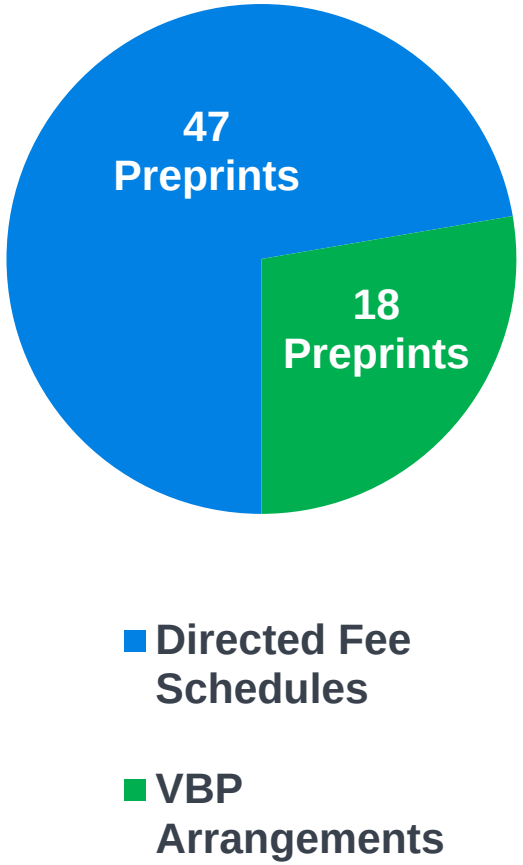
Approved preprints by state



- CMS provided **65** approved Preprints and supporting documentation submitted by **23** different states
- Approved Preprints for a given state ranged from **one to seven**, with **14 states** having more than one approved Preprint

Approved preprint categories and expected duration





Approved state directed fee schedule types

Fee schedule type (Not mutual exclusive)	Examples	Total preprints
Minimum Fee Schedule	*Directing managed care plans to pay no less than FFS rates*	25
Uniform Dollar or Percentage Increase	*Directing managed care plans to pay a per claim add-on or percentage increase above currently negotiated rates*	21
Maximum Fee Schedule	*Directing managed care plans to pay no more than the maximum FFS rate*	2
Total Unique Directed Fee Schedules		**47**

State directed fee schedule common arrangements

The most common combinations of State Directed Fee Schedule type and provider type are:

1. *Mental health and HCBS providers with minimum fee schedules* (***16 Preprints***):
   Many of these arrangements involve a minimum fee schedule based on FFS rates under the state plan

2. *Hospitals with a uniform dollar or percentage increase* (***13 Preprints***):
   Many of these arrangements involve the distribution of a fixed payment pool or a prospective increase to claim payments based on recent (monthly or quarterly) utilization

3. *Professional service providers and minimum fee schedules* (***8 Preprints***):
   Many of these arrangements involve a minimum fee schedule based on average commercial rates

State directed fee schedule components

Payment mechanisms

- Directed fee schedule increases can be made either **prospectively** (for each claim) or **retrospectively** (via lump sum payments based on prior period volume)
- Ultimately payments must be based on **utilization and delivery of services** in the contract period

Funding sources

- **10 Preprints** funding the state share of payments through **IGTs**
- **10 Preprints** funding the state share of payments through **provider taxes**
- **Nine states** reported the use of **hospital taxes**, five of which replaced an existing supplemental payment program

Goals and objectives

- The most frequently cited goal/objective was **maintaining access to care**
- States are not required to provide specific performance measures for State Directed Fee Schedules

Approved state directed VBP arrangement types

VBP Type (Not mutual exclusive)	Examples	Total preprints
Medicaid-Specific Delivery System Reform	*Statewide Medicaid initiative, typically with another Alternative Payment Model (APM)-based VBP type*	11
Population-Based Payments / ACO (Category 4 APM)	*Population-based payments such as global budgets, and integrated payment and delivery systems such as ACOs*	7
Quality Payments / Pay for Performance (Category 2 APM)	*Incentive payment programs for development of infrastructure and operations, and improved quality and outcomes*	6
Performance Improvement Initiative	*Incentive programs to report and demonstrate improvements in access and quality, typically with another APM-based VBP type*	3
Multi-Payer Delivery System Reform	*Statewide all-payer initiatives, typically with another APM-based VBP type*	2
Bundled Payments / Episode-Based Payments (Category 3 APM)	*Shared savings arrangements, bundled payments, and episode-based payments*	1
Other Value-Based Purchasing Model	*Other initiatives such as a dental incentive program*	1
Total Unique Valued-Based Purchasing Arrangements		**18**

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Note: APM categories refer to HCP-LAN's "Alternative Payment Model" framework

State directed VBP arrangement components

Participating providers

- Most VBP arrangements **involved professional service providers, hospitals, or clinics** as part of broader state delivery system reform initiatives
- Examples include **ACOs** or **pay-for-performance programs**

Funding sources

- **4 Preprints** funding the state share of payments through **IGTs**
- **2 Preprints** funding the state share of payments through **provider taxes**

Goals and objectives

- The most frequently cited goals/objectives were:
  - Improving **care quality and outcomes**
  - Reducing **delivery system fragmentation** and
  - Enhancing **care integration**

State directed fee schedules: Considerations

While simplistic on the surface, the implementation of a State Directed Fee Schedule has the potential to introduce risk to the state and health plans

Considerations for states pursing directed fee schedules include:

	▪ Managed Care Plan Compliance
	▪ Fee Schedule Updates
	▪ Managed Care Plan Utilization Risk
	▪ Provider Utilization Risk
	▪ Revenue Source Risk

State directed payment approval: Common issues

Common CMS requests during the state directed payment review and approval process:

	▪ Requests for supplemental payment benchmarks to Medicare or commercial payments
	▪ Requests for estimates of the magnitude of the capitation rate for each rate cell
	▪ Requests for the specific funding source (if not state general funds) and documentation of formal IGT agreements
	▪ Requests for more detailed quality metrics, goals, objectives and milestones, and a schedule of the state's evaluation of program progress
	▪ Requests for more a detailed description of changes in program parameters over a multi-year initiative

Panel discussion

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Thank you

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