Mercer

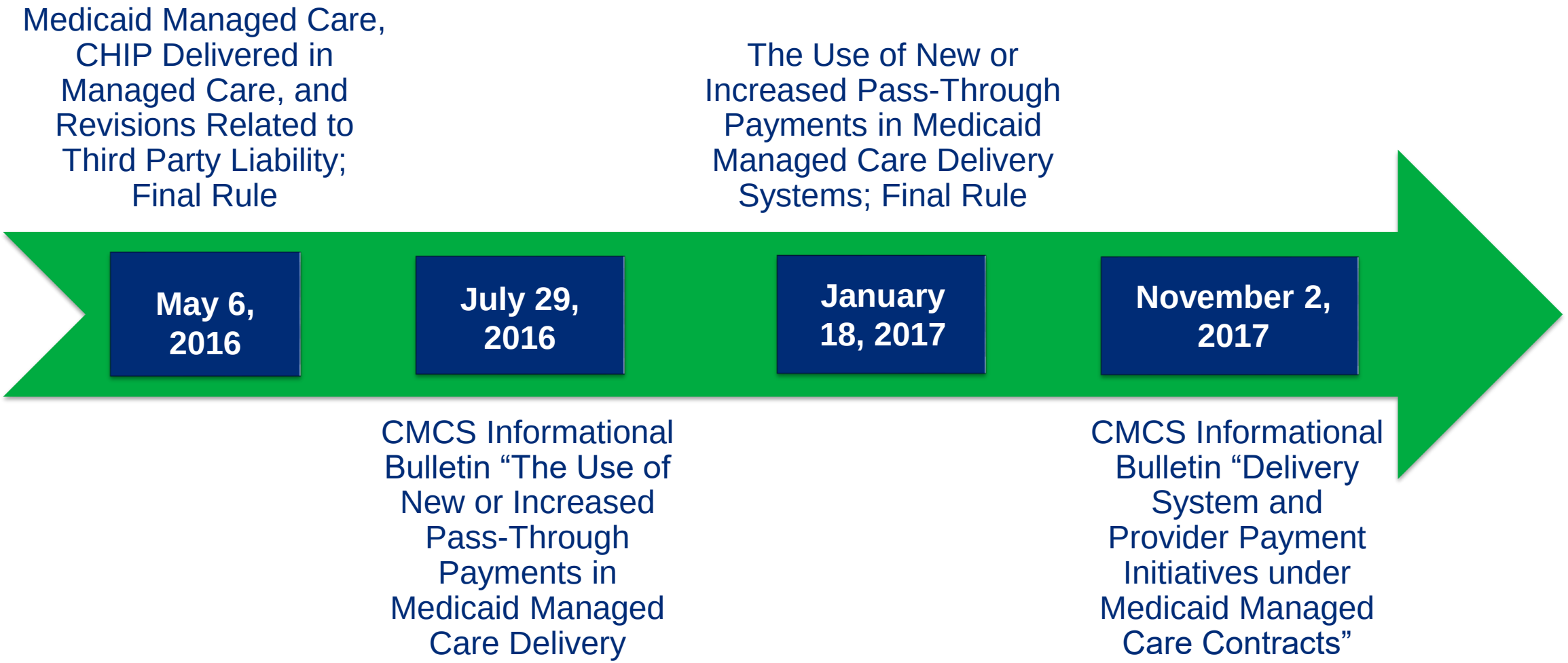
welcome to brighter

Directed Payments Under Managed Care

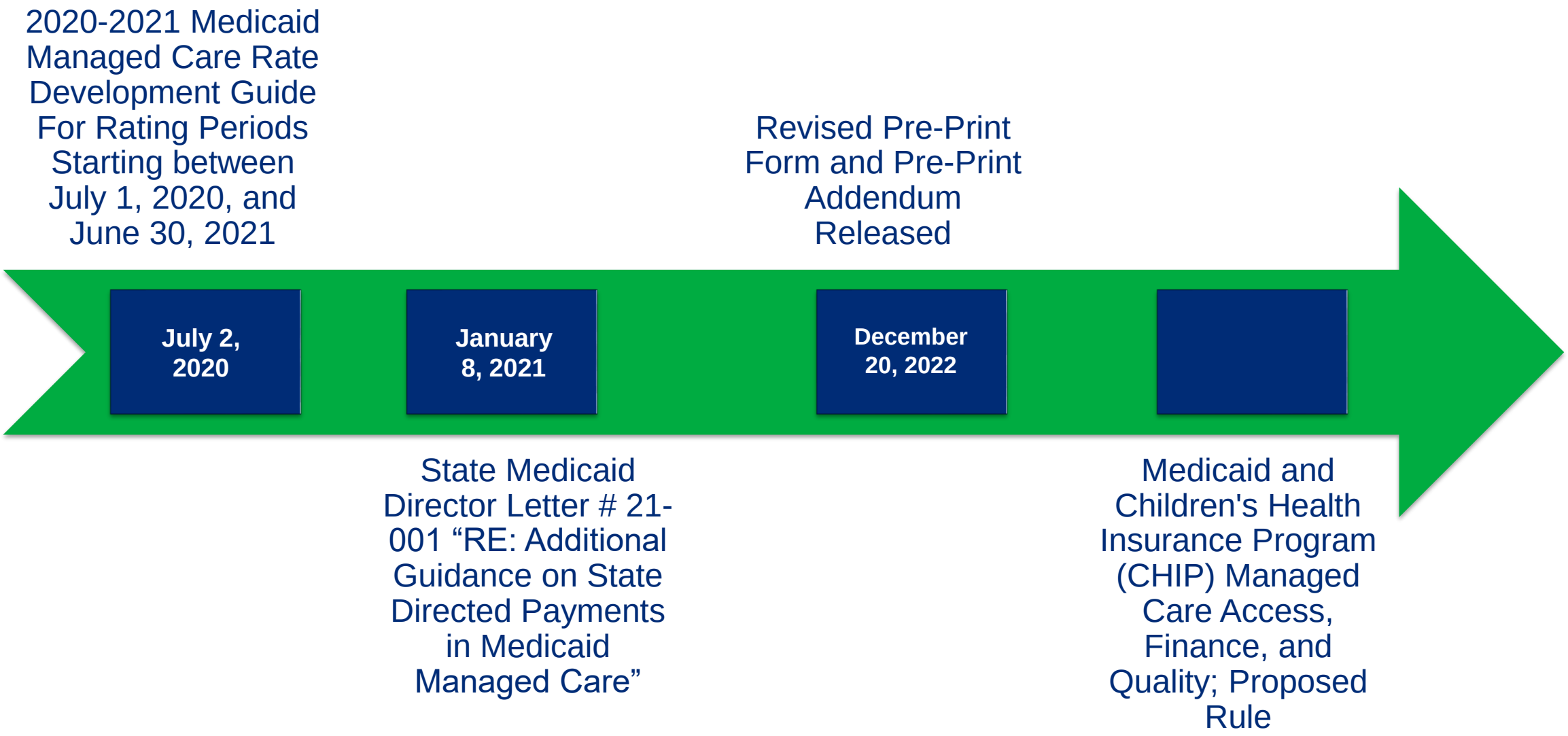
August 8, 2023

A business of Marsh McLennan

Directed Payments Timeline



Directed Payments Timeline



Types of Directed Payments

Uniform Rate Increase

- 42 CFR §438.6(c)(1)(iii)(C)
- Requires Managed Care Organizations to pay a uniform amount or percentage above the MCOs negotiated rates.
- Most common form of directed payments.
- Equivalent to supplemental payments under Fee for Service.
- Oregon: Uniform increase established by the state for inpatient and outpatient hospital services provided by Diagnosis-Related Group (DRG) hospitals for the rating period covering January 1, 2023, through December 31, 2023, incorporated in the capitation rates through a separate payment term of up to $600,000,000.

Types of Directed Payments

Minimum or Maximum Fee Schedule

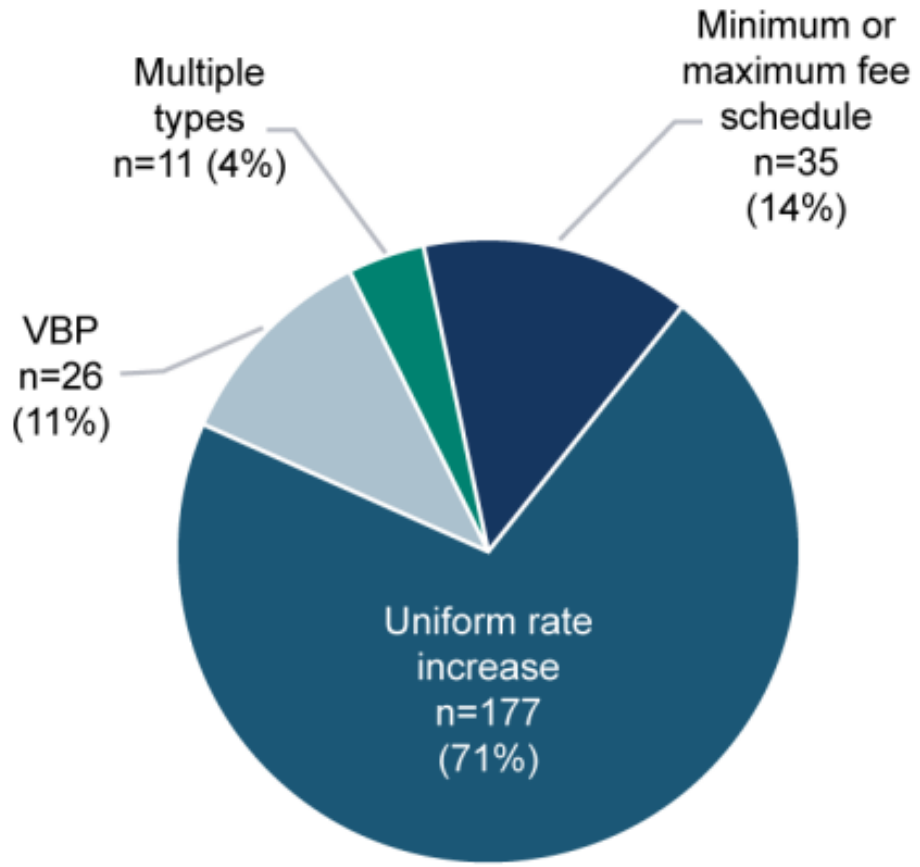
- 42 CFR §438.6(c)(1)(iii)(A), 42 CFR §438.6(c)(1)(iii)(B) or 42 CFR §438.6(c)(1)(iii)(D).
- State Medicaid Agency sets a floor or ceiling for the base payments that an MCO can pay a provider for services.
- Most common is that MCOs pay no less than the fee schedule under Fee for Service.
- North Carolina: Minimum fee schedule for outpatient laboratory services provided by in-state acute care hospitals and critical access hospitals for the rating period covering July 1, 2022, through June 30, 2023.

Types of Directed Payments

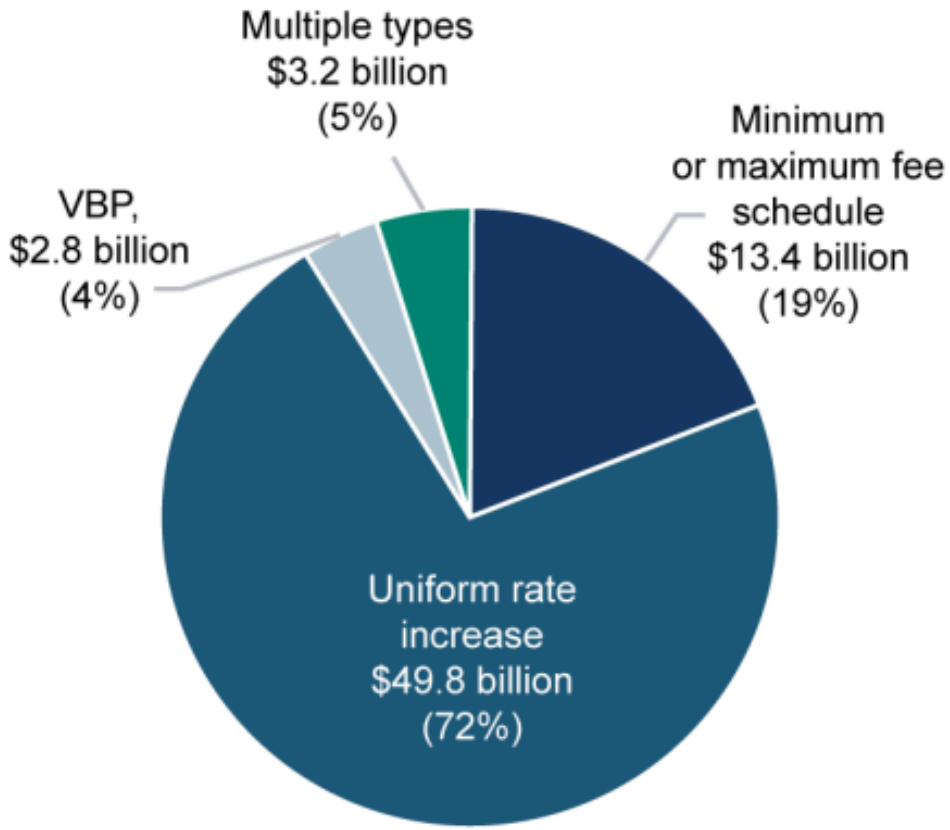
Value-Based Payments

- 42 CFR §438.6(c)(1)(i) or 42 CFR §438.6(c)(1)(ii)
- Requires Managed Care Organizations to pay to implement VBP Model
  - Pay-for-Performance
  - Shared Savings Arrangements
  - Models that require participation in multi-payer or Medicaid-specific delivery system reforms
  - Other Alternative Payment Arrangements
- Arizona: Value Based Payment for targeted Investment program established by the state for inpatient services provided at eligible hospitals for the rating period covering October 1, 2021 through September 30, 2022 and incorporated in the capitation rates through a separate payment term of up to $1.7 million.

State Direct Payment Types and Projected Payment Amounts



Approved directed payment arrangements
N = 250



Total projected spending
= $69.3 billion

Table obtained from MACPAC June 2023 Issue Brief “Directed Payments in Medicaid Managed Care”. Table based on information obtained from CMS approved SDPs from July 1, 2021, to February 1, 2023.

Requirements of State Directed Payments

Required Date and Timing Information

- Managed Care Contract Rating Period
- Requested Start Date
- Duration for State Directed Payments

May 3, 2023 Proposed Rule Additions

- Propose to require that all SDPs requiring written prior approval from CMS must be submitted to CMS no later than 90 days in advance of the end of the rating period.
- Propose to address the use of shorter-term SDPs in response to infrequent events, such as PHEs and natural disasters.

Requirements of State Directed Payments

Incorporation Into Managed Care Contracts

Current Requirements

Contract arrangements that direct the managed care plan's expenditures must have written approval from CMS prior to implementation and before approval of the corresponding Medicaid managed care contract(s) and rate certification(s).

Managed care contracts must identify value-based purchasing model(s) for provider reimbursement.

May 3, 2023 – Proposed Rule Changes

Require MCO contracts to detail SDP dates, amounts, fees, procedure codes, provider classes, and other SDP details as applicable.

Requirements of State Directed Payments

Value Based Payments (VBP) / Delivery Reform System (DRS)	State must identify the class or classes of providers that will participate in the payment arrangement.
	State must describe how the payment arrangement intends to recognize value of outcome over volume of services.
	State must identify the measure(s), baseline statistics, and targets the State will tie to provider performance.
	State must provide assurance that the SDP uses the same terms of performances to the class or classes of providers providing services under the contract.
	State must provide assurance that the SDP makes use of a common set of performance measures across all of the payers and providers.
	State must provide assurance that the SDP does not allow the State to recoup any unspent funds allocated for the SDP from the MCOs.

Requirements of State Directed Payments

Value Based Payments (VBP)/ Delivery Reform System (DRS)	Proposes to remove the existing requirements at §438.6(c)(2)(iii)(D) that currently prohibit States from recouping unspent funds allocated for these SDPs.
Changes Under May 3, 2023 Proposed Rule	Remove the existing requirements that currently prohibit States from setting the amount or frequency of the plan's expenditures.
	Require that population-based and condition-based payments be conditioned upon either the delivery by the provider of one or more specified Medicaid covered service(s) during the rating period or the attribution to the provider of a covered enrollee for the rating period for treatment.
	Modify 42 CFR §438.6(c)(3)(i) to add that a multi-year written prior approval may be for of up to three rating periods (codifying existing CMS policy).

Current Preprint Requirements of State Directed Payments

State Directed Fee Schedules

Determine Type of Fee Schedule SDP

- Maximum fee schedule
- Minimum fee schedule
- Uniform dollar or percentage increase

Identify Basis for Fee Schedule SDP

- Approved State Plan fee schedule
- Medicare fee schedule
- Alternative fee schedule developed by the State
- State must explain how fee schedule is reasonable and appropriate.

Requirements for Maximum Fee Schedule

- State assures that MCOs have retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- Identify the process for plans and providers to request an exemption if contract obligations require payment to exceed maximum fee schedule.
- Describe number of exemptions and how these exemptions impacted rate development.

Uniform Dollar or Percentage Increase Questions

- Uniform Dollar Amount or Uniform Percentage Increase
- What is the magnitude of the increase?
- Describe how it will be paid out to providers.
- Describe how the increase was developed and show it is reasonable and appropriate.

Preprint Requirements of State Directed Payments

State Directed Fee Schedules

May 3, 2023 Proposed Rule – Pre-Print Exclusion

- Allow States to use 100% of Medicare Fee Schedule without pre-print approval
- Allow States to use 100% of Medicaid State Plan approved Fee Schedule without pre-print approval

May 3, 2023 Proposed Rule – Average Commercial Rate

- Allow total SDP payments to equal the Average Commercial Rate.
- States will need to supply an ACR demonstration and comparison of total payments to ACR.
- Sets requirements for demonstration of the ACR if a State seeks written prior approval for an SDP that includes I/P services, O/P hospital services, qualified practitioner services at an academic medical center.

May 3, 2023 Proposed Rule – Reconciliations

- No interim payments based on historical utilization with reconciliation after the end of the rate period of the SDP.

Requirements of State Directed Payments

Provider Class and Assessment of Reasonableness

Identify the class or classes of providers that will participate in this payment arrangement.

Inpatient hospital service, outpatient hospital service, professional services at Academic Medical Center, primary care services, specialty physician services, nursing facility services, HCBS / personal care services, behavioral health inpatient services, behavioral health outpatient services, dental.

Define and justify the use of provider class if narrower than the previously listed classes.

Provider classes cannot be defined to only include providers that provide intergovernmental transfer.

Describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

How will the SDP interact with negotiated rate(s) between the plan and the provider?

Replace the negotiated rate.

Limit but not replace the negotiated rate.

Require a payment made in addition to the negotiated rate.

For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rate, States must provide an analysis showing the impact of the state directed payment on payment levels for each provider class.

Include an estimate of the base reimbursement rate the MCOs pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment.

Describe the data sources and methodology used for the analysis.

Describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

Requirements of State Directed Payments

Incorporation Into the Actuarial Certification

- Identify using the table for each actuarial rate certification review that includes state directed payments.

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)

- If state-directed payment not included in actuarial rate certifications, the State must provide estimate of when certification will be submitted to CMS for review.

Submission ETA

- Identify how SDP will/has been incorporated in the applicable actuarial rate certification.

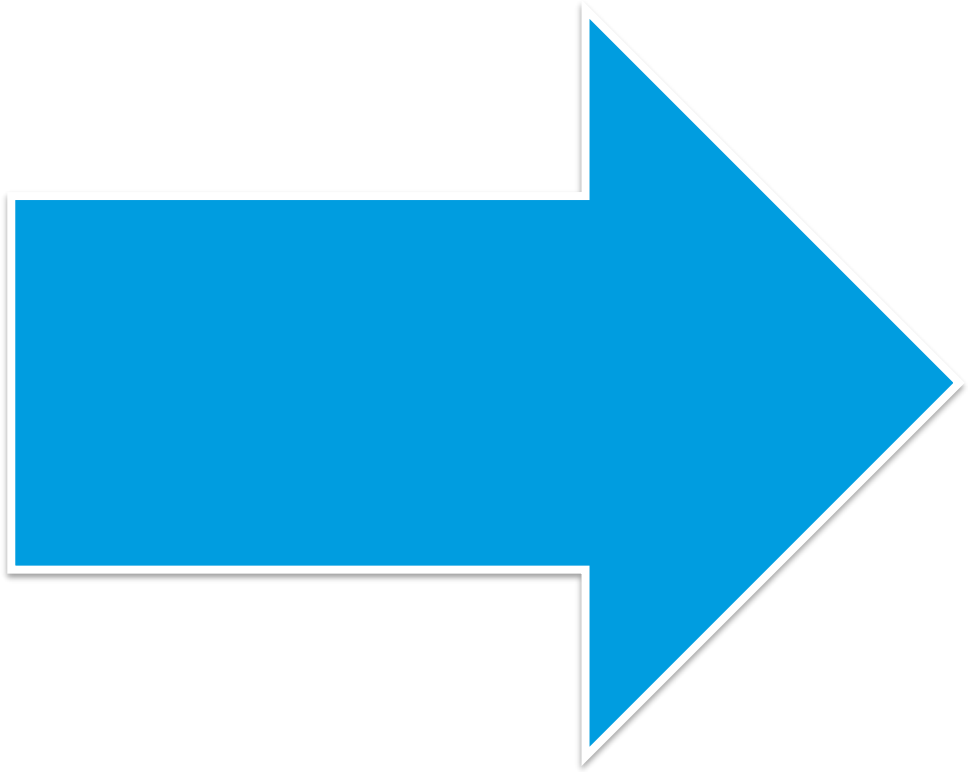
An adjustment applied in the development of the monthly base capitation rates paid to plans.

Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

Describe other option used.

Requirements of State Directed Payments

Incorporation Into the Actuarial Certification



In accordance with 42 CFR. §438.6(c)(2)(i), States assure that all expenditures for this SDP are developed in accordance with 42 CFR §438.4, the standards specified in 42 CFR §438.5, and generally accepted actuarial principles and practices.

Requirements of State Directed Payments

Incorporation Into the Actuarial Certification

May 3, 2023 Proposed Rule

- Require States to submit a rate certification or rate certification amendment incorporating the separate payment term within 120 days of either the start of the payment arrangement or written prior approval of the SDP, whichever is later.
- Propose that the State may pay each MCO a different amount under the separate payment term compared to other MCOs so long as the aggregate total dollars paid to all MCOs exceed the total dollars of the separate payment term for each respective Medicaid managed care program included in the Medicaid managed care contract.
- Propose that no later than 12 months following the end of the rating period, the State would have to submit documentation to CMS that includes the total amount of the separate payment term in the rate certification consistent with the distribution methodology described in the State directed payment for which the State obtained written prior approval.
- Propose that the State, through its actuary, would have to provide an estimate of the impact of the separate payment term on a rate cell basis, as paid out per the SDP approved by CMS.

Requirements of State Directed Payments

Intergovernmental Transfer

- State must provide information on the following: name of entities transferring funds, operational nature of the transferring entity, amount transferred by entity, taxing authority of transferring authority, does the transferring entity receive appropriations, and is the transferring entity eligible for SDP?
- Assure “that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.”
- Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement.

Provider Tax/Assessments

- Provide a table with the following: Name of the Health Care Related Provider Tax / Assessment; Identify the permissible class for this tax / assessment; Is the tax / assessment broad-based?; Is the tax / assessment uniform?; Is the tax / assessment under the 6% indirect hold harmless limit?; If not under the 6% indirect hold harmless limit, does it pass the “75/75” test?; Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
- Provide listing of any waiver(s) of the broad-based and/or uniform requirements for any SDP using a health care

Funding of the Non-Federal Share

Provider Donations

- Is the donation bona-fide?
- Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?

Required Assurance for All State Directed Payment Arrangements

- Assure the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements

Requirements of State Directed Payments

Funding of Non-Federal Share

May 3, 2023 Proposed Rule Changes

Non-Federal share of SDP arrangements must comply with Federal regulations.

States would be required to ensure that each participating provider in an SDP arrangement attests that it does not participate in any hold harmless arrangement with respect to any health care-related tax.

Requirements of State Directed Payments

Quality Criteria and Framework for All Payment Arrangements

Goals and Objectives	State Quality Strategies > Medicaid	Revisions	Every Three Years
Assure that SDP to advance at least one of the goals and objectives in the quality strategy required per 42 CFR §438.340.	States must post the final strategy online beginning July 1, 2018.	States must submit draft version and provide the target date for submission of the revised strategy and note any potential changes to the goals and objectives.	To be in compliance. with 42 C.F.R. §438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

Requirements of State Directed Payments

Quality Criteria and Framework for All Payment Arrangements

May 3, 2023 Proposed Rule Changes

States required to submit evaluation plan for any SDP that requires written approval.

Evaluation plan must identify at least two metrics that would be used to measure the effectiveness of the Payment arrangement in advancing the identified goal(s) and objective(s) from the State's managed care quality strategy on an annual basis

Require States to include baseline performance statistics for all metrics that would be used in the evaluation since this data must be established in order to monitor changes in performance during the SDP performance period.

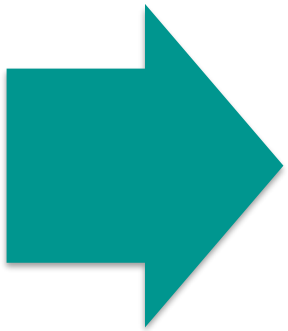
CMS clarifies its authority to deny proposed State Directed Payment plans if a written evaluation plan for the SDP which meets the new proposed requirements is not submitted by the State.

Propose to require that evaluation reports include the 3 most recent and complete years of annual results for each metric as approved under the evaluation plan approved as part of the preprint review.

Requirements of State Directed Payments

Incorporation into the Actuarial Certification

Current State Directed Payment Arrangements Denials Cannot Be Appealed



May 3, 2023

Proposed Rule Allows States to Appeal Denials to Health and Human Services (HHS) Department Appeals Board

Mercer

Services provided by Mercer Health & Benefits LLC.

A business of Marsh McLennan