MILLIMAN WHITE PAPER

Approved Medicaid State Directed Payments: How States are Using §438.6(c) "Preprints" to Respond to the Managed Care Final Rule

Executive Summary

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Introduction

In response to the Medicaid managed care final rule, many states have recently gained approval from the Centers for Medicare and Medicaid Services' (CMS) for "state directed payments" that support delivery system and provider payment reforms. Through state directed payments, states are permitted to direct managed care plans to make specified payments to healthcare providers when the payments support overall Medicaid program goals and objectives. Additionally, state directed payments provide a permissible mechanism for making supplemental payments in managed care programs, as an alternative to pass-through payments (which are phased out in the final rule).[1]

Approved Directed Payment Arrangements

Whereas pass-through payments were often opaque and not clearly understood by all affected parties, state directed payments enable states to establish clear guidelines and direction for managed care plans and providers. These arrangements also allow states to coordinate value-based purchasing (VBP) and other delivery system reform initiatives in managed care programs.

As states consider state directed payments, it can be helpful to understand the types of programs that have been approved by CMS. **This white paper provides background on state directed payment arrangements based on our review of §438.6(c) "Preprints" and supporting documentation for arrangements approved by CMS as of August 15, 2018.**

Highlights from our review of approved Preprint documentation are as follows:

- *Number of approved arrangements*. There were 65 approved state directed payment arrangements submitted by 23 different states. The number of approved Preprints for a given state ranged from one to seven, with 14 states having more than one approved Preprint.
- *Primary categories*. The Preprint form groups the State Directed Payment arrangements into two categories: "State Directed Fee Schedules" and "State Directed Value-Based Purchasing". Of 65 approved Preprints review, 47 (72%) were for State Directed Fee Schedules and 18 (28%) were for State Directed Value-Based Purchasing.
- *Directed State Fee Schedule strategies*. Payments to providers under State Directed Fee Schedules can be made via required fee schedule increases or lump sum payments. Either way, directed payment increases must be based on utilization and delivery of services in the managed care contract period for which the payment arrangement is approved.
- *Funding mechanisms*. We identified several State Directed Fee Schedules where the state share was funded either through an intergovernmental transfer (IGT) or a health care-related tax (also known as provider assessment or provider tax). Among the State Directed Fee Schedules applicable to hospitals, we found nine arrangements that reported funding through a provider tax, five of which referenced replacing an existing hospital supplemental payment program. We also found ten arrangements that reported funding through IGTs, which is permissible so long as payments are not conditioned solely on the state's receipt of the IGT.

- *Fee schedule goals*. For the State Directed Fee Schedule arrangements, many cited goals and objectives related to maintaining access to care.
- *Value-based purchasing goals*. For the State Directed Value-Based Purchasing arrangements, many cited goals and objectives related to improving care quality and outcomes, reducing delivery system fragmentation and enhancing care integration.
- *Value-based purchasing providers*. Many of the State Directed Value-Based Purchasing arrangements involved professional service providers, hospitals, and clinics as part of broader state delivery system reform initiatives with Accountable Care Organizations (ACOs) or pay for performance programs with specific quality metrics.
- *Preprint duration*. The "expected duration" reported by states in the Preprints ranged from one year to indefinite, with 17 Preprints with a one year expected duration and 48 Preprints with an expected duration of more than one year. Regardless of the expected duration, all State Directed Payment arrangements must be approved by CMS on an annual basis, even for expected multi-year arrangements.

Reforming state Medicaid provider reimbursement

The majority of approved arrangements to date have been for State Directed Fee Schedules. While simplistic on the surface, the implementation of a State Directed Fee Schedule has the potential to introduce risk to the state, health plans and providers. There are several considerations for states pursuing these types of arrangements, including managed care plan compliance and utilization risk, use of prospective vs. retrospective fee schedule updates, impacts on provider utilization and behavior, and revenue sources to fund enhanced payments.

As states establish State Directed Payment arrangements to implement VBP initiatives in managed care programs, and with the potential for CMS' evaluation criteria to evolve over time, the balance of these arrangements may shift from State Directed Fee Schedules to VBP. While generally more complex, VBP arrangements give states the flexibility to require managed care plan participation and direct managed care plan payments in value-based purchasing and other delivery system reform or performance improvement initiatives.

The full paper is available here.

Ohio Case Study

Milliman recently assisted the Ohio Department of Medicaid (ODM) with the design of an approved State Directed Value-Based Purchasing Preprint for the Care Innovation and Community Improvement Program (CICIP), effective July 1, 2018. CICIP is a "Quality Payments / Pay for Performance" State Directed Value-Based Purchasing arrangement applicable to professional service providers affiliated with four large Medicaid safety-net and academic medical centers. The goal of the CICIP is to incentivize improved healthcare for Medicaid beneficiaries at risk of, or with, an opioid or other substance abuse disorder.

Monthly CICIP payments are made from managed care plans to providers based on historical utilization information, which is similar with the uniform dollar increase approach used in many approved State Directed Fee Schedules. However, CICIP differs from Directed Fee Schedule arrangements in that ODM defined specific quality metrics and other value-based payment requirements that affect payment, and also implemented a retrospective reconciliation process to ensure that monthly payments are based on actual program utilization. With respect to the quality metrics and other value-based payment requirements, ODM implemented the following:

- Nine separate performance measures, including the number of dispensed opioid solid doses without Suboxone, follow-up visits after mental illness hospitalizations and emergency room utilization reduction.
- Three separate provider requirements related to care delivery, staff development, and peer education:
  1. Execute a population health approach to improving care, including patient risk identification and stratification, report reviews, team-based care, and participation in coalition meetings on quality program alignment, implementation, and best practices.
  2. Train prescribers on consensus-based opioid prescribing guidelines and on the use of electronic medical records (EMR) to promote prevention and appropriate pain treatment practices.
  3. Share best prevention and treatment practices with other practices.

By using a state directed payment arrangement, ODM was able to achieve greater specificity, control, and transparency regarding the total value and direction of payments, quality measures, and other operational considerations that are not typically found in pass-through payment arrangements.

FOOTNOTE

[1] 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).

About the authors

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