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Proposed updates to pass-through payment guidance

Opportunities for simplification, facilitating fee-for-service transitions

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In the November 14, 2018, federal register, the Centers for Medicare and Medicaid Services (CMS) released proposed updates to Medicaid managed care pass-through payment guidance promulgated in 42 CFR 438.6. The updates appear to simplify and streamline the approval process. In addition, new authority was proposed to facilitate fee-for-service (FFS) transitions.

The new proposed authority would allow for transitional pass-through payments to facilitate transitions from FFS delivery systems to managed care delivery systems. This applies to new populations and also to new services carved in for populations already under managed care.

In addition, CMS proposed administrative simplifications intended to streamline or eliminate the need for prior approval. These are described in this update to our May 2016 paper.[1]

Background

PASS-THROUGH PAYMENTS AFTER 2016

In Medicaid managed care regulations published in the Federal Register on May 6, 2016 ("the 2016 final rule")[2], and in clarifying guidance released January 2017 in 82 CFR 5415[3] (the 2017 pass-through payments final rule), CMS prohibited the use of most pass-through payments in managed care, allowing only transitional payments phasing out over five or 10 years, depending on the provider type. In response, states have worked to restructure reimbursement to retain funding streams deemed critical to key providers such as safety net hospitals. As discussed in our May 2016 paper, CMS suggested three types of approvable arrangements in 42 CFR 438.6(c): value-based purchasing programs, delivery system reform, or state directed fee schedules.

SECTION 438.6 PREPRINTS

The three types of arrangements approvable under §438.6 must meet a number of conditions and require prior CMS approval. To facilitate the approval process, CMS developed a form, the Section 438.6(c) preprint[4], to allow states to describe the type of arrangement proposed. The preprint must be approved by CMS prior to incorporating the arrangement in a Medicaid managed care rate certification. As of August 15, 2018, 65 preprints had been approved for 23 states. Milliman published a comprehensive review of these approved arrangements as of October 2018.[5]

New pass-through payments for transitions from fee-for-service

Under the 2017 pass-through payments final rule, all new pass-through payments are specifically prohibited. The new proposed regulations would provide significant authority to pay transitional pass-through payments for service or populations newly covered under managed care. The proposed authority is not time-limited, but does involve certain limitations.

INTENT

CMS noted in the proposed rule that states are continuing to shift members and services from FFS delivery systems into managed care. Additionally, the 2016 final rule, as clarified in the January

[1] Pass-through payment guidance in final Medicaid managed care regulations: Transitioning to value-based payments, delivery system reform, and required reimbursement. By Andrew Gaffner, Carmen Laudenschlager, and Christine M. Mytelka. May 10, 2016. Retrieved on December 6, 2018, from http://www.milliman.com/insight/2016/Pass-through-payment-guidance-in-final-Medicaid-managed-care-regulations-Transitioning-to-value-based-payments/

[2] 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).

[3] CMS provided additional clarification on transitional payments in the January 18, 2017 Federal Register (82 FR 5415), and prohibited any new or increased pass-through payments after July 2016.

[4] Section 438.6 (c) Preprint. Retrieved on December 6, 2018, from https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/438-preprint.pdf

[5] Approved Medicaid State Directed Payments: How states are using §438.6 (c) preprints to respond to the managed care final rule. By Jim B. Pettersson, Ben Mori, Luke B.G. Roth, and Jason Clarkson. October 2018. Retrieved on December 6, 2018, from http://www.milliman.com/uploadedFiles/insight/2018/Approved-Medicaid-State-Directed-Payments-full.pdf

2017 guidance, is potentially creating barriers in some states for transitioning members or services to managed care, given that supplemental payments are allowed under FFS, but would be limited or disallowed under managed care.

Transitioning to an alternative payment structure requires a significant amount of coordination and communication between multiple shareholders, including providers, CMS, the state, and managed care plans. To allow states time to transition these supplemental payments to an alternative type of payment under managed care, CMS is proposing to allow states to require managed care plans to make pass-through payments for up to three years from the beginning of the first rating period in which services or members transitioned from a FFS delivery system to a managed care arrangement.

PROVISIONS

The proposal allowing pass-through payments to continue under managed care contracts for three years is subject to several requirements. One significant requirement is that the services or members to be covered by managed care plans were previously covered under a FFS delivery system and will be covered by managed care for the first time. Additionally, the services to be reimbursed through a pass-through payment must have been previously subject to supplemental payments in the FFS delivery system, and the aggregate amount of the pass-through payment to be made in managed care for a provider type on an annual basis is no greater than the amount previously paid in the FFS delivery system to the provider type for a specified historical period.

CMS provides further detail on the calculation to ensure that the aggregate amounts under managed care do not exceed those paid under the FFS delivery system. Specifically, they propose using Medicaid Management Information System (MMIS) data from the 12-month period immediately two years prior to the first rating period under managed care.

The calculation would be performed for each provider type, which could be hospitals, physicians, or nursing facilities. Pass-through payments allowed under managed care for each provider type are further limited based on the portion of overall payments expected to transition from the FFS delivery system into managed care. There does not appear to be any requirement for pass-through payments to decline over the three-year period.

IMPLICATIONS

As mentioned previously, the purpose of implementing this change to the 2016 final rule is to allow states time to implement alternative payment methods when services or members are transitioned into managed care. Allowing this additional time will minimize disruption to safety net and other providers where these pass-through payments are critical for continued operation.

Given that the transition time is limited to three years, the implication in the proposed rule change is that any payment to providers under managed care will ultimately be tied to underlying utilization and services provided after transition to one of the alternative payment arrangements in §438.6(c).As with these arrangements, the proposed change to the rule appears to only work well to transition supplemental payments that are broad-based, not those limited to a small number of providers who provided intergovernmental transfers (IGTs) in the past.

Proposed updates to pass-through payment guidance

From discussions with the states, CMS identified several opportunities to simplify the §438.6(c) preprint approval process.

STATE PLAN APPROVED RATES

After the 2016 final rule, CMS noticed that one common type of request was for states to direct managed care organizations (MCOs) to pay no less than rates approved in the State Plan. CMS proposes to no longer require prior approval for such arrangements. (§438.6(c)(1)(iii)(A))

However, this streamlined authority is proposed only to apply to state plan approved per unit rates and not to supplemental payments approved in the state plan. Definitions for *State plan approved rates* and *Supplemental payments* were added to §438.6(a).

As with all directed payment arrangements, the new rule proposes to clarify that state directed payment of rates approved in the state plan must be developed using generally accepted actuarial principles and practices, and following all other applicable regulations.

OTHER TYPES OF APPROVABLE DIRECTED PAYMENTS

Although they would still require prior approval, the proposed rule singles out certain payments as generally acceptable in §438.6(c)(1)(iii)(E). These include:

- Cost-based rates
- Medicare-equivalent rates
- Commercial rates
- Other market-based rates

Directed payments using these methodologies would no longer need to be characterized as a minimum or maximum fee schedule or a uniform dollar or percentage increase. The additional authority is intended to encourage states to experiment with market-based payment models.

These rates must be generally available to network providers for a particular service and must continue to meet all requirements in §438.6(c)(2)(ii), such as being based on the utilization and delivery of services, treating all providers in a class equally, the prohibition on requiring IGTs, and requirement to link to the quality strategy and develop an evaluation plan.

AMOUNT AND FREQUENCY OF EXPENDITURES

CMS proposes to remove section §438.6(c)(2)(ii)(C), which currently prohibits states from directing the amounts or frequencies of payments to providers. By removing this section, CMS comments that it is removing an unintended barrier, and instead pledges support for innovative payment arrangements intended to transition from volume to value.

APPROVAL TIMEFRAME

In the commentary, CMS notes that payment arrangements may be included in multi-year managed care contracts even if they are subject to annual approval.

CMS proposes to add section §438.6(c)(3) to address when multi-year approvals would be permitted, clarifying and codifying guidance in the November 2, 2017, CMCS informational bulletin.[6] Approvals for more than one rating period are not available for state directed fee schedules under §438.6(c)(1)(iii), but are only available for initiatives under §438.6(c)(1)(i) or (ii): state directed value-based purchasing. Multi-year approvals must also meet the following criteria:

- The arrangement is clearly described by year, if it varies by year.
- Implementation, evaluation, and impact on the State's quality strategy are all clearly described.
- No changes are made to terms during the effective years. If the state determines changes are needed for subsequent years, these require prior approval.

Final thoughts

Almost half of the 50 states now have approved Section 438.6 preprints and experience with the approval process for directed payments. Although the approval process adds administrative complexity, most states are adapting, and the authors welcome CMS's proposed efforts to streamline the process.

The proposed transitional pass-through payments provide a new tool with the potential to ease transitions from fee-for-service, and CMS provides helpful clarifications and guidance regarding the intent of the 2016 final rule. Overall, the proposed regulation appears to signal a willingness by CMS to work with states to facilitate and support approvable arrangements.

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[6] CMCS Informational Bulletin. November 2, 2017. Retrieved on December 6, 2018, from https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf