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WHITE PAPER

State-directed payment considerations for the CMS Medicaid and CHIP Managed Care Access, Finance, and Quality proposed rulemaking

By Ben Mori, Amanda Schipp, Jason A. Clarkson, Carmen Laudenschlager, and Luke B.G. Roth

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Introduction and background

On April 27, 2023, the Centers for Medicare and Medicaid Services (CMS) released a notice of proposed rulemaking (NPRM) titled "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality"[1] (also referred to as the "Managed Care NPRM" or the "proposed rule"). In its proposed rule, CMS describes a range of potential policy changes related to 42 CFR §438.6(c) "state directed payment" (SDP) arrangements in Medicaid managed care (among other changes), citing the need to "increase transparency and accountability, standardize data and monitoring, and create opportunities for states to promote active beneficiary engagement in Medicaid and CHIP programs" in the fact sheet summary related to this rule.[2] Depending on the policies selected by CMS in its final rule, the proposed changes to SDPs could have significant implications and impacts on how states currently finance and reimburse providers. The Managed Care NPRM's public comment period is open as of this writing and is scheduled to conclude on July 3, 2023.

SUMMARY

Key proposed changes under managed care NPRM

1. Average Commercial Rates (ACR):
  a. Formalizes aggregate payment limit up to ACR
  b. Requires prospective ACR demonstration every three years and annual ACR benchmarking
  c. Alternative proposals presented to limit SDPs to Medicare for non-VBP arrangements, or limit SDPs to a percentage of managed care expenditures

2. Utilization-Based Payments
  a. Requires SDP payment distribution to be based on contract year utilization, and prohibits post-payment reconciliation
  b. Defines separate payment terms as fixed payment pools paid outside of capitation rates

3. CMS Review and Approval Process
  a. Establishes SDP submission timing requirements
  b. Prohibits preprint modifications following the conclusion of a rating period
  c. Exempts minimum fee schedules aligned to Medicare rates from preprint submission

4. Non-network Providers
  a. Removes "network provider" restriction to allow states to direct fee schedules for non-network providers

5. Provider Attestations
  a. Require states to collect hold harmless-related attestations from providers receiving SDPs

6. Key Reporting Requirements
  a. Annual directed payment report showing SDP distribution at the provider level
  b. Expected preprint form changes
  c. Evaluation report every three years based on "measurable performance targets"

SDPs allow states to require managed care plans to make specified payments to healthcare providers when the payments support overall Medicaid program goals and objectives.[3] In addition, these arrangements provide a permissible mechanism for making supplemental payments to providers through managed care programs, as an alternative to the legacy pass-through payments and "grey area" payments.[4] Whereas pass-through and grey area payments were often opaque and not clearly understood by all affected parties, SDPs enable state agencies 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.

This white paper contains a summary of key changes to SDPs under the proposed rule that may be impactful to state Medicaid agencies. Given the substantial number of changes proposed by CMS, this paper is not a comprehensive list, but rather highlights key proposed changes for states' consideration. If implemented, we anticipate many states will be required to revise existing SDP program design and operations to achieve compliance with the final rule.

Average commercial rate

Payment ceiling: ACR vs. Medicare rate

CMS is seeking comment on whether to set a payment ceiling for SDP at the average commercial rate (ACR) or whether to align with Medicare rates, although the proposed rule expresses a preference for the former. The SDP proposal that CMS expects to have the "most significant economic impact" is officially establishing an SDP aggregate "ceiling" based on ACRs.[5] This proposed ACR limit would be applicable to inpatient hospital services, outpatient hospital services, qualified practitioner services at academic medical centers, and nursing facility services. CMS does not propose to establish an SDP ceiling for other services at this time (other than the requirement that SDPs be "reasonable, appropriate, and attainable"), citing the need for future research.

This portion of the proposed rule, which would become effective in the first rating period following the final rule, is consistent with CMS's current operation procedures. CMS cited that it has approved 145 SDPs since 2017 for these service types[6] (expenditures totaling $11.6 billion in 2022)[7] where aggregate Medicaid managed care payments for each provider class were above Medicare payment levels (the basis for the traditional fee-for-service Upper Payment Limit) but did not exceed 100% of the ACR. While CMS has approved these types of SDPs on a case-by-case basis, it has not previously promulgated this ACR payment limit policy in rule.

Although this portion of the proposed rule would formalize its existing policy, CMS stated it is "concerned about incentivizing States to raise total payment rates up to the ACR based on the source of the non-Federal share, rather than based on furthering goals and objectives outlined in the State's managed care quality strategy."[8] In its fiscal projections, CMS estimates a range of potential SDP increases from *$0 to $17.3 billion per year* (total computable) by 2028 based on this proposed rule. The upper end of this range is based on CMS's expectation that additional states may increase SDPs to approach the ACR ceiling (especially for SDPs that currently pay up to Medicare).

To address its concerns about the potential increase in SDP expenditures, CMS is also considering an *alternative policy* that would place an "additional fiscal guardrail" and would limit the use of an ACR ceiling to *VBP initiatives only*. Under this alternative policy, for other "directed fee schedule" SDPs (such as minimum fee schedules, maximum fee schedules, and uniform increases) the payment ceiling would be the "Medicare rate." CMS is considering applying this Medicare ceiling to a range of provider types, expanding from the four proposed ACR provider types previously described to all provider types. CMS stated that its goal under this alternative policy is to "incentivize States to consider quality-based payment models that can better improve health outcomes for Medicaid managed care enrollees."[9] Given the numerous directed fee schedule SDPs with an ACR ceiling that have been previously approved by CMS, this alternative policy would require states to transition a significant portion of directed fee schedules to VBP in order to preserve existing funding levels. For states that are unable to make this transition, there would be a *significant reduction in SDPs*. Notably, CMS did not provide a fiscal estimate under this alternative scenario.

ACR demonstration requirements

For SDPs paying up to ACR, CMS is proposing additional documentation including an ACR demonstration and total payment rate comparison to the ACR, as described below.

ACR demonstration: ACR demonstrations, which detail how the ACR is calculated, are proposed to be required with the "preprint" form (the CMS SDP application) for submission beginning with the first rating period following the effective date of the final rule, and then updated at least every three years thereafter. CMS proposes that the payment data used in the ACR calculation must meet the following requirements:

1. Is specific to the state (as opposed to national data or supplementing with neighbor state data)
2. Is no older than the three most recent and complete years prior to the start of the rating period
3. Is specific to the service(s) addressed by the SDP
4. Includes the total reimbursement by the third-party payer and any patient liability, such as cost sharing and deductibles
5. Excludes payments to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and any noncommercial payers such as Medicare
6. Excludes any payment data for services not covered under the SDP's applicable Medicaid managed care contracts.

CMS explicitly said it is *not* proposing to require states to use a specific data source in its ACR demonstration. CMS described multiple acceptable data sources, including all payer claims data, proprietary commercial payment databases,[10] and hospital cost reports. CMS is also not proposing to require a specific template or format for the ACR demonstration.

Another important change is that CMS proposes to allow states to establish an ACR at the statewide service level that could be applicable to all provider classes in the SDP. Currently the ACR is required to be based on data specific to each provider class. CMS cites:

> *"Based on our experience, facilities that serve a higher share of Medicaid enrollees, such as rural hospitals and safety net hospitals, tend to have less market power to negotiate higher rates with commercial plans. Allowing States to direct plans to pay providers using a tiered payment rate structure based on different criteria, such as the hospital's payer mix, without limiting the total payment rate to the ACR specific to each tier (which would be considered a separate provider class), but rather at the broader service level would provide States with tools to further the goal of parity with commercial payments, which may have a positive impact on access to care and the quality of care delivered."*[11]

For example, states could establish a tiered set of uniform percentage increases, directing a higher payment rate to facilities with relative higher Medicaid utilization. These increases would be limited to a statewide ACR at the service level, rather than limited to the ACR at the provider class level as is currently required.

Under this proposed approach, rural hospitals and urban hospitals could have directed payment increases that result in the same statewide ACR target in aggregate (adjusted for service mix and volume), even if urban hospitals have higher negotiated rates with commercial payers. Note that a statewide ACR approach may reduce the ACR target for provider types with a relatively higher ACR (such as urban tertiary care hospitals); as such, states would still have the option of setting the ACR based on data specific to each provider class and service type.

Total payment rate comparison: CMS proposes to promulgate its current preprint requirement that states annually submit a payment benchmarking analysis for SDP approval. CMS's current preprint Table 2 requires states to demonstrate in a "provider payment analysis" that total Medicaid managed care payments (paid by plans to providers, including SDPs) as a percentage of "Medicare, or some other standardized measure" are less than 100% at the provider class level, separately for each broad service type (e.g., inpatient, outpatient, etc.).[12] CMS has previously accepted payments under Medicare, estimated costs incurred by providers, and payments under ACR as acceptable standardized measures for this analysis. For example, in a state with two provider classes for urban and rural hospitals along with inpatient and outpatient SDPs with an ACR ceiling, the total payment rate comparison would need to demonstrate that the proposed SDPs result in Medicaid managed care payments below the 100% ACR ceiling in aggregate separately for inpatient urban, inpatient rural, outpatient urban, and outpatient rural hospitals.

The Managed Care NPRM would formalize the payment benchmarking analysis and 100% of ACR as the maximum payment ceiling at the provider class level in a "total payment rate comparison." The total payment rate comparison would be based on Medicaid managed care utilization data specific to each provider class. As mentioned, ACR data applied to each provider class's Medicaid utilization may be based on statewide service-level commercial data.

Additional potential payment ceilings and limitations

CMS is also considering potentially imposing a statewide limit on the combined total expenditures across SDPs, citing the need to "address and improve program and fiscal protections to address the oversight risks identified by oversight bodies, ensure that risk-based contracts are used as intended, and that managed care plans that are 'at risk' truly have the ability to manage how their revenue is used to cover all reasonable, appropriate, and attainable costs under the terms of the contract."[13] Under this policy, CMS would not approve Medicaid managed care contracts if a state's total SDP expenditures exceeded a certain percentage of total Medicaid managed care costs. CMS did not provide a proposed threshold, but stated it believed 10% to 25% would be a "reasonable limit" and could be implemented at the statewide, rate cell, or service type level. CMS acknowledged "[s]uch an approach could have potential negative impacts on access to care that would need to be balanced with the need for improved program and fiscal integrity."[14] Depending on the limit threshold, this alternative policy may result in a *significant reduction in SDPs* both in terms of the number of SDP programs as well as the payment volume of those programs; however, CMS did not provide a fiscal estimate under this scenario.

Utilization-based payments

CMS proposes to require that directed fee schedules be conditioned on the utilization and delivery of services under the managed care contract rating period only (i.e., services incurred during the contract year). While the existing regulations require that SDPs be based on actual utilization and delivery of services, this new rule is more narrowly defined and would limit states' ability to reconcile payments to actual utilization in certain instances. Specifically, the proposed rule would prohibit a common practice whereby states direct managed care plans to make interim payments during the contract year based on historical utilization, and then conduct a payment reconciliation process after the contract end based on actual contract year utilization. If implemented, this proposal would have material implications to many existing SDPs, and as such, CMS is proposing to implement this requirement two years following the effective date of the final rule.

These programs are often paired with separate payment terms, in which the funds for the SDP are provided to the managed care plans outside of the capitation. Notably, CMS does *not* propose to eliminate separate payment terms, which it defines as a "pre-determined and finite funding pool that the State establishes and documents in the Medicaid managed care contract for a State directed payment."[15] CMS describes the most common separate payment term structure as follows (bold added for emphasis):

> *"[A] State first establishes a finite and predetermined pool of funding that is paid by the State to the plan(s) separately and in addition to the capitation payments for a specific SDP. The pool of funds is then disbursed regularly throughout the rating period (for example, quarterly) based on the services provided in that portion of the rating period (for example, quarter) to increase total provider payments or reach a specific payment rate target. Typically, States divide the dedicated funding pool into equal allotments (for example, four if making quarterly payments to their plans). They then* ***review the encounter data*** *for the service(s) and provider class identified in the approved preprint for the quarter that has just ended and* ***divide the allotment by the total service utilization*** *across all providers in the defined class (for example, inpatient discharges for all rural hospitals) to determine a uniform dollar amount to be paid in addition to the initial payment by the managed care plan for rendered services. The State will then pay the quarterly allotment to the managed care plans, separate from the capitation rate payment, and* ***direct them to use that allotment for additional retroactive payments to providers*** *for the utilization that occurred in the quarter that just ended. The State will repeat this process each quarter,* ***with the uniform increase changing for each quarter depending on utilization*** *but being paid uniformly to providers in the defined class for the services within that quarter (for example, inpatient discharges for rural hospitals). Other States have chosen to make payments semi-annually, annually, or monthly.*[16]

While CMS's proposed rule provides further definition on separate payment terms, it reiterated its "strong preference" for including SDP funding in the standard capitation rate development process. For states that maintain separate payment terms, the combination of CMS's proposed separate payment term definition along with the elimination of post-payment reconciliation indicates that fixed payment pools may be continued but must be distributed based on actual contract year utilization. This may pose logistical challenges for these states due to the lag in encounter data needed for retroactive payment calculations. States may wish to seek further clarification from CMS on whether this should be included in the final rule.

CMS review and approval process

Under the existing SDP approval process, CMS recommends that states submit preprint forms 90 days prior to the applicable rating period. However, this timeline is not a requirement, and much flexibility has been provided to states with respect to submission timing. Under the Managed Care NPRM, CMS is proposing new requirements related to the timeliness of SDP submissions, including the following:

- Single year SDP submissions to occur no later than 90 days prior to the end of the rating period, with any applicable amendments submitted prior to the end of the rating period.
- For multiyear SDPs, CMS is proposing that amendments be submitted within the first 120 days of each rating period and may not apply retroactively to completed rating periods.
- Rate certifications and managed care contracts related to SDPs must be submitted no later than 120 days after the effective date of the SDP or the CMS SDP approval date, whichever is later.

In proposing these requirements, CMS has reiterated a preference for preprint submissions to occur prior to the start of the rating period, while also formally prohibiting retroactive SDP applications or corresponding amendments to prior rating periods. These requirements align with CMS's proposal to no longer permit post-payment reconciliation processes, as all activities must be completed prior to the end of the applicable rating period.

In addition, CMS has proposed to no longer require prior approval (i.e., preprint forms) for SDPs that establish a Medicare-based minimum fee schedule. This exception to the SDP approval process may create a streamlined pathway for states to implement provider payment changes in situations where the preprint form and corresponding procedures may be time- or resource-prohibitive.

Non-network providers

CMS is proposing to remove the "network provider" restriction on SDPs implemented as a fee schedule requirement under 42 CFR §438.6(c)(1)(iii). This change would bring consistency between SDPs implemented as fee schedule arrangements and those implemented as value-based payments, where the "network provider" limitation does not exist in the current regulation. CMS indicates that limiting SDPs to network providers has "proven to be too narrow and has created an unintended barrier to States' and CMS' policy goals to ensure access to quality care for beneficiaries."[17]

This proposed rule, which would become effective the first rating period after the effective date of the final rule, eliminates the complexity of distinguishing between network and non-network providers as states would be allowed to direct Medicaid managed care plans to pay all providers in a defined class. In addition, increasing the scope of SDPs to allow the inclusion of non-network providers in minimum fee schedule requirements addresses potential access to care concerns. As an example, CMS anticipates this will provide the opportunity to allow managed care plans and providers additional time to negotiate rates for newly carved-in services, while still being eligible for SDPs.[18]

Note that the applicability of SDPs to non-network providers under this proposal does not apply to existing hospital pass-through payments (PTPs). All hospital PTPs must be eliminated no later than the rating period beginning July 1, 2027, and will continue to apply to network providers only.

Provider attestations

CMS proposes to require that states obtain an attestation from each provider receiving payments under the SDP that it "does not participate in any hold harmless arrangement with respect to any health care-related tax."[19] CMS describes hold harmless arrangements as "impermissible redistribution agreements…that produce a reasonable expectation that

taxpaying providers would be held harmless for all or a portion of their cost of a health care-related tax."[20] CMS reiterated its position that redistribution agreements would be inconsistent with "proper and efficient administration" of the Medicaid program and would result in disallowances "when it would be more efficient to not allow such expenditures to be made in the first place."[21] CMS's proposed rule would specifically require states to note their compliance in the preprint form to receive approval from CMS, and to also ensure that these provider attestations are made available to CMS for review upon request.

This proposed rule would impact the administrative effort to establish SDPs and receive ongoing approval where the nonfederal share is financed by healthcare-related taxes. States may face challenges in obtaining the attestations from all providers in the SDP, some of which may have concerns about disclosing private party business arrangements and being able to discern which arrangements are related to Medicaid supplemental payments. States would need to provide clarity to participating providers that CMS is only interested in business arrangements that could "result in a violation of Federal statutory and regulatory requirements."[22]

Key reporting requirements

The Managed Care NPRM includes the following anticipated reporting requirements:

Directed payment report

CMS proposes that states must submit to CMS and to the Transformed Medicaid Statistical Information System (T-MSIS) an SDP summary by each managed care plan with the following minimum data fields:

1. Provider identifiers
2. Enrollee identifiers
3. Managed care plan identifiers
4. Procedure and diagnosis codes
5. Allowed, billed, and paid amounts

CMS proposes that this data be submitted no later than 180 days after each rating period, following the release of reporting instructions by CMS.

Preprint forms

We anticipate CMS's proposed changes would necessitate updates to the existing preprint form if adopted in the final rule. Under CMS's proposed rule, states would be required to submit preprints to CMS no later than 90 days in advance of the end of the SDP rating period.

Evaluation plans

CMS proposes that for SDPs exceeding 1.5% of managed care capitation payments, an evaluation report be submitted using the state's proposed evaluation plan in its preprint form. CMS acknowledged the administrative burden of these reports and proposed this threshold to "allow States and CMS to focus resources on payment arrangements with the highest financial risk."

CMS proposes that the evaluation reports include the three most recently completed years of annual results for each metric in the evaluation plan. The first evaluation report would be due with the submission of the preprint form for the sixth rating period after the applicability date for the evaluation plan (containing results from the first three years after the applicability date). States would then be required to submit subsequent evaluation reports every three years, meaning the second evaluation report would be for the ninth rating period after the applicability date for the evaluation plan (containing results from years 4 through 6 after the applicability date). States would be required to continue submitting evaluation reports with this frequency throughout the life of the SDP.

CMS also proposes to require that states include "measurable performance targets" relative to the baseline statistic for each of the selected measures in their evaluation plan.[23] These performance targets cannot be based on administrative activities such as "reporting of data nor upon the participation in learning collaboratives or similar administrative activities."[24] While evaluation plans have been a required element of SDP approvals since the 2016 managed care rule, CMS asserted that most states have not complied with requests for evaluation data. Therefore, CMS also proposes to clarify that they have "the authority to disapprove proposed SDPs if States fail to provide in writing evaluation plans for their SDPs that comply with these regulatory requirements."[25]

Conclusion

The proposed provisions in the Managed Care NPRM include variable implementation timelines. CMS articulates such compliance requirements as a function of the next rating period following the effective date of the final rule. The table in Figure 1 contains a summary of key implementation timelines for the Managed Care NPRM provisions related to SDPs discussed in this white paper.

Figure 1: Managed care NPRM implementation timing

PROVISION	RATING PERIOD COMPLIANCE FOLLOWING EFFECTIVE DATE OF FINAL RULE
Average Commercial Rate *Payment Ceiling Codification*	1 Year
Utilization-Based Payments *No Post-Payment Reconciliation*	2 Years
Non-network Providers *Remove Prior Restrictions*	On Effective Date of Final Rule
CMS Review and Approval Process *Submission Timelines Requirements*	2 Years
Provider Attestations *Hold Harmless*	2 Years
Key Reporting Requirements *Evaluation Plans*	3 Years

In its detailed economic analysis, CMS estimates a wide range of SDP expenditure impacts from the proposed rule, depending on which set of policies it ultimately selects and whether states restrain SDPs, maintain SDPs, or create new SDPs in response to the final rule. Each state should evaluate the proposed rule to determine its own administrative needs to not only meet Managed Care NPRM reporting requirements, but also to evaluate how its current and newly proposed SDP programs would be affected by the proposed changes.

For those programs affected by the Managed Care NPRM, states should consider providing written comment to CMS within the formal public comment period, which ends on July 3, 2023. In addition, should the Managed Care NPRM be finalized as currently drafted, states may need to develop strategies to identify adjustments needed to preserve their program(s) or determine alternative initiatives that would sustainably achieve state goals and CMS compliance within the applicable timeframes outlined in the proposed rule.

[1] A copy of the Managed Care NPRM is available at: https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08961.pdf

[2] CMS (April 27, 2023). Summary of CMS's Access-Related Notices of Proposed Rulemaking: Ensuring Access to Medicaid Services (CMS 2442-P) and Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P). Retrieved May 10, 2023, from https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p.

[3] For more background on SDPs, see the Milliman white paper "Approved Medicaid State Directed Payments: How States are Using §438.6(c) "Preprints" to Respond to the Managed Care Final Rule."

[4] Medicaid and CHIP Managed Care Access, Finance and Quality, 88 Fed. Reg. 28112, May 3, 2023.

[5] Id. at 28227.

[6] Id. at 28122.

[7] Id. at 28227.

[8] Id. at 28123.

[9] Id. at 28124.

[10] For current SDPs, CMS has regularly approved the use of Milliman's Consolidated Health Cost Guidelines™ Sources Database (CHSD) for SDP ACR demonstrations.

[11] Medicaid and CHIP Managed Care Access, Finance and Quality, 88 Fed. Reg. 28126, May 3, 2023.

[12] CMS, "Section 42 C.F.R. § 438.6(c) Preprint – January 2021," pages 9-10.

[13] Medicaid and CHIP Managed Care Access, Finance and Quality, 88 Fed. Reg. 28127, May 3, 2023.

[14] Id. at 28127.

[15] Id. at 28146.

[16] Id. at 28144.

[17] Id. at 28115.

[18] Id.

[19] Id. at 28132.

[20] Id. at 28131.

[21] Id.

[22] Id.

[23] Id. at 28139.

[24] Id. at 28237.

[25] Id. at 28140.

About the Author(s)

Ben Mori

Seattle | Tel: 1 206 6138204

Amanda Schipp

Indianapolis

Jason A. Clarkson

Indianapolis | Tel: 1 317 5243591

Carmen Laudenschlager

Indianapolis | Tel: 1 317 5243570

Luke B.G. Roth

Seattle | Tel: 1 206 5045841

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