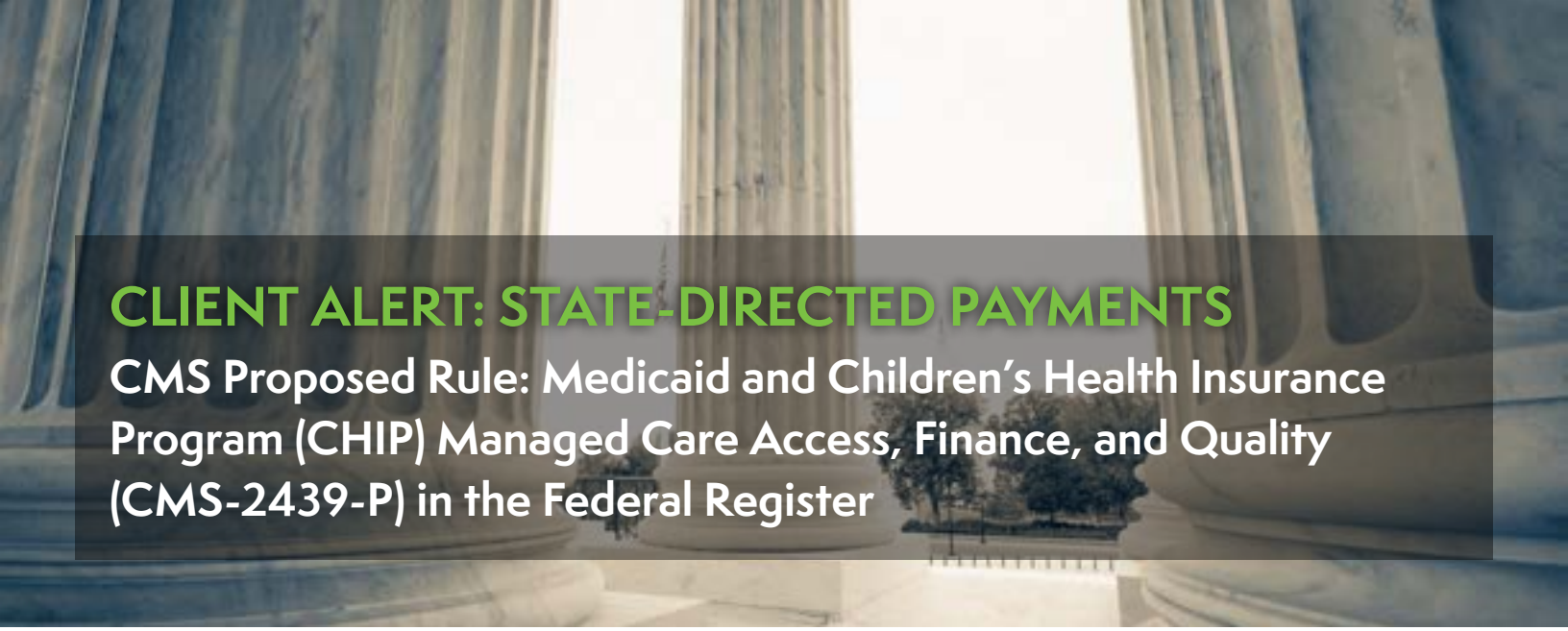

CLIENT ALERT: STATE-DIRECTED PAYMENTS

CMS Proposed Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register

On May 3, 2023, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule entitled: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register. Myers and Stauffer is providing this client alert to ensure states are aware of several notable and impactful provisions specific to state-directed payment (SDP) arrangements.

For the full proposed rule text, see https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

CMS states its intended purpose of the proposed SDP changes is to ensure the following policy goals:

- Medicaid managed care enrollees receive access to high-quality care under SDP arrangements.
- SDPs are appropriately linked to Medicaid quality goals and objectives for the providers participating in the SDP arrangements.
- CMS and the state have the appropriate fiscal and program-integrity guardrails in place to strengthen the accountability and transparency of SDP payment arrangements.

Proposed SDP regulatory revisions and new policy requirements are outlined in an order consistent with the proposed rule and consist of 14 primary topic areas identified by CMS.

1. Contract Requirements Considered to be SDPs (Grey-area Payments) (CMS CLARIFICATION ONLY)
2. Medicare Exemption, SDP Standards and Prior Approval (§ 438.6(c)(1)(iii)(B), (c)(2) and (c)(5)(iii)(A)(5))
3. Non-Network Providers (§ 438.6(c)(1)(iii))
4. SDP Submission Timeframes (§ 438.6(c)(2)(viii) and (ix))
5. Standard for Total Payment Rates of each SDP, Establishment of Payment Rate Limitations for certain SDPs and Expenditure Limit for all SDPs (§ 438.6(c)(2)(ii)(I) and (c)(2)(iii))
6. Financing (§ 438.6(c)(2)(ii)(G) and (H))
7. Tie to Utilization and Delivery of Services for Fee Schedule Arrangements (§ 438.6(c)(2)(vii)
8. Value-Based Payments and Delivery Reform Initiatives (§ 438.6(c)(2)(vi))
9. Quality and Evaluation (§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7)) Evaluation Plan
10. Contract Term Requirements (§ 438.6(c)(5))

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11. Including SDPs in Rate Certifications and Separate Payment Terms (§§ 438.6(c)(2)(ii)(J), (c)(6), and 438.7(f))
12. SDPs included through Adjustments to Base Capitations Rates (§ 438.7(c)(4) through (6))
13. Appeals (§ 430.3(d))
14. Reporting Requirements to Support Oversight (§ 438.6(c)(4))

1. Contract Requirements Considered to be SDPs (Grey-area Payments) (CMS CLARIFICATION ONLY)

CMS states its thinking has evolved since it published the November 2017 Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB) entitled, "Delivery System and Provider Initiatives under Medicaid Managed Care Contracts." The CIB outlined scenarios to provide examples of payments states may require managed care plans to make to providers outside of claim payments, which would not require CMS approval under § 438.6(c). One example described a scenario in which a state included contract language requiring managed care plans to make 20 percent of their provider payments as value-based purchasing (VBP) or alternative payment arrangements when the state did not mandate a specific payment methodology. CMS continues to believe this scenario does not meet the criteria for an SDP or a pass-through payment. CMS clarifies, however, that this situation would not be considered an SDP as the state was imposing a quality metric on the managed care plans rather than the providers. This situation would be addressed in § 438.6(b)(2) or (3) rather than in § 438.6(c).

In January 2021, CMS published State Medicaid Director Letter (SMDL) #21-001, which closed an unintentional loophole created in the November 2017 CIB related to general contractual requirements to increase provider payments that provide for or add an amount to the provider payments rates, but do not specify an amount, timing, or payment methodology. CMS originally noted this scenario would not require approval under 42 CFR § 438.6(c) as long as the state was not mandating a specific payment methodology or amounts under the contract. In addition, CMS noted that when the provider payment is tied to usage and delivery of a specific service, such payments would not be considered pass-through payments. The proposed rule reiterates CMS' amended position that these "grey-area payments" do require modification to comply with § 438.6(c) or (d). However, CMS did not propose any regulatory revision to reflect the reinterpretation of the regulation text. CMS seeks comment on whether additional clarification about these grey-area payments is necessary.

States with contract containing payment provisions CMS considers grey-area payments, will need to work toward compliance with § 438.6(c) or (d) requirements.

2. Medicare Exemption, SDP Standards and Prior Approval (§ 438.6(c)(1)(iii)(B), (c)(2) and (c)(5)(iii)(A)(5))

The proposed rule offers an exemption from written prior approval of the SDP to states adopting a minimum-fee schedule using Medicare approved rates for providers that provide a particular service under the contract. This exemption is similar to the 2020 final rule revision allowing states to implement an SDP based on an approved state plan rate methodology from written prior approval. CMS considers Medicare approved rates to be reasonable, appropriate, and attainable under § 438.4 and § 438.5, and therefore review of SDPs adopting Medicare approved rates is duplicative and unnecessary. The exemption only applies if the SDP requires 100 percent of the total published Medicare payment rate.

The SDP arrangement must use a total published Medicare payment rate in effect no more than three years prior to the start of the rating period to be considered permissible. States that adopt a minimum fee schedule using 100 percent of total published Medicare payment rates will still need to document these SDPs in the managed care contracts and rate certifications and must still comply with other requirement for all SDPs other than prior written approval by CMS.

CMS is proposing to add Requirements for Medicaid Managed Care Contract Terms for State directed payments for oversight and review purposes. Managed care plan contracts would have to specify which Medicare fee schedule(s) the state directs the managed care plan to use and any adjustments due to geography, such as rural designations, and provider type, such as critical-access hospital or sole-community-hospital designation. In addition, the contract would need to identify the period for which the Medicare fee schedule is in place, as well as the rating period used for the SDP.

Proposed applicability date: Upon effective date of the final rule.

CMS does not propose an alternative to the Medicare fee schedule for services such as home and community-based services (HCBS) or certain behavioral health and substance use disorder services not ordinarily covered by Medicare for which there would be no available fee schedule.

3. Non-Network Providers (§ 438.6(c)(1)(iii))

CMS is proposing to remove the term "network" from descriptions of SDP arrangements adopting minimum or maximum fee schedules or uniform dollar or percentage increases. The inclusion of the word "network" in the SDP arrangement descriptions has prevented states from including contract requirements to direct their Medicaid managed care plans on how to pay non-network providers. States may have an interest in ensuring their Medicaid managed care plans pay non-network providers at a minimum to avoid access to care concerns.

The term "network" would continue to be included in reference to pass-through payments in § 438.6(d).

Proposed applicability date: Upon effective date of the final rule.

This rule could eliminate the requirement for providers to become a network provider with a managed care organization (MCO), and eliminate the requirement to collect and document the network providers prior to developing SDP calculations.

4. SDP Submission Timeframes (§ 438.6(c)(2)(viii) and (ix))

CMS is proposing implementing the requirement for states to submit SDP requests for written prior approval 90 days in advance of the end of the rating period to which the SDP applies. Historically, CMS has experienced states routinely submitting SDP preprints at the end of the rating period with implementation dates retroactive to the beginning of the rating period. CMS strongly encourages states to submit SDPs in advance, preferably 90 days before the start of the rating period. However, it is proposing the aforementioned requirement to balance the need for state flexibility to address unforeseen changes that

occur after the managed care plan contract and rates have been developed with the need to ensure timely processing of managed care contract and capitation rates. Amendments to approved SDPs, as well as all required documentation for written approval, must be submitted prior to the end of the rating period for CMS to consider approval.

The CMS proposal addresses the use of shorter-term SDPs in response to infrequent events, such as public health emergencies and natural disasters, by permitting states to submit all required documentation before the end of the rating period for SDP proposals that would start less than 90 days before the end of the rating period.

For SDPs approved for multiple rating periods, the proposed rule would allow states to amend the approved preprint within the first 120 days of each subsequent rating period for which the SDP is approved after the initial rating period. The requested amendment could not make any retroactive changes to the SDP for the prior rate-setting periods.

CMS notes that written prior approval of an SDP does not obligate a state to implement the SDP. If a state chose not to implement an SDP for which CMS has granted prior approval, elimination of the SDP would not require any prior approval.

Proposed applicability date: No later than the first rating period beginning on or after two years after the effective date of the final rule.

CMS seeks comment on the proposed timeline, as well as additional options. States may need additional clarification regarding updating the final SDP paid amounts as amendments to the preprints for actual payments would have to be submitted after the end of the rating period.

5. Standard for Total Payment Rates of each SDP, Establishment of Payment Rate Limitations for certain SDPs and Expenditure Limit for all SDPs (§ 438.6(c)(2)(ii)(I) and (c)(2)(iii))

Standard for Total Payment Rates for Each SDP

CMS is proposing several requirements regarding the totality of provider payment rates under SDPs to ensure proper fiscal and programmatic oversight in Medicaid managed care programs. First, CMS is proposing to codify its direction provided in SMDL #21-001 that requires states to demonstrate that SDPs result in provider payments rates that are reasonable, appropriate, and attainable as part of the preprint review process. States would be required to provide documentation demonstrating this for each service and provider class. CMS proposes to define "total payment rate" as the aggregate for each managed care plan of:

i. The average payment rate paid by all managed care plans to all providers included in the specified provider class for each service identified in the SDP.

ii. The effect of the SDP on the average rate paid to providers included in the specified provider class.

iii. The effect of any and all other SDPs on the average rate paid to providers included in the specified provider class.

iv. The effect of all allowable pass-through payments as defined in § 438.6(a) paid to providers included in the specified provider class.

The proposed language includes a requirement that states must provide documentation demonstrating the total payments upon CMS request.

Establishment of Payment Rate Limits for Certain SDPs

To address concerns regarding the growth of SDPs and the lack of a regulatory payment ceiling CMS proposes the following:

1. *Historical Use of the Average Commercial Rate (ACR) Benchmark for SDPs.*
   CMS proposes to allow total payment rates in an SDP up to the ACR for certain services. Using the ACR allows states to ensure that Medicaid managed care enrollees have access to care that is comparable to access for the broader general public. It also provides for the least amount of disruption for states transitioning existing, and often long-standing pass-through payments, into SDPs. In addition, the ACR provides parity with Medicaid fee-for-service payment policy for qualified practitioners affiliated with and furnishing services at academic medical centers, physician practices, and safety-net hospitals where CMS has approved rates up to the ACR. States would be required to document the total payment rate specific to each service type included in the SDP and specific to each provider class identified in comparison with ACR.

2. *Proposed Payment Rate Limit for Inpatient Hospital Services, Outpatient Hospital Services, Qualified Practitioner Services at Academic Medical Centers, and Nursing Facilities.*
   CMS proposes imposing the ACR as the regulatory limit on the projected total payment rate for inpatient hospital services, outpatient hospital services, qualified practitioner services at an academic medical center, and nursing facility services. The proposed total payment limit would apply across all SDPs in a managed care program; for example, states would not be able to create multiple SDPs that applied, in part or in whole, to the same provider classes and be projected to exceed the ACR. CMS is not proposing to establish ACR payment ceilings on other types of services as states have found it difficult to obtain data on commercial rates for services such as HCBS, which are generally not covered by commercial payers. Similar concerns exist with behavioral health services and substance use disorder services, where Medicaid is the most common payer.

   A definition for inpatient hospital (42 CFR § 440.10), outpatient hospital (§ 440.20(a)), nursing facility (§ 440.40(a)), and academic medical center (§ 438.6(a)) services defined in other CFR sections would be added to the language.

   The language also includes other limits that under consideration if ACR is not selected (for providers noted above and other provider types), including:

   - Limiting to the Medicare rate.
   - Limiting to a rate between the Medicare rate and the ACR.
   - Limiting to the ACR for certain types of SDPs with value-based arrangements and the Medicare rate for other SDPs.

   CMS is seeking comment on these limit considerations, as well as, if a transition period should be implemented to phase in the limits applied for existing SDPs.

3. *Average Commercial Rate Demonstration Requirements.*
   To monitor compliance with the ACR limit proposal, CMS proposes states be required to provide two pieces of documentation: (1) an ACR demonstration; and (2) a total payment rate comparison to ACR. The ACR proposal would be submitted with the initial preprint submission (new, renewal, or amendment)

following the applicability date and then updated every three years, so long as the state continues to include the SDP in one or more managed care contracts, but would only be applicable to SDPs requiring prior written approval. CMS is not proposing to use a specific template for the demonstration and comparison to ACR. Nor is it requiring a specific source of data for the ACR analysis.

4. *Average Commercial Rate Demonstration and Total Payment Rate Comparison Compliance.* The ACR demonstration and total rate comparison would be required for SDPs needing written prior approval as part of the initial submission or renewal starting with the first rating period beginning on or after the effective date of the rule. The rate comparison would need to be updated with each subsequent renewal. The ACR demonstration would need to be updated once every three years, as long as the SDP continues to be included in the MCO contracts.

   CMS is considering (and seeking comments for) applying an overall expenditure limit to SDPs to help address and improve program and fiscal protections and oversight risks. Examples considered include:

   - Limit SDP expenditures similar to the five percent cost limit limit for In Lieu of Services.
   - Limit SDP expenditures to 10 to 25 percent of cost limit, or something within a reasonable range.
   - Apply SDP limits as a portion of total costs for each MCO plan.
   - Apply SDP limits as a portion of only inpatient, outpatient, nursing facility, and qualified practitioner costs for each MCO plan.
   - Apply SDP limits on a rate-cell basis.

Proposed applicability date § 438.6(c)(2)(ii)(I): Upon effective date of the final rule.
Proposed applicability date § 438.6(c)(2)(iii): No later than the first rating period for contracts beginning on or after the effective date of the final rule.

Although CMS did not propose a specific overall SDP limit, imposition of such a limit would significantly affect many states' SDP arrangements.

6. Financing (§ 438.6(c)(2)(ii)(G) and (H))

CMS proposes to add a requirement that explicitly requires SDPs to comply with all federal legal requirements for the financing of the non-federal share, including but not limited to 42 CFR § 433, subpart B, as part of the CMS SDP review process.

In addition, CMS proposes states 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 as specified in § 433.68(f)(3). CMS notes that such hold-harmless arrangements include those 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.

States would be required to note in the preprint their compliance with this requirement prior to CMS written prior approval of any contractual payment arrangement directing how Medicaid managed care plans pay providers.

Under this proposal, CMS may deny written prior approval of an SDP if it does not comply with requirements for financing of the non-federal share and/or the state does not require an attestation from each provider receiving a payment based on the SDP that it does not participate in any hold-harmless arrangement. Under the proposal, this would apply to all SDPs, regardless of whether written prior approval is required.

Proposed applicability date § 438.6(c)(2)(ii)(G): Upon effective date of the final rule.
Proposed applicability date § 438.6(c)(2)(ii)(H): No later than the first rating period for contracts beginning on or after two years after the effective date of the final rule.

The proposed regulation is similar to the guidance outlined in CMCS Informational Bulletin February 23, 2023, as well as proposed the Medicaid Fiscal Accountability Regulation, which was withdrawn by CMS. The state of Texas filed a lawsuit against CMS and the U.S Department of Health and Human Services challenging the legality of CMS' February 23, 2023, bulletin. The proposed attestation requirement would not go into effect until the first rating period for contracts beginning on or after two year after the effective date of the final rule, providing an opportunity for the court to weigh in on CMS' authority regarding private contractual agreements. As many states use provider taxes to finance of the non-Federal share of SDPs, developments on this issue could be very influential.

7. Tie to Utilization and Delivery of Services for Fee Schedule Arrangements (§ 438.6(c)(2)(vii)

A fundamental requirement of SDPs is that they are payments related to the delivery of services under the contract. SMDL #21-001 explained SDPs should be based on actual utilization and cannot be based solely on historical utilization. CMS proposes to codify this clarification. For fee schedule and uniform increase SDPs, CMS would require that all payments made under the SDP be conditioned on the utilization and delivery of services under the MCO plan contract for the applicable rating period only. CMS proposes to prohibit states from requiring managed care plans to make interim payments based on historical utilization and reconciling the interim payments to account for actual utilization after the close of the rating period. CMS states the reconciliation is inconsistent with prospective risk-based capitation rates developed for the delivery of services in the rating period.

CMS proposed two administratively less burdensome options in lieu of reconciliations: 1) using a minimum fee schedule; and 2) using a uniform increase. CMS previously issued guidance related to pass-through payments that were not directly linked to the delivered services or the outcomes of those services, thereby noting pass-through payments were not consistent with actuarially sound rates. CMS reached a similar conclusion in review of SDP proposals, which use reconciliation of historical to actual utilization. CMS states removing risk from managed care plans in connection with these types of SDPs is inconsistent with the nature of risk-based Medicaid managed care.

CMS notes the post-payment reconciliation process and SDP arrangements with separate payment terms are not the same. CMS is proposing guardrails around the use of separate payment terms through (§§ 438.6(c)(2)(ii)(J), (c)(6), and § 438.7(f)).

Proposed applicability date: No later than the first rating period beginning on or after two years after the effective date of the final rule.

States requiring health plans to pay providers based on a retrospective reconciliation process many times also use separate payment terms to pay the SDPs to health plans. The proposed prohibition on the retrospective reconciliation process may also affect how states pay health plans for the SDPs.

8. Value-Based Payments and Delivery Reform Initiatives (§ 438.6(c)(2)(vi))

CMS is proposing several changes to address how VBP initiatives can be tied to delivery of services to remove barriers that prevent states from using SDPs to implement VBP initiatives. It is proposing to codify existing policy that a multi-year written prior approval may be for up to three rating periods. Specific to SDPs involving VBP initiatives included in § 438.6(c)(1)(i-ii), CMS is proposing:

i. To remove the requirement that prohibits states from setting the amount or frequency of the plan's expenditures. CMS notes that allowing plans to retain discretion regarding amounts and payment frequency undermined states' ability to implement meaningful initiatives. In addition, inconsistencies in administration of these initiatives may undermine providers' confidence in the arrangement.

ii. To remove the requirement that prohibits states from recouping unspent funds allocated for these SDPs. CMS states that allowing plans to retain unspent funds when providers fail to achieve performance targets results in managed care plans profiting from weak provider performance. Removing this requirement could enable states to reinvest unspent funds to further promote VBP and delivery system innovation.

iii. To clarify how performance in these types of arrangements is measured for participating providers. CMS proposes to codify its interpretation that payment may not be based on "pay-for-reporting," and instead must be based on actual performance. In addition, it proposes states be permitted to use a performance measurement period that precedes the start of the rating period in which payment is delivered by up to 12 months. The performance measurement period must not exceed the length of the rating period.

    In an effort to establish guardrails for declining performance, SDP performance measurements would also be required to include a baseline statistic for all metrics to ensure performance has improved to receive payment. Payments would be required to be documented in the rate certification for the rating period in which the payment is delivered.

iv. To adopt requirements for use of population-based and condition-based payment in these types of SDP arrangements. CMS proposes to establish regulatory pathways for approval of VBP initiatives that may not be conditioned on specific performance measures. "Population-based payment" would be defined for Medicaid service(s) for a population of Medicaid managed care enrollees covered under the contract attributed to a provider or provider group. "Conditioned-based payment" would be defined as a prospective payment for a defined set of Medicaid service(s), that are tied to a specific condition and delivered to Medicaid managed care enrollees. Both types of payments would be conditioned on either the delivery by the provider of one or more specified Medicaid service(s) during the rating period or the attribution to the provider of a covered enrollee for the rating period for treatment.

    The attribution methodology would be required to use data that is no older than the three most recent and complete years of data. The population-based or condition-based payment would replace the negotiated rate between the plan and the providers to prevent any duplicate payments for the same service. CMS proposes to add a requirement preventing payments from being made in addition to other payments made by plans to the same provider on behalf of the same services included in the population- or condition-based payment.

The proposal also requires the payment include at least one performance measure and set the target for such a measure to demonstrate improvement over baseline at the provider-class level for the provider class receiving the payment. The state would be required to set the target for such a performance measure to demonstrate improvement over baseline.

Proposed applicability date § 438.6(c)(2)(vi)(A): Upon effective date of the final rule.

Proposed applicability date § 438.6(c)(2)(vi)(B), (C)(1), and (2): No later than the first rating period for contracts beginning on or after the effective date of the final rule.

Proposed applicability date § 438.6(c)(2)(vi)(C)(3), and (4): No later than the first rating period for contracts beginning on or after two years after the effective date of the final rule.

CMS does not appear to address how new VBP programs for which no baseline statistics are available will be impacted.

9. Quality and Evaluation (§ 438.6(c)(2)(ii)(D) and (F), (c)(2)(iv) and (v), and (c)(7))

Evaluation Plan

CMS proposes revisions to enhance its ability to collect evaluations of SDPs and enhance the level of detail described in the evaluation to shine a spotlight on evaluation results in determining future SDP approvals. States would be required to submit an evaluation plan for each SDP that requires written approval. The evaluation plan must:

1. Identify at least two metrics that would be used to measure the effectiveness of the payment arrangement in advancing the identified goal(s) and objectives(s) from the state's managed care quality strategy on an annual basis, with at least one of the metrics measuring performance at the provider-class level for population- or condition-based payments.
2. The metrics would need to be specific to the SDP and attributable to the performance by the providers for enrollees in all of the state's managed care program(s) to which the SDP applies, when practical and relevant.
3. At least one of the selected metrics must be a performance measure, as proposed by definition. States would be allowed to select maintaining access to care as a metric, but if a state elects access as a metric, CMS proposes to require states to choose a metric that measures maintenance of access and at least one additional performance-based metric.
4. States will be required to include baseline performance statistics for all metrics used in the evaluation, and would need to include measurable performance targets relative to the baseline statistic for each of the selected measures in their evaluation plan.

Evaluation Report

States would be required to provide commitment to submit an evaluation report if the final SDP cost percentage exceeds 1.5 percent. The proposed evaluation-reporting requirement is limited to states with SDPs that require prior approval.

The "final state-directed payment cost percentage" would be calculated based on the portion of the total capitation payments (including separate term payments) that is attributable to the state-directed payments, divided by the actual total capitation payments (including all SDPs, pass-through payments, and SDPs that are paid under separate terms).

The final SDP cost percentage would be measured distinctly for each managed care program and SDP. An actuary would be required to calculate the absolute change the SDP has on base capitation rates. The cost percentage would be calculated on an annual basis, and must only be submitted if needed to demonstrate a SDP is below 1.5 percent cost percentage to avoid evaluation plan submission requirements. The cost percentage calculation would be a separate report submitted concurrent with the rate certification submission for the rating period beginning two years after the completion of each 12-month rating period that included an SDP.

Evaluation reports would be required to include all of the elements approved in the evaluation plan. In addition, they would be required to include the three most recent and complete years of annual results for each metric. The first evaluation report would be required to be submitted no later than two years after the conclusion of the three-year evaluation period and subsequent reports would have to be submitted to CMS every three years after. States would also be required to publish their evaluation reports on their public facing website. All SDPs must result in achievement of the stated goals and objectives in alignment with the evaluation plan to receive continued approval. A new optional external quality review activity could be performed to support evaluation requirements. CMS invites public comment on requiring states procure an independent evaluator for SDP evaluations.

Proposed applicability date: No later than the first rating period for contracts with MCOs beginning on or after three years after the effective date of the final rule.

CMS plans to issue additional technical assistance on this subject.

10. Contract Term Requirements (§ 438.6(c)(5))

CMS has noted a variety of ways states include SDP requirements in their contracts, many of which CMS notes lack critical details to ensure that plans implement the contractual requirement with the approved SDP. CMS proposes to codify the following minimum requirements for the content of Medicaid managed care contract that include one or more SDP contractual requirement:

i. Start date and, if applicable, end date within the applicable rating period.

ii. Description of the provider class eligible for the payment arrangement and all eligibility requirements.

iii. Descriptions of each payment arrangement. Specific requirements are outlined based on the type of SDP (minimum fee schedule, uniform increase, maximum fee schedule, and VBP initiatives).

iv. Encounter reporting and separate reporting requirements the states need to audit the SDP and report provider-level payment amounts to CMS.

v. Indication of whether the state would be using a separate payment term for the SDP.

vi. SDP terms would be required to be described and documented in the contract no later than 120 days after the start of the SDP or approval of the SDP, whichever is later.

Proposed applicability date § 438.6(c)(5)(i) through (v): No later than the first rating period for contracts with MCOs beginning on or after two years after the effective date of the final rule.

Proposed applicability date § 438.6(c)(5)(vi): No later than the first rating period for contracts beginning on or after four years after the effective date of the final rule.

11. Including SDPs in Rate Certifications and Separate Payment Terms (§§ 438.6(c)(2)(ii)(J), (c)(6), and 438.7(f))

Contractual Requirements

Separate payment terms are unique to Medicaid managed care SDPs. CMS has not previously formally defined separate payment terms in regulations. CMS noted the increase in usage of separate payment terms in SDP arrangements, and notes that while there is risk for the providers, there is often little or no risk for the health plans related to the directed payment, which is contrary to the nature of risk-based managed care. CMS proposes to define "separate payment term" as a pre-determined and finite funding pool that the state establishes and documents in the Medicaid managed care contract for a specific SDP for which the state has received written approval. CMS proposes the following requirements for states using separate payment terms in their SDP arrangements:

i. Separate payment terms must be reviewed and approved as part of the SDP. CMS notes this is effectively its current practice today.

ii. Separate payment terms would be prohibited to fund SDPs that are exempted from the written prior approval process-specifically minimum fee schedules using state plan approved rates and approved Medicare fee schedules.

iii. Separate payment terms would be required to be specific to both an individual SDP and to each Medicaid managed care program.

iv. Separate payment term would not be allowed to exceed the total amount documented in the written prior approval for each SPD.

    a. CMS seeks comments and is considering requiring that the separate payment term equal the exact amount initially approved.

v. Separate payment terms must be documented in the MCO contracts no later than 120 days after the start of the payment arrangement or CMS approval, whichever is later.

vi. Separate payment terms would be prohibited from amendment after CMS approval except to account for an amendment to the payment methodology that is first approved by CMS as an amendment to the approved SDP.

Managed care contracts would be required to include the following components for separate payment terms:

1. The total dollars the state would pay to the plans.
2. The timing and frequency of payments that would be made.

3. A description or reference to the contract requirement for the specific SPD for which the separate payment term would be used.
4. Any reporting that the state requires to ensure appropriate reporting of the separate payment term for purposes of medical loss ratio (MLR) reporting under § 438.8.

Rate Certification Requirements

CMS proposes to codify existing practices that allow the state to pay each managed care plan a different amount under the separate payment terms as long as the aggregate dollars do not exceed the total dollars of the SDP. In addition, the state, through its actuary, would have to provide an estimate of the impact of the separate payment term on a rate-cell basis. CMS proposes new requirements for the state through its actuary to certify the total dollar amount for each separate payment term and submit rate certifications or amendments incorporating separate payment terms within 120 days of either the start of the payment arrangement or written approval of the SDP, whichever is later.

The state would be required to submit documentation to CMS that demonstrates that the total amount of the separate payment term in the rate certification is consistent with the SDP approval, no later than 12 months after the rating period.

CMS states it strongly prefers that SDPs be included as adjustments to capitation rates, as this is consistent with the nature of risk-based managed care. It is considering prohibiting all separate payment terms or additional restrictions on their use (such as restricting to only value-based SDPs) and seeks public comment.

Proposed applicability date §§ 438.6(c)(2)(ii)(J), 438.6(c)(6)(i) through (iv), 438.7(f)(1) through (3): Upon effective date of the final rule.

Proposed applicability date §§ 438.6(c)(6)(v), 438.7(f)(4): No later than the first rating period for contracts beginning on or after four years after the effective date of the final rule.

12. SDPs included through Adjustments to Base Capitations Rates (§ 438.7(c)(4) through (6))

CMS proposes three new requirements to address adjustments to managed care capitation rates that used for SDP.

i. Retroactive adjustments to capitation rates resulting from an SDP would have to be the result of an approved SDP being added to the contract, an amendment to an already approved SDP, a minimum fee schedule SDP, or a material error in the data, assumptions or methodologies used to develop the initial rate so that modification is necessary to correct the error.

ii. Revised rate certifications would have to be submitted to CMS regardless of the size of the capitation change per rate cell if related to SDP arrangements. Currently, states are permitted flexibility to increase or decrease the capitation rate per rate cell up to 1.5 percent during the rating period without submitting a revised-rate certification.

iii. Required rate certification documentation for SDPs incorporated through adjustments to base rates would have to be submitted no later than 120 days after either the start date of the approved SDP or 120 days after the date CMS issued written prior approval of the SDP, whichever is later.

Proposed applicability date § 438.7(c)(4) and (5): Upon effective date of the final rule.

Proposed applicability date § 438.7(c)(6): No later than the first rating period for contracts beginning on or after four years after the effective date of the rule.

13. Appeals (§ 430.3(d))

CMS proposes an avenue to permit states to dispute written disapprovals of SDPs. These disputes would be heard by the Health and Human Services Departments Appeals Board (Board) in accordance with procedures set forth in 45 CFR part 16. States would have 30 days to appeal to the Board after an appellant receives final written decision from CMS communicating written disapproval of an SDP. The Board has established general goals for consideration of cases within six to nine months.

Proposed applicability date: Upon effective date of the final rule.

CMS seeks comment on whether appeals should be channeled through the CMS Offices of Hearing and Inquiries or the Board to best serve the purposes of resolving disputes fairly and efficiently.

14. Reporting Requirements to Support Oversight (§ 438.6(c)(4))

CMS proposes two approaches to gaining more knowledge and insight into actual SDP spending to help in fulfilling its oversight and monitoring obligations. The first near-term proposal would use existing MLR reporting as a vehicle to collect actual expenditure data associated with SDPs, requiring managed care plans to include SDPs and associated revenue as separate lines in their MLR reports to states. States would be required to submit managed care plan-level SDP expenditures to CMS in compliance with § 438.74 MLR reporting.

CMS proposes a long-term requirement for states to annually submit data, no later than 180 days after each rating period to CMS' Transformed Medicaid Statistical Information System (T-MSIS), specifying the total dollars expended by each managed care plan for SDPs that were in effect for the rating period, including amounts paid to individual providers. CMS proposes to develop and provide a form through which the reporting would occur so that there would be one uniform template for all states to use. Minimum data fields would include: provider identifiers, enrollee identifiers, managed care plan identifiers, procedure and diagnosis codes, and allowed, billed, and paid amounts. Paid amounts would include the amount that represents the managed care plans' negotiated payment amount, the amount of the SDP, and amount for any pass-through payments under § 438.6(d), and any other amounts included in the total paid to the provider.

CMS also discusses other options that could be used to collect provider-level SDP data to gain insight into SDP payments. CMS considered supplemental reporting through the Medicaid Budget and Expenditure System similar to supplemental payment reporting. It also considered leveraging T-MSIS encounter data reporting and building additional fields in T-MSIS to capture more details about paid amounts, including the amount that was the managed care plan's negotiated payment amount, the amount of the SDP, the amount for any pass-through payments under § 438.6(d), and any other amounts included in the total payment amount paid to the provider.

Lastly, CMS considered whether to use a separate reporting mechanism for the new reporting of SDP provider-level data. It provided the example of the new portal developed for the submission of the Managed Care Program Annual Report. CMS seeks public comment on its proposal to use T-MSIS for the new reporting, or whether another reporting vehicle would be better suited for SDP reporting. It also seeks comment on how T-MSIS or another reporting vehicle could support capturing VBP arrangements in which payment is not triggered by an encounter or claim.

States would submit this data to CMS no later than 180 days after each rating period.

Proposed applicability date: The first rating period following the release of CMS guidance on the content and form of for the report.

Next Steps

The proposed rule will have a significant impact on the way states operationalize and monitor their SDP payment programs. States will need to review their SDP arrangements, managed care plan contracts, and financing structures as well as their rate certifications to determine the potential impact the proposal may have their current managed care program.

In addition, states will want to assess the new requirements outlined within the proposed rule to determine the potential impact on future program operations. Myers and Stauffer partners with more than 20 states and CMS in ensuring proper oversight of managed care health plans and compliance with CMS regulatory requirements, including all aspects of SDP arrangements. We are available to discuss any issues in the proposed rule. If you have any questions about the information in this alert or you would like help drafting formal comments, please contact the following members of our managed care engagement team.

The proposed rule is open for comments until July 3, 2023. Formal comments can be submitted here.

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