CLIENT ALERT: STATE-DIRECTED PAYMENTS

CMS Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-F)

State-Directed Payments (42 CFR § 438.6, § 438.7, and § 430.3)

On April 22, 2024, the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality rule was finalized by the Centers for Medicare & Medicaid Services (CMS). The final rule was published in the Federal Register on May 10, 2024. 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 finalized rule text, see https://www.federalregister.gov/public-inspection/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and.

CMS states its intended purpose of the 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.

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

1. Contract Requirements Considered to be SDPs (Grey-area Payments) (§ 438.6(c)(1)).
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 Time frames (§ 438.6(c)(2)(viii) and (ix)).
5. Standard for Total Payment Rates for 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 (c)(2)(ii)(H)).
7. Tie to Utilization and Delivery of Services for Fee Schedule Arrangements (§ 438.6(c)(2)(vii).
8. Value-Based Payments and Delivery System Reform Initiatives (§ 438.6(c)(2)(vi)).
9. Quality and Evaluation (§ 438.6(c)(2)(ii)(C), (c)(2)(ii)(D), (c)(2)(ii)(F), (c)(2)(iv), (c)(2)(v) and (c)(7)).

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10. Contract Term Requirements (§ 438.6(c)(5) and 438.7(c)(6)).
11. Including SDPs in Rate Certifications and Separate Payment Terms (§ 438.6(c)(2)(ii)(J), and (c)(6), and 438.7(f)).
12. SDPs Included through Adjustments to Base Capitations Rates (§ 438.7(c)(4) through 438.7 (c)(6)).
13. Appeals (§ 430.3(e)).
14. Reporting Requirements to Support Oversight and Inclusion of SDPs in MLR Reporting (§ 438.6(c)(4), and 438.8(e)(2)(iii)(C) and (f)((2)(vii)).

1. Contract Requirements Considered to be SDPs (Grey-area Payments) (§ 438.6(c)(1))

In January 2021, CMS published State Medicaid Director Letter (SMDL) #21-001, which closed an unintentional loophole created in the November 2017 Centers for Medicaid and CHIP Services Informational Bulletin 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 final rule reiterates CMS' amended position that these "gray-area payments" **do** require modification to comply with § 438.6(c) or (d). CMS added the phrase, "in any way," after "...The State may not...," to make the regulation more explicit that any state direction of an MCOs expenditures is impermissible unless it meets the requirements set forth in §438.6(c). In addition, the final rule moves the SDP definition to §438.2 from §438.6(a) in recognition of regulatory references to SDPs outside of §438.6.

CMS clarifies in response to a comment that prospective payment system (PPS) rates paid to FQHCs, RHCs, and demonstration CCBHCs are not considered SDPs. Section 438.6(c)(1) provides an exception for these statutorily-required PPS rates as they are included "in a specific provision of Title XIX or in another regulation implementing a Title XIX provision related to payments to providers."

Applicability date: July 9, 2024.

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

The final rule allows 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 SDPs based on an approved state plan rate methodology without 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. The "total published Medicare payment rate" refers to payment amounts calculated by the Medicare program for specific services under Medicare Part A and Part B. For example, the total published Medicare payment rate for inpatient hospital services

aligns with the inpatient prospective payment system web pricer amounts. CMS notes that SDPs with minimum fee schedule rates less than or greater than the total published Medicare rate are not within scope of the exemption. States that adopt a minimum fee schedule using 100 percent of total published Medicare payment or Medicaid state plan rates will still need to document these SDPs in the managed care contracts and rate certifications and must still comply with all SDP requirements other than prior written approval by CMS. CMS provides an example that a SDP evaluation report would not need to be submitted to CMS for review at a specified time, the state is required to continue to evaluate the SDP, and such evaluation must be made available to CMS upon request.

CMS added *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.

CMS did not include 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. They acknowledged that the exemption will not accommodate all service and provider types.

Applicability date: July 9, 2024.

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

CMS removed 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 previously prevented states from including contract requirements to direct their Medicaid managed care plans on how to pay non-network providers. CMS noted 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).

CMS clarified in response to a comment that the revision grants states the option to direct payments to network and/or non-network providers. States have the flexibility to elect whether an SDP is limited to network or non-network providers. This should be specified as a part of the provider class description in each SDP. In addition, CMS noted states may use network status as a basis on which to define provider classes or subclasses for an SDP requiring different fee schedules or rates.

Applicability date: July 9, 2024.

4. SDP Submission Time-frames (§ 438.6(c)(2)(viii))

CMS is implementing a requirement for states to submit all required documentation for each SDP, for which written documentation is required, and for each amendment to an approved SDP before the start of the SDP or the start date of the amendment. CMS makes clear that this means before the first payment to a provider

under the SDP and not the state's request for federal financial participation (FFP) for the state's payment to its managed care plan that incorporates the SDP. CMS noted this submission time-frame would provide additional flexibility for states establishing new SDPs, but would limit the additional flexibility for that SDP to that initial rating period. If the state wanted to renew the SDP, they would have to resubmit the preprint before the start of the rating period.

CMS notes the start date specified in the preprint is the date when the managed care plans must implement the payment arrangement, and therefore, it believes this is a more relevant date upon which to base the preprint submission than the start or end of the rating period. States are encouraged to submit their preprints as far in advance of an SDPs start date as possible to facilitate approval prior to the SDP start date. States remain at risk for a disallowance of FFP until CMS' approval of the preprint as well as the managed care contracts and capitation rates that include the payment arrangement, and all other conditions and requirements for FFP have been satisfied. CMS noted it is committed to working with states to review SDP preprints as expeditiously as possible, but did not commit to a specific approval time-frame when a commenter requested a 90-day time-frame be implemented for CMS' review.

Required SDP documentation, as applicable:

- Completed SDP preprint.
- Total payment rate analysis.
- ACR demonstration.
- Evaluation plan.
- Notes that documents should be accurate and complete as further described in CMCS Informational Bulletin "Medicaid and CHIP Managed Care Monitoring and Oversight Tools," published on November 7, 2023.

In the interim, CMS notes it will continue its current policy of not accepting submissions for SDPs after the rating period has ended until the applicability of the final rule revision.

Applicability date: No later than the first rating period beginning on or after July 9, 2026.

5. Standard for Total Payment Rates for 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 implemented 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 codified 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 are required to provide documentation demonstrating this for each service and provider class. CMS defined "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.

States must provide documentation demonstrating the total payment rate for each service and provider class upon CMS request. CMS notes it intends to continue to request information from all states for all SDPs documenting the different components of the total payment rate using a standardized measure such as Medicaid state plan approved rates or Medicare rates, for each service and each class included in the SDP. When the total payment rate analysis and documentation are to be submitted with the SDP preprint, it will largely be a projected amount, based on projections of payments and effects of those payments under SDP, which CMS will refer to as "projected total payment rate."

CMS commented they may issue additional guidance further detailing documentation requirements and a specified format to demonstrate the total payment rate.

Establishment of Payment Rate Limits for Certain SDPs

To ensure proper fiscal and programmatic oversight in Medicaid managed care programs, CMS implemented the following payment rate limits:

1. *Historical Use of the Average Commercial Rate (ACR) Benchmark for SDPs.*

   CMS will allow total payment rates in an SDP up to the ACR for certain services. Using the ACR will allow 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.

   CMS notes not all providers providing a particular service in Medicaid managed care must be included in an SDP. States are required to direct expenditures equally, using the same terms of performance, for a class of providers furnishing services under the contract; however, they are not required to direct expenditures equally using the same terms of performance for all providers providing service under the contract. For example, CMS has approved SDPs where states proposed and implemented SDPS that applied to provider classes defined by criteria such as participation in state health information systems or a learning collaborative, which were focused on health equity or social determinants of health.

2. *Payment Rate Limit for Inpatient Hospital Services, Outpatient Hospital Services, Qualified Practitioner Services at Academic Medical Centers, and Nursing Facilities.*

   CMS will impose 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 total payment rate limit for the four services types is applicable to minimum and maximum fee schedules and uniform dollar increases as well as to value-based payment (VBP) models, multi-payor or Medicaid-specific delivery system reform, and performance-improvement initiatives.

CMS clarified that the statutory and regulatory requirements for the upper payment limit (UPL) in Medicaid fee-for-service do not apply to risk-based managed care plans; therefore permitting states to direct managed care plans to make payments higher than the UPL does not violate any current Medicaid statutory or regulatory requirements. CMS noted establishing a payment limit based on a total payment limit less than the ACR could result in reductions in total payment rates from existing total payment-rate levels for some SDPs, particularly given the number of states with approved SDPs that exceed the Medicare rate. The 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 did not establish a regulatory payment-rate ceiling for services other than inpatient hospital services, outpatient hospital services, qualified practitioner services at academic medical centers, and nursing facilities, noting further research is needed before codifying a specific payment rate for these services. Although CMS has been permitting ACR as the payment-rate ceiling for other services, such as ground emergency ambulance services, CMS is not proposing to establish ACR as the regulatory ceiling at this time. 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 was added to §438.6(a).

CMS commented that as they monitor implementation of this SDP policy, in future rule-making they may consider establishing additional criteria for approval of SDPs at the ACR, such as meeting minimum thresholds for payment rates for primary care and behavioral health, to ensure the state and its managed care plans are providing quality care to Medicaid and CHIP enrollees and to support state efforts to further their overall program goals and objectives, such as improving access to care.

3. *Average Commercial Rate Demonstration Requirements.*

To monitor compliance with the ACR limit proposal, CMS will require states to provide two pieces of documentation: (1) an ACR demonstration; and (2) a total payment rate comparison to ACR. The ACR demonstration must be submitted with the initial preprint submission (new, renewal, or amendment) following the applicability date and then updated at least 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. The ACR demonstration is specific to the state and specific to the service type included in the SDP, rather than service and provider class level. States may still elect to provide a demonstration at both the service and provider class level, but this level of analysis is no longer required. CMS notes that allowing the ACR demonstration at the service level allows states flexibility in targeting increased reimbursement to specific categories of providers such as rural hospitals, which would have a lower ceiling at an individual provider class level.

The total payment rate comparison must be specific to each managed care program, be specific to each provider class to which the SDP applies, be projected for the rating period for which the written prior approval of the SDP is sought, use payment data that is specific to each service included in the SDP, and include a description of the components of the total payment rate as a percentage of the ACR.

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 total payment 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 noted states have the option to update the ACR demonstration any time a preprint is submitted to account for medical inflation. CMS also stated it may publish additional guidance on best practices for ACR and total payment demonstrations as well as a template to help facilitate CMS's review.

Monitoring of Actual SDP Payments

CMS is requiring states to submit to CMS no later than one year after each rating period, data to the T-MSIS specifying the total dollars expended by each managed care plan for SDPs, including amounts paid to individual providers. CMS plans to use the T-MSIS data to assess historical total payment rates for SDPs and could, for example, request corrective modifications to future SDP submissions to address discrepancies between projection of the total payment rate under the SDP and the actual payments made to eligible providers. See topic #14 below for additional details.

CMS opted not to implement an overall expenditure limit due to possible unintended consequences in states' efforts to further their overall Medicaid program goals and objectives, such as improving access to care for Medicaid beneficiaries and reducing health disparities through SDPs. The ACR payment limit that is finalized as part of this rule includes the majority of SDPs which CMS believes provides a reasonable and appropriate policy to ensure the fiscal integrity of SDP arrangements.

Applicability date § 438.6(c)(2)(ii)(I) (Rates are reasonable, appropriate, and attainable): July 9, 2024.

Applicability date § 438.6(c)(2)(iii) (ACR and Total Payment Rate Comparisons): No later than the first rating period beginning on or after July 9, 2024.

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

CMS added a requirement that explicitly states SDPs must 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. This includes requirements for health care-related taxes that are used by states to finance the non-federal share of SDPs. The taxes are required to be broad-based, imposed uniformly, and cannot contain hold-harmless arrangements.

In addition, the final rule stipulates 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 must ensure either that, upon CMS request, such attestations are available, or that the state provides an explanation that is satisfactory to CMS about why specific providers are unable or unwilling to make such attestations. For an explanation to be satisfactory, it must demonstrate to CMS why missing attestations do not indicate that a hold-harmless arrangement is or is likely to be in place and why the absence of the attestations therefore should not impact CMS' evaluation of the permissibility of the health care-related tax.

FFP is not permissible if the state share that is being matched does not comply with the conditions of 1903(w) of the Act, such as in the case of redistribution arrangements where providers are held harmless. CMS notes that regardless of whether the taxpayers participate voluntarily, whether the taxpayers receive the Medicaid payments from a Medicaid managed care plan, or whether taxpayers themselves or another entity make redistribution payments using dollars received as Medicaid payments, or with other provider funds that are replenished by the Medicaid payments, the taxpayers participating in these redistribution arrangements have a reasonable expectation that they will be held harmless for all or a portion of their tax amount, making the tax ineligible for satisfaction of the state share of an SDP.

States will 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. CMS may deny written prior approval of an SDP if it does not comply with the above outlined requirements. This applies to all SDPs, regardless of whether written prior approval is required.

The finalized regulation is similar to the guidance outlined in CMCS Informational Bulletin published February 23, 2023, as well as the proposed 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. On June 30, 2023 the federal district court in Texas issued a preliminary injunction enjoining the Secretary from enforcing the bulletin or from otherwise enforcing the interpretation of the scope of 42 U.S.C. 1396b(w)(4)(C)(i) (section 1903(w)(4)(C)(i) of the Act) found therein. CMS acknowledged the Texas preliminary injunction, and noted in its comments that it will abide by the injunction as long as it remains in effect in implementing the attestation requirements contained in the final rule. Whether the preliminary injunction applies only to the state of Texas is not clear. The attestation requirement would not go into effect until the first rating period beginning on or after January 1, 2028, providing CMS an opportunity to respond to the preliminary injunction and for additional litigation in the courts regarding CMS' authority over private contractual agreements. As many states use provider taxes to finance the non-Federal share of SDPs, developments on this issue could be very impactful.

Applicability date § 438.6(c)(2)(ii)(G): July 9, 2024.
Applicability date § 438.6(c)(2)(ii)(H): No later than the first rating period beginning on or after January 1, 2028.

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. This requirement that SDPs be tied to utilization and delivery of covered benefits differentiates SDPs from pass-through payments.

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. SMDL #21-001 explained SDPs should be based on actual utilization for the applicable rating period and cannot be based solely on historical utilization. CMS is codifying 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.

The final rule also prohibits 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. While historical data is appropriately used in capitation rate development, CMS notes it may not be used as the basis for interim payments from plans to providers. CMS clarifies in response to a comment, that the new regulation does not prohibit reconciliation of payments to actual utilization during the rating period when interim payments were also based on utilization during the rating period; thus allowing for claims runout, adjudication, and appeals when needed. Claims can continue to be paid after the rating period if they are for utilization that occurred in the rating period, either by date of receipt of the claim or date of service.

CMS notes that using historical data for SDPs and reconciliations essentially removes risk from the managed care plans participating in SDPs, which is inconsistent with the nature of risk-based Medicaid managed care. CMS states prohibiting these practices will alleviate oversight concerns, align with the risk-based nature of capitation rates, as well as restore program and fiscal integrity to these kinds of payment arrangements.

CMS revised the applicability date of this revision to no later than the first rating period beginning three years after the effective date of the final rule from the proposed two-year compliance period to align with the applicability of the prohibition against separate payment terms, which is also included within this final rule. CMS revised its position in the final rule regarding the tie between the use of separate payment terms and the post payment reconciliation process from the proposed rule.

Applicability date: No later than the first rating period beginning on or after July 9, 2027.

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

CMS is implementing 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 codifying 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 implementing the following:

Performance-based Payments

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 designed to assist in achieving critical program goals. 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 enables states to reinvest unspent funds to further promote VBP and delivery system innovation. If a state intends to recoup unspent funds from plans for any state directed payment, this must be clearly outlined in the state's preprint.

   In response to a comment to the final rule, CMS notes it did not propose nor is it finalizing spending requirements for recouped unspent state funds that were initially designed for payment for VBP initiative SDPs. It reminded states that the federal share of any recouped funds is subject to return via the CMS-64.

iii. To clarify how performance in VBP arrangements is measured for participating providers CMS is codifying its interpretation that payment for performance-based payments may not be based on "pay-for-reporting," and instead must be based on actual performance. CMS notes that administrative functions such as adhering to reporting requirements or participating in a learning collaborative can be a condition of eligibility for the SDP, but cannot be the performance measure utilized for payment. In addition, the final rule allows states 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.

   CMS notes in a response regarding the use of "pay-for-reporting" to establish baseline measurements, that states could first use a fee-based payment arrangement that is tied to utilization of services and use participation in a learning collaborative as a condition of provider eligibility for the fee-based SDP. Once reporting is established through the learning collaborative, the arrangement could be transitioned to a performance-based VBP.

   In an effort to establish guardrails for declining performance, SDP performance measurements will be required to include a baseline statistic for all metrics to ensure performance demonstrates either maintenance or improved performance over baseline to receive payment. CMS revised the final rule to allow for maintenance of performance to address that improved performance year after year may be impractical. Payments would be required to be documented in the rate certification for the rating period in which the payment is delivered.

Population-based and Condition-based Payments

iv. To adopt requirements for use of population-based and condition-based payment in VBP SDP arrangements the final rule establishes regulatory pathways for approval of VBP initiatives that may not be conditioned on specific performance measures. "Population-based payment" is defined as a

prospective payment 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" is 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 are 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 is 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 must replace the negotiated rate between the plan and the providers for the Medicaid covered service(s) being delivered as a part of the SDP to prevent any duplicate payments for the same service. The final rule also adds 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 final rule requires the payment include at least one performance measure and set the target for such a measure to demonstrate maintenance or improvement over baseline at the provider-class level for the provider class receiving the payment.

CMS notes in response to a comment regarding the development of capitation rates for population- and/or condition-based payments, it plans to publish guidance that includes practical examples of implementation strategies to help guide states as they design SDPs, particularly those that are VBP initiatives that include population- and/or condition-based payments.

Applicability date § 438.6(c)(2)(vi)(A): July 9, 2024.

Applicability date § 438.6(c)(2)(vi)(B), (C)(1), and (2): No later than the first rating period beginning on or after July 9, 2024.

Applicability date § 438.6(c)(2)(vi)(C)(3), and (4): No later than the first rating period beginning on or after July 9, 2026.

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

Evaluation Plan

CMS is implementing 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. CMS noted that historically SDP evaluation plans have been incomplete and routinely do not contain evaluation results. States are required to submit an evaluation plan for each SDP that requires written approval. The evaluation plan must:

1. Identify at least two metrics 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.
2. The metrics must 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, in compliance with the definition. States are allowed to select maintaining access to care as a metric, but if a state elects access as a metric, states are required 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 demonstrating either maintenance or improvement over the baseline for each of the selected measures in their evaluation plan.

Evaluation Report

CMS notes that consistent submission of evaluation results is important for transparency and for responsiveness to oversight bodies as the total dollars flowing through SDPs continues to increase. The final rule will require states to provide commitment to submit an evaluation report if the final SDP cost percentage exceeds 1.5 percent. The evaluation-reporting requirement is limited to states with SDPs that require prior approval. However, in situations where the SDP evaluation report is not required, the state is still required to continue to evaluate the SDP to comply with § 438.6(c)(2)(ii)(D) and (F), and such an evaluation must be made available upon CMS' request. The "final state-directed payment cost percentage" will 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 must be measured distinctly for each managed care program and SDP. An actuary will be required to calculate the absolute change the SDP has on base capitation rates. The cost percentage will 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 will 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 will be required to include all of the elements approved in the evaluation plan. In addition, they will be required to include the three most recent and complete years of annual results for each metric. The first evaluation report will be required to be submitted no later than two years after the conclusion of the three-year evaluation period (due with submission for the pre-print for the sixth rating period after applicability date) and subsequent reports would have to be submitted to CMS every three years after. States will also be required to publish their evaluation reports on their public facing website. CMS notes it plans to make evaluation results available on Medicaid.gov. 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 will be developed to support evaluation requirements. States may have the option to leverage the CMS-developed protocol or their EQRO to assist with evaluating their SDPs.

CMS plans to issue additional technical assistance on this subject to assist states in the development of evaluation plans in alignment with regulatory requirements and preparing subsequent evaluation reports.

CMS also commented on encouraging states to submit SDPs for primary care, maternal health, and behavioral health. Additionally, they expect states to consider examining parity in payment rates for primary care and behavioral health compared to other services, such as inpatient and outpatient hospital services, as part of their evaluation of SDPs.

Applicability date: No later than the first rating period beginning on or after July 9, 2027.

10. Contract Term Requirements (§ 438.6(c)(5) and 438.7(c)(6))

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 is codifying the following minimum requirements for the content of Medicaid managed care contracts that include one or more SDP contractual requirements:

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. SDP terms would be required to be described and documented in the contract and must be submitted to CMS no later than 120 days after the start of the SDP.

Applicability date § 438.6(c)(5)(i) through (iv): No later than the first rating period beginning on or after July 9, 2026.

Applicability date § 438.6(c)(5)(v): No later than the first rating period beginning on or after July 9, 2028.

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

CMS stated in the proposed rule, it strongly preferred that SDPs be included as adjustments to capitation rates rather than through separate payment terms, as inclusion as adjustments to capitation rates is consistent with the nature of risk-based managed care. They noted consideration of prohibiting all separate payment terms or additional restrictions on their use (such as restricting to only value-based SDPs), but sought public comment. CMS noted the increase in usage of separate payment terms in SDP arrangements, and highlighted 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 communicated it originally permitted the use of separate payment terms to provide flexibility to states as they adjusted to SDPs with the expectation states would transition over time to include all SDPs in capitation rates.

In the proposed rule, CMS defined "separate payment term", and included multiple contractual and rate certification requirements for SDPs paid under separate payment terms. However, after reviewing public comments, CMS noted its concern that the proposed parameters do not adequately address how the use of separate payment terms erodes the risk-based nature of payment to managed care plans and fiscal integrity in Medicaid managed care.

Commenters reaffirmed that separate payment terms are developed by the state rather than the state's actuaries, and the reasonableness of the amount of the separate payment term is generally not certified by the state's actuaries. Given its concerns regarding SDPs paid under separate payment terms, CMS is not finalizing its proposed provisions in §438.6(c)(6).

CMS instead revised §438.6(c)(6) to require that the final capitation rates for each managed care plan described in §438.3(c) account for all SDPs and that each SDP must be accounted for in the base data, as an adjustment to trend, or as an adjustment as specified in §§438.5 and 438.7(b). The final rule also prohibits states from either withholding a portion of the capitation rate to pay the managed care plan separately for a SDP, or requiring the managed care plan to retain a portion of the capitation rate separately to fulfill the contractual requirement of a SDP.

Under this final rule, States are also now permitted to recoup unspent SDP funds from plans as long as the recoupment methodology, recoupment process, and any other necessary details for recoupment are detailed in the SDP preprint and the contract documentation required in § 438.6(c)(5).

There were multiple comments in support of the proposed separate payment term regulation noting advantages and flexibility separate payment terms allow states. In addition, many commenters noted eliminating separate payment terms would be a notable departure from CMS current practices and could jeopardize the statutory mandate to safeguard equal access to care. CMS stated it is confident that states can transition existing SDPs that use separate payment terms into adjustments to base rates as the applicability date for the prohibition isn't until the first rating period that begins on or after three years following the effective date of the final rule.

Applicability date § 438.6(c)(2)(ii)(J): July 9, 2024.

Applicability date § 438.6(c)(6): No later than the first rating period beginning on or after July 9, 2027.

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

CMS is implementing three new requirements to address adjustments to managed care capitation rates related to SDPs.

i. Retroactive adjustments to capitation rates resulting from an SDP 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 must 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 will have to be submitted no later than 120 days after the start of the SDP.

Applicability date § 438.7(c)(4) and (5): July 9, 2024.

Applicability date § 438.7(c)(6): No later than the first rating period beginning on or after July 9, 2028.

13. Appeals (§ 430.3(d))

CMS is implementing an avenue to permit states to dispute written disapprovals of SDPs. These disputes will be heard by the Health and Human Services Departments Appeals Board (Board) in accordance with procedures set forth in 45 CFR part 16. States will 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.

CMS notes an administrative appeals process is a timelier and more cost-effective path to resolution than the court system. However, CMS states that nothing in the final rule precludes any party from seeking redress in the courts.

Applicability date: July 9, 2024.

14. Reporting Requirements to Support Oversight and Inclusion of SDPs in MLR Reporting (§ 438.6(c)(4), and 438.8(e)(2)(iii)(C) and (f)((2)(vii))

CMS's current review and approval process for SDPs is prospective; therefore, it has limited transparency regarding actual amounts that states provide to managed care plans for SDPs and actual amounts managed care plans pay providers. To gain more knowledge and insight into actual SDP spending to help in fulfilling its oversight and monitoring obligations, CMS proposed requiring utilizing 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. Under the proposed rule, states would also have been required to submit managed care plan-level SDP expenditures to CMS in compliance with § 438.74 MLR reporting. Based on comments CMS received regarding the extensive state and plan administrative work required to separately report these amounts, as well as the required CMS technical assistance that would have been necessary, CMS did not finalize these reporting requirements in the final rule. SDPs are required to be reported in the numerator and denominator of the MLR, however, there are not separate reporting requirements.

CMS instead is limiting its SDP reporting requirement to a long-term approach which will require states to annually submit data, no later than one year after each rating period to CMS's 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 plans 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 must 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 any other amounts included in the total paid to the provider, as applicable.

CMS intends to leverage T-MSIS encounter data reporting and build 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, and any other amounts included in the total payment amount paid to the provider. These details will allow CMS to obtain a better understanding of how SDPs are implemented by states and managed care plans, review SPDs on a state-by-state basis, identify potentially inappropriate payments, and analyze how well plans are administering the distribution

of SDPs across provider classes in the specified and approved SDPs. CMS noted it did not receive any comments from states opposing the use of T-MSIS for SDP reporting.

In regard to the collection of SDP information for value-based SDP arrangements, CMS notes it believes this information can be successfully captured elsewhere in T-MSIS, via financial transaction reporting, for example rather than via the encounter data format. CMS intends to further revise T-MSIS reporting the future to better enable states to report more complex SDP data easily and effectively.

CMS notes it will continue to develop and utilize a comprehensive approach to monitoring managed care program and plan performance, and will not rely on T-MSIS alone, but will collect information from states in multiple ways, including MCPAR, NAAAR, and MLR reports.

Applicability date: MLR reporting is effective July 9, 2024.

Applicability date: T-MSIS reporting is effective no later than the date specified in the T-MSIS reporting instructions released by CMS.

Next Steps

The final 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 final rule may have on their current managed care program.

In addition, states will want to assess the new requirements outlined within the final rule to determine the potential impact on future program operations. Many of the provisions within the final rule allow for a longer time before compliance is required. This enables states to chart out a strategic transition plan to limit disruptions in their Medicaid 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 assist with formulating a transition plan to ensure compliance or discuss any issues in the final rule. If you have any questions about the information in this alert, please contact the following members of our managed care engagement team.

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