



CMCS Informational Bulletin

DATE: November 2, 2017

FROM: Brian Neale, Director
Center for Medicaid and CHIP Services

SUBJECT: Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts

The Centers for Medicare & Medicaid Services' (CMS) Medicaid managed care rules¹ include requirements for how states may implement delivery system and provider payment initiatives under Medicaid managed care contracts, including those with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). These types of payment arrangements permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs. While CMS continues its review of the managed care rule, this informational bulletin provides information for states on strategies to implement such payment arrangements within the parameters of the rule.

Specifically, 42 CFR 438.6(c)(1)(i) through (iii) specify the ways states may set parameters on how expenditures under managed care contracts are made by managed care plans to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement. These state directed payments must be based on delivery and utilization of services to Medicaid beneficiaries covered under the contract, outcomes, and quality of the delivered services.² These permissible state directed payments fall into three categories³:

1. Directing managed care plans to implement specific ***value-based purchasing models***. Examples of value-based purchasing could include bundled payments, episode-based payments, accountable care organizations (ACOs), or other alternative payment models intended to recognize value or outcomes over the volume of services.
2. Directing managed care plans to implement ***multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives***. Examples of delivery system

1 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016) (available at: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>); and Medicaid Program; The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems; Final Rule, 82 Fed. Reg. 5415 (Jan. 18, 2017) (available at: <https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00916.pdf>).

2 These state directed managed care payments are in contrast to pass-through payments, which are disconnected from the amount, quality, or outcomes of services delivered to Medicaid managed care enrollees under the managed care contract; see: <https://www.medicare.gov/federal-policy-guidance/downloads/cib072916.pdf>.

3 These categories are not intended to be mutually exclusive.

reform or performance improvement initiatives could include pay for performance arrangements, quality-based payments, or population-based payment models.

3. Directing managed care plans to adopt specific types of *parameters for provider payments* for providers of a particular service under the contract, including minimum fee schedules, a uniform dollar or percentage increase, or maximum fee schedules.

Approval Criteria for State Directed Payment Arrangements

All state directed payments included in Medicaid managed care contracts under §438.6(c) must be based on the utilization and delivery of services to Medicaid beneficiaries covered under the contract in order to be approved by CMS, and these payments must be directed equally, using the same terms of performance across a class of providers. Provider participation in these state directed payments cannot be conditioned upon the provider entering into or adhering to intergovernmental transfer agreements.

The directed payments must also advance at least one of the goals and objectives in the state's Medicaid managed care quality strategy and have an evaluation plan to assess the degree to which the directed payment arrangement achieves its objectives. The basis and scope of the evaluation plan should be commensurate with the size and complexity of the payment arrangement. For example, a state implementing a minimum fee schedule to promote access to care may be able to utilize existing mechanisms to evaluate the effectiveness of the payment arrangement, such as external quality review (EQR) or an existing consumer or provider survey.

In general, an evaluation plan should include: the identification of performance criteria which can be used to assess progress on the specified goal(s) and objective(s); baseline data for performance measure(s); and improvement targets for performance measure(s). States have the ability to identify performance measure(s) that are most appropriate for this evaluation and may wish to consider using performance measures currently being used by the state or other existing measure sets in wide use across the Medicaid, CHIP, and Medicare programs to facilitate alignment and reduce administrative burden⁴.

In addition, if states elect to direct their managed care plans to implement a value-based or delivery system reform payment arrangement, such as those payment arrangements described in categories 1 or 2 above, these directed payments will also need to make provider participation available using the same terms of performance for a class of providers and use a common set of performance measures⁴ across all payers and providers participating in the reform or improvement initiative. For these value-based or delivery system reform payments, states cannot set the amount or frequency of the expenditures, nor can states recoup any unspent funds allocated for these payment arrangements from the managed care plans.

⁴ Examples of measure sets in wide use across Medicaid programs include the Medicaid and CHIP Child Core Set (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>), the Medicaid Adult Core Set (<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>), the Medicaid Health Homes Core Set (<https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-quality-reporting.html>), and the Core Quality Measure Collaborative sets (<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/core-measures.html>).

Multi-Year Approval of State Directed Payment Arrangements

Under §438.6(c), state directed payment arrangements cannot be renewed automatically beyond a fixed period of time. We have generally interpreted this fixed period of time under the regulation to be an annual term, as CMS explained in the final rule that we sought to evaluate and measure the impacts of these reforms, and we generally believe that this would require an annual review of the payment arrangements. However, we understand that some states are specifically pursuing multi-year payment arrangements to transform their healthcare delivery systems and believe that states can develop payment arrangements that are intended to pursue delivery system reform over a fixed period of time that is longer than one year. For example, states that have multi-year delivery system reform initiatives may want to pursue approval of a multi-year managed care directed payment arrangement that is commensurate with the length of their delivery system reform initiative.

In an effort to be mindful of states' payment reform efforts, we believe that under certain circumstances the regulatory requirements under §438.6(c) can support multi-year payment arrangements when the following criteria are met: (1) the state has explicitly identified and described the payment arrangement in the preprint as a multi-year payment effort, including a description of the payment arrangement by year, to the extent the payment arrangement varies by year; (2) the state has developed and described a plan for pursuing a multi-year payment arrangement, including the state's plan for multi-year evaluation, and the impact of a multi-year payment arrangement on the state's goal(s) and objective(s) in the state's quality strategy; and (3) the state will not be making any changes to the payment methodology described in the preprint for all years of the multi-year payment effort; and (4) CMS determines approval of a multi-year directed payment arrangement is appropriate.

If the state makes changes to the approved payment methodology during the multi-year payment effort, the state would be required to obtain written approval from CMS prior to implementation of the new or revised payment methodology. We believe that this approach under §438.6(c) will balance CMS' desire to evaluate these payment arrangements in Medicaid managed care with the goal of also reducing state administrative burden.

Payment Arrangements Not Subject to Approval Under 42 CFR 438.6(c)

Finally, we note the following situations would not constitute a payment arrangement requiring approval under §438.6(c):

1. States contractually implementing a general requirement for managed care plans to increase provider reimbursement for services provided to Medicaid beneficiaries covered under the contract, as long as the state is not mandating a specific payment methodology or amounts and managed care plans retain the discretion for the amount, timing, and mechanism for making such provider payments.
2. States contractually implementing a general requirement for managed care plans to utilize value-based purchasing or alternative payment arrangements when the state does not mandate a specific payment methodology and managed care plans retain the discretion to negotiate with network providers the specific terms for the amount, timing, and mechanism of such value-based purchasing or alternative payment arrangements.

To illustrate the aforementioned situations, a state implements a general requirement for managed care plans to increase their overall rates for primary care services provided to all Medicaid beneficiaries covered under the contract, or for managed care plans to make 20 percent of their provider payments as value-based purchasing payments. These examples would not be state directed payments under our interpretation of the regulation as long as the state is not mandating a specific payment methodology or amounts under the contract. In addition, we note that when payment is tied to the utilization and delivery of a specific service or benefit provided to a specific enrollee under the contract, such payments are not pass-through payments as defined in 42 CFR 438.6(a) and not subject to the requirements under 42 CFR 438.6(d).

Implementing State Directed Payment Arrangements and Technical Assistance

Contract arrangements that direct the managed care plan's expenditures must have written approval from CMS prior to implementation and before approval of the corresponding Medicaid managed care contract(s) and rate certification(s). The compliance date for §438.6(c) is the rating period for Medicaid managed care contracts beginning on or after July 1, 2017. To help expedite the approval process, CMS has developed the attached §438.6(c) preprint which implements the prior approval process and must be submitted and approved by CMS before implementing any of the specific payment arrangements described in §438.6(c). States should submit the §438.6(c) preprint via the regional office mailboxes that are currently in use. To ensure a timely review process for states, CMS is committing to process §438.6(c) preprints that do not contain significant policy or payment issues within 90 calendar days after receipt of a complete submission.

As part of a pilot program, CMS has already approved state directed payment arrangements in several states and found that early discussions with states and technical assistance on completing the preprint are beneficial for both states and CMS during the review process. We are including in **Appendix A** (<https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/appendix-a.pdf>) examples of approvable state directed payment arrangements. We encourage states to reach out early for technical assistance to expedite CMS' review of state proposals. Please contact your regional office representative or John Giles, Technical Director in the Division of Managed Care Plans, at (410) 786-1255 or via email at John.Giles@cms.hhs.gov. We look forward to continuing our partnership with you to deliver on our shared goals of providing high quality, sustainable healthcare to those who need it most.