MILLIMAN WHITE PAPER

Approved Medicaid State Directed Payments: How States are Using §438.6(c) "Preprints" to Respond to the Managed Care Final Rule

Analysis

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In response to the Medicaid managed care final rule, several states have recently gained approval from the Centers for Medicare and Medicaid Services' (CMS) for "state directed payment" arrangements that support delivery system and provider payment reforms.[1]

These arrangements allow states to require managed care plans to make specified payments to healthcare providers when the payments support overall Medicaid program goals and objectives. Additionally, these arrangements provide a permissible mechanism for making supplemental payments in managed care programs, as an alternative to pass-through payments (which are phased out in the final rule). Whereas pass-through payments were often opaque and not clearly understood by all affected parties, state directed payments enable states to establish clear guidelines and direction for managed care plans and providers. These arrangements also allow states to coordinate value-based purchasing (VBP) and other delivery system reform initiatives in managed care programs.

As states consider state directed payments, it can be helpful to understand the types of programs that have been approved by CMS. This white paper provides background on state directed payment arrangements based on our review of §438.6(c) "Preprints" and supporting documentation for arrangements approved by CMS as of August 15, 2018.

Background and history of supplemental payments

Supplemental payment programs, some of which are called upper payment limit (UPL) programs, constitute a major source of Medicaid revenue for providers in many states. Per a 2018 Medicaid and CHIP Payment and Access Commission (MACPAC) issue brief on Medicaid hospital supplemental payments, $47.2 billion, or 27 percent of total national Medicaid hospital expenditures, was attributable to supplemental payments.[2] For hospitals, the state share of non-Disproportionate Share Hospital (DSH) supplemental payments is funded primarily through health care-related taxes (32 percent of funding) and local governments (43 percent of funding), whereas state general funds accounted for only 22 percent of funding.[3]

The political support needed to implement supplemental payment programs involving local funding sources is highly dependent on a state's ability to financially support the providers that help to fund the state share of payments. As states transition Medicaid programs from fee-for-service (FFS) to managed care,[4] available FFS UPLs are decreasing, making it difficult to maintain the amount of supplemental funding that has historically been provided through these arrangements. As a result of this dynamic, many states used pass-through payments to maintain supplemental payment Medicaid revenue under managed care. Per CMS in the 2016 Federal Register:

> "Commonly, states that have moved from FFS to managed care have sought to ensure a consistent payment stream for certain critical safety-net hospitals and providers and to avoid disrupting existing IGT [intergovernmental transfer], CPE [certified public expenditure], and provider tax mechanisms associated with the supplemental payments."[5]

Pass-through payments and the Medicaid managed care final rule

In its May 6, 2016 Final Rule, CMS described the following concerns with pass-through payments:

- CMS viewed pass-through payments to be no different than the state making a payment outside of the contract directly to providers
- CMS had difficultly linking pass-through payments to services, utilization, quality, or outcomes
- CMS believed that pass-through payments limit managed care plans' ability to effectively use VBP strategies and implement quality initiatives.[6]

To address these concerns about pass-through payments, CMS introduced permissible alternative approaches, as documented in 42 CFR §438.6(c), "Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts." This section of the federal regulation provides specific mechanisms that can be used by states to support innovative efforts to transform care delivery and payment and allows states to contractually require managed care plans to adopt minimum fee schedules for provider payments, use VBP approaches for provider reimbursement, and participate in delivery system reform initiatives. Directed arrangements must be based on delivery and utilization of services, direct expenditures equally for a class of providers using a common set of performance measures, and advance at least one goal and objective in the state's quality strategy.

PASS-THROUGH PAYMENT BACKGROUND

As outlined in a May 2016 Milliman white paper,[7] 42 CFR §438.6(d) is summarized as follows:

- Pass-through payments are amounts paid to Medicaid managed care plans as supplemental payments or "add-ons" to the base capitation rate, where the plans are required to pass through the add-on payment to designated contracted providers.
- Pass-through payments are defined as any amount required by the state to be added to contracted payment rates that are not for any of the following purposes:
    1. Reimbursement for a specific service or benefit provided to a specific enrollee covered under the managed care contract
    2. Approved provider payment arrangements as described in §438.6(c)(1) of the final Medicaid managed care regulations
    3. A sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract
    4. Graduate medical education
    5. Federally qualified health center or rural health center wraparound
- Pass-through payments are limited for contracts beginning on or after July 1, 2017 as follows:
    1. Aggregate annual pass-through payments cannot exceed amounts that were approved by CMS as of July 5, 2016.
    2. Pass-through payments are phased out over 5- and 10-year periods, depending on provider type. For hospitals, the maximum allowable pass-through payment (based on the difference between managed care costs and claim payments for inpatient and outpatient combined) is phased down by 10 percent each year over a 10-year period, such that pass-through payments are no longer allowed for rating periods for managed care contracts beginning on or after July 1, 2027. For physician and nursing facility services, pass-through payments are no longer allowed after five years, with no phase down, such that pass-through payments are no longer allowed for rating periods for contracts beginning on or after July 1, 2022.

Introduction of the §438.6(c) preprint

On November 2, 2017, CMS provided clarifying guidance on permissible delivery system and provider payment initiatives as defined in 42 CFR §438.6(c) via an Informational Bulletin. The Informational Bulletin defined three types of state directed payment arrangements (which are not intended to be mutually exclusive) through which states may direct managed care plans to:

1. Implement **VBP models**. Examples include bundled payments, episode-based payments, accountable care organizations (ACOs), and other models that reward providers for delivering greater value and achieving better outcomes.
2. Implement **multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives**. Examples include pay for performance arrangements, quality-based payments, and population-based payment models.
3. Adopt specific types of **parameters for provider payments**. Examples include minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules.

Along with the Informational Bulletin, CMS released the "Section 438.6(c) Preprint" form for states to use when applying for approval of state directed payments. The Preprint provides additional information about CMS' expectations for permissible arrangements to support the approval process. The Preprint also cross-references VBP arrangements to categories in the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework.[8]

APM FRAMEWORK CATEGORIES

- Category 1: Fee-for-Service – No Link to Quality & Value
- Category 2: Fee-for-Service – Link to Quality & Value
- Category 3: APMs Built on Fee-for-Service Architecture
- Category 4: Population-Based Payment

The Preprint groups permissible state directed payment arrangements into two primary categories: "State Directed Value-Based Purchasing" and "State Directed Fee Schedules." The Preprint further defines the following types of permissible State Directed VBP arrangements using "check boxes" provided on the form (not mutually exclusive):

- **Quality Payments / Pay for Performance (Category 2 APM, or Similar):** foundational payments for infrastructure and operations, pay for reporting and pay for performance.
- **Bundled Payments / Episode-Based Payments (Category 3 APM, or Similar):** Shared savings arrangements, bundled payments, and episode-based payments.
- **Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or Similar):** Condition-specific population-based payments (e.g., capitated payments for specialty services), comprehensive population-based payments (e.g., global budgets) and integrated, comprehensive payment and delivery systems (e.g., ACOs).
- **Multi-Payer Delivery System Reform:** Initiatives to align payers across the state, including payment policies, quality measurement, administrative practices, and data-sharing. This option is often selected in tandem with another APM category-based VBP type.
- **Medicaid-Specific Delivery System Reform:** Medicaid delivery system and payment transformation efforts as alternatives to traditional fee-for-service arrangements. This option is also often selected in tandem with another APM category-based VBP type.
- **Performance Improvement Initiative:** Incentive programs to report and demonstrate improvements in access and quality.
- **Other VBP Model**

The Preprint also defines the following types of permissible State Directed Fee Schedules using check boxes (not mutually exclusive):

- **Minimum Fee Schedule:** Requirement of minimum reimbursement levels based on a specified methodology
- **Maximum Fee Schedule:** Requirement of maximum reimbursement levels based on a specified methodology
- **Uniform Dollar or Percentage Increase:** Requirement of an increase (either in dollar value or percentage increase) above currently negotiated rates

For State Directed Fee Schedules, the Preprint provides additional check boxes to specify the basis for the fee schedule that the state will require managed care plans to use (not mutually exclusive)[9]:

- A Medicare fee schedule
- An approved state plan fee schedule (in other words, FFS rates)
- An alternative fee schedule established by the state

CMS' §438.6(C) APPROVAL CRITERIA

CMS' Informational Bulletin provides clear guidance regarding what is required for approval of state directed payments in Medicaid managed care contracts via the Section 438.6(c) Preprint:

- Payments must be based on utilization and delivery of services to Medicaid beneficiaries covered under the contract.
- Payments must be directed equally, using the same terms of performance across a class of providers. (The Informational Bulletin does not provide a definition for the term "class" in this instance.)
- For VBP arrangements, a common set of performance measures must be used across the provider class.
- Payments cannot be conditioned upon the provider entering into or adhering to IGT arrangements. (This does not preclude states from funding the state share of state directed payments with IGTs; rather states cannot predicate directed payments to providers on the receipt of IGTs.)
- Payments must be consistent with advancing at least one of the goals and objectives in the state's managed care quality strategy. (The state must also have an evaluation plan in place to assess the effectiveness of the directed payment arrangement to achieve the stated objectives.)

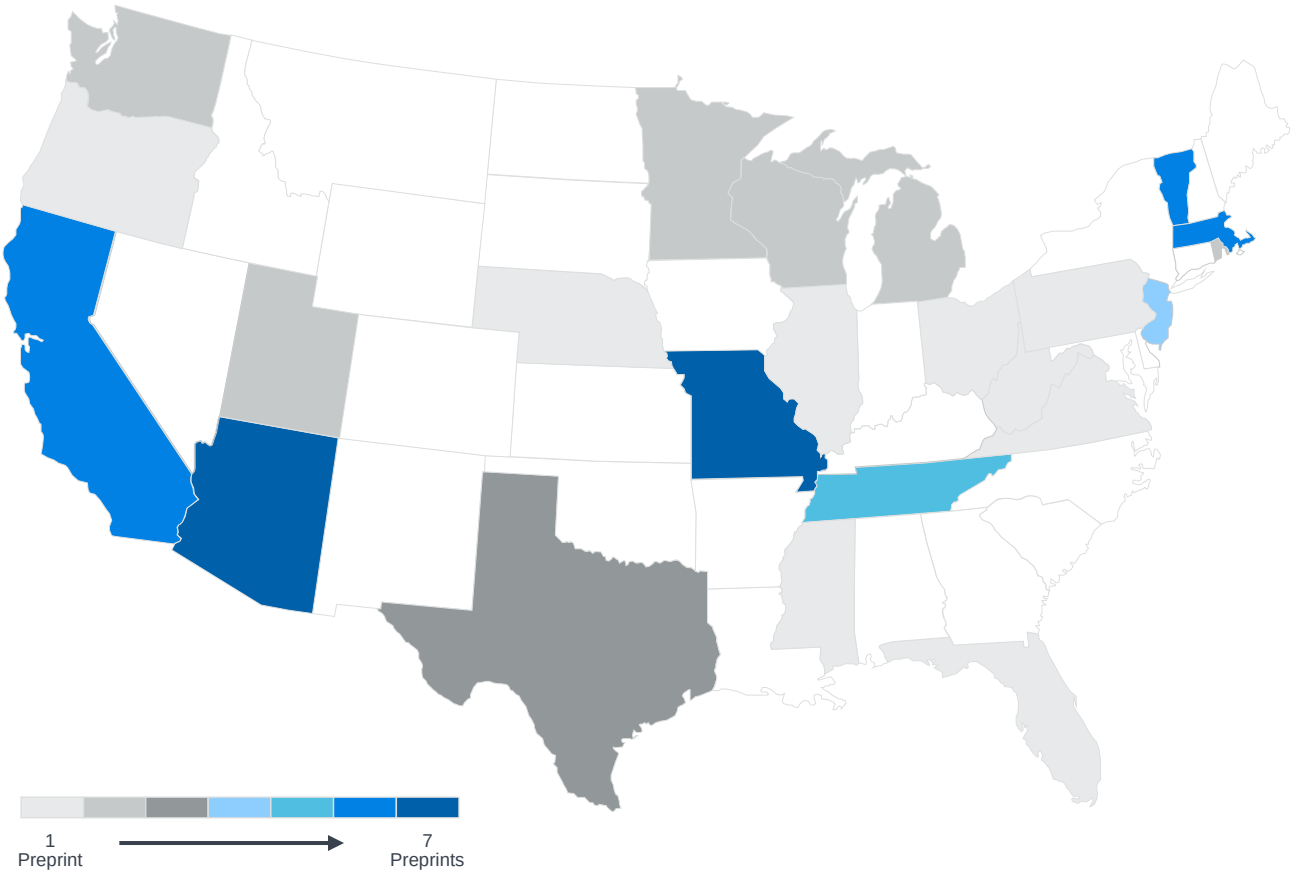
CMS' Informational Bulletin also states that for VBP arrangements, states cannot set the amount or frequency of the payments, nor can states recoup any unspent funds allocated for these payment arrangements from the managed care plans.

Lastly, while CMS has allowed states to specify the expected program duration of state directed payment arrangements in the Preprint, each state directed payment arrangement must be approved by CMS on an annual basis, even for expected multi-year arrangements.

Overview of approved section 438.6(c) preprints

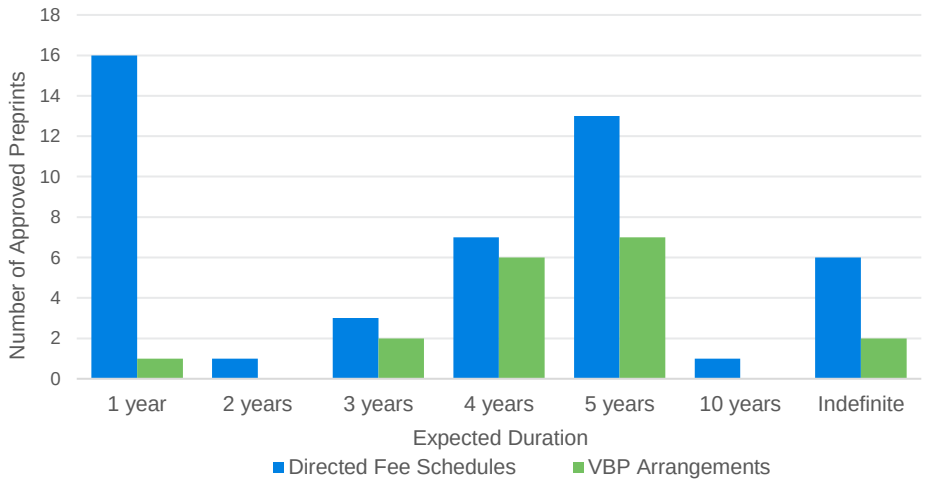
We have conducted a comprehensive review of all state directed payment arrangements approved by CMS as of August 15, 2018, obtained from CMS via a Freedom of Information Act (FOIA) request. CMS provided a total of 65 approved Preprints and supporting documentation that were submitted by 23 different states. As shown in Figure 1 below, the number of approved Preprints for a given state ranges from one to seven, with 14 states having more than one approved Preprint.

FIGURE 1: NUMBER OF APPROVED PREPRINTS BY STATE (AS OF AUGUST 15, 2018)



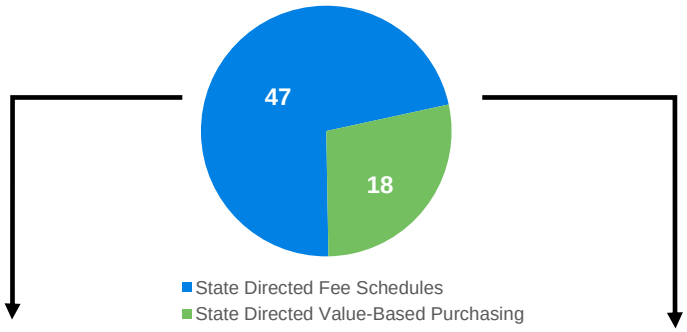
The expected duration across Preprints ranged from one year to indefinite, with 17 Preprints with a one-year expected duration and 48 Preprints with an expected duration of more than one year. As shown in Figure 2 below, most VBP arrangements had a longer expected duration (greater than one year), whereas Directed Fee Schedule arrangements were a mix of one-year and multi-year initiatives. Regardless of the expected duration specified in the Preprint, CMS correspondence consistently clarifies that approvals are for only one year, and states intending to continue the payment arrangement will need to obtain approval for each successive year.

FIGURE 2: EXPECTED DURATION



With respect to the two primary categories of state directed payment arrangements, 47 of the approved Preprints (72 percent) were for "State Directed Fee Schedules" and 18 of the approved Preprints (28 percent) were for "State Directed Value-Based Purchasing" arrangements. Figure 3 below shows the distribution of the types of approved Preprints.

FIGURE 3: APPROVED STATE DIRECTED PAYMENT ARRANGEMENTS



DIRECTED FEE SCHEDULES	
Fee Schedule Type (Can Have Multiple Types per Preprint)	Total Preprints
Minimum Fee Schedule	25
Uniform Dollar or Percentage Increase	21
Maximum Fee Schedule	2
Total Unique Directed Fee Schedules	47

VALUE BASED PURCHASING ARRANGEMENTS	
VBP Payment Type (Can Have Multiple Types per Preprint)	Total Preprints
Medicaid-Specific Delivery System Reform	11
Quality Payments / Pay for Performance	7
Population-Based Payments / ACO	6
Performance Improvement Initiative	3
Multi-Payer Delivery System Reform	2
Other Value-Based Purchasing (VBP) Model	1
Bundled Payments / Episode-Based Payments	1
Total Unique VBP Arrangements	18

The remainder of this white paper contains a detailed summary of our findings related to the two primary directed payment categories.

State Directed Fee Schedules

The most commonly selected *types* of State Directed Fee Schedules in the approved Preprints are minimum fee schedules and uniform increases (dollar or percentage-based). The most frequently chosen fee schedule *bases* were alternative fee schedules established by the state and approved state plan fee schedules. Several states did not select a fee schedule basis in their Preprint, with many citing that their proposed approach did not align with the Preprint's check boxes. Figure 4 below shows the distributions of types and bases for State Directed Fee Schedules in approved Preprints.

FIGURE 4: DIRECTED FEE SCHEDULES BY ARRANGEMENT TYPE AND BASIS

FEE SCHEDULE BASIS (CAN HAVE MULTIPLE BASES PER PREPRINT)	MINIMUM FEE SCHEDULE	UNIFORM DOLLAR OR PERCENTAGE INCREASE	MAXIMUM FEE SCHEDULE	TOTAL PREPRINTS
Alternative fee schedule established by the state	9	14	2	24
Approved state plan fee schedule (FFS)	16	0	1	16
None specified (other)	0	7	0	7
Medicare fee schedule	2	0	0	2
Total Unique Directed Fee Schedules	25	21	2	47

As shown in Figure 4, the most common combinations of State Directed Fee Schedule type and basis are:

- Minimum fee schedule (type) with an approved state plan fee schedule (basis) – 16 total Preprints. Many of these arrangements direct managed care plans to pay no less than FFS rates as defined in the state plan.
- Uniform dollar or percentage increase (type) with an alternative fee schedule established by the state (basis) – 14 total Preprints. Many of these arrangements involve a directed uniform percentage increase to claim payments above negotiated rates, or a distribution of a fixed payment pool allocated to providers based on utilization.
- Minimum fee schedule (type) with an alternative fee schedule established by the state (basis) – nine total Preprints. Many of these arrangements involve directed fee schedules based on average commercial rates (for physicians) or other cost-based rates (not related to the FFS state plan rates).

DIRECTED FEE SCHEDULE CONSIDERATIONS

While simplistic on the surface, the implementation of a State Directed Fee Schedule has the potential to introduce risk to the state and health plans. Additional considerations for states pursuing a directed fee schedule include the following:

- **Managed Care Plan Compliance.** A process and mechanism should be established to monitor and ensure managed care plan reimbursement is consistent with the directed fee schedule. Contractual requirements should be implemented to ensure managed care plan compliance with directed fee schedules.
- **Fee Schedule Updates.** States should develop a schedule and frequency related to updates for the directed fee schedule. In addition, it should be established whether fee schedule changes are made retrospectively or only prospectively.
- **Managed Care Plan Utilization Risk.** Directed fee schedules can introduce financial risk to managed care plans associated with utilization of services.
- **Provider Utilization Risk.** For directed fee schedules that target specific providers (e.g., faculty physicians or children's hospitals), the implementation of a directed fee schedule could incentivize managed care plans to direct utilization away from the participating providers.
- **Revenue Source Risk.** The amount of revenue required to fund the program (which may be generated either through healthcare-related taxes or IGT) has the potential to vary based on utilization and fee schedule changes over time. States will need to establish a process to monitor changes in revenue requirements to ensure that sufficient funding is available for the program.

For many alternative fee schedule arrangements (whether a uniform dollar increase or minimum fee schedule), states determine prospective per member per month (PMPM) rates to pay managed care plans based on projected utilization (for example, based on trended utilization from the prior year). Unlike pass-through payments, however, under a directed arrangement, states can require the plans to pay providers based on more recent utilization (for example, from the prior month or quarter). Some states (although not all) reconcile projected utilization compared to actual utilization and adjust final payments via a settlement process.

The approved State Directed Fee Schedules apply to a broad array of provider types. While most State Directed Fee Schedules apply to institutional providers such as hospitals and nursing facilities, there are fee schedules that apply to noninstitutional providers, including physician and other professional service, home and community-based services (HCBS), and transportation service providers.

Figure 5 below shows the distribution of provider types affected by approved State Directed Fee Schedules.

FIGURE 5: DIRECTED FEE SCHEDULES BY PROVIDER TYPE

PROVIDER TYPE (CAN HAVE MULTIPLE TYPES PER PREPRINT)	MINIMUM FEE SCHEDULE	UNIFORM DOLLAR OR PERCENTAGE INCREASE	MAXIMUM FEE SCHEDULE	TOTAL PREPRINTS
Hospitals	4	13	1	18
Physician and Other Professional Service Providers	8	5	1	13
Mental Health Providers	8	1	1	9
HCBS Providers	8	1	1	9
Nursing Facilities	4	2	2	7
Dental Providers	3	3	0	6
Transportation Providers	2	1	0	3
Other Clinics	2	1	0	3
Total Unique Directed Fee Schedules	**25**	**21**	**2**	**47**

As shown in Figure 5, the most common combinations of State Directed Fee Schedule type and provider type are:

- Hospitals with a uniform dollar or percentage increase – 13 total Preprints. Many of these arrangements involve the distribution of a fixed payment pool or a prospective increase to claim payments based on recent (monthly or quarterly) utilization.
- Mental health and HCBS providers with minimum fee schedules – 16 combined preprints. Many of these arrangements involve a minimum fee schedule based on FFS rates under the state plan.
- Professional service providers and minimum fee schedules – eight total preprints. Many of these arrangements involve a minimum fee schedule based on average commercial rates.

Although the Preprints do not include a prompt for information about the funding source for the state share of payments, our analysis of supporting documentation provided by CMS shows that CMS submitted a standard set of questions to Preprint applicants, including questions about the funding source for the state share of payments.

Figure 6 below shows the distribution of the funding source identified for 25 of the 47 approved State Directed Fee Schedule Preprints where supporting documentation was provided.

FIGURE 6: DIRECTED FEE SCHEDULES BY FUNDING SOURCE

FUNDING SOURCE (CAN HAVE MULTIPLE BASIS PER PREPRINT)	MINIMUM FEE SCHEDULE	UNIFORM DOLLAR OR PERCENTAGE INCREASE	MAXIMUM FEE SCHEDULE	TOTAL PREPRINTS
Intergovernmental Transfer (IGT)	2	8	0	10
Health Care-Related Tax	1	9	0	10
State General Fund	6	3	2	10
Other Nonstate General Fund	0	3	0	3
Not specified	17	5	0	22
Total Unique Directed Fee Schedules	**25**	**21**	**2**	**47**

As shown in Figure 6, we found multiple instances of approved State Directed Fee Schedule Preprints where the funding source for the state share of payments was an IGT or health care-related tax (also known as a provider assessment or provider tax). For the Preprints with the state share funded through an IGT, states had to provide assurances to CMS that funding for the State Directed Fee Schedules would be provided even if the IGT was ultimately not made by the provider (although if that occurred, it is possible a state may not seek re-approval of the Preprint).

For the State Directed Fee Schedules funded by providers – either through an IGT or a provider tax – we found the majority (17 of 20) were for uniform percentage increases to claim-based payments. Among the hospital Directed Fee Schedules, we found nine Preprints that referenced funding by a provider tax, five of which referenced replacing an existing hospital supplemental payment program. We also found 10 arrangements that reported funding through IGTs.

In the Preprint's "Payment Arrangement Quality Strategy Goals and Objectives" section, states reported a variety of goals and objectives related to maintaining access to care, improving care coordination and integrated systems, and referencing the state's quality strategy plan. To summarize the wide array of reported goals and objectives, we assigned a general "Goal Type" to each identified goal in the Preprints. Figure 7 below shows the distribution of quality goal types for State Directed Fee Schedules:

FIGURE 7: DIRECTED FEE SCHEDULES BY QUALITY GOAL TYPE

QUALITY GOAL TYPE (CAN HAVE MULTIPLE GOALS PER PREPRINT)	MINIMUM FEE SCHEDULE	UNIFORM DOLLAR OR PERCENTAGE INCREASE	MAXIMUM FEE SCHEDULE	TOTAL PREPRINTS
Improve Access to Care	28	14	1	42
Improve Quality/Outcomes	22	16	1	39
Reduce Costs	7	8	1	16
Promote Integrated Systems/ Care Coordination	11	2	0	11
Promote Community-Based Services	3	0	0	3
Total Unique Directed Fee Schedules	**25**	**21**	**2**	**47**

As shown in Figure 7, the most commonly cited quality goal for approved State Directed Fee Schedules, across types, is to improve access to care for a given service, particularly for hospitals (consistent with a methodology to establish minimum or enhanced reimbursement levels). Many of the goals related to improved quality/outcomes were applicable to professional service providers, with reported goals such as improved health outcomes via access to primary, preventive, and specialty care.

The Preprint's "Payment Arrangement Provider Performance Measures" section is currently not required for State Directed Fee Schedules. Based on our review of the Preprint's "Quality Strategy Goals and Objectives" section, we identified one State Directed Fee Schedule that provided specific performance measurements.

State Directed Value-Based Purchasing

CMS provided a total of 18 approved State Directed VBP Preprints and supporting documentation that were submitted by nine different states. The number of approved State Directed VBP Preprints for a given state ranges from one to six, with three states having more than one approved State Directed VBP Preprint.

The most commonly selected types of State Directed VBP arrangements are Medicaid-specific delivery system reform, quality payments / pay for performance, and population-based payments / ACO. Figure 8 below shows the distribution of types of State Directed VBP arrangements among the approved Preprints.

FIGURE 8: DIRECTED VALUE-BASED PURCHASING ARRANGEMENTS BY TYPE

VALUE-BASED PURCHASING ARRANGEMENT TYPE (CAN HAVE MULTIPLE TYPES PER PREPRINT)	TOTAL PREPRINTS
Medicaid-Specific Delivery System Reform	11
Population-Based Payments / ACO (Category 4 APM, or similar)	7
Quality Payments / Pay for Performance (Category 2 APM, or similar)	6
Performance Improvement Initiative	3
Multi-Payer Delivery System Reform	2
Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)	1
Other Value-Based Purchasing Model	1
Total Unique Valued-Based Purchasing Arrangements	**18**

The types of VBP arrangements were not mutually exclusive, and Medicaid-specific delivery system reform was selected in combination with another VBP type for six of the approved VBP Preprints. More specifically, of the 11 Preprints designated as Medicaid-specific delivery system reform arrangements, six have program designs that primarily provide foundational payments for infrastructure and operations, four have program designs that provide shared savings payments, and one has a program design that provides episodic payments.

The approved State Directed VBP arrangements apply to a broad array of provider types. Figure 9 below shows the distribution of provider types affected by approved State Directed VBP arrangements.

FIGURE 9: DIRECTED VALUE-BASED PURCHASING ARRANGEMENT BY PROVIDER TYPE

PROVIDER TYPE (CAN HAVE MULTIPLE TYPES PER PREPRINT)	MEDICAID-SPECIFIC DELIVERY SYSTEM REFORM	QUALITY PAYMENTS / PAY FOR PERFORMANCE	POPULATION-BASED PAYMENTS / ACO	PERFORM-ANCE IMPROVE-MENT INITIATIVE	MULTI-PAYER DELIVERY SYSTEM REFORM	BUNDLED PAYMENTS / EPISODE-BASED PAYMENTS	OTHER VALUE-BASED PURCHASING MODEL	TOTAL PREPRINTS
Physicians and Other Professional Service Providers	7	4	7	1	2	0	0	10
Hospital	4	2	3	3	0	0	0	6
Clinic	3	1	2	1	0	0	0	3
Dental Provider	0	1	0	0	0	0	1	2
Nursing Facility	0	1	0	0	0	0	0	1
Mental Health Provider	1	0	0	0	0	0	0	1
HCBS provider	1	0	0	0	0	1	0	1
Total Unique Value-Based Purchasing Arrangements	11	6	7	3	2	1	1	18

As shown in Figure 9, the most common State Directed VBP arrangements apply to physicians and other professional service providers, hospitals, and clinics. Many of the VBP arrangements applicable for these provider types were for broader state delivery system reform initiatives involving ACOs or pay-for-performance programs with specific quality metrics.

Figure 10 below shows the distribution of the funding source identified for 14 of the 18 approved State Directed VBP Preprints where supporting documentation was provided.

FIGURE 10: DIRECTED VALUE-BASED PURCHASING ARRANGEMENTS BY FUNDING SOURCE

FUNDING SOURCE (CAN HAVE MULTIPLE SOURCES PER PREPRINT)	MEDICAID-SPECIFIC DELIVERY SYSTEM REFORM	QUALITY PAYMENTS / PAY FOR PERFORMANCE	POPULATION-BASED PAYMENTS / ACO	PERFORMANCE IMPROVEMENT INITIATIVE	MULTI-PAYER DELIVERY SYSTEM REFORM	BUNDLED PAYMENTS / EPISODE-BASED PAYMENTS	OTHER VALUE-BASED PURCHASING MODEL	TOTAL PREPRINTS
State General Fund	4	3	5	2	2	1	1	8
Intergovernmental Transfer (IGT)	2	2	1	2	0	0	0	4
Other Sources	3	0	0	0	0	0	0	3
Health Care-Related Tax	1	0	1	2	0	0	0	2
None Specified	3	1	2	0	0	0	0	4
Total Unique Value-Based Purchasing Arrangements	11	6	7	3	2	1	1	18

As shown in Figure 10, we found multiple instances of approved State Directed VBP Preprints where the funding source for the state share of payments was an IGT or provider tax. For the provider-funded VBP arrangements, we found the majority was for Medicaid-specific delivery system reform involving performance improvement and pay-for-performance initiatives.

In the Preprint's "Payment Arrangement Quality Strategy Goals and Objectives" section, states reported a variety of goals and objectives related to improving quality and outcomes, improving care coordination and integrated systems, maintaining access to care, and referencing the state's quality strategy plan. Figure 11 below shows the distribution of our assigned quality goal types for approved State Directed VBP Preprints:

FIGURE 11: DIRECTED VALUE-BASED PURCHASING ARRANGEMENT BY QUALITY GOAL

QUALITY GOAL TYPE (CAN HAVE MULTIPLE GOALS PER PREPRINT)	EXAMPLE REPORTED GOALS AND OBJECTIVES	TOTAL PREPRINTS
Improve Quality/Outcomes	Enhance quality, including the patient care experience, in all programs	15
Promote Integrated Systems/ Care Coordination	Reduce fragmentation driving toward an integrated healthcare system	13
Improve Access to Care	Demonstrate a 5% improvement in the rate of adolescents receiving well care visits over the next two years	10
Reduce Costs	Align payment around improving population health outcomes, member experience, and controlling costs	5
Promote Community-Based Services	Decrease in institutional long-term care (LTC) utilization and increase in home and community-based services (HCBS) utilization	2
Total Unique Value-Based Purchasing Arrangements		**18**

The Preprint Form requires states requesting approval for State Directed VBP arrangements to provide a common set of performance measures that will be used across all of the payers and providers to which the Preprint applies, referred to as the "Payment Arrangement Provider Performance Measures." Most approved Preprints included specific performance measures that would be used in the payment arrangement; however, some approved Preprints did not, including one Preprint that stated the performance measures had not yet been determined.

OHIO CASE STUDY

Milliman recently assisted the Ohio Department of Medicaid (ODM) with the design of an approved State Directed VBP Preprint for the Care Innovation and Community Improvement Program (CICIP), effective July 1, 2018. CICIP is a "Quality Payments / Pay for Performance" State Directed VBP arrangement applicable to professional service providers affiliated with four large Medicaid safety-net and academic medical centers. The goal of the CICIP is to incentivize improved healthcare for Medicaid beneficiaries at risk of, or with, an opioid or other substance abuse disorder.

Monthly CICIP payments are made from managed care plans to providers based on historical utilization information, which is similar with the uniform dollar increase approach used in many approved State Directed Fee Schedules. However, CICIP differs from State Directed Fee Schedule arrangements in that ODM defined specific quality metrics and other VBP requirements that affect payment, and also implemented a retrospective reconciliation process to ensure that monthly payments were based on actual program utilization. With respect to the quality metrics and other VBP requirements, ODM implemented the following:

- Nine separate performance measures, including the number of dispensed opioid solid doses without Suboxone, follow-up visits after mental illness hospitalizations and emergency room utilization reduction.
- Three separate provider requirements related to care delivery, staff development, and peer education:
  1. Execute a population health approach to improving care, including patient risk identification and stratification, report reviews, team-based care, and participation in coalition meetings on quality program alignment, implementation, and best practices.
  2. Train prescribers on consensus-based opioid prescribing guidelines and on the use of electronic medical records (EMR) to promote prevention and appropriate pain treatment practices.
  3. Share best prevention and treatment methods with other practices.

By using a state directed payment arrangement, ODM was able to achieve greater specificity, control, and transparency regarding the total value and direction of payments, quality measures, and other operational considerations that were not typically found in pass-through payment arrangements.

Conclusion

The majority of approved arrangements to date have been for State Directed Fee Schedules. While simplistic on the surface, the implementation of a directed fee schedule has the potential to introduce risk to the state, health plans, and providers. There are several considerations for states pursuing a directed fee schedule, including managed care plan compliance and utilization risk, use of prospective vs. retrospective fee schedule updates, impacts on provider utilization and behavior, and revenue sources to fund payments associated with the directed fee schedule.

As states establish state directed payment arrangements to implement VBP initiatives in managed care programs, and with the potential for CMS' evaluation criteria to evolve over time, the balance may shift from directed fee schedules to VBP arrangements. While generally more complex, VBP arrangements give states the flexibility to require managed care plan participation and direct manage d care plan payments in VBP and other delivery system reform or performance improvement initiatives.

FOOTNOTES

[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).

[2] MACPAC, "Medicaid Base and Supplemental Payments to Hospitals" (June 2018).

[3] Ibid.

[4] For purposes of this paper, we use the term "managed care" to mean services provided through enrollment in a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as referenced in the final Medicaid managed care regulation.

[5] 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), page 27589.

[6] 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), pages 27588-27589.

[7] http://www.milliman.com/insight/2016/Pass-through-payment-guidance-in-final-Medicaid-managed-care-regulations-Transitioning-to-value-based-payments/

[8] Health Care Payment Learning and Action Network (HCP-LAN), "The APM Framework" (2017).

[9] Note that some states have a different basis for their fee schedule, and as a result, submitted Preprints where none of the fee schedule basis "check boxes" is selected.

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