MACPAC

Managed Care Issues and Use and Oversight of Directed Payments

Medicaid and CHIP Payment and Access Commission

Moira Forbes and Robert Nelb

Overview

- Federal managed care rules
- Recap of recent Commission work on managed care and value-based payment
- Key policy questions and preview of upcoming projects
- Discussion of use and oversight of directed payments

Key Policy Questions

- What are the effects of recent changes to federal managed care payment and network adequacy standards?
- Are processes for federal oversight of rate-setting methodologies sufficient to ensure that rates are sufficient and consistent with statutory goals?

Federal Managed Care Rules

- Federal rules for managed care oversight are codified in Part 438 of Section 42 of the Code of Federal Regulations (42 CFR Part 438)
- The Centers for Medicare & Medicaid Services (CMS) finalized a comprehensive update of the rule in June 2016, although some provisions were not implemented until 2017 or later
- On November 14, 2018 CMS published a notice of proposed rulemaking to amend the 2016 rule
- Final rule anticipated in fall 2019

2016 Rule: Key Provisions and Implementation Dates

- Rate setting (July 1, 2017)
  - Creates additional standards for developing capitation rates
  - Updates actuarial soundness requirements
- Directed payments (July 1, 2017)
  - Allows states to direct payments to providers as part of delivery system and provider payment initiatives
- "Pass-through" payments (July 1, 2017)
  - Prohibits CMS from approving any new pass-through payments
  - Requires existing arrangements to be phased out by July 1, 2022 (physicians, nursing facilities) or July 1, 2027 (hospitals)

2016 Rule: Key Provisions and Implementation Dates, Continued

- Medical loss ratio (MLR) reporting (July 1, 2018)
  - Requires managed care organizations (MCOs) to report information to allow MLR calculation
- MLR factor in capitation rates (July 1, 2019)
  - Requires states to develop capitation rates so that MCOs can reasonably achieve an MLR of 85 percent
- Network adequacy (July 1, 2018)
  - States must develop time and distance network adequacy standards and make the standards and monitoring public

2016 Rule: Key Provisions and Implementation Dates, Continued

- Quality (July 1, 2018)
  - States must develop a more comprehensive quality strategy
  - States must take a number of steps to improve transparency
  - States must create opportunities for stakeholder engagement
- Quality rating system (within 3 years of Federal Register notice)
  - States must implement a quality rating system for MCOs
- "In lieu of" services (as of the rule's effective date)
  - States can apply the "in lieu of" services provision to services provided in institutions for mental diseases

Proposed Changes to 2016 Rule

- Rate-setting
  - Allows states to use rate ranges in some instances
  - Prohibits retroactive changes to risk sharing
  - Provides more guidance on rates with different match
- Directed payments
  - Clarifies allowable types of directed payments
  - Changes CMS review requirements
- Pass-through payments
  - Allows states to make new pass-through payments for 3 years when transitioning to managed care

Proposed Changes to 2016 Rule, Continued

- Network adequacy standards
  - Eliminates requirement for time-and-distance standard; allows any quantitative standard
  - Allows states to define specialist types
- Quality rating system
  - Requires states to use core set of measures
  - Removes CMS pre-approval for state-specific quality rating system

Recent Commission Work

- March 2018: made three recommendations to streamline state mechanisms for managed care
  - in rationale noted that states and CMS must have a process and resources for oversight
- December 2018: reviewed information on state managed care network oversight
- January 2019: submitted comments on proposed rule
  - suggested that provider-level data on directed or pass-through payments be made public
  - stressed the importance of public engagement when changing network adequacy standards
  - described two data sources for consideration in evaluating the in-lieu-of payment policy

Related Commission Work

- Delivery system reform
  - March 2018: Issue brief on delivery system reform incentive program (DSRIP) waivers
  - April 2017: Update on delivery system reform
  - June 2015: Report chapter on using supplemental payments to drive delivery system reform
  - January 2014: Update on value-based payment models in four states
- Supplemental payments
  - March 2019: Report chapter on improving oversight of upper payment limit supplemental payments to hospitals
  - March 2014: Report chapter on the policy implications of supplemental payments

Areas of Focus for 2019-2020 Report Cycle

- How are states using the pass-through and directed payment options?
- How do state efforts to implement value-based payments under managed care contracts work and what are the outcomes?
- How does telehealth factor into how MCOs determine network adequacy?
- What are the mechanisms for monitoring, oversight, and accountability of dental services provided to children, and what does this look like in practice?
- Why do states not recoup money under a minimum MLR requirement?

Next Steps

- This morning: staff presentation on findings from review of approved directed payment plans and state quality strategies
- Subsequent meetings: present findings from work on pediatric dental oversight, value-based payments, telehealth, and MLR recoupments
- Monitor Federal Register for publication of final rule

Use and Oversight of Directed Payments in Managed Care

Overview

- Background
  - Supplemental payments in managed care
  - Directed payment option
- Use of directed payments
  - Directed fee schedules
  - Value-based purchasing (VBP)
- Policy questions and next steps

Supplemental Payments and Managed Care

- Prior to 2016, states were not allowed to make supplemental payments for services provided in managed care
- However, some states required MCOs to make additional payments to providers, known as pass-through payments
  - States would increase capitation rates and require MCOs to direct the additional funding to particular providers
  - Not tied to the amount of services provided
- The 2016 managed care rule phases out the use of pass-through payments over 10 years and creates a new option for directed payments

Directed Payment Option

- States can direct managed care payments to providers if they meet certain criteria
  - Payment must be tied to services provided under the managed care contract
  - Cannot be contingent on agreements to provide intergovernmental transfer (IGT) funding
  - Must advance at least one of the goals of the state's quality strategy
- Directed payment arrangements are reviewed by CMS and are not renewed automatically

Comparison of Requirements for Different Types of Payments

Requirement	UPL supplemental payments in FFS	Section 1115 supplemental payments (e.g., DSRIP)	Directed payments in managed care
Upper limit on payment amount	Amount that would have been paid based on Medicare payment principles, in the aggregate for a class of providers	Negotiated amount in the waiver terms and conditions Total waiver spending must be less than projected spending without the waiver	Amount that CMS approves in its review of directed payment preprints.
Duration of approval	Indefinite	5 years	1 year[1]
Monitoring/ evaluation	No evaluation; states must demonstrate compliance with the UPL annually	Independently evaluated according to an evaluation design plan approved by CMS	State-designed evaluation of the extent to which the payment advances at least one of the goals of the state's quality strategy

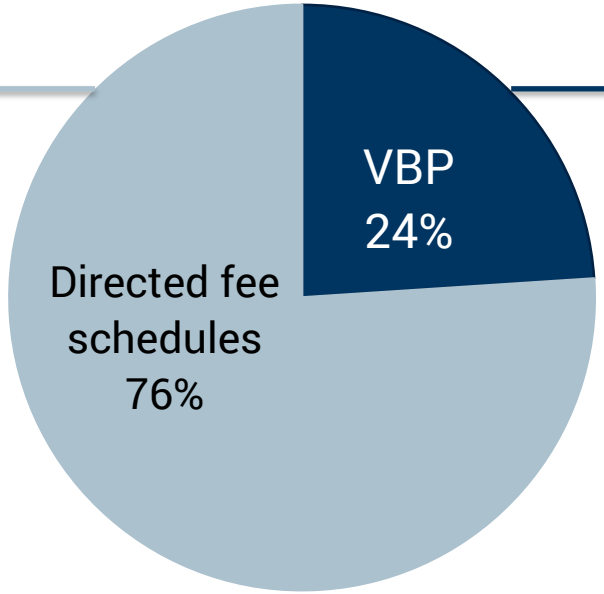
Notes: UPL is upper payment limit. FFS is fee-for-service. DSRIP is delivery system reform incentive payment.
[1] CMS has proposed to allow multi-year approval of directed payments for delivery system reform efforts.

MACPAC Analysis

- MACPAC reviewed approval documents for directed payment arrangements that had been approved as June 2019
  - 121 arrangements in 34 states
  - These data are not publicly available
- We also reviewed the most recent versions of state managed care quality strategies
  - Quality strategies are not approved by CMS but are posted on state websites

Distribution of Types of Directed Payment Arrangements, 2019

Fee schedule type	Share of fee schedule arrangements
Minimum fee schedule	61%
Uniform dollar or percentage increase	34%
Maximum fee schedule	11%



VBP type	Share of VBP arrangements
Pay for performance	52%
Population-based payment	24%
Bundled payment	7%
Other	31%

Notes: VBP is value-based purchasing. Based on analysis of 121 directed payment arrangements approved as of June 6, 2019. Totals do not sum because one directed payment arrangement can include multiple types of fee schedules or VBP.
Source: MACPAC, 2019, analysis of directed payment pre-prints approved as of June 6, 2019.

Directed Fee Schedules

- Minimum fee schedules are often based on Medicare or Medicaid FFS rates
- Uniform dollar or percentage increases are often based on a state-defined amount
  - Not subject to UPL rules
  - Appear to be related to provider taxes or IGTs
  - Most are targeted to hospitals
  - More $$ than DSH and non-DSH supplemental payments combined in some states
- The stated intent of most directed fee schedules is to improve access, but measures of access are not described

Value-Based Purchasing

- VBP directed payment arrangements support a variety of cost, quality, and access goals
  - About half target hospitals and half target other provider types, such as physicians
  - Measures that are used to make payments are also used to track the program's effectiveness
- California and Massachusetts operate directed payment VBP arrangements alongside DSRIP
  - The same providers can receive payments for meeting different quality goals
  - Not subject to same evaluation requirements as Section 1115 demonstrations

Policy Questions

- To what extent are directed payments and FFS supplemental payments interchangeable?
- Should the processes for overseeing these payments be different?
- What are the implications of directed payments on actuarial soundness requirements?
- How do directed payments relate to other approaches to promote the use of VBP in managed care?

Next Steps

- Currently interviewing states and MCOs about approaches to promote the use of VBP in managed care
- CMS may finalize its proposed revisions to the 2016 managed care rule this fall
- Potential proposed rule on FFS supplemental payments also expected this fall

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