Program Concept Paper: Mississippi Transitional Payments, Directed Payments, and Quality Incentive Payment Program

In consideration of the urgency to preserve critically needed Mississippi Hospital Access Program (MHAP) funding to Mississippi hospitals, the Mississippi Division of Medicaid (DOM) proposes an alternative pass-through and directed payments framework for consideration by the Centers for Medicare & Medicaid Services (CMS). This alternative approach builds on the framework discussions, constructive guidance we received from CMS, and Mississippi's overarching statewide healthcare objectives.

MHAP would transition to directed payments and a 10-year pass-through payment program according to the specifications and requirements of 42 CFR 438.6 et seq. The transitional payment pool (TPP) (i.e., pass-through payments), will consist of approximately $422.24 million. The TPP will be decremented by 10 percent per year, with the 10 percent removed from the TPP moving to directed payments as described below. At the end of year 10, the TPP will discontinue.

Directed Payments – Coordinated Care Organizations (CCO) Fee Schedule Adjustment (FSA) to Network Providers (Years One through 10)

- *DOM will require CCOs to provide a directed payments FSA to a class of network providers as follows:*

TABLE 1: FSA AND PROVIDER CLASS TYPES

	Inpatient Hospital	Outpatient Hospital
Critical Access Hospital (CAH)	Uniform dollar per discharge adjustment.	Uniform percentage increase.
Non-Critical Access Hospital (Non-CAH)	Uniform dollar per discharge adjustment.	Uniform percentage increase.

- *DOM will adjust capitation rates paid to CCOs and CCOs will make directed payments to providers.*
- *Capitation rates paid by DOM will be actuarially sound, in accordance with sections 438.4 and 438.5, and subject to CMS approval.*
- *DOM will demonstrate to CMS that directed payments are based on utilization and delivery of services.*
- *Directed payments made by CCOs will be made equally, using the same terms of performance for any provider within the eligible classes of providers.*
- *DOM has established classes of providers as shown in Table 2 on the following page:*

TABLE 2: PROVIDER CLASSES	
Inpatient Hospital	**Outpatient Hospital**
Critical Access Hospitals (CAHs)	Critical Access Hospitals (CAHs)
Non-Critical Access Hospitals (Non-CAHs)	Non-Critical Access Hospitals (Non-CAHs)

- *Directed payments will advance goals of the MississippiCAN Quality Strategy. NOTE: DOM is currently updating the Quality Strategy.*
- *DOM will utilize an evaluation plan that measures how the directed payments advance the Quality Strategy.*
- *The state share of payments will continue to be funded from provider taxes.*
- *The directed payments program will not be automatically renewed between years one and two. DOM will seek renewal from CMS and will collaborate with CMS to define the renewal process.*
- *It is anticipated that FSA payments will be approximately $110.87 million in year one and $110.87 million plus 10 percent of the TPP, for a total of $153.09 million in year two.*
- *The FSA payment amount will be held constant at the year two level for the remainder of the 10-year period (i.e., years three through 10).*
- *DOM may evaluate the permissibility and feasibility of additional directed payments (i.e., over and above those described in the preceding bullets), to further advance access, quality, and strategic policy initiatives in support of the Triple Aim.*
- *As a condition for enrollment in the directed payments programs, hospitals will be required to conduct the following activities, which shall be defined by DOM:*
    - *Participate in stakeholder engagement sessions.*
    - *Provide limited personnel or subject matter expertise to participate in quality committees and work groups.*
    - *Complete a community needs assessment.*
    - *Complete an evaluation of their health information technology capabilities.*
    - *Complete an evaluation of their health information exchange capabilities.*
    - *Identify potential partnerships and alliances to support quality improvement.*
    - *Other potential activities as DOM narrows the focus and direction of the Quality Incentive Payment Program (QIPP) to align the MississippiCAN Quality Strategy.*
- *Over the initial two year period, DOM, CMS, and Mississippi stakeholders will collaborate to work through the details of the QIPP. Hospitals will conduct the activities described above.*

Directed Payments – QIPP (Years Three through 10)

- *DOM seeks to create a stakeholder-informed, provider engaged, hospital-centric, QIPP that utilizes state and federal investments to improve the quality of care, outcomes, and health status of the Mississippi Medicaid coordinated care population.*
- *Improving the population health of Mississippians through the Medicaid program will involve a multi-year process of investments in infrastructure and practice transformation initiatives, with concentration on the health care objectives of DOM.*
- *For purposes of this initiative, DOM shall create Quality Improvement Groups (QIGs) [number TBD] across the state. Each QIG shall have an Anchor Hospital (AH), which shall serve as the hub and coordination point of QIPP activities for the group. In addition to an AH, each QIG shall include Collaborator Hospitals (CHs) and/or other providers or facilities as may be necessary. Every MHAP participating hospital within the QIG shall be eligible to participate in the QIPP and become a CH. However, the AH shall determine the participation of other providers and/or facilities as necessary.*
- *DOM shall define, and develop the criteria for establishing QIGs and AHs.*
- *The QIG shall be required to coordinate ongoing learning collaboration, formative evaluation, rapid cycle improvement, and other support which may be needed by the CHs as they progress through QIPP domains.*
- *Each participating QIG shall be required to complete the Maternal Child Health Domain and select from four disease-based initiative domains.*
- *The activities and level of performance required of the QIPP participating hospitals to receive payments will evolve over time from a pay-for-reporting model to a pay-for-performance model. Initial payments will be based on investments in infrastructure or other binary achievements. Later, payments will progress to the ability to report on required activities. Finally, hospital incentive payments will be based on the actual achievement of specified population health outcome measures.*
    - ***Infrastructure – Year Three.** Payment based on completing or achieving investment activities related to preparing the infrastructure to support the selected project domains. Such activities may include expanded hours, acquiring reporting capabilities, acquiring additional staff, training, process implementation, and other activities.*
    - ***Reporting – Year Four.** Payment based on the ability to report on specific project activities and interventions related to the metrics and outcomes associated with the selected project domains.*
    - ***Outcomes – Years Five through 10.** Payment based on achieving population health outcomes as a result of the investments in infrastructure, completion of activities, and other process improvements for the selected project domains.*
- *QIPP payments will be made via directed payments by the Mississippi Medicaid CCOs.*
- *An attribution model will be developed to properly identify and attribute members to a participating hospital as well as a CCO.*

- *Eligibility for QIPP payments will be determined for the QIG, collectively considering hospitals within the QIG as a single entity.*
- *Upon eligibility of the QIG, QIPP payments shall be made to individual hospitals.*
- *In the event that a QIG is determined ineligible for a QIPP payment, the QIG shall have 60 days until the end of the state fiscal year to cure the ineligibility. If the QIG is unable to cure the ineligibility, that QIPP payment shall be forfeited and redistributed to hospitals in other eligible QIGs.*

QIPP Financing

- *DOM will direct CCOs to make incentive payments to hospitals within eligible QIGs and will conduct procedures to ensure the CCOs have properly distributed the payments.*
- *In year three (QIPP year one), this pool will consist of approximately $42.22 million that providers will have the opportunity to earn in the investments in the infrastructure phase.*
- *In year four (QIPP year two), this pool will consist of approximately $84.45 million that providers will have the opportunity to earn in the pay-for-reporting phase.*
- *In year five (QIPP year three), this pool will consist of approximately $126.67 million that providers will have the opportunity to earn in the achieving population health outcomes phase.*
- *The QIPP will increase annually thereafter by the transfer of 10 percent of the TPP base amount of year one. Table 3, below, illustrates this transition of funds.*

TABLE 3: PROPOSED MHAP FUNDING TRANSITION*

Year	Period	Transitional Payment Pool (MHAP-TPP)	Annual Reduction in Pass Through Payments	Directed Payments Fee Schedule Adjustment (MHAP-FSA)	Quality Incentive Payment Program (MHAP-QIPP)	Total Annual MHAP Funding
A	B	C	D Phase out	E	F	G (C+E+F)
1	7/1/17-6/30/18	$422.24	$0.00	$110.87	$0.00	$533.11
2	7/1/18-6/30/19	$380.02	($42.22)	$153.09	$0.00	$533.11
3	7/1/19-6/30/20	$337.79	($42.22)	$153.09	$42.22	$533.11
4	7/1/20-6/30/21	$295.57	($42.22)	$153.09	$84.45	$533.11
5	7/1/21-6/30/22	$253.34	($42.22)	$153.09	$126.67	$533.11
6	7/1/22-6/30/23	$211.12	($42.22)	$153.09	$168.90	$533.11
7	7/1/23-6/30/24	$168.90	($42.22)	$153.09	$211.12	$533.11
8	7/1/24-6/30/25	$126.67	($42.22)	$153.09	$253.34	$533.11
9	7/1/25-6/30/26	$84.45	($42.22)	$153.09	$295.57	$533.11
10	7/1/26-6/30/27	$42.22	($42.22)	$153.09	$337.79	$533.11
11	7/1/27 - After	$00.00	($42.22)	$153.09	380.02	$533.11

** Approximate values in millions.*

QIPP Development Approach

- *Phase I: Research and Program Design.*
  - *Robust stakeholder engagement process will be conducted to inform of statewide needs, resources, considerations for program design features, and existing initiatives, as well as defining successes and opportunities within those initiatives. Stakeholders may include but will not be limited to:*
    - *Hospitals/other providers*
    - *Members/advocacy*
    - *Community groups/town halls*
    - *Coordinated care organizations*
    - *State sister agencies*
  - *DOM will:*
    - *Identify priority populations or disease-states/conditions to be targeted for inclusion in the QIPP*
    - *Ensure alignment with MississippiCAN Quality Strategy*
      - *Required Domain:*
        - *Maternal Child Health*
      - *Elective Domains – Disease-State Initiatives:*
        - *Influenza*
        - *Hepatitis*
        - *Hemophilia*
        - *Diabetes*
    - *Develop a limited selection of projects and key project parameters that DOM will require and/or permit. The hospitals will select their specific QIPP projects from this limited selection of valid QIPP projects.*

      1. ***Maternal Child Health.***

         a) *Maternal Health – Upon discharge following a vaginal or cesarean section delivery, the delivery hospital is required to schedule a postpartum visit with the patient's provider within the standard six week time period following delivery.*

         b) *Child Health – Upon discharge following birth via vaginal or cesarean section delivery, the delivering hospital is required to schedule the next appropriate periodicity visit for infants, in accordance with the American Academy of Pediatrics Bright Futures recommendations.*

2. ***Disease-State Initiatives.***

   a) *Influenza – Documentation will be required for all inpatient hospital admissions regarding influenza vaccination status for patients.*

      - *The question posed, patient response and vaccine administration will be documented on the inpatient discharge summary*

        - *The hospital will be required to submit the discharge summary via an established data interface*

   b) *Hepatitis – Documentation of patient education related to treatment and medication compliance for patients with a diagnosis of hepatitis on admission or during the course of the inpatient stay.*

      - *The questions posed, patient responses and medication and/or follow-up appointments will be documented on the inpatient discharge summary*

        - *The hospital will be required to submit the discharge summary via an established data interface*

   c) *Hemophilia – Documentation of patient education related to treatment and medication compliance for patients with a diagnosis of hemophilia on admission or during the course of the inpatient stay.*

      - *The questions posed, patient responses and medication and/or follow-up appointments will be documented on the inpatient discharge summary*

        - *The hospital will be required to submit the discharge summary via an established data interface*

   d) *Diabetes – Upon discharge for patients with a diagnosis of diabetes on admission or during the course of the inpatient stay, the hospital is required to schedule Diabetes Self-Management Training (DSMT) or education with the patient's provider within 120 days of discharge.*

- *Identify key infrastructure needs within the Mississippi health care delivery system*
- *Inventory existing initiatives/grants/successes that can be leveraged*
- *Develop a value/incentive-based alternative payment methodology to recognize hospital progress toward established milestones and metrics*

- *Phase II: Implementation.*
  - *Hospitals and/or QIGs will submit applications to DOM for QIPP participation. DOM will define minimum requirements that may include the level of commitment, proposed governance structure, financial stability, commitment from community partners, etc., as criteria for approval*
  - *The participating QIPP hospitals and/or QIGs will develop detailed project plans for DOM's evaluation and ultimate approval as a requirement for consideration for incentive payments*
  - *A valuation methodology will be developed for milestones and metrics and a process to assess progress toward these milestones and metrics will be deployed on a periodic basis*
  - *Hospitals and/or the QIGs within a QIG that have achieved the targeted performance metrics will receive an incentive payment directed to the hospital through the Medicaid CCOs*
  - *The QIGs will create a learning collaborative environment that will facilitate the sharing of best practices and lessons learned by hospitals. This will further foster the hospitals' success in meeting their metrics and improving the population health of the Mississippi Medicaid population*
  - *Hospitals within the QIG that are successfully achieving their desired outcomes will be expected to assist other hospitals within the QIG who may not be achieving similar successes. The AHs will serve a critical role in identifying, coordinating, and collaborating in such situations*
- *Phase III: Assessment.*
  - *DOM will assess the QIPP payment eligibility twice per year to identify payments earned or lost by the QIG*
  - *Any dollars forfeited by a QIG due to not meeting the achievement thresholds will be reinvested in the QIPP*
  - *DOM will perform an evaluation of the QIPP performance every three years*

Conclusion

- *Approaching the phase down of the supplemental pass-through payment in this manner will allow Mississippi to build the infrastructure and capabilities to succeed in a value-based payment environment.*
- *DOM seeks CMS' feedback, and ultimately approval, regarding this model as a vehicle to move Mississippi's current health care delivery system from a payment-for-volume system to one that recognizes payments for value and outcomes.*
- *DOM is committed to creating a successful QIPP that meets CMS rules and requirements. CMS technical assistance is requested to help develop an approvable program and provide the level of detail required by CMS for approval.*