Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

The Mississippi Division of Medicaid (DOM) requests directed payments for the managed care contract rating period from July 1, 2018 through June 30, 2019.

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

The requested start date for the payment arrangement is July 1, 2018.

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

The expected duration of the payment arrangement is 9 years from a start date of July 1, 2018.

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
☐ Multi-Payer Delivery System Reform
☐ Medicaid-Specific Delivery System Reform
☐ Performance Improvement Initiative
☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

☐ Minimum Fee Schedule
☐ Maximum Fee Schedule
☒ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

☐ The State is proposing to use an approved State plan fee schedule
☐ The State is proposing to use a Medicare fee schedule
☒ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

DOM will utilize four classes of providers: Non-CAH Inpatient Hospitals; Non-CAH Outpatient Hospitals; CAH Inpatient Hospitals; and CAH Outpatient Hospitals.

For inpatient hospital services, DOM is proposing to use a uniform per discharge Fee Schedule Adjustment per class for two classes of network providers, Critical Access Hospitals (CAH) and non-Critical Access Hospitals (non-CAH).

For outpatient hospital services, DOM is proposing to use a uniform percentage Fee Schedule Adjustment per class for two classes of network providers, CAH and non-CAH.

This approach and funding mechanism was developed to preserve access to care as well as critically needed MHAP funding to Mississippi hospitals in an amount that approximated current MHAP funding levels.

Additional detail regarding the proposed fee schedule is outlined in response #12 of this preprint.

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

   ☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

Under the Fee Schedule Adjustment, Mississippi's Managed Care Organizations also known as Coordinated Care Organizations (CCOs) will make a uniform per discharge adjustment for each inpatient hospital discharge within the CAH class of network providers as well as the non-CAH class of network providers. For outpatient hospital services, CCOs will make a uniform percentage increase to each payment within the CAH class of network providers as well as the non-CAH class of network providers. This program is predicated exclusively on utilization and delivery of services.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

For the Fee Service Adjustment directed payments, the following classes will participate:

Inpatient Hospital Services	Outpatient Hospital Services
Critical Access Hospitals	Critical Access Hospitals
Non Critical Access Hospitals	Non Critical Access Hospitals

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

DOM will utilize four classes of providers: Non-CAH Inpatient Hospitals; Non-CAH Outpatient Hospitals; CAH Inpatient Hospitals; and CAH Outpatient Hospitals.

For inpatient hospital services, DOM is proposing to use a uniform per discharge Fee Schedule Adjustment (FSA) per class for two classes of network providers, Critical Access Hospitals (CAH) and non-Critical Access Hospitals (non-CAH).

For outpatient hospital services, DOM is proposing to use a uniform percentage Fee Schedule Adjustment per class for two classes of network providers, CAH and non-CAH.

Funding pools for each class of network providers will be established as follows:
Non-CAH Inpatient Hospitals - $120,902,999.00
CAH Inpatient Hospitals - $1,571,791.00
Non-CAH Outpatient Hospitals - $28,946,810.00
CAH Outpatient Hospitals - $1,671,888.00

Interim FSAs for each of the classes of network providers will be calculated using inpatient discharges and outpatient payments from the fiscal period April 1, 2017 through March 31, 2018. This data represents the best information on utilization we will have available to use at the time the payment calculations need to be performed. These interim FSA payments will be adjusted using actual fiscal year utilization data in the fourth calendar quarter of state fiscal year (SFY) 2019. The actual utilization available at the time these calculations need to be performed will be data from the time period April 1, 2018 through March 31, 2019. Any underpayments will be paid via a lump sum payment and any overpayment will be recouped. The interim FSAs for each of the network providers may be adjusted throughout SFY 2019 using updated utilization data to ensure there are no large under/overpayments at the end of the fiscal year.

The remaining Transitional Payment Pool (TPP), approximately $380 million, will continue to be distributed using the State's past practices, with the exception that ten percent (10%) of these funds would be distributed using hospital DSH payments from SFY 2018 as the allocation basis.

These approaches and funding mechanisms were developed to preserve critically needed MHAP funding to Mississippi hospitals.

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

The draft version submitted for CMS approval is available at: https://medicaid.ms.gov/wp-content/uploads/2018/07/Managed-Care-Quality-Strategy-submitted-to-CMS-7.23.18.pdf

b. Date of quality strategy (month, year):

The Division of Medicaid is using the MississippiCAN quality strategy effective July 1, 2018.

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Improve Access to Medically Needed Services	DOM has adopted the majority of the National Adult and Child Health Care Quality Measures, along with state-specific performance measures. These state-mandated measures and projects address a range of priority issues for the Mississippi Medicaid populations. Final selection and approval of the performance measures will be the responsibility of the Office of Health Services, DOM leadership, and provider stakeholders.	5
Improve quality of care and population health	DOM has adopted the majority of the National Adult and Child Health Care Quality Measures, along with state-specific performance measures. These state-mandated measures and projects address a range of priority issues for the Mississippi Medicaid populations. Final selection and approval of the performance measures will be the responsibility of the Office of Health Services, DOM leadership, and provider stakeholders.	5

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	**Quality strategy page**
Improve efficiencies and cost effectiveness	DOM has adopted the majority of the National Adult and Child Health Care Quality Measures, along with state-specific performance measures. These state-mandated measures and projects address a range of priority issues for the Mississippi Medicaid populations. Final selection and approval of the performance measures will be the responsibility of the Office of Health Services, DOM leadership, and provider stakeholders.	5

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The requested Fee Service Arrangement will advance the goals of the MississippiCAN Quality Strategy by improving hospital provider payments which will ensure and promote continued access to care.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

The state's evaluation strategy will measure the directed payment plan's success in improving access to quality and appropriate health care services in a timely manner. To evaluate access and the success of the directed payments toward this goal, DOM will assess the following:

Hospital Network Access: DOM's targeted goal is to incur no loss of hospital provider participation. Active hospital provider participation in the MississippiCAN network as of June 30, 2019 will be compared to the active hospital provider participation as of July 1, 2018 as well as the baseline measurement as of July 1, 2017. Performance measurements will include interim quarterly measurements of hospital participation in the network as well as an annual participation assessment. Any decrease in hospital provider participation will be reviewed, and the reasons for the decrease will be explored and follow up will be conducted under DOM's direction. Any increase in hospital participation in the MississippiCAN program will also be noted.

Community Health Needs Assessment: To ensure access needs are identified and met, DOM will review the results of community health needs assessments completed by the hospitals as part of its evaluation plan. DOM will request hospitals to provide any assessments completed since its last review during this state fiscal year for ongoing review purposes.This aspect of the assessment is necessary to evaluate needed services to promote appropriate use of the emergency department and other hospital services and to identify any access barriers. The inclusion of the community needs assessment in the evaluation plan will identify improvement opportunities that can be deployed to further improve access to necessary and appropriate services.

Health Information Technology Assessment: Hospitals will complete an annual health information technology assessment which will identify health information technology adoption and use as well as the ability to share health information across a health information exchange. Hospitals will complete the health information technology assessment utilizing the tools and instructions endorsed by DOM. Inclusion of the health information technology assessment in the evaluation plan will assist in identifying opportunities to leverage health information technology to improve care and provide more appropriate and timely utilization of health care services.

Stakeholder Engagement: The evaluation plan will also include stakeholder engagement whereby the hospitals and other parties will be engaged in discussions regarding barriers and opportunities to improve timely access to appropriate health care services. The input from stakeholders will help assess success to date and influence future strategies for improving access and quality.

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

The payment arrangements will target all Medicaid enrollees of the MississippiCAN program. DOM has contracts with CCOs, who are responsible for providing services to the Mississippi Medicaid members who participate in the MississippiCAN program. As of May 2018, MississippiCAN enrollment was 451,931 members from two health plans: Magnolia Health (enrollment 237,516) and UnitedHealthcare Community Plan (enrollment 214,415). The MississippiCAN program accounts for approximately 68% of all Medicaid enrollment. For State fiscal year 2017, the average per member per month paid was $481.57. The MississippiCAN rate cells, age requirements, and categories of eligibility are as follows:

Table 4
Mississippi Division of Medicaid
Rate Cell Definitions

Rate Cell	Age Requirement	Category of Eligibility (COE)*
Children		
SSI / Disabled Newborns	Ages 0 – 12 months (13 month duration)	01, 19
Non-SSI Newborns – age 0 – 2 months	Ages 0 – 2 months (3 month duration)	03, 26, 71, 85, 87, 88, 91
Non-SSI Newborns – age 3 – 12 months	Ages 3 – 12 months (10 month duration)	03, 26, 71, 85, 87, 88, 91
MA Children	Ages 1 – 19	72, 73, 85, 87, 91
Quasi-CHIP	Ages 1 – 19	74
Pregnant Women		
Pregnant Women	Ages 8 – 64	88
Delivery Kick Payment**	Ages 1+	75, 85, 88
Other Populations		
MA Adults	Ages 19+	75, 85
Non-Newborn SSI / Disabled	Ages 1+	01, 19, 25
Foster Care	Ages 1+	03, 26
Breast and Cervical Cancer	N/A	27

** DOM updated COE codes effective January 1, 2014 to reflect new MAGI eligibility standards. COE codes 71, 72, 73, 74, and 75 are new codes and COE codes 85, 87 and 91 will be phased out. In addition, COE 88 changed from Pregnant Women and Infants to only Pregnant Women, with Infants covered under COE 71.*

***Delivery kick payment is only available for individuals in the MA Adult or Pregnant Women rate cells.*

Source: Milliman Client Report – SFY 2017 MississippiCAN Capitation Rate Development

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

Under the Fee Schedule Adjustment arrangement, the planned data stratification during the evaluation will include inpatient and outpatient hospitals further stratified by the hospital types of Critical Access Hospital and non-Critical Access Hospital.

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

No additional criteria.

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required to
rch existing data
resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

☐ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward/ Developer** (if State-developed measure, list State name)	**State Baseline** (if available)	**VBP Reporting Years***	**Notes****

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

☐ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

☐ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.