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*. 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 Submissions

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):
   July 1, 2019- June 30, 2020

2. Identify the State’s requested start date for this payment arrangement (for example, January 1, 2018): **July 1, 2019**

3. Identify the State’s expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years): **A minimum of five (5) years with annual submission of preprint and CMS approval.**

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, or alternative payment models (APMs), for provider reimbursement, such as 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)

☐ Bundled Payments / Episode-Based Payments (Category 3 APM)
☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM)
☐ 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.

N/A

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).

The state is using §438.6(c)(1)(iii)(B) to provide a uniform percentage increase of 158.8% of Medicare rates.

Mississippi seeks to preserve and improve access; strengthen workforce development through the recognition of the teaching hospital's contribution to address provider supply; and ensure availability of level 1 trauma facilities, level 4 neonatal intensive care, and organ transplant services in the network.

ACR & Payment Pool: To determine the level of the increase, the state calculated the Average Commercial Rate in accordance with fee-for-service CMS guidance "Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation", which is consistent with economy and efficiency. Using SFY 2018 actual utilization of services data, the uniform percentage was applied to calculate the separate payment term. The separate payment term will be paid quarterly.

Alternative Reconciliation Payment: Over the past months as hospitals have focused attention on the COVID-19 pandemic, there has been limited access to primary care and elective procedures. As a result, the State is expecting a decrease in the projected utilization of services during the second half of the program year. The decrease in utilization is causing a decrease in the final payment to the hospital provider. In an effort to minimize the negative impact of low utilization on this state directed payment, the State has an alternate calculation for the final payment.

Using the July 1, 2019 through December 31, 2019 period, the State will double this utilization period to determine a cap amount for the program year as this period is unaffected by COVID-19. At year end, a reconciliation will be prepared to determine the final payment. The State will review the January 1, 2020 through June 30, 2020 period in comparison to the cap amount and adjust the uniform percentage of 158.8% (of Medicare) to reach the calculated cap for the annual period. The calculated cap amount will be compared to the aggregate total of the first three (3) quarterly payments and the difference will determine the fourth and final quarterly payment.

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).

For the MS Medicaid Access to Physician Services Program (MAPS), the State will define a separate payment term in their contracts with the Managed Care Organizations (also known as Coordinated Care Organizations (CCO). This separate payment term will be paid to the eligible provider group in a total of four quarterly payments. The separate payment term amount will be established using actual SFY2018 utilization of services by the eligible provider group.

To set the payment term, the State reviewed SFY2018 actual claims, at the CPT code level, and applied the Average Commercial Rate percentage (158.8% of Medicare) to each claim to show the total dollar value increase.

The first three quarterly payments will be made in equal amounts calculated as one-fourth of the separate payment term. A reserve of 10% of the total payment term will be withheld until the fourth disbursement to ensure no overpayment is made.

See question 8 for the determination of the fourth and final quarterly payment.

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

1. Qualifying Criteria

Physicians and other eligible professional service practitioners as specified in section 2. below who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital. The term "qualifying hospital" means a Mississippi state-owned academic health science center with a Level 1 trauma center, Level 4 neonatal intensive care nursery, an organ transplant program, and more than a four hundred (400) physician multispecialty practice group. To qualify for the state directed payment, the physician or professional service practitioner must be:

a. **Licensed by the State of Mississippi, and**
b. **Enrolled as a Mississippi Medicaid provider.**

2. Qualifying Provider Types

For purposes of qualifying for state directed payments under this payment arrangement, services provided by the following professional practitioners will be included:

a. **Physicians,**
b. **Physician Assistants,**
c. **Nurse Practitioners,**
d. **Certified Registered Nurse Anesthetists,**

e. **Certified Nurse Midwives,**
f. **Clinical Social Workers,**
g. **Clinical Psychologists,**
h. **Dentists, and**
i. **Optometrists.**

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).

The state directed payment is a uniform percentage increase. Mississippi DOM will require that Medicaid CCOs provide the same percentage increase—158.8% of Medicare rates (or an adjusted rate as defined in question 8)—to all Qualifying Provider Types that meet the eligibility criteria for professional services.

<u>Quality Criteria and Framework for All Payment Arrangements:</u>

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.
Check box

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):

https://medicaid.ms.gov/wp-content/uploads/2018/06/Managed-Care-Quality-Strat-and-Appendices-Initial-Draft-6.21.18.pdf

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

July 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)**	

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	
Improve access to necessary medical services	**Connect beneficiaries with a medical home, increase access to healthcare providers, and improve beneficiaries' use of primary and preventive care services**	p. 5
Improve quality of care and population health	**Provide systems and supportive services, including care coordination, care management, and other programs that allow beneficiaries to take increased responsibility for their health care**	p. 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 rate increase will support the Qualifying Provider Types and their affiliated academic health science center continue to serve a significant share of the Mississippi DOM managed care beneficiaries. The evaluation criteria described below will connect beneficiaries with increased access to healthcare providers, and improve beneficiaries' use of primary and preventive care services as well as provide systems and supportive services in targeted areas that allow beneficiaries to take increased responsibility for their health care in alignment with Mississippi's quality strategy.

This will be accomplished by evaluating quality measures related to:

- **Behavioral Health Readmissions**- the HEDIS measures listed below monitor 7 day and 30 day follow ups after BH discharges
  - Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
  - Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
- **Pregnancy Improvement**- the Office of Population Affairs (OPA) has established measures that are designed to address the lack of validated population-level performance measures for contraceptive care. These measure females who have had a live birth and are provided with a most or moderately effective contraceptive method or LARC within 3 and 60 days of delivery, which aligns with DOMs initiative of additional reimbursement outside of the APR-DRG for LARCs at the time of delivery.
  - Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)
  - Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)
  - Contraceptive Care – All Women Ages 21–44 (CCW-AD)
  - Contraceptive Care – All Women Ages 15–20 (CCW-CH)
- **Respiratory Illness**- the measures below are a mix of HEDIS and Agency for Healthcare Research and Quality (AHRQ) that address admission rates and medication compliance
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
  - PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)
  - Asthma Medication Ratio: Ages 19–64 (AMR-AD)
  - Asthma Medication Ratio: Ages 5–18 (AMR-CH)
- **Exchange of Clinical and Claims Data**- Exchange of Clinical and Claims Data
  - The Qualifying Hospital will maintain an integrated clinical data exchange interface, using the Epic Care Everywhere module, with the MS Division of Medicaid for exchanging Meaningful Use Stage 2 Consolidated Clinical Document Architecture documents (C-CDA in XML)

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

Mississippi DOM or its designated evaluation entity will evaluate access and quality measures annually in alignment with the state's goals and objectives as delineated in the state's Medicaid Quality Strategy. Performance on these measures will be evaluated in comparison to a base year. The access and quality measures that will be evaluated are:

- **Behavioral Health Readmissions**- the HEDIS measures listed below monitor 7 day and 30 day follow ups after BH discharges
  - Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
  - Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)
- **Pregnancy Improvement**- the Office of Population Affairs (OPA) has established measures that are designed to address the lack of validated population-level performance measures for contraceptive care. These measure females who have had a live birth and are provided with a most or moderately effective contraceptive method or LARC within 3 and 60 days of delivery, which aligns with DOMs initiative of additional reimbursement outside of the APR-DRG for LARCs at the time of delivery.
  - Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)
  - Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)
  - Contraceptive Care – All Women Ages 21–44 (CCW-AD)
  - Contraceptive Care – All Women Ages 15–20 (CCW-CH)
- **Respiratory Illness**- the measures below are a mix of HEDIS and Agency for Healthcare Research and Quality (AHRQ) that address admission rates and medication compliance
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
  - PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)
  - Asthma Medication Ratio: Ages 19–64 (AMR-AD)
  - Asthma Medication Ratio: Ages 5–18 (AMR-CH)
- **Exchange of Clinical and Claims Data**- Exchange of Clinical and Claims Data
  The Qualifying Hospital will maintain an integrated clinical data exchange interface, using the Epic Care Everywhere module, with the MS Division of Medicaid for exchanging Meaningful Use Stage 2 Consolidated Clinical Document Architecture documents (C-CDA in XML)

☒ 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.

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 uniform percentage increase will be applied to all Medicaid beneficiaries enrolled in a CCO who receive services from a Qualifying Provider Type.

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

N/A

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

N/A

<u>Required Assurances for All Payment Arrangements:</u>

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 Applicable Submissions

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

Additional 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).

N/A

Additional 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 incentives under this payment arrangement (provider incentive measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement; a list of existing measure sets can be found here.

TABLE 17(a): Payment Arrangement Provider Incentive Measures					
Provider Incentive 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 (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)**	**Notes (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.)**
1 **N/A**					
2					
3					
4					
5					
If additional rows are required, please attach.					

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

N/A

<u>Additional Required Assurances for Value-Based Payment Arrangements:</u>

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.