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, 2020 through June 30, 2021.

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, 2020.

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 up to 7 years from a start date of July 1, 2020.

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 one class of hospital providers statewide.

For inpatient hospital services, DOM is proposing to use a uniform per discharge Fee Schedule Adjustment (FSA).

For outpatient hospital services, DOM is proposing to use a uniform percentage FSA.

As the state transitions from the historical Transitional Payment Pool to payments based solely on the FSA and the Quality Incentive Payment Program (QIPP), a floor adjustment of ten percent (10%) has been incorporated. The floor adjustment is necessary to mitigate negative impacts to providers related to Medicaid access to care.
This approach and funding mechanism was developed to preserve access to care as well as critically needed MHAP funding to Mississippi hospitals.

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. For outpatient hospital services, CCOs will make a uniform percentage increase to each payment. This program is predicated exclusively on utilization and delivery of services.

As part of the directed payments to be implemented in SFY 2021, CCOs will make quality incentive payments to inpatient hospitals based on two components: 1) Potentially Preventable Hospital Return (PPHR) rates, and 2) progress toward development and use of a statewide Health Information Network (HIN).

PPHR Rate: Incentive payments to inpatient hospitals will be made based upon their acceptance of the SFY 2021 PPHR rate improvement goal and the hospitals' quarterly attestation of receipt and review of PPHR rate reports. The PPHR reports will guide the hospitals' implementation of improvement initiatives. Hospitals that exceed the statewide targeted improvement goal during an annual performance assessment will be required to submit a corrective action plan to reduce their actual to expected PPHR ratios. These incentive payments are designed to recognize and influence appropriate utilization and delivery of services, quality improvement, and a reduction in readmission and emergency department visits. This portion of the MHAP establishes the basis for future implementation of value based payments.

HIN: In SFY2021, hospitals will be required to certify, prior to the first quarterly payment and with each quarter thereafter, their intent to collaborate to establish a statewide HIN and to participate in the statewide HIN once established.

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

The Fee Schedule Adjustment directed payments will be paid to all Mississippi Medicaid participating hospitals as one class with an adjustment for inpatient and outpatient services.

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 a single statewide class of hospital providers.

For inpatient hospital services, DOM is proposing to use a uniform per discharge FSA for the statewide class of network providers

For outpatient hospital services, DOM is proposing to use a uniform percentage FSA for the statewide class of network providers.

The estimated SFY 2021 payment pool for the statewide class uses three years of historical encounter data.

Total SFY 2021 Fee Schedule Adjustment = $317,886,793.

Interim FSAs for the statewide class of network providers will be calculated using inpatient discharges and outpatient payments from the fiscal period March 1, 2019 through February 29, 2020. 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 quarter of state fiscal year (SFY) 2021. The actual utilization available at the time these calculations need to be performed will be data from the time period March 1, 2020 through February 28, 2021. 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 2021 using updated utilization data to ensure there are no large under/overpayments at the end of the fiscal year.

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

An additional **$215,224,163** in payments will be recognized as a uniform payment adjustment related to a FSA quality incentive for providers meeting the requirements of the program. 50% of these payments will be linked to the PPHR rate metric and 50% will be linked to the HIN metric. The payments will be directed equally using the same terms of performance for the statewide class of inpatient hospitals. Inpatient discharges will be used to calculate a per discharge amount that will represent the uniform add-on amount. See description of the FSA incentive payment requirements in Response #10 of this preprint.

Total SFY 2021 Inpatient FSA Incentive Payments = $215,224,163

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 MississippiCAN Managed Care Quality Strategy 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 Manage Care Quality Strategy with an effective date of 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 necessary medical services		5
Improve quality of care and population health		5
Improve efficiencies and cost effectiveness		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 Schedule Adjustment will advance the goals of the MississippiCAN Quality Strategy by improving hospital provider payments which will ensure and promote continued access to care.

The Fee Schedule Adjustment quality incentive payments will advance the goals and objectives of the State's quality strategy by establishing a foundation for increased coordination and continuity of care.

- PPHR: SFY 2021 incentive payments continue a multi-year approach to improve hospital readmission rates. A focus on hospital readmission rates will drive the development of programs to improve coordination of care and continuity of care, especially across fragile transitions of care, which will support the goals of the MississippiCAN Quality Strategy.

- HIN: Mississippi also recognizes that active provider participation in an HIN is one tool to improve quality outcomes for patient care. Currently, Mississippi lacks a meaningful statewide HIN. Through a partnership with the Mississippi hospitals and the Mississippi Division of Medicaid propose to stand up a statewide HIN through which hospitals can share patient data, produce quality reports and analysis and provide continuity of care support to improve the quality of patient care and lower costs for the Division of Medicaid. The HIN incentive payments are part of a multi-year strategy to improve care coordination as well. The first year (SFY 2021) will be spent preparing and later connecting hospitals to the HIN. During Year 2 (SFY 2022), we expect all hospitals to be connected to the HIN and to use admissions, discharge, and transfer (ADT) notification. In year 3 and beyond, hospitals will be expected to use the HIN consistent with the CMS guidance for interoperability

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, 2021 will be compared to the active hospital provider participation as of July 1, 2020 as well as the baseline measurement as of July 1, 2018. 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.

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.

Potentially Preventable Hospital Return Rates: Hospitals will receive quarterly readmission rate reports with a rolling years' worth of data. These reports will be used in the assessment of hospitals' progress toward Targeted Improvement Goals. Assessment of hospitals' compliance with the requirements of the incentivized portion of the MHAP in SFY 2021 will be evaluated by receipt of inpatient hospital attestations indicating acceptance of the targeted improvement goal and receipt of quarterly PPHR reports from DOM. Hospitals that exceed the statewide targeted improvement goal during an annual performance assessment will be required to submit a corrective action plan to reduce their actual to expected PPHR ratios.

Health Information Network (HIN): HIN: In SFY 2021, DOM will ensure receipt of quarterly attestation of hospitals intent to collaborate and participate in a statewide HIN and measure the number of hospitals successfully on-boarded to the State's HIN once the HIN is established.

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 March 2020, MississippiCAN enrollment was 431,523 members from three health plans: Molina Healthcare (enrollment of 69,351), Magnolia Health (enrollment of 192,748) and UnitedHealthcare Community Plan (enrollment of 169,424). The MississippiCAN program accounts for approximately 64% of all Medicaid enrollment. For State fiscal year 2019, the average per member per month paid was $520.32. The MississippiCAN rate cells, age requirements, and categories of eligibility are as follows:

Table 1
Mississippi Division of Medicaid
Rate Cell Definitions

Rate Cell Grouping for Assumption Development	Rate Cell	Age Requirement	Category of Eligibility (COE)
Children	SSI / Disabled Newborns	Ages 0 to 12 months (13 month duration)	01, 19
Children	Non-SSI Newborns – age 0 to 2 months	Ages 0 to 2 months (3 month duration)	03, 26, 71, 88
Children	Non-SSI Newborns – age 3 to 12 months	Ages 3 to 12 months (10 month duration)	03, 26, 71, 88
Children	MA Children	Ages 1 to 19	72, 73
Children	Quasi-CHIP	Ages 1 to 19	74
Children	MYPAC[1]	Ages 1 to 20	N/A, Lckn_cd = SED
Children	Foster Care	Ages 1+	03, 26
Adult	Pregnant Women	Ages 8 to 64	88
Adult	MA Adult	Ages 19+	75
SSI	Non-Newborn SSI / Disabled	Ages 1+	01, 19, 25
SSI	Breast and Cervical Cancer	N/A	27

The MYPAC rate cell was previously called "SED Children" in SFY 2020.

Capitation rate cells for SFY 2021 were kept consistent with the SFY 2020 capitation rate cells, with the exception of the delivery kick payment. Prior to SFY 2021, a kick payment was made for delivery costs in the MA Adult or Pregnant Women rate cells. Starting in SFY 2021, these costs will be incorporated into the base capitation rate for those rate cells.

All rate cell eligibility excludes the following individuals not enrolled in MississippiCAN:

- Retroactive membership
- Dual eligible members
- Institutionalized beneficiaries in a long-term care facility
- Individuals in the following waiver programs: WAL, WED, WMR, or WTB
- Individuals diagnosed with Hemophilia or Von Willebrand disease

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 evaluation will stratify measures for all Mississippi hospitals as one class measured by inpatient and outpatient services.

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

No additional criteria will be used.

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.