DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

September 9, 2021

Drew Snyder, Executive Director
Division of Medicaid, Mississippi Department of Human Services
550 High Street, Suite 1000
Walters Sillers Building
Jackson, MS 39201-1325

Dear Mr. Snyder:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Mississippi's submission of an amendment for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The amendment was received by CMS on June 29, 2021 and has a control name of MS 438.6(c) Proposal C Technical Amendment 2020-2021.

Specifically, the following proposal amendment for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform percentage increase established by the state for physicians and professional services at eligible academic medical centers for the rating period covering July 1, 2020 through June 30, 2021

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the

aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

If you have questions concerning this approval or state directed payments in general, please contact Lovie Davis, Division of Managed Care Policy, at (410) 786-1533 or at lovie.davis@cms.hhs.gov.

Sincerely,

John Giles

Digitally signed by John Giles
Date: 2021.09.09 14:23:21 -04'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

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, 2020- June 30, 2021

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018): **July 1, 2020**

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years): **5 years, beginning July 1, 2019. There are 4 remaining years in the arrangement. The state will annually submit a preprint to request approval from CMS each year of the payment arrangement.**

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 to establish an alternative fee schedule. This directed payment will be 158.8% of Medicare rates. The estimated separate payment term for this directed payment is $37,000,000.

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 (ACR) 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. The approval letter for the FFS ACR calculation, the UPL MS Physician Guidance and ACR analysis showing the percentage increase are included as attachments. Using SFY 2019 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 for SFY 2021: Over the past year 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 SFY 2021. To minimize the negative impact of low utilization on this state directed payment, the State would like to propose an alternative reconciliation methodology, per CMS guidance.

The state will pay an amount equal to $37,239,855 as specified in the SFY2021 rate certification. The state will evaluate the utilization during this period in comparison to the prior year and calculate a revised ACR percentage to reach the calculated cap for the annual period.

Funding: The state share (or non-federal share) of the MS MAPS Program is entirely funded by Intergovernmental Transfers (IGTs) from the eligible public provider group the University of Mississippi Medical Center (UMMC), the only entity transferring funds.

UMMC is a state entity. UMMC does not have general taxing authority, and the State is not aware of any written agreements among the healthcare providers and entities related to the non-federal share of the payment arrangement.

UMMC receives a state appropriation for SFY 2021 which will be used to pay the IGT payment. UMMC is voluntarily providing the entirety of the non-federal share of the payment arrangement from its state appropriation.

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 (CCOs). 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 from a review of actual utilization of services by the eligible provider group.

To set the payment term, DOM reviewed SFY2019 actual claims, at the CPT code level, and applied the Average Commercial Rate percentage to each claim to show the total dollar value increase.

The first three payments will be made in equal amounts calculated as one-fourth of the separate payment term less a reserve amount. 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 final payment.

11. n 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.

The University of Mississippi Medical Center (UMMC) is the only academic medical center meeting the qualifying requirements and participating in the Mississippi Medicaid managed care program. UMMC, and its holdings and subsidiaries, include the following Mississippi Medicaid provider numbers:

Physician Group	Medicaid Provider Number
University Physicians	06635891
Hospital CRNA	09015456
Lexington HFMC	06300013
Lexington HFMCW	09016279
Lexington HCHC	09015369
Oral Surgery	09014021
Grenada CRNA	09013480
Grenada EKG	09011014
Grenada Spec	04557869
Grenada Women's	07436578

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.

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.

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)**	
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

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	**Objective(s)**	
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 to continue to serve a significant share of the Mississippi DOM managed care beneficiaries. By helping to ensure the financial security of this health system, the payment increase will enable UMMC to offer increased access to healthcare providers, and improve the delivery of primary and preventive care services to beneficiaries 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.

Limited availability within primary and preventive care services can impact timely access to care for Mississippi DOM managed care beneficiaries; this payment increase is intended to address such limitations. Mississippi DOM maintains that this strategic partnership with UMMC will increase access to primary and preventive care for its beneficiaries while delivering cost reductions over time as these services become more widely available.

To help ensure the funds from the payment increase support the goals of increasing access to primary and preventive care services, Mississippi DOM and UMMC collaborated to identify appropriate quality performance measures to tie the impact of the rate increase to quality metrics in line with UMMC's efforts.

DOM has identified measures intended to address the care of three sub-populations of beneficiaries both from the prevention and continuity of care perspective. These measures will be monitored and evaluated by Mississippi DOM on a quarterly basis:

- **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)
    - Tobacco Use: Screening and Cessation Intervention Ages 18 and older (MIPS 226)
- **Descriptive Narratives** – for each of the aforementioned measures, UMMC will submit written details of the changes implemented during the reporting period and descriptions of the impact of process changes, challenges and lessons learned.
- **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 Mississippi DOM.

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.

An evaluation of the progress made towards the advancement of the goals and objectives will be reviewed quarterly and annually by the Mississippi DOM or its designated evaluation entity. This evaluation includes a comparative analysis of the baseline metrics, any available state-wide averages and quarterly data reported by UMMC. As increasing beneficiaries' access to primary and preventative care is impacted by both process and outcomes measures, the Mississippi DOM will also evaluate the specific institutional changes implemented by UMMC during each measurement quarter.

The above referenced evaluation strategy was formed by the lesson-learned during the first program year. Metric performance was impacted during the first program year due to the foundational work required of the Mississippi DOM and UMMC to ensure the reporting criteria captures relevant data and allotted opportunities for targeted providers to create and implement process changes. While data reporting occurred during the first program year, the impact of the process changes on the managed care population will not be evident in the data analysis until the second program year. The longer the program extends, the statistical significance of the data will increase. The first program year's payments to UMMC started in December of 2019 following the receipt of program approval.

The evaluation plan below, for program year two, includes consideration of the impact of the March 2020 COVID-19 national emergency declaration as non-metric evaluation elements have been included to account for institutional change activities that can still occur. Mississippi DOM continues to support this critical healthcare institution through this state directed program despite the unknown impact on the delivery of care related to these measures.

Measure Name	Baseline Year	Baseline Statistic	Performance Target
Follow-Up After Hospitalization for Mental Illness – Child (7 day) – established patients	July 1, 2018-December 31, 2019	4.30%	4.43%
Follow-Up After Hospitalization for Mental Illness – Child (30 day) – established patients	July 1, 2018-December 31, 2019	19.10%	19.67%
Follow-Up After Hospitalization for Mental Illness – Adult (7 day) – established patients	July 1, 2018-December 31, 2019	6.10%	6.28%
Follow-Up After Hospitalization for Mental Illness – Adult (30 day) - established patients	July 1, 2018-December 31, 2019	13.70%	14.11%
Contraceptive Care: All Women Ages 15-20 - Child	July 1, 2018-December 31, 2019	0.00%	3.00%
Contraceptive Care: All Women Ages 21-44 - Adult	July 1, 2018-December 31, 2019	0.00%	3.00%
Contraceptive Care: Postpartum Women Ages 15-20 - Child	July 1, 2018-December 31, 2019	0.00%	10.05%
Contraceptive Care: Postpartum Women Ages 21-44 - Adult	July 1, 2018-December 31, 2019	0.00%	13.62%
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate - Adult	July 1, 2018-December 31, 2019	82.90%	70.00%
PQI 15: Asthma in Younger Adults Admission Rate - Adult	July 1, 2018-December 31, 2019	56.30%	52.50%
Tobacco Use: Screening and Cessation – Ages 18 and older (MIPS 226)	July 1, 2018-December 31, 2019	66.00%	67.98%
Descriptive Narratives (for each of the aforementioned measures)	N/A	N/A	UMMC will submit written details of the changes implemented during the reporting period and descriptions of the impact of process changes, challenges and lessons learned

Measure Name	Baseline Criteria	Performance Target Criteria
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.	UMMC will actively maintain, patch, and upgrade this interface, including testing such changes with DOM and DOM vendors, to ensure un-interrupted exchange, as well as provide DOM a minimum of 30 days-notice for major upgrades to the Epic system that could impact this interface with DOM.

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

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 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

Additional 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.