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Insights

A Direct Proposal: New Proposed Medicaid Rules for State Directed Payments

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By: Meghan M. Linvill McNab and Grant M. Achenbach

On May 3, 2023, the Centers for Medicare and Medicaid Services ("CMS") published not one, but two, proposed rules for state Medicaid programs. Totaling nearly 300 pages, these rules are aimed at strengthening Medicaid and improving access to care, quality, health outcomes, and health equity issues in the Medicaid fee-for-service ("FFS") programs, Medicaid Managed Care delivery systems, and home and community-based service ("HCBS") programs. The rules also address various monitoring, enforcement, and financing topics.

This article addresses the **Medicaid Managed Care Proposed Rule's** proposed changes to State Directed Payments ("SDP"), which are exceptions to the general prohibition on States directing expenditures by managed care entities.[1] SDPs were initially promulgated in the 2016 Medicaid Managed Care Rule, but have grown in popularity exponentially since their creation. In fact, CMS has reviewed over 1,000 SDP proposals since the 2016 rule. Given the pervasiveness of the use of SDPs, CMS has determined that it is necessary to ensure that SDPs are contributing to Medicaid quality goals and are developed and implemented with appropriate fiscal and program integrity guardrails. As a result, CMS is proposing numerous new SDP requirements, some of which are briefly summarized here:

Financing

The Proposed Rule adds a requirement that any SDP comply with Federal legal financing requirements of the non-federal (state) share of the Medicaid managed care expenditure.[2] While CMS recognizes that compliance with Federal legal financing requirements has always applied to Medicaid managed care, there was not a mechanism for CMS to condition approval of an SDP on compliance with such financing requirements or deny approval for failure to comply. By making compliance an express requirement for SDP approval, CMS will be able to deny approval of any SDP that it believes does not comply with Federal legal financing requirements. For instance, they will be able to deny approval if they believe there is an impermissible Intergovernmental Transfer ("IGT") or provider tax that has a mechanism to redistribute Medicaid dollars (effectively holding a taxpayer harmless). In the preamble, CMS made very clear that it would be scrutinizing the non-federal share source as part of the SDP pre-print review process.

The Proposed Rule also requires States to ensure each participating provider attests that it does not participate in a hold harmless arrangement and make available such attestations to CMS upon request. These revisions to address hold harmless arrangements are consistent with CMS' publication earlier this year regarding Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments.[3] This attestation process will likely necessitate education to providers around what constitutes a hold harmless arrangement.

Limit SDP to ACR

The Proposed Rule expressly limits SDP for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to the average commercial rate ("ACR") and sets forth the calculation of the ACR. ACR has historically been a limit for physician services in FFS, but this is the first time it has been expanded, in rule, to managed care services. CMS also notes that it is exploring other

limits, such as Medicare (like hospital and nursing facility FFS), Medicare for fee schedules and ACR for value-based arrangements, or ACR for all services (not just the four services mentioned above).

Conditions for Payment
The Proposed Rule clarifies that Fee Schedule SDPs must be based on delivery of services within the rating period and not solely based on historical utilization. In addition, States will be prohibited from requiring Managed Care Entities ("MCEs") to make interim SDP payments based on historical utilization and then reconciling to current utilization after the end of the rating period, which is a change from current CMS practice of allowing some SDPs to make interim payments based on historical data with a later reconciliation.

For SDPs that are Value-Based, Delivery System Reform, or Performance Improvement and make payments based on performance, the Proposed Rule prohibits conditioning payments on administrative activities, such as reporting data or participating in learning collaboratives. However, such reporting can be a condition for eligibility in the SDP with the actual SDP payment based on utilization. The Proposed Rule also sets forth certain conditions for SDPs that are population-based.

Evaluation Report versus SDP Cost % Report
The Proposed Rule adds a requirement for a written evaluation plan that identifies and measures the effectiveness of the SDP in advancing at least one of the goals and objectives in the quality strategy, including baselines and targets. States will then be required to submit an evaluation report to CMS if the final SDP Cost Percentage, calculated as the SDP divided by the total capitation payment, exceeds 1.5%. If the final SDP Cost Percentage is less than 1.5%, the State must simply submit the percentage report.

Separate Payment Term
Currently, States can pay managed care entities for SDP through an adjustment to the capitation rate or a separate payment term. In the Proposed Rule, CMS adds a definition of separate payment term and places certain limits on its use, including that separate payment terms cannot be used for SDPs that are fee schedule amounts based on state plan rates or Medicare rates. In the preamble to the Proposed Rule, CMS explains its preference that SDPs be an adjustment to the capitation rate paid to MCEs, rather than a separate payment term, but recognizes separate payment terms may be a useful tool for states making targeted investments in response to acute concerns around access care. We can expect States' use of separate payment terms, and the reasons for such use, to be subject to more scrutiny by CMS.

Appeal for Disapproval
To implement most SDPs, States must request CMS approval via a "pre-print" process. The Proposed Rule adds an opportunity for a State to appeal CMS' disapproval of a pre-print. Previously, there was not a formal disapproval and appeal process. Rather, States would voluntarily withdraw their pre-print if they learned CMS may not approve it.

Other
The Proposed Rule adds flexibility to certain SDPs by

i. Clarifying that SDPs based on Medicare rates do not require prior approval (pre-print) as long as they are based on the full Medicare rate that is no more than 3 years old.
ii. Eliminating the prohibition on States from directing the amount and timing of payments and recouping unspent dollars from MCEs, for Value-Based, Delivery System Reform, or Performance Improvement.
iii. Permitting SDPs to be for network and non-network providers.

The Proposed Rule also sets forth annual reporting and calculation requirements for States, and requires States to add detail regarding SDPs within the MCE contracts.

The Proposed Rule sets forth multiple proposed effective dates, that vary based on the applicable provision. Comments to the Proposed Rules are due by July 3, 2023.

If you have questions about the Proposed Rules and their potential impact on your State Directed Payments, please contact **Meghan M. Linvill McNab** or **Grant M. Achenbach**.

Disclaimer. The contents of this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult with counsel concerning your situation and specific legal questions you may have.

[1] The Medicaid Managed Care Proposed Rule also covers various other managed care topics, such as in lieu of services and settings, access, etc. The other Proposed Rule covering FFS and HCBS matters is available at: https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf
[2] Medicaid expenditures (whether in FFS or managed care) are funded via a combination of Federal dollars and non-Federal dollars, with the non-Federal dollars being composed of state appropriations, IGTs, provider taxes, etc.
[3] See Feb. 17, 2023 CMCS Informational Bulletin: https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf