CENTERS FOR MEDICARE & MEDICAID SERVICES

May 2025 MC-TAG

May 13, 2025

Logistics

- To submit **comments or questions**, click on the question and answer (Q&A) icon on the bottom of your screen. Please **list your state.**

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- **Slides and a recording** of the presentation will be emailed to registered participants within two weeks of the webinar.

Agenda

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General Reminders: Annual Reporting

- CMS wishes to remind states that there are managed care reporting requirements for states, including 3 annual reports:
    1. Managed Care Program Annual Report (MCPAR);
    2. Network Adequacy and Access Assurances Report (NAAAR); and
    3. Medical Loss Ratio (MLR) Report
- Further details on these reporting requirements can be found on the Managed Care Reporting webpage, including details on reporting timelines. For example, MCPARs for calendar year 2024 are due to CMS by June 29, 2025.
- States may also find it helpful to review a CMCS Informational Bulletin (CIB) published on June 12, 2024, which outlines these requirements.
- If your state requires additional technical assistance on these reports, please reach out to CMS at ManagedCareTA@cms.hhs.gov.

General Reminders: Contracts

- On November 7, 2023, to reduce process inefficiencies, CMS issued a CIB outlining minimum documentation standards for managed care plan contracts before CMS will begin our review and approval of contracts in accordance with 42 CFR 438.3(a). CMS also reminded states of these standards in a CIB published on June 12, 2024.
- Standards are being implemented in two phases. Phase 1 was effective for all contracts effective on or after July 1, 2024, and Phase 2 will begin for any contracts effective on or after July 1, 2025. New Phase 2 standards include:
  - Executed contract actions signed and dated by all parties;
  - MLR Summary Report;
  - Parity analysis;
  - Readiness review results; and
  - Submission of associated Medicaid/CHIP authority for contractual requirements.
- Further details on these minimum documentation standards are outlined in Appendix 2 of the above referenced 2023 CIB.

General Reminders: MC-Review Participation

- CMS is currently utilizing a web-based system, entitled Managed Care Review (MC-Review), for state submission and CMS review of Medicaid managed care contracts and rates.
- CMS believes this single web-based system for submission and review of Medicaid managed care contracts and rates will lead to increased efficiencies in our review process, increase transparency of our expectations by utilizing structured data fields to aid state submission of these actions, and reduce state administrative burden.
- 80% of states utilize MC-Review, and functionality continues to expand.
- We strongly encourage the remaining states (DC, GA, IL, MI, NE, NY, OK, TN, UT, and WA) to begin use of MC-Review to improve efficiencies.
- If your state is interested in participating in MC-Review, please reach out to CMS at ManagedCareTA@cms.hhs.gov.

State Directed Payments (SDPs): Background

- Under 42 CFR 438.6(c), state directed payments (SDPs) allow states to direct Medicaid managed care plans on how to pay a provider by mandating a specific payment methodology or amount.
- As noted in the 2024 Medicaid Managed Care Final Rule, CMS has always used the average commercial rate (ACR) as the fiscal benchmark for SDPs. Historically, CMS has never knowingly approved SDPs that were projected to result in total provider payment rates that exceed 100% of the ACR.
- The Final Rule (see 42 CFR 438.6(c)(2)(iii)) codified a provider payment limit for SDPs at 100% of the ACR for:
  - Inpatient Hospital Services
  - Outpatient Hospital Services
  - Nursing Facility Services
  - Qualified practitioner services at an academic medical center
- Each service type is defined in 42 CFR 438.6(a).

SDPs: Submission Requirements

- To demonstrate compliance with the regulatory requirements under 42 CFR 438.6(c)(2)(iii), states must submit minimum documentation with each preprint that includes at least one of the four service types (inpatient hospital services, outpatient hospital services, nursing facility services or professional services at an academic medical center) as required in 42 CFR 438.6(c)(2)(iii)(C).
- In order for CMS to deem a preprint submission complete and begin review, the state must submit the following items as it relates to this part:
    1. ACR Demonstration; and
    2. Total Payment Rate Comparison (Table 2 in the current preprint)

NOTE: The Total Payment Rate Comparison **is separate** from the ACR demonstration.

SDPs: ACR Demonstration

- Definition of the ACR at 42 CFR 438.6(a):
  - The ACR means the **average rate paid for services** by the highest claiming third-party payers for specific services as measured by claims volume.
- Under 42 CFR 438.6(c)(2)(iii)(A), the ACR demonstration must use data that:
  - Is **specific to the state**;
  - Is no older than the **three most recent and complete** years prior to the rating period of the initial request;
  - Is **specific to the services** addressed by the SDP;
  - Includes total reimbursement by the third-party and any patient liability, such as cost sharing and deductibles;
  - Excludes payments to FQHCs, RHCs, and other non-commercial payers, such as Medicare; and
  - Excludes any payment data for services or codes not covered by the Medicaid managed care plans.
- **The ACR demonstration must be submitted to CMS with the preprint and subsequently updated at least every 3 years thereafter.**

SDPs: ACR Demonstration Expectations

- The ACR demonstration should include sufficient data and analysis for CMS to understand how the state calculated the ACR.
- States should submit an Excel workbook or an actuarial analysis developed and signed by a certified actuary to document the ACR.
- In accordance with 42 CFR 438.6(c)(2)(iii)(C), the ACR demonstration must be **updated at least once every 3 years.**
- States cannot account for inflation or trend the ACR forward to the current rating period; the ACR must be based on historical, actual payment data. States instead have the option to update the ACR demonstration any time a preprint is submitted for CMS review (see https://www.federalregister.gov/d/2024-08085/p-749).
- The ACR is an **average rate paid for services** that should reflect commercial utilization and commercial payment rates. **Aggregate commercial spending alone is not sufficient as this is not a calculation of an average rate.**

$$\text{ACR} = \frac{\text{Historical Commercial Payments}}{\text{Historical Commercial Utilization}}$$

SDPs: ACR Data Sources

- CMS did not specify the data sources that states must utilize to calculate the ACR. However, in working with states, we have found the following data sources include both commercial utilization and payment data:
  - **All Payer Claims Databases (APCD).** APCDs are rich data sources that typically have both utilization and payment data for commercial payers. CMS recognizes that not all states have APCDs; however, those states that do, have found them to be a rich data source for ACR analyses.
  - **Provider surveys.** States may require that providers submit commercial payment and utilization data as a condition of the SDP. The state could require the submission of the data by providers in advance of the rating period in order to use the data to develop the ACR demonstration. CMS strongly recommends that the state institute a data validation process for the data submitted by providers to ensure the data is representative of the ACR.

SDPs: ACR Data Sources (continued)

- Some states also utilize provider cost reports
  - While these reports are a common and robust data source, CMS has found that they often do not include commercial utilization data. In order to identify an ACR, states will need to ensure this data is used in tandem with another data source that contains commercial payment and utilization data.
  - Additionally, CMS has concerns that cost reports alone may not meet specific regulatory requirements for the ACR demonstration. For example, it is difficult to ensure that such data:
    - Includes total reimbursement by the third-party payer and any patient liability, such as cost sharing and deductibles;
    - Excludes payments to FQHCs, RHCs, and other non-commercial payers, such as Medicare; and
    - Excludes any payment data for services or codes not covered by the Medicaid managed care plans.

Note: For the reasons stated above, CMS has found that the use of cost reports for the ACR demonstration has led to significantly more questions and analysis by CMS to ensure the data from these reports is reasonable and appropriate.

SDPs: Total Payment Rate Comparison

- Definition of Total Payment Rate at 42 CFR 438.6(a) is the aggregate for each managed care program of:
  - The **average payment rate (base)** paid by all managed care plans to all providers included in the specified provider class for each service identified in the SDP;
  - The **effect of the SDP (SDP)** on the average rate paid to providers included in the specified provider class for the same service in the preprint;
  - The **effect of any and all other SDPs (Other SDPs)** on the average rate paid to providers included in the specified provider class for the same service in the preprint; and
  - The **effect of any and all allowable pass-through payments (PTPs)** to be paid to any and all providers included in the provider class specified in the preprint on the average payment rate to providers in the specified provider class.

$$\textbf{Total Payment Rate} = \frac{\textbf{Average projected payment rate}}{\textbf{(base + SDP + Other SDPs + PTP)}}$$

SDPs: Total Payment Rate Comparison (continued)

- The Total Payment Rate Comparison, sometimes referred to as the Provider Payment Analysis, requires the state to **project** the average Medicaid managed payment rate for a Medicaid managed care program for the applicable rating period of the SDP compared to a historical ACR.
  - We encourage states to work with their actuaries to ensure this is developed in alignment with the same assumptions and data used for Medicaid managed care capitation rate development.
- To calculate the Total Payment Rate Comparison, the state will use the average projected payment rate by Medicaid managed care plans (numerator) divided by the ACR (denominator) calculated via the ACR demonstration for each column of Table 2. (See formula below)

$$\textbf{Total Payment Rate as a Percent of ACR} = \frac{\textbf{Average projected payment rate (base + SDP + Other SDPs +PTP)}}{\textbf{Historical ACR}}$$

SDPs: Total Payment Rate Comparison (continued)

- Under 42 CFR 438.6(c)(2)(iii)(B), the Total Payment Rate Comparison provides a comparison of the total payment rate for the specific services included in the SDP to the ACR that:
  - Is specific to **each managed care program** that the SDP applies to;
  - Is specific to **each provider class** that the SDP applies to;
  - Is **projected** for the rating period for which the state is seeking prior approval of the SDP;
  - Uses **payment data** that are specific to each service included in the SDP; and
  - Describes each of the components of the total payment rate as a percentage of the ACR for each of the services included in the SDP.

- **The Total Payment Rate Comparison must be submitted to CMS in the preprint and updated with each preprint amendment and renewal.**

SDPs: Example of Total Payment Rate Comparison

- Example: Uniform Increase for inpatient and outpatient hospital services for 1 hospital class (rural hospitals) in 2 managed care programs (A&B).
- As the comparison is needed for each managed care program using payment data specific to each service, we would expect to see 1 Total Payment Rate Comparison that provides the total payment rates with 4 separate lines as shown in the example using the appropriate historical ACR.

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
EX: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Inpatient Hospital Services – Rural – Program A	67%	17%	N/A	N/A	84%
b. Inpatient Hospital Services – Rural – Program B	57%	25%	N/A	N/A	82%
c. Outpatient Hospital Services – Rural – Program A	47%	35%	N/A	N/A	82%
d. Outpatient Hospital Services – Rural – Program B	45%	45%	N/A	N/A	90%
e.					-
f.					-
g.	-	-	-	-	-

Must be in terms of ACR

NOTE: Under this example, the state would also need 2 ACR demonstrations (1 for inpatient hospital services; 1 for outpatient hospital services) submitted with the preprint and updated at least once every three years.

SDPs: Resources

- Please reach out to the StateDirectedPayment@cms.hhs.gov mailbox with requests for technical assistance or for any SDP related inquiries.
- 2024 Medicaid Managed Care Final Rule, associated fact sheet and chart of applicability dates.
- State Directed Payments webpage on Medicaid.gov.
- Preprint Template and Addendum.

Q&A Session

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Thank you for participating!