Medicaid State Directed Payments

HCPF Tasks Related to Medicaid Managed Care Contracts

under Current Federal Regulations

After CMS approves a preprint, states must incorporate the directed payment arrangement into their managed care contract and rate certification.

An actuary must certify that the capitation rates are sufficient to cover the reasonable, appropriate, and attainable costs of the services provided under the contract, a standard known as actuarial soundness (42 CFR 438.4(a)).

SDP sections of rate certification and MCO contract must be submitted within 120 days after the payment start date

1. **Involvement of HCPF's actuary**

Milliman will need to certify the amount of the Separate Payments to the MCOs/RAEs are "actuarially sound".

Status must submit revised rate certification for any changes in the capitation rate per rate cell for any SDPs regardless of size of change.

Federal regulations addressing actuarially sound capitation rates are at 438.4 through 438.7.

The section of the SDP Preprint that describes actuarial certification is presented below:

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

33. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

2. Contract amendments to incorporate SDP issues

In its Final Rule, CMS required specific information regarding the SDPs that must be documented in each MCO contract.

To ensure that managed care plans receive necessary information on the State's intent and direction for the SDP, we are finalizing provisions that establish minimum documentation requirements for all SDPs and timeframes for submission of managed care contracts and rate certifications that incorporate SDPs (see sections I.B.2.e., I.B.2.k., and I.B.2.l. of this final rule for further details). We believe these requirements will help ensure that plans have sufficient and timely information to effectuate SDPs with providers.

CFR 438.6(c)(5):

(5) ***Requirements for Medicaid Managed Care contract terms for State directed payments.*** State directed payments must be specifically described and documented in the MCO's, PIHP's, or PAHP's contracts. The MCO's, PIHP's or PAHP's contract must include, at a minimum, the following information for each State directed payment:

(i) The State directed payment start date and, if applicable, the end date within the applicable rating period;

(ii) A description of the provider class eligible for the State directed payment and all eligibility requirements;

(iii) A description of the State directed payment, which must include at a minimum:

(A) For State directed payments described in paragraphs (c)(1)(iii)(A), (B), and (C) of this section:

(*1*) The required fee schedule;

(*2*) The procedure and diagnosis codes to which the fee schedule applies;

(*3*) The applicable dates of service within the rating period for which the fee schedule applies;

(*4*) For State directed payments that specify State plan approved rates, the contract must also reference the State plan page, when it was approved, and a link to the currently approved State plan page when possible; and

(*5*) For State directed payments that specify a Medicare-referenced fee schedule, the contract must also include information about the Medicare fee schedule(s) that is

necessary to implement the State directed payment, including identifying the specific Medicare fee schedule, the time period for which the Medicare fee schedule is in effect, and any material adjustments due to geography or provider type that need to be applied.

(B) For State directed payments described in paragraphs (c)(1)(iii)(D) of this section:

(*1*) Whether the uniform increase will be a specific dollar amount or a percentage increase of negotiated rates;

(*2*) The procedure and diagnosis codes to which the uniform dollar or percentage increase applies;

(*3*) The specific dollar amount or percentage increase that the MCO, PIHP or PAHP must apply or the methodology to establish the specific dollar amount or percentage increase;

(*4*) The applicable dates of service within the rating period for which the uniform increase applies; and

(*5*) The roles and responsibilities of the State and the MCO, PIHP, or PAHP, the timing of payments, and other significant relevant information.

(C) For State directed payments described in paragraph (c)(1)(iii)(E) of this section:

(*1*) The fee schedule the MCO, PIHP, or PAHP must ensure that payments are below;

(*2*) The procedure and diagnosis codes to which the fee schedule applies;

(*3*) The applicable dates of service within the rating period for which the fee schedule applies; and

(*4*) Details of the State's exemption process for MCOs, PIHPs, or PAHPs and providers to follow if they are under contractual obligations that result in the need to pay more than the maximum fee schedule.

(D) For State directed payments described in paragraphs (c)(1)(i) and (ii) of this section that condition payment based upon performance:

(*1*) The approved performance measures upon which payment will be conditioned;

(*2*) The approved measurement period for those measures;

(*3*) The approved baseline statistics for all measures against which performance will be measured;

(*4*) The performance targets that must be achieved on each measure for the provider to obtain the performance-based payment;

(*5*) The methodology to determine if the provider qualifies for the performance-based payment, as well as the amount of the payment; and

(*6*) The roles and responsibilities of the State and the MCO, PIHP, or PAHP, the timing of payments, what to do with any unearned payments, and other significant relevant information.

(E) For State directed payments described in paragraphs (c)(1)(i) and (ii) of this section using a population-based or condition-based payment as defined in paragraph (a) of this section:

(*1*) The Medicaid covered service(s) that the population or condition-based payment is for;

(*2*) The time period that the population or condition-based payment covers;

(*3*) When the population or condition-based payment is to be made and how frequently;

(*4*) A description of the attribution methodology, if one is used, which must include at a minimum the data used, when the panels will be established, how frequently those panels will be updated, and how the attribution methodology will be communicated to providers; and

(*5*) The roles and responsibilities of the State and the MCO, PIHP, or PAHP in operationalizing the attribution methodology if an attribution methodology is used.

(iv) Any encounter reporting and separate reporting requirements necessary for auditing the State directed payment in addition to the reporting requirements in paragraph (c)(4) of this section; and

(v) All State directed payments must be specifically described and documented in the MCO's, PIHP's, and PAHP's contracts that must be submitted to CMS no later than 120 days after the start date of the State directed payment.

3. SDPs and MCO MLR

In its Final Rule, CMS provided direction on how to incorporate SDPs into MLR:

Numerator: SDPs made by a managed care entity to a provider should be counted as incurred claims

Denominator: payments from the State to a managed care entity should be counted as premium revenue.