Changes to Medicaid State Directed Payments in the 2024 Final Rule

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MEDICAID MANAGED CARE FINAL RULE

On April 22, CMS released the **Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule**

- This rule finalized a proposed rule published in May 2023, and covers a variety of components of Medicaid managed care, including State Directed Payments.
- State Directed Payments allow states to require Medicaid managed care plans to make enhanced Medicaid payments to eligible providers based on one or more of a prescribed set of methodologies approved by CMS.

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SDP PAYMENT CEILING

CMS codified the average commercial rate (ACR) as the SDP spending limit for four provider types

These include inpatient, outpatient, practitioner services at academic medical centers, and nursing facility services

Frequency

ACR demonstrations must be submitted initially and then at least every three years and be based on data no older than three years prior to the rating period.

Calculation

Rule does not prescribe a set methodology but can now be done at the statewide level rather than by class. Total payment analysis must still be done by class.

Other Provider Types

The ACR will be used for other provider types for now, but there are concerns that the ACR is not appropriate for services that may generally be paid better under public payers than commercial, and CMS wants to be flexible.

Total Expenditure Limit

Rule does not create an overall expenditure limit for SDPs.

Applicability Dates: Effective at Publication

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HOLD HARMLESS ARRANGEMENTS

- CMS is becoming increasingly concerned that hold harmless arrangements exist for SDP programs independent of state involvement.
- They argue that if they were public, the financing would be deemed impermissible, so providers should have to attest to the absence of such arrangements.
- CMS also issued an informational bulletin the same day as the rule explaining that they will not enforce the attestations until 2028, but they will be gathering information and asking questions as SDPs are proposed

Rule requires providers to submit attestations

"…attest that they do not participate in any hold harmless arrangement for any health care-related tax as specified in § 433.68(f)(3) of this subchapter in which the State or other unit of government imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold the taxpayer harmless for all or any portion of the tax amount…"

Applicability Dates: Rating Period Beginning On or After January 1, 2028

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INTERIM PAYMENTS AND RECONCILIATION

- To tie payments to utilization and facilitate cash flow, many SDPs rely on a process of making interim payments based on a prior period's data and reconciling to actual rate year data after allowing for sufficient claims runout.
- Rule expressly prohibits the use of prior period data even in the case of payments to be reconciled.

Example of allowable reconciliation

"…Estimated interim payments are made by the plans to providers based on actual experience…within the rating period to ensure there is no disruption in cash flow… Claims can be continued to be paid by the plans to the providers after the end of the rating period, provided they are for utilization that occurred within the rating period, either by date of receipt of the claim or date of service… Payment adjustments from the plan to the provider can still be used to ensure the plan's payments to providers have been accurately tied to utilization within the rating period…The regulation does not prohibit reconciliation of payments to actual utilization during the rating period when interim payments were also based on utilization during the rating period."

Applicability Dates: First rating period on or after three years after the effective date of the final rule (est. 7/9/27)

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SEPARATE PAYMENT TERM

The rule outlaws the use of separate payment terms for SDPs

The majority of SDPs now rely on the use of a "separate payment term" in the MCO rate certifications to separately identify and pay the SDP outside of the MCO's standard PMPM reimbursement. This brings up several concerns:

- **Transparency:** By including the SDP in the PMPM, it will be much more difficult to track the spending amounts in the aggregate and at the provider level. CMS believes the new requirements around T-MSIS reporting will improve transparency.
- **Matching Payments to Financing Levels:** Many SDPs are financed through provider taxes or intergovernmental transfers. By paying SDPs to plans through PMPMs, it will be difficult to ensure programs are not being over/under spent.
- **MCO Oversight:** Without paying the SDPs separately, it will be much more difficult to ensure the MCOs are paying out the full SDP amounts and there will be little protections against them redirecting utilization to non-SDP providers.

42%

SDPs were included as separate payment term 2016-2022

55%

SDPs were included as separate payment term that began in CY 2021

"Such practices are contradictory to the prospective nature of risk-based managed care rate setting".

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QUALITY REQUIREMENTS

SDPs must result in *"achievement or maintenance of stated goals and objectives"*

This codified language allows CMS to disapprove SDPs based on missing performance targets, although they appear to still give states a long runway before taking that action.

Required Measures

Each preprint must have at least two metrics —one of which must be performance-based. Metrics should be specific to the eligible providers and the managed care program for which the SDP applies *"when practical and relevant".*

Evaluation Plan and Report

All preprints must include an evaluation plan, but only SDPs that exceed a certain threshold will be required to submit an evaluation report to CMS and post publicly (all others will need to have reports available upon request). Evaluation reports must be submitted within two years of the end of the first three-year period and then every three years thereafter.

Disapproval

CMS notes that there may be reasons for missing performance targets that the state may wish to explain in the first evaluation report. However, if the second also shows the state missing performance targets, they will not approve the SDP.

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VALUE-BASED PAYMENTS AND DELIVERY SYSTEM REFORM INITIATIVES

CMS provides some flexibility with regards to VBP and delivery system reform initiatives and more clearly outlines performance requirements

- **Allows states to set the amount or frequency of the plan's expenditures**
- **Allows states to recoup unspent funds from MCOs** (methodology must be in approved preprint)
- **Performance-based payments cannot be based on administrative activities**
- **Allows for performance to be based on data from up to 12 months prior** (payment still applies to rating period)
- **Codified approval period limit to be three years** (aligns with requirements for state quality strategy updates)
- **Allows for performance to improve or maintain but wants to see improvement towards goals under state's quality strategy**

Applicability Dates: First rating period on or after the effective date of the final rule (est. 7/9/24)

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OTHER NOTABLE COMPONENTS OF THE FINAL RULE

Payment at 100% of Medicare

- Allows for SDP at 100% of Medicare without prior written approval.
- Cannot be any amount above or below 100% for this to apply.
- Effective with publication of the final rule.

Non-Network Providers

- Removes the requirement that SDPs can only be made to providers within network with the MCOs.
- Effective with publication of the final rule.

Submission Deadlines

- Requires that all preprints be submitted prior to their effective date.
- Must include also include total payment rate analysis, ACR demonstration, and evaluation plan.
- Effective first rating period beginning on or after two years after rule effective date.

Reporting

- States must submit to the T-MSIS, no later than one year after each rating period, SDP amounts paid by each plan to individual providers.
- Effective first rating period following the release of reporting instructions by CMS.

Contract Requirements

- MCO contracts must include detailed descriptions of SDPs, including methodology for payments, amounts to be paid, and provider eligibility criteria.
- Effective first rating period beginning on or after two years after rule effective date.

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