Milliman

Pass-through payment guidance

Final Medicaid managed care regulations

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“This changes everything.”

Agenda

Pass-through payment guidance

- CMS position on pass-through payments
- Definition
- Timing and transition
- Medical loss ratio
- Impact on state programs and provider funding
- Potential state alternatives

CMS position on pass-through payments

Underlying principles	
Managed care plans must make all payments to providers	And payments must be either: –For services provided under the contract –For the quality of services provided
Managed care plans must maintain ability to control and responsibility for the full payment	Supports the MC plans' –Ability to enroll providers, –Manage care delivery –Implement quality initiatives

CMS considers this codification of longstanding policy

Definition of pass-through payments

Any amount required by the state to be added to the contracted payment rates between the managed care plan and providers that is NOT for the following:

1. A specific service or benefit provided to a specific enrollee
2. A provider payment methodology permitted under §438.6(c)
3. A sub-capitated payment
4. A GME payment
5. FQHC or RHC wrap-around payment

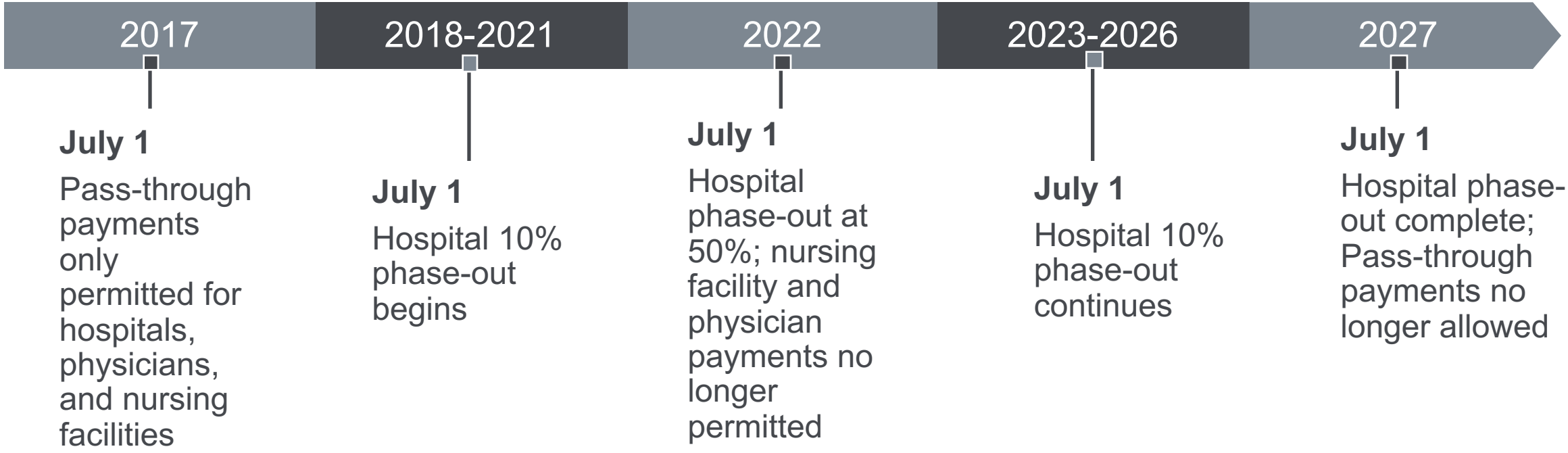
Defined by what it's not

Consistent with the 2016 Medicaid managed care rate development guide

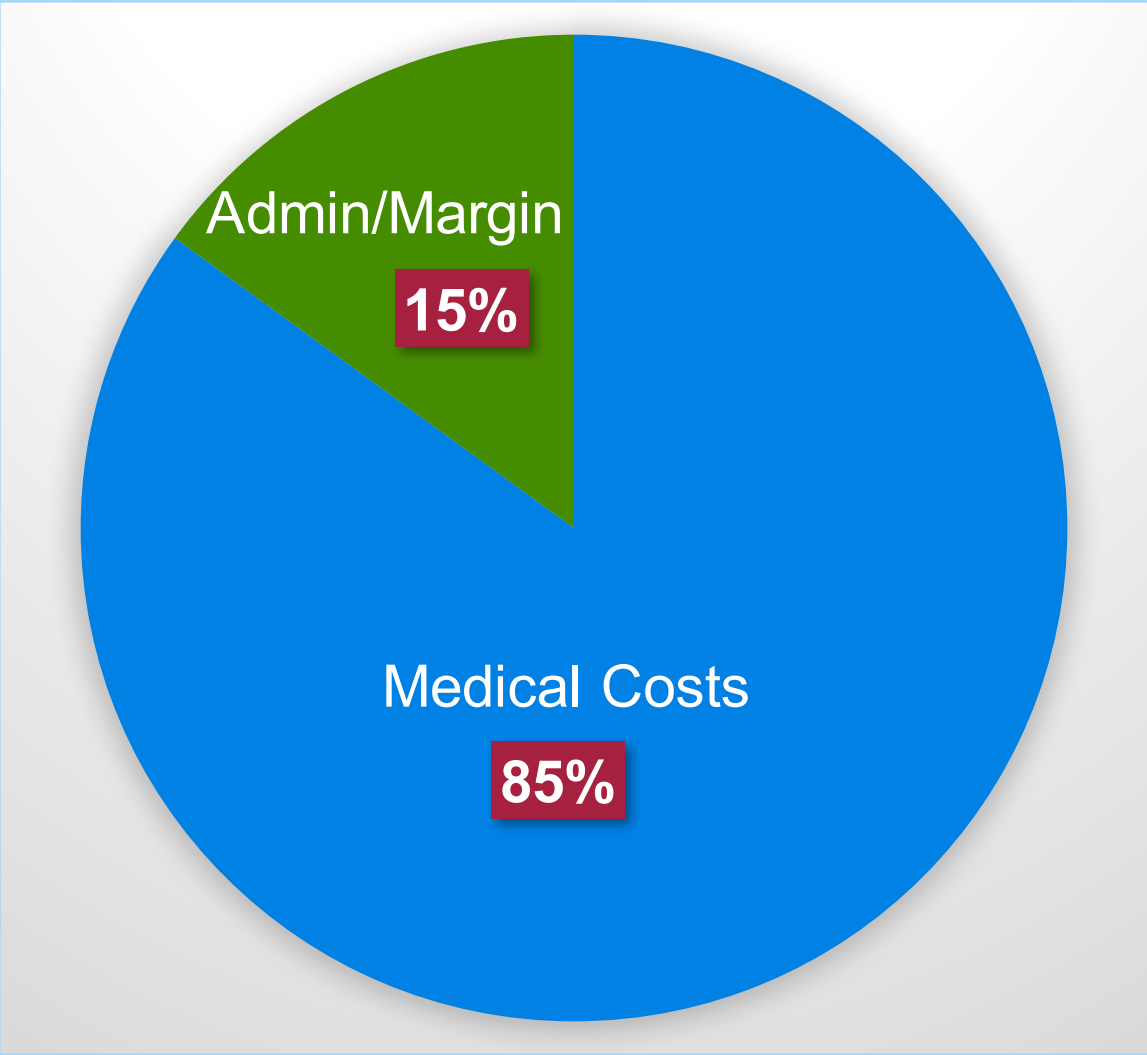
Timing and Transition

- Effective July 1, 2017
- Significant financial reliance by safety-net providers
- Hospitals
  - 10-year phase-out schedule
  - 10% reduction in “base amount” each year
- Physicians/Nursing Homes
  - 5-year phase-out schedule

Timing and Transition



Medical Loss Ratio



Calculation Requirements

- Minimum 85% MLR capitation rate target
- Consistency with Medicare Advantage and Commercial
- No maximum MLR rate target
- MLR calculation excludes all pass-through payments

Impact on state programs and provider funding

Examples of current role of pass-through payments

- Safety-net providers: Serve a significant number of Medicaid recipients
- Teaching hospitals: Serve a disproportionate share of Medicaid patients and complex cases
- Medical schools: Support educational and research missions

Impact on state programs and provider funding

State concerns and CMS thoughts

State Concerns	CMS Thoughts
–Pass-through straightforward –New payments will be spread across multiple providers –Variances in payments difficult for providers to handle –Changes in state law necessary –Disincentive for use of managed care	–Pass-through not actuarially sound –Limit managed care plans' ability to effectively manage care delivery

Potential state alternatives

Goals for transition

§438.6(c)

Pass-through payments

- Not directly related to services or quality
- Not available to all providers

Allowable alternative state direction

- Reimbursement range
- Value-based payments
- Delivery system reform

Retain critical funding streams

- Adequate reimbursement for providers
- Support state policy goals

Reimbursement direction and provider assessments

Base mechanisms to assure and fund adequate provider reimbursement

Reimbursement	Provider assessments
–All providers in a class –Same terms of performance –Not conditioned on IGTs –Related to utilization and delivery of services	–Broad-based –Uniformly imposed –No hold harmless –Apply to all in-state providers, public and private

State flexibility on provider classes

Network providers

Class of providers

Utilize with care

Exceptions: GME, DSH, and wrap-around FQHC/RHC payments

Payment	Payee	Purpose
Graduate medical education (GME)	–Primarily teaching hospitals	–To support provider training –Considerable flexibility to states on amount and structure
Disproportionate share hospitals (DSH)	–Primarily safety net hospitals	–To support hospitals most impacted by uncompensated care or low Medicaid payments
Wrap-around payments	–FQHCs/RHCs, reimbursed at cost	–Support their mission to provide primary care to all, regardless of ability to pay

Not subject to Medicaid managed care regulations

Delivery system and payment reform

May be used instead of or in addition to reimbursement direction

Examples

- –Value–based payment: related to outcomes, not volume
- –DSRIP programs
- –Infrastructure development: key provider capacity or HIT
- –Care innovation: medical homes, ACOs, discharge transition, phys/beh integration

CMS Requirements

- –Program participation available to all providers in a class
- –Amount and frequency of payments determine by managed care plan
- –State may not recoup unspent funds

Can coordinate with bonus/ incentives to MC plans

Carve-out

Last resort

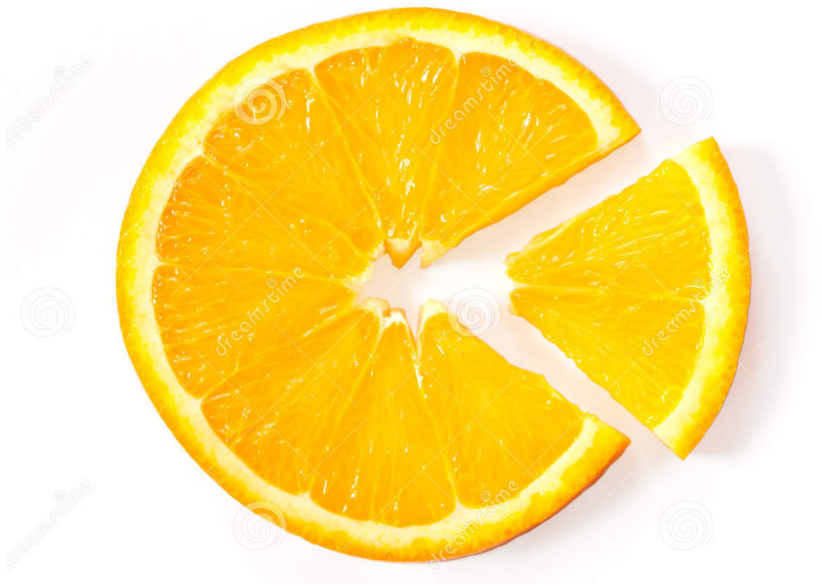
Potential Drawbacks

–Loss of integration

–Reduction in quality

–Increase in costs

(Impact depends on service)



Carved out services not subject to Medicaid managed care regulations

Conclusions

Transition may require significant time and effort.

- Stakeholder and provider engagement
- May require changes to state laws
- CMS approval
- Evaluation of financial impact to state, MC plans, and each provider

Limitations

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Thank you

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