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State Directed – Payment Programs

State Directed – Payment Programs

Federal Authority

- States are generally prohibited from directing the reimbursement rates or methodology paid by a Medicaid managed care organization to a provider.
- An exception exists in federal regulation under 42 CFR 438(6)(c).
- The exception criteria allow states to direct MCOs to pay a provider in a specific way if the criteria are met and the state receives approval from CMS.

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42 CFR 438.6(c) Directed Payment Types

- Value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.
- A multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.
- Adopt a minimum fee schedule (based upon the state plan rates or otherwise).
- Provide a uniform dollar or percentage increase.
- Adopt a maximum fee schedule.

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42 CFR 438.6(c) Directed Payment Approval Criteria

- Approval must be received by CMS in writing.
  - The approval document that the state submits to CMS is called a "pre-print."
- The payment arrangement must be actuarially sound
- The arrangement:

  (A) Is based on the utilization and delivery of services;

  (B) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;

  (C) Expects to advance at least one of the goals and objectives in the quality strategy in § 438.340;

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42 CFR 438.6(c) Directed Payment Approval Criteria (cont.)

- The arrangement:

  (D) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in § 438.340;

  (E) Does not condition provider participation in contract arrangements under paragraphs (c)(1)(i) through (iii) of this section on the provider entering into or adhering to intergovernmental transfer agreements; and

  (F) May not be renewed automatically.

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Framework for DPP Approvals

Directed-Payment Programs for FY22

- Directed-Payment Programs are key to the DSRIP and NAIP transitions
- DPP levels in FY22 are also critical in the determination of BN for the rest of the waiver
- The waiver includes a framework for the state and CMS to work together to get FY22 DPPs approved
- Includes new reporting requirements about provider-level payments and achievements
- Programs include: CHIRP; TIPPS; QIPP; RAPPS; BHS; and Ambulance ACR

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DPP Approval Milestones

Timelines	Description	Responsible Party
Day 1	Texas submits pre-prints to CMS	Texas
Day 31 (+30 days)	CMS sends Texas Requests for Additional Information (RAIs) necessary for approval	CMS
Day 45 (+15 days)	Texas provides responses to RAIs	Texas
Day 65 (+20 days)	CMS notifies Texas of anticipated approval or sends Round 2 RAIs	CMS

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DPP Approval Milestones (cont.)

Timelines	Description	Responsible Party
Day 67 (+2 days, and every 2 business days after)	If Round 2 RAIs are sent, Texas and CMS have call to discuss outstanding questions	Both
Day 70 (+5 days, and every 5 days after any additional RAIs)	Texas provides responses to Round 2 RAIs	Texas

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Thank you

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