

Pass-through payment guidance in final Medicaid managed care regulations: Transitioning to value-based payments, delivery system reform, and required reimbursement

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As managed care has replaced fee-for-service (FFS) in the Medicaid market, states have often sought to replicate fee-for-service supplemental provider payment programs in managed care.

Supplemental payment programs, sometimes called upper payment limit (UPL) programs, constitute a major source of revenue for providers in many states. Pass-through payments are the primary mechanism currently used to retain supplemental payment funding in managed care.

Final Medicaid managed care regulations, released April 25, 2016,¹ confirm that pass-through payments will be restricted in the near future and ultimately eliminated. In this paper, we provide an overview of pass-through payment provisions in the new regulations, including the rationale and phase-out timing of the Centers for Medicare and Medicaid Services (CMS). We also discuss some of the difficulties the loss of pass-through payments will cause for states and providers and suggest a number of potential changes states can consider to mitigate the impact on managed care programs.

In this paper, we use the term “managed care plan” to mean a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as referenced in the final Medicaid managed care regulation.

Overview of provisions

PASS-THROUGH PAYMENT DEFINITION

Pass-through payments are amounts paid to Medicaid managed care plans as supplemental payments or “add-ons” to the base capitation rate. The plans are required to pass through the add-on payment to designated contracted providers. Section 438.6(a) of final regulations defines pass-through payments

as any amount required by the state to be added to contracted payment rates between the managed care plans and providers that is not for any of the following purposes:

1. A specific service or benefit provided to a specific enrollee covered under the contract
2. Permissible provider payment methodologies outlined in §438.6(c)(1) of the final Medicaid managed care regulations
3. A sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract
4. Graduate medical education (GME) payments
5. Federally qualified health center (FQHC) or rural health center (RHC) wraparound payments.

This definition is generally consistent with CMS’s 2016 Medicaid Managed Care Rate Development Guide.

CMS UNDERLYING PRINCIPLES

CMS commentary on pass-through payments emphasizes that actuarial soundness requires the capitation rates to cover all reasonable, appropriate, and attainable costs of *providing services under the contract*, and associated administrative costs. Other than the exceptions noted in the previous section, CMS does not believe the actuarial soundness definition permits additional payments to providers that are not directly related to delivery of services under the contract.

Contract provisions under §438.6 illustrate these principles by only allowing states to direct expenditures based on utilization, delivery of services covered under contract, and quality and outcomes of services.

TIMING AND TRANSITION (PHASE-OUT)

The section limiting state direction of provider payments, §438.6(c), is effective for contracts beginning on or after July 1, 2017. This appears to imply that 2016 contracts and early 2017 contracts may continue to be approved with pass-through payments under prior regulatory guidance.

Transition time to phase out supplemental payments is provided for hospitals, physicians, and nursing facilities. CMS acknowledges the significant financial reliance that safety-net providers place on pass-through payments funded through the Medicaid managed care program. As such, the final rule allows for a transition period for states to restructure pass-through

1 Federal Register (May 6, 2016). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Retrieved May 6, 2016, from <http://federalregister.gov/a/2016-09581>.

payments into permissible payment mechanisms as defined in §438.6(c)(1)(i) through (iii) and further discussed in the Potential State Alternatives section below.

Beginning with contracts effective on or after July 1, 2017, pass-through payments for hospitals must be phased out within 10 years—that is, for contracts beginning on or after July 1, 2027. Under §438.6(d)(2), CMS has instituted a 10-year phase-out schedule to reduce the allowable amount of pass-through payments for hospitals by 10% per year. Therefore, states may require pass-through payments as high as 100% of the “base amount” for contract years starting July 1, 2017, with a 10% reduction in each successive year. The base amount is an estimate of the UPL differential for the eligible population during the 12-month period two years prior to the rating period. It is calculated by taking the difference between FFS and/or managed care payments for the eligible population (without supplemental payments) and what Medicare would have paid on a FFS basis for the same services.

CMS believes pass-through payments for physicians and nursing facilities will be easier to transition than for hospitals. Therefore, these payments must be eliminated within five years. Unlike hospital pass-through payments, CMS has not regulated annual phase-down requirements for physicians and nursing facilities.

MEDICAL LOSS RATIO TREATMENT

Treatment of pass-through payments for medical loss ratio (MLR) calculations was clarified in §438.8(e)(2)(v)(C) and §438.8(f)(2)(i) of the final Medicaid managed care regulations. Pass-through payments that are not directly related to specific utilization, or quality of services, should be excluded from both the numerator and denominator of the managed care plans’ reported MLRs.

Impact of state programs and CMS response

CURRENT ROLE OF PASS-THROUGH PAYMENTS

Historically, states have used pass-through payments to ensure funding to specific providers who serve a significant number of Medicaid recipients. An example of this is funding safety-net providers, who largely focus on providing care to low-income and uninsured populations. Pass-through payments can also play a critical role in funding teaching hospitals, medical schools, and faculty physicians at these schools. Teaching hospitals treat a disproportionate share of Medicaid patients and complex cases. Additional funding can be needed to support the educational and research missions of these facilities, providing a benefit to the overall community.

STATE CONCERNS WITH ALTERNATIVE APPROACHES

Pass-through payments have given states a relatively straightforward approach to employ additional funding to promote quality of care and access to specific providers. The new rule requires any additional payments to be tied to utilization of services by the Medicaid population, which may spread these payments out across more providers than intended. Because total payments are limited by availability of funds, this may destabilize safety-net providers.

Additionally, total pass-through payments are easier to calculate and budget for than payments tied to utilization, both for the providers receiving the payments and the MCOs passing on the payments, as well as the state Medicaid programs. Level payments from year to year can be critical to smaller providers, especially in years when utilization is lower than average and employee salaries and costs are difficult to cover. More variances in state payments may be difficult to account for in funding mechanisms from year to year as well.

FIGURE 1: PASS-THROUGH PAYMENTS — TIMING AND TRANSITION

CLASS OF PROVIDER	CONTRACT YEARS PRIOR TO JULY 1, 2017	CONTRACT YEARS BEGINNING ON OR AFTER JULY 1, 2017, BUT BEFORE JULY 1, 2022	CONTRACT YEARS BEGINNING ON OR AFTER JULY 1, 2022, BUT BEFORE JULY 1, 2027	CONTRACT YEARS BEGINNING ON OR AFTER JULY 1, 2027
Hospital— inpatient and outpatient	May be approved under prior regulatory guidance	Pass-through payments to be phased out under a 10-year schedule, beginning at 100% of the base amount for the first contract year on or after July 1, 2017, and decreasing by 10 percentage points each successive year		Pass-through payments not permitted
Physicians and nursing homes	May be approved under prior regulatory guidance	Pass-through payments permitted under transition provisions	Pass-through payments not permitted	Pass-through payments not permitted
All other providers	May be approved under prior regulatory guidance	Pass-through payments not permitted	Pass-through payments not permitted	Pass-through payments not permitted

Many states have laws and agreements in place that are predicated on current funding mechanisms. Renegotiating agreements and modifying laws may require considerable time and effort.

Currently, supplemental payments made for Medicaid members under a fee-for-service arrangement with the state are not subject to the new regulations. Therefore, the new regulations do not represent a level playing field and may dis-incentivize the use of managed care.

CMS RESPONSES TO STATE CONCERNS

In the final regulations, CMS did not respond directly to states' concerns. Instead, it listed concerns with pass-through payments.

- CMS's interpretation of statutory authority requires managed care payments to providers to be directly related to delivery of services under the contract (in order to be actuarially sound)
- Pass-through payments limit the managed care plans' ability to effectively manage care delivery and implement value-based purchasing strategies and quality initiatives

In response to the concern that final regulations may dis-incentivize the use of managed care, CMS noted that statutory requirements for payments under managed care are not the same as under fee-for-service.

Potential state alternatives

Under CMS's conceptual framework, payments to providers should be directly related to services provided to beneficiaries under the contract or value-based payment structures for such services. Further, CMS maintains that managed care plans should maintain the ability and responsibility to utilize the full value of the capitation payment for delivery of services and associated administrative costs.

Within this framework, we discuss allowable payment structures that maintain or partially maintain funding streams to critical providers.

SET MINIMUM REIMBURSEMENT

Under §438.6(c)(1)(iii), states are permitted to require managed care plans to adopt a minimum fee schedule or provide a uniform dollar or percentage increase to providers. For example, the state could mandate minimum physician reimbursement at a certain percentage of a benchmark rate, such as Medicare or the Medicaid fee-for-service fee schedule. Minimum hospital reimbursement could similarly be set at a percentage of Medicare or at a fixed percentage or dollar increase from the Medicaid fee-for-service reimbursement level.

Although in general CMS expects mandated reimbursement to be applied to a broad set of providers who provide a particular service, the regulations allow some flexibility:

- **Class of providers:** In response to comments, CMS states that it would be allowable to differentiate a "class of providers" from other providers offering the same services, potentially mandating higher reimbursement to this class or restricting participation in delivery system or payment reform. (§438.6(c)(2)(i)(B).) As examples of what may be considered a "class of providers," CMS suggested primary care physicians, public hospitals, and teaching hospitals as part of the final rule. If "class of providers" may be defined as any defined group that may need higher reimbursement to assure access or quality, this methodology likely could be applied to many provider groups that commonly receive supplemental payments.
- **Network providers:** §438.6(c)(1)(iii) specifically refers to network providers. This may imply that out-of-network providers may be paid at a lower rate. Out-of-state providers are often out-of-network, so this may facilitate using provider assessments to fund mandated reimbursement as discussed in the next section of this paper.

The state's ability to mandate different minimum reimbursement for classes of providers who provide the same service should be exercised with caution to avoid unintended consequences. For example, if mandated reimbursement for a protected class is too high relative to perceived value, managed care plans may reduce referrals to these providers or even decline to include them in networks.

Where states set higher minimum reimbursement, managed care plans will have the ability to fully utilize a larger capitation payment. This increases both the risk and opportunity associated with managing care and focusing on quality.

FUNDING HIGHER MINIMUM MANDATED REIMBURSEMENT

Although higher mandated reimbursement may mitigate the loss of supplemental payments for healthcare providers, a source of funding must also be found. For states that already have provider assessments in place, funding may already be adequate to support mandated minimum reimbursement. But in many states, supplemental payment funding relies heavily on provider intergovernmental transfers (IGTs). Because the new regulations specifically prohibit states from conditioning state-directed payments on IGTs (§438.6(c)(2)(i)(E)), states relying on IGTs must find alternative funding sources.

Provider taxes may form a reasonable alternative funding source for hospitals. One potential advantage of provider taxes is that they are generally applied to both public and private providers. This may be preferable if both public and private hospitals are expected to benefit from higher minimum reimbursement in the capitation rates. A potential disadvantage is that provider taxes cannot be adjusted to be proportional to the benefit each individual provider realizes from enhanced

reimbursement. The tax must be broad-based (applied to all providers in the class) and uniform (the same per diem or percentage of revenue for all providers), while the benefit of enhanced reimbursement may vary significantly, depending on each individual provider's Medicaid utilization.

Another feature of provider taxes is that states only have authority to impose taxes on in-state providers, so out-of-state providers will not contribute to provider tax revenue. The regulations allow state-directed minimum reimbursement to be applied only to network providers, which will often allow exclusion of out-of-state providers from the benefits funded by these taxes.

One disadvantage of provider taxes is that they are generally limited to 6% of net provider revenue (§433.68(f)). This is unlikely to pose a significant barrier for hospital providers, who serve a large number of commercial and Medicare patients in addition to Medicaid patients. But for nursing homes, where Medicaid revenue often constitutes over half of net revenue, the 6% safe harbor requirement is likely to limit funding available from this source.

(We would like to caution readers that implementation of a provider tax is a complex undertaking, and a comprehensive review of all the considerations is beyond the scope of this paper.)

Note that CMS objections to IGT funding may be limited to the common practice of requiring IGTs as a condition of participation under state-directed managed care plan expenditures (§483.6(c)(2)(i)(E)). In commentary, CMS notes that a provider's eligibility for payment should be solely based on satisfactory performance and not on compliance with an IGT agreement that may only be available to governmental entities. However, CMS did not explicitly forbid the use of IGTs as a financing mechanism for the nonfederal share. This limited response may imply that IGT funding is permissible, at least under some circumstances, as long as it is not a condition of participation.

Early adopter

The State of Indiana has mandated minimum provider reimbursement under the Healthy Indiana Plan (HIP) since 2008. Most providers participating in the HIP program are reimbursed directly by the managed care plans using Medicare payment principles. Starting in 2017, Indiana is planning to require the managed care plans to pay hospital providers at an enhanced Medicaid rate for all Medicaid managed care programs, including HIP. The enhanced Medicaid fee schedule for hospitals is approximately the upper payment limit. Enhanced hospital reimbursement will be funded through a hospital provider assessment fee.

GME AND DSH

States that wish to direct additional funding to teaching hospitals or safety-net hospitals may make additional direct payments to these institutions (outside of the capitation rates) through graduate medical education (GME) payments or disproportionate share hospital (DSH) payments. These payments remain an exception to the general rule that prohibits the state from making payments directly to providers (other than the managed care plan) for contracted services (§438.60).

States that carve GME payments out of the capitation rates in order to make payments directly to teaching hospitals are permitted considerable flexibility in the amount and structure of payments.² States are able to support a wider range of clinicians than under Medicare GME and can structure payments to support state policy objectives such as clinical workforce goals.

DELIVERY SYSTEM AND PAYMENT REFORM

Under §438.6(c), CMS permits three mechanisms under which states are permitted to direct managed care plan payments to providers. In addition to the mechanism requiring managed care plans to conform to a minimum or maximum fee schedule, states may direct payments to support either value-based purchasing or delivery system reform.

Although formal delivery system reform incentive payment (DSRIP) programs are not mentioned explicitly in the final regulations, these programs may be viewed as a model for the type of program CMS may approve under the final regulations. Examples of DSRIP programs are:

- Infrastructure development of key provider capacity or health information technology investment
- Care innovation projects focused on improving care delivery or quality, such as medical homes, accountable care organizations (ACOs), discharge transition, and physical and behavioral health integration³

Six states have approved III5 waivers related to DSRIP: California, Kansas, Massachusetts, New Jersey, New York, and Texas. These programs received \$3.6 billion in federal funds during FFY 2015, primarily directed to hospitals.⁴ DSRIP programs serve a dual role. They have the potential to drive

2 National Academy of Sciences (July 29, 2014). Graduate Medical Education That Meets the Nation's Health Needs. Retrieved May 6, 2016, from <http://www.nationalacademies.org/hmd/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx>.

Association of American Medical Colleges (April 2010). Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey. Retrieved May 6, 2016, from https://members.aamc.org/eweb/upload/Medicaid%20Direct_Indirect%20GME%20Payments%20Survey%202010.pdf.

3 MACPAC (June 2015). Chapter 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform. Report to Congress on Medicaid and CHIP. Retrieved May 6, 2016, from <https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf>.

4 MACPAC, *ibid.*

delivery system reform by providing a framework and critical capital for investments. At the same time, they are attractive to states because they have the capacity to replace fee-for-service supplemental payments in managed care.

There are some notable differences between existing DSRIP programs and the programs described in regulations. Under the regulations in §438.6(c), states must make delivery and payment reform programs available to all providers in a class, whereas in DSRIP programs, states have the flexibility to define eligible providers more narrowly. Also, IGTs from public hospitals are a primary funding source for four of the six states implementing DSRIP and are a condition of participation. This type of arrangement is explicitly prohibited in regulations. It is

unclear how CMS will interpret existing arrangements in the light of the new regulations.

Under DSRIP, payments are earned by achieving milestones, which may include implementation and reporting milestones. However, ultimately success of these programs will depend on meeting clinical and quality outcome improvement milestones.

INCENTIVE AND WITHHOLD PAYMENTS

If the state directs managed care plan payments to providers under §438.6(c), including value-based purchasing models, delivery system reform, or minimum required reimbursement provisions, the estimated cost of the directed payments must be included in capitation rates. This poses a substantial risk for states and managed care plans, especially with regard to

FIGURE 2: SUMMARY OF POTENTIAL ALTERNATIVES TO PASS-THROUGH PAYMENTS

MECHANISM	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Set minimum reimbursement	State may set minimum reimbursement for managed care plans to pay providers	<ul style="list-style-type: none"> Replaces provider revenue from supplemental payments Can target a class of providers (e.g., primary care physicians rather than all physicians) 	<ul style="list-style-type: none"> Generally requires a funding source Difficult to target to specific providers—must target a class of providers Cannot support funding that is not related to Medicaid utilization (e.g., uncompensated care)
GME and DSH	States may continue to make GME and DSH payments outside the capitation rates	<ul style="list-style-type: none"> Allows focused funding for teaching hospitals and safety net providers. May be funded by IGTs 	<ul style="list-style-type: none"> Only available to eligible providers GME: Primarily teaching hospitals DSH: Primarily safety net providers
Delivery system and payment reform	States may require plans to implement specified payment or delivery reforms	Provides a mechanism to support value-based purchasing and delivery reform	<ul style="list-style-type: none"> Generally requires a funding source Must target a class of providers rather than specific providers regardless of whether all are ready or willing
Incentive and withhold payments	Financial rewards for meeting quality and performance goals	<ul style="list-style-type: none"> Rewards quality Could potentially be used to mitigate risk from delivery system and payment reform 	<ul style="list-style-type: none"> Bonus payments may require funding Incentives limited to 5% of capitation Must be linked to state quality strategy
Carve-out services	Specific services may be excluded from managed care contracts	<ul style="list-style-type: none"> Providers may receive supplemental payments under fee-for-service Supplemental payments may be conditioned on IGTs 	<ul style="list-style-type: none"> Potential loss of service integration and quality Potential disincentive to rebalancing
Fund with provider assessments	State assessment on a broad-based class of providers, applied uniformly	Accesses funding from both public and private providers	<ul style="list-style-type: none"> Assessments for each provider cannot be directly related to enhanced funding the provider receives Assessments may only be levied on in-state providers Assessment limited to 6% of net provider revenue, in aggregate
Fund with IGTs	A governmental entity may transfer money to the Medicaid account to assist with an expenditure of interest	Flexible, with few reporting requirements	<ul style="list-style-type: none"> IGTs are limited to governmental providers The IGT cannot be a condition of participation for providers Little contractual protection

Note: These mechanisms are not mutually exclusive, but are intended to be mixed and matched.

value-based payments and delivery reform as it may be difficult to predict the extent to which healthcare providers will earn payments by achieving outcome improvement milestones. Regulations specifically prohibit the state from recouping any unspent funds (§438.6(c)(2)(ii)(D)).

It may be possible to partially mitigate this risk by coordinating incentive and withhold payments to the managed care plans with state-directed payment reform to be implemented between managed care plans and providers. Under this design, when healthcare providers meet milestones and earn additional payments from the managed care plans, the managed care plans will also earn additional payments from the state.

CARVE-OUT SERVICES

Where another acceptable solution cannot be found for a given class of providers, states continue to have the option to carve out services. Services that are carved out of managed care contracts and provided on a fee-for-service basis are not subject to Medicaid managed care regulations. Currently, for services provided on a fee-for-service basis, providers may receive supplemental payments to enhance reimbursement, subject to the UPL, and these payments may be conditioned upon IGTs.

There are several potential drawbacks to this approach. The state may anticipate a loss of service delivery integration, leading to a reduction in quality of care and increase in costs. The adverse impact may vary by the type of service carved out. For example, a carve-out of hospital services may lead to more significant integration concerns than a carve-out of dental services. For some services, a carve-out may jeopardize policy goals. For example, if the state is unable to provide nursing facility and other long-term care (LTC) services under managed care, it may compromise efforts to attain rebalancing targets.

Fee-for-service supplemental payment programs are also subject to CMS approval and oversight. CMS has historically viewed these programs as supporting access to quality care, but may target this area for restriction in a future round of regulation. The U.S. Government Accountability Office (GAO) views non-DSH fee-for-service supplemental payments as high-risk and has requested action from CMS, including additional reporting requirements, clarification of permissible methods for calculating payments, and annual audits to ensure compliance.⁵

Conclusions

CMS has clearly articulated its position on pass-through payments in managed care. Because of the critical importance of the funding these payments currently represent, planning for the transition from pass-through payments to allowable alternative structures will be a high priority for states and providers, requiring robust provider and stakeholder engagement, discussion on approaches to care delivery and payment, development of systems to measure quality, and evaluation of financial impact.

5 U.S. Government Accountability Office (April 2013). 2013 Annual Report: Actions Needed to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits. Pub. No. GAO-13-279SP. Retrieved May 6, 2016, from <http://www.gao.gov/assets/660/653604.pdf>.

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