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HEALTH LAW NEWS

APRIL 26, 2016

CMS'S NEW MEDICAID MANAGED CARE RULE PROVIDES A TEMPORARY SUBSTITUTE FOR UPPER PAYMENT LIMIT PAYMENTS AND OTHER SUPPLEMENTAL PAYMENTS

On May 6, 2016, CMS will publish its new Medicaid managed care rule, which will permit states to require Medicaid MCOs[1] to make enhanced payments to targeted hospitals, physicians and nursing facilities for a limited number of years. This is a departure from current practice in which states are prohibited from directing a Medicaid MCO's expenditures under its contract with the state. The new approach is intended to be a substitute – although not a complete or permanent one – for upper payment limit payments and other supplemental payments that terminate due to a state's conversion from a fee-for-service reimbursement methodology to a risk-based managed care methodology.[2]

PASS-THROUGH PAYMENTS FOR HOSPITALS

The new rule refers to these targeted, enhanced payments as "pass-through payments."[3] Simply stated, pass-through payments for hospitals may be required under a state's contracts with Medicaid MCOs but must be phased out over a 10-year period that begins with contracts that start on or after July 1, 2017.[4] The *total* amount of pass-through payments paid by MCOs to hospitals during a contract year may not exceed a percentage of the "base amount" calculated for that year, beginning with 100 percent for contracts starting on or after July 1, 2017 and decreasing by 10 percentage points each successive year.[5] The calculation of the "base amount"[6] for a contract year is summarized as follows:

- Step One: Identify the inpatient and outpatient hospital services that will be provided for the populations under managed care contracts for the contract year for which the base amount of pass-through payments is being calculated.
- Step Two: For the hospital services identified in Step One, identify which of those services were provided to the relevant populations under managed care contracts for the 12-month period that began 2 years prior to the contract year for which the base amount of pass-through payments is being calculated and compare reasonable estimates of the aggregate difference between: (a) the amount Medicare would have paid for those hospital services as utilized under the MCO contracts 2 years prior; and (b) the amount MCOs (not including pass-through payments) for those hospital services utilized under the MCO contracts for the 12-month period that began 2 years prior to the contract year for which the base amount of pass-through payments is being calculated.
- Step Three: For the hospital services identified in Step One that were provided to the relevant populations under fee-for-service during the 12-month period that began 2 years immediately prior to contract year for which the base amount is being calculated, compare actual or reasonable estimates of the aggregate difference between: (a) the amount Medicare fee-for-service would have paid for those hospital services as utilized under fee-for-service 2 years prior; and (b) the amount the state paid under fee-for-service (*not including supplemental payments*) for those hospital services utilized 2 years prior.
- Step Four: Sum the reasonable estimates of the aggregate differences calculated in Step Two and Step Three. The sum of these estimates is the "base amount" for the contract year.

It is important to note that the base amount for a contract year represents the total amount of pass-through payments that may be made to all hospitals in a state, in the aggregate, during a contract year. *Significantly, the new rule does not specify a methodology for calculating the amount of pass-through payments an individual hospital may receive for a contract year*. Consequently, hospitals will need to work closely with their respective state Medicaid agencies to formulate an appropriate payment methodology.

PASS-THROUGH PAYMENTS FOR NURSING FACILITIES AND PHYSICIANS

For MCO contracts starting on or after July 1, 2017 through contracts beginning on or after July 1, 2021, a state may require pass-through payments, at any amount, to nursing facilities and physicians under the MCO contract (unlike for hospitals, pass-through payments for nursing facilities and physicians are not subject to a "base amount" calculation). For contracts beginning on or after July 1, 2022, the state

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cannot require pass-through payments for physicians or nursing facilities under a MCO contract.

The rule does not dictate how much an individual nursing facility, or physician, may receive in pass-through payments for a contract year. As noted above with regard to hospitals, nursing facilities and physicians will need to work with their state Medicaid agencies to establish appropriate payment methodologies for their respective pass-through payments.

PRACTICAL TAKEAWAYS

CMS intends for the above-described pass-through payments to serve as a means for affected health care providers to transition to reimbursement that is based on value-based payment methodologies and/or delivery system reform initiatives. Indeed, the new rule provides states with the opportunity to develop and implement initiatives such as pay-for-performance arrangements, bundled payments and other value-based purchasing models (including multi-payer initiatives). In the meantime, in states that have converted, or which plan to convert, from a fee-for-service reimbursement methodology to a risk-based managed care methodology, the new managed care rule allows pass-through payments to serve as a temporary substitute for upper payment limit payments and other types of supplemental payments.

If you have any questions on this topic, please contact Tim Kennedy at (317) 977-1436 or tkennedy@hallrender.com or your regular Hall Render attorney.

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[1] Although this article refers exclusively to MCOs and MCO contracts, the new managed care rule similarly addresses "prepaid ambulatory health plans" ("PAHPs") and PAHP contracts, as well as prepaid inpatient health plans ("PIHPs") and PIHP contracts.

[2] Please note, the regulations do not address the use of IGTs to fund the state share of these targeted payments.

[3] Under the regulations, a "pass-through payment" is any amount required by a state to be added to the contracted payment rates between an MCO and a hospital, physician or nursing facility that is not for the following purposes: (i) a specific service or benefit provided to a specific enrollee covered under the contract; (ii) certain specified delivery system and provider payment initiatives detailed in the regulations; (iii) a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; (iv) GME payments; or (v) FQHC or RHC wrap-around payments. Pass-through payments will be considered in determining the actuarial soundness of capitation rates.

[4] Under the new rule, the status of pass-through payments for MCO contracts beginning *before* July 1, 2017 is less than clear. In the preamble to the rule, CMS maintains that its longstanding policy has been to prohibit pass-through payments. However, CMS also acknowledges that "a number of States have integrated some form of pass-through payments into their managed care contracts for hospitals, nursing facilities, and physicians." Adding to the confusion, CMS also states in the rule's preamble that, for MCO contracts beginning before July 1, 2017, States will not be held out of compliance with certain of the new regulations (including the new regulation governing pass-through payments, found at 42 C.F.R. § 438.6(d)) so long as they comply with the "corresponding standard(s)" codified in the regulations under 42 C.F.R. part 438 as of October 1, 2015. Prior to this new rule, however, CMS's regulations did not officially recognize pass-through payments. Consequently, there is no "corresponding standard" for pass-through payments in the October 1, 2015 version of the regulations under 42 C.F.R. part 438. Given that CMS acknowledges that many states have already implemented pass-through payments under their managed care programs, and in light of the fact that the new rule does not expressly call for those states to cease their pass-through payments until July 1, 2017, it is possible (and perhaps likely) that CMS will not be actively seeking to terminate pass-through payments that are currently being made.

[5] For example, for the 2017 contract year, up to 100 percent of the base amount calculated for 2017 may be paid to hospitals, in the aggregate, via pass-through payments; for the 2018 contract year, up to 90 percent of the base amount calculated for 2018 may be paid to hospitals, in the aggregate, via pass-through payments; for the 2019 contract year, up to 80 percent of the base amount calculated for 2019 may be paid to hospitals, in the aggregate, via pass-through payments, etc.

[6] The base amount must be calculated on an annual basis and must be recalculated annually.

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