OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

PRESERVING FEDERAL FUNDS

Transitioning Medicaid Fee for Service Supplemental Payments to Directed Payments under Managed Care Regulations.

There are clear approaches to transition from Medicaid Fee-for-Service (FFS) supplemental payments to "directed payments" under Medicaid Managed Care (MMC) that have been approved by CMS in other states to preserve supplemental payments in a managed care model.

Oklahoma, like many states, makes supplemental payments through its Medicaid program to certain types of providers in addition to claims-based payments. These supplemental payments are typically allocated among the members of a particular provider type based on the amount of Medicaid revenue that they receive and are not directly tied to covered Members or covered services.

In 2016, CMS finalized a MMC regulation that includes the guidance around directed payments. Because capitation rates under MMC must be actuarially sound, traditional supplemental payments are not permitted. However, 'directed payments' allow for the state Medicaid agency to give the MMC organizations direction as to how to allocate a portion of the funds included in the actuarially certified capitation rates. This allocation must be done uniformly across a defined class of providers, and all providers must be contracted with the Managed Care Organizations (MCOs) paying the "directed payments". The state must seek approval for these payments annually by filing a Section 438.6(c) preprint document with CMS, which involves filling out a template promulgated by CMS describing how the "directed payment" will work, as well as including the spending in the actuarial rate certification to be approved by CMS.

"Directed Payments" must be based on actual utilization and the delivery of services meaning that the payments must be tied to services in the payment period. Although the directed payments are not contingent on the achievement of quality measures, the state must provide justification as to how the payments will further one or more of the goals in the state's quality strategy.

Uniform Dollar or Percentage Increase Approach
Federal regulations allow for several types of "directed payments" under §438.6 Special contract provisions related to payment.

1. **Minimum fee schedule** for providing a particular service under contract
2. **Uniform dollar or percentage increase** for providing a particular service under contract
3. **Maximum fee schedule** for providing a particular service under contract

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4. **Value-based purchasing models** such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services
5. Multi-payer or Medicaid-specific **delivery system reform or performance improvement initiatives**

For Oklahoma hospital "directed payments", OHCA will pursue a uniform percentage increase approach. This will preserve current payments and structure to the greatest extent possible. Under a uniform percentage increase approach, the directed payment portion of rates would be held by the state and not initially distributed to the MCOs with the per member per month payments. Instead, the state would hold the directed payments until the applicable encounter data is available. The state would then use paid encounters by MCO by provider to determine the allocation of the add-ons.

Supplemental Payments to Qualifying Providers	**Recommended Payment Design**
SHOPP Inpatient and Outpatient	Uniform percentage add-ons for inpatient and outpatient services (both traditional and expansion) to all contracted, in-state hospitals. To mirror the current program, separate uniform rates should be set for: - Critical Access Hospitals vs. all other hospitals - Privately owned hospitals vs. non-state government owned hospitals
Level 1 Trauma Center Supplemental	Uniform percentage add-ons for inpatient and outpatient services (both traditional and expansion) to hospitals with Level 1 trauma centers.

Although OHCA is already working with CMS on preprint documents to ensure there is no loss of supplemental funding, CMS finalized a new rule last week that allows for a 3 year window for states to transition traditional supplemental payments to a directed payment model. Transitioning to directed payments will require minor statutory changes in the Hospital Tax statute. However, this final rule does allows us to make those changes in future years.

Preserving 100% Federal Match for Tribal Health Services.

Moving to a managed care model will not result in a loss of funding as it relates to services to tribal members. American Indian/Alaska Native members will be classified as "opt-in" to managed care, which means they will have the choice to remain in the OHCA patient-centered medical home model or choose to become a SoonerSelect member enrolled in a

managed care plan. If they do not choose to opt-in to managed care, the billing and claims process will remain as it is today with all IHCP claims being sent to and paid by OHCA.

If a member chooses to enroll in a managed care plan:

- OHCA will reimburse Indian Health Care Providers (IHCP) for services eligible for 100% federal reimbursement and are provided by an IHCP to AI/AN Health Plan enrollees.
- If the service is not eligible for 100% federal reimbursement, IHCPs will bill the managed care organization (MCO) regardless of whether or not the IHCP is contracted with the MCO in- or out-of-network.
- If an IHCP renders services to a non-AI/AN individual who is in a managed care plan, the IHCP will bill the MCO regardless of whether or not the IHCP is contracted with the MCO.
- In accordance with CMS State Health Official Letter #16-002, IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for AI/AN eligibles and Health Plan enrollees. Such services are eligible for 100% federal funding.
    - Providers will bill the MCO regardless of whether or not the provider is contracted with the MCO.
    - Managed care organizations shall provide reporting in the timeframe and format required by OHCA to facilitate the state's collection of 100% federal funding for these services.
    - Managed care organizations shall also facilitate the development of care coordination agreements between Indian Health Care Providers and other non-IHS/Tribal providers as necessary to support the provision of services for AI/AN Health Plan enrollees.
- Managed care organizations will be required to have a tribal liaison to ensure Indian Health Care Providers have a single point of contact and to advise the MCOs on tribal policies.