DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMCS Informational Bulletin

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FROM: Vikki Wachino
Director, Center for Medicaid and CHIP Services

SUBJECT: **The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems**

The purpose of this Informational Bulletin is to address questions regarding the ability of states to increase or add new pass-through payments under Medicaid managed care plan contracts and capitation rates, and to describe CMS' plan for monitoring the transition of pass-through payments to approaches for provider payment under Medicaid managed care programs that are based on the delivery of services, utilization, and the outcomes and quality of the delivered services.

Background

The Centers for Medicare and Medicaid Services' (CMS) recent Medicaid managed care regulations[1] strengthen existing policy that prohibit states from directing managed care plans' expenditures under the contract. The regulations also provide exceptions to this general rule and permit states to direct managed care plans' expenditures for provider payment through the managed care contracts in a manner based on the delivery of services, utilization, and the outcomes and quality of the delivered services. The exceptions are for value-based purchasing models, to implement delivery system reform, or to adopt parameters for provider payments. Specifically, §438.6(c)(2)(i) requires that any state direction of managed care plan expenditures for provider payments:

1. Be based on the utilization and delivery of services;
2. Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;
3. Expects to advance at least one of the goals and objectives in the managed care quality strategy;
4. Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the managed care quality strategy;
5. Does not condition provider participation in the arrangements on the provider entering into or adhering to intergovernmental transfer agreements; and

[1] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016).

6. May not be renewed automatically.

Additional conditions are also applicable for specific types of state direction under §438.6(c)(2)(ii). States are required to demonstrate in writing that these conditions are met and obtain CMS approval prior to implementing arrangements that direct managed care plan expenditures to providers.

In the Medicaid managed care regulations, CMS acknowledged that despite its policy that states should not direct managed care plans' expenditures under the contract, a number of states have integrated some form of additional payment to providers, defined in the final rule as pass-through payments,[2] into their managed care contracts for hospitals, nursing facilities, and physicians. Two common reasons for these pass-through payments are that states that have moved from fee-for-service (FFS) to managed care sought to ensure a consistent payment stream for certain critical safety-net hospitals and providers and to avoid disruption of existing IGT, CPE, or provider tax mechanisms associated with supplemental payments under a UPL program. These pass-through payments as currently structured do not meet the conditions in §438.6(c)(2).

In the final rule, CMS recognized the challenges associated with transitioning existing pass-through payments into payments for the delivery of services covered under the contract to enrollees or value-based payment structures for such services. The transition from one payment structure to another may require robust provider and stakeholder engagement, agreement on approaches to care delivery and payment, establishing systems for measuring outcomes and quality, planning, and evaluating the potential impact of change on Medicaid financing mechanisms. In an effort to provide a smooth transition for providers, to support access for beneficiaries, and to provide states and managed care plans with adequate time to design and implement payment systems and renegotiate provider contracts that link provider reimbursement with services covered under the contract or associated quality outcomes, the Medicaid managed care regulations provide for transition periods related to pass-through payments for specified providers. The regulations provide a 10-year transition period for hospitals, subject to certain limitations on the maximum amount of pass-through payments permitted.[3] The regulations also provide a 5-year transition period for pass-through payments to physicians and nursing facilities.

The purpose and intention of these transition periods is to acknowledge that pass-through payments existed prior to the final rule and to provide states, network providers, and managed care plans time and flexibility to integrate pass-through payment arrangements into different payment structures[4]. These payment structures could include value-based purchasing, performance improvement initiatives, and enhanced fee schedules or other approaches linking payments to delivered services or the outcome and quality of those services.

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[2] Section 438.6(a) defines a pass-through payment as any amount required by the state to be added to the contracted payment rates between the managed care plan and hospitals, physicians, or nursing facilities that is not for the following purposes: a specific service or benefit covered under the contract and provided to a specific enrollee; a provider payment methodology permitted under §438.6(c)(1)(i) through (c)(1)(iii) for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

[3] See §438.6(d)(2) through (3) for limitations on the maximum amount of hospital pass-through payments allowed.

[4] See §438.6(c)(1)(i) through (c)(1)(iii) for some examples of allowed payment models.

Adding New or Increased Pass-Through Payments to Managed Care Contracts

Since publication of the Medicaid managed care regulations, CMS has received inquiries about states' ability to integrate new or increased pass-through payments into Medicaid managed care contracts. CMS believes that adding new or increased pass-through payments into Medicaid managed care contracts is inconsistent with the goals and objectives associated with the transition periods under the Medicaid managed care regulations. As stated in the final rule, pass-through payments are not consistent with statutory requirements in section 1903(m) of the Social Security Act and regulations for actuarially sound capitation rates, nor do pass-through payments tie provider payments with the provision of services. The final rule maintains existing policy that states may not direct managed care plans' expenditures under the contract except as otherwise specified in §438.6(c). However, CMS did not require the immediate transitioning of pass-through payments for specified providers into other payment structures due to concerns that an abrupt end to pass-through payments for hospitals, physicians, and nursing facilities could create significant disruptions for some safety-net providers who serve Medicaid managed care enrollees. Adding new or increased pass-through payments for hospitals, physicians, and nursing facilities, beyond what was included as of July 5, 2016, into Medicaid managed care contracts would exacerbate a problematic practice that is inconsistent with statutory and regulatory requirements, complicates the required transition of these pass-through payments to permissible provider payment models, and reduces managed care plans' ability to effectively use value-based purchasing strategies and implement provider-based quality initiatives.

CMS intends to further address this policy in future rulemaking, linking pass-through payments through the transition period to amounts in place at the time the Medicaid managed care rule was effective on July 5, 2016.

Monitoring Pass-Through Payments

Questions have also arisen about the implementation of the policy on pass-through payments. CMS will use its contract and rate certification approval processes to closely monitor pass-through payments. Under §438.7(d), CMS will require the state to provide detail on any pass-through payments that the state requires of managed care plans in order to ensure that the capitation rates have been developed consistent with applicable rules and are actuarially sound. This can be done in the contract, the actuarial certification, or supplementary materials until such time as states must comply fully with §438.6(c) and (d) and explicitly detail any pass-through payments in the Medicaid managed care contract. CMS will request detailed information during the review of the rate certification that describes all existing pass-through payments included in the rates for the rating period, including:

1. A description of the pass-through payment;
2. The amount of the pass-through payments, both in total and on a per member per month basis;
3. The network providers receiving the pass-through payments;
4. The financing mechanism for the pass-through payment; and
5. The amount of pass-through payments made to providers in previous years.

As part of its review and approval processes, CMS intends to ensure that the pass-through payments comply with:

1. Section 438.4(a) in that the capitation rates with the pass-through payments are projected to provide for all *reasonable*, *appropriate*, and *attainable* costs that are required under the terms of the contract;
2. For rating periods for Medicaid managed care contracts beginning on or after July 1, 2017, Section 438.6(d) in that the pass-through payments do not exceed the maximum amount allowed;
3. Section 1902(a)(2) of the Act and §433.53(c)(2) in that the provider's receipt of the pass-through payment is not conditioned on the provider entering into or adhering to intergovernmental transfer agreements.

Technical Assistance

CMS is available to provide technical assistance to states with transitioning pass-through payments to payment models consistent with §438.6(c), as well as to assist states in properly integrating and documenting existing pass-through payments into contracts and rate certifications. For additional information on this Informational Bulletin, please contact James Golden at james.golden@cms.hhs.gov or 410-786-7111.