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Proposed Rule to Further Limit Pass-Through Payments in Medicaid Managed Care

OVERVIEW

On November 22nd, the Department of Health and Human Services (HHS) issued a proposed rule that would make changes to the Medicaid and CHIP Managed Care final rule published on May 6, 2016. The final rule required states to start phasing out pass-through provider payments beginning July 1, 2017. The Center for Medicaid and CHIP Services initially published a July 29, 2016 informational bulletin articulating concerns and expectations for states under the Medicaid Managed Care final rule. This proposed rule elaborates on that July guidance.

CMS required states to phase out most pass-through payments over a 5- or 10-year transition period, based on provider types, with specific limits and annual reductions required for payments made to hospitals. Since the release of the final rule, some states have contacted CMS about increasing or adding new pass-through provider payments under their managed care contracts that could run contrary to CMS' goals in the final rule for reforming the Medicaid Managed Care delivery system.

This proposed rule would prohibit states from increasing pass-through provider payments under Managed Care in the intervening time before the July 1, 2017 phase-out date in the final rule.

HHS will accept comments on the proposed rule until December 22, 2016. The proposed rule is available here.

PASS-THROUGH PAYMENTS IN MEDICAID MANAGED CARE

Near-term increases in pass-through payments are contrary to CMS' goals for eliminating those same payments from managed care delivery systems. The proposed rule would limit pass-through payments and require that any payments made during a phase-out period generally be no greater or directed to more providers than the payments already authorized and approved by CMS on or before June 5, 2016, when the Medicaid Managed Care final rule went into effect.

CMS clarified in the Medicaid Managed Care final rule that incentive payments for delivery system reform and quality improvement are among the only types of supplemental payments that states can continue directing to providers through managed care contracts. States also may no longer require managed care plans to pay providers specific amounts based on participation in Intergovernmental Transfers (IGTs) or other metrics unrelated to services delivered or outcomes achieved.

CMS intended for states to comply with the new rules limiting pass-through payments beginning July 1, 2017, rather than at the time of initial publication. CMS expected states to use the delayed compliance date to identify unallowable pass-through payments in current managed care contracts and transition to allowable payment models that facilitate delivery system reform in Medicaid managed care, rather than to add or increase pass-through payments to providers.

Limiting Pass-through Payments During Phase-Out

States seeking to continue pass-through payments to hospitals, physicians or nursing facilities would be required to prove those pass-through payments were already in place based on past managed care contracts or rate certifications reviewed or approved by CMS on or before July 5, 2016. In the proposed rule, CMS is making the following additional changes to limit pass-through payments:

- ***Retroactive adjustments or amendments:*** Other than adjustments to the permitted base amount, states cannot retroactively adjust managed care contracts or rate certifications to add new or increased pass-through payments to those already in place. The proposed rule clarifies how CMS will calculate permitted pass-through payment amounts.

- ***Maximum annual pass-through amount:*** States would be limited to a maximum annual pass-through payment amount during the transition periods. Hospital limits would be calculated separately from those for physicians and nursing facilities, but both types of providers would have limits tied to previously-approved pass-through amounts based on prior contracts or rate certifications.

- ***Flexibility in who receives pass-through payments:*** The limits would apply based on provider type but not specific providers. Therefore, under the proposed rule different hospitals could receive pass-through payments than the hospitals receiving those pass-through payments in prior years.