



DELIVERY SYSTEM REFORM LEGISLATION

SB1337



Supplemental and Managed Care Directed Payment Programs for Hospital Services



OKLAHOMA
Health Care Authority



Report of the Oklahoma Health Care Authority's plans to continue supplemental payment programs and implement a managed care directed payment program for hospital services that complies with the reforms required by SB 1337 (2022).

I. Introduction

Oklahoma Medicaid (commonly known as SoonerCare) currently reimburses hospitals for care delivered to members through a combination of base payments for services rendered and supplemental payments. Base payments to all SoonerCare contracted hospitals account for \$1.7 billion or roughly 60% of hospital reimbursements each year, while supplemental payments to qualifying SoonerCare contracted hospitals account for \$1.1 billion or 40% of total hospital payments.

After the State transitions to Medicaid Managed Care (MMC), it will no longer be permitted to utilize the current payment structure to make most types of supplemental payments. To ensure that hospitals receive comparable reimbursement after the transition to managed care, the Oklahoma Health Care Authority (the Authority) has worked with stakeholders to develop the following proposal for transitioning hospital supplemental payments to a new directed payment structure.

II. Current Payment Structure

Oklahoma currently makes base payments and supplemental payments to hospitals for services provided under the fee-for-service (FFS) program.

Inpatient Base Payments. To calculate inpatient base reimbursement, Oklahoma uses a Diagnosis Related Group (DRG) methodology.

- Hospitals have a base payment dependent on hospital characteristics that is multiplied by the applicable DRG weight.
- Hospitals also receive outlier payments to offset a portion of costs above a specified threshold.



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerca.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



Outpatient Base Payments. Today, hospitals receive a base reimbursement for most services based on 93.63% of the Medicare fee schedule.

Supplemental Payments. Oklahoma also makes several categories of supplemental payments to hospitals. The three major categories are:

- **Disproportionate Share Hospital (DSH) payments.** Oklahoma makes several categories of DSH payments. Public, Private, Non-State Governmental Owned (NSGO) hospitals and Institutions for Mental Disease (IMDs) receive DSH payments based on size and facility specific upper payment limits.
- **Graduate Medical Education (GME).** Qualifying Teaching Hospitals receive supplemental reimbursement from the Direct Medical Education and/or the Indirect Medical Education programs.
- **Upper Payment Limit (UPL) Payments.**
 - **Level 1 Trauma payments.** Level 1 Trauma hospitals receive a UPL payment to cover the difference between Medicaid payments/costs and what Medicare would have paid or cost. Oklahoma has only one Level 1 Trauma hospital, which is a public hospital eligible to finance the non-federal share of these payments through intergovernmental transfers (IGTS).
 - **Supplemental Hospital Offset Payment Program (SHOPP) payments.** Qualifying hospitals receive a UPL payment to cover the difference between Medicaid payments and what Medicare would have paid or cost. Participating hospitals fund the non-federal share of these payments through a provider assessment.



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerca.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



State appropriations fund the non-federal share of base payments, but the sources of the non-federal share for supplemental payments are predominantly provider assessments and intergovernmental transfers.

III. Proposed Payment Methodology: Guiding Principles

The Authority has developed a proposed approach to hospital reimbursement in managed care based on the following guiding principles:

- Ensure reimbursement adequately compensates hospitals for provision of Medicaid.
- Link compensation directly to services rendered to members.
- Promote value in the health care system.
- Achieve cost neutrality to the State.
- Demonstrate cost effectiveness to the Centers for Medicare and Medicaid Services (CMS).

The Authority has and will continue to work closely with the Oklahoma Legislature to secure any legislative authority needed to implement the approach proposed in section IV.

IV. Proposed Payment Methodology: Base Payments

Under the proposed model for base inpatient and outpatient payments, each hospital will continue to be reimbursed under the existing methodology in FFS and reimbursement in MMC will comply with Senate Bill 1337, which states:

- *Until July 1, 2026, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from managed care organizations and dental benefit managers contracted entities to providers who elect not to enter into value-based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by*



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



such providers to members of the state Medicaid program. Except as provided by subsection I of this section, until July 1, 2026, such reimbursement rates shall be equal to or greater than:

- *For an item or service provided by a participating provider who is in the network of the managed care organization or dental benefit manager contracted entity, one hundred percent (100%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority; or*
- *For an item or service provided by a non-participating provider or a provider who is not in the network of the managed care organization or dental benefit manager contracted entity, ninety percent (90%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority as of January 1, 2021.*
 - Additionally, non-participating providers will not be eligible for participation in DPPs.

DSH and GME payments will continue to be paid directly by the Authority and would remain outside of Managed Care Entity (MCE) capitation payments, as permitted under federal rules.

This model will result in no disruption to the distribution of funds among hospitals for inpatient or outpatient base reimbursement or GME payments. However, there is a potential impact to DSH payments. Since DSH payments are limited by a hospital specific UPL, the increased funds from directed payments may result in reduction of DSH payments or ineligibility for DSH payments.

The remaining content will focus on UPL payments.



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerca.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



V. Proposed Payment Methodology: Directed Payment Programs (DPPs)

There are clear approaches to transition existing Medicaid FFS supplemental payments to “directed payments” under MMC that have been approved by CMS in other states and will prevent qualifying providers from receiving less revenue from SoonerSelect than they would under FFS. In some instances, there is an opportunity to enhance reimbursement levels to certain providers since MMC is not subject to Medicare-based UPL limits.

Oklahoma, like many states, makes supplemental payments through its SoonerCare 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 received and are not directly linked 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 direct the MMC organizations how to allocate a portion of the funds included in the actuarially certified capitation rates. In accordance with 42 CFR 438.6(c)(1)(iii), *directed payments* must be limited to network providers. A class of providers can be as broad as all hospitals licensed in the state or as narrow as state teaching hospitals, given that there is a policy case to be made for the class definition and the allocation of payments must be performed uniformly across the class of providers. The state must seek approval for these payments annually by filing a Section 438.6(c) preprint document with CMS, which describes how the directed payment will be operationalized, 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 linked 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.



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



Allowable DPP Approach

Federal regulations allow for several types of directed payments under §438.6 Special Contract Provisions related to payment.

1. **Minimum or maximum fee schedule:** a type of directed payment that sets parameters for the base payment rates that managed care plans pay for specified services. Most of these fee schedules require MCOs to pay providers no less than the FFS rate approved in the Medicaid state plan. Some states also use the Medicare fee schedule, or another fee schedule established by the state, to set minimum or maximum payment rates for providers.
2. **Uniform rate increase:** a type of directed payment that requires MCOs to pay a uniform dollar or percentage increase in payment above negotiated base payment rates. These types of arrangements are the most similar to supplemental payments in FFS.
3. **Value-Based Payments (VBP):** a type of directed payment that requires MCOs to implement VBP models, such as pay-for-performance incentives, shared savings arrangements or other alternative payment models. This category also includes arrangements that require MCOs to participate in multi-payer or Medicaid specific delivery system reforms.

Based on the desired continuity of the existing supplemental payments structure in Oklahoma and Senate Bill 1396, the following payment design is recommended:



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



| DPPs for Qualifying Providers | Recommended Payment Design |
|--|---|
| SHOPP DPP - Inpatient and Outpatient | Uniform amount (inpatient services) and percentage (outpatient services) add-ons to all contracted, in-state hospitals. To mirror the current program, separate uniform rates would be set for: <ul style="list-style-type: none"> - Critical Access Hospitals vs. all other hospitals - Privately owned hospitals vs. non-state government owned hospitals |
| Level 1 Trauma Center DPP - Inpatient and Outpatient | Uniform amount or percentage add-ons for inpatient and outpatient services (both traditional and expansion) to hospitals with Level 1 Trauma centers. |

Directed Payment Design and Options for Justifying Directed Payments

Federal managed care regulations (42 CFR 438.202(e)), regardless of the existence of directed payments, require that states develop and submit a copy of a Quality Strategy to assess and improve the quality of services offered under managed care within a state. As previously discussed, all directed payments are expected to advance goals and objectives outlined in the state’s submitted Quality Strategy. The preprint document asks for references to the specific goals and objectives and requires the identification of measures related to those.

Below are potential priorities that would fit well within the state’s goals for MMC. These examples largely relate to general measures of quality, but if the state has specific goals related to health concerns such as reduction of opioid use, measures related to those issues could be utilized.





| Goal/Objective Theme | Potential Measure |
|---|--|
| Access to Care | MCE Hospital Network: Assessing the number of providers enrolled or contracted with MCEs in the state with a target of maintaining or improving the number at year end. |
| Promotion of High-Quality Care/Triple Aim | All Cause Readmission: Reduce the number of patients readmitted within 30 days of discharge from a hospital. |
| Improve Provider Experience and Network Relationships | Improving the Processing of Claims: This may involve measures related to turnaround time for correcting and resubmitting denied encounters, lag time between the date of service and the submission date to the state and accuracy/completeness of the claims received. <i>In the initial year, this could be a reporting measure.</i> |

Directed Payment Funding Pools

As mentioned previously, in existing FFS supplemental payment programs, qualifying hospitals receive a UPL payment to cover the difference between Medicaid payments and what Medicare would have paid or cost. This is commonly referred to as the “UPL gap.” For the hospital DPPs, the Authority will propose to CMS that the funding pools be established based on the difference between SoonerSelect base payments and 90% of the Average Commercial Rate (ACR). A recent Milliman commercial benchmarking report for 2021 showed that the national commercial reimbursement as a percentage of Medicare was 198% (Oklahoma 159%) for inpatient and 261% (Oklahoma 222%) for outpatient. For 2022, that was 206% and 257%, respectively. This UPL method change will substantially increase the pool of funds available for distribution to qualifying Oklahoma hospitals. The analysis of the ACR to be utilized and the pool of funds available is ongoing.



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



VI. Incorporating Directed Payments Programs (DPPs)

Utilizing a directed payment pre-print as the authority vehicle and subject to CMS approval, the Authority will incorporate into the SoonerSelect program an existing supplemental payment program (SHOPP), which has been an integral part of our SoonerCare FFS program since 2011 and an existing supplemental payment program (Level 1 Trauma), for which Oklahoma only has one eligible level 1 Trauma hospital that serves more SoonerCare members than any other hospital. As proposed, the DPP will continue to support Oklahoma hospitals that provide critical access to quality healthcare services to SoonerSelect members.

Consistent with 42 CFR 438.6(c)(1)(iii)(C), SoonerSelect MCEs will provide a uniform amount (for inpatient services) or percentage (for outpatient services) increase to qualifying Oklahoma hospitals. These payments will encourage Oklahoma hospitals to contract with SoonerSelect MCEs and will enhance access to hospitals statewide for all SoonerCare members.

The uniform increases will be determined by the state and will be adjusted during the rate year based on actual utilization. The state projects in aggregate payments to equal 90% of the ACR as mandated in Oklahoma Senate Bill 1396. In the event utilization declines, per-services payment may increase but will not exceed 100% of the ACR. The full pool of funds established based on projection of the gap between the Medicaid base reimbursement and the ACR will be expended.

SoonerSelect MCE encounter data will be used to directly link payments to utilization of inpatient and outpatient services by participating hospital for plan members. SoonerSelect MCEs are required to submit encounter data to the Authority in accordance with formatting and timeliness standards set forth in their contracts with the State. Upon completion of a quarter, the Authority will calculate each hospital's payment increase by MCE using valid encounters paid during the previous quarter. The Authority will then issue directed payments to each SoonerSelect MCE for distribution to qualified providers based on the increase calculated for inpatient and outpatient services provided to the MCE's members. Due to the uniform increase being calculated after the encounter has been paid, the directed payment will occur retroactively to each MCE based on actual encounters paid during the previous quarter. Final reimbursement



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



is intended to result in approximately 90% of the state determined ACR, in accordance with Oklahoma Senate Bill 1396.

For certification of the managed care rates, the state's contracted actuary will include an estimated gross payment amount in the initial rate certification letter. Once all payments have been made at the end of the contract year, the actuary will use the actual payment data to certify final MCE rates.

VII. Changes to Provider Assessments

Hospitals will continue to provide funding for the non-federal share as described in current statute or interagency agreements, except that total contributions subject to upper payment limit-based payments will increase to reflect the increase in amount of supplemental reimbursement due to the shift from a Medicare based upper payment limit to an average commercial rate based upper payment limit.

VIII. Conclusion

The purpose of this report is to inform key stakeholders on the Authority's plans to continue hospital supplemental payment programs and implement MMC DPPs for hospital services that complies with the reforms required by Senate Bills 1337 and 1396.

At this time, the Authority believes Medicaid-specific funding can be maintained as currently implemented and authorized by state law and does not propose any additional modifications to preserve supplemental payments and managed care directed payments.

Below is a quick reference timeline of activities related to DPP design and implementation:



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767



| Task | Target Completion Date |
|--|------------------------|
| Convert Historical FFS Supplementals to Directed Payments | |
| Begin informal discussions with CMS on preprint design | January 2023 |
| Submit all preprints, will not require separate preprints for the traditional and expansion populations | April 2023 |
| Incorporate estimated directed payment spending into capitation rate development | October 2023 |
| Submit all required changes to the state plan to reduce or remove FFS supplemental payment language as appropriate | December 31, 2023 |
| Implement SoonerSelect | April 1, 2024 |
| Make first quarter directed payments | July 2024 |



ADDRESS

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105



WEBSITES

oklahoma.gov/ohca
mysoonerCare.org



PHONE

Admin: 405-522-7300
Helpline: 800-987-7767