LANE POWELL

MEMORANDUM

April 17, 2018

CONFIDENTIAL ATTORNEY WORK PRODUCT

TO: Brendan Williams, President/CEO New Hampshire Health Care Association

FROM: Joseph M. Greenman

RE: Legal Analysis of New Hampshire Medicaid Managed Care Proposal to Direct NF Payments in a Fully Capitated Model

I. INTRODUCTION

The New Hampshire Department of Health and Human Services ("DHHS"), the agency overseeing the state's Medicaid program, established a Medicaid Managed Care ("MMC") program in 2013, pursuant to legislation passed in 2011. This is referred to as "Phase 1" of implementation of managed care. The initial plan included authorization of managed care to ultimately include Long-Term Services and Supports ("LTSS"), referred to as "Phase 2" of the implementation process.

On June 6, 2016, the Governor of New Hampshire signed into law SB 553 instructing DHHS to convene a Working Group of stakeholders and present to the Legislature an implementation plan for the remaining unimplemented phases of the MMC program as established in RSA 126-A:5, XIX. The implementation plan must address LTSS. The plans for implementation of nursing facility ("NF") and home care services provided under the Choices for Independence Waiver ("CFI") into managed care shall be prepared prior to implementing an effort to incorporate all remaining LTSS into MMC.

The following year, the Legislature enacted Senate Bill 155 (2017 Laws Ch. 258), which requires the Department to incorporate both CFI waiver services and NFs into MMC beginning on July 1, 2019. In March 2018, the New Hampshire Department of Health and Human Services ("DHHS") released the Implementation Plan for Medicaid Care Management – Nursing Facility/Choices for Independence Services. This implementation plan only addresses the process for transitioning services provided under the CFI waiver and NFs to managed care, consistent with the directive of Senate Bill 155.

Under New Hampshire's current Medicaid system, where LTSS is carved out from the state's managed Medicaid program, NFs receive payments through as many as three different funding sources: (1). Base payments in an amount equal to their per diem rate – calculated based on costs and acuity – reduced to account for state appropriations. N.H. Admin. Rules, He-E 806.01. (2). NFs receive an additional payment increasing their per diem rate known as Medicaid Quality Incentive Payments ("MQIP"). MQIP reimbursement is funded by the Nursing Facility Quality Assessment ("NFQA") – a 5.5% tax on revenue. N.H. Rev. Stat. § 151-

E:15. (3). County NFs receive Proportionate Share Payments ("ProShare") to cover the difference between the Medicaid per diem rate and the corresponding rate paid under Medicare. *Id*. at 167:18-h. ProShare payments are funded with intergovernmental transfers ("IGTs") from the counties. *Id*.

The DHHS implementation plan includes a section on rates and payments, resulting from concerns expressed by stakeholders that incorporating LTSS in the state's Medicaid managed care plan will jeopardize current financing for LTSS, specifically NF services and including county NFs. Each of the ten counties operates one or more NFs (Coos County operates two), providing a critical role in meeting safety-net needs. In these NFs, county governments provide the state share of Medicaid ProShare costs, which receives a federal match at a rate of 50%.

Federal regulations expressly prohibit states from making a payment to a provider for services available under the contract between the state and the managed care plan. 42 CFR § 438.60. In its implementation plan and at public hearings, DHHS asserts that while New Hampshire may not make MQIP and ProShare payments to NFs directly after implementation of Phase 2 in 2019, New Hampshire may require that the contracted Managed Care Organizations ("MCOs") make directed pass-through payments to the county NFs.

You have asked us to analyze whether the Centers for Medicare & Medicaid Services ("CMS") is likely to approve the pass-through payments described and proposed by DHHS. Our analysis demonstrates that, contrary to the assertions of DHHS, CMS may well reject the pass-through payments proposed by DHHS as prohibited by recently adopted federal regulations because the rules now largely disfavor allowing states to direct pass-through payments under MMC and DHHS has not outlined a proposal that illustrates how its proposed directed LTSS pass-through payments will conform with one of the three permitted exemptions.

II. MEDICAID MANAGED CARE REGULATIONS AND PASS-THROUGH PAYMENTS

On May 6, 2016 CMS published a comprehensive revision of the federal rules governing MMC. These are the first comprehensive amendments to the MMC rules since 2002. These rules amended section 438.6, dealing with special contract provisions related to payment.

Under MMC, MCOs receive risk-based capitation payments to carry out the obligations under the contract with the state. Section 438.6(c) establishes the general rule that dictates that except for the specified exemptions under the rule, the state may not direct MCO's expenditures under the contract. Section 438.6(c) establishes parameters whereby the state can direct expenditures under the contract.

The exemptions identified in the rule allow for the state to require MCOs to: (1). Implement value-based purchasing models for provider reimbursement, such as pay-for-performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; (2). Participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative; and (3). Adopt a minimum fee schedule for network providers that provide a particular service under the

contract or provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Id.*

When CMS published the rule in the Federal Register, it included significant commentary totaling nearly 400 pages. This includes several pages confirming the agency's intent to significantly restrict pass-through payments in the near future and ultimately eliminate them altogether. At the outset CMS declares its overall legal justification for phasing out and ultimately eliminating pass-through payments:

> We believe that the statutory requirement that capitation payments to managed care plans be actuarially sound requires that payments under the managed care contract align with the provision of services to beneficiaries covered under the contract. Aligning provider payments with the provision of services through managed care contracts is also necessary to support improved care delivery and transformative innovation. In our review of managed care capitation rates, we have found pass-through payments being directed to specific providers that are generally not directly linked to delivered services or the outcomes of those services. These pass-through payments are not consistent with actuarially sound rates and do not tie provider payments with the provision of services. 81 Fed. Reg. 88 at 27587 (May 6, 2016).

The final rule did make an allowance for transition periods for pass-through payments to hospitals, physicians and NFs to enable affected providers, states, and managed care plans to transition pass-through payments into payments tied to services covered under MCO contracts, value-based payment structures, or delivery system reform initiatives. Under this rule, beginning with contracts effective on or after July 1, 2017, pass-through payment for NFs must be eliminated within five years. *Id.* at 438.6(d)(5). CMS subsequently clarified this rule through an amendment published on January 18, 2017 that prevents increases in pass-through payments and the addition of new pass-through payments beyond those in place when the pass-through payment transition periods were established, in the final Medicaid managed care regulations effective July 5, 2016. The practical impact of this modification to the rule governing permitted transition periods of pass-through payments is that CMS will not permit a pass-through payment exceeding the aggregate amounts of pass-through payments that were in place at the time the May 6, 2016 final rule became effective on July 5, 2016. 82 Fed. Reg. 11 at 5417 (January 18, 2017).

The subsequent rule clarifying the timelines for permitted pass-through transition payments arose from CMS's concern that states were seeking to adopt new or increased pass-through payments for contracts prior to July 1, 2017. CMS enacted through this rule its belief that states that do not currently have pass-through payments in their managed care contracts do not need transition periods for their MCO contracts to avoid disruption. CMS believes that states that do not have pass-through payments in place are starting their MMC programs from a clean slate in terms of adopting payment mechanisms and systems described in § 438.6(c). *Id.* at 5419. Further, encouraging or enabling states to add or increase such pass-through payments during the transition periods only exacerbates the challenges of eliminating them and transitioning to

actuarially sound rates, or establishing value-based payment arrangements, delivery system reform, and fee schedule and payment rate reforms. *Id.*

III. APPLICATION OF FEDERAL PASS-THROUGH REGULATIONS TO NEW HAMPSHIRE'S PLANNED MMC PHASE 2

In its published MMC Phase 2 implementation plan, DHHS claims:

> The existing financing mechanisms, MQIP and ProShare may be used to access the funding that would inform directed MCO payments. MCOs will be required to use rates established by the State. Such rates will be no less than the rates paid to providers in SFY 2018. Implementation Plan for Medicaid Care Management – Nursing Facility/Choices for Independence Services at p. 23 (March 2018).

Likewise, on April 13, DHHS publicly released a memorandum prepared by Manatt analyzing whether the state will be able to establish directed payments to NFs, providing payments through managed care that are equivalent to the current applicable FFS payments. Manatt's analysis concluded, in agreement with DHHS's position, that New Hampshire will be able to replicate the exiting financing and payment mechanisms for NFs after the proposed transition to MMC through use of directed payments.

The language of the rule, and lengthy CMS commentary accompanying the publication of the rule, do not support DHHS's position.

A. New Hampshire Can Use Existing Financing Mechanisms but is Limited in How It Chooses to Direct MCO Payments

As previously established, MQIP is financed through a 5.5% tax on NF revenue and ProShare is financed by a combination of county tax revenue and matched federal Medicaid contribution. The federal rules for provider taxes and IGTs do not prohibit their use under MMC. Such taxes and IGTs may still be rendered to the state Medicaid program and be designated to finance payments for medical assistance under the state plan.

Contrary to DHHS's claim, the ability of states to direct these revenues to providers is significantly constrained by federal regulations. Any directed payment to providers must fall into one of the exemptions to the general rule prohibiting state directed payments under MMC. Further, New Hampshire does not qualify for eligibility for a transition period allowing otherwise prohibited directed payments because these directed payments were not in effect for managed care contracts and rate certifications as of July 5, 2016.

The only permissible way for New Hampshire to direct these revenues to a specific class of providers, such as NFs, is through the designated exemptions, namely value-based payment arrangements, delivery system reform, and fee schedule and payment rate reforms. In addition, states can set minimum provider payment requirements but must demonstrate, in writing, that the arrangement directs expenditures equally, and using the same terms of performance, for a class

of providers providing the service under the contract. 42 CFR § 438.6(c)(2)(i)(B). Furthermore, the state must demonstrate, in writing, that the arrangement does not condition network provider participation in the exempted pass-through contract arrangements on the network provider entering into or adhering to intergovernmental transfer agreements. *Id.* at 438.6(2)(i)(E).

DHHS and Manatt argue that by using the term "class of providers" CMS has implicitly granted permission to states to direct payments in a manner that treats public and private providers differently, such as mandating MCOs pay enhanced payments to public providers. DHHS and Manatt assert, without citation, that in the "preamble" to the final CMS MMC rule, CMS provides the possibility of allowing different application of the pass-through payment exemptions to public and private providers. 81 Fed. Reg. 88 at 27586.

DHHS's interpretation of CMS's intent is incorrect in two ways. First, CMS's commentary is specifying that the use of class of provider in the rule is for the purpose of permitting states to limit a fee schedule, or delivery system reform, or performance improvement initiative to primary care physicians, public hospitals, and teaching hospitals. This part of CMS's commentary only alludes to limiting the application of fee schedules and participation in alternative payment models to the referenced providers, not mandating enhanced pass-through payments. Moreover, CMS explains its intended application of this subsection in a different comment prior to the comment relied on by DHHS, clarifying its expectation that states demonstrate that all providers of the service are being treated equally, including both public and private providers as specified in the underlying rule. *Id.* at 27583. Finally, CMS does not include NFs in its example of types of providers that may be separated into subclasses. Second, CMS is very clear regarding its intent to eliminate pass-through payments that are not consistent with CMS's regulatory standards for actuarially-sound rates because they do not tie provider payments with the provision of services. 82 Fed. Reg. 11 at 5415. CMS further clarifies its regulatory intent to states such as New Hampshire proposing to transition from a fee-for-service ("FFS") system to MMC:

> For states with supplemental payments that were made under Medicaid FFS or section 1115 demonstration programs prior to July 5, 2016, we believe that as part of a state's transition to a managed care delivery system, **the state needs to integrate such FFS supplemental payments into allowable payment structures that tie managed care payments to services and utilization covered under the contract**. [emphasis added] Integrating the FFS supplemental payments into allowable payment structures at the time of the transition will ensure that the state can hold managed care plans accountable for the cost and quality of services delivered under the contract. *Id.* at 5421.

DHHS and Manatt rely on one, vague, parenthetical comment from CMS suggesting the possibility of differential payments between public and private providers, amidst a sea of contrary rule commentary establishing CMS's clearly-stated objective otherwise, to justify its argument that CMS will approve its Phase 2 draft plan. CMS will likely not use this oblique reference to contradict its stated objective to constrain pass-through payments unless they align payment with the provision of services. In fact, CMS links this policy to the prohibition against

states making a payment to a provider for services available under the contract between the state and the MCO, stating, "[I]f the state is making a pass-through payment by requiring a managed care plan to pay network providers in a manner that is not related to the delivery of services, this situation is no different than the state making a payment outside of the contract directly to providers." 81 Fed. Reg. 88 at 27589.

Moreover, in the rule clarifying the requirements of pass-through payments, CMS discusses its work with one state making a formal proposal for pass-through payments. CMS has been working with that state to revise its proposal to tie such payments to the utilization and delivery of services as well as the outcomes of delivered services. 82 Fed. Reg. 11 at 5426.

In the unlikely event that DHHS is correct, and CMS approves a plan submission from New Hampshire that directs pass-through payments of ProShare payments to the county NFs, such a proposal could invite unintended consequences. For example, if directed pass-through payments for county NFs are too high relative to perceived value (or competing network providers), managed care plans may reduce referrals to these providers or even decline to include them in networks.

B. New Hampshire is Limited in How It Can Require MCOs to Set Rates

Despite DHHS's assertion to the contrary, federal regulations are clear on the manner in which states are permitted to direct payments made by MCOs under the contract. See the exemptions outlined on P. 2 of this analysis. New Hampshire has two FFS NF funding mechanisms that DHHS believes it could convert into pass-through payments. Starting first with MQIP, New Hampshire would need to either take MQIP revenues and allocate them under a value-based purchasing model, or allocate them equally to all NFs under a directed minimum fee schedule. The former modification would alter the current allocation of provider reimbursements and the latter might not contain adequate revenue to maintain present rate levels for all providers.

Regarding ProShare, the only approximate, permitted method for dispersing county revenues is directing them to fund a minimum fee schedule for all New Hampshire NFs. Allocating these revenues to over 70 NFs as opposed to the eleven current recipients will result in the current recipients receiving significantly lower per-diem rates.

Beyond the rule and rule commentary, CMS has also cast doubt on Manatt's assertion via sub-regulatory guidance. On July 29, 2016, the CMS Center for Medicaid and CHIP Services ("CMCS") published the informational bulletin titled, The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems. CMCS acknowledged that:

> [D]espite CMS's 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, 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 [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).

§438.6(c)(2)(B) is the provision that requires that all MMC contract arrangements must direct expenditures equally, using the same terms of performance, for a class of providers providing the service under the contract. This CMCS bulletin is yet another indication supporting the conclusion that CMS may well reject a proposal from New Hampshire to direct MMC payments to replicate current NF reimbursements under MQIP and ProShare. This guidance also undermines Manett's assertion that counties presumably would continue to make IGTs at current dollar levels under MMC because CMS will not permit contracts conditioning the provider's receipt of the pass-through payments on the provider entering into or adhering to intergovernmental transfer agreements. In other words, the regulation states that under MMC, the IGT arrangement cannot be legally required and voluntary participation may no longer be of interest to counties if they determine that they are paid less than what they contribute.

Using the limited methods for directing payments under MMC, New Hampshire could direct significant resources to NFs, but creating or maintaining these directed payments may prove difficult because they come at the expense of payments to other providers or MCO payment initiatives under MMC. Even where net aggregate NF reimbursement is maintained under MMC, reimbursements for individual providers will change, with some receiving more and others less. It is unlikely that all individual rates will be no less than the rates paid to providers in SFY 2018 for each NF.

C. Additional Authority Inconsistent With DHHS's Argument

CMS drafted considerable commentary to support its objective to severely limit directed pass-through payments in the MMC rule and its follow-up rule clarifying pass-through payments in MMC. There are two additional authorities provided by CMS that augment the conclusion that New Hampshire's proposal to direct payments to NFs is inconsistent with CMS rules.

In the impact statement for the rule clarifying pass-through payments, CMS states that relative to the current baseline, the clarifying rule builds on the prior MMC final rule and may further reduce the likelihood of increases in, or the development of, new pass-through payments, which could reduce state and federal government transfers to hospitals, physicians, and NFs. *Id.* at 5427. CMS goes on to acknowledge that states may instead increase, or develop actuarially-sound, payments that link provider reimbursement with services covered under the contract or associated quality outcomes. *Id*. Direct payments made for the purpose of maintaining the level of reimbursement that they experienced under the state's predecessor FFS system to NF is inconsistent with the impact statement and suggests CMS would reject them.

Finally, CMS clarified treatment of pass-through payments for medical loss ratio ("MLR") calculations in § 438.8(e)(2)(v)(C) and § 438.8(f)(2)(i) of the final MMC rule. Upon the effective date of the rule, pass-through payments that are not directly related to specific utilization, or quality of services, should be excluded from both the numerator and denominator

of the MCO's reported MLRs. In other words, CMS wants to significantly constrain MCOs from using pass-through payments as legitimate medical expenses in order to meet their new minimum 85% MLR requirement.

These final two points found in the rules, while not directly related to the regulations governing directed pass-through payments, support the totality of the regulations adopted by CMS and CMS's commentary accompanying those regulations. CMS is on record having articulated a desire to constrain state-directed pass-through payments in MMC. CMS believes these payments are contrary to its regulatory standards for actuarially-sound rates because they do not tie provider payments with the provision of services. Ultimately, CMS believes that when pass-through payments guarantee a portion of a provider's payment and divorce the payment from service delivery, it is more challenging for managed care plans to negotiate provider contracts with incentives focused on outcomes and managing individuals' overall care. *Id*. at 5425.

IV. CONCLUSION

DHHS asserts that it will be able to direct Medicare-based rates, using the same methodology used currently in ProShare, as the minimum Medicaid rate for all public NFs. Such a payment strategy is inconsistent with federal MMC regulations and guidance. Nothing in the regulations support CMS in approving a state plan that directs payments in this manner to facilities merely because they are publicly-owned NFs. These directed payments would not be tied to utilization, delivery of services covered under the contract, and quality and outcomes of services. CMS has made clear in its regulations and policy that it does not believe that these payments constitute actuarially-sound rates. Nor did these payments exist under the state's MMC program on or prior to July 5, 2016 to qualify for the five-year transition period.

CMS might approve a Phase 2 MMC plan where New Hampshire sets a "full acuity rate" as a minimum fee schedule for all state NFs. This could qualify as a permitted exemption to the prohibition on directed pass-through payments, but CMS would require that these rates be uniform for all NFs. Ultimately, it may prove difficult to maintain an acceptable uniform full acuity rate where MCOs want to use capitated NF funds to allocate reimbursements for alternative lower cost services available under the CFI waiver, or to implement NF reimbursement incentives focused on outcomes and managing individuals' overall care.