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

February 10, 2023

Tricia Roddy
Deputy Medicaid Director
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

Dear Tricia Roddy:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Maryland's submission of an amendment for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The amendment was received by CMS on September 30, 2022 and a revised preprint was received on December 19, 2022. The control name is MD_Fee.VBP_AMC.PC.SP_Amend_20220101-20241231.

Specifically, the following amendment for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform percentage increase and value-based payment established by the state for professional services at an academic medical center, primary care services, specialty physician services, and qualifying practitioner services for the rating period covering January 1, 2022 through December 31, 2024 incorporated in the capitation rates through a separate payment term of up to $37.8 million.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period(s), or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Therefore, CMS strongly recommends that states share this approval letter and the final approved preprint with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

The total dollar amount approved for the separate payment term for this state directed payment is $37.8 million within the HealthChoice managed care program. If the total amount of the separate payment term is exceeded from what was approved under this preprint or, the payment methodology is changed from the approved preprint, CMS requires the state to submit a state directed payment preprint amendment. Please note that if the separate payment term amount documented within the rate certification exceeds the separate payment term amount approved under the preprint, then the state will be required to submit a rate certification amendment to address the inconsistencies between the rate certification and the approved preprint.

CMS is able to approve this preprint with a requirement that the state submit an updated Table 7 that aligns with the state's March 2022 quality strategy and a response to Preprint Question 43 that describes how the payment arrangement will advance goal(s) and objective(s) from the state's revised quality strategy in the state's preprint submission for calendar year 2025 for CMS prior approval under 42 CFR 438.6(c). Our understanding is that the state will be submitting an updated quality strategy. We defer to the state to work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox on this effort.

If you have questions concerning this approval or state directed payments in general, please contact [redacted], Division of Managed Care Policy, at [redacted] or at [redacted].

Sincerely,

John Giles

Digitally signed by John Giles
Date: 2023.02.10 09:05:05 -05'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2022 - December 31, 2024
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2022
3. Identify the managed care program(s) to which this payment arrangement will apply:
   HealthChoice
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $37.8M for Program Year 4 (PY4)
   a. Identify the estimated federal share of this state directed payment: $24.4M for PY4
   b. Identify the estimated non-federal share of this state directed payment: $13.4M for PY4

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☒ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:
Total dollar amounts will be updated
☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The Managed Care Organizations (MCOs) will pay supplemental payments for services provided by physicians and other eligible professional service practitioners. The eligible provider group will receive quarterly payments following utilization of services by managed care enrollees. Please see answer to question 19 for additional details on how the payment arrangement is based on utilization and delivery of services.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Please see Maryland's 1115 demonstration, and renewal application:
https://health.maryland.gov/mmcp/pages/1115-healthchoice-waiver-renewal.aspx

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☒ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

The Maryland Quality Innovation Program (M-QIP) is currently in its third year of implementation having received approval for Program Year 1 (PY1) on 03/18/2020, Program Year 2 (PY2) on 01/14/2021 and Program Year 3-5 (PY3) on 2/22/2022. During the first two years of the program, five percent of payments were at-risk, dependent on submission of an annual Infrastructure Activities Report documenting the clinical implementation and innovation activities implemented by the eligible provider group to meet the program's quality objectives. In Program Years 3 – 5 (PY3-5), an increasing percentage of the program's dollars will be at risk dependent on performance on the metrics included in Table 1 / Question 12 below.

M-QIP continues to focus on the following three priority areas described below. Each of these areas of focus are aligned with the Maryland's Total Cost of Care (TCOC) waiver and our Statewide Integrated Health Improvement Strategy (SIHIS) approved by the Center for Medicare and Medicaid Innovation (CMMI) in March of 2021. Under these initiatives, Maryland will work to improve outcomes associated with substance use disorder, diabetes, and childhood asthma.

M-QIP Focus areas:
1. Reverse Integration – Improving Health Outcomes through the Integration of Medical and Behavioral Healthcare into Medication Assisted Treatment Programs.

Through its Health and Recovery Practice (HARP), the multispecialty "reverse integrated" comprehensive medical practice co-located with the University of Maryland Addiction Treatment Programs at 1001 West Pratt Street in West Baltimore, the eligible provider group will provide preventive care and address underlying conditions to reduce utilization of high-cost emergency department and inpatient services for its patients. HARP's clinical plan enhances access to care using non-traditional approaches such as open scheduling, on demand and walk-in care, coordination with methadone dispensing staff/schedules, and use of the methadone dispensing intervention as an opportunity to dispense other medications for chronic medical conditions. A more complete description of this program is included in the attachment PY1 Infrastructure Activities Report and the PY2 Infrastructure Activities Report.

2. Proactive Diabetes Care Program

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. See measures, baseline statistics, and targets attached in document named "Section IIa_Question 13_Evaluation plan for PY3 preprint."						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment. **Performance-based payment will be triggered in program years 3 through 5.**
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here. **Please see attached document named "Section IIa_Question 13_Evaluation plan for PY3 preprint**.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

Methodology framework: The goal in setting performance targets was to establish challenging, yet attainable goals which demonstrate the program's positive impact on patient care for the specific program cohorts. The first two years of the program served as program development years and did not include performance improvement targets but did require submission of annual Infrastructure Activities Reports documenting the efforts undertaken to impact performance improvement. The PY1 Infrastructure Activities Report and a Mid-year report for PY2 are attached to this document. The final PY2 report will be submitted to MDH in the first quarter of calendar 2022.

Improvement targets for this preprint submission cover PYs 3 – 5. To eliminate annual variation, baselines were calculated as an average of three years: calendar 2017 – 2019. The Emergency Department and Inpatient Hospital utilization measures were compared to Medicaid benchmarks on a per 100k members basis. This comparison demonstrated that the performance of the program cohorts significantly exceeded statewide norms, therefore, performance targets were defined as a percentage improvement from the baseline across the three program years. This methodology was then used to determine improvement targets for the remaining measures as well.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

The structure of this value-based program dictates that financial payout be tied to performance on quality measures and the attainment of the goals within the program. In PYs 3-5 (January 1, 2022 – December 30, 2024), the annual at-risk payment will be tied to performance on the measures outlined above. The table below shows the quality payment structure.

# of Performance Measures Met	% of risk-based performance payment earned
7-9 measures	100%
5-6 measures	75%
3-4 measures	50%
1-2 measures	25%
0 measures	0%

In addition, the percentage of at-risk payments will increase through PYs 3-5 as below:

PY3: January 1, 2022 – December 31, 2022 – 5%
PY4: January 1, 2023 – December 31, 2023 – 10%
PY5: January 1, 2024 – December 31, 2024 – 15%

c. For state-developed measures, please briefly describe how the measure was developed?

Screening and referral for Social Determinants of Health Needs:
The clinical team designing M-QIP's Reverse Integration program recognized that the health of their patients was impacted by a variety of underlying social conditions including homelessness and food insecurity. The development of a comprehensive process of screening and referral to address social determinants of health needs was identified as an integral aspect of treating the whole patient. A review of NQF and NCQA quality measures show that this is an area of emerging quality measurement. Lack of national standards and the developmental nature of this specific program led the state to focus on expansion of screening as the measure of improvement for this aspect of M-QIP. Clinical teams will assure alignment with other work underway by working to partner with agencies such as CRISP who have developed a Social Determinants of Health eReferral Tool.

Average Wait-Time in Days

The eligible provider organization has utilized Average Wait-Time in Days as an internal measure of patient access for many years. The statistics have been used to develop goals for improvement and inform planning for staffing. The historical internal statistics for wait-time demonstrated this to be an area in which improvements to patient access and satisfaction could be made.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☒ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

January 1, 2022 - December 31, 2024

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The payment would result in a 72% increase to Medicaid reimbursement for all Medicaid managed care services eligible for supplemental payments, which equates to $56.38 on average per CPT code unit of service for PY4. Redetermined annually

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

MDH will issue the program payments quarterly to the MCOs, who will distribute the directed payments to FPI at the end of each quarter. Following the end of the program year, quality measurements will be assessed and reconciliation to actual units will be performed.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

Using a uniform increase tied to services under the contract rating period, the total M-QIP payments are equal to the difference between the eligible provider's negotiated Medicaid rates with MCOs and their average commercial rate (ACR) for the actual utilization in the prior contract year for enrollees covered under the contract. Average commercial rate (ACR) demonstrations show that enhanced payment is made up to the amount of payment allowed by the top (generally five) commercial payers, including copays and deductibles, for each service (by CPT billing code) provided by the eligible provider group for the enhanced payment, the state finds the determination of the directed payment to be appropriate and reasonable for eligible provider group.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☒ professional services at an academic medical center
- ☒ primary care services
- ☒ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☒ Other: • Doctor of Medicine • Doctors of Osteopathy • Certified Registered Nurse Anesthetists (CRNAs) • Certified Registered Nurse Practitioners • Physician Assistants • Certified Nurse Midwives (CNMs) • Cli

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Qualifying Criteria includes the following below:

Physicians and other eligible professional service practitioners as specified in section B below who are employed by or affiliated with a state-owned university. To qualify for the supplemental payment, the physician or professional service practitioner must be:
1. licensed by the State of Maryland; and
2. enrolled as a Maryland Medicaid provider; and
3. employed by or affiliated with a state-owned university

The only eligible physicians and professional service practitioners are employed by the University of Maryland or by the University of Maryland Faculty Physicians, Inc (FPI).

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The provider class defined in Question 20b, are essential providers to improve access in the West Baltimore area and Prince George's County, which are both designated high-needs geographic Health Professional Shortage Area (HPSA) for primary care as well as a medically underserved area. The initiatives defined through the M-QIP will expand the number and variety of providers serving West Baltimore and Prince George's County through innovative approaches to care.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The state directed payment is a uniform percentage increase. MDH will require that Medicaid MCOs provide the same percentage increase—172% of Medicaid rates—to all Qualifying Provider Types that meet the eligibility criteria for professional services.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Physicians and professional service Practitioners employed by the University of Maryland or by the University of Maryland Faculty Physicians, Inc (FPI).	84.00%	57.00%			141.00%
b.	0.00%	0.00%			0.00%
c.	0.00%	0.00%			0.00%
d.	0.00%	0.00%			0.00%
e.	0.00%	0.00%			0.00%
f.	0.00%	0.00%			0.00%
g.	0.00%	0.00%			0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☒ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The data source utilized to determine the analysis in Question 23 is the eligible provider's ACR%, Average Commercial Reimbursement and Medicare Equivalent Reimbursement. Utilizing the Medicare Physician Fee Schedule and the Clinical Laboratory Fee Schedule the eligible provider's data is repriced to Medicare resulting in the Medicare Equivalent Reimbursement. Following repricing, all eligible provider's Average Commercial Reimbursement, Medicare Equivalent Reimbursement, and Base Medicaid Reimbursement are aggregated across the eligible providers in the class. Average Base Payment Level from Plans to Providers (absent the SDP) is determined by dividing the Base Medicaid Reimbursement by Medicare Equivalent Reimbursement. Effect on Total Payment Level of State Directed Payment (SDP) is determined by dividing the Total State Directed Payment by the Medicare Equivalent Reimbursement.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

In alignment with existing CMS guidance Medicaid Qualified Practitioner Services – Methodologies for Enhanced Payment Made to Physicians and Practitioners Associated with Academic Medical Centers and Safety Net Hospitals and Upper Payment Calculation, the state's process for determining that the proposed directed payment is appropriate and reasonable involves analysis to ensure payment reflects the difference between Medicaid and Commercial rates and that payment at commercial reimbursement is not exceeded with the supplemental payment.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Please see attachment "Section IV_Question 29a_MCO Grant Agreement_CY2023_M-QIP"

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Maryland_HealthChoice_20230101-20231231_Certification_20221110	11/29/2022	Yes	pages 33 - 35
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Separate payment terms offer administrative simplicity to the state agency administering the directed payments, ease of tracking and verification of accurate payment for providers from the MCOs and reduces burden on MCOs by limiting the need to update systems to integrate and account for inclusion of directed payment in monthly cap rates and ensuring that PMPMs impacted by the directed payment are captured correctly and corresponding directed payment occurs.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. University of Maryland, Baltimore (UMB)	State entity	$ 13,410,970.00	No	$247M	Yes
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://health.maryland.gov/mmcp/healthchoice/Pages/quality_strategy.aspx
- **b.** The effective date of quality strategy. August 1, 2015

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year): Dec-22
- **b.** Note any potential changes that might be made to the goals and objectives.

Currently out for public comment, draft has been submitted to CMS. Final will depend in part on stakeholder and CMS input, please see attached updated draft.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Improve the quality and health care performance continually using evidenced-based methodologies for evaluation		6, 33,34
b. Compare Maryland's results to national and state performance benchmarks to identify areas of success and improvement		6, 33,34
c. Reduce administrative burden on the MCOs and the program overall		6, 33,34
d. Assist the Department with setting priorities and responding to identified areas of concern with the Health Choice's participant population	Note: The page numbers referenced are related to the Quality Strategy from August 2015. The state is working on an updated Quality Strategy and intends to submit to CMS by Dec. 2022.	6, 33,34

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

M-QIP fully aligns with and supports the goals and objectives of Maryland's quality improvement strategy as well as the goals laid out in Maryland's Total Cost of Care Model underway with CMMI. The three domains described in question 11 are designed to impact the three key health priorities identified by the Maryland Department of Health (MDH), Maryland Opioid Operational Command Center, and the Health Services Cost Review Commission: including 1) Opioid Mortality, 2) Diabetes Prevention and Management and 3) Child Health – specifically the impact of asthma. The metrics by which M-QIP will be evaluated closely support the principles of care transformation which are the foundation of Maryland's quality improvement strategy.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Reference the attached in Question 12 / Table 1.				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Attached as "Section VII_Question43c_M-QIP Infrastructure Activities Report PY1" and "Section VII_Question43c_M-QIP Infrastructure Activities Report PY2" Evaluation findings will be made available to CMS once they are complete in 2023.