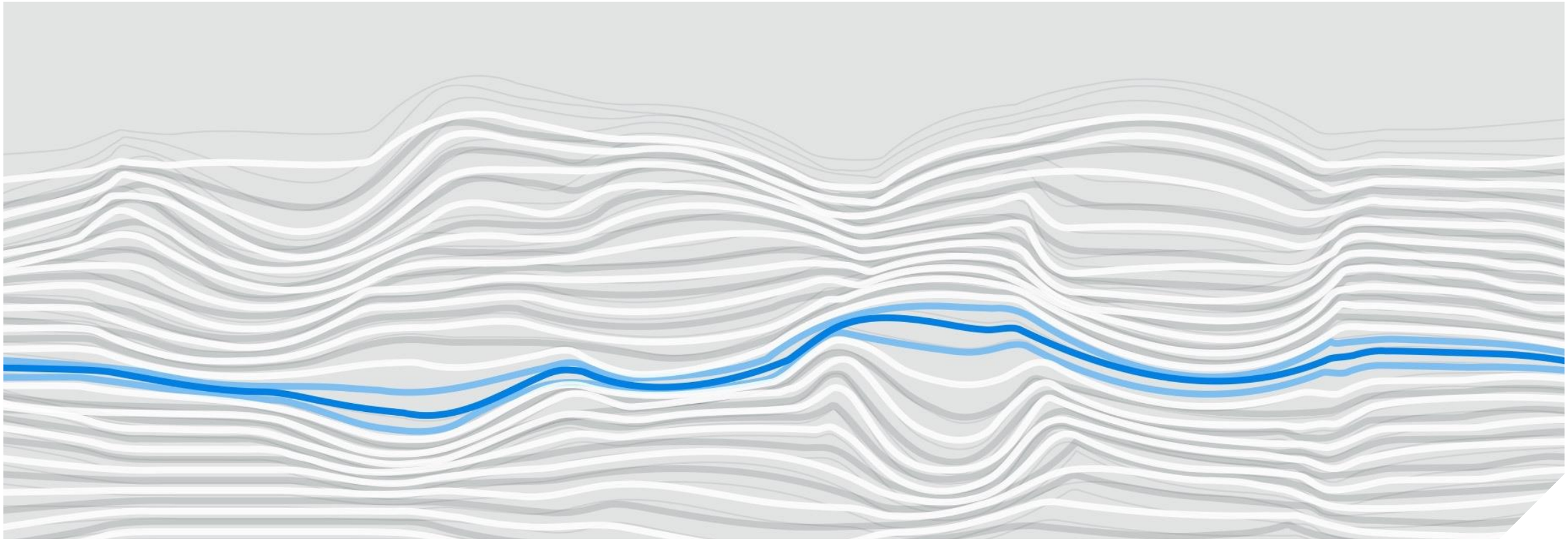
Milliman

Oklahoma Health Care Authority

Preliminary Supplemental Hospital Offset Payment Program (SHOPP) Design

April 20, 2023

Draft & Preliminary



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Background

Background

- Oklahoma Senate Bill 1337 (2022) mandates that supplemental payment levels must be maintained or increased with the implementation of a managed care delivery system for Oklahoma's Medicaid program.
- Additionally, Oklahoma Senate Bill 1396 (2022) mandates that the Oklahoma Health Care Authority (OHCA) increase payments under the managed care Supplemental Hospital Offset Payment Program (SHOPP) to the equivalent of 90% of the average commercial rate.
  - Modeling of managed care SHOPP payments (described further in later slides) is based on historical FFS claims for members in managed care eligible aid categories and health programs.
  - For the portion of members remaining in FFS Medicaid, SHOPP payments will be subject to current FFS SHOPP methodologies and will not increase to the equivalent of 90% of the average commercial rate.
- In response to these legislative mandates, OHCA has engaged Milliman to support evaluation of design options, analytical modeling, stakeholder engagement, and preprint development for directed payment arrangements that will be effective at the time that OHCA implements the new managed care delivery system on April 1, 2024.

Statutory Requirements

Managed Care Payment Pool Calculation

- Oklahoma Senate Bill 1396 (2022) specifies certain methodologies to be used by OHCA to establish payment pools and distribute quarterly managed care SHOPP payments
  - Amends Oklahoma Statutes Title 63 Section 3241.4.F.2 to calculate the managed care portion of SHOPP payments (referred to as the “managed care gap”) as the difference between:
    - Ninety percent (90%) of the average commercial rates benchmark for hospital inpatient and outpatient services provided to Medicaid managed care enrollees and
    - The total amount of Medicaid managed care base rate claims payments for hospital inpatient and outpatient services provided to Medicaid managed care enrollees.
  - Also amends Oklahoma Statutes Title 63 Section 3241.4.F.4 to define separate managed care SHOPP payment pools to be established by class of service and provider:
    - A hospital inpatient managed care payment pool established from funds derived from the managed care gap for inpatient services,
    - A hospital outpatient managed care payment pool established from funds derived from the managed care gap for outpatient services, and
    - A critical access hospital payment pool established from funds transferred from the pools defined above.

Statutory Requirements

Allocation of Managed Care Payment Pools

- Oklahoma Senate Bill 1396 (2022) amends Oklahoma Statutes Title 63 Section 3241.4.F.5 through 3241.4.F.7 to direct OHCA to distribute the managed care SHOPP payment pool amounts quarterly based on the following methodologies:
  - A per-discharge uniform add-on amount for the hospital inpatient managed care payment pool,
  - A uniform percentage add-on amount for the hospital outpatient managed care payment pool,
  - The estimated amount calculated by OHCA, not to exceed billed charges, for each critical access hospital.
- The bill provides OHCA with the authority to use “good-faith reasonable estimates if complete data does not exist or is not available” in the calculation of the managed care SHOPP payment pools and quarterly distribution amounts.
- The bill further recognizes that any calculation of managed care SHOPP payments is subject to approval by CMS, which has codified the approval criteria for state directed payments in 42 CFR §438.6(c) and has promulgated additional guidance in rule making, a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, a State Medicaid Directors Letter, and information published on the Medicaid.gov website.

State Directed Payments: Intro to Regulatory Framework

- 42 CFR § 438.6(c) allows states to require managed care plans to make **specified payments to providers** that **support delivery system and provider payment reforms**
  - Provides a permissible mechanism for making state directed payments, including **supplemental payments** (referred to as "**separate payment terms**") in managed care programs
- CMS guidance regarding approval of the "Preprint" form, which is the application for State Directed Payment arrangements, requires that states must do the following in their proposed arrangements:

Base payments on **utilization and delivery of services** under the contract for the applicable rating period	Direct expenditures **equally**, and using the **same terms of performance**, for each class of eligible providers	Include an **evaluation plan** to measure the degree to which the arrangement advances at least one of the goals and objectives in the state's quality strategy	Receive approval on an **annual basis** - even for expected multi-year arrangements	Not condition provider participation on entering into or adhering to intergovernmental transfer (IGT) agreements

Proposed Design

Proposed Design

Overview of Fixed Pool Approach

Parameter	Note

Type of Directed Payment Arrangement	• Fee schedule arrangement:
	  • Uniform dollar increase for inpatient hospital services
	  • Uniform percentage increase for outpatient hospital services

Classes of Services and Providers	• Two separate classes of services:
	  • Inpatient hospital services
	  • Outpatient hospital services
	• Separate classes of providers for Critical Access Hospitals (CAHs) vs. all other eligible hospitals
	• OHCA is also evaluating potential separate classes for NSGO vs. private hospitals

Managed Care Gap (Payment Pool) Calculation	• Establish each class's total contract year payment pool prospectively by:
	  • Calculating each class's managed care gap based on the difference between base Medicaid payments and 90% of commercial payment equivalent using a 12-month period of historical claims experience (October 1, 2021, through September 30, 2022)
	  • Grossing up the calculated difference by a factor of 125% to align with the anticipated initial 15-month contract period of Oklahoma's new managed care program (April 1, 2024, through June 30, 2025)
	• Limit Medicaid claims experience to members in aid categories / health programs eligible for managed care

Payment Distribution	• Pay 20% of each class's pool to the eligible providers each quarter, with distribution of payments as follows:
	  • **Inpatient services:** Based on each hospital's proportion of historical Medicaid inpatient discharges
	  • **Outpatient services:** Based on each hospital's proportion of historical Medicaid outpatient payments
	• Payments to a given provider are <u>not</u> floored at or otherwise based on historical SHOPP payments made under OHCA's FFS Medicaid program

Proposed Design

Illustration of Fixed Pool Approach

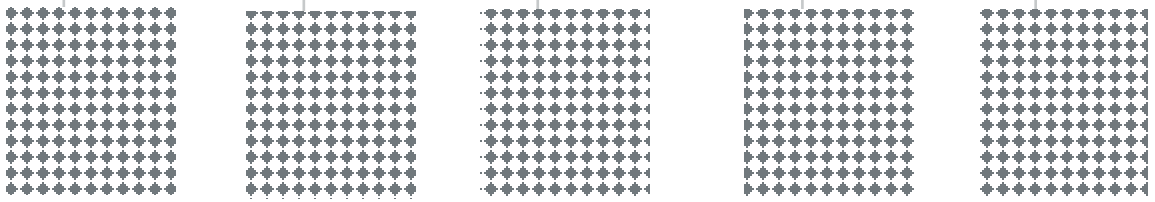
Separate Payment Pool by Class of Service and Provider

Managed Care Gap

Quarterly Directed Payment

1 **2** **3** **4** **5**

Quarterly Hospital Directed Payments



Allocation Basis

Prospectively established fixed payment pool for each class of services and providers for 15-month initial contract period

Pay 20% of each class's pool to the eligible providers each quarter

Inpatient services: Based on each hospital's proportion of historical Medicaid inpatient discharges
Outpatient services: Based on each hospital's proportion of historical Medicaid outpatient payments

Proposed Design

Reconciliation and Quality Framework

Parameter	Note
Reconciliation Process	• Annual settlement to contract period utilization after there is sufficient encounter data runout following the end of the contract period • Reconciliation process is anticipated to be limited to potentially redistributing a given payment pool across qualifying hospitals within that pool • Reconciliation process is not anticipated to redistribute funding across payment pools or otherwise impact the size of the payment pool for each class of services or providers. • Utilization used in the reconciliation will be limited to in-network services – i.e., services where the hospital is in-network for the specific managed care plan that covers the patient • OHCA is exploring options to establish a corridor to mitigate the potential for and potential size of any reconciliation adjustments

Quality Framework	• Milliman is working with OHCA to identify quality goals and objectives that align with OHCA's quality strategy
	• Core Set measures recommended by CMS and under consideration by OHCA for inclusion in the evaluation plan include:
	  • Plan All-Cause Readmissions (PCR-AD)
	  • PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)
	  • PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
	  • PQI 08: Heart Failure Admission Rate (PQI08-AD)
	  • PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)
	• Quality goals, objectives, and measures are not anticipated to impact payment amounts (either for individual providers or in total) in the first year of the SHOPP directed payment.

Proposed Design

Estimating Commercial Payment Equivalents for Managed Care Gap Calculation

Commercial Benchmark Data Source

- Commercial claims experience from Milliman's Consolidated Health Cost Guidelines™ (HCG) Sources Database Plus (CHSD+)
- Several national and regional health plans contribute their annual enrollment and claims detail to the CHSD+

Calculation of Commercial Benchmarks

- Reliance on claims data for approximately **$1.5 billion in commercial allowed amounts** for inpatient and outpatient hospital services provided to individuals residing in Oklahoma from March 2021 through February 2022
- Calculation of commercial allowed-to-billed ratios by Milliman HCG service line and geographic area

Calculation of Commercial Payment Equivalents

- Multiply reported billed charges in Medicaid claims experience by commercial allowed-to-billed ratios
- Billed charges for outpatient claim lines identified as denied in Oklahoma's MMIS and billed charges for claims with $0 in total reported allowed amount will be excluded for purposes of calculating commercial payment equivalents, to better align with basis of CHSD+ data

Proposed Design

Milliman Facility Inpatient (FIP) and Outpatient (FOP) Service Lines

MILLIMAN SERVICE LINES	
FIP Medical	FOP Radiology - CT/MRI/PET - MRI
FIP Rehabilitation	FOP Radiology - CT/MRI/PET - PET
FIP Surgical	FOP Pathology/Lab
FIP Psychiatric - Hospital	FOP Pharmacy - General
FIP Psychiatric - Residential	FOP Pharmacy - Chemotherapy
FIP Substance Use Disorders - Hospital	FOP Cardiovascular
FIP Substance Use Disorders - Residential	FOP PT/OT/ST
FIP Mat Norm Delivery	FOP Psychiatric - Partial Hospitalization
FIP Mat Norm Delivery - Mom/Baby Combined	FOP Psychiatric - Intensive Outpatient
FIP Mat C-section Delivery	FOP Substance Use Disorders - Partial Hospitalization
FIP Mat C-section Delivery - Mom/Baby Combined	FOP Substance Use Disorders - Intensive Outpatient
FIP Well Newborn - Normal Delivery	FOP Other - General
FIP Well Newborn - C-section Delivery	FOP Other - Blood
FIP Well Newborn - Unknown Delivery	FOP Other - Clinic
FIP Other Newborn	FOP Other - Diagnostic
FIP Maternity Non-Delivery	FOP Other - Dialysis
FIP SNF	FOP Other - DME/Supplies
FOP Observation - Without ED	FOP Other - Treatment/Specialty Services
FOP Observation - With ED	FOP Other - Pulmonary
FOP Emergency Department	FOP Other - Urgent Care
FOP Surgery - Hospital Outpatient	FOP Preventive - General
FOP Surgery - Ambulatory Surgery Center	FOP Preventive - Colonoscopy
FOP Radiology General - Therapeutic	FOP Preventive - Mammography
FOP Radiology General - Diagnostic	FOP Preventive - Lab
FOP Radiology - CT/MRI/PET - CT Scan	

Next Steps

Next Steps

- Complete initial modeling of managed care gap and hospital distributions for each service and provider class
- Finalize design
  - Provider classes
  - Distribution methodology
  - Reconciliation process
  - Quality goals, objectives, and metrics
- Preprint submission to CMS

Limitations

Milliman prepared these materials for the specific purpose of supporting discussion of the Directed Payment Design and Implementation Support scope of work with the Oklahoma Health Care Authority (OHCA), the Oklahoma Hospital Association, and hospital representatives. This material should not be used for any other purpose.

The information contained in this material is preliminary and subject to change based on the availability of additional data and information, final OHCA policy decisions, and the CMS approval process. The final design of the managed care SHOPP directed payments may vary significantly from the information presented in this material.

This material has been prepared solely for the use and benefit of OHCA, and it is only to be relied upon by OHCA. Milliman does not intend to benefit, and assumes no duty or liability to, any third party recipient of its work. This work should only be reviewed in its entirety.

In preparing this material, we relied on guidance and information provided by OHCA and other sources, including documentation supporting the development of Oklahoma's managed care program, other Oklahoma Medicaid program background documents, documentation and prior modeling related to SHOPP and Level I Trauma supplemental payments in Oklahoma's Medicaid FFS program, documentation and prior modeling of potential future SHOPP and Level I Trauma directed payments under a new managed care program, and other information. We have also relied on approval criteria for state directed payments in 42 CFR §438.6(c) and additional Centers for Medicare and Medicaid Services (CMS) guidance for the design of state directed payments in rule making, the 438.6(c) Preprint form, a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, a State Medicaid Directors Letter, and information published on the Medicaid.gov website. We accepted this information without audit, but reviewed the information for general reasonableness. If the data or other information provided by OHCA or other sources is inaccurate or incomplete, our results will be likewise inaccurate or incomplete.

Nick Bauman is a Senior Consulting Actuary at Milliman and is a member of the American Academy of Actuaries and meets the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of his knowledge and belief, this communication is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with OHCA signed on January 19, 2023, apply to this material and its use.

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Thank you

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