IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

MISSOURI HOSPITAL ASSOCIATION,	)	
Petitioner/Plaintiff,	)	
v.	)	**Case No.**
MISSOURI DEPARTMENT OF SOCIAL SERVICES, **Serve: Missouri Department of Social Services** **221 W. High Street, Room 230** **Jefferson City, MO 65101**	)	**Division:**
JENNIFER TIDBALL, In her official capacity as Acting Director of the Missouri Department of Social Services, **Serve: Jennifer Tidball** **221 W. High Street, Room 230** **Jefferson City, MO 65101**	)	
MO HealthNet DIVISION, **Missouri Department of Social Services,** **Serve: MO HealthNet Division** **615 Howerton Ct,** **Jefferson City, MO 65109**	)	
KIRK MATHEWS, in his official capacity as Acting Director of the MO HealthNet Division **Missouri Department of Social Services** **Serve: Kirk Mathews** **MO HealthNet Division** **615 Howerton Ct,** **Jefferson City, MO 65109**	)	
Respondents/Defendants.	)	

VERIFIED PETITION
FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

In November 2020, Todd Richardson ("Richardson"), then Director of the MO HealthNet Division ("MHD" or "Defendant MHD"), Missouri Department of Social Services, conveyed to Missouri Hospital Association ("Plaintiff" or "MHA") staff MHD's intention to implement the conversion of managed care Full Medicaid Pricing ("FMP") payments to directed payments for both inpatient and outpatient services because of the Centers for Medicare & Medicaid Services ("CMS") concerns with the current managed care payment structure. MHD staff indicated CMS had expressed those concerns in the Fall of 2019.

In February 2021, having provided no additional information or answers to MHA's questions about the department's plans, MHD advised MHA staff of a significantly revamped plan for implementing the directed payments. The original proposal did not allow for any payment rate negotiations between hospitals and the managed care plans. Richardson further advised MHA Staff that MHD intended to implement the policy change by contract amendment, and not through the promulgation of Regulations or "Rules".

MHA Staff was further advised by Richardson that the directed payment rates will include hospital-specific minimum and maximum contracted payment rates expressed as percentages of total payment rates in MHD's fee-for service ("FFS") system, inclusive of the FFS per diem and Medicaid add-ons for inpatient services, and the FFS payment and direct Medicaid add-ons for outpatient services. Despite these claims, the payment rates in the fee-for-service system will differ from the presumed fee-for-service rates used in the state's proposed directed payment methodology.

These directed payments are to provide a range of reimbursement amounts for each hospital within a particular hospital class in which the health plans can negotiate payment rates for inpatient and outpatient hospital services. Under the second iteration of a directed payment policy,

negotiated reimbursement must be inclusive of amounts previously identified as FMP payments, and must be tied to inpatient and outpatient hospital utilization.

MHD indicates their directed payment proposal is budget neutral. Mercer, the MO HealthNet's Actuary, distributed a hospital specific spreadsheet that shows otherwise. In the aggregate, hospitals are projected to lose approximately $45 million between inpatient and outpatient services with very limited notice. MHA and its members have reason to believe the fiscal impact will be greater.

Plaintiff has confirmed that in spite of MHA advising the Defendants of the need for Defendants to promulgate a Rule that establishes the contract requirements executed between the managed care plans and the providers,[1] the Defendants intend to adopt the change through amendments to the State's contracts with the managed care plans, and not in compliance with Section 208.153, RSMo or Chapter 536 RSMo, which requires any policy of general applicability to be properly promulgated pursuant to, and in compliance with Chapter 536 RSMo. Section 208.153, RSMo requires MHD to "define the reasonable costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits" by rule.

This is a policy initiative that if implemented as planned by MHD, through contract amendments and not through the statutorily required rulemaking process that requires transparency, public input and legislative oversight, will significantly cut payments to many Missouri hospitals.

Plaintiff and Relator Missouri Hospital Association ("MHA" or "Plaintiff") brings this Petition against the Missouri Department of Social Services ("DSS"), Acting Director of the

[1] Letter, March 2, 2021, to Todd Richardson, Director MO HealthNet Division, from Daniel Landon and Kim Duggan, Missouri Hospital Association's Senior V.P. of Governmental Relations and Vice President of Medicaid and FRA respectively, attached hereto as **Exhibit 1**, and incorporated herein.

Missouri Department of Social Services Jennifer Tidball ("Tidball") in her official capacity, the MO HealthNet Division, a Division of DSS ("MO HealthNet"), and Kirk Mathews in his official capacity of the Acting Director of the MO HealthNet Division ("Mathews"), seeking a Declaratory Judgment, Temporary Restraining Orders, Preliminary and Permanent Injunctions, Writs of Mandamus and/or Prohibition and other relief, and in support states as follows:

PARTIES

1. Missouri Hospital Association ("MHA") is a duly-formed corporation authorized to do business within the state of Missouri pursuant to Chapter 355 pertaining to Not-for-Profit corporations.

2. Its offices are located at 4712 Country Club Drive, Jefferson City, Missouri, 65109-4541.

3. As a nonprofit membership association MHA represents nearly all acute care hospitals in the state, as well all of the federal and state hospitals and rehabilitation and psychiatric care facilities.

4. As stated in its Articles of Incorporation, attached hereto as **Exhibit 3**, and incorporated herein, MHA's purpose:

> shall be to promote the health and welfare of the citizens of Missouri by assisting member institutions in offering high quality health care services. The Association shall serve as an advocate and representative of hospitals in improving the methods of health care delivery and financing. The Association shall promote efficiency and effectiveness in the delivery and financing of health care services to patients. It shall encourage continuing professional education of the public, promote health careers, and maintain such affiliations as shall be mutually beneficial, cooperate with other organizations as appropriate and provide leadership for hospitals.

5. Defendant Missouri Department of Social Services is an agency of the State of Missouri established under Article IV, Section 37 of the Missouri Constitution, and §660.010, RSMo, with its official place of business in Cole County, Missouri.

6. DSS's headquarters are located at 221 W. High Street, Room 230, Jefferson City, MO 65102.

7. Jennifer Tidball ("Tidball") is the Acting Director of the Missouri Department of Social Services and has oversight and authority regarding the procurement of service contracts, policies, and rulemaking for the Department.

8. Ms. Tidball is being named in her official capacity.

9. Defendant MO HealthNet Division ("MHD" or "Defendant MHD") is an agency of the State of Missouri, established within the Department of Social Services pursuant to §208.201.1, RSMo, with its official place of business in Cole County, Missouri.

10. MHD's headquarters are located at 615 Howerton Ct., Jefferson City, MO 65109.

11. The MHD is the agency of the State of Missouri that is statutorily charged with the obligation to implement the State of Missouri's Medicaid program for children and their families in Missouri.

12. MHD is the state agency assigned to administer payments to providers under the MO HealthNet Program.

13. Pursuant to § 208.001, RSMo, MHD is authorized to promulgate rules, including emergency rules if necessary, to implement the provisions of the Missouri continuing health improvement act, including but not limited to the form and content of any documents required to be filed under such act.

14. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in the Missouri continuing health improvement act, shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028.

15. Kirk Mathews is the Acting Director of MHD, is named in his official capacity, and whose office is located at 615 Howerton Ct., Jefferson City, MO 65109.

JURISDICTION AND VENUE

16. The circuit court has original jurisdiction over all cases and matters, civil and criminal. Mo. Const. Art. V, §14.

17. This Court has personal jurisdiction over the DSS and MHD as they are both state agencies and instrumentalities of the State of Missouri.

18. The Court has personal jurisdiction over the named Defendants/Respondents as each is acting on behalf of her respective state agency in their official capacities within the State of Missouri.

19. This Court has the subject matter jurisdiction and authority to hear all matters related to the constitutionality and lawfulness of an agency's actions under §536.150, RSMo. Chapter 526, and Chapter 527 of the Revised Statutes of Missouri, and Missouri Rules 87 and 92

20. Additionally, this Court has the authority and jurisdiction to issue original writs to compel ministerial acts or to prohibit an official from exceeding his or her authority and jurisdiction in their official capacity under Article V, Sec. 14 of the Missouri Constitution.

21. Among the powers granted to MO HealthNet Division under §208.201.6(1), RSMo, is the power to sue and be sued.

22. This action challenges the validity of actions of Defendants Missouri Department of Social Services and MO HealthNet Division seeking to implement a new agency statement of general applicability that implements, interprets, and/or prescribes law or policy, and/or that describes the procedure or practice requirements of the agency that directly affect the right and

ability of MHA's members which participate in the MO HealthNet Program to be reimbursed for providing covered inpatient and outpatient services to eligible MO HealthNet enrollees.

23. MHA is not required to exhaust any administrative remedy because administrative agencies lack the authority to grant the relief sought, the only issue presented for adjudication is a question of law, and requiring the exhaustion of administrative remedies would result in undue prejudice because of the irreparable harm that will be suffered by MHA's members if they are unable to secure immediate judicial consideration of their claims.

24. Venue is proper in the Circuit Court of Cole County, Missouri, pursuant to §508.010 and §536.050, RSMo., and is also independently proper in the Circuit Court of Cole County, Missouri, as the officials whose acts must be compelled or restrained are located within Cole County.

FACTS COMMON TO ALL COUNTS

25. In Missouri, the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq., are known as "MO HealthNet".

26. Medicaid also means "MO HealthNet" wherever it appears throughout Missouri Revised Statutes.

27. The title "division of medical services" also means "MO HealthNet division".

28. The mission of the DSS is "to lead the nation in building the capacity of individuals, families, and communities to secure and sustain healthy, safe, and productive lives."

29. In November 2020, Todd Richardson ("Richardson"), then Director of the MO HealthNet Division ("MHD" or "Defendant MHD"), Missouri Department of Social Services, conveyed to Missouri Hospital Association ("Plaintiff" or "MHA") staff, of MHD's intention to

implement the conversion of managed care Full Medicaid Pricing payments to directed payments for both inpatient and outpatient services because of the Centers for Medicare & Medicaid Services ("CMS") concerns with the current managed care payment structure.

30. Richardson further advised MHA Staff that MHD intended to implement the policy change by contract amendment, and not through the promulgation of Regulations or "Rules".

31. In February 2021, MHD informed MHA staff of a significantly revamped methodology for implementing the conversion to directed payments.

32. Through a letter dated March 2, 2021, ("MHA Letter"), attached hereto as **Exhibit 1,** and incorporated herein, the MHA, by and through Daniel Landon, Senior V.P. of Governmental Relations and Kim Duggan, Vice President of Medicaid and FRA, advised Todd Richardson, then Director of the MHD, of their alarm that the MHD intended to "implement a significant change in payment methodology effective July 1" but had not yet shared its proposal in writing nor supplied aggregate or hospital specific data or details.

33. The MHA Letter included specific questions concerning the policies the MHD was developing concerning Provider Classes, Benchmarks, the Alternative Fee Schedule, Transparency and Reporting and Fee for Service Impact. Those questions had previously been sent to Richardson in December 2020, to which MHA received no response.

34. It is important to note that a significant portion of the capitated rates paid to the managed care plans for hospital services are paid with funds generated through Missouri's Federal Reimbursement Allowance ("FRA"), a state provider tax.

35. The FRA surpasses all but two of the largest sources of general revenue.

36. MHA Staff was further advised by Richardson that the directed payments will include hospital-specific minimum and maximum contracted payment rates expressed as

percentages of total payment rates in MHD's fee-for service ("FFS") system, inclusive of the FFS per diem and Medicaid add-ons for inpatient services, and the FFS payment and direct Medicaid add-ons for outpatient services. Despite these claims, the payment rates in the fee-for-service system will differ from the presumed fee-for-service rates used in the state's proposed directed payment methodology.

37. These directed payments are to provide a range of reimbursement amounts for each hospital within a particular hospital class in which the health plans can negotiate payment rates for inpatient and an outpatient hospital services.

38. Under this new directed payment policy, negotiated reimbursement must be inclusive of amounts previously identified as FMP payments, and must be tied to inpatient and outpatient hospital utilization.

39. MHD indicates their directed payment proposal is budget neutral. Mercer, MO HealthNet's Actuary, distributed a hospital specific spreadsheet that shows otherwise. In the aggregate, hospitals are projected to lose approximately $45 million between inpatient and outpatient services with very limited notice. MHA and its members have reason to believe the fiscal impact will be greater.

40. Plaintiff has confirmed that in spite of MHA advising the Defendants of the need for Defendants to promulgate a Rule that establishes the payment methodology for the contracts executed between the managed care plans and the providers,[2] the Defendants intend to adopt the change in policy through amendments to the State's contracts with the managed care plans, and

[2] Letter, March 2, 2021, to Todd Richardson, Director MO HealthNet Division, from Daniel Landon and Kim Duggan, Missouri Hospital Association's Senior V.P. of Governmental Relations and Vice President of Medicaid and FRA respectively, attached hereto as **Exhibit 1**, and incorporated herein.

not in compliance with Chapter 536 RSMo, which requires any policy of general applicability to be properly promulgated pursuant to, and in compliance with Chapter 536 RSMo.

41. In fact, on Friday June 4, 2021, an email, attached hereto as **EXHIBIT 2**, and incorporated herein, was received by Ms. Kim Duggan, Missouri Hospital Association's Vice President of Medicaid and FRA ("Duggan"), from Mr. Tony Brite, Chief Financial Officer for the Defendant MO HealthNet ("Brite"), in which Brite advised Duggan that:

> MHD is converting the managed care program Full Medicaid Pricing (FMP) payment to directed payments for inpatient and outpatient hospital services effective July, 2021 based on a directive from the Centers for Medicare & Medicaid Services (CMS). This policy directive was reiterated in a State Medicaid Director Letter ("SMDL") released on January 8, 2021.

42. Brite further advised Duggan that pursuant to federal rule[3] the Defendants have the ability to direct its health plans in how to pay network providers. *See* **EXHIBIT 2**.

43. He called such action by the Defendants as the establishment of a "directed payment program" which must comply with CMS regulations and overall reimbursement levels by hospital class compared to benchmarks such as FFS, Medicare and/or average commercial rates for reasonableness and be approved annually by CMS through a formal approval process. *Id.*

44. However, Brite advised Duggan "[t]hese directed payments are pending CMS review for compliance and reasonableness and may be subject to change." *Id.*

45. It is unclear what if anything in regard to the elements of the policy the Defendants have provided to CMS for CMS to approve the new State policy, the directed payments program.

46. Attached to Brite's email were four documents:

[3] 42 CFR §438.6(c)

47. The first document, attached hereto as **EXHIBIT 3**, and incorporated herein, contains the proposed language to form the managed care contract amendments on hospital directed payments and non-participating provider reimbursement.

48. The second document, attached hereto as **EXHIBIT 4,** and incorporated herein, is a Non-participating outpatient add-on exhibit.

49. The third document, attached hereto as **EXHIBIT 5,** and incorporated herein, is a Hospital inpatient rates exhibit.

50. The fourth document, attached hereto as **EXHIBIT 6**, and incorporated herein, are Amended directed payment documents.

51. Plaintiff, its members and the public do not know the basis for the Defendants' policy as to which hospital provider classes would be used under the proposed directed payment fee schedule methodology.

52. Plaintiff, its members and the public do not know the basis for the state's decision to assign a hospital to a provider class a hospital that meets the criteria of more than one provider class.

53. Plaintiffs and the public do not know if MHD will still be required to compare total payments to a benchmark like Medicare or commercial rates, and the basis for MHD's choice.

54. Nor do Plaintiffs nor the public know the results of such a comparison.

55. Plaintiff, its members and the public do not know how the direct Medicaid add-ons for outpatient services are reflected in the rate ranges under the directed payment methodology.

56. Neither the Plaintiff, its members, nor the Public know the basis for the policy as to the range of minimum and maximum payments, for each class of providers, and from which the providers and health plans shall be required to contract.

57. The Defendants have not provided reasonably available empirical data that includes an assessment of the effectiveness and the cost of any elements of the new policy, both to the state and to any private or public person or entity affected by such policy.

58. Further, defendants openly admit that CMS may disapprove the new policy, withhold funding, or direct certain amendments to the policy.

59. This policy initiative, if implemented as planned by MHD, through contract amendments and not through the statutorily required rulemaking process that requires transparency, public input and legislative oversight, will significantly cut payments to many Missouri hospitals.

60. CMS informed MHD in late 2019 that it should change its payment methodology.

61. Section 208.153, RSMo states: "Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein provided."

62. MHD has a statutory obligation to establish its payment methodologies by rule.

63. 536.010(6), RSMo, defines the term "Rule" as "each agency statement of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of any agency."

64. The definition goes on to define certain exceptions to this definition, however, none are applicable here.

65. MHD's conversion of managed Full Medicaid Pricing payments to directed payments for both inpatient and outpatient services b is an agency statement of general applicability that describes the organization, procedure and practice requirements of the agency.

66. MHD was put on Notice that their intention to implement the policy conversion of managed Full Medicaid Pricing payments to a directed payments program for both inpatient and outpatient services because of the Centers for Medicare & Medicaid Services ("CMS") concerns with the current managed care payment structure, would constitute the definition of a "Rule" under Chapter 536 RSMo.

67. Yet, MHD has not promulgated any such Rule.

COUNT I
DECLARATORY AND INJUNCTIVERELIEF

68. MHA incorporates by reference paragraphs 1 – 67 above.

69. Sec. 536.010(6), RSMo, defines the term "Rule" as "each agency statement of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of any agency."

70. Sec. 536.010(6), RSMo, defines the term "Rule" as "each agency statement of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of any agency."

71. The definition goes on to define certain exceptions to this definition, however, none are applicable here.

72. Yet, neither the Department of Social Services nor the MO HealthNet Division have followed the steps required by §536.021, RSMo, for duly promulgating a rule, to include, but not limited to, filing of a proposed order of rulemaking, holding public hearings on the proposed rule, accepting and addressing statements in favor or opposition to the proposed rule, and the filing of a final order of rulemaking.

73. MHD has not promulgated any such Rule, and was made aware of this prior to the bringing of this lawsuit.

74. The contract amendments MHD proposes to execute will be a statement of general applicability that implements, interprets, or prescribes law or policy of MHD, or that describes the organization, procedure, or practice requirements of MHD, and MHD will be outside of their statutory authority to direct the amendment of the contracts because of its failure to comply with §536.021 RSMo, its failure to properly adopt the policies that form the requirements of the contract, and such contract will be null and void without such authority.

75. Plaintiffs are entitled to recovery of a reasonable attorney fees and costs pursuant to §536.021, RSMo.

WHEREFORE the Missouri Hospital Association prays that this Honorable Court:

a. Declare that §536.021 RSMo, requires MHD and DSS to properly promulgate a Rule or Rules to effectuate the change in payment for service policy of the State Medicaid program before MHD may lawfully amend certain contracts for services between plans and providers can be authorized;

b. Grant Preliminary and Permanent Injunctive relief enjoining the Defendants from executing any contract amendments related to, or intended to implement, the change in payment for service policy and conversion of managed care Full Medicaid Pricing payments to directed payments for both inpatient and outpatient services, without first promulgating Rules in compliance with Chapter 536, and in particular 536.021 RSMo;

c. Issue a Writ of Mandamus directed to the named Respondents directing them to initiate the rule-making process pursuant to Chapter 536 RSMo before making any policy changes in the implementation of the conversion of managed care Full Medicaid Pricing payments to a system of directed payments for both inpatient and outpatient services;

d. Taxing the costs against Defendants;

e. Awarding Plaintiffs their reasonable attorney's fees and costs pursuant to §536.021, RSMo; and

f. Such further relief as the Court deems just and proper.

COUNT II

TEMPORARY RESTRAINING ORDER

76. MHA incorporates by reference paragraphs 1 – 75 above.

77. Defendants have confirmed, through Mr. Tony Brite's email of June 4, 2021, that in spite of MHA advising the Defendants of the need for Defendants to promulgate a Rule that establishes the contract requirements executed between the managed care plans and the providers,[4] the Defendants intend to adopt the change in policy requirements established by CMS on a contract by contract basis, and not in compliance with Chapter 536 RSMo, which requires any policy of general applicability to be properly promulgated pursuant to, and in compliance with Chapter 536 RSMo.

78. This is a policy initiative that if implemented as planned by MHD, through contract amendments and not through the statutorily required rulemaking process that requires transparency, public input and legislative oversight, will significantly cut payments to many Missouri hospitals.

79. Defendants have not provided a rational basis for even an "emergency action", let alone a need to ignore the requirements of Chapter 536, nor have they shown the need for a July 1, 2021, effective date, given their admission that CMS has not yet approved the new policy.

[4] Letter, March 2, 2021, to Todd Richardson, Director MO HealthNet Division, from Daniel Landon and Kim Duggan, Missouri Hospital Association's Senior V.P. of Governmental Relations and Vice President of Medicaid and FRA respectively, attached hereto as **Exhibit 1**, and incorporated herein.

80. Defendants have not followed procedures which comply with the protections extended by the Missouri and United States Constitutions.

81. Defendants have not followed procedures in the promulgation of this new policy that was best calculated to assure fairness to all interested persons and parties under the circumstances.

WHEREFORE, for the above enumerated reasons Missouri Hospital Association prays that this Court Issue a Temporary Restraining Order enjoining and prohibiting the Department of Social Services or MO HealthNet Division and all those acting in concert with Defendants, from implementing the policy conversion of managed care Full Medicaid Pricing payments to a system of directed payments for both inpatient and outpatient services solely through contract amendments, or from executing any contract amendments for such payments and services until further order of this court.

Respectfully Submitted,

SPENCER FANE LLP

/s/Joseph P. Bednar, Jr.
Joseph P. Bednar, Jr., MO #33921
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Attorneys for Petitioner/Plaintiff

STATE OF MISSOURI)
) SS
COUNTY OF COLE)

VERIFICATION STATEMENT

I, Kimberly Duggan, being first duly sworn upon my oath state that I am an authorized officer of Plaintiff/Petitioner Missouri Hospital Association and have been authorized by the Association to make this verification statement on its behalf. I have read the foregoing Petition and verify that the factual matters stated therein are true and accurate and based on my personal knowledge and belief.

Kimberly Duggan

Kimberly Duggan
Missouri Hospital Association

Subscribed and sworn to before me this 11th day of June 2021.

My Commission Expires: 1/20/2024.

Kelli D. Stiles

Notary Public

KELLI D. STILES
Notary Public - Notary Seal
Cole County - State of Missouri
Commission Number 12383363
My Commission Expires Jan 20, 2024

WSD User

kstiles

Exhibit 1 - March 2 2021 Letter to Todd Richardson(5007718.1).pdf

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MHA
Management Services

Herb B. Kuhn
President and CEO
P.O. Box 6766
Jefferson City, MO 65102

March 2, 2021

Todd Richardson
Director
MO HealthNet Division
Mo. Department of Social Services
P.O. Box 6500
Jefferson City, MO 65102

Dear Todd:

Thank you for the recent update regarding the proposed change to the current Full Medicaid Pricing arrangement. Although no presentation was available during the February 19, 2021, conference call, it is MHA's understanding that MHD now plans to rebase hospital per diem rates effective July 1, 2021, as it develops its Medicaid directed payment approach based on an alternative fee schedule. We are alarmed that it is already March and MHD still has not shared its proposal in writing nor supplied aggregate or hospital-specific data or details. As noted in the attached letter dated December 9, 2020, until we are able to share these details and the hospital-specific data with our members, we cannot speak to MHA's stance on the proposal.

As you requested, we have revised our questions previously submitted based on the limited information that was shared with us during the February 19, 2021, conference call. We would appreciate your prompt response.

PROVIDER CLASSES

Questions

1. How did MHD decide which hospital provider classes would be used under the proposed directed payment fee schedule methodology?

2. How did MHD decide how to assign to a provider class a hospital that meets the criteria of more than one provider class?

3. Is a hospital's classification subject to change mid-year if, for example, it terminates its teaching program or changes the number of licensed beds during a year?

BENCHMARKS

Question. Under MHD's revised proposal to rebase per diem rates, is MHD still required to compare total payments to a benchmark like Medicare or commercial rates? If so, what were the results?

DEVELOPMENT OF MHD'S PROPOSED ALTERNATIVE FEE SCHEDULE

Questions

1. Will MHD provide MHA with the hospital-specific detail used to support its revised proposal?

2. Will the rebased hospital per diem rates be based on cost reports ending in 2018 trended to SFY 2022 for all hospitals, or will MHD use the cost report currently used based on a hospital's status as a DSH Tier 1, DSH Tier 2 or safety net?

3. What trends will be applied to the base cost reports to calculate the rebased per diem and from what source will the trends be determined?

4. Will the Medicaid managed care share of the assessment be added to the rebased per diem rate? If not, how and for what time period will the Medicaid managed care share of the FRA assessment be reimbursed?

5. Will the managed care portion of the utilization adjustment be added to the rebased per diem rate?

6. It is our understanding that MHD will establish a range for each class of providers that hospitals and health plans can negotiate payments. How will the minimum/maximum range be determined for each class?

7. What is the proposed minimum/maximum range for each class?

8. How will hospitals that do not contract with one of the health plans be paid?

9. How will new facilities be paid prior to having their own hospital-specific cost report?

10. How will the managed care share of the outpatient FRA be paid?

11. How does the proposed alternative fee schedule methodology impact the capitated rates MHD pays to the health plans?

FUNDING

Comments

- It is essential the MHD and MHA work together to determine the appropriate amount of FRA that will be used to fund the capitated rates paid to the managed care plans under the proposed methodology.

- Using the FRA to fund payments for deliveries and low birth weight newborns weighing less than 1,500 grams causes significant payment delays; therefore, we recommend FRA funds not be used to fund these payments under the new methodology.

- Since out-of-state hospitals are not subject to the FRA assessment, we maintain our position that no FRA funds should be used to fund payments to out-of-state hospitals.

Question. Will MHD adjust capitated rates in the next rating period if managed care expenditures are less than anticipated (i.e., the managed care plans deny a significant number of days)? If so, when and how often would adjustments occur?

TRANSPARENCY AND REPORTING

Comments

- We understand that MHD plans to implement this new payment methodology through a managed care contract amendment. The impact of this change certainly has general applicability to hospitals and their reimbursement. As a result, we assert MHD should promulgate a regulation that would allow for industry-wide feedback through a formal comment process before implementation.

- We believe MHD should require the managed care plans to submit more complete and accurate claims data (i.e., an NPI that crosswalks to the state's Medicaid provider number, days, charges, revenue codes, ME code) that could be used for DSH audit purposes as the state transitions to the directed payment methodology. This would offer greater transparency and would provide the managed care claims data required for the DSH audits.

- It is essential the MHD and MHA work together to develop reports that will accurately reflect the hospital-specific managed care payments by funding source for each payroll.

Question. How will MHD ensure the managed care plans pay hospitals according to the new fee schedule? What is the appeal/remediation process if there is a dispute?

FEE-FOR-SERVICE IMPACT

Comment. We recommend exploring whether it would be advantageous to shift more of the FRA assessment to fund the fee-for-service payments and less to fund the managed care payments.

Questions

It is our understanding that MHD plans to rebase fee-for-service per diem rates effective July 1, 2021. Following are two related questions.

1. Will the rebased fee-for-service per diem rate include the FFS share of the assessment or will it continue to be paid as an add-on payment?

2. Will the fee-for-service portion of the utilization adjustment be added to the rebased per diem rate or will it continue to be paid as an add-on payment?

3. If MHD rebases the FFS per diem rates, how will it ensure the continuation of the out-of-state payment?

We look forward to receiving responses to these questions, as well as additional information about MHD's revised directed payment proposal. As further information is provided, we may have additional questions.

We would like to reiterate our concern that MHD is planning to implement a significant change in payment methodology effective July 1, but it has yet to provide MHA or its member hospitals a comprehensive proposal. We would urge MHD to delay implementation to allow time to thoroughly evaluate the proposal and provide sufficient notice to hospitals.

Sincerely,

Daniel Landon
Senior V.P. of Governmental Relations

Kim Duggan
Vice President of Medicaid and FRA

dl/kd:kh

c Tony Brite
Christina Jenks

WSD User

kstiles

Exhibit 2 - June 4 2021 Email from Tony Brite(5007719.1).pdf

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Hospital Directed Payments and Non-par Reimbursement [encrypt]

From: Brite, Tony
To: Kim Duggan
Cc: Mathews, Kirk, Garber, Bobbi, Logan, Rebecca L, Sutter, Connie M
Sent: 6/4/2021 2:04:08 PM6/4/2021 2:04:08 PM
Attachments: 2.6.19 Hospital Payments_Clean.docx 2.6.20 Non Par Hospitals_Clean.docx Hospital IP Rates.xlsx Non-Parti

Hello Kim,

As has been communicated in the last several months, MHD is converting the managed care program Full Medicaid Pricing (FMP) payments to directed payments for inpatient and outpatient hospital services effective July 1, 2021 based on a directive from the Centers for Medicare & Medicaid Services (CMS). This policy directive was reiterated in a State Medicaid Director Letter (SMDL) released on January 8, 2021. Prior to this directive and national guidance, CMS was withholding managed care rate approvals as far back as state fiscal year (SFY) 2018 placing federal matching funds and FMP funds at risk. To secure rate approval and federal funds for these rating periods and future periods, MHD must convert the managed care hospital reimbursements to directed payments by July 1, 2021. Per 42 CFR §438.6(c), a state Medicaid agency has the ability to direct its health plans in how to pay network providers. These directed payment programs must be approved annually by CMS through a formal approval process. CMS review of directed payments includes compliance with CMS regulations and overall reimbursement levels by hospital class compared to benchmarks such as FFS, Medicare and/or average commercial rates for reasonableness. Additionally, per regulation, payments must be tied to actual utilization. These directed payments are pending CMS review for compliance and reasonableness and may be subject to change. Failure to comply with approved directed payments could result in delaying approval of rates, risking federal matching funds and/or being assessed disallowances to be paid to CMS.

To support further understanding and transparency related to these directed payments, attached you will find the following documents:

- Managed care contract language on hospital directed payments and non-participating provider reimbursement
- Non-participating outpatient add-on exhibit
- Hospital inpatient rates exhibit
- Amended directed payment documents

Additional guidance from CMS in the January 8, 2021 SMDL can be found at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf."

Thank you,

Tony Brite
Chief Financial Officer
MO HealthNet Division
Missouri Department of Social Services

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Exhibit 3 - Proposed Contract Language(5007720.1).pdf

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2.6.19 Hospital Reimbursement

a. Hospital Classes

1) Effective July 1, 2021, health plans shall reimburse in-network hospitals for inpatient and outpatient services by hospital class as described in this section.

2) Hospital classes are defined to account for similar characteristics and follow the below hierarchy. Hospitals are attributed to only one provider class based on the hierarchy, and attribution is determined as of January 15th preceding the next July rating period. A hospital will remain in the attributed hospital class for the entirety of a rating period.

3) The hospital classes and hierarchy are defined as:

i. Children's Hospitals: defined based on the Missouri hospital's Medicare number starting with 2633.

ii. Federal Critical Access Hospitals (CAHs): defined based on the Missouri hospital's Medicare number starting with 2613.

iii. Specialty Hospitals: defined based on the Missouri hospital's Medicare number starting with either: 2620, 2621, 2622, 2630, 2641, 2642, 2643, or 2644.

iv. Teaching Hospitals: defined based on Missouri hospitals receiving GME payments.

v. 1-100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from cost report information.

vi. More Than 100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from cost report information.

b. Inpatient Hospital Reimbursement

1) Effective July 1, 2021, health plans shall reimburse hospitals for inpatient services based on the minimum and maximum percentages by hospital class applied to the inpatient alternative fee schedule, which is the approved State Plan Fee-for-Service total payments for inpatient hospital services (Fee-for-Service inpatient per diem plus the direct Medicaid add-on) published at ADD LINK.

2) Health plans may contract with hospitals at rates within the established minimum and maximum percentages associated with the applicable hospital class as outlined in the table below. No in-network hospital shall be paid below 100% of the alternative fee schedule, nor more than the maximum percentage for the applicable hospital class. Reimbursement rates must be all inclusive and paid based on utilization during the rating period.

Hospital Classes	Inpatient	
	Minimum Percentage of Alternative Fee Schedule	Maximum Percentage of Alternative Fee Schedule
Children's Hospital	100%	115%
Federal Critical Access Hospitals	100%	102%
Specialty Hospitals	100%	130%
Teaching Hospitals	100%	130%
1-100 Licensed Beds	100%	102%
More than 100 Licensed Beds	100%	110%

3) Health plans may utilize Alternative Payment Models that are more advanced in the provider risk continuum than paying on a per diem basis with advanced notification to the state agency. Overall pricing levels for these arrangements must be consistent with the inpatient hospital reimbursement levels described herein. The health plan must provide supporting evidence of equivalence with the notification to the state agency.

c. Outpatient Hospital Reimbursement

1) Effective July 1, 2021, health plans shall reimburse hospitals for outpatient services based on the minimum and maximum percentages by hospital class applied to the MHD Managed Care Outpatient Alternative Fee Schedule approximating 90% of Medicare published at https://dss.mo.gov/mhd/providers/files/outpatient-simplified-fee-schedule.pdf.

2) Health plans may contract with hospitals at rates within the established minimum and maximum percentages associated with the applicable hospital class as outlined in the table below. No in-network hospital shall be paid below 100% of the alternative fee schedule, nor more than the maximum percentage for the applicable hospital class. Reimbursement rates must be all inclusive and paid based on utilization.

Hospital Classes	Outpatient	
	Minimum Percentage of Alternative Fee Schedule	Maximum Percentage of Alternative Fee Schedule
Children's Hospital	100%	440%
Federal Critical Access Hospitals	100%	110%
Specialty Hospitals	100%	215%
Teaching Hospitals	100%	170%

1-100 Licensed Beds	100%	165%
More than 100 Licensed Beds	100%	180%

3) Any increase in negotiated outpatient rates by hospital for SFY 2022 shall be limited to five percentage points (5%), unless below the minimum required, and shall not exceed the maximum fee schedule amount for a particular hospital within a hospital class. This limitation on negotiated increases applies to all hospitals contracted at any time during the previous rating period (July 1, 2020 through June 30, 2021) and is compared to the most recent contracted rates in that period. For example, if a hospital that is in the Teaching hospital class previously contracted with a health plan at 107% of the Alternative Fee Schedule, the outpatient rates could be negotiated up to 112% of the Alternative Fee Schedule for SFY 2022.

4) Health plans may utilize Alternative Payment Models that are more advanced in the provider risk continuum than paying on a per diem basis with advanced notification to the state agency. Overall pricing levels for these arrangements must be consistent with the outpatient hospital reimbursement levels described herein. The health plan must provide supporting evidence of equivalence with the notification to the state agency.

d. Health plans may request an exemption to these reimbursement terms if there is a demonstrated need to pay more than the maximum percentage applicable to a particular hospital. The state agency may provide approval of the exception based on evaluation of several factors compared to the request: hospital costs, Fee-for-Service reimbursement levels, other reimbursement levels within the applicable hospital class, and other reimbursement levels contracted by the health plan or other payers for hospital services in other lines of business such as commercial.

e. Hospitals not participating in a health plan network will be reimbursed for services provided to managed care enrollees consistent with section 2.6.20 (Reimbursement for Non-Participating Hospitals).

f. Health Plan Attestation of Compliance

1) No later than thirty (30) calendar days after the start of the rating period, the health plan shall provide the state agency with a written attestation of compliance with the requirements of section 2.6.19 (Hospital Reimbursement). The attestation should include a list of all contracted hospitals and confirmation that negotiated rates comply with the parameters of the directed payment or are negotiated based on a state agency approved exception. The written attestation shall also address any anticipated exemption requests, including the provider name and estimated date of submission of the exemption request to the state agency.

2) The health plan shall submit a revised written attestation of compliance on a quarterly basis if contracting with a new hospital or renegotiating hospital contracts. The written attestation of compliance shall be submitted in the frequency required by the state agency

as indicated in the Reporting Requirements document located and periodically updated on the MO HealthNet Managed Care website (https://dss.mo.gov/business-processes/managed-care/). For example, the first revised written attestation shall be for quarter 1 of SFY22 (July 1 through September 30) and shall be due on the last business day of the month following the end of the quarter, or October 31.

3) If the state agency determines the health plan's written attestation misrepresented compliance with the requirements of section 2.6.19, the liquidated damages applicable to hospital reimbursement set forth in section 2.29.5.b will be assessed.

2.6.20 Reimbursement for Non-Participating Hospitals:
The health plan shall reimburse non-participating hospitals based on the table below. The percentage indicated by hospital class is the percentage to be applied to the Managed Care Inpatient or Outpatient Hospital Alternative Fee Schedule rate as noted in section 2.6.19 (Hospital Reimbursement) effective on the date the service was provided by the hospital.

Hospital Class	Reimbursement Percentage Applied to MC IP Alternative Fee Schedule	Reimbursement Percentage Applied to MC OP Alternative Fee Schedule
Children's Hospitals	90%	90%
Federal Critical Access Hospitals	90%	90%
Specialty Hospitals	90%	90%
Teaching Hospitals	90%	90%
1-100 Licensed Beds	90%	90%
More Than 100 Licensed Beds	90%	90%

a) For outpatient hospital services, the health plan shall reimburse non-participating hospitals for 90% of the Direct Medicaid Add-on in addition to the percentage of the Managed Care Outpatient Alternative Fee Schedule listed in the table above. Please refer to the schedule of hospital specific percentage add-ons (published at: https://dss.mo.gov/mhd/providers/files/outpatient-simplified-fee-schedule.pdf) to be applied to the Managed Care Outpatient Alternative Fee Schedule. Non-participating payments shall be 90% of the amount resulting from the Managed Care Outpatient Alternative Fee Schedule increased by the hospital specific add-on percentage.

b) This reimbursement rate does apply to non-participating hospitals providing behavioral health services.

c) This reimbursement rate does not apply to the following, or any other non-participating reimbursement rates required under law or in this contract, including but not limited to:

    1) Services for outpatient hospital durable medical equipment,

    2) Emergency services provided by out-of-network providers (2.6.12.a.2).

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Exhibit 4 - Nonparticipating Hospital Direct Medicaid AddOon Percentage (outpatient Hospital services)(5007716.1).pdf

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Non-Participating Hospital Direct Medicaid Add-on Percentage (Outpatient Hospital Services)

Hospital NPI	Medicare Number	Hospital Name	Hospital Type[1]	Outpatient DMAO Percentage[2]
1649299827	260032	Barnes-Jewish Hospital	Teaching	24.6%
1144238908	260191	Barnes-Jewish St. Peters Hospital	Teaching	16.6%
1831107895	260162	Barnes-Jewish West County Hospital	Teaching	14.4%
1770536740	260034	Bates County Memorial Hospital	1-100 Licensed Beds	23.9%
1063470763	260214	Belton Regional Medical Center	1-100 Licensed Beds	14.3%
1902817844	260068	Boone Hospital Center	More Than 100 Licensed Beds	17.7%
1235102690	260009	Bothwell Regional Health Center	1-100 Licensed Beds	14.9%
1811905375	260057	Cameron Regional Medical Center Inc.	1-100 Licensed Beds	10.1%
1174597892	260047	Capital Region Medical Center	Teaching	23.0%
1508935891	260091	CARDINAL GLENNON CHILDRENS HOSPITAL	Children's	16.0%
1528067113	261332	Carroll County Memorial Hospital	CAHs	4.3%
1477535326	261324	Cass Regional Medical Center	CAHs	11.1%
1720039605	261323	Cedar County Memorial Hospital	CAHs	11.1%
1942247044	260095	Centerpoint Medical Center of Independence	Teaching	16.3%
1659364206	264012	CenterPointe Hospital	Specialty	10.0%
1760973044	264032	CenterPointe Hospital of Columbia LLC *	Specialty	0.0%
1366515488	263302	Children's Mercy Kansas City	Children's	31.7%
1639186760	260180	Christian Hospital	Teaching	14.1%
1003981549	260195	Citizens Memorial Hospital	1-100 Licensed Beds	10.7%
1942279500	261303	Community Hospital - Fairfax	CAHs	10.0%
1922514629	261325	Cox Barton County Hospital	CAHs	11.1%
1760443980	260094	Cox Medical Center Branson	More Than 100 Licensed Beds	11.4%
1093740128	260040	CoxHealth (L.E. Cox Medical Center)	Teaching	21.9%
1194757500	261329	Cox-Monett Hospital Inc	CAHs	11.1%
1609894716	261301	Ellett Memorial Hospital	CAHs	10.0%
1609870310	261322	Excelsior Springs Hospital	CAHs	11.1%
1730182478	260142	Fitzgibbon Hospital	1-100 Licensed Beds	19.8%
1265546048	260137	Freeman Health System	Teaching	0.0%
1598873796	261331	Freeman Neosho Hospital	CAHs	0.0%
1417367665	260209	Fulton Medical Center, LLC	1-100 Licensed Beds	21.1%
1710075361	260175	Golden Valley Memorial Healthcare	1-100 Licensed Beds	19.2%
1922042704	260025	Hannibal Regional Hospital	1-100 Licensed Beds	49.9%
1528062569	261312	Harrison County Community Hospital	CAHs	2.2%
1528069101	264013	Heartland Behavioral Health Services	Specialty	0.0%
1912948308	261321	Hedrick Medical Center	CAHs	8.0%
1962578609	261314	Hermann Area District Hospital	CAHs	11.1%
1649244583	263027	Howard A. Rusk Rehabilitation Center	Specialty	0.0%
1477648178	261336	Iron County Medical Center	CAHs	9.4%
1265612188	262018	Kindred Hospital Northland	Specialty	0.0%
1447337449	262010	Kindred Hospital St. Louis	Specialty	0.0%
1679520258	261320	Lafayette Regional Health Center	CAHs	3.0%
1386619450	260186	Lake Regional Health System	1-100 Licensed Beds	11.8%
1720165327	264024	Lakeland Behavioral Health System	Specialty	0.0%
1437105574	262015	Landmark Hospital of Cape Girardeau	Specialty	0.0%
1972732378	262020	Landmark Hospital of Columbia, LLC	Specialty	0.0%
1972633410	262016	Landmark Hospital of Joplin	Specialty	0.0%
1497281489	263033	Landmark Rehabilitation Hospital Of Columbia *	Specialty	0.0%
1225085871	260190	Lee's Summit Medical Center	Teaching	10.3%
1811036726	260177	Liberty Hospital	More Than 100 Licensed Beds	15.2%
1720163025	261302	Madison Medical Center	CAHs	9.5%
1467543090	261316	Mercy Hospital Aurora	CAHs	3.4%
1003201955	261338	Mercy Hospital Carthage	CAHs	0.0%
1285676932	261317	Mercy Hospital Cassville	CAHs	3.3%
1508859661	260023	Mercy Hospital Jefferson	More Than 100 Licensed Beds	10.2%
1700112745	260001	Mercy Hospital Joplin	More Than 100 Licensed Beds	10.1%
1447284898	260059	Mercy Hospital Lebanon	1-100 Licensed Beds	14.3%
1962808733	261319	Mercy Hospital Lincoln	CAHs	0.0%
1578504056	260065	Mercy Hospital Springfield	More Than 100 Licensed Beds	8.3%
1427098169	260020	Mercy Hospital St. Louis	Teaching	12.4%
1285664177	260052	Mercy Hospital Washington	More Than 100 Licensed Beds	9.9%
1871928473	263032	Mercy Rehabilitation Hospital Springfield	Specialty	0.0%

Non-Participating Hospital Direct Medicaid Add-on Percentage (Outpatient Hospital Services)

Hospital NPI	Medicare Number	Hospital Name	Hospital Type[1]	Outpatient DMAO Percentage[2]
1811048614	263029	Mercy Rehabilitation Hospital St. Louis	Specialty	0.0%
1023053477	261335	Mercy St. Francis Hospital	CAHs	2.9%
1487663506	260108	Missouri Baptist Medical Center	Teaching	10.9%
1295743169	261337	Missouri Baptist Sullivan Hospital	CAHs	11.1%
1831269539	260113	Missouri Delta Medical Center	More Than 100 Licensed Beds	11.9%
1770554305	260074	Moberly Regional Medical Center	1-100 Licensed Beds	26.2%
1437259694	260006	Mosaic Life Care at St. Joseph (Heartland Regional Medical Center)	More Than 100 Licensed Beds	7.6%
1568695781	262019	Mosaic Life Care at St. Joseph, LTAC (Heartland LTAC Hospital)	Specialty	0.0%
1265906663	260050	Mosaic Medical Center - Maryville	1-100 Licensed Beds	10.0%
1942283866	260061	Nevada Regional Medical Center	1-100 Licensed Beds	9.5%
1629062799	260096	North Kansas City Hospital	More Than 100 Licensed Beds	14.3%
1104899442	260022	Northeast Regional Medical Center	Teaching	7.9%
1306893268	261328	Northwest Medical Center	CAHs	0.0%
1790115939	264031	Osage Beach Center for Cognitive Disorders	Specialty	0.0%
1831115641	260078	Ozarks Medical Center	More Than 100 Licensed Beds	15.2%
1932117173	261315	Parkland Health Center - Bonne Terre	CAHs	9.0%
1003824061	260163	Parkland Health Center -- Farmington	More Than 100 Licensed Beds	12.1%
1437179710	260070	Pemiscot Memorial Hospital	More Than 100 Licensed Beds	0.0%
1194211037	264033	Perimeter Behavioral Hospital Of Springfield *	Specialty	0.0%
1982699328	261311	Perry County Memorial Hospital	CAHs	8.3%
1417991159	261307	Pershing Memorial Hospital	CAHs	8.0%
1891766051	260017	Phelps County Regional Medical Center	More Than 100 Licensed Beds	25.5%
1205837218	261333	Pike County Memorial Hospital	CAHs	0.0%
1700831724	260119	Poplar Bluff Regional Medical Center	More Than 100 Licensed Beds	17.8%
1508938044	260219	Progress West Hospital	1-100 Licensed Beds	13.8%
1609870195	261305	Putnam County Memorial Hospital	CAHs	0.0%
1235117532	263303	Ranken Jordan Pediatric Bridge Hospital	Children's	28.6%
1245220052	261327	Ray County Memorial Hospital	CAHs	11.1%
1770557431	263028	Rehabilitation Institute of St. Louis, The	Specialty	10.0%
1134187842	260027	Research Medical Center	Teaching	16.6%
1831218601	264020	Royal Oaks Hospital	Specialty	0.0%
1467412726	260183	Saint Francis Medical Center	More Than 100 Licensed Beds	10.0%
1053353490	260216	Saint Luke's East Hospital	More Than 100 Licensed Beds	0.0%
1063494177	260138	Saint Luke's Hospital of Kansas City	Teaching	0.0%
1942241799	260062	Saint Luke's North Hospital - Smithville	More Than 100 Licensed Beds	27.2%
1639177561	261318	Salem Memorial District Hospital	CAHs	1.1%
1548215106	261313	Samaritan Hospital	CAHs	0.0%
1083624647	261310	Scotland County Hospital	CAHs	0.0%
1215116827	262017	Select Specialty Hospital - Springfield	Specialty	0.0%
1275533747	262013	Select Specialty Hospital - St. Louis	Specialty	0.0%
1942343447	263304	Shriners Hospitals for Children	Children's	10.0%
1225462336	264030	Signature Psychiatric Hospital	Specialty	10.0%
1801990825	260160	Southeast Health Center of Stoddard County	1-100 Licensed Beds	0.0%
1811006661	260110	Southeast Hospital	More Than 100 Licensed Beds	25.2%
1598835308	260104	SSM Health DePaul Hospital - St. Louis	Teaching	21.2%
1942685920	260105	SSM Health Saint Louis University Hospital	Teaching	32.2%
1851496152	260081	SSM Health St. Clare Hospital	More Than 100 Licensed Beds	13.7%
1871665380	260200	SSM Health St. Joseph Hospital - Lake St. Louis	More Than 100 Licensed Beds	12.2%
1467521146	260005	SSM Health St. Joseph Hospital - St. Charles	More Than 100 Licensed Beds	13.4%
1952390122	260064	SSM Health St. Mary's Hospital - Audrain	1-100 Licensed Beds	12.6%
1518065523	260011	SSM Health St. Mary's Hospital - Jefferson City	More Than 100 Licensed Beds	9.6%
1659511988	263031	SSM Rehabilitation Hospital	Specialty	0.0%
1912109919	260210	St. Alexius Hospital, Broadway Campus	Teaching	16.8%
1568481984	260077	St. Anthony's Medical Center	More Than 100 Licensed Beds	15.8%
1528463080	260085	St. Joseph Medical Center - Kansas City	More Than 100 Licensed Beds	21.9%
1992727663	263301	St. Louis Children's Hospital	Children's	25.5%
1508366949	260176	St. Luke's Des Peres Hospital	Teaching	10.0%
1346251543	260179	St. Luke's Hospital	Teaching	16.0%
1255587747	263030	St. Luke's Rehabilitation Hospital	Specialty	0.0%
1912303579	260193	St. Mary's Medical Center - Blue Springs	Teaching	15.0%
1073587655	261330	Ste. Genevieve County Memorial Hospital	CAHs	0.0%

Non-Participating Hospital Direct Medicaid Add-on Percentage (Outpatient Hospital Services)

Hospital NPI	Medicare Number	Hospital Name	Hospital Type[1]	Outpatient DMAO Percentage[2]
1114067832	261306	Sullivan County Memorial Hospital	CAHs	10.5%
1790740363	260024	Texas County Memorial Hospital	1-100 Licensed Beds	11.4%
1962572396	260091	Total - SSM Health St. Mary's Hospital - St. Louis	Teaching	22.7%
1467595793	260048	Truman Medical Center Hospital Hill	Teaching	12.0%
1376686600	260102	Truman Medical Center Lakewood	Teaching	9.1%
1699769901	260141	University of Missouri Hospital and Clinics	Teaching	31.7%
1194838821	261308	Washington County Memorial Hospital	CAHs	0.0%
1083601330	260097	Western Missouri Medical Center	1-100 Licensed Beds	1.1%
1841274057	261309	Wright Memorial Hospital	CAHs	11.1%

[1] *Reflects change of Lee's Summit Medical Center from 1-100 Licensed Beds to Teaching Hospital Class.*

[2] *This column represents the Direct Medicaid Add-on (DMAO) percentage for each in-state hospital. For outpatient hospital services, the health plan shall reimburse non-participating hospitals for 90% of the DMAO in addition to 90% of the Managed Care Outpatient Simplified Fee Schedule, consistent with the policy outlined in the Health Plan contract. For example, if a non-participating hospital has a DMAO percentage of 20.0% and 100% of the Outpatient Simplified Fee Schedule payments equal $150 - the total payment would be $162 (i.e., $150 X 1.20 X 90%).*

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Exhibit 5 - Hospital inpatient rates exhibit.pdf

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Count	National Provider Identifier (NPI) Number	Provider Name	SFY 2021 Inpatient Per Diem Rate	SFY 2022 DMAO Per Diem
Instate Hospitals				
1	1649299827	Barnes-Jewish Hospital	$ 1,209.91	$ 1,544.41
2	1144238908	Barnes-Jewish St. Peter's Hospital	$ 848.17	$ 1,023.44
3	1831107895	Barnes-Jewish West County Hospital	$ 795.04	$ 2,668.60
4	1770536740	Bates County Memorial Hospital	$ 731.27	$ 2,316.92
5	1063470763	Belton Regional Medical Center	$ 1,516.87	$ 533.62
6	1902817844	Boone Hospital Center	$ 1,028.86	$ 1,496.43
7	1235102690	Bothwell Regional Health Center	$ 769.49	$ 1,031.16
8	1811905375	Cameron Regional Medical Center	$ 810.20	$ 943.99
9	1174597892	Capital Region Medical Center	$ 1,065.76	$ 1,302.90
10	1528067113	Carroll County Memorial Hospital	$ 3,552.16	$ -
11	1477535326	Cass Regional Medical Center	$ 2,072.50	$ -
12	1720039605	Cedar County Memorial Hospital	$ 1,745.72	$ -
13	1942247044	Centerpoint Medical Center of Independence	$ 1,128.29	$ 1,277.41
14	1659364206	CenterPointe Hospital	$ 371.24	$ 419.86
15	1760973044	CenterPointe Hospital of Columbia LLC	$ 1,748.38	$ -
16	1366515488	Children's Mercy Hospital	$ 1,945.85	$ 3,469.57
17	1639186760	Christian Hospital Northeast	$ 781.21	$ 1,281.23
18	1003981549	Citizens Memorial Healthcare	$ 714.86	$ 1,371.56
19	1942279500	Community Hospital Association	$ 3,508.78	$ -
20	1922514629	Cox Barton County Hospital	$ 2,363.39	$ -
21	1760443980	Cox Medical Center Branson	$ 755.98	$ 845.06
22	1194757500	Cox-Monett Hospital	$ 2,485.14	$ -
23	1609894716	Ellett Memorial Hospital	$ 5,683.89	$ -
24	1609870310	Excelsior Springs Hospital	$ 2,918.83	$ -
25	1730182478	Fitzgibbon Memorial Hospital	$ 741.32	$ 1,008.70
26	1265546048	Freeman Health Systems	$ 819.74	$ 525.29
27	1598873796	Freeman Neosho Hospital	$ 1,859.42	$ -
28	1417367665	Fulton Medical Center	$ 917.07	$ 583.65
29	1710075361	Golden Valley Memorial Hospital	$ 738.44	$ 1,889.89
30	1922042704	Hannibal Regional Hospital	$ 670.31	$ 1,732.54
31	1528062569	Harrison County Community Hospital	$ 2,453.49	$ -
32	1528069101	Heartland Behavioral Health Services	$ 545.26	$ 204.45
69	1568695781	Heartland LTAC Hospital	$ 1,714.64	$ -
68	1437259694	Heartland Regional Medical Center	$ 990.20	$ 623.80
33	1912948308	Hedrick Medical Center	$ 2,212.82	$ -
34	1962578609	Hermann Area District Hospital	$ 2,035.21	$ -
35	1477648178	Iron County Medical Center	$ 3,558.91	$ -
36	1265612188	Kindred Hospital Northland	$ 1,782.01	$ -
37	1447337449	Kindred Hospital St. Louis	$ 919.51	$ 830.10
38	1093740128	L.E. Cox Medical Center	$ 746.01	$ 824.37
39	1679520258	Lafayette Regional Health Center	$ 3,383.73	$ -
40	1386619450	Lake Regional Hospital	$ 973.68	$ 1,461.32
41	1720165327	Lakeland Behavioral Health System	$ 326.46	$ 106.73
42	1437105574	Landmark Hospital of Cape Girardeau	$ 1,109.72	$ 262.72
43	1972732378	Landmark Hospital of Columbia	$ 1,456.65	$ 419.56
44	1972633410	Landmark Hospital of Joplin	$ 1,372.58	$ 164.79

Count	National Provider Identifier (NPI) Number	Provider Name	SFY 2021 Inpatient Per Diem Rate	SFY 2022 DMAO Per Diem
45	1497281489	Landmark Rehabilitation Hospital Of Columbia	$ 2,408.64	$ -
46	1225085871	Lee's Summit Medical Center	$ 1,351.09	$ 1,381.64
47	1811036726	Liberty Hospital	$ 1,145.85	$ 1,130.10
48	1548215106	Macon County Samaritan Memorial Hospital	$ 1,961.26	$ -
49	1720163025	Madison Medical Center	$ 2,124.80	$ -
50	1467543090	Mercy Hospital Aurora	$ 2,204.57	$ -
51	1003201955	Mercy Hospital Carthage	$ 2,797.59	$ -
52	1285676932	Mercy Hospital Cassville	$ 3,100.27	$ -
53	1508859661	Mercy Hospital Jefferson	$ 1,046.33	$ 1,050.04
54	1700112745	Mercy Hospital Joplin	$ 1,432.04	$ 716.75
55	1447284898	Mercy Hospital Lebanon	$ 1,130.72	$ 1,294.09
56	1962808733	Mercy Hospital Lincoln	$ 2,362.36	$ -
57	1568481984	Mercy Hospital South	$ 864.20	$ 804.20
58	1578504056	Mercy Hospital Springfield	$ 869.28	$ 1,449.37
59	1427098169	Mercy Hospital St. Louis	$ 1,107.64	$ 924.43
60	1285664177	Mercy Hospital Washington	$ 1,083.02	$ 1,662.29
61	1871928473	Mercy Rehabilitation Hospital Springfield	$ 1,191.81	$ 224.58
62	1811048614	Mercy Rehabilitation Hospital St. Louis	$ 1,085.57	$ 407.34
63	1023053477	Mercy St. Francis Hospital	$ 3,769.81	$ -
64	1487663506	Missouri Baptist Medical Center	$ 1,051.32	$ 1,349.43
65	1295743169	Missouri Baptist Sullivan Hospital	$ 1,739.48	$ -
66	1831269539	Missouri Delta Medical Center	$ 1,360.00	$ 258.91
67	1770554305	Moberly Regional Medical Center	$ 887.69	$ 1,179.90
70	1265906663	Mosaic Medical Center - Maryville	$ 770.37	$ 715.03
71	1942283866	Nevada Regional Medical Center	$ 781.29	$ 452.99
72	1629062799	North Kansas City Hospital	$ 945.42	$ 1,127.61
73	1104899442	Northeast Regional Medical Center	$ 1,018.62	$ 1,122.00
74	1306893268	Northwest Medical Center	$ 2,335.69	$ -
75	1790115939	Osage Beach Center for Cognitive Disorders	$ 931.10	$ 245.49
76	1831115641	Ozarks Medical Center	$ 1,119.19	$ 193.94
77	1003824061	Parkland Health Center	$ 715.80	$ 1,090.32
78	1932117173	Parkland Health Center - Bonne Terre	$ 13,072.61	$ -
79	1437179710	Pemiscot Memorial Hospital	$ 726.08	$ 101.42
80	1194211037	Perimeter Behavioral Hospital Of Springfield	$ 2,433.37	$ -
81	1982699328	Perry County Memorial Hospital	$ 2,312.03	$ -
82	1417991159	Pershing Memorial Hospital	$ 2,227.32	$ -
83	1891766051	Phelps Health	$ 774.62	$ 1,251.12
84	1205837218	Pike County Memorial Hospital	$ 1,745.84	$ -
85	1700831724	Poplar Bluff Regional Medical Center	$ 1,437.78	$ 280.59
86	1508938044	Progress West Hospital	$ 2,403.79	$ -
87	1609870195	Putnam County Memorial Hospital	$ 2,188.13	$ -
88	1235117532	Ranken Jordan	$ 2,278.60	$ 1,431.90
89	1245220052	Ray County Memorial Hospital	$ 3,267.14	$ -
90	1770557431	Rehabilitation Institute of St. Louis	$ 1,101.58	$ 313.58
91	1134187842	Research Medical Center	$ 745.28	$ 1,269.57
92	1831218601	Royal Oaks Hospital	$ 592.61	$ 1,411.13
93	1649244583	Rusk Rehabilitation Center, LLC	$ 787.52	$ 467.73

Count	National Provider Identifier (NPI) Number	Provider Name	SFY 2021 Inpatient Per Diem Rate	SFY 2022 DMAO Per Diem
94	1639177561	Salem Memorial District Hospital	$ 1,286.59	$ -
95	1083624647	Scotland County Hospital	$ 2,098.36	$ -
96	1215116827	Select Specialty Hospital - Springfield	$ 1,579.49	$ -
97	1275533747	Select Specialty Hospital - St. Louis	$ 1,030.39	$ 370.31
98	1942343447	Shriner's Hospitals for Children - St. Louis	$ 4,446.44	$ 14,317.76
99	1225462336	Signature Psychiatric Hospital	$ 882.31	$ -
100	1801990825	Southeast Health Center of Stoddard County	$ 915.70	$ 457.69
101	1811006661	Southeast Hospital	$ 962.88	$ 1,085.36
102	1508935891	SSM Health Cardinal Glennon Children's Hospital	$ 1,321.23	$ 2,122.97
103	1598835308	SSM Health DePaul Hospital - St. Louis	$ 826.78	$ 583.47
104	1851496152	SSM Health St. Clare Hospital - Fenton	$ 1,146.71	$ 1,100.22
105	1871665380	SSM Health St. Joseph Hospital - Lake St. Louis	$ 759.63	$ 1,259.42
106	1467521146	SSM Health St. Joseph Hospital - St. Charles	$ 883.55	$ 368.47
107	1942685920	SSM Health St. Louis University Hospital	$ 1,586.88	$ 1,365.45
108	1952390122	SSM Health St. Mary's Hospital - Audrain	$ 501.01	$ 1,016.84
109	1518065523	SSM Health St. Mary's Hospital - Jefferson City	$ 1,245.40	$ 1,055.78
110	1962572396	SSM Health St. Mary's Hospital - St. Louis	$ 568.65	$ 1,164.01
111	1659511988	SSM Select Rehab St. Louis LLC	$ 1,376.34	$ 136.73
112	1912109919	St. Alexius Hospital	$ 611.41	$ 652.91
113	1467412726	St. Francis Medical Center - Cape Girardeau	$ 1,076.76	$ 1,869.55
114	1528463080	St. Joseph Medical Center - Kansas City	$ 1,213.85	$ 1,531.15
115	1992727663	St. Louis Children's Hospital	$ 1,791.91	$ 2,243.24
116	1508366949	St. Luke's Des Peres Hospital	$ 729.39	$ 2,574.72
117	1053353490	St. Luke's East Hospital	$ 1,896.46	$ 232.44
118	1063494177	St. Luke's Hospital of Kansas City	$ 1,010.76	$ 1,233.32
119	1346251543	St. Luke's Hospital West	$ 912.61	$ 1,410.37
120	1942241799	St. Luke's North Hospital	$ 776.69	$ 844.33
121	1255587747	St. Luke's Rehabilitation Hospital	$ 1,265.64	$ -
122	1912303579	St. Mary's Medical Center - Blue Springs	$ 1,007.62	$ 1,497.05
123	1073587655	Ste. Genevieve County Memorial Hospital	$ 1,698.24	$ -
124	1114067832	Sullivan County Memorial Hospital	$ 1,637.80	$ -
125	1790740363	Texas County Memorial Hospital	$ 434.29	$ 1,107.57
126	1467595793	Truman Medical Center Hospital Hill	$ 927.38	$ 1,417.05
127	1376686600	Truman Medical Center Lakewood	$ 749.35	$ 1,713.41
128	1699769901	University of Missouri Hospital and Clinics	$ 1,352.73	$ 1,522.07
129	1194838821	Washington County Memorial Hospital	$ 1,451.03	$ -
130	1083601330	Western Missouri Medical Center	$ 898.74	$ 1,341.75
131	1841274057	Wright Memorial Hospital	$ 3,147.23	$ -

Out of State (OOS) Hospitals whose Inpatient and Outpatient Rate(s) are based on Cost Report data:

1	1154400232	Children's Mercy South	$ 1,423.36

OOS Hospitals whose Inpatient Rate is based on Cost Report & Outpatient Rate is based on Statewide Average:

1	1255378337	Menorah Medical Center	$ 1,269.83
2	1578500484	Overland Park Regional Medical Center	$ 1,226.74

Count	National Provider Identifier (NPI) Number	Provider Name	SFY 2021 Inpatient Per Diem Rate	SFY 2022 DMAO Per Diem
3	1154303337	St Luke's South Hospital	$ 2,421.03	
4	1649259656	University of Kansas Hospital Authority	$ 1,525.12	
Statewide Average Rates Paid to all other OOS Hospitals			$ 1,040.67	

WSD User

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Exhibit 6 - Amended Directed Payment Documents(5007717.1).pdf

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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):

   July 1, 2021 through June 30, 2022

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.*

   July 1, 2021

3. Identify the managed care program(s) to which this payment arrangement will apply:

   Missouri HealthNet Division (MHD) Managed Care Program

4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment:

   a. Identify the estimated federal share of this state directed payment: $734,922,488

   b. Identify the estimated non-federal share of this state directed payment:

      $372,555,643.

      Note that the estimated dollar amounts are based on FMAP percentages effective FFY 2022 and do not reflect the enhanced 6.2% FMAP from the Families First Coronavirus Response Act due to the uncertainty of the end date.

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:

      ☐ 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).

MHD developed a minimum and maximum fee schedule that will be used for reimbursement of inpatient hospital service utilization by MO HealthNet managed care enrollees. The minimum and maximum fee schedule will be directly compared to the approved State Plan fee-for-service (FFS) total payments for inpatient hospital services. The negotiated rates within the minimum and maximum fee schedule will be the basis for reimbursement of inpatient hospital services utilized beginning July 1, 2021.

   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.

Attached are the reimbursement pages for inpatient reimbursement from the state plan.

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).

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.						
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.
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.

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.

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?

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

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.

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)

The alternative fee schedule for the inpatient directed payment is the approved State Plan FFS total payments for inpatient hospital services. These total payments include the inpatient hospital per diem reflective of hospitals costs from the hospitals 1995 cost report trended to 2001 (or cost from the hospital's first full year cost report trended to the SFY in which the rate was set if the hospital opened after 1995) and direct Medicaid add-on amounts that bring total FFS payments to current hospital cost levels. MHD developed a minimum and maximum fee schedule based on this alternative fee schedule that will be used for reimbursement for utilization of inpatient hospital services to MHD managed care enrollees.

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

The minimum and maximum fee schedule was developed using a comparison of current managed care inpatient hospital reimbursement to the alternative fee schedule by hospital class. Health plans can contract with hospitals within the established minimum and maximum percentages applied to the approved State Plan FFS total payments associated with the applicable hospital class. MHD compared the projected reimbursement levels under this directed payment by hospital provider class to the estimated total FFS payments. Additionally, the projected reimbursement levels were compared to estimated Medicaid cost levels using Medicare cost reporting principles. The directed payment is not intended to increase inpatient managed care reimbursement to hospitals in the aggregate.

[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).

Please refer to the below table that compares anticipated projected reimbursement to Medicaid costs and FFS total payment levels.

Class	Expected SFY 2022 Directed Payment Reimbursement	Estimated SFY 2022 Medicaid Costs	Expected Payments as % of Estimated Medicaid Costs	Estimated SFY 2022 FFS Total Payments	Expected Payments as % of FFS Total Payments
Children's Hospitals	$303,378,862	$283,983,054	107%	$274,567,375	110%
Federal CAH's	$8,386,717	$6,301,859	133%	$8,304,031	101%
Specialty Hospitals	$19,527,608	$17,455,333	112%	$18,166,056	107%
Teaching Hospitals	$362,389,694	$472,618,877	77%	$307,424,983	118%
1-100 Licensed Beds	$25,304,507	$33,647,066	75%	$24,923,905	102%
More Than 100 Licensed Beds	$149,274,755	$209,838,062	71%	$139,525,540	107%

Note that Expected SFY 2022 amounts reflect expected reimbursement for the existing managed care program utilizing SFY 2019 managed care utilization and reimbursement by hospital trended to SFY 2022. These amounts do not tie to the expenditures included in response to Question 4 that reflect total expected expenditures inclusive of increasing managed care enrollment due to economic conditions.

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.

The minimum and maximum fee schedules were established by hospital class to account for differing hospital characteristics and potential contracting obligations. Given that the maximums are established above current approved FFS Total Payment levels and are based on current managed care reimbursement levels, it is not expected that existing contract obligations for hospitals would necessitate reimbursement at levels higher than the maximum reimbursement level by hospital class established by this directed payment. However, if a hospital and health plan need to request an exemption from the maximum reimbursement level, MHD will evaluate the requested reimbursement level compared to the hospital's costs, FFS reimbursement levels, other reimbursement levels within the applicable hospital class, and other reimbursement levels contracted by the health plan for inpatient hospital services in other lines of business such as commercial.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

No exemptions are anticipated for the current rating period for the reasons described in the above response.

ii. Granted in past years of this payment arrangement

Not applicable

d. Describe how such exemptions will be considered in rate development. As no exemptions are anticipated, there will be no impact to the rate development process.

As no exemptions are anticipated, there will be no impact to the rate development process.

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?)

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).

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

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
- [ ] Other:

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

MHD developed provider classes for hospitals with similar characteristics that follows the below hierarchy. Hospitals will be attributed to only one provider class based on the hierarchy.

The provider classes are defined as:

1. Children's Hospitals: defined based on the Missouri hospital's Medicare number starting with 2633

2. Federal Critical Access Hospitals (CAHs): defined based on the Missouri hospital's Medicare number starting with 2613

3. Specialty Hospitals: defined based on the Missouri hospital's Medicare number starting with either: 2620, 2621, 2622, 2630, 2641, 2642, 2643, or 2644

4. Teaching Hospitals: defined based on Missouri hospitals receiving GME payments

5. 1-100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from FYE 2017 cost report information.

6. More Than 100 Licensed Beds: defined based on licensed bed information listed on the Missouri Department of Health website and from FYE 2017 cost report information.

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 classes are not defined in the State Plan and intergovernmental transfers (IGTs) are not the source of the non-federal share of this directed payment. MHD developed a provider class hierarchy for in-state hospitals, as listed in Question 20b, where each hospital is assigned to only one class. The hierarchy follows the order listed above. For example, a hospital would first be reviewed to see if it meets the criteria for the "Children's Hospital" class and then "Federal CAH", and so on. To determine the hospital classes, MHD reviewed the characteristics of each hospital to identify similarities in services provided and populations served, in the comparability of overall costs, and in the comparability of projected payments compared to Medicaid cost levels using Medicare cost reporting principles.

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.

MHD developed a minimum and maximum fee schedule that will be used for reimbursement for utilization of inpatient hospital services to MHD managed care enrollees. The minimum and maximum fee schedule directly compares to the approved State Plan FFS total payments for inpatient hospital services. Each hospital within a class is subject to the same minimum and maximum fee schedule. The percentages outlined below are applied to the alternative fee schedule for each class to develop the minimum and maximum fee schedules.

Class	Minimum Applied to Alternative Fee Schedule	Maximum Applied to Alternative Fee Schedule
Children's Hospitals	100%	115%
Federal CAH's	100%	102%
Specialty Hospitals	100%	130%
Teaching Hospitals	100%	130%
1-100 Licensed Beds	100%	102%
More Than 100 Licensed Beds	100%	110%

Upon approval by MHD, health plans may utilize Alternative Payment Models that are more advanced in the provider risk continuum than paying on a per diem basis. Overall pricing levels for these arrangements must be consistent with the directed payment. Such arrangements would not result in adjustments in the rate development process as the overall pricing levels are to be consistent with the directed payment. This process is distinct from the exemption process (described in response to Question 18b) to exceed the maximum reimbursement level by hospital class established by the directed payment.

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 complete 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.					
b.					
c.					
d.					
e.					
f.					
g.					

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.

Not applicable

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

See response to Question 17b.

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).

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

The state will be submitting the contract amendment in June 2021. The identifier of the contract action will be Amendment #014. The state directed payment will be captured in Section 2.6.24.

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.

Anticipated June 2021.

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.			
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.

    Not applicable

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: Healthy Families Trust Fund & Life Sciences Research Trust Fund (Tobacco Settlement Funds), Health Initiative Funds, Premium Funds, Uncompensated Care Funds

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.					
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. Federal Reimbursement Allowance	Hospital	Yes	Yes	Yes		No
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://dss.mo.gov/mhd/mc/pdf/2018-quality-stri

b. The effective date of quality strategy. July 1, 2018

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: June-2021

b. Note any potential changes that might be made to the goals and objectives.

Overall goals will remain the same.

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. Ensure appropriate access to care	Ensure timely access to care and ensure an adequate healthcare network	25-26
b.		
c.		
d.		

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.

The State is establishing a minimum and maximum range of reimbursement for inpatient hospital services that is consistent with total FFS reimbursement for such services. Maintaining parity of reimbursement across delivery systems supports the goal of ensuring appropriate access to inpatient services for Medicaid managed care enrollees.

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 assurethe 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. Follow-Up After Hospitalization for Mental Illness (30 days)	CY 2020	TBD - MY2020 HEDIS rates will be available in June 2021	Increase by two percentage points, the percentage of managed care participants, ages 6 and above, that receive a follow-up visit within 30 days after discharge from a mental health hospitalization.	
ii. Plan All-Cause Readmissions	CY 2020	TBD - MY2020 HEDIS rates will be available in June 2021	For members 18 years and older, reduce by two percentage points, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	
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.

Not applicable

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):

   July 1, 2021 through June 30, 2022

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.*

   July 1, 2021

3. Identify the managed care program(s) to which this payment arrangement will apply:

   Missouri HealthNet Division (MHD) Managed Care Program

4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment:

   a. Identify the estimated federal share of this state directed payment: $523,188,330

   b. Identify the estimated non-federal share of this state directed payment:

   $265,220,847.

   Note that the estimated dollar amounts are based on FMAP percentages effective FFY 2022 and do not reflect the enhanced 6.2% FMAP from the Families First Coronavirus Response Act due to the uncertainty of the end date.

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 anew 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:

      ☐ 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).

MHD developed a minimum and maximum fee schedule that will be used for reimbursement for all outpatient hospital services provided by hospitals to MHD managed care enrollees. The minimum and maximum fee schedule will be directly compared to the MHD Managed Care Outpatient Alternative Fee Schedule referred to as the Outpatient Simplified Fee Schedule (OSFS) to be implemented by MHD effective July 1, 2021. This fee schedule is approximating 90% of the Medicare Outpatient Hospital Fee Schedule rates for Missouri. The negotiated payments within the minimum and maximum fee schedule is the basis for reimbursement for outpatient hospital services utilized beginning July 1, 2021.

   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.

Attached are the reimbursement pages for outpatient reimbursement from the state plan.

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).

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.						
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.
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.

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.

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?

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

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.

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)

The alternative fee schedule for the outpatient directed payment is the OSFS to be implemented by MHD effective July 1, 2021. This fee schedule is approximating 90% of the Medicare Outpatient Hospital Fee Schedule rates for Missouri. MHD developed a minimum and maximum percentage based on this alternative fee schedule that will be used for reimbursement for utilization of outpatient hospital services to MHD managed care enrollees.

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

The minimum and maximum fee schedule was developed using a comparison of current managed care outpatient hospital reimbursement to the alternative fee schedule, by hospital class. Health plans can contract with hospitals within the established minimum and maximum percentages applied to the OSFS associated with the applicable hospital class. MHD compared the projected reimbursement levels under this directed payment by hospital provider class to the estimated total FFS payments. Additionally, the projected reimbursement levels were compared to estimated Medicaid cost levels using Medicare cost reporting principles. The directed payment is not intended to increase outpatient hospital managed care reimbursement to hospitals in the aggregate.

Please refer to the below table that compares anticipated projected reimbursement to Medicaid costs and FFS total payment levels.

[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).

Class	Expected SFY 2022 Directed Payment Reimbursement	Estimated SFY 2022 Medicaid Costs	Expected Payments as % of Estimated Medicaid Costs	Estimated SFY 2022 FFS Total Payments	Expected Payments as % of FFS Total Payments
Children's Hospitals	$224,952,709	$154,170,323	146%	$69,160,017	325%
Federal CAH's	$30,482,157	$31,818,494	96%	$28,525,270	107%
Specialty Hospitals	$752,226	$753,062	100%	$628,606	120%
Teaching Hospitals	$184,730,271	$155,759,959	119%	$117,907,119	157%
1-100 Licensed Beds	$40,146,934	$39,296,062	102%	$27,948,305	144%
More Than 100 Licensed Beds	$125,861,913	$107,078,696	118%	$80,854,754	156%

Note that the Expected SFY 2022 amounts reflect expected reimbursement for the existing managed care program utilizing SFY 2019 managed care utilization and reimbursement by hospital trended to SFY 2022. These amounts do not tie to the expenditures included in response to Question 4 that reflect total expected expenditures inclusive of increasing managed care enrollment due to economic conditions.

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.

The minimum and maximum fee schedules were established by hospital class to account for differing hospital characteristics and potential contracting obligations. Given that the maximums are established above anticipated FFS reimbursement levels and are based on current managed care reimbursement levels, it is not expected that existing contract obligations for hospitals would necessitate reimbursement at levels higher than the maximum reimbursement level by hospital class established by this directed payment. However, if a hospital and health plan need to request an exemption from the maximum reimbursement level, MHD will evaluate the requested reimbursement level compared to the hospital's costs, FFS reimbursement levels, other reimbursement levels within the applicable hospital class, and other reimbursement levels contracted by the health plan for outpatient hospital services in other lines of business such as commercial.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

No exemptions are anticipated for the current rating period for the reasons described in the above response

ii. Granted in past years of this payment arrangement

Not applicable

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

As no exemptions are anticipated, there will be no impact to the rate development process.

[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?)

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).

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

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
- ☐ Other:

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

MHD developed provider classes for hospitals with similar characteristics that follows the below hierarchy. Hospitals will be attributed to only one provider class based on the hierarchy. The provider classes align with the hospital classes outlined for the inpatient directed payment.

The provider classes are defined as:
1. Children's Hospitals: defined based on the Missouri hospital's Medicare number starting with 2633

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 classes are not defined in the State Plan and intergovernmental transfers (IGTs) are not the source of the non-federal share of this directed payment. MHD developed a provider class hierarchy for in-state hospitals, as listed in Question 20b, where each hospital is assigned to only one class. The hierarchy follows the order listed above. For example, a hospital would first be reviewed to see if it meets the criteria for the "Children's Hospital" class and then "Federal CAH", and so on. To determine the hospital classes, MHD reviewed the characteristics of each hospital to identify similarities in services provided and populations served, in the comparability of overall costs, and in the comparability of projected payments compared to Medicaid cost levels using Medicare cost reporting principles.

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.

MHD developed a minimum and maximum fee schedule that will be used for reimbursement for utilization of outpatient hospital services provided to MHD managed care enrollees. The minimum and maximum fee schedule directly compares to the OSFS to be implemented July 1, 2021 and approximating 90% of Medicare outpatient hospital reimbursement rates for Missouri. Each hospital within each class is subject to the same minimum and maximum fee schedule. The percentages outlined below are applied to the alternative fee schedule for each class to develop the minimum and maximum fee schedules.

Upon approval by MHD, health plans may utilize Alternative Payment Models that are more advanced in the provider risk continuum than paying total payments. Overall pricing levels for these arrangements must be consistent with the directed payment. Such arrangements would not result in adjustments in the rate development process as the overall pricing levels are to be consistent with the directed payment. This process is distinct from the exemption process (described in response to Question 18b) to exceed the maximum reimbursement level by hospital class established by the directed payment.

Class	Minimum Percentage of Alternative Fee Schedule	Maximum Percentage of Alternative Fee Schedule
Children's Hospitals	100%	440%
Federal CAH's	100%	110%
Specialty Hospitals	100%	215%
Teaching Hospitals	100%	170%
1-100 Licensed Beds	100%	165%
More Than 100 Licensed Beds	100%	180%

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 complete 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.					
b.					
c.					
d.					
e.					
f.					
g.					

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.

Not applicable

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

See response to Question 17b.

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).

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

The state will be submitting the contract amendment in June 2021. The identifier of the contract action will be Amendment #014. The state directed payment will be captured in Section 2.6.24.

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.

Anticipated June 2021

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.			
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.

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: Healthy Families Trust Fund & Life Sciences Research Trust Fund (Tobacco Settlement Funds), Health Initiative Funds, Premium Funds, Uncompensated Care Funds
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.					
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. Federal Reimbursement Allowance	Hospitals	Yes	Yes	Yes		No
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://dss.mo.gov/mhd/mc/pdf/2018-quality-strategy.pdf
- **b.** The effective date of quality strategy. July 1, 2018

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: June-2021
- **b.** Note any potential changes that might be made to the goals and objectives.
  Overall goals will remain the same.

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. Ensure appropriate access to care	Ensure timely access to care and ensure an adequate healthcare network	25-26
b.		
c.		
d.		

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.

The State is establishing a minimum and maximum range of reimbursement for outpatient hospital services that is consistent with total FFS reimbursement for such services. Maintaining parity of reimbursement across delivery systems supports the goal of ensuring appropriate access to outpatient services for Medicaid managed care enrollees.

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. Follow-Up After Hospitalization for Mental Illness (30 days)	CY 2020	TBD - MY2020 HEDIS rates will be available in June 2021	Increase by two percentage points, the percentage of managed care participants, ages 6 and above, that receive a follow-up visit within 30 days after discharge from a mental health hospitalization.	
ii. Use of Opioids from Multiple Providers	CY 2020	TBD - MY2020 HEDIS rates will be available in June 2021	This measure assesses the rate of health plan members 18 years and older who receive opioids from multiple prescribers and multiple pharmacies.	
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.

Not applicable