MEDICAID DIRECTED PAYMENT PROGRAM & PROVIDER ASSESSMENT

DATA ESTIMATES AS OF 4/18/24

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POLICY LANDSCAPE

- Medicaid reimbursements are not keeping up with the cost of care.
- Nearly $1B in losses from public programs.
- 55% of Nebraska hospitals ran a negative operating margin in the last quarter.
- State projected to run a $130M deficit in FY 26-27.
- Establish a partnership with state to pursue maximum allowable federal reimbursement for Medicaid.

MEDICAID PROVIDER RATE HISTORY

Nebraska Hospital Costs v. Medicaid Reimbursement

12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
-4.0%

% Change from previous year

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 *2021 *2022 *2023

Nebraska hospital cost data from National Health Expenditures Data (CMS.gov) & *NHA survey data

- Nebraska Hospital Costs (2003-2023 average 5.65%)
- Nebraska Medicaid Reimbursement (2003-2023 average 1.56%)

RATE INCREASE THROUGH A PROVIDER ASSESSMENT & DIRECTED PAYMENT PROGRAM

- 44 states have a hospital assessment (tax) supporting rates.
- 68.68% blended FMAP. $1 invested by provider assessment is matched about $2.19 by Federal government.
- In 2016, CMS authorized Directed Payments through MCOs and allowed up to average commercial rates.

KEY PRINCIPLES

CMS

- No hold harmless on assessments paid.
- Assessment must be uniform and broad-based or meet statistical limitations.
- Must be tied to state's Medicaid quality strategy and likely will have some at-risk quality component.

NHA

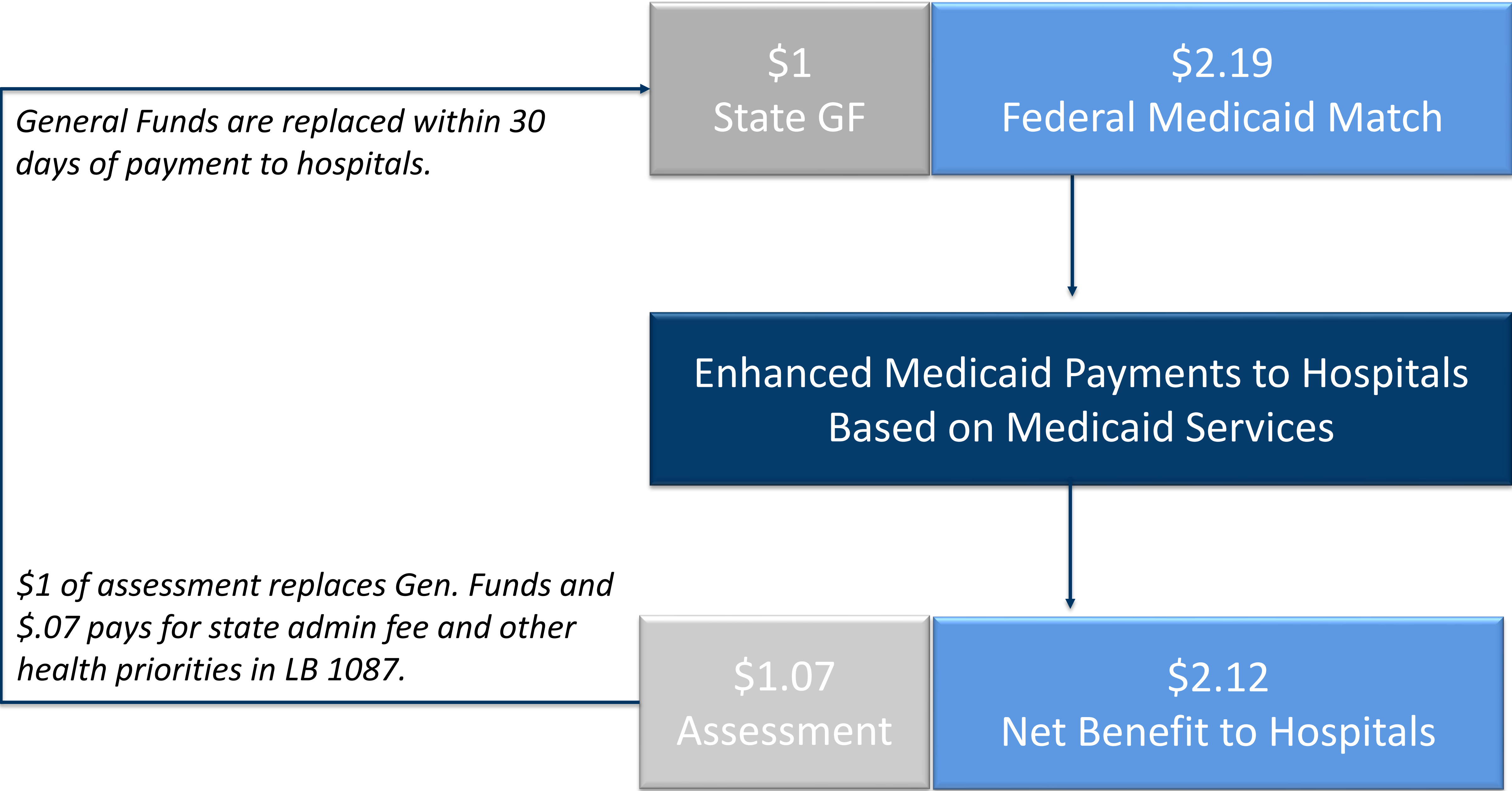
- Better statewide access to care for Medicaid population.
- Minimize, and hopefully eliminate, net contributors.
- New Federal funds would supplement, not supplant, state funds.
- Assessment funds not used for other purposes.
- Legislative trigger to eliminate assessment if Federal funds goes away.

HOSPITAL QUALITY ASSURANCE AND ACCESS ASSESSMENT ACT

- Directs DHHS to establish a Directed Payment Program for inpatient and outpatient services and gives them authority to establish an assessment.
- Maintain language that keeps base Medicaid rates and total funding at FY24 level.
- State receives 3% of assessment amount for administrative fees, 3.5% for non-hospital Medicaid rates or state HIE, and 0.5% for expansion of clinical nurse training sites.
- Nebraska hospitals will invest $50M per year in health care workforce development.
- DHHS will partner with Nebraska hospitals to implement initiatives to improve children's mental health, adult mental health, maternity care, and senior care.
- NHA approved quality measures.

MEDICAID DIRECTED PAYMENT FLOW

PAYMENTS MADE QUARTERLY



Assessment paid based on hospital net revenue.

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DIRECTED PAYMENT OPPORTUNITY

		Inpatient	Outpatient	Total
A	Est. 95% ACR	$803 Million	$1,235 Million	$2,038 Million
B	Current Payments	$287 Million	$349 Million	$636 Million
C = A - B	**Opportunity**	**$516 Million**	**$886 Million**	**$1,402 Million**
D	Est. FMAP			68.68%
*E = (1 - D) * C*	**Assessment Financing Needed**			**$440 Million**

MODEL SUMMARY

	4/2024 Modeled Impacts w/ State & NHA Admin
New State Directed Payments	$1,402 Million
Hospital Assessment, including admin	-$479 Million
Loss of DSH	-$40 Million
Net Impact	**$883 Million**
Net Contributors	2
Net Losses	-$1.6 Million
Net Contributors, net of systems	1
Net Losses	$259k

ASSESSMENT RATE DETERMINATIONS

- HMA evaluated 12 different combinations of inpatient and outpatient assessments
  - Inpatient included days, discharges, and revenue
  - Outpatient included revenue
  - All bases with and without Medicare
- Sensitivity testing indicated that best assessment approach:
  - Inpatient based on **Net Inpatient Revenue**
  - Outpatient based on **Net Outpatient Revenue**

NHA BOARD-APPROVED ASSESSMENT RATES

- Assessment on net inpatient and outpatient revenue (FY 22).

	IP Assessment Rate	OP Assessment Rate
Full Rate	6.44%	7.12%
CAH	5.80%	6.23%
CAH w/ <$5M OP	0.00%	1.78%
Childrens	1.29%	1.78%
Specialty	1.61%	3.56%
***LTAC**	1.61%	3.56%
REH	0.00%	1.78%

- Each hospital assessment will be initially set for 6 months, then aligned to the MCO plan years for 12-month periods going forward.
- Assessment portions will not change during these 18 months, but rates could fluctuate up or down as FMAP changes.

QUARTERLY PAYMENT CALCULATIONS

- **Estimated** payment increases, includes MCO payments and settlements:
  - Inpatient = 177.65%
  - Outpatient = 278.86%
- **Final payment percentages will be determined by Medicaid utilization.**
- Federal approval of Directed Payment amount - $1.402B ($516M IP + $886 OP)
  - $129M IP + $221.5M OP = $350.5M per quarter
  - Paid proportionally to hospitals based on IP & OP utilization.
  - For quarterly payments, DHHS will use paid claims from two quarters prior.
  - Reconciliation will take place on actual services provided 6-9 months after year end.

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DIRECTED PAYMENT NEXT STEPS

- Finalize model.
- DHHS will submit CMS documents.
  - Preprint (expected to take about six months):
    - Directed Payment framework needs CMS approval prior to implementation.
  - Tax waiver (expect approval within two months):
    - Authority to utilize a non-uniform tax.
    - Preprint contingent on financing approval.
- Retroactive to July 1, 2024.

DIRECTED PAYMENT NEXT STEPS

- Implementation date will depend on CMS response time.
  - While materials are pending at CMS, NHA and HMA will work with DHHS and members to map out implementation details.

- Other: CMS Medicaid Managed Care Rule.
  - Expect final rule at the end of April.
  - Will have long term implications on directed payments.

Quality Components of Medicaid Directed Payment Program

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Measures Selection:

Behavioral Health

Aging and Chronic Care

Maternal Safety

Patient Safety

- At least 1 measure -- per defined buckets
- Focus for a 3-year period.
- Measures will be retired after 3 years, unless work needs to be extended based on performance.
- Measures can be retired prior to 3 years if goals are met and sustained.
- New measures will be added over time to continue to drive high-quality care and improve patient outcomes.

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Measure Selection and Data Analysis:

- Created an Advisory Council with diverse representation.
- The council worked together to determine metrics that were valuable and cross-cutting.
- The team will continue to meet throughout the project to analyze performance and determine measures updates and changes.
- Data will be submitted and analyzed quarterly by NHA Quality Team and the Advisory Council.
- Statewide data will be submitted to CMS annually.

Measure List:

Self-Reported Metrics:

- Social Determinants of Health Screening (SDoH)
- Post-Partum Maternal Depression / Anxiety Screening
- CAUTI

NHA Reported Data:

- Use of ED for Behavioral Health as a Primary Diagnosis
- Unique organizations that are engaged with Age-Friendly Health Systems

LB1087 IMPLENTATION ADVISORY COMMITTEE

- Medicaid Innovation and Rate Stabilization (MIRS) Task Force will conclude work at the end of May.

- New LB 1087 Implementation Advisory Committee
  - 15 members – CEOs or CFOs
  - 10 elected by District CEOs (2 per district). Election by email in early May.
  - Board Chair will appoint one additional member per district to ensure balanced representation and will select Co-Chairs.
  - Advise NHA Board, NHA staff, and DHHS on implementation issues, including implementation agreements between hospitals, NHA, and DHHS as well as future model development.
  - 1 year approval with option for renewal by NHA Board.

- NHA Medicaid Quality Advisory Council will remain in place.

MEDICAID DIRECTED PAYMENT IMPLENTATION BUDGET

- Governor/DHHS is expecting NHA to do the heavy lifting.
- Initial drafting by NHA senior staff. Three components:
  - Financial & General Administration
  - Quality Improvement Programming
  - Policy & Member Engagement
- Board will review and give approval for budget framework and specifics components of the budget at the June meeting.
  - Financial administration staff will need to be hired this summer.
- Final annual administrative budget will be reviewed and approved by the Board at the October meeting.
- NHA will have a TPA agreement with member hospitals.

KEY MEETINGS

- Medicaid Directed Payment Quality Overview on April 30th.
- NHA August In-Person District Meetings.
  - District I – August 12
  - District II - August 19
  - District III – August 27
  - District IV – August 28
  - District V – August 23