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COVID-19

Targeted Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis

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The COVID-19 pandemic has caused dramatic changes in utilization that threaten the financial stability of providers and may jeopardize access to care during and after the national emergency.

- **Hospitals.** Between March-August 2020, a combination of lost revenue related to fewer elective procedures and emergency department / outpatient encounters, and higher costs related to COVID-19 (e.g. surge planning, procurement of PPE, increased staffing costs, etc.) has put many hospitals in a precarious financial position. (Some hospitals in hotspots saw a surge in COVID-19 patients that offset the revenue decline and may cover increased costs; most hospitals across the country did not.) Even after accounting for federal support from the Provider Relief Fund, hospital operating margins are estimated to be -7% in the second half of 2020, compared to a 3.5% positive margin in 2019[1,2], according to one recent estimate.
- **Other Providers.** In addition, many other providers that rely on face-to-face visits—including primary care, behavioral health, and providers of long-term services and supports—have seen large utilization declines due to social distancing requirements, with outpatient visits falling 60 percent in April 2020. As of July 2020, outpatient visits remain 10 percent below the pre-COVID-19 baseline, even after accounting for the increased use of telemedicine.[3] Against a backdrop of many essential Medicaid providers, particularly smaller ones, having only a few weeks of cash reserves on hand, these providers are at risk for closure in the very near term. For example, pediatricians have reported dramatic drops in patient encounters that have not rebounded at the rate of other provider utilization – currently 26% below pre-COVID-19 baseline – with many pediatric primary care practices having to reduce employee hours

and lay off staff to stay afloat. Overall, as of the end of July 2020, Medicaid visits have been slower to rebound than encounters covered by other payors (14% below pre-COVID utilization baseline, compared to 10% for Medicare and commercial).[4,5]

Federal and state governments have acknowledged and responded to the financial challenges facing providers in several ways. The Centers for Medicare & Medicaid Services (CMS) is continuing to offer relief from rules that can be a barrier to providing care during the crisis and has offered states some simplified ways to make changes to their Medicaid state plans, including streamlined approval of disaster-related State Plan Amendments (SPAs) and Section 1915(c) Appendix Ks for home and community based services and providers. In June 2020, CMS also released new guidance allowing increased flexibility related to managed care directed payments.[6] Congress has also taken action: the four federal stimulus bills enacted to date[7] have provided supplemental funding to states, local governments and providers to address the crisis, including a $150 billion Coronavirus Relief Fund for states and local governments, and a $175 billion fund for healthcare providers (see Manatt's summary of the legislation).

More than five months since the President's national emergency declaration, the pandemic continues to rage in many parts of the country. Most of the Provider Relief Fund dollars have been distributed, yet providers are still experiencing lost revenue and increased costs related to COVID-19. Under any scenario, Medicaid payment strategies—especially for providers serving high numbers of Medicaid patients—remain a critical tool for states to support providers as new COVID-19 hotspots emerge and utilization patterns change. Many of these payment arrangements—especially those that advance payments to providers with a subsequent reconciliation based on actuals—may also accelerate the adoption of permanent alternative payment models (APMs), which are often based on a similar foundation.

As these payment strategies differ depending on the Medicaid delivery system, the tables below distinguish between Medicaid fee-for-service and managed care, and include the relevant providers, description of the approach, authority needed, and considerations for each strategy.

Medicaid Fee-For-Service

The strategies that follow are in addition to traditional tools states are using to increase provider reimbursement (e.g. across-the-board rate increases, maximizing supplemental payments based on state's existing FFS supplemental payment methodology, etc.)

Provider Class	Approach	Authority	Considerations / State Examples
All Providers	**Make advanced, interim payments to providers with a reconciliation at a later date.** • CMS has granted authority to five states to make advanced, interim payments to providers before the provider has rendered services.[8] Under such an arrangement, the state could make interim payments based on a provider's historical claims volume before COVID-19. At a	SPA	• Unlike other strategies, payment is an advance. However, offers a quick funding stream for short-term cash flow needs.

Provider Class	Approach	Authority	Considerations / State Examples
	later date, the state would perform a reconciliation based on the provider's billable claims during the relevant period. • The approach can provide upfront funds and, at a later date, providers would need to repay the Medicaid agency for payments in excess of billable claims.		• Could be paired with other funding mechanisms *State Example: North Carolina* • Any Medicaid provider that requests can receive advanced, interim payments[9]
Non-institutional Providers *(not subject to UPL)*	**Set fee-for-service base rates at a level that allows providers to be paid equal to the prior year's Medicaid costs or Medicaid payments despite new, lower utilization levels.** For example: 1. Identify providers' average Medicaid service payments and total utilization for a six-month period pre-COVID-19, as reported by providers 2. Identify actual utilization between March – August 2020 (six-month COVID-19 period) 3. Identify percent change in service utilization pre-COVID-19 (step 1) and post-COVID-19 (step 2) 4. Increase providers' rates by percent change (step 3) 5. Assuming post-COVID-19 utilization in subsequent months is similar to March – August 2020, the total payments will equal pre-COVID-19 payment levels. o For example, during the 6 month period before COVID-19, the state identified 10 total encounters, with payments of $10/encounter, for a total of $100 in payments to the provider. During March – August 2020, the provider had only eight encounters, due to COVID-19. The percent change between the two periods reflects a 25 percent reduction in utilization, i.e., (10-8)/8. The State would increase per-encounter payment rates by 25% to $12.50 per service to account for the decrease in utilization. Assuming utilization for the next six months (Sept. 2020-February 2021) is similar to March – August 2020, the provider would receive $100 in reimbursement ($12.50*8) during the six month period, equal to the aggregate payments before COVID.	SPA	• For providers not subject to a UPL, CMS has discretion to approve payments based on principles of economy, efficiency and quality of care • CMS may be more likely to approve a cost-based methodology. Non-institutional providers, however, may not have reliable cost data, in which case state could propose using aggregate payments

Provider Class	Approach	Authority	Considerations / State Examples
Hospitals, Nursing Facilities and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs) *(providers subject to upper payment limits at 42 CFR 447.272)*	**Preserve overall payments to institutional providers at prior year's level.** • Identify upper payment limit (UPL) cap for the current year using prior year's data (standard practice) in order to rebase supplemental payment in light of current year's reduced utilization • Identify room underneath the cap using current year's actual/projected claims payments at lower utilization levels • Consider how to allocate UPL gap across providers based on need • Reconciliation would be needed to ensure that claims payments plus UPL payments are below aggregate cap based on prior year's data.	SPA	• UPL calculations typically use lagged data, but CMS may have questions about validity of UPL demonstration using combination of lagged data and projected changes • May want to revisit UPL formula to ensure appropriate targeting
Providers Rendering Services under 1915(c) Home and Community-Based Services Waivers	**Request authority under appendix K to modify provider payment rates/methodologies to respond to the emergency,** including: • Temporarily increase provider payment rates for waiver services • Temporarily include retainer payments to personal assistants (in various services in which personal care is provided) to address emergency related issues, such as when the waiver participant is hospitalized or absent from his/her own for a period of no more than 30 days • Permit payment for services rendered by family caregivers/legally responsible individuals (if they do not already).	Appendix K	• States can request significant flexibility, including use of retainer payments, for HCBS providers to address significant financial hardship they may experience due to the crisis • Dozens of states have received approval to modify provider payment rates under Appendix K[10]

Medicaid Managed Care

Note: Unlike strategies in Medicaid fee-for-service (FFS), strategies below could apply be applied to all providers contracting with managed care

Approach	Authority	Considerations / State Examples
Encourage and/or incentivize plans to increase payments to providers with declining utilization. • Request that plans pay providers at levels similar to the prior year's payments, notwithstanding reduced utilization, citing the need for plans to maintain adequate networks and meet medical loss ratio (MLR) requirements	Existing state authority (unless state wants to provide an incentive payment for plans that voluntarily comply, which would require CMS approval if part of a new incentive initiative)	• State can point to the need to maintain network adequacy and meet MLR requirements, as well as other points of leverage, to increase the likelihood that plans voluntarily make these payments • Governmental managed care plans may be more willing to pay providers regardless of utilization • To implement an incentive arrangement or increase capitation rates up to 1.5%, states would need to amend their contracts

Approach	Authority	Considerations / State Examples
o For example, request that plans pay behavioral health providers 1/12 of last year's total payments each month. • To encourage plans to develop strategies to support providers, states could also: o Make incentive payments to plans based on the parameters in 42 CFR 438.6(b) (up to 5 percent above the actuarially sound capitation rates) o Alternatively, states could increase capitation rates by 1.5% (maximum increase that does not require states to submit a revised rate certification to CMS)[11]		with plans and submit to CMS for approval. CMS has indicated it will review contract amendments on an expedited basis • Absent an incentive payment or capitation rate increase, no CMS approval is necessary *State Example: Washington State* • Worked with MCOs to develop voluntary payment "stabilization" arrangements for financially distressed behavioral health providers[12]
Make directed payments to providers to match historical payment levels. • Leverage new flexibilities under recent Medicaid managed care directed payment guidance to increase payments to providers. • For example, state could: 1. Identify the relevant provider class 2. Identify providers' monthly Medicaid payments from the most recent pre-COVID-19 year 3. Calculate the actual MCO utilization and payments to provider class on a monthly basis 4. Subtract historical monthly payments (step 4) from actual payments (step 4) to identify payment gap 5. Divide payment gap (step 4) by the actual units of service (step 3) to identify the per-service directed payment increase amount	438.6(c) preprint	On May 14, 2020 CMS issued guidance providing greater flexibility to make directed payments under managed care during the public health emergency.[13] This includes: • **Higher Limits on Per-Service Payment Levels**. CMS has previously used the average commercial rate (ACR) as a ceiling on directed payment arrangements. During the pandemic, CMS will evaluate directed payments to ensure providers will *not receive total payments that exceed what was assumed in capitation rates* absent the public health emergency. Capitation rates assumed normal utilization levels, so spreading the same dollars across sharply lower utilization may mean that, on a per-service basis, payments are considerably higher that the ACR • **Retroactive implementation of directed payments**. Under federal directed payment regulations, directed payments must be tied to utilization. However, to reach total payment levels equal to assumptions built into capitation rates, directed payments can be made retroactively based on services delivered by a group of providers back to the beginning of the rate year. *As a result, states can implement*

Approach	Authority	Considerations / State Examples
6. Direct MCOs to make per-service directed payments increases based on actual utilization		*directed payments mid-rate year as a tool to address provider shortfalls* • States are required to establish a two-sided risk corridor on their Medicaid managed care rates as a condition for CMS approval of the directed payment, and must also submit a preprint and contract amendment. CMS will not require a rate amendment if payment amounts are de minimus (less than 1.5 percent per rate cell) *State Example: New Hampshire* • Took ~1.5 percent of its capitation payments from September 1, 2019 through June 30, 2020 and required MCOs to distribute them to six distinct provider classes[14] • The directed payment is structured as a uniform percentage increase for each provider class (percentage differs by class) • Even though the directed payment was not approved until April 2020, it was retroactive to Sept. 2019
Make pass-through payments to critical providers • Request authority from CMS to make pass-through payments to providers based on defined parameters negotiated with CMS • Depending on current rates and utilization, may require adjustments to the rate	1115 waiver	• Current federal regulations strictly limit the use of pass-through payments (see 42 CFR 438.6(d)). However, CMS's proposed managed care rule released in November 2018 would grant states authority to make pass-through payments for a period of time after the state transitions services and/or populations to managed care • State could request that CMS grant the ability to make pass-through payments on a temporary basis (e.g. for duration of the National Emergency) based on a methodology approved by CMS under Medicaid fee-for-service (e.g. UPL payment methodologies) • CMS has not approved any pass-through payment requests to date; however, similar outcome can be achieved through new flexibilities related to directed payments

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[9] CMS. North Carolina State Plan Amendment #20-0008. May 2020, available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NC/NC-20-0008.pdf.

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[11] 42 CFR §438.7(c)(3)

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[14] Six provider classes are: critical access hospitals; residential substance use disorder providers; home health care providers; private duty nursing providers; personal care providers; federally qualified health centers and rural health centers. New Hampshire Department of Health and Human Services. Approved Section 438.6(c) Preprint: Directed Payment State Plan Amendment. June 2020. Available here.