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

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STATE Health & Value STRATEGIES COVID-19

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About State Health and Value Strategies

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Agenda

- Context: Provider Challenges and Federal/State Response
- Medicaid Managed Care Strategies
- Medicaid Fee-for-Service Strategies

Context: Provider Challenges and Federal/State Response

COVID-19 Has Dramatically Impacted Financial Stability of Providers

Hospitals

- Experienced lost revenue from cancelled elective procedure and emergency department / outpatient visits, and higher costs related to COVID-19 (e.g. surge planning, procurement of PPE, increased staffing costs, etc.)
- Even after accounting for federal support, hospital margins are estimated to be -7% in the second half of 2020, compared to 3.5% in 2019, according to one analysis.

Other Providers

- Outpatient visits fell by 60% in mid-April and are still 10% lower compared to a pre COVID-19 baseline, even after accounting for increased telemedicine visits

Sources: American Hospital Association. New Analysis Shows Dramatic Impact of COVID-19 on Hospital & Health System Financial Health. July 2020. Available here.; The Commonwealth Fund. The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots. August 2020. Available here.

States are Implementing Medicaid Payment Strategies to Supplement Federal Stimulus Funds

Federally-Driven Strategies

- **Federal stimulus bills,**[1] which provided supplemental funding to states, local governments, and providers, including $150 billion Coronavirus Relief Fund for states and $175 billion Provider Relief Fund

State-Driven Strategies

- Dozens of states have implemented Medicaid payment increases through disaster relief state plan amendments, appendix K (for home and community based service providers), and managed care
- This presentation focuses on innovative payment strategies states can continue to take in managed care and FFS to sustain providers during the public health emergency

Focus of this presentation

[1] *As of April 21, 2020: H.R. 266, Paycheck Protection Program and Health Care Enhancement Act; H.R. 748, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); H.R. 6201, Families First Coronavirus Response Act; H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*

Sources: Kaiser Family Foundation. Options to Support Medicaid Providers in Response to COVID-19. June 2020. Available here.; CMS. Section 438.6(c) Preprint: Directed Payment State Plan Amendment. Available here.

Medicaid Managed Care Strategies

Background: CMS's May Guidance Provides New Managed Care Payment Flexibilities During Public Health Emergency

Directed Payments

Guidance gives states new flexibility to implement managed care directed payments, including:

- **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 than the ACR.
- **Retroactive implementation of directed payments**. Directed payments must be tied to utilization, but CMS's guidance confirmed that 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 directed payments mid-rate year as a tool to address provider shortfalls, depending on how COVID-19 continues to impact provider utilization and payment levels.*

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).

Guidance also clarifies that states may direct MCOs to make "retainer payments" to providers for home and community-based services covered under the managed care contract.

Based on CMS guidance, states are implementing a variety of strategies to increase managed care payments to providers. States that have not yet adopted directed payment strategies can do so for duration of public health emergency.

[1] *As of August 26, 2020: H.R. 266, Paycheck Protection Program and Health Care Enhancement Act; H.R. 748, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); H.R. 6201, Families First Coronavirus Response Act; H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*

Make Directed Payments to Providers to Match Historical Payment Levels

How It Works*	Example
A. Identify applicable provider class to receive directed payment	Community-based behavioral health providers
B. Identify providers' monthly Medicaid payments from the most recent year pre-COVID 19	$100
C. On a monthly basis, calculate actual MCO utilization and payments to provider class	$50; 10 units of service
D. Subtract historical monthly payments (Step B) from actual payments (Step C) to identify payment gap	$100-$50=$50
E. Divide payment gap (Step D) by actual units of service (Step C) to identify per-service directed payment increase	$50/10=$5
F. Direct MCOs to increase per-service directed payments by the amount identified in Step E based on actual utilization	$5*10=$50 in increased payments is added on to the $50 they already received

Note: *Represents one directed payment approach. States are implementing a wide array of directed payments based on federal directed payment regulations (42 CFR 438.6(c) and COVID-19 directed payment guidance; see next slide)

Make Directed Payments to Providers to Match Historical Payment Levels: State Examples

Virginia

- Increased per-service reimbursement for many primary care services (evaluation and management codes) by 29% between March - June 2020
- Directed payment designed to ensure dollars built into capitation rates for primary care services reach providers despite lower than expected utilization
- Virginia Department of Medical Assistance Services estimates directed payment will increase payments for primary care services by $30 million

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[1]
- 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

[1] *Six provider classes: 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.*

Sources: Virginia Department of Medical Assistance Services. Virginia Medicaid Agency Announces Emergency Relief for Providers. June 2020. Available here.; New Hampshire Department of Health and Human Services. Approved Section 438.6(c) Preprint: Directed Payment State Plan Amendment. June 2020. Available here.

Encourage Plans to Increase Payments to Providers with Declining Utilization

How It Works

- **Request that plans pay providers at levels similar to the prior year's payments, regardless of actual utilization**
  - *For example, request that plans pay behavioral health providers 1/12 of last year's total payments each month.*
- **To support plans' efforts to maintain adequate provider networks, states could:**
  - **Make incentive payments to plans** based on the parameters in 42 CFR 438.6(b) (up to 5% above the actuarially sound capitation rates)
  - **Increase capitation rates by up to 1.5%** without triggering need for new rate certification; contract amendment needed

Considerations

- **State can point to the need to maintain network adequacy and meet MLR requirements**
- **Governmental managed care plans may be more willing to pay providers** regardless of utilization
- **To implement an incentive arrangement, states would need to amend their contracts** with plans and submit to CMS for approval.

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CMS approval of contract amendment (needed only for approval of new incentive arrangement and/or capitation rate increases)

State Example: Washington

- Worked with MCOs to develop voluntary payment "stabilization" arrangements for financially distressed behavioral health providers

Source: Washington State Health Care Authority. Integrated Managed Care Behavioral Health Provider Supporting During the COVID-19 Pandemic. March 2020. Available here.

Make Pass-through Payments to Essential At-Risk Providers

How It Works

- **Request authority from CMS to make pass-through payments** to providers based on defined parameters negotiated with CMS

Considerations

- **Current federal regulations strictly limit the use of pass-through payments** (see 42 CFR 438.6(d)), but CMS's proposed 2018 managed care rule opens the door to exceptions.
- **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

Authority

1115 waiver

Medicaid Fee-for-Service Strategies*

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.)*

Make Advanced, Interim Payments to Providers with Subsequent Reconciliation

How It Works

State makes interim, advanced payments based on provider's historical claims volume before COVID-19

Provider receives interim payment amount and continues to submit claims for services rendered

State performs reconciliation at later date by comparing advance payments with actual claims submitted to identify provider overpayment

Provider repays state Medicaid agency for any overpayment (over time; not necessarily single payment)

State Medicaid agency repays federal share of any overpayment to CMS

Applicable Provider Class
All Providers

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State Plan Amendment

Considerations

- **Unlike other strategies, payment would be a loan**. However, offers a quick funding stream for short-term cash flow needs
- Could be paired with other funding mechanisms

State Example: North Carolina

- Any Medicaid provider that requests can receive advanced, interim payments

Source: CMS. North Carolina State Plan Amendment #20-0008. May 2020. Available here.

Set FFS Base Rates to Match Prior Year's Costs / Payments Despite Lower Utilization

How It Works*	Example
A. Identify applicable provider class to receive payment increase	Community-based behavioral health providers
B. Identify providers' average Medicaid service payments and total utilization for a six-month period pre-COVID 19	$10/per unit of service; 10 units for a total payment of $100
C. Identify actual utilization between March-August 2020 (6-month COVID 19 period)	8 units of service
D. Identify percent change in utilization pre (Step B) and post (Step C) COVID 19	(10-8)/8=25%
E. Increase rates by percent change identified in Step D	25%
F. Assuming post-COVID 19 utilization in subsequent months is similar to March-August 2020, total payments will approximate pre-COVID payment levels	8 units of service * $12.50 per unit (original $10 rate increased by 25%)=$100

Applicable Provider Class

Non-Institutional Providers (not subject to UPL)

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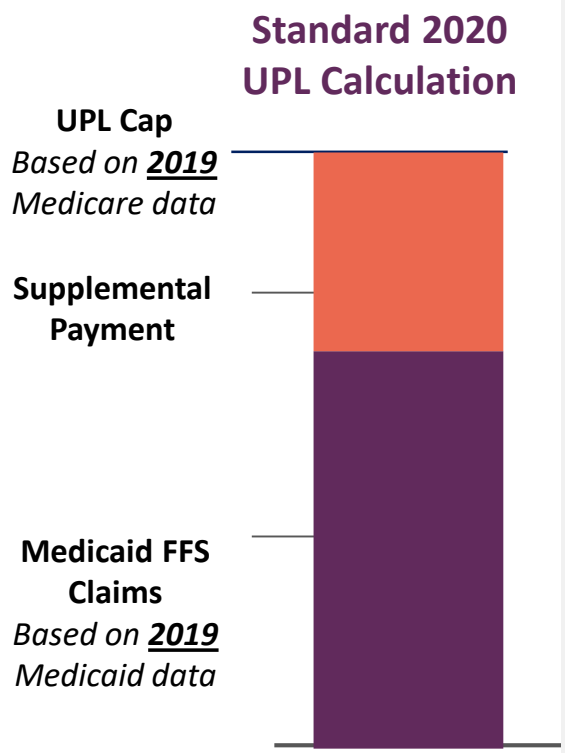
Considerations

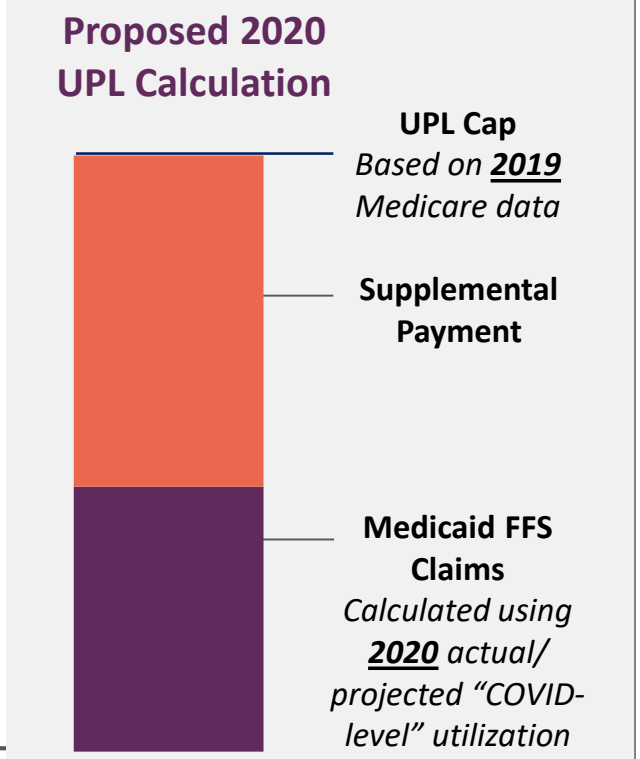
- **For providers not subject to a UPL, CMS has discretion to approve payments** based on principles of economy, efficiency and quality of care
- **CMS may be more likely to approve a cost-based methodology**. Non-institutional providers, however, may not have reliable cost data, in which case state could propose using aggregate payments

***Note:** Represents one approach to maintaining historical payment levels for non-institutional providers. States have a wide array of options for increasing Medicaid FFS rates to providers.

For Institutional Providers Subject to UPL, Adjust UPL Calculation to Preserve Aggregate Payment Levels

How It Works





To maximize UPL room, use last year's UPL cap and this year's lower, COVID-level FFS claims

Applicable Provider Class
Hospitals, Nursing Facilities and/or ICFs/IIDs (providers subject to upper payment limits at 42 CFR 447.272)

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State Plan Amendment

Considerations

- **CMS may have questions about validity of UPL demonstration** using combination of lagged data and projected changes
- **May want to revisit distribution of UPL payments** to ensure appropriate targeting based on provider needs

Thank You

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