

COVID-19

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

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

- **Hospitals.** With elective cases generally cancelled, hospitals have sharply lower utilization and revenue. Some hospitals in hotspots are seeing a surge in COVID-19 related usage, which may offset some or all of the revenue decline and in some cases increase their costs. For hospitals not yet treating significant numbers of COVID-19 patients, including many critical access hospitals, the sharp decline in utilization puts them in a precarious financial position.
- **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—are seeing large utilization declines due to social distancing requirements. Increased use of telemedicine may offset a portion of that lost revenue, but providers are likely to still bear significant losses that can threaten their ability to keep their doors open during and after the crisis. It is not unusual for essential Medicaid providers, particularly smaller ones, to have only a few weeks of cash reserves on hand, putting them at risk for closure in the very near term.

Federal and state governments have acknowledged and responded to the financial challenges facing providers in several different ways. The Centers for Medicare & Medicaid Services (CMS) is continuing to offer wide-ranging relief from rules that can be a barrier to providing care during the crisis and has offered states simplified ways to make changes in their Medicaid state plans and to request disaster-related waivers. Several states have submitted 1115 waivers requesting CMS approval to establish “disaster relief funds,” paid for with Medicaid dollars, to

further assist providers (these requests are pending with CMS). Congress has also taken action: the three federal stimulus bills enacted to date¹ provide 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 \$100 billion fund for providers (see [Manatt's summary of the legislation](#)).

While it will take some time for waiver requests to be reviewed and for the new federal funds to be released, more immediately available tools can help ensure payments continue flowing to providers despite substantial utilization changes. The options below draw from but modify existing practice; some may require CMS approval, including, in some instances, 1115 waiver authority.² The requests, however, are narrow, and they build on, and are logical extensions to, approved payment mechanisms. When they need to be reviewed by CMS, they could be acted on quickly, particularly if CMS continues its current approach of providing unprecedented levels of flexibility (e.g., in 1115 waivers) in response to the COVID-19 challenge. To ensure the strategies are as effective as possible, states will need to clearly communicate with providers across the delivery system – both to understand priorities with regard to enhanced payment needs, but also to make providers aware of payment changes through provider bulletins, webinars, provider associations, and other communication channels.

As the strategies differ depending on the 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.

¹ [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”

² This list is not exhaustive. For example, many states are requesting the ability to make retainer payments to home and community-based service providers either through Appendix K (for 1915(c) waiver providers) or 1115 waivers (for a broader set of Medicaid beneficiaries receiving home and community-based services).

Medicaid Fee-For-Service

Provider Class	Approach	Authority	Considerations
All Providers	<p>Make advanced, interim payments to providers with a reconciliation at a later date</p> <ul style="list-style-type: none"> In a recent FAQ, CMS noted that states can request authority to make advanced, interim payments to providers before the provider has rendered services. For example, the state could make interim payments based on a provider’s historical claims volume before COVID-19. At a later date, the state would perform a reconciliation based on the provider’s billable claims during the relevant period. The approach would provide upfront funds and, at a later date, providers would need to repay the Medicaid agency for payments in excess of billable claims. CMS notes that it will review interim payment requests on an expedited basis. 	SPA	<ul style="list-style-type: none"> Unlike other strategies, payment would be an advance. However, offers a quick funding stream for short-term cash flow needs. Could be paired with other funding mechanisms
Non-institutional Providers (<i>not subject to UPL</i>)	<p>Set fee-for-service rates at a level that allows providers to be paid equal the prior year’s Medicaid costs or Medicaid payments despite new, lower utilization levels. For example:</p> <ul style="list-style-type: none"> Identify providers’ annual Medicaid costs or payments from the most recently available year Estimate annual “post-COVID 19” Medicaid utilization levels based on experience since National Emergency Declaration as reported by providers (e.g., if provider A reported 10 encounters per week since Declaration, state would estimate 520 annual encounters) Identify interim per-unit payment, representing the prior year’s total Medicaid costs/payments divided by estimated encounters Pay providers based on interim payment rate for duration of National Emergency (plus additional time, if applicable) Upon end of payment methodology, reconcile actual encounters during which the payment methodology was in effect with the projected number of encounters used to determine the per-unit payment amount. <ul style="list-style-type: none"> For example, in calculating the interim rate, the state assumed costs of \$1,040 and 520 encounters, for a total payment of \$2 per encounter. If at the end of the year the provider had only 400 encounters (including telehealth) for a total payment of 	SPA	<ul style="list-style-type: none"> For providers not subject to a UPL, CMS has discretion to approve payments based on principles of economy, efficiency and quality of care CMS is familiar with cost-based payments and thus may be more likely to approve a cost-based methodology. Non-institutional providers, however, may not have reliable cost data. If a state is concerned about the availability or reliability of cost data for some providers, the state could seek approval to base payments on the prior year’s aggregate Medicaid payments. The state has easy

Provider Class	Approach	Authority	Considerations
	<p>\$800 (\$400*2), the provider would receive an additional payment of \$240 to equal its estimated costs/prior year's payments (\$800 + \$240 = \$1,040).</p>		<p>access to aggregate FFS claims for each provider. CMS, however, may be less familiar with a payment methodology tied to historical payments</p>
<p>Hospitals, Nursing Facilities and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs) <i>(providers subject to upper payment limits at 42 CFR 447.272)</i></p>	<p>Preserve overall payments to institutional providers at prior year's level.</p> <ul style="list-style-type: none"> • 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 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. 	<p>SPA</p>	<ul style="list-style-type: none"> • 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
<p>Providers Rendering Services under 1915(c) Home and Community-Based Services Waivers</p>	<p>Request authority under appendix K to modify provider payment rates/methodologies to respond to the emergency, including:</p> <ul style="list-style-type: none"> • 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). 	<p>Appendix K</p>	<ul style="list-style-type: none"> • 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

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

Strategy	Approach	Authority	Considerations
Encourage and/or incentivize plans to increase payments to providers with declining utilization	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ○ 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) • Alternatively, states could increase capitation rates by 1.5% (maximum increase that does not require states to submit a revised rate certification to CMS)³ 	CMS approval of contract amendment (needed only for approval of new incentive arrangement)	<ul style="list-style-type: none"> • 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 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.
<u>Make directed payments in advance of CMS approval</u>	<ul style="list-style-type: none"> • Request authority to make directed payments to providers based on the parameters set forth in 42 CFR 438.6(c) in advance of CMS approval. 	438.6(c) preprint plus 1115 waiver (needed only for ability to implement prior to approval)	<ul style="list-style-type: none"> • Would require 1115 waiver because state would make payments based on a methodology that ordinarily requires CMS approval prior to implementation • Because directed payment approval often takes several months, approach could expedite payments to providers

³ 42 CFR §438.7(c)(3)

Strategy	Approach	Authority	Considerations
			<ul style="list-style-type: none"> • Most appropriate if state wants to make directed payments based on standard parameters approved by CMS in other states (e.g. per-unit dollar or percentage increase, with payments below the average commercial rate); if payments were to exceed the average commercial rate, the state may want to secure CMS approval to minimize risk of CMS disapproving the request after implementation. • If directed payments were implemented in the middle of the rate year, CMS would need to permit states to submit a midyear rate adjustment. (Prior to the pandemic, CMS was trying to discourage such requests, but, it presumably will face a slew of rate adjustment requests in 2020 and 2021 due to COVID-19. Also, here, the rate adjustment would be paired with a contract change, so CMS has another reason to be willing to reopen rates.)
<p>Make directed payments to providers on a cost basis (or as an alternative, based on prior year's payments), with interim payments and final reconciliation</p>	<ul style="list-style-type: none"> • Implement same approach as described under Medicaid FFS above but using a directed payment framework • State would: <ul style="list-style-type: none"> ○ Identify the relevant provider class ○ Develop an interim per-unit payment methodology based on prior year's costs or payments ○ Reconcile to costs incurred upon conclusion of payment methodology • Depending on current capitation rates and utilization, may require adjustments to the capitation rate 	<p>438.6(c) preprint</p>	<ul style="list-style-type: none"> • Payments under this proposed approach may exceed the average commercial rate (ACR), which CMS has typically used as a ceiling on directed payments. However, CMS has discretion to approve directed payments above the ACR and, in the 2018 proposed managed care rule, noted cost-based payment methodologies as an acceptable approach. CMS would also have discretion to approve a methodology linked to prior year's payments. • Similar to the above strategy, if directed payments were implemented in the middle of the rate year, CMS would need to permit states to submit a midyear rate adjustment.

Strategy	Approach	Authority	Considerations
			<ul style="list-style-type: none"> • Approach would pay critical provider types— e.g. primary care, behavioral health and LTSS providers—assuming that their costs would remain roughly the same while utilization would drop significantly. • If capitation rates increase by not more than 1.5%, a new rate certification is not needed. A contract amendment reflecting the rate would be needed.
Make pass-through payments to critical providers	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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)

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