

COVID-19

Medicaid Enhanced Provider Payment Strategies and COVID-19: Questions and Answers

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Introduction

As the coronavirus (COVID-19) pandemic continues to progress, providers across the continuum of care are experiencing significant changes in utilization resulting in declining revenue and jeopardizing access to care. The federal government has acknowledged the financial challenges facing providers through supplemental funding included in the three federal stimulus bills enacted to date—the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); the Families First Coronavirus Response Act; and the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020—and several states have submitted Section 1115 waivers requesting the Centers for Medicare & Medicaid Services (CMS) approval to establish “disaster relief funds,” paid for with Medicaid dollars, to further assist providers.

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. This Q&A provides a moment-in-time update in response to questions SHVS has received regarding the April 9 *Targeted Options for Increasing Medicaid Payments to Providers During COVID-19 Crisis* [Webinar](#) and corresponding [Toolkit](#).

1. Question: *What is a directed payment?*

Answer: A directed payment is when a state requires that a managed care plan pay a particular group of providers in a certain way. For example, the state could require that plans pay all hospitals the Medicaid fee-for-service (FFS) rate or that they increase rates for behavioral health providers by 10 percent. States are allowed to require that plans pay providers in a particular way, so long as the payments are tied to utilization, apply to all providers in a class (which may be broadly or narrowly defined), and are linked to the state’s quality strategy. States must get approval in advance from CMS before requiring that plans make these payments. See question two (below) for additional details.

2. Question: *Do COVID-19-related directed payments require prior approval from CMS?*

Answer: Yes. States can request authority to make Medicaid managed care (MMC) directed payments to providers based on the parameters set forth in [42 CFR 438.6\(c\)](#) by submitting the [Section 438.6\(c\) Preprint](#). Prior to the COVID-19 crisis, it often took several months to secure approval of a preprint. Some states have submitted requests for Section 1115 waivers to enable them to make directed payments prior to receiving CMS approval. As of April 17, CMS has not

approved such requests; CMS has stated that it intends to approve preprints related to COVID-19 quickly.

3. Question: *How could states leverage directed payments to respond to the COVID-19 pandemic?*

Answer: States can use directed payments to distribute Medicaid funding to providers during the COVID-19 crisis in several ways. The most straightforward route is to require that managed care plans increase rates to providers by a certain amount—e.g., 15 percent. Since utilization has declined sharply for many providers, even a large rate increase might not provide enough funding. As an alternative, as is described in the [Toolkit](#), states could require that managed care plans pay providers an amount based on their average monthly payments before the pandemic began to ensure that providers have sufficient funding to continue operations. Because directed payments must be linked to encounters, states would need to estimate encounters for different types of providers to set an interim rate. States could then have the plans reconcile payments up or down if encounters are lower or higher than projected.

4. Question: *Have any providers disclosed their estimated dollars of revenue lost as a result of COVID-19?*

Answer: No. States should, however, be requesting this information from their providers to gauge the level of need. States with large FFS programs may have a better sense of shifts in utilization from claims data; states with MMC should work with plans to get more real-time information on utilization to shape decisions.

5. Question: *What are some provider payment strategies that would require states to use Section 1115 authority?*

Answer: States will need a Section 1115 waiver to receive a pool of money to distribute to providers that is not tied to utilization. For example, if a state wanted a pool of money that it could use to reimburse hospitals for part of the cost of reconfiguring their space to prepare for a surge of COVID-19 patients, it would need a waiver. Similarly, states with MMC programs would need a waiver if they wanted to make payments directly to providers serving MMC enrollees, rather than having the dollars go through the plan. As of April 17, CMS has not approved any requests for Section 1115 waivers related to payments.

6. Question: *Since Section 1115 waivers require budget neutrality, how should states be thinking about these calculations as they pertain to directed payments?*

Answer: When CMS released its [COVID-19 1115 Waiver Demonstration Template](#), it announced that it is not requiring states to demonstrate budget neutrality for these time-limited waivers.

7. Question: *In the context of the COVID-19 pandemic, what does it mean to later reconcile provider payments?*

Answer: Reconciliation would look different, depending on the specific type of payment. If a state were establishing a Medicaid advance payment program through which a provider could receive, for example, a payment equal to three months of payments prior to COVID-19, the state might reconcile those payments by comparing the advance payment to the subsequent utilization and

requiring a payback if the advance payment exceeded the amount owed for the subsequent utilization. With respect to a FFS or directed payment that intends to target the prior monthly payment but at lower utilization levels, a state could set an interim payment rate at the average monthly payment divided by the projected number of encounters. The state (in FFS) or the plan (in MMC) would pay claims at this new, higher interim reimbursement rate. At the end of the month, the state or plan could compare the projected encounters to the actual encounters. If the projected encounters were higher than the actual encounters, that would mean that total payments for time period were lower than the target. At reconciliation, the state or plan could reconcile to the target by retroactively increasing the payment rates to reach the average monthly amount.

8. Question: *Have any states considered provider payment options that use FFS payments to supplement managed care plan reimbursement?*

Answer: Without a Section 1115 waiver, a state cannot pay a provider an additional amount [except for Disproportionate Share Hospital (DSH) and Graduate Medical Education (GME)] outside of what the plan pays. States can, however, require that plans pay additional amounts on top of their negotiated rates (see questions above for additional details). Many states with MMC programs still have FFS programs for some populations. In that case, the state could increase rates through the FFS program to offer more support to providers.

9. Question: *Would it be possible for states to pursue some sort of value-based loan program (e.g., focused on immunizations, well-child visits, asthma)? If so, could states use this mechanism in lieu of interest or payback?*

Answer: The extent of a state's flexibility to waive interest or payback depends on whether the state is seeking federal Medicaid match. If the state would like federal matching dollars for the loan payment, it would need to receive approval from CMS, likely through a Disaster Relief State Plan Amendment (SPA). States generally have flexibility to determine whether to charge interest on advance payments and other types of loans. A state could choose to waive interest for providers attaining certain quality measures, assuming CMS approved this in a SPA. CMS is less likely to approve waiving payback entirely, but it is possible CMS would permit such an arrangement.

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