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

April 9, 2020

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STATE Health & Value STRATEGIES COVID-19

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

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Agenda

- Context: Provider Challenges and Federal/State Response
- Medicaid Managed Care Strategies
- Medicaid Fee-for-Service Strategies
- State Spotlights: New Hampshire and Washington State
- Q & A

Context: Provider Challenges and Federal/State Response

COVID-19 Threatens Financial Stability of Providers

Hospitals

- Elective cases cancelled, leading to sharply lower utilization and revenue
- Increased investment to prepare for the surge
- For many hospitals, COVID-19 related utilization is not offsetting losses

Other Providers

- Social distancing requirements pose additional challenges for providers that rely on face-to-face visits
- Shift to telemedicine is not sufficient to prevent significant revenue losses
- Limited cash may put essential Medicaid providers at risk of closure

Implementing an information-sharing process between Medicaid agency and providers is critical to understanding provider needs and adjusting payment strategies to address them

Targeted Medicaid Strategies Can Provide Quick Relief that Amplifies Impact of Other Federal and State Funds

Federally-Driven Strategies

- **Federal stimulus bills,**[1] which provide supplemental funding to states, local governments, and providers, including $150 billion Coronavirus Relief Fund for states and $100 billion fund for providers

State-Driven Strategies

- Emergency 1115 waiver requests to establish **"disaster relief funds"** to assist providers
- **Targeted Medicaid strategies to increase payments to providers**

Focus of today's webinar

[1] *As of April 9, 2020: 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*

Medicaid Managed Care Strategies

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)

Early State Action

New Hampshire, Washington, California (various counties)

Managed Care | Fee-for-Service

Make Directed Payments to Providers in Advance of CMS Approval

How It Works

- 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**

Considerations

- **Would require 1115 waiver** because methodology would ordinarily requires CMS approval prior to implementation
- **Approach could expedite payments to providers** because directed payment approval often takes several months
- **Most appropriate if state wants to make directed payments based on standard parameters approved by CMS in other states**
- **If directed payments were implemented in the middle of the rate year, CMS would need to permit states to submit a midyear rate adjustment**

Early State Action
Washington

Authority
1115 Waiver (needed only for ability to implement prior to approval)

Make Directed Payments to Providers to Match Prior Year's Aggregate Costs/Payments

How It Works*

A. Identify applicable provider class to receive directed payment

B. Identify providers' annual Medicaid costs or payments from the most recently available year pre-COVID 19

C. Estimate annual "post-COVID 19" Medicaid utilization levels based on experience since National Emergency Declaration

D. Identify interim per-unit payment, representing prior year's total Medicaid costs/payments divided by estimated encounters

E. Pay providers based on interim payment rate for duration of National Emergency (plus additional time, if applicable)

F. Upon end of payment methodology duration, reconcile actual encounters with the projected number of encounters used to determine the per-unit payment amount

Considerations

- **Payments under proposed approach may exceed the ACR**, which CMS has typically used as a ceiling on directed payments. However, CMS has discretion to approve directed payments about the ACR
- **If directed payments were implemented in the middle of the rate year, CMS would need to permit states to submit a midyear rate adjustment**
- **Approach would pay critical provider types** assuming that their costs would remain roughly the same while utilization would drop significantly.

Authority

438.6(c) preprint

Note: *Represents one directed payment approach. States have a wide array of options for directed payment methodologies as long as they remain within parameters of federal directed payment regulations (42 CFR 438.6(c))

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)

Authority
1115 waiver

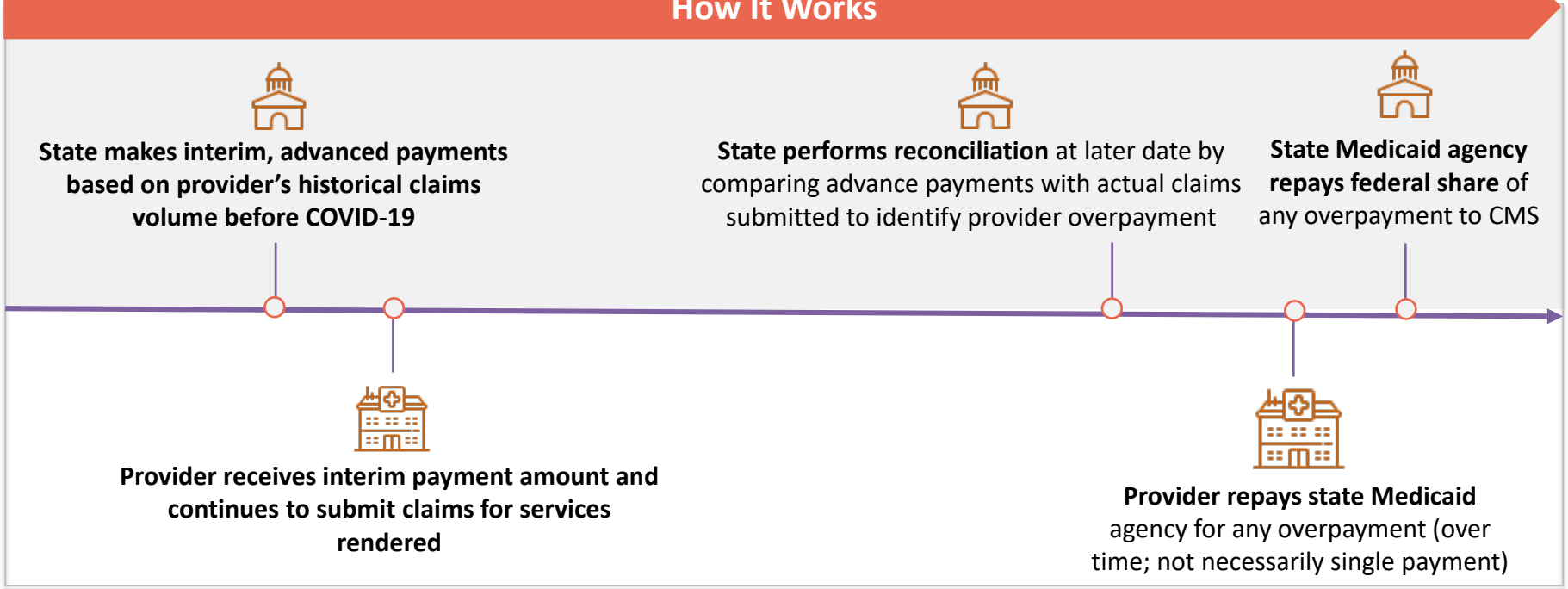
Early State Action
Rhode Island

Medicaid Fee-for-Service Strategies*

Strategies that follow are **in addition to traditional tools states can use 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



Applicable Provider Class
All Providers

Authority
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

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

How It Works

- Implement similar approach as described under Medicaid managed care adapted to a fee-for-service framework (e.g., approval through state plan amendment rather than preprint)
- State would:
  - ✓ **Develop an interim per-unit payment methodology** based on prior year's costs or payments, adjusted for projected post-COVID 19 utilization levels
  - ✓ **Reconcile actual discharges/encounters** upon conclusion of payment methodology

Applicable Provider Class Non-Institutional Providers (not subject to UPL)

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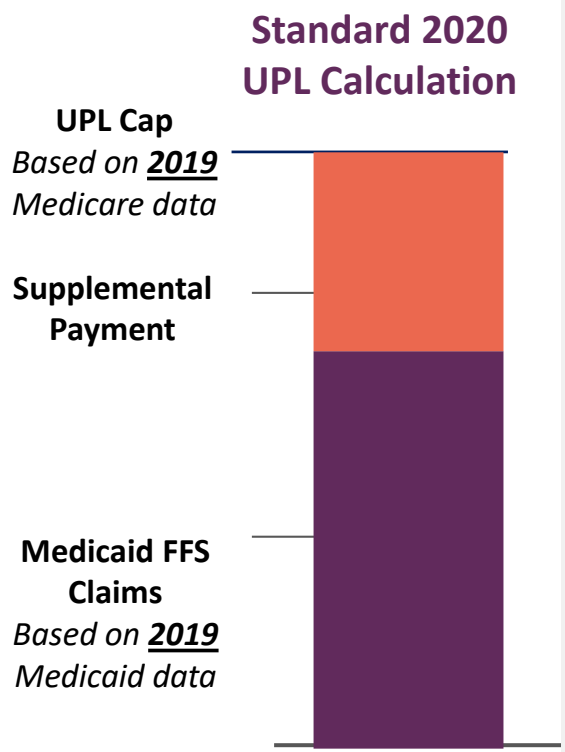
State Plan Amendment

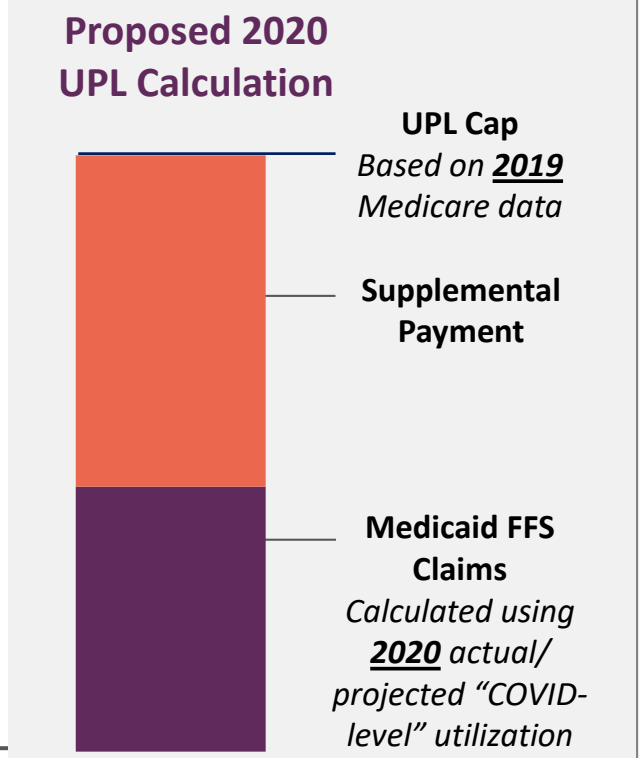
Considerations

- **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

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)

Authority
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

State Spotlights

New Hampshire and Washington State: Strategies to Sustain Providers

New Hampshire

- **Send directive to managed care plans**, emphasizing that they share accountability and responsibility for ensuring stability of their provider networks
- **Reallocate 1.5% of capitation dollars** to select provider rate enhancements
- **Remove managed care withholds,** acknowledging MCO efforts to stabilize provider networks
- **Implement managed care directed payments for providers**

***Panelist**, Henry Lipman, New Hampshire Medicaid Director*

Washington

- **Publish joint State/MCO commitments to sustain behavioral health (BH) providers,** including:
  - State:
    - ✓ Share data with MCOs on at-risk providers
  - MCOs:
    - ✓ Pay all outstanding claims
    - ✓ Develop customized funding strategies for at-risk providers (e.g. advanced payments, capitated contracts)
- **Make new and expedite existing FFS supplemental payments** to at-risk hospitals

***Panelist,** Jason McGill, Assistant Director, Washington State Health Care Authority*

Questions?

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Thank You

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