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New CMS Bulletin Highlights Medicaid Managed Care Tools to Support Essential Providers During COVID-19

The Big Picture

On May 14, 2020, the Centers for Medicare and Medicaid Services (CMS) issued an [Informational Bulletin](#) to describe Medicaid managed care options to mitigate the impact of the COVID-19 pandemic on Medicaid providers. The Bulletin indicates that CMS is interested in helping states use Medicaid managed care to support providers through the pandemic, an issue taking on greater urgency as Medicaid providers across the country face sharp declines in utilization and increases in COVID-related costs that leave them at risk of closing permanently. Most notably, the Bulletin highlights how, under certain conditions, states can use existing authority to require plans to make directed payments to providers to help them weather the financial impacts of the pandemic, including COVID-19 expenses and steep revenue declines. As a condition of securing CMS approval to amend contracts mid-year to require plans to make such payments, states also must adopt a two-sided risk corridor for Medicaid managed care rates to protect states, the federal government and plans from higher or lower-than-expected utilization in light of COVID. Overall, the guidance clarifies how Medicaid managed care states may use existing tools to support providers through the early stages of the pandemic, but, is unlikely to eliminate calls for more federal funds to be directed to Medicaid providers.

Background

With providers across the country reporting unprecedented declines in utilization and growing reports of practices closing and health care providers facing unemployment, states are interested in finding ways to support them in remaining open during the pandemic. Medicaid agencies, in particular, are keenly interested in supporting Medicaid providers in order to stave off permanent closures to protect access to care. While some resources are available to providers through the \$175 billion Provider Relief Fund (see [April 24](#) Manatt Insights summary), the biggest share of these dollars has been distributed to Medicare providers based on overall revenue, and not targeted to Medicaid providers. This has left primary care doctors, OB/GYNs, behavioral health providers, dental providers, non-emergency medical transportation companies, home and community-based care workers, and safety net institutions that serve large numbers of Medicaid beneficiaries at risk for financial distress or closure.

Medicaid managed care plans continue to be paid based on pre-COVID utilization projections, and, as a result of steep declines in non-COVID utilization, may have unspent premium dollars remaining. States, therefore, are exploring whether and how to require plans to distribute some of these dollars to Medicaid providers to help them remain open pending further support from the Provider Relief Fund and other sources. The situation is complicated by federal regulations at 42 CFR 438.6(c) that restrict the circumstances under which states can direct plans to use capitation funds in specific ways. Of particular note, the regulations require that any directed payments must be based on “utilization and delivery of services,” which complicates using directed payments to help providers deal with sharp declines in

services and procedures. The new Bulletin identifies some ways that states could effectively still support providers facing sharp utilization declines and resulting revenue gaps despite this requirement.

Option to Direct Plans to Increase Payments to Providers to Reflect COVID-19

The Bulletin highlights that states can seek approval of a directed payment to require plans to increase payments to providers in response to new COVID-19 expenses and/or lost revenue. To secure approval of such a directed payment, the state must establish that the directed payment meets the following conditions:

- **Links to utilization and delivery of services under the current contract rating period.** The directed payment must be linked to utilization and providers' delivery of services to enrollees; a state cannot simply tell a plan to send a pot of money to a vulnerable provider without regard to the services it provides Medicaid beneficiaries. Therefore, it is straightforward for states to use directed payment to increase payments to providers facing new COVID-related expenses (e.g., a state with an approved directed payment SPA could require plans to pay a \$20 per day add-on fee per nursing home resident due to new testing and personal protective equipment demands). Moreover, as long as a state maintains a link to utilization that occurred at some point during the current contract year, it also can use directed payments to offer relief to providers facing revenue loss. For example, a state could direct plans to retroactively increase rates on services that were provided by a group of providers *before* COVID-19 hit back to the beginning of the contract year, providing them with timely financial support despite the fact that they are currently seeing few patients. See Box 1 for an example. Alternatively, a state could require that plans pay significantly higher amounts—like 75% or more higher than usual—for the lower amounts of utilization during the pandemic.

Box 1: Using Rate Increases Linked to Prior Utilization to Address Lost Revenue Among Essential Providers: A Hypothetical Example

Consider a state with a Medicaid managed care plan year that runs from June 1, 2019 through May 31, 2020. For the sake of simplicity, assume that pediatric providers lost all of the Medicaid revenue they otherwise would have received in April and May of 2020 (2/12 months = 16.6 percent of revenue). The state could direct plans to pay a 16.6 percent add-on fee to pediatric providers for all visits that occurred between June 1, 2019 – March 31, 2020, the 10-month period before the pandemic drove down utilization. The additional revenue from this 16.6 percent add-on would be roughly equivalent to the revenue that pediatric providers would have received in April and May of 2020 in the absence of COVID-19.

Although not explicitly delineated in the Bulletin, there are numerous ways in which states could deploy the flexibility to direct payments to providers to keep them open and operating through COVID-19 despite utilization declines, including:

- Establishing a dollar amount or percent of capitation payments that are available for distribution (rather than specifying an add-on percentage to payments).
- Setting directed payments at a level that takes into account the extent to which providers have been able to offset declines in in-person visits with telehealth encounters.
- Targeting the directed payments to providers most at-risk of collapsing (as long as the directed payments are provided consistently to all providers within a defined class).

- **Directs expenditures equally, and using the same terms of performance, for a class of providers.** The Bulletin clarifies that CMS generally will defer to states to define the class of providers receiving directed payments. It notes that states might want to target providers that serve a high volume of Medicaid beneficiaries, specifically citing the example of dental providers, behavioral health providers, home health and personal care attendants, pediatric providers, federally-qualified health centers, and safety-net hospitals.
- **Maintains or Establishes a Two-Sided Risk Corridor.** The Bulletin requires states to maintain or establish a two-sided risk corridor on their Medicaid managed care rates as a condition of securing approval for a directed payment during the public health emergency. CMS instituted the requirement because of the significant uncertainty surrounding the impact of COVID-19 on Medicaid managed care rates and the reality that directed payments could lead to a plan using up capitation dollars. In the Bulletin, CMS recommends that states establish a risk corridor based on a target Medical Loss Ratio (MLR) and offers an example of how to structure one. CMS has long disfavored states creating retrospective risk corridors in the middle of a contract year and has proposed rules to prohibit the practice. In a nod to the unprecedented nature of the pandemic, CMS explains in the Bulletin that it will disregard its concerns about retrospective risk corridors for the duration of the public health emergency.
- **Appropriate Rates.** The Bulletin reminds states that they must ensure that directed payments result in rates that are “reasonable, appropriate and attainable.” During the public health emergency, CMS views this as requiring states to document that their directed payments will not result in providers receiving total payments that exceed what was assumed in capitation rates absent the public health emergency. In the future, CMS plans to return to a standard of requiring States to comprehensively document that their directed payments do not result in providers receiving more than they would under Medicare, commercial rates or another appropriate benchmark.
- **Advances at least one of the state’s managed care quality strategy goals and objectives.** Under federal regulation at 42 CFR 438.6(c), states must explain how their directed payments connect to their Medicaid managed care quality strategies. The new Bulletin highlights that during COVID-19 states can identify as a goal the imperative to ensure the “continued availability and accessibility of covered services for Medicaid managed care enrollees.” Given the universal nature of the impact of COVID on accessibility to services, states should find it relatively easy to explain why a directed payment could help the state to meet this goal.
- **Additional standards.** States must have an evaluation plan for their directed payments; ensure that they do not require or condition provider participation on making an intergovernmental transfer payment; and, agree that the directed payment arrangement will not renew automatically without further CMS review at the end of the current contract period.

On Process and Timing

The Bulletin describes steps that CMS is taking to simplify the approval process for directed payment preprints for the current rating period. These include offering a [specialized draft pre-print](#) and allowing states to dispense with a comprehensive new rate certification if they are making de minimis (less than 1.5 percent) changes to their rates and already have a two-way risk corridor in place. Even so, the process is likely to take some time and states interested in establishing a directed payment to help providers cope with COVID may want to consider moving quickly to submit a request. States can retroactively implement a directed payment (i.e., back to the beginning of the current contract year) as

long as they submitted a request for approval during the current contract year. CMS, however, will not allow states to apply for approval of a directed payment for a rating period that already has ended.

In the future, CMS plans to return to requiring full rate certifications for all directed payment changes (as will still be required for states establishing a two-way risk corridor or adopting more than a de minimis change to their rates); work with states to finalize approval prior to the beginning of a new rating period; and ban the retroactive application of directed payments back to the beginning of a contract year.

Additional Options for Directed Payments on Retainer Payments and Existing Fee-for-Serve Contract Requirements

Along with outlining the ways in which states can use directed payments generally to support providers through the public health emergency, the Bulletin clarifies two discrete circumstances in which CMS is prepared to work quickly to approve state directed payments.

Option for States with Existing Directed Payment SPAs that Require Use of Fee-for-Service Rate Schedule

Even prior to COVID-19, a number of states had secured approval of directed payments that allow them to require plans to pay certain providers in accordance with state-determined rates. The CMS Bulletin clarifies that when a state 1) already requires plans to use a fee schedule for specific provider types or services; 2) has an approved directed payment for these payments; and 3) has adopted changes to the fee schedule under a disaster relief SPA in response to COVID-19, it can require plans to adopt the new, higher rates. CMS must review the change, but, if the impact is de minimis (defined as a change of less than 1.5 percent in the capitation rate per rate cell), the state need only submit a revised contract amendment to the federal agency. If it is more than de minimis, the state must submit a revised contract amendment and a new actuarial rate certification, but, when doing so, may submit a simplified version.

Requiring Plans to Make Retainer Payments to HCBS providers

As CMS has reiterated in other recent guidance, states have had the authority since 2000 to make retainer payments to home and community-based service providers. These payments allow for the reimbursement of providers for care specified in a beneficiary's person-centered service plan when circumstances prevent the person from receiving those services. During the current pandemic, a common example is that a home care worker might not be able to provide services for several days to a beneficiary who is quarantined. Since retainer payments are specifically linked to the delivery of services in an individual's person-centered service plan, and are made only when circumstances prevent an individual from receiving those services, the Bulletin notes that these payments automatically meet the requirement that state directed payments be based on the utilization and delivery of services. As long as a state can meet the other requirements for directed payments, it, therefore, should be able to secure a directed payment approval from CMS for authorized retainer payments. CMS released a [pre-populated preprint](#) that states may use to make such changes.

Conclusion: Implications for States, Providers, Plans and Other Stakeholders

The new Bulletin is a useful review of options available to states and includes resources, such as COVID-specific templates for directed payments and a model two-sided risk corridor, that are likely to make it easier for states to use directed payments as a strategy to support Medicaid providers during the public health emergency. It, however, does not dramatically simplify the process, which still requires review by CMS and documentation that directed payments are appropriate and reasonable. In many instances, states also will need to provide new rate certifications, particularly if they are adding a two-sided risk corridor as is now required as a condition of receiving approval of a COVID-19 directed payment.

As notably, directed payments may be most effective as a short-term bridge to more sustainable support for Medicaid providers. While many plans may have some unused capitation dollars at the moment, it remains unclear what will happen to Medicaid expenditures in the weeks and months ahead as people who have deferred medical care begin to go out again and plans face a possible increase in demand for testing resources. If utilization remains low and directed payments turn out not to be an appropriate or sustainable source of funding, it will increase the already-significant pressure for the federal government to offer more direct support through the \$175 billion Provider Relief Fund or other means.

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