MERCER

COVID-19

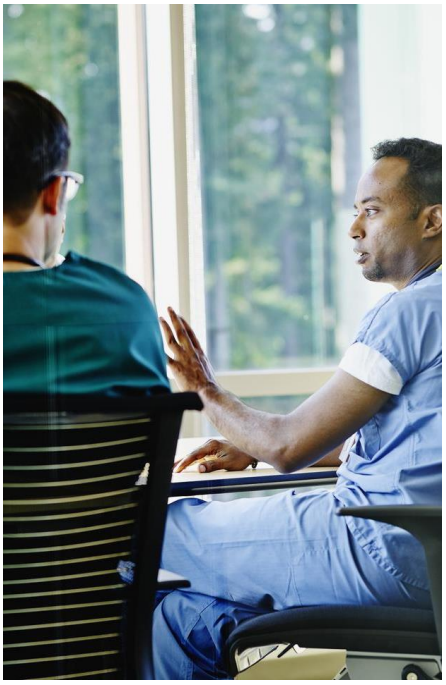
Medicaid Provider Reimbursement Strategies and Rate Setting Considerations

May 18, 2020

Background

State's Medicaid programs are facing significant uncertainty due to the COVID-19 public health emergency. Hospitals overwhelmed with COVID-19 patients, providers experiencing revenue losses and overall solvency issues, potential enrollment surges due to significant unemployment in the state and limited ability for state staff to work remotely have caused financial and operational strain on state Medicaid programs. This resource outlines provider reimbursement strategies, by provider type, to address these issues and pathways to maintain an appropriate network of providers both during and after the public health emergency.

Under managed care delivery systems, many of the approaches below may be implemented by managed care organizations (MCOs) on their own without rate or contract changes subject to Centers for Medicare & Medicaid Services (CMS) approval. Given the speed at which some providers need to have their financial issues addressed, it is recommended that states work with their managed care plans to voluntarily implement different provider payment approaches. States should remind managed care plans of the network adequacy requirements under the contract to ensure they are doing all they can to maintain adequate networks, and provide the best possible quality of care for their membership. States can also enforce the expanded use of telehealth for services as well as require managed care plans to implement alternative payment methods through provider contracting strategies. This could be achieved by dictating the percent of service expenditures that need to be associated with an alternative payment methodology without specifying the specific methodology and provider types, which would avoid the directed payment approval process.



CMS has created a COVID-19 managed care mailbox, CMCSManagedCareCOVID19@cms.hhs.gov, for COVID-19-related directed payment preprints, managed care contract amendments and rate certification amendments for expedited review.

To the extent a state needs to direct their MCOs to undertake a specific provider reimbursement strategy or modify an existing directed payment in response to the COVID-19 public health emergency, CMS' May 14, 2020 guidance sets forth the documentation requirements for approval. CMS also provided prepopulated directed payment preprints to require MCOs to pay retainer payments authorized through Appendix K or an 1115 demonstration and other temporary provider payment increases. Those examples specify the necessary elements of an evaluation plan, which is based on ensuring network access for enrollees.

CMS expects states to consider how the payment approach affects the existing capitation rates, which may require a rate certification amendment especially if the impact of the directed payment is outside the +/- 1.5% flexibility afforded states in 42 CFR 438.7(c)(3). States will also be required to implement a retroactive two-sided risk corridor due to the uncertainty of utilization, overall cost of services and enhanced Federal Medical Assistance Percentage authorized in the CARES Act. Rate considerations and CMS' expectations for risk mitigation are addressed under the Capitation Rate Setting Considerations section of this document.

CMS will require documentation that the provider payment levels are reasonable and appropriate in comparison to the total payments the provider would have received absent the COVID-19 public health emergency. In addition, the state must document that the addition of the directed payment results in total payments to the provider class that remain consistent with the utilization assumptions in the initial rate certification. States that maintain enhanced provider payments after the public health emergency period is over will need to analyze payment levels compared to either Medicare or the average commercial rate.

Furthermore, CMS is currently evaluating historical Medicaid provider reimbursement under FFS and managed care delivery systems to develop distributions from the CARES Act appropriation for provider relief. These sums would be in addition to financial relief provided to Federally Qualified Health Centers (FQHCs), hospitals, and other provider types through other appropriations or programs authorized in the CARES Act. CMS is likely to consider funding available to or received by providers through these avenues when evaluating COVID-19-related directed payments.

States will need to consider the duration of the directed payment to respond to the COVID-19 public health emergency.

1

A directed payment may have retroactive applicability to an earlier period within the rating period so long as CMS receives the directed payment preprint before the close of the rating period.

2

If the directed payment is a minimum fee schedule consistent with an emergency state plan amendment (SPA) changing fee-for-service (FFS) provider reimbursement, the disaster SPA authority and directed payment ends with the close of the federal public health emergency declaration. If the desired timeframe for the directed payment exceeds the anticipated duration of the public health emergency, the preprint should select the minimum fee schedule options based on the state plan and an alternative fee schedule.

3

If the directed payment methodology is not tied to a disaster SPA, but is time limited, states should include the proposed end date in the directed payment preprint or plan to withdraw the preprint by the desired end date.

Provider Reimbursement Strategies

Different strategies may be better suited for different provider circumstances. The potential approaches include:

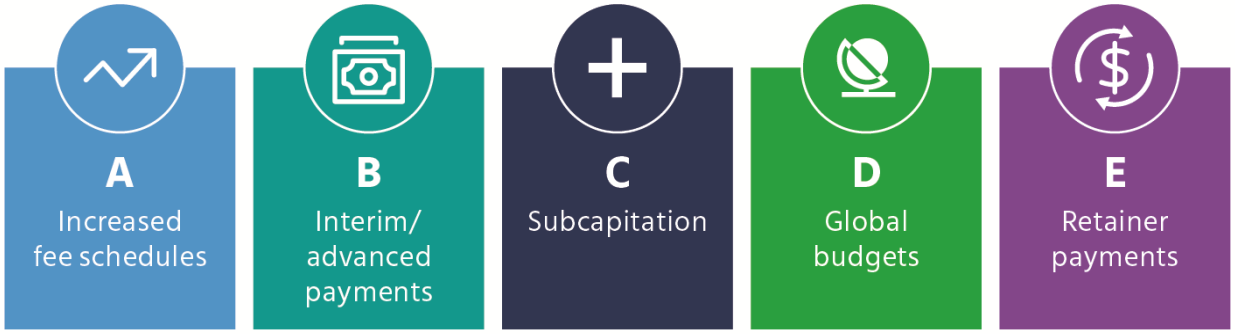


Table 1 explains the challenges faced by different Medicaid providers and indicates the provider reimbursement strategies that may be considered. Descriptions of the provider reimbursement strategies, identified as A–E above, as well as policy and operational considerations that may vary by provider type are addressed in Table 2.

Table 1. Provider Types and Corresponding Provider Reimbursement Strategies

Provider Type	Provider Circumstances	A	B	C	D	E
Hospitals with high prevalence of COVID-19	These providers are experiencing increased utilization for COVID-19 patients, but reduction in elective procedure utilization.	X				
Hospitals with low prevalence of COVID-19	These providers are experiencing decreased utilization and revenue.	X	X	X	X	
FQHCs	These providers are seeing decreased utilization and revenue.	X	X	X	X	
Other acute and BH providers	These providers have more ability to use telehealth (PCPs, specialists, BH providers, dentists).These providers are seeing decreased utilization and revenue.	X	X	X	X	
HCBS providers	These providers are seeing decreased utilization and revenue and, in some cases, have had to stop accepting individuals (adult day care).	X	X	X	X	X
NF/ICF Facilities	These providers may be lacking resources to be able to treat and protect residents and staff against COVID-19, and may see decreased admissions into the facility. Providers may also be experiencing increased costs due to higher wages for staff (e.g., hazard pay) as well as increased costs for personal protective equipment.	X	X		X	

Table 2. Provider Reimbursement Strategies and Considerations

Provider Payment Approach	Considerations
Increased Fee Schedules • Increase base rates through uniform percentage or dollar increase or mandated minimum fee schedule. • Increase fee schedules or an add-on payment (e.g., kick payment to the provider) for COVID-19 related utilization. • Option for providers that are still providing services, but experience decreased utilization or need to account for additional PPE when providing the service.	• As this approach is tied to actual utilization, it is likely easier to receive CMS approval. • If FFS rates are increased for this purpose in a disaster SPA, the directed payment would be a minimum fee schedule based on the State Plan (streamlined preprint). Note that this increase would be limited to the period the disaster SPA is in effect. • If a directed payment tied to the State plan is currently in place for the provider, the reimbursement expectation under managed care would correspond with the disaster SPA. No revision to the preprint, contract amendment or risk mitigation strategy will be necessary in this situation. • No reconciliation required. • **HCBS providers:** Appendix K authority can increase fee schedules but if the MCOs would be required to follow the fee schedule increase, a directed payment preprint would be required. Note that Appendix K approvals can have an authorization period longer than the emergency declaration timeframe; actuaries should review the end date for any Appendix K fee schedule increases.
Interim or Advance Payments Pay provider an amount based on historical utilization and reconcile to actual utilization. This arrangement functions as a loan to the provider that is "repaid" by actual utilization. If actual utilization did not meet historic utilization levels, the MCO would need to recoup funds from the provider.	• Per CMS' guidance, such an arrangement can be implemented voluntarily by MCOs, but is unlikely to be approved as a directed payment. • To the extent a state wants to pursue a directed payment, CMS has made advance payments under traditional Medicare and acknowledged interim payments as a FFS strategy (see COVID-19 FAQ IV.B.1). However, states should anticipate extended negotiation with CMS to receive approval. • This strategy may be relevant for providers experiencing a decrease in utilization that are not eligible for Retainer Payments in Appendix K. • This strategy may be paired with increased fee schedules to reduce the potential amount the provider would return to the MCO. • MCOs may voice concern about recouping funds from providers, particularly if the provider closes, files for bankruptcy or transfers ownership. • **Hospitals and NF/ICF Facilities:** To the extent any increases in supplemental payments are happening on the FFS side, those impacts will need to be considered.

Provider Payment Approach	Considerations
Subcapitation Arrangement Pay provider a PMPM based on historical utilization. No reconciliation is required as the subcapitation payments represent payment in full for services.	• States should categorize this type of payment as a value-based payment strategy in the directed payment preprint; however, such an approach may require additional negotiation with CMS. • Methodology for assignment of enrollees to the provider for purposes of payment would be required, which may be difficult for some provider types. • Provider would not be able to bill for services individually as the subcapitation arrangement represents payment in full for services during the month. • This arrangement would require MCOs to renegotiate and execute revised provider agreements and suspend claims payment. • Reconciliation on member months may need to occur if the assigned enrollees go to a different provider. • To mitigate concerns that the subcapitation arrangement would be insufficient in the event actual utilization exceeded projections used to develop the subcapitation amounts, the MCOs could be required to pay the higher of the subcapitated arrangement or actual claims according to existing provider agreements (or a complementary directed payment such as a minimum fee schedule). Such an approach may require MCOs to pay providers in arrears or conduct a retroactive adjustment to payments. • Another option would be to institute a risk corridor between the MCO and provider to resume claims-based payments if actual utilization exceeds that assumed in the subcapitation arrangements. This could be a one-sided risk corridor as the arrangement is not between the state and MCO. • **Hospitals:** If surge happens related to COVID-19, may also need to include an add-on payment for COVID-19-related inpatient services. • **FQHCs:** Will require a comparison to PPS for actual utilization to ensure they received at least the PPS they would have received based on actual utilization. • **HCBS Providers:** Appendix K retainer payments will need to be considered in the development of the subcapitation approach.

Provider Payment Approach	Considerations
Global Budget Pay a provider a lump sum amount based on historical utilization without assignment of enrollees. No reconciliation is required as the global budget payment represents payment in full for services.	• States should categorize this type of payment as a value-based payment strategy in the directed payment preprint; however, such an approach may require additional negotiation with CMS. • Provider would not be able to bill for services individually as the global budget represents payment in full for services during the period covered by the global budget payment. • This arrangement would require MCOs to renegotiate and execute revised provider agreements and suspend claims payment. • To mitigate concerns that the global budget amount would be insufficient in the event actual utilization exceeded projections used to develop the global budget, the MCOs could be required to pay the higher of the global budget or actual claims according to existing provider agreements (or a complementary directed payment such as a minimum fee schedule). Such an approach may require MCOs to pay providers in arrears or conduct a retroactive adjustment to payments. • Another option would be to institute a risk corridor between the MCO and provider to resume claims-based payments if actual utilization exceeds that assumed in the global budget. This could be a one-sided risk corridor as the arrangement is not between the state and MCO. • **FQHCs:** Will require a comparison to PPS for actual utilization to ensure they received at least the PPS they would have received based on actual utilization. • **Hospitals:** If COVID-19 surge in utilization occurs, may also need to include an add-on payment for COVID-19-related inpatient services. • **HCBS Providers:** Appendix K retainer payments will need to be considered in the development of the global budget. • **Hospitals and NF/ICF Facilities:** To the extent any increases in supplemental payments are happening on the FFS side, those impacts will need to be considered in development of the global budget amount.
Retainer Payments Pay a provider an amount based on a percentage of historical utilization authorized in Appendix K of the 1915(c) waiver or an 1115 for 1915(i) services. This payment is reconciled to any utilization that occurs during the timeframe corresponding to the retainer payment to avoid duplication, but there would be no recoupment if utilization were less than the retainer payment. To date, CMS has limited retainer payments to personal care and adult day habilitation.	• If the state directs MCOs to pay the exact amount of the retainer payment, completion of CMS' prepopulated directed payment preprint is required and will expedite CMS review. • CMS is concerned about duplication of payment, so to the extent that the provider bills for any services, those would need to be reconciled. • Expenditures for services rendered by a family member or provider other than the provider receiving the retainer payment are a different service.

Capitation Rate Setting Considerations

Generally, Medicaid capitation rates are constructed from a historical base of utilization and cost from the managed care program or the FFS program. Prior to COVID-19, state directed payments were evaluated for potential capitation rate implications and acknowledged in the actuarial certification. From a similar perspective, any new state directed payments should be evaluated for potential impact on the Medicaid capitation rates. During the CMCS call on managed care rate flexibilities, OACT indicated that any new directed payment may require a new certification. However, states and their actuaries should consider whether current capitation rates remain actuarially sound to accommodate directed payments or provider reimbursement changes voluntarily undertaken by the MCOs. In the event such a situation occurs, documentation supporting the appropriateness of the current capitation rates should be supplied to CMS. Furthermore, states have the option to use the +/- 1.5% flexibility per rate cell in 42 CFR 438.7(c)(3) and the ability to monitor expenditures during the rating period and determine if a retroactive rate adjustment should be pursued per 42 CFR 438.7(c)(2). However, CMS' guidance favors risk mitigation strategies as a way to address differences in actual utilization and cost from what was initially assumed.

CMS' recent guidance requires a risk mitigation strategy to accompany any new directed payment implemented in response to the public health emergency. As noted earlier, CMS will require states to provide supporting documentation that demonstrates that the addition of a directed payment does not result in total payments for the class of providers that would exceed what was previously assumed in the capitation rates. This documentation will support the directed payment preprint if a new certification is not otherwise warranted. While this language appears to limit new directed payments to a ceiling of previously assumed costs, scenarios exist for certain provider types where it may be reasonable to expect payment levels to increase under the directed payment due to increased costs for hazard pay, personal protective equipment and other considerations. In a situation where provider payments are expected to increase program costs, states are expected to submit an actuarial certification and associated capitation rate change to the extent that the change is greater than 1.5%.

This section addresses different types of directed payments and considerations for capitation rate review. As the capitation rates provide funding for all covered services based on expected utilization and cost, a directed payment targeted at a specific provider type in response to COVID-19 creates additional questions on how the overall capitation funding approach is impacted. It is also important to consider any risk sharing currently in place in the contract (e.g., a risk corridor or minimum MLR) and how that interacts with any new risk mitigation strategies.

MCOs have flexibility to initiate many of these same reimbursement changes or alternative reimbursement requirements without state direction. A reasonable premise is that voluntary provider reimbursement changes undertaken by the MCOs do not require a near term rate consideration. If MCOs are reluctant to undertake alternative reimbursement methodologies without state direction, Mercer expects that MCOs will take the position that any contract amendment should be accompanied by a rate adjustment or modification to risk sharing.

1. **Minimum Fee Schedules:**

    A. Standard Rate-Setting: if a state stipulates a minimum fee schedule, the capitation rates should be evaluated to ensure the reimbursement assumptions underlying the rates provide funding to meet that requirement.

    B. COVID-19 Considerations:

        i. Unit cost considerations in capitation rates should be evaluated in relation to state directed minimum fee schedule:

            a. If the fee schedule is implemented to address hazard pay or overtime, these programmatic changes may indicate corresponding support that a capitation adjustment is necessary (although risk sharing around utilization would be prudent).

            b. A rate change should be considered based on OACT commentary during a national call, but CMS' guidance provides options, including the +/- 1.5% flexibility and risk mitigation that may alleviate the need for a capitation rate increase.

        ii. Utilization reductions may mitigate the overall impact of any minimum fee schedule change. As noted, these considerations at a minimum should be monitored and could be considered to offset the unit cost considerations in the overall capitation rate:

            a. OACT commentary implies this uncertainty is best addressed through risk sharing versus assumed implicit offset to any unit cost increase.

            b. For changes to existing directed payment arrangements, CMS guidance allow flexibility to states and their actuaries on whether utilization assumptions should be revised.

            c. Risk mitigation is another tool that could be used to address utilization uncertainty and is required for any new directed payments implemented in order to respond to the COVID-19 public health emergency.

2. Interim or Advance Payments:

A. Standard Rate-Setting: these considerations are not part of prospective rate setting, but rather evaluated based on actual utilization in encounter data.

B. COVID-19 Considerations: capitation rates include considerations for historical utilization and payments to providers. For many MCOs, payments to their large provider groups and hospitals are likely relatively consistent on a monthly basis:

i. An interim or advance payment based on historical payment levels does not create capitation issues, but it is prudent to ensure the calculation and reconciliation to actual utilization is in place.

ii. As noted earlier, CMS has indicated this option likely cannot be implemented via a directed payment. As such, voluntary MCO action would not create capitation concerns.

3. Retainer Payments:

A. Standard Rate-Setting: retainer payments are not generally considered costs for service utilization in capitation rates, but retainer payments approved under Appendix K are categorized as service payments.

B. COVID-19 Considerations: capitation rates include considerations for historical utilization and payments to providers. Retainer payments are being evaluated to maintain cash flow to providers heavily reliant on Medicaid funding to ensure access to services in the future:

i. Appendix K of 1915(c) waivers currently allow retainer payments for services that include habilitation or personal care.

ii. States are requesting flexibility from CMS to extend retainer payments to other provider types including FQHCs, BH providers and dentists. However, CMS has yet to authorize such arrangements.

iii. As retainer payments are intended to stabilize payment levels to providers experiencing a decline in utilization, the retainer payment itself does not necessarily create capitation rate implications. The capitation rate already reflects historical utilization.

iv. For 1915(c) waiver services, retainer payments are being considered along with other flexibilities that include family caregivers being employed to deliver services during this crisis. In this instance, the overlap of services delivered by family caregivers and the retainer payment may create a capitation rate impact to consider.

v. CMS seemed open to furthering discussion of retainer payment concepts where states pay providers a retainer payment via FFS and adjust capitation rates to remove consideration for the services funded via a retainer.

4. **Subcapitation Payments or Global Budgets:**

   A. Standard Rate-Setting: provider subcapitation or global budgeting is generally reviewed based on the utilization and cost of the services covered by the arrangement.

   B. COVID-19 Considerations: capitation rates include considerations for historical utilization and payments to providers. A subcapitation arrangement calculated from historical utilization and cost does not necessarily create a capitation rate issue:

      i. Targeting a subcapitation arrangement to certain provider types may limit the flexibility of MCOs to address surges in expenses in other service categories (e.g., hospitals) if too much money is tied up in subcapitation for other provider types.

      ii. Reconciliation or risk sharing considerations may be appropriate to consider based on actual utilization. These arrangements could be constructed to fund a minimum percentage (e.g., 75%) of the expected monthly cost, while still giving MCOs some financial flexibility.

      iii. Subcapitation arrangements will also need to consider enrollment surge implications to assess whether the PMPM should be adjusted for acuity differentials as the Medicaid enrollment grows.

5. **Directed Payments based on utilization perhaps via a pooled funding approach:**

   A. Standard Rate-Setting: utilization-based payments may be administered outside of the monthly capitation payment. This approach, referred to as a separate payment term in the 2019–2020 Rate Development Guide, may be subject to future CMS guidance to limit its application; however, such formal policy guidance has yet to be issued by CMS.

   B. COVID-19 Considerations: payment pools distributed based on utilization may help address surges in expenses for certain providers. However, this type of arrangement does not address any "over-funding" of the current capitation rates based on reduced utilization for other procedures.

As noted earlier, any contracts requiring MCOs to take certain actions may result in the MCOs also expecting some financial relief or risk protection. This could take the form of a risk corridor that provides protection for surges in expenses for certain services. For states desiring to increase capitation rates, minimum MLRs provide some protection of utilization coming in lower than expected. However, the interaction between capitation payments and risk sharing are complex and require further discussion and thought outside of this document.

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