

# Designing payment arrangements for Medicaid providers in response to the COVID-19 emergency

Considerations for state policymakers and Medicaid program leadership

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## Introduction

COVID-19 has added significant financial stress to the healthcare delivery system and uncertainty around the short- and long-term economic viability of healthcare providers. Unlike other emergencies, where healthcare providers may experience an influx of patients, many providers are now experiencing significantly reduced utilization and therefore reduced revenues (whether due to stay-at-home orders, saving capacity for COVID-19, or avoiding infections in the hospital). Demonstrating the magnitude of the reduction in utilization for some healthcare providers, researchers at Harvard University observed a nearly 60 percent reduction in visits to a national sample of ambulatory practices from the beginning to the end of March.<sup>1</sup> Compounding the issue of reduced utilization, some providers that are on the front lines of treating individuals with COVID-19 have also experienced higher than usual costs associated with increasing capacity and purchasing necessary equipment and supplies. While large for-profit healthcare provider entities with existing capital reserves or greater access to capital markets may be able to weather the storm, other small, rural, or safety net provider entities may require additional support to keep their doors open.<sup>2,3,4</sup>

Given these circumstances, many state Medicaid agencies have been evaluating options to provide emergency funding to healthcare providers to maintain access to care in their programs. For the short term, emergency funding can help protect system capacity by addressing provider cash flow shortages and maintaining employment of the direct care workforce. In the long term, however, state Medicaid agencies must be mindful of how emergency funding arrangements fit into broader transformational goals for their healthcare delivery systems, as well as the fiscal sustainability of payment increases through, and potentially even after, the end of the COVID-19 emergency period—whenever that may be.

<sup>1</sup> Mehrotra, A. et al. (April 23, 2020). "What Impact Has COVID-19 Had on Outpatient Visits?". The Commonwealth Fund. Retrieved April 23, 2020 from <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>.

<sup>2</sup> Paavola, A. (April 7, 2020). "150 hospitals furloughing workers in response to COVID-19". Becker's Hospital Review. Retrieved April 15, 2020 from <https://www.beckershospitalreview.com/finance/49-hospitals-furloughing-workers-in-response-to-covid-19.html>.

<sup>3</sup> Neighmond, P. (April 6, 2020). "Growing Costs And Shrinking Revenues Squeeze Hospitals As They Brace For Coronavirus". NPR. Retrieved April 15, 2020 from <https://www.npr.org/sections/health-shots/2020/04/06/828108255/growing-costs-and-shrinking-revenues-squeeze-hospitals-as-they-brace-for-coronav>.

<sup>4</sup> Ellison, A. (March 23, 2020). "Hospitals face financial fallout from COVID-19: 6 things to know". Becker's Hospital Review. Retrieved April 15, 2020 from <https://www.beckershospitalreview.com/finance/hospitals-face-financial-fallout-from-covid-19-6-things-to-know.html>.

## Federal legislation and guidance

Through both the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act (PPPHEA), healthcare providers battling the novel coronavirus will receive billions of dollars in emergency funding.<sup>5,6,7</sup> Provisions of the CARES Act and PPPHEA that have already increased funding to providers include:

- Appropriation of \$175 billion in funding for hospitals and other healthcare providers through the Public Health and Social Services Emergency Fund (PHSSEF, or commonly known as the “Provider Relief Fund”), with which “the Administration is working to address both the economic harm across the entire healthcare system due to the stoppage of elective procedures, and addressing the economic impact on providers incurring additional expenses caring for COVID-19 patients, and to do so as quickly and transparently as possible.”<sup>8</sup>
- Appropriation of \$25 billion for COVID-19 testing through the PHSSEF, including \$600 million for Federally Qualified Health Centers (FQHCs) and \$225 million for Rural Health Clinics (RHCs).
- Appropriation of \$1.32 billion in grants for health centers (as defined in 42 CFR §254b, including Federally Qualified Health Centers) to detect, prevent, diagnose, or treat COVID-19.
- Elimination of \$4 billion in FY 2020 Medicaid Disproportionate Share Hospital (DSH) allotment reductions, reversal of \$4 billion in FY 2021 DSH allotment reductions, and postponement of the start of FY 2021 DSH allotment reductions from October 1, 2020 to December 1, 2020.<sup>9</sup>
- Suspension of the 2 percent reduction in Medicare fee-for-service provider payments due to federal sequestration rules;
- A 20 percent increase in Medicare payments for services provided to individuals diagnosed with a COVID-19 under the Hospital Inpatient Prospective Payment System (IPPS).
- Creation of the Medicare Accelerated and Advanced Payments Program, which has already directed over \$51 billion in accelerated and advance payments to healthcare providers.<sup>10</sup>
- Appropriations of \$660 billion in forgivable low-interest loans for small businesses and \$500 billion in Treasury loans and loan guarantees for large and mid-size businesses.

The Families First Coronavirus Response Act (FFCRA) also effected a number of changes in federal rules, regulations, and guidance for state Medicaid programs.<sup>11,12</sup> Most notably, state Medicaid agencies may now claim an additional 6.2 percentage points to all ordinary state- and territory-specific Federal Medical Assistance Percentages (FMAPs) for Title XIX (traditional Medicaid), which also indirectly enhances the FMAP for Title XXI (the Children’s Health Insurance Program, or CHIP).<sup>13</sup> These FMAP increases reduce the non-federal share of expenditures required to administer these programs. Per CMS, the increased FMAPs are available for expenditures incurred on or after January 1, 2020 through the end of the quarter in which the public health emergency ends.<sup>14</sup> However, state policymakers and Medicaid program leadership should be aware that to qualify for the FMAP increases, states must also meet certain requirements related to eligibility, enrollment, and premiums, as well as coverage and cost-sharing for services related to COVID-19.<sup>15</sup> The costs associated with these requirements may cut into, and for some states may even outweigh, any potential savings in non-federal expenditures.

<sup>5</sup> Library of Congress. “H.R.748 - CARES Act”. Retrieved April 15, 2020 from <https://www.congress.gov/bill/116th-congress/house-bill/748>.

<sup>6</sup> Library of Congress. “H.R.266 - Paycheck Protection Program and Health Care Enhancement Act”. Retrieved April 24, 2020 from <https://www.congress.gov/bill/116th-congress/house-bill/266>.

<sup>7</sup> CMS (April 13, 2020). “COVID-19 FAQs on implementation of Section 6008 of the Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security (CARES) Act”. Retrieved April 15, 2020. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

<sup>8</sup> HHS (April 22, 2020). “HHS Announces Additional Allocations of CARES Act Provider Relief Fund”. Retrieved April 22, 2020 from <https://www.hhs.gov/about/news/2020/04/22/hhs-announces-additional-allocations-of-cares-act-provider-relief-fund.html>.

<sup>9</sup> CMS (April 13, 2020). “COVID-19 FAQs on implementation of Section 6008 of the Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security (CARES) Act”, Response to Question G.43. Retrieved April 15, 2020. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

<sup>10</sup> CMS (April 9, 2020). “CMS News Alert April 9, 2020”. Retrieved April 15, 2020 from <https://www.cms.gov/newsroom/press-releases/cms-news-alert-april-9-2020>.

<sup>11</sup> Library of Congress. “H.R.6201 – Families First Coronavirus Response Act”. Retrieved April 15, 2020 from <https://www.congress.gov/bill/116th-congress/house-bill/6201/text>.

<sup>12</sup> CMS (Updated April 2, 2020). “COVID-19 FAQs for State Medicaid and CHIP Agencies”. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

<sup>13</sup> CMS (Updated April 13, 2020). “Families First Coronavirus Response Act – Increased FMAP FAQs”, Responses to Questions A.1, A.2, and A.4. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>.

<sup>14</sup> Ibid, Response to Question A.5

<sup>15</sup> Ibid, Response to Question B.1.

Combined, the FFCRA, CARES Act, and PPPHCEA have rapidly infused hundreds of billions of dollars into the healthcare delivery system, including direct emergency funding to healthcare providers through grants and loans. Now, state policymakers and Medicaid leadership must determine how to maintain access to care for Medicaid beneficiaries, leveraging available funding and allowable payment mechanisms.

## Considerations for state Medicaid policymakers and leadership

Policymakers and Medicaid program leadership in many states are evaluating options to provide emergency funding to healthcare providers that serve Medicaid enrollees in an effort to maintain access to care. As state policymakers and Medicaid program leadership evaluate options to make emergency payments to providers, they will need to consider questions such as:

1. Which healthcare providers are most in need of emergency funding to maintain access to care for Medicaid beneficiaries?
2. What are the existing sources of emergency funding to providers in the state?
3. How much additional emergency funding should be provided and for what duration?
4. What will be the source of the non-federal share of new or increased Medicaid payments?
5. What payment mechanisms will be used to distribute the new or increased Medicaid payments?
6. Do the amounts and mechanisms of the Medicaid payments conform to all applicable rules and regulations?

The answers to the first three questions (related to which providers are most in need of emergency funding, the existing sources of emergency funding, and the amount and duration of additional emergency funding) will vary across Medicaid programs based on local conditions and considerations, including individual state fiscal constraints. State policymakers and Medicaid program leadership should be especially concerned about the financial stability of safety net and rural providers, particularly those that have not already received sufficient funding to maintain operations through the CARES Act and PPPHCEA.<sup>16</sup>

State Medicaid programs that decide to provide additional emergency funding will need to determine the source of the non-federal share of funding, and should consider the following:

- **Reductions in utilization that are the cause of financial hardship for providers may also be resulting in savings for Medicaid programs.** To the extent that Medicaid program expenditures are reduced due to lower utilization of elective and non-emergent services, this may free up existing state appropriations for some Medicaid programs.
- **Similarly, reductions in utilization for providers may also be resulting in savings for Medicaid managed care organizations (MCOs).** It may be possible for Medicaid programs to coordinate with their contracted MCOs to use these savings to provide emergency funding to the MCOs' network providers. In particular, states should be mindful of how reductions in utilization are affecting the medical loss ratios (MLRs) of their contracted MCOs.
- **The temporary 6.2 percent FMAP increase will reduce states' non-federal share of Medicaid expenditures.** The 6.2 percent increase in the FMAP may free up existing state appropriations for some Medicaid programs such that it will be possible to increase payments without a net change in state expenditures.
- **State appropriations through the CARES Act's Coronavirus Relief Fund should not be used to fund the non-federal share of Medicaid expenditures.** This is consistent with the standing prohibition against "recycling" of federal funds.

However, quantification of the savings associated with reductions in utilization and increases in FMAP will not be straightforward, and it may be difficult to model the fiscal impact of new or increased Medicaid payments.

- For many Medicaid programs, it is difficult to discern how much utilization has decreased since the beginning of the federal COVID-19 emergency on January 27, 2020, and it is even more difficult to develop projections of utilization through and after the end of the COVID-19 emergency period.
- Utilization of elective procedures could begin to increase again even before the end of the emergency period.
- At some point in the future, there could be a surge of pent up demand from patients for delayed care as the pandemic wanes.<sup>17</sup>

<sup>16</sup> Ellison, A. (March 23, 2020). "Hospitals face financial fallout from COVID-19: 6 things to know". Becker's Hospital Review. Retrieved April 15, 2020 from <https://www.beckershospitalreview.com/finance/hospitals-face-financial-fallout-from-covid-19-6-things-to-know.html>.

<sup>17</sup> Kramer, M. et al. (April 2, 2020). "COVID-19: Health cost issues for U.S. healthcare payers now and in the days ahead". Retrieved April 15, 2020 from <https://us.milliman.com/en/insight/COVID-19-Health-cost-issues-for-US-healthcare-payers-now-and-in-the-days-ahead>.

- Beyond the potential surge in pent up demand for currently enrolled Medicaid beneficiaries, there may also be significant increases in Medicaid enrollment due to the impact that COVID-19 is having on the economy and employment.<sup>18</sup>
- Savings in non-federal expenditures resulting from the 6.2 percent increase in FMAP may be offset by costs associated with meeting the eligibility, enrollment, premium, coverage and cost-sharing requirements.
- States should consider that increases to payment rates or additional supplemental payments, although temporary by design, could establish a new baseline of expected reimbursement by providers, which may be politically difficult to retract to previous levels after the emergency period ends.

Finally, leadership will need to determine allowable mechanisms through which the emergency funding will be distributed and verify that the payment amounts do not exceed regulatory limits. The allowable mechanisms and regulatory limits vary depending on whether the payments are made through a Medicaid fee-for-service or managed care program.

In Medicaid fee-for-service (FFS) programs, states have the ability to increase payment rates or to make supplemental payments to providers for state plan services and home-and-community-based (HCBS) 1915(c) waiver services using a State Plan Amendment (SPA) or HCBS 1915(c) waiver Amendment K. In Medicaid managed care programs, states have the ability to increase payment rates or to make supplemental payments to providers for services covered by managed care plans using a 438.6(c) Preprint. In March 2020, CMS created Emergency Medicaid SPA, Amendment K, and Section 438.6(c) Preprint templates to assist states with time-limited state plan amendment and state direct payment arrangement submissions in response to the COVID-19 emergency. In its COVID-19 Medicaid FAQs, CMS stated that it will “work with states on an expedited basis to review all relevant statutory authorities to find potential pathways to support Medicaid providers during the COVID-19 pandemic.”<sup>19</sup>

In the following sections, we describe considerations for state policymakers and Medicaid leadership related to allowable mechanisms and regulatory limits for new or increased payments to healthcare providers in response to the COVID-19 emergency.

#### ALLOWABLE MECHANISMS AND REGULATORY LIMITATIONS FOR PROVIDER PAYMENTS IN FFS PROGRAMS

Per CMS guidance, states can increase FFS program payments to providers through an emergency SPA as follows:

- Uniform percentage increase for all services in a provider-type’s fee schedule.
- Modifying an existing fee schedule, targeting specific services or provider classes. For example, states can make Medicare-style increases for COVID-19 related inpatient diagnosis related groups (DRGs).
- Supplemental payment increases made on a lump sum basis.

Additionally, FFS rate and supplemental payment increases must meet the following requirements (among others):

- **Payments must be consistent with efficiency, economy, and quality of care, as specified in section 1902(a)(30)(A) of the Social Security Act.**<sup>20</sup>
- **Payments must be compliant with the Upper Payment Limit (UPL) regulations for applicable provider types.** CMS has provided guidance that states can increase the “UPL ceiling” to account for COVID-19 related increases in allowable facility costs or Medicare payments (depending on the UPL basis).<sup>21</sup> CMS has not published guidance as of this writing on how or whether states should consider changes in claim volume from the UPL base data period (two years prior) to the UPL year impacted by COVID-19.
- **“Stay-open” or retainer payments to providers with reduced utilization due to cancelled elective services or workforce shortages may not be made “for time when care is not provided to beneficiaries”.**<sup>22</sup> However, for patients quarantined away from a facility, states have the option to cover and pay for temporary absences under Medicaid reserve bed authority per 42 C.F.R. 447.40.<sup>23</sup>

<sup>18</sup> Rogers, H. et al. (April 23, 2020). “Estimating the impact of COVID-19 on healthcare costs in 2020”. Retrieved April 23, 2020 from <https://www.milliman.com/en/insight/Estimating-the-impact-of-COVID19-on-healthcare-costs-in-2020>.

<sup>19</sup> CMS (Updated April 2, 2020). “COVID-19 FAQs for State Medicaid and CHIP Agencies”. Response to Question E.15. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

<sup>20</sup> CMS. “Medicaid Disaster Relief for the COVID-19 National Emergency State Plan Amendment Instructions”. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-instructions.pdf>.

<sup>21</sup> CMS (Updated April 2, 2020). “COVID-19 FAQs for State Medicaid and CHIP Agencies”, Response to Question E.12. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.

<sup>22</sup> Ibid, Response to Question E.15.

<sup>23</sup> Ibid, Response to Question E.22.

In Medicaid FFS programs, states also have the ability to reimburse providers under an interim or periodic payment methodology. Per CMS guidance, interim payments “would not be a prepayment prior to services being furnished, but rather would represent interim payments for services furnished that are subject to final reconciliation.”<sup>24</sup> States must describe in their emergency SPA how they will compute interim payment amounts for providers (e.g., based on the provider’s prior claims payment experience) and how they will subsequently reconcile the interim payments with final payments for which providers are eligible based on actual billed claims.

Interim payments would improve short-term cash flow to providers because they would not have to wait for payment during the normal claim submittal and adjudication process. However, if implementing interim payments, states should take great care in establishing the interim payment amounts, as overstating periodic payments may result in a “fiscal cliff” for some providers at the time of the required payment reconciliation.

### HCBS waiver amendment K

CMS has developed “Appendix K” to enable states to request emergency amendments to their 1915(c) HCBS waiver(s) during the COVID-19 pandemic. Many states have included in their Appendix K amendments temporary increases to payment rates for HCBS waiver services. Per CMS guidance, under Item K-2-f, states can increase a service rate to incentivize a larger pool of providers, and to compensate providers for additional risk, qualifications/trainings, or more intensive services.<sup>25</sup> Based on our review of COVID-19 Appendix K documents approved as of April 24, 2020, many states have requested flexibility to establish rate increases under existing reimbursement methodologies up to certain levels, with some states requesting rate increases of up to 50 percent.<sup>26</sup>

Under Item K-2-j, states can add retainer payments to personal assistants for personal care and habilitation services when the waiver participant is hospitalized or absent from home, or when closure is necessary to prevent the spread of COVID-19.<sup>27,28</sup> Per CMS guidelines, the retainer time limit cannot exceed the lesser of 30 consecutive days or the number of days for which the state authorizes a payment for “bedhold” in nursing facilities.<sup>29</sup> Based on our review, some states make retainer payments only for individuals under medical quarantine, whereas other states make retainer payments to providers with utilization below a certain percentage of pre-COVID-19 levels. These retainer payments are not permissible for 1915(c) HCBS waiver services outside of habilitation and personal care, or for 1915(i) SPA HCBS services.

### ALLOWABLE MECHANISMS AND REGULATORY LIMITATIONS FOR PROVIDER PAYMENTS IN MANAGED CARE PROGRAMS

States can increase managed care program payments to providers through an emergency 438.6(c) Preprint as follows:

- Establishing a minimum fee schedule for qualifying services rendered by a specified class of providers.
- Providing a uniform dollar or percentage increase in payments for qualifying services rendered by a specified class of providers.
- Establishing a value-based purchasing arrangement for qualifying services rendered by a specified class of providers. However, note that this type of arrangement may require a longer federal approval process than establishing a minimum fee schedule or providing a uniform dollar or percentage increase.

Additionally, per CMS guidance, state directed payment arrangements must meet the following requirements, among others:

- **Funds must flow through the managed care plans.** Therefore, it may be necessary for states to amend managed care plan contracts and actuarial rate certifications to account for any new directed payment arrangements.
- **Distribution of funds must be based on utilization and delivery of services in the managed care contract period.** While CMS does provide states with the flexibility to implement these arrangements retroactively to the beginning of the current managed care contract period, it may be difficult to design arrangements that expedite delivery of a sufficient

<sup>24</sup> Ibid, Response to Question E.13.

<sup>25</sup> CMS. “1915(c) Waiver Appendix K COVID-19 Prepopulated Template Instructions”. Retrieved April 15, 2020 from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-appendix-k-instructions.pdf>.

<sup>26</sup> Approved COVID-19 Appendix K Documents available at <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html>.

<sup>27</sup> Ibid.

<sup>28</sup> CMS. “1915(c) Home and Community-Based Services Waiver Instructions and Technical Guidance - APPENDIX K: Emergency Preparedness and Response”. Retrieved April 15, 2020 from <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf>.

<sup>29</sup> CMS (July 25, 2000). “Olmstead Update No: 3 Subject: HCFA Update”. Retrieved April 15, 2020 from <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>.

amount of emergency funding for states with limited experience in the current contract period (e.g. states with calendar year contracts). However, some approved arrangements distribute interim payments based on utilization prior to the current contract period, with reconciliation based on contract period utilization.

- The state must expect the arrangement to advance at least one of the goals and objectives in the state quality strategy, and the state must have an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy. Generally, we expect the goals and objectives of many emergency arrangements to be related to maintaining access to care for Medicaid program beneficiaries during and immediately following the COVID-19 emergency period.

To expedite the design of state directed payment arrangements, states should consider options for simplifying administration and minimizing financial risk to the state and to MCOs. For example, it may be helpful for states to design directed payment arrangements similar to supplemental payments, where the state determines the value of the payments to each provider and then directs the payment of lump sum amounts to providers through the MCOs. There are a number of approved state directed payment arrangements with this general framework.<sup>30</sup> Ultimately, states that wish to use state directed payment arrangements to provide emergency funding should tailor their arrangements according to their unique goals and circumstances.

## Conclusion

There are significant opportunities for state Medicaid agencies to provide funding to healthcare providers to maintain access to care during and immediately following the COVID-19 emergency period. However, though CMS has created emergency channels and expedited approval processes, federal regulatory requirements related to the amount and structure of provider payments remain. As states design payment arrangements for Medicaid providers in response to the COVID-19 emergency, they must be mindful of these regulatory requirements, as well as long-term fiscal constraints and policy objectives.

## About the authors

The authors are Medicaid finance and policy consultants with the Milliman state Medicaid consulting group.

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<sup>30</sup> Pettersson, J. et al. (October 2018). "Approved Medicaid State Directed Payments: How States are Using §438.6(c) 'Preprints' to Respond to the Managed Care Final Rule". Retrieved April 15, 2020 from <https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx>.



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