

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
May 19, 2020
3:00 pm ET

Operator: Standing by. At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time you may press star 1 on your phone to ask a question.

I would like to inform all parties that today's conference is being recorded. If you have any objections you may disconnect at this time. I will now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you. Good afternoon everyone and welcome to today's All-state call. I will now turn to Calder and he will share today's highlights for today's discussion. Calder?

Calder Lynch: Thanks Jackie. Good afternoon everyone. Thank you for joining us. We are pleased today to have an all-state call that will be focused on topics that I know has come up in many of our group as well as individual conversations. And that is around managed care payment methodologies as well as options that states can explore under their managed care contracts and rates to respond to the public health emergency.

We recognize that with the dramatic shifts in healthcare utilization that are occurring because of COVID-19 many states are now seeking ways to address the impacts on their providers who are serving Medicaid beneficiaries in a managed care delivery system as well as just to reflect the realities of the shifting dynamics.

So today, John Giles the newly minted director of CMCS' division of managed care policy will share highlights from the managed care options and responding to COVID-19 informational bulletin that we released last Thursday, May 14th.

For those of you who haven't looked at this informational bulletin yet it is available on our Medicaid.gov Web site. And it describes options that states may utilize to temporarily modify provider payment methodologies and capitation rates under their Medicaid managed care contract to address the impacts of the public health emergency while preserving the system of care and access to services for beneficiaries.

(John) will explain how states can use these flexibilities that align with our current statutory and regulatory managed care requirements such as state directed payments as well as permissible retainer payments that are allowable under the existing authorities like the appendix case of the 1915c waivers that apply to certain HCBS providers.

After his discussion, Laura Schneider, a technical director in the Division of Managed Care Policy will also provide additional information about the state directed payment preprints that were released alongside the informational bulletin. As a mechanism to help make it easier for students to access these flexibilities.

After the managed care presentation we will of course as usual open up the lines to your questions on this topic as well as others you may need to ask about.

In addition to staff from our division of managed care health we also have staff in the CMS Office of the Actuary on the line who are here and available to help answer questions on this topic as well. And as mentioned we will start with questions to the managed care presentation for which we have staff on our team as well as OACT on the line.

After Q&As on that topic we will open up the lines for your more general questions. And if I could just make sure the CMS staff who are on the speaker line could please make sure you have your phone muted. We are getting a little bit of feedback from someone on an unmuted line.

So before I turn it over to John I wanted to share a bit more information on two topics. The data collection efforts related to the provider relief fund as well as eligibility verification plan.

On the provider relief fund efforts I first want to thank every state and territory who we have been working with to collect Medicaid and CHIP provider data over the last two weeks.

Our team has already shared many state files with HRSA and we are continuing to evolve...

Woman: Jelly jar.

Calder Lynch: Hi I think we have got someone on the line who is not muted. I don't know operator if you are able to identify that line and mute it. That would be helpful.

Our team has already shared many state files with HRSA as we are able to complete initial data quality checks. We are continuing to resolve few remaining issues with a handful of states.

We know that as HRSA as our partner begin conducting some of the analysis of that data. We are going to remain available to support that process. But they also need to ask questions directly to the technical team.

So we are the process of determining state points of contact on the data submissions so that we can share those with HRSA. And we are confirming those state lead now with state Medicaid and CHIP directors of who they would like to designate as that point of contact.

We continue to keep you posted on the progress of this work on distributing provider relief fund payments to Medicaid providers as we are aware of those details we will be sharing them with you.

On the second topic that I wanted to mention. In the last round of FAQs we released additional guidance about eligibility verification related flexibilities that states may adopt during the public health emergency.

States who are speaking to change MAGI based verification policies should submit those changes to CMS for review. And states can use the streamline verification plan addendum template that was released last month and available on Medicaid.gov. Or make updates to their existing MAGI based verification plans and send them to CMS for review.

Verification plan changes do not require formal approval by CMS. So states should not include them with their disaster SPA submission. So just wanted to make that clarification. And we have got staff on the line from the Children's and Adults health programs group if that sparks further questions.

So with that I will turn it over to John to begin his presentation on the managed care guidance. John?

John Giles:

Thank you Calder and good afternoon everyone. As Calder just discussed, we understand that many states are seeking ways to temporarily modify payment methodologies and capitation rates under their Medicare managed care contracts. To help address the impacts of the public health emergency.

In the guidance that was released last Thursday we provided three main areas of guidance and options that states can consider as part of their managed care programs.

As part of this guidance we are specifically announcing temporary and targeted flexibilities to help states address the public health emergency. I wanted to start by highlighting that the options in this guidance align with current statutory and regulatory requirements including the managed care capitation rates much be actuarially sounds. And that state directed payments under managed care contracts must be based on the utilization and delivery of

services under the current contract.

I wanted to spend just a few minutes today providing a high level overview of each of the options discussed in the guidance. In the first part of the guidance we have wanted to highlight the options that states have to adjust their managed care capitation rates to reflect temporary increases in Medicaid fee for service provider payments.

We understand that many states have implemented or are in the process of implementing temporary increases in Medicaid fee for service provider payment rates as part of the disaster state plan amendment in response to COVID-19.

Such temporary rate increases in fee for service fee schedules may have a corresponding impact on a state's managed care capitation rates. Where states have existing contractual requirements that require managed care plans to adopt the Medicaid fee for service provider rates for specific provider types or services.

In order to revise a state managed care capitation rates to reflect these temporary increases in fee for service fee schedules, states can utilize a few options.

One, states can utilize the existing de minimis rate adjustment flexibility by increasing or decreasing the capitation rate per rate cell of less than 1.5%. Or two, states can submit a rate amendment for capitation rate adjustments that result in an increase or decrease of more than 1.5% per rate cell.

To expedite the review and approval of these rate amendments, states and actuaries can develop a revised actuary and rate certification that contains only the information needed to incorporate the temporary payment increases. I would highlight that under both of these options a contract amendment will be required.

In the second part of the guidance we wanted to highlight how states can require managed care plans to make retainer payments to certain habilitation and personal care providers.

We know that many states have received approval from CMS to make retainer payments as authorized as part of the state's 1915c HCBS waiver or Section 1115A demonstration waiver for 1915c HCBS services using the Appendix K authority.

In this guidance, we are clarifying a state's ability to utilize state directed payments to contractually require managed care plans to make these retainer payments to providers where the authorized service is covered under the managed care contract.

In order for states to seek approval under state directed payments, the retainer payments must be authorized as part of the 1915c HCBS waiver or Section 1115A demonstration waiver for 1915c HCBS services.

Once those retainer payments are authorized under one of those authorities, a state directed payment preprint can be submitted to effectuate the state directed retainer payments under a state's contract with its managed care plans.

In order to facilitate our expedited review and approval of these payments, CMS is making a prepopulated template available to states for minimum fee schedule requirements that are tied to the approved retainer payments.

In the third part of the guidance, we wanted to highlight how states can use state directed payments to temporarily enhance provider payments in managed care to respond to the unique circumstances of the public health emergency.

We understand that many states are interested in ways to contractually require the managed care plans to make specific payments to providers to help mitigate the impact of the public health emergency.

To help states comply with regulatory requirements for state directed payments in response to COVID-19, our guidance lays out a framework that will help states design these payment arrangements and facilitate all review and approval process.

Now I am not going to cover the entire framework from the guidance. But I did want to provide a few key highlights. The first highlight is that there must be a connection and a tie to utilization and delivery of services under the current managed care contract.

We provide states a few specific examples where states can require plans to provide a uniform dollar or percentage increase in per service payment amounts for furnishing covered services to enrollees covered under the contract in order to effect the total payments to providers. These examples are described in more detail in an appendix that we published along with the guidance.

The second highlight is that there must be a connection to quality and evaluation. We understand that many of these state directed payments will be implemented to ensure the continued availability and accessibility of covered services for Medicaid managed care enrollees. We have provided sample language that states can use and consider to help draft their prepopulated preprint.

The third area I wanted to highlight was around risk mitigation. We will require states to implement two sided risk mitigation for these types of state directed payments. Since there is significant uncertainty related to cost and utilization due to the public health emergency and state directed payments may limit capitation revenue in responding to the public health emergency.

CMS will require the implementation of a two sided risk mitigation strategy when states implement new state directed payment intended to mitigate the impact of the public health emergency.

For example, states could institute a two sided risk corridor based on a target medical loss ratio. We have provided more detail on this example and approach. And have included that in the published appendix.

Finally, we are permitting some targeted administrative flexibilities in key areas of a state's design and implementation of state directed payments. First, they are not requiring a comprehensive provider payment rate analysis. But instead we are asking states to provide supporting documentation regarding the total provider payment levels.

Second, we are permitting states to implement state directed payments retrospectively to the start of the current contract rating period. For states operating on a state fiscal year basis, this means that the submissions for the state fiscal year '20 rating period would need to be submitted to CMS before July 1 of 2020.

We are also not requiring rate certification amendments for new state directed payments if the amounts of those payments are within the + or - 1.5% per rate cell de minimis amount in accordance with other existing regulatory flexibilities.

Finally, just as we did for retainer payments we have also published a second prepopulated version of our state directed payment preprint to facilitate a more streamlined submission and review process for states.

And with that I wanted to reiterate that CMS remains committed to prioritizing and expediting our review of COVID-19 related managed care actions. And we are always available to provide technical assistance to states on any of these areas of guidance.

And now my colleague, Laura Schneider will briefly highlight the prepopulated template examples that we have already mentioned a few times today. Laura?

Laura Schneider: Thank you John. So as John had noted we did publish along with the informational bulletin two example preprints that can be used for obtaining approval of state directed payments as described in the guidance.

The first is for states that want to effectuate retainer payments. That they have authority under existing Medicaid authorities to make such as an Appendix K under 1915c waiver to certain habilitation and personal care providers in managed care.

The second is for states that want to require state directed payment under the managed care plans make state directed payments temporarily enhance provider payments in response to COVID-19.

You will note in both examples that the - it is the same form that is used today that states are familiar with. We have seen a (unintelligible) payment. We have highlighted in four places where states will need to provide additional information and prepopulated some of the responses that traditionally states would need to provide as part of the review process and submission.

You will note that the example for the retainer payments that much of the form has been prepopulated in recognition of this specific example and the use of retainer payments as a monthly scheduled requirement on managed care plans for these particular provider types. In recognition that they have the authority already for these payments underneath the existing Medicaid authorities such as the Appendix K mentioned earlier.

The example for other types of state directed payments that Managed Care plans would make in response (unintelligible) to temporarily enhance provider payments still has some of the similar fields prepopulated in recognition of the flexibilities described in the guidance in the informational bulletin. But does have a few other fields that states will need to respond to such as the type of payment arrangement whether it is a minimum fee schedule or a uniform increase for example.

So having said that, these are examples that we have provided to help facilitate review of these state directed payments. States are not obligated to use these forms but we publish them with the help and intention of helping states to pull together the necessary documentation and information to facilitate those reviews and be as timely as possible.

We do also recommend that states that are submitting preprints to do state directed payments in response to COVID-19. Submit these and any other related managed care actions that they have developed in response to those contact amendments or any rate amendments to the COVID-19 mailbox that is listed at the end of the informational bulletin.

And as John noted, we are available if states have any questions or concerns as they review the example preprint and review the guidance. We are available for technical assistance as needed.

And with that I think I will turn it back over to Jackie Glaze to transition into any questions that folks have on this topic.

Jackie Glaze: Thank you Laura, thank you (John). So as Laura indicated we are now ready to take your questions specific to the managed care discussion. So Denise can you open up the phone lines at this point?

Operator: Thank you and we will now begin the question-and-answer session. If you would like to ask a question please press star 1. Unmute your phone and record your name clearly. Your name is required to introduce your question.

It does take a few moments for the questions to come through. Please stand by. The first question comes from Adam Profit. Your line is open.

(Adam Profit): Thank you. This is Adam Profit in Kansas. Thank you CMS team for taking the time to walk us through this. My question I believe is for John.

As it relates to risk mitigation strategies you mentioned that if we are going to do these directed payments we will be required to do a risk corridor or similar strategy. Is that across the entirety of the program or is it specific to the areas that have the directed payment? It feel like it should be across the entire the program for the entire year to make it completely fair and two sided.

(John Giles): Yes thanks Adam. We definitely agree with you. In the guidance we recommended applying those risk mitigation strategy across all of the medical cost. Obviously we provide a couple of examples of that and provide that this is really standard language that we would expect. And that if you want to have a different design we are happy to talk to you about that.

But we would agree with you we think that it should be applied across the program and across all of the medical costs.

(Adam Profit): And retro to the beginning of the contract period for us would be Jan 1?

(John Giles): Yes. We have provided guidance that we would allow that to go retrospectively back to the beginning of the current rating period.

(Adam Profit): All right fantastic. Thank you so much.

Operator: And as a reminder it is star 1 if anyone would like to ask a question. I have no questions at this time.

Jackie Glaze: Thank you so we will just take any questions you may have. Managed care anything else that you would like to ask us.

Operator: One moment. I have a question coming through. The next question comes from Nicole. Your line is open.

(Nicole): Hello it is a follow up question on the scope of the risk mitigation strategy. So would there be instances where CMS entertains a risk mitigation strategy that

was tailored to a more narrow set of purposes? For example, under an integrated Medicare Medicaid contract you know and maybe that is a direct payment that is only attaching to the services that Medicaid has primary care responsibilities for.

And so wondering if the risk corridor requirements here, the risk mitigation strategy requirement here could be tailored to those specific services under an integrated Medicaid/Medicare product?

(John Giles): Hi Nicole this is John. I think you raise a really good example and I think that would be something we would be willing to entertain. And I think your reason makes a lot of sense. I do know we have the Office of the Actuary on the line and I would also to defer to them if they would like to address that question.

I think from a policy perspective though we could certainly take a look at that and work with the state to adjust that appropriately. OACT would you offer anything different there?

Tristan Cope: Hi this Tristan Cope Office of the Actuary. No I think I agree with John. We made the recommendation to do all medical costs but obviously that is not going to work in every situation. And we will definitely work with states to explore other options as they deem it appropriate for particular situations.

(Nicole): Okay thank you.

Operator: I do have several other questions at this time. Up next is James. Your line is open.

(James): Hello. I had questions related to periods of ineligibility due to asset transfers. So if we decide in a certain scenario that we can't discontinue long term care nursing facility benefits or home and community based services due to an asset transfer. Are we required to wait until the COVID-19 emergency period

ends in order to impose those penalty periods?

Calder Lynch: Checking to see if we have someone on from CAPHG perhaps to address that?

Sarah Delone: I beg your pardon. I had a little bit of trouble hearing. Can you just repeat the question?

(James): Sure. So based on the guidance that was issued in certain scenarios we can impose - certain scenarios we can impose penalty periods due to asset transfers which will lead to periods of ineligibility for long term care and home and community based services. In other scenarios we can't because we would discontinue individuals' long term care and nursing facilities and home and community based services.

So in the scenarios where we can't discontinue benefits do we have to wait until the COVID-19 emergency period ends in order to impose the penalty periods which leads to ineligibility for long term and home and community services?

Sarah Delone: This is one where I would really want to phone a friend, Jean Coffey but I think the phone lines for him aren't working right now. So let us take that back. That question is very much (unintelligible) wrapped up in the policy, you know, deliberations that we have been, you know, struggling to get out to you all and are really working hard to do so.

But let me take that back and talk to Jean about that asset transfers and you know obviously going to need to consult with others and make sure that we give you the right answer. We are trying to get guidance out on all of those questions as soon as we possibly can.

Operator: And are you ready for the next question?

Calder Lynch: Yes please.

Operator: Thank you. That comes from Grant Cummings. Your line is open.

(Grant Cummings): Hello, I was wondering if the retainer payment supplied to services that include rehabilitation as part of the benefits? I am thinking of residential services or some other services that might not be strictly habilitation but might include habilitation as part of the benefit.

(Ralph Lollar): Calder if you would like, this is Ralph. I can answer that.

Calder Lynch: Yes go ahead Ralph.

(Ralph Lollar): Okay retainer payments link back to an SMD that is about personal assistance and personal care services. Generally state have moved away from in many cases labeling their services personal care, personal assistance and call them habilitation services. Residential habilitation, state habilitation are big examples of that.

Retainer payments would apply to a service that is titled, habilitation but includes a component of personal care. So as long as personal care services are being rendered in the course of rendering that service, retainer payments fall within that scope.

(Grant Cummings): Thank you.

(Ralph Lollar): You're welcome.

Operator: The next question comes from Stuart Gordon. Your line is open.

(Stuart Gordon): Good afternoon Calder. This relates to the CARES Act provider relief payments. I know previously with regard to the Medicare providers the payment went right to the Medicare providers.

In many states, states such as Texas, the majority of the providers are

operating within managed care. Are the payments only going to go to fee for service providers? Or will there be a payment to the MCOs to make payments to the Medicaid providers within the MCO?

Calder Lynch: Sure. So the intent is that payments would go directly to providers really irrespective of a states' delivery system. Whether it is fee for service, managed care versus which is why we asked and states provided their provider data files to use to include payments to providers.

Both that were made directly through fee for service as well as those that were made through MCO. So that information is being aggregated and will help to facilitate payments directly to providers that account for both fee for service and managed care volume.

So that is the intent and we are in the process now of course of working, you know, we provided the data to HRSA. They are conducting the analytics necessary to report those payments. But this actually also requires that the payments go directly to the providers.

(Stuart Gordon): Thank you Calder.

Operator: Up next is Nevada. Your line is open. Would you like me to move on?

Calder Lynch: Let me just check to make sure they weren't muted when asking their question.

Operator: Okay.

Calder Lynch: You were asking a question. You may have been muted. Okay go ahead with the next one.

Operator: I will play their name. I may have heard it incorrectly. One moment. Jeff your line is open.

(Jeff): Hey everyone this is (Jeff). Just real quick question on the MLR requirements that there is directed payments that are implemented. In that requirement just as the risk corridor is offered to the MCOs? Or does this require participation from all the MCOs in the programs?

(John Giles): Hi this is John. So for the state directed payments that we are envisioning in the Section 3 of the guidance where we talk about the risk mitigation. It would be a requirement that states design and implements that two sided risk mitigation strategy with their plans.

So it wouldn't just be optional for the plans to participate. It would be required for the program.

(Jeff): I see okay thank you very much that is helpful.

Operator: The next question is from Pamela Winsell. Your line is open.

(Pamela Winsell): Yes hi my question is about the use of the CR modifier. We are - I am trying to get the answer that is the CR modifier to be added to all waiver claims submitted during the public health emergency? Or only the services included in Appendix K?

Calder Lynch: Ralph is that a question for you maybe?

(Ralph Lollar): I think that is a state specific question. I think it is how you are identifying the services that you were rendering. And I am not sure whether it is only for retainer payments to extend specific modifier that will allow them to track retainer payments. But it is something that is more state specific than I can answer at this point.

Perhaps if you could give us what state you are in. We will add your contact information. I will dig a little deeper in that.

(Pamela Winsell): Okay. I am from Illinois. And my question is my understanding is there is an

increased match on waiver services during the public health emergency. Is that correct?

(Ralph Lollar): You are talking - are you talking about the match that came in through the CARES Act?

(Pamela Winsell): Yes.

(Ralph Lollar): Okay we are going to have to pull more people into this than me.

(Pamela Winsell): Okay.

Calder Lynch: Yes there is an enhanced FMAP broadly for the states that to comply with the conditions of the Family First Coronavirus Response Act. But there is not I don't believe a special enhanced FMAP in effect for waiver services related to COVID.

(Pamela Winsell): Not FMAP just the enhanced rate of FFP for the waiver services.

Calder Lynch: I think it is probably best if we follow up offline.

(Pamela Winsell): Okay.

Calder Lynch: A little bit more specifics since it sounds like a state specific issue.

(Pamela Winsell): Okay. All right thank you.

Operator: Up next is Dan. Your line is open.

(Dan): Thank you. My recollection is that on a prior call that OACT participated in - the guidance at the time that directed payments would not be approved and what additional funding was going to be provided as part of that. Is that still the guidance or is the new direction related to risk corridor or risk mitigation strategies kind of the way that that is being addressed now?

(John Giles): Hi so this is John. I can take that question. So this is part of the guidance that we sort of talk about in the payment level section. That states would be required to provide some supporting documentation that demonstrates that the addition of the directed payments did not result in total payments that would exceed what was or would have been assumed in the original capitation late certification absent the public health emergencies.

So that is only the standard that we would use to evaluate the addition of dollars for state directed payments or changes within the cap rate. So I think that would be the standard we would use and we would work with you to sort of collect that documentation at the time of review.

(Dan): I see. And I guess just a quick follow up. Would that need to be demonstrated on a rate cell basis related to the 1.5% threshold? Or is that more dependent on the structure of a given payment?

(John Giles): I think it would depend on the structure of the payment is certainly a way to do it. Would be to demonstrate it at a rate level but there may be other ways that we could collect that documentation as well. And so I think we would just work with you one on one on the development of that payment to make sure that we have everything supported.

Laura or OACT would you add anything to that answer?

Laura Schneider: This is Laura. I don't think there anything really to add. I think we are intending to work with states because this is a challenging time with the changes that are happening around utilization. And so it is our intention to work with states to collect that information dependent upon the resources available and level of information available.

(Dan): Great thank you.

Operator: Up next is Nicole Cuomo. Your line is open.

(Nicole Cuomo): Hi thank you. I believe we know the answer to this but we wanted to clarify because we had heard some concerning report. If we were not able to acquire all of the banking data for all of our providers. HRSA is still intending to issue paper checks for those providers where that bank data wasn't available. Is that correct?

Calder Lynch: Yes we are working with HRSA now to, you know, to figure out to support their efforts. To figure out the best way to make the payments. But yes the intention is to figure out one, is there another source of data that we can tap into to facilitate electronic payments?

And if not, then you know what is the best way to collect that information? You know whether that is going and asking the providers to submit it or finding a more manual process? We are definitely not intending to exclude providers if the states weren't able to provide that information and just may delay the actual payments to some degree.

(Nicole Cuomo): Okay thank you.

Operator: There are no other questions at this time.

Calder Lynch: Well we appreciate everyone joining us this afternoon and for the questions that you have raised. We will resume our next call next week, now next Tuesday now that we have moved to a weekly format. And we will talk to you then. Thank you.

Operator: Thank you. That does conclude today's conference. We appreciate your participation. You may disconnect at this time. Speakers allow...

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