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Special Bulletin

May 15, 2020

CMS Issues New Guidance to States Regarding COVID-19-related Provider Directed Payments under Medicaid Managed Care

The Centers for Medicare & Medicaid Services issued new guidance to states to allow temporary COVID-19-related modifications in provider payment methodologies and capitation rates under Medicaid managed care plans. Please see the CMS information bulletin to state Medicaid agencies for details. The AHA, in its advocacy with CMS, requested many of the additional flexibilities regarding provider payment and capitation rates found in this new guidance to states. The following is a summary of the key provisions.

State Directed Payments to Temporarily Enhance Provider Payment. States are permitted to contractually require managed care plans to make directed payments to providers to help mitigate the impacts of the COVID-19 public health emergency. The guidance requires that the directed payment must: be connected to utilization; advance quality goals and strategies, including responding to a pandemic; treat providers in a class, such as safety net hospitals, dental, and behavioral health centers equally; include risk mitigation strategies, such as risk corridors; require appropriate payment levels when compared to a benchmark, such as Medicare rates; and allow states to implement the directed payments retrospectively to the start of the current rate period. States meeting these stipulations will be required to submit to CMS certain rate certification documentation. CMS will expedite the review process for directed provider payments and encourages states to model requests on provided examples and use pre-print templates of a state requiring managed care plans to temporarily enhance provider payments in response to COVID-19.

Adjust Managed Care Capitation Rates to Reflect Temporary Increases in Medicaid Fee-for-Service Provider Payments. States have two options to adjust managed care capitation rates to reflect temporary increases in provider payments. States will be permitted to exercise the current *De Minimis* rate adjustment authority to increase a rate cell of less than 1.5% by only submitting a contract amendment to CMS. If a state wishes to increase the rate cell above 1.5%, the state must submit a revised actuarial rate certification and contract amendment to CMS for expedited agency review.

Require Managed Care Plans to Make Certain Retainer Payments. States are currently authorized through Section 1915 (c) to allow certain home and community-based providers to bill and receive retainer payments for individuals enrolled in Medicaid even if the services cannot be provided during a public health emergency. This guidance would allow states to contractually require managed care plans to make these retainer payments to providers where the authorized service is covered under the contract.

Further Questions
If you have questions, please contact the AHA at 800-424-4301.