National MLTSS Health Plan Association

Managed Care Provider Payment Pathways During COVID-19 - Advanced Payments and Retainer Payments

Background and Purpose

On May 14, 2020, CMS provided guidance through its informational bulletin *Medicaid Managed Care Options in Responding to COVID-19* on how states and managed care plans can use existing regulatory and sub-regulatory guidance to assist providers. [1] The May 2020 document primarily seeks to clarify permissible actions by states related to Medicaid managed care plan payments to providers during the public health emergency. The document also provides additional clarifications on actions plans may voluntarily take in support of their provider networks.

The goals of the document are (1) to inform relevant stakeholders (e.g. managed care organizations, state Medicaid programs, and relevant Medicaid providers) on the regulatory framework of the provider payment methodologies included in the May 2020 document and (2) serve as a reference tool during efforts to implement those methodologies. The May 2020 document outlines CMS's rationale on two provider payment methodologies – **Advanced Payments** and **Retainer Payments** – and their use in the managed care context. Additionally, it provides considerations for how these methodologies may be administered by states and plans.

Finally, in an appendix attached to document we have included draft recommendations to state Medicaid agencies seeking to implement retainer payments that provides considerations beyond those included in recent CMS guidance.

Advanced Payments

Generally, "advanced payments" are intended to provide necessary funds to providers when there is a disruption in claims submission and/or claims processing. The payments are typically based on providers' billing history and are reconciled at some future time once services and claims resume. Thus, **advanced payments *are not* directly tied to the provision of services**.

The Medicare program operates an advanced payment program and initially relied on it during the beginning of the COVID-19 outbreak. However, once the money associated with the CARES Act's provider relief fund began to be distributed, the program was put on hold so as to prevent providers from receiving both advanced payments and provider relief funds.

Because Medicaid payment procedures are largely controlled by each individual state, there is no corresponding federal advanced payment program in Medicaid. However, CMS has released guidance that permits states to implement an "**interim payment methodology**" via state plan amendments

[1] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf

(SPAs).[2] Submitted SPAs must explain how a state will compute interim payment amounts for providers and subsequently reconcile those payments at a later time.

How Advanced Payments May Be Administered:

While states are free to implement interim payment methodologies via SPAs, they are not able to force managed care organizations to administer those interim payment methodologies. CMS explicitly stated this in their May 2020 guidance. CMS reasoned that since advance payments are not tied directly to the provision of services, they do not fall within the parameters of state directed MCO expenditures outlined at 42 CFR § 438.6(c). They also noted that while states may not force MCOs to implement advance payments, MCOs are free to do so on their own volition.

Because states are unable to force MCOs to implement interim payment methodologies due to the restrictions at § 438.6(c), states can only unilaterally implement such methodologies onto their fee-for-service (FFS) programs. This is borne out in recent examples of interim payment methodologies from North Carolina and California. In North Carolina's recent SPA, the state adopted a broad-spectrum approach that would allow any Medicaid-enrolled provider to alter its reimbursement methodology to an interim payment approach. North Carolina is free to do this because all services in that state are in FFS. In contrast, California's interim methodology only applies to certain behavioral health providers, which is still part of the state's FFS program.

However, managed care entities are free to voluntarily implement interim payment methodologies if they so choose. For example, MCOs could consider restructuring their payment strategies to mimic the types of prospective capitation payments included in the comprehensive primary care plus (CPC+) track. Two California MCOs have already adopted similar approaches.

Retainer Payments

Generally, "retainer payments" permit providers to bill for services even though the services are not actually being provided. These payments are traditionally associated with pauses in otherwise ongoing and long-term services as a means of "saving a bed" or a patient's "spot" within that provider's facility/service pool. Thus, **retainer payments *are* linked to the delivery of services**.

In Medicaid, retainer payments were originally permitted for reserving beds in an inpatient facility (42 CFR § 447.40) during a patient's temporary absence from that facility so long as that absence was part of the patient's plan of care. On July 25, 2000, CMS released guidance that extended Medicaid retainer payments to personal assistance services (such as personal care or attendant services) under HCBS waivers, but only when a beneficiary is temporarily (less than 30 days) hospitalized.[3] That guidance is

[2] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
[3] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd072500b.pdf

cited and reiterated in the section on retainer payments in the current 1915(c) Appendix K.[4] Appendix K permits retainer payments for personal care and habilitation services.

However, in the June 30, 2020 changes to Medicaid FAQs issued in light of the COVID-19 public health emergency, CMS reinterprets the July 2000 guidance as referring to a broader array of provider types. Specifically, CMS states that retainer payments available for personal care services "may also be viewed to incorporate the breadth of HCBS in which support for activities of daily living or instrumental activities of daily living occur. This would typically encompass most residential habilitation programs as well as many non-residential day programs providing services (because personal care is a component of the service)." Thus, CMS suggests that one of the qualifying criteria for receipt of retainer payments is that the provider is providing some form personal care services, regardless of where those services are actually occurring (home or institutional). Moreover, CMS clarifies that retainer payments can be used to preserve the availability of such personal care services (e.g. retain the availability of an individual's personal attendant when an event removes an individual from his or her home or place of service receipt).

CMS has also included authority for states to implement Medicaid retainer payments in the COVID-19 1115 demonstration template. However, in the approval letter for Washington's 1115 demonstration (the first COVID-19 1115 demonstration approved – in April, 2020) CMS approved retainer payments only for the specific provider types and day limit outlined in the July 2000 guidance. This was despite Washington state's attempts to implement retainer payments outside of these parameters.

How Retainer Payments May Be Administered:

Unlike advanced payments, retainer payments *are* linked to the provision of services. In the May 2020 guidance on MCO options in responding to COVID-19, CMS states that this connection to the provision of services allows states to require managed care plans to implement retainer payments as a form of directed payments under § 438.6(c). More specifically, CMS states that since retainer payments are "specifically linked to the delivery of services specified in an individual's person-centered service plan, and are made only when qualifying circumstances prevent an individual from receiving those services…those payments meet the requirement in 42 CFR 438.6(c)(2)."

In order for a state to implement retainer payments through MCOs, the payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration waiver for section 1915(c) HCBS services, or other Medicaid authority. The June 2020 guidance clarified that retainer payments can be implemented without any special guardrails or protections for one 30-day period. States can choose to extend this period for up to three 30-day periods, but must then adopt the guardrails outlined in that guidance (e.g. limit payment to reasonable amounts and collect provider attestations).

[4] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-instructions.pdf

The range of provider types eligible for mandatory retainer payments are likely to be informed by the original July 2000 guidance and CMS' June 2020 interpretation of that guidance. Thus, the general requirement that providers must offer personal care or attendant services is likely to hold as general qualifying criteria (from the July 2000 guidance), but the types of providers that actually offer "personal care" are interpreted as operating in both home and community/institutional settings (from the June 2020 guidance). This means states have relatively wide latitude to determine which providers must receive retainer payments.

With respect to how retainer payments paid through MCOs are funded, their classification as a state directed payment in the May 2020 guidance suggests that the payments would have to come out of MCO capitation rates and not some additional funding stream. Generally, the state directed payment parameters outlined at 42 CFR 438.6(c) describe when states can direct MCO "expenditures under the contract." While the term "expenditure" is not explicitly defined in that section (or elsewhere in regulation), the term is consistently used throughout other relevant sections to refer to those things that MCOs spend their money on. For example, in section 438.8, which outlines the components of MCO medical loss ratios (MLR), CMS regulations classify what types of MCO "expenditures" can count towards the numerator portion of the MCO's MLR. Moreover, the only form of money that MCOs receive "under the contract" is their capitation rates from the state. Thus, because retainer payments are a type of directed payment, and because directed payments are meant to be used by states to guide how MCOs spend the money they receive under the contract, it is reasonable to assume that MCO retainer payments would only be paid by the money the MCO receives under the contract – namely, their capitation rates.

While retainer payments are classified as a form of state directed payment, CMS has clarified that they are not subject to the 2-sided risk mitigation requirement outlined in the May 2020 guidance.[5] In the third section of that guidance, CMS states that they will require a 2-sided risk mitigation strategy "when states implement new state directed payments intended to mitigate the impacts of the public health emergency." However, CMS does not consider retainer payments to be a "new" form of state directed payment as they do the more complicated options outlined in the third section. Instead, as indicated in the prepopulated retainer payment form that was released along with the May 2020 guidance, and as stated in the guidance itself, state directed retainer payments are to be implemented as a "minimum fee schedule requirement."

The characterization of retainer payments as a "minimum fee schedule requirement" is a direct reference to earlier CMS guidance on state directed payments released in November 2017, which is cited and relied on in the May 2020 guidance. [6] In the November 2017 guidance CMS outlines three categories of permissible state directed payments: 1) payments meant to implement specific value-based purchasing models, 2) payments meant to implement multi-payer or Medicaid-specific delivery

[5] The MLTSS Association has spoken directly with relevant CMS administrators on this topic. What follows is a summary of their reasoning behind this clarification.
[6] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf

system reform or performance improvement initiatives, and 3) payments meant to adopt specific types of parameters for provider payments. These three categories are captured at § 438.6(c)(1)(i)-(iii), and minimum fee schedules are specifically permitted under § 438.6(c)(1)(iii)(A).

Because retainer payments are seen by CMS as a type of already-permissible type of state directed payment, CMS does not believe that the requirements outlined in the third section of the May 2020 guidance applicable to the "new" forms of directed payment, including the 2-sided risk mitigation strategy requirement, should apply to retainer payments.

Appendix – Recommendations on State Implementation of Retainer Payments

Recommendations for Effective Implementation of HCBS Retainer Payments during the COVID-19 Pandemic

Across the nation, quarantine activities during the COVID-19 public health emergency have led to the temporary closure of some Home and Community-Based Service (HCBS) providers and a corresponding decrease in these providers' utilization and revenue. To address this, CMS clarified in recent guidance that states can require that Medicaid Managed Long-Term Services and Supports (MLTSS) health plans make retainer payments to certain habilitation and personal care providers, even if the services cannot be delivered by those providers, as long as the payments have been authorized under specific Medicaid authorities[1] and the state has submitted a state directed payment preprint.

<INSERT HEALTH PLAN> takes this situation very seriously, fully supports our contracted HCBS providers that have had to close, and has taken several steps already to ensure continued access to care for our MLTSS beneficiaries impacted by these closures. <INSERT HEALTH PLAN> has, for example, provided the services normally delivered by these closed facilities, such as meals and personal attendant care, in alternative settings using alternative means, oftentimes at much higher cost without the economies of scale afforded in congregate settings like Adult Day Centers.

To address these increased <INSERT HEALTH PLAN> costs, and support our contracted HCBS providers that have temporarily closed or are unable to render services, <INSERT HEALTH PLAN> recommends that <INSERT NAME OF STATE AGENCY> publish guidance that goes beyond the language found in the state's 1915 Appendix K waiver or other waiver application, and that sets clear expectations for HCBS providers and MLTSS health plans as it relates to the state directed retainer payment, including: 1. Provider eligibility for the payment; 2. Roles and responsibilities of all parties; and 3. Calculation of the payment and subsequent reconciliation.

Provider Eligibility for State Directed Retainer Payments:

1. In general, only HCBS providers who are closed and do not have the ability to gain other revenue, or redirect their staff, should receive a retainer or state-directed payment. For

[1] Retainer payments must be authorized as part of the1915(c) HCBS waiver, section 1115(a) demonstration waiver for 1915(c) HCBS services, or other Medicaid authority.

example, retainer payments should only be made to adult day care providers that are "stand-alone" and not connected to a facility that already has a mechanism for provision/payment of service, as the Florida Agency for Health Care Administration requires.

2. CMS guidance allows retainer payments for habilitation and personal care providers. Some state waivers include services under the category of "habilitation" that may not always be appropriate for retainer payments during the COVID-19 pandemic (such as "prevocational services" and "supported employment") unless the MLTSS beneficiary is an "essential worker" as defined by Congress. States are encouraged to pursue other means of supporting providers of these particular HCBS services in a way that can be considered on an individual, case-by-case basis. In addition, some States are allowing habilitation services to be temporarily provided in an alternative setting (such as Intellectual/Developmental Disability (IDD) Day Habilitation in an IDD Residential setting, and therefore, habilitation providers should only be included if they have closed their services, and are not able to provide the service in an alternative setting, or to provide a temporary, alternative service.

3. Retainer payments for personal care should not be available when "another reasonably equivalent assignment is made available to a direct care worker or when the worker is laid off and collecting unemployment," as directed by the Pennsylvania Department of Human Services.

4. Retainer payments, along with any other funding sources, should not exceed the provider's operating expenses. For example, The Florida Agency for Health Care Administration requires HCBS providers receiving state directed retainer payments to attest on a Medicaid Retainer Payment Form:
    a. If they have requested and/or received financial assistance through federal or state COVID-19 relief programs, including but not limited to the Paycheck Protection Program, small business loan, etc.
    b. That they will not lay off staff, will maintain staff salary, wages, and benefits at existing levels, and will re-hire staff who have already been laid off as a result of the COVID-19 pandemic; and
    c. That if funds received from the retainer payments and other funding sources related to the COVID-19 pandemic (including but not limited to the Paycheck Protection Program) exceed total operating expenses for the time period for which the funds are intended, the HCBS provider will return any overpayment to <INSERT HEALTH PLAN>.

Roles and Responsibilities of all Parties

1. <INSERT NAME OF STATE AGENCY> policy guidance should clarify whether or not HCBS providers receiving state directed retainer payments are responsible to provide any alternate services in receipt for their retainer payment.

2. HCBS providers receiving retainer payments should have to confirm after receipt of the retainer payment that it covers services in full during the identified period of time, and should not bill for services during the month in which the retainer payment is made.

3. MLTSS health plans should be required to develop a service authorization process for the retainer payment and to make the retainer payment within a certain number of business days.

Calculation of the State Directed Retainer Payment and Subsequent Reconciliation

1. Given the many different scenarios that may exist depending on a geographic location's re-opening status (e.g. some closed HCBS facilities are completely unable to provide alternative services; others may be closed but partially able to provide services, or closed but allowed to provide and bill for the same services in a different setting (and shift their staff to that setting), or closed but providing a different service (e.g. attendant care) in the member's home setting; and still others that may be open but unable to serve all enrollees due to enrollees being quarantined), it is recommended that <INSERT NAME OF STATE AGENCY> issue a specific HCBS retainer payment methodology that takes into account these various scenarios and the normal, average vacancy rate for the service, rather than just a blanket requirement for <INSERT HEALTH PLAN> to pay HCBS providers what they would have billed had the services been provided.

2. Given this variability and the uncertainty in predicting future COVID-19 impacts, <INSERT NAME OF STATE AGENCY> should require reporting by <INSERT HEALTH PLAN> that is not administratively burdensome, but that is adequate enough to inform capitation rate adjustments and rate certification for the new state directed retainer payments, regardless of impact (e.g. even if it is less than +/-1.5%). <INSERT NAME OF STATE AGENCY> should conduct a reconciliation process at the end of the rate period to ensure retainer payments made to HCBS providers were reasonable compared to the total payments HCBS providers would have received.

3. <INSERT NAME OF STATE AGENCY>'s State actuary should meet with <INSERT HEALTH PLAN> and the other MLTSS health plans in the state prior to preprint submission to review the data and analysis the actuary will be using to determine the impact of the HCBS retainer payments in order to ensure the rates remain sound and plans have an understanding of the assumptions behind the preprint.