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Support for Managed Care and Provider Networks During the COVID-19 Emergency Response

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Federal and state agencies and health care systems are well into the emergency response phase for COVID-19. Many health systems across the nation are working at or above capacity to provide care for those afflicted with the virus, while others are experiencing significant declines in revenue. As the roll-out of guidance prioritizes ways to support acute care needs, managed care organizations (MCOs) are quickly translating these opportunities to address the strain on their health care delivery systems for specific Medicaid populations. Within this rapidly evolving environment, MCOs are identifying a range of important issues requiring immediate attention from state Medicaid agencies to support their plans and providers.

We recently spoke with Jennifer McGuigan Babcock, senior vice president of Medicaid policy, and Enrique Martinez-Vidal, vice president of quality and operations at the Association for Community Affiliated Plans (ACAP), to discuss key considerations for state Medicaid agencies in meeting the needs of beneficiaries in the current pandemic environment.

Q: We know that during the COVID-19 response, health care utilization has dramatically shifted. What are the most pressing concerns that you're hearing from providers about financial viability?

A: J. Babcock: We've heard feedback from our provider partners that we should address the needs of Medicaid providers — including non-hospital providers and clinicians — in federal COVID-19 response roll-outs. The utilization landscape has drastically changed across delivery systems and Medicaid-dependent and non-hospital providers are also in need of urgent support. We know from The Commonwealth Fund's recent report that from early March through mid-April of the pandemic response, overall outpatient visits decreased by 60 percent. So far, most provider relief funding distributed by Health and Human Services (HHS) was given only to providers with Medicare fee-for-service experience. This has drastically disadvantaged Medicaid-dependent and non-Medicare providers and clinicians, including small independent and pediatric practices, non-emergency medical transportation providers, dental practices, long-

term services and supports providers, and behavior health providers. Until May 1, HHS had not yet signaled that it would provide funding from the CARES and PPPHCE Acts' Public Health and Social Services Emergency Fund to health care providers other than those captured in the first distributions, although late last week we were glad to observe the agency sent a letter to states asking for data on Medicaid-participating providers. The provider viability issue is so big and worryingly urgent now that HHS has to include these providers in future action. We have to advance congressionally appropriated financial support to providers, clinicians, and other health professionals, in addition to hospitals right away. What would Medicaid provider networks in the upcoming years look like if thousands of independent practitioners close or are acquired by larger provider entities?

E. Martinez-Vidal: Another really important longer-term issue for viability is performance requirements and rate-setting implications for plans and providers. Because of the significantly increased acute care needs and health care facilities working at or above capacity, plans and providers do not have time to document certain items appropriately to meet state and federal requirements for measures used for quality reporting, meeting state contractual requirements, or for reimbursement based on achieving certain quality scores. Resources and guidance for MCOs on interim documentation and coding requirements for HEDIS, etc. are critical. The current decline in non-essential and or delayed services being underutilized will lead to incomplete data to inform rate setting for the next fiscal year. It's essential for states to consider the implications of incomplete data and how to prevent inappropriate changes in plan and provider reimbursements.

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Q: One of the new coverage benefits provided by Centers for Medicare & Medicaid Services (CMS) during this time is the use of telemedicine to replace in-person visits in an effort to reduce the risk of COVID-19. Have you heard of any issues related to implementing this benefit?
A: J. Babcock: At this point, we have to ensure that telehealth is providing high quality and effective health care. We know that compliance requirements have been adjusted temporarily — and this is appropriate given the crisis — but states should begin to consider continuity and quality of telehealth services even beyond the pandemic. States will need to provide oversight on HIPAA privacy standards and provider licensing as their plans consider adopting the telemedicine benefit indefinitely.

E. Martinez-Vidal: We also know that documentation and telehealth codes that were authorized by the federal government and state agencies to use during this response phase was an immediate concern for plans for reimbursement and rate-setting purposes. We hope that states have already begun to find solutions, such as creating resource sheets for MCOs and providers to outline appropriate codes and documentation related to telemedicine. States also may need to provide financing support for safety net clinics or small physician offices that lack resources to invest in the needed technology.

Q: Do you think that plans have what they need to navigate all the COVID-19 screening and treatment services that have been added?
A: E. Martinez-Vidal: MCOs could definitely use help in this area. If they haven't already done so, states should consider providing guidelines that clarify the expansion of benefits for diagnostic tests, administration of tests by outpatient or emergency room providers and facilities, and treatment of illness and complications related to COVID-19. MCOs will benefit from knowing whether cost sharing is in place for beneficiaries or which services do or do not need prior authorizations. As patients start completing their care, now is the time to also address unexpected charges or bills for COVID-19 services that are covered entirely by new Medicaid/Medicare requirements or other private plan commitments. Managed care plans will need to navigate cost correction for beneficiaries if they are getting charged incorrectly by labs or providers.

J. Babcock: Also, because of a focus on the acute care setting when providing screening and treatment services, federally qualified health centers and home health agencies have not been adequately prioritized to receive guidance and resources, such as staffing and workforce contingency plans if or when employees are affected by the pandemic. We've heard that many facilities, and particularly home health and personal attendant services, still do not have adequate supplies of personal protective equipment (PPE) to protect staff and patients.

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Q: There are extensive changes coming from CMS to support the U.S. health care system during the COVID-19 response. What else would you say is important to highlight in supporting providers and plans?
A: E. Martinez-Vidal: One support mechanism that comes to mind is related to the expansion of workforce and care settings. With the health care system at capacity, there are Medicaid waivers that provide options for alternative care sites and expanding the health care workforce. We think that providing a resource for hospitals and non-hospital facilities on specific administrative requirements or changes that would streamline or enhance the process to increase staff and care delivery sites as soon as possible would be helpful for MCOs.

J. Babcock: If we look beyond this initial response phase, states will need to know when and how COVID-19 related flexibilities will end. We think that preparedness planning guidance from states on how to phase out implementation of COVID-19 related federal statutes may be helpful. As the Federal Medical Assistance Percentage increased by 6.2 percent during this response and there are other federal emergency authorities granted, we have to ask what will trigger the end of the declaration? Will coverage phase out state-by-state or regionally depending on pandemic status and capacities? These are considerations that MCOs will benefit from if we plan ahead.

Q: A slew of new data has been released about racial and ethnic health disparities being exacerbated by COVID-19. What can you tell us about where states should focus their efforts on this important topic?
A: J. Babcock: We are seeing across the country that communities of color, particularly Black people, face a higher risk of becoming severely ill and dying from COVID-19 infection. Even though only a few states are reporting COVID-19 cases and deaths by race as of early May, preliminary data show that Black people are dying at a higher rate. As an example, in Washington D.C. Black people make up 45 percent of the total population, but account for 47 percent of confirmed coronavirus cases and 79 percent of deaths as of May 2, 2020. Data from jurisdictions across the U.S., such as Chicago, Michigan, and Louisiana show a similar impact.

As a first step to addressing health disparities, it is critical for states to support their plans in collecting comprehensive data by race and ethnicity to explore the impact of COVID-19 on communities of color. Race stratified data is necessary to improving health and economic disparities moving forward. States may collaborate with MCOs to enhance access to health care specifically for communities of color. How will people of color, who are disproportionately uninsured, gain access to care? States can implement targeted health education for disproportionately affected populations on the various federally approved COVID-19 related services. They can develop ways to assist patients with where and how to obtain testing and treatment.

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A Call to States

As the pandemic continues, states will need to understand and adapt to the changing needs of MCOs as they navigate how best to serve their populations under extremely challenging circumstances. How will states prioritize the development and dissemination of resources? How can states collaborate with MCOs to provide short- and long-term responses to the most pressing issues that have come up during COVID-19? ACAP and CHCS welcome states to share their most effective strategies to support their MCOs during and in the aftermath of this pandemic. Please share with us at mail@chcs.org.