DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard,
Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMCS Informational Bulletin

DATE: August 24, 2020

FROM: Anne Marie Costello
Acting Center Director

SUBJECT: Nursing Home Strategies for COVID-19 Only Isolation of COVID-19 Residents

This Center for Medicaid & CHIP Services Informational Bulletin (CIB) identifies flexibilities available to state Medicaid agencies to enhance payment for nursing facilities (also referred to as nursing homes throughout this CIB) during the COVID-19 public health emergency to account for potentially increased resident acuity levels and to support any necessary actions that facilities are implementing to mitigate the further spread of COVID-19, such as isolation or quarantine of residents and adherence to Federal infection control guidelines. This CIB also highlights specific actions that certain states have already taken to better support the nursing facilities' ability to safely care for all residents, including COVID-19 positive residents, during this public health emergency, and how enhanced nursing facility payment supported those efforts. With this CIB, the Centers for Medicare & Medicaid Services (CMS) is encouraging states to utilize these flexibilities to improve care for Medicaid beneficiaries residing in nursing facilities.

Background

Since the outset of the COVID-19 public health emergency the Federal government made it a priority to offer assistance to providers of America's healthcare system, including $100 billion to establish a provider relief fund, which Congress subsequently augmented with an additional $75 billion. In March 2020, CMS created a Medicaid Disaster Relief State Plan Amendment (SPA) template[1] to assist states in responding to the COVID-19 public health emergency. This streamlined SPA template combines multiple, time-limited state plan options into a single template, eliminating the need to submit multiple SPA requests. States have utilized this new SPA template to implement temporary changes to eligibility, enrollment, benefits, premiums, cost sharing, and provider payments including: coverage of the new eligibility group for COVID-19-testing, temporary elimination of cost sharing, expansion of telehealth for covered Medicaid services and temporary rate increases to providers to recognize higher costs related to

[1] https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html

COVID-19 treatment. One of the key authorities approved through the use of the Medicaid Disaster Relief SPA template has been to increase nursing facility payment rates.

States generally have significant flexibility in modifying state plan payment rates and methodologies for nursing facilities consistent with Section 1902(a)(30)(A) of the Social Security Act. States can increase payments to recognize additional costs incurred in delivering Medicaid services, including additional labor costs and supply costs such as costs for personal protective equipment. States can further target payment increases to nursing facilities that are treating residents diagnosed with COVID-19, or to nursing facilities in geographic areas that are experiencing an outbreak. Through the Medicaid Disaster Relief SPA process, CMS has prioritized the review and approval of state proposals to enhance payment to nursing facilities so that they may be better able to provide quality care to all residents during the public health emergency. CMS has already approved numerous Medicaid disaster relief SPAs that provide for increases or add-ons to nursing facility payment rates to account for the impact of the public health emergency, including increased costs of operation and higher resident acuity.

Examples of nursing facility payment enhancements available to states

- Per diem dollar increases or percentage increases to existing base rates – some states have increased payment rates across-the-board, while others are targeted for facilities with residents who are diagnosed with COVID-19.

- Establishment of new payment methodologies for nursing facilities serving as isolation centers.

- Temporarily modifying existing rate setting methodologies (such as allowing additional costs to be considered), removing certain state plan-established payment penalties (for example, penalties for not filing cost reports timely, or for not meeting state-determined metrics), or creating an option for facilities to apply for specialized payment adjustments under extraordinary circumstances.

- Creation of new targeted supplemental payments or modified existing supplemental payments to accelerate the timing of the payments.

- Modifications to state bed hold policies under 42 C.F.R. § 447.40, to adjust the maximum number of reimbursable leave of absence days or other policy limitations established in their state plans, or to increase the payment rate for bed hold days.

Flexibilities available in managed care

In states that have a ***managed care*** delivery system, states can direct specific payments made by managed care plans to providers through a state-directed payment. Under 42 C.F.R. § 438.6(c), states can include contractual requirements for their managed care plans to pay a specific minimum fee schedule or a specific uniform dollar or percentage increase for a class of providers, including nursing facilities. While the actuarial soundness and rate development requirements under 42 C.F.R. §§ 438.6(c)(2), 438.4, and 438.5 still apply to these payment arrangements, CMS has implemented an expedited review and approval process for states

seeking to implement these state directed payments. Additional details on CMS' approval framework and an example preprint are available in the May 14, 2020 CMCS Informational Bulletin.[2]

Consistent with previously published FAQs[3], states can also consider paying for services outside of the managed care capitation rates as a non-risk payment arrangement. This arrangement can be structured as either a separate non-risk contract with the managed care plans (see the definition of "non-risk contract" at 42 C.F.R. § 438.2) or as an amendment to existing managed care plan contracts to include a non-risk payment. The state will need to be able to identify relevant costs and/or beneficiaries accurately within the managed care plan contracts. The state would then need to amend their contracts to clearly define the benefits the plans must cover on a risk basis and the benefits that are excluded from the capitation rates and will be covered on a non-risk basis. The state and its actuary will also need to determine if a rate amendment is necessary (i.e., to address any services previously included in capitation rate development that now need to be removed and paid on a non-risk basis). If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with the upper payment limits specified in 42 C.F.R. § 447.362 for non-risk contracts.

Examples of flexibilities states have implemented:

- Ohio provides tiered payments, based on an individual resident's level of COVID-19 quarantine or isolation, to nursing facility health care isolation centers (HCIC) for COVID-19 (see https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-20-0012.pdf). These payments differ for quarantine ($250 per patient day) or level of isolation needed (from $300 per patient day, to $984 per patient day if mechanical ventilation is needed). Although Ohio originally submitted a state directed payment proposal to operationalize this payment arrangement in its managed care contracts, they have decided to implement a non-risk payment arrangement for these payments. Rather than designating certain facilities as COVID-19 only, Ohio developed policies and practices based around designating specific sections of a facility for quarantine or isolation, which many facilities were already equipped for, and would allow residents to remain in their home facility. In a case where there is a primary payer other than Medicaid, the provider bills the primary payer first, and then the state Medicaid agency reimburses the difference between that payment and the COVID-19 enhanced rate.

- Michigan implemented increased payment rates for nursing facilities that are designated by the state as a "COVID-19 Regional Hub" (see https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-20-0005.pdf). These nursing facilities receive an initial $5000 per bed payment in the first month to address staffing needs and infrastructure changes required to assure the facilities are able to meet the patient safety protocols necessary with higher level of care. Nursing facilities were required to demonstrate the ability to physically separate patients by submitting their floor plans

[2] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051420.pdf.
[3] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

for state review. After the first month, a supplemental payment of $200 per resident per day will be built into the per diem rates for these nursing facilities. In order to qualify for admission into a regional hub bed, patients had to either be discharged from a hospital or transferred from another nursing facility that was unable to safely isolate the patient. Like Ohio, Michigan utilized the fact that many facilities already had isolation and quarantine areas to create areas within a facility for COVID-19 quarantine and isolation with enhanced procedures and requirements such as dedicated staff for that unit. Michigan is also piloting in 11 counties a long-term care emergency support staffing initiative, to assist long-term care facilities experiencing staffing shortages due to COVID-19 (see https://www.michigan.gov/coronavirus/0,9753,7-406-98158-533608--,00.html).

- Iowa will provide COVID-19 Relief Rate (CRR) payments to nursing facilities that either have a designated isolation unit for COVID-19 treatment or have been designated in their entirety for COVID-19 treatment (see https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-20-0013.pdf). CRR payments are an add-on payment of $300 per day to eligible nursing facilities for each resident in one of the designated units who is discharged from a hospital to the nursing facility, is pending test results for COVID-19, or has received a positive COVID-19 result. Iowa submitted a state directed payment proposal to operationalize this payment arrangement in its managed care contracts.

Additional Resources for nursing facilities

Through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act (PPPCHE), the federal government has allocated $175 billion in payments to be distributed through the Provider Relief Fund to support healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic. These payments do not need to be repaid to the US government if providers comply with the terms and conditions. The funds are being distributed to eligible providers through a series of distributions that include:

- $50 billion general distribution for providers that bill Medicare fee-for-service (Parts A or B);
- $15 billion general distribution for providers that participate in state Medicaid/CHIP programs, Medicaid managed care plans, or provide dental care, that did not qualify for $50 billion general distribution for Medicare fee-for-service providers;
- $4.9 billion targeted distribution for Medicare- and Medicaid-certified skilled nursing facilities with at least six beds; and
- $5 billion targeted distribution for nursing facilities and long-term care facilities, including $2.5 billion to support increased testing, staffing, and PPE needs and $2.5 billion based on performance with minimizing the spread of COVID and COVID-related fatalities among the facility's residents.

A portion of the Provider Relief Fund funds are also being distributed to healthcare providers who have provided treatment for uninsured COVID-19 patients on or after February 4, 2020. Providers can request claims reimbursement and will be reimbursed at Medicare rates, subject

to available funding. Nursing facilities may also be eligible for future allocations of the Provider Relief Fund. Additional information on future distributions will be made available on HHS' Provider Relief Fund webpage at www.hhs.gov/providerrelief.

Previously, CMS had issued a toolkit for states to mitigate COVID-19 prevalence in nursing facilities (https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf). Additionally, in July, HHS announced an initiative to distribute rapid point-of-care testing devices to nursing homes in COVID-19 hotspot geographic areas in the United States (https://www.hhs.gov/about/news/2020/07/14/trump-administration-announces-initiative-more-faster-covid-19-testing-nursing-homes.html). CMS has also provided guidance for other congregate setting provider types to mitigate the spread of COVID-19.[4]

Conclusion

CMS encourages states to utilize the flexibilities available to support the nursing facilities' ability to safely care for all residents, including COVID-19 positive residents, during this public health emergency. CMS encourages states to do so through close alignment with applicable CDC guidance and in close coordination with the state agency responsible for survey and certification of nursing facilities.

If states have questions about this informational bulletin or need technical assistance regarding these flexibilities, please contact Todd McMillion, Director of the Division of Reimbursement Review, at Todd.McMillion@cms.hhs.gov or John Giles, Director of the Division of Managed Care Policy, at John.Giles1@cms.hhs.gov.

[4] See https://www.cms.gov/files/document/qso-20-20-allpdf.pdf and https://www.cms.gov/files/document/covid-faqs-non-long-term-care-facilities-and-intermediate-care-facilities-individuals-intellectual.pdf.