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Addressing Nursing Facility Financing Challenges during MLTSS Program Development

APRIL 2022

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AUTHORS

Camille Dobson, MPA, Deputy Executive Director, ADvancing States

Diane Gerrits, MBA-HCM, President, Innovation Matters in Health

Amanda Schipp, JD, Senior Healthcare Consultant, Milliman

Gwyn Volk, MA, Senior Healthcare Consultant, Milliman

Jill Herbold, FSA, MAAA, Principal and Consulting Actuary, Milliman

Luke Roth, Senior Healthcare Consultant, Milliman

ADVANCING STATES

The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key managed long-term services and supports (MLTSS) policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

For more than 70 years, **Milliman** has pioneered strategies, tools and solutions worldwide. As one of the largest consulting and actuarial firms in the world, Milliman consultants are recognized leaders in the markets they serve. Milliman insight reaches across global boundaries, offering specialized consulting services in healthcare, employee benefits, life insurance and financial services, and property and casualty insurance.

Acknowledgments

Managed long-term services and supports (MLTSS) is now the Medicaid delivery system in half the states. States seeking to modernize and improve their long-term services and supports systems continue to use managed care plans to help them achieve their goals.

Operating an efficient and effective MLTSS program requires thoughtful program design, capable health plan partners, strong state oversight, and appropriate accountability mechanisms. ADvancing States has been deeply engaged in providing technical expertise and assistance to our member states as they plan, design, implement, and evaluate their MLTSS programs through our MLTSS Institute. The Institute brings together state MLTSS directors with health plan thought leaders to drive improvements in key MLTSS policy issues and facilitate sharing and learning among states.

The Institute has published eight issue briefs in the past five years, and is pleased to present a much-needed exploration of how traditional Medicaid financing approaches can pose a barrier to MLTSS development and implementation as well as highlight potential solutions. We are excited to partner with Milliman to bring attention to this aspect of Medicaid program design and operations. We appreciate the expertise they brought to this subject.

I remain deeply grateful to our visionary Board of Directors, state long-term services and supports leaders, and thought leaders at national health plans who understand that well-run, high-quality MLTSS programs benefit us all, and are willing to invest their time and resources to support the implementation of such programs. We offer special thanks to the following state LTSS leaders - Jakenna Lebsock, Colby Shaeffer and Benjamin Kauffman (Arizona); Steve Groff, Lisa Zimmerman and Kathleen Dougherty (Delaware); Amy Penrod and Brad Ridley (Kansas); Patti Killingsworth and Zane Seals (Tennessee); and Karen Kimsey and Chris Gordon (Virginia) - who graciously gave their time and expertise to this project.

Martha D Roherty

Martha Roherty, Executive Director
ADvancing States

MLTSS Institute Advisory Council 2022

Sharon Alexander, President, Long Term Services and Supports, Amerihealth Caritas

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Curtis Cunningham, Assistant Administrator, Benefits and Service Delivery, Wisconsin Department of Health Services

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Michelle Martin, Senior Policy Director, LTSS, UnitedHealthcare Community and State

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Maureen Pero, Strategy and Growth Executive, Aetna Medicaid

Sarah Triano, Senior Director, LTSS Business Development, Centene Corporation

Karla Warren, Integrated Care Manager, Ohio Department of Medicaid

Executive Summary

The historical approaches state Medicaid agencies have used to finance and pay for institutional nursing facility (NF) services have posed challenges for reforming the provision of long-term services and supports (LTSS), particularly as more states transition to managed long-term services and supports (MLTSS).[1] In 43 states and the District of Columbia, provider taxes on NFs are a source of financing the non-federal share of Medicaid program expenditures, and many states are using these tax revenues to support supplemental payments to NFs and other providers in their fee-for-service (FFS) programs.[2] Most states also reimburse NFs using cost-based per diem rates in their FFS programs. In this paper, we provide key insights for state officials regarding federal Medicaid managed care regulations pertinent to financing NF services as well as options to meet the requirements.

Overview

Many states must change the mechanisms and/or non-federal share funding sources used to pay for NF services as they transition to managed care. States have multiple options available which can be leveraged to retain robust access to NF services for Medicaid enrollees while ensuring the transition supports enrollees' access to the most efficient and effective care.

Extensive stakeholder engagement — both early and often — is one of the most, if not the most, critical keys to success when transitioning to MLTSS.

After providing historical context for NF services and financing in Medicaid in this paper, we discuss financing the non-federal share of Medicaid expenditures using four non-state sources of funds: health care provider and managed care organization (MCO) taxes; intergovernmental transfers; certified public expenditures; and bona fide donations. Of these sources, taxes on NFs are the most common and have been used by many states to support supplemental payments to NFs. However, such supplemental payments are not permissible under Medicaid managed care regulations.

We then discuss options to address NF payment challenges under Medicaid managed care, including:

- **Pass-through payments:** In many states, a sizable portion of the total reimbursement paid to NFs has historically been via supplemental payments. States are now permitted to transition supplemental payments to pass-through payments for up to three years as populations or services are first moved into managed care.[3]
- **State-directed payments:** States may use directed payment arrangements to set minimum and maximum fee schedules, implement value-based purchasing incentives, and target uniform dollar or percentage increases to specific provider classes.[4] For the purposes of transitioning to MLTSS, many states have leveraged state directed payment flexibility by establishing minimum fee schedules to maintain historic FFS reimbursement levels, as well as provide enhanced funding to NFs through uniform dollar or percentage increase arrangements.
- **Nursing facility fee schedules:** Some states have successfully preserved payment enhancements financed via provider taxes through a combined strategy of maintaining a state plan FFS cost-based per diem rate fee schedule and establishing the state's fee schedule as a minimum in the MLTSS program.

Key Takeaways

In order to comply with federal regulations, many states need to change the mechanisms used to pay for NF services as they transition to managed care.[5] As highlighted during interviews conducted with representatives from five state Medicaid agencies (Arizona, Delaware, Kansas, Tennessee and Virginia), extensive stakeholder engagement — both early and often — is one of the most, if not the most, critical keys to success when transitioning to MLTSS. States have used directed payments, minimum fee schedules, and other options discussed in this paper to ensure that payments for NF services under Medicaid managed care meet all requirements and maintain robust access to NF services for Medicaid enrollees. New programs also have a time-limited opportunity to use pass-through payments to ease the transition to a managed care delivery system.

Introduction and Background

Over the last two decades, state Medicaid programs have made considerable efforts to reform the provision of long-term services and supports (LTSS) including rebalancing the share of spending for home and community-based services (HCBS) relative to institutional settings.[6] However, the historical approaches state Medicaid agencies have used to finance and pay for institutional NF services have posed challenges for LTSS reform. The challenges are exacerbated for states contemplating a transition to managed long-term services and supports (MLTSS) because some financing and payment mechanisms used in fee for service (FFS) programs are not permissible in managed care. In preparation for operating an MLTSS program, states need a thorough understanding of how their state finances the program that they wish to transform.

In preparation for operating an MLTSS program, states need a thorough understanding of how the state finances the program that they wish to transform.

In this paper, we review the historical landscape for the financing of and payments for institutional NF services by state Medicaid programs, as well as pertinent requirements specific to Medicaid managed care and the challenges they present. We then discuss potential options available to states to address the funding of NF services in order to facilitate their MLTSS reform efforts. The potential options are informed by states that have successfully addressed the challenges and implemented Medicaid MLTSS programs.

Historical Context

States' focus on rebalancing utilization and spending between institutional and HCBS settings reflects the desire to move away from Medicaid's historic reliance on institutionalizing older adults and people with disabilities. At program inception in 1965, states were required to cover NF services under the Medicaid program, but there was no similar requirement to cover HCBS. Starting in 1981, Congress allowed states to use 1915(c) waiver authority to provide HCBS to eligible individuals who would otherwise be institutionalized.[7] Additional federal legislation, regulations, and litigation offered new avenues and flexibilities to states to provide HCBS over time.

As of FY 2019, almost 59 percent of the $162 billion in Medicaid LTSS spending was on HCBS.Of the other 41 percent of Medicaid LTSS expenditures, the vast majority of spending was for services provided by NFs. However, there is significant variation across states regarding the share of Medicaid LTSS spending on HCBS relative to care provided in nursing facilities, ranging from a low of 33 percent in Mississippi to a high of 83 percent in Oregon.[8]

Over the time that NF services have mandatorily been provided in Medicaid programs, many states have developed complex financing strategies and payment methodologies that both states and NF providers have become reliant upon.

43 states and the District of Columbia had a provider tax on nursing facility services.

Medicaid Financing Overview

Medicaid programs are jointly financed by states and the federal government. The federal financial participation (FFP) received by each state is determined according to the state's federal medical assistance percentage (FMAP), as defined in the Social Security Act §1905(b). Each state's FMAP is calculated based on the state's per capita income relative to national per capita income, with a minimum FMAP of 50 percent and a maximum FMAP of 83 percent.[9]

Sources of the Non-Federal Share of Medicaid Expenditures

The Social Security Act allows states to finance up to 60 percent of the non-federal share of Medicaid expenditures with non-state sources of funding.[10] In state fiscal year 2018, states financed approximately $63 billion (28 percent) of the approximately $224 billion in total non-federal share of Medicaid program expenditures using revenues from providers and local governments. Four states financed over 40 percent of their non-federal share of Medicaid program expenditures from providers and local governments, with the highest state financing 52 percent.[11] States use four common mechanisms to finance the non-federal share of Medicaid program expenditures:

1. **Health care-related taxes (provider and MCO taxes).** A state may impose a fee or assessment on health care providers or MCOs to finance a portion of the non-federal share of Medicaid program expenditures. There are specific requirements for taxes to be eligible for FFP — namely that the fee or assessment must be broad-based and uniformly imposed across the class of health care providers or services being taxed. It also must not hold taxpaying entities harmless in other words, the provider paying the assessment must not be guaranteed to get the value of the assessment back in payments. Federal regulations provide a safe harbor for the hold harmless requirement for taxes that do not exceed 6 percent of net revenues for the taxpaying entities.[12,13] There has recently been significant growth in the number of states implementing new MCO taxes, and as of state fiscal year 2021, at least 14 states had an MCO tax in place.[14]

2. **Intergovernmental transfers (IGTs).** A state may receive public funds directly from local government entities, including healthcare providers that are government-owned or operated.[15] In some cases, privately owned NFs have entered into arrangements with public hospitals in order to be classified as a government-owned facility for the purposes of receiving IGT-funded supplemental payments.[16]

3. **Certified public expenditures (CPEs).** A state may certify expenditures of local government entities, including healthcare providers that are government-owned or operated or quasi-government providers, to obtain federal matching funds. The certified expenditures must be for Medicaid-covered services provided to Medicaid enrollees.[17] CPEs pose administrative and regulatory challenges when beneficiaries are moved into a managed care delivery system.

4. **Bona fide donations.** Federal regulations define a bona fide donation as "a provider-related donation that has no direct or indirect relationship to Medicaid payments made to (1) the health care provider; (2) any related entity providing health care items and services; or (3) other providers furnishing the same class of items or services as the provider or entity."[18] This definition does not include donations that are part of a hold harmless arrangement that directly or indirectly returns some or all of the donation to the provider, the provider class, or any related entity.[19] Further, the federal regulations establish financial limits, such that provider-related donations that do not exceed $5,000 per year for an individual provider or $50,000 per year for a healthcare organization, are presumed to be bona fide donations.[20] Any funds that exceed these amounts or are otherwise not deemed to be bona fide (such as having an indirect relationship to Medicaid payments), are not eligible for FFP and will be deducted from FFP calculations for the state.

Due to the limitations on bona fide donations, states have primarily relied on the first three of the above mechanisms to finance their Medicaid programs. Specifically, of the $63 billion in non-federal share of Medicaid program expenditures financed through these mechanisms in state fiscal year 2018, 59 percent were from provider taxes, 35 percent were from IGTs, and 6 percent were from CPEs.[21,22]

Nursing Facility Participation in Financing Strategies

The vast majority of NF providers are private, for-profit entities, with only seven percent of NFs nationwide being government-owned.[23] Because only local government entities or providers that are government-owned or operated may participate in IGT or CPE arrangements, provider taxes are the primary mechanism being used by state Medicaid agencies to generate the non-federal share of Medicaid program expenditures from NFs. As of FY 2016, 43 states and the District of Columbia had a provider tax for NF services, making it the most common provider tax used by states to enhance the non-federal share of Medicaid program financing. These provider taxes generated significant funds, with 32 state Medicaid agencies having a NF tax exceeding 3.5 percent of net patient revenues and 20 agencies having a NF tax exceeding 5.5 percent of net patient revenues.[24]

Nursing Facility Payments

Most state Medicaid programs use cost-based per diem payment methodologies to provide reimbursement for NF services.[25] While most states regularly rebase their rates to account for changes in provider costs, the underlying cost-based payment methodologies have generally been in use for extended periods of time with little change. Additionally, the use of these cost-based payment methodologies—with little change over the years—has historically afforded a high level of financial stability to NFs.

Nursing facilities' willingness to participate in provider taxes, CPEs, and IGTs suggests they support these mechanisms for the financing of Medicaid program expenditures for NF services. Additionally, NFs may be more willing to finance the non-federal share of Medicaid program expenditures when there is a clear link between the financing provided and payments received, such as through transparent documentation of how the financing supports rate increases or by linking the financing to a specific supplemental payment.[26]

25 states provided some type of supplemental payment to nursing facilities as of 2019.

Historically, many states have used supplemental payments to provide additional funding to NFs in Medicaid FFS programs.[27] These payments, which sometimes lack a direct connection to the quality and utilization of services rendered, are permitted in FFS Medicaid by federal regulations. According to recent analyses by the Medicaid and CHIP Payment and Access Commission (MACPAC), 25 states provided some type of supplemental payment to NFs as of 2019, an increase from 20 states in 2014. Eighteen of these 25 states were providing these supplemental payments to only public NFs.[28,29]

Medicaid Managed Care Reimbursement Regulatory Structure

In a managed care delivery system, states pay MCOs a per member per month capitation rate for the provision of covered services. The framework for setting capitation rates is established in federal regulations. Per regulations issued by the Centers for Medicare & Medicaid Services (CMS), states are not permitted to make payments to providers other than through their contracted MCOs except when those payments are statutorily required, because if actuarially sound capitation rates are sufficient to cover the reasonable, appropriate, and obtainable costs of providing services covered under the managed care contract, then providers, arguably, would not need additional payments for services.[30] Therefore, one potential effect of the move to MLTSS is that it can lead to a loss of supplemental payment funding for NFs, as the managed care capitation rates must be inclusive of all payments for services provided under the contract, thus eliminating the ability of the state to make separate supplemental payments to the NFs.

Prior to 2016, a few states offset the loss of FFS supplemental payments for NFs by increasing capitation rates paid to MCOs and requiring MCOs to direct these additional funds to NFs. These payments, known as pass-through payments, are categorized as a type of supplemental payment to NF providers that are not directly tied to utilization of those services.

The Medicaid Managed Care Final Rule provided permissible mechanisms for states to direct payments within the managed care delivery system.

In 2016 when the Medicaid managed care rules were updated (Medicaid Managed Care Final Rule), one of the significant changes was phasing out pass-through payments in Medicaid managed care. CMS concluded that pass-through payments were inconsistent with actuarial soundness requirements for capitation rate setting in managed care. However, CMS acknowledged that such payments have been an essential source of funding for safety-net services and will take time to effectively reform, so it provided for a transition period to allow states utilizing existing pass-through payments to transition to utilization and quality-based payments.

The Medicaid Managed Care Final Rule also provided permissible mechanisms for states to direct payments within the managed care delivery system. The exception established in 42 CFR 438.6(c)[31], gives states limited flexibility to require MCOs to make specific payments to providers through one of the following types of programs:

- **Fee schedule.** Examples include mandating payment of minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules.
- **Value-based purchasing model.** Examples include bundled payments, episode-based payments, shared savings/risk arrangements, and other models that reward providers for delivering greater value and achieving better outcomes.
- **Multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives.** Examples include pay for performance arrangements, quality-based payments, and population-based payment models.

The use and spending of state directed payments has grown substantially since the creation of the payment option in 2016, with MACPAC recently reporting an increase from 65 arrangements in 2018 to more than 200 as of 2020.[32] CMS amended the Medicaid managed care rules in 2020 to allow states to implement minimum fee schedule directed payments for network providers based on state plan approved rates without the submission of a preprint, citing in part administrative duplication of rates that have already been reviewed and approved by CMS.[33] Notably, however, CMS has reiterated the need for these minimum fee schedule arrangements to still meet all federal compliance requirements set forth in regulation (e.g., based on utilization, expected to advance at least one goal in the quality strategy, has an evaluation plan, and not renewed automatically).[34]

Addressing Payments for Nursing Facility Services in Medicaid Managed Care

To transition from FFS to managed care, particularly for LTSS, a state Medicaid program needs to carefully plan to transition payments for NF services to conform to Medicaid managed care regulations. There are several viable approaches available to address the payment challenges described above. These options were identified and expanded through structured interviews with representatives from five states Medicaid agencies — Arizona, Delaware, Kansas, Tennessee, and Virginia. The following options are discussed in more detail below:

A. **Transition supplemental payments to short-term pass-through payments;**
B. **State directed payment arrangements;**
C. **Standardize and update NF reimbursement;**
D. **Value-based payment strategies; and**
E. **Diversification of services provided by NFs.**

Regardless of the specific strategies used, it is important to note one theme shared consistently by the interviewees from all five state Medicaid agencies: the need for on-going strategic and nuanced stakeholder engagement. Stakeholder engagement allows for building consensus regarding the overall goals and objectives of the reform, how they will be operationalized, and how progress toward those goals and objectives will be measured and evaluated. Strategies typically used include all stakeholder webinars, town halls, focus groups, workgroups, dedicated landing webpages with relevant materials, in person meetings for feedback weekly or monthly and tailored communications with clear messaging.

Developing a formal and frequent stakeholder engagement plan is necessary to clearly articulate the state's strategies, clarify roles and responsibilities, and identify timelines. Given the long-term nature of LTSS reforms, it may be necessary to develop short- and long-term stakeholder engagement plans that are updated over time to reflect project challenges and successes. Implementing these plans successfully often requires significant resources which will need to be accounted for during the state budgeting process.

A. Transition Supplemental Payments to Pass-through Payments

The original Medicaid Managed Care Rule in 2016 provided for a fixed transition period for states to phase out their supplemental payments to hospitals by July 1, 2027, and to physicians and NFs by July 1, 2022.[35] However, in late 2020, CMS updated the rule to permit a new three-year transition period for any state transitioning new services or populations into managed care. CMS recognized that "the use of pass-through payments in place as of the 2016 final rule as an upper limit on permitted pass-through payments during the transition periods described in § 438.6(d) effectively precludes new managed care programs from adopting pass-through payments under the current law."[36] CMS also acknowledged that "by providing states, network providers, and managed care plans time and flexibility to integrate current pass-through payment arrangements into permissible managed care payment structures, states would be able to avoid disruption to safety-net provider systems that they have developed in their Medicaid programs."[37] CMS therefore implemented a flexible transition period, not based on specific calendar date, but rather allowing a transition period of up to three years from the beginning of the first rating period in which the services were transitioned from FFS to the managed care model. This newly introduced transition period removes a barrier to states considering transitioning to managed long term care by preserving current funding mechanisms during implementation of MLTSS. For example, a state that wants to implement a new MLTSS program starting July 1, 2025 would be able to create a new pass-through payment for NFs starting July 1, 2025 through June 30, 2028. Effective July 1, 2028, the state would need to use one of the permissible options discussed in Section B below.

States are able — for up to three years — to preserve current supplemental payments during MLTSS implementation.

With this new flexibility, states that are newly implementing MLTSS can transition existing supplemental payments into managed care gradually to reduce potential disruption of drastic changes to existing funding structures.

B. State-Directed Payment Arrangements

Federal regulations permit states to direct MCO expenditures in limited circumstances related to implementing value-based purchasing (e.g., pay for performance, episode-based payment, or population-based payment), delivery system reform (e.g., multi-payer initiatives to reform care delivery systems), or state-directed fee schedules (e.g., minimum or maximum fee schedules, or a uniform payment increase).[38]

During the interview process, representatives from all five states reported using state-directed payment arrangements to help maintain historic FFS state plan reimbursement rates under managed care, mostly through minimum fee schedule arrangements. According to Patti Killingsworth, Assistant Commissioner and Chief of Long-Term Services and Supports for TennCare (the Tennessee Medicaid agency), "NF occupancy rates have declined significantly since implementation of MLTSS but enhanced payments to NFs as part of a new quality and acuity-based reimbursement system financed in part through a provider assessment fee has helped drive more person-centered care, while allowing facilities to remain solvent and avert wide-spread closures."

While state-directed payment arrangements typically require states to submit an annual preprint for CMS approval, per the updated 2020 Medicaid Managed Care Final Rule, states are no longer required to submit a preprint for state-directed payments seeking to adopt minimum fee schedules using state plan approved rates.[39] This flexibility allows states to transition existing state-specific and historic state plan reimbursement to managed care, including facility specific cost-based methodologies.

C. Standardize and Update Nursing Facility Reimbursement

Standardizing and updating NF reimbursement rates can be a key strategy to support the transition to MLTSS. By providing continued oversight and management of NF fee schedules, states can guide the amounts that managed care plans pay NFs for their services. Additionally, using 42 CFR 438.6(c) state directed payments, states may establish a minimum fee schedule using NF reimbursement methodologies and rates that are established by the state. Particularly during the transition to MLTSS, state oversight and management of NF fee schedules can provide financial predictability and stability to NFs.

Based on interviews and a review of approved 438.6(c) preprints for select states with relatively mature MLTSS programs, we found that many continue to maintain fee schedules for NFs in their Medicaid state plans and require their managed care plans to reimburse NFs no less than the state plan fee schedule amounts.[40] Additionally, the states interviewed have successfully preserved payment enhancements financed via provider taxes through a combined strategy of maintaining the state plan fee schedule and establishing the state's fee schedule as a minimum for the MLTSS program.

D. Value-Based Payment Strategies

Value-based payment strategies can be established to incentivize providers to support the state's overall quality goals, such as providing financial incentives to NFs for contributions to achieving rebalancing goals (i.e., through the identification and transitioning of enrollees to HCBS). Such value based purchasing strategies could support more sustainable revenue for NFs through rebalancing by shifting reimbursement from being wholly volume driven to outcomes driven. A handful of states have also had success incorporating value-based payment strategies directly as a component of the state-plan approved reimbursement methodology to reward providers meeting targeted quality metrics, such as resident satisfaction and staffing ratios. The Integrated Care Resource Center sponsored by CMS has provided a resource outlining how states have used value-based payment approaches to improve quality.[41] These value-based purchasing strategies can be implemented through state-directed payment arrangements that incorporate value-based payments as fee schedule adjustments or, integrated more generally into MCO-driven VBP-related contract requirements that seek alignment between MCO initiatives and the state's quality and rebalancing goals.

E. Support Diversification of Services Provided by Nursing Facilities

Diversification of NF services could support NF fiscal stability in state healthcare markets that increasingly value HCBS and help states continue to leverage NF revenue via provider taxes. Diversification strategies could include allowing NFs and hospital systems to provide HCBS, such as adult day health services or meal provision for individuals living in the community. However, state and federal regulations could pose a challenge to those efforts.

Many MLTSS states continue to maintain fee schedules for NFs in their Medicaid state plans and require their managed care plans to reimburse NFs no less than the state plan fee schedule amounts.

Conclusion

Many states are considering ways to successfully transition their LTSS programs from FFS to managed care. A thorough understanding of how the state is currently financing and paying for NF services is key to achieving this objective. Under Medicaid managed care, federal regulations require that all payments made to providers be from MCOs, not the state, and that they are linked to the utilization of services. Hence, many states must change the mechanisms used to pay for NF services as they transition to managed care. With extensive stakeholder engagement, states have used directed payments, minimum fee schedules, and other viable alternatives discussed in this paper to ensure that payments for NF services under managed care meet the requirements of federal regulations and maintain robust access to NF services for Medicaid enrollees.

Caveats, Limitations, and Qualifications

The material in this issue brief represents the opinion of the authors and is not representative of the views of Milliman or ADvancing States. As such, Milliman and ADvancing States are not advocating for, or endorsing, any specific views contained in this issue brief.

The information in this issue brief is intended to provide an overview of the financing and payments for NF services by state Medicaid agencies. This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit any third party that receives this issue brief. Any third-party recipient of this issue brief that desires professional guidance should not rely upon this issue brief, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this issue brief to a third party should be in its entirety.

A co-author of this issue brief, Jill Herbold, is a member of the American Academy of Actuaries and meets the qualification standards to provide this issue brief.

Endnotes

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