



April 13, 2020

COVID-19 Medi-Cal Contracting & Funding Frequently Asked Questions

Governor Newsom declared a State of Emergency on March 4th to address the global COVID-19 outbreak. Since this time dozens of State actions have been implemented, including a \$1.1 billion State emergency appropriation, State-directed Medi-Cal flexibilities, and a clarion call for local, State and county collaboration at all levels. Governor Newsom has emphasized the need to take proactive measures, and for all levels of government to pursue action steps to mitigate the COVID-19 pandemic. This includes working collaboratively with all health and human services system providers.

1. Why are Behavioral Health Providers grappling to deliver all anticipated contracted services?

The COVID-19 situation is fluid and requires vastly different approaches to service delivery than ever anticipated. State and County public health orders for sheltering in-place, school closures, and social distancing upended traditional service delivery approaches. State guidance has been necessary to clarify telehealth services, and Medi-Cal flexibilities for the delivery of services, including authorization for treatment setting shifts.

As a result, anticipated service units from March 1 through June 30, 2020 will be impacted. Providers are taking action steps to increase telehealth access and remote services, to utilize alternative settings, and to outreach to clients and families. Client cancellations have occurred and family access to technology is often limited. We are making staff adjustments, service site changes, and technology adaptations as rapidly as is feasible utilizing both State and county direction, as required by Medi-Cal.

Further, existing contracts reflect often drastically different needs than the services our communities essentially need now as a result of the COVID-19 crisis. There is a client-centered need to provide for contract flexibilities.

2. Why are nonprofit providers financially impacted by this decline in service units?

COVID-19 disruption to service delivery necessitates collaboration with non-profit providers regarding contract agreements, made in good faith, prior to this public health and safety emergency.

Existing contracts are built based on traditional service delivery arrangements with known building blocks, using the Medi-Cal Fee-for-Service structure. This balance of funding and known service delivery has been up-ended, meaning a precipitous loss of revenue could occur, leaving potentially closed doors.

In addition, we are identifying staff to fill-in gaps, to serve in potentially hazardous conditions, and making clinical adaptations to address this new environment, all of which requires stable and reliable funding.

3. Why are interim monthly payments necessary for fee-for-service providers to weather this uncertain time?

Absent predictable revenue, nonprofits are forced to quickly conduct layoffs and associated service reductions to mitigate financial losses. Cash flow balance is imperative to continue professional staff resources and expertise for local non-profits.

Interim monthly payments make sense for *both* the county and non-profit providers. It provides protection for counties since contract caps remain in place, alleviating concern of exceeding designated levels. End of the year adjustments remain in place thereby ensuring access to federal financial participation through Medi-Cal. The cash flow facilitates continuation of services by non-profits.

Interim payments can take several forms. They can be based either on 1/12 of existing contract caps, or 1/4 of remaining contract funds for FY19-20, or any other monthly invoicing process based on actual costs. As noted in the State's boilerplate contract with counties, broad authority is granted to counties to subcontract with local providers, including payment methodology.

4. What allows counties to adjust Medi-Cal rates mid-year?

Counties have broad discretion over the rates paid to each provider. This is because rates are established by each county through their "County Maximum Allowable" rate-setting process, *not* through the Department of Health Care Services.

County contracts are set with each provider individually at the beginning of each fiscal year and defined as "interim rates". Medi-Cal rates are typically based on that provider's projected actual cost of providing the contracted units of service, but usually, these rates evolve by the end of the fiscal year depending on the service utilization.

For example, when a provider reaches their contract cap and continues to bill Medi-Cal during the contract period, the rate is reduced at the end of the fiscal year through the cost settlement process, resulting in the adjusted rate to be lower than the interim rate. Further, when the provider is not able to achieve the anticipated minutes, the rate can be adjusted up as long as it's justified by incurred expenses and the total costs do not exceed the contracted amount.

5. Why is temporarily adjusting Medi-Cal rates for contract providers an effective tool to respond to the COVID-19 pandemic?

Both Congress and the federal Administration recognize the urgent need for increased federal financial support, including through Medicaid. As such, an increase of 6.2 percent (for a total of 56.2 percent) in Medicaid federal funding has been authorized for California's Medi-Cal Program.

Counties establish our provider rates specific to the service, region and unique needs of the population being served. Federal funds are currently being provided at the enhanced level of 56.2 percent. This enhanced match is provided on all Medi-Cal eligible services which therefore, enables counties to more comprehensively extend and utilize county funds designated for Medi-Cal provided services.

By adjusting county-determined Medi-Cal rates for contract providers for fiscal year 2019-20, the county can ensure that it is able to draw down the enhanced federal funding to its fullest margin.

The only requirement for adjusting Medi-Cal provider rates at the federal level is to justify the cost. The Department of Health Care Services has requested the federal CMS to recognize California's need for adjusted Medi-Cal rates for behavioral health providers and this will be processed quickly.

6. Do counties need special permission or approval to increase CBO rates (during contracting, mid-year, or at year end)?

No. Counties are able to negotiate provider rates at any time and may update those rates prior to or during the fiscal year in which those rates apply, and may adjust rates after the close of the fiscal year via cost reconciliation. This may be done at any time and at their discretion. Indeed, Counties have significant flexibility in determining rates and the structures of their contracts within their own MHP and across their CBOs.

7. How do you determine the rate when the cost per minute was less prior to March 2020?

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This interim rate enables the provider to receive monthly payment based on billable service units, and *under regular circumstances*, the revenue generated closely corresponds to the cost of providing the service. The final rate, used for year-end cost reporting, accounts for *all* revenue and expenses across the fiscal year. It reflects any necessary adjustments to revenues and expenses, including any changes made to rates.

The COVID-19 emergency has substantially disrupted service delivery and requires a retooling of the interim rate amount. Federal action which increased California's Medi-Cal federal funding from 50 percent to 56.2 percent, reflects the urgent need to buoy health and behavioral health care providers.

Increasing the interim rate for March and onward through the 2019-20 fiscal year to address COVID disruption will result in a modest, and much needed, temporary increase. With the *final rate* calculation reflecting the entirety of fiscal year 2019-20, the impact of the service unit losses in the final quarter of the fiscal year will be mitigated as illustrated in the example below:

Pre-COVID-19. Provider A contracted to provide 100 units of service at \$1 per service, for a total fiscal year 2019-20 contract cap of \$100.

COVID-19 Impact. Provider A is only going to be able to generate 90 units of service over the entire fiscal year (their losses in the final quarter of fiscal year 2019-20 were more significant, but averaged out over the full year, they are only 10 units short).

Resulting Change. Throughout the COVID-19 crisis, the county continues to pay Provider A the regular monthly payment based on their contract cap to cover their monthly costs.

Using the end-of-year reconciliation process to adjust the rate per service, the county adjusts Provider A's contract to reflect 90 units of service at \$1.11 per service, for a total fiscal year 2019-20 contract cap of \$100. The cost per unit of service is recorded in the county's cost report to the State and all allowable Medi-Cal billable services are eligible for federal financial participation at the enhanced rate of 56.2%).

8. Is it allowable for counties to adjust service rates with contracted providers during the contract term?

Yes.

Not only are interim rates adjusted at the end of the fiscal year, but counties may adjust service rates with contract providers during the contract term at any time. In fact, as described above, many counties set an interim rate at the beginning of the fiscal year and then adjust or revise the rate at the end of the fiscal year.

9. If there's a rate adjustment, what is the cost to the county?

There is no additional cost to the county. The maximum county obligation remains the same regardless of the rate. This is because each provider has a contract cap that is established through the county. This maximum cannot be exceeded.

A rate adjustment simply allows the provider to utilize the part of their contract that would otherwise go unspent.

10. Is this a permanent or temporary adjustment?

This is a temporary adjustment to address the unanticipated impact of the COVID-19 pandemic. As with all other contract years, counties will have full discretion to renegotiate rates and reset contract allocations and caps at the beginning of fiscal year 2020-21.

The goal of the temporary adjustment is two-fold:

- To protect the county against any potential loss in federal financial participation as a result of the disruption in service units; and
- To keep contract providers financially sustainable through the crisis, preventing unnecessary layoffs of staff and service disruptions for clients.

11. Will this impact the county's cost settlement with the State?

No, it will not impact the final cost settlement.

While the county's rates claimed to the State may be different than the rates they claim for the provider, ultimately the county settles with the State to cost. So as long as the county, through its own cost settlement with providers, ensures there are valid costs incurred to support the adjusted rates, the cost settlement process with the State remains the same.

Given that county-operated programs and services are experiencing exactly the same challenges of moving to telehealth, it is likely that the rates counties claim through the cost settlement process for their own services will similarly be higher than their provisional rates. The difference is that the counties do not have the same contractual limits that providers do, and they are paid monthly based on an allocation formula, not specific to claimed services.

12. Aren't there additional costs to the county needed to put this change in place?

The only change to the payment process is that instead of paying for the claimed service units, the county will pay a flat amount (1/12 of the annual amount, or 1/4 of the last four months - March through June 2020 - of the amount left within the contract). The county encumbered these costs already in order to develop the contract with each provider. The county is also being paid a monthly allocation by the state based on its interim (or provisional) rate, so this should not be a barrier to make payments to providers.

13. What will happen when the county undergoes an audit for this period?

Audit risk should be minimal. The use of existing documentation and reporting protocols should be used, as with any Medi-Cal contracted service in behavioral health. State and federal audits focus on ensuring appropriate documentation for services provided and that public revenue was spent on billable services and allowable costs.

The proposed solution reflects monthly interim payments based on actual costs, with a final cost reconciliation process based on service units provided and a rate adjustment to reflect the actual cost of providing the units of services.

14. How will CBOs be held accountable to ensuring they are making every effort to maximize their productivity?

Providers are eager to collaborate with county leadership to identify accountability mechanisms that reflect this unique and unprecedented period.

This could include weekly and/or monthly productivity reports - above and beyond those traditionally required in existing contracts -- to reflect the provider's efforts to reach clients, mitigate technological barriers preventing telehealth provision, retain workforce and ensure the health and safety of staff and clients, and address emerging community behavioral health needs.

The county may also consider a provider-by-provider "floor" for anticipated service units during the remainder of the fiscal year, dependent on service type and other considerations, to which a provider may be held.

15. Why can't CBOS just rely on available federal aid, such as financial support made available through the CARES Act?

Federal relief available through the CARES, and Families First Act, offers different opportunities for providers to access much needed stabilizing funds. While these opportunities are important, there are several challenges associated with the federal stimulus that will cause problems for nonprofits already struggling with cash flow issues and revenue generation.

First, all available loan options are highly competitive, with applications for a limited amount of funding coming from industries and entities all across the country. There is no guarantee that all CBOs will be able to secure funding through these channels. Further, the Paycheck Protection Program loans are only available to nonprofits with fewer than 500 employees. The lack of federal guidance available to loan processing entities has delayed the roll-out of the loan programs, and these delays are coming at exactly the moment when cash flow crises are forcing nonprofits to layoff or furlough their workforces.

Regarding the Economic Injury and Disaster Loans or new Economic Stabilization Fund midsize loans, it will be difficult, if not impossible, for many nonprofits to make payments on any federal loans in the coming year given the compounding effect of revenue generation shortfalls resulting from COVID-19 and the economic downturn we are experiencing. Even less guidance exists publicly on how the midsize loan program will be operationalized for the nonprofits excluded from the Paycheck Protection Program. In short, the federal stimulus does not mitigate the urgent cash flow concerns threatening nonprofits and will force many nonprofits to accrue unnecessary debt, ultimately perpetuating the financial instability of the sector.

The enhanced federal funding of 56.2 percent provided to California's Medi-Cal Program was clearly intended to address publicly provided services in the health and behavioral health arena.

16. If no contracting flexibility action is taken, what will the impact be on our children, families, and communities?

Absent any contracting flexibility for behavioral health providers, as noted above, the primary concern is that the public health system will incur losses and layoffs during this time that will permanently erode the public safety net for individuals who need it most.

Nonprofit providers represent a critical and sizable component of the public safety net for our most vulnerable citizens, providing anywhere from 65-85% of public behavioral health services across the California's most populous counties. [Kaiser Family Foundation](#) data from 2019 suggests that California was currently meeting only 30% of the demand for professionally trained behavioral health workers *before* the COVID-19 crisis. If we see mass layoffs across the sector during this time, we risk driving workers from the field permanently and degrading our workforce in ways that *will take years to rebuild*.

We are all experiencing distress during these times of uncertainty, and we know the isolation and real financial consequences are felt most by our low-income residents who were already experiencing distress prior to the crisis. There are already early indicators that the most vulnerable families are experiencing increased suicidality, domestic violence, child abuse, and substance use.

Behavioral health services are needed now, more than ever, and they will be all the more important in helping our communities weather the long-term economic impact the COVID pandemic is sure to have on our State and country in the coming months and years. Ensuring the sustainability of the public safety net during this crisis will ensure our ability to meet the critical existing and emerging needs in our communities through the duration of this crisis and beyond.