THE FUTURE OF MEDICAID REIMBURSEMENT

What Do Proposed Regulations Mean For Provider & Health Plan Reimbursement?

September 14, 2023

VBCExhibitHall.com

Educational Webinar Series

ATTAC CONSULTING GROUP

ABOUT US

Founded in 2003, ATTAC Consulting Group is recognized as a premier national consulting and auditing firm serving insurers, managed care and provider organizations on issues related to:

- Medicare Advantage
- Medicare Part D
- Medicaid
- Duals Programs
- ACOs
- Health Exchange (ACA) products

We specialize in:

- Risk Adjustment for Medicare Advantage, ACA & Medicaid Plans
- Regulatory Compliance
- Medicaid Bids
- Provider Access Surveys
- Provider Network Development
- Operational Excellence, Business Transformation, & Systems

SPEAKER INTRODUCTIONS

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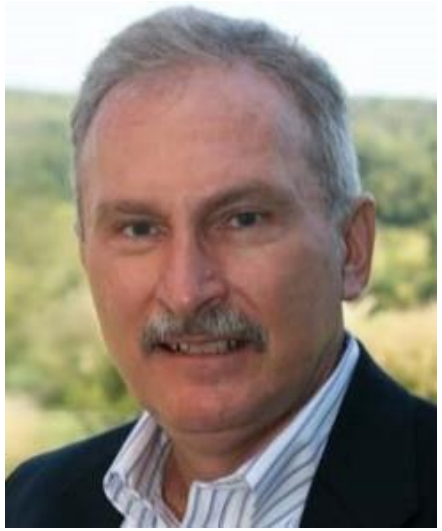


AGENDA

- **What does the future of Medicaid reimbursement look like?**
- **What is the impact of proposed regulations (even if not fully adopted)?**
  - Will changes to state-directed payments impact provider rates?
  - Will new requirement on Medicaid vs. Medicare reimbursement comparison drive value-based payment (VBP)?
  - Will proposed provider network adequacy & appointment time requirements drive higher reimbursement & attract new providers?
- **What impact will proposed reimbursement requirements & current VBP mandates have on Medicaid bids?**

POLLING QUESTION #1

How many of you (select all that apply):

1. Operate a Managed Medicaid Health Plan?
2. Operate a Managed Medicaid Behavioral Health Plan?
3. Sponsor a Medicaid ACO?
4. Have heard of HCP-LAN?

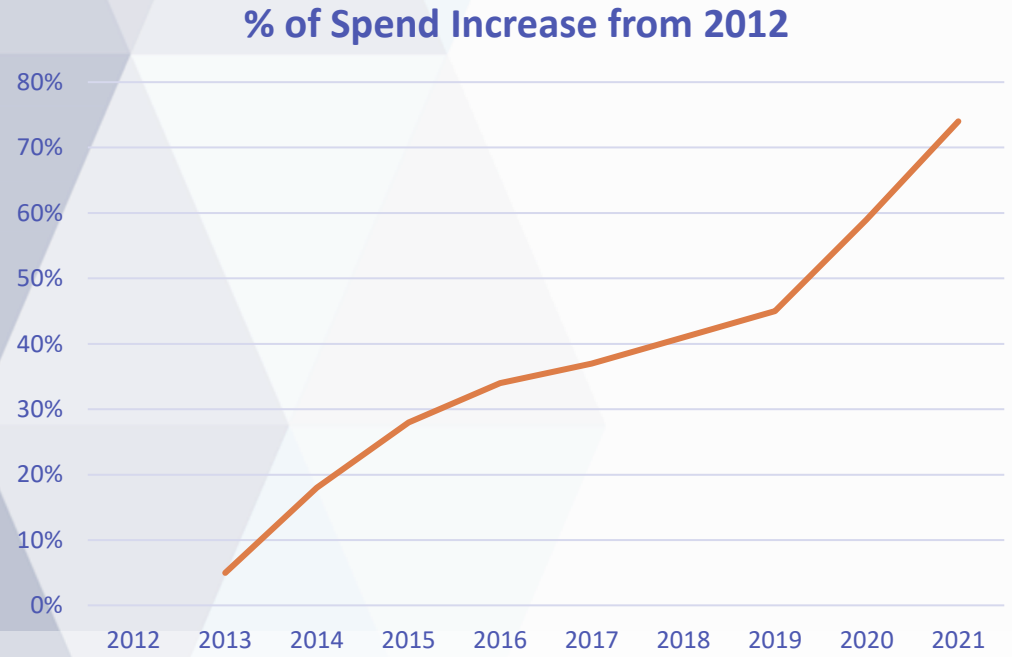
THE FUTURE OF MEDICAID REIMBURSEMENT

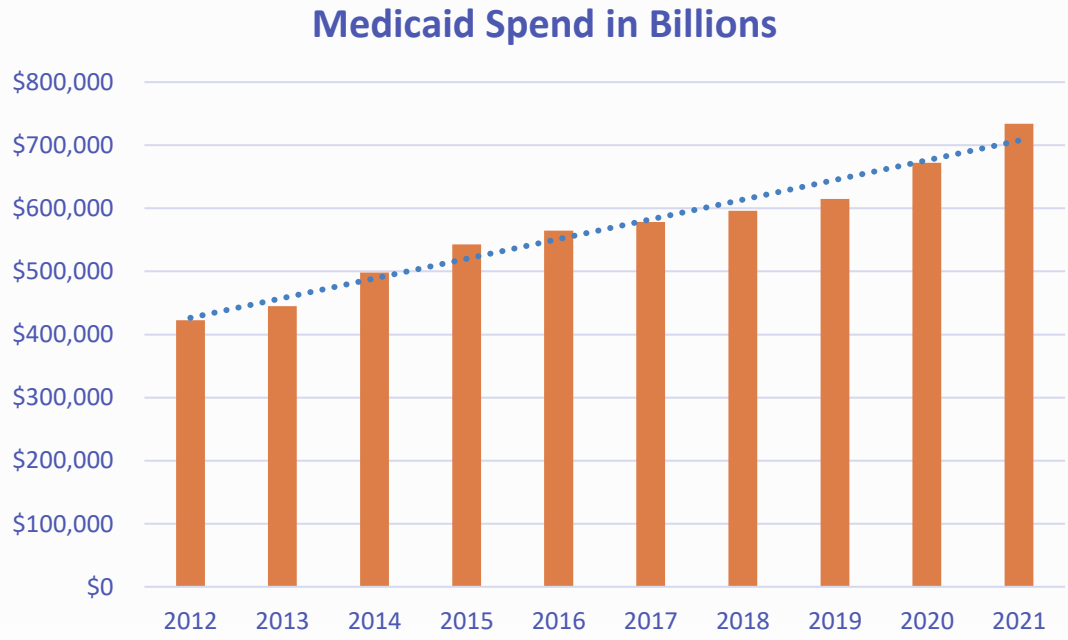
Factors that may impact Medicaid provider reimbursement

- Increasing overall costs of Medicaid, especially the Federal Medical Assistance Percentage (FMAP)
- Changing demographics & service mix after Medicaid expansion
- Federal (& some state) regulatory requirements

HEADING TOWARDS A TRILLION: MEDICAID COSTS AFTER MEDICAID EXPANSION

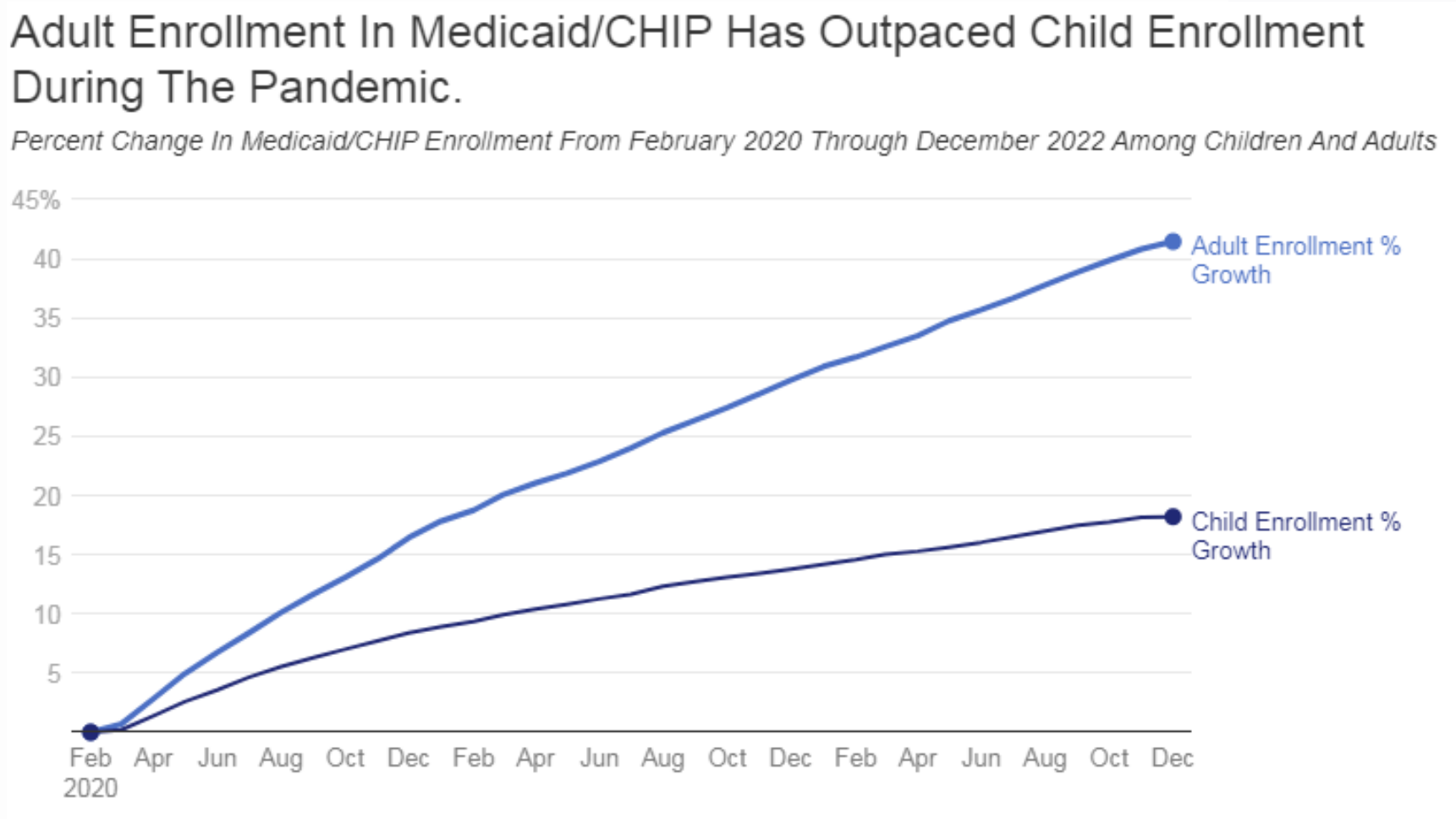
Total Medicaid Spending, 2012-2021, in Billions: Percent Increase from 2012





Source: National Health Expenditures, 2023

DEMOGRAPHIC CHANGES: MORE ADULTS, SUBSTANCE ABUSE, HEARTS & SPECIALISTS



Source: KFF

IMPACT OF FEDERAL REGULATIONS & GUIDANCE

CMS: When you pay (most of) the bills, you get to make the rules.

September 15, 2020

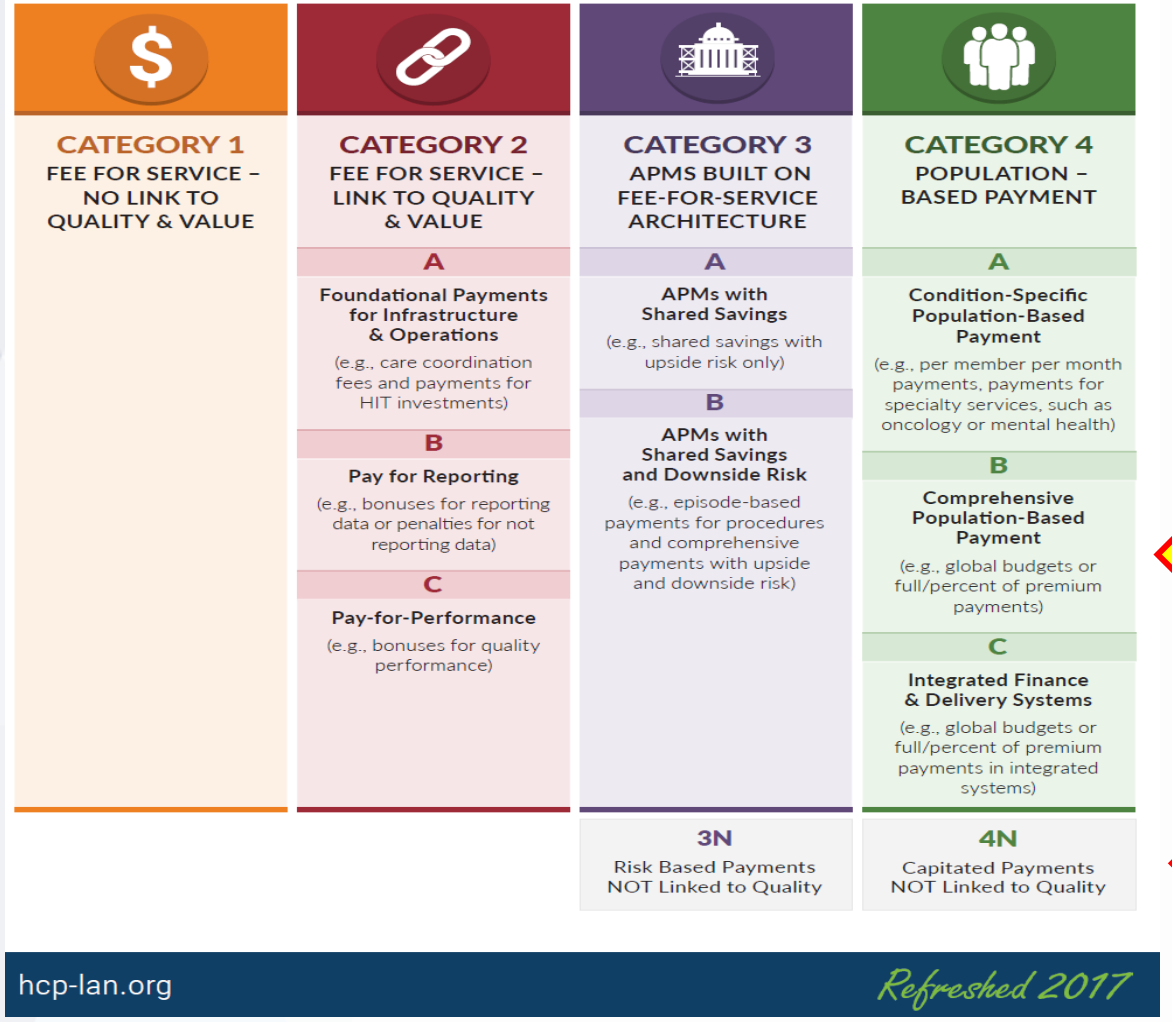
Dear State Medicaid Director:

The purpose of this letter is to provide information on how states can advance value-based care (VBC) across their healthcare systems, with a particular emphasis on Medicaid populations, and to share pathways for adoption of such approaches with interested states. VBC seeks to hold providers accountable for providing high quality care, and can also be a part of the solution to reduce health disparities in the healthcare system, to maximize benefits to patients, and to eliminate unnecessary procedures. Under VBC arrangements, providers are rewarded – based on specific evidence of performance on quality measures – for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives, as part of a larger healthcare system effort. The Centers for Medicare & Medicaid Services (CMS) believes that value-based payment (VBP) is a key driver of VBC. Value is more likely to improve across the larger healthcare system when provider incentives are aligned across payers. By advancing VBC in Medicaid, states have the opportunity to improve beneficiary health while reducing costs. This letter discusses pathways, including increased flexibility available under the state plan, towards the adoption of VBP models in Medicaid.

HEALTH CARE PAYMENT: LEARNING & ACTION NETWORK (HCP-LAN)

- Roadmap for CMS & Medicaid VBP targets
- Adoption by states for Medicaid Bids & Rebids
- Tied to existing CMS APM & ACO initiatives
- HCP-LAN goals are being incorporated into state Medicaid Health Plan bids

HCP-LAN GOALS IN STATE MEDICAID MANAGED CARE BIDS



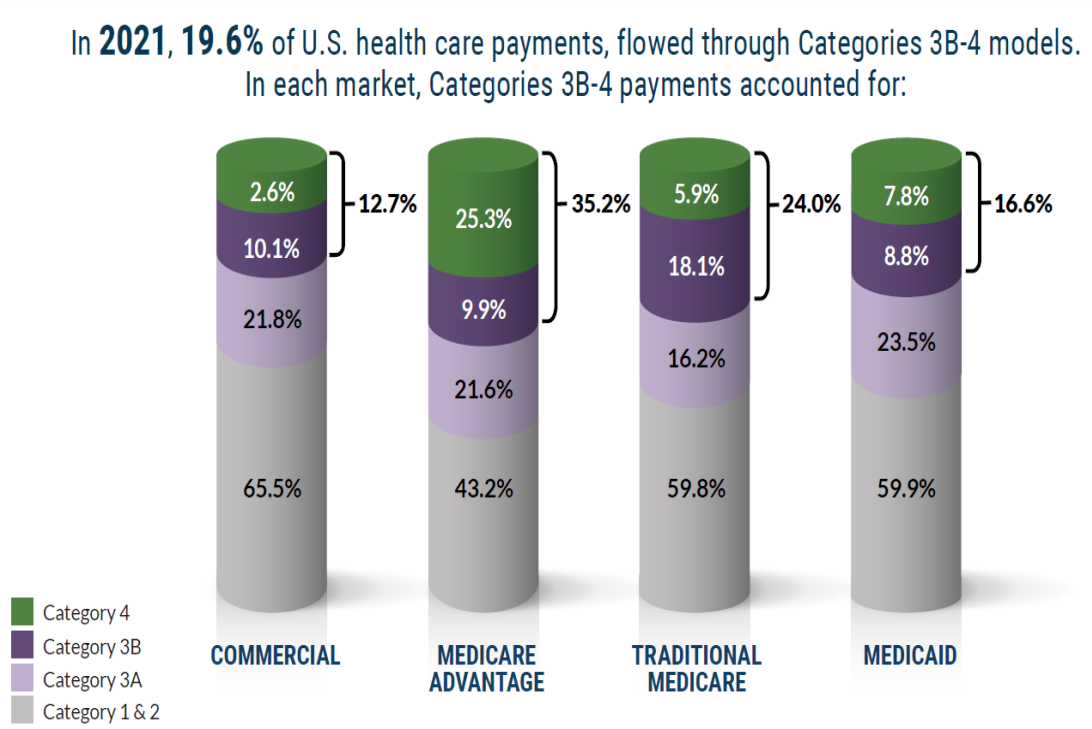
HCP-LAN Categories

Only Categories 3B and 4 Count

Pure capitation does not count

HCP-LAN RESULTS & GOALS BY LINE OF BUSINESS

Results by Line of Business



Goals by Line of Business

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

VALUE-BASED PAYMENTS THAT WORK FOR MEDICAID

- **Primary care first, modified**
  - Variable capitation, fee schedule & global savings
    - Moving "unassigned" members to care
- **Episodes of care**
  - OB, prenatal, post-natal
- **Bundled payments**
  - Per diems, DRGs & post-acute care
  - Addressing SDOH impacts on cost
- **CMS AHEAD Model**
  - Global budget
  - Multi-payer, statewide
  - VT all-payer ACO
  - MD total cost of care
  - PA rural health (PARHM)

POLLING QUESTION #2

Should state Medicaid managed care bids require a single vendor for medical, behavioral health and community care services?

1. Yes
2. No

POTENTIAL IMPACT OF PROPOSED REGULATIONS

- Wish lists, stalking horses & the unsaid
- Access, access, access
- Measure access via appointment times
  - BH, primary care, OBGYN
- States required to adopt provider network adequacy for key providers
- No funny biz with state directed payments
- Greater scrutiny of state & health plan provider reimbursement levels

PROPOSED REGULATIONS

Establish maximum appointment wait time standards for routine primary care (adult & pediatric), OBGYN services, outpatient mental health & substance use disorder services (adult & pediatric), & a state-selected service (adult & pediatric if appropriate)

- MH/SUD 10 days
- Primary care, OBGYN 15 days
  - Tighter standards than ACA or MA
- Measure average for wait times and establish improvement goals based on specialty
  - Plans—and providers—need to know and monitor wait times by specialty
- VBP tied to wait-time goals
- Higher fees for first appointment
- Reserved blocks of time
- Incentives/grants to increase capacity
- Increased access will lead to increased short-term costs, need for expanded networks

PROPOSED REGULATIONS

Require states to use independent entity to conduct annual secret shopper surveys to:

- Validate managed care plans' compliance with appointment wait-time standards
  - States requirements beyond PCP's, OB/Gyn and Behavioral Health
- Validate accuracy of provider directories and identify errors
  - State maintained provider master files still require input from plans and providers
- Identify providers who don't offer appointments
- Incentives/penalties tied to member satisfaction & wait times
  - Need to evaluate current wait times and tie incentive to incremental goals
  - Member surveys used to monitor providers not offering appointments
- Incentives/penalties to encourage providers to keep rosters & addresses current
- Incentives/grants to providers who provide immediate member ombudsman services
- Fee schedules based partially on access levels

PROPOSED REGULATIONS

Require states to submit annual payment analysis that compares managed care plans' payment rates for certain services as a proportion of Medicare's payment rate and, for certain home & community-based services, the state's Medicaid state plan payment rate

- Fees closer to Medicare will reduce incentives for VBP
- Fees closer to Medicare will increase incentives for VBP
- Setting fees at or above Medicare will eat into pool for State Directed Payments
  - CMS directed payments like AHEAD Model vs. State directed payments
- Plans may avoid paying higher FFS by mandating or encouraging VBP
- Higher fees for VBP will not fully solve the problem of availability of HCBS
  - Build vs. rent organizational structure and providers; workforce development

PROPOSED REGULATIONS

Require that provider payment levels for inpatient & outpatient hospital services, nursing facility services & professional services at an academic medical center not exceed average commercial rate

- Ceiling of commercial rates will encourage academic medical centers to use VBP to prevent comps
- Ceiling of commercial rates will only lead to increases in commercial rates
- Determining true commercial rates will take 10 years & may lead to Medicare-based rates (in some states)

PROPOSED REGULATIONS

Require Medicaid managed care plans to submit actual expenditures & revenues for State Directed Payments (SDPs) as part of medical loss ratio reports to states & require states to submit these amounts as separate line items in annual medical loss ratio summary reports to CMS

- Restrictions—and reporting on—SDP will shift from “subsidies” to VBP
- The 1.5% of total expenditures for SDP will have limited impact if spread evenly
- Provider-affiliated health plans VBP/SDP payments will be scrutinized

PREDICTED TRENDS IN MEDICAID REIMBURSEMENT

- Integration of state bids for medical, behavioral health & community services
  - Health plans buying or starting HCBS organizations
- VBP to enhance integration & address social determinants of health goals
- Stratification of VBP by specialty/service category
  - Increased presence of venture capital focused specialty health
- CMS & many states will push VBP models comparable to Medicare APMs & LAN-HCPC categories

AUDIT IMPLICATIONS FOR VALUE-BASED & RISK-SHARING CONTRACTS

- Bonus payments outside of MLR and CMS allowable categories
- Recoupment of CMS refunds
- Payments to related entities inconsistent with market norms
- Using HCP-LAN as a guide (but maybe not a safe harbor)

POLLING QUESTION #3

What do you think will be the biggest impact on reimbursement if proposed regulations are adopted?

1. Commercial payment limit on academic medical centers
2. New requirements for state directed payments
3. Requiring Medicaid reimbursement to be compared with Medicare
4. Other

QUESTIONS

Please send questions via webinar control box or contact us directly

Visit our Virtual Exhibit Booth at VBCExhibitHall.com

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RESOURCES

- MACPAC: Medicaid & CHIP Payment Access Commission
www.macpac.gov

- HCP-LAN: Health Care Payment Learning & Action Network
www.hcp-lan.org

- Medicaid/Medicare VBP: CMS Innovation Center
www.innovation.cms.gov