Rates HHSC Leadership Discussion

August 11, 2023

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Overview

- Managed care plans are impacted by rate changes from Provider Finance in three ways:
  - Rate increases
  - Rate methodology
  - Premium Rate setting
- Managed care is 97% of the Medicaid market (and growing). It's vital that projects—especially rate methodology changes– are designed with managed care included in the focus - this includes early notification, fiscal impact to MCO claims, impact to premiums, provider contract changes, implementation time, and impact to encounters.
  - PFD does not currently meet with MCOs/DMOs to inform on, and accept input around, rate changes.
  - Projects should not originate from the state's FFS vendor without substantial consideration of managed care in addition to FFS.
  - Often, the impact to managed care is not fully considered when changes are recommended.

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Overview, cont’

- Earlier communication and collaboration will help all of us to be more successful with timely implementation of PFD initiatives.
  - This approach will not only improve efficiency, but will also significantly enhance the experience of our members and providers.
- Cross-collaboration between MCS, MCOs/DMOs, and CFO (particularly PFD) would ensure that rate initiatives are:
  - informed by managed care, and
  - follow the most effective implementation paths.
- Notification of rate changes impacting managed care (via public hearings and stakeholder engagement meetings) are too late in the rate setting process for meaningful input from MCOs.
  - This results in inefficient implementation efforts, wasted resources, delays, and confusion for plans and providers.

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Overview, cont’

- Fee-for-service rates impact the managed care delivery system. MCOs often have their own reimbursement structures and utilize alternative payment and value-based care models.
  - Certain tenants vary by MCO. It is important to get a wide array of input before requiring changes around rate methodology.

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Solutions

- Managed care is 97% of the Medicaid market (and growing). It's vital that projects– including rate methodology changes and rate increases– are designed with managed care included in the focus. This includes:
  - Early notification
  - Fiscal impact to MCO claims
  - Impact to premiums
  - Provider contract changes
  - Implementation timeline
  - Impact to encounters
  - Configuration information
- Consistent collaboration between MCOs, PFD, and MCS: standing meetings to discuss upcoming changes and ongoing implementation efforts.

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Solutions, cont’

- Send updates out for comment, consider MCO input and make changes as needed, then respond to comments.
  - MCO and DMO financial staff need to be involved early if there are updates to rate methodology or rate increases so PFD and the plans can consider, develop, and fully understand contractual and system impacts around rate changes.
  - For major methodology changes, build in time to obtain health/dental plan comments in a similar process to UMCM amendments.
  - For methodology changes or rate increases, include MCOs into the TMHP notification process via CORs. If a COR is sent to TMHP, loop in the MCOs to determine (and account for) impact.

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Solutions, cont’

- Provide MCOs/DMOs **written confirmation** of upcoming changes, and what those changes entail.
  - While verbal guidance through meetings are effective, plans must have directives in writing in order to take action.
  - Plans prefer UMCC amendments. MCO Notices with specific guidance with rate information and a go-live date are acceptable, but MCO Notices rarely provide enough detailed information and lack the same authority and clarity needed for audits and compliance.
- Depending on the change, MCOs need information on:
  - Mandated effective date (if any), written guidelines defining the new reimbursement methodology, different scenarios, impact to provider contracts, reprocessing of claims, configuration information

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Solutions, cont’

- Rate changes should account for MCO/DMO implementation timelines, including but not limited to:
  - Rate increases take 90 days, or 60 days if rushed.
  - It can take up to 6 months to update provider contracts.
  - It can take up to 30 days to train providers on any reimbursement changes.
  - 6-12 months for major configuration changes, testing, and training
  - Time to coordinate within internal teams to effectively determine impact of changes to rate increases and methodologies, and time for MCOs/DMOs to report that impact back to the state.
  - SPA and TAC approval *before* impact can be reliably assessed, to inform needed updates/configurations around rate changes.
    - MCOs need full, final requirements to configure their systems.
    - Proposed rules and draft SPAs can change as they navigate the approval process.
    - Insofar as there are no operational impacts, certain updates can be worked in tandem.
  - The plans need time to perform testing on updates before they go live.

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