Universal Health Care Commission's
Finance Technical Advisory Committee meeting

January 12, 2024

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Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee
Meeting Materials

January 12, 2024
2:00 p.m. – 4:30 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC)

Agenda

Friday, January 12, 2024

Zoom meeting **2:00 – 4:30 PM**

FTAC members:		
☐ Pam MacEwan, FTAC Liaison	☐ Eddy Rauser	☐ Kai Yeung
☐ Christine Eibner	☐ Esther Lucero	☐ Robert Murray
☐ David DiGiuseppe	☐ Ian Doyle	☐ Roger Gantz

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order	1	Pam MacEwan, FTAC Liaison
2:05-2:08 (3 min)	Roll call	1	Angela Castro, Senior Health Policy Analyst Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 11/09/2023	2	Pam MacEwan, FTAC Liaison
2:10-2:25 (15 min)	Public comments	3	Pam MacEwan, FTAC Liaison
2:25-2:35 (10 min)	Updates from the Commission's December meeting	4	Liz Arjun, Senior Consultant Health Management Associates
2:35-3:10 (45 min)	Waiver options for integrating Medicaid • FTAC Q&A and discussion	5	Dan Meuse, Deputy Director, State Health and Values Strategies Princeton University
3:10-3:30 (20 min)	Washington's experience with Medicaid waivers • FTAC Q&A and discussion	6	Mich'l Needham, Chief Policy Officer Health Care Authority
3:30-4:00 (30 min)	Study overview: *Avoiding Medicaid - Characteristics of Primary Care Practices* with no Medicaid Revenue • FTAC Q&A and discussion	7	Steven Spivack, PhD, MPH Director of Quality Measurement and Data Analytics Lewin Group
4:00-4:30 (30 min)	FTAC discussion and guidance to UHCC	8	Pam MacEwan, FTAC Liaison
4:30	Adjournment		Pam MacEwan, FTAC Liaison

Tab 2

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

November 9, 2023
Virtual meeting held electronically (Zoom)
2–4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the sixth meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

One FTAC member offered an amendment on page 4. Members present voted by consensus to adopt the September 2023 meeting summary as amended.

Public comment

Cris Currie, volunteer, Health Care for All – Washington, suggested Medicaid Managed Care Organizations (MCOs) be evaluated for their value and that FTAC view background presentations as recordings ahead of meetings.

Lori Bernstein shared personal experience with an MCO requiring prior authorization for a COVID-19 booster, asked if 2024 FTAC meetings would be extended, and for action items from the last meeting to be highlighted.

Roger Collier remarked that while approval of a Section 1115 waiver to transfer Medicaid enrollees to an untested system is unlikely, the federal government may be amenable to such after the future system demonstrates ability to combine programs.

Raleigh Watts mentioned health carriers' reported profits and encouraged FTAC to examine the benefits of a state-administered program (Model A as proposed by the Universal Health Care Work Group) such as the Washington Health Trust.

Kathryn Lewandowsky, Vice Chair, Whole Washington, noted the financial benefit for large employers to be self-insured versus smaller companies struggling to afford employees' benefits from the marketplace.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

With additional resources allocated to this work, the Commission voted to extend 2024 meetings to three hours. FTAC agreed to add calls on off months for discussion if needed. Today's meeting will provide an overview of Medicaid and will surface opportunities to include Medicaid in Washington's future system. The January 2024 meeting will build off this one and explore topics and themes identified by FTAC for further discussion.

Presentation: Washington's Medicaid enrollment processes

Joan Altman, Director of Gov't Affairs & Strategic Partnerships, Washington Health Benefit Exchange (HBE)
Melissa River, Lead Policy Manager, Office of Medicaid Eligibility & Policy, Health Care Authority (HCA)

The Health Care Authority (HCA) is the Washington state agency for policy and purchasing of Apple Health (Medicaid) programs. The Health Benefit Exchange (HBE) operates Washington's marketplace and Healthplanfinder, a streamlined application for both Medicaid and individual market coverage. Both agencies work together to facilitate Medicaid eligibility and enrollment.

Apple Health is divided into Classic Medicaid (individuals aged 65 and older, or individuals that have blindness or a disability) and modified adjusted gross income (MAGI) -based Medicaid (individuals aged 64 and younger). For MAGI, Healthplanfinder determines eligibility, facilitates plan selection and automatic enrollment, and processes renewals. Healthplanfinder interfaces with state and federal databases to provide enrollees' real-time eligibility. HCA contracts with the Department of Social and Health Services (DSHS) to administer Classic Medicaid and to facilitate eligibility. Apple Health applications are accepted year-round and eligible individuals are approved for a one-year period. Beginning July 1, 2024, Apple Health coverage will extend to residents who meet income requirements regardless of immigration status (limited enrollment based on current funding levels).

Presentation: Understanding Washington's Medicaid program & opportunities for universal health care

Roger Gantz, FTAC Member

Medicaid is the nation's publicly funded health insurance program for people with low income. For low-income Medicare enrollees, Medicaid also provides wrap-around coverage for services not covered by Medicare. Jointly financed by the federal government and states, Medicaid is administered by states within federal guidelines. States are reimbursed by the federal government for a percentage of Medicaid allowable costs - the federal medical assistance percentage (FMAP). Washington's current FMAP is 50 percent, though certain eligibility groups have higher FMAPs. States must cover certain "mandatory" populations and can receive federal funding to cover "optional" populations.

Asset/resource eligibility requirements apply only to certain groups under Classic Medicaid. The proportion of Medicaid enrollment to expenditures by eligibility group was illustrated. Washington covers the 15 mandatory benefits under federal law and 28 other optional services.

Washington's Medicaid program does not have any premium or point of service cost-sharing. Generally, Medicaid payment rates are lower than Medicare and commercial payment rates for the same services. However, for certain provider types, e.g., rural health clinics (RHCs), Medicaid payment rates may be higher due to federal payment requirements.

Apple Health is largely administered by MCOs with 1.8 million Apple Health beneficiaries currently enrolled in managed care. Evidence on the impact of MCOs on quality, access to care, and costs is limited.

While Medicaid eligibility is categorical (e.g., income, age, disability status), there may be waiver strategies, e.g., Section 1115 demonstration waivers, to incorporate Medicaid into Washington's universal health care system. Medicaid's breadth of benefit coverage, e.g., dental, hearing, and long-term care and support services, could be treated as supplemental coverage to the universal plan and provided through separate delivery systems.

Discussion

The logistics of retaining the federal match under a 1115 waiver is important, e.g., people could fail to provide necessary eligibility information. ProviderOne, the current program through which the state claims federal match rates, will likely need to stay in place but could be simplified. Healthplanfinder could also be continued, though more information is needed to determine whether asset tests for Classic Medicaid can be worked around. ProviderOne also divides payments based on eligibility groups and assigns the correct match rate and dollar amount the state will draw back.

The assumption is that FMAPs would continue in a universal system, though federal dollars could not be claimed for anyone other than those currently eligible for Medicaid under existing eligibility criteria.

Generally, Medicaid's provider reimbursement rates are lower compared to commercial coverage and Medicare. However, for hospital providers, supplemental payments are added to Medicaid rates bringing them close to, if not at, what Medicare pays. Though, this is not the case for non-hospital physicians, so Medicaid provider rates could be examined more selectively on the assumption that the state could retain access to supplemental dollars. Even selectively increasing Medicaid provider rates would be a state expense and the implications of doing so need to be examined. In a future system, provider rates will need to be standardized. Commercial payment benchmarks are too high and increasing Medicaid rates to match them would subsidize inefficiency.

Members saw value in evaluating whether MCOs are beneficial for quality, access to care, and costs. Commission Member Jane Beyer attended the meeting and suggested looking into Connecticut's experience shifting their Medicaid program away from managed care and back to a fee-for-service model in 2011.

Members agreed that a comparison of benefits between Medicaid, Medicare, the marketplace, and public employees' benefits does not exist. An actuarial analysis comparing these benefits and the respective provider rates would be helpful to anchor the Commission's discussion of a uniform benefit design.

FTAC's next meeting will further examine what surfaced at today's meeting with regards to Medicaid.

Adjournment

Meeting adjourned at 3:57 p.m.

Next meeting

January 12, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

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Universal Health Care Commission's

Finance Technical Advisory Committee

Written Comments

Received From October 26

Written Comments Submitted by Email

Additional Comments Received at the November FTAC Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=geBg2zo6yzo

Public comments received since (October 26) through the deadline for comments for the January meeting (December 29)

Submitted by Cris Currie
11/09/2023

FTAC:

I'm Cris Currie, a volunteer with HCFA-WA. A July OIG Report estimates that MCOs denied 1 in 8 Medicaid pre-authorizations in 2019. In Washington, Molina denied 19.3%, Amerigroup denied 14%, United Healthcare denied 11.5%, and Coordinated Care denied 8.4%. Since the state totals of preauthorizations are not listed, we can't translate percentages into actual numbers of denied payments, but we can assume it is unacceptably quite high, especially when the denial rate for Advantage plans is much lower, and Traditional Medicare's is near zero. Besides numbers, we need to know what these people do for treatment when claims are denied, what their doctors think of the situation, and how much money is being wasted on these poorly functioning MCOs. Clearly a more robust evaluation of MCO value is needed. So instead of spending your time at these meetings on such things as the mechanics of how Medicaid works in theory, I would suggest you relegate this and other background presentations to recordings to be viewed at other times, and spend your far too limited meeting time discussing important issues like the ones I just raised. Thank you.

Here are some good resources for understanding how Connecticut's Medicaid program has saved money and increased quality over its old MCO approach.

The Connecticut HUSKY Health, state self-insured managed fee for service Medicaid program description. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/Overview-of-HUSKY-Health---consolidated-issue-briefs-9-12-18.pdf

A brief history of the program. https://stateline.org/2012/04/09/connecticut-revisits-old-school-medicaid-financing/

An evaluation of the program after 7 years. https://cthealthpolicy.org/wp-content/uploads/2019/02/Medicaid-2019-brief-formatted-copy.pdf

An insider's story of how CT eliminated its MCOs and created their current system. https://pnhp.org/system/assets/uploads/2022/03/CTManagedCare_Toubman.pdf

A comparison between innovative Medicaid programs in Connecticut, Minnesota, and Oregon https://chlpi.org/wp-content/uploads/2014/01/PATHS-Innovations-and-Insights-in-Medicaid-Managed-Care-3.21.16.pdf

Submitted by Lori Bernstein
11/09/2023

Hi there,
I'd like to share my comments in writing too.

*The UHCC asked the FTAC to answer **5 specific questions related to Medicaid**, yet judging from the meeting materials, today's presentation looks to be a general overview of Medicaid rather than a detailed answer to each of the questions. This doesn't seem like the best use of the Commission's limited time.*

*Furthermore, with respect to the issue of time, the UHCC has committed to 1) having staff highlight key action items in the summary of the previous meeting and 2) sending out videos of presentations in advance so that Commissioners can come to meetings prepared for discussion. 3) lengthening the meeting time from 2 to 3 hours. Are these steps **the FTAC is willing to take?***

*Lastly, I would like to speak to the issue of denials within Medicaid Managed Care Organizations. I'm on Medicaid. When I showed up for my appointment to get the new Covid booster, I was told that my insurer, Amerigroup, required prior authorization, After going to the trouble of getting the prior authorization from my PCP, Amerigroup denied payment. The letter they sent stated that the vaccine isn't "medically necessary" and that it's not covered under my pharmacy benefit. It's been 6 weeks and the issue is still unresolved. I don't know whether all Medicaid MCOs are refusing coverage of the vaccine, but **this would not be a problem if we had a state-based, single payer system.***

Respectfully,
Lori Bernstein

Submitted by Kathryn Lewandowsky
11/09/2023

At your last meeting in Bill Kramer's discussion, He noted that "based on recent research, large employers nationally are paying between 200-300 percent of Medicare (with variation between and within states) for health benefits. Is there an argument that a universal health care system will relieve some of this pressure for employers?"

And it made me remember some of the benefits of a Single Payer Healthcare plan.

For background-
I used to work for a very large religious based healthcare system and they were self insured. So it behooved them to encourage employees to use their own hospital and clinics. In that situation where the employer is not only the insurance provider but also the healthcare provider it makes good business sense to make payments of 200-300% of Medicare because you are essentially transferring employees healthcare dollars from the employee's healthcare benefits package to the healthcare provider's arm of their business.

The point I would like to make though is that we know that we can save money with a single payer plan because our large employers have the benefit of their size to be "self insured". And Why do they do

this? Because they know that administratively, it saves money to have just one pool of dollars and just pay for their employees basic healthcare needs. They also do this because they realize that they save money over purchasing healthcare on the open market.

Our smaller companies do not have that benefit of size and are therefore stuck having to purchase their employees healthcare policies from the marketplace. Many of them cannot afford to do that anymore. Because even in light of record profits, our for-profit entities are not satisfied.They continue to ask for unsustainable premium rate increases.

This is why companies like my son's employer are having to cancel their employees healthcare benefits, forcing their employees to purchase their own individual policies or go without. Unfortunately he makes too much money to qualify for Medicaid and can't afford to pay market prices for health insurance.

This is why Americans are sick and tired of purchasing a product that they don't want and can't afford. They just want healthcare for themselves and their families. And they want to have it provided at their hometown doctor's office, not some "Network" chosen by said for-profit insurance companies.

Are we really willing to pass this broken and corrupt system onto the backs of our children and grandchildren? I am not! And that is why I will keep fighting for an equitable, cost effective, universal healthcare system for all of Washington's residents and lead the way for the rest of the country.

Kathryn Lewandowsky, BSN, RN
Whole Washington- Board Vice-Chair
One Payer States- Treasurer

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SB 5335 establishes the Washington Health Trust and outlines funding, benefits coverage, provider reimbursements, and implementation. Whole Washington works to build legislative support for the Washington Health Trust, requiring majority support in the House, Senate, and from the Governor. Read more about SB 5335. We also work through the Ballot Initiative process when our legislative process fails us.

Together we can all have healthcare free at the point of service; that is comprehensive with no copays or deductibles and that puts billions of dollars of savings into the pockets of regular people just like you and me!. Healthcare that will take care of all of our people from Cradle to Grave! Please go to WholeWashington.org and donate today! It will take all of us demanding these basic human rights from the global elite! Together we can do this!

"Never believe that a few caring people can't change the world, For indeed that's all who ever have" Margaret Mead

Submitted by Roger Collier
12/27/2023

Dear FTAC members --

Happy New Year!

At the December Commission meeting I expressed disappointment that the Commission had failed to meet its target dates for deciding which population groups should be eligible for inclusion in a State universal health care plan. In fact, the Commission has failed to make *any* decisions at all regarding eligibility.

FTAC is in a position to move the Commission's decision-making process forward by making specific recommendations, but has not so far done so.

Given that the State has been studying universal health care since 2019 (and expending substantial dollars in doing so), some efforts to accelerate the process seem appropriate. In an attempt to clarify the issues relating to eligibility I have prepared the attached paper. I would be happy to discuss it with the committee.

Thank you,

Roger Collier

THREE OBSTACLES TO UNIVERSAL HEALTH CARE

And a Possible Strategy

1. MEDICARE BENEFICIARIES

1.1 million enrollees (estimated)

THE OBSTACLE:

Medicare laws and regulations do not allow the transfer of Medicare beneficiaries to a State Universal Health Care plan.

- There is no feasible waiver process that would allow federal Medicare regulations to be overridden to allow such a transfer.
- Most Medicare beneficiaries are satisfied with their current coverage and would likely oppose a mandated switch to an untested State plan.
- It is highly unlikely that federal administrators would support moving any Medicare beneficiaries to an untested State plan.

POSSIBLE ALTERNATIVE(S)

Some seamlessness between Medicare and a State plan might be achieved if the State plan supplemented Medicare (like a Medigap plan) or treated Medicare as third party coverage (with the State plan rebilling Medicare for Medicare-covered services). A more modest alternative might be to offer the State plan as a Medicare Advantage option. All three approaches have problems.

- Any approach which supplements (or rebills) Medicare will be costly for the State, unless the cost is passed on to Medicare beneficiaries – in which case it is likely to be hugely unpopular with the beneficiaries.
- A Medicare Advantage approach (assuming it is possible to maneuver around federal regulations) will only work if the State plan is much less costly than competing insurer offerings – something that is highly uncertain.

2. SELF-INSURED EMPLOYERS

2.5 million enrollees (estimated)

THE OBSTACLE

The federal Employee Retirement Income Security Act (ERISA) preempts state regulations that "relate to" self-insured employer plans. The US Supreme Court has indicated that an "exorbitant" state tax on such plans would likely be preempted. In other words, an "exorbitant" payroll tax to help fund a universal health plan would not be allowed.

- The Supreme Court's warning about an "exorbitant" tax came in a ruling that *allowed* a 24 percent tax on some hospital claims. However, the Court commented: "*there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate [and would be preempted*]."
- FTAC's expert on ERISA law indicated that a Washington payroll tax would probably not be preempted. However, she failed to recognize today's huge variations in employee benefits that would result in some employers facing a *doubling or more* of their costs if a payroll tax were imposed[1]. It is impossible to know how the courts might decide, but if a 24 percent tax begins to raise red flags, a 100 percent or more cost increase may well be ruled unacceptable.
- Regardless of whether or not a Washington payroll tax is preempted, an employer suit could take as much as four years[2] to reach a final decision – on top of the time for the Commission to make final recommendations and the Legislature and Governor to enact legislation.

[1] Based on data from the Kaiser Family Foundation national employee benefits survey. Employers with the most generous current benefits would experience lower costs.
[2] Based on the recent City of Seattle case.

POSSIBLE ALTERNATIVE(S)

A play-or-pay model in which employers are required to provide some level of health benefits or pay a tax might avoid the mandatory payroll tax issue (and would not add to the State budget), although this would be contrary to the concept of *universal* health care.

- FTAC's ERISA expert cited two cases in which federal appeals courts ruled that play-or-pay models were not preempted. However, she failed to cite two other cases in which different appeals courts ruled that play-or-pay models *were* preempted.
- Depending on the benchmark benefit level, this could still result in doubling of some employers' benefit costs.
- Whether or not this approach would be preempted, it could still face up to a four or more years' delay in the courts.

Requiring all employers to offer the State plan as an employee option might avoid preemption -- if this did not increase employer benefit costs.

- The implication is that any increased costs would be borne by the employees choosing the State plan – something that would be unpopular with employees and their unions.

A payroll tax much lower than that considered by other states (like Oregon) might reduce the risk of preemption.

- This would leave Washington (which currently has no income tax) with no obvious mechanism for closing the funding gap.
- A much lower taxing level might be used to fund a State catastrophic care plan, although this would be contrary to the concept of a single universal plan.

MEDICAID (APPLE HEALTH)

1.6 million enrollees (estimated)

THE OBSTACLE

Section 1115 of the Social Security Act allows some waivers of Medicaid regulations, thereby offering a possible path to incorporating Apple Health into a State universal health care plan. However, federal policy requires that waivers be budget neutral to the federal government and initially limited to no more than five years. Most importantly, federal approval is required before waivers are granted.

- Moving more than a million and a half Medicaid enrollees from a functioning system to an untried State plan is unlikely to gain easy federal approval. Federal administrators will be justifiably nervous of the possibility of consolidation resulting in chaos.
- Medicaid advocates will be equally concerned about problems for enrollees, as will providers with numbers of Medicaid patients.
- Moving Medicaid enrollees into a universal system that essentially guarantees coverage creates a problem of federal payment: how will the federal government determine how many Medicaid eligibles it will subsidize if there is no eligibility determination?
- State submittal of a waiver request provides no guarantee of federal approval – ever! Moreover, federal review can take literally years[3] as a state tries to respond to questions and negotiates details.

POSSIBLE ALTERNATIVE(S)

A State plan might be offered to Medicaid enrollees as an alternative to

[3] A recent CMS snapshot of the status of submitted waivers showed eight (out of thirty) still pending after a year. (CMS did not report "worst case" for review time.)

existing managed care options.

- For this to be feasible, the State plan benefits would have to be at least as generous as those of Medicaid, with costs that could be far greater if the State plan imposes few restrictions on provider choice.

It may be possible for the State to simplify the federal subsidy calculation by agreeing to a global cap on federal payments[4].

- This approach would likely put the State at risk for any unanticipated increase in the Medicaid eligible population – as might happen in the case of a future pandemic.

Federal waiver approval will be far more likely if the State has already demonstrated its ability to consolidate some existing programs into a health plan with common benefits – essentially a "mini version" of a full State universal health care plan.

- This could mean, for example, consolidating PEBB, SEBB, Exchange plans, and non-self-insured plans into a single Statewide plan with more than one million enrollees.

[4] As Rhode Island and Vermont have done.

A POSSIBLE STRATEGY

The preceding sections identify major obstacles, substantial uncertainties, and considerable potential delays facing a State universal health care plan. To move forward, decisions must be made, recognizing that these may need to be revisited if things change. The following is proposed as a possible strategy.

Step 1 – Set aside for the foreseeable future any further consideration of including Medicare beneficiaries in a State universal plan.

- As of now, the obstacles to including Medicare beneficiaries are overwhelming.
- Further consideration of this issue will delay analysis of ERISA and Medicaid.
- This would be consistent with Oregon's Task Force decision about Medicare.
- Inclusion of Medicare beneficiaries could be revisited once all other features of the State plan are fully operational.

Step 2 – Discuss further with legal experts the likelihood of ERISA preemption of a plan dependent on payroll taxes. In particular, the State should pursue the question of how a doubling of benefit costs for *some* employers might be viewed by the courts.

- Given that FTAC's ERISA expert has already given her opinion (but without considering the impact of some employers' costs being doubled), it might be appropriate to get a second opinion.
- A second opinion on the risk of preemption of a play-or-pay model, *taking into account all court decisions*, might also be appropriate.

Step 3 – Design and implement a "mini-version" of the State plan, to include, at a minimum, current enrollees in PEBB, SEBB, Exchange plans, plus other individual and small group insurance.

- This is proposed as the first phase of State plan implementation because it requires no federal approvals other than a Section 1332 waiver for Exchange enrollees (which could be postponed). It will require concurrence (or at least minimal opposition) from public and educational employee groups and some insurers. However, this concern is equally applicable to any more comprehensive State plan proposal.

Step 4 – Plan for inclusion of Apple Health enrollees *after* a "mini-version" of the State plan is fully operational.

- It is highly unlikely that federal administrators will grant a waiver to consolidate a functional Medicaid plan into an *untried* State system.
- Eventual inclusion of Medicaid in a State plan will require rate normalization, and also agreements from all providers to accept Medicaid enrollees.

Roger Collier was formerly CEO of a national health care consulting firm. His experience includes responsibility for managing the implementation of new state and federal health care programs for millions of enrollees.

Tab 4

Washington State Health Care Authority

Commission Updates

- At their December meeting, the Commission discussed transitional solutions and how they would like to sequence topics and grouped some topics under new headings.

- The Commission agreed that the FTAC should play a similar role as in 2023 and focus on universal design topics- the first topic being Benefits and Services.

- The Commission will seek to draw more connections between long-term design work, transitional solutions, and current topics being discussed and deliberated.

Commission's Prioritization and Grouping of Transitional Solutions for 2024

Administrative Simplification and Increase Provider Participation in Public Programs

- Improve and align network adequacy standards
- Provider Administrative simplification
- Standardize claims adjudications
- Motivate interest in preventative and primary care among providers

Maximizing, Leveraging, and Expanding Current Programs

- Auto-enroll Medicaid to no-premium or lower-cost plans Exchange
- Codify and fully fund Apple Health expansion
- Increase participation in the Medicare Savings Program
- Consolidate and expand state purchasing

Being Addressed Elsewhere (will be reported on in Commission meetings)

- Services not covered by the Balanced Billing Protection Act
  - Uncovered ambulance services
- Provider rate regulation

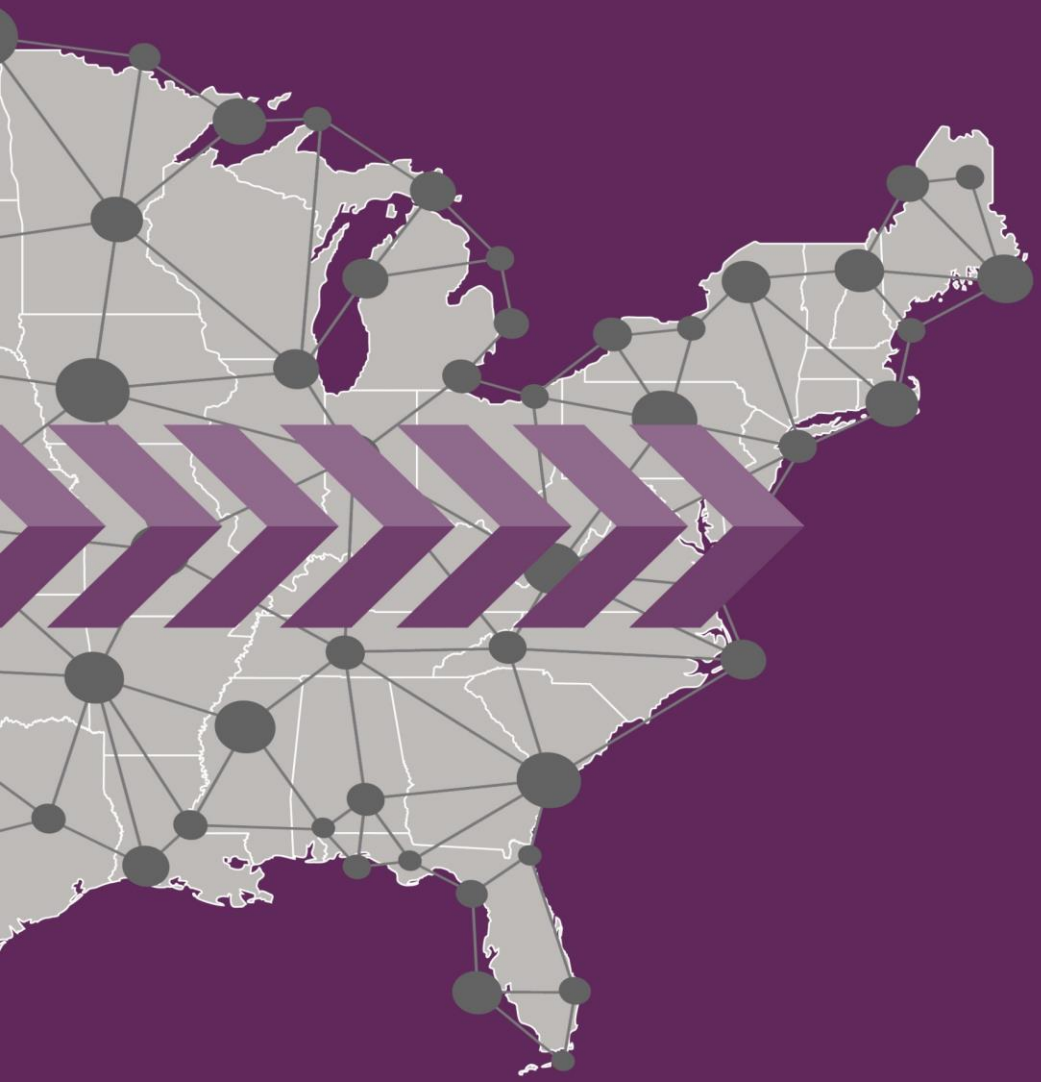
UHCC's Questions for FTAC on Medicaid

Questions from the Commission for FTAC to provide guidance:

- Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- What have other states done with 1115 waivers to expand eligibility?
- What are the reasons for Medicaid enrollees' barriers to access, e.g., lower reimbursement rates?
- What barriers exist with regards to Medicaid provider rate increases, e.g., ongoing work to increase primary care rates?
- What federal barriers exist with regards to:
  - Asset limitations for enrollees of classic Medicaid?
  - Provider reimbursement?

Tab 5

Washington State Health Care Authority



Medicaid Waivers: Understanding Their Use and Opportunities

Presentation to the WA Universal Health Care Commission

Dan Meuse

January 12, 2024

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this presentation was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About Dan Meuse

Dan Meuse serves as the Deputy Director of State Health and Value Strategies, a program of the Robert Wood Johnson Foundation. In this role, Dan manages and coordinates technical assistance providers serving states and works with states to identify their assistance needs and policy goals. He was deeply involved in the implementation of the Affordable Care Act at the state level as Deputy Chief of Staff for Rhode Island's Lieutenant Governor. Dan serves as a Lecturer in Public Affairs at the School of Public and International Affairs at Princeton University.

Agenda

Understanding Medicaid Waivers in a Universal Coverage Context

- What are Medicaid waivers and what can states do with them?
- What are the limits for Medicaid waivers?
- How do states maintain federal match?
- Must waivers be different for different populations?
- What have other states done to expand coverage through Medicaid waivers?
- Considerations for Washington

Medicaid Waivers

Two Core Waiver Programs: 1115 and 1915

1115 Waivers

Broad authority to waive Medicaid requirements to carry out a demonstration project.

Allows states to receive matching funds for otherwise unallowed expenses.

Can allow states to use indirect spending as match for Medicaid federal financial participation (FFP).

1915 Waivers

Limited waiver authority: 1915(b) allows for limits in service providers and 1915(c) allows for service comparability (home and community-based services).

Waivers let states design more specific programs to meet state needs for traditional Medicaid services and populations.

Medicaid Waivers

Examples of How States Use 1115 Waivers

- If federal law prevents a needed service or benefit:
  - Medicaid cannot pay for "Institutes of Mental Disease" (IMD) – inpatient mental health services at a designated facility – for patients 21-64.
  - Substance-use disorder (SUD) treatment may require an inpatient stay and states have used 1115 waivers to allow IMD services for SUD.
- If federal law prevents a desired population from being covered:
  - Medicaid cannot pay for health services for incarcerated individuals, except for inpatient hospitalization. Many states would like to provide services to individuals as they approach their release date to support transitions out of carceral settings.
  - 1115 waivers have been used to extend services to persons 30 days pre-release.
- If federal law prevents certain program administration elements:
  - Medicaid does not allow premiums except under certain circumstances. Some states wanted to apply premiums to the ACA expansion population.
  - 1115 waivers were used to design premiums and co-pays for Medicaid Expansion coverage.

Medicaid Waivers

How 1115 Waivers Are Negotiated and Managed

- Approvals are at the discretion of the HHS Secretary
  - Must be "budget neutral" – cost to federal government must be the same with or without the waiver.
  - Must promote the objectives of the Medicaid program.
- Approvals represent the policy of the administration and require significant review
  - Complex 1115 waivers can take multiple years to be negotiated.
  - The Office of Management and Budget (OMB) reviews all elements of the waiver for allowable elements, budget neutrality and policy alignment.
  - Before 2021, no 1115 waiver was rescinded by an incoming administration, but that practice was changed.

Medicaid Waivers

Considerations for Washington

- The federal government does not consider contingency
  - If the 1115 waiver would require other waivers (section 1332, CMMI, etc.) to function or meet budget targets, the federal government will not consider the other waivers to be approved in its consideration.
- Program integrity and evaluation are large components
  - States that seek to expand covered populations are subject to audit requirements to ensure that enrollees meet eligibility requirements.
  - States that propose alternative benefits or services as replacement services are subject to audit and case reviews to ensure that enrollees are not worse off under the waiver.
  - Because 1115 is a demonstration program, states are required to complete robust evaluations of the project based on criteria determined by the federal government.

Expanding Coverage Through 1115 Waivers

Many states have expanded coverage through waivers, but it is usually to limited populations.

- Mandatory Populations
- Optional Populations
- Waiver Populations
- Mandatory Benefits
- Optional Benefits
- Waiver Benefits

Expanding Coverage Through 1115 Waivers

Many states have expanded coverage through waivers, but it is usually to limited populations.

- Incarcerated individuals 30-90 days pre-release
- Post-partum individuals
- Individuals with SUD
- Individuals up to 200% of the federal poverty level (FPL)
- Caregivers of children
- Seniors with mental health needs

DC: Adults are covered up to 215% FPL. This expansion was a state plan amendment (SPA).

NM: Recently inquired about an expansion to 400% FPL. CMS said it would be "allowable."

Expanding Coverage Through 1115 Waivers

Expanding Through a SPA vs. Waiver

- **State Plan Amendment**
  - Expanding coverage through a SPA will open FFP funds, but will require state match.
  - SPA expansions will require specific mandatory and optional benefits to be provided based on the expansion.
- **Waiver**
  - Expanding coverage through a waiver could use credits for other spending (DSHPs) as the state match, but overall FFP needs to stay neutral.
  - Different benefit packages could be designed for expanded populations.
  - Premiums and co-pays could be included.

Discussion

Thank You

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Tab 6

Washington State Health Care Authority

Washington's experience with Medicaid waivers

A brief introduction for the UHCC Finance Technical Advisory Committee

Mich'l Needham, Chief Policy Officer

Washington State Health Care Authority

A brief introduction to waiver process and timing

- Waiver development process
  - CMS requirements
  - Legislative role
- What does the waiver period look like
  - Sample MTP timelines
- Implementation process

What is an 1115 Medicaid waiver?

- The federal government grants a waiver to allow states to do something under Medicaid that they couldn't ordinarily do under Medicaid rules.
  - Waivers have specific requirements, including "waiving" of a federal statute or rule, and federal budget neutrality, among others.
  - Section 1115 of the Social Security Act gives the Secretary of Health and Human Services approval authority
- Waivers can cover experimental, pilot, or demonstration projects that demonstrate and evaluate potential Medicaid and CHIP program changes that improve care, increase efficiency, and reduce costs.

1115 Waiver development process and timeline – CMS requirements

1. **Concept design**. Draft a white paper to outline the concept and the rationale for the 1115 waiver request. The concept should clearly address why an 1115 waiver is the best vehicle for the proposal.
   - Legislative engagement (bills, budget provisos…)
   - Identify specific laws/regulations proposing to waive
   - Drafting application
2. **Data collection.** Begin collecting data early in the process as this will take time and is often the final hold-up on the complete application. Data should include:
   a. Historical expenditures, if available. If not available, try to establish a proxy for historical expenditures.
   b. Historical enrollment or proxy for historical enrollment.
   c. Projected enrollment, including total enrollment and unduplicated enrollment.
   d. Budget neutrality projections, including establishing a cost trend.

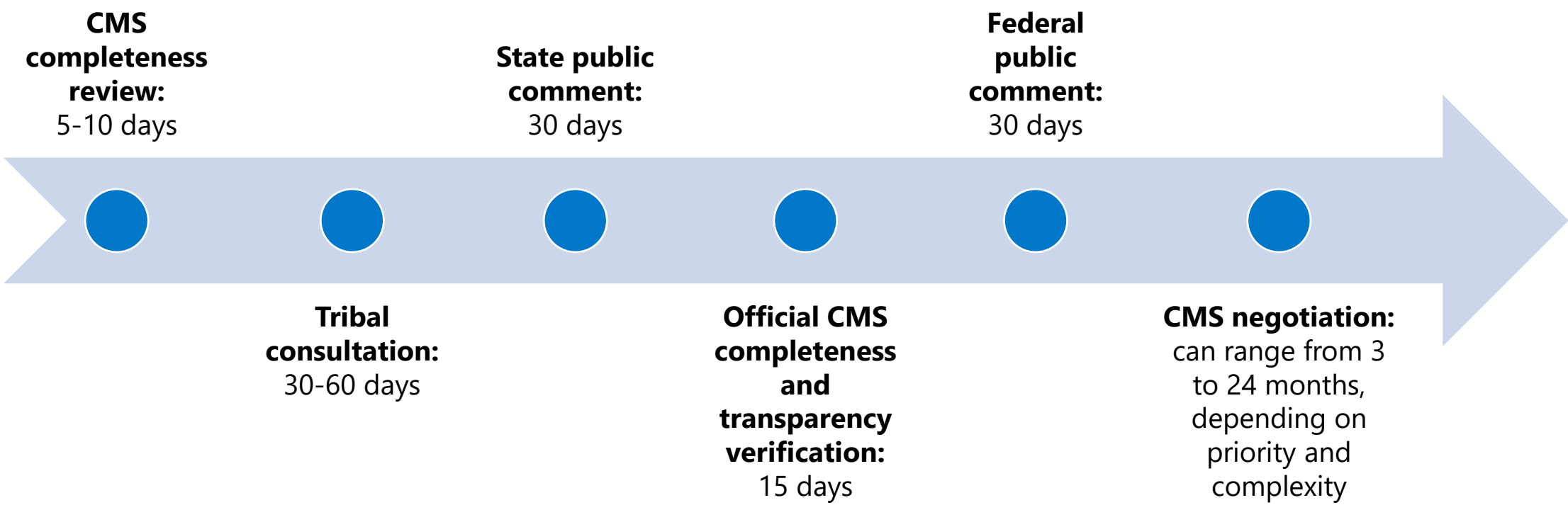
1115 Waiver development process and timeline, cont.

3. **CMS completeness review**. Prior to public comment, CMS can do a completeness review to confirm all application requirements are fulfilled. Ask CMS to review the forthcoming process and timeline for public notice, public comment, public forums, tribal consultation, and other transparency requirements.
4. **Tribal consultation**. Tribal consultation should be coordinated early so that tribal input is included prior to the public comment process, in the event that tribal input could substantively impact the application materials.

1115 Waiver development process and timeline, cont.

5. **Public comment and transparency**. Coordinate early on the timeline for submission and posting in the State Register. Posting is supported by Office of Rules & Publications, Division of Legal Services. This posting starts the 30-day public comment period. Typically, two public webinars are held in place of public forums.
6. **CMS negotiations**. CMS negotiation process and timeline depends entirely on the precedent of approval and the complexity of the request. It also depends on the order of priority and the "wait list" depending on other state requests, expiring waivers, and CMS capacity.

1115 Waiver development process and timeline, cont.



Example timelines from MTP experience

- **Time to develop and negotiate**
  - Medicaid Transformation Project (MTP) 2.0 – development of concepts, refinement, application: started summer 2020 on extension planning and concept paper
  - Application submitted July 2022 – CMS negotiation through June 30, 2023
- **1115 demonstration waivers are authorized for five-year periods**
  - MTP 2.0 approved for July 1, 2023, through June 30, 2028
  - Initial MTP waiver authorized January 2017 through December 2021, (with CMS 1-year extension and 6-month extension for negotiation period through June 2023)
- **Many steps after approval**
  - Protocol documents for each program, implementation plans for each program, evaluation design with external evaluator(s)
  - Legislative authorization/spending authority
  - Program implementation – **may take several years** for new services depending on protocol negotiation, complexity of implementation design, and coordination with new providers
  - Quarterly reports and annual reports, external evaluation reports – periodic and final

Sustaining the waiver

- Waiver period of 5 years
- Application to renew due 12 months prior to end date
- Examine what can be put in permanent authorities (State plan amendment, or SPA)
  - *Example: Does it fit within the Medicaid law, or does it still require a waiver of law to sustain?*
- Start waiver process again with experience, data, budget neutrality “savings”, concept paper, modifications, etc.

Sample of post-approval CMS deliverables

Post Approval Protocols		
(completed)	Submit Draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding & Mechanics Protocol (Attachment D)	STCs 7.15, 7.16
(completed)	Submit Tribal Engagement and Collaboration Protocol (Attachment H)	STC 7.6
(completed)	Submit Value-Based Roadmap (Attachment E)	STC 7.21
(completed)	Submit Financial Executor Role (Attachment F)	STC 7.8
(completed)	Submit Foundational Community Supports Protocol (Attachment I)	STC 10.8
(completed)	SUD Implementation Plan	STC 11.2
(completed)	SMI Implementation Plan	STC 12.2
(completed)	SUD and SMI/SED Monitoring Protocol	STC 20.6
150 days after approval date	Monitoring Protocol(s)	STC 20.7
9 months after approval date	Reentry Demonstration Initiative Implementation Plan	STC 14.9
9 months after approval date	Reentry Demonstration Initiative Reinvestment Plan	STC 14.10
180 days after approval date	Protocols for HRSN Infrastructure and HRSN Services	STC 15.7
90 days after approval date	Provider Rate Attestation Table	STC 16.14
Evaluations		
180 calendar days after approval date	Submit Draft Evaluation Design	STC 21.3
One year prior to the expiration of the demonstration	Submit Draft Interim Evaluation Report	STC 21.7
60 calendar days after receipt of CMS comments	Submit Revised Interim Evaluation Report	STC 21.7
Within 18 months after approval period ends	Submit Draft Summative Evaluation Report	STC 21.8
60 calendar days after receipt of CMS comments	Submit Revised Summative Evaluation Report	STC 21.8
No later than 60 calendar days after June 30, 2026	Submit SUD Mid-point Assessment	STC 20.10
No later than 60 calendar days after June 30, 2026	Submit SMI/SED Mid-point Assessment	STC 20.11
No later than 60 days after the third year of demonstration implementation	Submit Reentry Demonstration Initiative Mid-Point Assessment	STC 20.12

Questions and discussion

Washington State Health Care Authority

Tab 7

Washington State Health Care Authority

Avoiding Medicaid: Characteristics of Primary Care Practices with no Medicaid Revenue

Presentation to the Washington Universal Health Care Commission's
Finance Technical Advisory Committee

January 12, 2024

Steven Spivack, PhD

Disclaimer

The material presented today does not represent the official position of the Lewin Group/Optum/United Health Group and was authored while I was an employee of Yale University.

Acknowledgements

- Coauthors: Valerie Lewis, Genevra Murray, Hector Rodriguez
- This work was supported by the Agency for Healthcare Research and Quality’s (AHRQ's) Comparative Health System Performance Initiative under Grant #1U19HS024075, which studies how health care delivery systems promote evidence-based practices and patient-centered outcomes research in delivering care.

Background

- Prior research has demonstrated that up to one-third of all **physicians** refuse to accept new Medicaid patients[1]
- Commonly cited reasons for refusal to participate include low reimbursement rates and burdensome administrative and billing requirements
- Less is known about the types of **practices** that do and do not accept Medicaid and their characteristics

1. Decker SL. In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. Health Aff (Millwood). 2012;31(8):1673-1679. doi:10.1377/hlthaff.2012.0294

Research Objective

- Examine the proportion of **primary care practices** with no Medicaid revenue and how those practices compare to practices with Medicaid revenue across key organizational characteristics and population health capabilities

Data and Sample

- 2017-2018 National Survey of Healthcare Organizations and Systems primary care practice survey
- Survey sample was extracted from the IQVIA OneKey database and included all medical practices with three or more physicians in an adult primary care specialty
- Practices = set of clinicians delivering care at a single location in group practice
- Final sample = 1,731 practices (response rate 47%)

Variables

- Defined three groups of Medicaid revenue as proportion of total revenue
  1. 0%
  2. >0-10%
  3. >10%
- Created composite measures for
  1. Care processes for complex patients
  2. Participation in payment reform
  3. Use of registries across clinical conditions
  4. Screening for social factors
  5. Patient engagement and activation initiatives
  6. Health information exchange capabilities
  7. Health information technology capabilities

Statistical Analyses

- Descriptive statistics to compare practices by revenue category
- Standardized scores (0-1) for performance on 7 composite measures and compare mean scores across revenue categories
- Generalized ordered logistic regression predicting practices' probability of being in the 0%, >0-10%, and >10% Medicaid groups
  - Adjust for practice ownership, total number of PCPs, proportion of clinicians who are PCPs, FQHC status, whether the practice resided in a Medicaid expansion state, rural/urban location of the practice, patient income/poverty

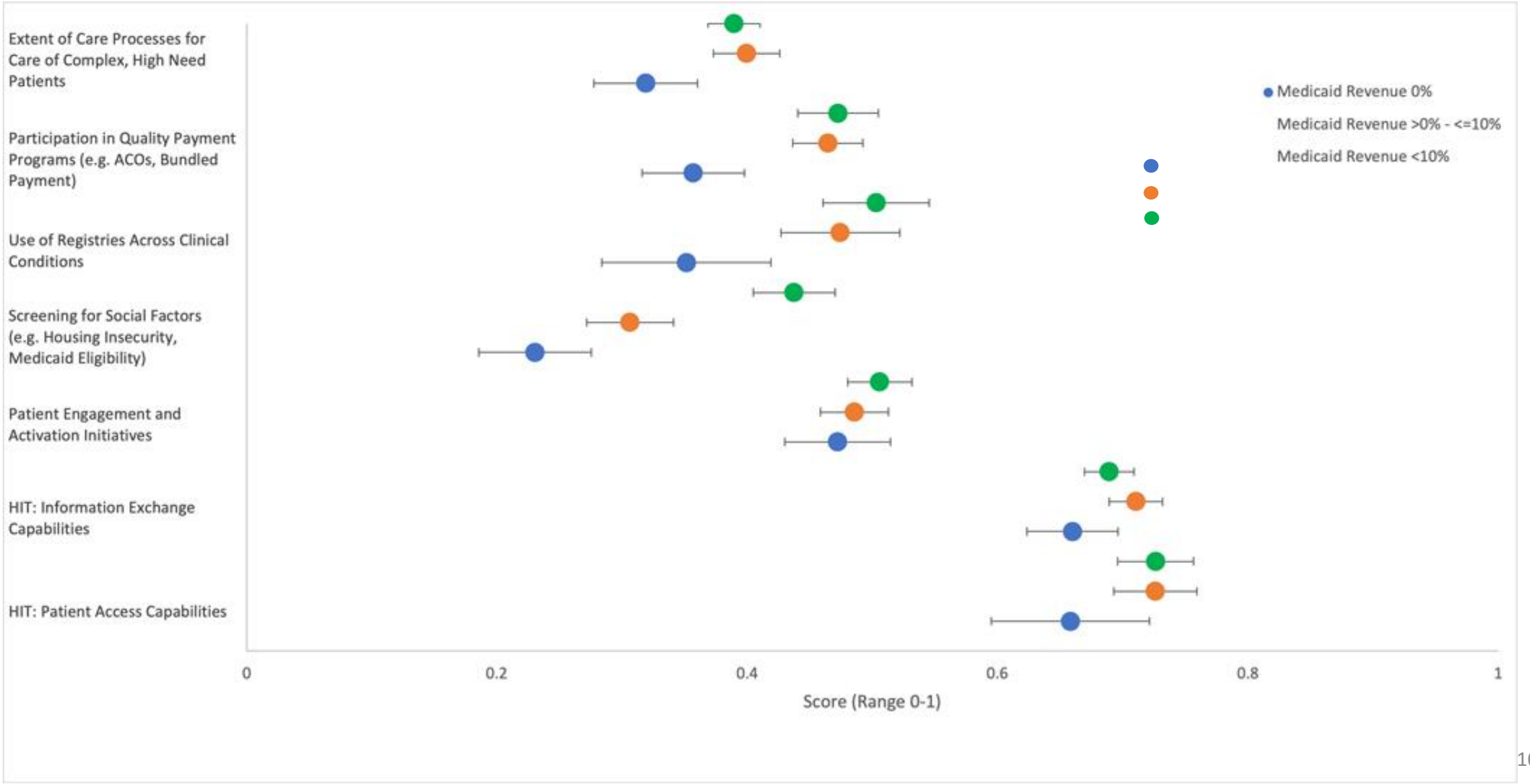
Results

Unadjusted key characteristics of primary care practices by Medicaid revenue group

		No Medicaid (N=288)	Medicaid >0-10% (N=655)	Medicaid >10% (N=788)
Ownership	Health System	0.09	0.36	0.54
	Hospital	0.11	0.38	0.51
	Larger Physician Group	0.23	0.43	0.34
	Independent Physician Practice	0.27	0.39	0.33
Total Number of PCPs	3–10	0.20	0.37	0.42
	11–50	0.09	0.33	0.58
	50+	0.11	0.36	0.53
Proportion clinicians who are PCPs		0.72	0.69	0.62
FQHC	Yes	0.05	0.16	0.79
	No	0.19	0.42	0.39
Medicaid Expansion State	Yes	0.15	0.35	0.51
	No	0.21	0.39	0.40
Proportion of patients in poverty		0.10	0.25	0.65
Rural-urban category	Metropolitan	0.19	0.39	0.42
	Micropolitan	0.04	0.22	0.74
	Rural	0.02	0.25	0.72

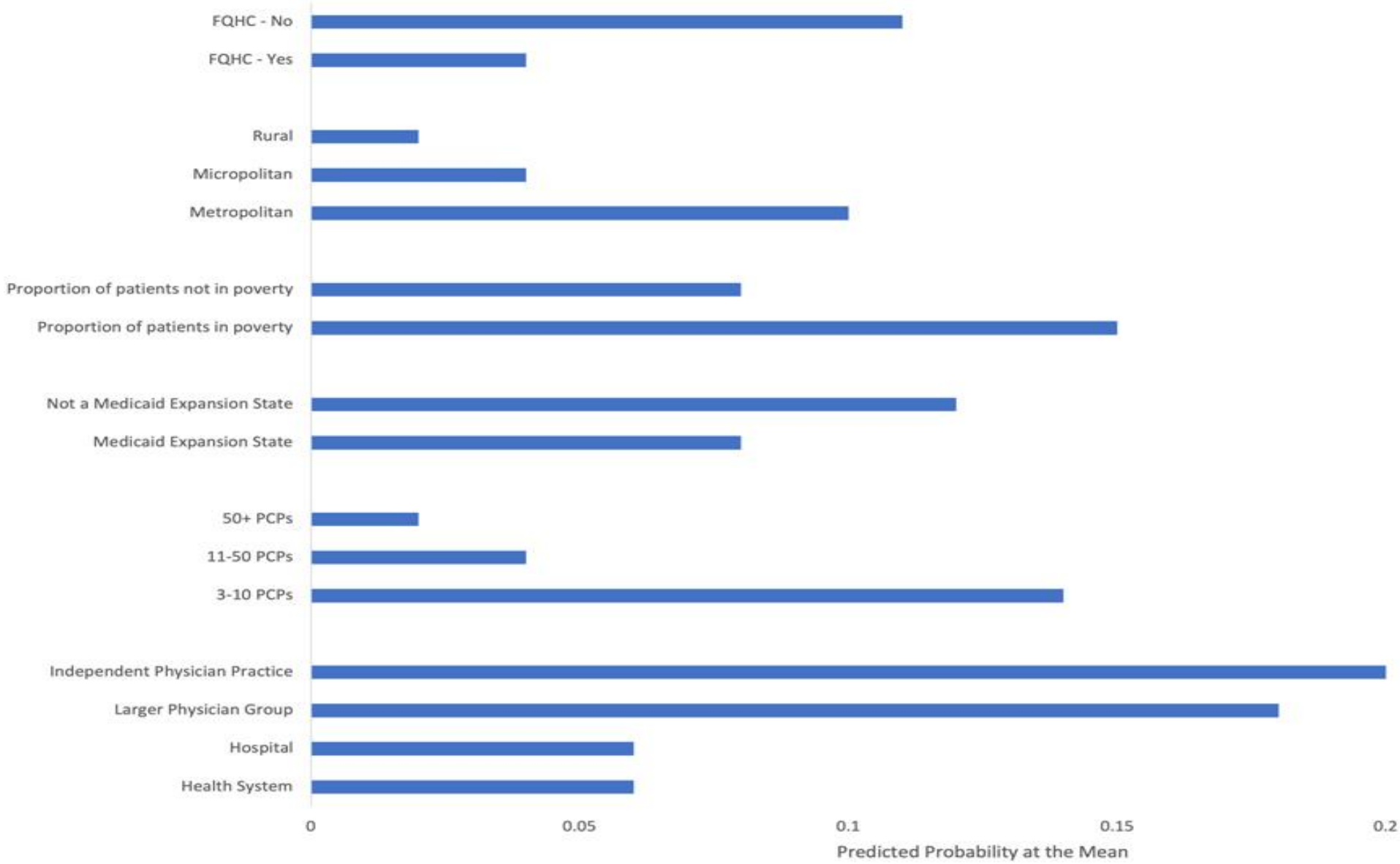
Results

Predicted probabilities of a practice having no Medicaid revenue across key practice characteristics



Results

Predicted Probabilities at the Mean for Practices not Accepting Medicaid



Discussion

- 17% of practices had no Medicaid revenue
- Practices with no Medicaid revenue were on average smaller, independent, had a higher proportion of primary care physicians in the practice, more likely to be urban, in low poverty areas, and in states that have not expanded Medicaid
- Some reasons for not accepting Medicaid may be:
  - Organizational capabilities and infrastructure
  - Access to a large enough patient base outside of Medicaid
  - Less advanced population health and IT capabilities

Discussion

- Some possible interventions to increase uptake in Medicaid participation among practices include
  - Increase reimbursement rates (most challenging option to implement)
  - Focus efforts on smaller, independent practices and what they need (e.g., streamlining billing and administrative requirements, timelier claims processing, more technical assistance)
  - Practices residing in areas with more individuals receiving Medicaid may be more likely to move from the 0% to >0-10% category
  - Harness power of consolidated systems and managed care

Questions and discussion

By Steven B. Spivack, Genevra F. Murray, Hector P. Rodriguez, and Valerie A. Lewis

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Avoiding Medicaid: Characteristics Of Primary Care Practices With No Medicaid Revenue

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ABSTRACT Primary care access for Medicaid patients is an ongoing area of concern. Most studies of providers' participation in Medicaid have focused on factors associated with the Medicaid program, such as reimbursement rates. Few studies have examined the characteristics of primary care practices associated with Medicaid participation. We used a nationally representative survey of primary care practices to compare practices with no, low, and high Medicaid revenue. Seventeen percent of practices received no Medicaid revenue; 38 percent and 45 percent were categorized as receiving low and high Medicaid revenue, respectively. Practices with no Medicaid revenue were more often small, independent, and located in urban areas with higher household income. These practices also have lower population health capabilities.

Access to primary care for Medicaid patients has long been a concern among patients and policy makers.[1,2] Previous research has demonstrated that up to one-third of all physicians refuse to accept new Medicaid patients,[1] and these percentages have not changed significantly during the past decade.[3–5] As additional states continue to adopt Medicaid expansion and Medicaid managed care continues to grow,[6,7] there is a renewed interest in access to care for Medicaid patients and participation among primary care providers.[8–11] Most studies examining primary care providers' participation in Medicaid investigate how factors related to the Medicaid program may influence providers' decisions to accept Medicaid patients. For example, studies have examined how Medicaid reimbursement rates and billing requirements affect primary care clinicians' participation in Medicaid.[1,2,4,12–14] Other studies have examined how Medicaid expansion, which increases the number of Medicaid patients in a state, influences providers' participation in Medicaid.[3,15]

In contrast, comparatively little scholarship has examined the provider side. The few studies that examined how provider characteristics are associated with Medicaid participation found that physicians who do not accept Medicaid are more likely to operate in smaller, independently owned practices; care for wealthier patients; and earn a fixed salary.[1,2] This research is based on physician-level data, meaning that there is the possibility that other physicians, physician assistants, or nurse practitioners in these same practices do accept Medicaid. Thus, there may be important differences in rates of Medicaid participation among physicians compared with practices. In addition, group practices (rather than individual providers) are often the locus of decisions and activities that shape Medicaid participation. For example, practices share systems for scheduling, billing, staffing, hiring, and practice management; negotiate contracts and reimbursement with insurers; engage in joint purchasing; and determine provider compensation models.[16–19] Thus, the group practice is likely a key actor in determining which clinicians care for patients on Medicaid, but currently little literature speaks to this question.

In addition to the lack of data on practice-level characteristics associated with Medicaid

participation, there is also an important gap regarding how practices with varying levels of Medicaid participation differ in quality-of-care activities. Prior research suggests that physicians believe that Medicaid's low reimbursement rates prevent practices from adequately investing resources to improve quality.[20] However, we are unaware of studies that have examined how population health capabilities in particular differ by primary care practices' Medicaid participation rates. A richer understanding of variation in Medicaid participation across practices can provide insight into provider-side barriers to increasing Medicaid access and routinely engaging in population health activities.

In this study we used new, nationally representative survey data on primary care practices in the US to examine the proportion of those practices with no Medicaid revenue and how they compare to practices with Medicaid revenue across key organizational characteristics and population health capabilities.

Study Data And Methods

DATA AND SAMPLE We used data from the National Survey of Healthcare Organizations and Systems primary care practice survey fielded in 2017–18 (response rate: 47 percent). The survey covered a range of domains, including practice size, ownership, and care delivery initiatives and capabilities. Respondents were most commonly a practice manager or administrator. The survey methods have been previously reported on.[21–24]

The survey sample was extracted from the IQVIA OneKey database and included all medical practices with three or more physicians in an adult primary care specialty (internal medicine, geriatrics, general practice, or family practice). The data were developed using the American Medical Association's Physician Masterfile, publicly available sources, and proprietary data collection strategies. Although OneKey data are primarily used for commercial purposes, they have more recently been used by academic and government researchers,[25–29] including as a sample frame for a prior national survey.[17,18,30]

Practices were defined as a set of clinicians delivering care at a single location in group practice. A stratified cluster sample design was used to sample practices under varied organizational structures, including independent practices and those that are part of multi-tier corporate structures. Our final analytic sample included 1,731 practices.

STATISTICAL ANALYSES We split practices into three groups: no Medicaid revenue, Medicaid revenue of 10 percent or less, and Medicaid revenue greater than 10 percent. We tested several thresholds as part of our sensitivity analyses. Results were similar across specifications, so we selected the 10 percent threshold because it splits practices fairly evenly. We compared unadjusted differences across groups on several practice-level characteristics using chi-square tests for categorical variables, adjusted Wald tests for normally distributed continuous variables, and Mann-Whitney U tests for non–normally distributed continuous variables.

Next, we compared unadjusted practice capabilities by Medicaid revenue category. We calculated seven composite measures representing engagement with population health and quality initiatives: extent of care processes for complex patients, participation in payment reform, use of registries across clinical conditions, screening for social factors, patient engagement and activation initiatives, health information exchange capabilities, and health information technology capabilities for patient access. We standardized all composite measures to a 0–1 scale for ease of comparison. We tested for differences in mean composite scores across Medicaid revenue categories using adjusted Wald tests.

Finally, we estimated a generalized ordered logistic regression model predicting practices' probability of being in the 0 percent, 10 percent or less, and more than 10 percent Medicaid revenue groups. We chose to use a generalized ordered logistic regression model because our ordered logistic regression model failed the proportional odds assumption. We adjusted our model for practice ownership, total number of primary care providers, proportion of clinicians who are primary care providers, federally qualified health center status, whether the practice was located in a Medicaid expansion state, rural/urban location of the practice, median income of people in the practice's ZIP code, and whether 20 percent or more of people in the practice's ZIP code had incomes below the federal poverty level. We calculated predicted probabilities at the mean for each variable.

Survey weights were developed and applied in all analysis to account for sample design and nonresponse. As shown in online appendix exhibit A1,[31] we compared respondents, nonrespondents, and the entire sample frame across several measures; our analysis showed no systematic nonresponse bias.

LIMITATIONS We acknowledge several limitations to our methodology. First, as with any survey, there is the possibility of measurement error due to self-reporting, and we recognize that practices' reported payer mix may differ from their actual payer mix. In general, this type of error in our dependent variable would not bias our regression estimates unless the error was also

correlated with our independent variables.[32] Second, our survey excluded solo or dual-physician practices. Thirty-five percent of family physicians operate in solo or dual practices.[33] These practices may represent a distinct group of clinicians, and our results might not reflect their experiences. Third, slightly more than half of practices failed to respond to our survey. Although internal analyses demonstrated no significant differences between respondents and nonrespondents, as shown in appendix exhibit A1,[31] it is possible that our survey does not fully represent our sample frame.

Study Results

PRACTICE CHARACTERISTICS A total of 288 practices (17 percent) reported receiving no revenue from Medicaid, 655 (38 percent) had Medicaid revenue of 10 percent or less, and 788 (46 percent) had more than 10 percent Medicaid revenue (exhibit 1). In exhibit 1 we present row proportions for each variable by Medicaid revenue category. As practices moved across categories toward greater Medicaid revenue, they were generally more likely to be larger practices owned by a health system or hospital, operating in Medicaid expansion states, caring for less affluent patients, and classified as federally qualified health centers. For example, the proportion of practices with no Medicaid revenue was three times larger for independent practices than for practices owned by a health system (0.27 versus 0.09). The proportion of federally qualified health centers with no Medicaid revenue (0.05) was significantly lower than the proportion of those centers with more than 10 percent Medicaid revenue (0.79). The proportion of practices caring for large percentages of patients living in poverty was more than six times higher in practices with more than 10 percent Medicaid revenue (0.65) than practices with no Medicaid revenue (0.10).

ADJUSTED RESULTS The results of our generalized ordered logistic model were similar to unadjusted results. Holding all other variables at their means, we observed similar proportions across most of our study variables. The full table of predicted probabilities at the means is in appendix exhibit A2.[31] When looking at predicted probabilities at the means for only those practices with no Medicaid revenue, we observed several key patterns (exhibit 2). Practices with

EXHIBIT 1

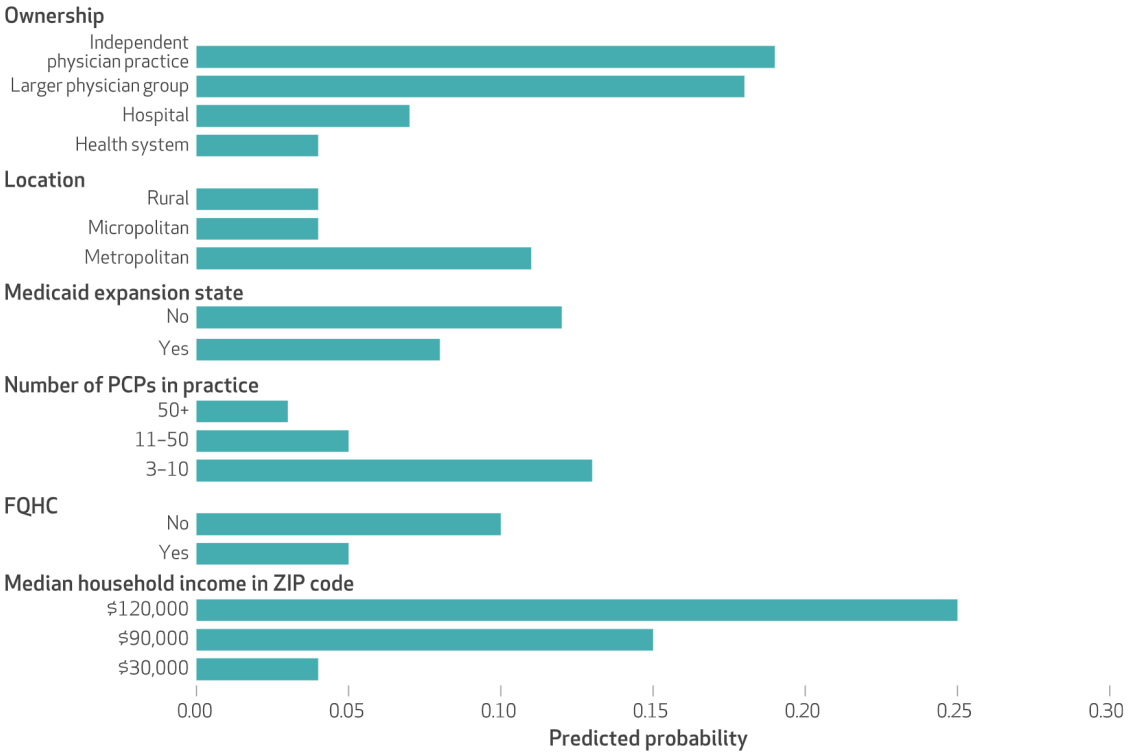
Unadjusted key characteristics of US primary care practices, by Medicaid revenue group

	No Medicaid, mean (n = 288)	Medicaid >0%–10%, mean (n = 655)	Medicaid >10%, mean (n = 788)
Ownership****			
Health system	0.09	0.36	0.54
Hospital	0.11	0.38	0.51
Larger physician group	0.23	0.43	0.34
Independent physician practice	0.27	0.39	0.33
Total number of primary care providers****			
3–10	0.20	0.37	0.42
11–50	0.09	0.33	0.58
50+	0.11	0.36	0.53
Proportion of clinicians who are primary care providers****	0.72	0.69	0.62
Federally qualified health center****			
Yes	0.05	0.16	0.79
No	0.19	0.42	0.39
Medicaid expansion state**			
Yes	0.15	0.35	0.51
No	0.21	0.39	0.40
Proportion of patients in poverty[a] ****	0.10	0.25	0.65
Rural or urban category****			
Metropolitan	0.19	0.39	0.42
Micropolitan	0.04	0.22	0.74
Rural	0.02	0.25	0.72

SOURCE Authors' analysis of data from the National Survey of Healthcare Organizations and Systems. **NOTES** Significance indicators are from chi-square tests for categorical variables, adjusted Wald tests for normally distributed continuous variables, and Mann-Whitney U tests for non–normally distributed continuous variables. Analysis applies survey sample weights to account for clustered sampling design and nonresponse. [a]Defined as 20 percent or more of people in the practice's ZIP code having incomes below the federal poverty level. **$p < 0.05$ ****$p < 0.001$

EXHIBIT 2

Mean predicted probabilities of practice characteristics for US primary care practices with no Medicaid revenue



SOURCE Authors' analysis of data from the National Survey of Healthcare Organizations and Systems. **NOTES** Generalized ordered logistic regression model adjusted for ownership, federally qualified health center (FQHC) status, number of primary care providers (PCPs) in the practice, percent of providers who are PCPs, Medicaid expansion state, median household income of people in the practice's ZIP code, urban/rural location, and indicator for practices with 20 percent or more of people in the practice's ZIP code having incomes below the federal poverty level. Predicted probabilities shown were calculated holding all other variables in the model at their means. The analysis applies survey sample weights to account for clustered sampling design and nonresponse.

zero Medicaid revenue had significantly higher predicted probabilities of being independently owned than being owned by a hospital or a health system. These practices also had significantly higher predicted probabilities of operating in a metropolitan area (versus rural or micropolitan areas) and employing 3–10 primary care providers (versus 11–50 or 50+). Practices with zero Medicaid revenue had significantly lower predicted probabilities of being located in a Medicaid expansion state, being classified as a federally qualified health center, or caring for patients living in census tracts with lower median household income.

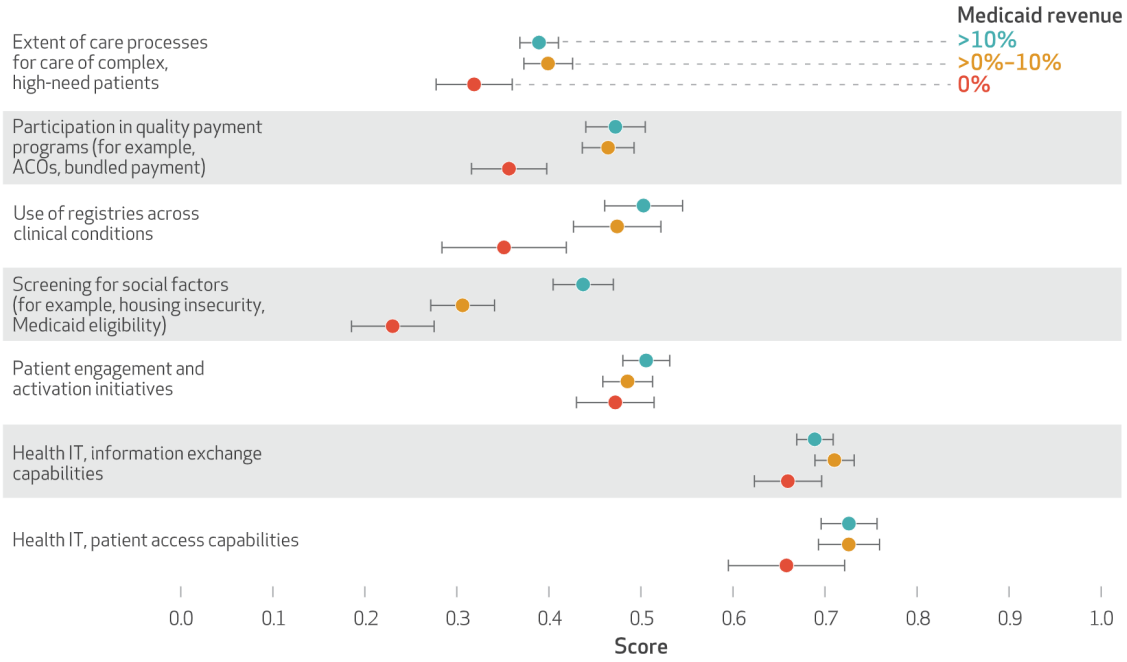
POPULATION HEALTH AND QUALITY CAPABILITIES When examining unadjusted measures of population health and quality capabilities as measured by the composite score mentioned above, we found that practices with no Medicaid revenue possessed generally less robust capabilities than those with 0–10 percent and those with more than 10 percent Medicaid revenue (exhibit 3). These differences were significant for the care of complex, high-need patients (0.32 versus 0.40 versus 0.39; $p = 0.003$), participation in quality payment programs (0.36 versus 0.46 versus 0.47; $p < 0.001$), use of registries across clinical conditions (0.35 versus 0.47 versus 0.50; $p < 0.001$), and screening for social factors (0.23 versus 0.31 versus 0.44; $p < 0.001$). There were no significant differences between practices with and without Medicaid revenue on patient engagement and activation activities (0.47 versus 0.49 versus 0.51; $p = 0.334$), health information exchange capabilities (0.66 versus 0.71 versus 0.69; $p = 0.051$), or health information technology patient access capabilities (0.66 versus 0.73 versus 0.73; $p = 0.136$).

Discussion

Our study documented that primary care practices with no Medicaid revenue are different in key ways from practices with low or high Medicaid revenue. Practices with no Medicaid revenue, on average, are smaller, are independent, and have a higher proportion of primary care physicians in the practice. This finding suggests that

EXHIBIT 3

Population health and quality capabilities across US primary care practices, by Medicaid revenue group



SOURCE Authors' analysis of data from the National Survey of Healthcare Organizations and Systems. **NOTES** The dots represent means, and the bars represent 95% confidence intervals. Composites are standardized such that each composite can take values ranging from 0 to 1. The analysis applies survey sample weights to account for clustered sampling design and nonresponse. Cronbach's α for each composite is >0.8 with the exception of health information technology (IT), patient access capabilities. Differences across revenue categories are significant at the 0.05 level (Wald test) for the care of complex, high-need patients; participation in quality payment programs; use of registries across clinical conditions; and screening for social factors. ACO is accountable care organization.

organizational capabilities and infrastructure likely play a key role in practices' decisions to accept Medicaid. Second, practices with no Medicaid revenue are more likely to be urban, in low poverty areas, and in states that have not expanded Medicaid. This finding suggests that providers who have access to a large enough patient base outside of Medicaid may be less willing to take Medicaid. Finally, our findings show that practices with no Medicaid revenue are less advanced on several population health capabilities. Although we frame this about practices with no Medicaid revenue, we also see many of the same patterns when comparing practices with low and high Medicaid revenue.

Our findings sit within the larger body of work examining Medicaid participation, particularly factors that induce the choice to accept Medicaid[15,34–37] and the effects of this decision. Notably, measuring Medicaid participation is challenging,[38,39] and we focus on primary care practices to highlight organizational features salient to Medicaid participation. Our finding that 17 percent of practices have no Medicaid revenue is lower than what older studies have found[1,4] but closer to more recent work on this topic.[40] This difference may be likely attributable to two key factors. First, our study focuses on primary care practices as opposed to individual physicians as the unit of analysis, both changing the unit and including nurse practitioners and physician assistants delivering primary care who were excluded in analysis of physicians. Second, our outcome was current Medicaid revenue, as opposed to physicians' willingness to accept new Medicaid patients, and our category of no Medicaid revenue likely encompasses practices where some physicians retain existing Medicaid patients but no longer take new patients.

Although some of our findings mirror those in the literature (such as associations with area income or state Medicaid expansion status), our study highlights the key roles played by organizational features such as practice size and ownership in Medicaid participation. Moreover, we also examined how practices' Medicaid revenue is associated with practice capabilities. Our findings suggest that practices with no Medicaid revenue also have fewer capabilities around quality of care and population health than practices with low or high Medicaid revenue. Although the evidence on how such capabilities influence patient outcomes is scant, our results suggest that practices opting out of Medicaid are generally less

advanced than those that accept Medicaid and may lack key capabilities for caring for patients with complex needs.

Our results have several policy implications, and policy makers or Medicaid managed care organizations may consider tailoring policy to the state and local context. There are likely multiple viable approaches to increasing the share of primary care practices participating in Medicaid that focus on key segments of primary care practices. One approach may be to target small, independent practices, since administrative burden has been cited as a reason physicians are reluctant to accept Medicaid.[2] In other cases, it may be more productive to focus efforts on key segments of primary care that may be poised to best serve Medicaid patients. For example, focusing on nonparticipating practices in areas with a high concentration of Medicaid patients may be a more valuable use of resources.

It is likely that some combination of strategies may be most effective, such as state efforts to reduce the administrative burden of Medicaid coupled with targeted outreach or technical assistance to key segments of a state's primary care practices. Of course, clinicians also choose where they practice. Some clinicians may choose to practice independently and locate in affluent areas, giving them sufficient revenue to forgo Medicaid participation. Further research is needed to disentangle these choices and their effects on Medicaid participation.

An additional implication of our study is that greater Medicaid acceptance may be an unintended result of increasing consolidation of primary care, particularly as the financial realities of the coronavirus disease 2019 (COVID-19) pandemic have increased pressure on practices to consolidate. As practices join larger health care systems, centralized administration and billing handled by the system may result in practices seeing more Medicaid patients. Similarly, in states with a strong Medicaid managed care presence, the negotiating power that providers secure through consolidation may result in higher negotiated reimbursements or payments (such as care management payments) that make Medicaid participation more attractive.

Finally, our results suggest that Medicaid expansion is associated with increased participation in Medicaid but by itself is insufficient to increase participation. Even in expansion states, 15 percent of practices still have no Medicaid revenue, and another 35 percent derive less than a tenth of their revenue from Medicaid. Overall, 21 percent of the US population is covered by Medicaid,[41] with proportions higher in expansion than nonexpansion states. This suggests that the uneven share of Medicaid revenue across practices is likely still a barrier to care for many patients, even in expansion states.

Conclusion

Efforts by policy makers and health plans to improve Medicaid access may be most successful if focused on removing barriers faced by independent, small practices in accepting Medicaid. Policies to reduce administrative burden and improve infrastructure for population health may help equip primary care practices to accept Medicaid payment. ■

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Tab 8

Washington State Health Care Authority

UHCC's Questions for FTAC on Medicaid

Questions from the Commission for FTAC to provide guidance:

- Does a comparison of benefits exist for Medicare, Medicaid, and Public Employee Benefits (PEB)?
- What have other states done with 1115 waivers to expand eligibility?
- What are the reasons for Medicaid enrollees' barriers to access, e.g., lower reimbursement rates?
- What barriers exist with regards to Medicaid provider rate increases, e.g., ongoing work to increase primary care rates?
- What federal barriers exist with regards to:
  - Asset limitations for enrollees of classic Medicaid?
  - Provider reimbursement?

FTAC Discussion

The challenges for integrating Medicaid differ from Medicare and ERISA, but there may be unique opportunities e.g., How can the richness of Medicaid benefits be preserved for Medicaid-eligible individuals while providing positive aspects of Medicaid coverage to the broader population?

- What are some of the positive and negative aspects of WA's Medicaid program that should be considered?
- Ideas for improving access/motivating provider participation in Medicaid?
- What should the Commission should keep in mind in their upcoming discussions on benefits and services, e.g., the Commission is prioritizing transitional solutions such as administrative simplification and provider participation.

Medicaid Guidance to the Commission

FTAC Vote:

Motion to recommend that the Commission consider pursuing an 1115 demonstration waiver when appropriate to include Medicaid enrollees in Washington's universal health care system, details of which will need to be developed once benefits and services are determined.

Pam MacEwan, FTAC Liaison

Medicaid Guidance to the Commission

FTAC Vote:

Motion to recommend that in their transitional solutions work, the Commission consider paths to simplify administration for the Medicaid program which may help motivate provider participation in Medicaid.

Pam MacEwan, FTAC Liaison

Medicaid Guidance to the Commission

FTAC Vote:

Motion to recommend that the Commission consider options to selectively increase Medicaid rates for smaller/independent physicians.

Pam MacEwan, FTAC Liaison

Medicaid Guidance to the Commission

Other considerations and/or guidance to the Commission:

Motion to _____

Pam MacEwan, FTAC Liaison

Medicaid Considerations for UHCC

Roger Gantz

The below are intended to provide FTAC with additional considerations for discussion and guidance to the Commission on Medicaid at the January 12 meeting. These may also offer the Commission further insight into key issues for any development of an 1115 waiver and other issues they may need to consider in their work to determine benefits and services.

1115 Waiver General Design

At their December meeting, the Commission chose to prioritize several transitional solutions for 2024, including "consolidating and expanding state purchasing." An 1115 demonstration waiver concept design could be developed in conjunction with the design of the consolidated state agency purchasing system, which could include PEBB, SEBB, Retirees, qualified health plans on the Exchange, and Medicaid related programs.

Eligibility

There are existing federal Medicaid eligibility laws (e.g., 42 USC 1396a(10)(ii)(X) and 1396a(m)) that would allow Washington to eliminate Medicaid Categorically Needy (CN) and Medically Needy (MN) Aged, Blind and Disabled (ABD) asset provisions without an 1115 waiver. (NOTE: Washington's Medicaid CN and MN ABD eligibility groups are the only groups that have asset/resource requirement limitations.)

Benefits

An actuarial benefit comparison among Washington's Medicaid, PEBB, SEBB, qualified health plans, Medicare, and if possible, the largest group market plan may be helpful in discussions regarding "uniform benefit design" for the unified financing system, and for examining options for incorporating the Medicaid and Exchange programs into a consolidated state purchasing system.

Benefits

As the Commission has noted, reducing the current Medicaid benefit is not likely or desirable. It may be possible that those Medicaid services not included in the uniform benefit design, such as long-term and support services, could be deemed supplemental coverage for Medicaid beneficiaries.

Cost-Sharing

There are federal Medicaid premium and cost-sharing limits (42 CFR 447.50-90) that may or may not be waived by the Centers for Medicare and Medicaid Services (CMS). Given this limitation, it may be helpful to compare the Affordable Care Act's (ACA) premium tax credits and cost sharing reductions and the state's "Premium Assistance and Cost Sharing Program (RCW 43.71.100).

Provider Reimbursement

Though provider reimbursement has not yet been determined by the Commission, it may be

helpful to understand options for increasing Medicaid rates to a percentage of Medicare as other states have considered for their health reform system, and as a program in Washington does currently. For example, Oregon's Joint Task Force on Universal Health Care adopted a 124% of Medicare payment pricing to maintain an existing aggregate level of reimbursement. Washington's Cascade Select program currently requires a reimbursement level of 160% of what Medicare would pay.

Provider Reimbursement

Washington's Medicaid program has existing special payments which will need to be addressed in designing a uniform benefit and payment design. These include hospital disproportionate share (DSH) payments, Medicare upper payment limits for hospital and nursing home services, federally qualified health centers (FQHC) and rural health care centers (RHCs), as well as state special payment programs.

Provider Reimbursement

In order for Medicaid to be incorporated in a "universal financing system" with a uniform benefit design, Medicaid payment rates will need to be "normalized" to a standard payment level. This would require financing through either the existing General State Fund (GF-S) structure or other strategies.

Next Steps

- Pam MacEwan, FTAC Liaison, will share information from today's discussion about Medicaid with UHCC at their February meeting.

- FTAC's Medicaid discussions will also be captured in a Medicaid Memo and shared with UHCC (FTAC will have opportunity to review before the memo is shared with UHCC).

Thank you for attending the Finance Technical Advisory Committee meeting!

Washington State Health Care Authority