FACT SHEET: MEDICAID MANAGED CARE RULE

CHANGES TO SUPPLEMENTAL PAYMENTS FOR CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS

April 2018

INTRODUCTION

In April of 2016, the federal Centers for Medicare & Medicaid Services (CMS) published the Medicaid and CHIP Managed Care Final Rule.

The rule, many provisions of which went into effect July 1, 2017, is a sweeping update to the regulatory framework for Medicaid managed care for the first time in many years, aligning it as much as possible with Medicare and other commercial insurance requirements for issues like rate setting, access standards, grievances and appeals, and quality. Significantly for California's 21 public health care systems, the rule also places new restrictions on how health care providers may receive supplemental payments in the Medicaid managed care context.

CAPH/SNI is working with the California Department of Health Care Services (DHCS), Medi-Cal managed care plans and CMS to implement changes that bring public health care system Medicaid managed care supplemental payments into compliance with the rule.

What are Supplemental Payments?

In order to partially bridge the gap between Medi-Cal base rates and the actual cost of providing care, California's public health care system have for years financed and received supplemental payments for services provided to patients enrolled in Medi-Cal managed care plans. These supplemental payments add up to more than $1 billion in federal funds each year and are an absolutely critical source of funding for public health care systems.

As Medi-Cal is a state/federal partnership, federal funding must be matched by a "non-federal share," which, in the case of supplemental payments, is provided by public health care systems themselves, at no additional cost to the State.

When these payments were historically made, public health care systems and DHCS agreed to an appropriate amount of funding needed to more closely approximate each public health care system's unreimbursed costs. Each public health care system provided the non-federal share to the state, and the state then provided the total enhanced payment with the federal match back to the public health care systems, via Medi-Cal managed care plans.

These types of supplemental payment arrangements must meet new requirements under the new rule and be pre-approved by CMS. Failure to comply with the new requirements would mean the loss of well over $1 billion a year in federal funding to California's public health care systems.

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What Changed?

The Managed Care Rule limits the ability of states to direct payments to health care providers, unless certain conditions are met. Among the allowable exceptions are payments tied to performance, and payments that provide a uniform payment increase which includes a pre-determined increase over contracted rates.

Some of the existing supplemental payments to public health care systems did not meet these conditions; in order to retain this critical funding, the payments must be restructured.

Have The Restructured Payments Been Approved?

CMS has approved the State's proposal to restructure supplemental payments to public health care systems for FY 17-18, which covers the period July 1, 2017 to June 30, 2018. The proposal contains two elements – a Quality Incentive Program (QIP) and an Enhanced Payment Program (EPP). The funding requested for both the EPP and QIP together is intended to replace at least the levels of certain supplemental funding public health care systems received in managed care prior the implementation of the managed care rule. The State will be submitting proposals for the QIP and EPP for subsequent rate years.

QUALITY INCENTIVE PROGRAM (QIP)

OVERVIEW

The Quality Incentive Program (QIP) represents a new pay-for-performance program for California's public health care systems that converts funding from previously-existing supplemental payments into a value-based structure, meeting the Managed Care Rule's option that allows payments tied to performance. QIP payments will be tied to the achievement of performance on a set of established quality measures for Medi-Cal managed care enrollees. If all public health care systems achieved their QIP performance milestones, they would collectively receive between $320- $450 million in federal funding.

STRUCTURE

Public health care systems will be required to choose at least 20 measures to report on, from a list of 26 possible measures. These measures are divided into four categories:

Primary Care
These measures align with current health plan reporting efforts and promote higher quality care in the ambulatory care setting.

Specialty Care
These measures focus largely on cardiac care, as heart disease is the second-largest cause of mortality in California (behind cancer) and the largest in the U.S.

Inpatient Care
Many of these high-value patient safety measures align with improvement work that public health care systems undertook as part of the 2010-2015 Delivery System Reform Incentive Program (DSRIP).

Resource Utilization
These measures, mostly derived from the Society of Hospital Medicine's Choosing Wisely campaign, aim to reduce unnecessary utilization and improve quality of care. There is also a utilization measure to help address the current opioid epidemic.

Program Year 1 of QIP has a retroactive start date of July 1, 2017 and ends June 30, 2018. Baseline performance will be set using performance rates from that time period and Program Year 1 payments will be based on pay-for-reporting. After Program Year 1, the proposal to CMS intends to convert the basis of payment to performance.

ALIGNMENT WITH PRIME

The QIP is structured similarly to the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, part of the state's section 1115 Medicaid waiver, called Medi-Cal 2020.

The QIP's measures do not directly overlap with any of the quality measures being used in PRIME, but are designed to be complementary. For more on PRIME and the Medi-Cal 2020 waiver, visit **caph.org/waiver**.

QIP MEASURES

Primary Care
Comprehensive Diabetes Care (CDC): Eye exam
Comprehensive Diabetes Care (CDC): Blood Pressure Control
Comprehensive Diabetes Care (CDC): A1C Control (<8%)
Asthma Medication Ratio
Children and Adolescent Access to Primary Care
Medication Reconciliation Post Discharge
Immunization for Adolescents
Childhood Immunizations
7-day Post-Discharge Follow-Up Encounter for High-Risk Patients

Specialty Care
Coronary Artery Disease (CAD): Antiplatelet Therapy
CAD: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin-Receptor Blocker (ARB) - Diabetes or Left Ventricular Systolic Dysfunction (LVSD)
CAD: Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or LVSD
Heart Failure: ACE/ARB for LVSD
Heart Failure: Beta-Blocker Therapy for LVSD
Atrial Fibrillation/Atrial Flutter: Chronic Anti-Coagulation

Inpatient Care
Surgical Site Infections (SSI)
Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections
Appropriate Treatment of Methicillin-Sensitive Staphylococcus Aureus (MSSA) Bacteremia
Stroke and Stroke Rehabilitation: Discharged on Antithrombotic

Resource Utilization
Emergency Department Utilization of CT for Mild Blunt Head Trauma for Patients ≥18 years old
Emergency Department Utilization of CT for Mild Blunt Head Trauma for Patients 2-17 years old
Unplanned Reoperation Within the 30 Days of Postoperative Period
Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients
Concurrent Use of Opioids and Benzodiazepines

ENHANCED PAYMENT PROGRAM (EPP)

OVERVIEW

The Enhanced Payment Program (EPP) creates a funding pool to supplement the base rates public health care systems receive through Medi-Cal managed care contracts. Rather than being tied to performance metrics, the EPP meets the Managed Care Rule's option that allows payments that provide a uniform increase within a class of providers such as a pre-determined increase over contracted rates.

STRUCTURE

The enhanced payments that public health care systems would be eligible to receive depend largely on systems' existing payment arrangements with their managed care plans. Public health care systems will self-finance the non-federal share required and collectively receive roughly $1 billion in federal funding in EPP payments through the plans.

To be compliant with the rule, public health care systems have been divided into five different classes, with EPP payment terms defined according to the class:

- University of California Health Systems *(UC Davis, UC Irvine, UCLA, UC San Diego, UC San Francisco)*
- Northern California public health care systems that predominantly receive funding from managed care health plans via full-risk capitation *(San Francisco Health Network, Santa Clara Valley Medical Center)*
- County-run or county affiliated public health care systems with Level I or II Trauma for predominantly fee-for-service contracts *(Alameda Health System, Arrowhead Regional Medical Center, Kern Medical, Natividad Medical Center, Riverside University Health System, Ventura County Medical Center)*
- Other County public health care systems for predominantly FFS contracts *(Contra Costa Regional Medical Center, San Joaquin General Hospital, San Mateo Valley Medical Center)*
- Los Angeles County Department of Health Services *(which oversees LAC+USC Medical Center, Harbor-UCLA Medical Center, and Olive View-UCLA Medical Center)*

For public health care systems that enter into predominantly capitated contracts with health plans (where they take on substantial financial risk from the plan), the majority of the enhanced funding available for those types of contracts will be used to increase capitated revenues received from the plans. The remaining funding will be used to enhance payments for non-capitated contracted services provided to health plan members where the public health care system does not receive capitated payments, but rather is paid on a fee-for-service basis.

For those public health care systems that are predominantly paid on a fee-for-service by their contracted health plans, roughly 60 to 70% of the enhanced funding available for those types of contracts will be used to enhance payments received for inpatient days, distributed pro rata based on utilization. The remaining 30 to 40% would do the same for non-inpatient services.

Providers whose status changes in the future can move into another class. For instance, if a hospital moves from a Trauma III to a Trauma II, they would move into the class for Trauma I and II in the following rate-setting year.

IMPACT ON HEALTH PLANS

The QIP and EPP present new opportunities for collaboration between public health care systems and Medi-Cal managed care plans. The QIP is a performance-based program that aligns clinical and quality measures with those that Medi-Cal managed care plans are already reporting, creating a shared interest in both entities working together to demonstrate improvement. In fact, QIP projects and metrics were developed jointly by clinical leaders in public health care systems and Medi-Cal managed care plans, in order to be most valuable and meaningful.

The EPP provides critical funding to public health care systems and is intended to mitigate health plan concerns around the potential risks of this new program. Health plans will receive an add-on to their managed care rates and provide interim payments to providers throughout the year. Payments will be reconciled at the end of the year, protecting health plans from any risk associated with payment.

The submission of encounter data will be important in determining payment for the QIP and EPP, which could result in more accurate data shared between public health care systems, health plans and the state and benefit all parties involved.

LOOKING AHEAD

As with other performance-based programs, public health care systems have demonstrated a willingness to restructure supplemental payments by tying them to performance metrics, a clear demonstration of their dedication to improving care across their systems.

As CMS reviews the State's proposal for subsequent QIP and EPP rate years, we are hopeful that our federal partners will appreciate public health care systems' reliance on these funds, and their leadership in providing value-based care.