FACT SHEET: MEDICAID MANAGED CARE RULE

Changes to Supplemental Payments for California's Public Health Care Systems

What is the Managed Care Rule?

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 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) to refine and finalize a proposal that would 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 financed by public health care systems themselves, at no additional cost to the State.

When these payments have been historically made, public health care systems and DHCS have agreed to an appropriate amount of funding needed to more closely approximate the public health care system's unreimbursed costs. Each public health care system has provided the non-federal share to the state, and the state has 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 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 roughly $1 billion a year in federal funding to California's public health care systems.

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 pre-determined increase over contracted managed care rates.

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

The proposal developed by CAPH/SNI and DHCS contains two elements – a Quality Incentive Program (QIP) and an Enhanced Payment Program (EPP). The funding requested for both the QIP and EPP combined 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.

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QUALITY INCENTIVE PROGRAM (QIP)

OVERVIEW

The Quality Incentive Program (QIP) is meant to meet the Managed Care Rule's exception that allows payments tied to performance. The QIP would represent a new pay-for-performance program for California's public health care systems that would convert funding from previously-existing supplemental payments into a value-based structure. QIP payments would be tied to the achievement of performance on a set of clinically-established quality measures for Medi-Cal managed care enrollees. As proposed, if all public health care system achieved its performance milestones, they would collectively receive $640 million (including federal and non-federal share) in QIP payments through the plans.

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 health care systems undertook as part of the 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.

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.

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
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) would create a funding pool that would be used to supplement the base rates public health care systems receive through Medi-Cal managed care contracts, meant to meet the managed care rule's exception that allows payments that provide 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. As proposed, public health care systems would finance and collectively receive roughly $1.6 billion (including federal and non-federal share) in EPP payments through the plans.

Public health care systems are divided into five different classes, with payment terms defined according to the class:

1. University of California Health Systems (UC Davis, UC Irvine, UCLA, UC San Diego and UC San Francisco)
2. Northern California public health care systems that predominantly receive funding from managed care health plans via full-risk capitation (San Francisco Health Network and Santa Clara Valley Medical Center)
3. County-run or county affiliated public health care systems with Level I or II Trauma for fee-for-service contracts (Alameda Health System, Arrowhead Regional Medical Center, Kern Medical, Natividad Medical Center, Riverside University Health System and Ventura County Medical Center)
4. Other County public health care systems (Contra Costa Regional Medical Center, San Joaquin General Hospital and San Mateo Valley Medical Center)
5. Los Angeles County Department of Health Services (which oversees LAC+USC Medical Center, Harbor-UCLA Medical Center, Olive View-UCLA Medical Center, and Rancho Los Amigos Rehabilitation 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 would be used to increase capitated revenues received from the plans. The remaining funding would be used to enhance payments for non-capitated 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 60-70 % of the enhanced funding available for those types of contracts would be used to enhance payments received for inpatient days, distributed pro rata based on utilization. The remaining 30-40% 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.

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, 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.