CALIFORNIA ASSOCIATION of PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Financial Services Training

Module 2:

PHS Financing: Managed Care

May 11, 2021

FST Schedule

Date	Topic
Wednesday, May 5 from 11-1:30	Introduction to Public Health Care System (PHS) Financing
Tuesday, May 11 from 11-1:30	Managed Care Financing
Wednesday, May 19 from 10-12:30	Claiming, Reporting, & Revenue Maximization
Wednesday, May 26 from 11-1:30	Realignment and Waivers

Objectives

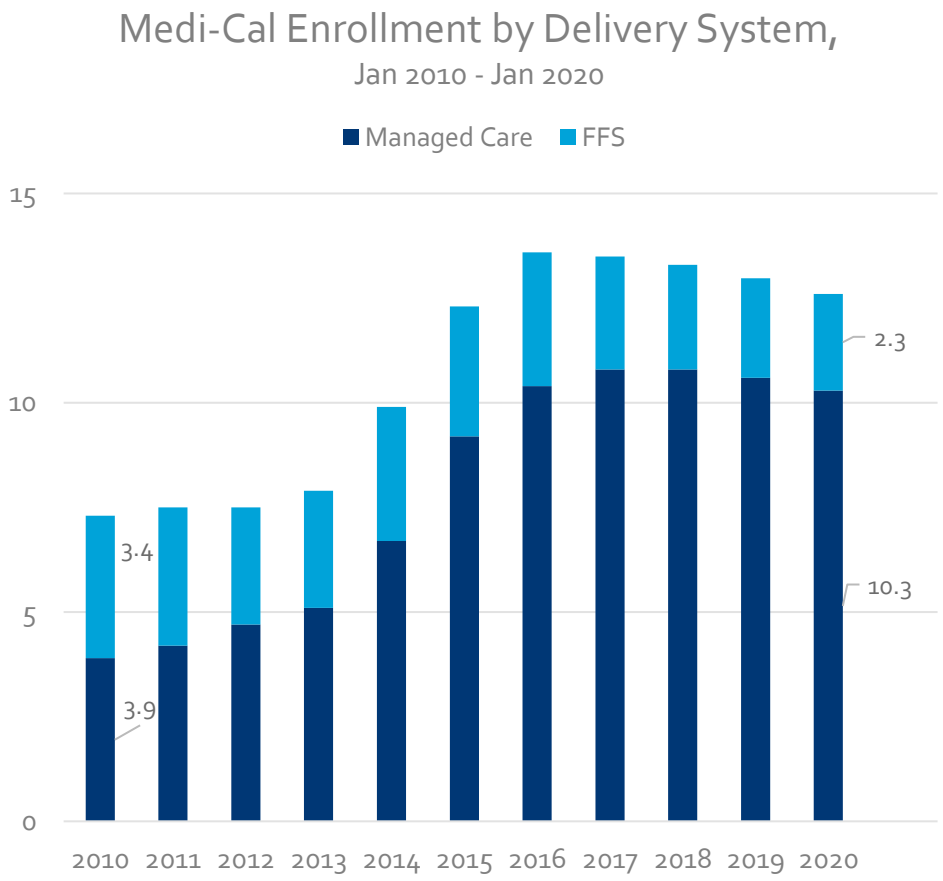
To understand:

1. Increasing importance of Medi-Cal Managed Care and MC supplemental payments to PHS
2. Development of managed care supplemental payments
3. Structure and implications of current supplemental payments (Rate Range IGT, GME, QIP, EPP)
4. EPP encounter data: processes, mechanisms for improvement, and reconciliation practices

Managed Care in Context

Managed Care in California

- Different systems in different counties (Two plan, COHS, GMC, etc.)
- Increasing importance for state over time
  - Increased enrollment
  - Increased responsibilities
    - CalAIM
    - Carve-in of services



Source: CHCF Medi-Cal Facts and Figures; Medi-Cal June 2020 Fast Facts

Managed Care & PHS Financing

- Increasing over time, now predominant portion of Medi-Cal business
- Supplemental payments that go through managed care plans (directed payments) greatly increased in size
  - Managed Care Rule
  - PRIME moving into QIP
- Need to work more closely with plans
  - Encounter data for EPP
  - Timing and mechanics of supplemental payments

Managed Care Supplemental Payments

Supplemental Payments – What Are They?

- Supplement our base rates in Medi-Cal Managed Care
- Needed to help cover our costs
- Increasingly important over time
  - Governed by changing federal regulations
  - Growth of Managed Care within the Medi-Cal program
- Require us to work closely with plans
  - Changing relationship over time – directed payments vs. voluntary

Medicaid Managed Care Rule

Directed Payments

- States previously paid plans and directed those payments be made to certain providers
- New rule prohibits directed payments except under certain exemption
- Requirements mostly became effective July 1, 2017

Historical directed payments

- PHS supplemental payments that have ended because of the Managed Care rule
  - SPD-IGT and MCE-to-cost: Supplemental payments to bring PHS "up to cost" for certain populations
    - MCE – Medi-Cal expansion population ("new")
    - SPD – seniors and persons with disabilities (other than those who also have Medicare)
    - Estimated costs only
    - Not for all PHS
  - Hospital fee managed care portion
- Programs that have changed: Rate range

Medicaid Managed Care Rule

Directed Payments – Exceptions:

State can direct plan payments to providers to implement:

QIP

(i) Value-based purchasing models

(ii) Multi-payer or Medicaid-specific delivery system reform or performance improvement initiative

(iii) Or to require a plan to:

(A) Adopt a minimum fee schedule for network providers that provide a particular service under the contract;

EPP

(B) Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract; or

(C) Adopt a maximum fee schedule for network providers

Question - Which exception fits EPP and which one fits QIP?

Directed Payment Exemptions Approval Process

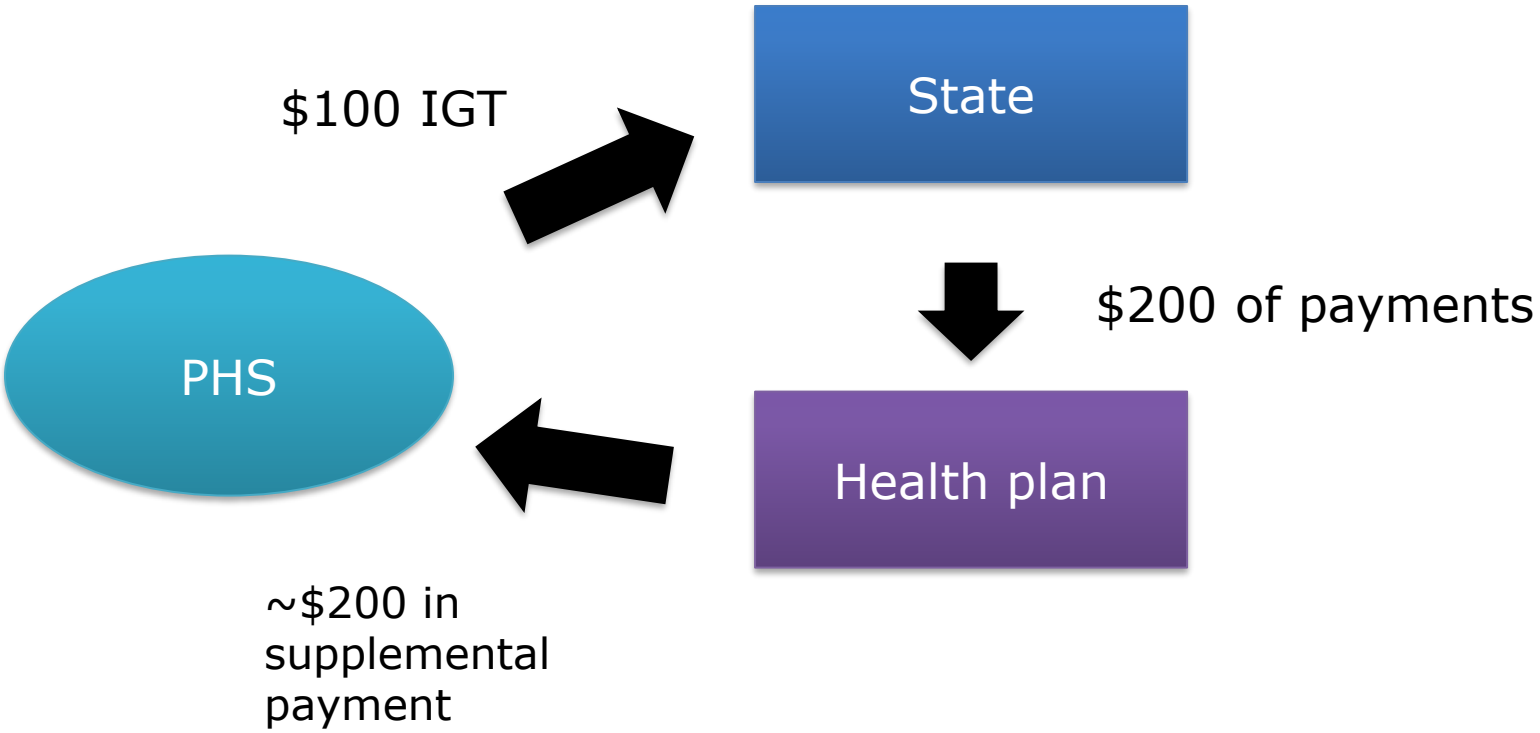
To be approved, directed payment must have the following components:

- **Across all** Medi-Cal managed care members – TANF, all SPD, MCE
- Direct its payments uniformly **within a class of providers**
- Advance at least one of the goals and objectives in the state's quality strategy
- Have an **evaluation** plan to determine whether it actually advanced the stated quality goals
- Not condition provider participation on IGTs
- Not renewed automatically
- Based on utilization and delivery of services **prospectively**

Current Managed Care Supplemental Payments

Name	Description	Net FFP, FY 18-19
Rate-range IGT	Range between lowest & highest actuarially sound rates state may pay plans; state fee on IGT 20% (one exception)	$771 million (after state fees)
Enhanced Payment Program (EPP)	Fixed pools for DPHs, prorated based on managed care encounters or revenue for fully capitated providers	$1.176 billion
Quality Incentive Program (QIP)	Fixed pools for DPHs, distributed by num. managed care lives served/assigned, earned by meeting quality metric targets	$512 million (available)
Graduate Medical Education (GME)	Calculations similar to Medicare GME (direct & indirect) for teaching costs, but for Medi-Cal Managed Care services.	$170 million

Mechanics of Managed Care Supplemental Payments



Rate Range IGT

Rate Range: Old and New

- Very valuable to DPHs: $771 million in FY 18-19
- State determined it wanted RRIGT to be considered non-directed/non-pass through
- Prior state laws/practices became inapplicable:
  - Directing 75% of MCE portion of rate range to counties
  - Keeping DPHs at no less than historical amount for old-eligible RRIGT
- Became entirely voluntary on part of plans
  - Important reminder that relationship with plans is more important than ever to ensure maximizing all supplemental funding

Rate Range: Admin Fees

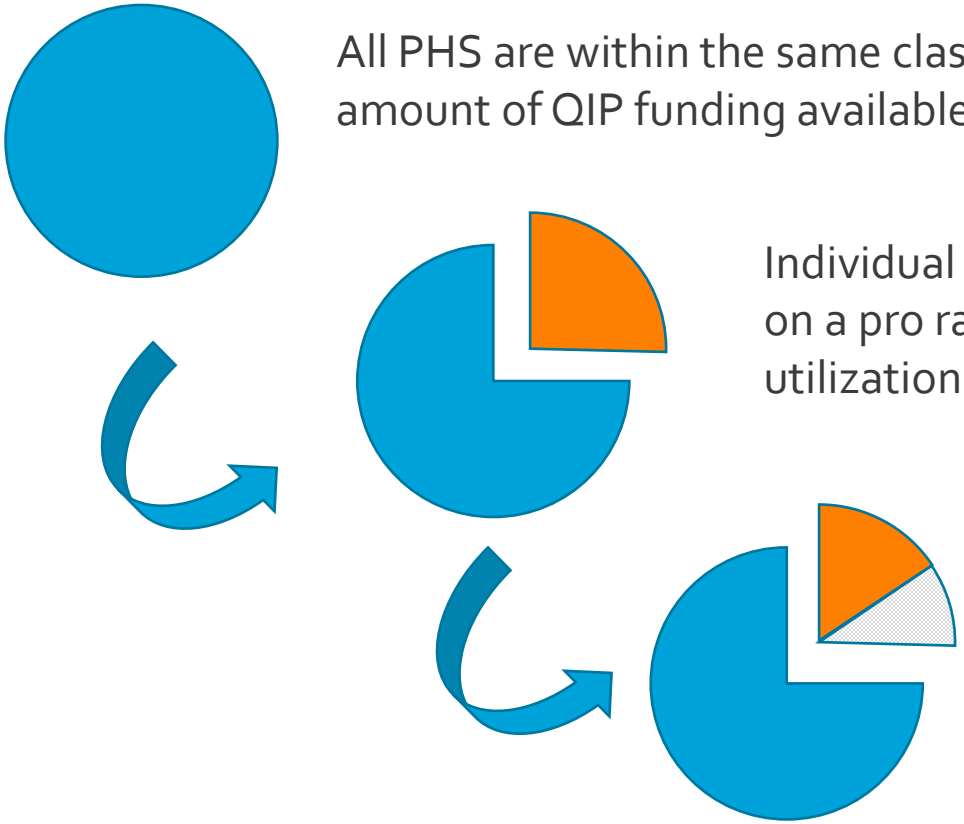
- State admin fee:
  - Required by state law as condition of participation
  - 20% of IGT put up
    - Exception: MCE IGT by county PHS
    - Paid simultaneous to, and on top of, IGT (not part of IGT or deducted from state plan)
- Plan admin fee:
  - Plan may require as condition of cooperation, but does not have to (many charge $0)
  - Usually no more than a percent or two

QIP

Quality Incentive Program

QIP Structure and Distribution

- Value-based supplemental payment that ties payment to attainment of quality metrics
- Worth $512 m FFP in FY18-19 and PHS earned 93% of those funds
- Grew to $1.2 b FFP in CY2021 with inclusion of PRIME



All PHS are within the same class and with an aggregate amount of QIP funding available for claiming

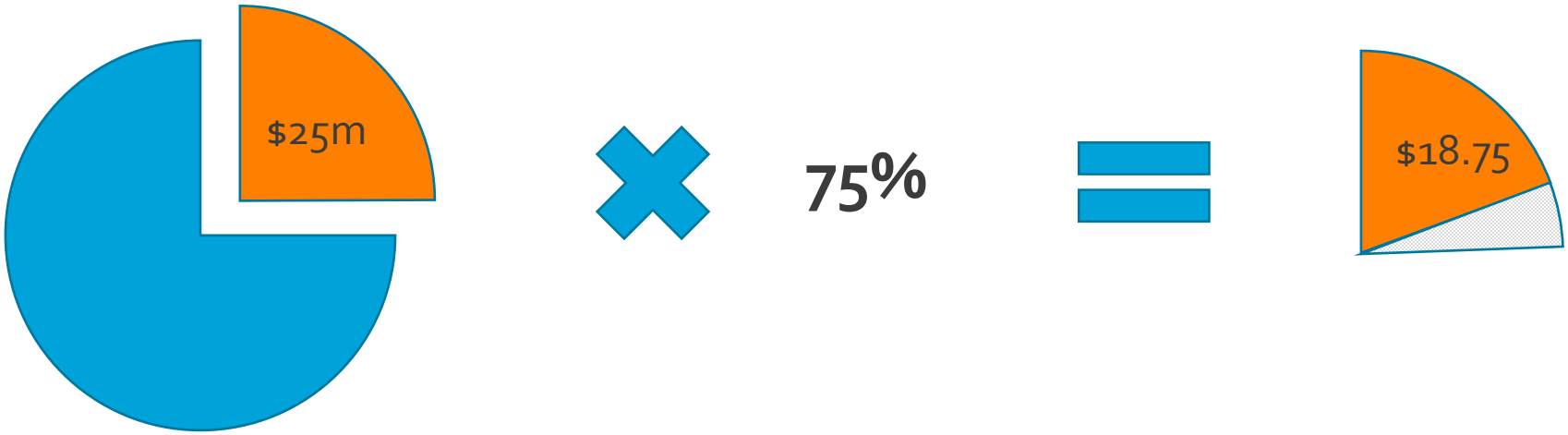
Individual PHS get a share of the pool based on a pro rata percentage of managed care utilization and assignees

PHS earn all or some of their share based on their attainment of quality metrics.

QIP Earning: Example

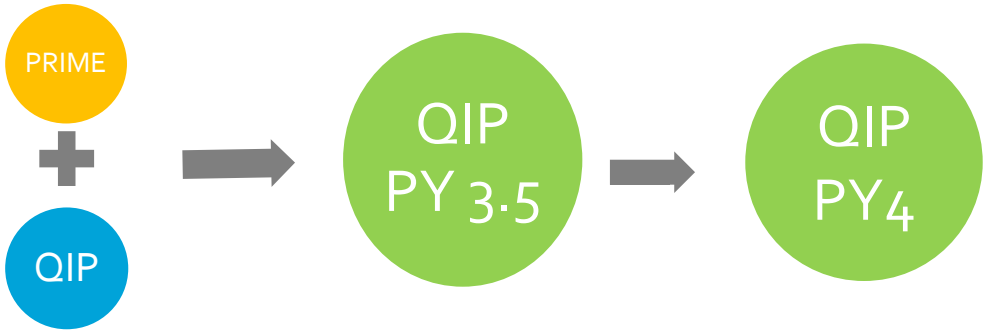
Step 1
PHS is allocated 25% of total QIP earnable based on having 25% of eligible assignees and utilization

Step 2
PHS total earnable is multiplied by the share of their reported metrics they met. In this case the PHS met 15/20 reported metrics.



PRIME to QIP Evolution

- Starting in QIP PY 3.5 (July-Dec 2020) PRIME funds transitioned to QIP but with full reporting of both measure sets
- Starting PY4 (CY 2021) PHS will report a consolidated set of metrics



FY 2019-20	Jul-Dec 2020	CY 2021
PRIME: $1.07b, gross QIP: $701.5m, gross	$886.25m, gross	$1.833b, gross

GME

Graduate Medical Education

GME

- Only managed care supplemental that is not included in rates and does not pass through plans at any point
- Worth $371m gross, $170m FFP in FY18-19
  - DGME $110m
  - IME $261m
- Calculated from Medicare Cost Reports following Medicare GME methodologies, "as if" they credited Medi-Cal like they did Medicare
  - Interim payments and later reconciliation payments from final reports
  - Blended FMAP methodology in development (50% in interim)

EPP

Enhanced Payment Program

EPP

- $1.17m FFP, $1.5b gross FY18-19
- DPHs are divided into five classes
- Pooled approach with pro rata internal distribution by class
- Approximately trended by hospital CPI

Class A	Class B	Class C	Class D	Class E
Northern CA with full-risk capitation	Counties with Level I or II Trauma with FFS	Other Counties with FFS	University of California	Los Angeles County
San Francisco Santa Clara	Alameda Arrowhead Kern Natividad Riverside Ventura	Contra Costa San Joaquin San Mateo	UC Davis UC Irvine UCLA UCSD UCSF	LAC+USC Harbor Olive View
$324 m	$270 m	$88 m	$215m	$638 m

Gross amounts for FY 18-19

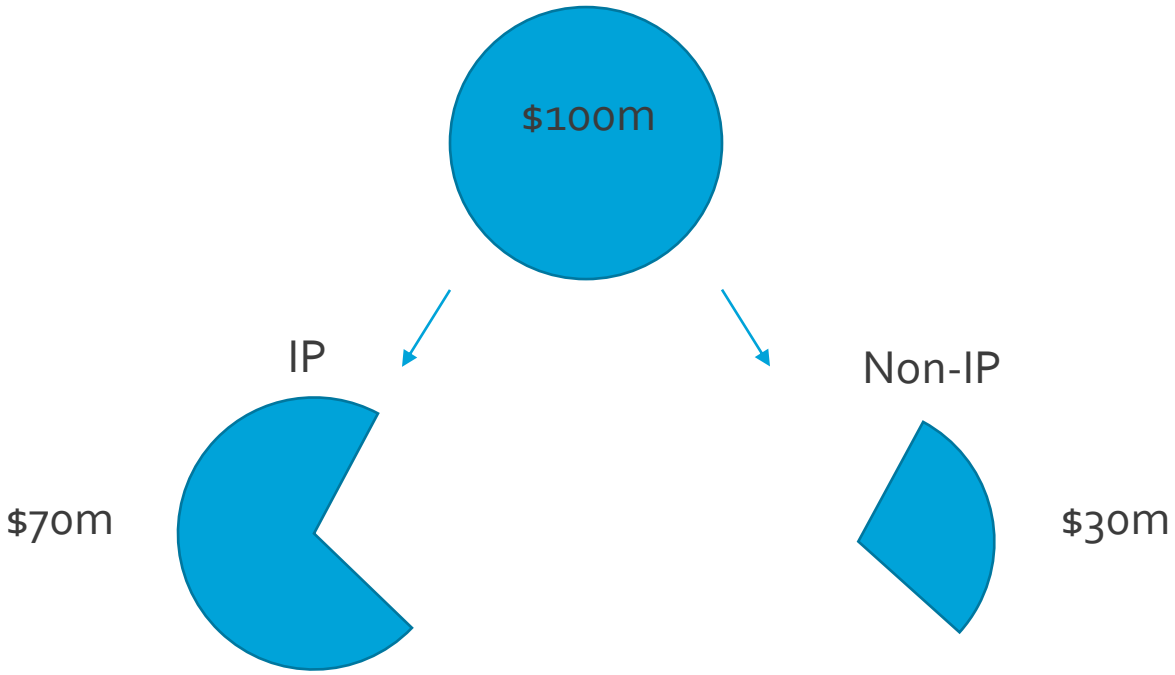
EPP Pro Rata Distribution

- Internal distribution within each class based on actual utilization and/or capitated revenues
- Duals Excluded

EPP FFS	EPP Capitation
• Distribution within the class based on contracted services: • 70% of total pool for actual inpatient days • 30% of total pool for non-inpatient services (excluding FQHC services)	• Most of available funding (90% of total pool funding) to be distributed pro rata based on a percentage of cap revenues • For services not paid under capitation number of such IP days and non-IP services (10% of pool)

EPP FFS Pro Rata Distribution

Applies to EPP FFS Classes and 10% of funding for EPP Capitation Classes



EPP Implications

Distributions will be based on *actual* data from plans to State for EPP

Distributions are based on your data and data from other PHS in your class

Risks

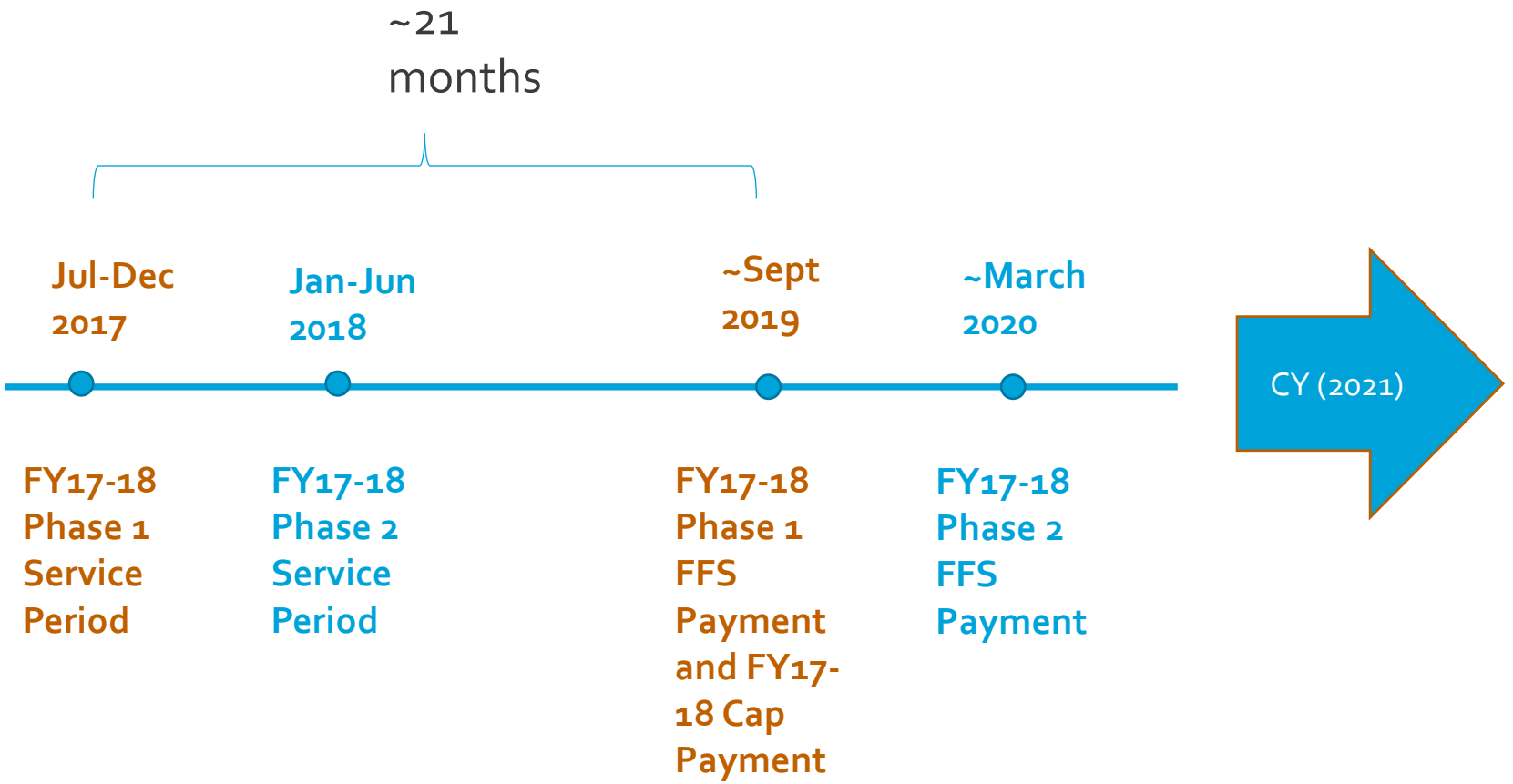
Unreliability of state/plan data

Actuarial-soundness limitations

Total net value depends on blended FMAP

Determined by which services provided to which aid codes

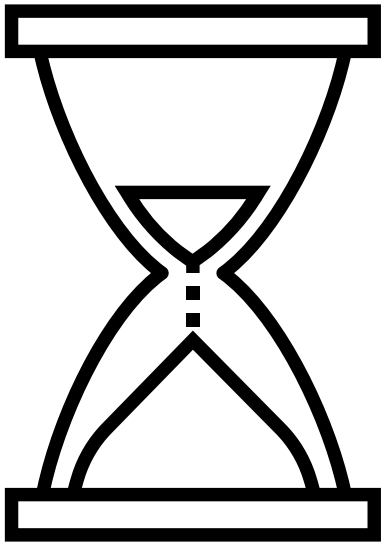
Timeline: Phases of EPP



EPP/QIP Next Steps

Next Steps

- Preprints approved through bridge period 19-20
  - Still awaiting final approval for previous years' rates
- Potential periodic resizing of pools based on utilization changes, cost growth
- Ongoing work with state and plans on EPP encounter data and internal distribution



Break!

We'll start again at 12:00 pm

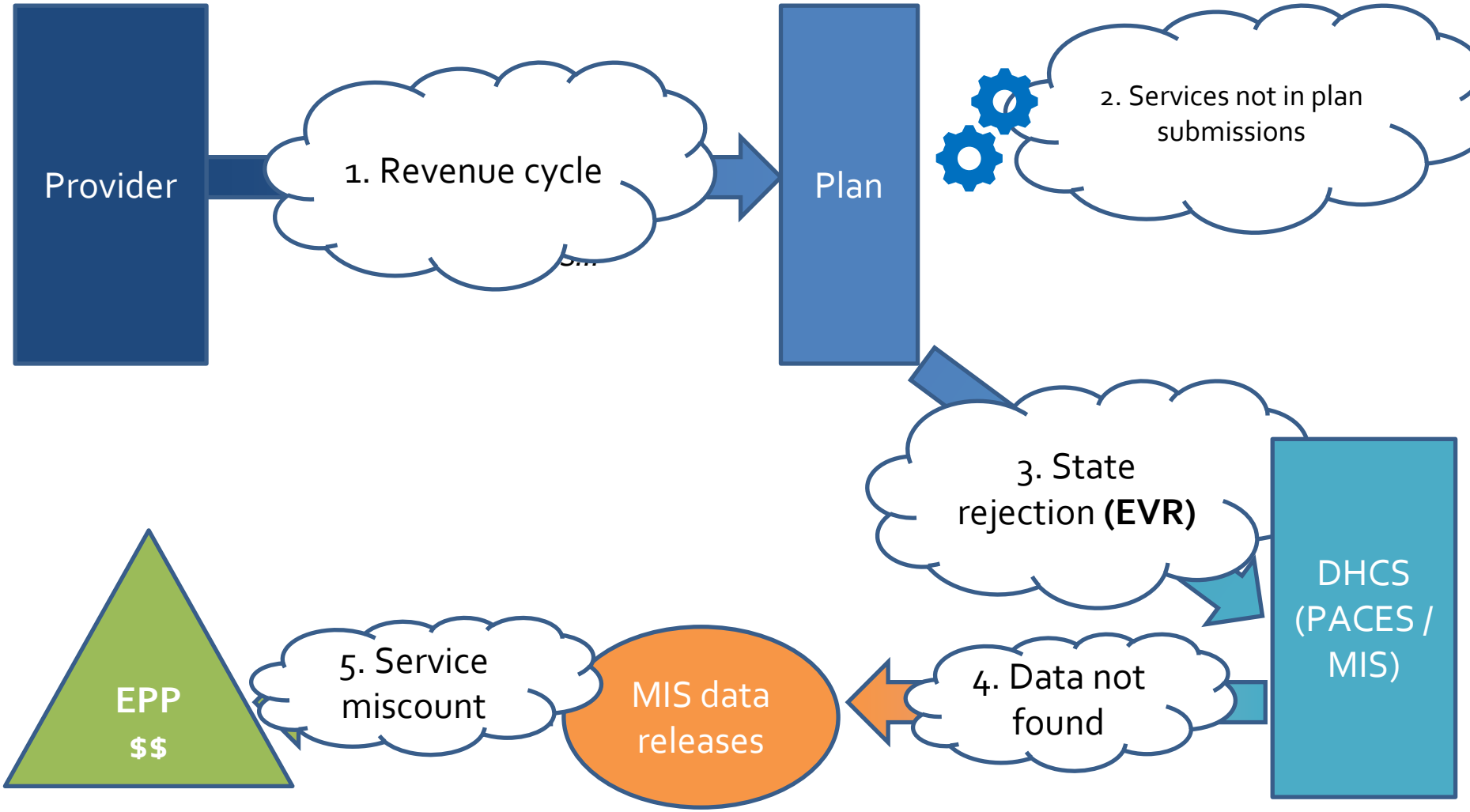
Improving EPP Encounter Data

Volume Chart Discrepancies and Sustainable Reconciliation Practices

Topics

1. Locating and chasing down gaps
2. Areas where processes exist
3. Areas where processes are in development: service counting, service identification
4. Building new and better processes
5. Q&A

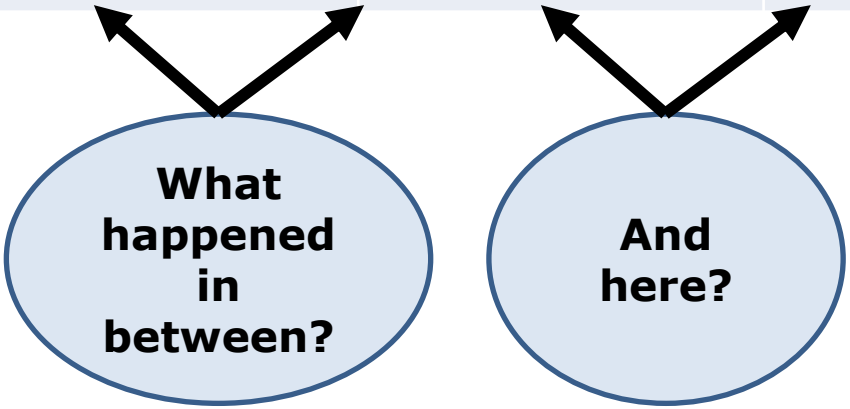
Chasing Down Gaps: Where Did the Service Fall Out?



Example utilization comparison

Services by one provider, for one contracted plan

	Provider database	Plan database	State MIS (volume data)
IP days	3,000	2,000	1,000
ER services	10,000	6,000	5,000
OP services	11,000	10,000	7,000
PCP services	20,000	7,000	1,000
Specialty physician services		12,000	10,000
FQHC services	10,000	8,000	10,000



Processes that exist, and who manages them

- Provider to plan:
  - Provider's revenue cycle / billing teams (sometimes encounter data team)
  - Data warehouses; IPAs; other intermediaries
  - Plan's "inbound" team
- Plan to state:
  - Plan's "outbound" team

Action: Make sure you have at the table all people involved in these existing processes, at all the stages

Processes that need to exist

- Tracking and reconciling encounters from end to end, rather than at each stage
- Cross-referencing and matching:
  - Encounter data from state (SFTP flat files aka volume charts)
  - Data in your own financial and billing systems
  - Acknowledgements from plans – or fix requests
- Validating National Provider Identifiers (NPIs) are complete and updated
- **New:** Ensuring all NPIs are in plan 274 transmissions, listing you as contracted provider

Example of hazards

- Because of being used with the wrong NPI, a stay is not identified as inpatient and gets sorted as outpatient by process of elimination – or not counted at all
- Service mis-identified as FQHC which is not counted for EPP
- State splits out stays as of Jan. 1 and Jul. 1, creates failure to match on dates of admission / discharge
- Many more!

Identify which fields are the most reliable to use for data matching, and develop a protocol

Sample encounters to see if they made it from end to end – if not why not

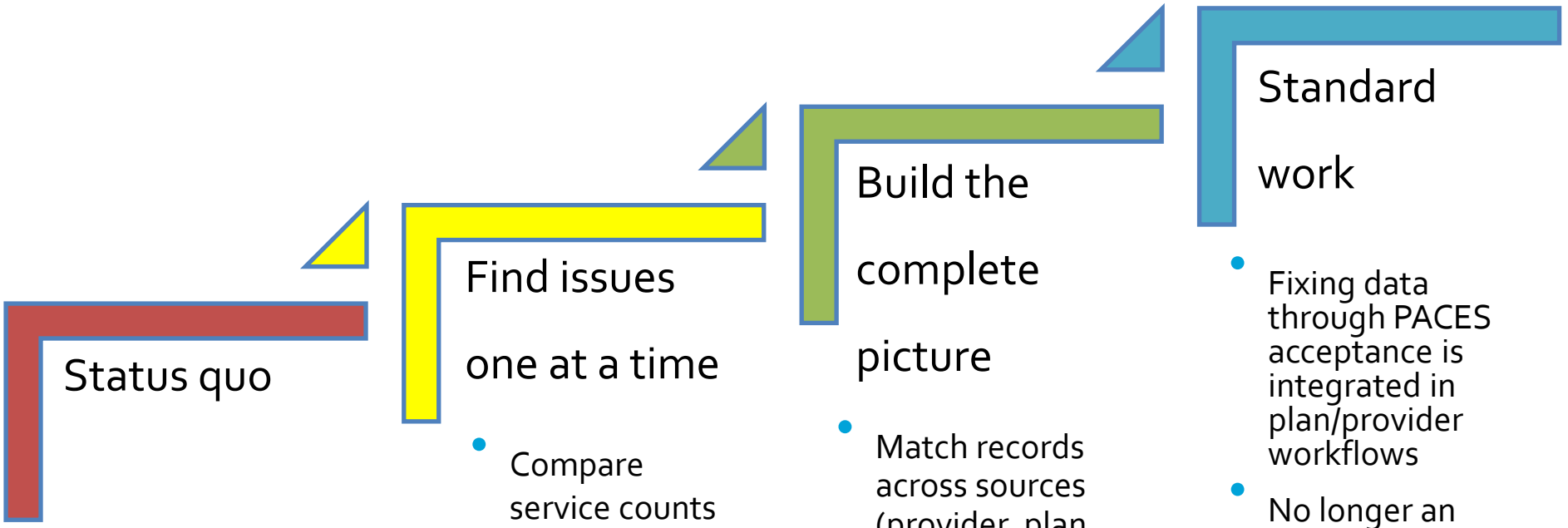
Chasing down issues: Questions to ask

How much impact would there be if we fixed this issue? (# days? # visits?)

Do we know how to fix this issue, or is more research needed?

Who is the person or office best suited to follow up on it?

Reconciliation: Ladder of Progress



Final Observations

- Don’t postpone action to the next volume data release
- Don’t make the perfect the enemy of the good
- Continually learning new things and how to work better together – plan/provider partnership
- Ultimate goal: for this work to be part of the routine process

Implications, Revisited

- This effort began as a salvage operation to try to maintain value of prior supplemental payment programs
- We have since seized opportunities to extend, increase, hedge against potentially difficult negotiations
- Overall funding now significantly higher than before, but not guaranteed – work is required to keep it up

Implications, Revisited

- We are continuing to let the State off the hook for paying such low rates; fate more in Fed's hands with approval every 3-5 years

- Important to work with your plans to ensure data accuracy & seek even greater rates
  - Under old structure, you were limited to cost – no longer!

- If it keeps up & continues to grow, will grow to be our largest supplemental funding source

Future of EPP

- EPP still needs CMS re-approval each year
- Potential to re-benchmark if service volume goes up enough
- State justifies it partly by its effect as incentive to improve encounter data quality
- CMS may eventually want to see less reliance on FFS-like methodology

Takeaways from Today's Session

Key Takeaways

- Increasing importance of Medi-Cal Managed Care and MC supplemental payments to PHS
- Managed care supplemental payments have grown over time into programs that are key to PHS financial success
  - Rate Range IGT
  - GME
  - QIP
  - EPP
- Working with and through plans is more important than ever
  - Timing and process of payments
  - EPP Encounter data

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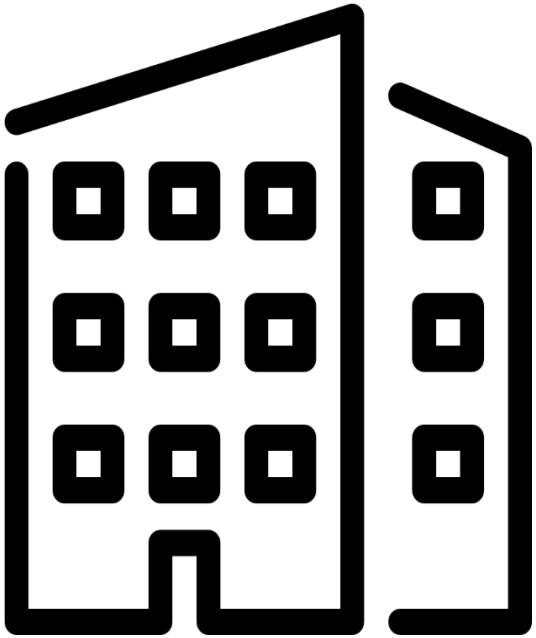
Optional Office Hours



- CAPH staff will be hosting regular office hours, continuing this **Friday May 15 from 12:00 – 1:00 pm**
- Bring any and all questions related to the training

Evaluation

Please let us know how we did by filling out the evaluation using the following link or QR code:

https://www.surveymonkey.com/r/2021FSTmodule2