Funding Flexibility

Care Coordination Advisory Committee

October 5, 2018

Meeting Objective

The committee will discuss key components of DHCS' population health management strategy. It will provide recommendations, direction, and advice concerning a core set of standards and expectations regarding appropriate care coordination activities and requirements for Medi-Cal delivery systems.

Today we will discuss:

- Shared Savings Models
- Value-Based Payment
- In Lieu of Services
- Regional Model Approach
- FQHC Payment in Managed Care

Guiding Principles

- Improve the member experience.
- Meet the behavioral, developmental, physical, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Focus on assessing and addressing social determinants of health and reducing disparities or inequities.
- Focus more on value and outcomes.
- Look to eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Shared Savings Models

Shared Savings

Shared savings arrangements can happen at multiple levels:

- State payment arrangements with Medi-Cal Managed Care Plans (MCP)
- MCP payment arrangements with providers/provider groups

State to MCPs
Current Rate-Setting Background

- In general, for any given rate-setting year, DHCS and its actuaries employ a combination of plan-specific utilization and risk-adjusted county average utilization to inform each MCP's rates.
- There is a lag involved in the process; the rates are based on data from about 2.5 years prior to the beginning of the rate year.
- Data includes MCP-specific encounter data and supplemental utilization and cost data.
- Various adjustments are made to account for changes that took place during or after base data period.
- Efficiency adjustments are applied at MCP level.
- Apply administrative and profit load.

State to MCPs
Current Rate Setting

- Challenges with methodology raised by MCPs
  - Does not encourage MCPs to improve health care access and quality or address social determinants of health that impact member health.
  - Because rates are based on historical utilization/cost, if MCPs invest in reducing costs, rates go down in future years.
  - Efficiency adjustments are one-sided, lowering rates rather than rewarding or encouraging efficient care.

Shared Savings

- Shared savings models are based on the principle of sharing in any decreased costs between two entities.
- Typically a cost is projected for a set of services or set of individuals.
- If the actual expenditures come in below a certain threshold the two entities involve share those dollars.

Discussion

- Are shared savings models a potential way to modify Medi-Cal managed care reimbursement?
- What types of populations/services might best be suited to these types of arrangements?
- Are these arrangements best done at the state/plan level or plan/provider level?

Committee Discussion

Value-Based Payments

Value-Based Payments

- For reasons similar to those in the prior section, value-based payment (VBP) arrangements are another potential financing methodology that could create incentives for specific outcomes.
- As with shared savings models, VBPs can be developed at the state-to-plan level or the plan-to-provider level

Value Based Payments

VBPs come in a multitude of forms:

- Capitation withholds, penalties or bonuses
- Alternative payment methods (APM)
- Enhancing financing for health-related investments
- Adding risk adjustment for social determinants of health to rate-setting methodology

APM Descriptions

- Introductory APMs
  - Fee-for-service payments tied to quality performance
- APMs
  - Bundled payments with shared savings/risk
  - Episode-based payments with shared savings/risk
  - Shared savings/risk tied to cost of care
  - Total cost of care shared savings/risk
- Prospective Payments
  - Bundled payments with full risk
  - Episode-based payments with full risk
  - Condition-specific capitated payments
  - Population capitated payments

MCPs to Providers

- As of 2017, 39 states contract with comprehensive risk-based MCPs to provide care.
- 22 states require or plan to require MCPs to make a target percentage of provider payments through APMs
- 12 states require or plan to require MCPs to adopt specific APMs.

Source: Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans

Current Example: PRIME

- Purpose: Improve the health of Californians by advancing improvements in the quality, experience and value of care that Designated Public Hospitals (DPHs) and District and Municipal Public Hospitals (DMPHs) provide.
- Builds on the success of the Delivery System Reform Incentive Program (DSRIP) that significantly improved care delivery in the DPH systems.
- Incentive payments are earned based on the achievement of specified benchmarks across various metrics.
  - Domain 1: Outpatient Delivery System Transformation
  - Domain 2: Targeted High-Risk or High-Cost Populations
  - Domain 3: Resource Utilization Efficiency
- Requires achievement of set targets for moving toward alternative payment methods for DPHs over the course of Waiver.

PRIME: APM Requirements

A goal of the waiver is to move participating DPH PRIME providers toward a value-based payment structure when receiving payments for managed care beneficiaries.

The waiver establishes DPH APM targets in the aggregate that, if not met, result in financial penalties.

These target percentages are based on the number of Medi-Cal managed care beneficiaries assigned to DPHs where all of, or a portion of, their care is paid for under a contracted APM:

- 50% by January 2018 (DY 13)
- 55% by January 2019 (DY 14)
- 60% by end of waiver (DY 15)

5% of DPH PRIME funding at risk in DY14 and DY15 is tied to the achievement of the APM targets.

PRIME: APM Payment Types

Four ways for payments to be counted towards APM threshold

1) Partial Capitation: Primary care only

2) Partial-plus Capitation: Primary care and some specialty care (varies)

3) Global Capitation: Primary, specialty, ancillary and/or hospital care

4) Additional payment methodologies approved by the State and CMS (set forth in Attachment R of 1115 Waiver Special Terms and Conditions)

Discussion

- Should VBP be instituted in Medi-Cal managed care? (If so, at what level?)
- How much of total reimbursement is it appropriate to include in value-based arrangements such as incentives?
- Would statewide/standardized VBP requirements from plan to provider be useful, or should there be more local flexibility? Is there a middle ground?
- Post 2020, can we or do we incorporate the concepts of PRIME into managed care?

Committee Discussion

In Lieu of Services

In Lieu of Services

- What are “in lieu of services”?
- What are the types of services being requested?
- Difference between state plan benefit and in lieu of services
- Pros, cons and considerations of in lieu of services
- Whole Person Care Pilot services
- Institutions for mental diseases (IMD) Flexibility

In Lieu of Services

42 C.F.R. § 438.3(e)(2) identifies four criteria for when services may be covered by an MCO, PIHP, or PAHP in lieu of services that are covered under the State plan:

1. State determines that alternative service or setting is medically appropriate and cost effective substitute;
2. Enrollee is not required to use the alternative service or setting;
3. Approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract and will be offered at the option of the MCO, PIHP, or PAHP; and,
4. Utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services.

Examples of In Lieu of Services Mentioned during Site Visits

- Respite or recuperative care
- Sobering centers
- Jail re-entry coordination
- Psychosocial aspects of care, including non-clinical care coordination such as Community Health Workers (CHWs)/peer support
- Home and community-based services such as habilitation, private duty nursing, congregate living facilities, support services provided in a licensed residential facility (short-or-long term), minor home repairs and adaptive equipment
- Housing liaison services
- Mobile triage team – street-based care team
- Patient health coach
- Community paramedics (EMS)
- Personal care services (if member can't self-direct IHSS, or to supplement IHSS or until IHSS is in place)
- Meals (home-delivered)

Medi-Cal Benefits

- Legislative changes generally required
- Benefits are predefined and established
- MCPs develop utilization management, generally based on existing standards
- MCPs work with provider community to prepare

In Lieu of Services

- Develop policy to define types of allowed services
- Benefit allowances to be established
- MCPs to develop utilization management from new policy
- MCPs to create provider network
- DHCS federally required to determine appropriateness and cost-effectiveness of services

In Lieu of Services Pros/Cons

- Pros:
  - Allows for needs outside of traditional benefits, such as air conditioners and other supportive services.
  - Allows MCPs to be creative in using resources.
  - Allows for regional/cultural considerations.
  - Provides the ability to pilot innovative delivery of care.
- Cons:
  - Potentially difficult to align with Utilization Management standards.
  - May cause differences in services offered among managed care plans in the same service area and across the state.

In Lieu of Services Challenges

- MCP rates must be developed considering the cost of State Plan-approved services versus the cost of the In Lieu of Services.
- Difficult to assign value to services that do not have measurable outcomes.
- Change in the way MCPs provide services; may require extensive training/hiring new staff and educating enrollees.

In Lieu of Services
Other Considerations

- Allow MCPs to propose services to be delivered based on service area
- Set required and optional In Lieu of Services
- Do not allow In Lieu of Services

Whole Person Care

The Whole Person Care (WPC) Pilot program is designed to leverage community resources to coordinate health, behavioral health, and social services in order to improve the health outcomes of Medi-Cal beneficiaries who are high utilizers of the health care system.

WPC themes include:

1. Supporting vulnerable populations (e.g., chronically ill, homeless, reentry)
2. Enhancing care coordination
3. Sharing data across the system

Whole Person Care Services

- Enhanced Medi-Cal Services
  - Enhanced Community Based Care Coordination and Care Management often using Community Health Workers
  - Enhanced Medical Homes
  - Post Incarceration Service Coordination
- New Services
  - Housing and Homeless Services
  - Recuperative Care
  - Respite Care
  - Sobering Center

Whole Person Care: Enhanced Medi-Cal Services

Enhanced Care Management

Provides liaison between health, behavioral health, social services, and the community resources to facilitate access to services and improve the quality of service delivery. Reduce access barriers, provide in-person ongoing care management and support, and work with system-wide care managers to provide coordination.

Enhanced Medical Homes

- SUD Diversion
- Behavioral Health Medical Homes
- Intensive Service Recipient Services provides in-hospital and in-home visits with a care coordination team, planning a daily program following release from institution, medication adherence supports, assistance in arranging support services like transportation, housing and food.

Post Incarceration Services

Services include Medi-Cal enrollment assistance, SSI advocacy, transportation, service coordination across health, behavioral health, social services, and the community resources, access to medications as release, etc.

Whole Person Care: New Services

Housing and Homeless Services

- Develop an individualized housing support plan based upon the medical and housing assessment.
- Housing locational service to identify safe and affordable housing, ensure that the living environment is safe and ready for move-in.
- Develop a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Assistance to help mediate tenant disputes and services to ensure client is a ‘good’ tenant.

Recuperative Care and Respite Care

- Short-term residential care for those recovering from an acute illness or injury that allows individuals with unstable living situations the opportunity to rest in a safe environment while accessing appropriate care.
- Assistance with activities of daily living.
- Linkages to health, behavioral health, social services, and the community resources.
- Coordination with permanent housing providers.

Sobering Center

- Sobering centers provide a safe, supportive, environment for individuals found to be publicly intoxicated, primarily those who are homeless or those with unstable living situations, to become sober.
- Medical triage, wound dressing changes, and rehydration service.
- Bedding during recovery.
- Linkages to health, behavioral health, social services, and the community resources.

Questions

- What are the most important aspects of the Whole Person Care that are not currently covered in Medi-Cal?
- Should these services be covered as a state plan benefit or through other avenues, such as In Lieu of Services? (Note that not all of these are eligible to be covered SPA benefits.)
- For the services listed above which are enhanced or not currently offered in Medi-Cal, which would you prioritize as considerations and why?
- If DHCS were to recognize and allow for ‘in lieu of’ services, should there be a standardized set of services or should plans have flexibility?

Committee Discussion

Medicaid IMD Exclusion

- Medicaid statute prohibits federal funding for care provided to certain patients residing in an Institution for Mental Disease (IMD).
  - Section 1905(a)(29)(B) of the Social Security Act
- Exclusion applies to individuals aged 21-64, for any medical assistance received (in or outside the facility) while a patient in an IMD.
- An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (42 C.F.R. 435.1010).

Flexibilities from IMD Exclusion

- "In lieu of" authority and IMDs: 42 C.F.R. 438.6(e)
  - Recent CMS policy allows FFP for capitated payments to managed care entities for enrollees aged 21-64 receiving psychiatric or SUD inpatient care of a short duration (15 days or less).
  - Makes FFP available without Expenditure Authority in an 1115 Waiver, but flexibility limited in scope, involves ongoing administrative checks, and requires a capitated payment structure.
- Congress considering further flexibility/changes in pending bills.

Flexibility from IMD Exclusion: SUD

- Available for delivery systems focused on individuals with substance use disorders.
  - CMS guidance available here
- DMC-ODS first approved in 2015 and continued in current Medi-Cal 2020 demonstration.
- DMC-ODS Expenditure Authority allows federal funding for short-term SUD residential care at facilities considered IMDs.
- Not an express “waiver” of IMD exclusion; rather, authorizes for “costs not otherwise matchable.”
- Expenditure authority N/A under Section 1915.

Flexibility from IMD Exclusion: Specialty Mental Health Services (SMHS)

- County Mental Health Plans are not under a risk-based capitated payment structure.
- Evaluate the “carve-out” of all SMHS.
- Evaluate the “carve-out” of inpatient acute psychiatric services.
- Request authority from CMS to allow payments to non-risk PIHPs for services provided in an IMD for a short-term stay.

Committee Discussion

Regional Model Ideas

Regional Model Ideas

- Medi-Cal managed care today generally is operated on a county-by-county basis, both from a service area perspective and rate setting perspective.
- Possible options to consider are:
  - Institute regional rate setting (regional rate averaging with risk adjustment).
  - Change the current county-by-county structure of plans/service areas and instead have service areas that span regions with more than one county.

Regional Rate Setting

- With a couple exceptions, rates in Medi-Cal managed care are set by plan by county.
- DHCS could look at expanding the rating region beyond a single county.
- This would require risk adjustment across counties, as well as the potential for wage adjustments.
- This would require consistent benefits across counties in a region.
- Would allow for including COHS in regional rate averaging and risk adjustment, instead of just current COHS individual plan based rates.

Regional Service Areas

- In general, plan service areas are also county based.
- Medi-Cal could instead go to a regional approach where individual health plans would offer services across service areas that span multiple counties.
- This type of change could mitigate some of the county transfer issues with changing health plans for beneficiaries who move across county lines.

Questions

- What are the benefits of moving to either or both types of regional approaches?
- What are the cons of moving to either or both types of regional approaches?
- What are concerns that the committee thinks such approaches might raise?

Committee Discussion

FQHC Payment in Managed Care

Delegation of FQHC-PPS Responsibility

- Federal statute requires that Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) receive their full Prospective Payment System (PPS) rate when providing covered services to Medicaid beneficiaries.
  - Section 1902(bb) of the Social Security Act

- In managed care, FQHCs and RHCs are entitled to supplemental payments to account for the difference between their PPS rate and payment received from a managed care plan ("wrap payment" currently from the State).

Delegation of FQHC-PPS Responsibility

- Current CMS policy (available here) allows for simplifications through an approved Alternative Payment Model (APM) in the State Plan.
  - Each FQHC/RHC must agree to use the APM, and
  - APM results in a FQHC/RHC receiving at least full PPS.

- But, CMS requires states to retain reconciliation and oversight responsibilities for PPS payments under an approved APM.
  - This, along with the voluntariness requirement above, diminishes the utility of PPS delegation via an APM.

Delegation of FQHC-PPS Responsibility

- Evolving area currently subject to litigation.
- Recent Fifth Circuit ruling that the Medicaid Act did not prohibit Texas from requiring its managed care plans to fully reimburse FQHC/RHCs at the PPS rate.
  - *Legacy Community Health Services v. Smith* (881 F.3d 358)
- Petition for review of this decision currently pending at the U.S. Supreme Court.

Committee Discussion

Next Meeting

Pros, Cons and Considerations of Services Carved out of Medi-Cal

Recap of Committee Discussion

Next Steps