Medi-Cal Explained FACT SHEET

Medi-Cal Payment to Managed Care Plans — Current Process and Challenges

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Introduction

Over the past decade, the California Department of Health Care Services (DHCS) has been steadily moving the Medi-Cal program to managed care from the fee-for-service model (FFS). As of 2018, DHCS had contracted with Medi-Cal managed care plans (MMCPs) to deliver at least some covered benefits in all 58 counties, accounting for 82% of all Medi-Cal enrollees.[1]

Under a managed care contract, an MMCP provides all covered services for a monthly capitation payment, also referred to as a per-member per-month (PMPM) payment.[2] Rates paid to doctors and hospitals in managed care networks are related to the monthly capitation payment received by the managed care plan from DHCS, but each MMCP has authority and responsibility to negotiate payment rates with providers in its county or service area. Many plans attempt to link their provider contracts to the state fee schedule, which is used in the FFS program. However, plans are also required to have enough contracted providers to ensure appropriate levels of access to care for their members. Because of wide variation in the availability of providers who will accept the state FFS payment rates, many plans pay providers at rates above this fee schedule.

Under the monthly capitation arrangement, the goal is to promote a system of managed care that is focused on providing quality and access to preventive care and medically necessary services and move away from a model in which payment is based on the volume of services provided. Aligning financial incentives helps reduce unnecessary use of high-cost services, such as hospital or skilled nursing facility stays. To ensure that plans do not unreasonably limit care to save money under capitation, DHCS has implemented monitoring programs of the MMCPs related to quality of care, access, and member grievances. The oversight combined with the financial incentives is intended to deliver care that is more cost effective and achieves better outcomes for members. This publication outlines how the Medi-Cal managed care capitation payment setting process works in California.

How Monthly Capitation Rates Are Set

The Centers for Medicare & Medicaid Services (CMS) sets federal rules that states must follow when contracting with MMCPs. The CMS rate-setting guide requires states to establish monthly

capitation rates that are expected to cover all projected costs of care for the services and populations covered under the MMCP contract. The state must obtain an independent actuarial certification of those rates. The actuarial certification contains detailed explanations of the data used to project the costs (e.g., cost of services, past and expected use of services) and lists additional factors (e.g., expected policy changes) that are included to determine the rates to meet this standard.

Separate payment rates are developed for groups of beneficiaries, which are called category of aid (COA). In California, the COAs covered under the MMCP contract include the following in all counties:

- Adult
- Child
- Affordable Care Act (ACA) optional expansion
- Aged/person with disability — Medi-Cal only
- Disabled dual eligible
- Aged dual eligible
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Maternity

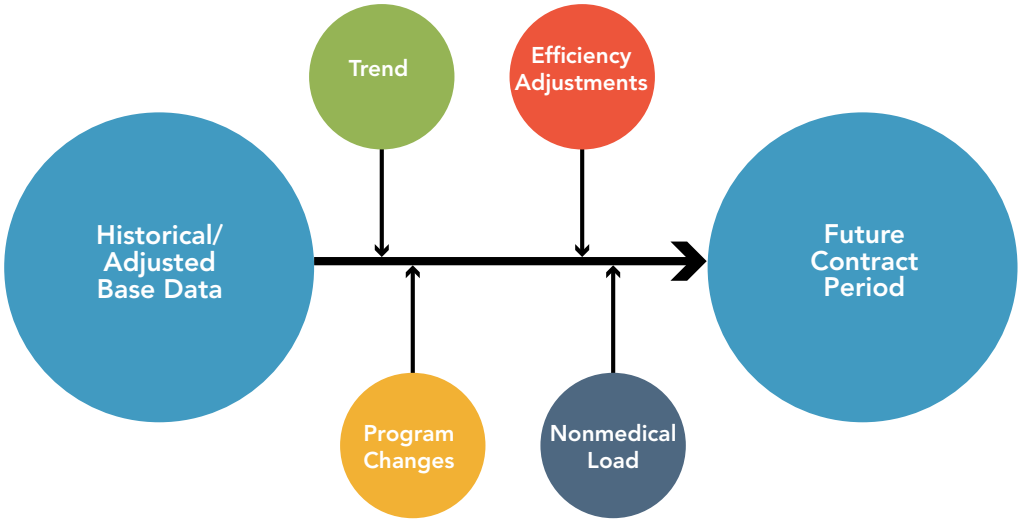
Certain managed care plans cover more than the populations listed above. Plan- or county-specific COAs may also include:

- Long-term care Medi-Cal only
- Long-term care dual eligible
- AIDS Medi-Cal only
- AIDS dual eligible

The current DHCS approach to MMCP rate setting uses health plan costs and data on use of services to establish the "base period." This base year is then adjusted to create the final monthly capitation payment as follows:

- DHCS collects data on actual plan medical costs and services provided from the previous calendar year (known as encounter data).
- DHCS also collects actual plan administrative costs from the previous calendar year.
- The data are analyzed, adjusted to address outliers, and validated, becoming the base period data.
- The base period data are updated to include trend adjustments for anticipated changes in utilization or costs; updates to nonmedical load (changes in program or administrative costs); legislative or administrative program changes (such as new benefits); and efficiency adjustments, which are expectations of the cost savings MMCPs can achieve for specific services.

Figure 1. Rate Development Process, 2018



Source: Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs California Health Care Foundation, 2018.

Adjusting for Program Changes

Program changes that impact cost and use of services require monthly capitation payment adjustments. Program changes can have either a direct or an indirect impact on expected costs to the plan and include the addition, modification, or elimination of a benefit or service; a provider FFS rate change (which impacts the rate those providers expect Medi-Cal to pay); a COA eligibility change; or an additional requirement placed on MMCPs (e.g., requiring health risk assessments for new plan enrollees). Program adjustments may take effect before the next rate development process, in which case the monthly capitation adjustment would operate retroactively.

Supplemental Rates

In addition to the base monthly capitation payments MMCPs receive, DHCS also makes supplemental payments for other covered benefits. As with risk adjustment, this applies only in counties where there is more than one MMCP.

When DHCS determines, based on historical data, that variation exists among MMCPs in the concentration of high-cost services, and it would be difficult for DHCS to project how that variation would impact each MMCP in a particular year, it can make supplemental payments. The most frequent of these supplemental payments is referred to as the maternity "kick" payment. For this maternity kick category, DHCS pays MMCPs a supplemental payment for all live births, covering both facility and physician costs.

DHCS also develops supplemental payments when new services or benefits are added and there are not adequate cost and utilization data available to incorporate these costs into the monthly capitation payment. Examples of this type of supplemental payment include the very expensive hepatitis C drugs that were approved for use starting in 2013, the inclusion of behavioral health treatment for children with autism spectrum disorder that began on July 7, 2014, and the inclusion of community-based adult services as a managed care benefit in 2013.

Looking Ahead

A key challenge in the current capitation payment approach is the lack of incentive for MMCPs to reduce costs over time. DHCS currently employs an experience-based approach to setting monthly capitation payments, as described above. This means that when an MMCP reduces costs through effective cost-management techniques, the base period costs reflect that decreased spending, which in turn results in reduced capitation levels in future years. This process, referred to as premium slide, fails to reward the MMCP for providing cost-effective care.

New incentives for MMCPs could reduce health care spending through greater use of value-based payments. There are several options, including a shared savings arrangement in which MMCPs would retain a percentage of savings above a predetermined benchmark. Another is the use of in-lieu-of services, which would allow MMCPs to include certain nontraditional or alternative services in their utilization data, as long as those services are cost-effective.

The current process to develop monthly capitation payments requires periodic supplemental data requests (SDRs) to address the constantly changing Medi-Cal environment and its impact on the costs plans incur. The SDRs are considered new benefits and incorporated into managed care either by federal requirements (e.g., ACA's essential health benefits) or by state action (e.g., movement of the Healthy Families Program into Medi-Cal). This introduces a significant administrative burden. A different process could align the SDRs with the annual capitation rate-setting process to minimize administrative time and effort.

Finally, the consistency and reliability of the MMCP encounter data that support the costs and utilization information submitted for the base period remain an area of high interest. The federal government will start to impose fines in the coming years on states that do not have adequate encounter data.[3]

Endnotes

1. "Medi-Cal Certified Eligibles - Recent Trends," California Department of Health Care Services, accessed November 29, 2018, www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx.
2. "Medi-Cal Managed Care Boilerplate Contracts," California Department of Health Care Services, last updated March 13, 2014, www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
3. *CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions*, The Kaiser Commission on Medicaid and the Uninsured, June 2016, http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care.

Acknowledgments

About Health Management Associates

Health Management Associates (HMA) is an independent national research and consulting firm in the health care industry. HMA helps clients stay ahead of the curve in publicly funded healthcare by providing technical assistance, resources, decision support and expertise.

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Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care-related organizations.

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.