Delivery System and Payment Reform: The Challenge for the Future

Don Kingdon, PhD
Harbage Consulting, Sacramento, CA

Federal Perspectives

- Exposure to increases in Medicaid and Medicare expenditures at a state and national level due to the ACA Medicaid coverage expansion and an aging demographic
- Fee-for-service payments for units of care are costly, administratively inefficient and incentivize volume of care rather than risk adjusted care (the right care, the right provider, at the right time and at the right price)
- Medicaid Information Technology Architecture incentives, HIPAA uniform coding requirements and Meaningful Use penalties and incentives lay the groundwork for uniform information informed quality and payment incentive structures

State Perspectives

- An emphasis under the provisions of a 1115 waiver on Medi-Cal managed care plan enrollment and capitated payments to contracted plans
- Cal Medi-Connect partnership with CMS to promote Medicare/Medicaid managed care plan enrollment and blended capitation rates
- Medi-Cal MH and AoD program and sales tax funding realigned to counties
- Modernization of state data systems in the context of capitation and health plan performance evaluation

County Perspectives

- Maximization of appropriate federal reimbursement in the context of the county Medi-Cal MH/AoD program realignment and certified public expenditure requirements
- Efficient, timely and accurate federal payments
- Appropriate and clear administrative, quality and results expectations to be addressed in the context of continuous quality improvement
- Proposition 30 state constitution and mandates protections

Federal Payment Requirements

- Medicare coverage and rates are determined by CMS and administered through a contracted fiscal intermediary or health plan
- Medicaid is a federal/state program subject to a CMS approved state plan outlining coverage, provider and reimbursement requirements unless specific provisions of the SSA are waived
- Medicaid requires a state match and allows for local government entities to participate using local tax funds through CPE or an IGT

Federal Payment Alternatives

- CMS can approve alternatives to the required state plan coverage and rates through waivers
- CMS can waive specific provisions of the SSA related to Medicaid freedom of choice and any qualified provider requirements
- Such waivers usually entail the addition of federal managed care requirements related to access, beneficiary protection, reimbursement and quality improvement

Medicaid Reimbursement

- States are reimbursed by CMS on a interim basis for covered services delivered to covered beneficiaries at the approved FMAP
- State claims for federal funds are subject to validation, reconciliation and cost settlement
- States may enter into non-risk or risk based agreements with CMS for federal reimbursement. FFS is an example of a non-risk payment arrangement and capitation is an example of a risk based payment

Medi-Cal County MHP Reimbursement

- The fiscal provisions for MHP federal reimbursement are linked to the 1915(b) waiver. The state plan includes a rate setting methodology which would be implemented absent the waiver
- The coverage, quality and provider requirements are linked to the state plan, the waiver and PIHP and managed care contract requirements
- County MHP financial participation is governed by the federal CPE interim and reconciled payment requirements and the state's FMAP percentages
- Counties use their realignment and MHSA funds as "cash flow" while waiting for federal reimbursement through claims reimbursement and final cost settlement

MHP Provider Requirements

- The MHP is required to address network adequacy, access and beneficiary protection consistent with the federal managed requirements unless a federal provision is waived such as comparability of services
- The MHP pays for inpatient and outpatient services using rates set either on a geographic basis or by each MHP through provider contracts
- Provider rates are subject to the Medicaid requirements and are determined and administered by the MHP through provider contracts
- State regulations differentiate between “network” and “organizational” providers from a administrative and reimbursement perspective

Delivery System Perspectives

- Managing care and risk requires monitoring and addressing prevalence, penetration, utilization and outcomes (including cost)
- Performance goals can be established for each of these areas including ; minimize false positives and negatives, maximize planned over unplanned service utilization, defined results (including cost) at the individual and risk adjusted cohort level
- Payment systems can be designed and implemented that incentivize providers to address these performance goals
- Each payment system will include a mechanism for the payer to address cost containment for the services delivered either through risk based contracts or through UR/UM, audit and disallowance
- **Risk based payment structures require significant changes in what you pay attention to and how you approach beneficiaries and providers**

Payment Perspectives

- Fee-for-Service payments are retrospective reimbursements for each unit of service or contact delivered at an agreed upon rate
- Prospective payments are reimbursements for an agreed upon array of services rather than for each unit or contact within the array
- Case rates are pre-paid reimbursements to providers for each enrolled and served consumer
- Capitation rates are pre-paid payments based on covered beneficiary enrollment

Payment Incentive Examples

- Fee-For-Service partial payment for each contact with the balance paid when agreed upon metrics are reached (pay for performance)
- Prospective payments adjusted to promote reduced length of stay, decreased readmissions, discharge coordination, utilization management goals or to address specific diagnostic conditions
- Case rates developed with an at risk component for higher level care, unplanned service utilization results, or diagnosis
- Per enrolled beneficiary capitation rates that may include a quality withhold paid when agreed upon metrics are met

Implications Discussion

- California has elected to transfer risk and responsibility for Medi-Cal Specialty MH and Drug Medi-Cal coverage to the counties along with dedicated tax revenues that are not subject to annual appropriation.
- Does the current county and cost based, FFS MH system get us where we want to be over the next five years?
- What are the implications for the DMC program associated with implementing a Medi-Cal managed care demonstration through the counties?
- Is a transition from a non-risk to an at risk federal payment structure necessary?

For more information, visit:

www.harbageconsulting.com