May Revise state Fiscal Year (FY) 2020-21
Medi-Cal Local Assistance Estimate
Policy Change 258; Managed Care Efficiencies

POLICY ANALYSIS: Medi-Cal Managed Care Efficiencies — Implementing Maximum Fee Schedule at APR-DRG for Inpatient Services for Private/District hospitals

Overview

The California Department of Health Care Services (DHCS) has proposed, effective January 1, 2021, to implement a maximum fee schedule (permitted by 438.6(c)(1)(iii)(c)) for Medi-Cal managed care plans to pay for inpatient hospital services. This would do two things immediately and have several long-term negative consequences. The immediate impacts:

1. A reduction in resources by an estimated $500 million that Medi-Cal managed care plans pay for patient care (Note: Of the $500 million reduction, Policy Change (PC) 258 scored savings of only $91 million from the General Fund in state FY 2020-21).
2. Implements a "onesize fits all" contractual requirement that eliminates Medi-Cal managed care plans' incentive to enter value-based contracts with providers that drive patient care coordination.

Over the longer term, this is likely to lead to myriad negative impacts on California's health care system including:

1. Replacement of long-standing value-based contracts between Medi-Cal managed care plans and hospitals with volume-based, fee-for-service contracts
2. Higher monthly insurance premiums for Californians, because as Medi-Cal pays less, other insurers will end up paying more
3. Fewer network providers, resulting in a more fragmented Medi-Cal managed care system
4. A loss of years of gains that have made California a national leader in the shift from volume-driven care to value-driven care
5. Higher inpatient utilization by Medi-Cal beneficiaries

Medi-Cal Managed Care Background and Benefits

- Medi-Cal now cares for more than 10 million Californians via the managed care delivery system. DHCS has historically advocated for novel payment systems, like managed care, that foster care coordination. This was most recently seen in the Medi-Cal 2020 Waiver. As a result, over the years Medi-Cal managed care plans have incentivized population-based payment methodologies to drive better care coordination and higher quality outcomes when compared to the Medi-Cal fee-for-service (FFS) delivery system.
- Benefits of a managed care system include localized control of the delivery of care. This includes risk-based arrangements between hospitals and health plans that share the responsibility of keeping Medi-Cal beneficiaries healthy and out of the hospital. Preventing avoidable hospital admissions correlates with better health outcomes. And by shifting from volume-based FFS reimbursement structures, health plans have been able to realize savings for the Medi-Cal delivery system.

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Proposal Details

- Effective January 1, 2021, DHCS is proposing to direct Medi-Cal managed care plans to pay private and district hospitals for inpatient care at a maximum fee schedule linked to the FFS All Patients Refined Diagnosis Related Groups (APR-DRG) rates. The FFS APR-DRG rate is the non-contracted rate.
- DHCS estimates the policy change to generate savings in state FY 2020-21 of $283 million total fund ($91 million general fund). This reflects only a partial year impact. Annually, this would cut $500 million in payments.

Impact

- On health plans:
  - Reduces total revenue available to pay for patient care
  - Eliminates flexibility with network provider contracts for inpatient services
  - Strain a health plan's ability to maintain an adequate network

- On hospitals:
  - Caps Medi-Cal managed care reimbursement at the non-contracted rate
  - Leads to higher inpatient utilization from Medi-Cal beneficiaries resulting from loss of incentives to manage patient care
  - Discourages contracting, which could lead to inadequate provider networks

- On health care enrollees:
  - Fewer in-network hospitals for Medi-Cal managed care enrollees to receive inpatient care
  - Higher monthly premiums because as Medi-Cal pays less, other insurers will end up paying more

Concerns

- Managed care inpatient reimbursement would be capped at the non-contracted rate, which has been frozen since state FY 2012-13.
- Loss of incentive between health plans and hospitals to share risk among payers and providers
- Proposed methodology calls into question the actuarial soundness of managed care rates
- Adds considerable challenges for Medi-Cal managed care plans to maintain an adequate network
- A financial crisis is the wrong time to overhaul the system: Hospitals would lose an estimated $500 million annually by implementing these changes