Hospital Fee Program and Medi-Cal Update
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California Hospital Association

Agenda
• Hospital Fee Program
  • Quick overview
  • Medicaid Managed Care Final Rules
  • Network Provider Definition
  • Hospital Fee Program VI Update
• Medi-Cal Update
  • Medi-Cal’s use of the 1115 Waiver Authority
  • Future of Medi-Cal

Hospital Fee Program Overview
Hospital Fee Program Overview

- Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital Fee Program in state law
- The program period from January 1, 2017, to June 30, 2019, is referred to as the Hospital Fee Program V
- The Hospital Fee Program V model was approved by Centers for Medicare & Medicaid Services (CMS) in December 2017

Basic Funding for the Hospital Fee Program V:

Available Revenue

- Fees collected based on approved CMS model (45%)
- Non-Medi-Cal Fee-For-Service IP Days
- Non-Medi-Cal Managed Care IP Days
- Medi-Cal FFS IP Days
- Medi-Cal Managed Care IP Days
- Federal Funds (55%)

Basic Funding for the Hospital Fee Program V:

Available Revenue for Supplemental Payments: $8B

- Less 24% of Net Benefit, and Admin Costs

Hospital Fee Program Overview

Payment structure for the Hospital Fee Program V:

Supplemental Payments

- Hospital Fee Program V Payments

Type of Payment
- FFS Supplemental Payments (50%)
- MC Pass Through Payments (25%)
- MC Directed Payments (25%)

Payment Methodology
- Based on 2013 Utilization
- Actual contracted utilization for Network Providers
Medicaid Managed Care
2016 Final Rule ("Final Rule")

- Pass-through payments (42 CFR §438.6(d)) were deemed impermissible under the Final Rule, and subject to a 10-year phasedown beginning 7/1/2017.
- Imposes an annual cap on pass-through payments equal to the aggregate pass-through payment amount submitted to CMS as of July 5, 2016.
  - Approximately $2 billion in California.
- Remaining Medi-Cal managed care supplemental payments must be made through a new permissible methodology (e.g. Directed Payments).

Medicaid Managed Care Final Rule

- The Final Rule (§438.6(c)) provides states with three options to direct payments:
  1. Value-based purchasing models;
  2. Delivery system reform and/or performance improvement initiatives;
  3. Minimum or maximum fee schedules, and uniform dollar or percent increases.
- All Directed Payments can only be for hospitals considered a “Network Provider” (will discuss later).
$2 billion Directed Payment method
- 70% IP | 30% OP

$2 billion Pass-Through method
- Uniform add-on per inpatient day and outpatient visit
- Network Providers for Contracted Services
- Current Utilization Data
- Only Paid/Partially Paid Claims

$4 Billion Managed Care Supplemental Payments

Pass-Through Payments
- Uniform add-on per inpatient day and outpatient visit
- No requirement to be a Network Provider
- Historic Utilization Data
- All Claims

Medicaid Managed Care Final Rule

• Per SB 239, 100% of Medi-Cal managed care supplemental payments must be spent on hospital services
• Risk losing $2 billion in supplemental directed payments if cannot guarantee all $2 billion goes toward hospital services
• After extensive advocacy by CHA, CMS granted flexibility in implementing retrospectively and eliminating financial risk for hospitals and health plans
Network Provider Definition
SFY 2017-18 and SFY 2018-19 only

On Oct. 5, 2018, DHCS released a Memorandum regarding the definition of a contracted service performed by a network provider for SFY 2017-18 and SFY 2018-19.

Hospitals should include the minimum criteria in all contractual agreements with Medi-Cal managed care plans or their delegated entities, including agreements that are retroactively effective back to July 1, 2017.

Inclusion of minimum criteria is necessary to qualify for supplemental Medi-Cal managed care payments under the Directed Payment method.

In order for the eligible service to count in the Directed Payment program for SFY 2017-18 and SFY 2018-19, the hospital’s agreement must:

1. Cover a defined population of Medi-Cal beneficiaries
2. Cover a defined set of one or more hospital services
   - Ex: emergency visits, transplants or burn cases
3. Specify rates of payment, or include a defined methodology for calculating specific rates of payment for services performed
4. Be for a set duration of at least 120 days.
   - Ex: Effective Jan. 1, 2018 – Apr. 30, 2018
Network Provider Definition
SFY 2017-18 and SFY 2018-19 only

The agreement must NOT:

1. Be limited to a single patient,
2. Be limited to a single case or instance only,
3. Permit payment to be negotiated on a per patient or single instance basis
4. Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement

Network Provider Definition
SFY 2017-18 and SFY 2018-19 only

- In delegated arrangements there must be a demonstrable "unbroken contracting path" between the primary Medi-Cal managed care plan and the hospital for:
  - The service rendered,
  - The member receiving the service,
  - The applicable date of service.

- "Unbroken contracting path" means a sequence of contracts linking the Medi-Cal managed care plans and a direct subcontractor, or a series of subcontractors, to the hospital

Network Provider Definition
SFY 2017-18 and SFY 2018-19 only

- Preliminary Results from DHCS for SFY 2017-18 Phase 1:

<table>
<thead>
<tr>
<th>DHCS Estimated SFY 2017-18</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Utilization (Days/Visits)</td>
<td>Approx. 875k days</td>
<td>Approx. 1.3M visits</td>
</tr>
<tr>
<td>Percent Contracted</td>
<td>92%</td>
<td>89%</td>
</tr>
<tr>
<td>Estimated Directed Payment Add On</td>
<td>$815/day</td>
<td>$105/visit</td>
</tr>
</tbody>
</table>

Note—Hospitals will receive their actual Phase 1 schedules from DHCS in August
Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

• DHCS has submitted the Rate Year 2019-20 (7/1/19-12/31/20) Directed Payment proposal to CMS
• Requirement still exists where “the State will direct Medi-Cal Managed Care Plans (MCPs) to make the directed payments to the class of private hospitals”…“based on their utilization of contracted services for network providers”
• DHCS’ existing contracts with MCPs include many contractual requirements of subcontractors that have historically not been strictly enforced

Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

• On Jan. 17, 2019, DHCS released an All Plan Letter (APL) 19-001 which provided guidance to MCPs regarding the definition of Network Provider status, effective July 1, 2019.
• APL 19-001 includes a 60-day time frame for MCPs to come into compliance
• Hospital should include the required characteristics as defined in APL 19-001, in their contracts with MCPs or their delegated entities
• Inclusion of required characteristics is necessary to qualify for Medi-Cal managed care supplemental payments under the Directed Payment method
Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

In order for the eligible service to count in the Directed Payment program beginning in SFY 2019-20, the hospital’s agreement must:

1. Be a written executed agreement with the MCP or a Subcontractor of the MCP and include all requirements of Attachment A of the APL 19-001;
   • Attachment A includes 31 items in a checklist format.
   • Examples include: (#1) specify services under the contract, (#7) requires Hospitals to comply with all monitoring provisions of the MCP contract, (#8) maintaining records for 10 years, (#17) providing interpreter services, (#18) grievances/appeal process, (#27) provision prohibiting balance billing, etc.

2. They must be enrolled in accordance with APL 17-019,
   • This APL details the responsibilities of the MCPs to screen and enroll all of their network providers pursuant to the Final Rule
   • MCPs have the option to develop and implement a screening and enrollment process that meets the requirements of the APL, or they may utilize the DHCS enrollment process

3. They must be reported on the MCP’s 274 File submitted to DHCS in accordance with APL 16-019;

4. They must be included in the MCP’s Network Adequacy filings (pursuant to APL 19-002)
3. They must be reported on the MCP's 274 File submitted to DHCS in accordance with **APL 16-019**:
   - This APL details the requirements of MCPs to submit their provider data to DHCS
   - The format that DHCS uses is the Accredited Standards Committee (ASC) X12N 274 (also referred to as the 274-File)
   - The Provider File (274-File) is required to be submitted to DHCS on a monthly basis, and DHCS uses it to assess network adequacy

4. They must be included in the MCP's Network Adequacy filings (pursuant to **APL 19-002**)
   - APL 19-002, released January 30, 2019, supersedes APL 18-005
   - This APL details the reporting requirements for MCPs for the Annual Network Certification process
   - MCPs are required to submit network certification documents to DHCS annually, and they are required to submit documentation to DHCS whenever there is a change in their network.

**Attachment A of the APL 19-001:**

- **Specification of the services to be provided by the Network Provider.**
  Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.

- **Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.

- **Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.

- **Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.

- **Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.

- **Network Provider’s agreement to submit reports as required by Contractor.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

- **Specification that the Network Provider must comply with all monitoring provisions of the MCPs’ contracts and any monitoring requests by DHCS.**
  Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
Network Provider Agreement must contain:

1. Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

2. Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out

3. Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider.

4. Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

5. Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System.

6. Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.

Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

Effective July 1, 2019 (SFY 2019-20)

Network Provider Definition

Attachment A of the APL 19-001:

a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller, or their designees.

b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California.

c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

d) Including all Encounter Data for a period of at least ten (10) years.

e) Including all Encounter Data for a period of at least ten (10) years.

f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time.

g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct

h) The Network Provider Agreement, at minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider.

2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes.

3) Contractor's actions/remedies if Network Provider's obligations are not met.

4) Contractor's actions/remedies if Network Provider's obligations are not met.

5) A mechanisms (including but not limited to access requirements and state's right to monitor, as set forth in applicable regulations) for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to access requirements and state's right to monitor, as set forth in applicable regulations.

6) In a form maintained in accordance with the general standards applicable to such book or record keeping.

7) In a form maintained in accordance with the general standards applicable to such book or record keeping.

8) In a form maintained in accordance with the general standards applicable to such book or record keeping.

9) In a form maintained in accordance with the general standards applicable to such book or record keeping.

10) In a form maintained in accordance with the general standards applicable to such book or record keeping.
Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination.

Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.

Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.

A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS.

Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.

A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS.

Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.

A provision prohibiting Network Providers from balance billing a Medi-Cal member.

Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.

A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training.

Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.

A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism.

Citation: Health & Safety Code §1367(h)(1).

A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.

A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights.

Citation: Health & Safety Code §1375.7

Updates on the next Hospital Fee Program VI

- Hospital Fee Program VI is currently under development by both CHA and DHCS.
- Next Program VI will be from 7/1/19-12/31/21
- Significant risks to maintain the net benefit level:
  - Declining Medi-Cal population
  - Declining Federal Medical Assistance Percentage
  - Decreases in Medicare reimbursement
  - More Fees needed for next program
Hospital Fee Program VI
July 1, 2019-December 31, 2021

Draft payment structure of the Hospital Fee Program VI:

<table>
<thead>
<tr>
<th>Supplemental Payments</th>
<th>Type of Payment</th>
<th>Payment Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Fee Program VI Payments</td>
<td>FFS Supplemental Payments (35-40%)</td>
<td>Based on 2016 Utilization</td>
</tr>
<tr>
<td></td>
<td>MC Pass Through Payments (25%)</td>
<td>Based on TBD Utilization</td>
</tr>
<tr>
<td></td>
<td>MC Directed Payments (35-40%)</td>
<td>Actual contracted utilization for Network Providers</td>
</tr>
</tbody>
</table>

**Estimated timeline:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Upper Payment Limit Validation</td>
<td>Feb-May 2019</td>
</tr>
<tr>
<td>2 OSHPD Data Validation</td>
<td>Apr 2019</td>
</tr>
<tr>
<td>3 UPL Development—Hospital Fee Program VI</td>
<td>May-Jun 2019</td>
</tr>
<tr>
<td>4 Model Development—Hospital Fee Program VI</td>
<td>Jul-Aug 2019</td>
</tr>
<tr>
<td>5 Deadline for DHCS to Submit Program VI to CMS</td>
<td>Sep 2019</td>
</tr>
<tr>
<td>6 Historic CMS Approval*</td>
<td>Mar-Jun 2020</td>
</tr>
<tr>
<td>7 FFS Payments Begin (90 days post CMS approval)</td>
<td>Jul-Sep 2020</td>
</tr>
<tr>
<td>8 Managed Care Payments Begin</td>
<td>Nov 2021</td>
</tr>
</tbody>
</table>

*Estimated CMS Approval of Tax Waiver and (2) FFS State Plan Amendments only

Medi-Cal Updates

§1115 Waivers in Medi-Cal
What is an §1115 Demonstration Waiver?

Table 1: Federal Authority Options

<table>
<thead>
<tr>
<th>State Plan</th>
<th>Medicaid Waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Plan is a contract between the state and the Federal Government</td>
<td>Medicaid waivers are cost-effective or cost-neutral</td>
</tr>
<tr>
<td>States may formally request to waive certain Medicaid federal requirements</td>
<td>Medicaid waivers are time-limited depending on the waiver type (approvals range from two years to five years)</td>
</tr>
<tr>
<td>State Plan includes populations to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative requirements for the State</td>
<td>States must meet certain requirements to evaluate and measure the impact of the waiver</td>
</tr>
</tbody>
</table>

Main Medicaid waiver types:

1. §1115 Demonstration Waivers
2. §1915(b) Managed Care Waivers
3. §1915(c) Home and Community Based Services Waivers
4. Combined §1915(b) and §1915(c) Waivers

No cost or budget requirements

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Medi-Cal use of the §1115 Waiver

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Medi-Cal §1115 Waivers</th>
<th>Waiver FFP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2010</td>
<td>Medi-Cal Hospital/Uninsured Demonstration</td>
<td>$3.8 Billion</td>
</tr>
<tr>
<td>2011-2015</td>
<td>Bridge to Reform (BTR) Waiver</td>
<td>$9.9 Billion</td>
</tr>
<tr>
<td>2016-2020</td>
<td>Medi-Cal 2020 Waiver</td>
<td>$7.1 Billion</td>
</tr>
</tbody>
</table>

Medi-Cal Updates

Future of Medi-Cal
Future of Medi-Cal

- Challenges with continuing large §1115 Waivers
  - Budget Neutrality Issues (§1915b, Managed Care)
- State’s goals
  - Alignment of existing and new Waivers

Future of Medi-Cal

<table>
<thead>
<tr>
<th>Medi-Cal 2020</th>
<th>New Authority</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>WPC</td>
<td>§1915b (Managed Care)</td>
<td>Integrated Payment Models Provider Cost Inclusion Individual Requests Detailed Approaches to Implementable Provider Diversity</td>
</tr>
<tr>
<td>PRIME-NOPH</td>
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</tr>
<tr>
<td>GPP</td>
<td>§1115 Waiver</td>
<td>Delayed Approaches to Implementable Provider Diversity</td>
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</tbody>
</table>

Future of Medi-Cal

- Stakeholder Process and Estimated Timeline:

  1. DHCS conducted a statewide assessment of Medi-Cal via the Care Coordination Group (CY 2018)
  2. DHCS worked with California Association of Public Hospitals/Health Systems and District Hospital Leadership Forum on the PRIME replacement proposal (Managed Care) to submit to CMS (6/30/19) Spring 2019
  3. DHCS to introduce full plan to the Stakeholder Advisory Committee Oct 2019
  4. Stakeholder engagement through small workgroups Oct 2019-June 2020
  5. Submit §1115 and §1915b Proposals to CMS June 2020
Questions?

Raise your hand or submit a question at www.menti.com and enter code 29 15 36

Thank You

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