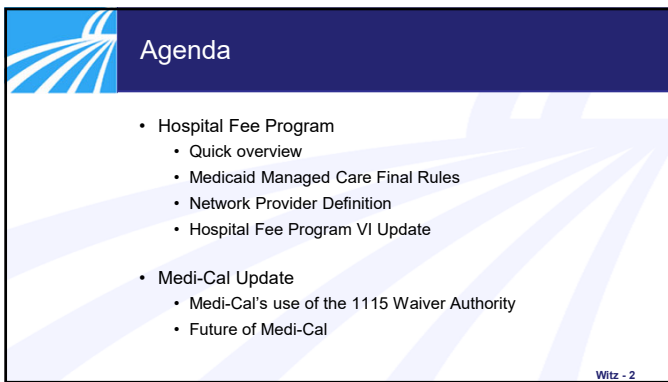
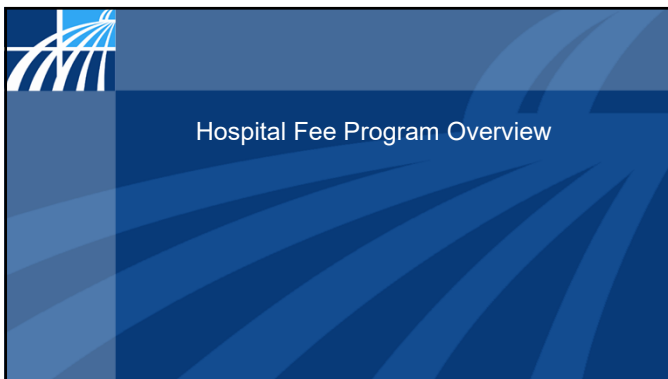



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Hospital Fee Program Overview

- 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

Witz - 4

4



Hospital Fee Program Overview


Basic Funding for the Hospital Fee Program V:

Fee Structure*	Revenue Source	Available Revenue
Non-Medi-Cal Fee-For-Service IP Days	Fees collected based on approved CMS Model (45%) (\$4B)	Available Revenue for Supplemental Payments (\$8B)
Non-Medi-Cal Managed Care IP Days		
Medi-Cal FFS IP Days		
Medi-Cal Managed Care IP Days		
Federal Funds (55%) (\$5B)		Less 24% of Net Benefits and Admin Costs (\$1B; State)

*Based on 2013 data

Witz - 5

5



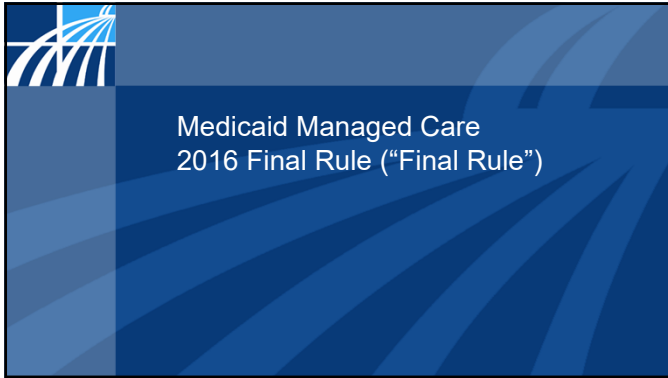
Hospital Fee Program Overview

Payment structure for the Hospital Fee Program V:

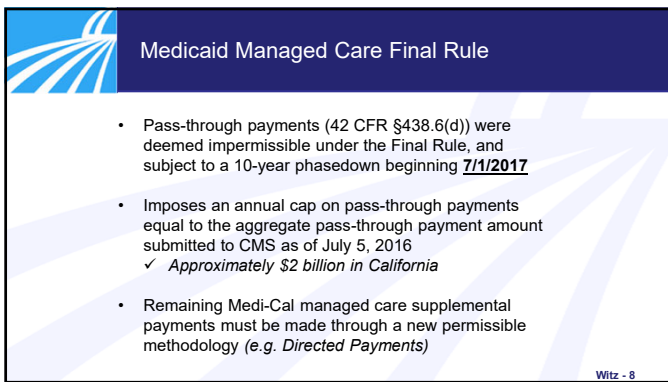
Supplemental Payments	Type of Payment	Payment Methodology
Hospital Fee Program V Payments	FFS Supplemental Payments (50%)	Based on 2013 Utilization
	MC Pass Through Payments (25%)	Based on 2013 Utilization
	MC Directed Payments (25%)	Actual contracted utilization for Network Providers

Witz - 6

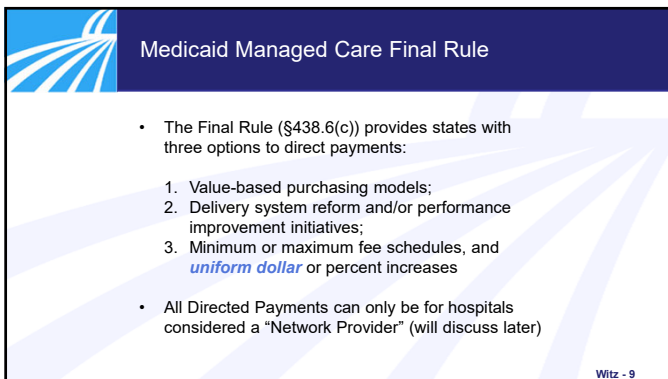
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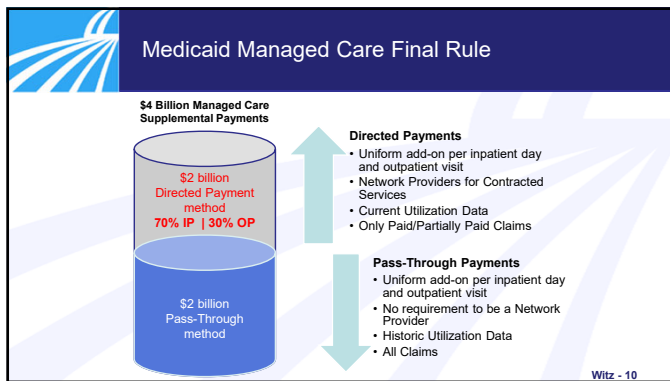
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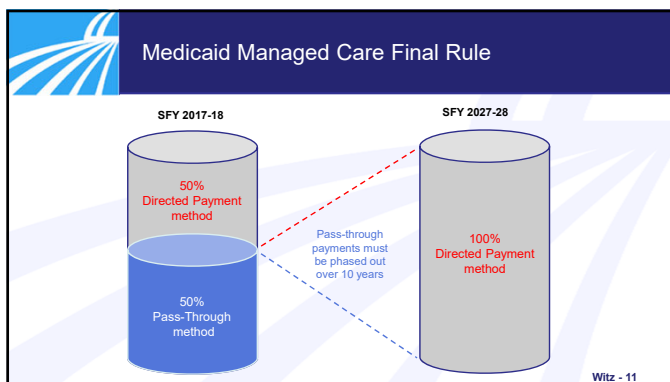
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- ### Medicaid Managed Care Final Rule
- Per SB 239, 100% of Medi-Cal managed care supplemental payments must be spent on hospital services
 - Risk losing \$2 billion in supplemental directed payments if cannot **guarantee** all \$2 billion goes toward hospital services
 - After extensive advocacy by CHA, CMS granted flexibility in implementing retrospectively and eliminating financial risk for hospitals and health plans
- Witz - 12


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Network Provider Definition

SFY 2017-18 and SFY 2018-19 Only

13




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

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Network Provider Definition


SFY 2017-18 and SFY 2018-19 only

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**:

- Cover a defined population of Medi-Cal beneficiaries
- Cover a defined set of one or more hospital services
 - Ex) emergency visits, transplants or burn cases
- Specify rates of payment, or include a defined methodology for calculating specific rates of payment for services performed
- Be for a set duration of at least 120 days.
 - Ex) Effective Jan. 1, 2018 – Apr. 30, 2018

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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

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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

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Network Provider Definition

SFY 2017-18 and SFY 2018-19 only

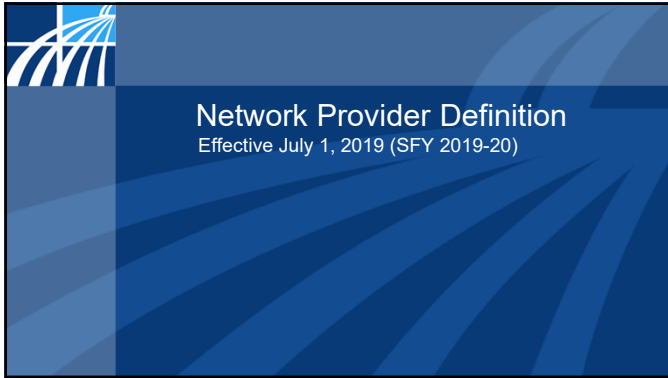
- Preliminary Results from DHCS for SFY 2017-18 Phase 1:

DHCS Estimated SFY 2017-18, Phase 1 (7/1/17-12/31/17)	Inpatient Pool	Outpatient Pool
Total Utilization (Days/Visits)	Approx. 975k days	Approx. 3.2M visits
Percent Contracted	92%	89%
Estimated Directed Payment Add-On	\$815/day	\$105/visit

Note—Hospitals will receive their actual Phase 1 schedules from DHCS in August

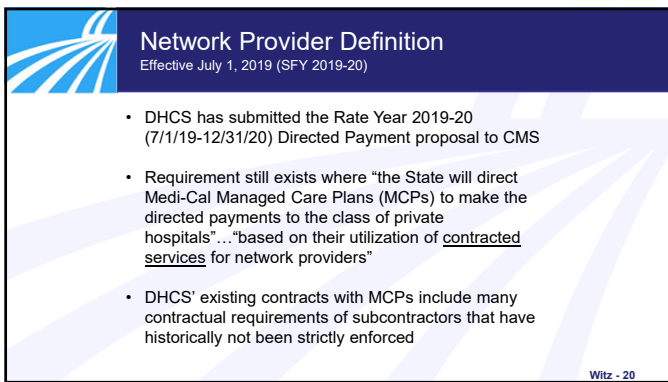
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Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

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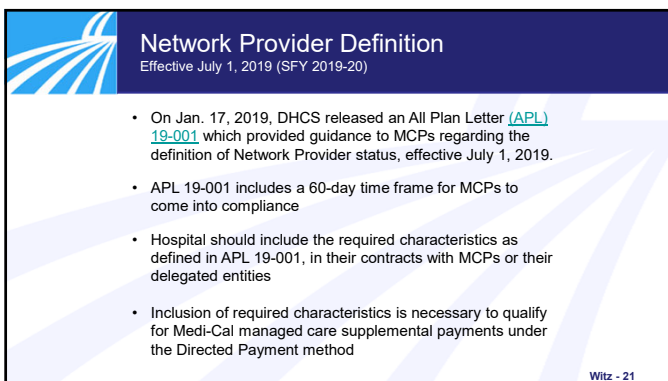


Network Provider Definition
Effective July 1, 2019 (SFY 2019-20)

- 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

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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

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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*

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

In addition to the requirements of Attachment A of APL 19-001, in order for hospitals to be considered a Network Provider beginning in SFY 2019-20, they **must also meet the following requirements:**

2. They must be enrolled in accordance with APL 17-019,
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)

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

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

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

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

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

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

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
1	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.3 and Title 22, CCR, Sections 53250(c)(1) and 53867.
2	Specification that the Network Provider Agreement must be governed by and interpreted 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.
3	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, Provisions 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the terms 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.
5	Language comparable to Exhibit A, Attachment 6, 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.
6	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.
7	Specification that the Network Provider must comply with all monitoring provisions of the MCP's contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7.42 (748-438.30), and Title 22, CCR, Sections 53250(c)(7) and 53867.

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available 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 Exhibit E, Attachment 2, Provision 20, Inspection Rights.	
a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), 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) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.	
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 initiation 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 Contractor to terminate their Network Provider Agreement due to fraud.	
Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.20.	
g) Recovery of the medical and financial costs of care or other consideration to be received by the Network Provider.	
Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.8 and Title 22, CCR, Sections 53250(a)(2) and 53807.	

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all subsubcontracts are in writing and require that the Network Provider:	
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 General, DOJ, and DMHC, or their designees.	
b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.	
Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.20.	
11 Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 24. Phase out Requirements, Subparagraph 8 in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.12.	
12 Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.12.	
13 Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.13 and Title 22, CCR, Sections 53250(a)(4) and 53807.	
14 Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.14 and Title 22, CCR, Sections 53250(v)(3) and 53807.	
15 Network Provider's agreement to not transfer from the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.15 and Title 22, CCR, Sections 53250(a)(5) and 53807.	
16 Network Provider's agreement to timely gather, preserve and provide to DHCS, any records to the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.16.	

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
17 Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.17.	
18 Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.18.	
19 Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.19.	
20 If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 6, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their 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 reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.20 and Exhibit A, Attachment 4, Provision 6.A.	
21 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 24.8.21.	
22 Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determines that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.22, 42 CFR 438.220(c)(1), and Title 22, CCR, Sections 53250 and 53807.	

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Network Provider Definition


Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
23	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. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.23 and 42 CFR 438.208</i>
24	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. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.24</i>
25	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. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.25 and any subsequent updates</i>
26	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. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.26 and any subsequent updates</i>
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.27</i>
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. <i>Citation: MCP Contract, Exhibit A, Attachment 6, Provision 24.8.28</i>
29	A provision affirming a Network Provider's right to access Contractor's dispute resolution mechanism. <i>Citation: Health & Safety Code §13677(a)(2)</i>
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §13677.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. <i>Citation: Health & Safety Code §1325.7</i>


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Updates on the next Hospital Fee Program VI

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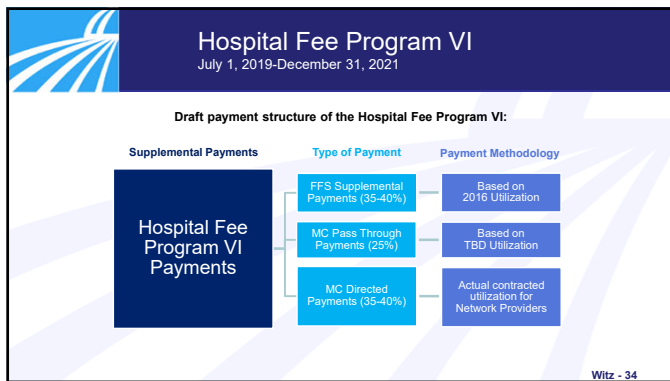
Hospital Fee Program VI

July 1, 2019-December 31, 2021

- 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

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Hospital Fee Program VI
July 1, 2019-December 31, 2021

• Estimated timeline:

	Activity	Timeframe
1	SFY 2018/19 Upper Payment Limit Validation	Feb-May 2019
2	Extract OSHPD Data (<i>Timeframe in Statute</i>)	Apr 2019
3	UPL Development—Hospital Fee Program VI	May-Jun 2019
4	Model Development—Hospital Fee Program VI	Jul-Aug 2019
5	Deadline for DHCS to Submit Program VI to CMS	Sep 2019
6	Historic CMS Approval* Timeframe (6-9 months)	Mar-Jun 2020
7	FFS Payments Begin (90 days post CMS approval)	Jul-Sep 2020
8	Managed Care Payments Begin	Nov 2021

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


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Medi-Cal Updates

§1115 Waivers in Medi-Cal

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Medi-Cal use of the §1115 Waiver


- What is an §1115 Demonstration Waiver?

Table 1: Federal Authority Options

State Plan	vs.	Medicaid Waivers
<ul style="list-style-type: none">State Plan is a contract between the state and the Federal GovernmentState Plan includes populations to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative requirements for the State		<ul style="list-style-type: none">States may formally request to waive certain Medicaid federal requirementsAll Medicaid waivers are <u>time-limited</u> depending on the waiver type (approvals range from two-years to five-years)
<ul style="list-style-type: none">Basic federal requirements apply to State Plan Amendments:<ol style="list-style-type: none"><u>Statewide</u>: changes must apply to Medicaid enrollees throughout the state.<u>Comparability</u>: comparable services must be available for all Medicaid populations<u>Choice of Providers</u>: beneficiaries must have the freedom of choice among healthcare providers.		<ul style="list-style-type: none">Main Medicaid waiver types:<ol style="list-style-type: none">\$1115 Demonstration Waivers\$1915(b) Managed Care Waiver\$1915(c) Home and Community Based Services WaiversCombined \$1915(b) and \$1915(c) Waivers
<ul style="list-style-type: none">No cost or budget requirements		<ul style="list-style-type: none">Waivers must be cost effective or <u>cost neutral</u>

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Medi-Cal use of the §1115 Waiver

Timeframe	Medi-Cal §1115 Waivers	Waiver FFP
2005-2010	Medi-Cal Hospital/Uninsured Demonstration <ul style="list-style-type: none">Non-Federal share for Medi-Cal IP shifts to DPHsDisproportionate Share Hospital (DSH) funding changesSafety Net Care Pool (SNCP) established to help cover uncompensated care costs for the uninsured	\$3.8 Billion
2011-2015	Bridge to Reform (BTR) Waiver <ul style="list-style-type: none">Low-Income Health Program (LIHP)Significant transition of populations into Medi-Cal managed carePilot Program in California Children's Services (CCS)Delivery System Reform Incentive Pool (DSRIIP) Program	\$9.9 Billion
2016-2020	Medi-Cal 2020 Waiver <ul style="list-style-type: none">Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME)Global Payment Program (GPP)Whole Person Care (WPC)Dental Transformation Initiative (DTI)	\$7.1 Billion

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Medi-Cal Updates

Future of Medi-Cal

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Future of Medi-Cal

- Challenges with continuing large §1115 Waivers
 - Budget Neutrality Issues ([SMD #18-009](#))
- State's goals
- Alignment of existing and new Waivers

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Future of Medi-Cal

Medi-Cal 2020	New Authority	Requirements
WPC	§1915b; Managed Care	Directed Payments +1-yr Approvals +Network Provider +CMS Evaluations +Individual Requests +Delayed Approvals +Actuarial Soundness +Payment Delays
PRIME-NDPH	§1915b; Managed Care	
PRIME-DPH	§1915b; Managed Care	
GPP	§1115 Waiver	+5-yr Approval +Delayed Approvals +Waiver Flexibility

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Future of Medi-Cal

- Stakeholder Process and Estimated Timeline:

	Stakeholder Activity	Timeframe
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

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Questions?

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

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Thank You

Ryan Witz
Vice President, Healthcare Finance Initiatives
California Hospital Association
rwitz@calhospital.org

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