2017-19 Hospital Fee Program

September 6, 2019

CALIFORNIA HOSPITAL ASSOCIATION

Welcome

Robyn Thomason
California Hospital Association

Faculty

Ryan Witz is CHA's vice president of healthcare finance initiatives. Ryan represents members' financial interests related to Medicare, Medi-Cal, commercial payers and other government entities. He provides support on financial and reimbursement issues affecting California hospitals and health systems, and is involved with the development and implementation of the hospital fee and other financing programs. Ryan joined CHA in December after 8-years of experience with DHCS.

3

Agenda

- Background
- Medicaid Managed Care Final Rules
- Implementation Timeline
- Encounter Detail Files
- Network Providers
- Hospital Fee Program VI

4

Background

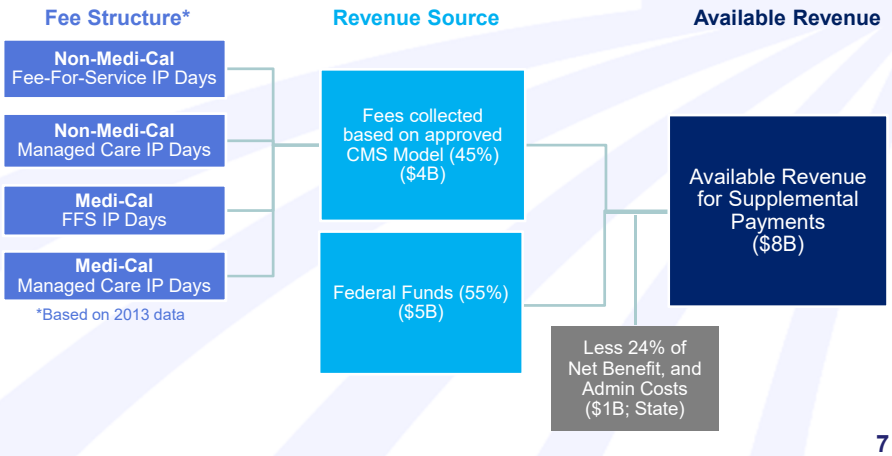
Hospital Fee Program Overview

- Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital Fee Program in state law.
- Hospital Fee Program V
  - January 1, 2017, to June 30, 2019
  - CMS Approved in December 2017
- Hospital Fee Program VI
  - July 1, 2019, to December 31, 2021
  - DHCS will submit to CMS before Sep. 30th

6

Hospital Fee Program Overview (cont.)

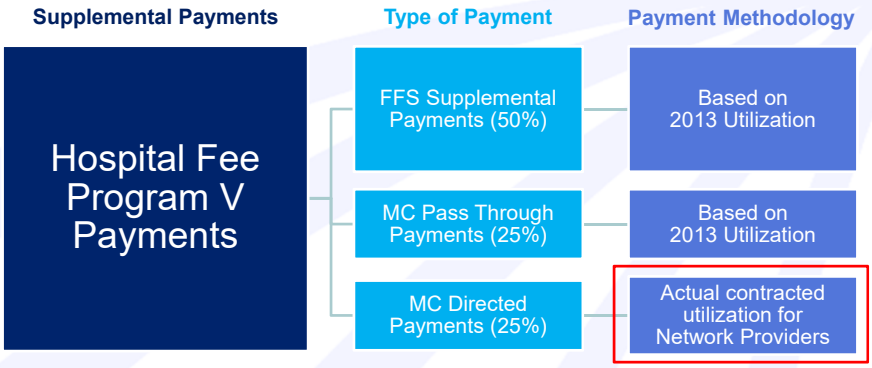
Basic Funding for the Hospital Fee Program V:



7

Hospital Fee Program Overview (cont.)

Payment structure for the Hospital Fee Program V:



8

Medicaid Managed Care 2016 Final Rule ("Final Rule")

Medicaid Managed Care Final Rule

- Pass-through payments (§438.6(d)) were deemed impermissible under the Final Rule, and subject to a 10-year phasedown beginning **July 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)*

10

Medicaid Managed Care Final Rule (cont.)

- The Final Rule (§438.6(c)) provides states with three options to direct payments:

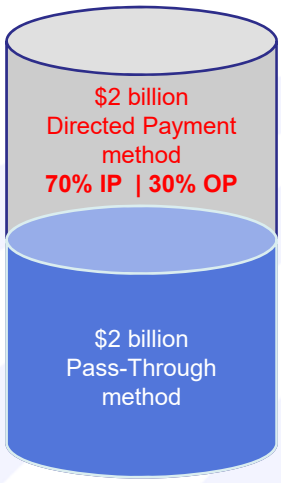
  1. Value-based purchasing models;
  2. Delivery system reform and/or performance improvement initiatives;
  3. Minimum or maximum fee schedules, and ***uniform dollar*** or percent increases.

- All Directed Payments can only be for hospitals considered a "Network Provider" (will discuss later)

11

Medicaid Managed Care Final Rule (cont.)

$4 Billion Managed Care Supplemental Payments



Directed Payments

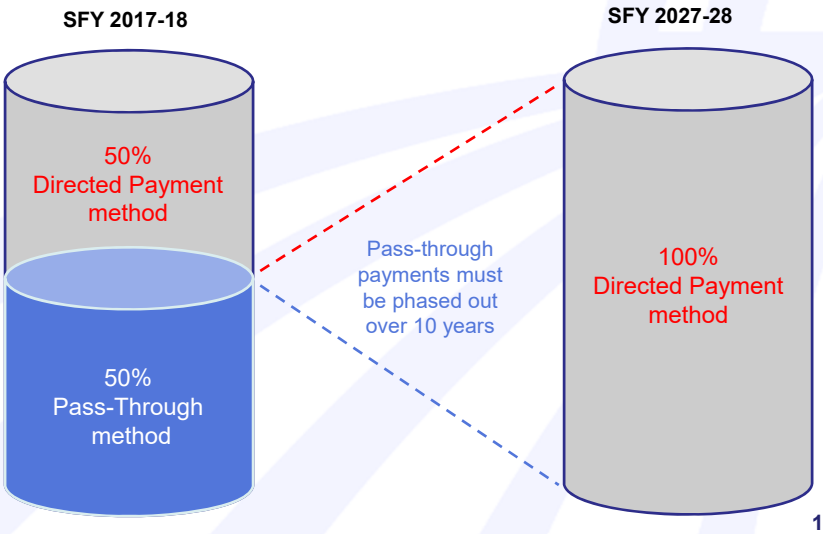
- Uniform add-on per inpatient day and outpatient visit
- Network Providers for Contracted Services
- Current Utilization Data
- Only Paid/Partially Paid Claims

Pass-Through Payments

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

12

Medicaid Managed Care Final Rule (cont.)



13

Medicaid Managed Care Final Rule (cont.)

- 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

14

Medi-Cal Managed Care Implementation Timeline

Two Year Federal Claiming Limit

- Per Section 1132 of the Social Security Act, states must file for federal matching funds within 2-years of the calendar quarter in which the expenditure was made
- Medi-Cal managed care supplemental payments for 7/1/17 – 12/31/17 must be paid to the health plans by September 30, 2019
- Failure to comply results in **forfeiture** of federal funds

16

Directed Payment Timeline
Phase 2 (1/1/18 – 6/30/18) MC2 DP[B]

ACTIVITY	Q1 CY2019	Q2 CY2019	Q3 CY2019	Q4 CY2019	Q1 CY2020	Q2 CY2020
Volume Charts - 5th Release (Time Period Phase 2)	Mar-19					
Volume Charts - 6th Release (Time Period Phase 2)		Apr-19				
Volume Charts - 7th Release (Time Period Phase 2)		Jun-19				
Deadline for Plans to Submit Phase 2: 1/1/18 – 6/30/18 Encounter Data to DHCS		Jun-30-19				
Hospitals and Plans work to populate Contract Status fields (1st Pass)			Jul-19			
Plans submit Detail File with Contract Status to DHCS (1st Pass)			Aug-1-19			
DHCS releases Statewide Detail File to Plans/Hospitals (Final Pass)				Sep-13-19		
Hospitals and Plans work to populate Contract Status fields (Final Pass)				Sep-19		
Plans submit Detail File with Contract Status to DHCS (Final Pass)				Oct-19		
DHCS validates Contract Status (Inc. sampling of Contracts)				Oct & Nov-19		
DHCS deadline to make the March Payment					Jan-1-20	
Health Plans Receive Supplemental Capitation Payments					Mar-20	
Hospitals Receive Supplemental Medi-Cal Managed Care Payments						May-20

** Estimates are subject to change.*

17

Directed Payment Timeline
Phase 1 (7/1/18 – 12/31/18) MC3 DP[A]

ACTIVITY	Q4 CY2019	Q1 CY2020	Q2 CY2020	Q3 CY2020	Q4 CY2020
Deadline for Plans to Submit Phase 1: 7/1/18 – 12/31/18 Encounter Data to DHCS	Dec-31-19				
Hospitals and Plans work to populate Contract Status fields (1st Pass)		Jan-20			
Plans submit Detail File with Contract Status to DHCS (1st Pass)		Feb-1-20			
DHCS releases Statewide Detail File to Plans/Hospitals (Final Pass)		Mar-20			
Hospitals and Plans work to populate Contract Status fields (Final Pass)		Mar-20			
Plans submit Detail File with Contract Status to DHCS (Final Pass)		Mar/Apr-20			
DHCS validates Contract Status (Inc. sampling of Contracts)			Apr & May-20		
DHCS deadline to make the September Payment				Jul-1-20	
Health Plans Receive Supplemental Capitation Payments				Sep-30-20	
Hospitals Receive Supplemental Medi-Cal Managed Care Payments					Nov-20

** Estimates are subject to change.*

18

Directed Payment Timeline

Managed Care Payment Timeline*				
State Fiscal Year (SFY)	**Managed Care Payment Type**	**Invoice Notation**	**Service Period**	**Est. Payment to Hospitals**
SFY 2016-17	Pass-Through	MC 1	1/1/17-6/30/17	May-19
SFY 2017-18	Pass-Through	MC 2 PT	7/1/17-6/30/18	May-19
	Directed Payment A	MC 2 DP A	7/1/17-12/31/17	Nov-19
	Directed Payment B	MC 2 DP B	1/1/18-6/30/18	May-20
SFY 2018-19	Pass-Through	MC 3 PT	7/1/18-6/30/19	Q2/Q3-20
	Directed Payment A	MC 3 DP A	7/1/18-12/31/18	Nov-20
	Directed Payment B	MC 3 DP B	1/1/19-6/30/19	May-21

**Estimates are subject to change*

19

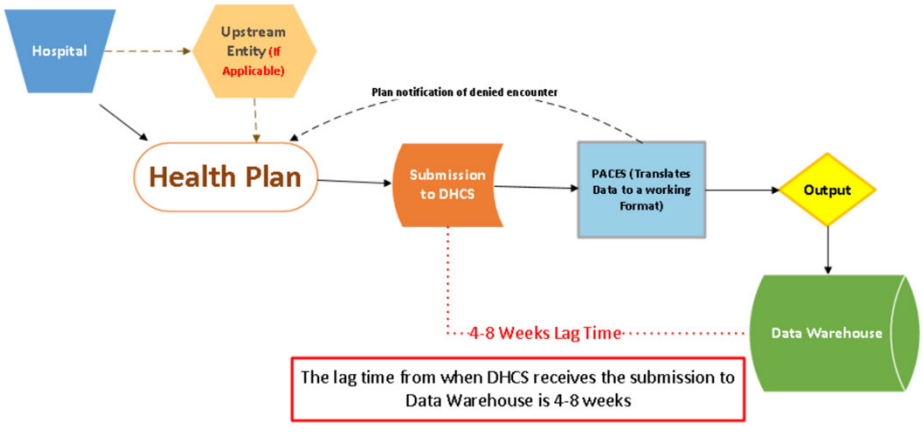
Encounter Detail Files

Encounter Detail Files

- CMS requires submission of encounter data in HIPAA compliant formats
  - DHCS receives encounter data in HIPAA compliant 837I (Institutional), 837P (Professional), and 837D (Dental) transaction formats
- Plans are required to submit complete, accurate, reasonable, and timely encounter data on at least a monthly basis
  - Plans today submit on a daily, weekly or monthly basis
- DHCS accepts or rejects each claim based on Medi-Cal eligibility and data completeness

21

DHCS Encounter Data Flow



22

Encounter Detail Files

Why should I be concerned about encounters?

- CMS requires encounter data files be used to calculate directed payment amounts

How do I know if our encounters made it to DHCS?

- DHCS has distributed several rounds of hospital-specific volume summaries, by plan, to all hospitals
- Hospitals are encouraged to compare volume summaries with internal utilization data and work with plans to reconcile significant differences

23

Volume Summaries

Volume summaries created using hospital reported National Provider Identifiers (NPIs)[1]

Inpatient
- General Acute Care
- Acute Rehab Units
- Acute Psych Units

Outpatient
- Outpatient Department
- Hospital Based Outpatient Clinics
- Emergency Visits (non-admission)

1) https://app.smartsheet.com/b/publish?EQBCT=425fbe695a4749c2a883616707292acd

24

Volume Summaries (cont.)

The following services are **excluded** from the Directed Payment portion of the Hospital Fee Program:

- Inpatient services provided to Medicare ***Part A*** enrollees, and Non-Inpatient services for Medicare ***Part B*** enrollees.
- Services provided to enrollees with Other Health Coverage
- State-only abortion services
- Long-term care services
- Services rendered by the following provider types:
  1. Cost-Based Reimbursement Clinics (CBRCs) (*LA Only*)
  2. Indian Health Care Providers (IHS/MOAs)
  3. Federally Qualified Health Centers (FQHCs)
  4. Rural Health Clinics (RHCs)

25

Troubleshooting Volume Summaries

Examples leading to variations in volume:

- DHCS rejected claim (even if paid by health plan)
  - Local HCPCS codes are not accepted—they must be cross-walked to national code
  - ICD-10 must be coded to highest specificity
  - Invalid revenue code, condition code or NDC
  - Missing or Incorrect NPI(s) or Tax ID
- Capitated or delegated volume not submitted upstream to primary health plan
- Fully or partially denied claim
- Clearinghouse delays in reporting
- Mom/Baby counting logic

26

Network Provider Definition

SFY 2017-18 and SFY 2018-19 Only

Contracted Service Requirement

- CMS approved the Directed Payment proposal for SFY 2017/18[1] on March 6, 2018, and
  SFY 2018/19[2] on December 17, 2018,
- In order to comply with the Federal Medicaid Managed Care Rule, a requirement of both proposals is "the State will direct MCPs to make the directed payments to the class of private hospitals"…"based on their utilization of contracted services for network providers"

1) https://www.dhcs.ca.gov/services/Documents/DirectedPymts/PH_DP_ApvLtr.pdf
2) https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Approval-Letter-2018-2019-PHDP.pdf

28

Network Provider Definition

SFY 2017-18 and SFY 2018-19 only

- On Oct. 5, 2018, DHCS released a Memorandum[1] 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

1)https://www.dhcs.ca.gov/services/Documents/DirectedPymts/DHCS_MEMO_Hospital_DP_Definition_20181005.pdf

29

Network Provider Definition (cont.)

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**:

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

30

Network Provider Definition (cont.)

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.

31

Network Provider Definition (cont.)

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

32

Network Provider Definition (cont.)

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	$800.62/day	$107.49/visit

Note—Hospitals received their actual Phase 1 schedules from DHCS on August 21st
***If you have not received your schedule, please contact: privatedp@dhcs.ca.gov*

33

Network Provider Definition

Effective July 1, 2019 (SFY 2019-20)

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.

35

Network Provider Definition (cont.)

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

36

Network Provider Definition (cont.)

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.*

37

Network Provider Definition (cont.)

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)

38

Network Provider Definition (cont.)

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.

39

Network Provider Definition (cont.)

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.

40

Network Provider Definition (cont.)

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.

41

Network Provider Definition (cont.)

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.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.*
2	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.*
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, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.*
4	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.*
5	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.*
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 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.*

42

Network Provider Definition (cont.)

Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
8	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 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 Contractor to terminate their Network Provider Agreement due to fraud. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).*
9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.*

43

Network Provider Definition (cont.)

Effective July 1, 2019 (SFY 2019-20)

Attachment A of the APL 19-001:

Network Provider Agreements must contain:	
10	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 14.B.10.*
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.*
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 14.B.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 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.*
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 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.*
15	Network Provider's agreement to hold harmless both 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 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.*
16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in 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 14.B.16.*

44

Network Provider Definition (cont.)

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 14.B.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 14.B.18.*
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.*
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, 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 14.B.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 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

45

Network Provider Definition (cont.)

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. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.*
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. *Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.*
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. *Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.*
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. *Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.*
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. *Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.*
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. *Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.*
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. *Citation: Health & Safety Code §1367 (h)(1).*
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	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*

46

Hospital Fee Program (VI) 2019-2021

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

48

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

DISCLAIMER ABOUT THE DRAFT PROGRAM VI MODEL

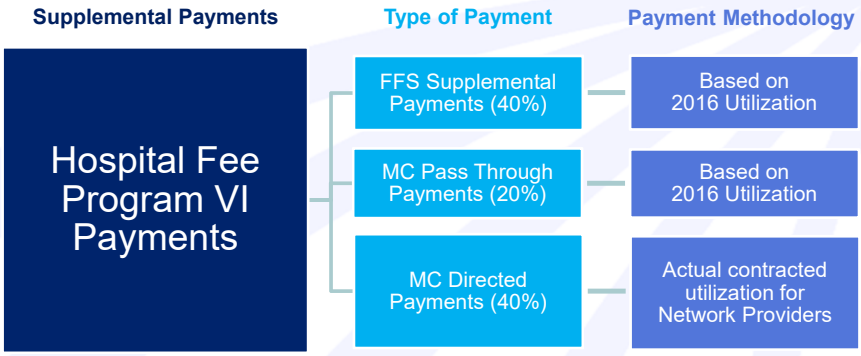
- The following slides were extracted from the latest draft Hospital Fee Program VI Model (Version 9/3/2019).
- There are still several assumptions that CHA and DHCS need to finalize prior to the submission to CMS.
- CHA will release a draft model with hospitals once there is a final draft available to release.

49

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

Draft payment structure of the Hospital Fee Program VI:



50

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

SEE DISCLAIMER ABOUT THE DRAFT PROGRAM VI MODEL FROM SLIDE 49.

DRAFT PROGRAM VI MODEL (Version 9/3/2019)

	HQAF V (CMS Approved)		HQAF VI (Draft Version 9/3/19)	
FFS Payments	10,485,308,238	51%	8,900,000,000	41%
Managed Care Payments	9,923,956,471	49%	12,800,000,000	59%
Fees	(10,229,917,473)		(11,600,000,000)	
Net	10,179,347,236		10,100,000,000	
Directed Payments	4,523,956,471	22%	8,300,000,000	38%

51

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

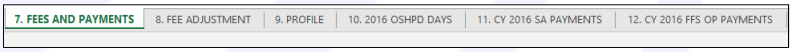
- **Organization of the next Model**
  - **"1. Fee Summary"**–Summary for entire HQAF VI Model
  - **"2. Assumptions and Guidance"**—Includes references to the formulas used for calculations throughout the model
  - **"3. Variable Input"**—Includes the input cells that are referenced throughout the model
  - **"4. FY 2019-20", "5. FY 2020-21", "6. FY 2021-22"**–These tabs are "the engine" with calculating fees and payments
  - **"6a.Gain.Contribute"**—This tab is only for CHA. Includes the summary impact by hospital.

52

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

- **Organization of the next Model**
  "7. Fees and Payments"—Includes the DHCS allocation for how they will collect in aggregate the fees broken up by FFS/Managed Care cycles.
  "8. Fee Adjustment"—Includes an overview of adjustments for the estimated DHCS fund balance.
  "9. Profile"—A new tool that hospitals can utilize to gather hospital specific impacts.
  "Tabs 10. through the end of the workbook"—underlying data used in the model.



53

Hospital Fee Program VI (cont.)

July 1, 2019-December 31, 2021

- **Technical changes**
  - In prior Hospital Fee models, the formulas used by the state were commonly used as VLOOKUP formulas.
  - The state has made changes away from VLOOKUP formulas into an INDEX/MATCH system.
    - INDEX () returns value of a cell in table based on column and row.
    - MATCH() returns the position of the cell in a row or column.

Actual Formula

=IFERROR(IF($P#="YES",INDEX('10. 2016 OSHPD DAYS'!BG:BG,MATCH(A#,'10. 2016 OSHPD DAYS'!$A:$A,0))*MEDI_CAL_FEE_FOR_SERVICE_RATE*AY#,0),0)

#=Cell Number

Translation

[LOGIC TEST] [IF TRUE] [IF FALSE]

=IFERROR(IF(HOSPITAL SHOULD BE TAXED="YES"),(PULL OSHPD DAYS FROM "COLUMN BG" ON '10. 2016 OSHPD DAYS' TAB FOR HOSPITAL) AND MULTIPLY DAYS BY MEDI-CAL FFS RATE (DEFINED),0),0)

54

Hospital Fee Program VI (cont.)

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 (*Timeframe in Statute*)	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

55

Questions?

Thank You

Ryan Witz
Vice President, Healthcare Finance Initiatives
California Hospital Association
(916) 552-7642 | rwitz@calhospital.org

57

Questions

Please type your question in the Q & A box, then press enter

Thank You and Evaluation

Thank you for participating in today's webinar. An online evaluation will be sent to you shortly.

For education questions, contact Robyn Thomason at (916) 552-7514 or rthomason@calhospital.org.

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