Hospital Fee Program 9

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Background

California Hospital Association

- The Hospital Fee Program uses private hospital fees—*instead of state General Funds*—to secure the maximum federal Medi-Cal funding available for hospitals
- Created in 2009, CHA led the efforts to continuously renew the program until voters passed Proposition 52 (2016) which permanently extended the program in state law
- Renewing each program period still requires a close partnership with the Department of Health Care Services (DHCS) and many components of federal approvals

How the Funding Works

California Hospital Association

How the Program is Funded

$5.4B
Hospital Fees
California hospitals' contribution

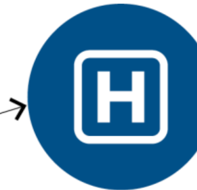
$6.5B
Federal Matching Funds
Includes "enhanced" federal matching due to Medi-Cal expansion

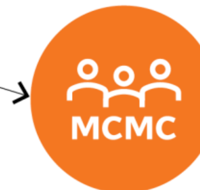
How Hospitals Receive Supplemental Payments

$11.9B
California Department of Health Care Services

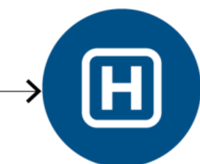
$1.3B
State Share — 24% for Children's Health Care Coverage

$2.8B
Supplemental FFS Payment





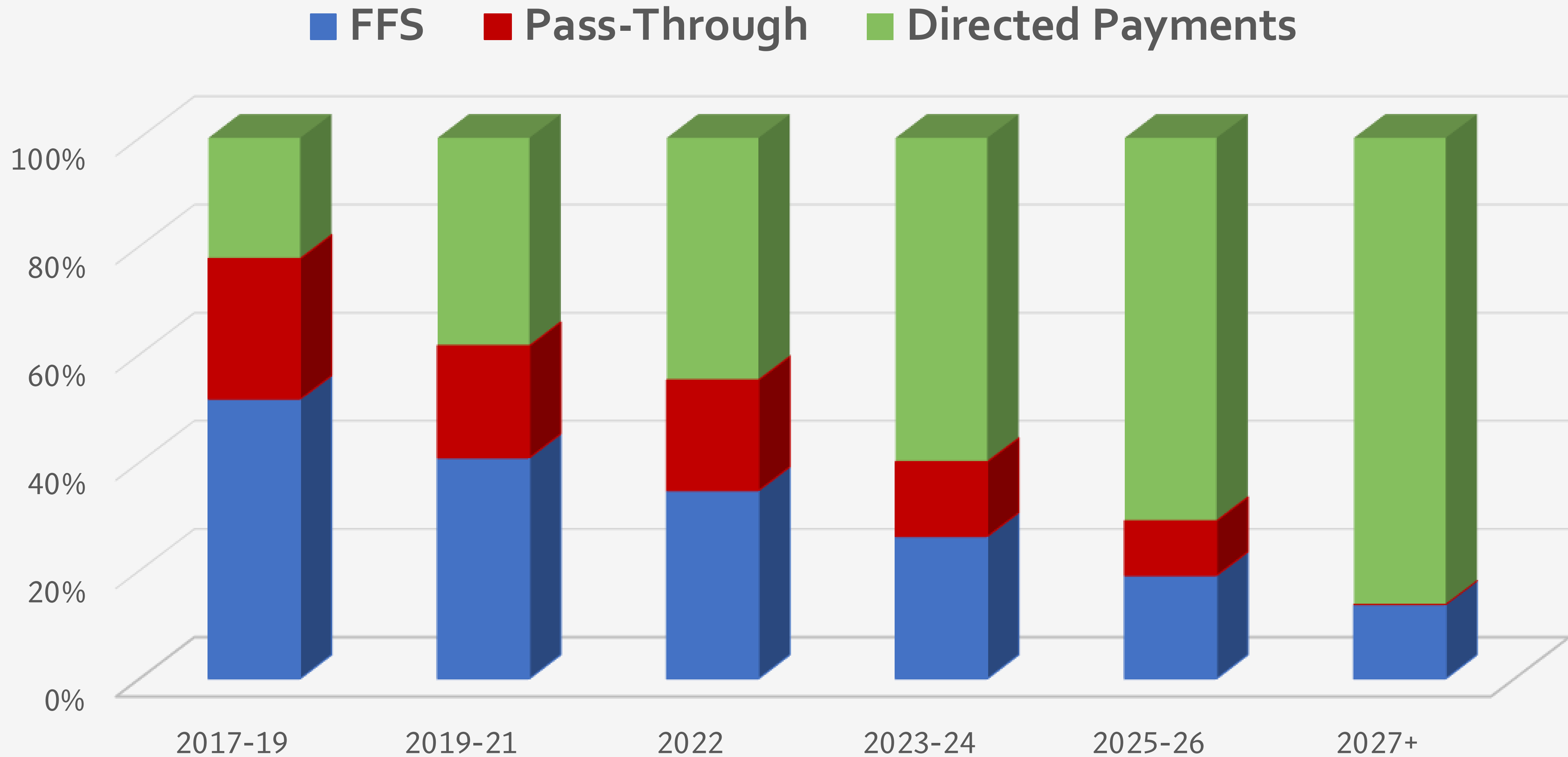
$7.8B
Increased Rates to MCMC Plans



$7.8B
Supplemental Payments
Made to hospitals by MCMC plans

Changes in Hospital Fee Payments

California Hospital Association



New Medicaid Managed Care Final Rule

California Hospital Association

- On April 22, the Centers for Medicare & Medicaid Services (CMS) released a final rule:

  [Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality]

- Final rule addresses several managed care topics, including some that affect the hospital fee program

41002 Federal Register / Vol. 89, No. 92 / Friday, May 10, 2024 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 438, and 457

[CMS–2439–F]

RIN 0938–AU99

Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule will advance CMS's efforts to improve access to care, quality and health outcomes, and better address health equity issues for Medicaid and Children's Health Insurance Program (CHIP) managed care enrollees. The final rule addresses standards for timely access to care and States' monitoring and enforcement efforts, reduces State burdens for implementing some State directed payments (SDPs) and certain quality reporting requirements, adds new standards that will apply when States use in lieu of services and settings (ILOSs) to promote effective utilization and that specify the scope and nature of ILOSs, specifies medical loss ratio (MLR) requirements, and establishes a quality rating system for Medicaid and CHIP managed care plans.

DATES:

Effective Dates: These regulations are effective on July 9, 2024.

Applicability Dates: In the SUPPLEMENTAL INFORMATION section of this final rule, we provide a table (Table 1), which lists key changes in this final rule that have an applicability date other than the effective date of this final rule.

FOR FURTHER INFORMATION CONTACT:

Rebecca Burch Mack, (303) 844–7355, Medicaid Managed Care.

Laura Snyder, (410) 786–3198, Medicaid Managed Care State Directed Payments.

Alex Loizias, (410) 786–2435, Medicaid Managed Care State Directed Payments and In Lieu of Services and Settings.

Elizabeth Jones, (410) 786–7111, Medicaid Medical Loss Ratio.

Jamie Rollin, (410) 786–0978, Medicaid Managed Care Program Integrity.

Rachel Chappell, (410) 786–3100, and Emily Shockley, (410) 786–3100, Contract Requirements for Overpayments.

Carlye Burd, (720) 853–2780, Medicaid Managed Care Quality.

Amanda Paige Burns, (410) 786–8030, Medicaid Quality Rating System.

Joshua Bougie, (410) 786–8117, and Chanelle Parkar, (667) 290–8798, CHIP.

SUPPLEMENTARY INFORMATION:

Applicability and Compliance Timeframes

States are required to comply by the effective date of the final rule or as otherwise specified in regulation text.

States will not be held out of compliance with the changes adopted in this final rule until the applicability date indicated in regulation text for each provision so long as they comply with the corresponding standard(s) in 42 CFR parts 438 and 457 contained in the 42 CFR, parts 430 to 481, effective as of October 1, 2023. The following is a summary of the applicability dates in this final rule:

BILLING CODE 4120–01–P

New Opportunities - Federal

California Hospital Association

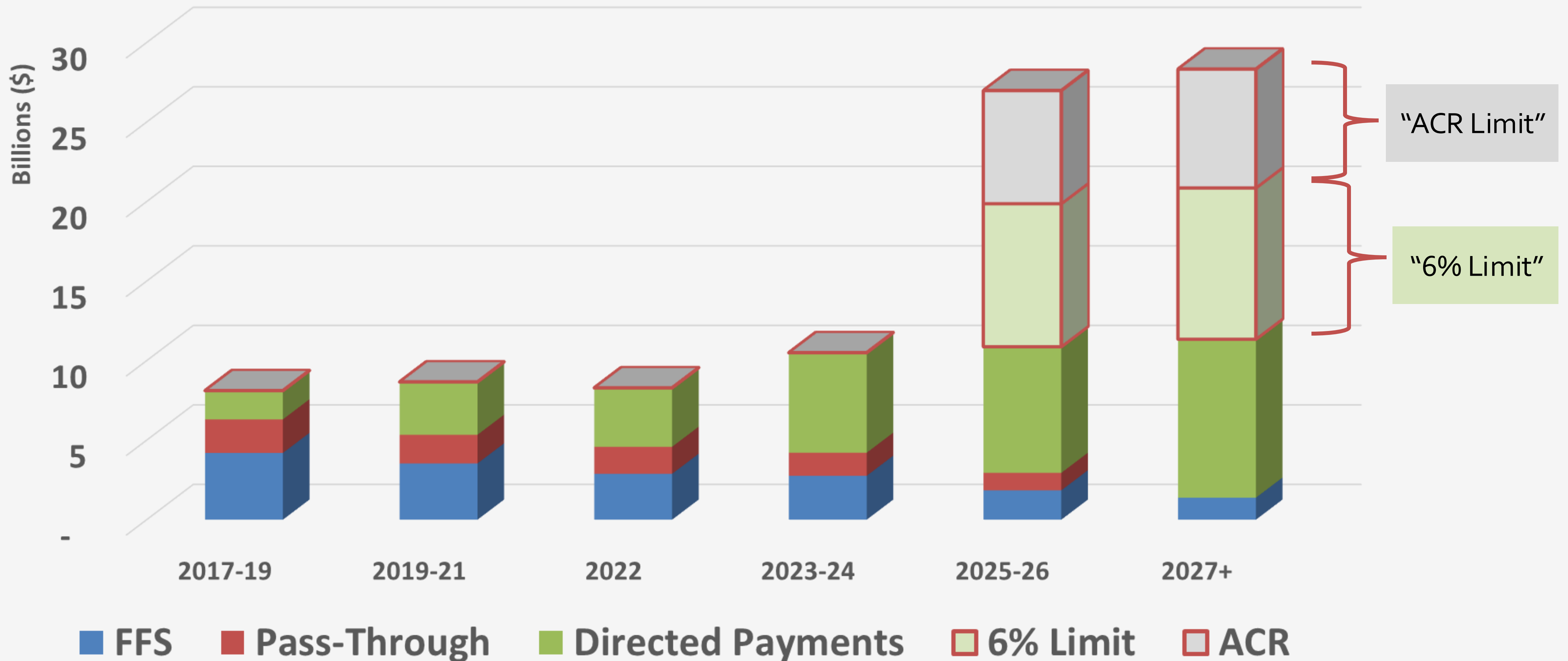
Average commercial rate (ACR) is the new ceiling for managed care directed payments.

<u>However:</u>

- Fees capped at 6% net patient revenue
- Program growth creates greater financial instability as higher fees are needed to make higher payments
- State takes 24% of total net benefit quarterly on the fee-for-service cycles
- Rates must still be certified by the State's actuaries

Program 9 Comparison

California Hospital Association



New Opportunities – Federal (continued)

California Hospital Association

Eliminated federal requirement that managed care directed payments are limited to “network providers”— now left to states’ discretion.

However:

- State reluctant to change requirement – incentivizes broader networks and more access
- Network provider status required, per statute, in managed care directed payments for public hospitals

New Opportunities – State

California Hospital Association

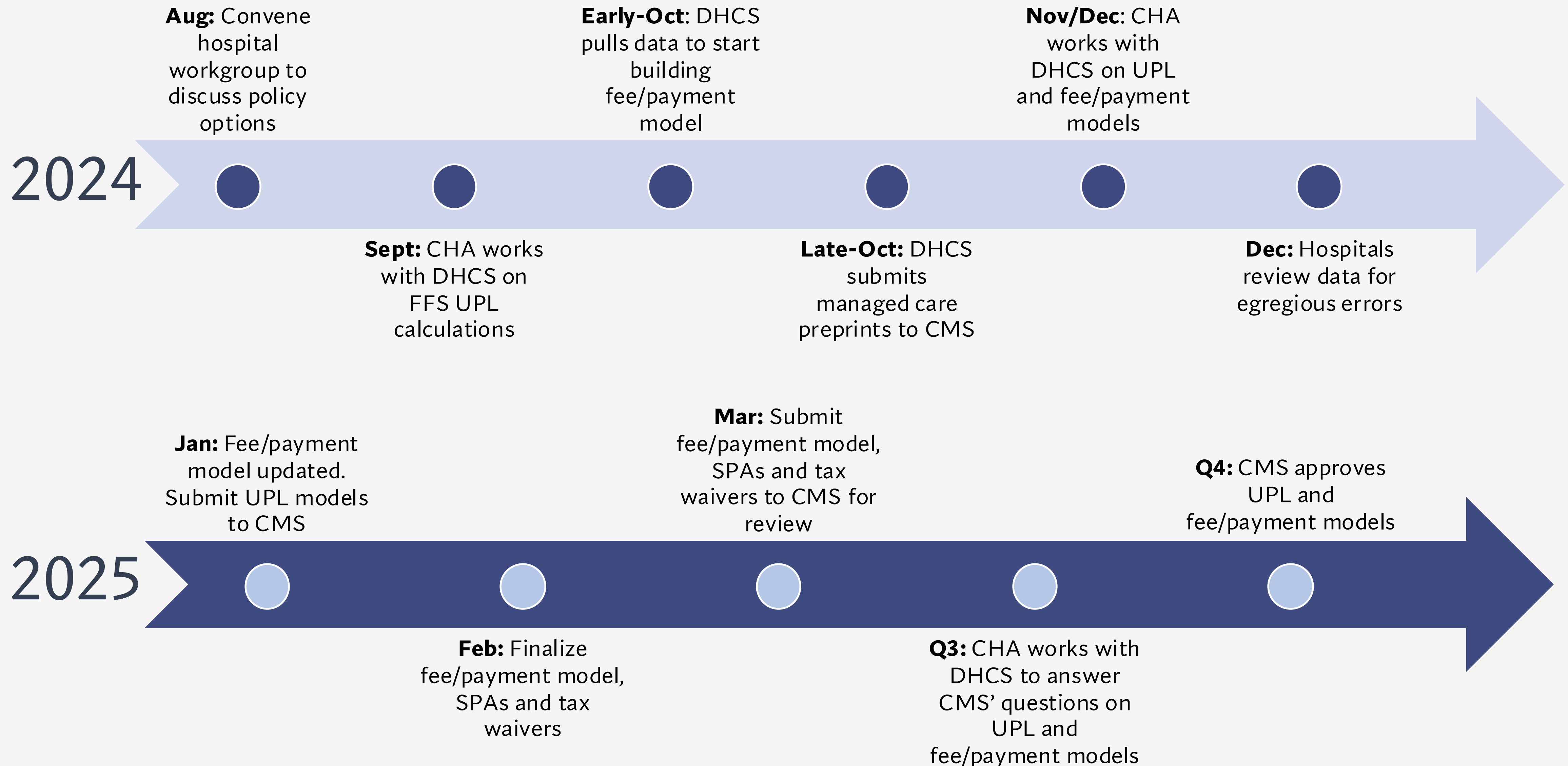
- **Children's Hospital Class** – New state law requires DHCS to create a children's hospital directed payment program. Starting in CY 2025, DHCS will combine this new program into the Hospital Fee Program as a separate "children's class"
- **Critical Access Hospital Class** – Potential to create a new class for CAHs
- **Interim Payments** – Exploring ways to accelerate or provide interim payments for managed care directed payments (currently 2-years in arrears)
- **State's 24% Administrative Fee** – Advocating to the administration to spread out the collection of the State's 24% administrative fee

Challenges

California Hospital Association

- In 2026, DHCS likely to require hospitals to shift some Hospital Fee Program funding into a ***new risk-based managed care quality program***
- 2016 federal regulations require managed care ***pass-through payments to phase-out and will expire at the end of CY 2026***
  - Funding for psychiatric, subacute, and California Children's Services (CCS) currently depend on pass-through payments
- Effective in 2028, federal regulations require states to collect provider attestations that specify there are no separate arrangements that ***"hold harmless"*** providers who are net contributors in the program

Timeline for Hospital Fee Program IX



Discussion

California Hospital Association

- What should CHA prioritize in our discussions with the state for the next hospital fee program?
  - *Growing directed payments, removing network provider requirements, new CAH class, interim directed payments, delaying collection of state's 24% share, minimizing risk in quality program?*
- What else should CHA ***consider*** as we work with the state to develop the next hospital fee program?