CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

2017–19 Hospital Fee Program Status Report

Approval Timeline

As previously reported in CHA News, the Department of Health Care Services (DHCS) submitted the 2017-19 Hospital Fee Program package to the Centers for Medicare & Medicaid Services (CMS) for review on March 30. DHCS does not expect CMS approval for the fee structure and the initial fee-for-service payments will be received prior to Dec. 31, 2017. Initial managed care rates (Jan. 1 2017 – Jun. 30, 2018) will not be submitted to CMS by DHCS for approval until the end of calendar year 2017.

Medicaid Managed Care Rules – Initial Concerns

As also reported in CHA News, last month DHCS submitted to CMS a proposal to bring California's Hospital Fee Program into compliance with the Medicaid Managed Care rules that were finalized in May 2016 and January 2017. The final rules impose an annual cap on the pass-through payment amount, equal to the amount included in a state's Medicaid managed care contracts on or before July 5, 2016. For California, supplemental Medi-Cal managed care payments made through the Hospital Fee Program will be capped at the state fiscal year 2013-14 payment amounts, beginning on July 1, 2017. This means that about half of the managed care funding will immediately transition to the new directed payment approach on July 1, 2017, and the other half will be paid through the historic pass-through approach. The remaining pass-through payments are subject to a phase-out over the next 10 years.

The new directed payments must be made on current adjudicated claims to network providers rather than using historical utilization to make the supplemental payment. This raises two concerns. First is the potential that excess directed payments may be made to health plans or that health plans may be left with unfunded liabilities, depending on estimated utilization compared to actual experience. This could leave health plans with tens of millions of dollars of financial risk and could create hundreds of millions of dollars of financial losses for hospitals. Neither of these situations is supported by CHA and a loss of funds would be prohibited by the Hospital Fee Program statutes protected by Proposition 52.

Medicaid Managed Care Rules – Progress on Solutions

Flexibility is now being considered by CMS on a state-by-state basis – a significant decision that was made on June 30. Under this new flexibility, CMS will allow for two fixed pools (inpatient and outpatient) that can be reconciled periodically to ensure all the funds are expended and to ensure that health plans will not receive incorrect amounts. Details will emerge as data is reviewed and modeling is performed to better understand the best approach for timing, interim payments, and a reconciliation process. ***This was an extremely important first step in addressing the concerns with the final rules. Without this first part accomplished, hospitals could have seen a reduction in managed care payments of over $1 billion, growing to nearly $4 billion.***

DHCS and CHA are working on modeling the scenarios under a two-pool approach. The inpatient pool would fund add-on directed payments for all inpatient days of service. The outpatient pool is limited by CMS to funding add-on directed payments for primary, preventive, and specialty-care services aimed at keeping people healthy or providing care in settings less costly than inpatient care, when appropriate. This process is data-intense and laborious. We are still at the stage of determining the best dataset to use to examine the information.

The federal rules continue to mandate that the directed payments only be made to network providers. CHA and DHCS are educating CMS on California's delegated model and demonstrating to them that network providers are not determined only by a direct contract with a primary health plan. We believe good progress is being made in the discussions. CHA is taking the position that if a hospital is included in determining network adequacy – even through a delegated model – then the hospital should be considered a network provider. CHA's goal is to ensure that the funding continues to follow the patient as it currently does for supplemental payments funded by the Hospital Fee Program.

The directed payment method is in effect as of July 1, 2017, however, DHCS will not submit rates to CMS for approval until the end of this calendar year. This gives sufficient time for thorough discussions to continue to make progress on working through details and concerns. DHCS expects CMS approval of the 2017-18 Medi-Cal managed care rates by the summer of 2018. After CMS approval is received, DHCS will begin the reconciliation process with the health plans to determine the annual network utilization for each hospital with each health plan. This will ensure that the health plans know exactly how much to pay each hospital and guarantee all Hospital Fee Program funds are dispersed.

Beginning with state fiscal year 2018-19, DHCS must submit the Hospital Fee Program managed care rates to CMS prospectively. This will allow the health plans to make Hospital Fee Program payments on each in-network claim upon adjudication. In addition, DHCS will perform a reconciliation at the end of the year to determine the level of funding that remains with each of the health plans. Once the utilization and remaining funds are known, DHCS will instruct the plans to make a supplemental reconciliation payment to the hospitals based on their annual utilization to ensure all of the remaining funds are dispersed.

The managed care pass-through payments (about half of the Hospital Fee Program managed care payments), will continue to be made to hospitals by health plans in the traditional method that has been used since the beginning of the Hospital Fee Program. This pass-through method will be required to phase-out over the next ten years and convert to the directed payment approach. We don't anticipate this phase-out will occur for another three or four years.

Hospitals should direct any questions about the Hospital Fee Program to Amber Ott, vice president strategic financing initiatives, at (916) 552-7669 or aott@calhospital.org, or Anne McLeod, senior vice president health policy and innovation, at (916) 552-7536 or amcleod@calhospital.org.