Network Provider Guidance

Information to Accompany All Plan Letter 19-001

Purpose

The purpose of this webinar is to inform Medi-Cal managed care plans (MCPs) on how the Department of Health Care Services (DHCS) evaluates Network Provider Status. This guidance will be in effect beginning July 1, 2019. The following topics will be covered:

- Required Characteristics of Network Providers
- Written Network Agreements
- Deadlines & Processes for Submitting Network Provider Boilerplates
- Directed Payment Impacts

Definition

A Network Provider is defined in 42 Code of Federal Regulations (CFR) § 438.2 to mean any provider, group of providers, or entity that has a Network Provider Agreement with a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of a state's contract with an MCO, PIHP, or PAHP. A Network Provider is not a subcontractor by virtue of the Network Provider Agreement.

Required Characteristics of Network Providers

A Network Provider Must:

- Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP.
- Be enrolled in accordance with All Plan Letter (APL) 17-019 and the Frequently Asked Questions (FAQs) unless enrollment is not required.
- Be reported on the MCP's 274 file submission.
- Be included on all network adequacy filings as outlined in APL 19-002.

Required Characteristics of Network Providers

Provider Network Agreement

- General requirements are outlined in APL 19-001 Attachment A; however, existing MCP contractual requirements and oversight obligations still apply.

Medi-Cal Enrolled

- All Network Providers must be screened and enrolled if there is a State level enrollment pathway (i.e. Fee-For-Service or other State entity).
- On January 23, 2019, DHCS emailed MCPs a resource list of provider types that are eligible to enroll through DHCS or other State enrollment entity.

Required Characteristics of Network Providers

274 File Submission Reporting

- All Network Providers must be entered in the 274 file submission regardless of the Annual Network Certification.
- Providers with Letters of Agreement or Continuity of Care Agreements should not be entered in the 274 file submission.

Required Characteristics of Network Providers

Network Adequacy Filings

- All Network Providers must be included in the Annual Network Certification (ANC) filing.
- The ANC certifies an MCP's network which must consist of Network Providers that meet the required network adequacy standards:
  - Provider ratios
  - Mandatory provider types
  - Time and distance for primary care physicians and specialists

Required Characteristics of Network Providers

Network Adequacy Filings

- Revised Network Certification Requirements APL 19-002, issued on January 30, 2019, addresses the updated network provider guidance.
  - Supersedes APL 18-005: Network Certification Requirements

Written Network Agreements

Contract Compliance

- All MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements

DHCS Must Review Boilerplates

- In accordance with the current Medi-Cal managed care contracts and 22 California Code of Regulations § 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use.

Purpose of Boilerplate Submission

Approval

- To ensure MCP compliant boilerplate templates that are reviewed and approved by DHCS.

Compliance

- To be compliant with federal regulations, Medi-Cal managed care contracts, state law, and APLs.

Consistency

- To have consistent and standardized boilerplate templates across all MCPs.

Deadlines & Processes for Submitting Network Provider Boilerplates

DHCS will have 60 days from the date of submission to review the templates. Approval will be given within 60 days for templates submitted that meet all requirements.

- Hospital provider templates are due to DHCS 60 days from the date the APL is issued.
- Non-hospital provider templates are due to DHCS 120 days from the date the APL is issued.

Deadlines & Processes for Submitting Network Provider Boilerplates

- MCPs are encouraged to submit one boilerplate template for hospital and non-hospital providers. Separate boilerplate templates are allowed.
- The boilerplate(s) must include all requirements identified in Attachment A of APL 19-001.
- Any additional provisions outside of Attachment A included in the boilerplate should be identified by the MCP to allow for a more expeditious review/approval process.

Directed Payment Impacts

42 CFR §438.6(c)

- Permits states to direct MCP expenditures to Network Providers via directed payment arrangements

Compliance

- MCPs must comply with directed payments:
  - Approved by CMS, as documented in CMS-approved preprints;
  - Approved in State law; and/or
  - Implemented by DHCS via APL or other similar guidance

Effective July 1, 2019

- Services provided under an agreement that does not meet the Network Provider criteria outlined in APL 19-001 will not be eligible for directed payments
  - Applies prospectively for dates of service on or after July 1, 2019

Pooled Directed Payments
(Based on Encounter Reporting)

Private Hospital Directed Payment

- Private hospitals
  - 1 statewide pool split into sub-pools for Inpatient (IP) and Emergency Room/Outpatient (ER/OP) services
  - Uniform dollar increases for eligible IP and ER/OP services
  - Final payments based on actual utilization (contracted services only) as reported in encounter data

Public Hospital Enhanced Payment Program

- Designated Public Hospitals and University of California systems
  - 5 fee-for-service pools split into sub-pools for IP (including Long-Term Care) and Non-IP services
- Uniform dollar increases for eligible IP and Non-IP services
- Final payments based on actual utilization (contracted services only) as reported in encounter data

Pooled Directed Payments

State Fiscal Years (SFY) 2017-18 & 2018-19

Funding is contingent upon actual utilization of contracted services in compliance with the below:

Agreements **MUST**

- Cover one or more defined non-excluded populations of Medi-Cal beneficiaries
- Cover a defined set of one or more non-excluded hospital services
- Specify rates of payment or include a defined methodology for calculating specific rates of payment
- Be for a term of at least 120 days, be signed and dated, and be effective for the date(s) of service

Agreements **MUST NOT**

- Be limited to a single patient only
- Be limited to treatment of a single case or instance only
- Permit payment to be negotiated on a per-patient or single instance of service basis
- Expressly permit the provider to select case-by-case whether to provide covered services to a covered patient

Delegated Arrangements

Unbroken Contracting Path

- Funding is contingent upon actual utilization of contracted services, as previously defined, ***AND***
- There must be a **demonstrable unbroken contracting path** between the MCP and hospital for:
  - The service rendered; and
  - The member receiving the service; and
  - The applicable dates of service
- "Unbroken contracting path" means a sequence of agreements (as defined) linking the MCP and a direct subcontractor, or a series of subcontractors, to the Network Provider

Directed Payments
SFY 2019-20

Effective July 1, 2019

- Services provided under an agreement that does not meet the Network Provider criteria outlined in APL 19-001 will not be eligible for directed payments
  - Prospective for dates of service on or after July 1, 2019
  - Applies to services provided under direct and delegated contracting arrangements

MCP Reporting for Pooled Directed Payments

- Continue to work with hospital Network Providers to provide accurate, complete, and timely encounter data reporting
- Continue to report encounter-level contracting status via a supplemental process, as directed by DHCS
- Additionally, report hospital Network Providers (contracted directly or through a subcontractor) on all applicable 274 filings

Directed Payments
SFY 2019-20

DHCS Review for Pooled Directed Payments

- Continue to sample Network Provider Agreements to test MCP-reported contracting status data
- Additionally, compare MCP-reported contracting status data to the MCP’s 274 filings for applicable service months
  - DHCS will share data with MCPs and hospitals indicating whether the National Provider Identifier (NPI) in the encounter record is present in the MCP’s latest available 274 filing for the corresponding service month
    - Data to be shared via the contracting status reporting process
  - Pursuant to APL 16-019, if 274 data for prior months is inaccurate/incomplete, MCPs are required to retroactively refile 274 data for affected months

Directed Payments
SFY 2019-20

Additional Guidance and Resources

- DHCS will arrange a separate webinar for MCPs and participating hospitals to discuss specific implementation timeframes for SFY 2019-20 pooled directed payment reporting mechanisms and review processes
- As applicable, additional guidance and resources will be posted to the DHCS Directed Payments Program website: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx

Key Takeaways

- Requirements for a Network Provider:
  - Executed written Network Provider Agreement (applies to delegated entities)
  - Enrolled in accordance with APL 17-019 and the FAQs unless not required
  - Reported on the MCP's 274 file
  - Included on all network adequacy filings as outlined in APL 19-002
- Network Provider Agreements must comply with contract requirements (applies to delegated entities).
  - Boilerplates must be submitted to DHCS for review and approval before use.
    - MCPs must submit updated hospital provider boilerplates within 60 days and updated non-hospital provider boilerplates within 120 days.

Key Takeaways (cont.)

- Effective July 1, 2019, only services provided under a Network Provider Agreement that meets the Network Provider criteria outlined in APL 19-001 will be eligible for directed payments.
  - Applies to direct and delegated contracting arrangements
- MCPs must:
  - Provide accurate, complete, and timely encounter data
  - Report encounter-level contracting status data
  - Report hospital Network Providers on 274 filings
- DHCS will:
  - Hold a separate webinar on implementation steps once Directed Payment work begins on SFY 2019-20 via existing Encounter Detail Volume Chart Process (currently working on SFY 2017-18)
  - Sample Network Provider Agreements
  - Compare contracting status data to the MCP’s 274 filings

Questions & Answers

- **Q:** Are hospitals required to submit updated Network Provider Agreement boilerplates to DHCS?
  - **A:** No. MCPs are required to submit updated Network Provider Agreement boilerplates to DHCS.
- **Q:** When do MCPs need to submit updated Network Provider Agreement boilerplates compliant with APL 19-001?
  - **A:** From the release date of APL 19-001 (January 17, 2019), MCPs have 60 days to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days to submit updated Network Provider Agreement boilerplates for non-hospital providers.

Questions & Answers (cont.)

- **Q:** Will hospitals under delegated arrangements be considered in-network or reported on the 274?
  - **A:** All Network Providers meeting the specified criteria must be reported on the MCP's 274 file submission, regardless of whether the Network Provider is contracted directly with the MCP or through a delegated entity of the MCP.
- **Q:** For directed payments, how will hospitals know whether they are included in the 274 file?
  - **A:** DHCS will share data via the contracting status flagging process indicating whether the NPI in the encounter record is present in the MCP's latest available 274 filing for the corresponding service month.
    - An additional data field will be added to MCP's/hospital's Encounter Detail Volume Chart files, the timing of this additional data field will be provided at a later date.

Questions & Answers (cont.)

- **Q:** For directed payments, will MCPs and hospitals continue to provide contract status data to DHCS through a supplemental process (on an encounter detail file)?
  - **A:** Yes. MCPs and hospitals must continue to work together to provide encounter-level contract status data via a supplemental process, as directed by DHCS.
- **Q:** Why is the supplemental reporting necessary if Network Providers will be reported in the 274 file?
  - **A:** Data in the 274 file is at the provider level, and thus supplemental, encounter-level data is needed at the service level and beneficiary level for the Directed Payments.

Questions & Answers (cont.)

- **Q:** For directed payments, what is the process if a hospital disagrees with the MCP's reported contract status?
  - **A:** Hospitals and MCPs are expected to work together to discuss and attempt to resolve differences in interpretation of contract status. DHCS is available to provide guidance regarding the requirements that apply during each service period.

- **Q:** How will hospitals be notified when additional guidance on directed payments has been finalized?
  - **A:** DHCS will send a notice to hospitals' identified directed payment contacts when additional guidance to directed payments is posted on the DHCS website.
  - https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx

Questions?