The Hospital Fee Program

In 2009, the Hospital Fee Program was created to ensure that California hospitals secured the maximum federal funding available for Medi-Cal. Hospitals in the program receive supplemental fee-for-service (FFS) and managed care payments to offset the losses incurred in caring for California's Medi-Cal population.

Beginning with the 2017-19 program, new federal Medicaid managed care rules require Medi-Cal managed care supplemental payments to be paid only for contracted services to in-network providers, based on actual utilization — referred to as "directed payments." This shift in payment structure carries through to the 2019-21 Hospital Fee Program.

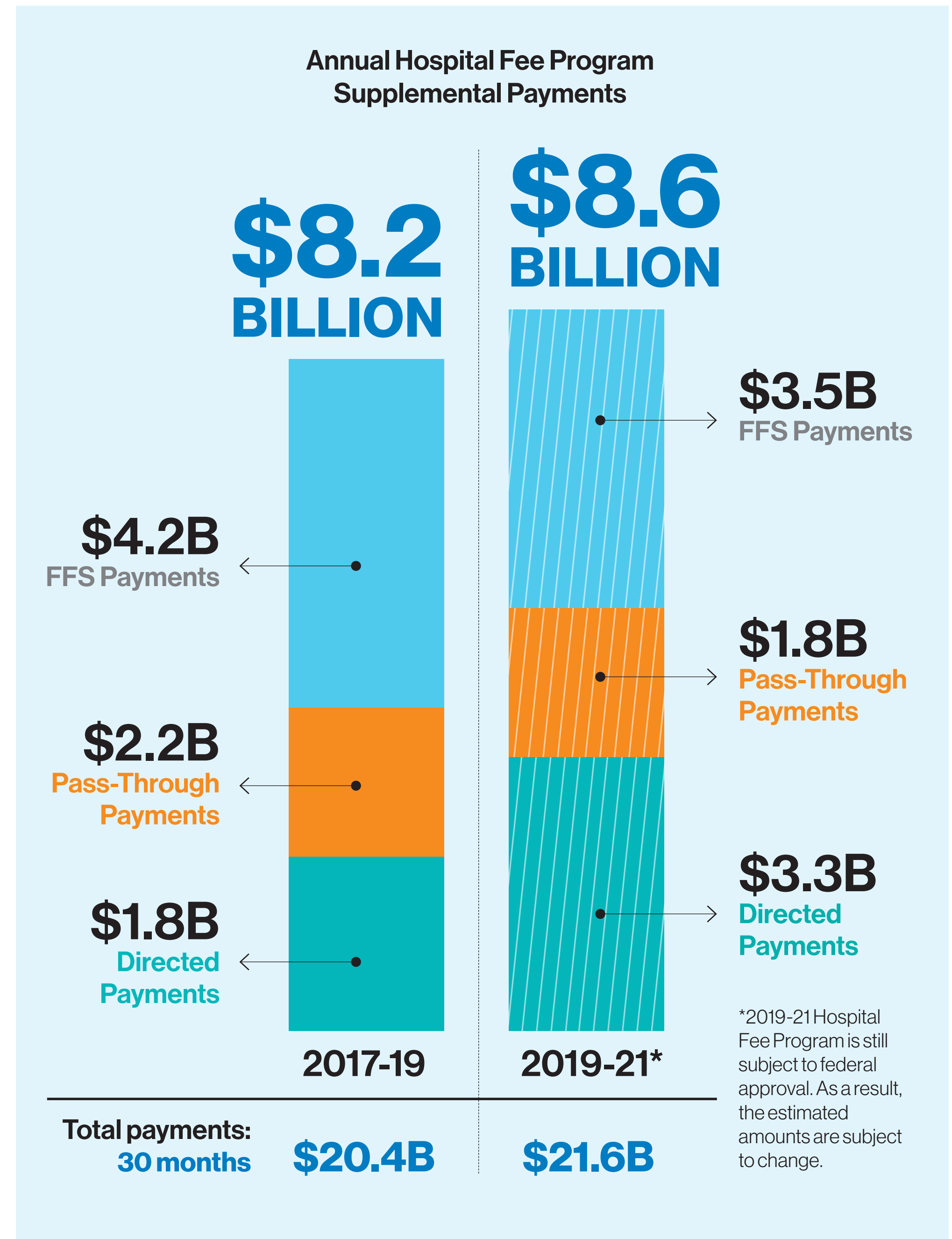
Pass-Through Payments

- Payments to hospitals based on the approved model
- Based on 2016 inpatient and outpatient utilization
- No requirement to be a network provider
- Uniform add-on per inpatient day and outpatient visit

Directed Payments

- State calculates payments based on accepted encounters
- Based on actual contracted inpatient/outpatient utilization
- Uniform add-on per inpatient day and outpatient visit
  - 70% of funding allocated for inpatient utilization
  - 30% of funding allocated for outpatient utilization
- Hospitals are required to be a network provider

→ **Want more information on network provider requirements? Watch CHA's webinar.**



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