State/Federal Regulatory Update

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California Hospital Association

California State Update

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State Overview

- What's New in Medi-Cal?
  - Post-Public Health Emergency: what is permanent?
  - New Policy Changes (enrollment, access)
- Medi-Cal Managed Care Is Changing…
  - Proposed Medicaid Managed Care Rulemaking
  - New DHCS Managed Care Contracts
  - CalAIM
- AB 1020
- Medi-Cal Audit and Cost Report Trends

Significant Medi-Cal Program Updates

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Significant Medi-Cal Program Updates

Unwinding COVID-19 Public Health Emergency Requirements and Flexibilities

- 2 general categories of activity:
  - (1) Unwinding the federal continuous enrollment condition
  - (2) Extending or sunsetting various program flexibilities approved under federal emergency authorities

- September 2023 Updated Medi-Cal PHE Unwinding Plan

Significant Medi-Cal Program Updates

Unwinding COVID-19 Public Health Emergency Requirements and Flexibilities

Continuous Enrollment Condition

- As a condition of the temporary 6.2% FMAP increase, states unable to disenroll Medicaid individuals enrolled as of March 18, 2020; March 31, 2023.
- FMAP increase incrementally phased down, and expired December 31, 2023
- Redeterminations in Medi-Cal underway: based on Nov. 2023 data, enrollment projected to decline by 1.9 million by the end of 2024, before leveling off
- Likely increase in hospital presumptive eligibility (fee-for-service based)
- Medi-Cal Continuous Coverage Unwinding Dashboards

Significant Medi-Cal Program Updates

Unwinding COVID-19 Public Health Emergency Requirements and Flexibilities

Extending/Sunsetting COVID era flexibilities

- Hospital Presumptive Eligibility:
  - Expansion to aged population continuing;
  - Second PE period allowance during calendar year sunset (excluding children)
- Telehealth:
  - Mostly extended per advisory group report and subsequent legislation (SB 184)
  - Maintained coverage of synchronous video and audio-only; asynchronous (store-and-forward, e-consults); brief virtual communications in physical health
  - Payment parity with in-person reimbursement continues for synchronous and asynchronous modalities
  - New patient: continues allowance for synchronous video
  - For more information: Medi-Cal Telehealth Resources

Significant Medi-Cal Program Updates

- Full Scope Medi-Cal for Adults 26-49 with Unsatisfactory Immigration Status
  - Effective January 1, 2024, all individuals without satisfactory immigration status but meet all other eligibility criteria eligible for full-scope Medi-Cal
  - Previously only restricted scope eligible (emergency and pregnancy-related care)
  - Mandatorily enrolled in a Medi-Cal plan
  - For more information: Ages 26 through 49 Adult Expansion
- Elimination of Asset/Resource Testing
  - Effective January 1, 2024, DHCS/counties no longer consider assets/resources for purposes of determining or renewing Medi-Cal eligibility for all populations
  - For more information: Asset Limit Changes for Non-MAGI Medi-Cal

Significant Medi-Cal Program Updates

Ensuring Access to Medicaid Services Proposed Rulemaking

- Published May 3, 2023 (alongside managed care rule discussed later)
- Release of final version imminent – in last stages of federal clearance
- CHA's submitted comment letter
- Key topics include:
    - Provider rate transparency, reporting and monitoring
    - Stakeholder advisory groups
    - Home and community-based services

Significant Medi-Cal Program Updates

Ensuring Access to Medicaid Services Proposed Rulemaking

Fee-for-service (FFS) payment transparency and analyses

- Publish all FFS rates and identify variance by population/provider/geography
- Comparative rate analyses to Medicare for primary care, obstetrics, gynecology, and outpatient mental health (recurring biennially)
- Two-tier documentation/analysis framework for proposed SPAs that would reduce or restructure rates
- CHA: good start to addressing longstanding issues, but more is needed (e.g. consideration of self-financed payments; recurring analyses for hospital and emergency department services outside of changes)

Medicaid Managed Care Access, Finance, and Quality Proposed Rule

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Medicaid Managed Care Proposed Rule

Medicaid and CHIP Managed Care Access, Finance, and Quality Notice of Proposed Rulemaking

- Proposed May 3, 2023
- Release of final version imminent – in last stages of federal clearance
- CHA's submitted comment letter
- Most significant revamp of Medicaid managed care policy since the 2016 final rule
- Topics addressed herein: (1) Access (2) Financing/State Directed Payments

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Medicaid Managed Care Proposed Rule

Access Highlights

- Appointment wait times - national maximums proposed:

Service Type	Proposed maximum wait time
Outpatient MHSUD (adult and pediatric)	10 business days from date of request
Primary care (adult and pediatric)	15 business days from date of request
Obstetrics and gynecology	15 business days from date of request
An additional service type selected by state	State-set standard

- State flexibility to establish more stringent standards; vary by appointment type, populations, geography; set standards for other appointments; allow exceptions

Medicaid Managed Care Proposed Rule

Access Highlights

- Requires states to conduct and report on enrollee experience surveys
- States required to conduct annual secret shopper surveys through independent entity to evaluate compliance with appointment wait times (90% standard) and accuracy of plan's provider directories
- Plans required to report on provider rates for certain categories (primary care, OB/GYN, OP mental health) as compared to Medicare

Medicaid Managed Care Proposed Rule

Financing and State Directed Payments

- Vital mechanism to ensuring access and adequate reimbursement
- Exception to general principle that States may not direct plan expenditures
- Two general types:
    - Minimum/maximum fee schedules or uniform dollar or percentage increases
    - Value-based or delivery system reform

Medicaid Managed Care Proposed Rule

Financing and State Directed Payments

- Currently, CMS requires directed payments to be tied to utilization in the contract year; distributed to a defined provider class; documented in plan contracts and rate certifications, with certain SDP types requiring prior CMS approval
- Proposal for a streamlined approach for certain SDPs (minimum fee schedule based on approved State plan rates or 100% of Medicare)
- For SDPs requiring prior approval, requires evaluation plan, with State evaluation report for SDPs exceeding 1.5% of total capitation
    - CHA comments:
        - Develop/promote use of hospital-specific performance measures
        - Allow P4R for at least new quality or value-based SDPs

Medicaid Managed Care Proposed Rule

Financing and State Directed Payments

Average Commercial Rate (ACR) Benchmark

- Propose to codify CMS standard of "reasonable, appropriate, and attainable"
- ACR as upper limit to SDPs for inpatient and outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers
    - No formal upper limit proposed for other services

Limits on Aggregate SDP Expenditure

- Comment solicited on applying aggregate limit as a % of managed care spend or on a provider/service category basis
- Serious potential impediment to access, and threatens financial viability given reliance on SDPs to achieve actuarial soundness and boost poor base reimbursement

Medicaid Managed Care Proposed Rule

Financing and State Directed Payments

- Network Provider Eligibility
  - Proposal to remove network provider requirement for uniform increment and minimum fee schedule SDPs
  - CHA strongly supported; DHCS supports state flexibility to pick-and-choose
- Provider Tax Hold Harmless Attestation
  - Would require each provider receiving an SDP funded by a Medicaid provider tax to attest they do not participate in any hold harmless (redistribution of funding to negate or minimize tax liability)
  - Coupled with expansive interpretation that hold harmless applies to purely private transactions without any State/local involvement (CMS Feb. 2023 bulletin)
  - CHA opposed on various legal and policy grounds, including the lack of statutory basis to regulate purely private transactions

Medi-Cal Managed Care

Model and Plan Changes

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Medi-Cal Managed Care – Model and Plan Changes

- Effective January 1, 2024 as approved under CalAIM 1115 demonstration and 1915(b) waiver amendments
- Changes to county-based managed care models, and plans contracted within several counties
- Approximately 99% of beneficiaries enrolled in a plan by/in 2024
- For more information:
    - DHCS Managed Care Transition Home Page
    - 2024 Plan Directory by County
    - 2024 DHCS Boilerplate Managed Care Contract (all models)

Medi-Cal Managed Care – Model and Plan Changes

Managed Care Model Changes

Five models employed based on county election:

1. County Organized Health System (COHS): single local government-run plan exempt from Knox Keene Act (KKA) licensure
2. Two-Plan: choice between two KKA licensed plans, one public Local Initiative and one commercial plan
3. Geographic Managed Care (GMC): choice of multiple KKA-licensed commercial plans
4. Regional: choice between two KKA licensed commercial plans (that serve two or more contiguous counties within the rural region)
5. Single Plan (NEW): single KKA-licensed local government-run plan

Medi-Cal Managed Care – Model and Plan Changes

Model changes in 17 counties

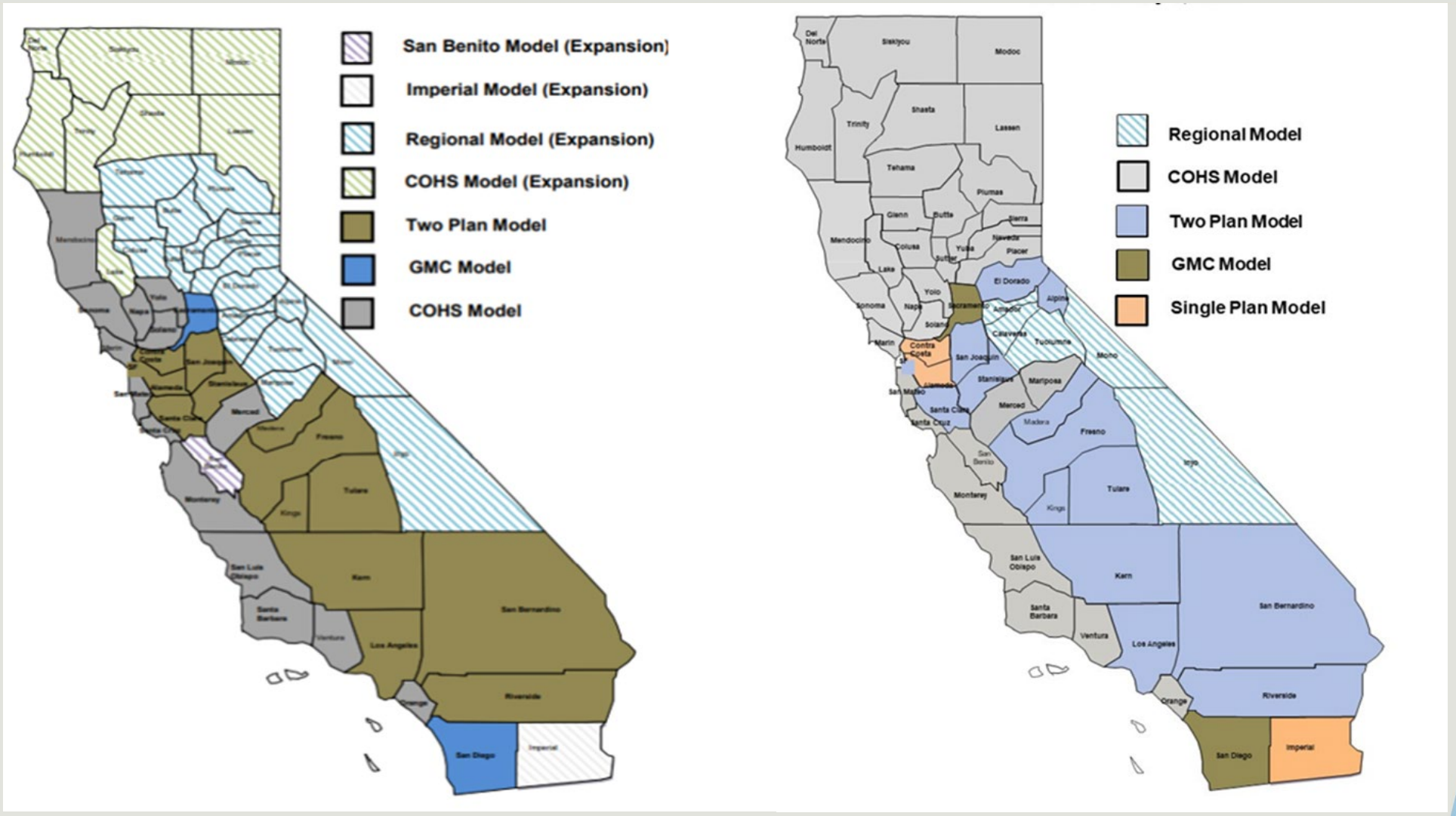
- Single Plan: Alameda (Alameda Alliance), Contra Costa (Contra Costa Health Plan), Imperial (California Health and Wellness)
- COHS expansion:
    - Central California Alliance for Health: Mariposa and San Benito
    - Partnership: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba
- Two-Plan: Alpine and El Dorado (Health Plan of San Joaquin dba Mountain Valley Health Plan)

Medi-Cal Managed Care – Model and Plan Changes

Commercial Plan Awards (21 counties in Two-Plan, GMC, and Regional models)

- Initially via competitive RFP but cancelled in late 2022
- DHCS instead exercised right to contract outside of RFP
- **Blue Cross (Anthem):** Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kern, Kings, Madera, Mono, Sacramento, San Francisco, Santa Clara, Tuolumne
- **Blue Shield** and **CHG Foundation**: San Diego
- **Health Net**: Amador, Calaveras, Inyo, Los Angeles (with subcontract to Molina for 50% of enrollment), Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne
- **Molina**: Riverside, Sacramento, San Bernardino, San Diego (and subcontract in LAC to Health Net for 50%)

Medi-Cal Managed Care – Model and Plan Changes



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Medi-Cal Managed Care – Model and Plan Changes

Kaiser Permanente Direct Contracts

- Effective January 1, 2024, Kaiser operating as a prime plan in 32 counties
- Per state legislation (AB 2724 - 2022), Kaiser held to same contractual standards as all other full-risk plans but for enrollment, and subject to additional Memorandum of Understanding
- Populations eligible to enroll (but maintain choice):
    - Prior individual or family linkage to Kaiser (including those previously assigned to Kaiser as a subcontractor)
    - Default enrollment subject to annual cap (3000 members in 2024)
    - Foster or former foster care youth
    - Individuals dually eligible for Medi-Cal and Medicare

2024 Medi-Cal Managed Care Contracts

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2024 Medi-Cal Managed Care Contracts

- New 2024 Medi-Cal managed care contracts impose substantial new responsibilities on health plans, some of which discussed in CalAIM update
- “Network Provider” status currently important to determine eligibility for directed payments
    - Contrast to “Subcontractors” that undertake plan obligations
- Definition continues to evolve

2024 Medi-Cal Managed Care Contracts

- Expansion of mandatory network provider agreement terms
  - Specification of services to be ordered and referred
  - Specification of governing laws and regulations
  - Requirement that network providers must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, e.g., all plan letters, and Medi-Cal managed care contracts between state and plans
  - Encounter data reporting and “any other reports or data as requested by” Medi-Cal managed care plan to meet reporting obligations to DHCS
  - Provision that “Network Provider” will be terminated or subject to other actions, fines, and/or penalties if DHCS or plan determines unsatisfactory performance
  - Expanded cultural competency, health equity and diversity training requirements
  - Notification of suspected fraud, waste or abuse within 10 working days; report identified overpayments within 60 calendar days

CalAIM Update

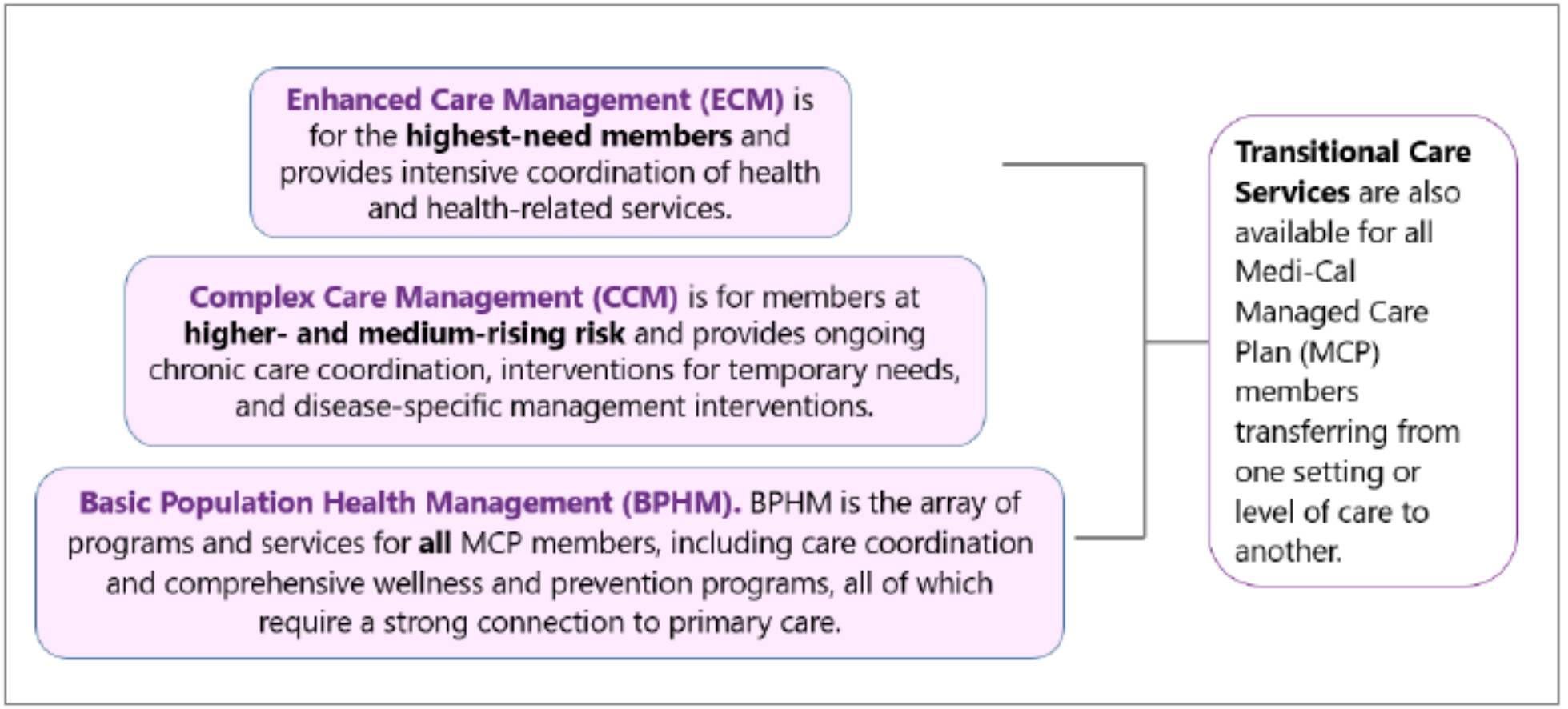
California Hospital Association

CalAIM Major Themes

- Increasing the Focus on High-Risk, High-Cost Populations
- Promoting Health Equity
- Transforming and Streamlining Managed Care
- Rethinking Behavioral Health Service Delivery and Financing
- Extending Components of the Current 1115 Waiver

CalAim Care Management

Figure 1: CalAIM Care Management Continuum



DHCS, Enhanced Care Management Policy Guide (Sept. 2023).

Enhanced Care Management: Target Populations

Transition away from Whole Person Care and Health Home Program into the Enhanced Care Management program

- Address clinical and non-clinical needs of high-need, high-cost Medi-Cal members

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Enhanced Care Management: Core Services

Core Components of ECM

- Outreach and engagement
- Comprehensive assessment and care management plan
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family supports
- Coordination of and referral to community and social support services

CalAIM: Community Supports

- Payment mechanism for managed care plans to provide 14 nonmedical services—known as “in lieu of services” (ILOS)
    - Named “Community Supports” by DHCS
- Not Medi-Cal benefits, but in lieu of Medi-Cal benefits, so by nature, optional
- Plans select which, if any, community supports to offer their members
- DHCS may identify more pre-approved community supports in the future

ILOS Options

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite);
- Respite Services;
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF);
- Day Habilitation Programs;
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (Home Modifications);
- Meals/Medically Tailored Meals;
- Sobering Centers; and
- Asthma Remediation.

Other Plan Changes Through Waivers

- Carve-in of long term care in all MCP counties
  - Pre-1/1/23, county operated health systems and Coordinated Care Initiative counties had long-term care carved into managed care
  - 1/1/23: carve in of SNF services in remaining counties
  - 1/1/24: carve in of subacute and ICF/DD services in remaining counties
  - For more information: Long-Term Care (LTC) Carve-In Transition
- Justice-Involved Reentry Initiative (Justice-Involved Initiative)
  - Targeted services to Medi-Cal eligible incarcerated individuals for up to 90 days pre-release
  - Intended to make transition to release, including enrollment in Medi-Cal managed care, seamless; may address some issues with law enforcement drop offs
  - For more information: Justice-Involved Initiative Home (ca.gov)

CalAIM

Pending Waiver Amendments & Related Demonstration Requests

- California Reproductive Health Access Demonstration (CalRHAD): Federally matched grants to reproductive health providers to enhance capacity and access, including investment in provider capacity and patient supports for CA beneficiaries and others experiencing access barriers; includes rural hospitals, small hospitals (fewer than 50 beds), and critical access hospitals
- Transitional rent services (Submitted application 10/20/23): Would authorize plans to elect to cover up to six months rent for eligible individuals where medically necessary based on HRSN criteria
- CA Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration (BH-CONNECT): Multifaceted initiative aimed at building a full continuum of care, strengthening workforce, and enhance federal funding ("IMD waiver")
- Continuous coverage for children up to age 5 (released DHCS proposal)

AB 1020/ Charity Care Update

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AB 1020 and Focus on Charity/Discount Care

- Adopted by CA Legislature in 2021, effective January 1, 2022
- Triggered by reports of hospitals not offering charity/discounted care
- Major provisions include:
  - Updated requirements on charity/discount policies
  - Enhanced notification to patients
  - Changes to process of selling patient debt
  - Increased enforcement by the Department of Health Care Access and Information (HCAI)
- New implementing regulations by HCAI from November 2023

Policy Updates/Creation: Charity/Discount Policies

- Hospital Fair Pricing Policy Compliance
  - **Increase eligibility** to 400% of the federal poverty level (up from 350%)
  - Clarifying eligibility includes annual out of pocket medical costs that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months
  - Can be limited to medically necessary services, but presumption applies unless attestation by referring provider
  - Other required language and formatting requirements
- Distinction between charity care (full charity care or reduced cost) and discount payment (limited to higher of Medicare/Medi-Cal and extended payment policy)
  - Can only request recent paystubs or income tax returns under discount policy

Policy Updates/Creation: Charity/Discount Policies

Other considerations

- 501r compliance for non-profit hospitals
- Ensuring that charity care can properly be accounted for in cost report pursuant to Medicare rules

Updates to Debt Collections

- Debt collection must comply with:
  - Hospital Fair Pricing Policy
  - Rosenthal Fair Debt Collection Practices Act
  - 501r requirements regarding collections
- Hospitals can only demand payment up to what Medicare or Medi-Cal would pay (whichever is greater) for patients eligible for discounted care
- Hospitals are now required to refund overcharges within 30 days

Updates to Debt Collection

Hospital or debt collector cannot report adverse information to a consumer credit reporting agency OR commence civil action against the patient for nonpayment **before 180 days after initial billing**. (*previously 150 days before*)

Hospital cannot sell patient debt to debt buyer unless:

- Hospital has found the patient ineligible for financial assistance OR the patient has not responded to any attempts to bill or offer financial assistance for 180 days
- Specified language is included in contracts with debt buyer re: incorrect calculations of balances
- Debt buyer must agree not to resell or transfer patient debt, except in limited circumstances
- Debt buyer cannot assess interest or fees on the patient debt.
- Debt buyer must be licensed as a debt collector by the Department of Financial Protection and Innovation.

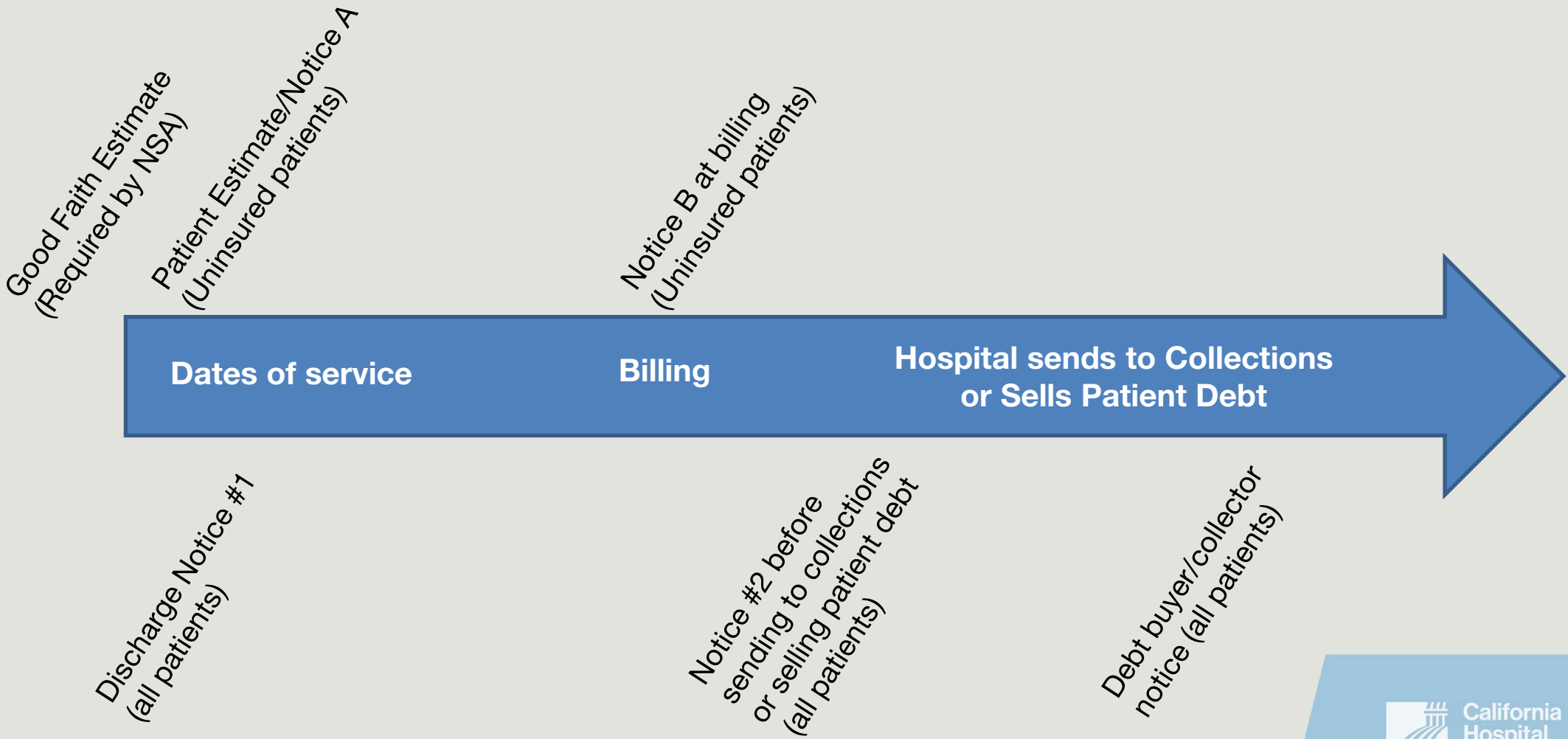
Policy Submission to HCAI

By Jan 1. 2023, hospital must **submit for review the following hospital policies** to HCAI biennially on January 1, or whenever a significant change is made:

- Discount payment policy
- Charity care policy
- Eligibility procedures for those policies and review process (may be included above)
- Application for charity care or discounted payment programs
- Debt collection policy

By Jan. 1, 2024 (or whenever regulations are promulgated), HCAI shall **impose an administrative penalty** (up to $40,000) if hospital's policy does not comply with state statues/regulations OR if hospital does not comply with the policy it provided

Hospital Postings on-site and on website



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Training

Implementation: consistency is key!

- Implementation and oversight for patient notices
  - Coordination with EHR systems for population of patient notices
- Training for patient financial service counselors
- Contracts with any entities performing debt collection activities must include strict provisions requiring compliance
- Ensure proper accounting of charity care and discounts for the purpose of cost reporting

Monitoring and Auditing

- Failure by hospitals to comply with the Hospital Fair Pricing Policy is what triggered AB 1020 and AB 532
- Monitoring of requests for financial assistance can be incorporated into current claim reviews or performed as a separate audit
- Consider regular monitoring of activities of any agents performing debt collection, including review of any court filings
- Recent interest in charity/discount care by local government agencies (SD and LA)

Other Medi-Cal FFS Updates

Medi-Cal Outlier Recalculations

- Medi-Cal has been recalculating outlier payments to APR-DRG hospitals for FYEs 2017 and later
- Magnitude of asserted overpayments in the range of $100M per year
- Multiple hospitals in litigation with DHCS

Medi-Cal Audits

- Focus by Audits and Investigations on areas likely to most impact reimbursement: outliers and cost-based payment cost centers
- Return to standard cost reporting principles, but with questionable deference to CMS interpretations
- NICU a significant are of focus
    - Issue that was raised years ago and mostly settled
    - to reduce costs associated with staffing in NICUs
    - Concern about unnecessary costs (babies in NICUs that are not 174, ovSeekingerstaffing of NICUs)

Medi-Cal Audits

- Focus on Cost-based Cost Centers
  - FQHCs and RHCs paid based on costs
  - Limiting requests for change of scope changes
  - Restricting allocation of overhead costs
  - Scrutiny on square footage and staffing costs
- Further focus on reducing wrap payments (e.g., for timeliness of billing or contract/non-contract status)

Questions?

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Thank You

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