Department of Health Care Services

MEMORANDUM

DATE: 10/05/2018

TO: All Medi-Cal Managed Care Health Plans and Hospitals

FROM: Lindy Harrington
Deputy Director, Health Care Financing
/s/ Lindy Harrington

SUBJECT: Hospital Directed Payment Definition for SFY 2017-18 and SFY 2018-19

The SFY 2017-18 and SFY 2018-19 hospital directed payment programs implement enhanced reimbursement to eligible and participating network hospitals for contract services. The below describes the requirements for a service provided by a hospital to qualify as a contract service by a network provider such that it is eligible for receipt of the following directed payments approved by CMS under 42 C.F.R. §438.6(c) when providing eligible contract services to Medi-Cal enrollees:

- Designated Public Hospital Enhanced Payment Program (as detailed at this link),
- Designated Public Hospital Quality Incentive Program (as detailed at this link), and
- Private Hospital Directed Payment Program (as detailed at this link).

For purposes of these specific hospital directed payments, a contract service performed by a network hospital is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Medi-Cal managed care health plan (MCP) by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in this notice for the applicable date(s) of service. The minimum criteria necessary to qualify for the directed payment for the non-excluded population types and non-excluded service providers are:

1. The agreement must cover one or more defined non-excluded populations of Medi-Cal beneficiaries and must not be limited to a single patient only.
2. The agreement must cover a defined set of one or more non-excluded hospital services, or when applicable non-hospital services, and must not be limited to treatment of a single case or instance only.
3. The agreement must specify rates of payment, or include a defined methodology for calculating specific rates of payment for services performed, applicable to the services and populations covered by the agreement, and must not permit payment to be negotiated on a per patient or single instance of service basis.
4. The agreement must not expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement.
5. The agreement must be for a set duration of at least 120 days.

In delegated arrangements where there is not a direct contract between the MCP and the hospital rendering services, there must be a demonstrable unbroken contracting path between the MCP and the provider for the service rendered, the member receiving the service, and the applicable dates of service that meets minimum criteria listed above. In this context, “unbroken contracting path” means a sequence of contracts meeting the minimum criteria defined above, linking the MCP and a direct subcontractor, or series of subcontractors, to the provider.

Commencing with rating periods beginning on or after July 1, 2019 (SFY 2019-20), in order for a hospital to qualify as a network provider of contracted services for receipt of the above-specified directed payments, the hospital and MCP must demonstrate to DHCS, in a form and manner required by DHCS, that all contractual arrangements linking the network hospital to the MCP comply with all applicable State and Federal requirements related to network providers and subcontractors in addition to the standards set forth in this guidance.