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Targeted Rate Increase (TRI) Sub-Capitated Compliance Attestation (due December 1, 2024)

The purpose of Targeted Rate Increase (TRI) Sub-Capitated Compliance Attestation is for participating physician groups (PPGs) to certify their compliance with provider reimbursement levels covered under sub-capitated contracts for TRI covered services. Sub-capitated contracts for this attestation include any reimbursement arrangement not tied explicitly to fee-for-service contracting. By signing, PPGs are attesting that they have themselves, or confirmed with their downstream providers, that each sub-contract to a provider has been analyzed and determined to meet or exceed the TRI requirements. This attestation will cover Calendar Year (CY) 2024 for TRI. This attestation must be submitted by each PPG to their Provider Network Manager, no later than December 1, 2024, certifying that their reimbursement levels meet the TRI requirements.

Scope of Attestation

The attestation must include all capitated contracts paid to PPG providers for the members which cover any of the TRI codes. Department of Health Care Services (DHCS) considers a capitated contract as any contract with a provider where the provision of payment is not based on the single specific service provided. DHCS is not asking for analysis of a contract with a delegated entity that will not be providing the service. The PPG is responsible for identifying which contracts are covered under this scope. A best practice could be to review both the Division of Financial Responsibility (DOFR) and submitted encounters under the contract to determine if at least one TRI-affected code is included. The PPG is responsible for analyzing each unique contractual relationship which encompasses the TRI codes at the TIN level. If such processes are delegated, PPG retains ultimate responsibility for ensuring such processes are accurately completed and, by signing the attestation, are attesting to such. Contracts established and paid directly to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Cost Based Reimbursement Clinics (CRBCs), and Indian Health Service (IHS) providers do not require attestation.

Process/Documentation

DHCS is not prescribing the methodology that a PPG must follow to document their compliance with the TRI attestation. The PPG can determine their compliance with the TRI requirements but must clearly demonstrate how their methodology was sufficient to determine compliance. DHCS may determine that an audit of the Medi-Cal Managed Care Plan (MCP) contractual reimbursement is necessary and will require the MCP to provide all necessary documentation and methodology behind their process. In this case, we would require PPGs to provide all necessary documentation and methodology behind their process. This would include providing documentation and methodology that their downstream subdelegates completed as part of this attestation.

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Health Net expects the PPGs to provide a summary of:

- Historical and credible encounter and eligibility data for the contract, pricing information for the utilization, and a methodology for developing a prospective Per-Member, Per-Month (PMPM) expense adjusting the historical data.
- The method used to price the services provided under the contract, including TRI and non-TRI eligible services.
- The analysis for each contract showing the above was completed and that a contract meets or has been adjusted to meet the TRI payment requirements.

Attestation

I, _______________________ duly authorized, certify on behalf of _________________________
Name PPG Name
that all downstream contracts have been reviewed and analyzed for compliance with TRI

reimbursement requirements. As of _________________, all downstream contracts meet or
Date
exceed the required reimbursement levels. Upon request, _________________________ will
PPG name
provide all documentation and methodologies to Health Net.

Return the signed attestation to your Provider Network Manager.

Print Name: ____

Title: ____

Signature: ____

Date: _____________