# Medi-Cal Financing: What It Means for California Hospitals

# Agenda

- The History, Growth, and Current Landscape of State Directed Payments (SDPs)

- CMS' Proposed Rule on SDPs
  - ✓ Medicare-based Limits
  - ✓ Separate Payment Term Phase Out
  - ✓ Elimination of Uniform Dollar Increases (UDIs)

- Impending Medi-Cal Eligibility Changes
  - ✓ Delivery System Transition of Individuals with Unsatisfactory Immigration Status (UIS) from Managed Care into Fee-for-Service (FFS)
  - ✓ CMS Interim Final Rule: Medi-Cal Work and Community Engagement Requirements

# The History, Growth, and Current Landscape of State Directed Payments (SDPs)

# History of Directed Payments

- Prior to managed care, states used Fee-for-Service supplemental payments (including UPL payments, DSH, and other methodologies).
- As states moved to managed care, states often used “pass-through” payments, which included flexibilities to pass funding down primarily to safety net providers.
- CMS’ 2016 Final Rule began a ten-year phase down of pass-through payments since they are not typically tied to specific services, utilization, or quality outcomes.
- Under 42 CFR §438.6(c), directed payments emerged as the replacement payment mechanism for supplemental payments in managed care.

# History of Directed Payments

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# Growth of Directed Payments

## National Context:

- State Directed Payments (SDPs) have grown significantly since 2017.
- Approximately 121 SDPs were approved by CMS as of 2019
- MACPAC identified 250 unique SDPs, representing $69.3 billion in Feb. 2023.
- As of Aug. 2024, there were 302 unique arrangements with $110.2 billion in projected annual spend with hospitals making up ~80% of all SDPs.

## Federal Reform Narrative:

- Medicaid financing is being framed as **waste, fraud, and abuse**
- Paragon and other conservative policy groups argue that SDPs allow states to draw down federal funds without state exposure.
- SDPs are described by critics as exploiting “loopholes” or “money laundering” schemes.

December 2023

GAO Highlights

Highlights of GAO-24-106202, a report to congressional addressees

MEDICAID MANAGED CARE

**Rapid Spending Growth in State Directed Payments Needs Enhanced Oversight and Transparency**

**Why GAO Did This Study**

In 2022, spending for managed care represented more than half of the $800 billion spent on Medicaid. The percentage is expected to continue growing in the next decade. With few exceptions, states may not direct managed care plans' payments to providers. However, CMS began allowing a new exception in 2017: state directed payments. Since then, states have made widespread use of directed payments; for example, to increase payments to safety net providers to ensure beneficiary access.

Among other issues, this report describes estimated spending for, and state financing of, state directed payments, and examines CMS's policies and procedures for approving these payments.

GAO analyzed information on approved state directed payments in effect in 2022, and interviewed CMS and Medicaid officials from five states. These states were selected, in part, based on having a directed payment estimated at $1 billion or more in 2022. GAO assessed CMS's policies and procedures against agency guidance and federal internal controls.

**What GAO Recommends**

GAO is making four recommendations to CMS, including to enhance the agency's fiscal guardrails for approving state directed payments, review outcome information at renewal, and make publicly available additional approval documents. The Department of Health and Human Services agreed with two recommendations. It neither agreed nor disagreed with the other two recommendations, but noted CMS actions underway to address them.

View GAO-24-106202. For more information, contact Catina B. Latham at (202) 512-7114 or lathamc@gao.gov.

**What GAO Found**

Using state directed payments, states can direct how Medicaid managed care plans pay providers in certain circumstances. This includes requiring payments in addition to the base payment rates negotiated between plans and providers. State directed payment spending has grown to at least $38.5 billion in 2022, the sixth year of state use, and further growth is expected.

**Estimated 2022 Spending for State Directed Payments, by State**



Source: GAO analysis of Centers for Medicare & Medicaid Services data (data); MapResources (map). | GAO-24-106202

Note: For more details, see figure 3 in GAO-24-106202.

States often relied on taxes on providers, instead of state general funds, to finance the nonfederal share of state directed payments. States' limited stake in the cost of state directed payments raises concerns for GAO given the weaknesses GAO identified in the Centers for Medicare & Medicaid Services' (CMS) policies and procedures for approving such payments.

- **Weak fiscal guardrails.** CMS has indicated that payments must be reasonable and appropriate, but has not established and communicated a definition of, or standards for, assessing that. CMS has set no other limits on spending under directed payments.
- **No consideration of payment outcomes when renewing.** CMS does not appear to consider state evaluation results or any other outcome information when deciding whether to approve a renewal of a directed payment.
- **Gaps in transparency.** CMS recently made payment applications publicly available, but does not post other information, such as attachments including important financing information, evaluation plans, and evaluation results.

These weaknesses leave the agency at risk of approving ineffective payments.

United States Government Accountability Office

# California's Hospital SDP Landscape

Approved 2025 Hospital SDPs

| Private Hospitals | | District Hospitals | | Public Hospitals | |
|---|---|---|---|---|---|
| PHDP: | $8.81 billion | DHDP: | $842 million | EPP: | $3.86 billion |
| | | DHDP QIP: | $178 million | DPH QIP: | $3.46 billion |

Key:

| |
|---|
| PHDP - Private Hospital Directed Payment |
| DHDP - District Hospital Directed Payment |
| DHDP - DHDP Quality Incentive Pool |
| EPP - Enhanced Payment Program |
| DPH QIP - Designated Public Hospital QIP |

- As of 2025, California has five hospital-specific SDPs totaling over $17.1 billion (annually)

# CMS' Proposed Rule on SDPs

- Medicare-based Limits
- Separate Payment Term Phase Out
- Elimination of Uniform Dollar Increases

# Medicare-based Limits for SDPs

- Proposed rule on SDPs imposes a phase-down of grandfathered SDPs that are above Medicare beginning with rating periods on or after January 1, 2028.
- For hospitals, the calendar year 2025, is the total payment level for grandfathering purposes.
- Grandfathered SDPs face a fixed 10% annual reduction applied to the original total payment amount until the “Medicare limit” is reached
  - Reduction does not compound year-to-year
  - CMS appears to require 10% gross reduction to entire aggregate pool for SDPs

*Example: If a total grandfathered payment level was $1 billion, then a $100 million per year phase-down would begin 2028.*

| CY 2026 State Directed Payments | Above Medicare? |
|---|---|
| Children's Hospital Supplemental Payment (CHSP) | YES |
| Community Clinic Directed Payment (CCDP) | NO |
| District Hosptial Directed Payment (DHDP) | YES |
| Enhanced Payment Program (EPP) | YES |
| Equity and Practice Transformation Payments (EPT) | NO |
| Private Hospital Directed Payment (PHDP) | YES |
| DMPH Quality Incentive Program (DMPH QIP) | YES |
| DPH Quality Incentive Program (QIP) | YES |
| Major Organ Transplant (MOT) | YES |
| Developmental Screening | NO |
| Prop 56 Family Planning | NO |
| Prop 56 Dental | N/A |

# Medicare-based Limits for SDPs

## Questions for the Panel:

- How have Medicare ceilings been calculated historically and will this methodology change with this rule?
- How will this impact classes or pooled amounts within a service line?
- What are concerns within the specific hospital SDP programs?

# Separate Payment Term Phase Out

- Maintains requiring prospectively set add-ons in 2027 and prohibition of separate payment terms beginning in 2028, but proposes a time-limited extension for grandfathered SDPs

- Grandfathered SDPs would not be required to comply with either requirement until the first rating period at or below the Medicare limit

- Despite the proposed rule allow for a delay, DHCS is proposing to implement assuming the 2027 and 2028 implementation dates.

# Medicare-based Limits for SDPs

-Approved SDPs
-No change to SDPs structures
-"Grandfathered 2025 Amts"
-Passthrough (12-mos)

-Pending SDPs
-No change to SDPs structures
-"Grandfathered 2025 Amts"
-Passthrough (12-mos)

-Change to SDP; Prospective PMPMs
-SPT are OK
-"Grandfathered 2025 Amts"
-Passthrough (6-mos only)

-Changes to Hospital SDPs (Risk-Based)
-10% Phasedown off 2025 Grandfathered Amounts
-No Passthrough

-10% Phasedown off 2025 Grandfathered Hospital SDPs
-Non-Risked Based / SPT are OK
-No Passthrough

-Hospital SDPs = 100% of Medicare
-Risk-Based SDP continue but at a reduced amount.

-Hospital SDPs = 100% of Medicare
-No more Uniform Dollar Increment (UDI) directed payments

# Separate Payment Term Phase Out

## Questions for the Panel:

- What does prospective add-ons entail and what are the risks?
- What do you see as the biggest issues/risks with the phase out of separate payment terms?
- What are areas that we should advocate for to mitigate risk?

# Elimination of Uniform Dollar Add-ons

- States would no longer be able use UDIs beginning Jan. 1, 2028, or for grandfathered SDPs, when Medicare ceiling is reached

- Limits how states can direct payments likely resulting in minimum/maximum fee schedule SDPs would not require prior written approval but must still be documented in contracts/rate certifications and state must document payment limit compliance

- CMS signals application of Medicare limits to VBP SDPs and thus casting doubt on its efficacy as post-OBBBA replacement

# Elimination of Uniform Dollar Increases

## Questions for the Panel:

- How does this impact the statewide financing arrangements?

- Are there any specific examples of how this impacts separate classes within a program?

# Impending Medi-Cal Eligibility Changes

- Delivery System Transition of Individuals with UIS from Managed Care into FFS
- CMS Interim Final Rule: Medi-Cal Work and Community Engagement Requirements

# Transition of UIS Population into FFS

- Transition of ~2 million beneficiaries from managed care into FFS
- Impacts vary by region
- Reimbursement in FFS delivery system typically at levels below managed care and not eligible for directed payments.

# Transition of UIS Population into FFS

## Questions for the Panel:

- How does this impact hospital directed payments?
- What do you see as the biggest areas of concern for hospitals?
- Are there any other coverage or eligibility changes you see for this population in the future?

# Work and Community Engagement Requirements

- CMS issues an interim final rule on June 1, establishing work and community engagement requirements as a new condition of eligibility within the “new adult group.”

- Medical frailty guidance narrowed as compared to statute.

- In 2027, exclusions from requirements may require documentation (including self-attestation); this is no longer allowed beginning in 2028

# Work and Community Engagement Requirements

Questions for the Panel:

- What are the major financial takeaways from this rule?

- How does this impact hospital presumptive eligibility?