February 24, 2022

The Honorable Susan Talamantes Eggman
Chair, Senate Budget and Fiscal Review Committee, Subcommittee No. 3 on Health and Human Services
1021 O St., Suite 8530
Sacramento, CA 95814

The Honorable Dr. Joaquin Arambula
Chair, Assembly Budget Committee, Subcommittee No. 1 on Health and Human Services
1021 O St., Room 6240
Sacramento, CA 95814

**Subject: Increase Access to Equitable Health Care — Support CHA Request**

Dear Senator Eggman and Assembly Member Arambula:

Medi-Cal provides health coverage to low-income Californians — one-third of the entire state and nearly half of all children — and those who rely on Medi-Cal coverage are disproportionately people of color (two-thirds are non-white). But Medi-Cal beneficiaries are shortchanged: systemic underfunding means that those who care for Medi-Cal patients are reimbursed just 74 cents for every dollar they spend providing care, resulting in fewer resources for California's most vulnerable communities.

The California Hospital Association (CHA) is pleased to support the additional ongoing Medi-Cal investments proposed by the Department of Health Care Services (DHCS), specifically with the expansion of coverage to all-income eligible Californians, new and expanded benefits authorized under the California Advancing and Innovating Medi-Cal initiative, and the elimination of Assembly Bill (AB) 97 payment reductions. Investing in the future of the Medi-Cal program will be critical as California recovers from the COVID-19 pandemic.

It is also refreshing to see the administration propose to eliminate the recession-era policies like AB 97 payment reductions and artificial budgeting tricks like delaying provider payments every June. The truth is, these old fee-for-service payment policies used to balance budgets of the past are no longer needed now that Medi-Cal managed care is the delivery system of choice for the state. It's clear that population-based payments to Medi-Cal managed care plans provide the state greater predictability and budgeting stability — a far better financial footing that will also protect against future volatility. While this stability for the Medi-Cal program allows the state to drive toward person-centered care and increased quality and outcomes, we will never make progress toward health equity if Medi-Cal continues to underfund care for those with the greatest needs.

Current state law requires Medi-Cal inpatient fee-for-service reimbursement for private and district hospitals to be fixed at 2012-13 levels, while expenses for patient care — things like health care worker salaries and benefits, medical supplies, pharmaceuticals, utilities, and more — have increased by more than 45% during that same period. And designated public hospitals use their own resources, instead of receiving state general funds, to provide care to Medi-Cal fee-for-service patients, resulting in reimbursement that only covers roughly half the cost to care for hospitalized patients.

The impact on communities of color is significant. Outdated payment methodologies and the state's overreliance on self-financed supplemental payment programs have led to substantial underfunding of the Medi-Cal program for patients and communities served by California's critical safety net providers, which disproportionately affects people who are often at the highest risk of poor health. The formula for reimbursing hospitals does not account for sicker, more disadvantaged communities and has not been increased since its inception a decade ago — all while the needs of communities with socioeconomic challenges have continued to grow.

Unfortunately, as the Medi-Cal program drives toward reform, continuing to rely on "provider-funded" Medi-Cal payments to help fill the increasing gap will perpetuate a cycle of health inequity. These policies have exacerbated the Medi-Cal shortfall and obscured the widening gap between health care resources for low-income communities and those for wealthier communities. It will take substantive changes to Medi-Cal reimbursement to course correct a deeply underfunded system.

For these reasons, CHA is proposing the following actions to address the systemic funding issues and take into account the individual challenges patients face:

- Replace the policy that froze hospital APR-DRG (a schedule of payments for common procedures) rates at 2012-13 levels
- New, annual payment adjustments to account for the social and environmental challenges patients may be experiencing
- Converting public hospitals' Medi-Cal fee-for-service inpatient reimbursement to a value-based structure that includes state general fund support

This proposal will modestly address the structural deficiencies in the current payment methodology that do not recognize the dynamic care models needed to effectively help our diverse Medi-Cal population. We look forward to discussing this proposal with you and your staff. Please reach out to me at (916) 812-7406 if you have questions prior to our discussions.

Sincerely,

Kathryn Austin Scott
Senior Vice President, State Relations and Advocacy

Attachments

cc: Members, Senate Budget Subcommittee No. 3
Members, Assembly Budget Subcommittee No. 1
Scott Ogus, Consultant, Senate Budget Subcommittee No. 3
Andrea Margolis, Consultant, Assembly Budget Subcommittee No. 1
Anthony Archie, Senate Republican Caucus
Eric Dietz, Assembly Republican Caucus
Dr. Mark Ghaly, Secretary, Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
Tam Ma, Deputy Legislative Secretary, Office of the Governor
Michelle Baass, Director, Department of Health Care Services