Overview of Medi-Cal Rate Setting

Background

California has an extensive history of using various mechanisms to fund Medi-Cal payments for hospital services. Originally, the main use of these various funding mechanisms was tied to specific programs authorized under time-limited federal waivers; however, over the past 15 years, the use of self-financing and/or provider taxes has grown into a critical element supporting the entire Medi-Cal program. The reliance on self-financing in the latest Medi-Cal estimate (state fiscal year 2021-22) now eclipses $11 billion dollars annually, or 10% of the state budget to support medical services. When matched with federal funding, the total impact exceeds $30 billion annually, which supports the 15 million beneficiaries enrolled in the Medi-Cal program.

These funding mechanisms and methodologies differ based on hospital type and delivery system. For instance, designated public hospitals (DPHs[1]) and non-designated public hospitals (NDPHs)/district hospitals may use certified public expenditures (CPEs) and intergovernmental transfers (IGTs) as additional funding mechanisms in both fee-for-service (FFS) and managed care delivery systems, while private not-for-profit and investor-owned hospitals cannot. To help understand these differences, it's best to examine the different Medi-Cal reimbursement as base payments and supplemental payments.

Base Payments — FFS base payment methodologies are highly prescribed pursuant to state law and federal state plan approvals, while managed care payments for inpatient services are subject to direct contract negotiations between managed care plans (MCPs) and hospital providers and can take many forms. More details are included later in this memo, but FFS inpatient reimbursement depends on the type of hospital:

- DPHs receive up to a portion of their actual audited costs.
- Private hospitals and NDPHs are reimbursed based on the All Patient Refined Diagnosis Related Groups (APR-DRG) methodology.

Supplemental Payments — In California, there are more than 30 supplemental payment programs that cover different hospital types and services (inpatient, outpatient, long-term care, etc.). These programs are approved by the Centers for Medicare & Medicaid Services (CMS) through various authorities: 1) 1115 Waivers, 2) state plan, 3) managed care directed payments, and 4) managed care rates. This document highlights only a few of the supplementals.

Benefit from the Public Health Emergency (PHE) — At the highest level, hospitals have received very little to no direct benefit by a change in Medi-Cal FFS reimbursement methodologies as a result of COVID-19. Any payment changes they received from Medi-Cal MCPs have been the result of contract

[1] "Designated Public Hospital" has the meaning given in subdivision (f) of Section 14184.10 of the Welfare and Institutions Code.

negotiations and discussions with health plans and not the result of Medi-Cal policy changes. The only benefit hospitals experienced through the PHE is due to an enhanced federal medical assistance percentage of 6.2%, which lowered the non-federal share needed to support their base and supplemental payments. However, not all of that benefit was actually observed by hospitals. For some programs, the enhanced federal funding was retained by the state; in other situations some of the funding hasn't been claimed yet; and in still other situations there is an expectation the state will recoup it in future reconciliations. Therefore, the incremental costs of COVID-19 have not been recognized through any meaningful changes in payment methodology in either Medi-Cal FFS payments or Medi-Cal MCP payments. As a result, the need to offset expenses submitted to the Federal Emergency Management Agency (FEMA) Public Assistance Program related to the COVID-19 PHE would be *de minimis* as it relates to Medi-Cal payments.

Based on this analysis, the only Medi-Cal payments received from the state that a hospital may need to offset expenses included in a FEMA public assistance application are for rate increases related to COVID-19 laboratory services, long-term care (LTC) services, certain durable medical equipment (DME), and COVID-19 vaccination administration. Medi-Cal payment methodologies for hospitals are briefly described below, including the limited circumstances in which payment has changed as a result of COVID-19.

Fee-for Service Delivery System

APR-DRG — Private and non-designated public/district hospitals receive base payments for FFS inpatient admissions using the APR-DRG methodology. APR-DRG is a bundled rate methodology that uses a patient's diagnosis/diagnoses and the severity of the patient's condition(s) further adjusted by a hospital-specific relative value and location to determine a bundled payment amount based on the type of admission and services performed. While a COVID-19 admission is reimbursable under the APR-DRG methodology, there was no premium/increase applied to COVID-19 admissions for Medi-Cal, unlike the 20% increase applied in Medicare Severity-Diagnosis Related Group (MS-DRG) for COVID-19 admissions. Furthermore, in California, the DRG methodology has been designed to be budget neutral based on 2012 payments such that annual updates to the DRG methodology are targeted to pay no more per weighted average admission than the weighted average admission in 2012. This budget-neutral methodology amounts to FFS payments frozen at 2012 levels. Therefore, not only did California hospitals not receive more for COVID-19-related admissions, they are being underpaid in their APR-DRG base rates for all admissions, including COVID-19, based on their actual cost as a result of the budget-neutral APR-DRG methodology administered in California. Due to systemic underfunding of the Medi-Cal program, hospitals that care for Medi-Cal patients are reimbursed only 74 cents on the dollar for the cost of care.

Outpatient/Professional Fee Schedule — All hospital types that deliver outpatient and professional services in the FFS system are reimbursed according to the Medi-Cal-established fee schedule. Upon delivering a service, hospitals and providers submit claims using procedure codes to identify the service provided and are paid according to the fee schedule for that procedure. The fee schedule does make some adjustments to the amount paid based on the provider type and the population served, and for some procedures (such as physician office visits) that provide a supplemental payment beyond the published fee schedule. However, aside from very specific instances that are further discussed below, the FFS fee schedule was not increased or modified to pay differently for services provided to treat COVID-19.

Public Hospital Cost-Based Reimbursement — California's DPH systems are paid up to their actual audited costs for FFS inpatient services provided to Medi-Cal members using a certified public expenditure (CPE) methodology. However, DPHs are responsible for funding most of the non-federal share of these payments. In other words, their CPE is what funds the non-federal share, and the state Medi-Cal program does not provide state dollars to fund the non-federal share of the DPH's costs. California has not altered this methodology or provided any direct state funding thus far as a direct result of COVID-19. Therefore, while DPHs are able to use their CPEs to claim federal funding for any increase in costs they have experienced for FFS Medi-Cal inpatient admissions as the result of the pandemic, they are still responsible for self financing the growth in the non-federal share of these costs.

Managed Care Delivery System

Managed Care Capitation Rates — Hospitals receive payments from Medi-Cal managed care plans for hospital services provided to health plan members. The level of base reimbursement is determined through contract negotiations with health plans, and these mechanisms can include a FFS structure, percentage of charges, per diem amounts, DRG-based system, risk-based sub-capitation and member assignment arrangement, and even pay for performance or shared savings incentive arrangements. Health plan capitation rates are based on principles of actuarial soundness and are developed by using historical health plan cost and utilization data and then applying various trends and program change adjustments to account for the costs associated with services to the populations they are contracted to cover during the time period in which they are covered. The data used to develop the most recent 2022 rates use actual experience from 2019 and, therefore, do not capture any of the impacts of COVID-19.

Lastly, the managed care plans receive additional funding to support public safety net providers within their capitations. Both DPHs and NDPHs are eligible for this additional funding and support these enhanced payments with IGTs. These payments mirror the base capitations for the plans and were also not adjusted due to the COVID-19 pandemic.

Supplemental Payments

1115 Waiver Programs (PATH and Global Payment Program) — Under the Providing Access and Transforming Health (PATH) initiative of California's recently approved 1115 Waiver[2], known as California Advancing and Innovating Medi-Cal (CalAIM), DPHs are eligible to receive funding to transition the previously approved 1115 Waiver program of Whole Person Care to the managed care delivery system, using a new enhanced care management (ECM) benefit and community supports (in lieu of services) benefits, and increase service capacity and infrastructure for ECM and community supports (CS). PATH funding and allocations to DPHs have no direct linkage to the COVID-19 pandemic, and COVID-19 is not an explicit condition that would qualify an individual for access to ECM or CS benefits.

CalAIM also extends the Global Payment Program (GPP) for a subset of DPHs. GPP is funded using most of California's federal disproportionate share hospital (DSH) allotment and additional funding authorized for uncompensated care under the safety-net care pool. The GPP allows eligible DPHs to repurpose DSH funding, which historically has only considered uncompensated costs for Medi-Cal and uninsured

[2] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf

inpatient services, to allow for spending on non-inpatient preventative care services for the uninsured. While services provided to uninsured individuals experiencing COVID-19 would be a part of the GPP framework, no increased funding or additional recognition of COVID-19 has been implemented in the GPP.

DSH and DSH-Replacement (DSH-R) — Given that eligible DPHs use the majority of California's federal DSH allotment through the GPP, what little federal DSH allotment is left is allocated for the subset of DPHs that are not in the GPP and the NDPHs. California still allows for private hospitals that would have been eligible to receive DSH funds through supplemental payments that equal what those hospitals would have otherwise received under DSH. These are supplemental payments that use state General Fund and non-DSH federal matching funds and are offset against the state's approved upper payment limit for FFS supplemental payments. In California, this is known as the DSH-Replacement (DSH-R) or Virtual DSH program. The funding methodology for DSH-R follows the historic DSH allocation methodology and, as such, there have been no adjustments or changes in the allocation methodology directly as a result of COVID-19. Uncompensated costs as a result of COVID-19 admissions would be captured as part of the DSH-R methodology, but COVID-19uncompensated costs are not being treated any differently than uncompensated costs for other conditions.

Regarding the remaining federal DSH allotment, eligible NDPHs and University of California hospitals receive DSH funds allocated using the historical DSH methodology; as such, no adjustments or changes to the allocation methodology have been implemented as a result of the pandemic. Uncompensated costs because of COVID-19 admissions would be captured as part of the DSH methodology, but COVID-19 uncompensated costs are not being treated any differently than uncompensated costs for other conditions.

Hospital Quality Assurance Fee (HQAF) Program — The HQAF program allows for improved hospital reimbursement of Medi-Cal services by assessing a fee on private hospitals based on their inpatient utilization, using that fee revenue to match with federal funding, and then paying supplemental payments to hospitals based on their Medi-Cal inpatient and outpatient utilization. All private general acute care hospitals must participate in the program except exempt facilities (e.g., public, small/rural, psychiatric, specialty, long-term care, and new hospitals). The FFS portion of HQAF payments and the fees assessed are fixed and based on historical utilization from a time prior to the pandemic (2018 utilization for the current program). Therefore, the impact of COVID-19 has not been captured under any FFS payments received by hospitals or fees paid by hospitals, and there have been no adjustments to the HQAF program directly because of COVID-19. In fact, the state has been in discussions since December 2021 and is still seeking approval from CMS for the HQAF program for 2022. The HQAF program uses the federal authority (upper payment limit) that allows hospitals to receive supplemental payments that would pay hospitals in aggregate up to what Medicare would pay for the same service. Despite the state's efforts at demonstrating actual experience related to the COVID-19 pandemic illustrating the higher Medicare payments for COVID-19 admissions, CMS has denied the proposed adjustments. Therefore, not only does the HQAF program not capture the impact of COVID-19 in the data, nor make any payment adjustments based on COVID-19, but CMS has also rejected the potential to recognize higher Medicare payments for COVID-19 in the upper payment limit calculations.

Managed Care Directed Payments — Directed payments are a financing mechanism used in managed care delivery systems that is in addition to the negotiation process between health plans and providers. They establish mandatory payment amounts for specified services.

DPH and district/municipal public hospital (DMPH) systems participate in a quality-based directed payment program known as the quality incentive program, which provides additional funding to DPH/DMPH systems for achieving certain quality benchmarks. While quality scores could capture the treatment of individuals with COVID-19, none of the quality measures are directly tied to COVID-19, and no increased funding was provided for the quality incentive program related to COVID-19. The non-federal share of these payments is financed through IGTs.

DPHs also participate in a directed payment program known as the enhanced payment program , which provides supplemental funding through managed care to DPHs based on their contracted inpatient and outpatient utilization. Like the other supplemental payment programs that are based on utilization, this program will pay additional funding for services provided to individuals with COVID-19. However, funding for the enhanced payment program was not increased as a result of COVID-19, and COVID-19 utilization does not pay any differently than other conditions.

The HQAF program described above also funds a private hospital directed payment (PHDP) program that provides eligible private hospitals additional funding for contracted inpatient and outpatient services provided to Medi-Cal managed care members. Like the other supplemental payment programs that are based on utilization, this program pays for services provided to individuals with COVID-19. However, funding in PHDP was not increased as a result of COVID-19, and COVID-19 utilization does not pay any differently than other conditions.

There are other directed payment programs that are not specific to hospitals, but hospitals or their contracted partners can receive them based on specific services (e.g., physician office visits, developmental and trauma screenings, or family planning services). None of these directed payments are for treating COVID-19, and while physician office visits to treat COVID-19 would qualify for a directed payment, the payment itself is not related to the COVID-19 condition and does not pay differentially based on it.

Other Supplemental Payments — There are also a variety of other Medi-Cal FFS supplemental payment programs authorized in California. Eligibility and funding levels for these supplemental payment programs vary. For instance, DPHs and DMPHs participate in a variety of CPE-based supplemental payments in order to receive federal reimbursement up to their audited costs for different categories of service (physician and non-physician services, distinct part-nursing facility services, and outpatient services). All DSH-eligible hospitals are eligible to receive outpatient DSH payments. Private hospitals are eligible for private hospital supplemental fund payments, and certain private hospitals are eligible for private trauma hospital payments. NDPHs also participate in the NDPH supplemental reimbursement program. All of these programs are authorized under the Medicaid state plan, which defines the eligibility, funding amounts available, and data to be used (if applicable). None of the data used thus far for these payments have captured COVID-19 experience, and there have been no adjustments in payment amounts or allocations of funds to attempt to pay a differential based on COVID-19 experience.

COVID-19-Related Payment Adjustments

As part of the COVID-19 PHE, CMS provided states the opportunity to seek federal approval for changes and flexibilities to their Medicaid programs that would be in effect through the PHE. This included flexibilities through section 1135 waivers and changes to their state plan, section 1115 Waivers, and Appendix K for home and community-based waiver programs. California received approval for a variety of program changes and flexibilities through these vehicles. As it relates to hospitals, the following approvals were granted during the PHE:

- **Rate Increase for COVID-19 Clinical Laboratory Services —** The Medi-Cal state plan limits reimbursement for clinical laboratory services to 80% of the Medicare fee schedule. The California Department of Health Care Services (DHCS) received Disaster State Plan approval to increase rates for COVID-19-related testing services and procedures to 100% of the Medicare fee schedule rates.
- **Rate Increase for LTC Services —** The Medi-Cal state plan establishes various methodologies for establishing FFS per diem rates for LTC facilities depending on the facility type, which includes skilled-nursing facilities that are a distinct part of a hospital . Under Disaster State Plan authority, DHCS received approval to increase LTC per diem rates, including for distinct-part nursing facilities, by 10% during the PHE.
- **Rate Increase for Certain DME —** The Medi-Cal state plan limits reimbursement for DME to 80% of the Medicare fee schedule for oxygen, oxygen equipment, and respiratory equipment. DHCS received Disaster State Plan approval to increase rates for these products and procedures to 100% of the Medicare fee schedule rates.
- **COVID-19 Vaccine Payment Rates —** Under the state plan, FFS reimbursement rates for vaccines are established according to the FFS fee schedule. Under Disaster State Plan authority, DHCS received approval to reimburse procedure codes related to the administration of the COVID-19 vaccine to 100% of the Medicare fee schedule rates.