2024 RURAL HEALTH CARE SYMPOSIUM RANCHO BERNARDO INN

Financial Sustainability

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Agenda

- Hospital Financial Condition
- State of the State Budget
  - Managed Care Organization Tax
- Medi-Cal Changes
  - Benefits, Eligibility, and Delivery Systems
- Medi-Cal Hospital "Self-Financing"
  - District and Hospital Fee
- Looking into the Future

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Hospital Financial Condition

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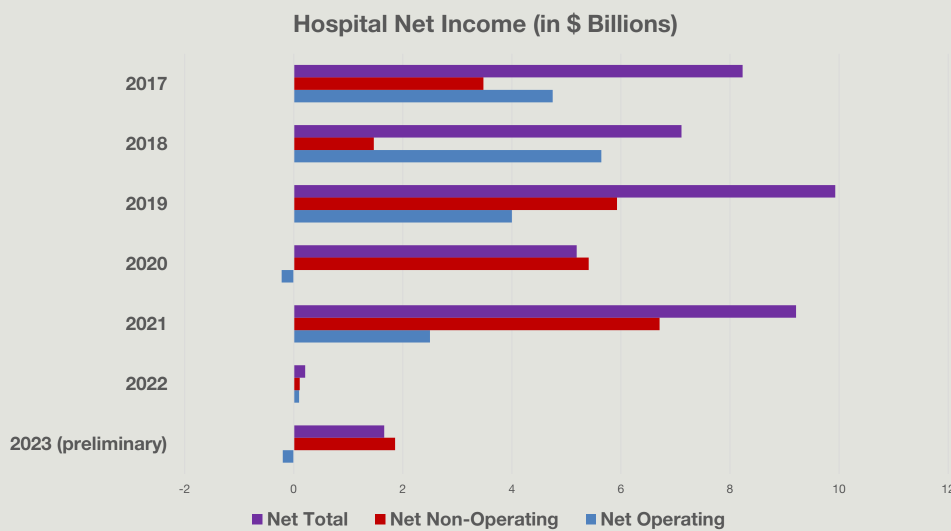
Snapshot of Hospital Income



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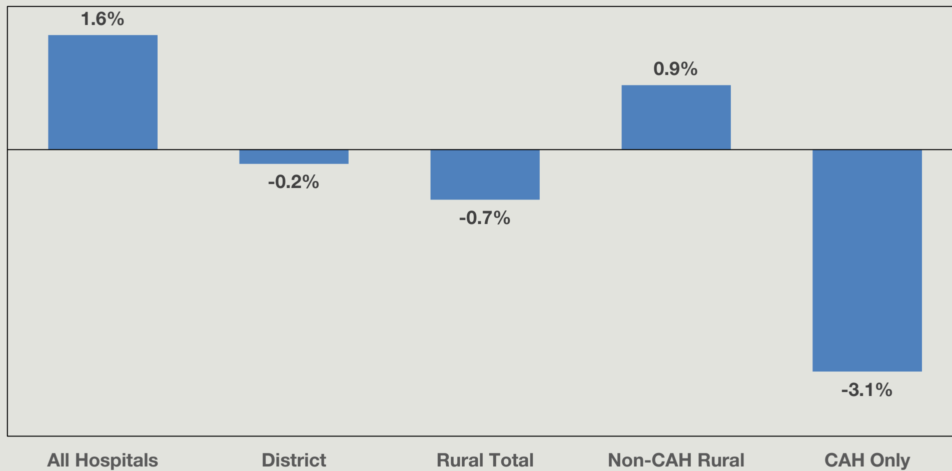
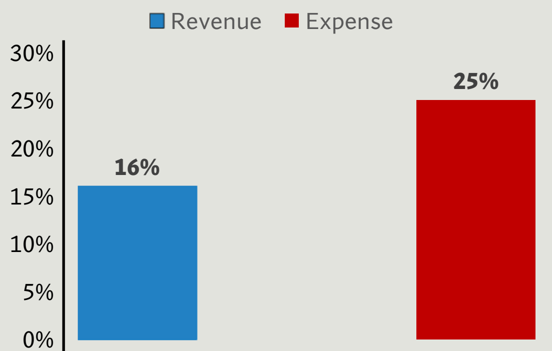
Snapshot of Hospital Operating Margins

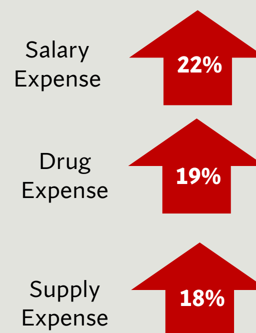


From 2019 to 2022, California hospitals' margins declined as expenses grew faster than revenue.

Growth in Revenue vs. Expenses
Per Adj. Discharge
2019 to 2022

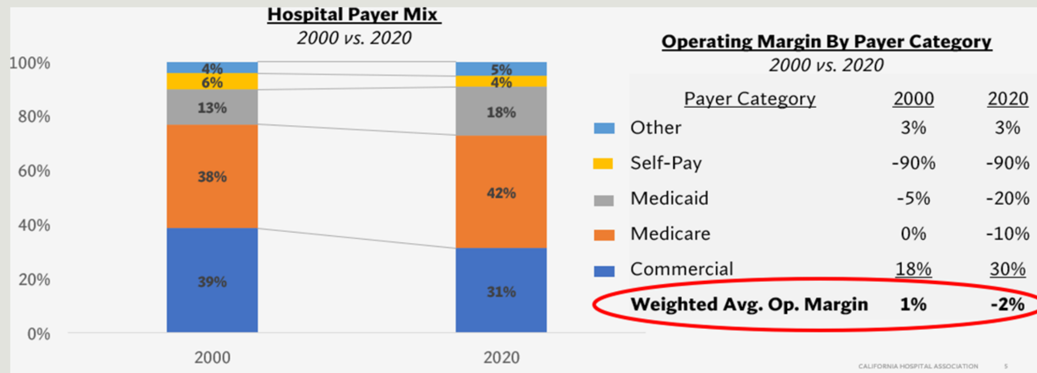


Change in Select CA. Hospital Costs
Per Adj. Discharge
2019 to 2022



Deteriorating Payer Mix

Over the last 20 years, the percentage of hospital revenue coming from governmental payers has increased, significantly depressing hospital operating margins.



Operating Margin By Payer Category
2000 vs. 2020

Payer Category	2000	2020
Other	3%	3%
Self-Pay	-90%	-90%
Medicaid	-5%	-20%
Medicare	0%	-10%
Commercial	18%	30%
Weighted Avg. Op. Margin	**1%**	**-2%**

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State of the State Budget

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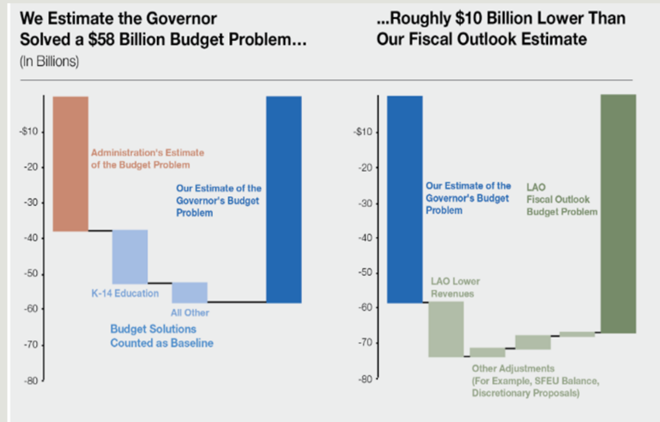
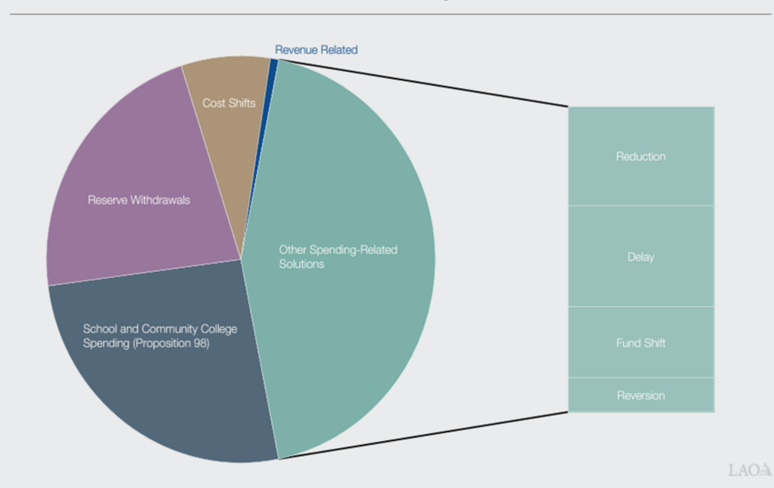
State of the State Budget

It isn't looking good…

- 2023 Budget Act Out Year GF deficit - $14 billion
- December 2023 – LAO Deficit Estimate - $68 billion
- January 2024 – Governor's Budget Deficit - $58 billion (or $38 billion depending on interpretation)
- February 2024 – LAO Deficit Estimate - $73 billion



State of the State Budget (cont.)



How did the Governor address the deficit?

- Reserves
- Cost/Fund Shifts
- Delayed Spending
- Reductions

Health programs relatively unscathed!

State of the State Budget (cont.)

Department/ Program Area	Description	2023-24	2024-25	2025-26
CalHHS	Health innovation accelerator initiative	—	—	$43
CDPH	Carryover from certain one-time funds in previous years	$268	—	—
CDPH	COVID-19 response	25	—	—
CDPH	Public health IT systems	9	—	—
CDPH	Public education and change campaign	—	$40	5
Aging	Modernizing the Older Californians Act	—	37	37
DHCS	Behavioral Health Bridge Housing program	—	—	235
DHCS	Behavioral Health Continuum Infrastructure Program	—	100	381
DHCS	Evidence-based and community-defined behavioral health programs	—	109	—
DSS	CalFresh minimum nutrition benefit pilot	—	15	—
HCAI	Carryover from certain one-time funds in previous years	565	—	—
Totals		**$867**	**$301**	**$701**

What are some further options?

- Pull back one time funding ($16 billion)
- Additional Reserve Spending
- Special Fund and Other Borrowing
- Program Cuts
- Or...

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Managed Care Organization Tax

- Federally permissible provider tax so long as it meets certain rules/criteria
- Effective April 1, 2023, through December 31, 2026 (3.75 years)
- Raises $34.7 billion in gross revenues with minimal net impact on plans
- Net benefit of $20.9 billion for the state
  - Allocates $12.9 billion to the state to address the state budget deficit
  - Dedicates $8 billion to the Medi-Cal Provider Payment Reserve Fund

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Managed Care Organization Tax (cont.)

Spending Plan: Calendar Year 2024 through Fiscal Year (FY) 2027-28

Category[2]	Estimated MPPRF ($millions)[3]	% of Annual Spend
Primary Care and Specialty Care		**62%**
Primary Care, Maternal Care, and Mental Health[4] *(started 1/1/24)*	$291	11%
Physician and Non-Physician Health Professional Services[5]	$975	37%
Community and Hospital Outpatient Procedures and Services	$245	9%
Abortion and Family Planning Access	$90	3%
Services and Supports for FQHCs and RHCs	$50	2%
Emergency and Inpatient Care		**21%**
Emergency Department (ED) (Facility and Physician) Services	$355	13%
Designated Public Hospitals	$150	6%
Ground Emergency Medical Transportation	$50	2%
Behavioral Health		**11%**
Behavioral Health Throughput *(starts 7/1/25)*	$300	11%
Healthcare Workforce		**6%**
Graduate Medical Education *(started 1/1/2024)*	$75	3%
Medi-Cal Workforce Pool – Labor-Management Committee	$75	3%
Total	**$2,656**	**100%**
Distressed Hospital Loan Program *(one-time: FY 2023-24)*	$150	
Small and Rural Hospital Relief for Seismic Assessment and Construction *(one time: FY 2023-24)*	$50	

What we know…

<u>2024</u>

- $150 million (one-time) – Distressed Hospital Loan
- $50 million (one-time) – Rural Seismic
- Professional Services (87.5% Medicare)

<u>2025</u>

- $245 million – Hospital Outpatient and ASC
- $255 million – ED Facility
- $150 million – Designated Public Hospitals
- $75 million – Graduate Medical Education
- $300 million – Behavioral Health Throughput
- Additional Professional Increases

Managed Care Organization Tax (cont.)

DHCS Proposal

<u>Hospital Outpatient and ASC</u>

- 2025 and 2026 – "Transitionary increases to baseline reimbursement." Estimated 10% "baseline increase" that will vary by region or facility, but would not be on a procedure code basis, plus additional undefined "equity adjustments"
- No Sooner than 2027 – Transition hospital outpatient reimbursement to Medicare-like outpatient prospective payment system (OPPS), with undefined Medi-Cal specific equity adjustments. Will be done in a "budget neutral" fashion.

<u>Concerns:</u>

- Very vague for 2025 and 2026, need more details
- OPPS has promise, but can it be implemented effectively
- Impact of transition from the "transitionary baseline" increases to OPPS

Managed Care Organization Tax (cont.)

DHCS Proposal

Emergency Department Facility

- 2025 and 2026 – "Transitionary increases to baseline reimbursement." Estimated 40% "baseline increase" that will vary by region or facility, but would not be on a procedure code basis, NO additional "equity adjustments"
- No Sooner than 2027 – Consider transition of ED facility reimbursement to Medicare-like outpatient prospective payment system (OPPS). Will be done in a "budget neutral" fashion.

Concerns:

- Very vague for 2025 and 2026, need more details
- OPPS has promise, but can it be implemented effectively
- Impact of transition from the "transitionary baseline" increases to OPPS

Managed Care Organization Tax (cont.)

DHCS Proposal

Behavioral Health Throughput

- Six-month delay in implementation (and funding). Shifting from January 1, 2025 ($300 million) to July 1, 2025 ($150 million).
- No proposal thus far; however, the Administration has stated they were not seeking to target inpatient services.

Concerns:

- Nothing proposed thus far, need more details
- Concern about 6-month delay
- No committed funding for hospitals

Managed Care Organization Tax (cont.)

What we don't know...

- Will the state maintain the funding commitment with the current deficit?
- What are the details and how will it work?
- MCO Ballot Initiative (would be effective 2027) and alignment with DHCS spending plan?
- Ongoing federal approval?

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Medi-Cal Changes

Shifting Environment

CalAIM Initiatives	Implementation Date
Medi-Cal Rx	• January 1, 2022
Enhanced Care Management (ECM)	• January 2022 – January 2024
Community Supports	• January 1, 2022 (plans can change every 6 months)
SMI/SED Demonstration Opportunity	• No sooner than July 1, 2023 (proposal to CMS)
Mandatory MCP Enrollment	• January 1, 2022 (non-duals) • January 1, 2023 (duals)
Long-Term Care Carve-In	• January 1, 2023, subacute January 2024
Behavioral Health Payment Reform	• July 1, 2023
Managed Care Regional Rates	• Phased implementation beginning 2025
Managed Care D-SNP Requirement	• January 2027?

Benefits – Doula, Dyadic Services, Mobile Crisis, Community Health Workers, Wellness Coaches, Telehealth Flexibility

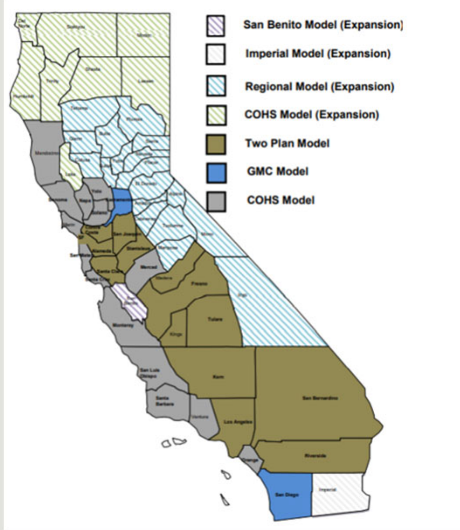
Eligibility – Full Scope Coverage for UIS Adults (ages 26-49), Continuous Coverage Under Age 5, One Year Postpartum, Asset Limit Elimination, Inmates

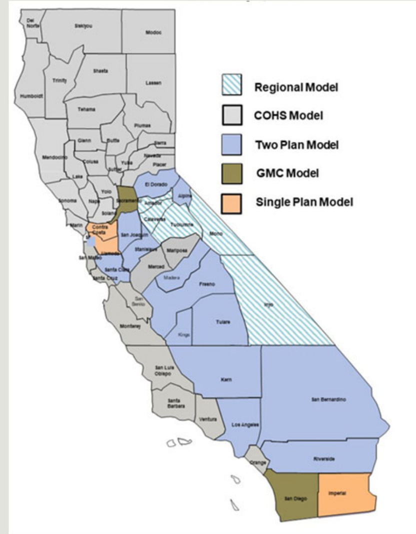
Unwinding the Public Health Emergency

Medi-Cal Eligibility Redeterminations

- Consolidated Appropriations Act of 2023 ended the continuous coverage requirement
- States have 14 months starting April 1, 2023, to complete redeterminations
- Originally estimated that approximately ***2-3** million* would lose Medi-Cal coverage over 12 months (July 2023-June 2024), likely to be a higher proportion of non-aged adults
- Likely to see upticks in hospital presumptive eligibility
- Coverage volatility throughout 2023-2024

Plan Changes, Effective January 2024





Plan Changes, Effective January 2024 (cont.)

Kaiser Direct Contract:

Counties where Kaiser participates as a Medi-Cal managed care plan	Direct contract (5) • Amador, El Dorado, Placer, Sacramento, San Diego Delegation/Subcontracted plan (17) • Alameda, Contra Costa, Kern, Los Angeles, Marin, Napa, Orange, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Ventura, Yolo	Today's counties (22) as a direct contract Direct contract in counties where Kaiser has another line of business (10) • Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, Yuba

Medi-Cal
"Self-Financing"

History of *"Self-Financing"* Medi-Cal Waivers

- **Prior to 2005**
  - LA County Only Waiver (1996-2005), managed care models (COHS, GMC), negotiated hospital contract rates
- **2005-10 Medi-Cal Hospital Uninsured Care Waiver**
  - Overhauled the contracting and financing of hospital services for public and private hospitals
  - Shifts public hospital systems to CPEs; overhauls DSH
- **2010-15 "Bridge to Reform" Waiver**
  - Focused on state's preparations for the implementation of Affordable Care Act
  - New public hospital financed supplementals: DSRIP
- **2016-21 Medi-Cal "2020" Waiver**
  - Converts DSRIP to PRIME, new Whole Person Care pilots, and implements Global Payment Program (GPP)
- **2021-26 "CalAIM" Waiver**
  - Standardizes Medi-Cal populations/benefits, implements new managed care benefits (ECM, CS), continues GPP

What does "Self-Financing" look like?	
Public Providers (District Hospitals, Designated Public Hospitals)	Certified Public Expenditures (CPEs) State and local government entities certify that they have spent CPE funds on items or services eligible for federal Medicaid matching funds. Intergovernmental Transfers (IGTs) Transfers of public funds between or within levels of government (e.g., county to state).
Private Providers (Private Hospitals)	Provider Taxes/Fees State-imposed taxes or fees on health care providers. To use provider taxes/fees as the nonfederal share, federal rules require the fee or tax to be broad-based and uniformly imposed. Federal rules also prohibit the state from holding similar providers harmless from the tax/fee burden.

District Hospital "*Self-Financing*" — Fee-for-Service

Medi-Cal: Base Payments vs. Supplemental Payments

Base Payments (Supported by State General Fund)

- Inpatient: All Patient Refined Diagnosis Related Groups (APR-DRGs)
- Outpatient: Medi-Cal Fee Schedule
- Rural Health Clinics: Prospective Payment System (PPS)

Supplemental Payments (Self-Financed)

- Inpatient: AB 113 (IGT supported)
- Outpatient: AB 915 (CPE program)
- Rural Health Clinics: Not applicable

District Hospital "*Self-Financing*" — Managed Care

Medi-Cal: Base Payments vs. Supplemental Payments

Base Payments (Supported by State General Fund)

- Inpatient: Negotiated Reimbursement (e.g., APR-DRGs, Per-Diem)
- Outpatient: Negotiated Reimbursement (e.g., Medi-Cal Fee Schedule)
- Rural Health Clinics: Negotiated Reimbursement (No less than FFS-equivalent, plus Code 18 billing DHCS for PPS "wrap-around" payment)

Supplemental Payments (Self-Financed)

- Quality Incentive Program (QIP) – (IGT supported)
- District Hospital Directed Payment Program (DHDP) – (IGT supported)
- Voluntary Rate Range Program (VRRP) – (IGT supported)
- Hospital Quality Assurance Fee (HQAF) Grants – (Private Fees)

Hospital Fee Program 8

- Program 8 (January 2023 – December 2024)
  - Federal Approval Received in December 2023
  - Phase-down of enhanced FMAP in 2023 and eliminated in 2024
  - FFS UPL declines due to transitioning populations into managed care
  - Passthrough begins to phase-out in 2024 due to federal rules ($500 million decline)
  - Significantly larger directed payment pool ($2.3 billion increase average annual)
    - Going from 44% (2022) to 66% (2024) of total payments
    - Built in FFS and Passthrough Declines
    - Cash flow changes, payments coming 2 years in arrears
    - Changing net benefit among hospitals – FFS/PT (static) and Directed Payments (actual unknown utilization), much harder to predict
  - Total payments increasing from $8.3 billion (2022) to $10.9 billion (2024)
  - Total Net Benefit $5.1 billion, increase of $960 million annually (23%)

Hospital Fee Schedule

HQAF Schedule				
Phase	**Cycle**	**Dates of Service**	**MC Payout Month**	**Estimated Date Hospitals Receive Cash**
HQAF VIII	Cycle 1	Jan - Mar 2023	N/A	2/19/2024
HQAF VII	MC1 DPa	Jan - Jun 2022	February 2024	3/29/2024
HQAF VIII	MC1 PT	Jan - Dec 2023	April 2024	5/30/2024
HQAF VIII	Cycle 2	Apr - Jun 2023	N/A	5/13/2024
HQAF VIII	Cycle 3	Jul - Sep 2023	N/A	6/10/2024
HQAF VIII	Cycle 4	Oct - Dec 2023	N/A	8/12/2024
HQAF VII	MC1 DPb	Jul - Dec 2022	September 2024	10/15/2024
HQAF VIII	Cycle 5	Jan - Mar 2024	N/A	10/14/2024
HQAF VIII	Cycle 6	Apr - June 2024	N/A	11/12/2024
HQAF VIII	Cycle 7	Jul - Sep 2024	N/A	12/16/2024
HQAF VIII	MC2 PT	Jan - Dec 2024	January 2025	3/1/2025
HQAF VIII	MC1 DPa	Jan - Jun 2023	March 2025	4/15/2025
HQAF VIII	Cycle 8	Oct - Dec 2024	N/A	5/12/2025
HQAF VIII	MC1 DPb	July - Dec 2023	September 2025	10/15/2025
HQAF VIII	MC2 DPa	Jan - Jun 2024	March 2026	4/15/2026
HQAF VIII	MC2 DPb	Jul - Dec 2024	September 2026	10/15/2026

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Looking into the Future

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Future of Medi-Cal *"Self-Financed"* Payments

Look into the Future

Impact of recent Medi-Cal "CalAIM" transitions

- Starting 2024, ***more than 99%*** of Medi-Cal beneficiaries will be enrolled with a Medi-Cal Managed Care.
- Hospital reimbursement will reflect this going forward!

> *"[CalAIM] is a once-in-a-generation opportunity to completely transform the Medicaid system in California."*
> *–Governor Gavin Newsom*

Uncertainty with Federal Regulations

- In April 2023, CMS proposed a new regulation impacting Medicaid Managed Care, could change the way State Directed Payments operate (e.g., PHDP, DHDP, QIP).
- Expectations are that CMS will finalize the regulation before the end of March.

Focus on Quality

- Recently, the state has emphasized significant growth of Managed Care supplemental payments can only be if the program focuses on furthering the Medi-Cal Comprehensive Quality Strategy.

Bottom line – as Medi-Cal fully shifts to Managed Care, more of hospital "Self-Financed" payments will flow through health plans and the programs will have to comply with likely new Federal Regulations and the state's quality goals.

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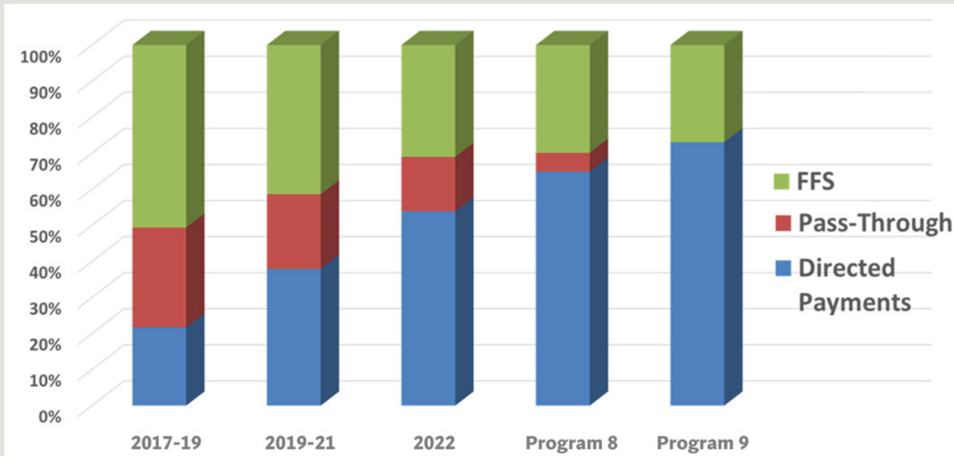
Hospital Fee Program: Looking to the Future

Payment changes over time:



Hospital Fee Program: Looking to the Future (cont.)

Potential changes to next Hospital Fee Program (Program 9) and beyond:

- Do we add a new Value-Based Program?
  - Discussions with DHCS have only just started
  - Any new program would increase overall funding *("grow the pie")*
- Do we make changes to existing Private Hospital Directed Payment (PHDP) program?
  - Hospital Classes
  - Acuity/Service Type Based Payments
- How will federal rule changes impact directed payments and provider taxes?
  - Directed Payment Caps (ACR vs Medicare vs Percent of Total Payments)
  - Contracting Requirement
  - Quality vs Utilization
  - Risk vs Pools

Future of Medi-Cal with OHCA

Will the new Office of Health Care Affordability (OHCA) and their "statewide spending target" consider the need for increased Medi-Cal investments?

OHCA staff has recommended to adopt a 3.0% statewide spending target for 2025-2029. This spending target was based on historical per capita health care spending data and would be applied to all payers—not exempting Medi-Cal.

- State law requires the Office to *"develop a methodology for approval by the board, that takes into account Medi-Cal and the specific provision of nonfederal share..."*

To date, the proposed OHCA methodology does not clearly account for these Medi-Cal self-financing specifics. It is unknown whether a provider that receives an increase of more than 3.0% year-over-year due to improved Medi-Cal self-financed supplemental payments will be subject to enforcement actions starting in CY 2026.

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Questions?

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Thank You

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