Medi-Cal Financing and Budget

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Agenda

- State of the State Budget
  - Managed Care Organization Tax
- Medi-Cal Hospital Financing
  - Diagnosis Related Groups
  - Disproportionate Share Hospital and Private Hospital Supplemental Fund
- Medi-Cal Hospital “Self Financing”
  - District Hospitals
  - Hospital Fee
- Looking to the Future

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State of the State Budget

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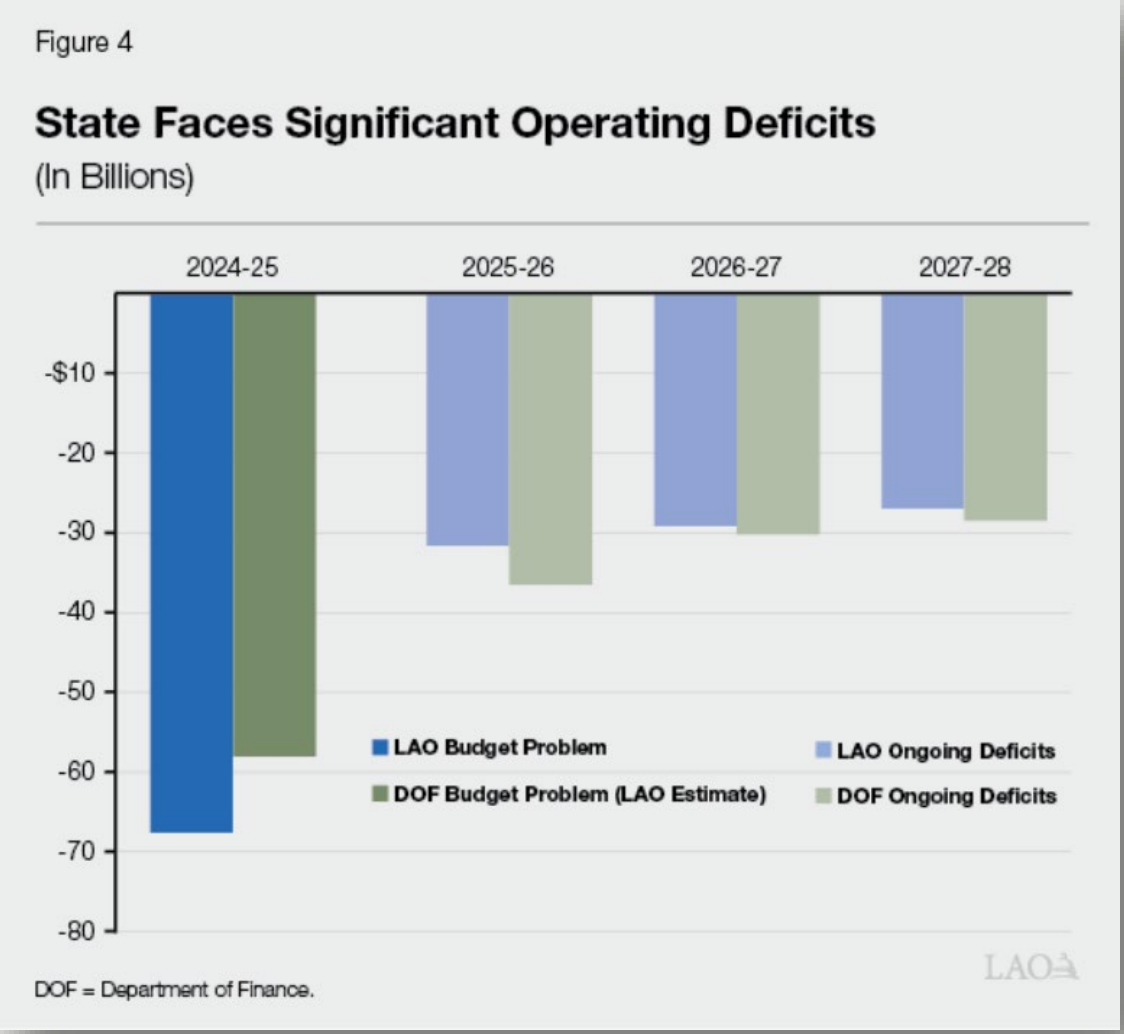
State is in Fiscal Crisis

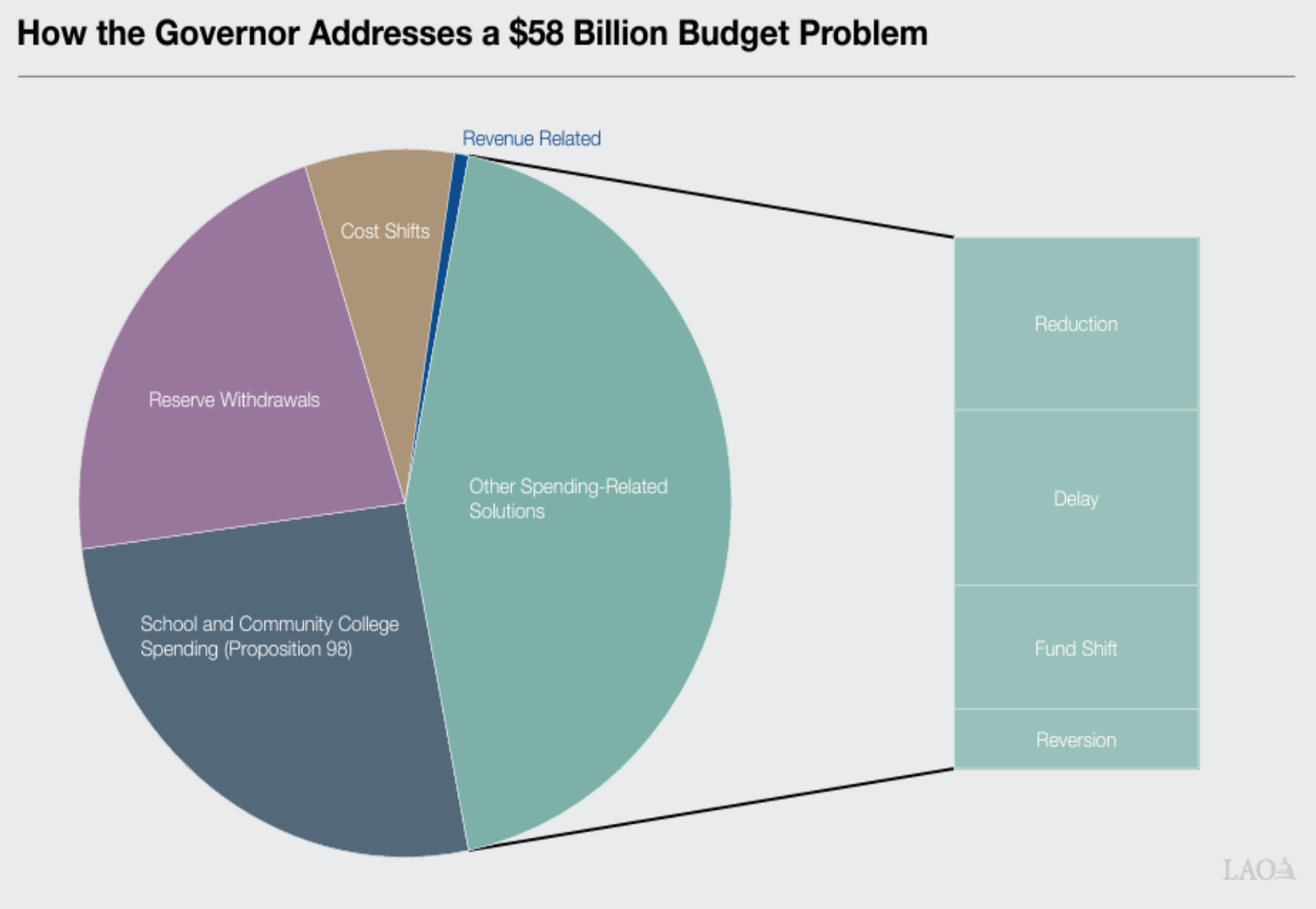


~$70 billion budget deficit this year

~$30 billion deficit projected throughout the multiyear

*State General Fund revenues are typically around $200 billion annually

State of the State Budget



How did the Governor address the deficit?

- Reserves ($13 billion)
- Cost/Fund Shifts ($5 billion)
- Delayed Spending ($5 billion)
- Reductions ($8 billion)

Health programs relatively unscathed!

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The Health Budget

Limited Solutions in the Health Care Space

- **MCO tax (discussed later)**
- **Behavioral Health Delays (from 2024-25 to 2025-26):**
  - Behavioral Health Continuum Infrastructure Program: $140 million
  - Behavioral Health Bridge Housing Program: $235 million
- **Health Care Workforce Delays and Eliminations**
  - Delay $140 million to 2025-26 for the nursing and social work initiatives
  - Delay $189 million for various behavioral health workforce initiatives
  - Eliminate use of unspent funds from the Clinic Workforce Stabilization and Retention Payment Program on health care workforce development programs: $15 million
- **Withdrawal of Medi-Cal Checkwrite Deferral**
  - Continue the deferral of the last two weeks of annual Medi-Cal fee-for-service payments from June to July: $533 million
- **Special Fund Loans**
  - $50 million from the Hospital Building Fund
  - $11 million from the Health Data and Planning Fund
  - $23 million form the Managed Care Fund

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
  - Proposes to increase the tax starting in Jan 2024 to generate $1.5 billion in higher revenues
  - Accelerates the use of $3.1 billion in reserves to address the deficit
- 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

MCO Tax

Last Year

- State reauthorized and obtained federal approval of the MCO tax
  - In effect April 2023 – December 2026
  - $5 billion annual (net) revenues
- Committed to using $2.7 billion annually on Medi-Cal provider payment increases (mostly beginning in 2025)
- Required Department of Health Care Services (DHCS) to release a spending plan in Jan 2025
- Coalition of health plans, providers, and labor support a voter initiative
  - Make the tax permanent in state law
  - Ensure the revenues support provider payment increases ongoing

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	

Managed Care Organization Tax

DHCS Proposal

Hospital Outpatient and ASC ($245 million MCO)

- 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.

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

Emergency Department Facility ($255 Million MCO)

- 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 ($150 million 2025, $300 million annual MCO)

- 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?

Medi-Cal Hospital Financing

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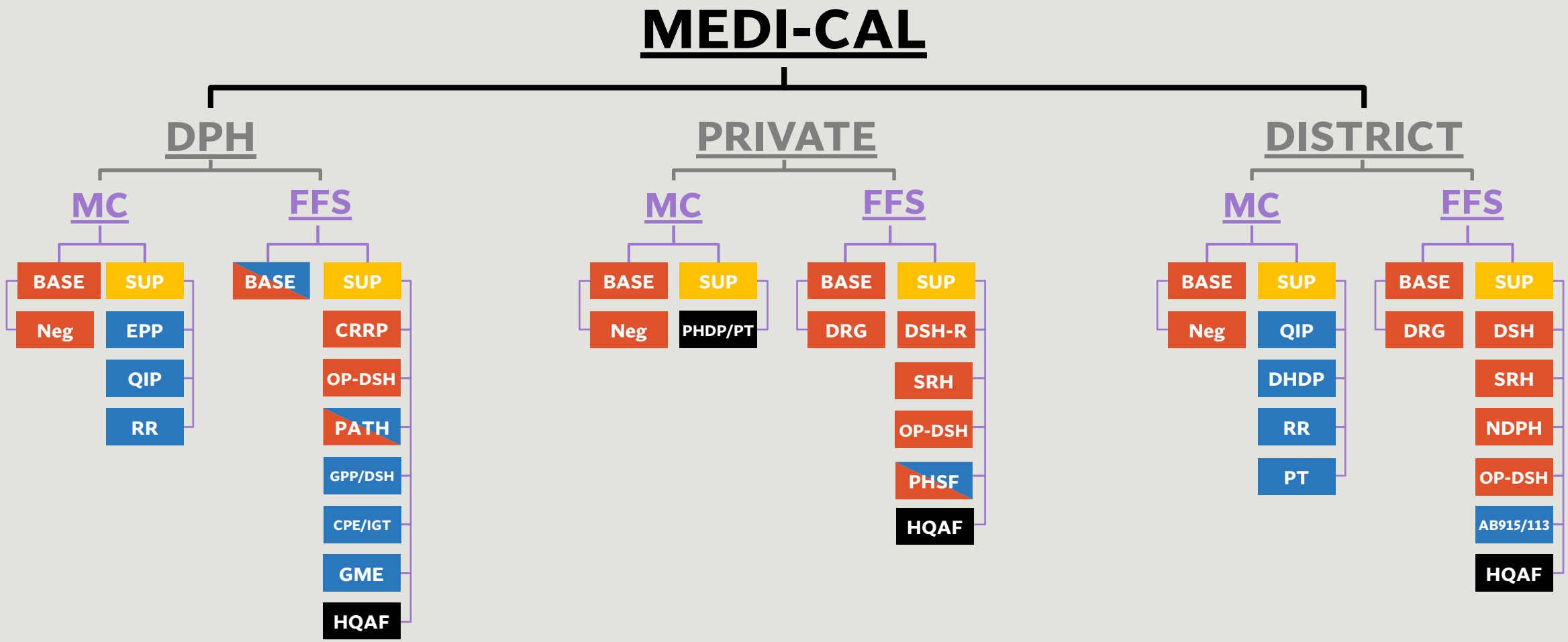
Hospital Financing



State funded Public/district hospital funded Hospital fee funded

Hospital Financing Acronyms

DPH – Designated Public Hospital
MC – Managed Care
FFS – Fee-for-Service
Base – Base Payment
Sup – Supplemental Payment
Neg – Negotiated rates/payments
EPP – Enhanced Payment Program
QIP – Quality Incentive Pool
RR – Rate Range
GPP – Global Payment Program
DSH – Disproportionate Share Hospital
PATH – Providing Access and Transforming Health
HQAF – Hospital Quality Assurance Fee

CPE – Certified Public Expenditure
IGT – Intergovernmental Transfer
GME – Graduate Medical Education
CRRP – Construction-Renovation Reimbursement Program
DRG – Diagnosis Related Groups
DSH-R – Disproportionate Share Hospital – Replacement
PHSF – Private Hospital Supplemental Fund
SRH – Small and Rural Hospital
DQIP – District Quality Incentive Program
DHDP – District Hospital Directed Payment
PT – Passthrough
NDPH – Non-Designated Public Hospital

All Patient Refined Diagnosis Related Groups (APR-DRG)

- Episodic/Bundled Payment
- Transitioned from CMAC to DRG methodology in July 2013, Districts in 2014
- Regular annual updates include:
  - Wage area index values, labor share, and wage area index neutrality factor
  - Cost-to-charge ratios (CCRs)
  - DRG Grouper Version and Weights
- Annual Policy Changes:
  - Outlier Threshold
  - Base Rate (Rural and Non-Rural
  - Policy Adjusters
- DHCS targets budget neutrality based on 2012-13 (ie no increase to base inpatient reimbursement in over a decade)
- Establishes out-of-network payment obligation in Managed Care (Rogers Rate)

Medi-Cal DSH & Private Hospital Supplemental Fund

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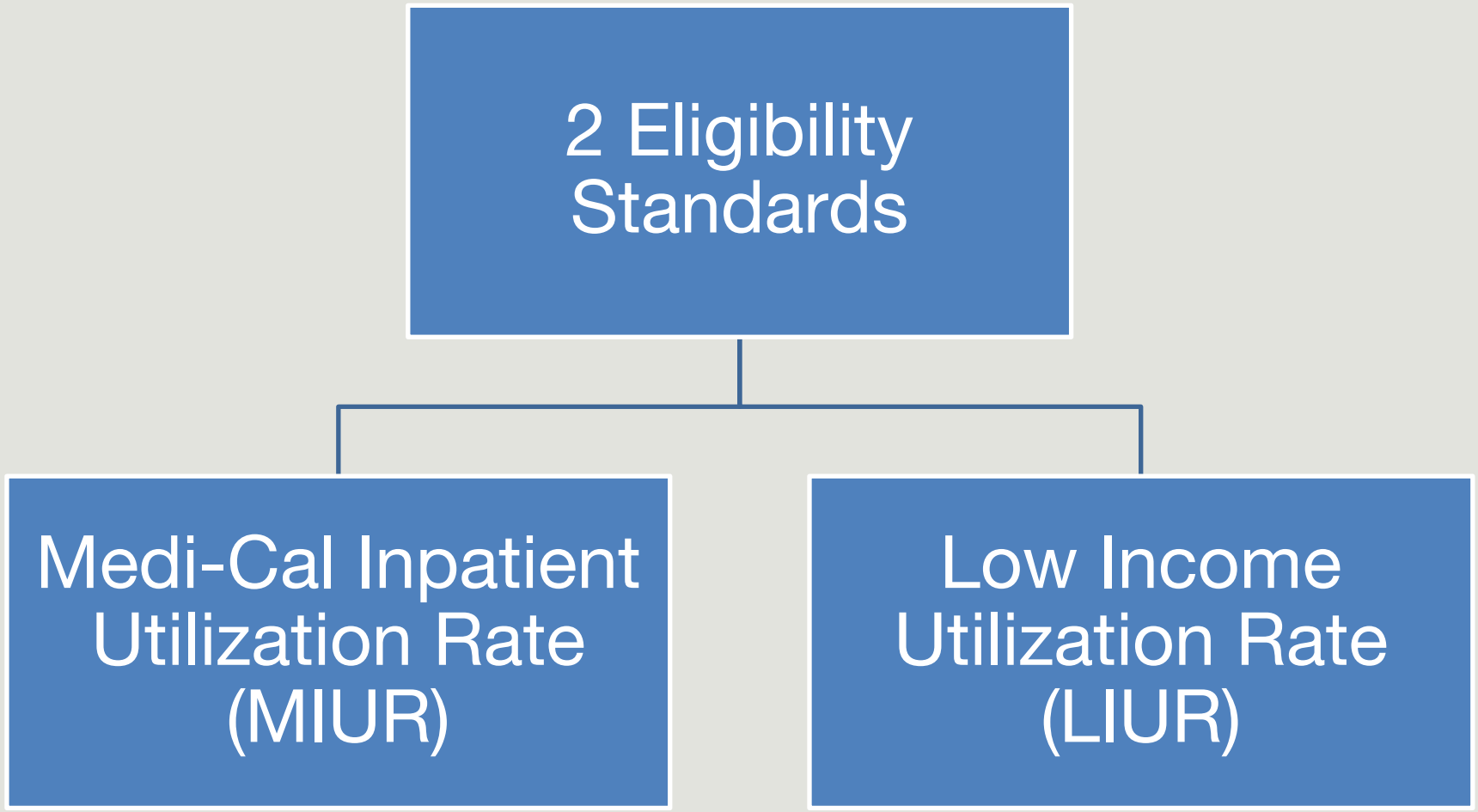
Medi-Cal DSH Mechanics - Eligibility



Medi-Cal DSH Mechanics – Eligibility (cont.)

Medicaid Inpatient Utilization Rate (MIUR)

- Definition: total inpatient acute days divided by total hospital inpatient acute days
- Eligibility threshold: > 1 standard deviation of the statewide mean
- Source: HCAi Annual Financial Disclosure Report (Page 4.1)
- Only utilized for DSH eligibility if LIUR standard not met
- Also used in determining ‘High Acuity’ supplemental payment eligibility in the HQAF program

Medi-Cal DSH Mechanics – Eligibility (cont.)

Low Income Utilization Rate (LIUR)

- Definition: Medi-Cal Revenue Fraction PLUS Charity Revenue Fraction
- Data Source: HCAi Annual Financial Disclosure Report (Page 12)
- Must be > or = 25% (absolute value)

Medi-Cal Revenue Fraction

$$\frac{\text{Medi-Cal Net Revenue}}{\text{Total Hospital Net Revenue}}$$

\+

Charity Fraction

$$\frac{\text{Gross Inpatient Charity}}{\text{Total Gross Inpatient Revenue}}$$

=

> 25%

** exclude HQAF and DSH*

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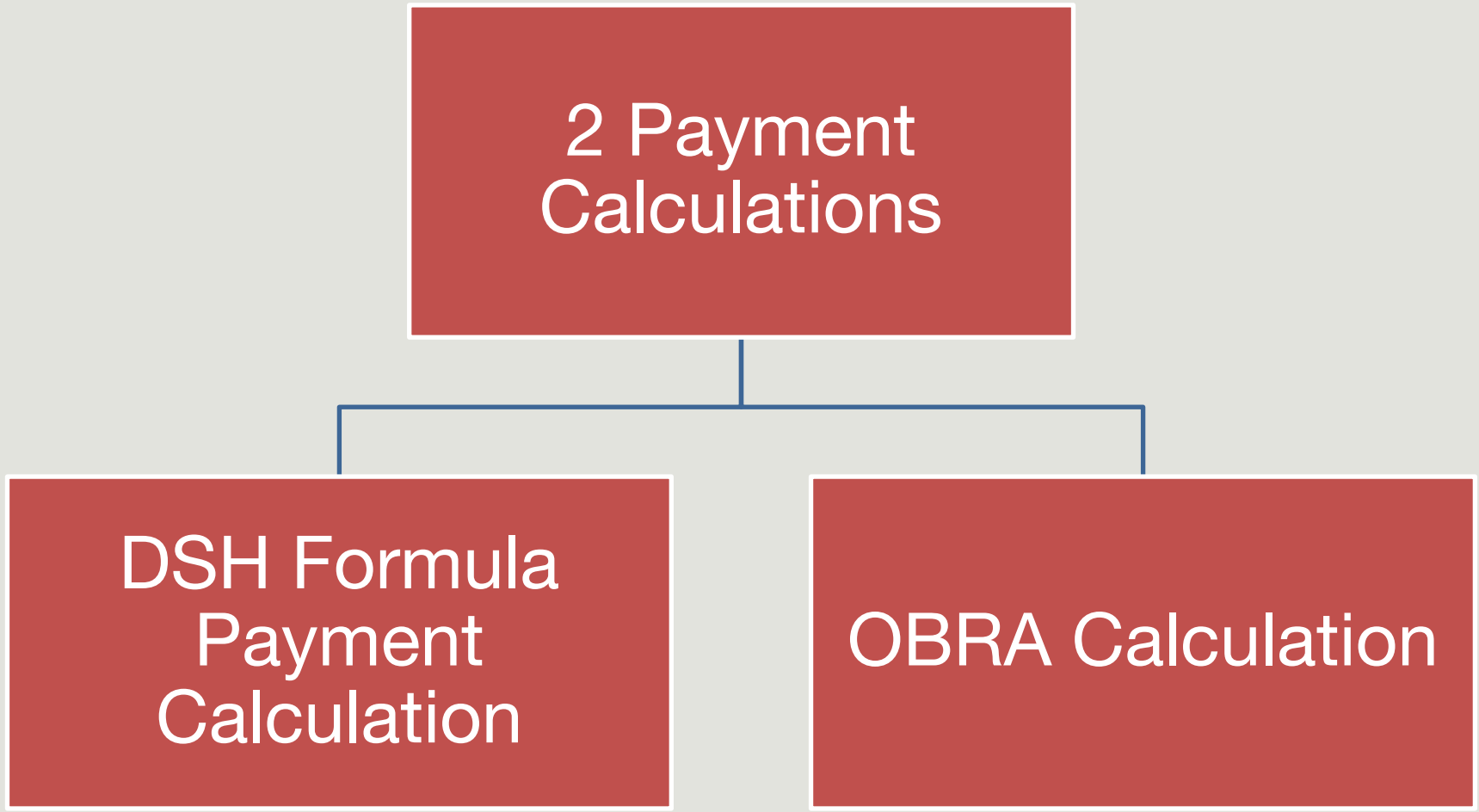
Medi-Cal DSH Mechanics - Eligibility

DSH Eligibility: Key Takeaways

- Timing: SFY minus 3 years = Hospital data year
  - Example: FY22 AFDR = DSH eligibility in SFY 24/25
- Timing: eligibility data becomes final in ~Oct/Nov each year
- Eligible hospitals must have at least 2 Obstetricians on staff that accept Medi-Cal in order to receive funds
- 100% of Medi-Cal capitation premium revenue counts for Medi-Cal net revenue; payments for OON services included as expenses…not deductions to revenue.
- Data refreshed each DSH year…contrast with HQAF
- Interplay between Medi-Cal net revenue and total hospital net revenue critical to LIUR

Medi-Cal DSH Mechanics - Payment



Medi-Cal DSH Mechanics – Payment (cont.)

OBRA Limit Calculation

- Definition: Total Medi-Cal and Uninsured Cost of Care

- High level calculation: Total Expenses X Medi-Cal/Uninsured %
  - Medi-Cal/Uninsured % = Medi-Cal/Uninsured gross revenue divided by total gross revenue
  - Source: HCAi Annual Financial Disclosure Report
  - Timing: FY22 OBRA Cost – CY23 Medi-Cal Payments = 24/25 OBRA Limit

- OBRA acts as a limit to the amount of DSH supplemental payments a hospital can receive

Calculated OBRA Costs **-** **Medi-Cal FFS, HMO and PHSF Payments** **=** **OBRA Limit for DSH Payments**

Medi-Cal DSH Mechanics – Payment (cont.)

DSH Formula Payment Calculation

- LIUR translates to standard formula DSH per diem established in state statute
  - Sliding scale based on hospital Peer Grouping
  - As LIUR increases the formula DSH per diem increases…some nuances
- Formula DSH per diem multiplied times the hospital's 'CAPDAYS'
  - CAPDAYS = paid Medi-Cal acute days X 80% (based on Date of Payment)
- Formula driven DSH payment amount reduced based on the total DSH funding available statewide

Formula DSH Per Diem **X** **CAPDAYS** **=** **Formula DSH Payment Amount**

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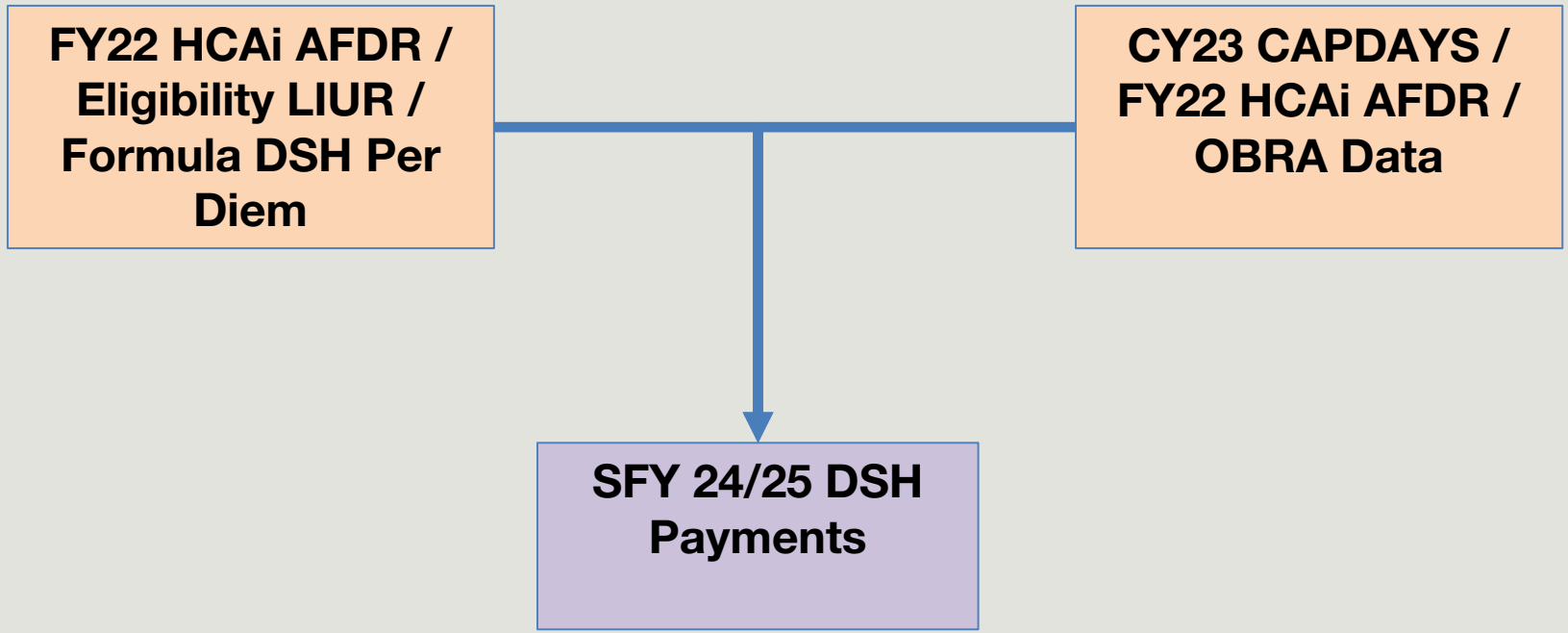
Medi-Cal DSH Mechanics – Payment (cont.)

DSH Payment: Key Takeaways

- Timing: SFY minus 2 years = Medi-Cal paid days data source
  - Example: CY23 CAPDAYS = DSH payment in SFY 24/25
- FFS days from state data warehouse; HMO days from Medi-Cal Managed Care Survey (MMCS) process
- Only paid days at the DSH eligible hospital count; based on date of payment; paid days at other hospitals not included for capitated hospital
- Increasing LIUR = Increased DSH Per Diem
- Fixed pool of funding statewide; funding based on state General Fund

Medi-Cal DSH – Eligibility / Payment Cycle

The Medi-Cal DSH Timeline Example



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Medi-Cal DSH Supplemental - PHSF

Private Hospital Supplemental Fund (PHSF)

- Formerly known as the Emergency Services and Supplemental Payment Fund (aka SB1255)
- PHSF eligible hospitals must be Medi-Cal DSH eligible and have an Emergency Department
- Converted in 2005 from a hospital specific, CMAC negotiated process to a fixed amount for continuously eligible hospitals
  - Newly eligible hospital (since 2005) distribution amounts based on per diem
- Approximately $236m annually split 50/50 between Children's and Private hospitals; not subject to the looming DSH cuts
- DHCS processing a one-time recoupment and redistribution in 23/24 to correct an error in previous distributions; results in additional $240m in PHSF during 23/24 SFY
  - Recoupment due in April; Redistribution scheduled for May 27th

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Medi-Cal DSH…Where are we now?

Current Medi-Cal DSH Program

- 1115 Waiver in 2005 shifted private hospitals out of the CPE/IGT driven program to a look alike DSH program (DSH Replacement; DSH-R) funded by matched state General Fund
  - Although funded differently DSH-R ‘tied’ to Federal DSH program and subject to program changes and funding changes

- The Affordable Care Act (ACA) and related Medi-Cal expansion in 2014 required a significant reduction in Medicaid DSH funding nationally.
  - ACA included a 10-year implementation plan with deep cuts only in the out years
  - Legislative action has successfully delayed the implementation and also condensed the timeframe over which the cuts would be implemented
  - Now the cuts have created a “DSH cliff” that calls for $32B nationally over 4 years
  - This would be a 52% cut in the program for California private hospitals

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
- FQHC/RHC: Prospective Payment System (PPS)

Supplemental Payments (Self-Financed)

- Inpatient: AB 113 (IGT supported)
- Outpatient: AB 915 (CPE program)

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)
- FQHC/RHC: 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)

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Hospital Fee Program 8 (January 2023 – December 2024)

Changes from Program 7

- Phase-Down of enhanced FMAP in 2023 and eliminated in 2024
- FFS UPL start to decline 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
  - 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%)

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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

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!

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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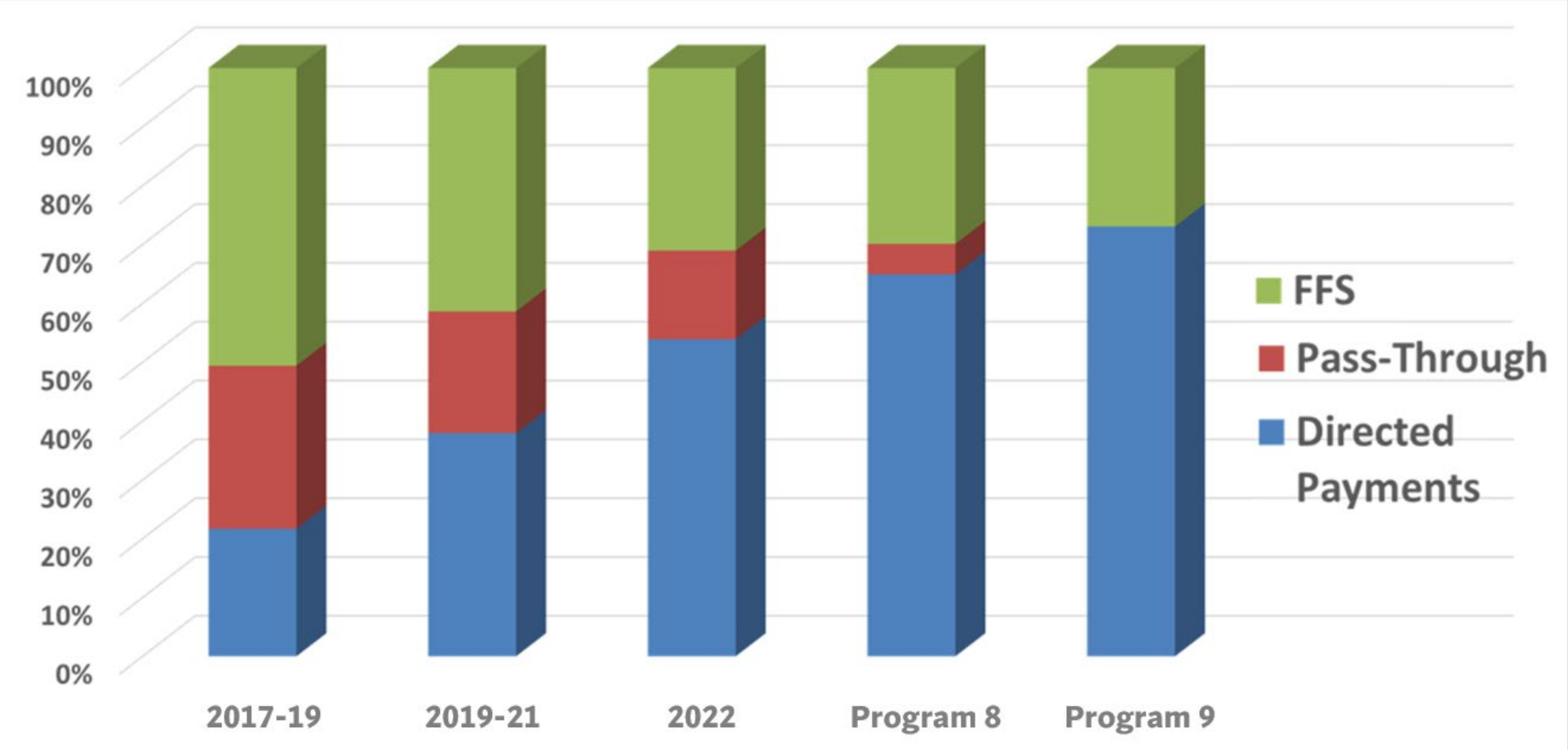
Hospital Fee Program: Looking to the Future

Payment changes over time:



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

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

- **<u>Do we add a new Value-Based Program?</u>**
  - Any new program would increase overall funding *("grow the pie")*

- **<u>Do we make changes to existing Private Hospital Directed Payment (PHDP) program?</u>**
  - Hospital Classes
  - Acuity/Service Type Based Payments

- **<u>How will federal rule changes impact directed payments and provider taxes?</u>**
  - 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.

Questions?

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Thank You

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