2025 | RURAL HEALTH CARE SYMPOSIUM | SACRAMENTO

Achieving Sustainability Through State Financing

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Agenda

- The Fiscal Landscape Assessment
  - California Risks
  - Federal Perspective
- What we've done, what's new, changes over prior year
- Directed Payments
- MCO Tax

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State of the State Budget

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State of the State Budget

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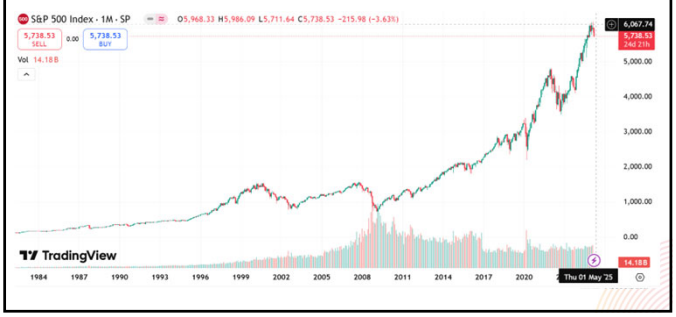
State of the State Budget



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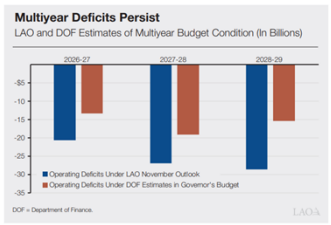
State of the State Budget

Even without Federal cuts, there are risks at the state level…

The state faces structural deficits under both our and the administration's forecasts for 2026-27, 2027-28, and 2028-29.



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State of the State Budget

The Governor's January Budget assumed the state has sufficient reserves to continue funding the government until 2027-28.

California State Budget
Total Reserves by Fiscal Year
2025-26 Governor's Budget

	2024-25	2025-26	2026-27	2027-28	2028-29
Total Reserves	$27,500	$16,979	$3,690	($15,459)	($30,828)

Source: California Department of Finance

A new Governor will assume office in January, 2027.

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State of the State Budget

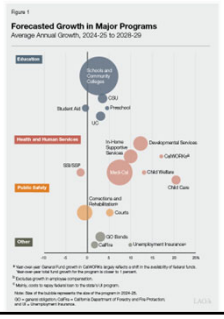
Focus on health care.

In 2018-19, General Fund spending in Medi-Cal was less than $19.7 billion. Projected to be $42.1 billion in 2025-26.

114% increase in 7 years.

Total Expenditures	FY 2024-25 Appropriation	Nov 2024 Estimate	Change Amount	Change Percent
Total Funds	$160,962.1	$174,612.1	$13,650.0	8.5%
Federal Funds	$98,510.6	$107,467.3	$8,956.7	9.1%
General Fund	**$35,022.7**	**$37,636.8**	**$2,614.1**	**7.5%**
Other Non-Federal Funds	$27,428.7	$29,507.9	$2,079.2	7.6%

Total Expenditures	FY 2024-25 Estimate	FY 2025-26 Estimate	Change Amount	Change Percent
Total Funds	$174,612.1	$188,139.2	$13,527.1	7.7%
Federal Funds	$107,467.3	$118,053.2	$10,585.9	9.9%
General Fund	**$37,636.8**	**$42,088.9**	**$4,452.1**	**11.8%**
Other Non-Federal Funds	$29,507.9	$27,997.1	($1,510.8)	-5.1%



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State of the State Budget

A Ray of Sunshine – the gift of time

California Proposition 2, Changes to State Budget Stabilization Fund Amendment (2014)

California Proposition 2 was on the ballot as a legislatively referred constitutional amendment in California on November 4, 2014. It was approved.[1]

A "**yes**" vote supported making the following changes:

- requiring 1.5% of general fund revenues and an amount equal to revenues derived from capital gains-related taxes in situations where such tax revenues are in excess of 8% of general fund revenues to be deposited into the Budget Stabilization Fund (BSA);
- requiring from the 2015-2016 fiscal year until the 2029-2030 fiscal year, 50% of the revenues that would have otherwise been deposited into the BSA to be used to pay for outstanding fiscal obligations;
- permitting the legislature to suspend or reduce deposits to the BSA and upon the governor declaring a budget emergency; and
- creating the Public School System Stabilization Account (PSSSA).

California Proposition 2

CALIFORNIA REPUBLIC

Election date
November 4, 2014
Topic
State and local government budgets, spending and finance
Status
✔ *Approved*

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Directed Payments: New Regulations

Medicaid Managed Care Final Rule

- On April 22, 2024, CMS released the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule.
- First major Medicaid Managed Care Rule since 2016.
- 2024 Final Rule included a variety of components impacting Medicaid managed care, including State Directed Payments (SDP).
- Key areas:
  - SDP Payment Ceiling
  - Separate Payment Terms
  - Quality Requirements
  - Non-Network

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Directed Payments: New Regulations

SDP Payment Ceiling

- The 2024 regulations codify that the ***average commercial rate (ACR)*** as the SDP spending limit for four provider types: inpatient, outpatient, practitioner services at Academic Medical Centers, and nursing facility services.
- This clarification provided additional support for growing the total Medi-Cal hospital directed payments (e.g., Hospital Fee Program, DHDP, EPP, QIP).
- Existing federal regulations cap fees on hospitals at 6% of net patient revenue, so California's Hospital Fee Program will likely never reach the ACR ceiling for most services.
- However, there is opportunity for private hospitals to receive additional directed payments other than those funded by the hospital fee (e.g., MCO tax).

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Directed Payments: New Regulations

Separate Payment Terms

Existing Practice

- States establish a fixed amount of money ("pool") for separate payment terms
- Require plans to pay hospitals based on utilization from a previous period
- Payments are made retroactively
- Plans are not "*at risk*" for the State Directed Payment (SDP)

The Change

- CMS will require states to incorporate SDPs as an adjustment to the base rates
- Prohibition will take effect for rate years after July 9, 2027

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Directed Payments: New Regulations

Quality

Existing Requirement
- States must implement a written quality strategy for assessing and improving the quality of health care services furnished by an MCO.
- SDPs must advance *at least one* of the goals and objectives in the quality strategy.
- Evaluations are required to measure the effectiveness.

The Change
- Each SDP proposal must have *at least two* metrics—one that is performance-based.
- Evaluation Plan and Report—all SDP proposals must include a plan, but only certain SDPs will need to submit an evaluation report to CMS and post publicly.
- Codified language that allows CMS to ***disapprove*** SDPs base on missing performance targets but permits a runway for States.

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Directed Payments: New Regulations

Network Requirement

Existing Practice
- Based on 2016 Final Rule, California's Hospital Fee Program has required hospitals to have a full contract ("***network provider agreement***") with the health plan to receive its directed payments.

The Change
- Under the 2024 Final Rule, CMS ***removed*** this requirement.
  - However, CMS left to the state's discretion.
- California will not lift the contracting requirement for 2025 but has signaled a willingness to discuss a limed set of services for out-of-network payments in 2026.

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Directed Payments: PHDP

Private Hospital Directed Payment (PHDP) Program

For CY 2025, DHCS will propose an increase to the program of $6 billion for a total pool size of $13.2 billion.

Table 1: Total Program Amount Year	Inpatient	Non-Inpatient	Gross Payments	Net Benefit
CY 2024	$ 5.0 billion	$ 2.2 billion	$ 7.2 billion	$5.3 billion
CY 2025	$ 7.4 billion	$ 5.8 billion	$ 13.2 billion	$8.4 billion

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Directed Payments: PHDP

Private Hospital Directed Payment (PHDP) Program

- New Classes: For CY 2025, the three classes being considered are Children's Hospitals ($1.3 billion), Critical Access Hospitals ($225 million), and All Other Hospitals.
- Labor and Delivery (L&D): DHCS will apply a 10% increase to the payments made for L&D services.
- Approval Timing: A draft preprint, which identifies the size and general structure of the program, was submitted in late December.
  - The state must submit the tax waiver and rate package by the end of March to secure a January 1, 2025, effective date.
  - Federal approval typically takes 6-9 months. Based on prior program approval timelines, we expect federal approval in the last quarter of 2025 with payments flowing to hospitals in 2026.

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Directed Payments: District Hospital Directed Payment

Since last year...

CY 2023

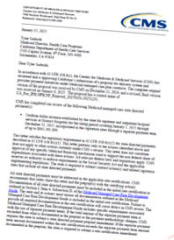
- Total Funding = **$200 million**
- Methodology: IP, LTC, Subacute, Non-RHC OP, and ED utilization. No Duals.
- Payments have started to flow (March/April 2025)

CY 2024

- Total Funding = **$207.3 million**
- Methodology expanded: Included Duals.

CY 2025

- CMS ***approved*** our DHDP preprint.
- Total Funding = **$842.4 million**
- Methodology expanded: New payment modifier (1.50) for labor & delivery services.



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Directed Payments: Quality Incentive Program (QIP)

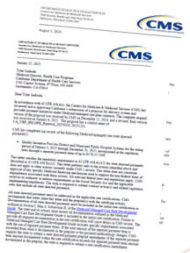
Since last year...

CY 2024

- CMS ***approved*** the CY 2024 DMPH QIP preprint.
- DHCS agreed to optional interim payments to help with cash flow.
- Total Funding = **$172.1 million**

CY 2025

- CMS ***approved*** the CY 2025 DMPH QIP preprint.
- Total Funding = **$178.5 million**
- Updated minimum number of metrics to 1 in Tier 1, decrease Tier 2 floor to 7 metrics.
- Updated allocation formula to a 50/50 split (MCO rev/metrics).



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Directed Payments: Targeted Rate Increase

- DHCS implemented the 2024 TRI Fee Schedule which authorized under the AB 119 (2023) MCO Tax bill.
- Provider eligibility was tied to professional billing on the ***CMS-1500 forms***, with exception of certain Obstetric and Non-Specialty Mental Health Services.
- Some Rural Health Clinics (RHCs) did see a correlated increase in reimbursement tied to payment parity.
- TRI payments were made by plans in late 2024.

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Prop 35/MCO Tax

MCO Tax Funding Allocations

Dollars in Millions; CHA Estimates

	2025		2026	
	State Funds	Total Funds	State Funds	Total Funds
Hospital Reimbursement Increases				
Emergency Department and Hospital Access	$255	$725	$255	$725
Outpatient and Clinic Access	$245	$490	$245	$490
Designated Public Hospitals	$150	$150	$150	$150
GME	$75	$75	$75	$75
Subtotals	**$725**	**$1,440**	**$725**	**$1,440**
Other Provider Reimbursement Increases				
Professional (Physicians) Services	$1,266	$3,120	$1,266	$3,120
Mental Health Throughput - Other	$300	$300	$300	$300
Emergency Room Physicians	$100	$250	$100	$250
Family Planning/Abortion	$90	$90	$90	$90
Health Care Workforce Investments	$75	$75	$75	$75
Ground Ambulance	$50	$130	$50	$130
Improved Clinic Quality	$50	$125	$50	$125
Subtotals	**$1,931**	**$4,090**	**$1,931**	**$4,090**
Investments Totals	**$2,656**	**$5,530**	**$2,656**	**$5,530**

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Prop 35/MCO Tax

DHCS Proposal, January 2024

Structure

- 2025 and 2026 – "Transitionary increases to baseline reimbursement." A "baseline increase" that will vary by region or facility but would not be on a procedure code basis. Some services eligible for additional undefined "equity adjustments."
- No Sooner than 2027 – Transition hospital outpatient reimbursement to Medicare-like outpatient prospective payment system (OPPS). Would 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

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Questions

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