California State Assembly

Assembly Budget Agenda

Subcommittee No. 1 on Health

Assemblymember Dr. Akilah Weber, Chair

Monday, February 26, 2024
2:30 P.M. – State Capitol, Room 126

Items To Be Heard

Public comment will be taken in person after the completion of all panels and any discussion from the Members of the Subcommittee.

Items To Be Heard

4260 Department of Health Care Services

Issue 1: Managed Care Organization Tax Proposals

The Governor's January Budget includes four proposals that affect the Managed Care Organization (MCO) Tax as follows and discussed below:

1. Proposal to increase the tax to raise $1.5 billion in additional state revenue;
2. Shift $3 billion in MCO Tax reserves to general support for Medi-Cal;
3. Targeted Rate Increases (TRI) for Medi-Cal providers; and
4. Budget Change Proposal (BCP) – Medi-Cal Targeted Provider Rate Increases & Investments Workload.

Proposal 1: Increase MCO Tax to Raise $1.5 Billion in Additional State Revenue

As a part of the 2023 budget (AB 119, Chapter 13, Statutes of 2023), the Legislature and Governor approved of reauthorizing the MCO tax, and the federal government approved of California's proposed new tax in December of 2023. The tax, as passed and approved of last year, is expected to result in $19.4 billion in new state revenue.

This proposal maintains the structure of the tax passed last year, but increases the amount of the tax on a per Medi-Cal enrollee basis, for 2024, 2025, and 2026, thereby resulting in approximately $1.5 billion in increased state revenue for a total of $20.9 billion. There would be no impact on commercial plans as the tax increase would be applied only to the Medi-Cal managed care plans which would be affected minimally, according to DHCS.

The increase in the tax rates can be seen in the following table from *The 2024-25 Budget Medi-Cal Analysis*:

Figure 9

Proposal Would Increase Rate on Medi-Cal Enrollment in Most Years

MCO Tax Rate on Medi-Cal Enrollment[a]

	2023[a]	2024	2025	2026
Enacted in 2023-24 budget	$182.50	$182.50	$187.50	$192.50
Proposed in *2024-25 Governor's Budget*	182.50	205.00	205.00	205.00
Percent increase	—	12%	9%	6%

[a]Rate applies to each plan's aggregate monthly enrollment level between 1,250,001 and 4,000,000 member months during calendar year 2022, with certain adjustments. The tax rate on commercial enrollment, which ranges between $1.75 and $2.25 depending on the year, remains at the enacted levels in the Governor's budget.

[b]Rate applies from April through December 2023.

MCO = managed care organization.

Early Action

In order to achieve this additional revenue, California would need to submit the proposed modifications to the tax to the federal government by mid-March, and therefore is requesting the Legislature take early action on this proposal by approving the proposed trailer bill language to effectuate this change. The proposed language can be found here:

https://esd.dof.ca.gov/trailer-bill/public/trailerBill/pdf/1044

Proposal 2: Shift $3 Billion in MCO Tax Reserves to General Support for Medi-Cal

The 2023 Budget Act assumes that the $19.4 billion in MCO Tax revenue would be split between Medi-Cal provider rate increases ($11 billion) and general support for the Medi-Cal program ($8.4 billion), which frees up General Fund for other parts of the budget.

This proposal shifts an additional $3 billion from rate increases, as well as the proposed increase of $1.5 billion, to general support for Medi-Cal, as follows:

	2023 Budget Act	Proposed 2024 Budget
Medi-Cal Rate Increases	$11 billion	$8.0 billion
Medi-Cal General Support	$8.4 billion	$12.9 billion
TOTAL	**$19.4 billion**	**$20.9 billion**

The administration explains that last year's budget approves of rate increases for approximately 5 years, and this proposal maintains the same level of rate increases but for only 4 years instead of 5. The administration also assumes that the state likely will want to identify new revenue or General Fund in order to maintain these rate increases in year 5 and on an ongoing basis.

Proposal 3: Targeted Rate Increases (TRI) for Medi-Cal Providers

The 2023 health omnibus trailer bill (AB 118, Chapter 42, Statutes of 2023) codifies a general structure for MCO tax-funded Medi-Cal rate increases, including, but not limited to, the following:

1. Requires the reimbursement rates for primary care services, obstetric care services, doula services, and certain outpatient mental health services to be the greater of 87.5% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, on the effective date of any necessary federal approvals and no sooner than January 1, 2024.

2. Requires DHCS to annually review and revise the reimbursement rates, and to develop and implement a methodology for establishing rates for these services.

3. Requires each Medi-Cal managed care plan to reimburse a network provider providing these services at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system.

4. Authorizes the transfer of $150 million from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in 2023-24.

5. Authorizes transfers of $75 million each calendar year to the University of California to expand graduate medical education programs.

6. Authorizes the transfer of $50 million in 2023-24 to the Small and Rural Hospital Relief Fund to support the Small and Rural Hospital Relief Program for seismic assessment and construction.

7. Requires DHCS to submit a plan for targeted increases to Medi-Cal payments or other investments, in relation to certain agreed-upon domains, to the Legislature as part of the 2024-25 Governor's Budget. Specifically, AB 118 includes the following:

14105.202. (a) The department shall submit to the Legislature, as part of the 2024–25 Governor's Budget, a plan for targeted increases to Medi-Cal payments or other investments as described in subdivision (c) of Section 14105.200. The targeted increases or other investments shall be designed to advance access, quality, and equity for Medi-Cal beneficiaries and promote

provider participation in the Medi-Cal program in the following domains, pursuant to criteria established by the department, which may account for, and be inclusive of, the exemption of applicable services from payment reductions pursuant to Section 14105.192:

(1) (A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services, and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(2) Specialty care services.

(3) Community or hospital outpatient procedures and services.

(4) Family planning services and women's health providers.

(5) Hospital-based emergency and emergency physician services.

(6) Ground emergency transport services.

(7) Designated public hospitals, as defined in subdivision (f) of Section 14184.101.

(8) Behavioral health care for beneficiaries in hospital and institutional long-term care settings.

(9) Investments to maintain and grow the health care workforce.

TRI Policy Paper

As required by the section of law above, DHCS has submitted a "policy paper" to the Legislature that outlines the specific methodology the department proposes for these rate increases. The full detail will be contained in proposed trailer bill language, which has not yet been finalized. Moreover, DHCS is also working on an update to the policy paper, specific to the rate increases for behavioral health providers.

The following is a summary of the proposed TRI spending plan:

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

Category [1/]	Estimated MCO Tax ($millions) [2/]	Estimated Total Fund ($millions) [2/]	% of Annual MCO Tax Spend
Primary Care and Specialty Care			**62%**
Primary Care, Maternal Care, and Mental Health [3/] *(started 1/1/24)*	$291	$727	11%
Physician and Non-Physician Health Professional Services [4/]	$975	$2,400	37%
Community and Hospital Outpatient Procedures and Services	$245	$490	9%
Abortion and Family Planning Access	$90	$90	3%
Services and Supports for FQHCs and RHCs	$50	$100+	2%
Emergency and Inpatient Care			**21%**
Emergency Department (ED) Physician Services	$100	$250	4%
ED Facility Services	$255	$725	9%
Designated Public Hospitals	$150	$375	6%
Ground Emergency Medical Transportation	$50	$130	2%
Behavioral Health			**11%**
Behavioral Health Throughput *(starts 7/1/25)*	$300	TBD ($300+)	11%
Healthcare Workforce			**6%**
Graduate Medical Education *(started 1/1/2024)*	$75	$75	3%
Medi-Cal Workforce Pool – Labor-Management Committee	$75	$75	3%
Total	**$2,656**	**$5,737+**	**100%**
Distressed Hospital Loan Program *(one-time: FY 2023-24)*	$150		
Small & Rural Hospital Seismic Relief *(one time: FY 2023-24)*	$50		

[1/] Increases or investments are proposed to start January 1, 2025, unless otherwise noted.
[2/] Amounts are presented on an annualized accrual basis. Medi-Cal is on a cash basis budget and amounts by fiscal year will vary.
[3/] Maternal Care includes obstetric and doula services. Mental Health means non-specialty mental health.
[4/] Physician and Non-Physician Health Professional Services include Primary Care, Maternal Care, Mental Health, and Specialty Care.

The MCO Tax TRI spending plan policy paper includes the following key proposals, as described in the following chart from the *The 2024-25 Budget Medi-Cal Analysis* and in more detail below:

Figure 13

Medi-Cal Provider Payments and Payment Methodologies Would Change in Several Ways

Major Components of Governor's MCO Tax-Funded Provider Payment Proposal (In Millions)

Service[a]	Amount		Proposal
	MCO Tax	Total Funds	
Physician and professional services	$1,075	$2,688	Tie most payments for primary care, obstetric care, non-specialty mental health care, specialty care, and emergency physician services to 80 percent to 100 percent of what Medicare pays, depending on the service. Adopt Medicare payment structure, including by adjusting rates for regional variations in cost. Adopt new equity adjustment to incentivize service delivery in underserved areas.
Hospital outpatient and emergency services	500	1,215	For outpatient services, transition toward Medicare prospective payment system and Medicare adjustments for regional variations in cost. Adopt new equity adjustment to incentivize service delivery in underserved areas. For emergency services, explore extent to which prospective payment system can be applied. Enact interim rate adjustments ranging on average from 10 percent to 40 percent prior to roll out of prospective payment system.
UC and county hospital inpatient services	150	375	Transition to prospective payment system, similar to the way Medi-Cal pays for inpatient services at private and district hospitals.
Abortion	90	90	Increase existing rates to a minimum of $1,150, with higher rates for certain geographic areas. Also sustain support for existing limited-term supplemental payment for abortion services at non-hospital clinics.
Ground emergency medical transportation	50	130	Increase rates to around 50 percent to 60 percent of Medicare and adopt Medicare payment structure.
Clinics	50	125[b]	Expand and convert existing supplemental payment program for non-hospital 340B providers into utilization and performance-based managed care directed payment.
Totals	**$1,915**	**$4,623**	

[a]Excludes proposed MCO tax allocations for behavioral health services and health care workforce initiatives, as the administration has not released detail on these proposals.

[b]Maximum amount estimated by Department of Health Care Services.

MCO = managed care organization.

Physician and Non-Physician Health Professional Services

DHCS proposes $2.4 billion ($975 million MPPRF*) for primary care, maternal care, non-specialty mental health, and specialty care services, and $250 million ($100 million MPPRF) for emergency department (ED) physician services.

- DHCS proposes to increase Medi-Cal rates for physician and non-physician health professional services to target specified percentages of Medicare rates on a procedure code basis, and to require Medi-Cal managed care plans to pay no less than the increased rates to their network providers.

- DHCS proposes to eliminate all remaining AB 97 reductions for physician services and to incorporate all Proposition 56 physician services supplemental payments into base rates for applicable procedure codes.

- For all included codes, DHCS proposes to geographically adjust rates in alignment with Medicare. Furthermore, DHCS proposes to apply additional equity adjustments to specified codes.

*MPPRF = Medi-Cal Provider Payment Reserve Fund (MCO tax revenue specifically for rate increases)

Target Percentages of Medicare

Procedure Codes	Target Percent of Medicare
Evaluation and Management Codes for: • Primary and Specialty Office Visits • Preventive Services • Care Management Maternal Care Services Non-Specialty Mental Health Services Vaccine Administration Vision (Optometric) Services	100% + Equity Adjustments
Evaluation and Management Codes for Emergency Department (ED) Physician Services	90%
Other Procedure Codes Commonly Utilized by: • Primary Care • Specialty Care • ED Providers	80%

Targeting Strategy

DHCS proposes to target specified codes to 100% of Medicare to advance preventive, primary care, maternal, and non-specialty mental health services in alignment with the DHCS Comprehensive Quality Strategy, and to increase members' direct access to office visits and community-based care.

- Other procedures codes are generally expected to be billed by a provider in conjunction with primary care and specialty office visits; or, in the case of specialty care provided in hospital inpatient settings, by physicians who are employed or contracted by the hospital providing inpatient care.

- Because primary care, specialty, and emergency physicians and non-physician health professionals utilize many of the same procedure codes across their respective scopes of practice, DHCS proposes to provide uniform rate increases for professional service procedure codes regardless of the specialty of the provider billing the service.

Eligible Providers:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Podiatrists
- Certified Nurse Midwives and Licensed Midwives
- Doula Providers
- Psychologists
- Licensed Professional Clinical Counselors
- Licensed Clinical Social Workers
- Marriage and Family Therapists
- Doctors of Optometry
- Audiologists

Geographic Adjustments

DHCS proposes to adopt Medicare's geographic structure consisting of 32 regions and to set Medi-Cal rates to the target percent of the Medicare rate applicable in the locality.

- Medicare geographic adjustments vary by procedure code based on the relative value of labor costs and practice costs included in the procedure code.

- Historically, Medi-Cal rates have been established on a uniform statewide basis benchmarked to the lowest rate effective on the Medicare fee schedule.

- DHCS states that adopting regional rates will advance access and equity by ensuring that Medi-Cal rates are competitive relative to other regional market purchasers and to reflect operating costs by areas of the state.

Equity Adjustments

DHCS proposes to allocate $200 million ($80 million MPPRF) for adjustments designed to promote provider participation in localities where members may face challenges with access to equitable health care due to health care worker shortages and to address social drivers of health.

- DHCS proposes to develop an equity index, in consultation with stakeholders, using a composite of existing data sources, including status as a health care worker shortage

area, status as a rural or frontier area, concentration of Medi-Cal members as a percent of regional population, and broader measures of social drivers of health such as the Healthy Places Index.

- DHCS states that localities may be established based on metropolitan statistical areas, counties, or sub-county service areas; further analysis is required. The index-based adjustment factors will be applied by grouping localities into percentiles, or tiers, based on score.

- This proposal allows DHCS to revise the adjustment factors in future years, in consultation with stakeholders, as new or improved data sources become available and in response to opportunities to improve or refine the factors' alignment to the goals of improving access and equity.

Annual Rate Updates

DHCS proposes to utilize Medicare rates effective in 2024 to establish targeted rate increases, effective January 1, 2025. DHCS explains that no rates will decrease relative to the Medi-Cal rate in effect on January 1, 2024.

- DHCS proposes to maintain geographic rates in relation to the Medicare rate in effect for each locality with a one-year lag.

- Any net changes to statewide weighted-average Medi-Cal rates would be considered annually through the state budget process.

- Rate increases for audiology services would include increasing the maximum allowed reimbursement for hearing aids.

- Professional services would not include other allied health providers, clinical laboratory services, radiology, and durable medical equipment.

Community and Hospital Outpatient (OP) and Emergency Department (ED) Facility Services

The Medi-Cal fee-for-service (FFS) delivery system currently reimburses outpatient and ED claims through a traditional FFS rate schedule, where each discrete service provided is billed separately on the claim and each service is reimbursed at a uniform statewide rate. A claim for a single visit may include many discrete procedures. Reimbursement methodologies for outpatient and ED facility services are not standardized in the Medi-Cal managed care delivery system.

DHCS is proposing to target annual investments of $490 million ($245 million MPPRF) for community and hospital OP services, including hospitals and ambulatory surgical centers, and $725 million ($255 million MPPRF) for ED facility services.

- DHCS proposes to transition hospital outpatient and ambulatory surgical center reimbursement, and to explore and engage stakeholders on transitioning ED facility reimbursement, to an Outpatient Prospective Payment System (OPPS) methodology, no sooner than January 1, 2027.

- In preparation for the transition to an OPPS methodology, DHCS proposes transitionary increases to baseline reimbursements in the FFS and managed care delivery systems beginning on January 1, 2025, until the implementation of the OPPS.

Outpatient Prospective Payment System (OPPS)

Under an OPPS methodology, a single bundled payment amount is established for different types of outpatient and ED visits similar to a Diagnosis Related Group (DRG) methodology. Visits are assigned prospective rates based on the diagnosis and key services provided.

- The bundled payment amount may be adjusted for regional cost differences between facilities. For example, Medicare adjusts payments using a regional Hospital Wage Index.

- DHCS proposes to geographically vary reimbursement under the new OPPS methodology in alignment with the geographic localities under the Medicare OPPS.

- DHCS proposes to apply regional or hospital-specific equity adjustments to reimbursement under the new OPPS methodology to mitigate reimbursement disparities and the future risk of hospital closures. The equity adjustments may consider status as a health care worker shortage area, status as a rural or frontier area or urban health desert, critical access hospital designation, and concentration of Medi-Cal members as a percent of regional population. Equity adjustments will not be applied to ED facility services.

- This proposal allows DHCS to revise the adjustment factors in future years, in consultation with stakeholders, as new or improved data sources become available and in response to opportunities to improve or refine the factors' alignment to the goals of improving access and equity.

Designated Public Hospitals

DHCS proposes to target investments of $375 million ($150 million MPPRF) for designated public hospitals (DPHs) including county hospital systems and University of California systems.

- DHCS proposes to transition reimbursement for DPH inpatient services in the Medi-Cal FFS delivery system from the existing Certified Public Expenditures methodology to a Diagnosis Related Group (DRG)-type methodology.

- DHCS proposes to sunset in two stages the current methodology that provides for interim per-diem reimbursement and a subsequent reconciliation to 100 percent of cost.

- A DRG methodology uses diagnosis and procedure codes to assign an All Patient Refined Diagnosis Related Group (APR DRG) category and illness severity level to determine the final reimbursement amount for each inpatient hospital stay.

- DHCS proposes to annually calibrate the DRG methodology to target $150 million state fund expenditures, and notes that actual expenditures may vary based on utilization.

- DHCS does not propose to utilize an outlier methodology initially, although DHCS may implement an outlier policy in future years, if warranted.

Abortion and Family Planning Services

DHCS proposes to target investments of $90 million MPPRF annually for abortion and family planning services.

- DHCS proposes to increase rates for surgical and medication abortions to $1,150 in the FFS delivery system, and to require Medi-Cal managed care plans to pay no less than the increased rates to their network providers.

- DHCS proposes to continue the Abortion Supplemental Payment Program with $15 million MPPRF through the current term of the MCO tax.

- In line with DHCS's proposed approach for primary care and specialty professional services, DHCS proposes to vary the rate for abortion services based on the Medicare geographic price index; $1,150 would be the rate in effect in the lowest priced region.

- The proposed rate increase will apply to the three most-commonly used abortion services codes (59840, 59841, S0199) and to six less commonly used surgical abortion procedure codes in the 59850 to 59857 range.

- DHCS states that the proposed rate increase is designed to provide reimbursement parity between surgical and medication abortions.

- DHCS proposes to fold the Proposition 56 supplemental payments for these codes into the new base rates.

Ground Emergency Medical Transportation (GEMT)

DHCS proposes to target investments of $50 million MPPRF annually for Ground Emergency Medical Transportation (GEMT) services.

- DHCS proposes to eliminate the 10 percent AB 97 reduction and to target a base rate of 50 to 60 percent of Medicare. Rate increases will apply in the FFS delivery system, and as the "Rogers Rate" for non-contracted providers in the managed care delivery system.

- DHCS proposes to adopt Medicare's pricing system to vary GEMT base rates by complexity, locality, and rural status. DHCS believes that adopting Medicare's structure will equitably target rate increases to areas with higher labor costs and higher operating costs due to low population density and make Medi-Cal rates more competitive with other regional payers.

- In future years, DHCS proposes to maintain the Medi-Cal base rates in relation to the Medicare rates. Any net changes to statewide weighted-average Medi-Cal rates would be considered annually through the state budget process.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

DHCS proposes to target investments of $50 million MPPRF annually for services and supports provided by FQHCs. AB 80 (Committee on Budget, Chapter 12, Statutes of 2020) authorized DHCS to implement a payment methodology to provide supplemental payments to qualifying non-hospital 340B community clinics to secure, strengthen, and support the community clinic and health center delivery system for Medi-Cal members.

- DHCS proposes to transition the existing non-hospital 340B supplemental payment program to a managed care directed payment, and proposes to increase the total targeted annual pool amount by $100 million to $205 million ($50 million MPPRF, at 50 to 60 percent average federal financial participation).

- DHCS proposes that the directed payment arrangement include both utilization-based payments and performance-based quality payments.

Proposal 4: Budget Change Proposal (BCP) – ***Medi-Cal Targeted Provider Rate Increases & Investments Workload***

DHCS requests 26 permanent positions, the conversion of 1 limited-term resource to a permanent position, and expenditure authority of $4,629,000 ($2,315,000 Managed Care Enrollment Fund (MCEF, MCO tax revenue); $2,314,000 Federal Fund (FF)) in Fiscal Year (FY) 2024-25 and $4,395,000 ($2,198,000 MCEF; $2,197,000 FF) in FY 2025-26 and ongoing. This request is for the following positions:

Division	Position
Fee-For-Service Rates Development Division (FFSRDD): 15 Permanent Positions and 1 LT Converted to Permanent effective 7/1/2024	• 1 Staff Service Manager (SSM) III • 1 Research Scientist (RS) V (Social/Behavioral Sciences) • 1 Medical Consultant (MC) II • 1 Office Technician (OT) • 1 SSM II • 1 Research Data Specialist (RDS) II • 2 SSM I • 2 Health Program Specialists (HPS) I (1 LT converted to Permanent) • 2 RDS I • 2 Research Data Analysts (RDA) II • 2 Associate Government Program Analysts (AGPA)
Office of Legal Services (OLS): 1 Permanent Position effective 7/1/2024	• 1 Attorney III
Safety Net Financing Division (SNFD): 10 Permanent Positions effective 7/1/2024	• 2 SSM I • 2 RDS I • 2 RDA II • 2 HPS I • 2 AGPA

Within FFSRDD, the Provider Rates Section (PRS) is responsible for developing and implementing Medi-Cal FFS outpatient provider rates and financing policies. According to DHCS, as currently resourced, PRS is equipped to support less-technically complicated FFS annual rate comparisons to Medicare rates for a small subset of provider types. In recent years, PRS has assumed new responsibility involving more complex programs such as the Federally Qualified Health Center Prospective Payment System and certain California Advancing and Innovating Medi-Cal initiatives, without commensurate increases in staffing resources. Historically, Medi-Cal rates for most outpatient provider types are not updated annually and are only periodically adjusted through the state budget process. The last comprehensive change in outpatient reimbursement rates authorized through the state budget process was the

supplemental payments funded by Proposition 56 in 2017-18 which had a far narrower scope and lower complexity than the targeted provider rate increases and investments proposed in accordance with AB 118.

Within SNFD, the Hospital Reimbursement and Realignment Section is responsible for developing and implementing FFS general acute care hospital inpatient provider rates and financing policies through the Diagnosis Related Group (DRG) Program and the Designated Public Hospital (DPH) Certified Public Expenditures (CPE) Program.

DHCS explains that the proposed MCO tax rate increases significantly increase the complexity of Medi-Cal FFS rate setting in three key ways: 1) the rates will track to changes to Medicare rates; 2) introducing geographic variation, which multiplies the number of rates by a factor of 32; and 3) introducing equity adjustments to the rates for professional and outpatient services.

LAO Comments

Increased Tax Proposal and Fund Shift Away from Rate Increases

The LAO believes that it makes sense for the state to maximize the benefit it can achieve from the tax by increasing the tax. Furthermore, they believe that increasing the tax is a "particularly attractive budget solution relative to other options as it does not necessitate scaling back core programs or imposing substantial new costs to California taxpayers."

The LAO points out that the proposed reduction ($3 billion) to the provider payment reserve would help address the deficit, however it would also accelerate when the potential MCO tax funding shortfall occurs by approximately one year. The LAO finds this to be a reasonable trade-off given that the near-term fiscal constraints are a certainty, whereas the state's fiscal condition in 4-5 years is less certain.

LAO Recommendations

The LAO recommends the Legislature approve of both the tax increase and the fund shift, totaling approximately $4.6 billion, as a budget deficit solution.

Targeted Rate Increases Proposal

The LAO's assessment of the MCO tax TRI proposals begins with these two broad observations:

- "*Much of Proposal Remains Conceptual*. In many ways, the administration's proposal is conceptual, with key details still forthcoming. For example, the administration also has not determined key details of the proposed equity adjustment. In some cases, the time line to implement changes has not been finalized. Moreover, some aspects of the

package—such as augmentations for behavioral health and health care workforce—are forthcoming.

- *Legislature Has Opportunity to Assess Broad Aspects of Proposal*. The administration states that it is planning to release a package of trailer bill legislation on the proposed increases. Over the coming months, the Legislature likely will have more opportunity to weigh the details of each proposed increase. With more information forthcoming, we focus our assessment on the broad architecture of the package."

The LAO also raised the following issues for consideration:

- *Tying Payments to Medicare*. Tying payment increases to Medicare has advantages, but also disadvantages such as that it effectively ties the state's Medi-Cal rates to federal decision-making.

- *Prospective Payment Systems*. The Proposed Prospective Payment system proposed for hospitals is worthy of consideration but further analysis is warranted to ensure that this new system provides the intended incentives and avoids unintended consequences.

- *Equity Adjustment*. The LAO states that: "An equity adjustment could better target resources and incentivize providers to serve Medi-Cal beneficiaries in these regions. That said, whether the adjustment as proposed would be of a sufficient size to alter provider behavior is uncertain."

- *Impact on Managed Care Rates*. The LAO points out that it is difficult to assess the impact this proposal will have on managed care rates, in the long-term.

- *More Details Needed to Assess*. As with many proposals, the LAO feels that the full details, that will be contained in the trailer bill language, are necessary to do a full assessment of the proposal.

- *Future Uncertainties*. The LAO points out the following future uncertainties:
  - The overall package of proposals lacks a long-term funding strategy;
  - The state's uncertain budget condition heightens funding risks; and
  - A ballot initiative, if passed by the voters, could enact changes to the MCO tax policies ultimately adopted by the Legislature.

LAO Recommendations

The LAO recommends that the Legislature focus on the following key principles in assessing and supporting MCO tax-funded rate increases:

"Target Increases to Highest Need Areas of Medi-Cal. We recommend the Legislature first consider which areas of Medi-Cal to target for augmentations. Though last year's enacted trailer bill legislation set forth specific areas for increases, the Legislature could consider how much funding to allocate and how to structure these allocations. For example, the Legislature could consider how much funding to allocate for base payment increases and how much funding to allocate for equity adjustments.

Focus on Changes That Make Medi-Cal Payment Methodologies More Rational. To the extent the Legislature would like to use these increases to also change the way Medi-Cal pays providers, we recommend it focus on approaches that make the existing methodology more rational. For example, the Legislature could consider tying certain provider payments to a percent of the Medicare level, as proposed, which would help to mitigate existing inequities and allow for a consistent approach to adjust rates over time. The Legislature could consider many other approaches as well, such as tying payments to delivering high-value services or meeting performance outcomes.

Implement Realistic Implementation Schedule. During budget hearings, we recommend the Legislature solicit more information from the department, managed care plans, and providers on the implementation of the recently enacted payment increases and any anticipated challenges to implement proposed increases in 2025. To the extent this information suggests the proposed timing of augmentations may not be feasible, we recommend the Legislature consider approving increases over a longer time frame. For example, the Legislature could delay the timing of certain increases and payment methodology changes, allowing more time for DHCS and managed care plans to prepare. Alternatively, the Legislature could phase in payment increases and changes over multiple years, such as by enacting a multiyear schedule to ramp up rate increases to the desired level. Such an approach could have the added benefit of spreading the fiscal risks of the proposed package over a longer period of time, including by delaying the timing of when the provider payment reserve is depleted.

Develop Plan for Oversight. As the administration releases proposed trailer bill legislation, we recommend the Legislature ensure it has an opportunity to review and approve key components of any provider payment changes before they go into effect. In cases where further study is warranted before implementing a change in payment methodology (such as adopting new hospital prospective payment systems), we recommend the Legislature authorize DHCS to study these effects and direct the department to report on its findings before enacting the new system. In addition, we recommend the Legislature be kept apprised of the package's implementation

by establishing reporting requirements in trailer bill legislation or supplemental reporting language. At a minimum, we recommend two reports: (1) an implementation update of approved rate increases, due March 2025, and (2) an initial analysis of how any enacted rate increases have affected access, quality, and equity in the Medi-Cal program, due March 2026.

Develop Sustainable Long-Term Plan for the Future. In crafting its MCO tax package, we recommend the Legislature develop a sustainable long-term plan that keeps in mind future uncertainties. For example, we recommend the Legislature plan for the possibility that the next MCO tax is smaller than this one and adopt an overall budget package with adequate capacity in the General Fund to sustain ongoing augmentations in the future. Such a plan also would consider the timing of when new augmentations and payment changes would begin and ensure these changes are not disrupted by the potential depletion of the provider payment reserve. Moreover, the Legislature may wish to consider the possibility that the voter initiative qualifies for the ballot and is enacted by voters and plan accordingly."

The LOA's full *The 2024-25 Budget Medi-Cal Analysis* can be found here: https://lao.ca.gov/Publications/Report/4838

Panel

- Michelle Baass, Director, Department of Health Care Services
- Lindy Harrington, Assistant State Medicaid Director, Department of Health Care Services
- Rafael Davtian, Deputy Director, Health Care Financing, Department of Health Care Services
- Laura Ayala, Assistant Program Budget Manager, Department of Finance
- Aditya Voleti, Staff Finance Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Panel

- Stuart Thompson, Senior Vice-President of Government Relations, California Medical Association
- Erica Murray, President and CEO, California Association of Public Hospitals and Health Systems
- Dennis Cuevas-Romero, Vice President of Government Affairs, California Primary Care Association
- Mark Farouk, Vice President, State Advocacy, California Hospital Association
- Lisa Matsubara, Chief Legal and Advocacy Officer, Planned Parenthood of California

- Matt Legé, Government Relations Advocate, SEIU California State Council
- Linnea Koopmans, Chief Executive Officer, Local Health Plans of California

Staff Comments

Consistent with the LAO recommendations, the proposed tax increase and fund shift from provider rate increases to the General Fund seem prudent and far less harmful than other kinds of budget solutions that reduce payments to providers or reduce various types of health or human services. The proposed TRI will need a lot more consideration and analysis, particularly as the proposal evolves to reflect conversations between the administration and key stakeholders.

Questions for DHCS:

1. Is there any opportunity to raise the tax even higher than what is being proposed?

2. Which Medi-Cal providers or services will still be subject to the AB 97 (2011) payment reductions after adoption of the administration's MCO tax proposals? Are there any physicians who will still be subject to the AB 97 rate reduction and not receiving an MCO rate increase?

3. We are hearing that there are persistent problems with accurate payments going out in a timely way within the existing Supplemental Payment Pool program; could you please share how you plan to address those problems prior to implementation of the proposed new managed care SPP under the MCO proposal?

4. Do you believe that the proposed DRG rate system for Designated Public Hospitals (DPHs) will adequately cover their Medi-Cal costs?

5. Could you please explain how the TRI proposal affects cost-based supplemental payments to DPHs?

Staff Recommendation: Hold all items open.

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