HOSPITAL FINANCING IN MEDI-CAL

High-Level Explainer – March 2024

Background

This document provides high-level information related to Medi-Cal payments to hospitals, including how payments are developed, how payments are financed, and recent and proposed changes that affect the payments hospitals receive.

Hospital financing consists of a complex web of reimbursement streams that are impacted by a multitude of factors. One critical reimbursement stream for many hospitals is Medi-Cal, California's Medicaid program administered by the Department of Health Care Services (DHCS). At the most basic level, a hospital's revenues consist of: (1) revenues from inpatient admissions, and (2) revenues from outpatient services which may include emergency room care, specialty care, primary care, and ancillary services. A hospital can look at these components by payer – commercial health plans, Medicare, and Medi-Cal. Different payers can reimburse a hospital in different ways, such as fee-for-service payments (for each distinct service), capitated payments (for each assigned member), bundled or episodic payments (for bundles of services or episodes of care), performance-based incentive payments and other value-based or alternative payment methods. To understand a hospital's financial position, all these factors must be considered and a hospital's "payer mix" determined – the percentage of each of these various payers as a proportion of a hospital's overall patient population or service mix.

Medi-Cal

Physical health services, including the vast majority of hospital services, provided to Medi-Cal members are covered in the fee-for-service and managed care delivery systems. In the fee-for-service delivery system, providers receive reimbursement directly from DHCS (or DHCS' fiscal intermediary). In the managed care delivery system, providers receive reimbursement from Medi-Cal managed care plans (MCPs) contracted by DHCS to arrange for the provision of covered services to Medi-Cal members in defined service areas.

Base and Supplemental Payments

Medi-Cal payments to hospitals include both base and supplemental payments. Supplemental payments are separate from and in addition to the base payments for

services rendered to Medi-Cal beneficiaries, and supplemental payment programs utilize federally approved financing mechanisms to increase reimbursements to hospitals.

Inpatient Services. The bulk of Medi-Cal payments to hospitals are for inpatient services. Hospitals are reimbursed for inpatient services provided to Medi-Cal members via a combination of base and supplemental payments in both the fee-for-service and managed care delivery systems.

- In the fee-for-service delivery system, both the base and supplemental payments are developed and proposed by DHCS and approved by federal Centers for Medicare and Medicaid Services (CMS). DHCS utilizes the full federal Upper Payment Limit (UPL), which limits Medi-Cal reimbursement for inpatient facilities to what would have otherwise been reimbursed under Medicare. The state's ability to raise fee-for-service rates is limited by the fact that fee-for-service rates are already at or near the federal UPL.
- In the managed care delivery system, the base payment is typically determined by the negotiated contract between a hospital and MCP. The supplemental payments are developed and proposed by DHCS and approved by CMS. The total payment amount including base and supplemental payments is subject to a variety of considerations, including a hard cap at the average commercial market rate. Hospitals can seek increases to their base reimbursement through negotiations with MCPs, while DHCS works with CMS to seek approval of appropriate increases to supplemental payments.

Outpatient Services. Hospitals are similarly reimbursed for outpatient services provided to Medi-Cal members via a combination of base and supplemental payments in both the fee-for-service and managed care delivery systems. In the fee-for-service delivery system, base payments for hospital outpatient services follow the Medi-Cal fee-for-service rate schedule. In the managed care delivery system, the base payment is determined by the negotiated contract between a hospital and MCP; for non-contract emergency and post-stabilization services, the base payment follows the Medi-Cal fee-for-service rate schedule. In both delivery systems, hospitals receive additional Medi-Cal supplemental payments for outpatient services.

Financing and Net Benefit

Medi-Cal payments are made when a state-generated share of the payment is passed up to the federal government, which then "matches" these payments based on a federal medical assistance percentage (FMAP) and returns to the state a full payment that is then provided to hospitals or health plans. CMS allows the state-generated payment (also known as the non-federal share) to be state General Fund (SGF) and/or locally

generated funds (also known as self-financing) such as certified public expenditures (CPE), intergovernmental transfers (IGT), and hospital quality assurance fees (HQAF).

The non-federal share of base payments to hospitals is financed predominantly using SGF, with some exceptions in the fee-for-service delivery system. The non-federal share of supplemental payments to hospitals is financed primarily using locally generated funds, with some exceptions that are financed using SGF. The net financial benefit to a hospital of a self-financed payment is not the full payment the hospital receives but rather the net of the payment they receive less the local funds they provided.

Payment Levels

The majority of Medi-Cal payments to hospitals are for inpatient services, as noted above, and in the managed care delivery system. At a statewide level, gross Medi-Cal managed care payment levels to hospitals match or exceed Medicare reimbursement rates, on average, and are roughly 50 percent of average commercial rates. In comparison, fee-for-service financing is more complex and variable by hospital type. Payment levels are often very different from one hospital to another, and reimbursement for outpatient services is generally lower than for inpatient services.

In general, DHCS increases the value of hospital supplemental payments in the managed care delivery system each year. Increases may be linked to growth in consumer price or other inflationary indexes, programmatic changes such as benefit or eligibility expansions, and other policy considerations such as implementation of quality-based payments or transitions of supplemental payments that are phasing down or sunsetting.

In recent years, DHCS, in partnership with hospitals, has made a concerted effort to increase hospital supplemental payments in the managed care delivery system. In the last three years (as of calendar year 2024, subject to CMS approval), DHCS increased the annual amount of self-financed hospital supplemental payments in managed care by:

- Approximately $3.2 billion (annualized) for private hospitals.
- Approximately $900 million (annualized) for designated public hospitals.
- Approximately $225 million (annualized) for district and municipal public hospitals.

A portion of these increases offset decreases to fee-for-service supplemental payments; and, as previously noted, the net benefit of these increases to hospitals is less than the total amount of the increases due to the nuance of self-financing. In total across the fee-for-service and managed care delivery systems, DHCS makes approximately $13–15 billion in net-benefit supplemental payments to hospitals each year in addition to their base payments.

Proposed MCO Tax-Funded Rate Increases and Investments

Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a Managed Care Organization (MCO) Tax effective April 1, 2023, through December 31, 2026. Subject to federal approval, MCO Tax revenues will be used to support the Medi-Cal program including, but not limited to, new targeted provider rate increases and other investments that advance access, quality, and equity for Medi-Cal members and promote provider participation in the Medi-Cal program. Following the principle that MCO Tax revenues should be used to support the Medi-Cal program at large and to bring in additional federal funding, hospital financing can be best supported using MCO Tax funds by maintaining existing services in the Medi-Cal program and minimizing the need for reductions, increasing base payments for services currently paid below federal rate limits when compared to Medicare, and substituting state funds for a subset of self-financed Medi-Cal payments to hospitals.

Pursuant to the 2023 Budget, DHCS developed targeted provider rate increases for primary care, maternity care, and non-specialty mental health services effective for dates of service on or after January 1, 2024. These rate increase will apply to eligible providers in the fee-for-service delivery system as well as eligible network providers contracted with MCPs. DHCS increased rates, as applicable, for targeted services to no less than 87.5 percent of the Medicare rate, inclusive of eliminating AB 97 provider payment reductions and incorporating applicable Proposition 56 supplemental payments into the base rate.

The 2024-25 Governor's Budget includes proposals for additional targeted provider rate increases, pursuant to AB 118 (Chapter 42, Statutes of 2023), effective January 1, 2025. The targeted provider rate increases most relevant to hospitals are:

- Increase base payment rates for maternity care to 100 percent of the geographically adjusted Medicare rate, plus additional equity enhancements.
- Increase base payment rates for emergency physician services to 90 percent of the geographically adjusted Medicare rate.
- Increase annual reimbursement for outpatient services by $490 million (total funds) and for emergency department facility services by $725 million (total funds), and transition base payments for these services to an Outpatient Prospective Payment System.
- Invest $150 million of MCO Tax funds annually into modernizing reimbursement methodologies for designated public hospital inpatient services in the fee-for-service delivery system and improving these hospitals' net benefit by reducing self-financing and increasing state-funded financing.

Appendix

The following table lists hospital supplemental payment programs in the fee-for-service and managed care delivery systems.

Program Name	Program Description	Financing	Hospital Type(s)	Delivery System[1]
Private Hospital Directed Payment Program	Requires MCPs to make utilization-based supplemental payments to private hospitals for qualifying network services.	HQAF	Private	MC
Designated Public Hospital Enhanced Payment Program	Requires MCPs to make utilization-based supplemental payments to designated public hospitals for qualifying network services.	IGT	Public	MC
Designated Public Hospital Quality Incentive Pool	Requires MCPs to make performance-based supplemental payments to designated public hospitals.	IGT	Public	MC
District and Municipal Public Hospital Directed Payment Program	Requires MCPs to make utilization-based supplemental payments to non-designated public hospitals for qualifying network services.	IGT	Public	MC
District and Municipal Hospital Quality Incentive Pool	Requires MCPs to make performance-based supplemental payments to non-designated public hospitals.	IGT	Public	MC
Private Hospital Pass-Through Payment Program	Requires MCPs to make supplemental payments to private hospitals for hospital services provided to Medi-Cal members.	HQAF	Private	MC
District and Municipal Hospital Pass-Through Payment Program	Requires MCPs to make supplemental payments to non-designated public hospitals for hospital services provided to Medi-Cal members.	IGT	Public	MC

[1] "FFS" denotes the fee-for-service delivery system; "MC" denotes the managed care delivery system.

Program Name	Program Description	Financing	Hospital Type(s)	Delivery System[1]
Martin Luther King, Jr. Community Hospital (MLKCH) Pass-Through Payment Program	Requires MCPs in Los Angeles County to make supplemental payments to the hospital to achieve minimum reimbursement levels consistent with State law requirements.	SGF	Private	MC
Benioff Children's Hospital Oakland Pass-Through Payment Program	Requires MCPs in Alameda County to make supplemental payments to the hospital that increase reimbursement for services provided to Medi-Cal members.	IGT	Private	MC
Private Hospital Supplemental Fund Program	Provides supplemental payments to private hospitals using SGF as the non-federal share of payments.	SGF	Private	FFS
SB 1100 Intergovernmental Transfer Program	Provides supplemental payments to private hospitals in Orange County, Alameda County, and the Grossmont Healthcare District.	IGT	Private	FFS
Construction Renovation Reimbursement Program – SB 1732	Provides supplemental payments to qualifying private and public hospitals that met initial program milestones for a portion of their debt service on revenue bonds issued to finance the construction, renovation, expansion, remodel, or replacement of an eligible hospital.	SGF	Both	FFS
Construction Renovation Reimbursement Program – SB 1128	Provides annual supplemental payments to nursing facilities that are distinct parts of a general acute care hospital for costs associated with the construction, renovation, expansion, remodel, or replacement of an eligible facility.	CPE	Public	FFS
Non-Designated Public Hospital Intergovernmental Transfer Program	Provides supplemental payments to eligible non-designated public hospitals for Medi-Cal fee-for-service inpatient hospital services on an annual basis.	IGT	Public	FFS

Program Name	Program Description	Financing	Hospital Type(s)	Delivery System[1]
Non-Designated Public Hospital Supplemental Fund Program	Provides supplemental payments to non-designated public hospitals using SGF of $1.9 million as the non-federal share of payments.	SGF	Public	FFS
Private Trauma Intergovernmental Transfer Program	Provides supplemental payments for outpatient hospital trauma and emergency services to private hospitals within Los Angeles County and Alameda County.	IGT	Private	FFS
Graduate Medical Education for Designated Public Hospitals Program	Provides payments to designated public hospitals on a quarterly basis in recognition of the Medi-Cal managed care share of direct and indirect graduate medical education (GME) costs.	IGT	Public	MC
Outpatient Hospital Supplemental Reimbursement Program (AB 915)	Provides annual supplemental payments to public acute care hospitals for outpatient fee-for-service services.	CPE	Public	FFS
Distinct Part Nursing Facility Supplemental Reimbursement Program	Provides supplemental payments for nursing facilities that are distinct parts of a general acute care hospital that is owned or operated by a city, city and county, or health care district and provides skilled nursing services to Medi-Cal members.	CPE	Public	FFS
Hospital Quality Assurance Fee Program	Provides supplemental payments to private hospitals for inpatient and outpatient services while also generating funding for Children's Health Care coverage and providing direct grants to public hospitals.	HQAF	Private, plus public grants	FFS
Martin Luther King Jr. Community Hospital Supplemental Payment Program	Provides supplemental payments to the hospital to achieve minimum reimbursement levels consistent with State law requirements.	IGT and SGF	Private	FFS
Physician and Non-Physician	Provides certified public expenditure reimbursement to	CPE	Public	FFS

Program Name	Program Description	Financing	Hospital Type(s)	Delivery System[1]
Practitioner Supplemental Reimbursement Program	eligible government-operated hospitals and their affiliated government-operated physician practice groups, for the uncompensated Medicaid costs of providing physician and non-physician practitioner professional services to Medi-Cal members.			
Disproportionate Share Hospital Program (DSH)	Provides supplemental payments to public hospitals that meet the criteria for DSH eligibility, for reimbursement of uncompensated care costs associated with inpatient hospital services provided to Medi-Cal members and uninsured individuals.	CPE, IGT, and SGF	Public	FFS
DSH Replacement Program	Provides inpatient supplemental payments to private hospital that meet the criteria for DSH eligibility, for reimbursement of uncompensated care costs associated with inpatient hospital services provided to Medi-Cal members and uninsured individuals.	SGF	Private	FFS
Outpatient DSH Program	Provides funding to hospitals that meet the criteria for DSH eligibility for providing a disproportionate share of outpatient services to Medi-Cal members.	SGF	Both	FFS
Outpatient Small and Rural Hospital Program	Provides small and rural hospitals for providing outpatient services to Medi-Cal members.	SGF	Both	FFS
Global Payment Program (GPP)	Provides funding to public health care systems for services provided to the uninsured population and promotes the delivery of more cost-effective, higher-value, and equity-enhanced care to the uninsured.	IGT	Public	FFS