DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MEDI-CAL TARGETED RATE INCREASES

2024-25 Governor's Budget Proposed Plan

Introduction

Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) authorized a Managed Care Organization (MCO) Tax, effective April 1, 2023, through December 31, 2026. 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. The Department of Health Care Services (DHCS) received federal approval of the MCO Tax on December 15, 2023.

Pursuant to Welfare & Institutions Code section 14105.201 (added by AB 118 [Chapter 42, Statutes of 2023]), DHCS developed "Phase 1" targeted rate increases for primary care, obstetric (including doula), and non-specialty mental health services for Medi-Cal providers, effective for dates of service on or after January 1, 2024. These rate increases apply to eligible providers in the Medi-Cal fee-for-service (FFS) delivery system as well as eligible network providers contracted with Medi-Cal managed care plans.[1] DHCS increased rates, as applicable, for targeted services to no less than 87.5 percent of the lowest Medicare rate in California, inclusive of eliminating AB 97 provider payment reductions and incorporating applicable Proposition 56 supplemental payment funding into the base rate. DHCS calculated an equivalent rate increase for services that do not have a rate established by Medicare. DHCS received federal approval of these targeted rate increases in State Plan Amendment (SPA) 23-0035.

Welfare & Institutions Code section 14105.202 requires DHCS submit to the Legislature, as part of the 2024-25 Governor's Budget, a plan for additional targeted increases to Medi-Cal payments or other investments using MCO Tax funds deposited in the Medi-Cal Provider Payment Reserve Fund (MPPRF). This policy paper outlines the additional ("Phase 2") targeted rate increases or other investments being proposed by the

[1] For more information, including the list of procedure codes and schedule of rates, see the Medi-Cal Targeted Provider Rate Increases and Investments webpage on the DHCS website.

Administration, consistent with the June 2023 proposed spending plan and the refreshed January 2024 proposed spending plan (see below).

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	

[2] Increases or investments are proposed to start January 1, 2025, unless otherwise noted.
[3] Displayed amounts are state funds only; provider payments will include federal match when available. These amounts are annual amounts on an accrual basis. Medi-Cal is on a cash basis budget and amounts by fiscal year will vary.
[4] Maternal Care includes obstetric and doula services. Mental Health means non-specialty mental health.
[5] Physician and Non-Physician Health Professional Services include Primary Care, Maternal Care, Mental Health, and Specialty Care. Emergency department physician services are included under Emergency Department (Facility and Physician) Services.

Physician and Non-Physician Health Professional Services

Effective January 1, 2025, DHCS is targeting annual investments of:

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

These investments are in addition to the $727 million ($291 million MPPRF) in rate increases, effective January 1, 2024, to increase rates for select services to 87.5 percent of the lowest Medicare rate, including $50 million MPPRF for services accelerated to January 1, 2024, due to specialty provider utilization of codes designated as "primary care" for purposes of the Phase 1 increases.

Rate Increases

DHCS proposes to increase Medi-Cal rates to target specified percentages of Medicare rates for these services 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. In conjunction with these rate increases, all remaining AB 97 reductions for physician services are proposed to be eliminated, and all Proposition 56 supplemental payments for physician services are proposed to be incorporated into base rates for applicable procedure codes. For all included codes, DHCS proposes to geographically adjust rates in alignment with Medicare, as described below. Furthermore, DHCS proposes to apply additional equity adjustments to specified codes, described below.

Investments	Total Fund ($millions)	MPPRF ($millions)
Rate Increases to Target Percent of Medicare	$2,488	$995
Equity Adjustments	$200	$80
TOTAL	**$2,688**	**$1,075**

Procedure Codes	Target Percent of Medicare
Evaluation & Management Codes for Primary Care and Specialist Office Visits, Preventative Services, and Care Management*	100%
Obstetric Services*	100%
Non-Specialty Mental Health Services*	100%
Vaccine Administration*	100%
Vision (Optometric) Services*	100%
Evaluation & Management Codes for ED Physician Services	90%
Other Evaluation & Management codes	80%
Other Procedure Codes commonly utilized by Primary Care, Specialist, and ED Providers	80%

** Procedure codes eligible for equity adjustments*

DHCS proposes to increase rates to 100 percent of Medicare for procedure codes utilized for evaluation and management for primary care and specialty office visits, preventative services, and care management; obstetric services; non-specialty mental health services; vaccine administration; and vision (optometric) services. Furthermore, DHCS proposes to apply additional equity adjustments to these codes, described below. These codes are targeted to advance preventive, primary care, maternal, and non-specialty mental health services in alignment with the DHCS Comprehensive Quality Strategy,[6] and to increase members' direct access to office visits and community-based care. Vision codes are targeted as optometrists generally do not utilize evaluation and management codes for standard office visits.

Additionally, **DHCS proposes to increase rates to 90 percent of Medicare for evaluation and management codes for ED visits and to 80 percent of Medicare for other procedure codes commonly utilized by primary care, specialist, and ED providers.** These codes include various types of specialized studies, therapies, surgical procedures, ED physician services, and specialty care provided in hospital inpatient and nursing facility settings. DHCS anticipates that these additional procedures will often be

[6] https://www.dhcs.ca.gov/services/Pages/DHCS-Comprehensive-Quality-Strategy.aspx

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.

Consistent with our Phase 1 approach, DHCS will calculate an equivalent rate increase for services that do not have a rate established by Medicare. For example, the structure of Medi-Cal anesthesiology rates does not crosswalk to Medicare rates, and Medicare generally does not reimburse audiology services. As such, DHCS will calculate equivalent rate increases for anesthesiology and audiology services based on analysis of Medicare, Department of Veterans Affairs, and commercial rates.

Eligible Providers

DHCS proposes to apply the rate increases to services that are billed on professional claims (CMS 1500 form) rendered by Physicians, Physician Assistants, Nurse Practitioners, Podiatrists, Certified Nurse Midwives, Licensed Midwives, Doula Providers, Psychologists, Licensed Professional Clinical Counselors, Licensed Clinical Social Workers, Marriage and Family Therapists, Optometrists, and Audiologists. Rate increases for audiology services include increasing the maximum allowed reimbursement for hearing aids. Furthermore, consistent with our Phase 1 approach, rate increases for obstetric care and non-specialty mental health services are proposed to also apply to services billed on institutional provider claims (CMS-1450 or UB-04 form). Professional services do not include other allied health providers, clinical laboratory services, radiology, and durable medical equipment.

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 to maintain administrative simplicity and create efficient incentives. Provider specialty data is not currently collected with sufficient precision to adjudicate claims with rates varying by specialty, and physicians can generally provide both primary care and specialty services within the scope of their medical licenses.

Geographic Adjustment

Medicare varies rates across California in 32 metropolitan statistical area (MSA)-based localities. Medicare geographic adjustments vary by procedure code based on the relative value of labor costs and practice costs included in the procedure code. The difference between the highest cost and lowest cost locality in California can be

between 5 and 30 percent. Historically, Medi-Cal rates have been established on a uniform statewide basis benchmarked to the lowest rate effective on the Medicare fee schedule. **DHCS proposes to adopt the Medicare locality structure and to set Medi-Cal rates to the target percent of the Medicare rate applicable in the locality.** 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.

For Phase 1, DHCS established targeted Medi-Cal rates, effective January 1, 2024, based on the lowest Medicare rate in effect in California in calendar year (CY) 2023. DHCS proposes to utilize Medicare rates effective in CY 2024 to establish targeted rate increases, effective January 1, 2025, on a locality basis, but no less than the Medi-Cal rate effective on January 1, 2024.

Medicare rates are often not finalized until soon before the beginning of the calendar year, and the United States Congress can make last-minute legislative changes to Medicare rates. By having Medi-Cal rates lag Medicare by one year, DHCS will have sufficient time to incorporate necessary expenditure authority through the state budget process and in the development of actuarially sound managed care capitation rates. **In future years, DHCS proposes to maintain geographic rates in relation to the Medicare rate in effect for the locality.** Any net changes to statewide weighted-average Medi-Cal rates would be considered annually through the state budget process.

Equity Adjustment

DHCS considered four key principles when determining the allocated amount and other parameters of the equity adjustment:

- DHCS prioritized the funding for increasing reimbursement for services directly aligned with the DHCS Comprehensive Quality Strategy, to 100 percent of the Medicare rate.
- DHCS prioritized the funding for geographic adjustments to target the Medicare rate applicable in each locality. It is expected that geographic adjustments will correlate with equity considerations.
- Equity adjustments must meaningfully affect provider behavior while not skewing provider incentives for the provision of medically appropriate care.
- Equity adjustments must follow a reasonably streamlined methodology that can be understood by physicians and non-physician health professionals.

Based on these considerations, **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 apply adjustment factors to procedure codes utilized for evaluation and management for primary care and specialty office visits, preventative services, and care management; obstetric services; non-specialty mental health services; vaccine administration; and vision services. This approach is intended to provide an adjustment that is large enough to affect provider behavior by targeting the equity adjustment factors toward a narrower set of high-impact services.

DHCS will work to develop an equity index 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. See Appendix A for further details. DHCS proposes to place greater weight on specific health care workforce-related indicators, which align better with the approach of applying equity adjustment factors on a geographic basis, than broader measures of population characteristics, which would align better with a hypothetical (but operationally infeasible) approach of applying equity adjustment factors on a member- or population-specific basis.

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. DHCS will consult with stakeholders on the selection of the index weights and resulting adjustment factors.

DHCS proposes to recalculate the actual adjustment factors periodically, no more than annually and no less than triennially. DHCS may revise the index 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 index's alignment to the goals of improving access and equity.

Community and Hospital Outpatient and Emergency Department Facility Services

Effective January 1, 2025, DHCS is targeting annual investments of:

- $490 million ($245 million MPPRF) for community and hospital outpatient services, including hospitals and ambulatory surgical centers.
- $725 million ($255 million MPPRF) for ED facility services.

Background

Facilities' costs for outpatient and ED services, both in Medi-Cal and Medicare, are reimbursed via institutional provider claims (CMS-1450 or UB-04 form). The Medi-Cal FFS delivery system currently reimburses institutional provider 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 outpatient 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.

Medicare reimburses outpatient and ED facility services using an Outpatient Prospective Payment System (OPPS). An OPPS has also been adopted by twelve other state Medicaid programs. Under an OPPS methodology, a single bundled payment amount is established for different types of outpatient and ED visits. 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. Medicare adjusts payments using a regional Hospital Wage Index. Generally, bundled payments incentivize more efficient provision of services over volume billing. Furthermore, an OPPS methodology creates a common language between the financing system and clinicians to measure outcomes and advance patient care quality.

Proposal

DHCS proposes to transition hospital outpatient and ambulatory surgical center reimbursement to an OPPS methodology, no sooner than January 1, 2027, to advance the economic and efficient provisioning of these services. Additionally, **DHCS proposes to explore and engage stakeholders on transitioning ED facility reimbursement to an OPPS methodology no sooner than January 1, 2027.** Additional analysis is required to map out the impacts of transitioning ED facility services to an OPPS methodology.

In preparation of 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.** Baseline increases will apply as regionally adjusted percentage increases to FFS and managed care reimbursements in these categories of service relative to current reimbursement levels, without establishing a procedure code-based fee schedule. Baseline increases will be adjusted on a regional basis designed to equalize baseline per member reimbursement levels for these categories of service with statewide average per member reimbursement levels adjusted for differences in regional labor costs using the Medicare hospital wage index.

DHCS estimates baseline increases will average approximately 10 percent for outpatient services and 40 percent for ED facility services. However, these increases will vary by region or facility. Transitionary baseline increases will not apply to facility claims for obstetric and non-specialty mental health services, which instead will be increased through the minimum fee schedule rate established for professional services. Facility claims for obstetric and non-specialty mental health services will transition to the OPPS methodology once it is established. For ED facility services, the transitionary baseline increases will be transitioned to a permanent methodology if a determination is reached not to proceed with reimbursing these services under an OPPS methodology.

DHCS proposes to calibrate the OPPS to be budget neutral relative to increased baseline reimbursements in the preceding two years, and to provide ongoing adjustments based on changes to Medicare rates. Any net changes to statewide weighted-average Medi-Cal rates would be considered annually through the state budget process. The application of transitionary baseline increases will be on a broad basis, rather than to targeted codes or categories of outpatient services, to support the goal of maintaining budget neutrality during the future transition to an OPPS methodology. Targeting the transitionary baseline increases to specific codes or categories of outpatient services would make it much more likely that a budget-neutral transition could not be achieved without significantly reducing reimbursement for a portion of the targeted codes or categories that received increases.

The OPPS methodology will be similar to the Medicare OPPS, but may include adjustments specific to Medi-Cal program requirements and populations. DHCS will consult with stakeholders on the development of the adjustment factors. DHCS may 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.

Geographic Adjustment

The Medicare OPPS geographically varies reimbursement across core-based statistical area-based localities, which largely overlap with MSAs and provide more granularity in certain instances. In addition, the Medicare OPPS utilizes hospital-specific wage index adjustments that are designed to mitigate wage index disparities between high and low wage index hospitals.

DHCS proposes to geographically vary reimbursement under the new OPPS methodology in alignment with the geographic localities under the Medicare OPPS. DHCS may revise the geographic basis of Medi-Cal's OPPS in future years as needed to improve or refine alignment to access, equity, and other needs specific to the Medi-Cal program.

Equity Adjustment

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. See Appendix A for more details. Equity adjustments will not be applied to ED facility services.

Designated Public Hospitals

Effective January 1, 2025, DHCS is targeting investments of $375 million ($150 million MPPRF) annually for designated public hospitals.

Proposal

Currently, designated public hospitals are reimbursed for inpatient services through a per diem base rate determined based on the hospital area of care and a subsequent reconciliation to 100 percent of cost based on findings on the provider's audited cost reports. **DHCS proposes to transition reimbursement for designated public hospital inpatient services from the existing Certified Public Expenditures methodology to a Diagnosis Related Group (DRG)-type methodology.**

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. It requires accurate and complete claim-level detail data to correctly assign to each inpatient stay a corresponding APR-DRG and severity level.

Initially, the designated public hospital DRG-type methodology will involve the following steps, annually:

- DHCS will forecast the number of designated public hospital stays by Medicaid Care Category (MCC), for example: Circulatory Adult, Gastroenterology Adult, Miscellaneous Adult, Miscellaneous Pediatric, Neonatal, Normal Newborn, Obstetrics, Other, Respiratory Adult, and Respiratory Pediatric. Stays will be forecasted based on historical designated public hospital inpatient utilization, as appropriately adjusted by DHCS, and an estimated ratio of days per stay.
- DHCS will determine a uniform base reimbursement rate per inpatient stay that is projected, across all forecasted designated public hospital stays, to result in reimbursement of $375 million.
- DHCS will determine an MCC-specific base reimbursement rate equal to the uniform base reimbursement rate multiplied by an MCC-specific case mix factor.
- DHCS will establish an MCC-specific adjusted reimbursement rate using a budget factor, as needed, to rebalance each reimbursement rate to target $375 million in total annual reimbursement.
- DHCS will establish an MCC-specific maximum reimbursement rate per stay to guard against unreasonable outputs of the methodology and ensure reimbursement per stay is reasonable. Any MCC-specific adjusted reimbursement

rates that exceed the maximum will be reduced to the maximum and the estimated “savings” will be proportionally redistributed to the other MCCs.

In applying the steps outlined above, DHCS will leverage data from the traditional (non-designated public hospital) DRG program when utilization data specific to designated public hospitals is not available or reliable. In future years, DHCS will select the most appropriate data sources for a given program year and may adopt methodological improvements that better align financial incentives to the economic and efficient provisioning of inpatient services by designated public hospitals.

The designated public hospital DRG-type methodology will apply to all designated public hospital systems, including county hospital systems and University of California systems. There will be no separate reimbursement methodology or policy adjustors for outlier claims, though DHCS may implement an outlier policy or policy adjustors in future years, if warranted. Changes in annual relative weight values, wage area index values, market basket inflation, and actual utilization will determine final reimbursement amounts each year. Total reimbursement under the designated public hospital DRG-type methodology may be greater or less than the targeted amount.

Reconciliation to 100 Percent of Cost

DHCS proposes to sunset in two stages the current methodology that provides for per-diem reimbursement and a subsequent reconciliation to 100 percent of cost. In the first stage, effective January 1, 2025, DHCS will continue to collect and review audited cost report data for each program year. DHCS will not perform the reconciliation to 100 percent of cost, except if DHCS determines that reimbursement to the DRG-type methodology is, either:

- less than 100 percent of cost for more than 50 percent of designated public hospitals; or
- less than 75 percent of cost for more than 25 percent of designated public hospitals.

If either of these criteria is met for a program year, DHCS will perform the reconciliation to 100 percent of cost for all designated public hospitals for that program year.
In the second stage, DHCS will no longer perform the reconciliation to 100 percent of cost. This stage will begin effective the program year following two consecutive program years in the first stage in which DHCS does not perform the reconciliation to 100 percent of cost pursuant to the methodology described above.

Abortion and Family Planning

Effective January 1, 2025, DHCS is targeting investments of $90 million MPPRF annually for abortion and family planning services.

Investment	MPPRF ($millions)
Abortion Services Rate Increases	$75
Abortion Supplemental Payment Program	$15
TOTAL	$90

Abortion services are unable to draw down federal Medicaid funding.

Abortion Services Rate Increases

As outlined in the following table, **DHCS proposes to increase rates for surgical and medication abortions to $1,150.** The proposed approach would ensure reimbursement parity between surgical and medication abortions.

Procedure Code	Description	Current Medi-Cal Rate *	Proposed Lowest Medi-Cal Rate
59840	Induced abortion, by dilation and curettage	$400.00	$1,150.00
59841	Induced abortion, by dilation and evacuation	$700.00	$1,150.00
S0199	Medication Abortion Bundle	$536.48	$1,150.00

**Current Medi-Cal rate reflects base rate and, for procedure codes 59840 and 59841, the Proposition 56 supplemental payment.*

In line with DHCS' proposed approach for primary care and specialty professional services, **DHCS proposes to vary the rate for abortion services based on the 32 Medicare geographic regions and the Medicare geographic price index**; $1,150 would be the rate in effect in the lowest priced region.

DHCS proposes to fold the Proposition 56 supplemental payments for these codes into the new base rates. The fiscal impact reflects the increased cost net of existing Proposition 56 supplemental payments. In addition to the three most-commonly used

abortion services codes, DHCS proposes to apply the $1,150 rate to six less commonly used surgical abortion procedure codes in the 59850 to 59857 range.

Abortion Supplemental Payment Program

The 2022 and 2023 Budget Acts authorized $15 million General Fund annually for a two-year limited-term supplemental payment program for non-hospital community clinics that incur significant costs associated with providing abortion services and that serve Medi-Cal members. Pursuant to Budget Act provisional language, federally qualified health centers are ineligible for the supplemental payment program. DHCS allocates the annual appropriation to quarterly pools and distributes supplemental payments to clinics proportionally to quarterly utilization of abortion procedure codes 59840, 59841, and S0199 in the FFS delivery system.[7] **DHCS proposes to continue this program with funding from the MPPRF through the current term of the tax.**

[7] See DHCS Provider Rates Policy Letter 23-001.

Ground Emergency Medical Transportation

Effective January 1, 2025, DHCS is targeting investments of $50 million MPPRF annually for Ground Emergency Medical Transportation (GEMT) services.

Background

Medi-Cal currently reimburses GEMT services at a flat statewide base rate of $118.20 for all transports except neonatal transports, which have a flat statewide base rate of $179.92. Base rates are subject to an AB 97 reduction of 10 percent. Private GEMT providers receive an additional fixed add-on payment of $220.80 funded with a Quality Assurance Fee (QAF). Public GEMT providers receive an additional fixed add-on payment of $946.92 funded by Intergovernmental Transfers (IGTs). The amount of the private provider add-on is limited by the federal requirement that QAF revenues do not exceed 6 percent of total provider revenues. The base rate plus public provider add-on cannot exceed the total average costs associated with providing transports under the Medi-Cal program. Approximately 75 percent of transports are by private providers, and 25 percent are by public providers.

Medicare varies the rate for transports in three main ways:

- Medicare has four levels based on the complexity of the life support services provided — Basic, Advanced Level 1, Advanced Level 2, and Specialty— and pays a higher rate for more complex transports. Medi-Cal has these four levels plus neonatal transports, but does not vary rates for complexity other than neonatal.
- Medicare varies the base rate across 32 localities in California based on labor cost differences.
- Within each locality, Medicare establishes an urban, rural, and super-rural rate based on the pick-up zip code. Super-rural zip codes are defined as the lowest 25th percentile of all rural populations arrayed by population density. The adjustment for rural areas is only about 1 percent, while the adjustment for super-rural areas is 22.6 percent. This adjustment recognizes that ambulances operating in rural areas have higher unit costs as fixed costs are spread across fewer trips.

Proposal

DHCS proposes to adopt Medicare's pricing system to vary GEMT base rates by complexity, locality, and rural status. 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.

DHCS proposes to eliminate the 10 percent AB 97 reduction and to increase the base rate to 50 to 60 percent of the Medicare base rate, effective January 1, 2025. DHCS proposes proportional increases for the neonatal transport service that does not have a Medicare rate. DHCS proposes to continue the $220.80 QAF add-on for private providers, but must adjust the public provider add-on based on the average increase in the base rate. However, public providers will still benefit by having a reduced IGT contribution for the non-federal share of the increased base rate.

Estimated Net Benefit ($ Millions)

Provider Type	Total Fund	MPPRF
Private	$117	$37
Public	$13	$13
TOTAL	$130	$50

Public providers do not see a federal fund benefit, as the maximum amount of allowable federal funds is already drawn down through the IGT program.

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.

Other Considerations

DHCS will continue to analyze the following additional areas for GEMT rate increases, within the proposed MPPRF funding amount:

- In addition to the per-transport fee, both Medi-Cal and Medicare pay a mileage fee for transports. The GEMT QAF and IGT have focused reimbursement increases on the per transport rates and have excluded the per mile rates. DHCS is analyzing increasing the mileage fee to a targeted percent of Medicare. The addition of milage fees would decrease the aggregate targeted rate increase for per-transport fees.

- Medi-Cal currently applies an 8.3 percent rate bump for "night call" trips between the hours of 7 p.m. and 7 a.m. Medicare ceased to provide a night call bump in 2006. Notwithstanding Medicare's policy, Medi-Cal could apply an increase to the targeted Medicare rates for night calls based on the current Medi-Cal policy. The addition of a night call bump would decrease the targeted rate increase for non-night call per-transport fees.
- Medicare's rural and super-rural adjustments are based on a national index of zip code's rural status and population density. DHCS is continuing to analyze whether a California-specific index of rural and super-rural status and adjustment factors may be more appropriate.

Services and Supports for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Effective January 1, 2025, DHCS is targeting investments of $50 million MPPRF annually for services and supports provided by FQHCs and RHCs.

Background

AB 80 (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. The supplemental payments support clinics that apply and certify they are providing an additional level of engagement to integrate and coordinate health care and manage the array of member health complexities.

The supplemental payments for qualifying non-hospital 340B community clinics are based on an estimated total pool amount of $105 million annually divided by the number of visits provided during a 12-month period. The supplemental payment amounts are calculated on a per visit basis and are in addition to any other amounts payable to clinic or center providers with respect to those services. The supplemental payments do not impact FQHC or RHC reconciliation of their prospective payment system rates.

Proposal

DHCS intends to transition the supplemental payment program for non-hospital 340B community clinics into a managed care directed payment arrangement, effective January 1, 2025. **DHCS proposes to increase the total targeted annual pool amount by $100 million to $125 million ($50 million MPPRF, at 50 to 60 percent average federal financial participation).**

The proposed directed payment arrangement will provide: 1) utilization-based payments; and 2) performance-based quality payments. DHCS will direct Medi-Cal managed care plans to reimburse network FQHCs and RHCs a uniform add-on payment for qualifying services on a per visit basis. The uniform add-on payment amount will be calculated prospectively based on a percentage of the total targeted annual pool amount divided by the projected number of qualifying visits. Actual payments may be higher or lower than the targeted sub-total based on actual utilization. In addition, DHCS will direct Medi-Cal managed care plans to reimburse network FQHCs and RHCs a

performance-based quality payment equivalent to the difference between total targeted annual pool amount and the actual utilization-based payments. In this way, the quality-based payment component will serve as a “balancer” to achieve at least the total targeted annual pool amount if actual utilization is significantly lower than projected. If the utilization-based payments equal or exceed the total targeted annual pool amount for a program year, no additional performance-based quality payments will be made.

Behavioral Health Throughput

Effective July 1, 2025, DHCS is targeting investments of $300 million MPPRF annually for behavioral health throughput. Additional details on these investments are forthcoming.

Health Care Workforce

Welfare & Institutions Code section 14105.200 (added by AB 118 [Chapter 42, Statutes of 2023]) authorized transfers from the MPPRF of $75 million annually to the University of California each calendar year to expand graduate medical education programs to achieve the goal of increasing the number of primary care and specialty care physicians in the state based on demonstrated workforce needs and priorities.

In addition, effective in 2025, **DHCS is targeting investments of $75 million MPPRF annually for the Medi-Cal Workforce Pool, to be established and administered by the Department of Health Care Access and Information (HCAI).**

Additional Considerations

State Law

DHCS will propose Trailer Bill Language to authorize the reimbursement methodologies proposed in this policy paper. The statutory changes will be designed to provide DHCS with the necessary authority to operationalize and maintain applicable methodologies and to obtain or maintain any necessary federal approvals.

State Operations

DHCS will seek appropriation through the state budget process for staffing and contract resources, as applicable, that are necessary for DHCS to be able to implement and maintain the proposed targeted rate increases and investments.

Appendix A: Equity Adjustments

DHCS will work to develop an equity index using a composite of existing data sources, including status as a health care worker shortage area, status as a rural or frontier area or urban health desert, 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.

- HCAI maintains data sets pertaining to the health care workforce in California, including Health Professional Shortage Areas for primary care, mental health, and dental health, Primary Care Shortage Areas, and Registered Nurse Shortage Areas. These shortage areas are primarily concentrated in California's rural north, the Sierra Nevada, the San Joaquin Valley, and urban health deserts in Los Angeles and San Diego counties. For more information, including maps of shortage areas, see https://hcai.ca.gov/workforce/health-workforce/workforce-data/#healthcare-workforce-datasets.

- There is no single, universally accepted definition of a rural or frontier area or urban health desert, and additional research is needed to determine the most appropriate data sources to delineate these localities. For example, Frontier and Remote (FAR) area codes developed by the United States Department of Agriculture's Economic Research Service and the Federal Office of Rural Health Policy designate distinct categories based on population size and distance from urban centers.[8] For a map of FAR area codes, see https://www.ers.usda.gov/webdocs/DataFiles/51020/52626_farcodesmaps.pdf?v=5579.1.

- The Healthy Places Index is a composite index that considers a range of economic, education, social, transportation, health care access, neighborhood, housing, clean environment, and decision support indicators to produce a community health score for localities in California. The least healthy communities are primarily concentrated in California's rural north, the San Joaquin Valley, and urban health deserts in Los Angeles and San Diego counties. For a map of localities by Healthy Places Index quartile, see https://map.healthyplacesindex.org/?redirect=false.

[8] See https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes.