Protect Access to Health Care Act Stakeholder Advisory Committee

Meeting

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

May 19, 2025

Agenda

Estimated Time:	***Topic:***
10:00 – 10:10 a.m.	**1. Welcome, Opening Comments, Roll Call**
10:10 – 10:50 a.m.	**2. Committee Member Feedback from April 14, 2025 Meeting**
	3. Protect Access to Health Care Act:
10:50 – 11:00 a.m.	a. Decision-Making Considerations
11:00 – 11:20 a.m.	b. Domain-Specific Spending Proposal Overview
11:20 – 12:00 p.m.	*BREAK*
12:00 – 1:30 p.m.	c. Proposed Payment Methodologies
1:30 – 2:55 p.m.	**4. Public Comment**
2:55 – 3:00 p.m.	**5. Meeting Adjournment**

Welcome, Opening Comments, and Roll Call

California Department of Health Care Services (DHCS) Introductions

- **Lindy Harrington**, Assistant State Medicaid Director
- **Rafael Davtian**, Deputy Director, Health Care Financing
- **Alek Klimek**, Assistant Deputy Director, Health Care Financing
- **Aditya Voleti**, Division Chief, Fee-For-Service Rates Development Division
- **Michelle Tamai**, Assistant Division Chief, Fee-For-Service Rates Development Division
- **Mathew Landing**, Section Chief, Capitated Rates Development Division
- **Hatzune Aguilar**, Stakeholder and Community Engagement Manager, Office of Communications
- **Eduardo Lozano**, Stakeholder Engagement & Outreach Analyst, Office of Communications

Committee Members (1/2)

- **Linnea Koopmans**, Committee Chairperson, Chief Executive Officer, Local Health Plans of California
- **Sergio Aguilar-Gaxiola, MD, Ph.D.**, Professor of Clinical Internal Medicine, UC Davis Health; Founder and Director, Center for Reducing Health Disparities
- **Irving Ayala-Rodriguez, MD**, Chief Medical Officer, Clinica Sierra Vista
- **Kristen Cerf**, President and Chief Executive Officer, Blue Shield of California Promise Health Plan

Committee Members (2/2)

- **Tam Ma**, Associate Vice President for Health Policy and Regulatory Affairs, UC Office of the President, University of California Health
- **Beth Malinowski**, Government Relations Advocate, SEIU California
- **Amy Moy**, Co-Chief Executive Officer, Essential Access Health
- **Jason Sorrick**, Vice President of Government Affairs, Global Medical Response
- **Ariane Terlet**, **DDS**, Chief Dental Officer, La Clinica

Committee Member Feedback from April 14, 2025 Meeting

PAHCA-SAC Request for Written Feedback

- At the April 14 meeting, DHCS requested Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC) members to provide written feedback to DHCS no later than April 25, 2025.
- Eight of nine incumbent PAHCA-SAC members provided feedback to DHCS. Committee members' written feedback has been posted on the PAHCA-SAC website under today's meeting materials.
- DHCS carefully considered and incorporated key takeaways from the PAHCA-SAC members' feedback in developing the proposed Proposition 35 Spending Plan for 2025 and 2026.

PAHCA-SAC Feedback Areas

General Feedback on Payment Methodologies

Domain-Specific Funding Proposals

Procedural Recommendations for the PAHCA-SAC

DHCS's Key Takeaways for Cross-Cutting Feedback on Payment Methodologies

- **Supplement Existing Funding**. All Proposition 35 payment mechanisms, including directed payments, should supplement, not supplant, existing funding.
- **Leverage Existing Payment Mechanisms for Efficiency.** Proposition 35 funds should align with existing payment mechanisms to expedite allocations and reduce administrative burden.
- **Directed Payments.** Members are generally supportive of using State Directed Payments (SDPs) for Proposition 35 but highlighted the need for thoughtfulness in tailoring methodologies for each domain and minimizing administrative complexity.
- **Federal Approvals**. Members suggested considering payment and grant methodologies for certain domains which would not require federal approval and could therefore accelerate use of funding.

Committee Member Questions and Discussion

Protect Access to Health Care Act

Decision-Making Considerations

Proposition 35 Spending Plan: Decision-Making Considerations

Consideration #1:

Comply with Laws, Regulations, and Guidance

Consideration #2:

Promptly Use Proposition 35 Funding

Consideration #3:

Ensure Fiscal Sustainability of the Medi-Cal Program

Consideration #4:

Advance Medi-Cal Program Policy Goals

Consideration #1:

Comply with Laws, Regulations, and Guidance

- Ensure that the Proposition 35 Spending Plan complies with the priorities and requirements approved by the voters and applicable federal laws and regulations.
- Ensure that Proposition 35 funds are only used for authorized purposes related to the Medi-Cal program.
- Align with requirements for increased provider payment levels relative to Medicare in the Behavioral Health Community Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration Special Terms & Conditions (STCs).

Consideration #2:

Promptly Use Proposition 35 Funding

- Prioritize timely and prompt use of Proposition 35 funds through the end of calendar year (CY) 2026.
- Seek opportunities to reduce complexity and increase efficiency in flow of payments.
- Consider impacts of federal approval timelines for both Fee-For-Service (FFS) and Managed Care, including State Plan Amendments (SPAs), SDPs, capitation rate changes, and managed care contracts and amendments when selecting payment mechanisms.

Consideration #3:

Ensure Fiscal Sustainability of the Medi-Cal Program

- Support and enhance the fiscal sustainability of benefits and coverage in the Medi-Cal program in the face of economic and political uncertainty.
- Avoid creating a fiscal cliff for the Medi-Cal program for expenditures which potentially exceed Managed Care Organization (MCO) Tax revenues after December 31, 2026.

Consideration #4:

Advance Medi-Cal Program Policy Goals

- Advance Proposition 35's goal of increasing access to quality health care by enhancing payments and workforce investments.
- Advance goals articulated in the DHCS Strategic Plan and Comprehensive Quality Strategy.
- Prioritize new funding for services for which rates do not receive annual cost-of-living increase.

Domain-Specific Spending Proposal Overview

CY 2025 & CY 2026 Allocation Overview

For each of CY 2025 and CY 2026, Proposition 35 allocates a fixed amount for Medi-Cal program expenditures in twelve broad domains.

Domain	$ Millions
General Support of Medi-Cal Program	$2,000
Primary Care	$691
Specialty Care	$575
Community and Outpatient Procedures	$245
Reproductive Health	$90
Services and Supports for Primary Care	$50
Emergency Department Facilities and Physicians	$355
Designated Public Hospitals	$150
Ground Emergency Medical Transportation	$50
Behavioral Health Facility Throughputs	$300
Graduate Medical Education	$75
Medi-Cal Workforce	$75
TOTAL:	**$4,656**

General Support of the Medi-Cal Program

- Use $2 billion for CY 2025 and $2 billion for CY 2026 to support a portion of the non-federal share of Medi-Cal managed care rates for health care services furnished to children, adults, seniors and persons with disabilities, and persons dually eligible for the Medi-Cal and Medicare programs.

Primary Care

- Proposition 35 allocates $691 million annually to primary care services for CY 2025 and CY 2026.
  - Under Proposition 35, primary care may include maternity care and non-specialty mental health services. Primary care may be delivered by non-physician health professionals.
- DHCS Spending Plan:
  - $215 million for CY 2025 and $226 million for CY 2026 to support the non-federal share of Targeted Rate Increases (TRIs) attributable to primary care providers.
  - $476 million for CY 2025 and $117 million for CY 2026 to support the non-federal share of managed care capitation base rate increases relative to CY 2024 for primary care services.
  - $348 million for CY 2026 to support the non-federal share of limited-term FFS supplemental payments and Managed Care uniform dollar increase (UDI) SDPs for primary care services no sooner than January 1, 2026, through December 31, 2026.

Specialty Care

- Proposition 35 allocates $575 million annually to specialty care for CY 2025 and CY 2026.
  - Under Proposition 35, specialty care includes health care services delivered by physicians or other licensees pursuant to the Medical Practice Act or the Osteopathic Act (licensees include Doctors of Podiatric Medicine).
- DHCS Spending Plan:
  - $134 million for CY 2025 and $141 million for CY 2026 to support non-federal share of TRIs attributable to utilization by specialty physicians other than emergency physicians.
  - $353 million for CY 2025 and $63 million for CY 2026 to support the non-federal share of managed care capitation base rate increases relative to CY 2024 for specialty care services.
  - $371 million for CY 2026 to support the non-federal share of limited-term FFS supplemental payments and Managed Care UDI SDPs for specialty care services no sooner than January 1, 2026, through December 31, 2026.
  - $88 million for CY 2025 is proposed to be unallocated. These funds will roll into the Improving Access to Health Care Subfund and be available for expenditure for CY 2027.

Emergency Department (ED) Facilities & Physicians

- Proposition 35 allocates $355 million annually to ED facility and physician services for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $7 million for CY 2025 and $7 million for CY 2026 to support the non-federal share of TRIs attributable to utilization by emergency physicians.
  - $93 million for CY 2025 and $93 million for CY 2026 to support the non-federal share of limited-term FFS supplemental payments and Managed Care UDI SDPs for emergency physician services no sooner than July 1, 2025, through December 31, 2026. Payments for CY 2025 are proposed to be condensed into six months.
  - $255 million for CY 2025 and $255 million for CY 2026 to support the non-federal share of a portion of increases in existing special-funded hospital SDPs relative to CY 2024 for emergency facility services, thereby increasing participating hospitals' net benefit.

Community and Outpatient Procedures

- Proposition 35 allocates $245 million annually to community and outpatient procedures for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $245 million for CY 2025 and $245 million for CY 2026 to support the non-federal share of managed care capitation base rate increases relative to CY 2024 for hospital outpatient services.

Reproductive Health

- Proposition 35 allocates $90 million annually to reproductive health care for CY 2025 and CY 2026.
- DHCS Spending Plan allocates $90 million for CY 2025 and $90 million for CY 2026 to the Department of Health Care Access & Information (HCAI) for investments addressing emergent needs in reproductive health including midwifery practitioner loan repayments and scholarships and expansion of education capacity for nurse midwives.
- DHCS will invite HCAI to consult with PAHCA-SAC at a future meeting on criteria or eligibility for payments or grants under this domain.
- This domain is not expected to draw down federal financial participation (FFP) or require federal approval.

Designated Public Hospitals

- Proposition 35 allocates $150 million annually to designated public hospitals (DPHs) for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $150 million for CY 2025 and $150 million for CY 2026 to support the non-federal share of a portion of growth in existing special-funded DPH Quality Incentive Pool (QIP) and/or DPH Enhanced Payment Program (EPP) SDPs relative to CY 2024, thereby increasing participating hospitals' net benefit.

Services and Supports for Primary Care

- Proposition 35 allocates $50 million annually to services and supports for primary care for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $50 million for CY 2025 and $50 million for CY 2026 to support the non-federal share of augmenting the Community Clinic Directed Payment (CCDP) Program.

Ground Emergency Medical Transportation (GEMT)

- Proposition 35 allocates $50 million annually to GEMT for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $27 million for CY 2025 and $27 million for CY 2026 to support the non-federal share of managed care capitation base rate increases relative to CY 2024 for GEMT services.
  - $23 million for CY 2025 and $23 million for CY 2026 to support the non-federal share of a limited-term FFS rate add-on for private provider GEMT services effective for dates of service no sooner than July 1, 2025, through December 31, 2026. Under existing state and federal law, Managed Care Plans (MCPs) must reimburse the FFS rate, including rate add-ons, for non-contracted GEMT services. Payments for CY 2025 are proposed to be condensed into six months.

Behavioral Health (BH) Facility Throughputs

- Proposition 35 allocates $300 million annually to BH facility throughputs for CY 2025 and CY 2026.
- DHCS Spending Plan:
  - $200 million for CY 2025 and $200 million for CY 2026 annually to improve data sharing, consent management, and care coordination among behavioral health providers.
  - $100 million for CY 2025 and $100 million for CY 2026 annually for Flexible Housing Subsidy Pools (“Flex Pools”).
- This domain is not expected to draw down FFP or require federal approval.

Graduate Medical Education

- Proposition 35 allocates $75 million annually to Graduate Medical Education (GME) for CY 2025 and CY 2026.
- DHCS Spending Plan allocates these amounts be to the University of California to expand GME programs.
- DHCS will invite the University of California to consult with PAHCA-SAC at a future meeting on criteria or eligibility for payments or grants under this domain.
- This domain is not expected to draw down FFP or require federal approval.

Medi-Cal Workforce

- Proposition 35 allocates $75 million annually to Medi-Cal workforce for CY 2025 and CY 2026.
- DHCS Spending Plan allocates these amounts to HCAI to support Medi-Cal workforce initiatives.
- DHCS will invite HCAI to consult with PAHCA-SAC at a future meeting on criteria or eligibility for payments or grants under this domain.
- This domain is not expected to draw down FFP or require federal approval.

Break

Proposed Payment Methodologies

Payment Methodology Overview

DHCS proposes to utilize several types of payment methodologies across more than one domain:

- TRI to no less than 87.5% of the Medicare rate.
- Managed care base capitation rate increases for specified service categories relative to the CY 2024 rating period.
- UDI for professional services to achieve aggregate payment levels relative to Medicare for specified services required by the BH-CONNECT Demonstration STCs.
- Increasing hospitals' net benefit in special-funded hospital SDPs.
- Other workforce, infrastructure, and quality investments.

TRI

TRI

- DHCS implemented TRI to no less than 87.5% of the lowest corresponding Medicare rate for primary/general care, maternal care, and non-specialty mental health services effective for CY 2024.
- These rate increases apply to eligible providers in the FFS delivery system, as well as eligible network providers contracted with MCPs. These rate increases have continued into 2025.
- DHCS proposes to use $356 million for CY 2025 and a projected $374 million for CY 2026 to support the TRI.

Allocation of TRI to Proposition 35 Domains

Proposition 35 Domain ($ Millions)	CY 2025	CY 2026
Primary Care	$215	$226
Specialty Care	$134	$141
ED Physicians	$7	$7
Total	**$356**	**$374**

- The 87.5% TRI were not designed to strictly segregate funds using the account structure mandated by Proposition 35. DHCS has modeled the approximate distribution between Proposition 35 allocations based on the best available data.
- Updated projections may be provided through the state budget process.

Considerations & Federal Approvals

- DHCS received federal approval of the TRI in SPA 23-0035. No new federal approval is required.
- DHCS implemented the TRI for services reimbursed directly by DHCS as of January 3, 2024, and published final guidance for MCPs on June 20, 2024. MCPs were required to fully implement the TRI by December 31, 2024.
- No new operational activities are required to secure federal approvals for CY 2025.

Committee Member Questions/Discussion

Managed Care Capitation Base Rate Increases

Considerations

- DHCS pays capitation rates to MCPs for every enrolled member per month (PMPM). Capitation rates change year-to-year because of projected changes to per-service costs, per-member utilization and acuity, and covered services.
- DHCS proposes to use $1.1 billion for CY 2025 and $452 million for CY 2026 in specified domains to support the non-federal share of estimated CY 2025 and CY 2026 capitation base rate increases relative to CY 2024 for service categories aligned with Proposition 35 domains.
- Increases in managed care rates are actual increases in DHCS' costs of purchasing health care services and reflect projections of MCPs' increased costs of purchasing health care services, due to expanded health care benefits, services, workforce, and/or payment rates.

Proposed Funding for Managed Care Capitation Base Rate Increases

Proposition 35 Domain ($ Millions)	CY 2025	CY 2026
Primary Care Services	$476	$117
Specialty Care Services	$353	$63
Community and Outpatient Procedure	$245	$245
GEMT	$27	$27
Total	**$1,101**	**$452**

Amounts are based on projected enrollment. Amounts may represent a portion, but not all, of the non-federal share of the projected capitation base rate increase associated with the service category. Projections are subject to refinement and rates are subject to amendment.

Federal Approvals

- Managed care capitation base rates are subject to review by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary for federal approval. No new or separate federal approvals will be required.

Committee Member Questions/Discussion

Uniform Dollar Increase (UDI)

UDI

- DHCS proposes to use $93 million for CY 2025 and $812 million for CY 2026 to support the non-federal share of limited-term UDIs for primary care, specialty care, and emergency physician services effective for dates of service through December 31, 2026, in both the FFS and Managed Care delivery systems.
- The UDIs will be designed to achieve aggregate payment levels relative to Medicare for specified services required by the BH-CONNECT Demonstration STCs.
- UDIs will require approval as a SPA for the FFS delivery system and as a directed payment for network services in the Managed Care delivery system.

BH-CONNECT Payment Levels Relative to Medicare

- The BH-CONNECT Demonstration was approved by CMS with requirements for DHCS to maintain the TRI payment levels through December 31, 2029, and to achieve specified payment levels relative to Medicare for specified services by December 31, 2026.
- DHCS must maintain these payment levels in each subsequent year through December 31, 2029, if an MCO tax exceeding the size of the AB 119 MCO tax is federally approved.

Procedure Code	Target
Evaluation & Management (E/M) Codes for Office Visits, Preventive Services, and Care Management	90%
Obstetric Services	90%
Evaluation & Management Codes for ED Physician Services	90%
Other Procedure Codes commonly utilized by Primary Care, Specialist, and ED Providers	80%
Non-Specialty Mental Health Services	87.5%
Vaccine Administration	87.5%

Proposed Funding for UDIs

Proposition 35 Domain ($ Millions)	CY 2025	CY 2026
Primary Care (effective 1/1/2026)	NA	$348
Specialty Care (effective 1/1/2026)	NA	$371
ED Physicians (effective 7/1/2025)	$93	$93
Total	**$93**	**$812**

- These funding amounts are projected to, in aggregate and with matching federal financial participation, achieve the payment levels relative to Medicare required by the BH-CONNECT Demonstration by December 31, 2026.

Considerations

- Compared to other types of directed payments, UDIs are relatively simpler and quicker to operationalize for MCPs. MCPs have experience with implementing UDIs for the historic Proposition 56 supplemental payments.
- DHCS proposes the UDIs to be limited-term through December 31, 2026, to prevent a fiscal cliff for the Medi-Cal program after MCO Tax allocations change in 2027.
- The proposed UDIs can be stacked “on top of” the TRI to 87.5% of the Medicare rate without requiring MCPs and providers to redevelop base payment rates in sub-capitated arrangements.

Federal Approvals

- For ED physician service UDIs effective no sooner than July 1, 2025:
  - DHCS will issue a SPA public notice by June 30, 2025, and submit a completed SPA package to CMS by September 30, 2025.
  - DHCS will submit a preliminary SDP preprint to CMS by June 30, 2025, and all required actuarial analyses and rate certifications by December 31, 2025.
- For additional or modified UDIs for primary care, specialty care, and ED physician services effective no sooner than January 1, 2026:
  - DHCS will issue a SPA public notice by December 31, 2025, and submit the completed SPA package to CMS by March 31, 2026.
  - DHCS will submit SDP preprints and rate certifications to CMS by December 31, 2025.
  - Because of the broader scope of these increases, additional policy development will be required to identify eligible procedure codes and provider types.

UDI Eligible Procedure Codes

- To accelerate funding for ED physician services, DHCS proposes to provide UDIs effective no sooner than July 1, 2025, through December 31, 2025, for the five most common ED E/M procedure codes (99281-99285) without geographic variation. Because funding for CY 2025 will be condensed over six months, the UDI amount for these codes will be approximately double for CY 2025 than for CY 2026.
- DHCS is considering implementing UDIs for primary care and specialty care on a procedure code and/or per-visit basis. To the extent these UDIs are implemented on a procedure code basis, DHCS will develop an eligible procedure code list and will likely provide the same UDI for each procedure code without regard to delivery system, service category, or geographic variation.
- DHCS is analyzing the broader universe of procedure codes commonly utilized by primary care, specialty care, and ED physicians for the UDIs effective no sooner than January 1, 2026, through December 31, 2026.

UDI Provider Eligibility

- In accordance with Proposition 35, DHCS proposes to define provider eligibility to include:
  - Physicians including Medical Doctors, Doctors of Osteopathy, and Doctors of Podiatric Medicine.
  - Other health professionals providing primary care, maternal health, and non-specialty mental health services.
- DHCS may require providers to have complete taxonomy information in order to be able to validate eligibility and map claims to the correct Proposition 35 funding allocation.
- DHCS does not propose to make FQHCs/RHCs eligible for the UDI, as they are reimbursed under a Prospective Payment System per-visit reimbursement model. Furthermore, unlike other professional providers, FQHCs and RHCs receive annual cost-of-living increases under state and federal law.

UDI Request for Feedback

- DHCS requests the committee members' written feedback on the criteria and eligibility for the proposed UDIs including:
  - Eligible procedure codes
  - Eligible provider types
  - Eligible provider taxonomy codes

Committee Member Questions/Discussion

Hospital SDP Programs

Hospital SDP Funding

- Hospital SDPs are generally "self-financed" through Intergovernmental Transfers (IGTs) for public hospitals and the Hospital Quality Assurance Fee (HQAF) for private hospitals, with matching federal funds.
- Hospital SDPs collectively increased by approximately $9.5 billion for CY 2025 over CY 2024.
- Hospitals typically consider their "net benefit" to be the difference between the total payments and the self-financed amount.
- DHCS proposes to use $405 million for CY 2025 and $405 million for CY 2026 to support the non-federal share of a portion of increases in existing special-funded hospital SDPs relative to CY 2024. Each annual allocation includes $255 million for ED facility services and $150 million for DPHs.

ED Facility Services

- DHCS proposes to allocate funding between hospital classes for ED facility services based on actual utilization for CY 2025 and CY 2026.
- Based on CY 2023 data, DHCS estimates this allocation to be:

Program ($ Millions)	CY 2025	CY 2026
Private Hospital Directed Payment Program (PHDP)	$210	$210
District Hospital Directed Payment (DHDP)	$20	$20
DPH-Enhanced Payment Program (EPP)	$25	$25
Total:	**$255**	**$255**

Considerations & Federal Approvals

- The increased hospital SDPs have variously either received federal approval or are pending federal approval.
- Leveraging the existing programs' infrastructure and increases will eliminate the need for DHCS to establish and seek approval for separate programs or to revisit already-approved increases with CMS.
- CY 2025 program payments will be made to MCPs no sooner than September 2026 and would be the earliest these funds could be used to increase the net benefit.

Committee Member Questions/Discussion

Community Clinic Directed Payment Program (CCDP)

Criteria & Eligibility

- DHCS proposes to allocate increased CCDP funding primarily to expanding the quality-driven portion of the program.
- DHCS is considering public feedback urging the department to expand the CCDP to include non-340B clinics.
- DHCS requests the PAHCA-SAC members' written feedback on eligibility criteria and potential quality metrics for the increased CCDP funding.

Federal Approvals

- DHCS must submit an amendment to the CCDP preprint to CMS by December 31, 2025, to make changes for the CY 2025 program year.

Committee Member Questions/Discussion

GEMT Rate Add-on

Considerations

- The GEMT rate add-on will require approval of a SPA for the FFS delivery system. Under existing state and federal law, MCPs must reimburse the FFS rate, including rate add-ons, for non-contracted GEMT services.
- The Proposition 35 rate add-on will be in addition to the GEMT Quality Assurance Fee (QAF) rate add-on.
- To expedite implementation and due to potential changes in available funds in CY 2027, DHCS does not propose to vary the rate add-on by procedure code or locality for CY 2025 and CY 2026.
- Because funding will be condensed over six months for CY 2025, the UDI amount for these codes will be approximately double for CY 2025 than for CY 2026.

Federal Approvals

- For the GEMT rate add-on for CY 2025, DHCS will issue a SPA public notice by June 30, 2025, and submit a completed SPA package to CMS by September 30, 2025. DHCS may consolidate this SPA with the annual GEMT QAF rate add-on SPA.
- While DHCS will not be required to submit an SDP preprint to CMS for the GEMT rate add-on, DHCS will be required to submit amended managed care rate certifications to CMS.
- For the GEMT rate add-on for CY 2026, DHCS will issue a SPA public notice by December 31, 2025, and submit the completed SPA package to CMS by March 31, 2026.

Committee Member Questions/Discussion

Request for Committee Members' Written Input

- DHCS requests the PAHCA-SAC members' written input on the materials presented today no later than Friday, May 30, 2025.
- Please email written input to DHCSPAHCA@dhcs.ca.gov.

Public Comment

Public Comment Procedures

- Public comment will include members of the public present in the room and those attending virtually. Comments will first be taken from in-person attendees followed by online attendees.
- Each speaker is allowed up to one minute to share their comments.
- Each speaker is requested to state their name and organization.
- DHCS will listen carefully to your comments but is not able to provide immediate responses to questions.
- If time runs out, members of the public can share additional comments via email to DHCSPAHCA@dhcs.ca.gov.

Meeting Adjournment

Appendix

Glossary

Glossary (1/3)

- BH: Behavioral Health
- BH-CONNECT: Behavioral Health Community Based Organized Networks of Equitable Care and Treatment
- CCDP: Community Clinic Directed Payment
- CY: Calendar Year
- DHCS: California Department of Health Care Services
- DHDP: District Hospital Directed Payment
- DPH: Designated Public Hospitals
- DPH-EPP: Designated Public Hospital-Enhanced Payment Program
- ED: Emergency Department
- E/M: Evaluation & Management
- FFP: Federal Financial Participation

Glossary (2/3)

- FFS: Fee-For-Service
- Flexible Housing Subsidy Pools: "Flex Pools"
- FQHC/RHC: Federally Qualified Health Centers / Rural Health Clinics
- GEMT: Ground Emergency Medical Transportation
- GME: Graduate Medical Education
- HCAI: Department of Health Care Access & Information
- HQAF: Hospital Quality Assurance Fee
- IGTs: Intergovernmental Transfers
- MCO: Managed Care Organization
- MCP: Managed Care Plan
- PAHCA-SAC : Protect Access to Health Care Act Stakeholder Advisory Committee
- PHDP: Private Hospital Directed Payment Program

Glossary (3/3)

- PMPM: Per Member Per Month
- QAF: Quality Assurance Fee
- QIP: Quality Incentive Pool
- RHC: Rural Health Clinics
- SDP: State Directed Payment
- SPA: State Plan Amendment
- STC: Special Terms & Conditions
- TRI: Targeted Rate Increase
- UDI: Uniform Dollar Increase

Supplementary Slides: SDPs, SPAs

SDPs

- Federal regulations (42 CFR 438.6(c)) prohibit states from directing how MCPs spend their capitation revenue on provider reimbursements except in limited cases in accordance with federal law or through allowable SDPs
- An SDP is required any time a state directs (i.e., compels) a MCP's payments to providers such as the payment amount (e.g., rate level), mode of payments (e.g., per-service, bundled, capitated, performance-based), or frequency of payments—except when the direction is required by federal law.

SDP Preprints

- States generally must submit a "preprint" for CMS approval describing the SDP. In addition, SDPs must be incorporated in MCP contracts and the actuarial certification of the capitation rates (both of which must also be approved by CMS).
  - A preprint is not required for certain SDPs that are based on rates approved in the Medicaid State Plan or equal to Medicare's rate. However, these SDPs are still subject to all other requirements.
- Historically, CMS has expected DHCS to submit all SDP preprints prospectively before their effective date but has provided DHCS with flexibility to amend SDPs back to the beginning of the rate year if such an amendment is submitted during the same rate year.
  - Amending an SDP retroactively incurs additional operational and federal risks depending on how substantive the change is.
- Beginning in 2027, federal regulatory changes require that all SDP preprints and amendments be submitted prior to the start date of the SDP or the effective date of the amendment, respectively; no retroactive changes will be permitted.

Other SDP Requirements

- DHCS must adjust MCPs' capitation rates to account for the additional cost of SDPs.
- States must demonstrate that total payment levels resulting from SDPs are reasonable, appropriate, and attainable.
- In addition, SDPs must:
  - Be based on the delivery and utilization of Medi-Cal services;
  - Direct expenditures equally for all providers in a "class of providers";
  - Advance, and result in achievement of, the goals and objectives of the state's quality strategy; and
  - Have an evaluation plan that measures the degree to which the SDP advances the stated goals and objectives.
- It typically takes 6-18 months to fully operationalize and implement an SDP inclusive of the federal approval process depending on the complexity of the payment methodology, necessary system changes, and volume of questions from CMS.

Types of SDPs

Minimum and/or Maximum Fee Schedule:

Require MCPs to pay no more than, no less than, or exactly a certain amount for a covered service.

Uniform Rate Increase:

Require MCPs to pay a uniform dollar or percentage increase in payment above negotiated base payment rates.

Value-Based Purchasing (VBP):

Require MCPs to implement VBP models, e.g., pay-for-performance, bundled payments, or other payment models intended to recognize value or outcomes over volume of services.

Delivery System Reform/ Performance Improvement Initiatives:

Require MCPs to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

Tradeoffs of Select Managed Care SDPs

	Pros	Cons
Minimum Fee Schedule	» Establishing a payment floor across applicable procedures » Prioritizes funding to providers currently being paid less » Creates a clear payment baseline for participation in the Medi-Cal program	» Moderately administratively difficult » Slower to implement than uniform dollar increase » Difficult to implement for providers who are reimbursed on a capitated basis
Uniform Dollar Increase	» Administratively simple » Quicker to operationalize than other options	» Requires all eligible services to receive a uniform increase and thus cannot target specific areas of concern.
Value-Based Payment	» Can be designed to specifically incentivize quality and value outcomes	» Most administratively burdensome to design and operate: • Requires establishment of detailed performance metrics and subsequent measurement » Payments typically flow after the performance measurement period

SPAs

- The State Plan is a comprehensive agreement between the State and CMS that describes the nature and scope of the Medi-Cal program and provides authority to draw down FFP for Medi-Cal program expenditures. Changes to the State Plan require federal approval.
- The State Plan, among other things, outlines methods and standards for FFS payments. However, the State Plan generally does not set managed care payment rates.
- Public notice is required for SPAs, including a general description of the proposed payment methodology, as follows:
  - 1-Day notice before effective date: for a change in methods and standards for setting payment rates.
  - 30-Day public comment period before submission to CMS to reduce or restructure rates.

CMS Review of SPAs

- A full SPA package, with additional technical detail, must be submitted to CMS by the end of the quarter in which the SPA is effective and can be retroactive to the first day of the quarter.
- CMS must approve, disapprove or request additional information within 90 days of submission or the SPA is deemed approved. If CMS requests additional information, the 90-day timeline starts over once DHCS provides responses.
- It typically takes 6-18 months to fully operationalize and implement a SPA inclusive of the federal approval process depending on the complexity of the payment methodology, necessary system changes, and volume of questions from CMS.