Protect Access to Health Care Act Stakeholder Advisory Committee

Meeting

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

April 14, 2025

Agenda

11:30 – 11:40	**1. Welcome, Opening Comments, Roll Call, and Agenda**
11:40 – 11:55	**2. Committee Governance & Election of Chairperson**
	3. Protect Access to Health Care Act:
11:55 – 12:25	a. Managed Care Organization (MCO) Tax and Proposition 35
12:25 – 1:05	b. Medi-Cal Financing Background
1:05 – 1:30	c. Committee Member Questions & Discussion
1:30 – 1:40	*Break*
1:40 – 2:35	d. Considerations for CY 2025 and CY 2026 Domains
2:35 – 3:05	e. Committee Member Questions & Discussion
3:05 – 3:25	**4. Public Comment**
3:25 – 3:30	**5. Closing**

Welcome

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
- **Eric Lichtenberger**, Branch Chief, Capitated 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 Member Introductions (1/2)

- **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
- **Linnea Koopmans**, Chief Executive Officer, Local Health Plans of California
- **Tam Ma**, Associate Vice President for Health Policy and Regulatory Affairs, UC Office of the President, University of California Health

Committee Member Introductions (2/2)

- **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
- ***Appointment Not Yet Confirmed,*** *Private Emergency Ground Ambulance Provider representing an organization that performs 500,000 or more emergency medical ground transports per year in California.*

Meeting Objectives

The Protect Access to Health Care Act Stakeholder Advisory Committee (PAHCA-SAC) is responsible for advising DHCS on developing and implementing components of the Protect Access to Health Care Act of 2024 (Proposition 35).

This meeting will officially launch the PAHCA-SAC to:

- Orient the PAHCA-SAC on the membership expectations for the Committee.
- Elect a Chairperson through a member vote.
- Create a shared understanding of the MCO tax, Proposition 35, and Medi-Cal Financing among PAHCA-SAC members.
- Provide an overview of domains and considerations for CY 2025 and CY 2026.

Members will have an opportunity for questions and discussion.

Committee Governance & Election of Chairperson

PAHCA-SAC Committee Charter

- The PAHCA-SAC is created by Article 8 (commencing with Section 14199.129 of the Welfare & Institutions Code) of Proposition 35.
- The sole purpose of the PAHCA-SAC is to research and analyze approaches and best practices for the development and implementation of components of Proposition 35, including:
  - Providing advice and written recommendations to DHCS;
  - Preparing reports for submission to DHCS (as needed).
- Proposition 35 requires DHCS to consult with, and obtain written input from, the PAHCA-SAC regarding the development and implementation of Proposition 35 requirements.
- The PAHCA-SAC is advisory only and does not possess decision-making authority. DHCS has sole and final decision-making authority to establish and make changes to payment methodologies.

PAHCA-SAC Governance

- **Member Appointment and Terms**: Members are appointed by the Governor, the Speaker of the Assembly, and the Senate President pro Tempore. Initial terms are two to four years; subsequent terms will be four-years in length.
- **Quorum Requirements:** Six PAHCA-SAC members shall constitute a quorum for purposes of voting and conducting business of the PAHCA-SAC.
- **Meeting Schedule:**
  - PAHCA-SAC meetings must be held, at minimum, biennially (once every two years).
  - The PAHCA-SAC may hold additional regular and special meetings at the call of the DHCS, the PAHCA-SAC or the Chairperson.
- **Participation and Logistics:** Virtual and in-person participation. Public can join the meeting but can only speak during the public comment period at the end of each meeting.
- **Meeting Materials:** Meeting materials will be posted to the Committee's webpage on the DHCS website. The Committee may post any report or recommendations to its webpage.
- **Subcommittees**: PAHCA-SAC may create subcommittees consisting of one or more of its members, and may delegate to a subcommittee any right or responsibility bestowed upon the committee.

Review of Bagley-Keene Open Meeting Act Requirements (1/2)

The Bagley-Keene Act requires open public meetings to ensure that state advisory bodies like the PAHCA-SAC operate with transparency and accountability.

How it applies to the PAHCA-SAC:

- **Open Meetings** – Meetings must be open to the public.
- **Advance Notice** – Meeting agendas must be posted at least 10 days in advance and include the date, time, location, and items for discussion.
  - No formal action or votes can be taken on an item that is not on the agenda, with two exceptions:
    - (1) There is an "emergency situation," defined as a work stoppage or other activity that severely impairs public health and/or safety or a crippling disaster that severely impairs public health and/or safety.
    - (2) There is "a need to take immediate action," and that need came to the Committee's attention after the agenda was posted.

Review of Bagley-Keene Open Meeting Act Requirements (2/2)

The Bagley-Keene Act requires open public meetings to ensure that state advisory bodies like the PAHCA-SAC operate with transparency and accountability.

How it applies to the PAHCA-SAC:

- **Virtual Attendance** – PAHCA-SAC members must advise of their plan to attend virtually so DHCS can post a public notice 24 hours before public meetings.
- **No Private Decision Making** – PAHCA-SAC members cannot discuss or make decisions on official matters outside of public meetings.
- **Voting must be recorded** – No secret votes can take place; a roll call of votes must be recorded.
- **Public Participation** – Must have a public comment period.

Election of Committee Chairperson

- The PAHCA-SAC Chairperson is elected from among the PAHCA-SAC membership. The chairperson shall preside at all PAHCA-SAC meetings and shall have all the powers and privileges of other Committee members.
- **Term and Eligibility:**
  - A member shall serve as Chairperson for a term of two years and is eligible for reelection.
- **Election Process:**
  - Interested members were requested to submit a written statement to DHCS by Thursday, April 10th, 2025. All statements will be presented during this meeting and are available during this meeting for public inspection.
  - Subsequently, the PAHCA-SAC will take a roll call vote to select the Chairperson.
  - The member receiving the majority of votes (i.e., 5 of 9 appointed members) will be elected Chairperson. If no member receives a majority of votes, the roll call vote will be repeated until a member receives a majority.

Elect Chair

MCO Tax and Proposition 35

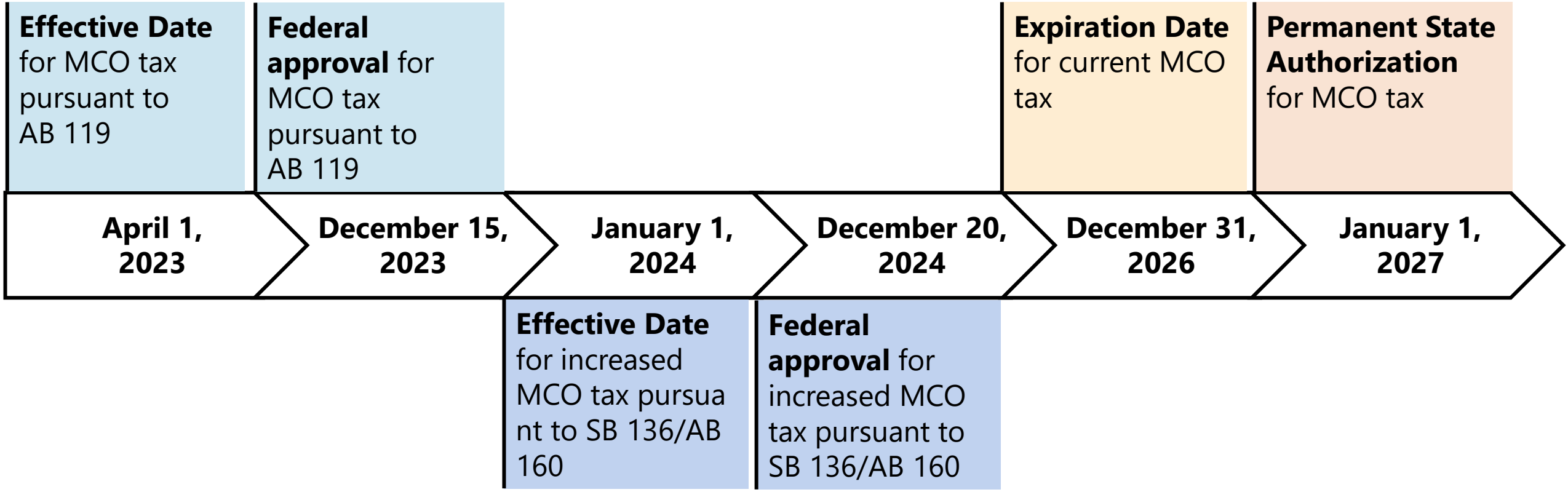
MCO Tax Background

- The MCO tax is a federally allowable health care-related tax, a Medicaid funding mechanism where states impose a tax on health care services, such as a tax on Managed Care Plans (MCPs) for each enrolled member.
- California has utilized a MCO tax for many years, requiring periodic Legislative/Federal approval and reauthorization. Net revenues from the MCO tax are used to support Medi-Cal expenditures.
- At this time, at least 20 states have enacted MCO taxes.
- Federal law affords states flexibility to tailor health care-related taxes within certain parameters to align with broader state tax policies and priorities for their Medicaid programs. States must obtain federal approval to waive requirements that health care-related taxes be broad-based and uniform. Current federal regulations establish a statistical test called "B1/B2".

Approval of Current MCO Tax

- The current MCO tax was enacted by the State Legislature in Assembly Bill (AB) 119 (Chapter 13, Statutes of 2023) effective April 1, 2023, through January 1, 2026, and increased taxes were imposed by Senate Bill (SB) 136 (Chapter 6, Statutes of 2024) and AB 160 (Chapter 39, Statutes of 2024) for January 1, 2024, through December 31, 2026.
- The MCO tax structure established by AB 119, and the increased tax structure imposed by SB 136/AB 160, is federally approved through December 31, 2026, under current federal regulations. However, in a companion letter to its approvals, CMS noted that it intends to change regulations governing the statistical test.
- Proposition 35 provides permanent State authorization for an MCO tax modeled after AB 119. However, DHCS will be required to seek federal approval.
- Changes to federal regulations could significantly limit the future size of the MCO tax. Furthermore, Proposition 35 imposes limits on DHCS's ability to modify the MCO tax structure on or after January 1, 2027.

Current MCO Tax Timeline



Overview of Proposition 35

- Proposition 35 deposits applicable MCO Tax revenue in a specified fund structure and continuously appropriates funding to DHCS to support the Medi-Cal program. Proposition 35 includes fixed spending allocations for CY 2025 and CY 2026. In CY 2027, Proposition 35 specifies a new percentage-driven account structure.
- While Proposition 35 allocates funding to specific purposes, it does not include specific payment methodologies. Proposition 35 authorizes DHCS to administratively adopt the specific payment methodologies, subject to consultation with the PAHCA-SAC.
- Proposition 35 creates other rules governing the use of funds subject to Proposition 35.

Proposition 35 Impact on MCO Tax

- Proposition 35 makes permanent the State law authority for the MCO tax. However, DHCS will need to seek applicable federal approvals for future periods starting January 1, 2027.
- Proposition 35 applies to MCO tax revenues authorized by AB 119 for tax periods on or after January 1, 2025.
- Proposition 35 does not apply to MCO tax revenues authorized by AB 119 for tax periods before January 1, 2025, or associated with the SB 136/AB 160 amendments to the MCO tax.

MCO Tax Gross Revenue ($ Millions)

	CY 2023	CY 2024	CY 2025	CY 2026	Total
AB 119	**$6,152.3**	**$8,468.0**	**$8,703.1**	**$8,938.2**	**$32,261.6**
AB 160	**-**	**$4,232.1**	**$4,000.8**	**$3,769.5**	**$12,002.4**

Evolution of MCO Tax Spending Plan Since 2023 Budget Act

- The 2023 Budget Act and AB 118 (Chapter 42, Statutes of 2023) authorized the use of MCO tax revenues for Targeted Rate Increases (TRI) starting in CY 2024 and other one-time investments in State Fiscal Year (SFY) 2024-25 and required DHCS to develop a spending plan for additional investments for inclusion in the 2024 Governor's Budget for other domains.
- The 2024 Budget Act and SB 159 (Chapter 40, Statutes of 2024) authorized a revised set of provider payment increases and Medi-Cal investments.
- The passage of Proposition 35 made inoperative investments outlined in SB 159 and enacted a revised set of allocations effective in CY 2025/CY 2026 and in CY 2027 and ongoing.
- DHCS prepared to implement SB 159 over the course of 2024. SB 159 included a different set of domains than Proposition 35, that would have been effective on a staggered basis in CY 2025 and with additional domains in CY 2026. The passage of Proposition 35 required DHCS to shift gears and begin considering new payment methodology proposals.

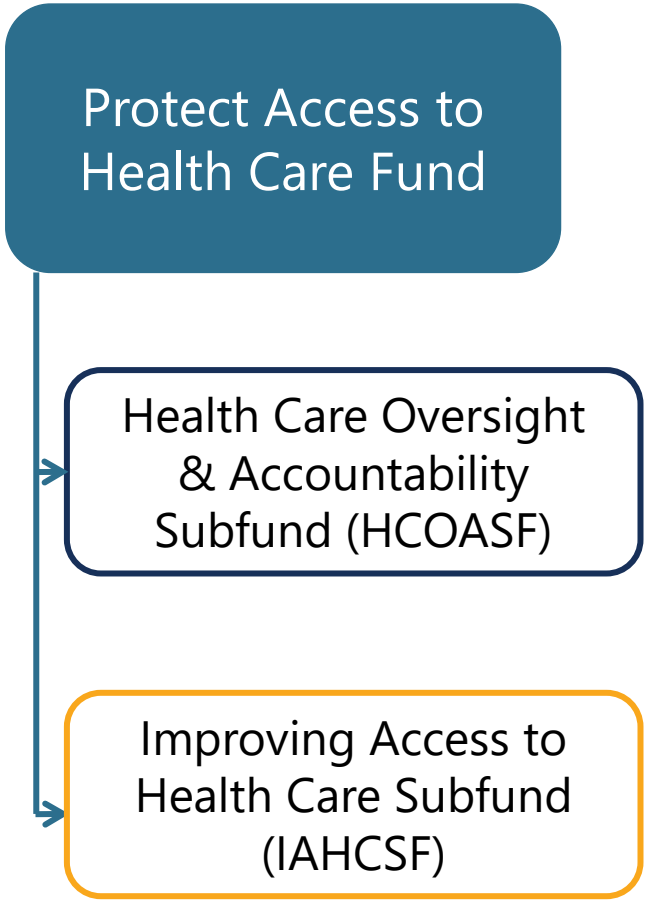
Proposition 35 MCO Tax Spending Plan

- DHCS, in consultation with the PAHCA-SAC, will develop new and/or revised payment methodologies that incorporate and build on, but are not identical to, the TRI, due to specific provisions in Proposition 35.
- DHCS must consult with, and obtain written input from, the PAHCA-SAC:
  - Before proposing a new or changed payment methodology.
  - When establishing criteria or eligibility for increased payments or grants
  - Each time DHCS issues official guidance, such as an All-Plan Letter.
- DHCS aims to design federally approvable payment proposals that advance the Medi-Cal program's goals for quality, access, and fiscal sustainability. DHCS is committed to strengthening Medi-Cal, improving access to care, and supporting the providers who serve more than 14 million Californians

Proposition 35 Funds & Federal Match

- DHCS has not missed any federal deadlines related to Proposition 35, and no federal funding has been left on the table.
- Under Proposition 35, MCO tax revenues are deposited in the Protect Access to Health Care Fund and cannot be used for any purposes other than those specified.
- When MCO tax revenues subject to Proposition 35 revenues are spent, DHCS will draw down applicable federal funding to the maximum extent allowed by the payment methodologies ultimately adopted.
- To date, DHCS has not yet collected MCO tax revenue subject to Proposition 35. The first collection date is April 30, 2025. Collection dates are scheduled to occur every three months thereafter on the 30th (e.g., July, October, January, April).

Proposition 35 Fund Flow



- First, monies are deposited in the HCOASF for:
  - Administrative and Oversight Costs.
  - Cost of increased capitation payments to MCPs accounting for their MCO tax obligations.
  - Funds allocated for CY 2025 and CY 2026.
  - Any unencumbered moneys remaining in the Subfund at the end of a calendar year are transferred to the IAHCSF.
- All remaining money is deposited in the IAHCSF:
  - Within the Subfund, revenue is allocated to over a dozen accounts/subaccounts on a percentage basis.
  - These funds are not available to be spent until 2027.

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 categories.

Domain	$ Millions
General Support of Medi-Cal Program	$2,000
Primary Care	$691
Specialty Care	$575
Community and Outpatient Procedures	$245
Abortion and Family Planning Services	$90
Services and Supports for Primary Care	$50
Emergency Room 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**

CY 2025 & CY 2026 Allocations

- The funds allocated for CY 2025 and CY 2026 are “continuously appropriated without regard to fiscal years”, meaning that the spending authority is available until these amounts are fully expended.
- However, funds must be “encumbered” by the end of the CY or else they will be transferred to the IAHCSF. Funds transferred to the IAHCSF are allocated on a percentage basis and will become available in 2027.
- Proposition 35 states that “unexhausted moneys in the fund that are allocated for expenditures associated with payments to Medi-Cal providers pursuant to a federally approved methodology, or a methodology for which federal approval is pending, shall be considered otherwise encumbered at the end of each applicable calendar year or fiscal year.”

CY 2027 Allocations

- Beginning in CY 2027, Proposition 35 payment increases will flow out of the individual accounts/subaccounts within the IAHCSF.
- The total size of the MCO tax in 2027 is uncertain pending potential changes in federal regulations. Funds will be allocated between accounts/subaccounts on a percentage basis. Total allocation amounts will vary from those effective for CY 2025 and CY 2026.
- Many of the CY 2025 and CY 2026 allocations have a counterpart in the CY 2027 and forward account structure. However, there are several new domains. Furthermore, accounts/subaccounts may have more specific limitations on their allowable uses compared to CY 2025 and CY 2026.
- Several of the CY 2027 accounts are funded only if annual net revenue exceeds $4.7 billion. Furthermore, some of the CY 2027 accounts have caps on how much annual revenue can be deposited.

Medi-Cal Financing Background

Medi-Cal 101

- Medi-Cal is California's medical assistance program covering more than 14 million income-eligible Californians.
- Medi-Cal is jointly funded by the State and through the federal Medicaid program. States must spend a "non-federal share" that is then used to "draw down" federal financial participation (FFP).
- The non-federal share may be supported by the State General Fund, State special funds, and permissible local government funds.
- The Centers for Medicare & Medicaid Services (CMS) is DHCS's federal oversight partner. To be eligible to draw down FFP, Medi-Cal must abide by federal laws and regulations and must obtain federal approval of specific payment methodologies from CMS.
- Medi-Cal also covers certain state-only funded populations and services.

Federal Financial Participation

- CMS funds a share of Medi-Cal's cost at varying Federal Medical Assistance Percentages (FMAP) depending on the member population and service.
- Regular FMAP for basic services and original Medicaid populations is 50%.
  - Certain expansion populations, under the Affordable Care Act Expansion and Children's Health Insurance Program, have higher FMAPs.
  - Certain services, such as family planning services, have higher FMAP.
  - Certain services, such as abortion services, are not eligible for FFP.
  - FFP for members who have federally unsatisfactory immigration statuses is only available for emergency and pregnancy-related services.

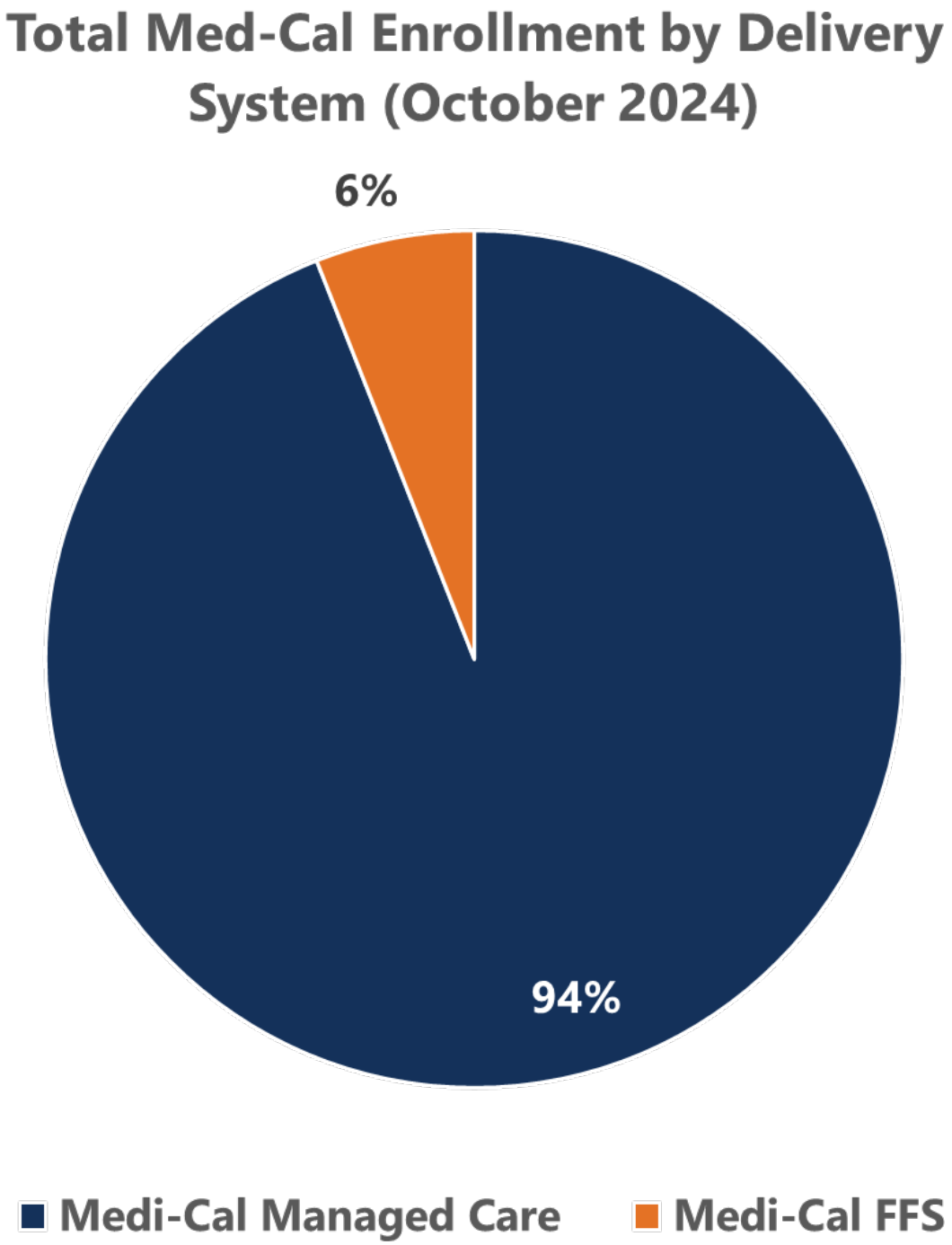
SFY 2024-25 Medi-Cal Budget

- SFY 2024-25 Medi-Cal budget as of the 2024 November Estimate:
  - Total Fund: $174.6 billion[1]
  - Federal Fund: $107.5 billion
  - State General Fund: $37.6 billion
  - Other Funds: $29.5 billion
- The Medi-Cal budget is updated twice a year through the Medi-Cal Local Assistance Estimate. DHCS generally must seek appropriations from the Legislature through the annual budget process.
  - The Governor introduces the proposed budget for the upcoming SFY in January and it must be approved by the Legislature in the Budget Act by June 30.
  - Some changes to the budget can be made mid-year administratively, but major changes require the Legislature to amend the Budget Act.
  - However, some fund sources, like Proposition 35, are continuously appropriated and do not require annual Legislative approval.

[1] Excludes funding in other state departments' budgets and local funds used to support Certified Public Expenditures.

Medi-Cal Delivery Systems

- Medi-Cal physical health, non-specialty mental health, and dental care services are generally provided to Medi-Cal enrollees through one of two delivery systems:
  - Fee-For-Service (FFS) Delivery System
  - Managed Care Delivery System
- Some other services are delivered through separate delivery systems including county-operated behavioral health services.



FFS Delivery System

FFS Delivery System

- FFS members receive health care services from providers registered (“enrolled”) with Medi-Cal.
- DHCS pays claims for covered services from these providers directly through the Fiscal Intermediary.
  - A provider serving members in the FFS delivery system may also serve members in the managed care delivery system
- Approximately 6% percent of Medi-Cal members are not enrolled in managed care and are served solely through FFS.

FFS Payments

- Providers who see patients in Medi-Cal FFS are paid according to the state-established Medi-Cal Fee Schedule.
- DHCS is responsible for developing the FFS reimbursement methodologies and rates, in accordance with state and federal law, regulations, and the California Medicaid State Plan.
- Federal law requires the State Plan to establish payment levels that are "consistent with efficiency, economy, and quality of care, and are sufficient to provide access." CMS evaluates economic efficiency relative to projected costs, Medicare's payment levels, and other upper payment limit demonstrations.

FFS Supplemental Payments

- Supplemental payments are additional payments to FFS providers in additional to the base FFS rates in accordance with the State Plan. Supplemental payments include:
  - Per-service rate add-ons.
  - “Pooled" payments.
- Supplemental payments do not change the base rate published on the Medi-Cal Fee Schedule.
- Medi-Cal FFS supplemental payments are in place across a range of services including, but not limited to, physician, dental, family planning, abortion, ground emergency transport, Federally Qualified Health Center (FQHC), and hospital services.

State Plan Amendments

- 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 State Plan Amendments (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.

Managed Care Delivery System

Managed Care Delivery System

- DHCS contracts with 25 full-service MCPs, 3 dental MCPs, and 31 Program of All-Inclusive Care for the Elderly (PACE) Organizations.
- MCPs build contracted provider networks to deliver covered services to enrollees, generally negotiating payment rates for the services (often different from FFS rates and methods).
- The State pays plans a prospective monthly capitation rate for each member, known as a per-member per-month (PMPM) payment.
- MCP contracts, inclusive of program requirements, covered services and capitation rates, must be submitted to, and be reviewed and approved by, CMS at least annually.

MCP Capitation Rates

- Capitation rates are paid by DHCS to MCPs for every enrolled member per service month, PMPM, regardless of whether the member utilized services or not for that month.
- Capitation rates are developed and actuarially certified on an annual basis.
  - Per federal regulation, capitation rates must be "actuarially-sound," i.e., rates must be sufficient to cover the reasonable and appropriate projected costs for enrollees accessing covered services plus operation of the MCP.
  - Capitation rates, via the actuarial certification, must be reviewed and approved by CMS annually, and any time the rates are amended.
- Capitation rates change year-to-year because of projected changes to per service costs, per member utilization and acuity, and covered services.

State Directed Payments

- Federal regulations 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 state direct payments (SDP).
- A SDP is required any time a state directs (i.e., compels) a MCP's payments to providers such as the amount of payments (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 SDPs 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 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 sub-capitated basis
Uniform Dollar Increase	» Administratively simple » Quicker to operationalize than other options	» Because the increase is uniform, the funding is less targeted
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

Committee Member Questions/Discussion

Break

Considerations for CY 2025 and CY 2026 Domains

General Considerations

- DHCS is exploring a variety of options to operationalize CY 2025 and CY 2026 investments.
- Different potential payment mechanisms have complex tradeoffs associated with economic incentives for MCPs/providers, timeframes required to operationalize payment increases, and federal approvals.
- Proposition 35 authorizes DHCS to establish and modify payment methodologies administratively, subject to consultation with the PAHCA-SAC.

Further Considerations

- For some domains, it may be more expedient to implement payment increases only in one delivery system without an accompanying payment increase in the other delivery system.
- Most federally approvable payment methodologies are utilization-driven and do not allow DHCS to establish a fixed cap on spending. DHCS will need to carefully design payment methodologies to comply with federal requirements and ensure the fiscal sustainability of the Medi-Cal program.

Professional Services

2024 Targeted Rate Increases

- 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.
  - The TRI also included eliminating historic AB 97 provider payment reductions for applicable services and incorporating applicable Proposition 56 supplemental payments into the base rates.
  - Some of the procedure codes included in the TRI could appropriately be provided by specialists. Generally, physician visits for both primary care and specialists are billed using the same procedure codes.
  - These rate increases apply to eligible providers in the FFS delivery system, as well as eligible network providers contracted with MCPs.
  - 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.

TRI Ongoing Impact

- DHCS received federal approval of the TRI in SPA 23-0035 on an ongoing basis. These rate increases have continued into 2025.
- The annual cost of continuing the TRI is projected to be $356 million State Funds; updated projections may be provided through the state budget process.
- The 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.

Category (as defined in Proposition 35)	$ Millions State Funds
Primary Care	$215
Specialty Care	$134
ED Physicians	$7
Total	**$356**

Primary Care

- **Description:** Proposition 35 allocates $691 million annually to primary care in 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.
- **Current Payment Approach:**
  - FFS: DHCS sets a fee schedule rate, subject to the TRI, at 87.5 percent of the lowest corresponding Medicare rate.
  - MCPs: Negotiated rates that are, or are projected to be, equal to or greater than the TRI minimum fee schedule.
  - The Equity and Practice Transformation SDP provides additional limited-term payments to advance health equity and reduce disparities.

Specialty Care

- **Description:** Proposition 35 allocates $575 million annually to specialty care in 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 who deliver services at least some of which do not qualify as primary care (e.g., cardiologist, gastroenterologist, oncologist).
- **Current Payment Approach:**
  - Some codes shared by both primary care and specialty care, such as office visits, are captured in the TRI for specialty care providers.
  - FFS: DHCS reimburses non-TRI codes at the Medi-Cal Fee Schedule rate.
  - MCPs: Negotiated rates between MCPs and providers for non-TRI codes.

Emergency Department Physician Services

- **Description:** Proposition 35 includes a combined allocation of $355 million annually in CY 2025 and CY 2026 for Emergency Department (ED) facility services and ED physician services in CY 2025 and CY 2026.
- In past iterations of the MCO Tax Spending Plan, the portion allocated to ED physicians was $100 million.
- **Current Payment Approach:**
  - FFS: DHCS sets a fee schedule rate for emergency physician services reimbursement at a percentage of the corresponding Medicare rate.
  - MCPs: Negotiated rates between MCPs and providers.
  - ED visit codes were not included on the TRI code list; however, ED physicians can bill some procedure codes from the TRI code list that can be provided in both emergency and primary care settings.
  - MCPs must cover out-of-network emergency services.

Professional Services Considerations

- Historically, DHCS provided Proposition 56-funded supplemental payments in both FFS and managed care for physician services that were incorporated into the TRI.
- Because professional services providers share many of the same procedure codes, the TRI was implemented for eligible provider types without regarding to primary or specialty care taxonomy codes.
  - Proposition 35 will require DHCS to discretely track the cost of primary care, specialty care, and ED physician payment increases separately.
  - Physicians can generally provide both primary care and specialty care services within the scope of their medical licenses and provider specialty data is not currently collected with sufficient precision to adjudicate claims with rates varying by specialty.

Target Payment Levels Relative to Medicare

- The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (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 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%

Facility Services

Community and Outpatient Procedures

- **Description:** Proposition 35 allocates $245 million annually to community and outpatient procedures in CY 2025 and CY 2026. These services may include those provided on an outpatient basis in hospitals or other types of community facilities.
- **Current Payment Approach:**
  - FFS: DHCS reimburses outpatient services at the Medi-Cal Fee Schedule rate. Hospital outpatient departments receive a 43.44 percent increase to base FFS rates. Hospitals additionally receive outpatient supplemental payments.
  - Managed Care: MCPs negotiate base rates with hospitals and community facilities. Various SDP arrangements impact base payments or require MCPs to make supplemental payments.

ED Facility Services

- **Description:** Proposition 35 includes a combined allocation of $355 million annually in CY 2025 and CY 2026 for ED facility services and ED physician services in CY 2025 and CY 2026.
- In past iterations of the MCO Tax Spending Plan, the portion allocated to ED facility services was $255 million.
- **Current Payment Approach:**
  - FFS: DHCS reimburses ED facility services at the Medi-Cal Fee Schedule rate. Hospitals may receive supplemental payments for certain ED facility services.
  - Managed Care: MCPs negotiate base rates with hospitals. DHCS directs MCPs to provide supplemental, directed payments to public and private hospitals.
  - MCPs must cover out-of-network emergency services.

Designated Public Hospitals

- **Description:** Designated public hospital (DPH) systems are designated in state law and operated by a county, a city or county, the University of California, or special hospital authority.
- **Current Payment Approach:**
  - FFS:
    - For inpatient services, DPHs are paid up to actual audited costs using a certified public expenditure (CPE) methodology for the federal share of the payments. The non-federal share of inpatient services is financed through local government funds.
    - For outpatient services, DPHs are reimbursed at the Medi-Cal Fee Schedule rate. Hospital outpatient departments receive a 43.44 percent increase to base FFS rates.
  - Managed Care: MCPs negotiate base rates with DPHs for both inpatient and outpatient services. DHCS directs MCPs to provide Enhanced Payment Program (EPP) and Quality Incentive Pool (QIP) SDP payments to DPHs.
  - DPHs receive additional supplemental payments through various safety net financing programs.

Current Hospital SDPs

- DHCS operates several hospital SDP programs which may interact with Proposition 35 domains.
- Hospital SDPs are, broadly, divided based on the type of hospital:
  - DPH;
  - District and Municipal Public Hospitals (DMPH);
  - Private Hospitals.
- All three classes of hospitals receive utilization-based dollar add-on SDPs.
- DPHs and DMPHs receive additional Quality Incentive Pool (QIP) value-based payments.
- Hospital SDPs include payments for inpatient, outpatient, and emergency department services, and DPHs and DMPHs receive payments related to professional services.

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 in CY 2025 over CY 2024.
- Hospitals typically consider their “net benefit” the difference between the total payments and the self-financed amount.

Hospital SDP CY 2025 Funding ($ Millions)

Program	Inpatient/ Long-Term Care	Outpatient/ Emergency Department	Non-Facility
DPH Enhanced Payment Program (EPP)	$2,690.2	$783.8	$391.0
Private Hospital Directed Payment (PHDP)	$7,384.9	$5,802.4	$0.0
DMPH Directed Payment (DHDP)	$463.3	$379.1	$0.0
DPH QIP	$727.4	$2,599.5	$136.8
DMPH QIP	$115.4	$60.7	$2.4
Children's Hospital Supplemental Payments	$113.6	$116.4	$0.0

Other Domains

Reproductive Health

- **Description:** Proposition 35 allocates $90 million annually to family planning and abortion services in CY 2025 and CY 2026. Medi-Cal covers comprehensive family planning services. FamilyPACT provides limited-scope coverage of family planning services through the FFS Delivery System to low-income Californians who do not otherwise qualify for full-scope Medi-Cal. Medi-Cal provides state-only coverage of abortion services.
- **Current Payment Approach:**
  - FFS: DHCS reimburses family planning and abortion services at the Medi-Cal Fee Schedule rate. Certain Medi-Cal Fee Schedule rates are increased for comprehensive family services pursuant to SB 94 (Chapter 636, Statutes of 2007). Supplemental payments are also available under Proposition 56 for family planning services (under Medi-Cal and FamilyPACT) and abortion services.
  - Managed Care: Rates are negotiated between MCPs and providers. MCPs must reimburse out-of-network providers at least the FFS rate for family planning services. DHCS directs MCPs to provide Proposition 56-funded SDPs for family planning and abortion services.
  - The TRI procedure code list did not include codes specific to family planning or abortion services; however, family planning providers may utilize certain TRI procedure codes that are shared by all providers such as office visits.

Reproductive Health Considerations

- The payment rates resulting from the Proposition 56 supplemental payments for family planning services significantly exceed Medicare rates, which may limit the federal approvability of further payment increases.
- Family planning services are generally eligible for 90% FFP.
- Abortion services are not eligible for FFP. Therefore, the state does not have to adhere to federal rules regarding SPAs and directed payments.
- Prior versions of the MCO Tax Spending Plan would have allocated approximately $70 million to additional abortion payment increases on a per service basis and $20 million to an FamilyPACT supplemental payment program.

Services and Supports for Primary Care

- **Description:** Proposition 35 allocates $50 million annually in CY 2025 and CY 2026 for "Services and Supports for Primary Care." In past iterations of the MCO Tax Spending Plan, this funding was allocated to supporting community clinics.
- **Current Payment Approach:**
  - FQHCs and Rural Health Clinics (RHCs) are reimbursed through a federally defined all-inclusive facility-specific prospective payment system (PPS) methodology and may also participate in alternative payment models.
    - FFS: FQHCs/RHCs receive the PPS rate directly from DHCS.
    - MCPs pay FQHCs/RHCs in parity with other providers and DHCS reconciles payments to the PPS rate.
  - Non-FQHC/RHC community clinics are generally reimbursed similarly to other primary care providers.
  - DHCS operates an additional Community Clinic Directed Payment program for nonhospital 340B community clinics. Prior versions of the MCO Tax Spending Plan would have increased the size of this program.

Ground Emergency Medical Transportation

- **Description:** Proposition 35 allocates $50 million annually to Ground Emergency Medical Transportation (GEMT) services in CY 2025 and CY 2026:
- **Current Payment Approach:**
  - FFS: DHCS sets a fee schedule rate for all transports and mileage. Base rates are subject to a 10 percent reduction per AB 97. Providers also receive supplemental rate add-ons.
    - Private GEMT providers: Quality Assurance Fee (QAF).
    - Public GEMT providers: IGTs.
  - Managed Care: MCPs must reimburse the FFS rate, including rate add-ons, for non-contracted services. Most GEMT services are non-contracted. MCPs may negotiate rates for contracted GEMT providers.
  - Under previous versions of the MCO Tax Spending Plan, DHCS had proposed to adopt Medicare's pricing system to vary GEMT payments by complexity, locality, and rural status. Medi-Cal's current payment structure does not vary rates based on these factors.

Other Domains

- Proposition 35 allocates $75 million annually to **Graduate Medical Education** in CY 2025 and CY 2026.
  - Under past versions of the MCO Tax Spending Plan, this amount was allocated to the University of California to expand graduate medical education programs to achieve the goal of increasing the number of primary care and specialty care physicians.
- Proposition 35 allocates $75 million annually to **Medi-Cal Workforce** in CY 2025 and CY 2026.
  - Under past versions of the MCO Tax Spending Plan, this amount was allocated to the Department of Health Care Access and Information (HCAI) to establish a Medi-Cal Workforce Pool.
- Proposition 35 allocates $300 million annually to **Behavioral Health Facility Throughputs** in CY 2025 and CY 2026.

Request for Committee Members' Written Input

- DHCS requests the PAHCA-SAC members' written input on the materials presented today no later than Friday, April 25, 2025.
- Please email written input to DHCSPAHCA@dhcs.ca.gov.

Committee Member Questions/Discussion

Public Comment

Meeting Closing