Senate Budget and Fiscal Review—Scott Wiener, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Caroline Menjivar, Chair
Senator Susan Talamantes Eggman, Ph.D.
Senator Shannon Grove
Senator Richard D. Roth

Thursday, April 18th, 2024
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

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PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Managed Care Organization (MCO) Tax – Targeted Rate Increases and Investments

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $1.9 billion ($774 million Medi-Cal Provider Payment Reserve Fund and $1.1 billion federal funds) in 2024-25, with a total annual impact of $5.4 billion ($2.2 billion Medi-Cal Provider Payment Reserve Fund and $3.2 billion federal funds) by 2026-27, to support targeted rate increases and investments for Medi-Cal providers beginning January 1, 2025. DHCS also proposes trailer bill language to implement these rate increases and investments. As of the publication of this agenda, the text of the proposed trailer bill language has not been released by the Administration.

Background. AB 119 (Committee on Budget), Chapter 13, Statutes of 2023, authorizes the assessment of a tax on managed care organizations operating in California to provide a stable funding source for the delivery of health care services in the Medi-Cal program, and support critical investments to ensure access, quality, and equity. The tiered, enrollment-based managed care organization (MCO) tax will be assessed from April 1, 2023, through December 31, 2026, on all full-service health plans licensed by the Department of Managed Health Care (DMHC) or contracted with the Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries. In addition, AB 119 establishes the Managed Care Enrollment Fund, into which the revenues from the tax will be deposited, and makes those revenues available, upon appropriation by the Legislature, to DHCS for the purposes of funding: 1) the nonfederal share of increased capitation payments to Medi-Cal managed care plans to account for their projected tax obligation, 2) the nonfederal share of Medi-Cal managed care rates for the delivery of health care services to beneficiaries of the Medi-Cal program, and 3) transfers to the Medi-Cal Provider Payment Reserve Fund to support investments in the Medi-Cal program.

SB 136 (Committee on Budget and Fiscal Review), Chapter 6, Statutes of 2024, approved by the Legislature in March 2024, modified the tiered tax amounts for the MCO tax approved by AB 119 to allow the state to draw down approximately $1.5 billion in additional federal funds to offset General Fund expenditures in the Medi-Cal program. As the nonfederal share of Medi-Cal expenditures are typically supported by the state's General Fund, these resources are available to help address the state's General Fund shortfall. The net benefit to the General Fund by fiscal year would be $395 million in 2023-24, $698 million in 2024-25, $467 million in 2025-26, and a net General Fund loss (compared to the previous estimate) of $102 million in 2026-27. In addition to these changes, the budget includes changes to the amounts of the tax previously allocated to support the General Fund in the 2023 Budget Act and ends MCO tax revenue support for targeted rate increases and investments one year earlier.

COMPARISON OF MULTI-YEAR MCO TAX REVENUE/EXPENDITURES ESTIMATES
2023 Budget Act to 2024 Governor's Budget

MCO Tax – Cash Basis by Fiscal Year (*at 2023 Budget Act*)					
(dollars in millions)	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**Total**
Total Revenue[1]	$8,269	$8,527	$8,762	$6,704	$32,261
Medi-Cal Capitation Rates[2]	$3,860	$3,415	$3,507	$2,077	$12,860
State's Net Benefit[3]	**$4,410**	**$5,112**	**$5,254**	**$4,626**	**$19,402**
General Fund Backfill[4]	$3,389	$1,858	$2,019	$1,050	$8,316
Proposed Rate Increases/Investments 2024[5]	$98	$240	$241	$241	$820
Proposed Rate Increases/Investments 2025[6]	$923	$3,014	$2,994	$3,335	$10,266
TOTAL MEDI-CAL INVESTMENTS	**$1,021**	**$3,254**	**$3,235**	**$3,576**	**$11,086**

MCO Tax – Cash Basis by Fiscal Year (*at 2024 Governor's Budget*)					
(dollars in millions)	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**Total**
Total Revenue[1]	$8,269	$9,770	$9,514	$7,138	$34,690
Medi-Cal Capitation Rates[2]	$3,464	$3,960	$3,792	$2,614	$13,831
State's Net Benefit[3]	**$4,805**	**$5,810**	**$5,721**	**$4,524**	**$20,859**
General Fund Backfill[4]	$4,409	$4,637	$2,485	$1,349	$12,880
Proposed Rate Increases/Investments 2024[5]	$396	$366	$380	$396	$1,538
Proposed Rate Increases/Investments 2025[6]	$0	$881	$2,339	$2,455	$5,601
TOTAL MEDI-CAL INVESTMENTS	**$396**	**$1,247**	**$2,719**	**$2,851**	**$7,139**

1 – Total Revenue is the total amount of revenue received by the state from the tax on managed care organizations.
2 – Medi-Cal Capitation Rates is the amount paid to Medi-Cal managed care plans in their capitation rates to account for the amount of tax paid to the state. Federal regulations require capitation payments to be actuarial sound and include the cost of taxes.
3 – State's Net Benefit is the amount of revenue received by the state, net of capitation payments paid to managed care plans.
4 – General Fund Backfill is the amount that addresses the General Fund shortfall in 2023-24 and subsequent years.
5 – Proposed Rate Increases 2024 include the increase to 87.5 percent of Medicare for primary care, obstetrics and non-specialty mental health; UC Graduate Medical Education; Distressed Hospital Loan Program; and Small/Rural Hospital Relief Program for Seismic Assessment and Construction.
6 – Proposed Rate Increases 2025 include the Administration's proposed increases for Medi-Cal providers, and investments in Behavioral Health Throughput (eff. 7/1/25), and the Medi-Cal Workforce Pool – Labor Management Committee (HCAI).

Federal Requirements for Health Care Related Taxes. Section 433.68 of Title 42 of the Code of Federal Regulations (42 CFR 433.68) authorizes state Medicaid programs to receive federal financial participation (FFP) for expenditures using health care-related taxes, as long as certain conditions are met. The MCO Enrollment tax qualifies as a health care-related tax. Taxes must be:

1) Broad-based – For a health care related tax to be considered broad based, it must be imposed on all non-federal (e.g. Medicare) and non-public providers in the state or jurisdiction imposing the tax (e.g. local government).
2) Uniformly imposed – For a health care related tax to be considered uniform, it must be applied at the same rate for all affected providers
3) No hold-harmless provisions – A taxpayer cannot be held harmless for the amount of the tax. A taxpayer is considered to be held harmless if there is a correlation between their Medicaid payments and the tax amount, all or any portion of the Medicaid payment varies based only on the tax amount,

or the state or other taxing jurisdiction provides for any direct or indirect payment or other offset for all or any portion of the tax amount.

States may apply for waivers to both the broad-based and uniform requirements. For a waiver of the broad-based requirements, a state must demonstrate that the tax is "generally redistributive" by calculating the proportion of tax revenue applicable to Medicaid under a broad-based tax (P1) and comparing it to the same proportion under the proposed tax (P2). A waiver may be approved if the ratio of P1/P2 is at least 0.95, and the excluded providers are in a list of providers defined in the regulation. For a waiver of the uniform requirements, a state must measure the ratio of the slope of a linear regression equation of a broad-based and uniform tax (B1) compared to the proposed tax (B2). The ratio of B1/B2 must be at least 0.95, and the excluded providers are in a list of providers defined in the regulation. The most recent MCO enrollment tax received a waiver of the uniform requirement, and was designed to comply with the required B1/B2 ratio.

Twenty Years of Provider Taxes on Managed Care Organizations in California. California imposes three provider-related taxes: a fee on certain general acute-care hospitals (Hospital Quality Assurance Fee or HQAF), a fee on free-standing skilled nursing facilities (AB 1629 Quality Assurance Fee), and a tax on enrollment in health care service plans in the state of California (Managed Care Organization or MCO Tax). For over twenty years, California has imposed a fee or tax on managed care organizations, the proceeds of which have been allocated entirely to offset state General Fund expenditures in Medi-Cal, until the most recent tax imposed in 2023.

Quality Improvement Fee (AB 1762 - 2003)

AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, authorized the state's first provider fee on Medi-Cal managed care organizations. The fee was implemented in July 2005 as a quality improvement fee of 5.5 percent of a plan's revenue. The 2005 Governor's Budget assumed net General Fund savings of $37.7 million as a result of the fee. The fee was allowed to expire in October 2009, as the federal government disallowed the fee because it was not sufficiently broad-based and, therefore, in violation of the relevant Medicaid regulations (see section below on "Federal Medicaid Requirements")

Gross Premiums Tax (AB 1422 - 2009)

AB 1422 (Bass), Chapter 157, Statutes of 2009, replaced the previous quality improvement fee with an extension of the state's existing gross premiums tax of 2.35 percent to Medi-Cal managed care plans. The tax had previously only been levied on insurance products, but taxation of Medi-Cal managed care plans under this existing tax regime was sufficient to comply with federal Medicaid regulations that the tax be broad-based. AB 1422 provided that revenue from the tax would serve as the non-federal share for expenditures in both the Medi-Cal program and the state's program for the federal Children's Health Insurance Program, known as the Healthy Families Program. The 2010 Budget Act assumed the gross premiums tax would provide $99.8 million to Medi-Cal and $82 million to Healthy Families in the 2009-10 fiscal year. The gross premiums tax was extended by Chapter 717, Statutes of 2010 (SB 853), and again by Chapter 11, Statutes of 2011 (ABX1 21), until June 30, 2012.

Managed Care Organization Tax (SB 78 - 2013)

SB 78 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2013 (SB 78), extended the gross premiums tax at its previous rate of 2.35 percent until June 30, 2013. SB 78 then authorized a tax of 3.9375 percent, equal to the state's portion of the sales and use tax, on the operating revenue of Medi-

Cal managed care organizations, known as the MCO tax. The tax was authorized for three years, until June 30, 2016. The 2013 Budget Act assumed a General Fund savings of $304.6 million for the Medi-Cal program from the MCO tax. Over subsequent years, additional populations began to enroll in Medi-Cal managed care, particularly related to the Optional Expansion of Medi-Cal pursuant to the federal Affordable Care Act. As a result, General Fund savings from the MCO tax grew significantly because the tax was a percentage of overall expenditures on Medi-Cal managed care. The 2016 Budget Act assumed $971.2 million of annual General Fund savings in the 2015-16 fiscal year, the last year of operation of this version of the MCO tax.

Managed Care Enrollment Tax (SBX2 2 - 2016)

In 2014, the federal government released guidance indicating that the structure of the state's MCO tax did not comply with federal Medicaid regulations. The state was instructed to make any necessary statutory changes to bring the tax into compliance by the end of the next scheduled legislative session, or the end of 2016. SBX2 2 (Hernandez), Chapter 2, Statutes of 2016, 2nd Extraordinary Session, authorized a tax on enrollment of managed care plans statewide, along with certain tax reform provisions. SBX2 2 created a tiered tax on the enrollment of health care service plans based on their enrollment as reported to the Department of Managed Health Care for the 12 month period of October 1, 2014 through September 30, 2015, known as the "base year". There were three sets of tiers: 1) Medi-Cal enrollees, 2) Alternate Health Care Service Plan enrollees (such as Kaiser), and 3) all other enrollees. Each tier, based on the number of member months, had a different tax rate per enrollee. The 2017 Governor's Budget assumed General Fund savings of $1.07 billion in 2016-17 and $1.63 billion in 2017-18 from the new MCO enrollment tax. SBX2 2 also contained tax reform components that exempted payers of the MCO tax from liability for the state's gross premiums tax and from the corporation tax. The 2017 Governor's Budget assumed a total annual General Fund revenue reduction of $370 million ($280 million gross premiums tax and $90 million corporation tax) for each of the three years of the tax.

Reauthorized MCO Enrollment Tax (AB 112 – 2019)

AB 112 (Committee on Budget), Chapter 348, Statutes of 2019, reauthorized a tax on managed care organizations operating in California, based on enrollment, beginning July 1, 2019, and ending January 1, 2023. The "base year" for enrollment was the cumulative enrollment for each plan between January 1, 2018, and December 31, 2018. The 2019 Budget Act assumed net revenue of $1.7 billion in 2019-20, $1.9 billion in 2020-21, $2.1 billion in 2021-22, and $2.4 billion in 2022-23. The tax authorized by AB 112 was allowed to expire at the end of 2023.

2023 Budget Act MCO Enrollment Tax Renewal. AB 119 implemented a multi-year tax on managed care organizations (MCO) beginning April 1, 2023, through December 31, 2026, to: 1) support the General Fund shortfall and achieve a balanced budget, 2) support Medi-Cal investments to ensure access, quality and equity over an eight to ten year period. The 2023 Budget Act also authorized expenditure authority of $214.7 million ($89.6 million Medi-Cal Provider Payment Reserve Fund and $125.1 million federal funds) to increase provider rates to 87.5 percent of the rate paid by the Medicare program, beginning January 1, 2024, for the following provider types: 1) primary care services and nonphysician professional services, 2) obstetric care services, and 3) outpatient, non-specialty mental health services. The 2023 Budget Act also included expenditure authority from the Medi-Cal Provider Payment Reserve Fund of $150 million for the Distressed Hospital Loan Program (one-time), $75 million for Graduate Medical Education (ongoing), and $50 million for Small and Rural Hospital Relief for Seismic Assessment and Construction (one-time).

The tax establishes three tiers of enrollment. Tier 1 includes enrollment up to 1,250,000. Tier 2 includes enrollment between 1,250,001 and 4,000,000. Tier 3 includes enrollment over 4,000,001. The tax only applies to enrollment in Tier 2 and was set at $182.50 per enrollee for Medi-Cal managed care plans and $1.75 per enrollee for non-Medi-Cal plans in 2023-24 and 2024-25. In 2025-26, the tax was set to rise to $187.50 per enrollee for Medi-Cal managed care plans and $2.00 per enrollee for non-Medi-Cal plans. In 2026-27, the tax would have risen again to $192.50 per enrollee for Medi-Cal managed care plans and $2.25 per enrollee for non-Medi-Cal plans.

MCO Tax – Enrollment Tiers and Tax Amounts
(as approved in the AB 119 and the 2023 Budget Act)

	Medi-Cal Tier 1	**Medi-Cal Tier 2**	**Medi-Cal Tier 3**	**Other Tier 1**	**Other Tier 2**	**Other Tier 3**
Enrollment:	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*
2023-24	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2024-25	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2025-26	$0.00	$187.50	$0.00	$0.00	$2.00	$0.00
2026-27	$0.00	$192.50	$0.00	$0.00	$2.25	$0.00

Federal Approval of the AB 119 Tax and Use for Provider Rate Increases. DHCS indicates, during its discussions with the federal Centers for Medicare and Medicaid Services (CMS), the design of the tax imposed by AB 119 utilizes ambiguities in current federal Medicaid regulations regarding the relative amounts of taxation between Medicaid and non-Medicaid plans to maximize federal funds and General Fund benefits. CMS has indicated to DHCS it intends to promulgate regulations to eliminate the ambiguity that allows this differential taxation to occur. However, CMS indicates it is willing to approve this version of the tax, including a significant allocation to support the General Fund shortfall, as long as the remaining General Fund savings are utilized to improve access, quality, and equity in the Medi-Cal program. The tax was approved by CMS in December 2023.

2024 Modification to MCO Tax Amounts to Draw Down Additional Federal Funds. SB 136, approved by the Legislature in March 2024, modified the tiered tax amounts for the MCO tax approved by AB 119 to allow the state to draw down approximately $1.5 billion in additional federal funds to offset General Fund expenditures in the Medi-Cal program. As the nonfederal share of Medi-Cal expenditures are typically supported by the state's General Fund, these resources are available to help address the state's General Fund shortfall. The net benefit to the General Fund by fiscal year would be $395 million in 2023-24, $698 million in 2024-25, $467 million in 2025-26, and a net General Fund loss (compared to the previous estimate) of $102 million in 2026-27. The new tax amounts by enrollment tier are as follows (changed amounts highlighted):

MCO Tax – Enrollment Tiers and Tax Amounts *(as modified by SB 136 in March 2024)*						
	Medi-Cal Tier 1	**Medi-Cal Tier 2**	**Medi-Cal Tier 3**	**Other Tier 1**	**Other Tier 2**	**Other Tier 3**
Enrollment:	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*
2023-24	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2024-25	$0.00	$205.00	$0.00	$0.00	$1.75	$0.00
2025-26	$0.00	$205.00	$0.00	$0.00	$2.00	$0.00
2026-27	$0.00	$205.00	$0.00	$0.00	$2.25	$0.00

The modified MCO tax is currently awaiting approval by the federal Centers for Medicare and Medicaid Services.

Governor's January Budget Proposes Targeted Rate Increases and Investments. In the Governor's January budget, DHCS requests expenditure authority of $1.9 billion ($774 million Medi-Cal Provider Payment Reserve Fund and $1.1 billion federal funds) in 2024-25, with a total annual impact of $5.4 billion ($2.2 billion Medi-Cal Provider Payment Reserve Fund and $3.2 billion federal funds) by 2026-27, to support targeted rate increases and investments for Medi-Cal providers beginning January 1, 2025. DHCS also proposes trailer bill language to implement these rate increases and investments. As of the publication of this agenda, the text of the proposed trailer bill language has not been released by the Administration.

According to DHCS, the expected annual expenditures for rate increases and investments are as follows:

Category	**Estimated Annual Expenditures**
Primary Care, Maternal Care, Mental Health (*eff. 1/1/2024*)	$291,000,000
Physician and Non-Physician Health Professional Services	$975,000,000
Community and Hospital Outpatient Procedures and Services	$245,000,000
Abortion and Family Planning Access	$90,000,000
Services and Supports for FQHCs and RHCs	$50,000,000
Emergency Department (Facility and Physician) Services	$355,000,000
Designated Public Hospitals Reimbursement	$150,000,000
Ground Emergency Medical Transportation	$50,000,000
Behavioral Health Throughput (*eff. 7/1/2025*)	$300,000,000
Graduate Medical Education (*eff. 1/1/2024*)	$75,000,000
Medi-Cal Workforce Pool – Labor-Management Committee	$75,000,000
TOTAL	**$2,656,000,000**

In addition to these ongoing expenditures, the MCO Tax provided support for $150 million one-time for the Distressed Hospital Loan Program, and $50 million one-time for the Small and Rural Hospital Relief for Seismic Assessment and Construction program.

Physician and Non-Physician Health Professional Services. DHCS proposes to increase Medi-Cal reimbursement rates for the following procedure codes as a percentage of Medicare reimbursement as follows:

Procedure Code Category	Target Percent of Medicare Reimbursement
Evaluation and 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 and Management Codes for ED Physician Services	90%
Other Evaluation and Management Codes	80%
Other Procedure Codes utilized by Primary Care, Specialists and ED	80%

Providers eligible for these rate increases are: 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.

Community and Hospital Outpatient and Emergency Department Facility Services. DHCS proposes to transition hospital outpatient and ambulatory surgical center reimbursement to an outpatient prospective payment system (OPPS) methodology, no sooner than January 1, 2027. DHCS also proposes to transition emergency department (ED) reimbursement to an OPPS methodology no sooner than January 1, 2027, after discussions with stakeholders. In preparation for the transition to the OPPS methodology, DHCS proposes transitionary increases to baseline reimbursements in the fee-for-service and managed care delivery systems beginning January 1, 2025, until the implementation of the OPPS methodology. The baseline increases would apply as regionally adjusted percentage increases to fee-for-service and managed care reimbursements in the relevant categories of service relative to current reimbursement levels. DHCS estimates these increases would average approximately 10 percent for outpatient services and 40 percent for ED facility services. When implemented, DHCS would calibrate the OPPS to be budget neutral relative to the increased baseline reimbursements in the preceding two years, and provide ongoing adjustments based on changes to Medicare rates.

Designated Public Hospitals Reimbursement. DHCS proposes to transition reimbursement for designated public hospital inpatient services from the existing certified public expenditure (CPE) methodology to a diagnosis related group (DRG)-type methodology. A DRG methodology would use diagnosis and procedure codes, as well as illness severity level to determine final reimbursement for each inpatient hospital stay. DHCS also proposes to phase out the CPE methodology in two phases leading to a subsequent reconciliation to 100 percent of costs. DHCS indicates it is engaging with public hospitals to refine the details of this proposal.

Abortion and Family Planning. DHCS proposes to increase rates for surgical and medication abortions to $1,150, to ensure reimbursement parity. The current Medi-Cal rate for induced abortion, by dilation and curettage, is $400. The current Medi-Cal rate for induced abortion, by dilation and evacuation, is $700. The current Medi-Cal rate for the Medication Abortion Bundle is $536.48. All of these rates would increase to $1,150.

In addition to the increased rates for surgical and medication abortions, DHCS proposes to continue the abortion supplemental payment program adopted in the 2022 Budget Act. This program provides support to non-hospital community clinics that incur significant costs associated with providing abortion services and that serve Medi-Cal members.

Ground Emergency Medical Transportation. DHCS proposes to increase the base rate for ground emergency medical transportation to between 50 and 60 percent of the Medicare base rate effective January 1, 2025. DHCS also proposes to adopt Medicare's pricing system to vary base rates by complexity, locality, and rural status.

Services and Supports for Federally Qualified Health Centers and Rural Health Clinics. DHCS proposes to increase the existing supplemental payment pool for non-hospital 340B community clinics by between $100 million and $125 million ($50 million Medi-Cal Provider Payment Reserve Fund). DHCS also proposes to transition the supplemental payment pool into a managed care directed payment, effective January 1, 2025. The directed payment would provide utilization based payments and performance-based quality payments.

Behavioral Health Throughput. DHCS proposes to invest $300 million from the Medi-Cal Provider Payment Reserve Fund to support behavioral health throughput. As of the publication of this agenda, no further details were available for this proposal.

Graduate Medical Education. DHCS proposes to transfer $75 million annually from the Medi-Cal Provider Payment Reserve Fund 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 in the state based on demonstrated workforce needs and priorities.

Health Care Workforce – Labor-Management Committee. DHCS proposes to transfer $75 million annually from the Medi-Cal Provider Payment Reserve Fund to HCAI to support the establishment and administration of the Medi-Cal Workforce Pool. No additional details are available for this proposal.

According to DHCS, all targeted rate increases for Medi-Cal providers would be used to establish new base rates for those providers, inclusive of the elimination of the remaining 10 percent provider rate reductions imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, as well as any relevant supplemental payments provided with Proposition 56 (2016) tobacco tax revenue.

Equity Adjustments. DHCS also proposes to allocate $200 million ($80 million Medi-Cal Provider Payment Reserve Fund) to support 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. The adjustments would apply to procedure codes 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. DHCS plans to develop an equity index to determine the distribution of equity adjustments that would include a composite of existing data sources such as health care worker shortage areas, rural or frontier areas, 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.

Alternative Targeted Investments in Medi-Cal. Since the Administration's initial proposal for an expanded MCO tax during the 2023 budget process, the subcommittee has received several alternative proposals for how the state might invest these dollars to strengthen the Medi-Cal program. These investments are as follows:

- *Multi-Year Continuous Enrollment in Medi-Cal for Children 0-5*. SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, requires DHCS to implement continuous coverage for children in Medi-Cal between ages zero and five. SB 189 (Committee on Budget and Fiscal Review), Chapter 189, Statutes of 2022, added a trigger that requires the Department of Finance to determine in the spring of 2024 that sufficient General Fund resources exist to support this eligibility change. It is unclear whether the Department of Finance will make such a determination. The implementation of the policy could be supported with MCO tax revenue, requiring expenditure authority of $20 million ($10 million Medi-Cal Provider Payment Reserve Fund) in 2024-25 and $40 million ($20 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

- *Share of Cost Reform – Maintenance Need Income Level Adjustment.* SB 184 also requires DHCS to reform calculations of share of cost and expand eligibility for Medi-Cal for medically needy older adults and persons with disabilities. Similar to the continuous coverage for children proposal, the share of cost reform is subject to a trigger that requires the Department of Finance to determine in the spring of 2024 that sufficient General Fund resources exist to support this eligibility change. The implementation of the policy could be supported with MCO tax revenue, requiring expenditure authority of $66.9 million ($33.4 million Medi-Cal Provider Payment Reserve Fund) in 2024-25 and $160.3 million ($80.2 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

- *Private Duty Nursing Rates.* A coalition of twelve organizations proposed expenditure authority of $123.9 million ($54.5 million Medi-Cal Provider Payment Reserve Fund) to support a 40 percent increase in Medi-Cal rates to help attract and retain nurses who provide home health care to pediatric patients. Private duty nursing (PDN) is continuous skilled nursing care provide in the home for medically complex and vulnerable pediatric and adult patient populations under Medi-Cal, many of whom require assistive technology such as ventilators and tracheostomies to sustain life. According to a recent analysis by David Maxwell-Jolly of California Health Policy Strategies, inadequate PDN reimbursement resulted in 25 percent fewer hours of in-home health care and a five-fold increase in delayed hospital discharges and readmissions. The analysis concluded the state could save hundreds of millions of dollars in unnecessary hospital costs by ensuring these fragile children can safely return home or to the community, rather than continuing to stay in the hospital.

- *Community-Based Adult Services (CBAS).* The California Association for Adult Day Services (CAADS) proposes to establish a rate floor for community-based adult services (CBAS), requiring managed care plans to pay CBAS centers at a rate greater than or equal to the Medi-Cal fee-for-service

rate. The 2019 Budget Act eliminated the 10 percent provider rate reductions for CBAS included in AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. As these restorations also resulted in an actuarial equivalent adjustment to managed care rates, the advocates contend this proposal should have no fiscal impact.

- *Congregate Living Health Facilities.* The Congregate Living Health Facilities Association requests expenditure authority of $15.5 million ($7.7 million Medi-Cal Provider Payment Reserve Fund and $7.7 million federal funds) to support increases for congregate living health facilities' daily rate from $490 to $675. Congregate Living Health Facilities provide care for the most medically fragile persons living in the community. Residents often have nowhere else to live because they require such a high level of acute care that often families cannot provide in their homes. Hospitals are incentivized to discharge and nursing homes provide a level of care lower than what CLHF residents require. No other provider is known to have not received any adjustment to their rates in 40 years. A rate increase will allow providers to increase wages, modernize medically assistive technology, and improve CLHF settings such as kitchen and dining rooms.

- *Community Health Worker, Promotoras, and Representatives.* A coalition of 46 organizations including the CA Pan-Ethnic Health Network, Vision y Compromiso, the California Primary Care Association, and others, request MCO tax resources to support a base rate increase for Community Health Workers, Promotoras, and Representatives (CHW/P/Rs) to at least 87.5 percent of Medicare, effective July 1, 2024. According to the coalition, a third of all Californians are enrolled in Medi-Cal and two thirds of Medi-Cal members are people of color. Yet, health outcomes pale by comparison for people of color, compared to their white counterparts in Medi-Cal and commercial coverage. CHW/P/R's reflect the communities they serve and their unique connection with the community has proven not only effective in supporting the COVID-19 response, improving outcomes for chronic diseases and mental health, and expanding access to healthcare services but also positions them as a pivotal component in efforts to transform the state's Medi-Cal program through the new Population Health Management service in CalAIM. With the promise of the CHW/P/R benefit, California has an opportunity to address care fragmentation, diversify the healthcare workforce, while also forging a stronger link between healthcare and public health through the use of CHW/P/Rs, but the potential of this workforce will remain unfulfilled without a greater and more targeted investment in a thriving CHW/P/R wage.

- *Chiropractic Benefits in Medi-Cal.* The California Chiropractic Association (CalChiro) requests approximately $7.3 million ($2.2 million Medi-Cal Provider Payment Reserve Fund) annually to restore the chiropractic benefit in Medi-Cal and to modify the two visit per month Medi-Cal limit to a 24 annual visit limit. According to CalChiro, for this modest investment, millions of Medi-Cal beneficiaries will have access to Doctors of Chiropractic (DCs) that have proven to be effective in providing nonpharmacological treatments to pain, reducing the need for prescription drugs such as opioids, and reducing the need for costly surgical interventions.

- *Orthotics and Prosthetics Reimbursement.* The California Orthotic and Prosthetic Association requests MCO tax resources to increase reimbursement rates for orthotics and prosthetics to at least 80 percent of the Medicare allowable rate and adjust the rate annually to conform with relevant changes in the Medicare program. According to COPA, there are nearly two-million people living with limb loss in the United States. Among those living with limb loss, the main causes are vascular

disease (54 percent) – including diabetes and peripheral arterial disease – trauma (45 percent) and cancer (less than 2 percent). Approximately 185,000 amputations occur in the United States each year. In 2009, hospital costs associated with amputation totaled more than $8.3 billion. African Americans are up to four times more likely to have an amputation than white Americans. Similarly, Latinx Americans are 1.5 times as likely to suffer an amputation as white Americans. This is higher than the five-year mortality rates for breast cancer, colon cancer, and prostate cancer. Of patients with diabetes who have lower extremity amputation, up to 55 percent will require amputation of the second leg within 2-3 years. Without a reasonable reimbursement methodology rate for "prosthetic and orthotic appliances" in the Medi-Cal program, socially vulnerable patients will continue to struggle with accessing care and suffer from ongoing mobility and independence challenges.

Panel Discussion. The subcommittee has requested representatives from the following organizations to serve as panelists to discuss the Administration's proposed MCO tax and provider rate increases, as well as alternative investments utilizing MCO tax revenue:

Panel 1:
- **California Medical Association (CMA)**
- **California Hospital Association (CHA)**
- **Planned Parenthood Affiliates of California**
- **California Primary Care Association (CPCA)**
- **Service Employees International Union – CA (SEIU-CA)**
- **Local Health Plans of California (LHPC)**
- **California Association of Health Plans (CAHP)**
- **California Association of Public Hospitals (CAPH)**

Panel 2:
- **California Association for Health Services at Home (CAHSAH)**
- **California Association of Adult Day Services (CAADS)**
- **Congregate Living Health Facilities Association**
- **The Children's Partnership (TCP)**
- **California Pan-Ethnic Health Network (CPEHN)**
- **Western Center on Law and Poverty (WCLP)**
- **California Chiropractic Association (CalChiro)**
- **California Orthotic and Prosthetic Association (COPA)**

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DHCS and panelists to respond to the following:

DHCS

1. Please provide an overview of the types of reimbursement codes and other investments included in the 2024 provider rate increases and investments package.

2. Please provide a brief overview of each of the proposed categories of investment described in the department's targeted rate increases policy paper.

3. Please provide a brief overview of the Community and Hospital Outpatient and ED Facility Services changes, particularly the transition to the OPPS.

4. Does the department have any additional details on the Behavioral Health Throughput and Medi-Cal Workforce Pool portions of the proposal?

5. Please describe how the department plans to implement the equity adjustments to the provider rate increases. How will these adjustments support the goals stated in the policy paper of improving access in areas with provider shortages or other challenging social drivers of health?

6. Please describe how these proposed rate increases would impact providers in the Hearing Aid Coverage for Children Program (HACCP).

CMA:

1. Please describe how CMA members, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax.

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

CHA:

1. Please describe how CHA members, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax.

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. How would the Administration's hospital-related reimbursement proposals impact the financial sustainability of distressed hospitals?

4. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

CAPH:

1. Please describe how CAPH members, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax.

2. In particular, how would the investments related to designated public hospitals improve the financial sustainability of public hospitals that serve a high proportion of Medi-Cal beneficiaries?

3. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

4. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

Planned Parenthood:

1. Please describe how Planned Parenthood clinics, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax.

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

4. How would Planned Parenthood clinics utilize these resources to improve the availability of abortion services for Californians and individuals traveling to California from nearby states with restrictive or uncertain legal landscapes for abortion services?

CPCA:

1. Please describe how CPCA member clinics, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax.

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

4. Please describe the impacts on clinic finances of the transition of the supplemental payment pool, including the proposed MCO tax investments, to a directed payment.

SEIU-California:

1. Please describe how SEIU members, as well as the Medi-Cal program generally, would benefit from the Administration's proposed targeted rate increases and investments from the MCO tax, including both the Medi-Cal Workforce Pool proposal and reimbursement rate increases more generally.

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

Local Health Plans of CA:

1. Please describe how local health plans have implemented, in the case of 2024 rates, and will implement, in the case of 2025 rates, the provider reimbursement rate increases in the Administration's proposal?

2. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

3. Has the availability and potential future availability of these resources affected rate negotiations with network providers?

4. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

CAHP:

1. Please describe how Medi-Cal managed care plans have implemented, in the case of 2024 rates, and will implement, in the case of 2025 rates, the provider reimbursement rate increases in the Administration's proposal?

2. Has the availability and potential future availability of these resources affected rate negotiations with network providers?

3. Have there been any challenges with implementation of the previously approved rate increases in 2024 that the department should avoid when implementing the 2025 investments?

4. Are there any adjustments to the Administration's proposal that you believe would better improve access to care, quality of care, or equity, for Medi-Cal beneficiaries?

PDN Coalition (CAHSAH):

1. Please describe the updated proposal to increase reimbursement for private duty nursing presented to the subcommittee during last year's budget process.

2. How would increased reimbursement for private duty nursing improve the ability for medically complex and vulnerable pediatric and adult Medi-Cal patients to remain stably in a home- or community-based setting?

3. Please describe how lack of available private duty nursing services impacts hospital inpatient stays and discharge planning.

CAADS:

1. Please describe the proposed rate increase and other reform proposals related to Community-Based Adult Services (CBAS).

2. How would these proposals improve the financial stability of CBAS centers and expand access to CBAS services for Medi-Cal beneficiaries?

CLHF Association:

1. Please describe the proposed adjustment to daily rates for Congregate Living Health Facilities (CLHFs).

2. How would this proposed adjustment improve the financial stability of CLHFs, and improve access to CLHF services for medically fragile Medi-Cal beneficiaries?

3. Please describe the role CLHFs play in providing discharge options for medically fragile individuals in hospital inpatient settings.

CPEHN:

1. Please provide CPEHN's analysis of the adequacy and effectiveness of the equity adjustment included in the Administration's proposal.

2. What changes or improvements could be made to the Administration's equity adjustments to accomplish their stated goals of addressing geographic shortages in access to equitable health care, and addressing the social drivers of health?

3. How could DHCS improve its methodology for identifying and/or investing in reducing disparities in delivery of health care to Medi-Cal beneficiaries with these resources?

The Children's Partnership:

1. Please describe how multi-year continuous eligibility for children ages 0-5 would improve access to, and continuity of, care for California's children.

2. Given the billions of dollars of investments in Medi-Cal proposed through the MCO tax, does the coalition supporting this proposal believe it would be reasonable for the Department of Finance to conclude that resources are not available to implement this proposal at May Revision?

Western Ctr on Law and Poverty:

1. Please describe how reforming the maintenance need income level to calculate "share of cost" would expand eligibility and improve care options for California's seniors and persons with disabilities.

2. Given the billions of dollars of investments in Medi-Cal proposed through the MCO tax, does the coalition supporting this proposal believe it would be reasonable for the Department of Finance to conclude that resources are not available to implement this proposal at May Revision?

California Chiropractic Association:

1. Please present the Association's proposal to restore the chiropractic benefit in Medi-Cal.

2. Please describe the barriers to accessing chiropractic services, for those for whom the benefit is still available, imposed by the two visit per month cap included in current regulations.

COPA:

1. Please present the Association's proposal to increase Medi-Cal reimbursement rates for orthotics and prosthetics providers using MCO tax resources.

2. Does the Association have an estimate of how many providers would expand services for Medi-Cal beneficiaries if provided a reimbursement rate increase?

3. Please describe how improving access to orthotics and prosthetics services helps improve quality of life for patients in need and avoid utilization of more costly medical services.