CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

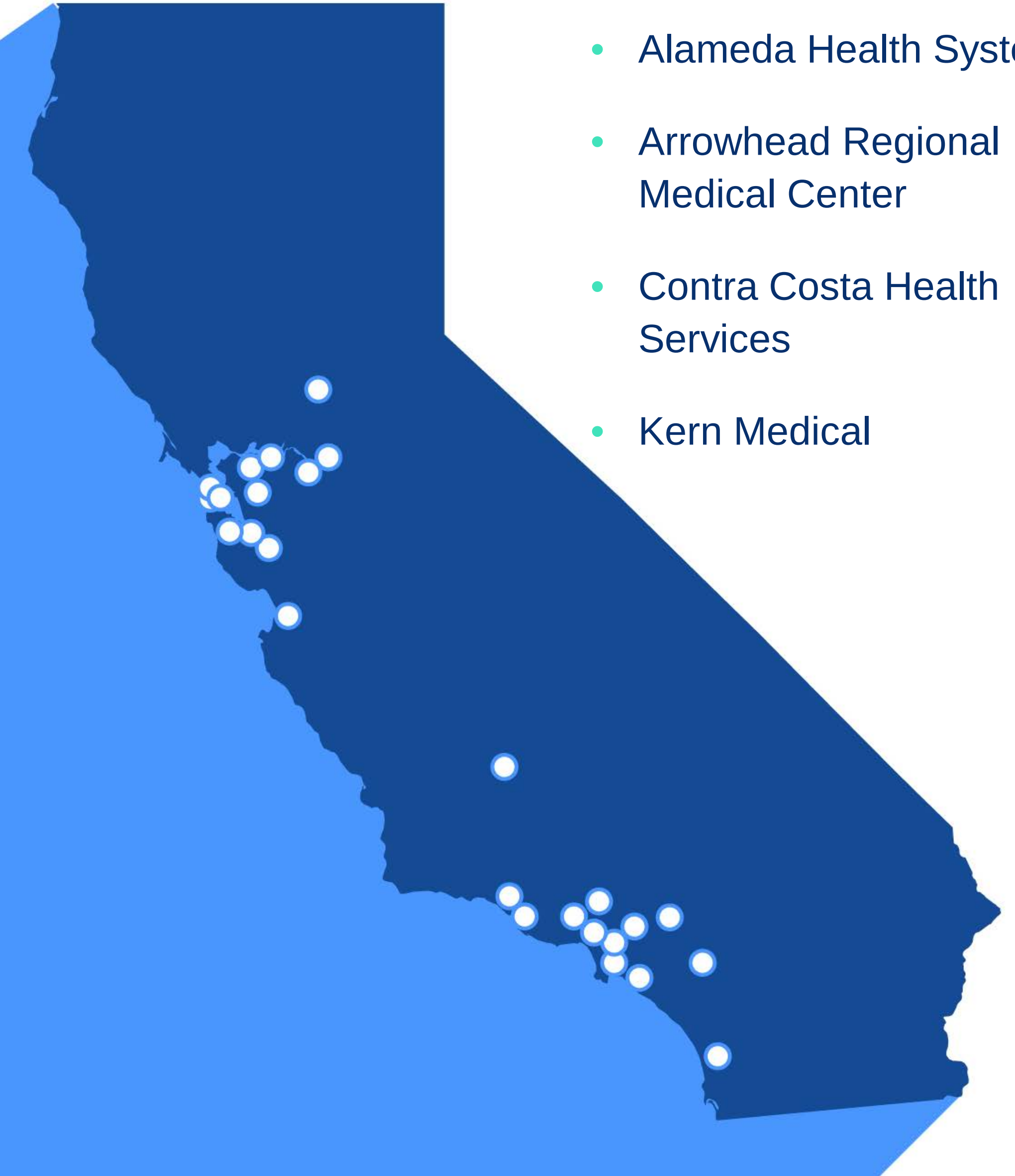
MCO Tax Importance to PHS and Our Looming Financial Challenges

Erica Murray, President & CEO

Testimony to Senate Budget Subcommittee 3

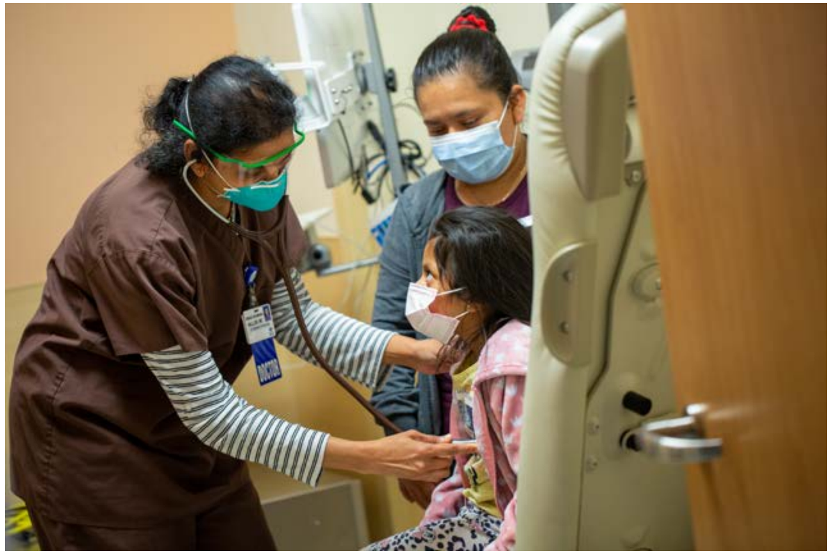
April 18, 2024

California's 21 Public Health Care Systems



- Alameda Health System
- Arrowhead Regional Medical Center
- Contra Costa Health Services
- Kern Medical
- LA County Department of Public Health Services
  - Harbor/UCLA Medical Center
  - Los Angeles General Medical Center
  - Olive View/UCLA Medical Center
  - Ranchos Los Amigos National Rehabilitation Center
- Natividad Medical Center
- Riverside University Health System
- San Francisco Department of Public Health
  - Zuckerberg San Francisco General
  - Laguna Honda Hospital and Rehabilitation Center
- San Joaquin General Hospital
- San Mateo Medical Center
- County of Santa Clara Health System
- Ventura County Health Care Agency
- UC Health
  - UC Davis Health
  - UC Irvine Health
  - UC San Diego Health
  - UC San Francisco Health
  - UC Los Angeles Health

The Value of Public Health Care Systems



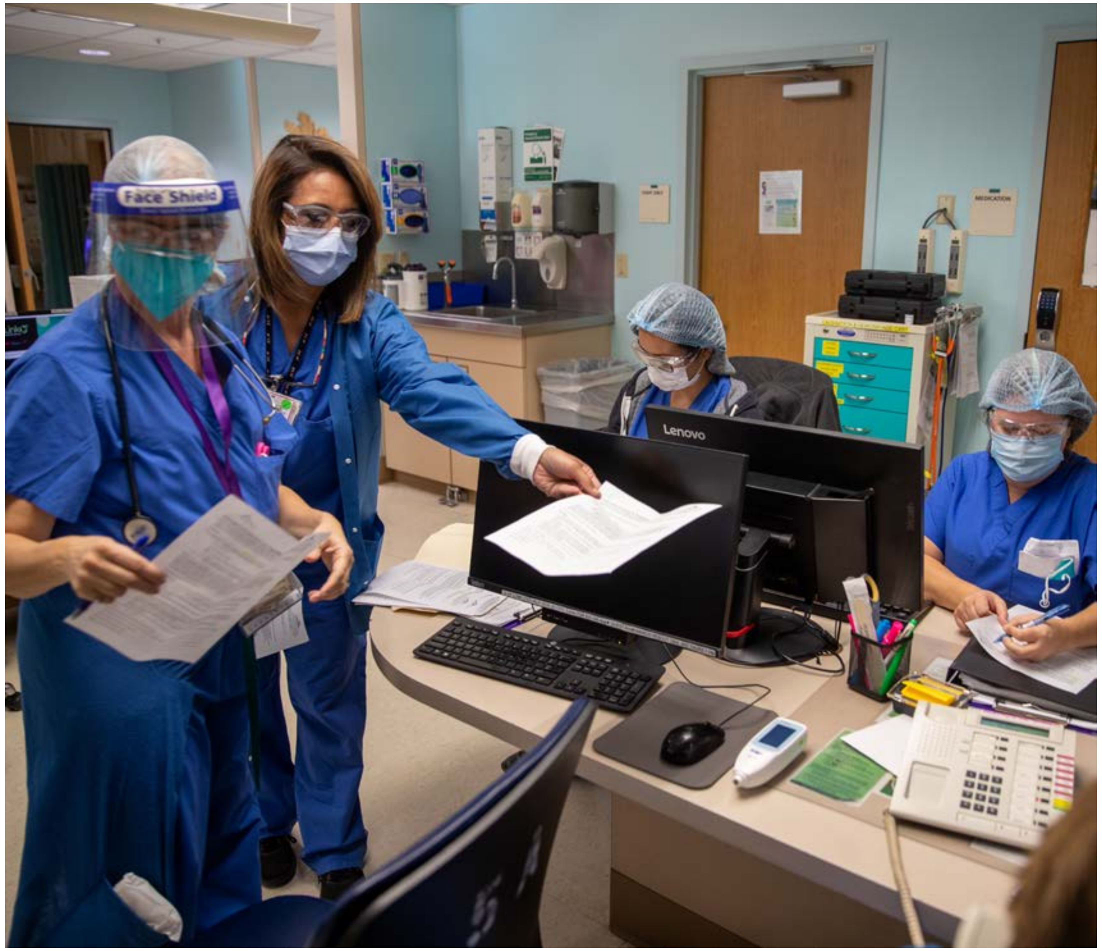
For Communities:

- **Major Providers of Medi-Cal**:
  - Section 17000 mission/mandate to provide indigent care
  - **6%** of all hospitals providing a **third** of all hospital Medi-Cal services
- **Experts** in meeting needs of low-income patients in historically marginalized communities
  - Offer the continuum: primary/specialty care, behavioral health, and coordinate to address social drivers of health
- **Half** of all trauma centers statewide

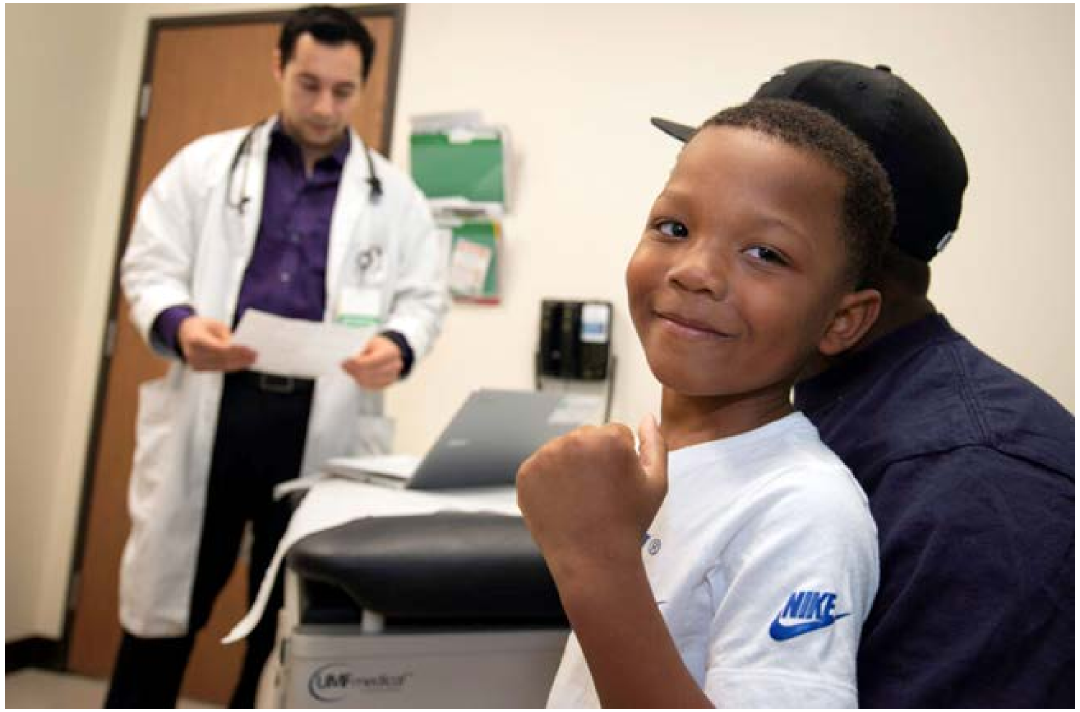
The Value of Public Health Care Systems

For the Health Care Workforce:

- Train half of all physicians in hospitals statewide
- Prioritize workforce diversity to reflect our patient population
- Frequently hire new graduates



The Value of Public Health Care Systems



For the State:

- **Key Drivers & Implementers of Legislative and Administrative Initiatives & Priorities**
  - Pandemic Response
  - CalAIM
  - Street Medicine/Homeless Services
- **Step In to Provide Access When Needed**
  - e.g., St. Louise, O'Connor, Madera, Tri City, El Centro, new acquisitions
- **Major Source of Financing for Medi-Cal**

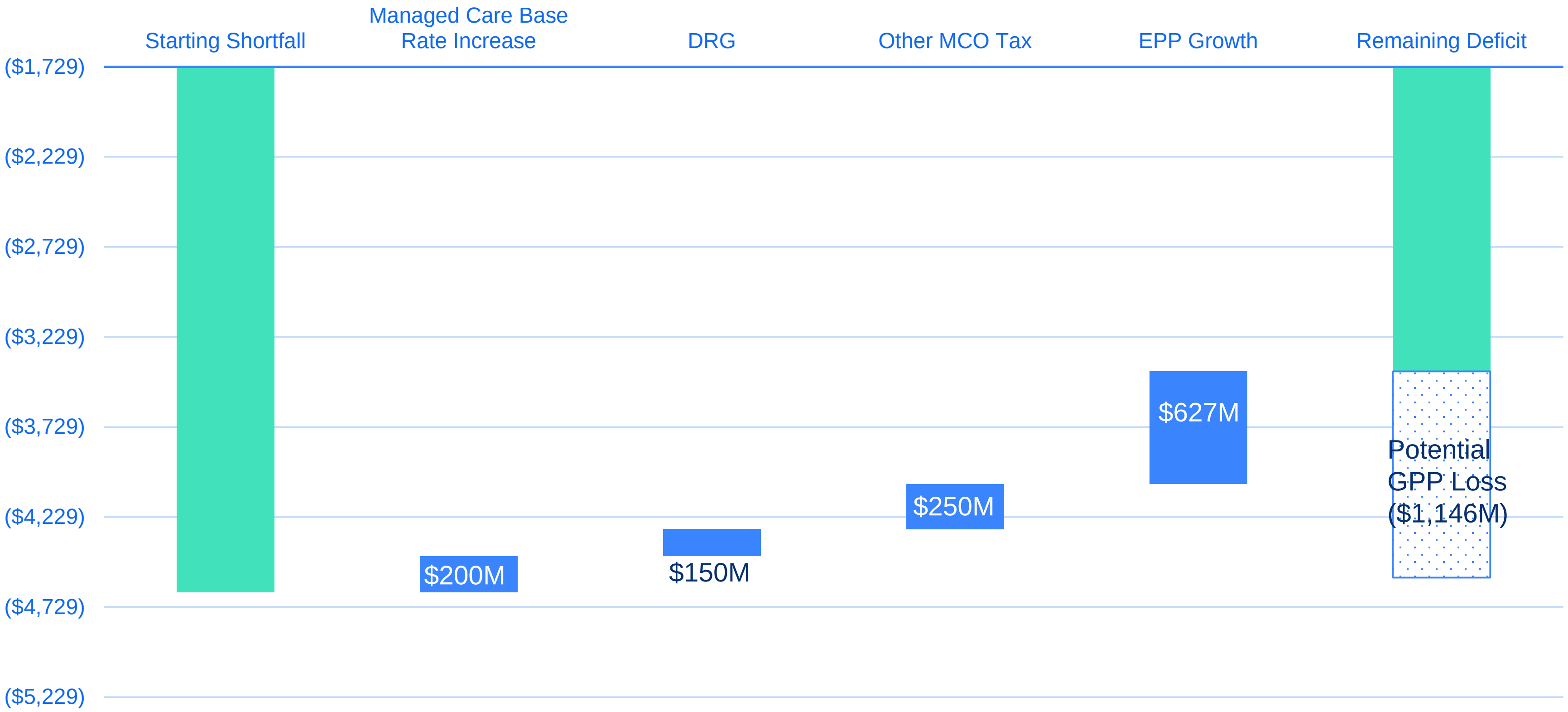
MCO Tax: $150 million for Public Health Care Systems (PHS)

- Dedicated funding for PHS for 2 reasons:
    1. Most PHS primary care services are provided in FQHCs, which will not benefit from the $291 million (starting in 2024) nor the $975 million (additional, starting in 2025) physician and non-physician professional care bucket
    2. Reflection of continued efforts with DHCS to address our $4+ billion structural deficit
- Concerns Re Elimination of Cost-Based Supplemental; Hope to see revisions in May

MCO Tax: other funding buckets

- Other MCO Tax buckets that reflect care provided by PHS and PHS should receive funding from:
    - **Community and Hospital Outpatient Procedures and Services;**
    - **ED Facility and ED Professional Services**
    - Graduate Medical Education
    - Behavioral health throughput
    - Abortion/Family Planning Access
    - Primary and Specialty Care (for non FQHC and CBRC clinics);
    - Services and Supports for FQHCs and RHCs

PHS Shortfall and Potential Solutions to Address It



Notes on Series:

1. Managed Care Base Rate Increases: Our members are in the process of negotiating base rate increases for 2025 and beyond.
2. DRG: This is the MCO Tax portion that will be used to make a PHS specific DRG-based payment for inpatient fee-for-service Medi-cal.
3. Other MCO Tax: This is an estimate on the potential impact of other MCO Tax initiatives on PHS Finances.
4. Enhanced Payment Program (EPP) Growth: DHCS has been working with PHS to grow the size of our EPP in CY2024 and CY2025, this is an estimate of potential growth.
5. Potential Global Payment Program (GPP): this is the estimated loss to PHS if the GPP is not extended

CAPH SNI