January 10, 2022

The Honorable Jim Wood
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Assembly Member Wood:

As a follow-up to CHBRP's analysis of Assembly Bill (AB) 1400, on December 9, 2021, the Assembly Committee on Health requested CHBRP provide a letter to assist in its consideration of potential implications of AB 1400. In particular, CHBRP was asked to look at assumptions/estimates for the following services if reimbursement rates were paid at Medicare rates:

(1) Long-term services and supports (LTSS)
(2) Inpatient hospital services
(3) Physician services
(4) Dental services

On March 3, 2021, the California Assembly Committee on Health requested that CHBRP complete a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. This limited analysis synthesized various robust studies and research to support consideration of the fiscal and policy implications of AB 1400 for California. CHBRP's prior analysis of AB 1400 may be accessed here.

The first item the Committee asked CHBRP's assistance with is the following:

a. Using 2018 estimates that Medi-Cal spent $16.2 billion on long-term care supports and services, CHBRP was asked to extrapolate this $16.2 billion figure into a Medicare fee-for-service (FFS) rate to illustrate the scale or difference in projected expenditures the increase in the reimbursement rates might be. Further, CHBRP was asked to trend such estimates forward to 2022, if possible. The Committee understood that Medicare only covers skilled nursing facilities (SNFs) but noted that a reasonable estimate/scenario would be helpful as an illustration.

Background on Long-Term Care Utilization and Estimates:

Approximately 100,000 Californians received long-term care services through certified nursing facilities in 2019.[1] The majority of residents were Medi-Cal enrollees (62%), whereas 15% had Medicare coverage, and 23% had private or other coverage (including self-pay). Medicare limits reimbursement for long-term care for rehabilitation services after a hospital stay, such that the burden of custodial long-term care falls upon Medi-Cal, private long-term care insurance, and out-of-pocket spending by individuals and/or their families. CHBRP reminds the Committee that as introduced, AB 1400 would greatly enhance the coverage for long-term care services throughout the state, but it would not only cover the costs from existing payers, it would likely subsidize families providing or financing caregiving on their own who do not currently benefit from one of the existing coverage programs.

CHBRP noted in its analysis of AB 1400 in the Spring of 2021 that "it is difficult to project the fiscal impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide due to lack of measurable data, availability of long-term care supply, and how informal caregivers would respond to AB 1400." Long-term care affects people of all ages and is a major driver of spending in public programs, namely Medicare and Medicaid. People with long-term care needs often go without appropriate or preferred care, and this places burdens on families due to excessive caregiving and financial responsibilities. Twenty percent of adults with long-term care needs who reside in their community are unable to access the care they need.[2,3] CHBRP's report also noted that the projected demographics of our aging population will add additional upward pressure on LTSS services in the next 1 to 2 decades.

Finally, CHBRP notes that the State of California currently administers LTSS, which provides long-term care services delivered through skilled nursing facilities, in-home supportive services, home and community-based services, community-based adult services, and a variety of other mechanisms. However, not all of the programs listed above are under the Medi-Cal umbrella; some are controlled and funded by the Department of Aging, the Department of Developmental Services, or the Department of Social Services. Although the Medi-Cal fee-for-service program spent approximately $16.2 billion on long-term care in 2018, there were other sources of services and spending for LTSS in the state.[4] In addition, *it is estimated that another $8.4 billion was*

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[1] Kaiser Family Foundation (KFF). State Health Facts: Total Number of Residents in Certified Nursing Facilities. 2019. Available at: https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/. Accessed April 20, 2021.

[2] Feder J, Komisar HL, Niefeld M. Long-term care in the United States: an overview. *Health Affairs (Millwood).* 2000;19(3):40-56.

[3] LTSS services can provide assistance with activities of daily living (ADL), which include eating, dressing, and bathing. LTSS also provides supports for instrumental activities of daily living (IADLs), which include tasks like housekeeping and financial management. LTSS is designed to help people with disabilities function in their daily lives, and leverages LTSS providers that include informal, unpaid support and formal, paid caregivers. LTSS can be delivered in different settings, such as intermediate care facilities for those with developmental disabilities, nursing homes for custodial care and rehabilitation patients, and community-based services (e.g., adult day services, assisted living).

[4] California Health Care Foundation (CHCF). Health Care Costs 101: U.S. Spending Growth Relatively Steady in 2018. California Health Care Almanac. 2020. Available at: https://www.chcf.org/wp-content/uploads/2020/05/HealthCareCostsAlmanac2020.pdf. Accessed January 1, 2022.

spent for long-term care in Medicare in 2017,[5] and an unknown amount was spent by individuals or their private long-term care insurance policy.

CHBRP Modeling of the $16.2 billion:

The 2019 Milliman Consolidated Health Sources Database (CHSD) data provide some insight to build a rough estimate of the following average costs for skilled nursing facility days by payer type in California. Note that these summaries reflect the same set of revenue codes for skilled nursing, though the mix by procedure code and diagnosis (reason for visit or intensity of services) may vary across payer type.

The Milliman data that CHBRP accessed illustrate that the average reimbursement for commercial group and individual membership for skilled nursing facility days is as follows.

Table 1. Reimbursement Rates by Payer for Long-Term Care and Home Health

Service Type	Medi-Cal Managed Care Rate	Commercial Payment Rate	Medicare (Original & Medicare Advantage)	Units of Services
Skilled nursing facility	$231 (~53% of Medicare)	$732	$435	Allowed per day

Source: California Health Benefits Review Program, 2022.

For this illustrative exercise, we used CMS expected health trend rates for Medicaid (2018-2027)[6] to apply on the $16.2 billion figure spent in Medi-Cal, from 2018 to 2022. Using an annual trend of 5.5%, the $16.2 billion in expenditures would trend to $17.1 billion in 2019, $18.0 billion in 2020, $19.0 billion in 2021, and $20.1 billion in 2022. Thus, our basis of comparison from the $16.2 billion in 2018 would be **$20.1 billion** in 2022, trended forward.

California spent roughly $3 billion for nursing home care in 2020.[7] Trending to 2022 at a 5.5% annual trend rate produces an estimate spend of $3.3 billion for nursing home care in 2022. If one uses the observed relationship that Medi-Cal reimburses approximately 53% of Medicare reimbursement levels for skilled nursing facility services to create a "proxy Medicare LTSS rate," then a very rough estimate of California's spend for nursing home care in 2022 at Medicare reimbursement levels would be approximately **$6.2 billion**.

[5] California Health Care Foundation (CHCF), Philip S, Mulkey M. Key Questions When Considering a State-Based, Single-Payer System in California. November 2017. Available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-KeyQuestionsSinglePayer.pdf. Accessed January 6, 2022.
[6] CMS. National Health Expenditure Data. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData. Accessed January 6, 2022.
[7] Kaiser Family Foundation. Distribution of Fee-for-Service Medicaid Spending on Long Term Care. 2020. Available at: https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed January 7, 2022.

Home health services account for roughly six times the expenditures spent (over nursing home care) in Medicaid in California,[8] or $19 billion in 2020. Trending out to 2022 at 5.5% annual trend produces an estimated spend of $21.2 billion for home health services in 2022. Estimates of Medi-Cal relativities to Medicare are challenging for several reasons, including the bundled payment structure used for Medicare and differences in services covered between Medi-Cal and Medicare. Work by Zuckerman et al. (2021)[9] estimates that California's Medi-Cal payments for physician services were 73% of Medicare, CHBRP believes that this is a reasonable assumption to use for this calculation given the limitations just described. If one uses the observed relationship that Medi-Cal reimburses approximately 73% of Medicare reimbursement levels for professional services to create a proxy Medicare rate for all home health services, then a reasonable estimate of California's spend for home health services for Medi-Cal members in 2022 at Medicare reimbursement levels would be approximately **$29.0 billion**.

In aggregate, trending the $16.2 billion estimates from 2018 in current Medi-Cal spending to 2022 (which would be $20.1 billion), accounting for trend and reimbursement level increases, projections for both home health and nursing home care could be **$35.3 billion in 2022** (accounting for rounding)**.**

Table 2. 2022 Estimated Projections Medi-Cal LTSS Spending to 2022 at "Proxy Medicare Reimbursement Rates"

Service Type	2022 Medi-Cal	2022 Medicare LTSS Rate	Total
Medi-Cal fee-for-service long-term care expenditures ($16.2 billion trended forward to 2022)	$20.1 billion		
Nursing home care	$3.34 billion	$6.2 billion	
Home health services	$21.2 billion	$29.0 billion	
Projected total home health and nursing care spending using "Medicare Rates"			**$35.3 billion**

Source: California Health Benefits Review Program, 2022.

The second item the Committee asked CHBRP's assistance with is the following:

[8] CMS. National Health Expenditure Data. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData. Accessed January 6, 2022.
[9] Zuckerman S. Medicaid physician fees remained substantially below fees paid by Medicare in 2019. February 1, 2021. *Health Affairs Journal*. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611. Accessed January 6, 2022.

b. The Assembly Committee on Health requested that CHBRP provide a further illustration of the following assumption: "If we assume that an additional 10% of the population would get LTSS under AB 1400 – how much would this estimate be? Assumptions are fine."

Using our estimates for home health and nursing home care for 2022 ($29.0 billion estimated earlier in this letter and $6.2 billion, respectively), and assuming an additional 10% of the population gets LTSS under AB 1400 (we'll assume at a similar ratio of service utilization as baseline), then **that estimate would be $38.83 billion in 2022, or an additional $3.53 billion.**

The third item the Committee asked CHBRP's assistance with is the following:

c. Provider Rates – assuming provider rates will be at Medicare FFS – Can CHBRP provide any estimate/assumption on:
   - Hospital Care – CHBRP was asked if CHBRP could get the latest spend (2018 or 2019, for example) on inpatient hospitalization; and, what would the estimate be if Medi-Cal spend were raised to Medicare FFS rate.[10]

According to a Medicaid and CHIP Payment Access Commission (MACPAC), Medicaid programs typically exceed Medicare rates for inpatient services once supplemental payments are included in the calculation. States typically have a base Medicaid inpatient FFS rate that is lower than Medicare but is enhanced through additional payments to hospitals over a specific period of time[11] (MACPAC, 2021). These types of supplemental payments include Disproportionate Share Hospital (DSH), indirect Graduate Medical Education (GME), and uncompensated care pool payments. Medicare's Upper Payment Limit (UPL) acts as a cap for payments to ensure hospitals are not overpaid for inpatient services, such that making Medicaid DRG payments equivalent to Medicare would potentially shrink the magnitude of supplemental payments and **would not result in large increases in overall spending in the Medicaid program.** According to another MACPAC study, aggregate reimbursement for Medicaid inpatient services often exceeds Medicare once supplemental payments are factored in (MACPAC, 2017). Furthermore, changing the base Medicaid rate could alter the mix of state share and federal matching funds paying for those services.

California has approximately 13.6 million Medi-Cal beneficiaries and 6.4 million Californians enrolled in Medicare (CHCF Almanac, 2021). 1.4 million Californians (seniors and people with disabilities) are "dually eligible" between the two programs.

[10] CHBRP interpreted "hospital care" to be inpatient care only and excluded outpatient facility fees (which often have a physician component included in the next section) from the hospital care calculation).
[11] MACPAC. Medicaid Base and Supplemental Payments to Hospitals. June 3, 2021. Available at: https://www.macpac.gov/publication/medicaid-base-and-supplemental-payments-to-hospitals/. Accessed January 6, 2022.

The fourth item the Committee asked CHBRP's assistance with is the following:

d. Commercial – CHBRP was asked to please provide an estimate if commercial spend is lowered to Medicare FFS rate. And, adjust for inflation to come up with 2022 assumption/estimate, if possible

Based on recent work, the difference between Medicare and commercial inpatient hospitalization reimbursement is significant. Kaiser Family Foundation analysis suggests that commercial insurers pay rates ranging from 160% to 250% of Medicare. On average, commercial rates are double that of Medicare. Based on $104 billion in spending on private insurance in California in 2014, and 36% of those services being hospital-based, we would anticipate that the $37.44 billion in hospital spending would drop to $18.72 billion in 2014 dollars if payment rates were halved by AB 1400. **Once inflated for 2022 dollars, the total hospital spending would be reduced by $22.3 billion for a total of $22.3 billion in spending.**

The fifth item the Committee asked CHBRP's assistance with is the following:

e. Physician and clinical services spend – if we get the latest spend on physician and clinical services spend:
   - Medi-Cal – What would be the estimate if Medi-Cal spend is raised to Medicare FFS rate.
   - Commercial – What would be the estimate if commercial spend is lowered to Medicare FFS rate.
   - Adjust for inflation to come up with 2022 assumption/estimate, if possible.

Recent work by Zuckerman et al. (2021)[12] estimates that California's Medi-Cal payments for physician services were 73% of Medicare. The Medicaid-to-Medicare payment ratio varies by service type, with the ratio being worse for obstetric services (61%) and better for primary care (76%). It is notable that in 2016, the Medicaid-to-Medicare payment ratio was only 0.52 (Zuckerman et al., 2017).[13] However, recent increases in the Medi-Cal primary care fee schedule due to the passage of Proposition 56, which added supplemental payments for over twenty evaluation and management-focused CPT codes. Implementation of the supplemental payments started in July 2017. If we assume that, on average, Medi-Cal Managed Care Plan (MMCP) payments to physicians are equivalent to the Medi-Cal Physician Fee Schedule, we would need to multiply current physician spending in Medi-Cal by 137% to estimate the total cost of

[12] Zuckerman S. Medicaid physician fees remained substantially below fees paid by Medicare in 2019. February 1, 2021. *Health Affairs Journal*. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00611. Accessed January 6, 2022.
[13] Zuckerman S, Skopac L, Epstein M. Medicaid Physician Fees after the ACA Primary Care Fee Bump. March 2017. Available at: https://www.urban.org/sites/default/files/publication/88836/2001180-medicaid-physician-fees-after-the-aca-primary-care-fee-bump_0.pdf. Accessed January 7, 2022.

physician fees under the Medicare Outpatient Prospective Payment Fee Schedule. Based on Kaiser Family Foundation's State Health Facts, California's total Medi-Cal spending from all sources was $88.74 billion in fiscal year 2020[14]. Based on 2014 data from CMS, physician services represented 15% of spending in Medi-Cal.[15]

Thus, $88.74 billion × 15% for physician services only × 37% = $18.24 billion total, which is an additional $4.93 billion in new spending in 2020 dollars.

If we were to inflate 2020 dollars to 2022 dollars using a low 1.74% annual medical Consumer Price Index (CPI) (which was the increase from November 2020 to November 2021), there would be $5.02 billion additional spending due to increasing the Medicaid Fee Schedule to be equivalent to Medicare for physician services only.

However, this rough calculation would ignore the Medi-Cal physician services delivered through federally qualified health centers (FQHCs) and look-alikes, which obtain cost-related reimbursement for their care, which already equals or exceeds the typical Medicare fee for equivalent services. If we remove the $4 billion in Medi-Cal–related collections for FQHC-provided patient services[16] from physician services spending in Medi-Cal, total current spending on physician services would be reduced to $9.3 billion; and increasing it by 137%, based on the Medicaid-to-Medicare payment ratio (Zuckerman et al., 2021), we would estimate $3.44 billion additional spending in Medi-Cal for a total of $12.74 billion in non-FQHC physician services spending. In 2022 dollars, that represents $3.57 billion in additional physician services spending for a total of $13.2 billion.

Commercial health insurance represents the majority of insured individuals in the state. Physician reimbursement rates in commercial insurance products exceed typical Medicare and Medicaid payments. Based on analysis by the Health Care Cost Institute, California's health insurers pay approximately 129% of Medicare for physician services. If reimbursement rates for commercially insured patients were reduced to Medicare levels due to AB 1400, the reduction in fees paid would result in $9.33 billion fewer dollars spent if the actual use of services were held constant and the reduction in fees did not change physician availability or consumer use of services. However, the actual spending change associated with reducing commercial fees to Medicare levels is unpredictable and would be influenced by physician response (i.e., delivering and providing additional services to recover lost revenue in a FFS environment) and consumer utilization of lower priced services due to lower coinsurance/copayments (i.e., potential induced demand).

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[14] Kaiser Family Foundation. Distribution of Medicaid Spending by Service. 2020. Available at: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed January 7, 2022.

[15] Kaiser Family Foundation. Distribution of Medicaid Spending by Service. 2020. Available at: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed January 7, 2022.

[16] Bureau of Primary Health Care, Health Resources and Services Administration. Uniform Data System Table 9D for FQHCs located in California, 2020. Available at: https://data.hrsa.gov/tools/data-reporting/program-data/state/CA/table?tableName=9D.

According to data from the California Health Care Foundation (CHCF),[17] (private health insurance spending was $104 billion in 2014. Based on the same report, approximately 26% of spending overall was on physician services, resulting in $27 billion spent on physician services in 2014. If we reduced that spending by 29% to reflect a reduction in commercial rates to Medicare rates, the amount would decrease to $19.2 billion for a reduction of $7.83 billion in 2014 dollars. In 2022 dollars (adjusted using the Medical CPI from 2014 to 2021 to trend forward), this would be equivalent to $9.33 billion in savings due to reduced commercial rates if we assume no changes in consumer utilization, physician availability, or physician response due to the reduction in physician fees.

The sixth item the Committee asked CHBRP's assistance with is the following:

f. Regarding dental services, CHBRP was asked to provide an estimate on how much Denti-Cal spend might increase if California were to use a "Medicare FFS rate". The Committee noted its understanding that Medicare does not generally cover dental services, but asked CHBRP if we could provide some assumptions on dental using available data.

In 2019-20, dental benefits constituted 1% of the total Medi-Cal budget of $94.7 billion, or approximately $9.5 billion.[18] Trended to 2022 at 4% annual trend, this would be approximately $9.85 billion.

Denti-Cal reimburses providers approximately 65% of what commercial plans reimburse providers for child dental services and approximately 87% for adult dental services.[19] Note that California's Denti-Cal reimbursement relative to commercial may look closer than in other states because of the prevalence of dental HMOs in California. In particular, dental HMOs are more widely offered than other states, so this unit-cost relativity is not generalizable to other states. We do not have a meaningful estimate for how Denti-Cal costs are distributed among adults and children, so we are simply averaging the reimbursement rates using a straight average, for an average Denti-Cal reimbursement of 76% of commercial reimbursement rates.

Because Medicare doesn't cover dental services, there's not a well-defined reimbursement level for dental for Medicare beneficiaries. Some Medicare Advantage plans do cover dental benefits. Our professional opinion is that it is reasonable to assume that commercial is approximately 120% of "proxy Medicare dental reimbursement levels."

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[17] https://www.chcf.org/publication/california-health-care-spending/

[18] California Health Care Foundation. *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*. California Health Care Almanac. Available at: https://www.chcf.org/wp-content/uploads/2021/08/MediCalFactsFiguresAlmanac2021.pdf. Accessed January 7, 2022.

[19] Gupta N, Yarbrough C, Vujicic M, Blatz A, Harrison B. Medicaid fee-for-service reimbursement rates for child and adult dental care services for all states, 2016. Health Policy Institute Research Brief. Chicago, IL: American Dental Association, Health Policy Institute; 2017.

If Denti-Cal were reimbursed at proxy Medicare dental reimbursement levels, the 2022 annual spend of **$9.85 billion would increase to $10.8 billion** ($9.85 billion / 76% Denti-Cal relativity to commercial / 120% commercial relativity to proxy Medicare).

Currently, Denti-Cal has a coverage cap. It will only provide up to $1,800 in covered services per year for adults. Some services are not counted toward the cap, such as dentures, extractions, and emergency services. Many commercial plans have caps of $1,500 per year.

CHBRP is unable to make further projections on Denti-Cal given the limited experience, pent-up demand, and uncertainty over how the market would respond to changes in reimbursement rates.

Thank you for allowing CHBRP the opportunity to further assist. We are happy to answer any questions.

Sincerely,

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