AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

MONDAY, APRIL 8, 2013

4:00 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

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4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: AFFORDABLE CARE ACT & "STATE-ONLY" PROGRAMS

The Administration is proposing to restrict eligibility for various "state-only" health programs, described below, by requiring that, beginning January 1, 2014, only individuals who cannot obtain comprehensive health coverage through the Health Benefits Exchange will remain eligible for these programs. The January budget assumes no savings as a result of this proposed restriction.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Stakeholders
- Public Comment

BACKGROUND

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law (Public Law 111-148) based on the vision and determination to extend access to health care and health insurance coverage to millions of Americans. Depending on how California chooses to implement the ACA, it has the potential to extend insurance coverage to millions of Californians in 2014 through an expansion to the Medi-Cal program, simplifications to Medi-Cal, and through the California Health Benefit Exchange (the Exchange, now named Covered California). It is estimated that, based on full implementation of the ACA, approximately 90 percent of non-elderly Californians will have health coverage under the ACA, and the number of uninsured is projected to decrease by between 1.8 and 2.7 million by 2019.

The January budget framed the ACA implementation in the context of two Medicaid expansions: a mandatory expansion and an optional expansion:

- *Optional Expansion*. As signed into law, the ACA mandated all states to expand eligibility in state Medicaid programs to cover childless adults with incomes up to 138 percent of the federal poverty (FPL). Subsequently, the Supreme Court ruling made this provision optional. The Governor's Budget includes this expansion according to two options: a state-based expansion or a county-based expansion. This expansion was discussed by this Subcommittee on March 6, 2013.

- *Mandatory Expansion*. The ACA mandates various simplifications to state Medicaid programs, and the Administration refers to these simplifications as a "mandatory expansion," given that simplifications invariably lead to increases in enrollment and retention of currently-eligible individuals.

Both the optional expansion and the mandated Medi-Cal simplifications are addressed in AB 1 X1 (Pérez) and SB 1 X1 (Hernández and Steinberg). The Administration has not yet put forth any proposed language on the optional expansion, however the Administration's proposal to implement the simplifications (or "mandatory expansion") are contained in proposed amendments to SB 28 (Hernández, 2013). The Legislature has yet to adopt these amendments and therefore the language is not yet public (i.e., in print), though the Administration has shared it with legislative staff, advocates and stakeholders.

While the Administration's proposed SB 28 amendments contain the ACA-mandated simplifications, they also contain various other provisions that are not requirements of the ACA. One of these provisions, the subject of this part of today's hearing, creates enrollment restrictions on various "state-only" programs, programs that are funded primarily with state funds and do not receive federal matching funds. The Administration is proposing that any individual seeking services, or to enroll in, several state-only programs (named and described below), on or after January 1, 2014 must first seek coverage through the Exchange. Individuals covered through the Exchange will not be eligible for these programs, and only those individuals who cannot gain coverage through the Exchange will be considered eligible for these programs. Individuals enrolled in the programs as of December 31, 2013 will be unaffected, unless they leave the program and attempt to re-enroll after January 1, 2014, in which case they would be subject to this new restriction. The programs include:

Genetically Handicapped Persons Program (GHPP). The GHPP provides medical care for adults with specific genetically handicapping conditions, including Hemophilia, Cystic Fibrosis, and Sickle Cell Disease. There is no income limit for eligibility, but some enrollees are required to pay an annual enrollment fee that is based on family income. The GHPP also provides “wrap-around” services, such as case management, to individuals who are enrolled in Medi-Cal or commercial insurance coverage.

Breast and Cervical Cancer Treatment Program (BCCTP). The BCCTP pays for cancer treatment for eligible California residents with incomes below 200 percent of federal poverty who are screened by Every Woman Counts, or Family PACT and found to be in need of treatment for breast and/or cervical cancer.

Prostate Cancer Treatment Program (also known as IMPACT). The IMPACT pays for prostate cancer treatment for up to 12 months for certain low-income men who do not have other sources of health coverage. Treatment is available throughout California. Qualifying individuals are referred to participating doctors in the area where they live. The IMPACT is operated under contract by the University of California, Los Angeles.

Every Woman Counts (EWC). According to federal and state law, EWC is the payer of last resort and breast and cervical cancer screening services are limited to uninsured and/or under-insured women. In 2013-14, EWC is expected to serve about 312,500 women, a slight increase from the previous year's caseload of 298,700 women.

AIDS Drug Assistance Program (ADAP). The Administration anticipates a significant reduction in ADAP expenditures due to thousands of ADAP-only clients purchasing health insurance through the Exchange. This will reduce ADAP drug expenditures because ADAP will no longer pay the full cost of those ADAP medications. Some of the reduction in drug expenditures can be seen already in the four counties that chose to offer Low Income Health Program (LIHP) benefits to clients with incomes between 134 and 200 percent FPL. The Administration has stated that ADAP will continue to pay client private insurance prescription deductibles and co-pays, but it is unknown what proportion of these claims will be eligible for rebates

State-Only Medi-Cal for Newly Qualified Aliens. The federal government only pays for restricted benefits (e.g., emergency services) for certain populations that meet all Medi-Cal eligibility standards. In California, newly qualified aliens are eligible to receive full Medi-Cal benefits and the costs of the additional benefits are funded entirely with state General Fund. Newly qualified aliens will be eligible to purchase subsidized coverage through the Exchange beginning January 1, 2014.

STAFF COMMENTS/QUESTIONS

This proposal has raised concerns that this new policy will restrict access to these programs unnecessarily, and potentially harmfully, even in the context of a fully-operational Exchange and possibly an expansion to Medi-Cal. The spirit and intent of the ACA is to increase access to health care, and the Subcommittee is concerned that this policy might restrict access instead. Moreover, with or without this policy, these programs should experience substantial caseload shifts as a result of ACA implementation and the related-fiscal impacts should be reflected in the budget. The Subcommittee has asked DHCS to present this proposal and respond to the following:

1. When is the Administration planning to develop estimates of cost savings and caseload shifts that would occur as a result of this proposal?

2. When is the Administration planning to develop estimates of cost savings and caseload shifts that would occur, regardless of this proposal, as a result of the ACA leading to individuals becoming eligible for coverage under the Exchange as well as individuals transitioning into county LIHPs in 2013?

3. Please provide a comparison of the level of services that individuals will receive if they are covered through the Exchange as compared to the services currently provided in these specific programs, focusing on ADAP and GHPP.

4. Please describe how this policy would be implemented, operationally, in terms of the process for these programs to verify an individual's eligibility for coverage through the Exchange.

5. Please explain the urgency and justification for implementing restrictions on state-only programs now in 2013, as compared to in 1-2 years when much more is known about the Exchange, the Medi-Cal expansion, the LIHP transition, and all other aspects of ACA implementation?

6. Would any other programs be affected? I.e., is the Administration considering proposing changes to other state-only programs related to the implementation of the ACA?

7. Would anyone who currently receives any type of health care services through these or other state programs no longer have access to at least this level of care as a result of this or any other aspect of the Administration's ACA-implementation proposal?

Staff Recommendation: No action recommended

ISSUE 2: GROSS PREMIUMS TAX ON MANAGED CARE ORGANIZATIONS & TRAILER BILL

The Administration proposes trailer bill language that reestablishes, and makes permanent, the gross premiums tax (GPT) imposed on Medi-Cal managed care plans, retroactive to July 1, 2012 when the tax last sunset. The Administration estimates that this will generate approximately $136 million in General Fund savings in 2012-13 and $233 million in General Funds savings in 2013-14.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

AB 1422 (Bass), Chapter 157, Statutes of 2009 extended the State's existing 2.35 percent gross premium tax on insurance (all types) to Medi-Cal Managed Care Plans. This tax became effective January 1, 2009, and was then extended to July 1, 2011 by SB 853 (Budget and Fiscal Review Committee), Chapter 717, Statutes of 2010. Subsequently, AB 21 X1 (Blumenfield), Chapter 11, Statutes of 2011 extended the sunset date to July 1, 2012, and included provisions that made the extension of the tax inoperable should any eligibility changes be made to the Healthy Families Program.

Revenues from this tax are matched with federal funds and have been used to:

- Provide a reimbursement rate increase to Medi-Cal Managed Care Plans;
- Provide a reimbursement rate increase to health plans participating in the Healthy Families Program; and,
- Fund health care coverage for children through the Healthy Families Program.

The Administration proposes to direct tax revenue to the Healthy Families Program in the current year, consistent with past use of the revenue, and in the budget year and beyond the revenue would fund children's health services through the Medi-Cal program, given the elimination of the Healthy Families Program agreed to through the 2012 budget.

AB 1422, and subsequent bills extending the tax, required the State to allocate 38.41 percent of the tax revenue to DHCS to provide enhanced rates to Medi-Cal Managed Care Plans. The remaining 61.59 percent of the tax revenue went to the Managed Risk Medical Insurance Board for essential preventive and primary health care services through the Healthy Families Program. The Medi-Cal Managed Care Plans affected by the tax included: 1) Two Plan Model (Local Initiatives); 2) County Organized Health Systems (COHS); 3) Geographic Managed Care; 4) AIDS Healthcare; and, 5) SCAN.

Increases in caseload in Medi-Cal managed care plans result in increased revenue for managed care organizations, and therefore will increase revenue to the state from this tax. Therefore, implementation of the Affordable Care Act (ACA) can be expected to increase the amount of revenue generated by this tax. Specifically, simplifications to the Medi-Cal program, that are required by the ACA (and referred to by the Administration as the "mandatory expansion"), will increase caseload, and the Administration's GPT revenue estimate accounts for this increase. The ACA-created optional expansion to Medi-Cal (increasing eligibility to 138 percent of federal poverty for childless adults) would also increase caseload, however the Governor's Budget estimate does not account for this increase in the tax revenue. The Administration explains that this increase was not included in the estimate due to the fact that the increase would only be realized if the state implements the expansion at the state-level, and not the county-level, per the two implementation options proposed by the Governor in January. The structure for implementing the optional expansion has yet to be agreed to by the Governor and Legislature, and was discussed by this Subcommittee on March 6, 2013.

STAFF COMMENTS/QUESTIONS

The Legislative Analyst has raised no concerns with this proposal in its current form, however, the Administration indicates that they are working on some potential changes to this proposal that will be contained in the Governor's May Revision.

Staff Recommendation: Hold open pending potential developments in the May Revision.

ISSUE 3: MANAGED CARE EFFICIENCIES PROPOSAL

The Governor's January budget assumes savings in 2013-14 of $134,641,000 to be achieved by implementing efficiencies in the managed care program, which would be reflected in lower rates paid to managed care plans through the Medi-Cal program.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The Administration states that the proposed managed care efficiencies do not require new statutory authority to be implemented, however they have not yet provided specifics on the efficiencies. The impetus for this proposal is the ten percent provider rate reduction, approved through AB 97 (budget trailer bill) in 2011, that the Administration plans to implement beginning June 2013. The rate reduction will be retroactive to June 2011 for fee-for-service providers, however a retroactive reduction cannot be applied to managed care.

STAFF COMMENTS/QUESTIONS

The Administration indicates that they anticipate including a more detailed proposal in the Governor's May Revise. The Legislative Analyst recommends not approving of the savings until more information is provided on: 1) how the efficiency adjustments will be incorporated into managed care plan rates; 2) how the changes will reduce General Fund costs; and, 3) what impact the changes will have on quality of, and access to, care for Medi-Cal beneficiaries.

Staff Recommendation: Hold open pending additional information at May Revise.

ISSUE 4: ANNUAL OPEN ENROLLMENT PROPOSAL & TRAILER BILL

The DHCS is proposing trailer bill language that would change the enrollment model for Medi-Cal managed care beneficiaries who are enrolled in Two-Plan Model and Geographic Managed Care counties to an annual enrollment period; an enrollee could only change plans once a year as compared to monthly which is currently allowed. The January budget includes $2 million in savings ($1 million General Fund) as a result of this change.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month. Today, approximately 16,687 enrollees (in Two Plan Model and Geographic Managed Care) may switch plans each month, which totals 200,240 changes per year.

Commercial health plans, Medicare Advantage and Part D Plans, and the Healthy Families Program all have annual open enrollment periods. DHCS contends that a 12-month lock-in with an open enrollment period would provide the following beneficial outcomes:

- Greater opportunity for the continuity of health care to the enrollees;

- Greater opportunity for the continuity in maintenance drug therapies since enrollees would have to go through medication step therapies when they join a new Health Plan;

- Greater opportunity for children to receive preventive visits since these are tracked by Health Plan providers;

- Improvement in the monitoring of clinical measures used to assess quality of care, such as, HEDIS® (Healthcare Effectiveness Data and Information System);

- Provides Medi-Cal enrollees with a better opportunity to become familiar with their Health Plan and comfortable with using their Health Plan;

- Reduces costs associated with multiple plan changes such as: multiple initial health assessments, informing materials (printing and distribution); and,

- Reduces access to prescription drug abuse, which is the reason behind many plan changes, according to DHCS.

Annual enrollment is expected to reduce the number of initial health assessments and mailings performed by plans, thereby resulting in cost savings. This proposal requires an amendment to California's 1115 Medicaid Waiver.

Beneficiaries would receive written notice 60 days prior to the end of an enrollment year, allowing them to change plans during this 60-day period. If the beneficiary does not elect to change plans, he or she would be required to remain in their plan for one year until the next open enrollment period. Under this proposal, a beneficiary would have the option to change to an alternate plan within the first 90 days following initial enrollment into a managed care plan.

This proposal differs from very similar proposals in prior years in that, initially, it would apply only to adults and families. The proposed trailer bill language requires DHCS to provide an assessment of the policy to the Legislature by January 1, 2015 in preparation for expanding the policy to all Medi-Cal populations, including seniors and persons with disabilities, on July 1, 2015.

STAFF COMMENTS/QUESTIONS

The Legislature has denied very similar proposals in recent prior years, and the Western Center on Law and Poverty continues to oppose this proposal stating that changing plans is a critical tool for Medi-Cal beneficiaries whose needs are not being met by their health plan.

The Legislative Analyst has no substantial concerns with this proposal, however suggests that perhaps it makes more sense to authorize the expansion to all Medi-Cal populations in 2015, rather than now, once an assessment of the initial application is complete.

The state is in the process of transitioning millions of Californians into managed care, which makes this a particularly turbulent, unsettled time period in managed care. Perhaps this policy would create less disruption at a later date.

Staff Recommendation: Hold open

ISSUE 5: HOSPITAL QUALITY ASSURANCE FEE EXTENSION SAVINGS

The Governor's January budget assumes $310 million in General Fund savings in 2013-14 that will result from revenue from a proposed 3-year extension to the Hospital Quality Assurance Fee (QAF), which is set to sunset on December 31, 2013.

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Federal law authorizes states to levy fees on health care providers if the fees meet federal requirements. Many states (including California) fund a portion of their share of Medicaid Program costs through a fee on health care providers. Under these funding methods, states collect funds (through fees, taxes, or other means) from providers, which are then matched to allow increased Medicaid reimbursement to providers. To prevent states from levying an assessment on only Medicaid providers, federal law requires provider fees to be "broad based" and uniformly applied to all providers within specified classes of provider and states are prohibited from having a provision that would ensure providers are "held harmless" from the impact of the fee. Health care related provider fees may only be imposed on 19 particular classes of health care items or services. Federal approval through CMS is required. In addition to the hospital QAF, California currently has a QAF for intermediate care facilities for the developmentally disabled, and a separate QAF for skilled nursing facilities.

California first enacted a Medi-Cal Hospital Provider Fee in 2009. AB 1383 (Jones), Chapter 627, Statutes of 2009, and AB 188 (Jones), Chapter 645, Statutes of 2009, enacted the framework for a Medi-Cal hospital provider fee, established fee payment amounts, a methodology for calculating and paying supplemental payments to private and district hospitals, supplemental payments to Medi-Cal managed care (MCMC) plans for hospital services, and allocated funds for children's health care coverage, DHCS administrative costs, and grants to public hospitals from the funds collected by the fee. AB 1383 was to become effective upon receipt of CMS approval and become inoperative on January 1, 2011. These measures generated $3.1 billion in revenue from hospitals paying the QAF. The QAF drew down an additional $3.2 billion in federal funds, and provided an overall benefit to the hospital industry of $2.6 billion. In addition, over the 21 month period in which AB 1383 and AB 188 applied, the QAF provided $560 million for children's health coverage, and $513 million in unmatched direct grants to DPHs.

SB 90 (Steinberg), Chapter 19, Statutes of 2011 established a new QAF and hospital supplemental payment program for the period between January 1, 2011 and June 30, 2011 that is similar to the previous fee and supplemental payment program. The most significant changes made to the funding distribution in SB 90 was the elimination of supplemental payments to the 48 NDPHs and grants to the 21 DPHs, and an increase in the per quarter amount for children's coverage (from $80 million per quarter to $105 million per quarter). In addition, SB 90 established an Inter-Governmental Transfer (IGT) program that allows the 48 NDPHs and 21 DPHs to use IGTs to increase the Medi-Cal capitation rate to MCMC plans with which they contract. According to the California Hospital Association (CHA), of the 357 licensed general acute care hospitals in the state, 237 pay the QAF under SB 90. Of the 237 hospitals paying the QAF, 15 independent hospitals and four hospital systems pay more in QAF than they receive back in supplemental payments. Across all private hospitals, SB 90 was estimated to provide $858 million in payments to private hospitals above the amounts paid in QAF by these hospitals.

Children's Coverage

California's QAF revenue has always been dedicated to supporting children's health care services. SB 335 (Hernández), Chapter 286, Statutes of 2011 extended the sunset again, and governs the current QAF. The CHA is the sponsor of this year's bill, SB 239 (Hernández and Steinberg) to extend the QAF again.

History and Proposed State General Fund Savings Based on Hospital QAF Revenue

Time Frame	Quarterly General Fund Savings
April 1, 2009 – Dec. 21, 2010	$80 million
Jan. 1, 2011 – June 30, 2011	$105 million
July 1, 2011 – June 30, 2012	$85 million
July 1, 2012 – June 30, 2013	$134 million
July 1, 2013 – Dec. 31, 2013	$155 million
Proposed: Jan. 1, 2014 – June 30, 2014	$155 million
Proposed: July 1, 2014 – Dec. 31, 2016	$?

STAFF COMMENTS/QUESTIONS

The CHA has raised concerns, and questions the accuracy of, the administration's revenue estimates. The administration states that, ultimately, the amount of QAF revenue is affected by certain variables, primarily the federal Upper Payment Limit as well as overall hospital revenue, which DHCS states is increasing.

Subcommittee staff has asked DHCS to provide an update on this proposal, and to respond to CHA's concerns regarding the assumed General Fund savings amount.

Staff Recommendation: Informational item; no action recommended

ISSUE 6: DIAGNOSIS RELATED GROUPS HOSPITAL PAYMENT SYSTEM IMPLEMENTATION ISSUES AND BUDGET CHANGE PROPOSAL

Diagnosis Related Groups (DRG) hospital payment system is a new payment system for private hospitals that was approved through the budget in 2010. DHCS plans to implement the DRG system beginning July 1, 2013. Hospitals have raised significant concerns with the time-line, and other aspects of the implementation, which are discussed below.

DHCS has included a Budget Change Proposal (BCP) in the January budget to request authority to convert one limited-term position to permanent to meet workload demand related to the implementation and on-going maintenance of the new Diagnosis Related Group (DRG) hospital payment system, at a cost of $121,000 ($61,000 General Fund and $60,000 federal funds).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Currently, the Medi-Cal program reimburses private hospitals in one of two ways:

1. Hospitals negotiate contracted rates with the Selective Provider Contracting Program (SPCP) within DHCS; these rates used to be negotiated by the California Medical Assistance Commission (CMAC). Hospitals are paid for the actual number of days a patient remains in their care, regardless of the specific diagnosis or treatment; or,

2. Hospitals that do not contract with the state, via the SPCP, are reimbursed with a cost-based methodology utilizing interim per-diem rates. At the end of the fiscal year, hospitals submit cost reports to DHCS on services, charges, and costs. DHCS then prepares a tentative rate adjustment, and has three years thereafter to conduct an audit of the cost report to determine the final settlement. Hospitals do not receive final payments for one-to-three years after the date the cost report was submitted.

The DRG payment system will replace the current system (i.e., both of the above methodologies) for private hospitals. In a DRG system, all patients are assigned to a specific DRG and are deemed to have a similar clinical condition requiring similar interventions, for which a single reimbursement rate is established. The payment system is based on applying the average cost for treating patients in the same DRG.

DHCS describes the benefits of DRG to include: improved beneficiary access to care, financial rewards to hospitals for care and operational efficiencies, increased payment fairness to hospitals, improved understanding of what services are being paid for, and the opportunity to evaluate and not pay for "hospital acquired conditions" or "never events" (events that should never occur in hospitals, for which payment is prohibited by the federal government).

BCP Justification

DHCS describes the transition to a DRG system as a "sea change," requiring substantial administrative, operational, technical and data changes, as well as a new education process for hospitals, staff, government officials, and other stakeholders.

Although DHCS already received 10 positions to administer the DRG program, DHCS states that there is a significant amount of specialized and technical work, for which current staff is insufficient. The requested position will be part of a team that makes annual technical adjustments to the DRG classification system to incorporate new treatment guidelines and technologies and refine its use. The position also will work on research, review, and updates of the hospital specific DRG discharge rates, cost to charge ratios, and the statewide cost to charge ratio. The position will collect hospital payment data, patient data, and other cost and utilization information, evaluate and review the percentage of payments made as outliers and the policy adjustors, to provide payment for pediatric and Neonatal Intensive Care Unit (NICU) stays.

Implementation Issues

The hospital industry states that it is supportive of moving to a DRG system, yet has raised significant concerns with the DRG implementation process. DHCS intends to implement beginning July 1, 2013, and states that much work has been done over the past two years to prepare the state for this transition, and that the state is in fact ready to implement. Hospitals, however, state that they are not at all ready to implement, and won't be on July 1, 2013. They also raise a host of other criticisms of the implementation process, including the following:

- The statute that authorized the DRG system requires implementation by June 30, 2014; hence, hospitals state that implementation could be delayed by as much as a year which would give hospitals the time they need to prepare. Subsequent legislation required implementation by July 1, 2012, which was then delayed by one year.

- Hospitals state that DHCS had been facilitating a stakeholder process on the DRG implementation and that the process stopped last May (2012), though DHCS has gone on since then to make significant policy decisions without

stakeholder input. DHCS states that the stakeholder process was designed from the start to last just one year, and that they nevertheless have continued to communicate with stakeholders.

- The data that DHCS is using to model the financial impact of transitioning to a DRG system is from 2009 and hospitals state that they were not consulted on the variables and methods used to trend that data forward to 2013. The California Hospital Association (CHA) has proposed using the first six months of implementation for data collection.

- The data described above formed the basis for DHCS to establish base rates, which were released later than expected; hence, hospitals state that they have insufficient time to analyze the accuracy of the rates and to budget for the anticipated financial impacts.

- Hospitals state that their information technology vendors cannot implement the needed updates to hospital IT systems until the State Plan Amendment (SPA) has been submitted and approved by the federal Centers for Medicaid and Medicare Services (CMS). DHCS indicates that it expects to submit the SPA within the next week, and expects to receive approval before July 1, 2013.

- CHA states that training and education for hospital staff have been "woefully inadequate," and the cost of the transition to ensure a successful transition have not been fully recognized. DHCS strongly disagrees with this assertion.

STAFF COMMENTS/QUESTIONS

The Legislative Analyst has no concerns with the proposed BCP at this time, and no other concerns have been brought to the Subcommittee's attention specific to the BCP.

In light of the concerns of hospitals regarding the timing and other aspects of the implementation of the DRG system, the Subcommittee may want to delay approving of resources for this purpose until some resolution has been reached between the hospitals and DHCS.

Subcommittee staff has asked DHCS to provide an update and to respond to the concerns and criticisms of the hospitals with regard to the implementation of DRG.

Staff Recommendation: Hold open

ISSUE 7: NON-DESIGNATED PUBLIC HOSPITALS PAYMENT SYSTEM BUDGET CHANGE PROPOSAL

DHCS is requesting funding and authority to convert 6.0 limited term positions to permanent in order to implement and maintain the new Non-Designated Public Hospital (NDPH) program, which is a new Medi-Cal reimbursement system adopted in the 2012-13 budget. The 2013-14 and on-going cost of these positions is $827,000 ($414,000 General Fund and $413,000 federal fund).

PANELISTS

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The 46 NDPHs fall into the following categories:

- 13 are contract hospitals;
- 19 are critical access hospitals;
- 31 are located in rural areas;
- 30 are located in health personnel shortage areas;
- 16 are located in medically underserved areas;
- 21 are Medi-Cal Disproportionate Share Hospitals;
- They range in size from 4 to 600 beds;
- Medi-Cal managed care payer mix ranges from 0 – 48%; and,
- Uninsured payer mix ranges from 1 – 15%.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 changed the reimbursement methodology for NDPHs. Prior to this new system, NDPHs received either: 1) the California Medical Assistance Commission negotiated per diem rates for contract hospitals; or, 2) cost-based reimbursement for non-contract hospitals. NDPHs also received supplemental reimbursement through the NDPH Supplemental Fund. Finally, the NDPHs also received funding through Inter-Governmental Transfers. The fee-for-service rates and reimbursements were paid with a 50:50 combination of State General Fund and federal financial participation.

The 2012-13 budget approved of changing the reimbursement system to the system used for Designated Public Hospitals, which is based on certified public expenditures (CPEs), and therefore involves no State General Fund. Under the CPE methodology, the NDPHs certify the cost of providing inpatient services to fee-for-service Medi-Cal beneficiaries and receive 50 percent reimbursement with federal funds. AB 1467 also requires DHCS to seek approval of an amendment to the 1115 Bridge to Reform Waiver in order to increase Safety Net Care Pool (SNCP) Uncompensated Care and Delivery System Reform Incentive Pool (DSRIP) funding for NDPHs.

NDPHs are not required to transition to this new CPE-based payment system, however DHCS expects that most or all will opt to do so. Any NDPH that opts out of this new system will automatically be transitioned to the Diagnosis Related Group (DRG) payment system for private hospitals, which DHCS plans to implement July 1, 2013. State statute gives the director of DHCS the authority to choose to not implement the CPE system at all should one or more hospitals choose not to opt into it.

The six existing limited term positions expire on December 31, 2013, and were provided to DHCS through the 1115 Waiver. Per state law, counties and public hospitals are required to fund any administrative costs related to waiver activities. However, these positions were never funded, and therefore never filled. DHCS is now proposing making the positions permanent and dedicated to implementing this new payment system for DNPHs.

The positions will be responsible for the following activities:

- Perform quality review activities related to NDPH payments;
- Establish system changes, reporting mechanisms, and other administrative operations;
- Perform dispute resolution for the NDPHs;
- Develop, implement, and administer protocols on SNCP and DSRIP claiming and reconciliations;
- Prepare correspondence, issue papers, briefing materials, and legislative proposals related to DSRIP;
- Develop bi-annual fiscal estimates and other fiscal reports;
- Provide technical assistance to NDPHs; and,
- Review cost reports and P-14 procedures and protocols and make needed adjustments.

STAFF COMMENTS/QUESTIONS

DHCS states that the workload need exists regardless of various variables. Specifically, DHCS states that additional staff is needed for NDPH payments even if there were no new payment system being implemented. For any hospitals that opt out of the CPE payment system, staff are needed for the conversion to the new DRG payment system, amend the 1115 Waiver, develop new claiming protocols, work with stakeholders, audits, and new DRG oversight activities.

The Legislative Analyst has no concerns with this proposal at this time, and no other concerns have been brought to the Subcommittee's attention.

The Subcommittee has asked DHCS to present this BCP.

Staff Recommendation: Hold open