California State Assembly

Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dr. Akilah Weber, Chair

Monday, March 11, 2024

2:30 P.M. - State Capitol, Room 447

Oversight Hearing: Hospital Financing and Closures

Overview of the Financial Health of California's Hospital Industry

- Kristof Stremikis, Director, Market Analysis and Insight
  California Health Care Foundation

Experiences and Perspectives of Private Hospitals

- Karen Paolinelli, RN, MSN, FNP-C, PA-C, DFAAPA, CEO
  Madera Community Hospital
- Elaine Batchlor, MD, MPH, CEO
  Martin Luther King Community Healthcare
- Todd Hofheins, COO
  Adventist Health
- Jim Suver, CEO
  Ridgecrest Regional
- Scott Evans, CEO
  Sharp Regional Hospitals

Experiences and Perspectives of Public and District Hospitals

- Erica Murray, MPA, President and CEO
  California Association of Public Hospitals and Health Systems
- Gary K. Herbst, CEO
  Kaweah Health
- Patty Maysent, CEO
  U.C. San Diego Health

Distressed Hospital Loan Program & Small and Rural Hospital Relief Program

- Elizabeth Landsberg, Director
  Department of Health Care Access and Information
- JP Marion, Deputy Director for Health Facility Loan Insurance
  Department of Health Care Access and Information
- Carolyn Aboubechara, Executive Director
  California Health Facilities Financing Authority

Medi-Cal Financing of Hospitals

- Michelle Baass, Director
  Department of Health Care Services
- Lindy Harrington, Assistant State Medicaid Director
  Department of Health Care Services

The Role of Commercial and Public Managed Care Plans

- Robert Moore, MD, MPH, MBA, Chief Medical Officer
  Partnership Health Plan of California
- Linnea Koopmans, CEO
  Local Health Plans of California
- Jedd Hampton, Director of Legislative Affairs
  California Association of Health Plans

Public comment will be taken in person after the completion of all panels and any discussion from the Members of the Subcommittee.

Background

Purpose of Hearing

A concerning number of hospitals in California have either closed in recent years, or are experiencing extreme financial distress and therefore are at high risk of closure. Moreover, increasingly, hospitals in financial distress are turning to closing their labor and delivery (L&D) wards as a way to help stabilize their finances. Both hospital and L&D closures clearly have a negative impact on access to care, where-ever they occur, and particularly in rural California. The goals of this hearing include:

- To increase the Legislature's understanding of California's hospital industry and how hospitals are financed;

- To increase the Legislature's understanding of the leading causes of financial distress in California's hospitals; and

- To help identify and define key policy and fiscal issues for the state and other key stakeholders, including: hospitals, managed care plans, and local government agencies.

Hearing Panels and Speakers

The hearing includes the following panels of experts and stakeholders:

Overview of the Financial Health of California's Hospital Industry

1. *How many and what types of hospitals does California have?*
2. *To what extent are hospitals and L&D wards closing?*
3. *What does state data tell us about the financial viability (profitability) of California's hospitals and the major causes of financial distress for hospitals?*
4. *What are the key policy issues the Legislature should consider?*

- *Kristof Stremikis*, Director, Market Analysis and Insight
  California Health Care Foundation

Experiences and Perspectives of Private Hospitals

1. *What are the most common causes of financial distress for private hospitals?*
2. *How many private hospitals have closed in the last ten years, and how many have closed L&D wards?*
3. *Is there a consistent correlation between the amount of Medi-Cal business and financial distress in private hospitals?*

4. *Is there more financial distress in for-profit vs. not-for-profit private hospitals, as a general rule?*

- *Karen Paolinelli, RN, MSN, FNP-C, PA-C, DFAAPA, CEO*
  Madera Community Hospital
- *Elaine Batchlor,* MD, MPH, CEO
  Martin Luther King Community Healthcare
- *Todd Hofheins*, COO
  Adventist Health
- *Jim Suver*, CEO
  Ridgecrest Regional
- *Scott Evans*, CEO
  Sharp Regional Hospitals

Experiences and Perspectives of Public and District Hospitals

1. *What are the most common causes of financial distress for public and district hospitals?*
2. *How many public and district hospitals have closed in the last ten years, and how many have closed L&D wards?*
3. *Is there a consistent correlation between the amount of Medi-Cal business and financial distress in public and district hospitals?*
4. *Is there more financial distress in district vs. public hospitals, as a general rule?*
5. *Is there more financial distress in public vs. private hospitals, as a general rule?*

- *Erica Murray,* MPA, President and CEO
  California Association of Public Hospitals and Health Systems
- *Gary K. Herbst*, Chief Executive Officer
  Kaweah Health
- *Patty Maysent*, CEO
  U.C. San Diego Health

Distressed Hospital Loan Program & Small and Rural Hospital Relief Program

1. *What are the goals of these two programs?*
2. *How much funding have these programs received and from what sources?*
3. *What do you believe has been accomplished by these programs?*

- *Elizabeth Landsberg*, Director
  Department of Health Care Access and Information
- *JP Marion,* Deputy Director for Health Facility Loan Insurance
  Department of Health Care Access and Information
- *Carolyn Aboubechara*, Executive Director
  California Health Facilities Financing Authority

Medi-Cal Financing of Hospitals

1. *How are public and private hospitals reimbursed for care provided to Medi-Cal beneficiaries?*
2. *For what reasons does the Medi-Cal program reimburse public and private hospitals differently?*
3. *How does the administration's MCO Tax Targeted Rate Increases proposal change Medi-Cal reimbursements and the reimbursement methodology for hospitals?*
4. *Is DHCS concerned about maintaining adequate access to care in light of recent hospital and L&D ward closures, and persistent financial distress in many hospitals?*

- *Michelle Baass*, Director
  Department of Health Care Services
- *Lindy Harrington*, Assistant State Medicaid Director
  Department of Health Care Services

The Role of Commercial and Public Managed Care Plans

1. *To what degree are Medi-Cal and commercial managed care rates paid to hospitals the cause of financial distress?*
2. *What are the challenges to increasing these rates?*
3. *What are other ways that managed care plans can help support and stabilize hospitals?*

- *Robert Moore*, MD, MPH, MBA, Chief Medical Officer
  Partnership HealthPlan of California
- *Linnea Koopmans*, Chief Executive Officer
  Local Health Plans of California
- *Jedd Hampton*, Director of Legislative Affairs
  California Association of Health Plans

Overview of Hospitals in California

There are over 450 hospitals and health systems in California, falling into three licensure categories: 1) General Acute Care Hospitals; 2) Acute Psychiatric Hospitals; and 3) Special Hospitals. Additional types of hospitals include:

- Inpatient Rehabilitation Hospitals
- Long Term Acute Care Hospitals
- Children's Hospitals
- Rural Hospitals (including federally-designated Critical Access Hospitals)

California's hospitals can also be categorized as follows:

- *Public Hospitals*: County-operated or affiliated, and five U.C. hospitals
- *District Hospitals*: Public hospitals operated by a local government agency or health care district
- *Private Hospitals*: Investor owned or not-for-profit

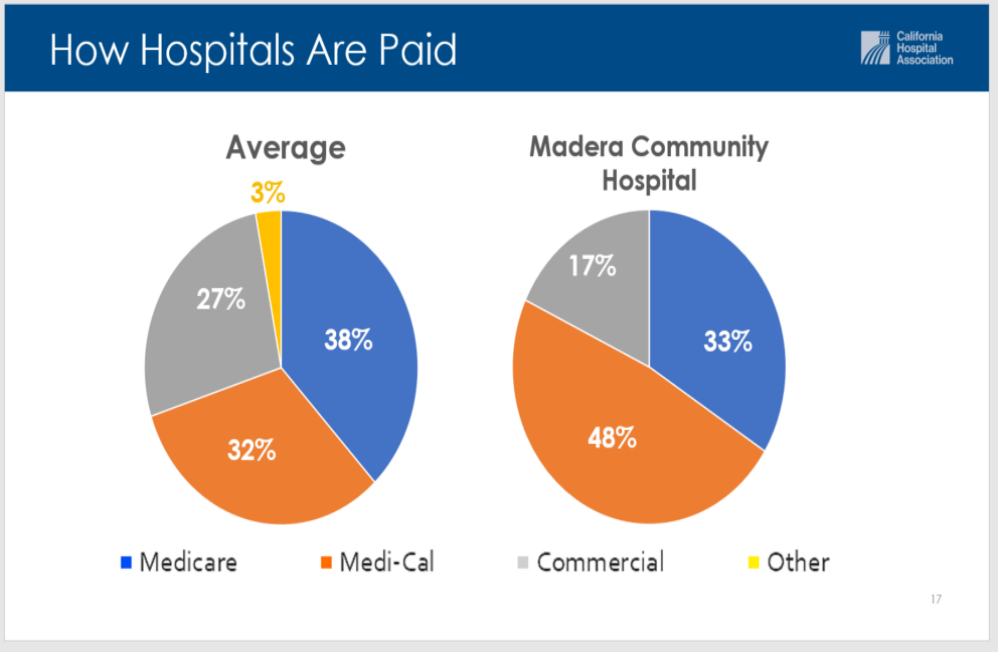
Finally, hospitals generally fall into one of the following two categories:

- *Stand-Alone Hospitals*: Independent; not owned or operated by a health system
- *Health Systems*: Organizations that own and operate a network of at least one or more health care facilities, such as hospitals

Hospital are financed with the following:

- Medi-Cal
- Medicare
- Commercial Insurance
- Other (self-pay, TriCare, counties, and other)

According to the California Hospital Association (CHA), commercial insurance is the only major payer that pays above cost for hospital care. The following diagram from CHA depicts the average payer mix (for the entire industry) compared to the payer mix for Madera Community Hospital:



CHA also provided the following breakdown of payer mix, comparing public hospitals to private hospitals, and comparing UC hospitals to non-UC public hospitals:

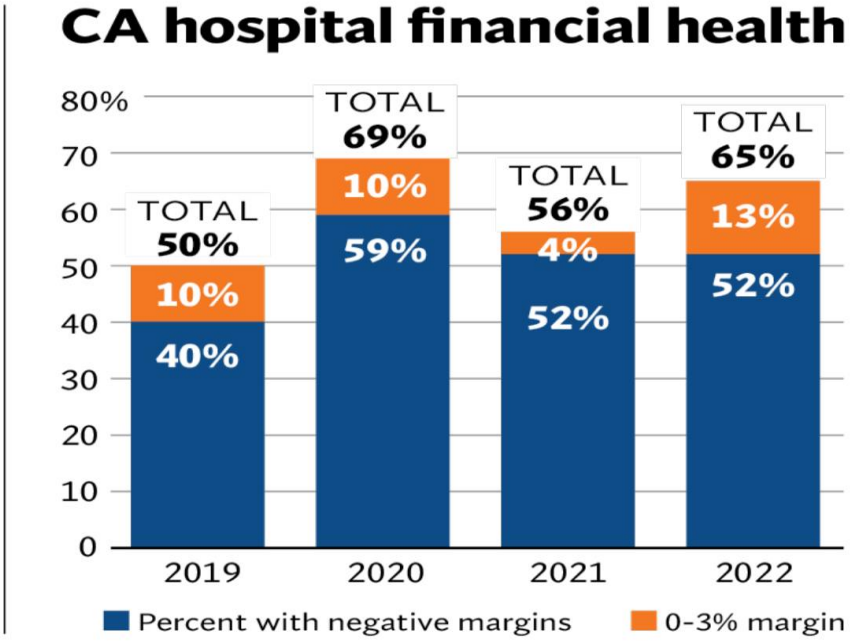
PAYOR	PUBLIC	NON-PUBLIC	U.C.	NON-U.C. PUBLIC
Medicare	30%	40%	37%	20%
Medi-Cal	44%	29%	27%	59%
Commercial	21%	28%	34%	11%
Other	5%	3%	2%	10%

Financial Distress in Private and District Hospitals

As evidenced by several hospital closures, bankruptcies, and L&D ward closures in recent years, California's hospital industry (both public and private) faces significant financial challenges. CHA describes the leading causes of this crisis as follows:

- "A systemic shortfall in reimbursement from Medi-Cal and Medicare. Medicare and Medi-Cal pay 75 cents for every dollar it costs to care for patients. Statewide, 72% of hospital volume comes from Medi-Cal and Medicare combined.
- An aging population will turn to Medicare in greater numbers (the over 65 population is expected to grow to one in five by 2030). This leaves fewer individuals with commercial insurance that can help offset Medicare and Medi-Cal reimbursement shortfalls.

- Health care costs are rising: Labor costs are up 8% over the past year (and projected to grow significantly); medical supplies are up 22%; and pharmaceuticals are up roughly $700 million over pre-pandemic levels."



CHA also provided the following data and analysis:

- "More than 50% of California hospitals lose money every day to care for patients.
- An estimated 1 in 5 California hospitals is at risk of closure.
- Hospitals face significant cost pressures:
    - A new $25-per-hour minimum wage for health care workers will cost billions more every year.
    - A 2030 deadline to ensure every hospital building is fully operational following an earthquake will cost more than $100 billion (hospitals that fail to meet the deadline will be forced to close).
- Unlike other organizations, hospitals can't simply increase prices to keep up with inflation, as Medicare and Medi-Cal rates are set by the government. Medicare and Medi-Cal pay just 75 cents for every dollar it costs to care for patients.
- Vital resources from a renewed tax on managed care organizations will help protect access to care, but represent only the first step to address systemic, multi-year shortfalls in government funding.
- Statewide, 70% of hospital volume comes from Medi-Cal and Medicare.
- An aging population will soon turn to Medicare in greater numbers. At the same time, fewer workers insured through their employers will be able to offset government shortfalls.
- As with all areas of the economy, health care costs are rising:
    - Labor costs are up 8% over the past year (and will rise significantly due to recent legislation)
    - Medical supply costs are up 22% over pre-pandemic levels
    - Pharmaceutical costs are up $700 million over pre-pandemic levels"

Tri-City Medical Center

Tri-City Medical Center is a good example of a highly distressed hospital that now has a promising future. Tri-City, a district hospital, was financially distressed prior to the pandemic (as were many hospitals, according to Tri-City executives), leaving the hospital unable to weather the pandemic storm. The pandemic was very costly for most or all hospitals as it resulted in unprecedented workforce shortages, a very expensive temporary workforce, costly COVID supplies, and the huge loss of revenue resulting from the significant reduction in patients.

Tri-City reports that 85 percent of their patient population are Medi-Cal or Medicare beneficiaries, and they were losing $4-10 million per year in labor and delivery. Specifically, the hospital lost $1,000 for every Medi-Cal birth. As a result, the hospital closed its L&D ward and all maternal and newborn services, including its neonatal intensive care unit (NICU), in October of 2023.

In an effort to find a long-term, sustainable path forward, Tri-City in the process of negotiating a joint powers agreement with the University of California, San Diego (UCSD) in which UCSD will be operating the hospital. All Tri-City assets and liabilities will be transferred to UCSD, however

the health care district will remain intact. There will be a new board, with limited oversight over the hospital, that will include district members, but not a majority of district members. Tri-City will be, in effect, a demonstration project for the first UC-operated community hospital that engages both UC and non-UC physicians. UCSD has committed to reopening the L&D services and providing north county's first-ever perinatology and high-level neonatal services, recognizing that this will require a significant investment on their part. Finally, patients of the new Tri-City community hospital will have access to the same world-class care available at UCSD, but without having to travel from northern San Diego County to La Jolla.

California Health Care Foundation (CHCF) Research

CHCF analyzed 2019-2022 rural hospital data and found the following:

- "Medi-Cal is a particularly important payor for rural hospitals in California. In 2022, Medi-Cal enrollees counted for half of all patient days and a third of discharges.
- Financial pressures across the hospital sector in 2022 were felt among rural hospitals in California. Rural CA hospitals reported losing roughly $37mm on patient care that year.
- Net patient revenue is roughly split between commercial, Medi-Cal and Medicare lines of business.
- In 2022, net patient revenue met approximately 99% of estimated patient care expenses. This ratio varied significantly among Medicare (77%), Medi-Cal (94%), and Commercial (148%) lines of business."

HEADING FOR AN ACUTE CRISIS? CALIFORNIA HOSPITAL FINANCIAL PERFORMANCE COMING OUT OF COVID-19

	2019	2020	2021	2022	2023
Net Patient Revenue	110,800,023,237	110,589,455,229	121,650,165,815	129,770,010,059	136,043,167,768
Other Operating Revenue	4,927,450,242	8,555,793,483	6,740,556,439	6,692,510,751	7,742,647,100
Total Operating Revenue	115,727,473,479	119,145,248,712	128,390,722,254	136,462,520,810	143,785,814,868
Total Operating Expenses	111,437,496,718	119,289,665,830	126,022,191,650	136,018,577,290	143,993,844,310
Net Operating Revenue	4,289,976,761	-144,417,118	2,368,530,604	443,943,520	-208,029,442
Net Nonoperating Revenue	5,769,206,331	5,379,315,880	6,572,695,883	332,787,547	7,288,255,478
Net Income (Pretax)	10,059,183,092	5,234,898,762	8,941,226,487	776,731,067	7,080,226,036

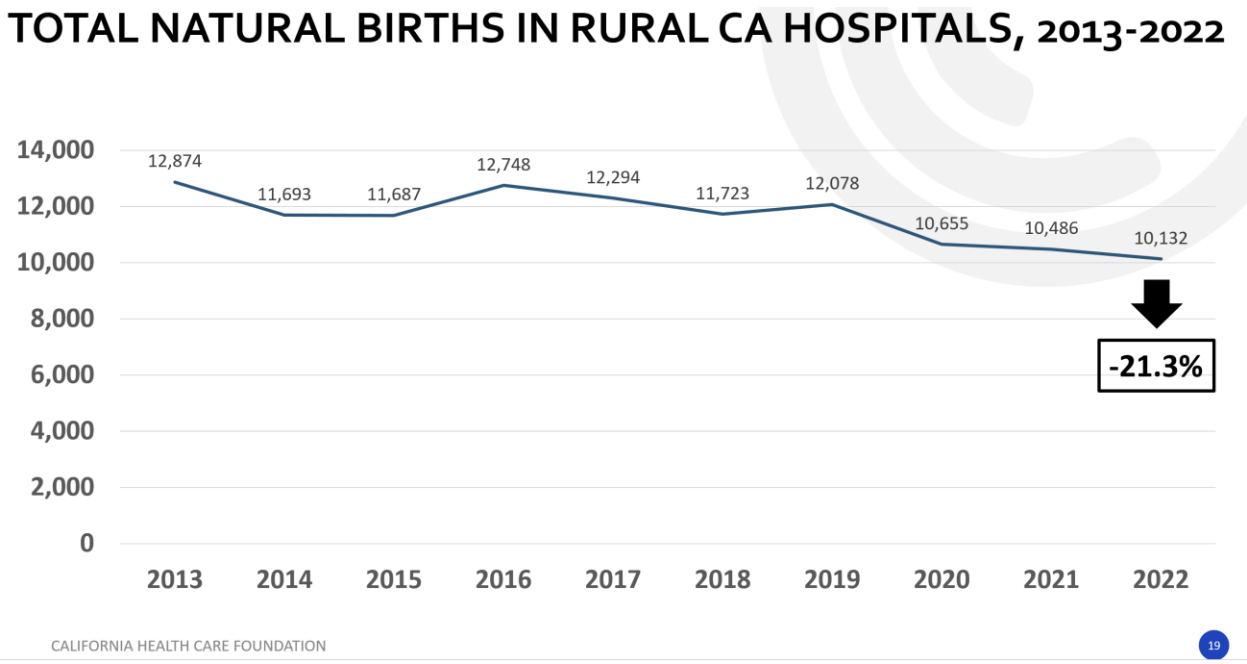
CALIFORNIA HEALTH CARE FOUNDATION

Labor & Delivery (L&D) Ward Closures

In large part due to the decreasing birth rate in California, combined with other factors, L&D is one of the mostly costly and financially unsustainable services in hospitals. For this reason, an increasing number of financially distressed hospitals are choosing to close their L&D wards. Just in San Diego County:

- Paradise Valley Hospital closed their L&D ward a few years ago;
- Palomar closed their L&D ward at Pomerado last year;
- Tri-City Medical Center closed their L&D ward in October of 2023; and
- Scripps announced that they are closing the L&D ward at their Chula Vista hospital last week.

The following chart from the California Health Care Foundation shows the drop in births in California's rural hospitals:



Financial Distress in Public Hospitals

The California Association of Public Hospitals and Health Systems (CAPH) has shared with legislative staff that public health systems (PHS) are facing a significant structural deficit of approximately $3.5 billion which is expected to reach the point of crisis in 2027. This has resulted from a history of managed care plans paying low base rates in light of substantial supplemental payments and now, due to CalAIM, a new focus on managed care base payments. CAPH explains that the many years of Medicaid 1115 federal waivers masked the underfunding that was occurring in the base rates to public hospitals. Under the waivers, most of the funding did not flow through managed care plans, and therefore with the transition away from 1115 waivers

to CalAIM, the funding will flow through managed care plans that have very low base rates. CAPH explains that the proposed conversion of supplemental payments to be incorporated into base rates is positive but will not address the problem fully. Moreover, public hospitals and Federally Qualified Health Systems are not proposed to be eligible for the MCO rate increases for primary and specialty care.

Since 2005, PHS have provided the State share for costs related to Medi-Cal fee-for-service inpatient services. In its January budget proposal, the Administration proposed to use $150 million of MCO Tax revenue to replace PHS payments with the State General Fund to help strengthen and stabilize PHS funding. In exchange, PHS would agree to convert these payments to a Diagnostic Related Group (DRG) structure, which is more of a value-based payment.

CAPH supports conversion to a DRG structure, however has grave concerns about the second component of the Administration's proposal: phasing out or eliminating a cost-based supplemental that would help PHS cover their costs for these services. CAPH states that the proposed $150 million falls far short of the total cost of these services, and that the DRG structure would cover just 22 percent of PHS costs. CAPH expects that, if implemented, the Administration's proposal to eliminate the cost-based supplemental could result in PHS losing funding.

Distressed Hospital Loan Program (DHLP)

The DHLP was established by AB 112 (Committee on Budget, Chapter 6, Statutes of 2023) to address urgent cash flow needs of the most financially distressed hospitals (i.e., those at highest risk of closing or already closed). The program was funded with $300 million ($150 million General Fund and $150 million MCO Tax revenue) to award loans to not-for-profit hospitals, public hospitals, and government entities representing closed hospitals. Hospitals that belong to integrated healthcare systems, with more than two separately licensed hospitals, were ineligible for DHLP loans. Prior to receiving a DHLP loan, hospitals were required to submit a plan to the California Health Facilities Financing Authority (CHFFA) and the Department of Health Care Access and Information (HCAI) with projections detailing the uses of the proposed loan and strategies proposed by the hospital's governing body to regain financial viability and to continue to operate. Prior to issuing a loan, HCAI was required to review the plan submitted by a hospital and make a determination that the plan was viable and that there was a reasonable likelihood that the hospital would be able to regain financial viability and continue to operate. Hospitals awarded a loan are required to begin making repayments of the loan after the first 18 months and to repay the entire loan within 72 months of the date of the loan.

In order to select the hospitals that would receive DHLP loans, HCAI developed a methodology for evaluating the loan applications that weighted the applications on four primary issues:

Loan Application Criteria	EVALUATION WEIGHT
Liquidity	**35%**
Days Cash on Hand	20%
Current Ratio	10%
Access to Working Capital	5%
Profit/Loss Analysis	**20%**
Operating Margin	5%
Impact of Operating Losses on Liquidity – "Cash Runway"	15%
Turnaround Plan	**25%**
Community Need	**20%**
Distance to Nearest Alternative Hospital	5%
Payor Mix	5%
Utilization Analysis	5%
Service Area Designation	5%

HCAI provided the following update on the DHLP on February 21, 2024:

- There were 17 loan awards determined after the Distressed Hospital Loan Program's application process. Immediately after the announcement to loan awardees, Beverly Hospital declined to accept its $5 million loan award, due to an imminent sale to Adventist Health. This $5 million loan award was then reallocated to Madera Community Hospital's $52 million loan award to reopen the closed hospital.

- As of February 14th, 12 of the 16 hospitals have completed their loan transaction and received their disbursements, totaling $201.65 million.

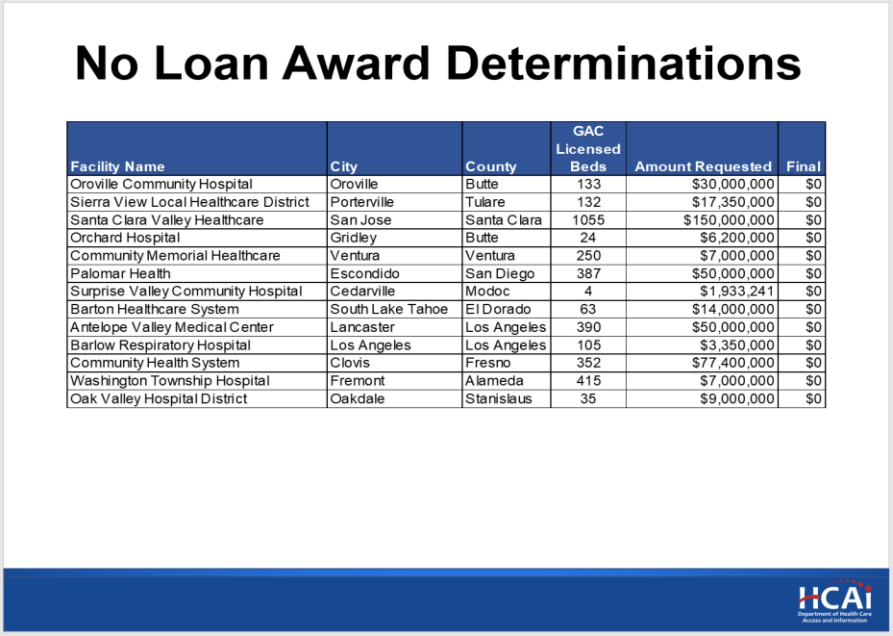
- Of the remaining four loans totaling $90.85 million, two transactions should be closed in the next 2-4 weeks. The remaining two transactions for Madera Community Hospital and Hazel Hawkins Memorial Hospital involve hospitals currently in bankruptcy and will take some time to obtain court approval to be able to accept the loans. Additionally, Madera Community Hospital is currently closed so we are evaluating and working with the hospital on the development of its reopening plan.

- Below is a detailed list of the awardees and their loan award status:

Hospital	Loan Award	Loan Date	Status Comment
Beverly Hospital	**$5,000,000**	Declined	Hospital acquired by Adventist shortly after original loan award. This loan award was rolled into Madera's allocation.
Chinese Hospital	**$10,350,000**	11/6/2023	Loan closed
Dameron Hospital Association	**$29,000,000**	1/2/2024	Loan closed
El Centro Regional Medical Center	**$28,000,000**	10/5/2023	Loan closed
Hayward Sisters Hospital, dba St. Rose Hospital	**$17,650,000**	12/6/2023	Loan closed
Hazel Hawkins Memorial	**$10,000,000**	In progress	Transaction working its way through bankruptcy court process.
John C. Fremont Healthcare District	**$9,350,000**	1/19/2024	Loan closed
Kaweah Delta Health Care District	**$20,750,000**	In progress	Hospital working with legal counsel on finalizing transaction documents.
Madera Community Hospital	**$57,000,000**	In progress	Working with hospital on reopening plan. Transaction will need approval from bankruptcy court.
Martin Luther King, Jr. Community Hospital	**$14,000,000**	11/29/2023	Loan closed
Palo Verde Hospital	**$8,500,000**	11/21/2023	Loan closed
Pioneers Memorial Healthcare District	**$28,000,000**	10/30/2023	Loan closed
Ridgecrest Regional Hospital	**$5,500,000**	11/29/2023	Loan closed
San Gorgonio Memorial Healthcare District	**$9,800,000**	1/18/2024	Loan closed
Sonoma Valley Hospital	**$3,100,000**	In progress	Waiting on hospital to finalize its review of transaction documents.
TriCity Medical Center	**$33,200,000**	11/29/2023	Loan closed
Watsonville Community Hospital	**$8,300,000**	10/30/2023	Loan closed

Number of Rural Hospitals Receiving DHLP Loans:

- 7 awardees are rural hospitals (41%)
- 3 awardees have Critical Access Hospital designations by the Centers for Medicare and Medicaid Services (18%)
- 8 awardees are non-designated public hospitals, also referred to as District Hospitals (47%)
- 7 awardees have less than 80 beds (41%)
- 9 awardees are designated within a medically underserved area or population (53%)



No Loan Award Determinations

Facility Name	City	County	GAC Licensed Beds	Amount Requested	Final
Oroville Community Hospital	Oroville	Butte	133	$30,000,000	$0
Sierra View Local Healthcare District	Porterville	Tulare	132	$17,350,000	$0
Santa Clara Valley Healthcare	San Jose	Santa Clara	1055	$150,000,000	$0
Orchard Hospital	Gridley	Butte	24	$6,200,000	$0
Community Memorial Healthcare	Ventura	Ventura	250	$7,000,000	$0
Palomar Health	Escondido	San Diego	387	$50,000,000	$0
Surprise Valley Community Hospital	Cedarville	Modoc	4	$1,933,241	$0
Barton Healthcare System	South Lake Tahoe	El Dorado	63	$14,000,000	$0
Antelope Valley Medical Center	Lancaster	Los Angeles	390	$50,000,000	$0
Barlow Respiratory Hospital	Los Angeles	Los Angeles	105	$3,350,000	$0
Community Health System	Clovis	Fresno	352	$77,400,000	$0
Washington Township Hospital	Fremont	Alameda	415	$7,000,000	$0
Oak Valley Hospital District	Oakdale	Stanislaus	35	$9,000,000	$0

HCAI
Department of Health Care Access and Information

CHFFA Proposed Trailer Bill Language

As described above, AB 112 established the DHLP and authorized CHFFA and HCAI to co-administer the program. The statute allows an amount not to exceed five percent of the total initial Program funds to be used to administer the Program for both CHFFA and HCAI, which totals $7.5 million in administrative funds. Per the statute, the Program will remain in effect until January 1, 2032. CHFFA staff will continue to collect and monitor payments and ensure compliance with loan conditions and terms from the hospitals for at least 72 months, which extends the responsibility of the Authority's loan administration duties to at least 2030. Additionally, CHFFA anticipates a reasonable likelihood of needing to utilize its outside counsel to assist in highly specialized bankruptcy proceedings while any loan amounts remain outstanding during the 72-month term of the loans. However, the statute mentions that the funds that are available for administrative costs to both CHFFA and HCAI shall only be available for encumbrance or expenditure until June 30, 2026.

Therefore, CHFFA is proposing trailer bill language to extend the administration deadline from June 30, 2026 to the sunset date of the Program of December 31, 2031 to allow CHFFA and HCAI to utilize the $7.5 million allocated for administrative costs for the work to be completed on the Program, including collecting all outstanding debt from borrowers, until at least 2030.

Small and Rural Hospital Relief Program (SRHRP)

SB 395 (Caballero, Chapter 489, Statutes of 2021) created the SRHRP within HCAI for the purpose of funding seismic safety compliance for small, rural, and critical access hospitals. This bill also required that ten percent of the revenue from the electronic cigarette excise tax be continuously appropriated to this program. In addition to this funding, the 2023 Budget Act included a one-time appropriation of $50 million in MCO Tax revenue to this program. HCAI provided the following recent update on the program:

"Since its inception:

- The excise tax on e-cigarettes has generated approximately $3.7 million in funding available for local assistance.
- Thirty (30) of the potentially eligible 102 hospitals have initiated applications for program participation.
- Twenty-two (22) have submitted updated seismic compliance plans to fulfill the first step of application requirements.
- Ten (10) participating hospitals have submitted grant applications, two (2) grants totaling $460,000 have been awarded to hospitals and a third is being processed for award imminently."

District Hospital Bridge Loan Program

The 2021 Budget Act and 2022 Budget Act both included $40 million to fund a loan program, operated by CHFFA, specifically for district/municipal hospitals experiencing significant cash flow challenges. These loans are required to be repaid within two years of the date of the loan, as compared to the DHLP loans which have a repayment timeframe of 6 years. The original justification for these loans was that they were needed as a "bridge" during a transition period related to the implementation of various Medi-Cal reforms that resulted in a delay of over $100 million in payments annually. However, these hospitals continue to struggle financially, largely due to the pandemic, and many are finding it very challenging to repay these loans within the required two years.

District & Municipal Hospitals	Year 1 - First Loan Loan Amount Approved	Loan Due Date	Year 1 - Second Loan Loan Amount Approved	Loan Due Date	Year 2 Loan Amount Approved	Loan Due Date	Total Loans
El Centro Regional Medical Center	$2,296,000	3/4/2024	$2,239,997	5/27/2024	$5,663,226	12/16/2024	**$10,199,223**
Hazel Hawkins Memorial Hospital	$1,253,000	2/28/2024	$1,222,438	5/3/2024	$3,090,086	1/3/2025	**$5,565,524**
Jerold Phelps Community Hospital	$511,000	5/17/2024					**$511,000**
John C Fremont Healthcare District	$551,000	2/28/2024	$537,560	4/1/2024			**$1,088,560**
Kaweah Delta Medical Center	$1,132,002	3/15/2024	$6,762,530	4/1/2024	$9,849,993	12/20/2024	**$17,744,525**
Northern Inyo Hospital	$497,000	2/3/2024	$484,877	5/3/2024			**$981,877**
Oak Valley District Hospital	$2,045,000	2/8/2024	$1,995,120	4/4/2024	$5,045,411	1/18/2025	**$9,085,531**
Palo Verde Hospital	$296,000	4/1/2024	$288,780	6/6/2024	$600,000	12/16/2024	**$1,184,780**
Palomar Pomerado Health	$3,481,000	2/3/2024	$3,396,094	4/1/2024	$8,578,801	12/20/2024	**$15,455,895**
Pioneers Memorial Hospital	$1,527,000	3/4/2024	$1,489,754	4/20/2024	$3,766,770	1/27/2025	**$6,783,524**
Plumas District Hospital	$296,000	4/14/2024					**$296,000**
San Gorgonio Memorial Hospital	$1,141,000	3/2/2024	$1,113,169	4/1/2024	$2,647,471	12/20/2024	**$4,901,640**
Sonoma Valley Hospital	$308,000	4/8/2024	$300,487	5/3/2024	$758,242	1/20/2025	**$1,366,729**
Tri-City Medical Center	$2,405,000	6/3/2024	$2,346,339	8/5/2024			**$4,751,339**
	$17,739,002		**$22,177,146**		**$40,000,000**		**$79,916,148**
Highlighted hospitals were approved for a distressed hospital loan.							
% of funds to distressed hospitals	**61.5%**		**73.5%**		**65.9%**		**67.1%**

Medi-Cal Financing of Hospitals

Medi-Cal payments to hospitals are complex and very different for private hospitals versus public hospitals. DHCS provided a background document, *Hospital Financing in Medi-Cal, High-Level Explainer – March 2024*, in preparation for this hearing. This document is on the Assembly Budget Subcommittee #1 website and can be accessed here: https://abgt.assembly.ca.gov/system/files/2024-03/attachment-hospital-financing-explainer-march-2024.pdf

As described in DHCS's document, Medi-Cal reimburses hospitals for services and care provided to Medi-Cal patients through both fee-for-service (FFS) and managed care. These payments are in the form of both base and supplemental payments. The majority of Medi-Cal payments to hospitals are for inpatient services and are made through managed care. The following table describes the basic types of payments to both public and private hospitals:

Medi-Cal Payments to Hospitals	
TYPE OF SERVICE	**TYPE OF PAYMENT**
Inpatient Services	
Fee-for-Service (FFS)	Both base and supplemental payments are proposed by DHCS, approved by CMS, and utilize the full federal Upper Payment Limit (UPL), which limits reimbursement to Medicare rates. The state's ability to raise FFS rates is limited by the fact that FFS rates are already at or new the UPL.

Managed Care	Base payments are negotiated between hospitals and managed care plans. Supplemental payments are developed by DHCS and approved by CMS. The total payment (base and supplemental) is subject to a hard cap at the average commercial market rate.
Outpatient Services	
Fee-for-Service (FFS)	Base payments follow the FFS rate schedule. Hospitals also receive supplemental payments.
Managed Care	Base payments are negotiated between hospitals and managed care plans. For non-contract emergency and post-stabilization services, the base payments follow the FFS rate schedule. Hospitals also receive supplemental payments.

According to DHCS: "In total across the fee-for-service and managed care delivery systems, DHCS makes approximately $13–15 billion in net-benefit supplemental payments to hospitals each year in addition to their base payments." According to CHA, Medi-Cal rates were last increased in 2012, whereas the Medi-Cal population has increased from 21 to 39 percent of the overall population in California.

Managed Care Organization (MCO) Tax

The Governor's Budget includes proposals for MCO tax revenue-funded "targeted rate increases" that include the following that affect hospitals:

- Increase base payment rates for maternity care to 100 percent of the geographically adjusted Medicare rate, plus additional equity enhancements.
- Increase base payment rates for emergency physician services to 90 percent of the geographically adjusted Medicare rate.
- Increase annual reimbursement for outpatient services by $490 million (total funds) and for emergency department facility services by $725 million (total funds), and transition base payments for these services to an Outpatient Prospective Payment System.
- Invest $150 million of MCO Tax funds annually into modernizing reimbursement methodologies for designated public hospital inpatient services in the fee-for-service delivery system and improving these hospitals' net benefit by reducing self-financing and increasing state-funded financing.

Community and Hospital Outpatient (OP) and Emergency Department (ED) Facility Services

The Medi-Cal fee-for-service (FFS) delivery system currently reimburses outpatient and ED claims through a traditional FFS rate schedule, where each discrete service provided is billed separately on the claim and each service is reimbursed at a uniform statewide rate. A claim for a single visit may include many discrete procedures. Reimbursement methodologies for outpatient and ED facility services are not standardized in the Medi-Cal managed care delivery system.

DHCS is proposing to target annual investments of $490 million ($245 million MPPRF) for community and hospital OP services, including hospitals and ambulatory surgical centers, and $725 million ($255 million MPPRF) for ED facility services.

- DHCS proposes to transition hospital outpatient and ambulatory surgical center reimbursement, and to explore and engage stakeholders on transitioning ED facility reimbursement, to an Outpatient Prospective Payment System (OPPS) methodology, no sooner than January 1, 2027.

- In preparation for the transition to an OPPS methodology, DHCS proposes transitionary increases to baseline reimbursements in the FFS and managed care delivery systems beginning on January 1, 2025, until the implementation of the OPPS.

Outpatient Prospective Payment System (OPPS)

Under an OPPS methodology, a single bundled payment amount is established for different types of outpatient and ED visits similar to a Diagnosis Related Group (DRG) methodology. Visits are assigned prospective rates based on the diagnosis and key services provided.

- The bundled payment amount may be adjusted for regional cost differences between facilities. For example, Medicare adjusts payments using a regional Hospital Wage Index.

- DHCS proposes to geographically vary reimbursement under the new OPPS methodology in alignment with the geographic localities under the Medicare OPPS.

- DHCS proposes to apply regional or hospital-specific equity adjustments to reimbursement under the new OPPS methodology to mitigate reimbursement disparities and the future risk of hospital closures. The equity adjustments may consider status as a health care worker shortage area, status as a rural or frontier area or urban health desert, critical access hospital designation, and concentration of Medi-Cal members as a percent of regional population. Equity adjustments will not be applied to ED facility services.

- This proposal allows DHCS to revise the adjustment factors in future years, in consultation with stakeholders, as new or improved data sources become available and in response to opportunities to improve or refine the factors' alignment to the goals of improving access and equity.

Designated Public Hospitals

DHCS proposes to target investments of $375 million ($150 million MPPRF) for designated public hospitals (DPHs) including county hospital systems and University of California systems.

- DHCS proposes to transition reimbursement for DPH inpatient services in the Medi-Cal FFS delivery system from the existing Certified Public Expenditures methodology to a Diagnosis Related Group (DRG)-type methodology.

- DHCS proposes to sunset in two stages the current methodology that provides for interim per-diem reimbursement and a subsequent reconciliation to 100 percent of cost.

- A DRG methodology uses diagnosis and procedure codes to assign an All Patient Refined Diagnosis Related Group (APR DRG) category and illness severity level to determine the final reimbursement amount for each inpatient hospital stay.

- DHCS proposes to annually calibrate the DRG methodology to target $150 million state fund expenditures, and notes that actual expenditures may vary based on utilization.

- DHCS does not propose to utilize an outlier methodology initially, although DHCS may implement an outlier policy in future years, if warranted.