



Healthcare Access in the Medi-Cal Program

October 2011

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California Assembly Bill (AB) 97 requires DHCS to implement up to a 10% provider payment reduction. Prior to implementation, DHCS must obtain approval from CMS to modify its Medicaid State Plan

The Centers for Medicare and Medicaid Services (CMS) required the California Department of Health Care Services (DHCS) to submit the following information: an outline of the baseline level of access to the Medi-Cal program, and the State's systematic approach to monitoring access to healthcare services.

In April 2011, CMS proposed new regulations affecting the review process for State Plan Amendments (SPAs). States proposing rate reductions must submit with their SPAs a baseline assessment of healthcare access for their fee-for-service (FFS) beneficiaries, and develop a plan for continuously monitoring healthcare access for FFS beneficiaries once provider rate reductions are implemented.

Defining Access to Healthcare Services

Access is generally thought of as a concept used to describe a broad set of concerns that focus on whether individuals or specific groups can obtain necessary healthcare services.

Defining access has been an evolutionary process. Initial attempts at defining access focused on whether individuals had insurance coverage. Later efforts were directed towards the number of providers and the efficiency of health care services¹.

¹ Gold, M. (1998). Beyond Coverage and Supply: Measuring Access to Healthcare in Today's Market. *Health Services Research*, 38, 809-829.

The National Academy of Science's Institute of Medicine (IOM) defines healthcare access as "the timely use of personal health services to achieve the best possible health outcomes²."

² Institute of Medicine. (1993) Access to Health Care in America. *National Academy Press*.

The Evolution of Medicaid Requirements Pertaining to Access to Healthcare Services

In 1989, Congress amended the Medicaid statute to place emphasis on access to healthcare services. Specifically, Section 1902(a)(30)(A) of the Social Security Act states, in part, that Medicaid plans must

“...assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in a geographic area.”

Until recently, the U.S. Department of Health and Human Services (HHS) had provided no thorough regulatory interpretation of the law. HHS had not provided guidance that explained how a state disclosed compliance with this provision or how to measure access.

Medi-Cal SPA Development

CMS identified the following principal areas that must be addressed in the SPA:

- Review all provider types affected by the proposed rate reduction and perform an initial evaluation of access and determine baseline utilization rates over CYs 2007 through 2009.
- Design and develop a process for continuously monitoring access to care that incorporates a quarterly monitoring or early warning element.
- Issue a corrective action plan when deficiencies are noted in access to healthcare services that includes explicit timelines for action.
- Design and develop an ongoing mechanism that allows beneficiary feedback, such as information collected through surveys, hotlines or beneficiary Ombudsman offices.
- Solicit input from beneficiaries and affected stakeholders with respect to the likely impact of the proposed changes.
- Design, develop, and issue an annual report describing and assessing access to healthcare services and make these reports available to the public.

California's state plan amendments were developed over a six-month period. DHCS staff, throughout the Department, evaluated all providers affected by the proposed rate reductions.

DHCS' Approach to Continuously Monitoring Access to Healthcare Services

DHCS' framework is adapted from a synthesis of several sources, including the IOM, the Agency for Healthcare Quality and Research, the MACPAC's report to congress, and the published works of health services researchers.

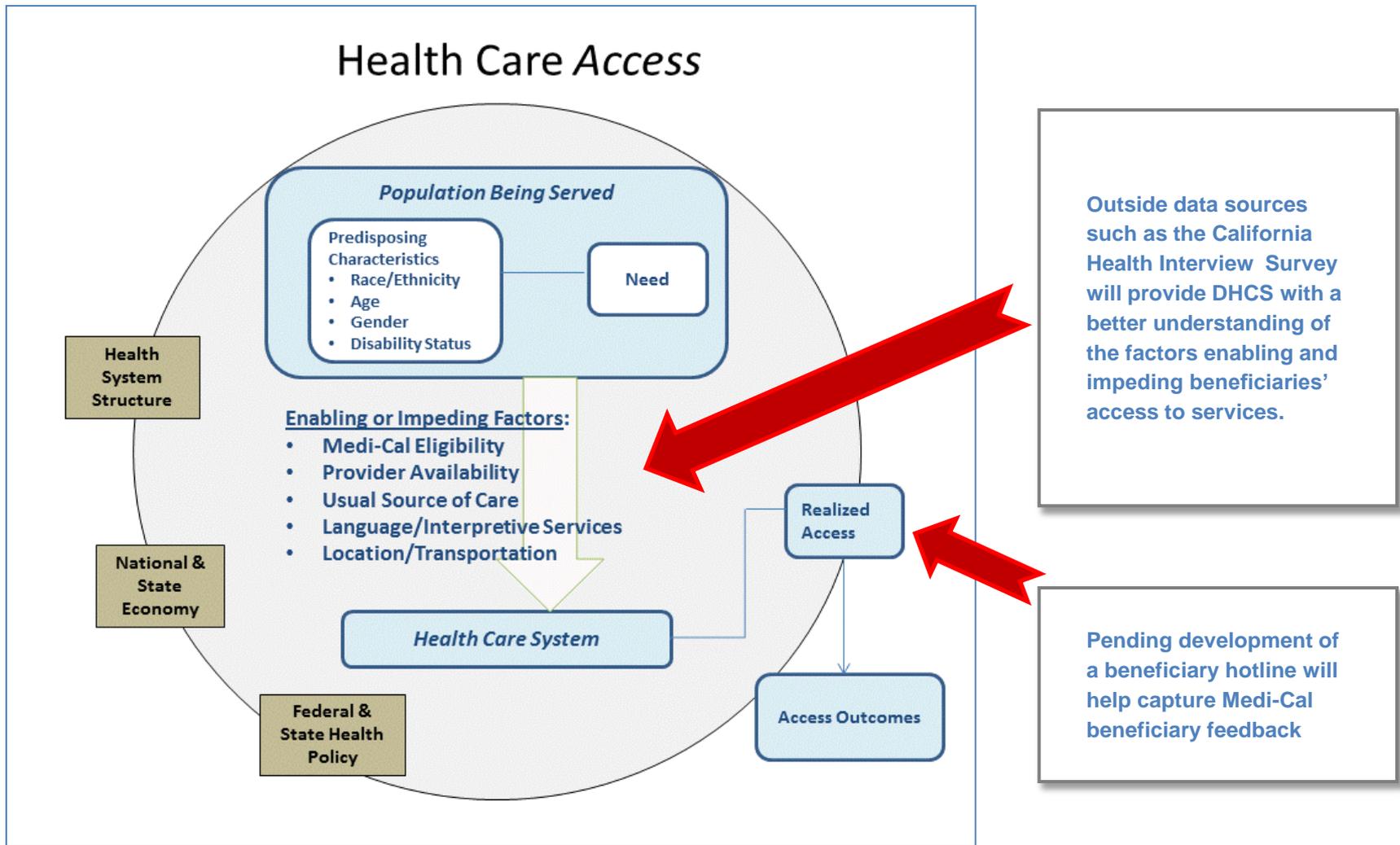
This framework establishes a basis for facilitating the Department's measurement and monitoring of healthcare access.

Monitoring access to healthcare services requires the identification of the various factors influencing utilization.

Determinants of Access:

- 1. Predisposing Characteristics of the Population.*
- 2. Need*
- 3. Enabling or Impeding Factors*
- 4. Realized Access*
- 5. Access Outcomes*

DHCS' Access Monitoring Framework



Medi-Cal Subpopulation for Whom DHCS Ensures Access for Purposes of the SPA

Distribution by Coverage and Care Delivery Category and Age Group; Calendar Year (CY) 2010

Age Group	FFS, Medi-Cal Only	Managed Care, Medi-Cal Only	FFS, Dual Eligible	Managed Care, Dual Eligible
Age 00 to 18	991,030	2,542,966	58	75
Age 19 to 64	1,385,688	1,203,264	245,035	83,702
Age 65 or Older	95,196	27,819	657,281	149,632
Grand Total	2,471,914	3,774,049	902,374	233,408
Percentage				
Age 00 to 18	40.09%	67.38%	0.01%	0.03%
Age 19 to 64	56.06%	31.88%	27.15%	35.86%
Age 65 or Older	3.85%	0.74%	72.84%	64.11%

During CY 2010, average monthly eligibles totaled 7.4 million.

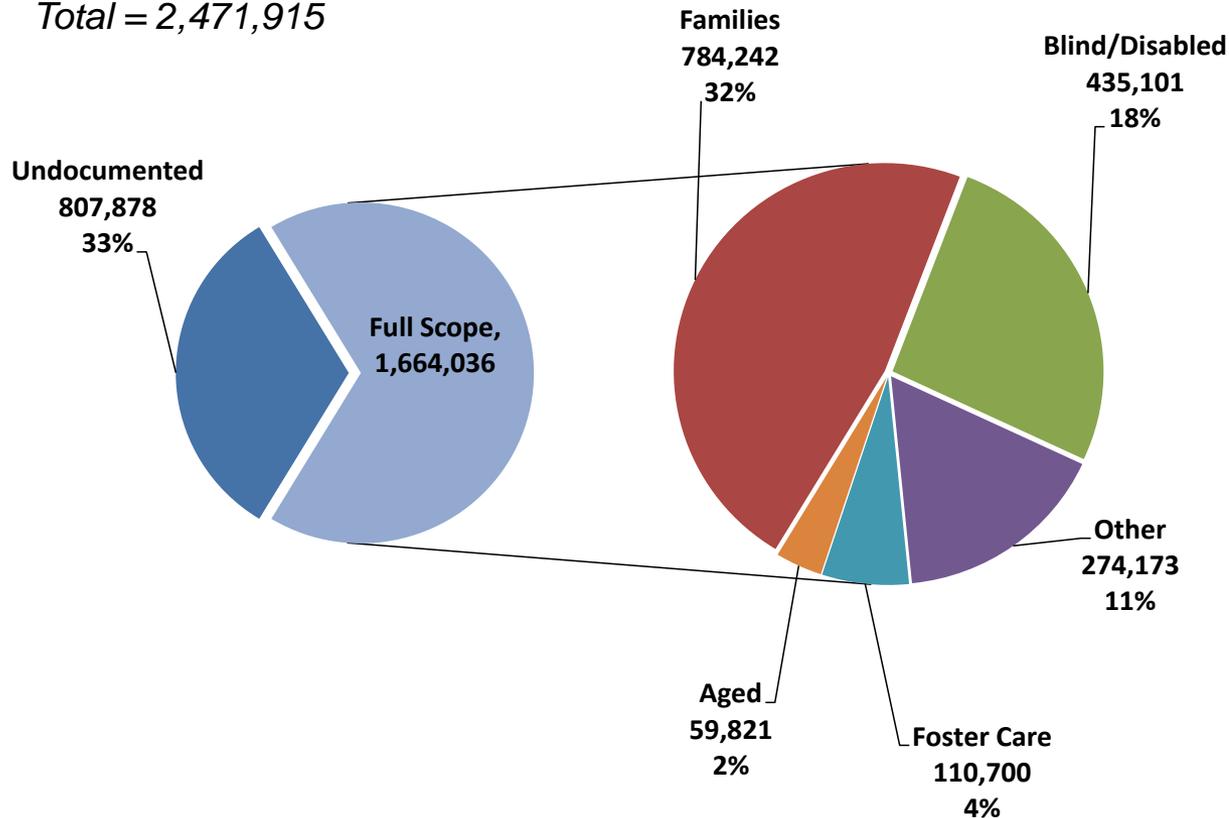
The current State Plan Amendments that will implement the AB 97 rate reductions require DHCS to ensure access to care for FFS, Medi-Cal only beneficiaries, who number roughly 2.5 million average monthly eligibles.

18% of these beneficiaries are blind and/or disabled, and many will be enrolling in managed care health plans in 2011 and 2012 under California's Section 1115 Demonstration waiver.

Source: Created by the DHCS Research and Analytic Studies Section using data from MEDS Eligibility System MMEF File. Data reflects a 12-month reporting lag.

Enrollee Characteristics of FFS, Medi-Cal Only Beneficiaries

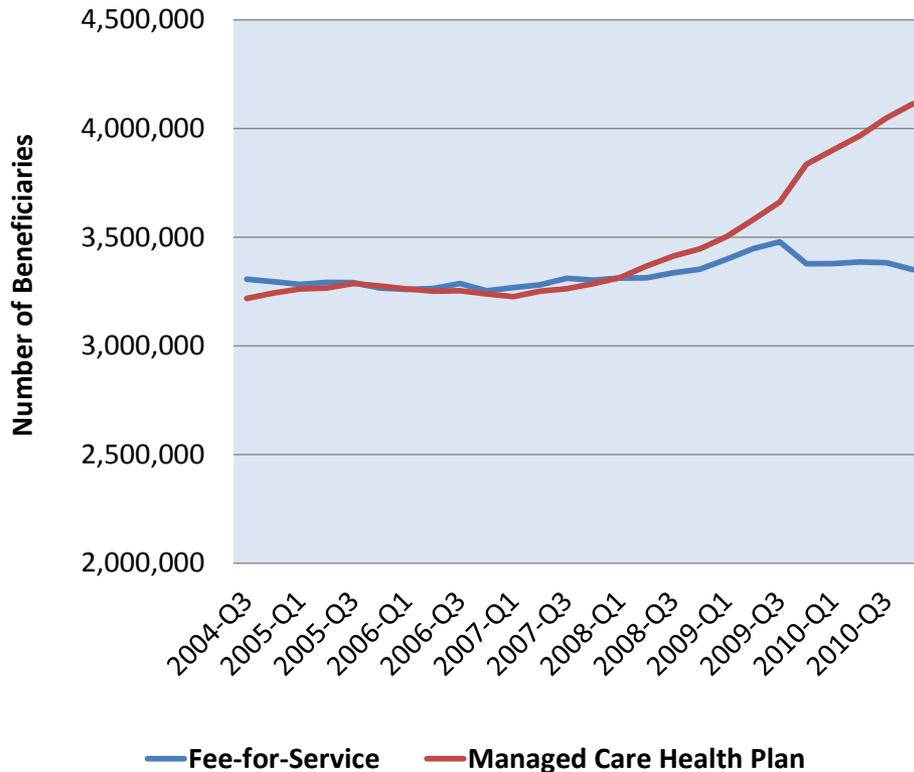
Average Monthly Enrollment
Total = 2,471,915



One third of the FFS, Medi-Cal only population were undocumented immigrants who were only eligible for emergency and pregnancy-related services. Undocumented immigrants account for approximately 44% of all Medi-Cal funded births in the state.

Source: RASS CINBxMOE Enrollment tables, extracts for months of enrollment in calendar year 2010

Trend in the Medi-Cal FFS and Managed Care Population



The number of Medi-Cal FFS beneficiaries will continue to decline as more counties and aid categories shift to Managed Care.

The abrupt drop in FFS enrollment was due to the transition of Sonoma, Merced, Kings, and Madera counties from a FFS delivery system to a managed care system.

Between the start of the recession and 2011, Medi-Cal experienced a significant expansion in enrollment. Roughly 1 million new eligibles were added.

Note: The numbers of beneficiaries represented in the chart include roughly 1,1 million dual eligible beneficiaries for whom Medicare is the primary payer. 900,000 are enrolled under Fee-for-Service and 200,000 under managed care.

Baseline Utilization and Initial Evaluation of Access to Healthcare Services

DHCS outlined the current level of access in the FFS, Medi-Cal only healthcare delivery model according to MACPAC's criteria.

Monitoring and analyzing the adequacy of the FFS, Medi-Cal only service delivery system provides a baseline for assessing how beneficiary's access to care and health outcomes are impacted by program changes.

Additionally, evaluating the program's growth trends and demographics provides administrators with a better understanding of the Medi-Cal population's healthcare needs.

Medicaid and CHIP Payment and Access Commission (MACPAC) Recommended Framework

Enrollees

- Eligibility Requirements & Copays
- Demographic & Geographic Characteristics
 - Women and Children
 - Culturally Diverse
 - Rural and Urban Areas
- Complex Healthcare Needs
 - Self-Rated “Poor” Health
 - Chronically Ill
 - Physically and Intellectually Disabled

Availability

- Providers
 - Supply
 - Mix of Specialists
 - Participation
 - Location to Enrollees
- Healthcare Settings
- Policies & Reimbursement Adequacy

Utilization

- Service Use
 - Variations by Subpopulations
 - Appropriateness of Use
 - Affordability of Services
- Usual Source of Care
- Enrollee Perceived Quality
- Transportation, Language & Office Hours

MACPAC’s recommended framework for evaluating healthcare access outlines three broad focus areas: enrollees and their unique characteristics, provider availability, and healthcare utilization. DHCS incorporated these three areas into the baseline access assessment and into its monitoring plan.

Source: This chart is adapted from Chapter Four of the Medicaid and CHIP Payment and Access Commission’s March 2011 report to Congress.

Baseline Healthcare Access Assessment, 2007 thru 2009

The baseline analysis of healthcare access followed a three prong approach:

- **Evaluation of Medi-Cal FFS population characteristics** included the size of the population, demographics, prevalence of clinical conditions, trends in enrollment, geographic dispersion, and length of enrollment.
- **Evaluation of FFS Medi-Cal provider network capacity** included population-to-provider ratios with comparisons to state-wide and geographic specific ratios, and HRSA's Health Professional Shortage Area (HPSA) benchmark. Network capacity analyses also included provider participations rates, and trends in provider enrollment by type.
- **Evaluation of service utilization trends** among specific FFS beneficiary subpopulations, by geographic regions and age groups. Comparisons to national norms or standards established by national medical organizations were made, when feasible.

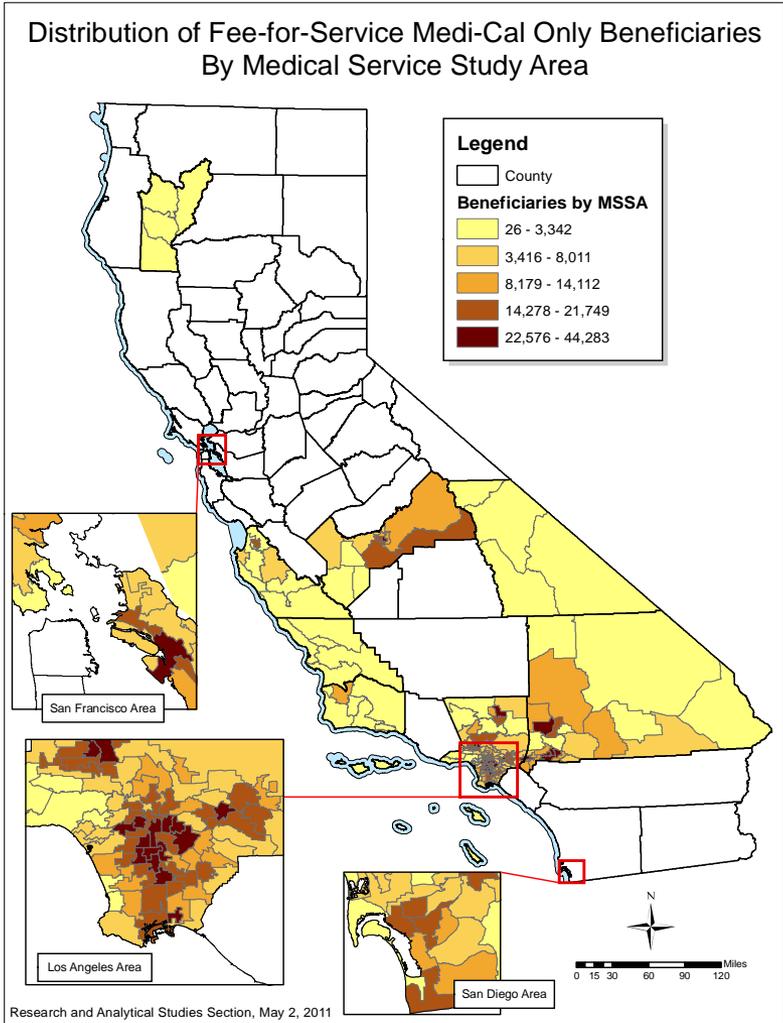
DHCS extracted data from administrative data sources for the period 2007 - 2009. During this period Medi-Cal absorbed nearly one million additional beneficiaries. DHCS evaluated the increased enrollment's impact on access to health care services over time. Specific service utilization trends included:

- *Physician/Clinics*
- *Emergency and non-Emergency Medical Transportation*
- *Home Health*
- *Hospital Inpatient and Outpatient Services*
- *Nursing Facilities*
- *Pharmacy*

1. Medi-Cal Enrollees

- The FFS, Medi-Cal only population represented 36% of the total Medi-Cal population and generated 62% of total FFS expenditures.
- The FFS, Medi-Cal only population were primarily enrolled in the following aid code categories: Families (32%), Blind/Disabled (18%), Foster Care (4%), and Aged (2%).
- The FFS, Medi-Cal only population was comprised of 57% females and 43% males. Around 42% of this population were children younger than 19 years of age, while Adults aged 19 – 64 and older than 64 years of age comprised 54% and 04% of the population respectively.
- Between 2007 and 2009, the FFS, Medi-Cal only population increased by 4.6%. The rate of increase among beneficiaries residing in metropolitan areas was similar at 4.3%, while those residing in non-metropolitan areas increased by twice the rate at 9%.
- The most prevalent conditions afflicting the FFS, Medi-Cal only population included: Hypertension, Diabetes, Back disorders, Hyperlipidemia and Bipolar Disorder. Together, these conditions affected more than ten percent of the population. The most expensive beneficiaries on a per-person basis are those with diagnoses for Respiratory Failure, Renal Failure, Leukemia, Hemophilia and Congestive Heart Failure.

Enrollee Characteristics – Geographic Distribution



Seventy-eight percent of the FFS, Medi-Cal population resided in areas with a population density classified as “urban”. Twenty-one percent lived in areas classified as “rural” and one percent were found in areas classified as “Frontier”.

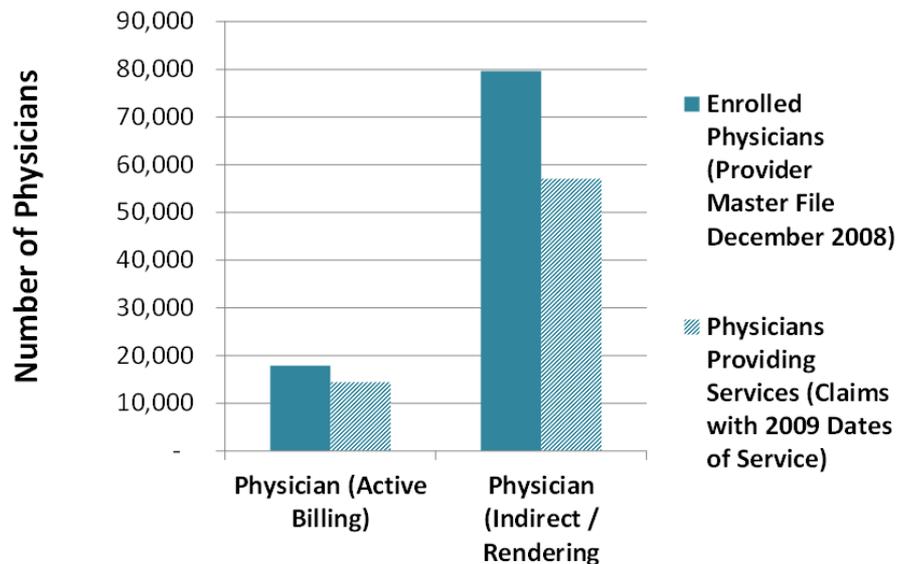
Beneficiaries are notably absent in the coastal counties that primarily utilize the County Organized Health System (COHS) model of managed care.

2. Provider Availability

- Provider Master File counts indicated that the number of enrolled Medi-Cal physicians has increased over the period 2008 through 2010. For instance, active Medi-Cal physicians and indirect billing physicians increased by 6%, and 11% over this time period respectively.
- The analysis of physician participation revealed a high number of physicians providing services in 2009. About 80% of the active physicians and 72% of indirect billing physicians enrolled in December 2008 provided Medi-Cal services and were paid in 2009.
- The Medi-Cal, FFS population-to-provider ratios ranged from 4.8 in San Mateo County to 289 in Glenn County. County-level Medi-Cal population-to-physician ratios tended to parallel trends for the entire State population.
- Urban areas enjoyed greater numbers of physicians relative to the population than rural areas. A greater proportion of care in rural counties was clinic-based compared to urban areas.
- The number of enrolled (durable medical equipment) DME providers increased by 6.1% from 2007 through 2011.
- The number of enrolled clinical laboratories increased by 18.8% from 2007 through 2011.
- The number of enrolled emergency medical transportation providers increased by 7.2% from 2007 through 2011. Air ambulance displayed a slight decline over this time frame, from 47 providers to 46, but has held stable at 46 providers since 2009.
- The number of enrolled non-emergency medical transportation providers increased by 7.2% from 2007 through 2011.
- The number of enrolled home health providers increased by 50.9% from 2007 through 2011.
- The population to provider ratio for dental services has increased, from 393 to 400 over the period 2007 through 2009.

Trend in Physician Enrollment and Participation

Number of Physicians				
Date / Status	Dec. 2008	Dec. 2009	Dec. 2010	Percent Change
Active / Billing	17,411	18,007	18,441	5.9%
Indirect / Rendering	79,420	84,439	88,262	11.1%



Counts of enrolled Medi-Cal physicians listed in the Provider Master File indicates that their number has increased.

To determine levels of participation, DHCS compared the number of enrolled physicians with the number of physicians who submitted claims or appeared as rendering physicians on claims.

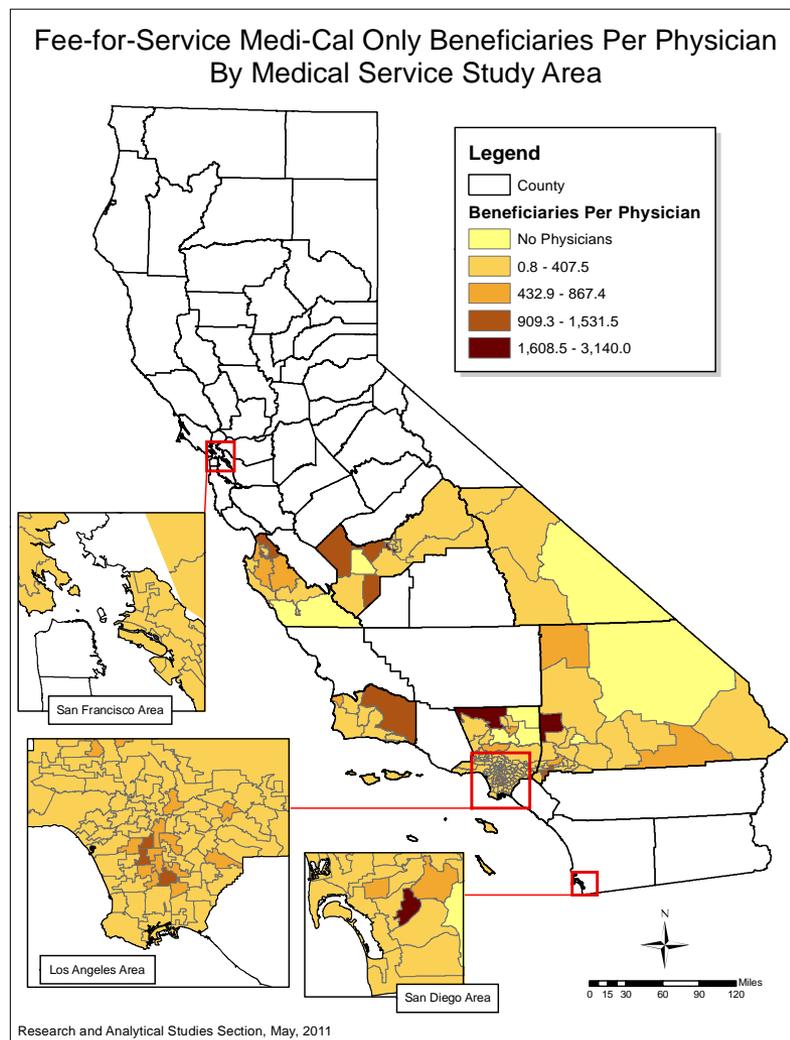
The analysis of physician participation revealed a high number of physicians providing services, as reflected in the Fee-for-Service claims data of 2009.

Source: Medi-Cal Provider Master File and Fiscal Intermediary's 35-File of Paid Claim records with dates from January 1, 2009 through December 31, 2009.

Population to Physician Ratios by MSSA

The MSSA map presents a picture of primary care physician capacity. The range of population-to-physician ratios spans from 0.8 to 3,140.0, with an overall average of 59 FFS beneficiaries for every Medi-Cal primary care physician.

The areas reported as having no physicians represent medically underserved areas and are underserved for all California residents



DHCS' analysis employed population-to-provider ratios based on enrolled "Active" billing and rendering (indirect) providers to measure potential access along a variety of dimensions. Ratios were studied at both the county- and MSSA-level and disclosed no alarming patterns that suggest acute shortages of physicians. The ratio of 59 beneficiaries for every primary care physician was far below the 3,500-1 ratio of "high need" based on HRSA's methodology.

3. Medi-Cal Utilization

- Service utilization rates per 1,000 member months varied little between 2007 and 2009, even though Medi-Cal enrollment increased by over 1 million due to the recession. Utilization rates for skilled nursing services experienced slight decreases during the study period. This is hypothesized to be attributed, in part, to the Department's efforts to shift beneficiaries away from institutional care to home and community based services.
- Among FFS, Medi-Cal only adults with at least 12 months of continuous enrollment, the proportion receiving an annual physician visit remained relatively unchanged from 2007 (81.9%) to 2009 (82.0%). This trend in physician visits compares favorably with results from the National Health Interview Survey (NHIS), and was shown to be similar to the national average of 80.6% among adults age 18 and older.
- Overall trends and fluctuations in service utilization rates by provider types subject to the rate reduction were found to be within the expected ranges using control chart methodology. Control limits set by this analysis will serve as reference ranges for future data observations, and provide a method for identifying deviations in predicted utilization patterns.
- Utilization of DME per 1000 member months remained relatively constant over the period evaluated. Adults were the primary users of this service.
- Utilization of clinical laboratory services per 1000 member months remained constant for both adults and children over the period evaluated.
- Utilization of non-emergency medical transportation services per 1000 member months increased over the period evaluated.
- Utilization of home health services declined for adults and children in every aid code category group and all geographic areas over the period evaluated.
- The percentage of children with an annual dental visit increased over the period 2007 through 2009 (45.3% to 49.2%).

Utilization of Medi-Cal Physician Services

Statewide Trends in Total Physician and Clinic Visits				
	Statewide Rates			
	2007	2008	2009	
Adults				
Aged	932.6	919.4	928.0	
Blind/Disabled	1076.8	1100.0	1134.2	*
Families	558.1	558.7	564.0	
Other	1162.0	1234.6	1284.8	*
Undocumented	277.7	274.4	262.6	*
All Adults	624.5	629.4	628.8	
Children				
Blind/Disabled	542.1	544.0	590.7	*
Families	308.8	306.7	321.5	
Foster Care	268.9	266.8	285.4	
Other	480.6	480.2	486.2	
Undocumented	230.9	222.9	206.3	*
All Children	339.5	337.2	348.4	

Source for tables above: Fiscal Intermediary's 35-File of Paid Claim records with dates from January 1, 2007 through December 31, 2009, and data from the MEDS Eligibility System, MMEF File.

* Data points for 2009 are statistically different from Years 2007 at $\alpha = .05$.

DHCS examined trends in physician and clinic visits for Medi-Cal FFS beneficiaries using broad age groupings (adult vs. child) and aid codes as a proxy for health and disability status.

Utilization rates for physician and clinic visits varied little over the three annual time periods, except among those in the Blind/Disabled and adults in the "Other" aid categories where utilization for both groups significantly increased from 2007 to 2009.

Services Exempt from the Payment Reductions

<i>Total Children Statewide</i>	<i>Proportion with at Least One Visit¹</i>	<i>National Average²</i>
<i>Age <1</i>	<i>92.3%</i>	<i>89.5%</i>
<i>1</i>	<i>89.3%</i>	
<i>2</i>	<i>82.7%</i>	
<i>3-4</i>	<i>74.9%</i>	
<i>5-9</i>	<i>54.4%</i>	
<i>10-14</i>	<i>47.4%</i>	
<i>15-17</i>	<i>51.8%</i>	
<i>18-20</i>	<i>50.4%</i>	

¹ Physician visits include visits to sole physician practitioners, physician groups, clinic visits, hospital outpatient ER visits, and hospital outpatient non-emergency visits.

² Source: Data from the National Health Interview Survey, as published in Health, United States, 2010, retrieved from www.cdc.gov/nchs/hus.htm

DHCS withdrew reduction proposals for:

- Physician and clinic visits due to the results from the above analysis]
- Home Health due to utilization declining over the three year period
- Distinct Part Adult Subacute due a shortage in bed capacity.
- ADHC centers in certain geographic areas due to the low supply of centers.

While the majority of Medi-Cal FFS children age 24 months and younger received at least one physician visit during the year (83% to 92%), only half of the children age 5 and older received the recommended annual physician visit as prescribed by the American Academy of Pediatrics during calendar year 2009.

These utilization rates are well below the national average of 90% for US children.

Merits of Baseline Assessment

Data prepared for the baseline analyses will serve as the foundation for comparing future data points, and will help DHCS assess the impact of newly implemented program policies in the Medi-Cal FFS program.

Although trends and fluctuations in most service categories subject to the rate reduction were found to be within the expected ranges, utilization trends in a few service categories raised concerns. To address these concerns, the Department modified its provider rate reduction policies to exclude these service categories: physician and clinical services for children ages 0-20, home health services, and distinct part adult sub-acute facilities.

Additionally, the baseline analysis helped the Department identify gaps in needed data pertaining to beneficiary feedback. Once identified, plans were undertaken to establish a beneficiary hotline to help address this data gap.

DHCS' Analytic Framework for Evaluating Healthcare Access

The process of monitoring healthcare access includes the collection and analysis of data, and the interpretation of trends.

DHCS identified several healthcare access measures based on each of three key areas recommended by MACPAC that are known to influence healthcare access, and that would provide useful data on access among Medi-Cal beneficiaries for state policymakers.

Once in place, data collected from the access measures may reveal problem areas or concerns affecting the appropriate use or underuse of healthcare services.

The steps involved in the access monitoring process include defining the problem area, undertaking investigations to identify the root cause of data variations, implementing solutions, and evaluating the effectiveness of these solutions.

DHCS' Reporting and Continuous Monitoring Activities

DHCS will continuously monitor Medi-Cal beneficiaries' access to healthcare services throughout the year.

Each calendar quarter DHCS will evaluate selected measures for evidence of an early warning alert that may signal a healthcare access problem.

Additionally, DHCS will annually report on the identified 23 specific access measures. Reports will be publically available on the Department's website.

DHCS' quarterly monitoring system incorporates four specific measures designed to alert DHCS of any access problems:

- 1. Change in Medi-Cal enrollment*
- 2. Provider participation rates*
- 3. Service rates per 1000 member months*
- 4. Beneficiary hotline calls*

Health Care Access Indicator Measures

<i>Topic/Measure</i>	<i>Frequency of Reporting</i>	<i>Administrative Data</i>	<i>Survey Data</i>	<i>Comparison</i>
Beneficiaries				
Percent Change in Medi-Cal Enrollment	Q	MMEF		Program Trends
Percent Change in Medi-Cal Dental Enrollment	Q	MMEF		Program Trends
Provider Availability				
Provider Supply Ratios	Y	MMEF, PMF		HRSA Ratios, Statewide Ratios
Dental Provider Ratios	Y	MMEF, PMF		Program Trends
Provider Participation Rates	Q	PMF, Claims		Program Trends
Pharmacy Participation Rates	Y	Claims, DCA Board of Pharmacy Licensing		Program Trends
LTC Provider Participation Rates	Y	CDPH Licensing And Certification Program data		Program Trends
Ratio of LTC Occupied Bed Days	Y	OSHPD and Audit Data		Program Trends
Medi-Cal LTC Bed Vacancy Rates	Y	OSHPD and Audit Data		Program Trends
Percent Beneficiaries with Usual Source of Care	Bi-Annually		CHIS	CHIS, NHIS, MEPS
Beneficiary/Provider Language Discordance	Bi-Annually		CHIS	CHIS Respondents with Other Insurance
Service Use				
Percent of Beneficiaries with at Least one Physician Visit	Y	MMEF, Claims		CHIS, NHIS, MEPS
Mean Physician Visits During the Year	Y	MMEF, Claims		NHIS
Percent Children with at Least one Dental Visit	Y	MMEF, Claims		CHIS, NHIS, MEPS
Service Utilization Rates per 1,000 Member Months	Q	MMEF, Claims		Program Trends
Emergency Department Rates per 1,000 Member Months	Y	MMEF, Claims		Program Trends
Beneficiary Perceived Timely Access to Needed Care	Bi-Annually		CHIS	CHIS Respondents with Other Insurance
Timely Prenatal Care	Y	Claims, Vital Stats		Births for Other Payer Sources and Statewide Births
Access Outcomes				
Preventable/Avoidable Hospitalization Rates	Y	Claims, OSHPD		Program Trends, Statewide Avoidable Hospital Rates
Percent of Low Birth Weight Babies	Y	Claims, Vital Stats		Births for Other Payer Sources and Statewide Births
Percent of Preterm Births	Y	Claims, Vital Stats		Births for Other Payer Sources and Statewide Births
Help Line Calls Categorized by Access Issues	Q	Call Center Data		Trends
NOTES: Q = Quarterly, Y = Yearly				

Summary of Provider Payment Reductions in SPAs

Approved 10/27/2011

Outpatient Providers		
Service	Effective Date	Reduction
Physicians (Children), Clinics (Children), Los Angeles County Clinics (Children)	3/1/09 - Forward	1%
Physicians (Adult), Clinics (Adult), LA Clinics (Adult), Optometry, & Dental	3/1/09 - 5/31/11	1%
	6/1/11 - Forward	10%
Other Medical - All Other	7/1/08 - 2/28/09	10%
	3/1/09 - 5/31/11	1%
	6/1/11 - Forward	10%
Hospital Outpatient Departments	7/1/08 - 2/28/09	10%
	3/1/09 - 4/5/09	1%
	1/1/11 - 4/12/11*	1%
Non Emergency Medical Transportation	7/1/08 - 11/16/08	10%
	3/1/09 - 5/31/11	1%
	6/1/11 - Forward	10%
Emergency Medical Transportation	7/1/08 - 2/28/09	10%
	3/1/09 - 5/31/11	1%
	6/1/11 - Forward	10%
Home Health	7/1/08 - 11/16/08	10%
	3/1/09 - Forward	1%
Pharmacy - Drugs	3/1/11 - 5/31/11*	5%
	6/1/11 - Forward	10%
Pharmacy - Non-Drugs	7/1/08 - 2/28/09	10%
	3/1/09 - 5/31/11	5%
	6/1/11 - Forward	10%
Adult Day Health Care	3/1/09 - 3/8/09	5%
	3/1/11 - 5/31/11* +	5%
	6/1/11 - Forward +	10%

For dates not specifically listed, provider payment for that category is not subject to a reduction during that period.

** Currently under injunction from this payment reduction.*

+ Payment reductions for Adult Day Health Care centers will be applied only in specified metropolitan areas.

Summary of Provider Payment Reductions in SPAs Approved 10/27/2011

LTC Providers		
Service	Effective Date	Reduction
Nursing Facility (NF) Level A	7/1/08 - 2/28/09	10%
	3/1/09 - 5/31/11	5%
	8/1/09 - 5/31/11	Frozen 0809 Rate Reduced by 5%
	6/1/11 - Forward	Frozen 0809 Rate Reduced by 10%
Distinct Part (DP) NF - Level B	7/1/08 - 2/28/09	10%
	3/1/09 - 4/5/09	5%
	8/1/09 - 2/23/10	Frozen 0809 Rate
	3/1/11 - 5/31/11*	Frozen 0809 Rate Reduced by 5%
	6/1/11 - Forward	Frozen 0809 Rate Reduced by 10%
DP Adult Subacute	7/1/08 - 2/28/09	10%
	3/1/09 - 4/5/09	5%
	8/1/09 - 2/23/10	Frozen 0809 Rate
DP Pediatric Subacute	7/1/08 - 2/28/09	10%
	3/1/09 - 4/5/09	5%
	8/1/09 - 2/23/10	Frozen 0809 Rate
	6/1/11 - Forward	TBD
Free standing (FS) NF-B & FS Adult Subacute (AB 1629)	8/1/09 - 7/31/10	0% Increase
	8/1/10 - 7/31/11	3.9% Increase
	6/1/11 - 7/13/12	10%
	8/1/12 - 7/31/13	2.4% Increase + Reimburse for 13 month 10% decrease
Intermediate Care Facility for the Developmentally Disabled	8/1/09 - 5/31/11	Frozen 0809 Rate
	6/1/11 - Forward	TBD
FS Pediatric Subacute Facilities	8/1/09 - 5/31/11	Frozen 0809 Rate
	6/1/11 - Forward	TBD
Rural Swing Bed	7/1/08 - 10/31/08	10%
	8/1/09 - 2/23/10	Frozen 0809 Rate
	3/1/11 - 5/31/11*	Frozen 0809 Rate
	6/1/11 - Forward	TBD

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Summary of Provider Payment Reductions in SPAs Approved 10/27/2011

Hospitals - Inpatient		
Service	Effective Date	Reduction
Non-Contract Hospitals (17 in Santa Rosa)	07/1/08 - 09/30/08	10%
	10/1/08 - 04/5/09	Lesser of 10% or average CMAC rate minus 5%
	04/6/09 - 11/17/09	10%
	01/1/11 - 04/12/11*	Lesser of 10% or average CMAC rate minus 5%
Non-Contract Hospitals (all others not contained in other categories)	7/1/08 - 9/30/08	10%
	10/01/08 - 4/5/09	Lesser of 10% or Average CMAC minus 5%
	4/6/09 - 12/31/10	10%
	1/1/11 - 4/12/11*	Lesser of 10% or Average CMAC minus 5%
Non-Contract Small & Rural (Critical Access Hospitals & Federal Rural Referral Centers)	7/1/08 - 10/31/08	10%
Non-Contract Small & Rural Hospitals (Non-CAH, Non-Fed RRC)	7/1/08 - 10/31/08	10%
	7/1/09 - 2/23/10	10%
	1/1/11 - 4/12/11*	10%
Non-Contract Hospital in Open Areas w < 3 Hospitals	7/1/08 - 4/12/11	10%

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