

**Medi-Cal Managed Care Program: Impact of the Rogers Amendment  
on Contracts between Participating Health Plans and Hospitals  
and Access to Hospital Services by Medi-Cal Beneficiaries**

Statutory Report to the California State Legislature  
Policy and Fiscal Committees

Submitted by:  
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# Medi-Cal Managed Care Program: Impact of the Rogers Amendment

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## Purpose of the Report

Subsections 14091.3 and 14166.245 were added to the Welfare and Institutions Code (W&I Code) as the State's effort to implement Section 6085 of the federal Deficit Reduction Act of 2005, also known as the "Rogers Amendment," and to establish separate payment amounts for emergency-based inpatient and post-stabilization services. "Emergency-based services" means hospitalization to treat acute symptoms of sufficient severity that the absence of immediate medical attention could place the patient's health in serious jeopardy (W&I Code Subsection 14007(d)). "Post-stabilization services" are medically necessary inpatient care following a physician's determination that the patient's health is no longer in sufficient jeopardy as to prevent the patient's transfer to another health care facility (W&I Code Section 14103.5).

This report refers to both the State and federal statutes as the Rogers Amendment. The intent of this law is to establish a basis for Medi-Cal managed care health plans to make reasonable payments to hospitals that are outside of a health plan's provider network (i.e., out-of-network hospitals) for outpatient services, emergency inpatient services, and post-stabilization services following an emergency-based hospital admission provided to Medi-Cal Plan enrollees. Historically, out-of-network hospitals have occasionally negotiated or litigated payments from participating health plans that were high enough for the federal Centers for Medicare and Medicaid Services (CMS) to determine as unreasonable. With this federal law, CMS intends to reduce the potential for legal disputes and payment issues between health plans and out-of-network hospitals over the cost of providing emergency inpatient and post-stabilization care to Medi-Cal beneficiaries. Therefore, the State Legislature determined that it should monitor the actual impact of this federal law on the State's Medi-Cal managed care program.

Subsection 14091.3(e) of the Welfare and Institutions Code mandates that the Department of Health Care Services (DHCS) provide a written report to the policy and fiscal committees of the State Legislature, "on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and Medi-Cal managed care health plans, including the increase or decrease in the number of these contracts." This law became effective January 1, 2007; therefore, the report will describe impacts from January 1, 2007 forward. DHCS collected data from Plans across all of its managed care programs: Two-Plan Model, County Organized Health Systems, Geographic Managed Care, and Program for All-Inclusive Care for the Elderly.

Medi-Cal managed care health plans were asked to provide data on the impact of the Rogers Amendment on hospital contracting from 2007 through 2009. With this information, DHCS was able to assess differences in reporting between health plans to determine if the conclusions from the data are consistent with actual practice. The overall completeness and consistency of the reported data was good. Some of requested data, especially related to post-stabilization, is not typically tracked or monitored by health plans; therefore, the data on bed days following an emergency-

based admission are more complete than for post-stabilization bed days. The results of this inquiry are included in this report. Despite the relative consistency of this data, only additional data collection over the four-year period of this review (January 2007–December 2010) will reveal the actual impact of the Rogers Amendment on hospital contracting and enrollee access to hospital services.

### **Contracts between Hospitals and Managed Care Health Plans**

To date, our analysis has identified no reliable trend in the numbers of hospitals contracting (i.e., in-network) with Medi-Cal managed care health plans since the Rogers Amendment became effective.

Our initial assessment indicates that the State’s version of Rogers required all but one health plan to *increase* payments to out-of-network hospitals; however, it is too soon to tell if these payments might decrease in subsequent years, as the Rogers Amendment intended. When surveyed, several Chief Financial Officers of health plans offered that the Rogers Amendment establishes a greater degree of “certainty” and “fairness” to the payment of out-of-network hospitals for emergency admissions despite increased costs. Rogers allows health plans to more accurately budget their operations.

Medi-Cal managed care health plans negotiate rates with out-of-network hospitals to cover the cost of treating their enrolled Medi-Cal members when they are admitted to out-of-network hospitals in need of emergency care. To establish a basis for reasonable payments, the Rogers Amendment requires health plans to pay out-of-network hospitals a rate based on the regional average of payments made to hospitals by the California Medical Assistance Commission (CMAC). However, CMAC’s calculation of regional average rates includes the much-higher rates paid to children’s hospitals and the CMAC-negotiated rates, which generally fall between the lower and higher bounds of the actuarially calculated rate ranges established by DHCS for managed care health plans. Therefore, nearly all participating health plans have historically negotiated rates with out-of-network hospitals that are much lower than the CMAC average.

Another possible reason for the lack of significant change in the number of contracted hospitals is that most hospitals have multiple-year contracts with health plans; therefore, this initial report, based on the first three years (2007, 2008, and 2009) of the study, might not reflect the full scope of change that may occur as multiple-year contracts expire. With a longer time horizon in which in-network hospital contracts might expire, and renegotiation ensues, it is possible that more significant findings might be shown in subsequent reports from DHCS to the State Legislature on this subject.

### **Enrollee Access to Hospital Services**

The Rogers Amendment addresses payments made to out-of-network hospitals that may be excessive. Therefore, the law requires DHCS to monitor out-of-network hospitals for any reduction in services provided to Medi-Cal beneficiaries that may be motivated by the out-of-network hospital having received lower payments for these services.

It is important to note that measurement of “access” may be problematic when it is linked to emergency-based admission because hospitals have little discretion under the law on whether to admit a patient if space is available per Title 42, United States Code, Section 1395dd.

Once a patient, admitted under emergency conditions, is determined to be stable, an out-of-network hospital must notify the patient’s Medi-Cal managed care health plan so the patient may be moved, at the health plan’s discretion, to a hospital that is contracted with the health plan for the patient’s post-stabilization recovery period. In some cases, hospital overcrowding or cost-savings efforts may prevent moving health plan enrollees to in-network hospitals.

DHCS collected data on emergency-based admissions to out-of-network hospitals paid for by health plans during calendar years 2007, 2008, and 2009. The data, collected on a quarterly basis for the first three years during which Rogers has been in effect, indicate little significant change from year to year. A sharp decrease in out-of-network emergency-based admissions in 2009 may indicate a future trend as described below. Each quarter, health plans paid for approximately 57,000 emergency-based admissions to out-of-network hospitals.

The data collected to date establishes a baseline against which DHCS will analyze changes in enrollee access to out-of-network hospitals that involve emergency admissions through calendar year 2010. The final report to the State Legislature in January 2011 will more accurately reflect the actual impact of the Rogers Amendment on enrollee access to hospital services.

The table (next page) and charts (following page) summarize the data received from Medi-Cal managed care health plans describing the number of bed days paid for that resulted from emergency-based admissions to both in-network and out-of-network hospitals. Data collected for these three years indicate enrollment of Medi-Cal beneficiaries in health plans increased by 11.44 percent. The number of bed days resulting from an emergency admission increased by 17.67 percent at in-network hospitals and *decreased* 9.50 percent at out-of-network hospitals for an average increase of 4.08 percent in emergency admissions. The number of post-stabilization bed days following an emergency admission increased by 9.08 percent at in-network hospitals and increased by 9.07 percent at out-of-network hospitals.

The trend away from providing emergency services in out-of-network hospitals has increased with the addition of 2009 data; however this trend continues to be tempered by significant differences in the data from one quarter to the next. This change may be affected by the continued expansion of the Medi-Cal Managed Care program, resulting in more hospitals contracting with more health plans. Only further data collection and time can confirm whether this trend is relevant to the Rogers Amendment.

**Medi-Cal Managed Care: Provision of Emergency-Based In-Patient Care by Hospitals In and Out of a Health Plan's Provider Network**

<b>All Emergency-Admission Bed Days from 2007 to 2009</b>					
	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	62,600	68,484	66,819	9.40%	6.74%
<b>30-Jun</b>	57,646	61,971	65,185	7.50%	13.08%
<b>30-Sep</b>	58,427	64,230	68,244	9.93%	16.80%
<b>31-Dec</b>	58,722	61,206	62,895	4.23%	7.11%
<b>Totals</b>	237,395	255,891	263,143	7.77%	10.93%

<b>All Post-Stabilization Bed Days from 2007 to 2009</b>					
	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	45,953	50,160	49,259	9.16%	7.19%
<b>30-Jun</b>	39,031	45,539	47,879	16.67%	22.67%
<b>30-Sep</b>	42,597	49,313	45,470	15.77%	6.74%
<b>31-Dec</b>	43,051	45,946	42,759	6.72%	-0.68%
<b>Totals</b>	170,632	190,958	185,367	12.08%	8.98%

<b>In-Network Emergency-Admission Bed Days from 2007 to 2009</b>					
Quarter Ending	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	48,004	51,111	52,866	6.47%	10.13%
<b>30-Jun</b>	43,685	47,217	51,337	8.09%	17.52%
<b>30-Sep</b>	43,400	50,197	55,082	15.66%	26.92%
<b>31-Dec</b>	44,223	47,319	51,352	7.00%	16.12%
<b>Totals</b>	179,312	195,844	210,637	3.32%	17.67%

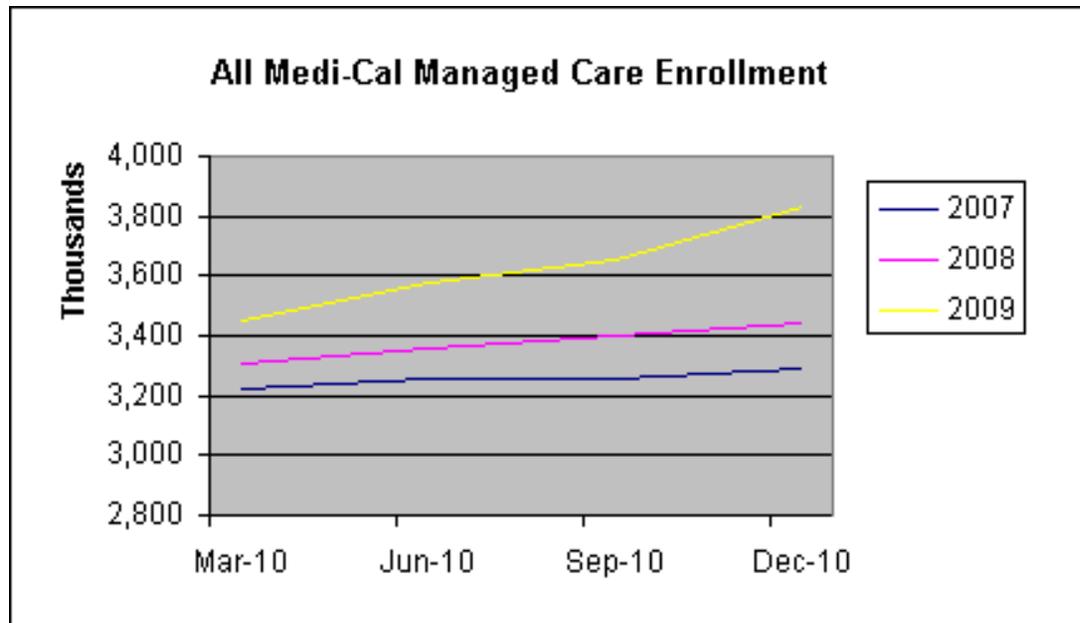
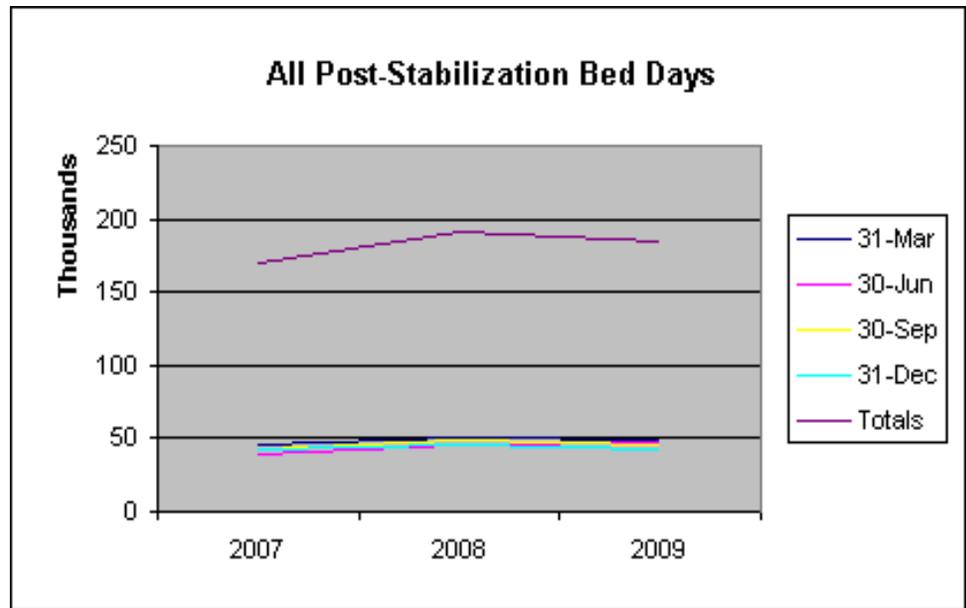
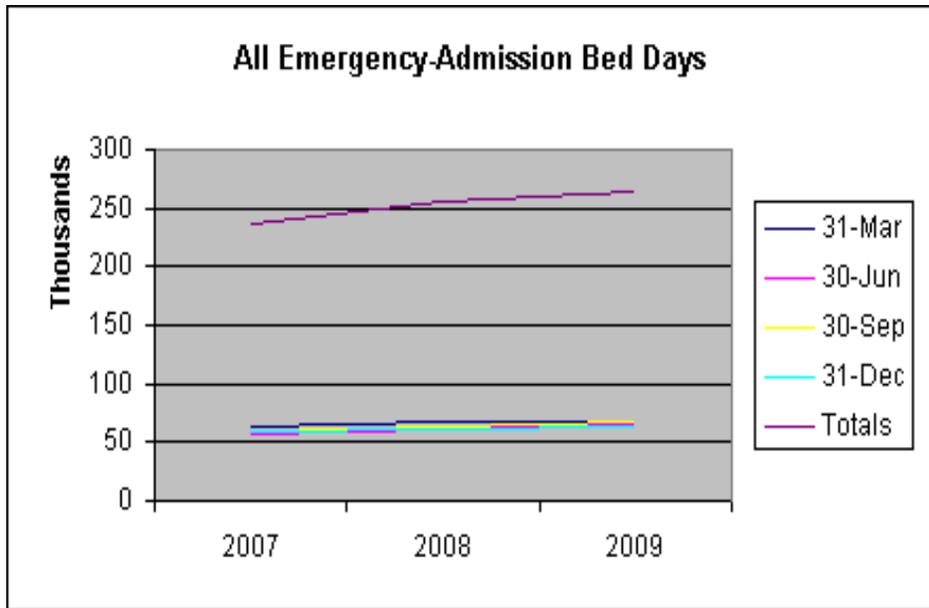
<b>In-Network Post-Stabilization Bed Days from 2007 to 2009</b>					
Quarter Ending	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	36,924	40,339	39,807	9.25%	7.81%
<b>30-Jun</b>	32,314	37,131	38,770	14.91%	19.98%
<b>30-Sep</b>	34,206	40,220	36,888	17.58%	7.84%
<b>31-Dec</b>	34,702	38,036	34,937	9.61%	0.68%
<b>Totals</b>	138,146	155,726	150,402	12.84%	9.08%

<b>Out-of-Network Emergency-Admission Bed Days from 2007 to 2009</b>					
Quarter Ending	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	14,596	17,373	13,953	19.03%	-4.41%
<b>30-Jun</b>	13,961	14,754	13,848	5.68%	-0.81%
<b>30-Sep</b>	15,027	14,033	13,162	-6.61%	-12.41%
<b>31-Dec</b>	14,499	13,887	11,543	-4.22%	-20.39%
<b>Totals</b>	58,083	60,047	52,506	3.47%	-9.50%

<b>Out-of-Network Post-Stabilization Bed Days from 2007 to 2009</b>					
Quarter Ending	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	9,029	9,821	9,452	8.77%	4.68%
<b>30-Jun</b>	6,717	8,408	9,109	25.17%	35.61%
<b>30-Sep</b>	8,391	9,093	8,582	8.37%	2.28%
<b>31-Dec</b>	8,349	7,910	7,822	-5.26%	-6.31%
<b>Totals</b>	32,486	35,232	34,965	9.26%	9.07%

<b>All Medi-Cal Managed Care Enrollment</b>					
	2007	2008	2009	2007-2008 Prcnt Chng	2007-2009 Prcnt Chng
<b>31-Mar</b>	3,224,257	3,303,541	3,453,020	2.46%	7.10%
<b>30-Jun</b>	3,258,263	3,361,756	3,580,834	3.18%	9.90%
<b>30-Sep</b>	3,256,813	3,402,600	3,653,196	4.48%	12.17%
<b>31-Dec</b>	3,286,347	3,440,000	3,832,055	4.68%	16.61%
<b>Average</b>	3,256,420	3,376,974	3,629,776	3.70%	11.44%

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## Future Updates

This is the second of four reports DHCS will provide to the State Legislature on this topic. The following table lists all four reports and the content they address pursuant to the Rogers Amendment (Welfare and Institutions Code, Section 14091.3(e)).

Due	Report To	Report On
October 1, 2009 §14091.3(e)(1)	Policy and Fiscal Committees	Impact of this section on: 1. Enrollee access to hospital services. 2. Health plan contracts with hospitals: a) Number of contracts
May 1, 2010 §14091.3(e)(1)	Policy and Fiscal Committees	Impact of this section on: 1. Enrollee access to hospital services. 2. Health plan contracts with hospitals: a) Number of contracts
August 1, 2010 §14091.3(e)(2)	Policy and Fiscal Committees	Implementation of this section on: 1. Enrollee access to hospital services. 2. Health plan capitation rates. 3. Extent of health plan contracting with hospitals. 4. Cost savings to the State.
January 1, 2011 §14091.3(e)(3)	Policy and Fiscal Committees	Implementation of this section on: 1. Enrollee access to hospital services. 2. Health plan capitation rates. 3. Extent of health plan contracting with hospitals. 4. Cost savings to the State.