

**Impact of the Rogers Amendment on  
Contracts between Participating Health Plans and Hospitals  
and the Affect on Medi-Cal Managed Care Enrollees**

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October 1, 2009

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

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## Purpose of the Report

Section 14091.3 was added to the Welfare and Institutions (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 services and post-stabilization services. 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 (Plans) to make reasonable payments to non-contracted hospitals for outpatient services, emergency inpatient services, and post-stabilization services following an emergency admission provided to Medi-Cal Plan enrollees. Historically, non-contracted hospitals have occasionally negotiated or litigated payments from 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 mitigate the legal disputes and payment issues between Plans and non-contracted hospitals over the cost of providing emergency 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 W&I 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 October 1, 2009 and May 1, 2010, "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". A final report is due on August 1, 2010, which is to include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of the section on managed care health plan capitation rates, the impact of this section on the extent of contracting between managed care health plans and hospitals, and fiscal impact on the state. This law became effective January 1, 2007; therefore, the report will describe impacts from January 1, 2007 forward. This report fulfills the October 1, 2009 required report.

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.

The Plans were asked to provide data on the impact of the Rogers Amendment on hospital contracting between 2007 and 2008. With this information, DHCS was able to assess differences in reporting between 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 Plans; therefore, the data on bed days following an emergency admission are more complete than for post-stabilization. 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.

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

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

DHCS requested and received data from 14 of the Plans subject to the Rogers Amendment. Of these Plans, 12 reported no change in the number of hospitals contracting with them to provide emergency services to their Medi-Cal members. One Plan reported a small reduction, and another reported a small increase. To date, the Rogers Amendment has resulted in no appreciable change in the number of hospitals contracting with Plans.

DHCS believes too little data has been collected at this stage to infer reliable conclusions. For example, this initial assessment indicates that the State’s version of the Rogers Amendment required all but one Plan to *increase* payments to non-contracted hospitals; however, it is too soon to tell if these payments might decrease in subsequent years, as the Rogers Amendment intended. Plans negotiate rates with non-contracted hospitals to cover the cost of treating Medi-Cal members admitted in need of emergency and post-stabilization care. To establish a basis for reasonable payments, the Rogers Amendment requires Plans to pay non-contracted hospitals a rate based on the regional average of payments made to hospitals by the California Medical Assistance Commission (CMAC). Plans have historically negotiated rates with hospitals at a lower than CMAC average regional rate. Therefore, in many cases, implementation of the Rogers Amendment resulted in Plans being required to *increase* the amounts paid to hospitals. For example, such rate increases can be attributed, in part, to CMAC’s calculation of regional average rates which include the much-higher rates paid to children’s hospitals.

Another possible reason for the lack of significant change in the number of contracted hospitals is that most hospitals have multiple-year contracts with Plans; therefore, this initial report, based on just two years (2007 and 2008), might not reflect the full scope of change that may occur as multiple-year contracts expire. With a longer time horizon in which hospital contracts might expire and re-negotiation 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 non-contracted hospitals that may be excessive. Therefore, the law requires DHCS to monitor non-contracted hospitals for any reduction in services provided to Medi-Cal beneficiaries that may be motivated by the non-contracted hospital having received lower payments for these services.

DHCS collected data on emergency admissions to non-contracted hospitals paid for by Plans during calendar years 2007 and 2008. The data, collected on a quarterly basis for the first two years during which Rogers has been in effect, indicate no discernable or significant change from year to year. Each quarter, Plans paid for approximately 8,000 emergency admissions to non-contracted hospitals.

Once a patient, admitted under emergency conditions, is determined to be stable, a non-contracted hospital must notify the patient's Plan so the patient may be moved, at the Plan's discretion, to a hospital that is contracted with the Plan for the patient's post-stabilization recovery period. In some cases, hospital overcrowding or cost-savings efforts may prevent moving Plan enrollees to Plan hospitals.

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

### **Data Summary Table**

The tables on the next page summarize the data received from Plans describing the number of bed days paid for that resulted from emergency admissions to both Plan and non-contracted hospitals. Data collected for these first two years indicates enrollment of Medi-Cal beneficiaries in Plans increased by 3.26 percent. The number of bed days resulting from an emergency admission increased by 3.32 percent at Plan hospitals and decreased 14.69 percent at non-contracted hospitals. Similarly, the number of post-stabilization bed days following an emergency admission increased by 1.21 percent at Plan hospitals and decreased by 5.88 percent at non-contracted hospitals. The trend away from providing emergency services in non-contracted hospitals is tempered by significant differences in the data from one quarter to the next. Only further data collection and time can confirm whether this trend is relevant to the Rogers Amendment.

Change in ER Bed Days from 2007 to 2008					
Quarter	3/31	6/30	9/30	12/31	Totals
Enrolled	2.05%	2.71%	4.05%	4.22%	3.26%
Plan Hosp	8.71%	16.56%	16.85%	4.95%	11.60%
Non-contracted Hosp	-5.02%	-13.42%	2.06%	-14.43%	-7.76%
Total Days	5.93%	10.83%	14.32%	1.60%	8.02%
% Plan Hosp	2.62%	5.17%	2.21%	3.29%	3.32%
% non-contracted Hosp	-10.34%	-21.88%	-10.72%	-15.78%	-14.69%

Change in Post-Stub Days from 2007 to 2008					
Quarter	3/31	6/30	9/30	12/31	Totals
Enrolled	2.05%	2.71%	4.05%	4.22%	3.26%
Plan Hosps	15.86%	11.99%	48.50%	-1.82%	18.38%
Non-contracted Hosp	-25.05%	25.23%	57.89%	-1.50%	9.79%
Total Days	7.06%	14.03%	50.06%	-1.78%	16.89%
% Plan Hosps	8.22%	-1.79%	-1.04%	-0.05%	1.21%
% non-contracted Hosp	-30.00%	9.82%	5.22%	0.28%	-5.88%

### Future Updates

The following table lists reports to be provided to the State Legislature by DHCS pursuant to the Rogers Amendment (W&I Code §14091.3(e)).

Due	Report On
October 1, 2009 §14091.3(e)(1)	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)	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)	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.