

Evaluation of Uncompensated Care Financing for California Hospitals

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1 Executive Summary

The healthcare industry is unique in the sense that hospital-related services cannot be withheld due to a lack of a patient's ability to pay, when they are determined to be emergency in nature. In addition, hospitals that treat a large proportion of low-income patients, such as safety net hospitals, will generally serve any patient who comes through their doors regardless of the patient's health insurance or financial status. As a result, many healthcare providers, and most notably public and private safety net hospitals that serve a disproportionate share of Medi-Cal and low-income individuals, provide services and expend resources treating patients for which they receive little or no direct reimbursement.

A variety of government programs exist to help reimburse healthcare providers for this otherwise uncompensated care. Among these programs are Medicare and Medicaid Disproportionate Share Hospital (DSH) programs which provide compensation to hospitals that treat a relatively high percentage of Medicaid, Medicare, and uninsured patients. In addition, some state Medicaid agencies have expanded Medicaid benefits under the Patient Protection and Affordable Care Act (ACA) and have utilized 1115 Demonstration Waivers to preserve their ability to direct funding for the uninsured population, which when combined, have helped to reduce the number of uninsured in the state, and to provide some compensation to providers for treating those who remain uninsured or cannot afford to pay for their services.

The California Department of Health Care Services (DHCS), which administers the Medicaid program in California (known as Medi-Cal), has administered various 1115 Demonstration Waivers since 2005 to introduce innovative service delivery and funding models. These waivers have included components that provide for the distribution of federally-authorized funding to help compensate targeted hospitals for care of the uninsured. Authorized by the Federal Centers for Medicare and Medicaid Services (CMS), the most recent 1115 waiver renewal for Medi-Cal was approved in December of 2015. Included in the Special Terms and Conditions (STCs) associated with the latest waiver renewal (referred to as the Medi-Cal 2020 Demonstration Waiver) were requirements for DHCS to contract with an independent entity to produce two reports that review uncompensated care, Medicaid financing, and Medicaid payment in the State of California. The first report, which was submitted to CMS on May 15, 2016, concentrated on the 21 Designated Public Hospitals (DPHs) in California. The DPHs are all safety net hospitals, have high Medicaid and uninsured utilization, and are the primary recipients of Medi-Cal DSH and Uncompensated Care Pool (UCP) funds.

Navigant Consulting, Inc. (Navigant) was engaged to prepare both reports under the waiver STCs. This report is the second report of the two required reports. This report expands the analysis of Medicaid funding and payment and uncompensated care in California as they relate to all hospitals in the State.

The cost of medical care to uninsured recipients has decreased significantly in California in recent years through policy changes made by DHCS and CMS. For example, the 1115 Demonstration Waiver finalized in 2005 contained a UCP and a Health Care Coverage Initiative (HCCI), which expanded coverage to low-income residents in eight public health care system counties. Healthcare coverage for the uninsured was further expanded in an 1115 Demonstration Waiver finalized in 2010 through the Low Income Health Program (LIHP). Through LIHP, counties offered enrollment and health benefits to uninsured individuals who

would eventually become eligible for coverage under the ACA – enrolling over 662,445 people by the 2013.¹

Beginning January 1, 2014, DHCS expanded Medi-Cal through the ACA. With Medicaid expansion, the number of uninsured in California dropped by nearly half, from 16 percent in 2013 to nine percent in 2015 according to studies by the California Health Care Foundation (CHCF) published in December 2016 and by the Medicaid and CHIP Payment and Access Commission (MACPAC) published in March 2017. Unfortunately, despite this tremendous progress, the CHCF study indicates that approximately 2.9 million Californians remain uninsured.

As agreed to by CMS and DHCS, the analysis of Medi-Cal and uninsured financing included in this report concentrates on services provided in State Fiscal Year (SFY) 2013/14, which covered the period from July 1, 2013 through June 30, 2014. This was a timeframe of transition for Medi-Cal as the LIHP program ended on December 31, 2013 and Medi-Cal expansion under the ACA became effective on January 1, 2014.

The results of this analysis for this 12-month time period indicate that Medi-Cal reimbursements almost covered the hospital cost of care for Medi-Cal eligible and uninsured recipients. The aggregate hospital pay-to-cost ratio for care of Medi-Cal recipients and the uninsured was 94 percent for the SFY 2013/14 period.² However the results vary by category of hospital from a high of 104 percent for private hospitals receiving DSH funds to a low of 72 percent for District/Municipal Public Hospitals (DMPHs). In addition, significant portions of the funding of the non-Federal share of the Medi-Cal program came from hospitals and other local governmental entities through a provider assessment, Inter-Governmental Transfers (IGTs), and Certified Public Expenditures (CPEs). We refer to these sources as “local funding.” In SFY 2013/14, a full 67 percent of the non-Federal share of funding for Medi-Cal hospital reimbursements was generated from these three sources, and the remaining 33 percent came from State general funds. After offsetting Medi-Cal reimbursements by the amount of local funding, the aggregate hospital pay-to-cost ratio for care of Medi-Cal recipients and the uninsured reduces to 73 percent. Then including the additional 75 percent of DSH claimable costs at high-DSH hospitals, the pay-to-cost ratio decreases to 70 percent.

Hospitals also reported charity care and bad debt for uninsured recipients during the SFY 2013/14 timeframe. A total of \$2.4 billion was reported as charity care and just under \$900 million was reported as bad debt for care of uninsured recipients. For all recipients, the numbers increase to \$2.6 billion for charity care and \$1.6 billion for bad debt.

The Federal DSH program, Medi-Cal DSH Replacement and California’s UCP are three instruments used to compensate hospitals for their Medicaid shortfall and offset the costs of caring for the uninsured. In SFY 2013/14 the Federal DSH program distributed just under \$2.4 billion, DSH Replacement distributed \$500 million and the UCP distributed \$622 million. However, \$1.2 billion of the DSH program and \$311 million of the UCP were funded through local sources making the net benefit to hospitals from these two programs equal to approximately \$1.5 billion.

¹ http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf

² The calculation of cost used to determine this pay-to-cost ratio includes 175 percent of DSH claimable costs for “high-DSH” hospitals, which, through a provision unique to California, are allowed to be reimbursed up to 175 percent of cost through the DSH program.

Both in SFY 2013/14 and currently, the Federal DSH, Medi-Cal DSH Replacement and UCP programs are critically important to the hospitals in California, because there continues to be an uninsured population, even after the Medicaid expansion authorized under the ACA. In addition, Medicaid rates do not always compensate hospitals for 100 percent of their costs in serving the Medicaid population, resulting in what is known as “Medicaid shortfall.” The analyses presented in this report indicate that Medi-Cal’s net reimbursement to hospitals, after offsetting payments for the local contributions that are used by DHCS as non-Federal funding sources, covers 73 percent of hospital cost for care of Medi-Cal and uninsured recipients in SFY 2013/14. Understanding that Medi-Cal expansion under the ACA was in place for only half of this time frame, it is reasonable to assume that reimbursements would have been higher in relation to cost in subsequent years. At the same time, the planned federal reductions in the size of the DSH program in years 2018 through 2025 will tend to erode these values over time. Further, the fate of Medicaid expansion under the ACA is unclear given the stated priorities of the current Federal administration. Any future considerations of uncompensated care pools and other waiver-related programs will need to consider all of these interrelated factors to successfully maintain a program that ensures access to quality healthcare for the Medicaid and uninsured recipients in California.

2 Introduction

In fiscal year 2014, the Medicaid and the State Children's Health Insurance Program (CHIP) were sources of health coverage for almost 87 million people, about 27 percent of the population of the United States.³ Those served by these programs included one-half of all children, many low-wage workers and their families, persons who have physical and mental disabilities, and seniors with Medicare. Together, the Medicaid and CHIP programs accounted for 16.8 percent, approximately \$509 billion, of total U.S. health care spending.⁴ Federal spending for Medicaid and CHIP is financed by general revenues.⁵

Governance and financing for Medicaid programs is a shared responsibility of the Federal government and the states. States that operate their Medicaid programs in compliance with Federal guidelines are entitled to Federal reimbursement for a share of their total program expenditures. States incur qualifying expenditure by making payments to health care providers and managed care plans, and by incurring costs associated with performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and processing claims. The state completes and submits quarterly expenditure reports in order to receive the Federal matching dollars.

In California, Medi-Cal accounted for 17.3 percent of State general revenue expenditures, or approximately \$16.7 billion in SFY 2013/14 for the Medi-Cal program (including administration), and \$15.6 billion for reimbursement of medical services. In addition, considerable local government funds and provider assessment contributed to augment the non-Federal share of the Medicaid program expenditures through the use of CPEs, IGTs and a hospital provider quality assessment fee. The total non-Federal share of funds coming from local governments and provider assessments comprised approximately \$7.3 billion in SFY 2013/14. With Federal matching funds added to the total non-Federal share, just under \$58.7 billion was expended by the California Medicaid program for reimbursement of medical services.^{6,7}

As a condition of receiving Federal Medicaid funds, Section 1902 of the Social Security Act (the Act) requires states to have an approved state plan on file with CMS, the Federal agency responsible for coordinating Medicaid, which details the manner in which the states implement all Federal Medicaid requirements. In conjunction with its mandate to manage costs and assure access to quality care, CMS monitors each state Medicaid program, oversees the approval of State Plan Amendments (SPAs), waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters. To the extent that material program modifications are subsequently needed, states are required to submit a SPA to CMS for review and approval in advance of implementing any changes.

³ MACPAC: <https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf>

⁴ MACStats: <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-3.-National-Health-Expenditures-by-Type-and-Payer-2014.pdf>

⁵ MACPAC. Report to the Congress on Medicaid and CHIP, (March 2011).

⁶ May 2014 Medi-Cal Estimate, May 6, 2014.

http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2014_May_Estimate/M1400_Complete_Estimate.pdf

⁷ *Governor's Budget 2013-14*, Enacted Budget Detail. Published June 27, 2013. <http://www.ebudget.ca.gov/2013-14/Enacted/agencies.html>

The Act further provides states flexibility in certain areas to operate their programs outside of some of the standard Federal requirements that would otherwise apply, known as waiver authorities. In particular, Section 1115 of the Act gives broad authority to the Secretary to authorize “any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs” specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design such as Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 demonstrations also include a research or evaluation component and are initially approved for five years, with potential for future renewals. The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction, with the condition that the programs remain budget neutral. Approval of states’ waiver applications and subsequent renewals are at the discretion of the Secretary of the Federal Department of Health and Human Services (HHS).⁸

All states operate one or more Medicaid waivers, and one of the goals of a number of the states’ waivers is to provide funding for care for the uninsured. In California, the Demonstration Waivers implemented in recent years represent a statewide multi-faceted health reform effort and have evolved over time to reflect new priorities and the enactment of the ACA. As these waivers have evolved and Medicaid expansion under the ACA has been implemented in California, more people have received health care coverage, and the overall rate of uninsurance has been reduced (see detailed discussion in Chapter 7). Nevertheless, there are still individuals who remain uninsured. In the 2005 and 2010 waivers, a funding pool known as the Safety Net Care Pool (SNCP) was included and authorized to attempt to accomplish several goals. One of the main components of the SNCP was a sub-program that provided matchable funding for healthcare providers for care of the uninsured, which was called the UCP program.

Most recently, Medi-Cal’s Demonstration Waiver was renewed at the end of December 2015, (to be effective through 2020), and is referred to as the Medi-Cal 2020 Demonstration Waiver. Under this new waiver, the UCP program was replaced by a new program called the “Global Payment Program (GPP), which establishes a statewide pool of funding for the remaining uninsured by combining federal DSH and uncompensated care funding, where select Designated Public Hospital systems⁹ can achieve their ‘global budget’ by meeting a service-based point threshold that incentivizes movement from high cost, avoidable services to providing higher value, and preventative services.”¹⁰ CMS also included in the Medi-Cal 2020 Demonstration Waiver a requirement for the State to commission two reports from a non-governmental entity that is independent of provider interests on Medicaid provider payments made under the SNCP. Pursuant to a technical assistance request from the California DHCS, Blue Shield of California Foundation engaged Navigant to perform the first of the two studies, and DHCS directly contracted with Navigant to conduct the second study.

⁸ Ibid.

⁹ Designated Public Hospitals that are not a part of the University of California system

¹⁰ DHCS website, at <http://www.dhcs.ca.gov/provgovpart/Pages/GlobalPaymentProgram.aspx>

2.1 Report Requirement

The requirement for the two uncompensated care studies was included as items 177, 178, and 179 in the STCs associated with the waiver renewal. As specified in the STCs, the first report evaluated uncompensated care at the 21 California DPHs, particularly highlighting the cost of charity care and bad debt, and the level of funding and payment under the UCP in SFY 2013/14. In addition, the report reviewed the demographics of California's population and discussed trends in factors that could impact the uninsured population. The intent of this analysis was to support a determination of the appropriate level of funding for the UCP component of the GPP in years two through five of the 2020 Demonstration Waiver. The second report extends the analysis to all Medicaid hospitals, inclusive of the DPHs, and requires examination of six additional elements.

Specifically, the following elements are addressed in this report consistent with the requirements specified in the Medi-Cal 2020 Demonstration Waiver STCs:

- Both studies were required to include an analysis of the impact of the UCP on those providers who participate in the pool with respect to:
 - Uncompensated care provided: The cost of uncompensated care provided to uninsured individuals, distinguishing between costs associated with charity care and those associated with bad debt, and the extent to which historical pool payments have addressed these costs
 - Medicaid provider payment rates
 - Medicaid beneficiary access
 - The role of managed care plans in managing care
 - Hospital revenue, including:
 - Total hospital system revenue from all payors
 - Total Medicaid revenue (including patient care revenue and all other Medicaid revenue such as demonstration revenue and incentive payments)
 - Total Medicaid patient care revenue
 - Total safety net care pool revenue
- The six additional required elements, which are unique to the second study include:
 - The role of the PRIME program for designated public hospital systems.
 - A detailed description and analysis of the current Medicaid hospital payment and financing system, with a major focus on services currently supported with pool funds;
 - The financing of overall uncompensated care in the state and the financing of providers that play a significant role in serving the Medicaid population and the low income uninsured, and the extent to which pool funds are needed to cover uncompensated care;
 - Reporting of how uncompensated care has changed since implementation of the ACA expansion;

- Information to support the goal for public health care systems to become self-sustaining entities that are not reliant on pool funds beyond 2020;
- Information that will inform discussions about potential reforms that will improve Medicaid payment systems and funding mechanisms and the quality of health care services for California’s Medicaid beneficiaries and for the uninsured.

2.2 Report Organization

In the first report, most data was displayed separately for each hospital because there were only 21 DPHs. In this second report, the number of included hospitals increases to 417. Thus, most data tables in this report summarize information by category of hospital.¹¹ We selected four hospital categories:

- Designated Public Hospitals (DPHs) – this category contains all the hospitals included in the first uncompensated care study
- District/Municipal Public Hospitals (DMPHs) – this category contains public hospitals that do not meet the criteria to be classified as a DPH
- Private with DSH – this category contains privately owned hospitals that qualify for funds through either the Federal DSH program or the “DSH Replacement” program
- Private without DSH – this category contains privately owned hospitals that do not qualify for funds through either the Federal DSH program or the DSH Replacement program

We chose to maintain a separate category for DPHs in this report to be consistent with how the findings were reported in the first report. DMPHs have similar funding options as DPHs because both categories of hospitals are publicly owned. In addition, the DMPHs receive a significant amount of their Medi-Cal funding through the Federal DSH program (14.5 percent) and DMPHs may participate in the PRIME program. Given these three facts, we chose to group the DMPHs in their own category. Finally, we chose to separate the private hospitals into two categories, those eligible for funds through the Federal DSH program and the “DSH Replacement”¹² program and those that do not qualify for either Federal DSH or “DSH Replacement” funds, because this report is concerned with cost and funding of uncompensated care and these two DSH programs are primary mechanisms through which Medi-Cal provides funding to qualifying hospitals to help offset uncompensated costs for low-income patients.

Outside of Medicaid managed care, nearly all programs defined in the 2010 “California Bridge to Reform” (BTR) Demonstration Waiver applied only to the DPHs and programs in the Medi-Cal 2020 Demonstration Waiver apply only to public hospitals – DPHs and DMPHs. This includes the UCP program and Delivery System Reform Incentive Program (DSRIP) defined in the 2010 waiver and the UCP, GPP and PRIME programs defined in the waiver finalized in 2015.

¹¹ As requested in the STCs, all data tables presented in the report have also been provided to DHCS in unlocked Excel worksheets to assist in review of the analysis, and in a format that can be shared with CMS, at their request.

¹² “DSH Replacement” is a supplemental payment program available to qualifying private hospitals that is not included in Medi-Cal’s annual Federal DSH allotment and does not require formal DSH audits, but is often reported together with money distributed through the Federal DSH program.

As an integral component of the evaluation Navigant made a presentation to relevant stakeholders, including representatives of the following hospital associations:

- California Association of Public Hospitals and Health Systems (CAPH)
- California Hospital Association (CHA)
- California Children’s Hospital Association (CCHA)
- Private Essential Access Community Hospitals (PEACH)
- District Hospital Leadership Forum (DHLF)

The remainder of this report is organized into the following sections:

- Section 3 – Background, where we provide general information on the Medi-Cal 1115 Demonstration Waivers, the SNCP and SNCP UCP programs, the new GPP program, and the scope of information provided in this report;
- Section 4 – Description of Hospital Payment Streams and Related Funding Sources, where we provide a high level description of Medi-Cal funding and payments;
- Section 5 – Analysis of Costs, where we document the costs incurred by the hospitals in providing care to Medicaid recipients and the uninsured;
- Section 6 – Comparison of Payments to Costs, where we calculate pay-to-cost ratios using a variety of combinations of payments and costs in order to offer a measure of the adequacy of Medicaid reimbursements to the hospitals;
- Section 7 – Analysis of Health Care Safety Net Challenges in California, where we describe factors to consider as the California SNCP program is evaluated for future periods;
- Section 8 – Role of Managed Care Plans in Managing Care;
- Section 9 – Role of the PRIME Program;
- Section 10 – The Future of Uncompensated Care Services and Related Funding in California;
- Section 11 – Conclusion, where we provide a brief conclusion related to this study of California’s SNCP program.

3 Background

This chapter provides background on the California waiver programs, sources of financial data used in the analysis, the services included in the study and the hospitals for which the study was conducted.

3.1 Safety Net Care Pool (SNCP) Program – Overview and History

3.1.1 2005 Demonstration Waiver

In 2005, California implemented the “Medi-Cal Hospital/Uninsured Care” Demonstration Waiver which fundamentally altered the way Medi-Cal pays hospitals and enabled California to stabilize and increase funding to its safety net hospitals. Historically, California relied heavily on IGTs from counties and the University of California to fund the non-federal share of its Disproportionate Share Hospital program and hospital supplemental payment programs. Among other initiatives, this Demonstration Waiver phased out the use of IGTs and allowed California the use of CPEs as the non-federal share of Medi-Cal expenditures. It also established a SNCP program with the purpose of offsetting expenditures associated with the uninsured as well as expanding health care coverage to the uninsured population, and in later years funding for Medi-Cal’s Designated State Health Program (DSHP). The “Medi-Cal Hospital/Uninsured Care” Demonstration Waiver also implemented the HCCI in 2007. As described above, HCCI expanded coverage options for uninsured individuals in California and increased the number of individuals with health coverage. Additionally, the “Medi-Cal Hospital/Uninsured Care” Demonstration Waiver, established three general categories of hospitals for reimbursement purposes: designated public hospitals which are hospitals owned by counties and the University of California; non-designated public hospitals (mainly district hospitals); and private hospitals.

3.1.2 2010 Demonstration Waiver

In 2010, California’s Demonstration Waiver was renewed and renamed the “California Bridge to Reform” (BTR) Demonstration Waiver. Under the BTR Demonstration Waiver, funds were provided in four different pools: Uncompensated Care Pool for services to the uninsured, DSRIP, Designated State Hospital Program (DSHP), the Low Income Health Program (the Medicaid Coverage Expansion and the Health Care Coverage Initiative).

With the implementation of the BTR Demonstration Waiver, measures were taken to prepare for Medicaid coverage expansion under the ACA. In addition to the pool funds described above, California implemented the LIHP, which was in effect from November 2010 through December 2013. The purpose of the LIHP program was to provide funding for coverage for low-income adults who would become eligible for coverage under the ACA. The LIHP was sub-divided into two programs, the Medicaid Coverage Expansion (MCE) and the HCCI. The non-Federal portion of funding for both programs was provided by counties through a combination of CPEs and IGTs. Each county was given the authority to determine the maximum percentage of the Federal Poverty Level (FPL) that would qualify for coverage within the LIHP.

The HCCI population comprised adults with family incomes between 133 percent of the FPL and up to 200 percent of the FPL who were not otherwise eligible for Medicaid or CHIP coverage. The HCCI program was funded through a Bridge to Reform capped funding pool. The program was capped at \$360 million annually for SFY 2010/11 through SFY 2012/13 and at

\$180 million for SFY 2013/14. This program was in place through December 31, 2013, at which point eligibles were referred to California’s Healthcare Marketplace (Covered California).

The MCE population comprised adults with family incomes at or below 133 percent of the FPL who were not otherwise eligible for Medicaid or CHIP coverage. The MCE program was not technically considered part of SNCP and was not subject to a funding cap. This program was in place through December 31, 2013, at which point eligibles were transitioned to the Medicaid managed care delivery system.

Another program funded through the BTR Demonstration Waiver was the DSRIP program. The goals of the DSRIP program under the BTR Demonstration Waiver were to enhance the quality of care and the health of individuals served, and as such, funding was available to public hospitals for efforts in developing and improving infrastructure to better serve clients, innovating and redesigning care delivery models, and investing in enhancing care for certain high-risk populations, among others. DSRIP payments were based on specified quality and process measures and were intended to support and incentivize public hospitals to implement such improvements.

Although the DSRIP program provides funding for DPHs, DSRIP payments are not direct reimbursement for services provided. Instead, such payments are intended to compensate hospitals for transformational improvements that support the goals of this program. The amounts related to the DSRIP to satisfy the requirements specified in Medi-Cal 2020 Demonstration Waiver STC 180(c)(iv) are shown in the table below.

The programs included as part of the 2010 BTR waiver are summarized in Figure 1, along with the total computable reimbursement to the DPHs in SFY 2013/14. As mentioned previously, only DPH hospitals were eligible to participate in these programs.

Figure 1: Bridge to Reform Funding for SFY 2013/14

BTR Program	Description	Eligible Providers	Total Computable Reimbursement to Hospitals
Safety Net Care Uncompensated Care Pool	Program established for payment of “care and services that meet the definition of ‘medical assistance’ contained in section 1905(a) of the Act that are incurred by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State.” ¹³	DPHs	\$622,000,000
Health Care Coverage Initiative	Restricted use funding to expand coverage to “[a]dults between 19 and 64 years of age who have family incomes above 133 percent through 200 percent FPL (or less as applicable based on participating county income eligibility standards).” ¹⁴ Program is part of the Low Income Health Program.	DPHs	\$ 31,227,582
Designated State Health Programs	State-only funded medical programs and workforce development programs that Federal funds may be requested under the BTR Demonstration Waiver that shall not exceed \$400 million per year.	Little or no impact to hospitals	\$0
Delivery System Reform Incentive Pool (DSRIP) Payments	The DSRIP program “is available for the development of a program of activity that supports California’s public hospitals’ efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve.” ¹⁵	DPHs	\$1,431,271,428
Total Reimbursement for the DPHs Under the BTR Program			\$2,084,499,010

As noted previously, the non-Federal share of these amounts was funded through either IGTs or CPEs. Thus, the net benefit to the hospitals related to these amounts is equal to the Federal share, or \$1,042,249,505.

3.1.3 2015 Demonstration Waiver

In December 2015, CMS approved the California Medi-Cal 2020 Demonstration Waiver, which became effective in January 2016. This demonstration continues the statewide health transformation and reform efforts and focuses on increasing value for patients. This new demonstration does the following:

¹³ California Bridge to Reform Demonstration Waiver Special Terms & Conditions, STC 35(b)(i), Page 14.

¹⁴ California Bridge to Reform Demonstration Waiver Special Terms & Conditions, STC 48(a)(ii), Page 24.

¹⁵ California Bridge to Reform Demonstration Waiver Special Terms & Conditions, STC 35(c), Page 16.

- Continues the managed care delivery system for Seniors and Persons with Disabilities (SPDs), the Coordinated Care Initiative (CCI), and the Drug Medi-Cal Organized Delivery System (DMC-ODS).
- Implements the Public Hospital Redesign and Incentives in Medi-Cal (PRIME), GPP, Whole Person Care (WPC) pilot program, and a Dental Transformation Initiative (DTI).
- Continues funding for uncompensated care costs through the GPP.

Under the new Medi-Cal 2020 Demonstration Waiver, the SNCP program has evolved into some of the programs listed above. Even so, the waiver continues to support safety net hospitals in providing funding for uninsured services. In particular, the UCP program has become part of the new GPP. The GPP combines UCP funds with Medicaid DSH funds, and disburses the funding through a global payment structure that focuses on value (rather than volume) to promote more cost-effective and higher value care delivery. The funds available for the uncompensated care component of the pool are set at \$236 million in Federal funds (\$472 million total computable). The non-Federal share of all GPP payments is being funded through IGTs.

The goal of the GPP is to assist Public Health Care Systems (PHCS) in providing uninsured services. Consistent with this goal, the GPP payment structure incentivizes the delivery of services in appropriate settings rather than through more costly emergency departments and inpatient hospital visits. The GPP payments made to providers are calculated through a value-based point methodology system that takes into account factors such as the service delivery setting, value for the patient, costs to the system, as well as the resource intensity of the service provided. The established point system is intended to motivate providers to provide fewer services that are considered more costly and avoidable, and promote services in more appropriate settings that are considered to be more cost-effective. To assist providers with this transition, the point-based methodology will be implemented incrementally throughout the five years of this demonstration. The methodology for determining the points related to specific services is described in detail in Appendix FF of the Medi-Cal 2020 Demonstration Waiver. Each year, DHCS will establish an annual budget and minimum point threshold for services provided for each Public Health Care System (PHCS) and make payments through this program on a quarterly basis at twenty-five percent of the entity's annual budget for the first three quarters with a year-end interim and a final annual reconciliation.

The six University of California System DPHs are not participating in the GPP. As a result, they do not receive uncompensated care supplemental payments through the GPP and receive their DSH reimbursements through the standard Medi-Cal DSH program, outside of the GPP.

In addition, the initiatives specific to the DSRIP program are not directly continued through the Medi-Cal 2020 Demonstration Waiver, however, the waiver implements the PRIME program which is intended to build off of the successes of the DSRIP program. The goals of the PRIME program are to improve population health and health outcomes, provide high-quality care to beneficiaries in the most appropriate settings, and to move toward value-based payments through alternative payment models among others.

A summary of the supplemental programs included as part of the 2015 Demonstration Waiver are included in Figure 2 along with an identification of the hospitals eligible to participate in these programs.

Figure 2: Payment Pools Defined in Medi-Cal 2020 Demonstration Waiver

Program	Description	Hospitals Affected	Annual Total Computable Maximum Reimbursement
Global Payment Program	Establishes a statewide pool of funding for funding uninsured services by combining federal DSH and uncompensated care funding; Evolution of the SNCP program and DSH from the 2010 waiver	Subset of the DPHs (UCs opted out)	Approximately \$2.9 billion annually
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	The California PRIME program is a five-year initiative under the Medi-Cal 2020 section 1115 waiver that builds upon the Delivery System Reform Incentive Payment (DSRIP) program established under the Bridge to Reform waiver. The goal of PRIME is to continue significant improvement in the way care is delivered through California's safety net hospital system to maximize health care value and to move toward alternative payment models (APMs), such as capitation and other risk-sharing arrangements.	DPHs and DMPHs	\$1.6 billion in years 1 through 3; \$1.4 billion in year 4; \$1.2 billion in year 5
Whole Person Care (WPC) pilot program	Support infrastructure changes to better integrate services among entities serving high users of multiple systems, services not covered or directly reimbursed by Medi-Cal, and other strategies to improve integration and reduce unnecessary utilization of services including inappropriate emergency department and inpatient hospital utilization	Select public and private hospitals	\$600 million
Dental Transformation Initiative (DTI)	Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this strategy aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.	No Hospitals	\$148 million
Total in Year 1			\$5.2 billion

3.2 Source of Financial Data

The sources of financial data for this report differ by provider category. We retrieved cost and payment data for the DPHs primarily from very detailed cost reports that are unique to DPHs under current Medi-Cal procedures. DPH data included in this report is consistent with the data included the first report, unless specifically noted otherwise. For non-DPHs, we relied on publicly available data, as well as data provided by DHCS. Our data sources are described for each of the hospital categories separately.

3.2.1 Designated Public Hospitals

Given the focus on uncompensated care at the DPHs, the existing Interim Hospital Payment Rate Workbooks (referred to as the “P14 reports”) were used as a primary data source. The P14 reports provide information designed to document the costs associated with the various categories of reimbursement under the 1115 Medi-Cal Hospital / Uninsured Care Demonstration (Waiver 11-W-00193/9), the Physician SPA (05-023), and the Los Angeles County Cost Based Reimbursement Clinics (CBRC) SPA. The versions of the P14 reports reviewed for this study contained the most currently available actual hospital cost data from SFY 2013/14 as reported on hospital Medi-Cal cost reports. Some of the cost reports had been audited, but others had not yet been audited at the time this study was performed.

In addition to the P14 reports, other existing and newly created data summaries were incorporated into this study. Most notably, the DHCS “Uncompensated Care” model was updated with the most currently available SFY 2013/14 cost information and used to identify SNCP UCP and DSH distributions. In addition, separate cost and payment summaries were developed for hospital outpatient services and distinct part nursing facility services for the Medicaid fee-for-service (FFS) program.

3.2.2 Private Hospitals and DMPHs

Private hospitals and DMPHs in California do not complete the P14 reports required for the DPHs. Therefore, we used other data sources to compile the payment and cost data necessary for this analysis. To determine Medi-Cal managed care, uninsured, and all-payer data for these providers, we relied on the publicly available data reports published by the California OSHPD. Unlike the P14 reports completed by the DPHs, the OSHPD reports are subject to only a desk audit for reasonableness.

To determine Medi-Cal FFS payments and estimated hospital costs, we relied on MMIS data provided by DHCS. We relied on MMIS data for Medi-Cal FFS information as opposed to OSHPD data since the OSHPD reports are not audited and MMIS FFS data is readily available, and are considered to be the most reliable data source for this type of data. California also has various supplemental payment programs available for DMPH and private hospitals, most of which are applicable to the FFS program. For each of these supplemental payment programs applicable to FFS, we relied on spreadsheets provided by DHCS that show the total payments made under each program to each provider for SFY 2013/14. The various supplemental payment programs are described in detail in Chapter 4 of this report. Finally, to determine estimated hospital contributions and payments to providers through the Hospital Quality Assurance Fee (HQUAF), California’s hospital assessment program, we relied on the assessment models in effect for the analysis period.

The timeframe for data included in this report is SFY 2013/14 which extended from July 1, 2013 through June 30, 2014. The FFS MMIS data as well as the supplemental payment information provided by DHCS were for the period covering SFY 2013/14. Thus, Navigant did not make any adjustments to this information. We did, however, have to make some adjustments to the OSHPD reported data. Hospitals submit OSHPD reports on an annual basis based on hospitals' cost reporting periods which do not all align with the SFY. As a result, it was necessary to make some adjustments to the data to estimate payments and costs for SFY 2013/14. Data for hospitals with a fiscal year different than the SFY were prorated from two different cost report periods, one ending Calendar Year (CY) 2013 and another ending in CY 2014, to get values that apply to SFY 2013/14. The first step in the proration process involved calculating average charge and payment values per day for each cost report period. The per day values were then multiplied by the number of days overlapping the analysis period. For example, for hospitals that report OSHPD data on a CY basis, the per day value was calculated for CY 2013 data and CY 2014. The CY 2013 per day value was multiplied by 184 days to determine the estimate for the first six months of SFY 2013/14 and the CY 2014 per day value was multiplied by 181 days to determine the amount for the second six months of SFY 2013/14. The resulting amounts were combined to estimate total SFY 2013/14 charge and payment amounts.

Hospitals are instructed to report charges and payments to OSHPD on an accrual basis. This means hospitals are supposed to report charges for services provided to patients in the hospitals' fiscal year that the service was provided, as opposed to when the services were billed, and irrespective of the timing of the payments. We have assumed that these accrual reporting instructions were followed by hospitals. However, this can be challenging for hospitals particularly for payments distributed well after the hospitals' fiscal years ended. For example, HQAF collections and distributions are commonly made one or two years after the timeframe to which the funds apply. In addition, CMS approval of HQAF distributions often occur retrospectively and hospitals are instructed to report HQAF contributions and revenues only after payment levels have been approved by CMS. As a result, there may be some level of imprecision in the OSHPD payment and charges data.¹⁶ We took steps to mitigate the risk of misstatement associated with this potential imprecision by using claim data and supplemental payment information from DHCS for all payments related to the Medi-Cal FFS program. This includes the amounts and timing of most supplemental payments and the majority of HQAF distributions. OSHPD payment information was only used to determine payment and cost for services to Medi-Cal managed care recipients and the uninsured.

To complete the analysis included in this report, it was also necessary to estimate costs incurred by hospitals for providing services based on hospital reported charge data. To estimate the costs for Medi-Cal FFS, Medi-Cal managed care, uninsured and all-payer data, we multiplied reported charges for the period by a cost-to-charge ratio (CCR) for each hospital. Where available, we used Medi-Cal specific CCR values calculated from Medi-Cal cost reports for hospital fiscal years ending in 2013 and 2014. However, Medi-Cal does not calculate CCRs for some hospitals, most notably psychiatric specialty facilities. For hospitals with no Medi-Cal

¹⁶ Specifically in SFY 2013/14, multiple prior year HQAF models were approved by CMS, so there is potential that some hospitals reported multiple years of HQAF payments in their FY 2013 or FY 2014 OSHPD reporting. However, any over-reporting of HQAF payments from prior years may be offset by the fact that SFY 2011/12 and SFY 2012/13 HQAF payments specific to managed care were lower than SFY 2013/14 payments because the Medi-Cal managed program was growing during this time. Given the time available to produce this report, there was no practical option to determine exactly what each hospital reported to OSHPD in 2013 and 2014. As a result, we used the data as reported in OSHPD and acknowledge a potential for the pay-to-cost ratios for private hospitals to be overstated by a couple of percentage points.

CCR, a CCR was determined based on published Medicare Cost Report (MCR) data retrieved from the Healthcare Cost Report Information System (HCRIS). In cases where MCR data for a hospital was not available to calculate a CCR, the CCR calculated and reported through OSHPD was used to estimate costs.

3.3 Services Included in this Study

In general, the funding, reimbursement and hospital cost of services provided to Medicaid recipients and the uninsured are considered in this study. More specifically, expenditures were incorporated for those services that were Federally claimable under the DSH and SNCP programs as authorized by CMS in SFY 2013/14. The specific medical services for which costs were defined as in-scope for this study include:

- Hospital inpatient and outpatient services for the Medicaid FFS program
- Hospital inpatient and outpatient services for the Medicaid managed care program
- Hospital inpatient and outpatient services for recipients dually eligible for Medicare and Medicaid
- Hospital inpatient and outpatient services for recipients enrolled in non-California Medicaid programs (out-of-state recipients)
- Hospital inpatient and outpatient services for uninsured recipients
- Medical services provided in hospital-based distinct part nursing facilities for the FFS and uninsured populations
- Medical services provided in hospital-based Federally Qualified Health Centers (FQHCs) for the FFS and uninsured populations
- Professional component of hospital-based physician and non-physician practitioner services provided in hospital inpatient, outpatient, skilled nursing facility, and clinic settings to the FFS, managed care, and uninsured populations
- Medical services provided in contracted hospitals and non-hospital clinics for the LIHP and the uninsured population

Data related to the medical services identified above is captured in the P14 reports and is utilized for the DPH analysis. The OSHPD reports require providers to report information on inpatient and outpatient services, clinics, skilled nursing, long-term care, and home health services for Medicaid, Medicare, and commercial payers. OSHPD data reports capture, for the most part, very similar data.

3.4 Hospitals Included in this Study

All acute care hospitals in California except those facilities owned by Kaiser Permanente and state-owned and operated forensic hospitals and psychiatric programs located in state prisons are included in this report. This includes acute care hospitals that specialize in mental health, substance abuse, and rehabilitation services. The total number of hospitals included is 448; 31 Kaiser Permanente facilities, five state forensic hospitals and three psychiatric programs located in state prisons are excluded.

Because of their unique model, Kaiser Permanente has been given a statutory waiver under State law and their hospitals are not required to report data to OSHPD at the same level of detail as other hospitals in California. As a result, the OSHPD data used by Navigant for this report was not available for the Kaiser Permanente hospitals. DHCS and Navigant worked with Kaiser Permanente to see if a separate data extract could be provided which would fulfill the needs of this particular study. Kaiser Permanente reviewed their data sources and responded indicating they could deliver a calculation of uncompensated care in total for Medi-Cal and non-member recipients for CY 2014. This data would not align with SFY 2013/14 and would not distinguish payments versus costs and would not distinguish Medi-Cal and uninsured recipients. Given these limitations in relation to the requirements of this study, we chose to exclude Kaiser Permanente hospitals from our data analyses. The five state-owned and operated hospitals and three psychiatric programs located in state prisons do not provide services to the general population and therefore do not report that data to OSHPD. As a result, they are similarly excluded.

All data tables provided in the body of this report summarize data by hospital categories. The data is summarized by category simply because of the impractical nature of separately listing all 417 hospitals included in the analysis in each data table. We chose four categories of hospitals for our summarizations as follows:

- DPHs – those hospitals included in the 2016 UCC report (21 facilities)
- DMPH – publicly owned hospitals that are not categorized as “Designated Public Hospitals” (53 facilities)
- Private hospitals that are eligible for the federal DSH or the DSH Replacement program (99 facilities)
- Private hospitals that are not eligible for the federal DSH or DSH Replacement program (244 facilities)

4 Description of Hospital Payment Streams and Related Funding Sources

4.1 Introduction

The California Medi-Cal program, like most Medicaid programs in the United States, is funded and disburses payments for hospital-related medical services in a variety of ways. This chapter describes the funding and payment mechanisms that were in effect during SFY 2013/14 and were applicable to all of the California's hospitals that provide services to Medicaid recipients and the low-income uninsured. These hospitals include DPHs, DMPHs, and private hospitals, both those that receive funds through the DSH program and those that do not. In addition, this chapter examines the funding and payment mechanisms related to the DSH program and the uncompensated care component of California's SNCP program in the BTR Demonstration Waiver.

Overall, the funding for payments of hospital-related medical services provided by hospitals to Medicaid recipients and the uninsured generally comes from five sources: 1) California State general funds; 2) local expenditures funded by non-State government sources that are reported as CPEs; 3) IGT funding from local government sources; 4) tax revenue produced by health care-related provider fees; and 5) Federal matching funds provided through CMS.

In SFY 2013/14, Medi-Cal payments were made to hospitals for services provided to Medi-Cal recipients and the uninsured in five forms: 1) Medi-Cal FFS payments; 2) capitation payments to Medicaid Managed Care Organizations (MCOs), which in turn, pay the hospitals for inpatient and outpatient services; 3) DSH payments; 4) various supplemental payments; and 5) Federal share of CPE amounts claimed for inpatient hospital services provided to FFS recipients at public hospitals.

4.2 Funding of Medicaid Payments

The Medi-Cal program receives Federal matching funds for medical services provided to non-expansion Medicaid recipients using a Federal Medical Assistance Percentage (FMAP) of 50 percent. This means that for every dollar spent by the Medicaid Agency, 50 percent comes from state resources and the other 50 percent comes from Federal resources. For the Medicaid expansion population, the FMAP percentage in SFY 2013/14 was 100 percent. This value is scheduled to gradually reduce to 90 percent by October 1, 2020.¹⁷

California also utilizes CPEs, IGTs, and provider assessments to help fund the non-Federal share of Medicaid reimbursements. CPEs may be used by public hospitals to certify cost incurred in the care of Medicaid recipients. IGTs may be used by public hospitals directly and by local governmental agencies to fund the non-Federal share of Medicaid reimbursements. Hospital provider assessments may be applied to public and private hospitals and, specifically in California, through the Hospital Quality Assurance Fee (HQAF) are applied to the DMPHs and the private hospitals. Assuming CMS approval of CPE claiming in SFY 2013/14, approximately 33 percent of the non-Federal share of Medi-Cal reimbursements to hospitals were funded by State general funds and the other 67 percent came from local sources through CPEs, IGTs and

¹⁷ Medi-Cal implemented Medicaid expansion as defined under the ACA beginning January 1, 2014.

the HQAF assessment. State and local government funding of the Medi-Cal program in SFY 2013/14 is summarized in Figure 3 below:

Figure 3: Comparison of State general funds to local funds supporting non-Federal share of Medi-Cal payments to hospitals

Funding Source	Dollars	Percent of Total Non Federal Share
State General Fund	\$ 3,554,891,751	33%
IGT	\$1,114,869,697	10%
CPE	\$2,658,999,495	25%
Provider Assessment (HQAF)	\$3,505,145,382	32%
Total Local	\$7,279,014,574	67%
Total Non-Federal Share	\$ 10,833,906,325	100%

Figure 4 below summarizes the distribution of State and local government funds for the four categories of hospitals. All DPHs and those private hospitals that do not receive DSH funds stand out for having the majority of the funding for the Medi-Cal reimbursements coming from local government sources.

Figure 4: Distribution of State and local funding of Medi-Cal payments across four categories of hospitals

Hospital Designation	State Share of Total Medi Cal Payments	IGT Funding	CPE Funding	Provider Assessment Funding	State General Funds	Percentage of Non Federal Share from State General Funds	Percentage of Non Federal Share from Local Funds
DPH	\$4,396,444,825	\$1,031,094,308	\$2,622,584,955	\$0	\$742,765,563	17%	83%
DMPH	\$ 431,706,750	\$41,673,778	\$36,414,541	\$0	\$ 353,618,431	82%	18%
Private w/ DSH	\$ 3,425,617,594	\$29,619,166	\$0	\$1,352,372,710	\$2,043,625,718	60%	40%
Private w/o DSH	\$ 2,580,137,156	\$12,482,445	\$0	\$2,152,772,672	\$ 414,882,039	16%	84%
Total	\$10,833,906,325	\$1,114,869,697	\$2,658,999,495	\$3,505,145,382	\$3,554,891,751	33%	67%

4.3 Hospital Claim-based, SNCP, DSH and Other Supplemental Payments

As noted in the section above, the hospitals evaluated in this report are DPH, DMPH, and private hospitals in California that provide services to Medicaid recipients. These hospitals receive payments through several different payment streams for the services they provide to Medicaid recipients. The following sections describe in detail the payment streams received by each provider category as well as the source of the funding for the program.

4.3.1 Claim-based Payments for Medicaid-Eligible Services

For this report, claim payments are the payments made based on submission of a claim from a hospital for services provided to Medicaid eligible individuals. Medi-Cal maintains a Medicaid Management Information System (MMIS) that adjudicates and determines reimbursement for

inpatient and outpatient claims for recipients in the FFS program. For Medicaid beneficiaries enrolled in managed care plans under Medi-Cal, the MCOs are responsible for the processing and payment of inpatient and outpatient claims.

Under the Medi-Cal FFS program, DPHs are primarily paid for inpatient hospital services through a CPE funding program. CPEs are expenditures incurred by a governmental entity (or a provider operated by a state or local government) under the approved state Medicaid plan, for health care services provided to Medicaid recipients. The public provider of services certifies the cost of services rendered to eligible individuals. The Medicaid agency records the certified expenditures, draws the Federal share of the expenditure from CMS, and pays the Federal matching funds to the provider. FFS reimbursement for services provided by DMPHs and private hospitals is calculated using Diagnosis Related Groups (DRGs), and the non-Federal portion of the payment is funded through State general funds.

For outpatient hospital services provided to recipients in the Medi-Cal FFS program by hospitals, DPHs, DMPHs, and private hospitals, payment is determined using a published fee schedule for individual services. The non-Federal share of outpatient FFS payment is funded from State general funds.

The payment methodology for hospital inpatient and outpatient services provided to Medi-Cal managed care recipients is based on the provider-specific contract provisions between the MCO and the hospital. Funding of the non-Federal share for these payments, for all hospital categories, primarily comes from State general funds.

4.3.2 Safety Net Care Pool (SNCP) Uncompensated Care Payments

The BTR Demonstration Waiver authorized Medicaid payments for the SNCP UCP, subject to the spending limits defined in the Demonstration Waiver STCs. These were payments available only to DPHs for uncompensated care not necessarily otherwise claimed through available DSH funding and included both hospital and non-hospital (such as clinic) services. The UCP provided payments to DPHs for services provided to uninsured individuals with no source of third party coverage for the services. The funds were available only for uncompensated expenditures for care and services that met the definition of ‘medical assistance’ contained in section 1905(a) of the Act that were incurred by public hospitals and their clinics, and their affiliated governmental entities.

The non-Federal share of the UCP payments was funded through the use of CPEs. The DPHs and/or their affiliated government entities reported and certified their costs to DHCS, who in turn drew the Federal share of the expenditure from CMS. The Federal matching funds were then distributed to the providers. In SFY 2013/14, the Federal matching funds for the UCP was capped at \$311 million.¹⁸ Continuing to current day under the Medi-Cal 2020 Demonstration Waiver, UCP payments are authorized and capped \$236 million in Federal matching funds, for DPHs participating in the GPP program.

¹⁸ Note: there was a rollover amount for the SFY 2013/14 HCCI allotment. Based on the interim claiming model, the amount was approximately \$25.7 million (total computable), of which half went to the DPHs, with a related FFP of \$6.5M.

4.3.3 DSH Payments

In general, DSH payments are Federally required Medicaid inpatient hospital payment adjustments for hospitals that serve a disproportionate share of low income patients. As such, DSH funds help to offset the Medicaid shortfall and the costs incurred for care of the uninsured. Medicaid shortfall is the difference between non-DSH Medicaid payments for hospital services and hospital costs to provide care to Medicaid recipients. The cost of care for uninsured is defined as hospital costs to care for recipients who have no health insurance or other source of third party coverage or whose health insurance does not cover any of the services related to an entire episode of care (such as a hospital admission). For DSH calculation purposes, costs of care for the uninsured are offset by patient payments.

Private, DPH, and DMPH hospitals may all receive DSH payments if they are determined to be eligible in a specific year. In SFY 2013/14, all 21 DPHs and 53 DMPHs qualified and received DSH payments through the Federal DSH program. Also in SFY 2013/14, 99 private hospitals qualified and received “DSH Replacement” supplemental payments. “DSH Replacement” is a supplemental payment program that began in 2005, is available to qualifying private hospitals, is not included in Medi-Cal’s annual Federal DSH allotment, does not require formal DSH audits, but is often reported together with money distributed through the Federal DSH program. Both Federal DSH and DSH Replacement payments are made directly from the Medicaid agency to hospitals independent of capitation payments made to MCOs.¹⁹ Total Federal Medicaid DSH payments to a hospital may not exceed the hospital’s cost for care of Medicaid recipients and the uninsured, net of FFS, managed care, and patient payments for services, with the exception described below for hospitals that meet the criteria for a “high DSH” facility.

Eighteen of California’s DPHs and 28 of California’s DMPHs qualify as “high DSH” facilities. These public hospitals draw from the Federal DSH allotment up to 100 percent of uncompensated Medi-Cal and uninsured hospital costs. Once claimed and received by the State, the Federal amounts are distributed to the facilities based on a statutory formula that generally takes into account hospitals’ Medicaid and uninsured discharges and uncompensated costs. Hospitals that qualify as “high DSH” facilities may also receive DSH payments in amounts up to 75 percent of their hospital-specific DSH claimable costs, so that the maximum DSH payments to the hospital equal up to 175 percent of the hospitals’ uncompensated Medi-Cal and uninsured costs as permitted under Federal law.²⁰

DSH payments made through the Federal DSH and the DSH Replacement programs in SFY 2013/14 are summarized in the following table.

¹⁹ In data figures throughout this report, DSH Replacement payments are listed in the same column as traditional DSH payments. In addition, DSH Replacement payments are included with fee-for-service payment, in contrast to traditional DSH payments which are primarily categorized as reimbursement for uninsured recipients.

²⁰ Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. Law 106-113) §607.

Figure 5: Medi-Cal DSH and DSH Replacement Payments in SFY 2013/14

Hospital Designation	Medi Cal DSH and DSH Replacement Payments
DPH	\$2,312,236,318
DMPH	\$144,323,856
Private w/ DSH ¹	\$526,249,107
Private w/o DSH	\$0
Total	\$2,982,809,281
¹ All payments listed in this figure for “Private with DSH” hospitals are supplemental DSH replacement payments and are not technically part of Federal annual DSH allotment.	

The non-Federal share of DSH funds comes from various sources depending on the type of provider. For DPHs, the non-Federal share is claimed through CPEs up to 100 percent of uncompensated Medi-Cal and uninsured hospital costs. For high-DSH DPHs, the non-Federal share for the additional 75 percent of claimable costs is provided through IGTs. For DMPHs, all of the non-Federal share of DSH reimbursements, including the additional 75 percent of costs for high-DSH hospitals is obtained from State general funds. The non-Federal share of funding of the DSH Replacement program for private hospitals is obtained through State general funds.

4.3.4 Other Supplemental Payments for Medicaid Services

California Medicaid has a variety of other Medicaid payments intended to supplement reimbursements made through claim payments. Most of the funding of the non-Federal share of these supplemental payments comes from CPEs, IGTs, and hospital provider assessment fees. Figure 6 below provides a listing and brief description of each of these supplemental payment streams. This table also indicates which provider types are eligible to receive supplemental payments from each program and the source of funding for the non-Federal share.

Figure 6: Medi-Cal Supplemental Payments

Supplemental Payments	Description	Eligible Providers ¹	IP/OP	Non Federal Share Funding
Medi-Cal Outpatient Disproportionate Share Hospital Factor	<p>Medi-Cal determines an outpatient disproportionate share factor to all hospitals in the State that provide outpatient services, and provides adjustments to the regulatory fee-for-service payments to hospitals that exceed the mean factor. The Department pays the supplemental amounts to those hospitals that are above the mean value of the factor on a quarterly basis. (Note that though this payment stream has the name DSH in the title, it is not a DSH payment from the Federal Medicaid DSH allotment, but hospitals must meet DSH eligibility in order to receive the payment increases).</p> <p>The non-Federal portion of this program is funded through the general fund.</p>	DPH, DMPH, Private	OP	General funds

Supplemental Payments	Description	Eligible Providers ¹	IP/OP	Non Federal Share Funding
DSH Replacement	Allows for the receipt of FFP for DSH Replacement supplemental payments made to eligible private hospitals. Payments are fee for service inpatient hospital supplemental payments and are subject to the private hospital upper payment limit. Payments are available for private hospitals identified on the State's disproportionate share list and are issued by DHCS.	Private	IP	General funds
Public Hospital Outpatient Services Supplemental Payment Program	CPE funded payment that provides supplemental reimbursement for outpatient hospital services to Medicaid beneficiaries provided by an acute care hospital that is owned or operated by a city, county, city and county, the University of California, or a health care district, which meets specified requirements. Supplemental reimbursement under this program is available for the federal share of costs that are in excess of the fee-for-service payments the hospital receives for outpatient hospital services; the hospital reports the costs as certified public expenditures for which it receives the Federal financial participation.	DPH, DMPH	OP	CPE
Managed Care SPD Rate Increase	Managed Care rate increases paid to Medi-Cal managed care plans to enable minimum cost-based payment level for services provided by Designated Public Hospitals and their affiliated public providers to Seniors and Persons with Disabilities (SPD) mandatorily enrolled in Medi-Cal managed care. The non-Federal share of the rate increases for all services provided by DPHs to this population comes from voluntary IGTs contributed by DPHs and their affiliated government entities. The only exception is the non-Federal share of these rate increases provided through State general funds for services offered to this population at LA County's Cost-Based Reimbursement Clinics (CBRCs). The SPD rate increase payments are distributed as increases to the capitation rates paid to the MCOs by Medi-Cal.	DPH	IP/OP	IGTs, General funds
Managed Care MCE Rate Increase	Managed Care rate increases paid to Medi-Cal managed care plans to enable minimum cost-based payment level for services provided by County Designated Public Hospitals and their affiliated public providers to newly Medicaid eligible adults under the ACA (MCE). The MCE rate increase payments are distributed as increases to the capitation rates paid to the MCOs by Medi-Cal. Funding for this rate increase came entirely from the Federal government in SFY 2013/14 using the Medicaid expansion 100% FMAP. As this FMAP reduces, the non-Federal share will come from the DPHs and their affiliated government entities.	DPH	IP/OP	N/A
Managed Care Rate-Range Increases	DPHs and their affiliated government entities may provide the non-Federal share of rate increases to Medi-Cal managed care plans from the lower bound of the rate ranges determined to be actuarially sound to the upper bound of the ranges associated with Medi-Cal managed care enrollees in the county where the	DPH, DMPH	IP/OP	IGT

Supplemental Payments	Description	Eligible Providers ¹	IP/OP	Non Federal Share Funding
	DPH operates. The rate increases received by the plans are to be used to compensate providers designated by the transferring entities for Medi-Cal services and support of the Medi-Cal program. DHCS has limited the extent to which rate range increases may be funded and designated by the transferring entities. In SFY 2013/14, the non-Federal share was provided through IGTs from local governments.			
Hospital Quality Assurance Fee Supplemental Payment	SB 335 laid the foundation for a Hospital Quality Assurance Fee (HQAF) on certain general acute care hospitals in order to make grant payments and supplemental Medi-Cal fee-for-service and managed care payments to hospitals up to the aggregate upper payment limit for the period of July 1, 2011-December 31, 2013. SB 239 primarily enacted the Medi-Cal Hospital Reimbursement Improvement Act of 2013, that imposes a QAF on certain general acute care hospitals in order provide the non-Federal share of increased managed care payments and fee-for-service payments for hospital services up to the aggregate upper payment limit for the period of January 1, 2014 – December 31, 2016.	DPH, DMPH, Private	IP/OP	HQAF
Distinct Part Nursing Facility (DP/NF) Program	CPE funded payment that provides supplemental reimbursement for skilled nursing services to Medicaid beneficiaries provided in a distinct part nursing facility level B (DP/NF-B) of an acute care hospital that is owned or operated by city, city and county or health care district, which meets specified requirements. Under this program additional reimbursement is available only for the federal share of costs that are in excess of the State's regulatory rate of payment the facility receives for nursing facility services under the current DP/NF fee-for-service methodology; the hospital reports the costs as certified public expenditures for which it receives the Federal financial participation.	DPH, DMPH	OP	CPE
Physician Non-Physician Practitioner Supplemental Payment (MD-SPA)	CPE funded payment that provides supplemental reimbursement to eligible government-operated hospitals or government entities, with which they are affiliated, for the otherwise uncompensated costs of providing physician and non-physician practitioner professional services to Medicaid beneficiaries. Supplemental reimbursement under this program is available for the costs that are in excess of the fee-for-service payments for the physician or non-physician practitioner services; the hospital or relevant government entity reports these uncompensated costs as certified public expenditures for which it receives the Federal financial participation.	DPH	IP/OP	CPE
Construction Renovation and Reimbursement	State general funded fee-for-service inpatient hospital supplemental payments to eligible hospitals for the financed amounts associated with the construction, renovation and replacement of qualifying hospital facilities. The supplemental payments are to be used by the hospitals for the payment of	DPH, Private	IP	General funds

Supplemental Payments	Description	Eligible Providers ¹	IP/OP	Non Federal Share Funding
	debt service incurred on revenue bonds for the eligible projects, which are narrowly defined with respect to plan submission date and hospital eligibility criteria.			
Private Hospital Supplemental Fund/ SB 1100 Program	Provides supplemental reimbursement to private hospitals from the Private Hospital Supplemental Fund (4260-601-3097) using General Fund, IGTs, and interest accrued as the non-Federal share of payments and 33.60% of the Stabilization funding for private hospitals as calculated by the formulas set forth in SB 1100 and SB 474.	Private	IP	IGT, General funds
Non SB 1100 Intergovernmental Transfers	Provides supplemental reimbursement via IGTs to Non-SB 1100 hospitals. Non-SB 1100 refers to those (private) hospitals in south LA County that were hit the hardest by the closure of Martin Luther King, Jr. (MLK) Hospital in 2007. LA County developed the 'Impacted Hospital (IGT) Program' aka 'IHP-IGT program' that would allow nine hospitals surrounding MLK to benefit from this IGT program. Non-SB1100 Hospitals are private hospitals that maintain a basic or comprehensive emergency department and are DSH-eligible.	Private	IP	IGT
Non-Designated Public Hospital Supplemental Reimbursement Program	Payments to the DMPHs will be from the DMPH Supplemental Fund using State General Fund (GF) and interest accrued in the DMPH Supplemental Fund as the non-Federal share of costs. Interest accrued in a fiscal year will be paid in the subsequent fiscal year.	DMPH	IP	General funds
Non-Designated Public Hospital IGT Program	SPA 10-026 requires DHCS to provide supplemental reimbursement for Medicaid fee-for-service (FFS) inpatient hospital services on an annual basis. Hospitals operated by a Government Entity, except those defined in Appendix 1 to Attachment 4.19-A, are qualified for participating in the voluntary program. AB 113 requires DHCS to establish, implement, and maintain the Non-Designated Public Hospital Intergovernmental Transfer Program. AB 113 requires the State to deposit the transferred funds into the Med-Cal Inpatient Payment Adjustment Fund (MIPA). The State is authorized to retain nine percent of each IGT amount to reimburse the department for administrative operating costs.	DMPH	IP	IGT
Enhanced Payments to Private Trauma Hospitals	IGT program that provides supplemental reimbursement for outpatient hospital trauma and emergency services to private hospitals within Los Angeles County and Alameda County that have demonstrated a need for assistance in ensuring the availability of essential trauma services for Medicaid beneficiaries and meet certain requirements specified in the State Plan Amendment.	Private	OP	IGT

Supplemental Payments	Description	Eligible Providers ¹	IP/OP	Non Federal Share Funding
Small Rural Hospital	This supplemental program increases the reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by small and rural hospitals. The Department reimburses eligible providers on a quarterly basis.	DMPH and Private	OP	General funds
Note: ¹ IP = Inpatient services; OP = Outpatient services				

4.3.5 Summary of Hospital Revenues

As mentioned in the Introduction chapter, the STCs defining requirements for this report indicated that the following subtotals of hospital revenue need to be described for the hospitals included in the report:

- Total hospital system revenue from all payers
- Total Medicaid revenue (including patient care revenue and all other Medicaid revenue such as demonstration revenue and incentive payments)
- Total Medicaid patient care revenue
- Total safety net care pool revenue

Figure 7 shows total all-payer revenue for all four categories of hospitals.

Figure 7: Total All Payer Hospital Revenue for Patient Care

Hospital Designation	Total All Payer Net Patient Care Revenue ¹
DPH	\$12,989,129,458
DMPH	\$5,092,338,138
Private w/ DSH	\$18,873,555,583
Private w/o DSH	\$45,663,801,133
Total	\$82,618,824,312
¹ All payer net patient revenue for the DPHs was retrieved from a spreadsheet provided by the California Association of Public Hospitals and Health Systems and used in the 2016 UCC report. For all other hospitals, net patient revenue was retrieved from data reported to OSHPD.	

Figure 8 below shows the payment amounts for the various Medi-Cal funding streams for SFY 2013/14 for the DPH, DMPH, and private hospitals. As mentioned in the Data Sources section, Medi-Cal FFS claim payments and supplemental payments were identified separately from CA-MMIS data and supplemental payment data available from DHCS. Medi-Cal managed care data, in contrast, was retrieved for the OSHPD dataset and does not distinguish claim payments separately from supplemental payments. Also note that this figure includes the total payment amount reported for Federal claiming purposes independent of the source of funding of the non-

Federal share. Net Medi-Cal reimbursement, which adjusts for local funding of the non-Federal share of the Medi-Cal program is provided in Chapter 6.

Figure 8: Total Medi-Cal Payments by Payment Stream

Hospital Designation	Medicaid FFS Claim Payments	Medi Cal Supplemental Payments	Medicaid Managed Care Payments	Medi Cal Uncompensated Care Pool Payments	Medi Cal DSH and DSH Replacement Payments	Total Medi Cal Payments
DPH	\$3,720,700,987	\$517,946,647	\$3,146,069,046	\$622,000,000	\$2,312,236,318	\$10,318,952,998
DMPH	\$264,078,626	\$206,825,525	\$381,045,943	\$0	\$144,323,856	\$996,273,951
Private w/ DSH	\$2,273,237,854	\$2,485,782,791	\$2,782,436,482	\$0	\$526,249,107	\$8,067,706,234
Private w/o DSH	\$1,887,098,979	\$2,074,315,307	\$2,536,156,666	\$0	\$0	\$6,497,570,952
Total	\$8,145,116,446	\$5,284,870,270	\$8,845,708,137	\$622,000,000	\$2,982,809,281	\$25,880,504,135

For the public hospitals, DPHs and DMPHs, the Federal DSH program is clearly a major source of Medi-Cal reimbursement as it comprises just under 22 percent of total Medi-Cal reimbursement in aggregate for these two categories of hospitals. The UCP, although smaller, is significant as well comprising 5.5 percent of Medi-Cal reimbursement to the public hospitals.

Figure 9 below displays “other” hospital revenues which either do not come from Medi-Cal (“Payments for Care of the Uninsured”) or are not related to patient care (“DSRIP Revenues”).

Figure 9: Total “Other” Hospital Revenues

Hospital Designation	Payments for Care of the Uninsured ¹	Medi Cal DSRIP Payments
DPH	\$166,112,716	\$1,431,271,428
DMPH	\$144,196,900	\$0
Private w/ DSH	\$379,027,451	\$0
Private w/o DSH	\$1,208,143,971	\$0
Total	\$1,897,481,038	\$1,431,271,428

¹ Payments for the uninsured for the DMPHs and private hospitals come from three categories in the OSHPD dataset: the California County Indigent Program, Other Indigent, and Other/Self Pay.

5 Analysis of Costs

5.1 Calculation of Costs

A key component of this report is to estimate the annual cost of uncompensated care provided by the California hospitals. For this report, we define uncompensated care as the gap between cost and reimbursement for hospital-related care provided to Medicaid beneficiaries, plus the gap between the cost of care and patient payments for hospital-related provided to the uninsured. The sources of cost included in this report are consistent with those included in the DSH and SNCP UCP in SFY 2013/14.

This chapter summarizes total applicable costs for services provided by California hospitals to Medi-Cal and uninsured recipients during SFY 2013/14. Costs are included for services provided in both the inpatient and outpatient settings as well as hospital-based long term care and clinic settings. In addition, for the Medicaid beneficiaries, we distinguish services reimbursed under both the FFS and the Medicaid managed care programs. Costs by hospital class for SFY 2013/14 are shown in Figure 10.

Figure 10: Hospital Costs for SFY 2013/2014

Hospital Designation	Medicaid FFS Costs	Medicaid Managed Care Costs	Uninsured Costs ¹	Total Cost of Care to Medicaid and Uninsured Recipients
DPH	\$4,048,641,652	\$3,373,462,691	\$2,121,908,158	\$9,544,012,501
DMPH	\$451,959,175	\$568,068,297	\$317,005,653	\$1,337,033,125
Private w/ DSH	\$3,829,249,452	\$3,211,770,180	\$1,044,249,916	\$8,085,269,548
Private w/o DSH	\$3,269,657,650	\$3,811,751,708	\$1,925,820,294	\$9,007,229,652
Total	\$11,599,507,929	\$10,965,052,876	\$5,408,984,021	\$27,973,544,826

¹ Costs for the uninsured as reported in the OSHPD dataset come from recipient self-pay and from the California County Indigent program.²¹

Medi-Cal is afforded unique consideration under Federal rules that authorize Federal matching funds on DSH payments made to California’s DPH and DMPH high DSH hospitals up to 175 percent of the uncompensated care cost for Medicaid eligible individuals and individuals with no source of third party insurance (as opposed to the customary 100 percent). Figure 11 shows total cost when including an additional 75 percent of costs applicable for high DSH payments.

²¹ In the OSHPD data reports, hospitals are instructed to report any applicable county indigent charges. The OSHPD manual defines indigent as “lacking the financial ability to reasonable be expected to pay for medical services received.” Specifically, hospitals are required to report all inpatient and outpatient charges for indigent patients, excluding those recorded in the County Indigent Programs category and including those who are being provided charity care by the hospital. The uninsured costs reflected in figure 10 for DMPHs and private hospitals are based on county indigent and self-pay reported data in the OSHPD reports.

Figure 11: Hospital Cost Including Claimable DSH Cost

Hospital Designation	Total Cost of Care to Medicaid and Uninsured Recipients	75 Percent of Claimable DSH Costs	Total Claimable DSH Costs
DPH	\$9,544,012,501	\$1,105,359,243	\$10,649,371,744
DMPH	\$1,337,033,125	\$254,745,215	\$1,591,778,340
Private w/ DSH	\$8,085,269,548	\$0	\$8,085,269,548
Private w/o DSH	\$9,007,229,652	\$0	\$9,007,229,652
Total	\$27,973,544,826	\$1,360,104,458	\$29,333,649,284

Eighteen DPH hospitals and 28 DMPH hospitals qualified as high DSH hospitals in SFY 2013/14.

5.2 Bad Debt and Charity Care

In the healthcare context, charity care is generally provided to individuals who do not have the financial capacity to pay, while bad debt is generally the result of a patient who has either demonstrated an ability to pay or fails to demonstrate an inability to pay by completing a required assessment. The requirements for this study, which are listed in the Demonstration Waiver STCs, requires an examination of these criteria, and ask for a distinction to be made for services “provided to uninsured individuals, distinguishing between costs associated with charity care from those associated with bad debt.” While charity care in principle can cover populations beyond the uninsured, this study limits the scope to charity care for those that are uninsured under Medicaid DSH rules.

There are several existing report formats that measure charity care and bad debt but none are formulated in manners that are usable for the purposes of this study. Therefore, taking the data directly from those reports is not a useful way to assess charity care for this study. For example, the MCR’s S-10 workbook measures uncompensated care for Medicare purposes, but explicitly states that the worksheet does not produce estimates for treating uninsured patients under the Medicaid program.²² Another source that measures charity care and bad debt is IRS Form 990 for non-profit hospitals, but is not used by government-owned hospitals, can extend to both insured individuals as well as the uninsured, and does not use Medicaid cost reporting methodologies. While this study cannot rely on the resulting data from these reports, there are numerous underlying principles for how these reports are generated, that can be useful in helping complete the charity care analysis required under this study.

5.2.1 Bad Debt and Charity Care

The Healthcare Financial Management Association (HFMA) has provided guidance to the hospital industry related to bad debt and charity care. Specifically, HFMA issued Principles and Practices Board Statement 15, “*Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers*,” on how to properly record bad debt expenses and costs related to charity care. These HFMA principles are also the underpinnings for the financial reports discussed in the paragraph above. Based on these principles, it is possible to start with uninsured costs as conventionally reported by hospitals under Medicaid

²² S-10 instructions.

(Medi-Cal in California) cost reporting methodologies and the Medicaid DSH definition of uninsured and to categorize those uncompensated costs into charity care versus bad debt.

In relation to charity care, HFMA states that “[n]o single set of criteria for charity care policies is universally applicable. Each institutional provider of healthcare services must establish its own policies that are consistent with the organization’s mission and financial ability, as well as with state laws.”²³ California State law establishes a floor for how hospitals define ability to pay, e.g., what are acceptable criteria for providing charity care. The first requirement is that all California hospitals must offer charity care to those under 350% of the FPL as well as follow other asset-testing requirements, all as set forth under California’s Hospital Fair Pricing Policies Act.²⁴ The second requirement is that counties are required to provide charitable care through their section 17000 requirement.²⁵ While both of these requirements serve as a minimum for all hospitals, some California hospitals provide charity care well beyond these minimum requirements.

HFMA has also stated that “the complexities of charity care policies and the difficult task of documenting charity care qualification have generally resulted in many charity care patients being classified as bad debt.”²⁶ In many cases, determination of financial capacity to pay, which is a significant determinant in the categorization of charity versus bad debt, can be an impractical method of measurement, particularly in cases involving emergency care and/or death. Charity determination can also be particularly challenging with individuals with limited English proficiency or behavioral health issues, who in fact make up a disproportionate share of the uninsured population. These individuals served by California hospitals are often eligible for charity care but this eligibility may not be formally captured in the required forms or accompanying data. The issue is also recognized by the IRS, which explicitly includes a section in Form 990 that allows non-profit hospitals to estimate their bad debt attributable to low-income individuals who have not gone through charity care qualification assessment procedures.

Given these complexities in accurately determining charity care versus bad debt, we relied on several sources of data for this information. For the DPHs, which were the only hospitals included in the 2016 uncompensated care report, bad debt and charity care information was provided by CAPH. DPHs relied on the principles set forth in HFMA Statement 15 and other charity reports noted above. To help DPHs break out charity care from their subset of uninsured services, the table below helps categorize uninsured care into following categories consistent with those principles:

- **County programs and charity discounts programs** are both means-tested programs and would therefore exclusively fall under charity care, using the DPH’s definitions for eligibility in compliance with California law.
- **Uninsured services for otherwise insured patients** may be consistent with the DSH rule which considers DSH-eligible costs as being “uninsured for the service.” These costs could be either bad debt or charity care. Otherwise covered services for which Medi-Cal will not reimburse under restricted Medi-Cal would be charity since Medi-Cal is means-tested, while

²³ Ibid

²⁴ California Health and Safety Code Section 127400 et seq.

²⁵ Public health care in California began more than a century and a half ago, as part of a state-mandated welfare responsibility. In 1933, this responsibility was codified in Section 17000 of the state’s Welfare and Institutions Code, which provides that counties have a statutory obligation to “relieve and support” their indigent residents who have no other source of care.

²⁶ HFMA. Keys to Reporting Uncompensated Care. <http://www.hfma.org/Content.aspx?id=7207>

uncovered services for third party would depend on whether or not the patient applied and qualified for the DPH's charity program.

- **Self-pay (imputed charity)**²⁷ includes individuals who either (i) were not originally classified as charity or low-income because they never completed a charity assessment but were means-tested at a different service date or (ii) are likely to be low-income based on information from other data sources such as income analysis by zip code or demographic, other available county data, etc. This methodology is consistent with how non-profit hospitals report bad debt in IRS Form 990, which allows hospitals to estimate and provide reasonable methodologies for the amount of bad debt attributable to low-income populations through sampling or some other means.
- **Self-pay (non-charity)** would be considered bad debt because the patients are either assessed to have the "ability to pay" or there is incomplete information to identify them as low-income. Includes individuals who have not completed the charity assessment process and whose ability-to-pay status could not be verified through other data sources.

For DMPHs and private hospitals, we relied on bad debt and charity care information reported in the OSHPD data reports. The OSHPD manual provides some guidance to hospitals for reporting bad debt and charity care. The OSHPD manual states that hospitals may report bad debt if "the party in debt, although determined able to pay, refuses to pay." The manual also states that hospitals may report charity care for services provided to a patient "who does not have the ability to pay for the services rendered." The reporting of bad debt as opposed to charity care is dependent upon the ability of the patient to pay for the services received. The OSHPD manual further provides guidance that the determination of the ability to pay should be made upon admission or as soon as possible thereafter. The manual also states that the criteria for determining those eligible for charity care should generally meet the hospital's requirements for indigency. Hospitals are required through OSHPD rules to maintain documentation regarding the criteria they use in determining charity care as well as written documentation on all charity care determinations.²⁸

The bad debt and charity care amounts in OSHPD represent charges rather than costs. In order to determine the related costs, we multiplied the bad debt and charity care charges by the hospital-specific CCRs as described in Chapter 3 of this report. The SFY 2013/14 bad debt and charity care costs for care of uninsured recipients for the four hospital categories are reflected in Figure 12 below.

²⁷ Imputed charity care was calculated for the DPHs and included in the 2016 UCC report. In that report, imputed charity care was calculated with support from CAPH. For this report, we did not include imputed charity care as we did not have an equivalent calculation of imputed charity care for the other hospital categories.

²⁸ OSHPD. Accounting and Reporting Manual for California Hospitals.
<http://www.oshpd.ca.gov/documents/HID/HospitalFormsInstructions/ch1000.pdf>

Figure 12: Hospital Bad Debt and Charity Care for Uninsured Recipients

Hospital Designation	Bad Debt	Charity Care	Total
DPH	\$248,048,607	\$1,523,178,157	\$1,771,226,764
DMPH	\$113,025,852	\$54,180,241	\$167,206,093
Private w/ DSH	\$211,248,056	\$296,975,665	\$508,223,722
Private w/o DSH	\$326,270,508	\$490,188,375	\$816,458,883
Total	\$898,593,023	\$2,364,522,438	\$3,263,115,461

Note: Imputed charity care was calculated for the DPHs and included in an equivalent table in the 2016 UCC report. In that report, imputed charity care was calculated with support from CAPH. For this report, we did not include imputed charity care as we did not have an equivalent calculation of imputed charity care for the other hospital categories.

The figure above identifies bad debt and charity care specifically for uninsured recipients, as requested in the waiver STCs. In addition, it shows that the amount of charity care at the DPHs²⁹, \$1.5 billion, is well above the \$622 million in total computable value available in the UCP in SFY 2013/14.

The two figures that follow identify bad debt and charity care for all payers.

Figure 13: Hospital Bad Debt Costs – All Payers

Hospital Designation	Uninsured	Other Payers	Total
DPH	\$248,048,607	\$86,832,925	\$334,881,533
DMPH	\$113,025,852	\$18,107,771	\$131,133,622
Private w/ DSH	\$211,248,056	\$40,750,564	\$251,998,621
Private w/o DSH	\$326,270,508	\$538,712,101	\$864,982,610
Total	\$898,593,023	\$684,403,363	\$1,582,996,386

Figure 14: Hospital Charity Care Costs – All Payers

Hospital Designation	Uninsured	Other Payers	Total
DPH	\$1,523,178,157	\$12,319,360	\$1,535,497,517
DMPH	\$54,180,241	\$13,270,540	\$67,450,780
Private w/ DSH	\$296,975,665	\$126,576,586	\$423,552,252
Private w/o DSH	\$490,188,375	\$71,512,458	\$561,700,833
Total	\$2,364,522,438	\$223,678,945	\$2,588,201,383

²⁹ The UCP was only available to DPHs.

6 Comparison of Payments to Costs

In this Chapter, we bring together the Medicaid base and supplemental payment information summarized in Chapter 4 with the Medicaid and uninsured cost information summarized in Chapter 5.

As we will discuss later in this chapter, for services where the non-Federal portion of funding is satisfied through CPEs, IGTs and provider assessment, the hospitals do not receive the full economic benefit of amounts claimed by DHCS for Federal matching purposes. In other words, since the non-Federal portion of these services are satisfied by the hospital or other related local funding sources, the net economic benefit for a substantial proportion of Medicaid and uninsured services provided by these hospitals equates to only half of the amounts claimed by DHCS.

In this chapter, we compare Medicaid payments to hospital costs in three different ways,

- 1) “Gross” – Including actual cost
- 2) “Gross with DSH rules” – Actual cost increased by 75 percent of DSH-claimable costs at high DSH hospitals
- 3) “Net” – Including actual cost and considering hospital funding of non-Federal share of Medicaid reimbursements

In addition, we estimate the effect of two significant upcoming changes in the Federal regulations – reductions in Medicaid DSH allotments and reductions in the Federal matching percentages for the Medicaid expansion population.

6.1 Estimate of Medicaid and Uninsured Utilization

To illustrate the hospitals’ dependence on Medicaid funding, we analyzed Medicaid utilization. Using estimated hospital cost as the measure, we calculated the percentage of hospitals’ services that are utilized by Medicaid enrollees and the uninsured. These results are shown in Figure 15.

Figure 15: Estimate of Medicaid and Uninsured Utilization by Hospital

Hospital Designation	Hospital Cost for Medicaid Recipients	Hospital Cost for Uninsured Recipients	Hospital Cost Medicaid plus Uninsured	Hospital Cost for All Recipients (All Payers)	Estimated Percentage of Medicaid and Uninsured Utilization
DPH	\$7,422,104,343	\$2,121,908,158	\$9,544,012,501	\$15,874,113,814	60%
DMPH	\$1,020,027,472	\$317,005,653	\$1,337,033,125	\$5,168,268,791	26%
Private w/ DSH	\$7,041,019,632	\$1,044,249,916	\$8,085,269,548	\$16,815,332,706	48%
Private w/o DSH	\$7,081,409,358	\$1,925,820,294	\$9,007,229,652	\$41,603,887,953	22%
Total	\$22,564,560,805	\$5,408,984,021	\$27,973,544,826	\$79,461,603,263	35%

Note: The Estimated Percentage of Medicaid and Uninsured Utilization was calculated using OSHPD cost data, which is a different method than used for calculation of the same value for the DPH’s in the Medi-Cal 2016 UCC report. However, the result is very similar. In the 2016 report, the Medi-Cal and Uninsured utilization at the DPH’s was estimated to be 56 percent. Using the calculations above, the value is 60 percent.

The values shown in Figure 15 above indicate that Medicaid recipients and the uninsured comprise a relatively high percentage of the patient mix for all categories of hospitals in California and, in particular, for the DPHs and Private hospitals receiving DSH funds. On average across the entire state, care for Medicaid and uninsured recipients comprises nearly one third of all hospital inpatient and outpatient costs in SFY 2013/14. In subsequent years, this percentage has likely increased as Medi-Cal expansion under the ACA was in place for only half of this time period. Clearly, many of the hospitals in the state are heavily dependent on Medi-Cal reimbursement levels.

6.2 “Gross” – Payment-to-Cost Comparison Using Actual Cost

In this section, payments and costs are determined using a method similar to the one used in cost-based annual hospital Upper Payment Limit (UPL) analyses.³⁰ That is, payments include the non-Federal share as well as the Federal matching portion, even in cases in which the non-Federal share is a CPE, IGT or provider assessment contribution. Also, the payment amounts include both claim payments and all supplemental payments intended to compensate hospitals for services provided to Medicaid and uninsured recipients. DSRIP payments are not included in this section, as they are not applicable to the costs of medical services offered to individual recipients. Finally, unlike UPL analyses and more like DSH analyses, payment and cost for both the FFS and managed care programs as well as for the uninsured are included in the numbers presented below.

In addition, costs included in this section are actual costs incurred for providing services in SFY 2013/14. The additional 75 percent added for DSH claimable costs at high DSH hospitals is not included.

The first two figures in this section, Figures 16 and 17, show payment-to-cost comparisons separately for Medi-Cal recipients (sum of FFS and managed care), and for the uninsured. These figures are followed by a third figure, Figure 18, which shows an overall comparison of payment-to-cost when combining the values from the two categories.

Figure 16 below contains payments and costs incurred by the hospitals in providing care to recipients and/or services covered by the Medi-Cal program. These are the services and payments provided to beneficiaries enrolled in either the FFS program or a Medicaid managed care plan.

³⁰ Medi-Cal uses a different method, the Medicare pay-to-charge ratio method, for calculating the upper payment limit in annual UPL reporting to CMS.

Figure 16: Payment-to-Cost Comparison for Services Provided to Medi-Cal Recipients

Hospital Designation	Claim Payments	Supplemental Payments	DSH Payments Applicable to FFS and MC	DSH Replacement Payments	Total Payments	Hospital Cost for Medi Cal Recipients	Pay to Cost Ratio
DPH	\$6,866,770,033	\$456,987,300	\$696,133,082	\$0	\$8,019,890,414	\$7,422,104,343	108%
DMPH	\$645,124,569	\$206,825,525	\$0	\$0	\$851,950,095	\$1,020,027,472	84%
Private w/ DSH	\$5,055,674,337	\$2,468,933,792	\$0	\$526,249,107	\$8,050,857,236	\$7,041,019,632	114%
Private w/o DSH	\$4,423,255,645	\$2,073,088,265	\$0	\$0	\$6,496,343,909	\$7,081,409,358	92%
Total	\$16,990,824,584	\$5,205,834,882	\$696,133,082	\$526,249,107	\$23,419,041,654	\$22,564,560,805	104%

Figure 17, below, contains payments and costs incurred by California hospitals in providing care to recipients who did not have insurance, or whose insurance did not cover the services provided. Payments made by Medi-Cal through the DSH and UCP programs are included in this table.

Figure 17: Payment-to-Cost Comparison for Services Provided to the Uninsured

Hospital Designation	DSH Payments Not Applied to FFS or MC	UCC Payments	Other Payments	Total Payments for Uninsured Recipients	Hospital Cost for Uninsured Recipients	Uninsured Pay to Cost Ratio
DPH	\$1,616,103,236	\$622,000,000	\$166,112,716	\$2,404,215,953	\$2,121,908,158	113%
DMPH	\$144,323,856	\$0	\$144,196,900	\$288,520,756	\$317,005,653	91%
Private w/ DSH	\$0	\$0	\$379,027,451	\$379,027,451	\$1,044,249,916	36%
Private w/o DSH	\$0	\$0	\$1,208,143,971	\$1,208,143,971	\$1,925,820,294	63%
Total	\$1,760,427,092	\$622,000,000	\$1,897,481,038	\$4,279,908,131	\$5,408,984,021	79%

Figure 18, below, combines the values from the two previous tables, thus presenting an overall payment-to-cost comparison for services provided to Medicaid recipients and the uninsured. As mentioned previously, the amounts shown in this figure include actual cost and all payments except for incentive payments made through the DSRIP program. Also, the amounts shown in this table do not include any offset for the local contributions to the non-Federal share of payments (i.e., through CPEs, IGTs, or the HQAF program).

Figure 18: Overall Payment-to-Cost Comparison for Medi-Cal Reimbursement to California Hospitals

Hospital Designation	Payments for Medi Cal Recipients	DSH and DSH Replacement Payments	UCC Payments	Payments for Uninsured Recipients	Total Payments for Medi Cal and Uninsured Recipients	Hospital Cost for Medi Cal Recipients	Hospital Cost for Uninsured Recipients	Hospital Cost for Medi Cal Plus Uninsured	Medi Cal and Uninsured Pay to Cost Ratio
DPH	\$7,323,757,333	\$2,312,236,318	\$622,000,000	\$166,112,716	\$10,424,106,367	\$7,422,104,343	\$2,121,908,158	\$9,544,012,501	109%
DMPH	\$851,950,095	\$144,323,856	\$0	\$144,196,900	\$1,140,470,851	\$1,020,027,472	\$317,005,653	\$1,337,033,125	85%
Private w/ DSH	\$7,524,608,129	\$526,249,107	\$0	\$379,027,451	\$8,429,884,687	\$7,041,019,632	\$1,044,249,916	\$8,085,269,548	104%
Private w/o DSH	\$6,496,343,909	\$0	\$0	\$1,208,143,971	\$7,704,487,880	\$7,081,409,358	\$1,925,820,294	\$9,007,229,652	86%
Total	\$22,196,659,466	\$2,982,809,281	\$622,000,000	\$1,897,481,038	\$27,698,949,785	\$22,564,560,805	\$5,408,984,021	\$27,973,544,826	99%

6.3 “Gross with DSH Rules” – Payment-to-Cost Comparison Using 175 Percent of DSH Applicable Costs

Payments included in Figure 19 are the same as those presented in the previous section. However, costs in this section have been increased by an amount equal to 75 percent of claimable DSH costs at those hospitals who qualify as high-DSH facilities.

Figure 19: Overall Payment-to-Cost Comparison when Including an Additional 75 Percent of DSH Claimable Costs

Hospital Designation	Total Payments for Medi Cal and Uninsured Recipients	Hospital Cost for Medi Cal Plus Uninsured	75% of Claimable DSH Costs for "High DSH Hospitals	Total Cost w/ 175% of Cost for "High DSH Hospitals	Pay to Cost Ratio w/ 175% of Cost for "High DSH Hospitals
DPH	\$10,424,106,367	\$9,544,012,501	\$1,105,359,243	\$10,649,371,744	98%
DMPH	\$1,140,470,851	\$1,337,033,125	\$254,745,215	\$1,591,778,340	72%
Private w/ DSH	\$8,429,884,687	\$8,085,269,548	\$0	\$8,085,269,548	104%
Private w/o DSH	\$7,704,487,880	\$9,007,229,652	\$0	\$9,007,229,652	86%
Total	\$27,698,949,785	\$27,973,544,826	\$1,360,104,458	\$29,333,649,284	94%

6.4 “Net” – Payment-to-Cost Comparison with Consideration of Local Funding of Medicaid Non-Federal Share

The payment-to-cost comparison displayed in this section describes the net economic impact to California hospitals for care provided to Medicaid and uninsured recipients, taking into consideration the local non-Federal contributions made through CPEs, IGTs and HQAF. In this section, CPEs, IGTs and HQAF contributions are subtracted from the payments listed in previous sections. Also, costs here are actual costs, without the addition of 75 percent of claimable DSH costs at high-DSH hospitals. The results show the actual net payments received by California hospitals from the Medicaid program after considering these local contributions.

Figure 20: Overall Payment-to-Cost Comparison Net of Local Funding of Medicaid Reimbursements

Hospital Designation	Total Payments for Medi Cal and Uninsured Recipients	IGT Funding	CPE Funding	Provider Assessment (HQAF) Contributions	Payment Reduced by Local Funding	Total Hospital Cost for Care of Medi Cal and Uninsured Recipients	Pay to Cost Net of Local Funding
DPH	\$10,424,106,367	\$1,031,094,308	\$2,622,584,955	\$0	\$6,770,427,104	\$9,544,012,501	71%
DMPH	\$1,140,470,851	\$41,673,778	\$36,414,541	\$0	\$1,062,382,532	\$1,337,033,125	79%
Private w/ DSH	\$8,429,884,687	\$29,619,166	\$0	\$1,352,372,710	\$7,047,892,812	\$8,085,269,548	87%
Private w/o DSH	\$7,704,487,880	\$12,482,445	\$0	\$2,152,772,672	\$5,539,232,764	\$9,007,229,652	61%
Total	\$27,698,949,785	\$1,114,869,697	\$2,658,999,495	\$3,505,145,382	\$20,419,935,211	\$27,973,544,826	73%

6.5 Considerations for the Future

This section describes and addresses potential changes in Federal rules and methods that may significantly affect hospital funding in future periods. Specifically, this section addresses scheduled reductions in the DSH allotment in California, and scheduled reductions in the FMAP for the ACA expansion population in future periods.

6.5.1 Reductions in DSH Allotment

Since 1981, Federal statute has required state Medicaid programs to make DSH payments to safety net providers that serve a high proportion of Medicaid and other low income patients. As described in Chapter 4, the purpose of DSH payments is to provide additional payments that take into account the costs associated with uncompensated care for the uninsured and to account for the Medicaid shortfalls that are incurred by hospitals serving a disproportionate share of such patients. In 2014, DSH payments across the nation totaled \$18 billion, with Federal funds accounting for approximately \$10 billion of that total. These payments are crucial for maintaining the financial sustainability of safety net providers. In SFY 2013/14 the total computable DSH allotment to California hospitals was \$3.0 billion, of which \$0.5 billion was funded through IGTs, thus resulting in a sizable \$2.5 billion net reimbursement to the facilities.

Under the assumption that increased health care coverage would lead to reductions in hospital uncompensated care and lessen the need for DSH payments, the ACA included reductions to Federal DSH allotments. The Federal DSH allotment reductions were originally scheduled to begin in Federal Fiscal Year (FFY) 2014. The reductions have been delayed through several subsequent signed laws. As a result, CMS will begin reducing the Federal Medicaid DSH allotments effective with fiscal year 2018, which begins on October 1, 2017.³¹ The Federal DSH allotment reductions are currently scheduled to occur in the following amounts and timeframe:

- FY 2018 – \$2.0 billion
- FY 2019 – \$3.0 billion
- FY 2020 – \$4.0 billion
- FY 2021 – \$5.0 billion
- FY 2022 – \$6.0 billion
- FY 2023 – \$7.0 billion
- FY 2024 – \$8.0 billion
- FY 2025 – \$8.0 billion

When the reductions were originally set to begin in 2014, CMS promulgated a regulatory methodology intended to be applied for the first two years of the cuts to better align DSH funds with states that have a high uninsured population. In addition, this original plan anticipated a future rule intended to revise the methodology once the relative impacts of states' decisions on Medicaid expansion were better understood. The methodology that CMS developed in 2014 took into account the following five factors when determining how the DSH allocation reductions would be distributed across states:

³¹ Federal Register / Vol. 81, No. 207 / Wednesday, October 26, 2016 / Notices, page 74433.
<https://www.gpo.gov/fdsys/pkg/FR-2016-10-26/pdf/2016-25813.pdf>

- Low-DSH factor – States that already receive low DSH allotments would receive a smaller proportion of the total DSH allocation reduction.
- Uninsured percentage factor – States that have lower uninsured rates relative to other states would receive a larger DSH allocation reduction.
- High volume of Medicaid inpatients factor – States would receive larger DSH allotment reductions if they do not target DSH payments to hospitals with high Medicaid volume.
- High level of uncompensated care factor – States would receive larger DSH allotment reductions if they do not target DSH payments to hospitals with high levels of uncompensated care.
- Budget neutrality factor – This factor is an adjustment to the high Medicaid and high uncompensated care factors that account for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under Section 1115 waivers in four states and the District of Columbia (California would not be affected by this factor).

While CMS has not yet proposed a DSH allotment reduction methodology for FY 2018, the MACPAC estimated the potential impact of the reductions based on the 2014 planned methodology.³² From that analysis, it estimates that the upcoming reductions will decrease California’s DSH allotment by 14.1 percent in FY 2018, which will have a significant effect on California’s safety net hospitals.

Figure 21: Current and Projected State DSH Allotment, FY 2017-2018 (millions)³³

FY 2017		FY 2018 Unreduced Allotment		FY 2018 Reduced Allotment		Difference (unreduced less reduced)		
Total (State & Federal)	Federal	Total (State & Federal)	Federal	Total (State & Federal)	Federal	Total (State & Federal)	Federal	Percent Reduction
\$2,407.1	\$1,203.6	\$2,431.8	\$1,215.9	\$2,088.9	\$1,044.5	\$342.8	\$171.4	-14.1%

The reduction in DSH funding, while significant, is still less than the national average of 16.6 percent. This is because despite the gain California has made under the ACA, California still has an uninsured rate of around 8.6 percent. This estimate represents a loss to the State of over \$171 million of the Federal DSH allotment in FY 2018.³⁴ As the total DSH allotment reduction increases over time, the California allotment will continue to decrease accordingly.

The MACPAC study analyzed the relationship between allotments and several potential indicators of the need for DSH funds, including changes in the number of uninsured individuals, and the amount and sources of uncompensated care costs in hospitals. The ACA coverage expansions affect the two types of hospital uncompensated care costs that DSH payments subsidize in different ways:

³² Report to Congress on Medicaid and CHIP, MACPAC, March, 2017. <https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

³³ Source: Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of FY 2016 DSH allotments, Congressional Budget Office projections of the Consumer Price Index for All Urban Consumers, 2012 Medicaid DSH audits, 2012 Medicare cost reports, and the U.S. Census Bureau 2015 American Community

³⁴ Ibid.

- **Unpaid cost of care** – as the number of uninsured declines, unpaid costs for the uninsured decrease
- **Medicaid shortfall** – as the number of Medicaid enrollees increases, Medicaid shortfall increases

In California, the uninsured rate fell by 50 percent from 2013 to 2015 (17.2 percent in 2013, to 8.6 percent in 2015).³⁵ Using the charity care and bad debt from the MCRs, MACPAC calculated a decline in uncompensated care as a 57 percent share of hospital operating expenses in 2013-2014.³⁶ The study was unable to calculate the offsetting impact of the Medicaid shortfall, since the state- and hospital-specific data for 2014 are not yet available.

6.5.2 Reductions in Federal Share

Like many other states, California expanded its Medicaid program through adjustments in eligibility requirements as defined in Part IV of the ACA of 2010. Preparation for Medi-Cal expansion began in 2010 through the LIHP program, which was authorized through the 2010 BTR waiver. Full Medicaid expansion under the ACA occurred in California beginning on January 1, 2014. This means Medi-Cal expansion was in effect for the last six months of the timeframe considered in this study, on top of the early expansion that was in effect for the first six months of the timeframe.

Recipients enrolled in the MCE portion of the LIHP program converted from LIHP, which utilized a 50 percent FMAP, to the “new eligible” category under Medicaid expansion, which utilized a 100 percent FMAP. The reduction in non-Federal share, which was coming from the DPHs and their local governments, for the time period of January 1, 2014 through June 30, 2014 is reflected in the numbers presented in this study. However, the 100 percent FMAP for the expansion population is temporary. It applies through FFY 2016 and then decreases incrementally down to 90 percent starting in FFY 2020. More specifically, this reduction in FMAP for the ACA Medicaid expansion population is scheduled as follows:

- (A) 100 percent for calendar quarters in 2014, 2015, and 2016;
- (B) 95 percent for calendar quarters in 2017;
- (C) 94 percent for calendar quarters in 2018;
- (D) 93 percent for calendar quarters in 2019; and
- (E) 90 percent for calendar quarters in 2020 and each year thereafter.

Because of this change in FMAP in the near future, the amount of non-Federal share contributed by the hospitals and their local governments will increase above the amounts required in the first six months of CY 2014.

³⁵ Barnett, J.C., and M.S. Vornovitsky, 2016, *Health insurance coverage in the United States: 2015*, Current Population Reports, P60-257(RV), Washington, DC: U.S. Census Bureau. <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.

³⁶ Report to Congress on Medicaid and CHIP, MACPAC, March, 2017. <https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

7 Analysis of Health Care Safety Net Challenges in California

In a landmark report issued in 2000, the Institute of Medicine defined the essential characteristics of safety net providers: they offer care to patients regardless of their ability to pay for services; and a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.³⁷ Several factors contribute to the ongoing need for supplemental funding streams to provide financial assistance for all safety net providers. These factors include state demographics, the number of uninsured and Medicaid reimbursement rates. The demographics of California's population reflect a high number of individuals that are likely to be in need of uncompensated care. Even with Medicaid expansion and the additional covered population under the ACA, California has a substantial number of people that remain uninsured. California's population of over 39 million, the highest in the nation, often exacerbates these important factors.³⁸ In this chapter, we review the current demographics of California's population more closely and discuss trends in factors that could impact the uninsured population.

7.1 Uninsured

The demographics of California, such as number of employed, age distribution, number of homeless and poverty levels, contribute to the high number of uninsured individuals in the State. In 2011, California had over seven million uninsured, accounting for 20 percent of the State population and 15 percent of uninsured nationally. According to a report published by the CHCF in December 2016, and consistent with the MACPAC study referenced in Section 6.5.1, the uninsured rate in California dropped by nearly half since the implementation of the ACA in 2014, from 16 percent in 2013 to nine percent in 2015. This is better than the national average calculated of 10.5 percent uninsured nationwide. However, 2.9 million Californians remained uninsured, higher than the average among states that have expanded Medicaid under the ACA.³⁹

"Key findings of the [CHCF] report include:

- The drop in the uninsured rate was mainly due to a seven percentage point increase in individually purchased insurance coupled with a five percentage point increase in Medi-Cal enrollment.
- One in three of California's uninsured had annual incomes of less than \$25,000. At this income level, people are potentially eligible for Medi-Cal.
- Of the State's remaining uninsured, one in four were aged 25 to 34, one in three were noncitizens, and more than half were Latino.
- Sixty-two percent of the uninsured were employed. Of the 1.8 million uninsured workers, 44 percent worked in firms with less than 50 employees.

³⁷ Lewin, M.E. et al. 2000. America's Health Care Safety Net: Intact but Endangered, Washington: National Academies Press.

³⁸ U.S. Census Bureau, July 1, 2015 Population estimate. http://www.census.gov/quickfacts/table/PST045215/06_00

³⁹ California's Uninsured: As Coverage Grows, Millions Go Without, California Health Care Foundation, December 2016.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaUninsuredDec2016.pdf>

- Fewer Californians cited “lack of affordability” as the main reason for going without health insurance in 2015 compared to 2014.”⁴⁰

Although the percentage of uninsured has decreased, according to the Kaiser Foundation, in 2015 California still had the second largest uninsured population in the nation at about 3 million people.⁴¹

Figure 22: Health Insurance Coverage of the Total Population – 2015

Location	Employer	Non Group	Medicaid	Medicare	Other Public	Uninsured	Total
United States	49%	7%	20%	14%	2%	9%	100%
	155,965,800	21,816,500	62,384,500	43,308,400	6,422,300	28,965,900	318,868,500
California	45%	9%	26%	10%	2%	8%	100%
	17,718,300	3,444,200	10,138,100	4,080,100	752,700	2,980,600	39,113,900

Source: Kaiser Family Foundation

Health coverage expansion through the ACA clearly contributed to the decline in the number of uninsured individuals. Figure 23 below illustrates the change in percentage of uninsured individuals between the ages of 0 and 64 between 2011 and 2014 in California.⁴² It also shows changes in insurance coverage levels for specific payer types. As shown in the figure above, there was a slight decline in the percentage of uninsured nonelderly persons between 2012 and 2013 by 0.8 percent. The first open enrollment on California’s exchange was for the period of October, 1 2013 through March 31, 2014, with coverage effective January 1, 2014. During this time period more than 3 million people obtained health coverage.⁴³ The level of uninsured nonelderly persons declined again in 2014 by another 1.9 percent, which was the first year of ACA implementation.

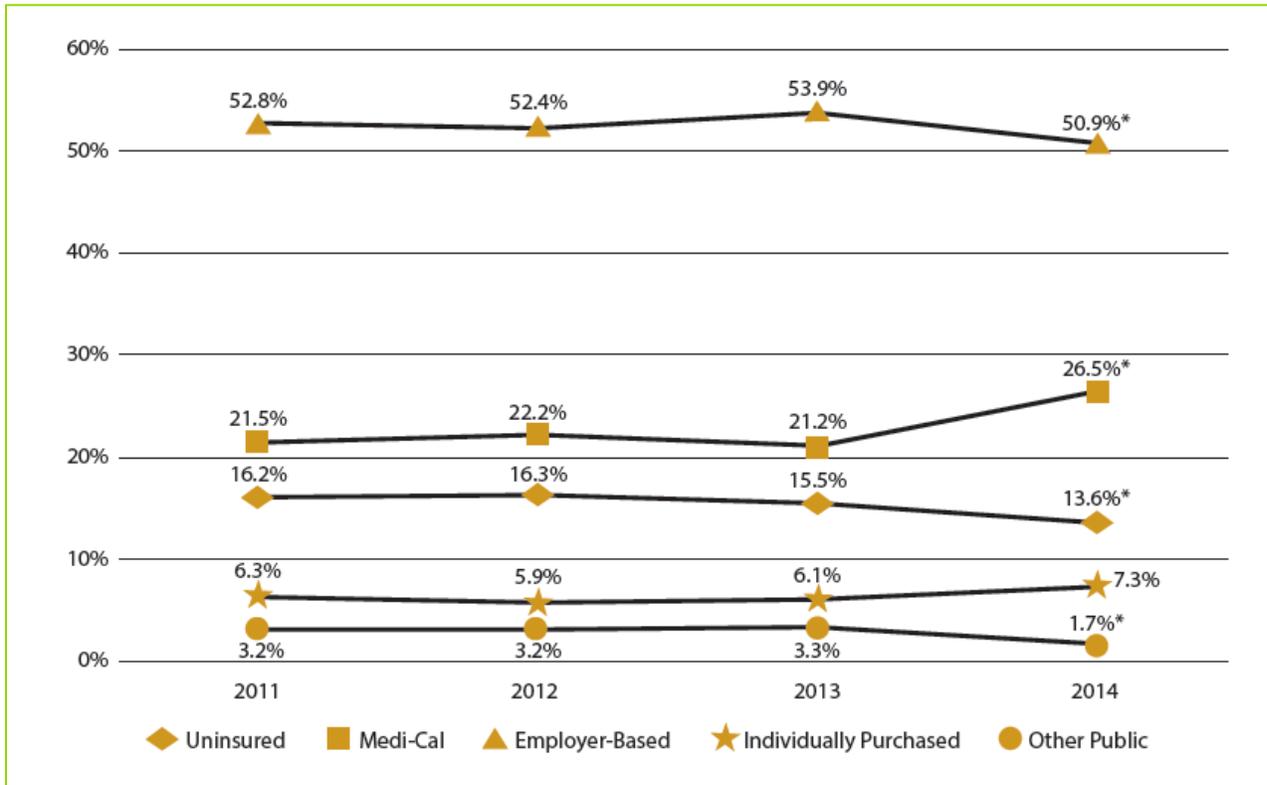
⁴⁰ Ibid

⁴¹ Kaiser Family Foundation, State Health Facts, 2015. <http://kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴² UCLA Center for Health Policy Research. Adult Medi-Cal Enrollment Surges, Uninsured Rate Plummets in 2014, August 2015. <http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Medi-Cal-factsheet-aug2015.pdf>

⁴³ Covered California Open Enrollment 2013-2014, Lessons Learned, October 2014. <https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf>

Figure 23: Health Insurance Coverage Among Nonelderly Persons, Ages 0-64, 2011-2014



Source: UCLA Center for Health Policy Research

Almost nine percent of the population in California representing about three million individuals remained uninsured in 2015.⁴⁴ A portion of this population may be eligible for Medi-Cal enrollment, but remain uninsured for various reasons. For example, as indicated in Figure 24 below, 35 percent of the uninsured believed they were ineligible for Medi-Cal (income too high, citizenship/ immigration status, had public coverage dropped/canceled) or did not know if they were eligible in the first year of the expansion.

⁴⁴ Kaiser Family Foundation, State Health Facts, 2015. <http://kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Figure 24: Reasons for Not Enrolling in Medi-Cal⁴⁵

Main Reason Not Enrolled in Medi Cal	Share of Eligible but Uninsured
Perceived Ineligible	22%
In process of getting insurance	20%
Have not taken action	15%
Chose not to have insurance	14%
Didn't know if eligible	13%
Other	16%

Source: UC Berkeley Center for Labor Research and Education
UCLA Center for Health Policy Research

In addition, a portion of the uninsured may lose eligibility for a period of time before regaining eligibility under Medi-Cal. This is referred to as “churning.” This occurs as individuals come in and out of Medicaid when income or life circumstances change, which creates gaps or interruptions in healthcare coverage. For example, because eligibility for Medicaid is determined by current monthly income, beneficiaries may temporarily lose coverage due to seasonal employment or overtime pay increases and then later requalify when their income dips. This phenomenon has long been reported as a problem adversely affecting access, continuity of care, ambulatory care use and health care costs. During non-covered periods, these individuals tend to rely on public and private safety net providers for services. Loss of Medicaid enrollment can also result from renewal requirements and processes that occur periodically (usually once a year), creating administrative barriers that leave some Medicaid members uninsured for some period of time despite still being eligible for Medicaid.

However, all public and private disproportionate share hospitals and health care systems participate in the Hospital Presumptive Eligibility (HPE) program established under the ACA. Individuals likely eligible for Medi-Cal that seek services through the HPE program are able to gain immediate access to full-scope Medi-Cal benefits on the basis of preliminary, self-reported information that is needed to determine their eligibility. Individuals determined to be presumptively eligible receive immediate access to temporary benefits, providing additional time needed to formally apply for the Medi-Cal program without delaying care. These individuals may also receive additional assistance with completing the Medi-Cal application.

The subsections that follow discuss each of the factors contributing to the number of uninsured in California.

7.1.1 Poverty

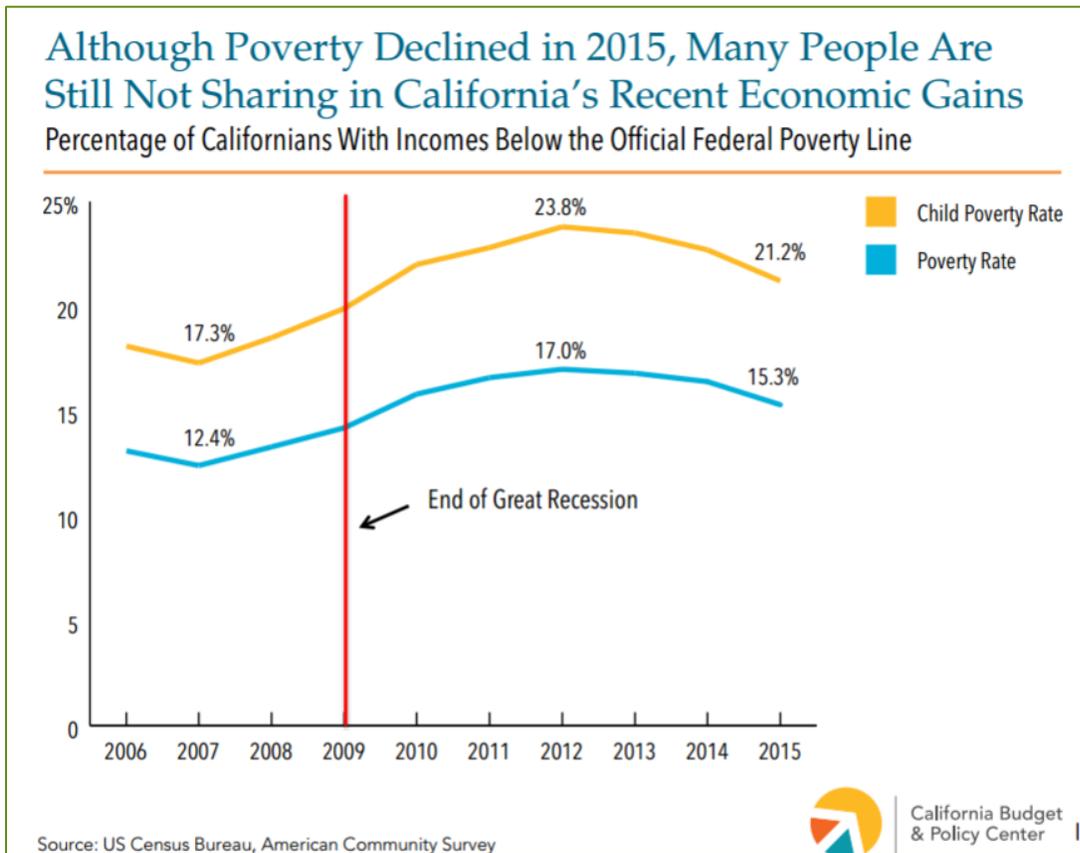
A significant factor contributing to the size of the safety net population is the number of Californians living in poverty. According to the California Budget and Policy Center, nearly 6 million Californians, including almost 2 million children, lived in poverty in 2015 based on the official poverty measure from Census figures released in September 2016. Specifically, 15.3 percent of Californians had incomes below the official poverty line in 2015, including more than

⁴⁵ UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research. Who Had Medi-Cal and Who Remained Uninsured in the First Year of Expansion? March 2016.
<http://laborcenter.berkeley.edu/who-had-medi-cal-and-who-remained-uninsured-in-the-first-year-of-expansion/>

1 in 5 California children (21.2 percent). After a period of steadily rising poverty levels from 2007 through 2012, the percentage of California’s population living in poverty declined in 2015 from 2014 levels, although overall levels of poverty remain higher than pre-recession levels. Based on the data evaluated by the California Budget and Policy Center, in 2007 the poverty level of the population as a whole was 12.4 percent and the poverty level for children was 17.3 percent, which was lower than 2015 levels.⁴⁶

Figure 25 below shows the changes in the percentage of Californians living in poverty between the period of 2006 and 2015.⁴⁷

Figure 25: Poverty Levels in California – 2006 to 2015



Source: California Budget and Policy Center

When using the Research Supplemental Poverty Measure (SPM) published by the US Census Bureau, which uses three year averages for state-level estimates, the poverty rate in California becomes even more significant. According to the SPM, 20.6 percent of Californians lived in poverty in 2013-2015.⁴⁸ The SPM rate for the United States as a whole during that period was 15.1 percent. Moreover, California had the highest SPM poverty rate of any state, as was also

⁴⁶ California Budget and Policy Center, <http://calbudgetcenter.org/resources/californias-official-poverty-rate-declined-2015-millions-people-still-not-sharing-recent-economic-gains/>.

⁴⁷ Ibid.

⁴⁸ The Supplemental Poverty Measure: 2015, Trudi Renwick and Liana Fox, September, 2016. <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-258.pdf>

the case the previous two years.⁴⁹ Figure 26 below compares the SPM between California and the United States for the three-year periods of 2013-2015, 2011-2013 and 2010-2012.⁵⁰

Figure 26: Supplemental Poverty Measure Comparison – California and United States

Supplemental Poverty Measure			
	2013-2015	2011-2013	2010-2012
California	20.6%	23.4%	23.8%
United States	15.1%	15.9%	16.0%

Source: United States Census Bureau

7.1.2 Unemployment

Another contributing factor to California’s high rate of uninsured is the rate of unemployment. In November 2012, California had the third highest unemployment rate in the country at just under ten percent according to data published by the Kaiser Family Foundation.⁵¹ Based on data published by the California Employment Development Department, it appears the unemployment rate in California increased between 2009 and 2010 following the nationwide financial crisis of 2007 – 2009, but has since declined annually. In 2016, the unemployment rate in California had decreased to 5.4 percent less, than half of the unemployment level in 2010.⁵²

California’s unemployment rate over time has generally followed the same pattern as the unemployment rate in the U.S. during the same time period. Data on national unemployment rates published by the Bureau of Labor Statistics indicates that following the financial crisis, the national unemployment rate also increased between 2009 and 2010, and has declined annually since. In 2016, the average national unemployment rate was 4.9 percent. By comparing California’s unemployment rate and the average national unemployment rate for 2016, it appears that California’s unemployment rate exceeds the national average by approximately 0.5 percent.⁵³

Figure 27 below shows the trend in the United States unemployment rate as compared with California during the period from 2009 to 2016.

⁴⁹ The District of Columbia had a higher SPM than California in the 2013-2015 period, with an average of 22.2%.

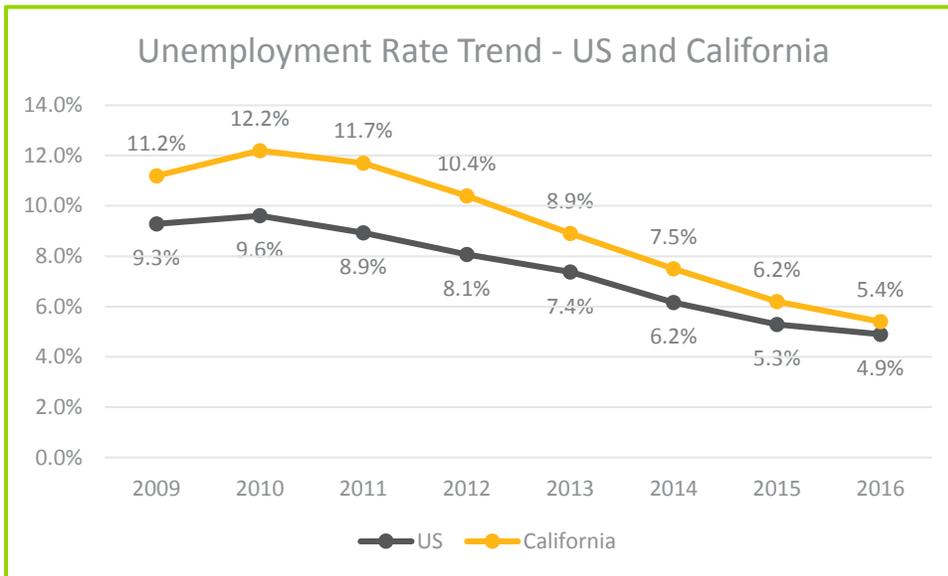
⁵⁰ California Poverty Rates Using the Official Poverty Measure and Research Supplemental Poverty Measure. http://sd30.senate.ca.gov/sites/sd30.senate.ca.gov/files/Supplemental%20Poverty%20Measure%20Oct.%202014_0.pdf

⁵¹ Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured. California’s Health Care Environment and Health Reform Efforts. https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8454-california_s-health-care-environment.pdf

⁵² CA Employment Development Department, Labor Market Information, California Labor Market Top Statistics, <http://www.labormarketinfo.edd.ca.gov/>

⁵³ United States Department of Labor, Bureau of Labor Statistics, <http://data.bls.gov/timeseries/LNS1400000>

Figure 27: US and California Unemployment Trend, 2009 – 2016



Source: Bureau of Labor Statistics and California Employment Development Department

Although the California unemployment rate continues to improve, the number of unemployed persons in the labor force remains high, at just over one million individuals (1,037,700).⁵⁴

7.1.3 Homelessness

Lack of adequate housing is another critical factor affecting the need for an effective health safety net. According to a report issued by the Corporation for Supportive Housing, “access to safe, quality, affordable housing – and the supports necessary to maintain that housing – constitute one of the most basic and powerful social determinants of health.”⁵⁵ As a group, the homeless tend to have high health needs across multiple systems of care. For example, homelessness, particularly when combined with behavioral health issues, is associated with increased risk for obesity, cardiovascular disease, diabetes, HIV/AIDS, hypertension and other chronic medical conditions due to factors such as sedentary lifestyles, risky behaviors, poor diet, lack of exercise, and metabolic alterations attributable to psychiatric medications.⁵⁶ That being the case, the health related costs for this group are often much higher than their absolute numbers might suggest.

Each year, during the last week in January, the local planning bodies responsible for coordinating the full range of homelessness services in a geographic area conduct one-night counts of sheltered and unsheltered individuals. The Department of Housing and Urban Development (HUD) compiles and analyzes these point-in-time counts to estimate and report to Congress on the levels of homelessness nationwide. On a single night in January 2016,

⁵⁴ California Employment Development Department, Labor Force, 2016.

<http://www.labormarketinfo.edd.ca.gov/cgi/dataanalysis/AreaSelection.asp?tableName=labforce>

⁵⁵ Housing is the Best Medicine Supportive Housing and the Social Determinants of Health, Corporation for Supportive Housing (CSH), July 2014. http://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf

⁵⁶ Ibid.

California accounted for 22 percent of the nation’s homeless individuals.⁵⁷ A report published by HUD in November of 2016 for Congress states that since 2007, the number of homeless individuals has declined in twenty-eight states including California. Although California experienced the largest decline of these twenty-eight states during the full reporting period with 20,844 fewer homeless (15 percent) in 2016 compared to 2007 levels, the number of homeless individuals increased between 2015 and 2016.⁵⁸ California continues to be the State with the highest rate of homelessness, and the highest number of homeless people, particularly individuals not in families.⁵⁹

Figure 28 below from the 2015 HUD report to Congress shows the states with the largest changes in homeless populations between the years 2007 and 2016. In addition, the figure includes a snapshot of the change in the homeless population for these states between 2015 and 2016.

Figure 28: States With Largest Changes in Homeless Individuals, 2007 – 2016

EXHIBIT 1.9: Largest Changes in Homeless People
By State, 2007–2016

2015–2016		2007–2016	
Largest Increases			
CALIFORNIA	2,404 / 2.1%	NEW YORK	23,751 / 37.9%
WASHINGTON	1,408 / 7.3%	MASSACHUSETTS	4,481 / 29.6%
DISTRICT OF COLUMBIA	1,052 / 14.4%	DISTRICT OF COLUMBIA	3,030 / 57.0%
COLORADO	597 / 6.0%	HAWAII	1,851 / 30.5%
OKLAHOMA	330 / 8.7%	IDAHO	498 / 28.5%
Largest Decreases			
FLORIDA	-2,341 / -6.5%	CALIFORNIA	-20,844 / -15.0%
NEW YORK	-1,898 / -2.2%	TEXAS	-16,666 / -41.9%
ILLINOIS	-1,587 / -12.0%	FLORIDA	-14,510 / -30.2%
MASSACHUSETTS	-1,527 / -7.2%	NEW JERSEY	-8,419 / -48.6%
NEVADA	-1,345 / -15.4%	GEORGIA	-6,730 / -34.3%

* Due to methodological changes, Michigan was excluded from the list of largest decreases from 2007-2016.

Source: US Department of Housing and Urban Development (HUD)

Across the country, more than one in five homeless people was located in either New York City (73,523 people or 13 percent of the homeless population in the country) or Los Angeles (43,854 people or 8 percent of the homeless population).⁶⁰ As illustrated in Figure 29, the geographic distribution of homelessness in California is concentrated in urban areas, although it is pervasive across the State.

⁵⁷ Department of Housing and Urban Development (HUD), The 2015 Annual Homeless Assessment Report (AHAR) to Congress, November 2015. <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Ibid.

Figure 29: 2016 Point in Time Counts by Continuum of Care (CoC)⁶¹

CoC Number	CoC Name	Total Homeless	Homeless Individuals	Homeless People in Families	Chronically Homeless
CA-600	Los Angeles City & County CoC	43,854	37,726	6,128	13,468
CA-601	San Diego City and County CoC	8,669	6,955	1,714	1,417
CA-501	San Francisco CoC	6,996	6,309	687	1,932
CA-500	San Jose/Santa Clara City & County CoC	6,524	5,585	939	2,146
CA-602	Santa Ana/Anaheim/Orange County CoC	4,319	3,028	1,291	716
CA-502	Oakland/Alameda County CoC	4,145	3,148	997	753
CA-506	Salinas/Monterey, San Benito Counties CoC	3,022	2,536	486	660
CA-504	Santa Rosa/Petaluma/Sonoma County CoC	2,906	2,517	389	747
CA-503	Sacramento City & County CoC	2,500	1,921	579	540
CA-606	Long Beach CoC	2,250	1,908	342	838
CA-608	Riverside City & County CoC	2,165	1,900	265	378
CA-508	Watsonville/Santa Cruz City & County CoC	1,959	1,454	505	573
CA-609	San Bernardino City & County CoC	1,887	1,422	465	405
CA-514	Fresno/Madera County CoC	1,883	1,684	199	546
CA-603	Santa Maria/Santa Barbara County CoC	1,813	1,385	428	453
CA-511	Stockton/San Joaquin County CoC	1,780	947	833	247
CA-505	Richmond/Contra Costa County CoC	1,730	1,366	364	384
CA-510	Turlock/Modesto/Stanislaus County CoC	1,434	1,147	287	361
CA-614	San Luis Obispo County CoC	1,368	1,200	168	418
CA-512	Daly/San Mateo County CoC	1,361	911	450	238
CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC	1,272	1,065	207	425
CA-611	Oxnard/San Buenaventura/Ventura County CoC	1,271	1,011	260	303
CA-507	Marin County CoC	1,258	1,070	188	257
CA-509	Mendocino County CoC	1,242	1,147	95	177
CA-522	Humboldt County CoC	1,134	989	145	377
CA-518	Vallejo/Solano County CoC	1,118	955	163	259
CA-604	Bakersfield/Kern County CoC	1,067	875	192	272
CA-515	Roseville/Rocklin/Placer, Nevada Counties CoC	1,021	861	160	347
CA-513	Visalia, Kings, Tulare Counties CoC	792	646	146	251
CA-524	Yuba City & County/Sutter County CoC	702	387	315	233
CA-526	Amador, Calaveras, Tuolumne and Mariposa Counties CoC	632	509	123	129
CA-519	Chico/Paradise/Butte County CoC	574	440	134	251
CA-521	Davis/Woodland/Yolo County CoC	532	322	210	89
CA-607	Pasadena CoC	530	453	77	201
CA-520	Merced City & County CoC	516	504	12	224
CA-613	Imperial County CoC	380	280	100	60
CA-529	Lake County CoC	332	210	122	24
CA-517	Napa City & County CoC	317	235	82	98

⁶¹ <https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/>

CoC Number	CoC Name	Total Homeless	Homeless Individuals	Homeless People in Families	Chronically Homeless
CA-525	El Dorado County CoC	269	192	77	139
CA-612	Glendale CoC	240	176	64	115
CA-527	Tehama County CoC	133	103	30	31
CA-615	Inyo, Mono, Alpine Counties CoC	130	110	20	33
CA-523	Colusa, Glenn, Trinity Counties CoC	115	71	44	33
	Total	118,142	97,660	20,482	31,548

7.2 Changes in Uncompensated Care Since ACA Expansion

As a result of the factors discussed in Section 7.1, the number of individuals in need of uncompensated care in California has steadily increased over time. At its simplest, uncompensated care consists of the cost of health services for which providers receive no payment from any payer or individual. California addressed this issue in 2010 when, as a part of its “Bridge to Reform” 1115 Medicaid Demonstration Waiver, California created the LIHP. LIHP was a county-based coverage expansion program that drew down Federal matching funds to provide medical services to low income adults not otherwise eligible for Medi-Cal. While the program did not offer benefits as comprehensive as Medi-Cal, the program covered over 650,000 individuals by the end of 2013.⁶²

Beginning January 1, 2014, California elected to expand Medicaid under the ACA. Under the Medicaid expansion, citizens and legal immigrants with income at or below 138 percent of the FPL that were benefiting from the LIHP were auto-enrolled into Medi-Cal. Those with incomes exceeding 138 percent FPL that were benefiting under the LIHP were transferred to the State’s health insurance Marketplace (formerly referred to as the Exchanges). Due to the increase in enrollment of individuals in Medi-Cal and those that took up coverage through the Marketplace, the number of uninsured individuals dropped to less than nine percent of the California population, which resulted in an aggregated decrease in the amount of uncompensated care provided across all hospitals in California.

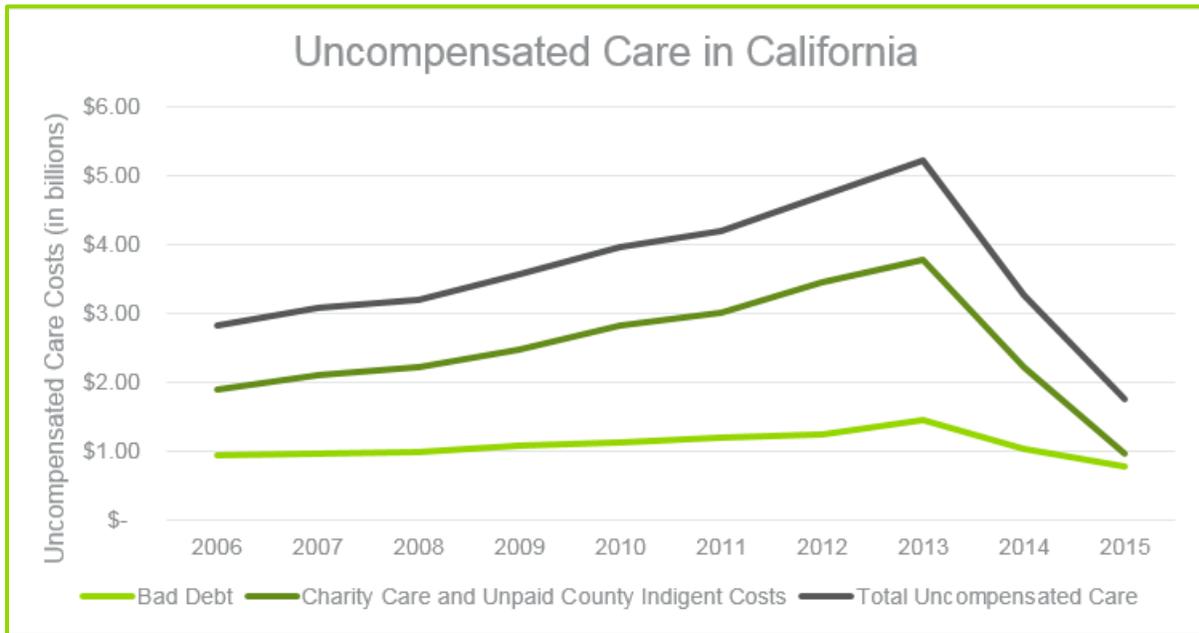
To evaluate the effect of the ACA expansion on uncompensated care costs, we also reviewed changes to the cost of charity care and bad debt over time, defined as follows:

- **Charity care** – The difference between the cost for patient services (based on full established charges adjusted by the cost-to-charge ratio) rendered to patients who are unable to pay for all or part of the services provided, and the amount paid by or on behalf of the patient. This includes the cost of charity care provided by non-county hospitals to indigent patients whose care is not the responsibility of the county, and unpaid county indigent care costs.
- **Bad debt** – Deductions from revenue resulting from uncollectible costs due to a patient’s unwillingness to pay.

Figure 30 illustrates the changes in uncompensated care costs during the period 2006 – 2015 for all hospitals in California.

⁶² Kaiser Family Foundation. The California Health Care Landscape. August 26, 2015. <http://kff.org/health-reform/fact-sheet/the-california-health-care-landscape/>

Figure 30: Uncompensated care costs in California hospitals (2006-2015)^{63,64,65}



Source: California Office of Statewide Health Planning and Development

Based on the results in Figure 30, the increased coverage achieved through Medi-Cal expansion under the ACA and through California’s Healthcare Marketplace resulted in a significant drop in overall uncompensated care with both charity care and bad debt decreasing in 2014 and 2015.

7.3 Access to Health Care Services

Consistent with the STC requirements in California’s Medi-Cal 2020 Demonstration Waiver, California is in the process of conducting a comprehensive Access Assessment (Assessment) to evaluate primary, core specialty, and facility access to care for Medi-Cal managed care beneficiaries.⁶⁶ The Assessment will be based on the current health plan network adequacy requirements set forth in the Knox Keene Health Care Service Plan Act of 1975 and DHCS/Medi-Cal managed care health plan contracts, as applicable. It will also take into consideration State Fair Hearing and Independent Medical Review (IMR) decisions, and grievances and appeals/complaints data as it reports on the number of providers accepting new beneficiaries.

⁶³ Data extracted from the 2006-2015 “Pivot Profile” downloaded from: <http://www.oshpd.ca.gov/HID/Hospital-Financial.asp#Profile>

⁶⁴ Data for this figure was retrieved from the OSHPD dataset for all hospitals, including the Designated Public Hospitals.

⁶⁵ Charity care and bad debt values in this figure include all recipients and payers, not just the uninsured. Cost-to-charge ratios used were annual statewide average cost-to-charge ratios identified in the OSHPD dataset for each included in the graph.

⁶⁶ Medi-Cal 2020 Waiver Special Terms & Conditions, STCs 65-69 on pages 44 and 46, [Medi-Cal 2020 Waiver Special Terms & Conditions](#)

To meet this requirement, the State is contracting with its External Quality Review Organization (EQRO), Health Services Advisory Group, to complete the Assessment.⁶⁷ As a part of the Assessment process, the State is establishing an Advisory Committee that will provide input into the structure and the draft report and recommendations of the Assessment. The Advisory Committee will include representatives from consumer advocacy organizations, providers and/or provider associations, health plans and/or health plan associations, and legislative staff. The Committee's role will be to provide input into the assessment structure including network adequacy requirements and metrics that should be considered, and to provide feedback on the Assessment structure and initial draft Assessment report.

The EQRO will produce and publish an initial draft and a final Assessment report that includes a comparison of health plan network adequacy compliance across different lines of business; and recommendations in response to any systemic network adequacy issues. The initial draft and final report will also describe the State's current compliance with the access and network adequacy standards set forth in the recently finalized Medicaid Managed Care rule. The Assessment will be ongoing through 2017, and the final release is contingent upon CMS approval of the design.

Given that this comprehensive, in-depth review is already in process, Navigant will not duplicate the efforts of the EQRO, but will defer to the findings published in the final report.

⁶⁷ Note that as of this report date, legislation which triggers amending the EQRO contract is pending legislative approval, although the Access Advisory Committee is being assembled.

8 Role of Managed Care Plans in Managing Care

The State of California began transforming its Medicaid program from a fee-for-service model to a managed care model over 30 years ago. As of 2013, over 5.7 million Californians were enrolled in a Medicaid MCO, constituting 67 percent of the total Medi-Cal enrollment.⁶⁸

California has established distinct delivery models for MCOs to deliver care to Medi-Cal beneficiaries. In addition to the traditional FFS program, six managed Medicaid models exist in California: County Organized Health Systems (COHS), Geographic Managed Care (GMC), the Two-Plan Model, the Regional model, Imperial, and San Benito. Each county has implemented one of these six models:⁶⁹

- **COHS** – The COHS is a health plan created by the County Board of Supervisors that contracts with the State to be the sole administrator of Medi-Cal benefits for an entire county. All Medi-Cal beneficiaries in the county, excluding certain carved out populations, are mandatorily enrolled in the single COHS plan. The COHS model exists in 22 counties.
- **GMC** – GMC is a Medi-Cal managed care model in which the State contracts with multiple commercial MCO options within a single county. The GMC model exists in 2 counties.
- **Two-Plan Model** – Under the Two-Plan Model, a Medi-Cal managed care model in which the State contracts with two MCO plans; one a Local Initiative (organized by the county) and the other a commercial health plan to administer Medi-Cal benefits to a specific county or counties, under which the beneficiaries have a choice between the two plans. The Two-Plan model exists in 14 counties.
- **Regional Model** – The regional model covers 18 counties, where there are two commercial plans that contract with the State for the entire region.
- **Imperial** – In the Imperial Model there are two commercial plans that contract with the State to provide Medi-Cal benefits in Imperial County.
- **San Benito** – In the San Benito Model, there is one commercial plan that contracts with the State to provide Medi-Cal benefits in San Benito County. In this county beneficiaries can choose the managed care plan or regular (fee-for-service) Medi-Cal.

The State pays the licensed health plan entities a monthly capitation payment for each beneficiary enrolled and the plan is responsible for assuring that care is delivered to its enrollees in a manner that meets statutory and contractual quality and access standards.

The Medi-Cal managed care plans are intended to play a significant role in managing care of Medicaid beneficiaries. In fact, financial savings is assumed based on the plans' ability to reduce utilization. Plans are also involved to varying degrees in other programs under the waiver. In certain counties, plans may work with the county to help manage care to the uninsured by providing assistance in tracking service use, managing care, or paying contracted providers similar to the functions plans perform under Medicaid managed care, and may help contribute data for reporting under the GPP.

⁶⁸ Kaiser Family Foundation. State Health Facts: Total Medicaid Managed Care Enrollment. 2013.

<http://kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/>

⁶⁹ California HealthCare Foundation. On the Frontier: Medi-Cal Brings Managed Care to California's Rural Counties. March 2015.

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FrontierMediCalMgdCareRural.pdf>

9 Role of the PRIME Program

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) is a payment program authorized by the Medi-Cal 2020 1115 Waiver. It allows California to fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects are reported on a broad range of metrics to meet quality benchmark goals. Over the course of the five-year demonstration, payments will increasingly move towards pay for performance.

Under PRIME, plans and PRIME providers are increasingly linked together through aligned goals in increasing the value of healthcare delivery. Under PRIME, DPHs and DMPHs are committed to achieving better outcomes in physical and behavioral health integration as well as in outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies. Under PRIME, by January 2018, all of California's DPH systems must contract with at least one Medi-Cal managed care plan in the service area they operate in, using an alternative payment methodology. By January 2018, 50 percent of the state's Medi-Cal managed care beneficiaries who are assigned to any one of California's DPH systems must receive all or a portion of their care under a contracted alternative payment model. These requirements tie payment and quality together by making the PRIME entity responsible not just for the quality outcome in order to earn PRIME payments, but to also have some of the service-based payment at risk as well, thereby encouraging better management of both quality and cost. By January 2019, the goal increases to 55 percent, and to 60 percent by the end of the waiver renewal period in 2020. In both of these years, five percent of the statewide yearly allocated PRIME pool amount for all DPH systems will depend on meeting these goals. Furthermore, overall improved performance by PRIME entities helps improve quality measure that plans are also held accountable for. Lastly, plans are accountable for meeting access standards, thus to the extent efficiency and access gains are made under PRIME, plans will also receive financial benefits related to those gains.

Funding for this pool will not exceed \$7.464 billion in combined Federal and local funding over a five-year period for DPH and DMPH to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to \$1.4 billion annually for the DPH systems and up to \$200 million annually for the DMPH systems for the first three years of the demonstration. After that time, the pool will phase down by ten percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration. Non-Federal funding for this program is obtained through the IGT process, where the governmental entities contribute 50 percent of the funding for the program.

The PRIME program also focuses on important initiatives related to improving population health and providing services in the most appropriate settings. PRIME features eighteen projects, organized into three different domains. Six of the projects, from the first two domains, are required for all DPH systems. In addition, each DPH system must select at least one optional project from each of the three domains, for a total of at least nine. Several DPH systems are taking on ten or more. DMPHs must select at least one project from any domain. The number of clinical projects the DMPHs are implementing ranges from one to ten, averaging three projects per DMPH.

- **Domain 1:** Outpatient Delivery System Transformation and Prevention
 - Integration of Physical and Behavioral Health
 - Ambulatory Care Redesign: Primary Care
 - Patient Safety in the Ambulatory Setting
 - Million Hearts Initiative
 - Cancer Screening and Follow-up
 - Obesity Prevention and Healthier Foods Initiative
- **Domain 2:** Targeted High Risk or High Cost Populations
 - Improved Perinatal Care
 - Care Transitions: Integration of Post-Acute Care
 - Complex Care Management for High Risk Medical Populations
 - Integrated Health Home for Foster Children
 - Transition to Integrated Care: Post Incarceration
 - Chronic Non-Malignant Pain Management
 - Comprehensive Advanced Illness Planning and Care
- **Domain 3:** Resource Utilization Efficiency
 - Antibiotic Stewardship
 - Resource Stewardship: High Cost Imaging
 - Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
 - Resource Stewardship: Blood Products

Payment is based on the achievement of targets for clinical measures, not on utilization.

PRIME aligns health system and managed care plan goals by promoting and aligning value-based care, focusing on outcomes, and incentivizing providers to take financial risk for the services they provide.

10 The Future of Uncompensated Care Services and Related Funding in California

As previously described in this report, uncompensated care comprises costs associated with patient-related care that exceed reimbursement for the services provided, as well as costs associated with providing services to the uninsured. Despite states' best efforts to eliminate uncompensated care, a portion of the population will always remain uninsured for various reasons. For instance, there will always be some individuals who elect not to purchase health insurance or some individuals who cannot obtain health insurance due to health, financial, or other reasons. Therefore, caring for the uninsured is not an issue that will be entirely resolved, and states will need to continue to find ways to support hospitals as they care for this population.

There is no simple roadmap for achieving the goal for public health care systems in California to become self-sustaining entities that are not reliant on pool funds. As long as there are uninsured individuals needing services, there will be a need for funding to help offset the costs incurred by hospitals and other providers while caring for these individuals. Alternatives for local funding to support payment for these services, such as IGTs, CPEs and provider taxes, simply tend to shift the financial burden associated with caring for these individuals among the Federal, State and local governmental entities and their taxpayers, and to some extent, the consumer.

One of the approaches taken by many states, including California, to reduce the number of uninsured individuals and reduce reliance on pool funds was to implement Medicaid expansion under the ACA.⁷⁰ Although California expanded Medicaid coverage under the ACA, thereby reducing the number of uninsured individuals in the state, and others were able to obtain coverage through the newly created Marketplace, a portion of the population still remains uninsured. As noted in Figure 22 above, in 2015, California still had the second largest uninsured population in the nation at about three million people.⁷¹ In SFY 2013/14, total uninsured costs for California hospitals totaled nearly \$5.5 billion. Total uninsured costs at public hospitals totaled \$2.5 billion.

The uncertainty about the future of the ACA is an important factor to consider when thinking about the future of uncompensated care. If the federal funds currently available for insuring the expansion population through the ACA become unavailable, a significant financial burden will shift back to the state and local government entities (and ultimately to the providers) related to this expansion population. If states are unable to fund the costs of continuing to provide health coverage to the expansion population through State or other local funding sources, these individuals will need to find coverage through other means (eg., employer-based or through the Marketplace), or they will become uninsured. This will result in higher levels of uncompensated care potentially comparable to or higher than the levels seen prior to the enactment of the ACA.

Understanding that there will always be a financial burden associated with hospital services provided to the Medicaid-eligible and uninsured populations, and that the public funding options are somewhat limited, payers also must take a close look at how they can create appropriate incentives in their funding/payment methods to improve the health of the population, thereby

⁷⁰ Note that many previously uninsured individuals not qualifying for Medi-Cal benefits under the Medicaid expansion were able to obtain coverage through the Marketplace, which was also a component of the ACA.

⁷¹ Kaiser Family Foundation, State Health Facts, 2015. <http://kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>

reducing the need for hospital and other medical service utilization, and how they can improve the health outcomes and lower the costs of serving those that ultimately need hospital and other medical services. California has already made significant commitments in this regard through implementation of GPP and PRIME. These programs are described in the following section.

10.1 Current Medi-Cal Initiatives for the Uninsured Populations

To address current and future funding challenges, states will need to align payment incentives with initiatives that support the ultimate goal to better manage healthcare costs for the uninsured population. Under the Medi-Cal 2020 Demonstration Waiver, California has implemented two programs that are focused on providing such incentives for improving health outcomes for the uninsured. These programs are the GPP and PRIME.

California currently supports DPHs that provide uninsured services through the GPP under the Medi-Cal 2020 Demonstration Waiver. As described earlier in this report, the GPP repurposes UCP and Medicaid DSH funds, and distributes the funding through an approach that focuses on value (rather than volume) to promote cost-effective and higher-value care delivery. More specifically, the goals of the GPP include: promote timeliness and convenience of services to the patient; increase access to care; provide earlier intervention; promote appropriate use of resources, health and wellness services that improve patient health; improve the likelihood of bringing patients into an organized system of care; and other initiatives that aim to mitigate future healthcare costs. California's innovative approach aligns payments associated with uncompensated care to higher-value care and incentivizes the delivery of services in more cost-effective and appropriate settings.

Medi-Cal will conduct two evaluations in future periods to examine the impact of the GPP, to evaluate the care and patients' experience provided by the PHCSs, and to understand the challenges and benefits of this approach. The first evaluation will focus on the first two Demonstration years under the GPP and the second evaluation will be incorporated in an interim evaluation report due at the end of Demonstration year four.

In addition to the GPP, California also implemented the PRIME program described previously in Section 9. DPHs and DMPHs are eligible to receive payments through the PRIME program if they develop five-year project plans that outline initiatives and programs the providers will undertake to improve the health outcomes of patients, improve the ability of entities to provide high-quality care and integrate behavioral health services, provide patient-centered team-based care, improve point-of-care services and complex care management, and adopt alternative payment models based on value-based payments.

Participating providers receive payments for undertaking projects that align with the goals of this program and submit required reports describing progress toward achieving program initiatives through established performance measures.

One of the PRIME program initiatives relates to integrating care and improving patient outcomes, and PHCSs may address this by developing plans around providing complex care management to high-risk medical populations. DPHs are required to provide complex care management to high-risk populations. Complex care management involves coordinating activities designed to more effectively assist patients and their caregivers in managing medical conditions and co-occurring psychosocial factors, usually provided to patients who have serious medical needs and often experience a high number of hospitalizations or emergency

department visits, with the goal of improving the health of the patient and reducing the need for hospital care. Another example of a PRIME program initiative related to providing high-quality patient-centered care includes physical and behavioral health integration, also a requirement for DPHs.

Other hospitals in the State continue to utilize other funding streams to support uncompensated care. The University of California medical centers and the DMPHs have access to the portion of federal DSH funds that were not included in the GPP to help offset uncompensated costs under the pre-GPP methodology. The private DSH hospitals receive a Medicaid supplemental funding stream called DSH Replacement that supports uncompensated care in much the same manner as the federal DSH program, but with other matched Medicaid funds rather than using the fixed federal DSH allotment. These additional financial supports will continue to be needed even in a post-ACA environment to support uninsured services.

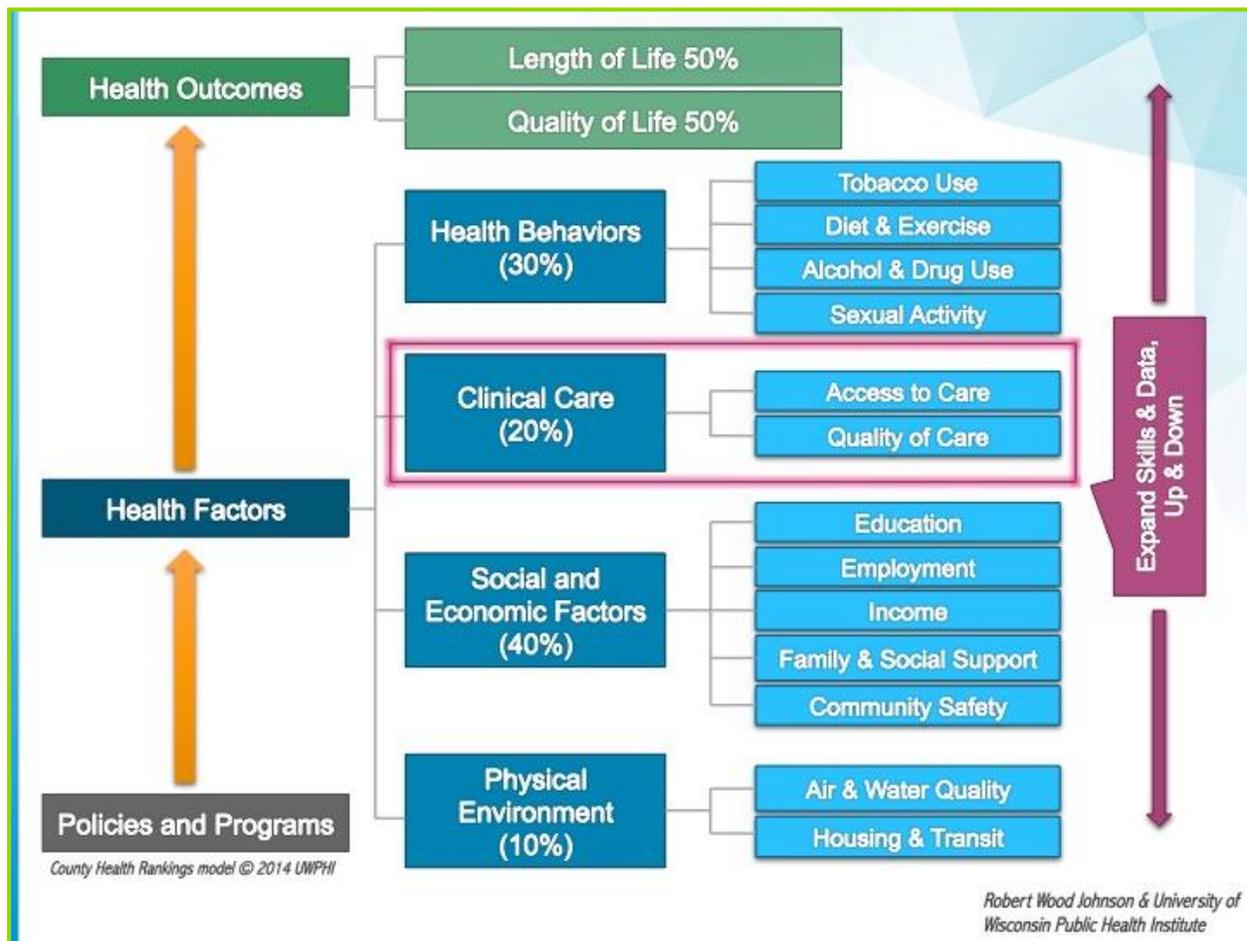
10.2 Improving Population Health Management and Reducing High Cost Utilization

As stated previously, some portion of the population will always remain uninsured. Understanding that, states must maintain a strong focus on population health management and improving the overall health status of the uninsured population with the goal of reducing the need for hospitalizations. This addresses not only the obligation to deliver care to uninsured individuals in need of medical services, but also the obligation to the taxpayers who provide the funding for the services. Reducing the need for emergency or inpatient hospitalizations requires the implementation of initiatives and programs that improve this population's health, and focus on integrated care models that incentivize service delivery in the most appropriate settings. This approach will better manage healthcare costs associated with the uninsured population, and ultimately create more sustainable healthcare systems.

California has historically taken an innovative approach to paying providers for uncompensated care through their initiatives to align payments from UCP funds to health outcomes and service delivery. We believe the positive steps California has already implemented with both the GPP and PRIME program initiatives support the goals of improving the health of all patients served by public hospitals, including the uninsured population, and better managing healthcare costs.

Nationally, many initiatives focus on improving population health management through the provision of preventative care and counseling, and clinical outreach. Also, various initiatives related to linking clinical and community services address the needs of patients with goals of reducing healthcare costs, reducing preventable hospitalizations, and improving the health of the population. As illustrated in Figure 31 below, based on information compiled by the Robert Wood Johnson Foundation to report to communities on the relative health of their residents, 80 percent of what drives health outcomes relates to factors outside the traditional characterization of healthcare delivery. For example, when healthcare delivery systems address health behaviors (tobacco use, diet and exercise), social and economic factors (employment, education, income), and physical environment (air quality, water quality, housing), outcomes will improve.

Figure 31: County Health Rankings Model



Source: Robert Wood Johnson Foundation and Wisconsin Public Health Institute⁷²

While comprehensively describing opportunities for improving public health for the uninsured population in California goes beyond the scope of this report, we do provide some examples of recent initiatives as illustrations of how others have intended to address this issue.

1. **CMS Pilot Program:** CMS has initiated a new pilot program through which 32 organizations will test three separate initiatives related to integrating clinical and community services. The first initiative establishes coordination with community organizations to assist patients with accessing the services they require. The second initiative involves providers working to ensure that the services a patient requires are available. The last initiative through this pilot program relates to increasing the awareness of patients to services available in the community.

⁷² 2015 County Health Rankings Key Findings Report, A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. <http://www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418649>

2. **Free or Low-Cost Community Clinics:** In 2012, researchers at Penn State College of Medicine analyzed data on the use of emergency department services by uninsured individuals along with information on the reliance of these uninsured individuals on free clinics to determine if such clinics could reduce the usage of emergency rooms.⁷³ Researchers studied three years of data for a sample of uninsured individuals and determined that those who received services through free clinics were less likely to require lower levels of care at emergency departments. The results suggest that uninsured individuals who access free clinics will less frequently use the emergency department as their source of primary care. Researchers concluded that free clinics can provide important primary care for the uninsured which can help to reduce non-emergency visits to emergency departments. Since the emergency department delivers extremely expensive and inefficient care for non-emergent visits, the free clinics provide a more cost effective solution.

3. **Environmental Intervention:** Cone Health in Greensboro, N.C., partnered with the University of North Carolina at Greensboro, the Greensboro Housing Coalition and others to address the pediatric asthma rate in their community, which disproportionately affects low-income children. The pilot project identified 41 families with asthmatic children and examined their environment. Participants were able to improve heating and air systems, remove the causes of mold, eliminate pests, battle dust mites and improve cleaning methods in the homes of asthmatic children. As a result, this population experienced fewer asthma attacks which resulted in less rescue medication use and fewer trips to the ED. The housing interventions showed a 52.6 percent reduction in hospital costs and charges. The post-intervention hospital treatment for asthma services reduced related hospital costs an additional 82.5 percent. As an added benefit, children reported sleeping better such that parents were less stressed worrying about their children and missed fewer days of work to care for their asthmatic child.⁷⁴

These are just some examples of initiatives intended to reduce costs by addressing the uninsured population's reliance on the use of emergency department or inpatient hospital services. Again, given that there will always be some portion of the population that remains uninsured, the best option for achieving self-sustaining medical programs for the uninsured in the absence of continued federal or state funding is by reducing the population's dependence on expensive health services.

10.3 Measuring Uncompensated Care Funding in the Future

As stated earlier in this chapter, despite a state's best efforts to eliminate uncompensated care, a portion of the population will always remain uninsured since some individuals will always elect not to purchase health insurance, or some individuals will be unable to obtain health insurance due to health, financial, or other reasons. Therefore, the issue of caring for the uninsured will never completely disappear.

Today, hospitals that claim federal funding for uncompensated care must demonstrate that they made eligible expenditures in compliance with DSH audit requirements. Under the GPP, the

⁷³ Free clinics reduce emergency department visits, say researchers. (2013, January 23). Retrieved April 11, 2017, from <http://news.psu.edu/story/142860/2013/01/23/health-and-medicine/free-clinics-reduce-emergency-department-visits-say>

⁷⁴ 19 hospitals and health systems with unique population health initiatives, Laura Dyrda. September 12, 2016. <http://www.beckershospitalreview.com/hospital-management-administration/17-hospitals-and-health-systems-with-unique-population-health-initiatives.html>

STCs include reporting requirements that include submitting encounter-level data that will demonstrate which services were provided and claimed. However, hospitals may not separately track all services provided to the uninsured and the costs associated with those services, especially if they are not necessary to comply with federal audit and reporting requirements. More detailed tracking of services and costs related to caring for the uninsured would allow states and providers to more accurately measure uncompensated care costs statewide and at each hospital.

A solution to this issue could involve CMS establishing requirements that oblige providers to submit claims for services provided to this population. Submitting claims for services provided to the uninsured would allow both states and CMS to better account for costs associated with this population. This would also allow for more detailed analyses related to the types of services received by the uninsured and the frequency in the utilization of certain types of services required by this population. Such a requirement would need a clear and consistent definition of “uninsured” services, and pairing with some type of incentive for providers to submit this data. Incentives could include reimbursement for the additional administrative costs of submission, and funding that is linked to this population, which could be a commitment to continue, or perhaps increase funding to help offset the costs associated with serving this population.

11 Conclusion

The requirements for this report as defined in the STCs for the Medi-Cal 2020 Demonstration Waiver (an 1115 waiver) request a review of Medi-Cal funding and payment for hospitals with a concentration on uncompensated care and “pool” funds.⁷⁵ This report is an extension of a similar report submitted to CMS in May of 2016, which reviewed similar items specifically for the 21 Designated Public Hospitals in California. Included in this report is a review of levels of uncompensated care in California before and after implementation of Medicaid expansion through the ACA. Also included is a review of Medi-Cal funding and reimbursements to hospitals for care of both Medi-Cal beneficiaries and the uninsured. Medi-Cal reimbursements are defined through a combination of relatively standard funding mechanisms, such as fee-for-service, Medicaid managed care and the DSH program, and through more unique mechanisms defined and authorized through an 1115 Demonstration Waiver process.

The timeframe of medical services used in our review of Medi-Cal funding, payment, and hospital costs is SFY 2013/14, which began on July 1, 2013 and ended on June 30, 2014. This timeframe was determined by DHCS and CMS during the process of finalizing the STCs for the Medi-Cal 2020 Demonstration Waiver. At that time, SFY 2013/14 was the most current year for which complete data was available. Midway through SFY 2013/14, effective January 1, 2014, DHCS began expansion of the Medi-Cal program as authorized by the ACA. As a result, the data included in this report partially reflect the impact of Medicaid expansion, but do not fully measure the impact of Medicaid expansion on the level of uninsured care provided in California.

Analyses of the uninsured population and uncompensated care show significant reductions after Medi-Cal was expanded through the ACA. With Medicaid expansion, the number of uninsured in California dropped by nearly half, from 16 percent in 2013 to nine percent in 2015 according to recent independent studies by the CHCF and MACPAC. In addition, data from OSHPD indicate that hospital charity care costs have decreased from just under \$4 billion in 2013 to about \$1 billion in 2015. Unfortunately, despite this tremendous progress, the CHCF study indicates that today, approximately 2.9 million Californians remain uninsured and the OSHPD data still show a significant amount of charity care. In addition, the OSHPD data shows nearly another \$1 billion in cost related to bad debt for insured and uninsured recipients, at least some of which is truly charity care but was not reported as such because of the practical challenges with accurately identifying charity care. These numbers suggest that some form of reimbursement for Medicaid shortfall and care of the uninsured is still needed even after the Medicaid expansion.

To further review Medi-Cal hospital reimbursements for Medi-Cal beneficiaries and the uninsured, we compared Medi-Cal payment to hospital cost in a variety of ways. During SFY 2013/14, Medi-Cal reimbursed hospitals for healthcare services through fee-for-service claim payments, Medicaid managed care claim payments and supplemental payments made directly from Medi-Cal to hospitals. The supplemental payments were defined through a variety of programs unique to Medi-Cal, along with the DSH program and the UCP defined in the 2010 Bridge to Reform Demonstration Waiver. Considering these various programs, our analysis of payment versus cost performed independent of the source of the non-Federal share of Medi-Cal funding identified the following:

⁷⁵ We interpreted “pool” funds to be those distributed through the Uncompensated Care Pool.

- Medi-Cal claim payments⁷⁶ covered approximately 75 percent of hospital costs for care of Medi-Cal beneficiaries.
- Medi-Cal claim payments plus supplemental payments (excluding the DSH and UCP programs) covered approximately 99 percent of hospital costs for care of Medi-Cal beneficiaries.
- The combination of Medi-Cal service payments (claim and supplemental) plus DSH and UCP payments covered approximately 99 percent of the costs incurred in providing care to Medi-Cal recipients and the uninsured.
- When considering the additional 75 percent of DSH claimable costs that Medi-Cal is statutorily allowed to contribute, payments cover 94 percent of total hospital costs.

A significant portion of the funding for the non-Federal share of Medi-Cal comes from local sources in the form of CPEs, IGTs, and the HQAF assessment. These three sources contributed \$7.3 billion or 67 percent of the total \$10.8 billion non-Federal share of Medi-Cal hospital reimbursements in SFY 2013/14. When reducing Medi-Cal payments by excluding the local contributions to the Medi-Cal program, our analysis of net payment versus cost identified the following:

- The combination of Medi-Cal service payments (claim and supplemental) plus DSH and UCP payments net of local funding covered approximately 73 percent of the costs incurred in providing care to Medi-Cal recipients and the uninsured.
- When considering the additional 75 percent of DSH claimable costs that Medi-Cal is statutorily allowed to contribute, net payments cover 70 percent of costs.

Cost coverage varies somewhat by category of hospital both with and without consideration of local funding as shown in the following figure:

Figure 32: Cost Coverage by Hospital Category With and Without Consideration of Local Funding for the Medi-Cal Program

Hospital Designation	Total Hospital Cost for Care of Medi Cal and Uninsured Recipients Including 175% at High DSH Hospitals	Total Medi Cal Payments	Pay to Cost Ratio Independent of Source of Non Federal Share	Medi Cal Payments Reduced by Local Funding	Pay to Cost Ratio Net of Local Funding
DPH	\$10,649,371,744	\$10,424,106,367	98%	\$6,770,427,104	64%
DMPH	\$1,591,778,340	\$1,140,470,851	72%	\$1,062,382,532	67%
Private w/ DSH	\$8,085,269,548	\$8,429,884,687	104%	\$7,047,892,812	87%
Private w/o DSH	\$9,007,229,652	\$7,704,487,880	86%	\$5,539,232,764	61%
Total	\$29,333,649,284	\$27,698,949,785	94%	\$20,419,935,211	70%
Note(s):					
1) Claim, supplemental, DSH, and UCP payments are included in this figure.					
2) Cost of care for both Medi-Cal and uninsured beneficiaries are included in the hospital cost column.					

⁷⁶ Our analysis considered all Medicaid managed care payments to be claim payments because Medi-Cal does not track the method of payment used by managed care plans.

One of the goals of this report, as stated in the STCs was to provide “information to support the goal for PHCSs to become self-sustaining entities that are not reliant on pool funds beyond 2020.” We believe that any future decisions related to pool funds need to be made from a wholistic viewpoint which considers the levels of uncompensated care, Medicaid shortfall, and the DSH program. In theory, the UCP could be disbanded in the future if DSH payments are proven to be sufficient to cover Medicaid shortfall and care of the uninsured. However, plans exist at the Federal level to greatly reduce the DSH program in the near future. In addition, the current Federal administration is considering changes to the ACA that may affect Medicaid expansion. Thus, the landscape of uncompensated care in California may be different when renewing the current 1115 Demonstration Waiver than it is now. That landscape should be considered based on a comprehensive understanding of all Medi-Cal reimbursements and all applicable and appropriate hospital costs when defining future Medi-Cal programs, which will ensure access to quality healthcare for Medi-Cal and uninsured beneficiaries.

Appendix A: Regulatory Summary

California's Medicaid program is operated in accordance with a variety of Federal and State laws and regulations, as well as agreements between California and the Federal CMS. This Appendix details the Federal and State requirements relevant to the funding streams, payment and costs addressed in this study.

A.1 Federal Medicaid Requirements

The Medicaid program is authorized and governed by Title XIX of the Social Security Act (SSA). Within the Title XIX provisions there is broad flexibility for states to customize Medicaid to meet the specific health care needs of the state and its population.

A.1.1 Medicaid State Plan⁷⁷

Each state operates its Medicaid program in accordance with a state plan submitted to and approved by CMS that describes the nature and scope of the program (e.g., administrative structure and operations, eligibility, covered benefits, payment methods). The Medicaid state plan is an agreement between the state and the Federal government describing how that state administers its Medicaid program. It provides assurance that the state will abide by Federal rules such that it may claim Federal matching funds for its program activities. Section 1902(a) of the SSA establishes the state plan requirement, and details the specific elements to be addressed. The state plan sets out the groups of individuals to be covered, the services to be provided, the methodologies used for providers to be reimbursed and the related administrative activities operated by the state. In the event that a state needs to make a change to its program policies or operational approach, the state is required to submit a SPA to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid state plan with new information.

A.1.2 Medical Assistance Expenditures⁷⁸

Medicaid programs are jointly funded by the Federal government and the state government. Section 1903(a) of the SSA establishes that financing for the Medicaid program is a shared responsibility of the Federal government and the state. States that operate their Medicaid programs in accordance with the approved Medicaid state plan (or an approved demonstration) are entitled to Federal financial participation (FFP) for a share of their medical assistance expenditures as defined in SSA Section 1905(a). Medical assistance expenditures include payments to Medicaid providers and Medicaid managed care plans, and are matched with FFP at a rate equal to the FMAP defined in SSA Section 1905(b) and other provisions of SSA. States also claim FFP based on expenditures they incur performing administrative activities such as making eligibility determinations, enrolling and monitoring providers, and processing claims. The state completes and submits quarterly expenditure reports to claim the Federal matching dollars.

⁷⁷ SSA 1902(a)

⁷⁸ SSA 1903(a), SSA 1905(a) and SSA 1905(b)

A.1.3 Federal Medical Assistance Percentage/Federal Financial Participation⁷⁹

According to SSA Section 1905(b) the FMAP for a state is based on a formula which takes into consideration the per capita income of the state relative to the national per capita income, subject to a minimum of 50 percent and maximum of 83 percent. Each state receives multiple FMAP values: one FMAP is assigned for the traditional Medicaid program, one for the CHIP program, and there are additional rates for the cost of administering the Medicaid program and for making upgrades to the program. Certain services also receive a higher FMAP. For states that expand Medicaid, there is also a separate FMAP for the expansion population. California's FMAP for Medicaid is currently 50 percent, with the exception of the expansion population, and for CHIP is 65 percent for this time period.

A.1.4 The Non-Federal Share⁸⁰

Federal Medicaid requirements establish parameters around the sources states may rely on to provide the "non-Federal" share of Medicaid expenditures. According to the Code of Federal Regulations (CFR) at 42 CFR 433.51, public funds may be considered as the state's non-Federal share in claiming FFP if they meet the following conditions:

- The public funds are appropriated directly to the state or local Medicaid agency, or are transferred from other public agencies to the state or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
- The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

In practice, there are three common methods other than appropriations to the state Medicaid agency (e.g., state general funds) that are used to fund the non-Federal share of a Medicaid program. These are inter-governmental transfers, certified public expenditures, and provider taxes/assessments:

- **Inter-governmental Transfers (IGTs)** – A transfer of public funds to the State Medicaid agency from another public agency.
- **Certified Public Expenditures (CPEs)** – costs incurred and certified by a public entity or governmental unit as representing allowable Medicaid expenditures.
- **Provider Taxes/Assessments** – State and/or local tax revenue are recognized as public funds that may serve as the non-Federal share of Medicaid expenditures. Taxes or fees imposed on health care items or services may also be used, subject to certain restrictions set forth in SSA Section 1903(w) and 42 CFR 433.55 et seq.

⁷⁹ SSA 1903(a) and SSA 1905(b)

⁸⁰ SSA 1902(a)(2)

A.2 Waiver Authorities

Federal law allows the Secretary of the HHS to grant states flexibility to customize how Medicaid is implemented by waiving certain Federal requirements that would otherwise apply. Multiple waiver authorities in the SSA provide the means to waive certain provisions of the Medicaid statutes such as eligibility and benefits and to explore new approaches to health care delivery and payment. This flexibility has enabled states to test and implement significant changes to their programs on a pilot basis.

All states operate one or more Medicaid waivers, which are categorized as program waivers or research and demonstration projects:

- **Section 1115(a)**⁸¹ gives broad authority to the Secretary to authorize “any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs” specified in that section of the Act. Under the Section 1115 research and demonstration authority, states may receive waivers of certain provisions of the Medicaid and CHIP statutes related to state program design, such as eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program. Section 1115 Demonstrations include a research or evaluation component and usually are approved for a five-year period, with a potential for up to a five-year renewal period after the first five years. An important provision of Section 1115(a) is that in addition to waiving Section 1902 state plan requirements, it authorizes Federal matching of costs which would otherwise not be matchable as medical assistance expenditures under Section 1903(b).
- **Section 1915(b)**⁸² waivers permit states to implement service delivery models (e.g., those involving primary care case management programs or managed care plans) that restrict beneficiaries’ choice of providers other than in emergency circumstances.
- **Section 1915(c)**⁸³ of the Medicaid statute authorizes states to provide home and community-based services (HCBS) as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with mental retardation (ICF-MRs), and hospitals, and to waive the statewideness requirement of who is eligible to receive HCBS services.

Regardless of the type of waiver, estimated Federal spending over the period for which the waiver is in effect cannot be greater than it would have been without the waiver. Approval of states’ waiver applications is at the discretion of the Secretary of HHS.

States have used Section 1115 authority in a variety of ways and for an array of purposes. In California, a statewide Demonstration Waiver has been in place since 2005, and has evolved over time through amendments and renewals to reflect new priorities and the enactment of the ACA, including components of the SNCP.

⁸¹ SSA 1115(a)

⁸² SSA 1915(b)

⁸³ SSA 1915(c)

A.3 Medicaid Payments

Section 1902 of the SSA establishes standards for Medicaid fee-for-service rates. Namely, the state must develop methods and procedures relating to the utilization and payment for services:

“as may be necessary to safeguard against unnecessary utilization of such care and services and to 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 the geographic area”⁸⁴

In addition, Medicaid rates for hospital services must take into account the situation of hospitals which serve a disproportionate number of low-income patients, and those with special needs.⁸⁵

Medicaid programs frequently authorize supplemental payments to certain Medicaid providers, which are paid in addition to base rates:

- **DSH payments** are federally required Medicaid payment adjustments for hospitals that serve a disproportionately high number of low-income patients with special needs.⁸⁶ DSH payments to a hospital may not exceed the hospital’s total annual uncompensated care costs for providing hospital services (net of non-DSH Medicaid payments and payments by uninsured patients) to Medicaid individuals and individuals with no source of third party coverage for the hospital services they receive.⁸⁷
- **Non-DSH supplemental payments** may be distributed for a variety of reasons, most common of which are Graduate Medical Education (GME) payments, UPL payments, and incentive payments.
 - UPL payments are additional FFS payments that are made, usually in a lump-sum, to offset some or all of the difference between total traditional claims-based Medicaid payments for services and the maximum payment level allowed under the Medicare UPL regulations for those services.
 - GME payments are made to teaching hospitals to help provide support for operating GME programs. These payments are also subject to the UPL,
 - Incentive payments are made to hospitals for achieving certain incentive goals related to patient quality or access, and can be made directly by states to providers.

The UPL regulations establish the maximum amounts of FFS Medicaid that are eligible for Federal matching funds. The maximum total payment is generally calculated as an approximation of what Medicare would pay for these same services, or as an approximation of hospital costs to provide these services following the Medicare allowable cost rules.⁸⁸ UPL regulations establish limits on the Federal portion of Medicaid outlays for recipients paid under Medicaid FFS programs.

⁸⁴ SSA 1902(a)(30)(A)

⁸⁵ SSA 1902(a)(13)

⁸⁶ SSA 1923(b)

⁸⁷ SSA 1923(g)

⁸⁸ 42 CFR §447.271, §447.272, §447.321, and §447.325

DSH funds are provided as an annual statewide allotment of Federal funds, calculated based on Section 1923 of the SSA.⁸⁹ The state uses the allotment to make payments to qualifying providers subject to facility-specific DSH limitations. DSH limits are calculated individually for each hospital based on payments and costs for care of Medicaid recipients (both FFS and managed care) plus the cost of uncompensated care.⁹⁰

For services and enrollees covered by Medicaid managed care plans, the state pays rates to the plan in accordance with its contract. For risk or capitation contracts, the amounts paid by the state to the plan must comply with Federal requirements to be “actuarially sound.”⁹¹ Medicaid managed care plan can negotiate rates with providers of services.

A.3.1 Managed Care Final Rule

On April 25, 2016, CMS published the Medicaid and CHIP Managed Care Final Rule (the Rule), which is intended to align key rules with those of other health insurance coverage programs, modernize how states purchase managed care for beneficiaries, and strengthen the consumer experience and key consumer protections. This final rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade. Given the magnitude and complexity of the rule, full analysis of the implications for uncompensated care and the managed care program going forward is still pending.

As noted in the report, California only uses uncompensated care funding for uninsured services and does not use UCP funds to support Medi-Cal managed care shortfalls. Managed care costs are reported on the P-14 by the providers, and changes to the Medi-Cal managed care shortfall will impact DSH calculations. It will be important to monitor how CMS implements the provisions of the Rule to identify any potential impact to the UCP.

A.4 California State Plan Provisions Applicable to DPHs

Pursuant to the Federal requirements described in Section 10.1.1, the California Medicaid State Plan sets out the groups of individuals to be covered, the services to be provided and the methodologies used for providers to be reimbursed. In regards to payments for the DPHs in this report, the State Plan provides a list of these government-operated hospitals in Appendix 1 to Attachment 4.19-A. DPH services to fee-for-service Medi-Cal beneficiaries are reimbursed using a cost-based reimbursement methodology as follows:

- **Inpatient hospital services** are reimbursed an interim per diem rate computed on an annual basis using the hospital’s most recently filed cost report (Medi-Cal 2552-96). The DPHs provide the non-Federal share of the inpatient hospital services reimbursement using a certified public expenditure. Each hospital’s interim Medicaid payments and any interim Medicaid adjustments for services rendered in a fiscal year are subsequently reconciled to the cost report for that same fiscal year as finalized by California Department of Health Services, Audits and Investigations (A&I). At the end of the reconciliation process, if it is

⁸⁹ SSA 1923(g)

⁹⁰ 42 CFR Part 447, Subpart E

⁹¹ SSA 1903(m)(2)

determined that there is an overpayment, adjustments will be made to offset or otherwise recover the overpayment.⁹²

- **Outpatient hospital services** are reimbursed based on the lesser of the hospital's usual charge to the general public and the limits specified in the California Code of Regulations (CCR) for services.⁹³ In addition, the DPHs receive supplemental reimbursement for costs that are in excess of the payments the hospital receives per visit or procedure code for outpatient hospital services from any source of Medi-Cal reimbursement. The Medicaid outpatient hospital costs are reduced by Medi-Cal paid claims data to determine the amount of supplemental payment. The DPHs provide the non-Federal share of the supplemental payments through a certified public expenditure. The state will reconcile annually (and for three years after the period related to the claim) to cost information from settled/audited cost reports for the same fiscal period. When any reconciliation results in an underpayment or overpayment, the State will adjust the facility's supplemental payment no less than annually.⁹⁴
- **Professional services** are reimbursed to the DPHs through Medi-Cal fee-schedule payments for professional services, as well as supplemental reimbursement for the uncompensated Medicaid professional costs. The DPHs provide the non-Federal share of the supplemental payments through a certified public expenditure. The interim supplemental payment is calculated to approximate the difference between the FFS payment and the allowable Medicaid costs related to the professional component of physician or non-physician practitioner services eligible for FFP. This computation of establishing the interim Medicaid supplemental payments is performed on an annual basis using the Medi-Cal 2552 cost report. Reconciliation of the finalized costs to all Medicaid payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. At the end of the final reconciliation process, if it is determined that a hospital received an overpayment, the overpayment will be properly credited to the Federal government.⁹⁵
- **Non-Hospital Clinic Services** are reimbursed to the DPHs through Medi-Cal fee schedules, plus a supplemental payment methodology that allows the DPHs to receive Medi-Cal reimbursement for their uncompensated costs of providing such services.⁹⁶ The DPHs provide the non-Federal share of the supplemental payments through a certified public expenditure.
- **Cost-Based Reimbursement** is provided for Medi-Cal covered ambulatory care services, including physician and non-physician professional services, provided in hospital outpatient

⁹² California State Plan, Attachment 4.19-A, pp 46-51: Reimbursement to Specified Government-Operated Hospitals for Inpatient Hospital Services.

⁹³ California State Plan, Attachment 4.19-B, pp 1-5

⁹⁴ California State Plan, Attachment 4.19-B, pp 46-50, Supplemental Reimbursement for Public outpatient Hospital Services.

⁹⁵ California State Plan, Attachment 4.19-B, pp 52-63, Reimbursement to Specified Government-Operated Providers for Costs of Professional Services.

⁹⁶ California State Plan, Attachment 4.19-B, Supplement 10: Supplemental Reimbursement for Publicly Owned or Operated Clinic Services

departments and freestanding clinics owned and operated by the County of Los Angeles.⁹⁷ The non-Federal share of these “CBRC” payments is provided by state general funds.

- **DSH facilities** are eligible to receive additional payment adjustments based on consideration of their service to a disproportionate number of low-income patients with special needs. Payment adjustments for DPHs are based on the uncompensated Medicaid and uninsured costs of each hospital. In addition, DPHs that qualify as “high DSH” based on having a Medicaid utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for the State, or the hospital’s low income patient utilization rate exceeding 25 percent (as defined in SSA Section 1923(b)), are eligible to receive additional Direct DSH payments equal to amounts up to 75% of the hospital’s uncompensated care costs, consistent with Federal law.⁹⁸ All DSH payments are subject to an aggregate cap based on the Federal DSH allotment for California.

⁹⁷ California State Plan, Supplement 5 to Attachment 4.19-B

⁹⁸ California State Plan, Attachment 4.19-A, pp 18-37, Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals

Appendix B: Acronyms Referred to In the Report

- ACA: Patient Protection and Affordable Care Act
- BTR: Bridge to Reform Demonstration Waiver
- CAPH: California Association of Public Hospitals and Health Systems
- CBRC: Cost Based Reimbursement Clinics
- CCI: Coordinated Care Initiative
- CHIP: Children’s Health Insurance Program
- CMS: Centers for Medicare and Medicaid Services
- COHS: County Organized Health System
- CPE: Certified Public Expenditures
- DHCS: California Department of Health Care Services
- DMC-ODS: Drug Medi-Cal Organized Delivery System
- DP/NF: Distinct Part Nursing Facility
- DPH: Designated Public Hospital
- DMPH: District/Municipal Public Hospitals
- DRG: Diagnosis Related Groups
- DSH: Disproportionate Share Hospital
- DSHP: Designated State Health Programs
- DSRIP: Delivery System Reform Incentive Payments
- DTI: Dental Transformation Initiative
- EQRO: External Quality Review Organization
- FFP: Federal Financial Participation
- FFS: Fee for Service
- FFY: Federal Fiscal Year
- FMAP: Federal Medical Assistance Percentage
- FPL: Federal Poverty Level
- FQHC: Federally Qualified Health Centers
- GAO: Government Accountability Office
- GMC: Geographic Managed Care
- GPP: Global Payment Program
- HCBS: Home and Community-based Services
- HCCI: Health Care Coverage Initiative
- HFMA: Health Financial Management Association

- HHS: Federal Department of Health and Human Services
- HPE: Hospital Presumptive Eligibility
- HQAF: Hospital Quality Assurance Fee
- HUD: U.S. Department of Housing and Urban Development
- ICF-MR: Intermediate Care Facilities for Individuals with Mental Retardation
- IGT: Intergovernmental Transfers
- LIHP: Low Income Health Program
- MACPAC: Medicaid and CHIP Payment and Access Commission
- MCE: Medicaid Coverage Expansion
- MCO: Managed Care Organizations
- MMIS: Medicaid Management Information System
- OIG: Office of Inspector General
- OSHPD: Office of Statewide Health Planning and Development
- PHCS: Public Health Care System
- PRIME: Public Hospital Redesign and Incentives in Medi-Cal
- QAF: Quality Assurance Fee
- SFY: State Fiscal Year
- SHO: State Health Official
- SMD: State Medicaid Director
- SNCP: Safety Net Care Pool
- SPA: State Plan Amendment
- SPD: Seniors and Persons with Disabilities
- SSA: Social Security Act
- STC: Special Terms and Conditions
- UCP: Uncompensated Care Pool
- UPL: Upper Payment Limit
- WPC: Whole Person Care