Evaluation of Uncompensated Care Financing for California Designated Public Hospitals

Prepared for:

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1 Executive Summary

The healthcare industry is unusual in the sense that services cannot be withheld due to a lack of ability to pay. This is particularly true of public safety net hospitals who must treat any patient who comes through their doors, independent of the patient's health insurance or financial status. As a result, many healthcare providers, and most notably public safety net hospitals, 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 and uninsured patients. In addition, some state Medicaid agencies have utilized 1115 Demonstration Waivers to expand Medicaid coverage, thus reducing the number of uninsured in the state, and to provide compensation to providers for treating those who remain uninsured. The Patient Protection and Affordable Care Act (ACA) of 2010 also offers states an avenue to expand Medicaid coverage and significantly reduce the number of individuals without medical insurance. However, even in states that have expanded Medicaid through the ACA, some level of uninsured individuals remain. Health plans do not always cover all necessary services, which also contributes to a remaining, albeit reduced, level of uncompensated care.

This report reviews the level of uncompensated care at the 21 Designated Public Hospitals (DPHs) in the State of California, all of which are considered to be safety net hospitals. This report reviews efforts by the California Department of Health Care Services (DHCS) and the Federal Centers for Medicare and Medicaid Services (CMS) to reimburse the California DPHs for uncompensated care through the California Medicaid program (Medi-Cal). Since 2005, DHCS has utilized a combination of the DSH program and an 1115 demonstration waiver to provide compensation to California DPHs for care of the uninsured. In the 2005 and 2010 waivers, the key component used for this purpose was the Safety Net Care Pool (SNCP). Included in the SNCP program were multiple sub-programs intended to provide compensation for care to the uninsured, including the Health Care Coverage Initiative (HCCI), Delivery System Reform Incentive Pool (DSRIP), Designated State Health Programs (DSHP), and the Uncompensated Care Pool (UCP). In addition, during the timeframe of the 2010 waiver, DHCS expanded the Medi-Cal program through the ACA. In the most recent waiver renewal, which was approved in December 2015, the SNCP program was replaced with a new set of programs which were designed to build upon programs from previous waivers and adjust to the new healthcare landscape in California which includes an expanded Medi-Cal program and Federal subsidies for other low-income individuals to purchase medical insurance through the Healthcare Marketplace. In this new waiver, which is referred to as the "Medi-Cal 2020 Demonstration Waiver," the UCP program will evolve into the Global Payment Program (GPP). DSH payments will be moved under the GPP for those DPHs who have agreed to participate in the GPP.

Included in the Special Terms and Conditions (STCs) associated with the Medi-Cal 2020 Demonstration Waiver were requirements for DHCS to contract with an independent entity or entities to produce two reports, which review uncompensated care in the State of California. Specifically the STCs state:

i. "The first report, due May 15, 2016, will focus on Designated Public Hospitals. The objective of this report will be to support a determination of the appropriate level of

Uncompensated Care Pool funding at those providers in years two through five of the demonstration. CMS will provide a formal determination of the funding levels for demonstration years two through five within 60 days of receipt of the complete report.

ii. The second report, due June 1, 2017, will focus on uncompensated care, provider payments and financing across hospital providers that serve Medicaid beneficiaries and the uninsured under the current demonstration. The report will include 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."[1]

The STCs go on to say, "The first report must review the impact of the uncompensated care pool on those providers who participate in the UCP with respect to the cost of uncompensated care provided to uninsured individuals, distinguishing between costs associated with charity care from those associated with bad debt, and the extent that historical pool payments have addressed these costs."[2] This document fulfills the requirements of the first report, and as stated above, will be used as input in determining the level of UCP funding for the DPHs in years two through five of the Medi-Cal 2020 waiver.

This report reviews funding, Medi-Cal payment, and hospital costs for care provided by the DPHs to Medicaid recipients and the uninsured. Services provided in state fiscal year (SFY) 2013/14, which began on July 1, 2013 and ended on June 30, 2014, were used for this analysis. During this timeframe, total uncompensated care cost for the DPHs was calculated to be $225 million when including the additional 75 percent of DSH claimable cost allowed under Federal statute for Medi-Cal.[3] The $225 million in uncompensated costs exists even after accounting for $2.3 billion in DSH payments and $622 million in UCP payments. In addition, these dollar amounts were calculated without consideration of the source of the non-Federal share of the reimbursements. Currently, the DPHs and/or their local governmental entities contribute a significant portion of the non-Federal share of their Medi-Cal reimbursements. When taking this into account by reducing reimbursements by local contributions made through Inter-Governmental Transfers (IGTs) and Certified Public Expenditures (CPEs) total uncompensated care was calculated to be nearly $2.8 billion. Again, the $2.8 billion amount was calculated when including State and Federal portions of DSH and UCP payments.

Total cost of care provided at the DPHs to the uninsured was $2.0 billion, which was calculated as gross costs minus uninsured patient payments. Of this $2.0 billion, just under $1.5 billion was determined to be from charity care, while the remaining $0.5 billion was bad debt when calculated using strict and conservative guidelines for the definition of charity care. When using the DPH imputed charity care values, which are calculated using IRS Form 990 guidelines,

[1] Centers for Medicare and Medicaid Services, *Special Terms and Conditions* for the *California Medi-Cal 2020 Demonstration*, Document number 11-W-00193/9, STC number 178, (2015).
[2] Centers for Medicare and Medicaid Services, *Special Terms and Conditions* for the *California Medi-Cal 2020 Demonstration*, Document number 11-W-00193/9, STC number 180, (2015).
[3] For this report, we define uncompensated care as the gap between cost and reimbursement for hospital-related care (including professional services) provided to Medicaid beneficiaries, plus the gap between the cost of care and patient payments for hospital-related and non-hospital services provided to the uninsured. The sources of cost included in this report are consistent with those included in the DSH and SNCP UCP program in SFY 2013/14.

$1.768 billion was identified as charity care and just under $0.25 billion was determined to be bad debt.[4]

Whether using the $1.5 billion or $1.768 billion estimate of charity care, the amount of charity care is well above the $622 million and $472 million total computable amounts allocated for the UCP in SFYs 2013/14 and 2015/16, respectively. However, the University of California (UC) hospitals are not eligible to participate in the GPP defined in the Medi-Cal 2020 waiver. When excluding the UC hospitals, total charity care under the strict definition totals just under $1.4 billion and total imputed charity care is just under $1.6 billion. Again, both of these values are well above the $472 million total computable allocated for the UCP in SFY 2015/16. In addition, the DPHs are funding the non-Federal share of the UCP through IGTs, meaning that the net benefit to the DPHs from the UCP will only be the Federal portion, which is $236 million.

As part of this study, we reviewed overall pay-to-cost values for the DPHs based on Medi-Cal payments and hospital cost for care of Medi-Cal recipients and uninsured. We found that the combination of Medi-Cal service payments plus DSH and UCP payments covered approximately 109 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 98 percent of costs. In addition, the DPHs and their affiliated local governments contribute a significant portion of the non-Federal share of Medicaid reimbursements through a combination of CPEs and IGTs. Our analysis determined that these contributions by the DPHs and their affiliated local governments amounted to 83 percent of the non-Federal share of their Medi -Cal funding in SFY 2013/14 – a total of $3.65 billion. When reducing Medi-Cal payments to account for the DPHs contributions to the Medi-Cal program, we find that the net payments to the DPHs covered only 71 percent of costs even when the additional 75 percent of DSH claimable costs was not included.

In conclusion, our analysis shows that there continues to be uncompensated care in the State of California even after the State expanded Medi-Cal under the ACA and increased coverage through the Healthcare Marketplace. In addition, at the DPHs, most of this uncompensated care is charity care, and the charity care totals are well above the UCP allocation for SFY 2015/16, which is the first year of the Medi-Cal 2020 waiver.

[4] The imputed charity care values were determined when estimating the number of uninsured that would have been identified as charity care had the patients completed all of the financial reporting required to formally qualify a patient as charity care.

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.[5] 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.[6] Federal spending for Medicaid and CHIP is financed by general revenues.[7]

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 costs. States incur these costs by making payments to health care providers and managed care plans and by 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, the Medicaid program (Medi-Cal) accounted for 17.3 percent of State general revenue expenditures, or approximately $16.7 billion in SFY 2013/14. In addition, a considerable amount of local government funds were contributed to the non-Federal share of the Medicaid program through the use of CPEs, IGTs and a healthcare provider quality assessment. The combined non-Federal share of funds comprised a total of $6.2 billion in SFY 2013/14. With Federal matching funds added to the total non-Federal share, this resulted in just under $62.4 billion expended by the California Medicaid program.[8] [9]

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 state implements all Federal Medicaid requirements. To the extent that material program modifications are subsequently needed, states are required to submit a state plan amendment (SPA) to CMS for review and approval in advance of implementing any changes. In conjunction with its mandate to manage costs and assure access to quality care, CMS monitors each state Medicaid program, oversees the approval of SPAs, waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters.

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

[5] MACPAC: https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2015.pdf
[6] MACStats: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-3.-National-Health-Expenditures-by-Type-and-Payer-2014-1.pdf
[7] MACPAC. Report to the Congress on Medicaid and CHIP, (March 2011).
[8] http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2014_May_Estimate/M1400_Complete_Estimate.pdf
[9] http://www.ebudget.ca.gov/2013-14/Enacted/agencies.html

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 up to a five-year renewal term. 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).[10]

All states operate one or more Medicaid waivers and one of the major goals of such waivers is to provide 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, with the implementation of the ACA, more people have received health care coverage, and the overall rate of uninsurance has been reduced. 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 to accomplish several goals. One main component of the SNCP was a sub-program which provided compensation to healthcare providers for care of the uninsured called the Uncompensated Care Pool (UCP).

Most recently, Medi-Cal's Demonstration Waiver was renewed at the end of December, 2015 and is applicable through 2020, and is referred to as the Medi-Cal 2020 Demonstration Waiver. In this version, the UCP program has evolved into the GPP. In addition, DSH payments have been moved under the GPP for non-UC DPHs. Also included in the Medi-Cal 2020 Demonstration Waiver, is requirement from CMS for the State to commission a report 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 Consulting, Inc. (Navigant) to perform this study.

The requirement for an independent report on uncompensated care was included as items 178, 179, and 180 in the STCs associated with the waiver renewal. As specified in these STCs, the report evaluates uncompensated care at the 21 California DPHs, particularly highlighting the cost of charity care versus bad debt, and the level of funding and payment under the UCP in SFY 2013/14. In addition, we review the demographics of California's population more closely and discuss trends in factors that could impact the uninsured population. The intent of this analysis is 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.

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

- The impact of the uncompensated care pool on those providers who participate in the pool with respect to:

[10] Ibid.

  - 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; and
  - Role of managed care plans in managing care.

- The following information is provided for the hospital providers covered in the report:
  - 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.

All data presented in the report is also 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.

As an integral component of the evaluation Navigant conducted interviews with DHCS staff and relevant stakeholders, including representatives of the California Association of Public Hospitals and Health Systems (CAPH).

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

- Section 3 – Background, where we provide general background 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 DPHs in providing care to Medicaid recipients and the uninsured;
- Section 6 – Comparison of Costs to Payments, 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 DPHs;
- Section 7 – Analysis of Trends in Utilization and Access to Care, where we describe factors to consider as the California SNCP program is evaluated for future periods; and
- Section 8 – Role of Managed Care Plans in Managing Care;
- Section 9 – Conclusion, where we provide a brief conclusion related to this study of California's SNCP program.

3 Background

3.1 Role of Public Hospitals

California's public health care systems include 15 county-owned and operated health care systems, and six University of California Medical Centers, and serve the counties where more than 80 percent of Californians live. These systems account for just six percent of the state's hospitals, but provide more than 40 percent of hospital care to the state's remaining uninsured.

The collective mission of these health care systems remains the provision of high quality health care to all who need it, regardless of insurance status or ability to pay. Public health care systems provide a comprehensive range of health care services, including primary care, outpatient specialty care, emergency and inpatient services, rehabilitative services, and in some instances long-term care, while at the same time providing core community benefits such as trauma care, burn care, and the training of over half of the new doctors in California.

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.

In 1964, just before the historic creation of the Medicare and Medicaid programs, California had 66 county-owned and operated hospitals. In the decades since then, a majority of these facilities have either closed or turned into private hospitals. Three have become University of California medical centers. Today, the remaining county-run systems and UC medical centers form the core of California's health care safety net.

Various efforts have been made over the years, at the state and Federal level, to provide additional support for hospitals that care for a disproportionately large share of low-income patients with little or no ability to pay. For instance, the Federal Medicaid DSH payment adjustment requirement was imposed in 1981 to support hospitals that particularly focused on a disproportionate share of care for low-income populations.

In 2005, California received its first 5-year section 1115 waiver for public hospitals, in which public hospitals began providing the non-Federal share not just for DSH and supplemental payments which they had been doing long before 2005, but for the entirety of their Medi-Cal inpatient fee-for-service rates.

They also provided the non-Federal share for 1115 demonstration programs like the SNCP UCP, and the HCCI, which expanded coverage to low-income residents in 8 public health care system counties.

The 2010 waiver further expanded both the financing role and the unique safety net role of the public health care systems to prepare California for the ACA. These systems engaged in a first-in-the-nation quality improvement effort through the DSRIP, working on hundreds of quality improvement projects to expand access to care and improve health outcomes, with funding available for achieving pre-determined benchmarks.

Counties also actively engaged in a pre-ACA expansion effort, Low Income Health Program (LIHP), which built on the experience of the HCCI from 2005. There, 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 end of the waiver in 2013.[11] These individuals were then able to transition to Medi-Cal or other coverage in 2014. Counties and public health care systems financed the non-Federal share of the funding for both the DSRIP and LIHP in addition to the non-Federal share they were already providing for programs like DSH.

Since 2014, public health care systems have continued to focus their efforts on enrolling patients in coverage, including through the use of Hospital Presumptive Eligibility, which has provided timely and critical access to Medi-Cal benefits during a time of great program transition and growth due to the ACA.

While in many respects these systems see a need to focus on becoming "providers of choice" in a coverage environment, they also are driven to retain their core mission of providing care to all who need it, regardless of insurance status, including through new programs in the Medi-Cal 2020 waiver such as the GPP described later in this chapter, funded in part by the SNCP UCP.

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

3.2.1 2005 Demonstration Waiver

In 2005, California implemented the "Medi-Cal Hospital/Uninsured Care" Demonstration Waiver. Among other initiatives, this Demonstration Waiver established a established SNCP program with the purpose of covering expenditures associated with the uninsured as well as expanding health care coverage to the uninsured population, and in later years funding for DSHP. The "Medi-Cal Hospital/Uninsured Care" Demonstration Waiver also implemented the HCCI in 2007. As described above, HCCI expanded expanded coverage options for uninsured individuals in the state and increased the number of individuals with health coverage.

3.2.2 2010 Demonstration Waiver

In 2010, California's Demonstration Waiver was renewed and renamed the "California Bridge to Reform" (BTR) Demonstration Waiver. Through this renewed Demonstration Waiver, the SNCP program was not only continued but expanded to ensure continued support for coverage of uncompensated care costs. However, under the BTR Demonstration Waiver, SNCP funding was not solely dedicated to covering uncompensated care costs. In addition to the UCP, funds from the SNCP program were used to fund the DSRIP program, DSHP, the Workforce Development in Low Income/Underserved Communities program, and the HCCI program.

With the implementation of the BTR Demonstration Waiver, measures were taken to prepare for Medicaid coverage expansion under the ACA. One such measure was the creation of the LIHP, which was in effect from November 2010 through December of 2013. The purpose of the LIHP program was to provide coverage for low-income adults who would become eligible for coverage under ACA. The LIHP was sub-divided into two programs, HCCI and the Medicaid Coverage Expansion (MCE). Both programs were funded by counties through a combination of

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

combination of CPEs and IGTs. Also, each county was given the authority to determine that maximum percentage of the Federal Poverty Level (FPL) that would qualify for coverage within LIHP.

The HCCI population consisted of adults with family incomes between 133 percent of the FPL and 200 percent of the FPL who were also not otherwise eligible for Medicaid or CHIP coverage. The HCCI program was funded through SNCP, and was subject to a Federal funding cap. The program was capped at $360 million annually for SFY 2010/11 through 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 consisted of 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 a new adult group for which services were obtained through the Medicaid managed care delivery system.

Another program funded through SNCP in 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 does provide funding for DPH hospitals, we recognize that DSRIP payments are not direct reimbursement for services provided or patient revenue. Instead, such payments are intended to compensate hospitals for improvements that support the goals of this program. The amounts related to the DSRIP program are included in the table below to satisfy the requirements specified in Medi-Cal 2020 Demonstration Waiver STC 180(c)(iv).

The programs included as part of the SNCP program in the 2010 BTR waiver are summarized in the table below, along with the total computable reimbursement to the DPHs in SFY 2013/14.

Figure 1: Safety Net Care Pool Programs in SFY 2013/14

SNCP Program	Description	Related to Designated Public Hospitals	Total Computable Reimbursement to DPHs
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."[12]	Yes	$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)."[13] Program is part of the Low Income Health Program.	Yes	$ 31,227,582
SNCP 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.	No	$0
SNCP 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."[14]	Yes	$1,431,271,428
Total Reimbursement for the DPHs Under the SNCP Program			$2,084,499,010

As noted previously, the non-Federal share of these reimbursements was either IGTs or CPEs. Thus, the net benefit to the hospitals would be only the Federal share, or $1,042,249,505.

3.2.3 2015 Demonstration Waiver

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

- 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).

[12] California Bridge to Reform Demonstration Wavier Special Terms & Conditions, STC 35(b)(i), Page 14.
[13] California Bridge to Reform Demonstration Waiver Special Terms & Conditions, STC 48(a)(ii), Page 24.
[14] California Bridge to Reform Demonstration Waiver Special Terms & Conditions, STC 35(c), Page 16.

- 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 care to the uninsured. 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. During the first year of the GPP, the funds available for the uncompensated care component of the pool were set at $236 million in Federal funds ($472 million total computable). The non-Federal share of all GPP payments will be funded through IGTs.

The goal of the GPP is to assist public health care systems in providing services to uninsured individuals. Consistent with this goal, the GPP payment structure incentivizes the delivery of services in appropriate settings rather than through more costly emergency room departments and inpatient hospital visits. The GPP payments made to providers will be 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 more 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 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 along with one year end interim and one final annual reconciliation.

The six UC DPHs will not be participating in the GPP. As a result, they will not receive uncompensated care supplemental payments through the GPP and will 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 towards value-based payments through alternative payment models among others.

3.3 Source of Financial Data

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 program.

3.4 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, we incorporated costs that are claimable under the DSH and SNCP programs as defined 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 fee-for-service 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 Fee For Service (FFS) and uninsured populations
- Medical services provided in hospital-based Federally Qualified Health Centers (FQHCs) for the FFS population and the uninsured
- 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

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 for the State's DPHs. In addition, we examine 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.

Funding for payment of hospital-related medical services provided by DPHs to Medicaid recipients and the uninsured generally come from five sources: 1) California state general revenue 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 DPHs for services provided to Medi-Cal recipients and the uninsured in six forms: 1) Federal share of CPE amounts for inpatient hospital services provided to fee-for-service recipients; 2) claims payments for outpatient hospital services provided to Medicaid fee-for-service recipients; 3) capitation payments to Medicaid MCOs, which in turn, pay DPHs for inpatient and outpatient services provided to Medicaid managed care recipients; 4) payments authorized by DHCS as part of the Demonstration Waiver; 5) DSH payments; and 6) a small number of other periodic supplemental payments.

4.2 Funding of Medicaid Payments to the Designated Public Hospitals

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 half, or 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. [15]

Because the California DPHs are all public entities, they are eligible to utilize CPEs and IGTs to help fund the non-Federal share of Medicaid reimbursements. In SFY 2013/14, approximately 17 percent of the non-Federal share of reimbursements to the DPHs were funded by State general funds and the other 83 percent came from local sources through CPEs and IGTs. This is summarized in Figure 2 below:

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

Figure 2: Comparison of State general funds to Local funds supporting non-Federal share for the DPHs

Funding Source	Dollars	Percent of Total Non-Federal Share
State General Fund	$742,765,563	17%
CPE	$2,622,584,955	60^
IGT	$1,031,094,308	23%
Total Local	$3,653,679,262	83%
Total Non-Federal Share	$4,396,444,825	100%

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

4.3.1 Claim-based Payments for Medicaid-eligible Services

Under the 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 and draws the Federal share of the expenditure from CMS, and pays the Federal matching funds to the provider.

For outpatient hospital services, DPHs are paid on a FFS basis using a published fee schedule for individual outpatient services. For this report, claim payments are the payments made based on submission of a claim from the hospital for services provided to Medicaid eligible individuals. Medi-Cal maintains a Medicaid Management Information System (MMIS) that processes outpatient claims based on the published fee schedule.

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. The payment methodology for inpatient and outpatient services is based on the provider-specific contract provisions between the MCO and the hospital.

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 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 were funded through the use of CPEs. The DPHs and/or their affiliated government entities reported and certified their costs to the 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.[16]

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 with special needs. As such, DSH funds help to cover hospital costs for Medicaid shortfall and 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.

DSH payments may be made directly from the Medicaid agency to hospitals independent of capitation payments made to MCOs. Total 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.

All but three of California's DPHs qualify as "high DSH" facilities.[17] The DPHs draw from the Federal DSH allotment through the use of CPEs, 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 DPHs based on a statutory formula that generally takes into account hospitals' Medicaid and uninsured discharges and uncompensated costs. DPHs that qualify as "high DSH" facilities may also receive IGT-funded 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.[18]

4.3.4 Other Supplemental Payments for Medicaid Services

California Medicaid has a variety of other Medicaid payments intended to supplement the funding received through the CPE program for DPHs. Figure 3 below provides a listing and brief description of each of these supplemental payment streams.

[16] 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.
[17] UC San Francisco, UCLA - Santa Monica, and UCLA – Westwood do not quality as high DSH hospitals.
[18] Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. Law 106-113) §607.

Figure 3. Medicaid Supplemental Payments

Supplemental Payments	Description
Medi-Cal Outpatient Disproportionate Share Hospital Factor	Medi-Cal determines an outpatient disproportionate share factor to all hospitals in the state that provides 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).
Outpatient Hospital 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 costs of services 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.
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.
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.

Supplemental Payments	Description
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 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 239 established a program that imposes a Quality Assurance Fee (QAF) on certain general acute care hospitals in order provide the non-Federal share of increased managed carepayments and fee-for-service payments for hospital services up t to the aggregate upper payment limit for the period of January 1, 2014 – December 31, 2016.
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 the state, a county, city, city and county or health care district, which meets specified requirements. Under this program additional reimbursement is available only for the costs of services 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.
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.
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 debt service incurred on revenue bonds for the eligible projects, which are narrowly defined with respect to plan submission date and hospital eligibility criteria.

Figure 4 below shows the funding source for the non-Federal share of all Medi-Cal payment streams to the DPHs.

Figure 4: Non-Federal Source of Funding for DPH Medicaid Payment Streams

Payment Description	Funding Source for Non-Federal Share			
	IGT	CPE	Hospital Fee	General Fund
Inpatient FFS Payments		98%		2%
Base Payment		√		
Other (Admin Days, Blood Factor, and Other)				√
Medicare Crossovers				√
Psychiatric Services		√		
Outpatient FFS Payments		42%		58%
Base Payment				√
Medi-Cal Outpatient Disproportionate Share Hospital Factor				√
Outpatient Hospital Services Supplemental Payment		√		
FQHCs				√
CBRCs				√
Inpatient and Outpatient Managed Care	55%		2%	43%
Claim (base) payment				√
Managed Care SPD Rate Increase	√			
Managed Care MCE Rate Increase[1]	N/A[1]			
Managed Care Rate-Range Increase	√			
Hospital Quality Assurance Fee			√	
Distinct Part Nursing Facility (DP/NF)		38%		62%
Base Payment				√
Supplemental Payment		√		
Physician Non-Physician Practitioner – Fee for Service		68%		32%
Base Payment				√
Supplemental Payment		√		
Physician Non-Physician Practitioner – Managed Care	47%			53%
Base Payment				√
Supplemental Payment	√			
LIHP Program		100%		
MCE Recipients		√		
HCCI Recipients		√		
Safety Net Care Uncompensated Care Pool		100%		
Disproportionate Share Payments	42%	58%		
Construction Renovation and Reimbursement Program				100%
Total	23%	59%	0%	17%

Notes:
[1] When the FMAP for the newly eligible ACA population decreases from 100 percent, the full non-Federal share will be paid by DPHs.

Figure 5 below shows the payment amounts for the various funding streams for SFY 2013/14. Note that this figure includes the total payment amount reported for Federal claiming purposes, and the payment amounts distributed to the DPHs net of the funding contributions made by them to cover portions of the non-Federal share of the payments.

Figure 5: Total Payments by Payment Stream

Payment Description	Payments by Type of Payment	
	Total Payment Amount Used for Federal Claiming Purposes	Payment Amount Net of Amount Funded by DPH
Inpatient FFS Payments	$3,222,999,459	$2,240,464,766
Outpatient FFS Payments	$636,781,961	$513,088,693
Inpatient and Outpatient Managed Care[1]	$1,856,539,610	$1,399,567,777
Distinct Part Nursing Facility (DP/NF)	$31,248,301	$25,384,493
Physician Non-Physician Practitioner – Fee for Service	$286,658,566	$189,829,964
Physician Non-Physician Practitioner – Managed Care	$417,034,676	$324,218,201
LIHP Program	$872,494,760	$442,707,107
Safety Net Care Uncompensated Care Pool	$622,000,000	$311,000,000
Disproportionate Share Payments	$2,312,236,318	$1,156,118,159
Construction Renovation and Reimbursement Program	$60,959,347	$60,959,347
Uninsured Patient-Related Payments	$105,153,369	$105,153,369
Totals	$10,424,106,367	$6,768,491,876

Notes:
[1] When the FMAP for the newly eligible ACA population decreases from 100 percent, the full non-Federal share will be paid by DPHs.

4.3.5 DPH Total All Payor 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 included.

- The following information is provided for the hospital providers covered in the report:
  - 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

Figure 6 below shows these revenue streams for each DPH facility.

Figure 6: Total All Payor Revenues by DPH

DPH	All Payor Net Patient Revenue, Including Demonstration Revenue, Reduced by CPE/IGT Funding	Total Medicaid Revenue Including Demonstration Revenue, Reduced by CPE/IGT Funding	Medicaid Patient Care Revenue, Reduced by CPE/IGT Funding	Safety Net Care Pool Uncompensated Care Pool Revenue, Reduced by CPE Funding
Alameda Health System	$305,726,875	$369,225,998	$261,540,070	$19,690,651
Arrowhead Regional Medical Center	$393,393,627	$338,506,705	$255,941,765	$6,033,853
Contra Costa Regional Medical Center	$424,556,706	$355,000,363	$288,285,900	$7,044,066
Kern Medical Center	$249,128,023	$201,394,156	$138,021,909	$5,413,075
Los Angeles*	$2,420,695,401	$1,980,794,819	$1,272,784,977	$134,558,588
Natividad Medical Center	$176,023,596	$117,384,200	$94,668,845	$2,735,233
Riverside Univ Health System – Med Cntr	$364,678,374	$309,298,127	$211,138,432	$9,913,793
San Francisco General Hospital	$589,646,415	$411,356,333	$276,666,930	$26,926,619
San Joaquin General Hospital	$216,123,016	$153,806,903	$111,070,714	$5,457,769
San Mateo Medical Center	$142,906,240	$155,765,463	$103,789,641	$11,979,535
Santa Clara Valley Medical Center	$959,586,472	$737,634,047	$550,168,372	$32,292,607
UC Davis	$1,564,815,447	$622,942,454	$511,191,328	$8,390,461
UC Irvine	$787,491,304	$332,724,357	$268,983,569	$9,305,979
UC San Diego	$1,204,388,407	$433,290,875	$330,322,307	$14,239,897
UC San Francisco	$1,804,685,232	$463,836,188	$413,144,782	$4,089,757
UC Los Angeles**	$1,868,539,932	$308,485,759	$262,002,391	$2,971,217
Ventura County Medical Center	$232,380,105	$194,616,070	$135,540,836	$9,956,898
Total	$13,704,765,172	$7,486,062,818	$5,485,262,770	$311,000,000

Note(s):

- All payor patient revenues are net of DPH-provided non-Federal share (CPEs and IGTs), and may reflect different amounts of supplemental funding than this report otherwise reflects, such as different DSH or SNCP UCP distributions among DPHs based on earlier data. All payor revenues may also exclude SNCP UCP claimed with non-hospital provider costs (e.g., county mental health clinics).

5 Analysis of Costs

A key component of this report is to estimate the annual cost of uncompensated care provided by the DPHs in California. For this report, we define uncompensated care as the gap between cost and reimbursement for hospital-related care (including hospital-based physician and professional services) provided to Medicaid beneficiaries, plus the gap between the cost of care and patient payments for hospital-related and non-hospital services 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 the DPHs 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, services reimbursed under both the fee-for-service and the Medicaid managed care programs are included. Costs by hospital for SFY 2013/14 are shown in Figure 7.

Figure 7: Hospital Costs for SFY 2013/2014

Hospital	Medicaid FFS Costs	Medicaid Managed Care Costs	Uninsured Costs	Total Cost for Care of Medicaid and Uninsured Recipients
Alameda Health System	$197,632,693	$158,892,197	$126,454,870	$482,979,760
Arrowhead Regional Medical Center	$172,032,219	$180,506,971	$52,924,717	$405,463,906
Contra Costa Regional Medical Center	$148,823,878	$215,577,878	$58,520,847	$422,922,603
Kern Medical Center	$100,428,331	$89,808,314	$34,286,315	$224,522,959
Los Angeles*	$929,346,441	$913,010,248	$870,357,116	$2,712,713,805
Natividad Medical Center	$56,970,241	$60,879,810	$21,198,762	$139,048,814
Riverside Univ Health System – Med Cntr	$161,565,197	$156,077,517	$70,149,236	$387,791,951
San Francisco General Hospital	$169,234,775	$212,901,334	$175,240,469	$557,376,578
San Joaquin General Hospital	$81,875,217	$71,844,949	$38,572,963	$192,293,129
San Mateo Medical Center	$50,638,899	$79,992,826	$78,943,458	$209,575,184
Santa Clara Valley Medical Center	$380,943,265	$326,152,805	$226,328,852	$933,424,922
UC Davis	$401,067,038	$194,867,249	$89,118,429	$685,052,716
UC Irvine	$177,751,976	$156,948,640	$57,111,532	$391,812,148
UC San Diego	$301,851,433	$162,108,833	$93,818,520	$557,778,786
UC San Francisco	$336,203,841	$208,284,183	$32,058,344	$576,546,368
UC Los Angeles**	$299,731,604	$86,766,540	$27,248,175	$413,746,319
Ventura County Medical Center	$82,544,602	$98,842,396	$69,575,554	$250,962,553
Total	$4,048,641,652	$3,373,462,691	$2,121,908,158	$9,544,012,501

Notes:
* Los Angeles includes,
LA County Harbor/UCLA Medical Center
LA County Olive View Medical Center
LA Cnty Rancho Los Amigos National Rehab Cntr
LA County USC Medical Center
** UC Los Angeles includes,
UCLA - Santa Monica
UCLA – Westwood

Medi-Cal is afforded unique consideration under Federal rules that authorize fFderal matching funds on DSH payments made to California's high DSH DPHs 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 8 shows total cost when including an additional 75 percent of costs applicable for DSH payments.

Figure 8: Hospital Cost Including Claimable DSH Cost

Hospital	Total Cost for Care of Medicaid and Uninsured Recipients	75 Percent of Claimable DSH Costs	Total Cost Including 175% of DSH Costs
Alameda Health System	$482,979,760	$62,457,772	$545,437,532
Arrowhead Regional Medical Center	$405,463,906	$36,308,348	$441,772,255
Contra Costa Regional Medical Center	$422,922,603	$64,351,449	$487,274,052
Kern Medical Center	$224,522,959	$14,782,763	$239,305,722
Los Angeles*	$2,712,713,805	$304,115,890	$3,016,829,695
Natividad Medical Center	$139,048,814	$15,301,275	$154,350,089
Riverside Univ Health System – Med Cntr	$387,791,951	$29,625,711	$417,417,662
San Francisco General Hospital	$557,376,578	$82,431,005	$639,807,583
San Joaquin General Hospital	$192,293,129	$16,114,529	$208,407,659
San Mateo Medical Center	$209,575,184	$22,344,813	$231,919,996
Santa Clara Valley Medical Center	$933,424,922	$131,830,044	$1,065,254,965
UC Davis	$685,052,716	$90,490,422	$775,543,138
UC Irvine	$391,812,148	$88,764,257	$480,576,405
UC San Diego	$557,778,786	$102,580,162	$660,358,949
UC San Francisco	$576,546,368	$0	$576,546,368
UC Los Angeles**	$413,746,319	$0	$413,746,319
Ventura County Medical Center	$250,962,553	$43,860,803	$294,823,356
Total	$9,544,012,501	$1,105,359,243	$10,649,371,744

Notes:
* Los Angeles includes,
LA County Harbor/UCLA Medical Center
LA County Olive View Medical Center
LA Cnty Rancho Los Amigos National Rehab Cntr
LA County USC Medical Center
** UC Los Angeles includes,
UCLA – Santa Monica
UCLA – Westwood

5.1 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 are not formulated in a manner that is 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 Medicare cost report'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[19]. Another source specific to California is the Office of Statewide Health Planning and Development's (OSHPD's) annual financial data, which is based on financial reports from all California hospitals. OSHPD charity data is inapplicable to the scope of this study as it can include both insured and uninsured individuals and is presented purely as gross charges with no conversion to costs. Lastly, IRS Form 990 for non-profit hospitals measures charity and bad debt, 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.

The Health 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 DPHs under Medicaid 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."[20] 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.[21] The second requirement is that counties are required to provide charitable care through their section 17000 requirement (see section 3.1 above). While both of these requirements serve as a minimum for all hospitals, many DPHs often 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."[22] 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

[19] S-10 instructions
[20] Ibid
[21] California Health and Safety Code Section 127400 et seq.
[22] HFMA. Keys to Reporting Uncompensated Care. http://www.hfma.org/Content.aspx?id=7207

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 DPHs' patient population. These individuals served by DPHs 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 their 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, 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 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)** 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 though 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.

Using these guidelines, the California DPHs calculated their charity care and bad debt for SFY 2013/14 with results shown in Figure 9 below.

Figure 9: Hospital Uncompensated Care

DPH	Uninsured Cost	Bad Debt Percentage	Bad Debt Expense Net of Imputed Charity	Imputed Charity Care Percentage	Estimated Bad Debt Expense Likely Eligible for Charity Care	Charity Care Percentage	Charity Care Amount	Estimated Total Charity Care Amount
Alameda Health System	$124,578,267	4.49%	$5,591,316	10.88%	$13,554,115	84.63%	$105,430,587	$118,984,702
Arrowhead Regional Medical Center	$52,425,654	22.55%	$11,824,436	0.00%	$0	77.45%	$40,603,669	$40,603,669
Contra Costa Regional Medical Center	$50,049,553	1.30%	$650,738	18.00%	$9,008,920	80.70%	$40,389,989	$49,398,909
LA County Harbor/UCLA Medical Center	$255,286,537	13.75%	$35,104,497	24.49%	$62,519,673	61.76%	$157,664,965	$220,184,638
Kern Medical Center	$34,116,516	8.00%	$2,729,321	10.06%	$3,432,122	81.94%	$27,955,073	$31,387,195
LA County USC Medical Center	$403,256,600	10.37%	$41,825,035	12.67%	$51,092,611	76.96%	$310,346,279	$361,438,890
Natividad Medical Center	$19,652,779	17.57%	$3,453,722	0.00%	$0	82.43%	$16,199,786	$16,199,786
LA County Olive View Medical Center	$123,068,071	15.70%	$19,318,173	16.46%	$20,257,004	67.84%	$83,489,379	$103,746,383
Riverside Univ Health System – Med Cntr	$69,253,813	11.80%	$8,170,836	0.75%	$519,404	87.45%	$60,562,459	$61,081,863
LA Cnty Rancho Los Amigos National Rehab Cntr	$75,910,301	1.15%	$875,324	1.79%	$1,358,794	97.06%	$73,678,538	$75,037,332
Santa Clara Valley Medical Center	$210,489,913	5.01%	$10,549,728	11.16%	$23,490,674	83.83%	$176,453,694	$199,944,368
San Francisco General Hospital	$170,179,501	7.67%	$13,058,685	3.10%	$5,275,565	89.23%	$151,851,169	$157,126,734
San Joaquin General Hospital	$38,244,219	15.58%	$5,958,401	19.04%	$7,281,699	65.38%	$25,004,070	$32,285,769
San Mateo Medical Center	$77,152,903	10.39%	$8,016,798	0.00%	$0	89.61%	$69,136,716	$69,136,716
UC Davis	$59,309,961	23.40%	$13,878,531	0.00%	$0	76.60%	$45,431,430	$45,431,430
UC Irvine	$52,145,797	14.57%	$7,596,551	33.99%	$17,724,356	51.44%	$26,823,798	$44,548,154
UCLA - Santa Monica	$2,543,510	56.78%	$1,444,306	4.94%	$125,649	38.28%	$973,656	$1,099,305
UCLA - Westwood	$16,227,370	53.71%	$8,715,938	12.60%	$2,044,649	33.69%	$5,467,001	$7,511,650
UC San Diego	$90,762,213	27.48%	$24,939,293	27.48%	$24,941,456	45.04%	$40,879,301	$65,820,757
UC San Francisco	$25,827,321	38.72%	$9,999,570	0.00%	$0	61.28%	$15,826,982	$15,826,982
Ventura County Medical Center	$66,273,990	21.65%	$14,347,408	4.40%	$2,916,056	73.95%	$49,009,616	$51,925,672
Total	$2,016,754,789		$248,048,607		$245,542,747		$1,523,178,157	$1,768,720,904

The scope of charity and bad debt assessment required by the STCs limits this examination to uninsured uncompensated costs, but hospitals do incur other uncompensated costs. First, Medicaid shortfalls are not included within the scope of the assessment. Second, unpaid third party underinsured costs, including copayments and deductibles, are also outside of the study scope. Both of these components could contribute to low-income uncompensated costs in ways not shown in this study, particularly as California DPHs have seen significant increases in Medi-Cal patients and in some patients with insurance products requiring high copays and deductibles.

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 and IGTs, the DPH hospitals do not receive the full economic benefit of amounts claimed by DHCS through claim (base) payments, DSH and SNCP UCP for purposes of claiming FMAP. 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.

As described previously, the primary source of payment and cost data presented in this chapter were the "Interim Hospital Payment Rate Workbooks" (referred to as the "P14 reports") which are created annually by each DPH and are used for a variety of purposes, most notably identification of hospital and non-hospital costs for the DSH and UCP programs. The reports are also used for calculating CPEs for medical services provided to the Medi-Cal population.

In this chapter, we use the data from the SFY 2013/14 P14 reports to compare Medicaid payments to hospital costs in three different ways,

1) "Gross" – Including actual cost
2) "Gross with DSH rules" – Actual cost, but increased by 75 percent for qualifying DSH applicable costs
3) "Net" – Including actual cost and considering DPH 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.

All of the tables listing DPHs in this chapter group the Los Angeles County DPHs into two systems. This is consistent with the way these facilties are normally reported. The two systems are:

- Los Angeles, including,
    - LA County Harbor/UCLA Medical Center
    - LA County Olive View Medical Center
    - LA Cnty Rancho Los Amigos National Rehab Cntr
    - LA County USC Medical Center

- UC Los Angeles, including,
  - UCLA – Santa Monica
  - UCLA – Westwood

6.1 Estimate of Medicaid and Uninsured Utilization by the DPHs

To illustrate the DPHs dependence on Medicaid funding, we analyzed Medicaid utilization. Using inpatient days as the measure, we estimated the percentage of each DPH's services that are utilized by Medicaid and the uninsured. These results in shown in Figure 10.

Figure 10: Estimate of Medicaid and Uninsured Utilization by DPH.

Hospital	Overall Inpatient Days	Medicaid Inpatient Days	Uninsured Days	Total Medicaid and Uninsured Days	Estimate of DPH Business from Medicaid and Uninsured Recipients
Alameda Health System	54,818	36,530	8,625	45,155	82%
Arrowhead Regional Medical Center	103,099	57,953	9,655	67,608	66%
Contra Costa Regional Medical Center	38,359	21,472	2,960	24,432	64%
Kern Medical Center	50,812	32,107	3,592	35,699	70%
Los Angeles*	393,352	268,274	61,937	330,211	84%
Natividad Medical Center	38,312	22,565	1,159	23,724	62%
Riverside Univ Health System – Med Cntr	118,465	49,625	7,456	57,081	48%
San Francisco General Hospital	74,414	43,904	6,574	50,478	68%
San Joaquin General Hospital	40,590	28,256	2,783	31,039	76%
San Mateo Medical Center	11,052	4,931	2,391	7,322	66%
Santa Clara Valley Medical Center	108,812	54,204	11,168	65,372	60%
UC Davis	176,576	70,206	14,166	84,372	48%
UC Irvine	97,125	39,855	5,171	45,026	46%
UC San Diego	156,405	55,602	14,876	70,478	45%
UC San Francisco	182,750	63,519	3,494	67,013	37%
UC Los Angeles**	248,472	58,144	2,057	60,201	24%
Ventura County Medical Center	42,903	22,899	5,240	28,139	66%
Total	1,936,316	930,046	163,304	1,093,350	56%

Notes:

1) Medicaid Inpatient Days obtained from CMS 2552-10 cost report filings (Worksheet S-2 Part I Line 24 and 25 Columns 1, 2 and 5). Overall Inpatient Days obtained from CMS 2552-10 cost report filings (Worksheet S-3 Part I Lines 14 and 17 Column 8). Data is from cost reports ending during SFY 2014.
2) Uninsured patient days obtained from P14 reports submitted by hospitals.

As expected, the values shown in Figure 10 above indicate that Medicaid recipients and the uninsured comprise a relatively high percentage of the patient mix for the DPHs in California. Over half of the DPHs have Medicaid and uninsured utilization above 64 percent and average

Medicaid and uninsured utilization for all the DPHs is 56 percent. Clearly, the DPHs are heavily dependent on Medi-Cal reimbursement levels.

Attachment F of the BTR Demonstration Waiver (Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming) requires the use of a hospitals Medi-Cal 2552-96 cost report for the development of cost per diems for inpatient routine services and cost-to-charge ratios for inpatient and outpatient ancillary services. These cost per diems and cost-to-charge ratios are necessary for the proper apportionment of a hospitals cost. In addition, the Funding and Reimbursement Protocol requires the State to "develop/identify a separate cost reporting tool and receive CMS approval for such cost reporting prior to claims for Federal matching funds" for non-hospital based costs which might be claimed.[23] DHCS and CAPH worked together to develop the "Interim Hospital Payment Rate Workbooks" (referred to as the "P14 reports") which are created annually by each DPH and are used for a variety of purposes, most notably identification of hospital cost for the DSH and SNCP programs. The reports are also used for calculating CPEs for medical services provided to the Medi-Cal population and our the primary source of payment and cost data presented in this chapter.

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 annual hospital Upper Payment Limit (UPL) analyses. 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 or an IGT. Also, the payment amounts include both claim payments and all supplemental payments intended to compensate the DPHs 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. (DSRIP payments are included in Section 6.3.) Finally, unlike UPL analyses, payment and cost for both the fee-for-service and managed care programs as well 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 is not included.

The first three figures in this section show payment to cost comparisons separately for fee-for-service, managed care, and the uninsured. Finally a fourth figure shows an overall comparison of payment to cost when combining the values from the three categories.

[23] California Bridge To Reform Demonstration Waiver Attachment F pages 81.

Figure 11 below contains payments and costs incurred by the DPHs in providing care to recipients and/or services covered by Medicaid fee-for-service. These are the services and payments authorized by the FFS SPAs.

Figure 11: Payment to Cost Comparison for Services Reimbursed by the Medi-Cal Fee-for-Service Program

DPH	Medicaid FFS					
	Claim Payments	Supplemental Payments	DSH Payments Applicable to FFS	Total Payments	Cost	Pay-to-Cost Ratio
Alameda Health System	$169,655,764	$29,573,671	$7,990,402	$207,219,837	$197,632,693	105%
Arrowhead Regional Medical Center	$161,245,566	$17,933,085	$0	$179,178,651	$172,032,219	104%
Contra Costa Regional Medical Center	$137,211,577	$11,069,508	$27,673,393	$175,954,478	$148,823,878	118%
Kern Medical Center	$94,031,862	$13,576,606	$0	$107,608,468	$100,428,331	107%
Los Angeles*	$840,724,239	$94,067,175	$0	$934,791,414	$929,346,441	101%
Natividad Medical Center	$52,265,786	$7,378,026	$0	$59,643,812	$56,970,241	105%
Riverside Univ Health System – Med Cntr	$143,500,080	$23,310,221	$0	$166,810,300	$161,565,197	103%
San Francisco General Hospital	$168,909,540	$13,510,921	$10,493,665	$192,914,126	$169,234,775	114%
San Joaquin General Hospital	$81,107,436	$8,639,928	$0	$89,747,363	$81,875,217	110%
San Mateo Medical Center	$41,191,091	$6,229,094	$0	$47,420,185	$50,638,899	94%
Santa Clara Valley Medical Center	$320,081,691	$47,223,744	$30,504,551	$397,809,987	$380,943,265	104%
UC Davis	$412,810,506	$40,738,913	$39,214,065	$492,763,484	$401,067,038	123%
UC Irvine	$164,028,489	$20,549,691	$0	$184,578,180	$177,751,976	104%
UC San Diego	$245,214,434	$50,037,982	$37,274,929	$332,527,345	$301,851,433	110%
UC San Francisco	$350,196,710	$32,585,777	$0	$382,782,487	$336,203,841	114%
UC Los Angeles**	$267,627,663	$31,304,254	$0	$298,931,917	$299,731,604	100%
Ventura County Medical Center	$70,898,552	$9,258,704	$4,491,971	$84,649,227	$82,544,602	103%
Total	$3,720,700,987	$456,987,300	$157,642,975	$4,335,331,262	$4,048,641,652	107%

Figure 12, below, contains payments and costs incurred by the DPHs in providing care to recipients and/or services covered by Medicaid managed care organizations (MCOs). Based on Medicaid payments, approximately 46 percent of Medicaid services provided at the California DPHs are paid by MCOs.

Figure 12: Payment to Cost Comparison for Services Reimbursed by the Medi-Cal Managed Care Program

	Medicaid Managed Care				
DPH	Claim Payments	DSH Payments Applicable to Managed Care	Total Payments	Cost	Pay-to-Cost Ratio
Alameda Health System	$175,590,478	$9,171,061	$184,761,539	$158,892,197	116%
Arrowhead Regional Medical Center	$164,178,048	$40,013,835	$204,191,883	$180,506,971	113%
Contra Costa Regional Medical Center	$173,005,591	$67,340,760	$240,346,351	$215,577,878	111%
Kern Medical Center	$100,510,910	$0	$100,510,910	$89,808,314	112%
Los Angeles*	$1,015,698,453	$0	$1,015,698,453	$913,010,248	111%
Natividad Medical Center	$48,810,978	$23,843,767	$72,654,746	$60,879,810	119%
Riverside Univ Health System – Med Cntr	$158,905,678	$0	$158,905,678	$156,077,517	102%
San Francisco General Hospital	$182,217,848	$27,506,244	$209,724,092	$212,901,334	99%
San Joaquin General Hospital	$61,832,029	$8,198,225	$70,030,253	$71,844,949	97%
San Mateo Medical Center	$91,080,952	$0	$91,080,952	$79,992,826	114%
Santa Clara Valley Medical Center	$311,338,701	$72,416,598	$383,755,298	$326,152,805	118%
UC Davis	$140,595,063	$67,968,626	$208,563,688	$194,867,249	107%
UC Irvine	$84,747,490	$106,957,124	$191,704,614	$156,948,640	122%
UC San Diego	$113,217,822	$36,923,394	$150,141,216	$162,108,833	93%
UC San Francisco	$146,427,016	$30,012,230	$176,439,246	$208,284,183	85%
UC Los Angeles**	$104,966,293	$0	$104,966,293	$86,766,540	121%
Ventura County Medical Center	$72,945,697	$48,138,243	$121,083,940	$98,842,396	123%
Total	$3,146,069,046	$538,490,106	$3,684,559,152	$3,373,462,691	109%

Figure 13, below, contains payments and costs incurred by the DPHs in providing care to recipients who did not have insurance, or whose insurance did not cover the services provided. Payments made by Medicaid through the DSH and SNCP programs are included in this table, as they are intended primarily to compensate for costs incurred by hospitals in treatment of the uninsured.

Figure 13: Payment to Cost Comparison for Services Provided to the Uninsured

DPH	Uninsured					
	DSH Payments Not Applied to FFS or MC	SNCP Payments	Other Payments	Total Payments	Cost	Pay-to-Cost Ratio
Alameda Health System	$106,723,373	$39,381,303	$1,876,603	$147,981,280	$126,454,870	117%
Arrowhead Regional Medical Center	$51,258,123	$12,067,707	$14,878,645	$78,204,475	$52,924,717	148%
Contra Costa Regional Medical Center	$24,960,439	$14,088,132	$14,283,569	$53,332,140	$58,520,847	91%
Kern Medical Center	$63,542,706	$10,826,150	$169,799	$74,538,655	$34,286,315	217%
Los Angeles*	$613,335,516	$269,117,177	$17,986,094	$900,438,787	$870,357,116	103%
Natividad Medical Center	$10,896,373	$5,470,467	$4,723,635	$21,090,475	$21,198,762	99%
Riverside Univ Health System – Med Cntr	$79,074,579	$19,827,586	$7,823,572	$106,725,737	$70,149,236	152%
San Francisco General Hospital	$120,058,801	$53,853,239	$5,060,968	$178,973,008	$175,240,469	102%
San Joaquin General Hospital	$27,836,344	$10,915,537	$4,038,623	$42,790,504	$38,572,963	111%
San Mateo Medical Center	$41,575,258	$23,959,070	$5,071,394	$70,605,722	$78,943,458	89%
Santa Clara Valley Medical Center	$152,951,237	$64,585,215	$23,072,738	$240,609,190	$226,328,852	106%
UC Davis	$67,744,770	$16,780,922	$35,958,593	$120,484,285	$89,118,429	135%
UC Irvine	$58,338,250	$18,611,957	$4,965,735	$81,915,943	$57,111,532	143%
UC San Diego	$122,557,664	$28,479,795	$4,833,307	$155,870,765	$93,818,520	166%
UC San Francisco	$22,441,254	$8,179,513	$6,231,023	$36,851,790	$32,058,344	115%
UC Los Angeles**	$15,426,505	$5,942,435	$8,477,294	$29,846,233	$27,248,175	110%
Ventura County Medical Center	$37,382,044	$19,913,797	$6,661,124	$63,956,965	$69,575,554	92%
Total	$1,616,103,236	$622,000,000	$166,112,716	$2,404,215,953	$2,121,908,158	113%

Figure 14, below, combines the values from the three 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 to not include any offset for the local contributions to the non-Federal share of payments (i.e., through CPEs or IGTs).

Figure 14: Overall Payment to Cost Comparison for Medi-Cal Reimbursement to the DPHs

DPH	Payment	Cost	Pay-to-Cost Ratio
Alameda Health System	$539,962,656	$482,979,760	112%
Arrowhead Regional Medical Center	$461,575,008	$405,463,906	114%
Contra Costa Regional Medical Center	$469,632,969	$422,922,603	111%
Kern Medical Center	$282,658,033	$224,522,959	126%
Los Angeles*	$2,850,928,654	$2,712,713,805	105%
Natividad Medical Center	$153,389,033	$139,048,814	110%
Riverside Univ Health System – Med Cntr	$432,441,715	$387,791,951	112%
San Francisco General Hospital	$581,611,226	$557,376,578	104%
San Joaquin General Hospital	$202,568,121	$192,293,129	105%
San Mateo Medical Center	$209,106,858	$209,575,184	100%
Santa Clara Valley Medical Center	$1,022,174,475	$933,424,922	110%
UC Davis	$821,811,457	$685,052,716	120%
UC Irvine	$458,198,736	$391,812,148	117%
UC San Diego	$638,539,326	$557,778,786	114%
UC San Francisco	$596,073,522	$576,546,368	103%
UC Los Angeles**	$433,744,443	$413,746,319	105%
Ventura County Medical Center	$269,690,133	$250,962,553	107%
Total	$10,424,106,367	$9,544,012,501	109%

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

Payments included in the figure presented in this section 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. To calculate the additional cost, costs from the P14 reports that were categorized as "DSH Only" or "DSH and SNCP" were summed and then multiplied by 0.75.

Figure 15: Overall Payment to Cost Comparison when Including an Additional 75 Percent of DSH Claimable Costs

DPH	Payment	Cost	75% of Claimable DSH Cost	Total Cost with 175% of DSH	Pay-to-Cost Ratio with 175% of DSH
Alameda Health System	$539,962,656	$482,979,760	$62,457,772	$545,437,532	99%
Arrowhead Regional Medical Center	$461,575,008	$405,463,906	$36,308,348	$441,772,255	104%
Contra Costa Regional Medical Center	$469,632,969	$422,922,603	$64,351,449	$487,274,052	96%
Kern Medical Center	$282,658,033	$224,522,959	$14,782,763	$239,305,722	118%
Los Angeles*	$2,850,928,654	$2,712,713,805	$304,115,890	$3,016,829,695	95%
Natividad Medical Center	$153,389,033	$139,048,814	$15,301,275	$154,350,089	99%
Riverside Univ Health System – Med Cntr	$432,441,715	$387,791,951	$29,625,711	$417,417,662	104%
San Francisco General Hospital	$581,611,226	$557,376,578	$82,431,005	$639,807,583	91%
San Joaquin General Hospital	$202,568,121	$192,293,129	$16,114,529	$208,407,659	97%
San Mateo Medical Center	$209,106,858	$209,575,184	$22,344,813	$231,919,996	90%
Santa Clara Valley Medical Center	$1,022,174,475	$933,424,922	$131,830,044	$1,065,254,965	96%
UC Davis	$821,811,457	$685,052,716	$90,490,422	$775,543,138	106%
UC Irvine	$458,198,736	$391,812,148	$88,764,257	$480,576,405	95%
UC San Diego	$638,539,326	$557,778,786	$102,580,162	$660,358,949	97%
UC San Francisco	$596,073,522	$576,546,368	$0	$576,546,368	103%
UC Los Angeles**	$433,744,443	$413,746,319	$0	$413,746,319	105%
Ventura County Medical Center	$269,690,133	$250,962,553	$43,860,803	$294,823,356	91%
Total	$10,424,106,367	$9,544,012,501	$1,105,359,243	$10,649,371,744	98%

6.4 "Net" – Payment-to-Cost Comparison with Consideration of DPH Funding of Medicaid Non-Federal Share

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

Figure 16: Overall Payment to Cost Comparison Net of Local Funding of Medicaid Reimbursements

DPH	Payment	CPE Funding of the Program	IGT Funding for the Program	Payment Reduced by CPEs and IGTs	Cost	Pay-to-Cost Ratio
Alameda Health System	$539,962,656	$139,159,856	$64,333,789	$336,469,011	$482,979,760	70%
Arrowhead Regional Medical Center	$461,575,008	$124,439,429	$34,652,254	$302,483,325	$405,463,906	75%
Contra Costa Regional Medical Center	$469,632,969	$99,408,150	$48,131,065	$322,093,755	$422,922,603	76%
Kern Medical Center	$282,658,033	$84,298,789	$22,983,108	$175,376,136	$224,522,959	78%
Los Angeles*	$2,850,928,654	$805,617,701	$313,313,535	$1,731,997,418	$2,712,713,805	64%
Natividad Medical Center	$153,389,033	$36,168,291	$9,644,842	$107,575,900	$139,048,814	77%
Riverside Univ Health System – Med Cntr	$432,441,715	$129,586,890	$34,441,739	$268,413,087	$387,791,951	69%
San Francisco General Hospital	$581,611,226	$136,768,852	$76,158,455	$368,683,918	$557,376,578	66%
San Joaquin General Hospital	$202,568,121	$47,689,937	$20,392,906	$134,485,278	$192,293,129	70%
San Mateo Medical Center	$209,106,858	$43,712,477	$23,766,182	$141,628,199	$209,575,184	68%
Santa Clara Valley Medical Center	$1,022,174,475	$238,951,649	$101,213,490	$682,009,336	$933,424,922	73%
UC Davis	$821,811,457	$162,588,898	$69,809,793	$589,412,767	$685,052,716	86%
UC Irvine	$458,198,736	$99,078,871	$46,695,457	$312,424,407	$391,812,148	80%
UC San Diego	$638,539,326	$154,652,311	$73,212,673	$410,674,343	$557,778,786	74%
UC San Francisco	$596,073,522	$132,237,750	$29,149,584	$434,686,188	$576,546,368	75%
UC Los Angeles**	$433,744,443	$111,514,815	$41,065,473	$281,164,155	$413,746,319	68%
Ventura County Medical Center	$269,690,133	$76,710,288	$22,129,964	$170,849,881	$250,962,553	68%
Total	$10,424,106,367	$2,622,584,955	$1,031,094,308	$6,770,427,104	$9,544,012,501	71%

6.5 Considerations for the Future

This section describes and addresses potential changes in Federal rules and methods that may significantly affect funding for DPHs 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 the California DPHs was $2.3 billion, resulting in a sizable $1.15 billion in net reimbursements to the 21 DPHs.

Under the ACA the Federal DSH allotment reductions were originally scheduled to begin in Federal Fiscal Year (FFY) 2014. Through several signed laws, the latest being the Medicare Access and CHIP Reauthorization Act of 2015 (PL 114-10), CMS will begin reducing the Federal Medicaid DSH allotments beginning in 2018. The decision to reduce the DSH allotment is based on the probable decrease in uncompensated care resulting from the expected increase in the number of individuals with insurance due to Medicaid expansion and the availability of subsidized coverage in the new health insurance marketplace. 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:

- 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, we estimated the potential impact of the reductions based on the 2014 planned methodology. From that analysis, it appears likely that the upcoming reductions will have a significant effect on California's safety net hospitals. We anticipate that there may be a significant reduction in DSH funding based on the significant decrease in California's uninsured population with the expansion of Medicaid, and the resulting decrease in uncompensated care. Both of these factors were key components of the 2014 CMS reduction methodology. We estimate that California may lose over $130 million of the Federal DSH allotment in FY 2018. This estimate is based on the assumption that California will receive the same percentage of national DSH reduction in 2018 as had been proposed for 2014 at 6.52 percent, assessed against the $2 billion reduction scheduled in FY 2018. [24] As the total DSH allotment reduction increases over time, California will see a much greater reduction, potentially growing to over $520 million by 2025.

This reduction will significantly affect the amount of payments available to safety net hospitals. Based on the FY 2015 Preliminary DSH Allotment of almost $1.2 billion, there will be approximately $2.4 billion in total DSH payments available for DSH hospitals in California, including the non-Federal share. We project that as a result of the planned reduction, the total DSH payments available could drop to $2.2 billion in FY 2018, and to $1.7 billion in FY 2025.

The DPH hospitals receive the majority of California's DSH allotment. Based on a review of the allotment percentage from 2010-2011 through 2013-2014, the DPH hospitals portion of the allotment has decreased. Using the percentage decrease between 2012-2013 and 2013-2014, the potential DSH reduction related to the DPH hospitals could potentially decrease total DSH payments in FY 2018 by $256 million, and by $1.008 billion in FY 2025. The net reduction to DPH hospitals is estimated at $2.73 billion during the reduction period of FY 2018 through FY 2025.

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. And 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

[24] Medicaid Program; State Disproportionate Share Hospital Allotment Reductions – Proposed Rule. May 15, 2013. "The final rule is substantively the same as the method in the proposed rule," Medicaid Program; State Disproportionate Share Hospital Allotment Reductions – Final Rule. September 18, 2013. Page 57309.

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, the amount of non-Federal share contributed by the DPHs and their local governments will in the near future increase above the amounts required in the first six months of calendar year 2014.

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.[25] Several factors contribute to the ongoing need for supplemental funding streams to provide financial assistance for all safety net providers, and DPHs in particular. These 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, 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.[26] In this chapter we review the 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 described above 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. Primarily as a result of Medicaid expansion through the ACA, California's uninsured population has recently dropped to roughly 10 percent, consistent with the nationwide average.[27] (However, California's uninsured population is higher than the average among states that have expanded Medicaid under the ACA.) Although the percentage of uninsured has decreased, California still has the second largest uninsured population in the nation at almost 4 million people.

Figure 17: Health Insurance Coverage of the Total Population – 2014[28]

Location	Employer	Non-Group	Medicaid	Medicare	Other Public	Uninsured	Total
United States	49%	6%	19%	13%	2%	10%	100%
California	46%	7%	25%	10%	2%	10%	100%
	17,703,700	2,778,800	9,618,800	4,049,000	634,400	3,916,700	38,701,300

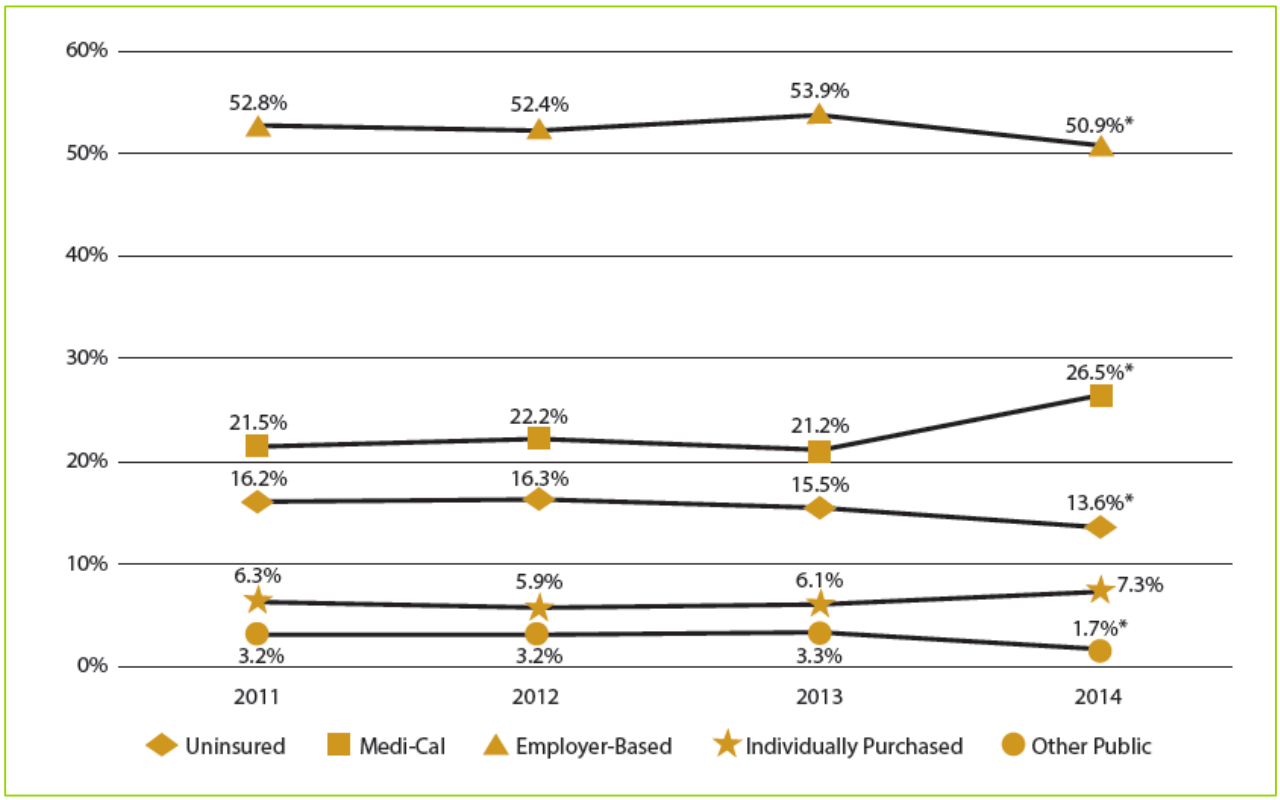
Source: Kaiser Family Foundation

Health coverage expansion through the ACA has also contributed to the decline in the number of uninsured individuals. Figure 18 below illustrates the change in percentage of uninsured individuals between the ages of 0 and 64 between 2011 and 2014 in California.[29] It also shows

[25] Lewin, M.E. et al. 2000. America's Health Care Safety Net: Intact but Endangered, Washington: National Academies Press.
[26] U.S. Census Bureau, July 1, 2015 Population estimate. http://www.census.gov/quickfacts/table/PST045215/06,00
[27] 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
[28] Kaiser Family Foundation, Health Facts, 2015. http://kff.org/other/state-indicator/total-population/
[29] 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

changes in insurance coverage levels for specific payer types. As shown in the figure, there was a slight decline in the percentage of uninsured nonelderly persons between 2012 and 2013 of 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.[30] The level of uninsured nonelderly persons declined again in 2014 by another 1.9 percent, which was the first year of ACA implementation.

Figure 18: Health Insurance Coverage Among Nonelderly Persons, Ages 0-64, 2011-2014



Source: UCLA Center for Health Policy Research

According to the UCLA Center for Health Policy Research findings, in 2014 approximately 13.6 percent of the population in California remained uninsured. A portion of this population may be eligible for Medi-Cal enrollment, however, a portion of this population may remain uninsured for various reasons. For example, as indicated in Figure 19 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 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, which creates gaps or interruptions in healthcare coverage. This has long been reported as a problem adversely affecting access, continuity of care, ambulatory care use

[30] Covered California Open Enrollment 2013-2014, Lessons Learned, October 2014. https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf

and health care costs. During non-covered periods, these individuals tend to rely on the safety net providers for services. Loss of Medicaid enrollment can 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.

Figure 19: Reasons for Not Enrolling in Medi-Cal[31]

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

However, all public health care systems are participating in the Hospital Presumptive Eligibility program, so individuals likely eligible for Medi-Cal that seeks services at their facilities are able to gain immediate access to full-scope Medi-Cal benefits on the basis of preliminary, self-reported information about their eligibility. For individuals determined eligible, they receive immediate access to temporary benefits, providing time is needed to formally apply for the Medi-Cal program without delaying care, and may receive additional assistance with completing the Medi-Cal application.

Contributing factors to the number of uninsured in California include poverty, unemployment, homelessness and immigration.

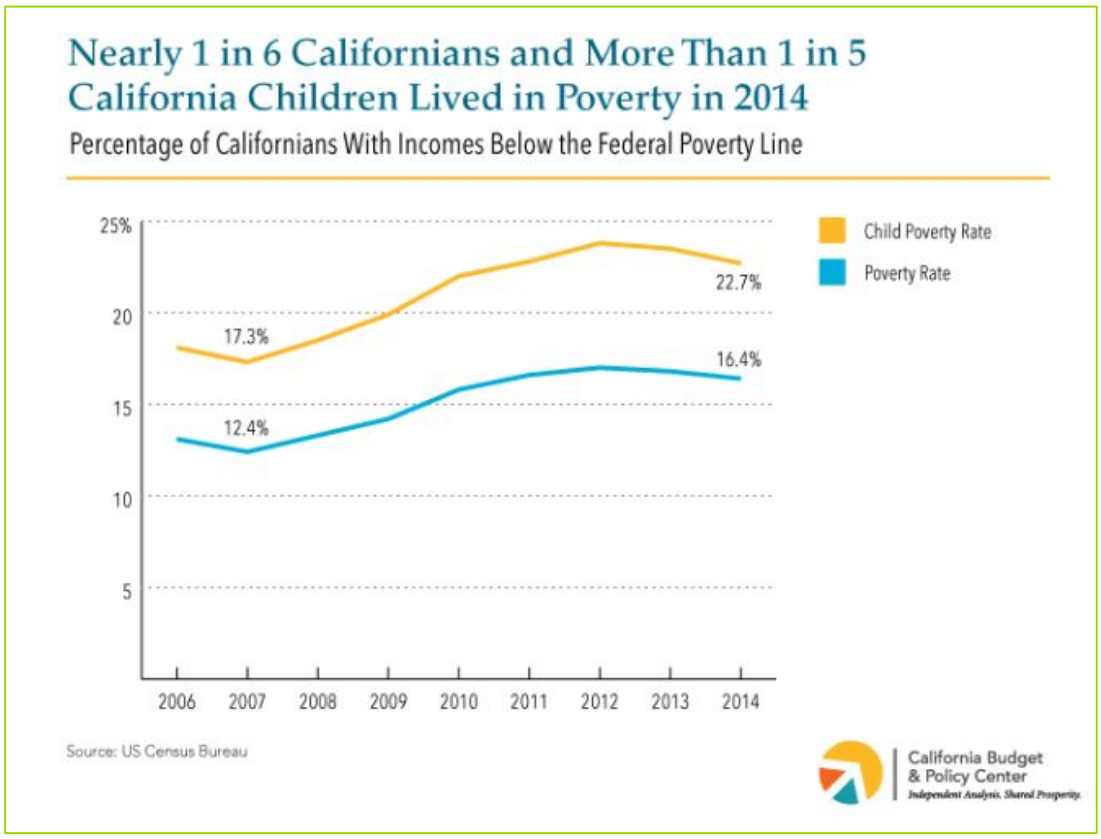
7.1.1 Poverty

A significant factor contributing to the health safety net population is the number of Californians living in poverty. According to the California Budget and Policy Center, approximately one in six Californians lived in poverty in 2014. This equates to approximately 16.4 percent of the population in 2014. The poverty level in California for children is even higher with one in five children living in poverty in 2014, or approximately 22.7 percent of children in the State. After a period of steadily rising poverty levels from 2007 through 2012, the percentage of California's population living in poverty declined in 2014 from 2013 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 2014 levels.[32]

[31] 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/
[32] California Budget and Policy Center, http://calbudgetcenter.org/resources/new-poverty-figures-underscore-that-california-should-do-more-to-ensure-the-states-economy-works-for-everyone/.

Figure 20 below shows the changes in the percentage of Californians living in poverty between the period of 2006 and 2014.[33]

Figure 20: Poverty Levels in California – 2006 to 2014



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, 23.4 percent of Californians lived in poverty in 2011-2013. The SPM rate for the United States as a whole was 15.9 percent. Moreover, California had the highest SPM poverty rate of any state, as was also the case the previous year. The tables below compare the SPM between California and the United States for the three-year periods of 2011-2013 and 2010-2012.[34]

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

[33] Ibid.
[34] 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

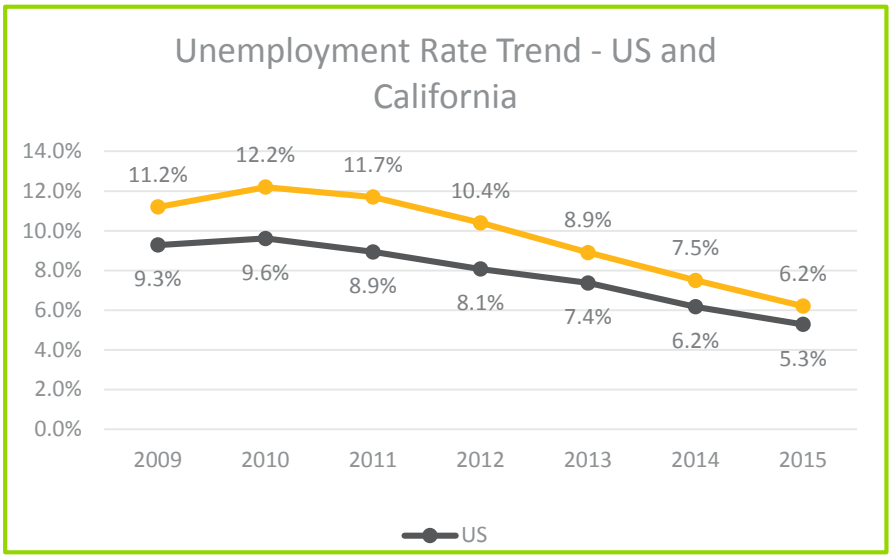
7.1.2 Unemployment

California's high rate of poverty is partially caused by a high 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.[35] It is important to consider how the unemployment rate in California has fluctuated in recent years. 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 2015, the unemployment rate in California had decreased to 6.2 percent which is nearly half of the unemployment level in 2010.[36]

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 the national unemployment rate 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 also declined annually since. In 2015, the average national unemployment rate was 5.3 percent. By comparing California's unemployment rate and the average national unemployment rate for 2015, it appears that California's unemployment rate exceeds the national average by approximately 0.9 percent. [37]

Figure 21 below shows the trend in the United States unemployment rate as compared with California during the period from 2009 to 2015.

Figure 21: US and California Unemployment Trend, 2009 – 2015



Source: Bureau of Labor Statistics and California Employment Development Department

[35] 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

[36] CA Employment Development Department, Labor Market Information, California Labor Market Top Statistics, http://www.labormarketinfo.edd.ca.gov/

[37] United States Department of Labor, Bureau of Labor Statistics, http://data.bls.gov/timeseries/LNS14000000

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."[38] 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.[39] That being the case, the health related costs for this group are often much higher than their absolute numbers might suggest.

On a single night in January 2015, California accounted for 26 percent of the nation's homeless individuals.[40] A report published by the U.S. Department of Housing and Urban Development (HUD) in November of 2015 for Congress states that since 2007, the number of homeless individuals has declined in twenty-eight states including California. Although the number of homeless individuals increased between 2014 and 2015, California experienced the largest decline of these twenty-eight states during the full reporting period with 17,796 fewer homeless (16 percent) in 2015 compared to 2007 levels.[41] Nevertheless, California continues to be the state with the highest rate of homelessness, and the highest number of homeless people, particularly individuals not in families.[42]

Figure 22 below from the 2015 HUD report to Congress shows the states with the largest changes in homeless populations between the years 2007 and 2015. In addition, the figure includes a snapshot of the change in the homeless population for these states between 2014 and 2015.

Figure 22: States With Largest Changes in Homeless Individuals, 2007 – 2015

EXHIBIT 2.8: Largest Changes in Homeless Individuals
By State, 2007–2015

	2014–2015		2007–2015	
Largest Increases				
NEW YORK	3,492	10.7%	NEW YORK	8,079 / 28.8%
CALIFORNIA	2,391	2.6%	NEVADA	1,381 / 21.3%
OREGON	1,473	18.4%	HAWAII	972 / 29.2%
WASHINGTON	1,136	10.0%	OHIO	695 / 10.1%
ILLINOIS	802	10.9%	WISCONSIN	589 / 24.5%
Largest Decreases*				
TEXAS	-2,912	-15.2%	CALIFORNIA	-17,796 / -16.0%
GEORGIA	-2,701	-21.8%	TEXAS	-10,041 / -38.2%
FLORIDA	-2,405	-8.4%	FLORIDA	-6,715 / -20.3%
MICHIGAN	-989	-13.1%	ARIZONA	-3,472 / -34.7%
MISSOURI	-873	-20.3%	GEORGIA	-2,819 / -22.5%

* Due to methodological changes, Michigan was excluded from the list of largest decreases from 2007-2015.

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

[38] 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
[39] Ibid.
[40] 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
[41] Ibid.
[42] Ibid.

Across the country, more than one in five homeless people was located in either New York City (75,323 people or 14%) or Los Angeles (41,174 people or 7%).[43] As illustrated in Figure 23, the geographic distribution of homelessness in California is concentrated in urban areas, although it is pervasive across the State.

Figure 23: 2015 Point in Time Counts by Continuum of Care[44]

CoC Number	CoC Name	Total Homeless	Homeless Individuals	Homeless People in Families	Chronically Homeless
CA-601	San Diego City and County	8,742	6,761	1,981	1,689
CA-500	San Jose/Santa Clara City & County	6,556	5,648	908	2,207
CA-502	Oakland/Alameda County	4,040	3,055	985	750
CA-506	Salinas/Monterey, San Benito Counties	2,959	2,506	453	598
CA-608	Riverside City & County	2,372	2,066	306	532
CA-609	San Bernardino City & County	2,149	1,524	625	564
CA-508	Watsonville/Santa Cruz City & County	1,964	1,483	481	582
CA-514	Fresno/Madera County	1,722	1,410	312	368
CA-614	San Luis Obispo County	1,515	1,157	358	415
CA-611	Oxnard/San Buenaventura/Ventura County	1,417	1,084	333	523
CA-507	Marin County	1,318	1,115	203	281
CA-518	Vallejo/Solano County	1,082	968	114	227
CA-509	Mendocino County	947	818	129	112
CA-513	Visalia, Kings, Tulare Counties	862	725	137	349
CA-524	Yuba City & County/Sutter County	716	420	296	198
CA-516	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties	591	504	87	298

[43] Ibid.
[44] 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-613	Imperial County	554	432	122	179
CA-521	Davis/Woodland/Yolo County	498	362	136	87
CA-526	Amador, Calaveras, Tuolumne and Mariposa Counties	430	337	93	101
CA-529	Lake County	315	211	104	0
CA-517	Napa City & County	293	226	67	132
CA-525	El Dorado County	269	157	112	104
CA-612	Glendale	208	133	75	69
CA-527	Tehama County	138	115	23	34
CA-523	Colusa, Glenn, Trinity Counties	136	80	56	35
CA-615	Inyo, Mono, Alpine Counties	53	46	7	19
	Total	**115,738**	**93,156**	**22,582**	**32,227**

7.1.4 Immigrant Population

California's population is not only large but is also very diverse. California has more immigrants than any other state in the nation at over 10 million.[45] Half of California's immigrants are non-citizens, representing 24 percent of non-citizens nationally.[46] While many non-citizens may be insured or eligible for Medi-Cal, a large percentage are currently uninsured. As a result of cultural and language barriers these populations have difficulty identifying and accessing resources to obtain health coverage and may rely heavily on safety net providers for health care services.

Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants and legal immigrants residing in the U.S. for less than five years are ineligible for federally funded health coverage. Although non-citizens represent only seven percent of the population nationwide, non-citizens made up 21 percent of the uninsured population in 2014.[47] Within the large immigrant population in California, there are a number of unauthorized and undocumented. The Migration Policy Institute compiled information from a number of sources to produce a state-by-state profile of characteristics related to this population. Selected economic and demographic statistics for California are displayed in Figure 24. According to the study, there were about 3 million unauthorized immigrants in California, under eight percent of the total population. Of these, 58 percent were uninsured, and 66 percent were below 200 percent FPL.[48]

[45] 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

[46] The term "non-citizen" refers to individuals who are not citizens or nationals of the U.S.

[47] Kaiser Family Foundation. Summary: Key Facts about the Uninsured Population. October 5, 2015. http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

[48] Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2013 American Community Survey (ACS), 2009-2013 ACS pooled, and the 2008 Survey of Income and Program Participation (SIPP) by James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute. http://www.migrationpolicy.org/programs/us-immigration-policy-program-data-hub/unauthorized-immigrant-population-profiles

Figure 24: Profile of the Unauthorized Population: California[49]

Demographics	Estimate	% of Total
Unauthorized Population	3,034,000	100%
Family Income		
Below 50% of the poverty level	389,000	13%
50-99% of the poverty level	565,000	19%
100-149% of the poverty level	585,000	19%
150-199% of the poverty level	467,000	15%
At or above 200% of the poverty level	1,028,000	34%
Access to Health Insurance		
Uninsured	1,774,000	58%
Age Profile		
Under 16	214,000	7%
16 to 24	459,000	15%
25 to 34	858,000	28%
35 to 44	794,000	26%
45 to 54	436,000	14%
55 and over	272,000	9%

Source: Migration Policy Institute analysis of U.S. Census Bureau data

The number of uninsured in this population, while significant, is less than half of the overall uninsured for the State, per Figure 17 above. In summary, there is no one factor that accounts for the remaining uninsured population in California. Rather, it is a combination of all the factors discussed here.

7.2 Access to Health Care Services

Consistent with the STC requirements in California's Medi-Cal 2020 Demonstration Waiver, the State 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.[50] 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 Department of Health Care Services/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.

To meet this requirement, the State is contracting with its External Quality Review Organization (EQRO), Health Services Advisory Group, to complete the Assessment.[51] 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

[49] Ibid.
[50] Medi-Cal 2020 Waiver Special Terms & Conditions, STCs 65-69 on pages 45 and 46, Medi-Cal 2020 Waiver Special Terms & Conditions
[51] 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.

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, with the final report expected in June 2018.

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.

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.[52] California has established distinct delivery models for MCOs to deliver care to Medi-Cal beneficiaries, which are administered by the counties. In addition to the traditional FFS program, six managed Medicaid models exist in California: County Organized Health Systems (COHS), Geographic Managed Care (GMC), theTwo-Plan Model, the Regional model, Imperial, and San Benito. Each county has implemented one of these six models:[53]

- COHS – An ihealth plan created by the County of Board Supervisors 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 – 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 – 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 – A group of 18 counties in which 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.

Unlike other states that used SNCP UCP funding to support Medi-Cal shortfalls, California's SNCP UCP Pool is only for uninsured services. Although managed care costs are reported on the P-14 by the providers, these costs are used only for DSH calculations, and not used for the purpose of determining SNCP funding, nor the calculation of the UPL. That being the case, managed care has no impact related to the SNCP and is outside the scope of this analysis and report.

[52] Kaiser Family Foundation. State Health Facts: Total Medicaid Managed Care Enrollment. 2013. http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/

[53] 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 Conclusion

Consistent with the requirements of the 2020 Demonstration Waiver this report reviewed the level of uncompensated care at the 21 DPH facilities in the State of California, all of which are safety net hospitals. The report also reviewed the joint efforts by the California DHCS and CMS to reimburse the California DPHs for uncompensated care through the California Medi-Cal program. As stated in the Demonstration Waiver STCs, the objective of this report will be to support a determination of the appropriate level of UCP funding at those providers in years two through five of the demonstration

To review the funding, Medi-Cal payment, and hospital costs for care provided by the DPHs to Medicaid recipients and the uninsured, this analysis used services provided inSFY 2013/14, which began on July 1, 2013 and ended on June 30, 2014. The following information was confirmed by the analysis:

- During this timeframe total uncompensated care cost for the DPHs was calculated to be $225 million when including the additional 75 percent of DSH claimable cost allowed under Federal statute for Medi-Cal and including DSH and SNCP reimbursements.
- Total cost of care provided at the DPHs to the uninsured was $2.0 billion. Of this $2.0 billion, just under $1.768 billion was determined to be from charity care, when using the guidelines consistent with IRS form 990.
- When using more restrictive definitions of charity care, which require financial forms to be completed by the patient, about $1.5 billion was identified as charity care and $0.5 billion was determined to be bad debt.

Regardless which method is used to calculate the charity care, at either $1.768 billion or $1.5 billion the amount of charity care is well above the $622 million and $472 million total computable amounts allocated for the UCP in SFYs 2013/14 and 2015/16, respectively.

We note that the University of California hospitals are not eligible to participate in the GPP defined in the Medi-Cal 2020 waiver. That being the case, we looked at the charity care totals excluding the UC hospitals. Under that scenario, total charity care under the guidelines totals $1.6 billion and under stricter guidelines is $1.4 billion. Again, both of these values are well above the $472 million total computable allocated for the UCP in SFY 2015/16. Moreover, the DPHs are funding the non-Federal share of the UCP through IGTs, such that the net benefit to the DPHs from the UCP will only be the Federal portion, which is $236 million.

For the cost analysis we reviewed overall pay-to-cost values for the DPHs based on Medi-Cal payments and hospital costs for care of Medi-Cal recipients and uninsured patients. The results of that analysis are as follows:

- The combination of Medi-Cal service payments plus DSH and UCP payments covered approximately 109 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 98 percent of costs.
- The DPHs and their affiliated local governments contribute a significant portion of the non-Federal share of Medicaid reimbursements through a combination of CPEs and IGTs which

amounted to 83 percent of the non-Federal share of Medi-Cal funding in SFY 2013/14 – a total of almost $3.65 billion.

- When reducing Medi-Cal payments by excluding the DPHs contributions to the Medi-Cal program we found that the net payments to the DPHs covered only 71 percent of costs even when the additional 75 percent of DSH claimable costs was not included. This burden will increase as the FMAP for the Medi-Cal expansion population drops over time.

In summary, the analysis confirms that there is significant uncompensated care in the State of California even after Medi-Cal expansion and increased insurance coverage under the ACA. For the DPHs, most of this uncompensated care is charity care, and the charity care totals well above the UCP allocation for SFY 2015/16, which is the first year of the Medi-Cal 2020 waiver.

10 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.

10.1 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.

10.1.1 Medicaid State Plan[54]

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.

10.1.2 Medical Assistance Expenditures[55]

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.

[54] SSA 1902(a)
[55] SSA 1903(a), SSA 1905(a) and SSA 1905(b)

10.1.3 Federal Medical Assistance Percentage/Federal Financial Participation[56]

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 administrating 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.

10.1.4 The Non-Federal Share[57]

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 Federal Financial Participation (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.

[56] SSA 1903(a) and SSA 1905(b)
[57] SSA 1902(a)(2)

10.2 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)**[58] 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)**[59] 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)**[60] 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.

[58] SSA 1115(a)
[59] SSA 1915(b)
[60] SSA 1915(c)

10.3 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"*[61]

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.[62]

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.[63] 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. [64]
- **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 Graduate Medical Education 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.[65] UPL

[61] SSA 1902(a)(30)(A)
[62] SSA 1902(a)(13)
[63] SSA 1923(b)
[64] SSA 1923(g)
[65] 42 CFR §447.271, §447.272, §447.321, and §447.325

regulations establish limits on the Federal portion of Medicaid outlays for recipients paid under Medicaid FFS programs.

DSH funds are provided as an annual statewide allotment of Federal funds, calculated based on Section 1923 of the SSA.[66] 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.[67]

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."[68] Medicaid managed care plan can negotiate rates with providers of services.

10.3.1 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.

10.4 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

[66] SSA 1923(g)
[67] 42 CFR Part 447, Subpart E
[68] SSA 1903(m)(2)

Services, Audits and Investigations (A&I). At the end of the reconciliation process, if it is determined that there is an overpayment, adjustments will be made to offset or otherwise recover the overpayment.[69]

- **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.[70] 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.[71]

- **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.[72]

- **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.[73] 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

[69] California State Plan, Attachment 4.19-A, pp 46-51: Reimbursement to Specified Government-Operated Hospitals for Inpatient Hospital Services.
[70] California State Plan, Attachment 4.19-B, pp 1-5
[71] California State Plan, Attachment 4.19-B, pp 46-50, Supplemental Reimbursement for Public outpatient Hospital Services.
[72] California State Plan, Attachment 4.19-B, pp 52-63, Reimbursement to Specified Government-Operated Providers for Costs of Professional Services.
[73] 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.[74] 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.[75] All DSH payments are subject to an aggregate cap based on the Federal DSH allotment for California.

[74] California State Plan, Supplement 5 to Attachment 4.19-B
[75] California State Plan, Attachment 4.19-A, pp 18-37, Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals

11 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
- DSH: Disproportionate Share Hospital
- DSHP: Designated State Health Programs
- DSRIP: Delivery System Reform Incentive Payments
- DTI: Dental Transformation Initiative
- EQRO: External Quality Review Organization
- FFS: Fee for Service
- FFY: Federal Fiscal Year
- FMAP: Federal Medical Assistance Percentage
- FPL: Federal Poverty Level
- FQHC: Federally Qualified Health Centers
- 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
- 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
- MCE: Medicaid Coverage Expansion
- MCO: Managed Care Organizations
- MMIS: Medicaid Management Information System
- OSHPD: Office of Statewide Health Planning and Development
- 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