SECOND HALF YEAR 2016 REPORT
MEDI-CAL BENEFICIARIES' ACCESS TO GENERAL ACUTE CARE AND REHABILITATION-ONLY HOSPITAL BEDS

Introduction

California's Medicaid program, Medi-Cal, provides medically necessary health care services for millions of the State's low-income individuals, families, seniors, and those with disabilities. The federal Equal Access provision requires that these 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."[1] In this bi-annual report, the California Department of Health Care Services (DHCS) reviews hospital utilization and beneficiary access to care during the time period of July 2016 through December 2016. DHCS uses a systematic approach for measuring access to Medi-Cal Fee-for-Service (FFS) beneficiaries' access to hospitals reimbursed under the Diagnosis Related Group (DRG) methodology and rehabilitation-only hospitals. This report also includes designated public hospitals (DPHs), as requested in the last submitted access report. The bi-annual report describing Short-Doyle Mental Health Medi-Cal beneficiaries' access to psychiatric hospitals will be provided under a separate cover.

Public Process to Engage Stakeholders

DHCS engages the inpatient provider community by providing a variety of provider outreach, education, and training resources to ensure accurate knowledge of Medi-Cal policies and procedures, and to help prevent potential claiming and payment problems. DHCS offers DRG-specific trainings, such as for billing, which explains correct claims submission requirements and billing practices. DHCS also maintains a designated DRG email address to provide a direct line of communication between DHCS and hospital providers to assist them with Medi-Cal billing policies and procedures, correct completion of claim forms, claim denials, and provider manual information.

To facilitate early detection of potential or emerging DRG issues related to reimbursement, DHCS closely tracks trends and themes from provider trainings and outreach, Medi-Cal Help Line calls, and DRG mailbox inquires. Frequently Asked Questions (FAQs) have been developed and posted on DHCS's website. Providers may access webinar recordings, FAQs, DRG-related bulletins, and additional key resources on the DHCS DRG website. Provider claiming and education issues are addressed on an ongoing basis by updating the FAQs, or devising new provider trainings that address common DRG-specific questions. Important updates are also made available through monthly provider bulletins and updates to the Medi-Cal provider manual available at the DHCS Medi-Cal Provider Manuals website. The constant and ongoing stakeholder-DHCS collaboration helps ensure that rates are set in a proper manner and issues with service provision and/or claiming are recognized and addressed in a timely manner.

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[1] Section 1902(a)(30)(A) of the Social Security Act.

Medi-Cal FFS Beneficiary Access to Care

In State Fiscal Year (SFY) 2016-17, DHCS estimates 20.44 percent of all certified eligible Medi-Cal beneficiaries were FFS eligible.[2] Adequate access to inpatient services enables these typically more medically fragile individuals to have access to the care they need. DHCS bi-annually prepares a report of utilization for these individuals and performs analyses to determine whether there are access issues with respect to hospitals reimbursed under the DRG methodology, rehabilitation-only hospitals, and DPHs. In November 2015, CMS finalized amendments to Subpart B of part 447 of title 42 of the Code of Federal Regulations (42 CFR 447) that addresses the states' methods for assuring access to covered Medicaid services in the Medicaid Fee-for-Service (FFS) delivery systems. The regulations detail a standard process for states to document compliance with section 1902(a)(30)(A) of the Social Security Act, including the design and development of an access monitoring plan that includes specific healthcare measures, beneficiary access to providers, access and utilization of healthcare services, and regular monitoring of payments. In response to the new CMS regulations, DHCS developed a comprehensive beneficiary access to care monitoring plan, *California's Fee-for-Service Medi-Cal Program Health Care Access Monitoring Plan (September 2016)*[3]. The DHCS publication contains a detailed analysis on the needs of Medi-Cal FFS beneficiaries, provider availability, changes in beneficiary utilization and services, characteristics of Medi-Cal beneficiary population, and service payment information. This report is provided to CMS every three years and is available for public review and feedback on the DHCS website.

Beneficiary Access to Care, Three Provider Closings

DHCS regularly monitors whether hospital closures could have an impact on Medi-Cal FFS beneficiaries' access to care. DHCS has an interagency agreement (IA) in place with the California Department of Public Health (CDPH) for the purpose of CDPH notifying DHCS of hospital closures or terminations from the Medi-Cal program. According to the terms of the IA, "CDPH is delegated the authority to collect, maintain, and transmit to DHCS copies of provider agreements with health facilities and agencies it certifies as meeting federal requirements for participation in Medi-Cal and to impose sanctions authorized under federal law or under state law, as well as to terminate the provider agreement for a Medi-Cal provider's noncompliance with applicable standards and regulations."

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[2] Department of Health Care Services, 2017 May Estimate/M1704_Caseload_Tab.pdf.
[3] *California's Fee-for-Service Medi-Cal Program Health Care Access Monitoring Plan, September 2016 may be accessed at* Access Monitoring Plan, September 2016.

CDPH notifies DHCS when health facilities are placed under temporary management or receivership, fined, or closed. As a result, the DHCS Provider Master File (PMF) is updated with pertinent information, and is available to appropriate CDPH's Licensing and Certification employees with read-access. The PMF is regularly used to inform state programs of provider activities including termination, closure, change of ownership, and/or changes of National Provider Identifiers (NPI).

Upon receiving information from CDPH, DHCS compiles a semi-annual report that lists, by county, the number of active Medi-Cal DRG-reimbursed hospitals, DPHs, rehabilitation-only hospitals, and providers that have closed, are on suspension, or have been terminated from the Medi-Cal FFS program. A summary of this report is included as Appendices A, B, C, and D. DHCS analyzes available data through the Office of Statewide Health Planning and Development (OSHPD) both for overall access and for service line item access.

For hospitals reimbursed under the DRG methodology, DHCS monitors inpatient hospitals' utilization and payments by Medicaid Care Category (MCC) and applies policy adjustors on certain MCC when necessary. There were no new policy adjustors introduced in SFY 2016-17 from the year prior; this was the first year that all DRG hospitals no longer received transitional rates. For State Fiscal Year (SFY) 2015-16, DHCS implemented an obstetrics policy adjustor of 1.06 since it was determined that payments for stays in this MCC in FY 2013-14 were among the lowest when compared to other care categories. DHCS continues to monitor whether this policy adjustor is positively impacting care in the obstetrics MCC.

Since the previous bi-annual access report, Temple Community Hospital and Tri-City Regional Medical Center (also known as Garden Regional Hospital and Medical Center or GRHMC) have formally closed. Temple Community Hospital in Los Angeles closed due to low revenue and increasing costs, including a $50 million expense of retrofitting the hospital to meet California earthquake safety requirements.[4] Temple Community was a General Acute Care hospital with 150 licensed beds, including 138 general acute beds, 12 intensive/critical care unit beds, and 20 skilled nursing beds. The 70-year old hospital was located in an area with more than 139 hospitals within 30 miles, many of those offering the same or similar services. Temple Community Hospital gradually limited its services and patient base during the 2014-15 calendar year, eventually closing its doors to patients in September 2014. DHCS received notification of Temple's

[4] News of Temple Community Medical Center closure can be found at Temple Community Medical Center closure

closure in February of 2017 due to delays in updating the Provider Master File. Thus, the impact of this hospital closure is included in this access report.

Based on the data shown in Table A, DHCS anticipates that St. Vincent Medical Center and Hollywood Presbyterian Medical Center, both of which are geographically located within 2 miles of Temple Community Hospital, have the combined capacity to accommodate the Medi-Cal FFS beneficiaries who used to receive care at Temple. In addition, Temple Community Hospital's Medi-Cal FFS patient base is exclusively adult. Therefore, pediatric and neonatal services should not be affected by its closure.

TABLE A: Bed Utilization Among Three Closing Facilities, CY 2014[5]

Licensed Bed Classifications	Temple Community Hospital	St. Vincent Medical Center	Hollywood Presbyterian
Medical/Surgical	34,638	92,598	80,886
Perinatal	0	0	12,444
Pediatric	0	0	4,026
Critical Care (Adult)	3,012	24,522	13,176
Respiratory	0	0	0
Burn	0	0	0
NICU	0	0	5,490
Rehabilitation	0	6,954	10,248
Total Bed Days	37,650	124,074	126,270
Total Patient Days	4,097	47,048	64,741
Total Occupancy %	11%	38%	51%

In the First Half 2016 Access Monitoring Report, DHCS reported that GRHMC was experiencing cash flow problems and may be forced to close if it did not receive additional funds. GRHMC filed for bankruptcy in June 2016 and officially closed in January 2017 after a deal with a potential buyer fell through. Regarding the impact of this closure, the First Half 2016 Access Monitoring Report indicated that beneficiary access to care in that geographic area should not be affected by GRHMC's closure.

In addition to regularly utilizing OSHPD data sources for occupancy and vacancy information, DHCS also monitors DRG provider reimbursement and availability on an ongoing basis, and annually publishes a hospital characteristics file.[6] The hospital characteristics file contains information on DRG and non-DRG hospitals (DPHs and

[5] 2014 OSHPD Hospital utilization data was used due to the closure of Temple Hospital in 2015 and was the most current data available for this hospital.
[6] DHCS published Hospital Characteristics files for FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17, i.e., every year that DRG has been implemented.

Rehabilitation-only). Excluding the non-DRG providers, the total DRG hospital count in FY 2013-14, 2014-15, 2015-16, from the previous access report, and 2016-17 are relatively similar. The list of DRG hospitals are provided in Appendix D, under a separate cover.

The data indicates that overall availability of general acute care (GAC) beds in calendar year (CY) 2016 remained relatively constant to the prior year. A detailed breakdown of GAC bed availability and utilization by county for hospitals that are reimbursed under the DRG methodology, and DPHs, can be found in Appendix A. Appendix B presents the occupancy and vacancy rates for rehabilitation-only facilities in California. A description of the data, methods, and limitations can be found in Appendix C.

Vacancy Rates

This report uses OSHPD Fiscal Year End (FYE) 2015 data on hospital bed utilization, and compares it to 2016 Medi-Cal FFS eligibles' potential need for inpatient GAC services. The data shows that the unweighted average vacancy rate in GAC beds (including DPH, NDPH, and rehabilitation beds at DRG hospitals) was 46% in FYE 2015, and DRG bed day availability was 12,488,029.[7] There were 2,548,167 Medi-Cal FFS eligibles between January and October 2016.[8]

The ratio of vacant bed days to Medi-Cal FFS eligibles serves as an early gauge of access. If we divide the number of vacant bed days by the average number of Medi-Cal FFS eligibles, we find that there are an additional 4.90 bed-days per Medi-Cal FFS beneficiary.

The data regarding total GAC bed day availability indicates that the system, as a whole, should be capable of accommodating additional patients in the event of an increase of Medi-Cal FFS eligibles, because the average length of stay for all of California's beneficiaries in State Fiscal Year 2016-17 is 4.1 bed days per beneficiary.[9]

Regarding rehabilitation-only facilities, in FYE 2015, the last year for which OSHPD annual utilization data is available, there were eight (8) acute inpatient rehabilitation-only facilities in California. The facilities represented in the data set are located in Butte (1), Fresno (1), Kern (1), Los Angeles (1), Orange (2) and San Bernardino (2) counties. A detailed bed utilization breakdown of rehabilitation-only bed availability and utilization by county can be found in Appendix B. OSHPD reported a total of 136,879 bed-days

[7] 2015 OSHPD Hospital annual utilization data is used to calculate the bed day availability.
[8] FFS Medi-Cal eligibles without Medicare Part A coverage data was pulled from MISDSS on March 3, 2017.
[9] SFY 2016-17 DRG claims paid through December 31, 2016.

per year, an average occupancy rate of 74 percent, and an average vacancy rate of 26 percent for California rehabilitation-only facilities during 2015. There were 443 beds available in rehabilitation-only hospitals in FYE 2015.

Conclusion

This preliminary access analysis does not suggest that there are currently access issues to GAC services, including rehabilitation services, for Medi-Cal FFS beneficiaries. This may be due to an increase in overall GAC beds, an increase in hospital vacancy rates, and DHCS' ongoing efforts to enroll Medi-Cal beneficiaries into Medi-Cal Managed Care delivery system.

As a follow up to this report, DHCS will continue to monitor the Medi-Cal FFS population's access to GAC services, and apply policy adjustors when necessary.

APPENDIX A: General Acute Care Hospital Utilization FYE 2015[10]

County	Number of Hospitals	Number of Licensed Beds	Licensed Bed Days per Year	Patient Days per Year	Occupancy Rate %	Vacancy Rate %
Alameda	17	3,068	1,125,280	580,672	50%	50%
Amador	1	52	18,980	9,088	48%	52%
Butte	4	485	177,025	124,713	57%	43%
Calaveras	1	48	17,520	3,843	22%	78%
Colusa	1	42	15,330	2,207	14%	86%
Contra Costa	9	1,638	603,342	324,926	54%	46%
Del Norte	1	49	17,885	6,271	35%	65%
El Dorado	2	162	59,130	28,353	45%	55%
Fresno	9	1,712	611,240	379,184	62%	38%
Glenn	1	47	17,155	726	4%	96%
Humboldt	5	275	100,375	46,134	46%	54%
Imperial	2	268	97,820	38,041	40%	60%
Inyo	2	29	10,585	3,025	17%	83%
Kern	11	1,421	520,639	255,864	49%	51%
Kings	2	191	69,715	39,010	46%	54%
Lake	2	62	22,630	11,787	52%	48%
Lassen	1	38	13,870	3,664	26%	74%
Los Angeles	95	22,255	8,090,877	4,499,840	56%	44%
Madera	2	462	168,630	96,515	56%	44%
Marin	4	441	160,965	77,642	51%	49%
Mariposa	1	18	6,570	651	10%	90%
Mendocino	3	141	52,287	20,780	40%	60%
Merced	2	230	83,950	46,005	43%	57%
Modoc	2	20	7,300	551	7%	93%
Mono	1	17	6,205	1,183	19%	81%
Monterey	4	734	271,685	129,655	43%	57%
Napa	2	364	132,556	50,586	38%	62%
Nevada	2	139	50,735	24,256	44%	56%
Orange	33	5,879	2,155,999	1,110,336	51%	49%
Placer	3	732	267,732	170,500	59%	41%

[10] This data includes all GAC beds, including DRG-reimbursed hospitals, DPHs, and hospital-based rehabilitation beds. A list of all rehabilitation-only facilities is located in located in Appendix B.

APPENDIX A: General Acute Care Hospital Utilization FYE 2015 (cont.)

County	Number of Hospitals	Number of Licensed Beds	Licensed Bed Days per Year	Patient Days per Year	Occupancy Rate %	Vacancy Rate %
Plumas	3	44	16,060	2,850	17%	83%
Riverside	18	3,448	1,257,770	695,339	55%	45%
Sacramento	11	3,187	1,057,978	669,004	63%	37%
San Benito	1	62	22,630	7,142	32%	68%
San Bernardino	23	3,836	1,400,884	820,963	59%	41%
San Diego	24	6,220	2,369,576	1,249,205	53%	47%
San Francisco	12	2,760	1,042,650	434,989	42%	58%
San Joaquin	8	1,191	428,835	215,570	50%	50%
San Luis Obispo	4	470	166,650	69,097	44%	56%
San Mateo	8	1,089	397,485	165,289	42%	58%
Santa Barbara	5	779	287,755	140,252	49%	51%
Santa Clara	12	3,482	1,269,260	738,388	58%	42%
Santa Cruz	3	359	131,035	71,961	47%	53%
Shasta	5	601	219,365	108,849	44%	56%
Siskiyou	2	61	22,265	7,470	34%	66%
Solano	5	672	245,280	132,523	54%	46%
Sonoma	8	755	275,575	139,272	51%	49%
Stanislaus	7	1,332	486,180	293,979	60%	40%
Sutter	2	60	24,868	6,467	26%	74%
Tehama	1	76	27,740	8,065	29%	71%
Trinity	1	25	9,125	2,024	22%	78%
Tulare	3	604	220,460	86,162	39%	61%
Tuolumne	2	84	30,660	20,494	67%	32%
Ventura	10	1,348	492,020	260,697	53%	47%
Yolo	2	125	45,625	19,101	44%	56%
Yuba	1	173	63,145	45,699	72%	28%
Grand Total	407	73,862	26,964,888	14,476,859	54%	46%

APPENDIX B: Rehabilitation-only Hospitals Utilization FYE 2015[11]

County	Rehab Hospitals	Rehab Beds	License Bed Days/Year	Patient Days/Year	Occupancy Rate %	Vacancy Rate %
Butte	1	40	14,600	6,753	46%	54%
Fresno	1	62	22,630	17,786	76%	24%
Kern	1	66	24,090	20,982	87%	13%
Los Angeles	1	68	24,820	22,044	89%	11%
Orange	2	54	19,714	16,680	92%	8%
San Bernardino	2	85	31,025	16,749	40%	60%
Grand Total	8	443	136,879	100,994	74%	26%

APPENDIX C: Study Data and Limitations

Data: For this study, DHCS collected demographic, hospital, and FFS data for each county from several resources including: California Department of Finance[12], US Census Bureau[13], California Department of Public Health[14], Office of Statewide Health Planning and Development,[15] and the DHCS Management Information System/Decision Support System (MIS/DSS)[16]. The occupancy and vacancy rates of GAC inpatient services were determined using industry accepted standards[17].

Methods: The ratio of licensed hospital bed-days to Medi-Cal FFS eligibles was based on OSHPD's total hospital inpatient census days divided by the average number of eligible beneficiaries over a 10-month calendar year (January – October 2016) from MIS/DSS. Individuals who were dually eligible for Medi-Cal and Medicare Part A were excluded from the analysis as Medicare Part A specifically covers inpatient

[11] This data only includes information for "stand-alone" Rehabilitation-only hospitals and does not include rehabilitation beds that are located as part of a GAC hospital. Data for GAC hospital rehabilitation beds is included in Appendix A.
[12] California Department of Finance data extracted on March 1, 2017.
[13] US Census Bureau data extracted on January 18, 2017.
[14] CDPH data extracted on January 18, 2017.
[15] OSHPD data extracted on February 1, 2017.
[16] MIS/DSS data extraction on March 6, 2017.
[17] Formula for occupancy rate is taken Johns, Merida, *Health Information Management Technology: An Applied Approach,* Chicago, Illinois, AHMA Press, 2011, p. 551. The vacancy rate is determined by subtracting the occupancy rate from 100 percent.

hospitalizations. All other Medi-Cal FFS eligible beneficiaries were included in this study. The data on the Medi-Cal FFS eligible population was extracted from the MIS/DSS system three (3) months after it was initially submitted to DHCS by the 58 counties, providing sufficient time for all counties to report the most accurate data with adequate time to make any corrections, if necessary.

Limitations: OSHPD collects hospitalization rates on an annual (calendar year) basis and publishes those rates once all, or almost all, hospitals have submitted their data.[18] As a result, there is an annual lag in reporting and the last data set that was readily available to DHCS is FYE 2015. The number of eligible Medi-Cal FFS beneficiaries is based on the number of monthly eligible beneficiaries during the months of January 2016 through October 2016, hospital counts are based on hospitals with active licenses during the State Fiscal Year 2016-17, and hospital bed utilization is based on the 2015 OSHPD hospital utilization data. Additionally, Hospitals regularly place their GAC and rehabilitation beds in suspense, either due to low demand or for other reasons. The data on beds placed in suspense also lags by one year, and is often not reported at the same time as other hospital utilization data. To the extent possible, these beds have been excluded from the analysis.[19]

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[18] To somewhat compensate for this, OSHPD typically publishes a preliminary data set followed by a final data set. However, the preliminary data set tends to be incomplete and the data is un-audited.

[19] It is also worth noting that bed day availability is reported differently by different kinds of hospitals with larger hospitals that are typically located in the more urban areas utilizing in-house coders and, as a consequence, reporting actual bed availability for that year. The more rural and smaller hospitals tend to utilize off-site coders and, consequently, tend to report bed day availability by multiplying the number of beds by 365 or 366 in a leap year.