STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 445-1912

March 26, 1982

To: All County Welfare Directors Letter No. 82-14

MEDICAID INPATIENT HOSPITAL REIMBURSEMENT

Federal regulations (CFR 42-447.254) require that any significant proposed change in the Statewide method or level of reimbursement for Medicaid inpatient hospital services be publicly noticed prior to the proposed effective date of the change. A local agency in each county must also be identifed where copies of the proposed changes are available for public review. Although this regulation is not a significant change, we believe there is sufficient public interest that notice should be given.

The county welfare offices in each California county have been so designated for the enclosed regulations on inpatient hospital reimbursement. We therefore request that you post these regulations and the accompanying cover memo in your main county welfare office for a period of sixty days. The hearing for this regulation will be conducted on April 26, in Sacramento.

If you have any questions regarding this letter or the enclosed materials, please contact your Medi-Cal program consultant at (916) 445-1912.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 322-4990

NOTICE OF ADOPTION OF EMERGENCY REGULATIONS OF THE DEPARTMENT OF HEALTH SERVICES

The Department of Health Services will hold a public hearing at 10:00 a.m. on April 26, 1982, in the Auditorium at 714 P Street, Sacramento, California, at which any person may present statements or arguments orally or in writing relevant to the following regulations in Title 22, Division 3, of the California Administrative Code, summarized below which were adopted, amended or repealed and filed as an emergency on January 27, 1982. Statements or arguments submitted in writing must be received by the Department by 5:00 p.m. on April 26, 1982, and should be addressed to the Office of Regulations, Department of Health Services, 714 P Street, Room 1601, Sacramento, CA 95814. At such time or at any time thereafter said Department of Health Services may certify such emergency action as provided in Section 11346.1, Government Code, or without further notice may repeal or amend said emergency actions. Other proposed regulation changes may be heard at this same time, for which an agenda will be posted at the time and place noted above.

The emergency action taken is pursuant to the authority vested by Sections 10725, 14105 and 14124.5 of the Welfare and Institutions Code and AB 1260, Chapter 1163, Statutes of 1981, Section 29 and is to implement, interpret or make specific Section 14105.1 of the Welfare and Institutions Code and AB 1540, Chapter 1004, Statutes of 1981, Section 8.

Informative Digest:

Current State statutes and regulations require the Department of Health Services to limit reimbursable hospital cost increases in 1981-1982 to six percent over the average amount paid, on a per discharge basis, during 1980-1981. Adjustments in interim payment rates are provided for, consistent with the six percent limit; adjustments to the allowable rates due to changes in case mix provided for in accordance with a specified methodology.

Federal law and regulations require that state payment rates for inpatient hospital services take into account the situation of hospitals that serve a disproportionate share of low income patients with special needs.

This regulation defines both low income patients with special needs and disproportionate share as they relate to the six percent discharge limit. This regulation also provides for increases in Medi-Cal reimbursable hospital cost increases for hospitals with a disproportionate share of low income patients, according to a specified methodology.

Specifically, these emergency regulation changes adopt new Section 51540.

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| Estimated annual reduction in savings to the Department | : $15,085,000 | (Gen.Fund $10,275,000) |
| Cost to any local agency or school district that is required to be reimbursed under Section 2231 of the Revenue and Taxation Code | : None | |

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| Other nondiscretionary costs/savings imposed on local agencies | : | None |
| Reduction in savings in federal funding to the State | : | $4,810,000 |
| Impact on small business | : | None |

Inquiries concerning the emergency administrative action may be directed to Ron C. Wetherall, Chief, Office of Regulations, at (916) 322-4990.

The express terms of the emergency action using underline to indicate additions to, and ~~dash-out~~ to indicate deletions from, the California Administrative Code, are available to the public upon request by writing to the Office of Regulations, Department of Health Services, 714 P Street, Room 1601, Sacramento, CA 95814. The aforementioned address will be the location of public records, including reports, documentation, and other materials related to the emergency action.

The Department of Health Services has prepared a STATEMENT OF REASONS for the emergency action, has available all the information upon which its proposal is based, and has available the express terms of the emergency action, pursuant to Section 11346.5(b), Government Code.

DEPARTMENT OF HEALTH SERVICES

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Original signed by

Dated: February 11, 1982

Beverlee A. Myers
Director

STATEMENT OF REASONS

The purposes of this regulation are twofold: First, to define hospitals which serve a disproportionate share of low income patients with special needs, and second, to specify the process by which the Department of Health Services will take into account the atypical costs of such hospitals when establishing Maximum Allowable Rate Increases for inpatient hospital services.

As amended by AB 1260, Section 14105.1 of the Welfare and Institutions Code limits final settlements by Medi-Cal for inpatient hospital services to a six percent increase over the prior base period's payment per discharge. Section 2173 of the Federal Omnibus Reconciliation Act of 1981 and the resulting federal regulations, 42 CFR Part 447.252, require that State payment methodologies for inpatient hospital services--such as the six percent payment per discharge limit--take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Section 51540 improves upon the existing payment system by fulfilling that requirement and setting out a process to define disproportionate share hospitals and to allow them to receive a certain measure of relief from the six percent payment per discharge limit. Application of the disproportionate share criteria is, therefore, necessary to implement the six percent payment per discharge limit fully, effectively, and in accordance with federal law and regulations.

Section 29 of AB 1260 requires the Director of Health Services to adopt regulations relating to the six percent payment per discharge limit on an emergency basis in accordance with the provisions of the Administrative Procedures Act, Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code. It also states that, "For the purposes of the Administrative Procedures Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare."

Development of the six percent payment per discharge limit was one of several actions taken by the Legislature and the Administration in response to the realization that, without a fundamental change in the methods of reimbursing hospital costs, the State will be unable to ensure the continuation of the Medi-Cal program in its current form. Effective implementation is critical for the continued provision of program services. Effective implementation also requires that special consideration be given to those hospitals that treat a large volume of low income patients. Such hospitals, especially those in urban areas, provide many important public health and social services to residents of their areas, as well as serving as hospitals of last resort for the poor. As a result, these hospitals often experience special costs. Meeting these costs is sometimes difficult since the hospitals also frequently receive only a relatively small proportion of their overall revenues from non-public sources. For these reasons, many such hospitals are now and will

continue to be financially distressed, and will experience special costs that the State should take into consideration when setting payment rates. In doing so, the mandate of the Legislature must also be considered—to balance the need for relief with the very tight budget constraints facing the State Treasury and the Medi-Cal program. The Medi-Cal program must control costs while still maintaining an acceptable cash flow to those institutions providing quality health services to the low income population in an economical and efficient manner. The methodology specified in this regulation responds to the needs of both the hospitals and the State.

Federal law and regulation require that consideration be given to hospitals serving a disproportionate share of low income patients. Low income patients are defined in this regulation by using Medi-Cal gross revenues as reported on the California Health Facilities Commission's disclosure reports. Many state Medicaid programs (Medi-Cal in California) cover only public assistance recipients--those persons receiving cash payments through Supplemental Security Income (Aged, Blind or Disabled) or Aid to Families with Dependent Children. California's Medi-Cal program covers not only the public assistance recipients, but the Medically Needy and Medically Indigent populations as well.

Persons who are designated Medically Needy meet the criteria for public assistance, but have too much income and/or property to qualify for cash payment. Still, their financial resources are inadequate to meet their medical expenses. Medically Indigent beneficiaries do not qualify for any of the public assistance programs but, like the Medically Needy, they need help in paying their medical expenses. There are over 600,000 Medically Needy and Medically Indigent beneficiaries in the Medi-Cal program. Because California's Medi-Cal program already covers such a large number of indigents—beyond the core group of public assistance recipients—the use of data reflecting Medi-Cal utilization among hospitals gives us a sufficiently accurate measure of the relative number of low income patients served by most hospitals. Some public hospitals must meet additional requirements relating to treatment of low income patients. To take into account the special situations of those hospitals, consideration is also given to sources of public revenues other than Medi-Cal when we are measuring their low income patient load.

The threshold point in the methodology specifies what proportion of low income patients a hospital must have, as a minimum, in order to be defined as having a disproportionate share. This regulation sets the threshold at 31 percent, an amount equal to the statewide mean plus one standard deviation of California hospitals' Medi-Cal gross revenues as a percent of their total gross revenues (reported on the California Health Facilities Commission's fifth year disclosure reports, for fiscal years ending June 30, 1979 to June 29, 1980). This threshold allows between 10 and 20 percent of the state's hospitals to be defined as having a disproportionate share of low income patients. Providing relief from the six percent payment per discharge limit to that number of hospitals is consistent with federal law and regulation, and strikes a reasonable balance between recognizing State budget constraints and taking into account the special needs of hospitals serving a high volume of low income patients.

To determine the amount of relief provided to a disproportionate share hospital, we multiply a hospital's disproportionate share percentage* by 0.10145. That product is added to the current six percent Maximum Allowable Rate Increase to give the new Adjusted Maximum Allowable Rate Increase for that hospital.

The multiplier 0.10145 is based on the intent and on the inherent cost assumptions underlying the Legislature's passage of AB 1260. The Department's May 1981 Medi-Cal Estimate, which was presented to the Legislature during their budget deliberations, projected a 13 percent rate of increase in inpatient hospital costs per day. This projection was based upon historical trends and upon the assumption that no new actions would be taken by hospitals to control cost increases. These continuing double digit increases when costs are not controlled is the very reason the State has had to implement the six percent payment per discharge limit.

It is appropriate that some relief should be provided to disproportionate share hospitals, as discussed above. But if the Medi-Cal program is to survive, relief must be limited to reasonable cost increases, and must be provided only to those hospitals carrying the majority of burden in an economical and efficient manner. Therefore, in recognition of: (1) the intent of the Legislature; (2) the budgetary assumption that, uncontrolled, inpatient hospital costs per day would increase by approximately 13 percent; and (3) the relief that disproportionate share hospitals would reasonably need, the maximum relief allowed using the disproportionate share criteria will be an increase of the Maximum Allowable Rate of Increase from six percent to 13 percent. The multiplier of 0.10145 is the application of this 13 percent maximum in the calculations.

Under the methodology, hospitals serving 100 percent low income patients would be allowed a 1981-82 rate increase of up to the full 13 percent over 1980-81. Those with 31 percent or less low income patients would remain at the six percent maximum. Hospitals serving between 31 and 100 percent low income patients would have their Maximum Allowable Rate of Increase adjusted upward by 0.10145 percent for each percentage point that their proportion of low income patients exceeds 31 percent.

We believe that this approach recognizes the fact that hospitals serving a higher proportion of low income patients may provide a higher proportion of special services, and that such hospitals experience more difficulty in controlling some cost factors. It is appropriate then to provide some relief to disproportionate share hospitals. The amount of relief provided through this regulation is calculated according to a hospital's proportion of low income patients and to its overall Medi-Cal activity. The specified methodology also takes into account the intent of the Legislature when it originally passed the six percent payment per discharge limit--that the rapidly rising costs of inpatient hospital services must be reduced to reasonable rates of increase.

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* Disproportionate share percentage is calculated as follows:

1. Divide the sum of the hospital's Medi-Cal gross revenues and revenues from other public sources by its total gross revenues.
2. Subtract 31 percent (the threshold point).
3. The remainder left in 2 above is the hospital's disproportionate share percentage.

Documentation and sources used by the Department of Health Services in developing this regulation change include the following:

1. Section 14105.1 of the Welfare and Institutions Code as amended by AB 1260, Chapter 1163, Statutes of 1981.

2. Section 2173(a)(1) of the Federal Omnibus Reconciliation Act of 1981.

3. Section 29 of AB 1260, Chapter 1163, Statutes of 1981.

4. California Health Facilities Commission, Fifth Year Disclosure Reports, for hospital fiscal years ending between June 30, 1979 and June 29, 1980.

5. Department of Health Services' computer printout showing the mean and standard deviation of Medi-Cal Gross Revenues as a percentage of Total Gross Revenues using data from 4 above.

6. Public hearing testimony relating to Section 51538 of Title 22, Division 3 of the California Administrative Code.

7. Federal Register, Volume 46, No. 189, Wednesday, September 30, 1981, Interim final regulations on the Medicaid Program: Payment for Long-Term Care Facility Services and Inpatient Hospital Services, pp. 47964-47973.

8. Eligibility Trend Report, Department of Health Services, Fiscal Forecasting Section, October 1981.

9. Medi-Cal Estimate, Department of Health Services, May 1981.

(1) Adopt new Section 51540 to read:

51540. Hospitals with a Disproportionate Share of Low Income Patients

(a) In accordance with federal law and regulation, adjustments may be made in the application of the maximum allowable rate of increase provisions specified in Section 51538 to take into account the situations of hospitals serving a disproportionate share of low income patients with special needs. The disproportionate share adjustments shall be made in accordance with the requirements of this section, but shall not apply to payments made for services rendered prior to July 1, 1981 or after June 30, 1982.

(b) Interim payment rates to disproportionate share hospitals, as defined in this section, shall be adjusted as soon as reasonably possible to accomplish a rate of payment increase to those hospitals for inpatient services, this rate of payment increase to be consistent with the provisions of this section and Section 51538.

(c) The reimbursement principles employed by the Department in final settlement pursuant to this section shall be the methods in effect prior to the effective date of federal approval for the maximum allowable rate of increase provisions in Section 51538, for any services rendered prior to that time. For services rendered between the effective date of federal approval and June 30, 1982, the reimbursement principles will be in accordance with the alternative methods adopted for use subsequent to the effective date of federal approval.

(d) Low income patients with special needs are defined and measured for the purposes of this section by using Medi-Cal gross revenues as reported to the California Health Facilities Commission. Consideration is also given to public revenue from sources other than Medi-Cal.

(e) A hospital is defined as having a disproportionate share of low income patients with special needs if its proportion of low income patients, as defined in (d) above, is greater than 31 percent of the total gross revenues reported by that hospital to the California Health Facilities Commission. A hospital's disproportionate share percentage is calculated using the following methodology:

(1) Divide the sum of Medi-Cal gross revenues and revenues from other public sources by total gross revenues.

(2) Subtract 31 percent from (1) above.

(3) The remainder left in (2) above is a hospital's disproportionate share percentage.

(f) The methodology for determining the adjusted maximum allowable rate of increase for a disproportionate share hospital is as follows:

(1) The disproportionate share percentage calculated in (e) above is multiplied by 0.10145.

(2) The product of (f) (1) above is added to the current six percent allowable maximum rate increase. This sum is the adjusted maximum allowable rate of increase for hospital inpatient services for a disproportionate share hospital.

(g) The Department may modify the adjusted maximum allowable rate of increase calculated above for a hospital, if it determines that certain conditions exist, including but not limited to, the following:

(1) The hospital reported revenue data inaccurately on its California Health Facilities Commission disclosure report, and that inaccurate reporting affects the calculation of the adjusted maximum allowable rate of increase as defined in this section.

(2) The hospital can demonstrate that the maximum allowable rate increase of six percent will have an adverse impact upon its costs attributable to serving disproportionate numbers of low income patients, and that this impact will cause an unreasonable reduction in access and availability of inpatient care for Medi-Cal patients.

(3) The hospital is a rural hospital or sole community hospital as specified in Section 51537(g) and (h) and can demonstrate that the maximum allowable rate increase of six percent will have an adverse impact on its costs attributable to its situation as a rural hospital or sole community hospital, and that this impact will cause an unreasonable reduction in access and availability of inpatient care for Medi-Cal patients.

(h) Rate modifications granted in (g) above shall be reflected in a hospital's interim payment rate as soon as reasonably and administratively possible after the modification is approved.

Note: Authority: Sections 10725, 14105,and 14124.5, Welfare and Institutions Code, and Chapter 1163, Statutes of 1981, Section 29 (AB 1260).

Reference: Section 14105.1, Welfare and Institutions Code, and Chapter 1004, Statute of 1981, Section 8 (AB 1540).