The Medi-Cal hospital inpatient rate freeze was one of several cost-containment proposals put forth by the Administration. The Medi-Cal hospital inpatient rate freeze was one of several cost-containment proposals put forth by the Administration. However, several other measures, such as co-pays for emergency room visits and hospital stays, which were opposed by CHA, were rejected by the budget conference committee. Two proposals that would have reduced funding to disproportionate-share hospitals by approximately $100 million also were not included in the final budget, due in part to CHA’s opposition.

Medi-Cal Rate Freeze

Included in health budget trailer bill SB 853 (Budget and Fiscal Review Committee) is a provision to freeze inpatient Medi-Cal rates to those that were in effect Jan. 1, 2010, or July 1, 2010, whichever is less. The Administration included the rate freeze in the May revision to the budget.

The rates will be frozen until the Medicaid Management Information System converts to claims processing based on the new diagnosis-related group (DRG) payment method also contained in SB 853 (see below).

The freeze is for both contracted and non-contracted hospitals. If a contracted hospital becomes non-contracted, or if a non-contracted hospital becomes contracted, the lower rate will apply to either situation.

New Payment System

SB 853 requires the Legislature to design a new Medi-Cal hospital inpatient payment system based on DRGs by June 30, 2014.

The new payment system is expected to ensure:

- Higher payments for patients with more serious conditions.
- Hospital efficiency by managing length of stay.
- Improved transparency and understanding.
- Improved fairness.
- Administrative efficiency for hospitals and the Medi-Cal program (elimination of Treatment Authorization Requests).
- Consistency and credibility.

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Simplification of determining and making payments to hospitals.
- Improved quality and outcomes.
- Implementation of provisions related to hospital-acquired conditions.
- Support of provider compliance with state and federal requirements.

The new payment methodology will be used for patients in all general acute-care hospitals, including Medicare Critical Access Hospitals. However, it excludes designated public, psychiatric and rehabilitation (including alcohol and drug) hospitals.

Factors such as hospital case mix, patient classification, geographic or regional differences, and payment models used in other states, will be considered in determining the base price(s). The new payment system is expected to be budget neutral and result in state budget savings in future years.

**Other Program Changes**

The budget reflects Medi-Cal savings of $147 million (General Fund) through the enrollment of seniors and people with disabilities into managed care. SB 208 (Steinberg, D-Sacramento) contains the implementing language.

As proposed in the May revision, the budget discontinues payments of Medicare Part B premiums for beneficiaries whose incomes exceed the Medi-Cal eligibility threshold by less than $500 per month. This is a General Fund savings of $1 million.

The budget also suspends cost-of-living adjustments for the budget year for counties to administer the eligibility functions of the Medi-Cal program. In addition, the budget establishes a process for the Department of Health Care Services (DHCS) to develop a new methodology to annually establish the rates paid to counties for eligibility services in order to increase clarity and transparency in this process.

Also as proposed in the May revision, the budget reduces radiologist rates to 80 percent of Medicare rates to save $10.5 million in General Fund expenses.

The budget also clarifies that continuous annual eligibility for children in Medi-Cal will remain in effect indefinitely. Two years ago, the budget adopted semi-annual eligibility-reporting requirements for children. However, federal health care reform contains an eligibility-related maintenance of effort, thereby requiring the state to adopt continuous annual eligibility.

Budget trailer bill language extends the sunset date for one year of the state statute that implements the federal Rogers Amendment. Enacted as part of the Deficit Reduction Act of 2005, the Rogers Amendment sets a limit on the amount that a Medicaid managed care plan can reimburse a non-contracted hospital that provides emergency services to one of the plan’s members. It requires hospitals to accept no more than the amount they could collect under the fee-for-service Medicaid program. State law, enacted in 2008, required DHCS to report to the Legislature by August 1, 2010, on the implementation of the rates. The statute sunsets Jan. 1, 2011. DHCS has not provided the report to the Legislature and, therefore, proposed a one-year extension of the sunset date to allow sufficient time to review the report and discuss the merits of a longer extension.

**Department of Mental Health Rates**

The health budget trailer bill specified maximum payment rates to community hospitals for Department of Mental Health (DMH) patients residing at state hospitals. The bill allows DMH to contract with providers for the provision of emergency health care services at a rate equal to or less than the amount payable under the Medicare fee schedule. The bill also specifies that the maximum reimbursement payment rates for contracted services with hospitals can be no greater than 130 percent of the amount payable under the Medicare fee schedule. The maximum rates established for contracted services shall not apply to reimbursement for administrative days, transplant services, services provided pursuant to competitively bid contracts, or services provided under a contract executed prior to Sept. 1, 2009. The budget reflects savings to the General Fund of $2 million.

**Next Year’s Budget**

To come to an agreement, all sides were forced to compromise in some areas, but claimed victories in others. The Governor was able to reduce pension benefits for future state employees, block general tax hikes and place a measure on the ballot (in 2012) to strengthen the state’s “rainy day fund.” Republicans agreed to suspend a corporate tax deduction for two years, but stopped tax increases the Democrats had hoped to obtain. Democrats spared safety-net programs by reducing cuts to $7.5 billion instead of the $12 billion originally proposed by the Governor. All agreed to optimistic revenue projections, which means the next Governor and Legislature may have to grapple with a state budget much earlier than usual due to overly optimistic assumptions in this year’s budget.
Lawmakers Pass Legislation to Implement Section 1115 Waiver

At the same time the Legislature passed the budget bill and related trailer bills, it also passed SB 208 (Steinberg, D-Sacramento) and AB 342 (Perez, D-Los Angeles), which make statutory changes necessary for the Department of Health Care Services (DHCS) to implement the proposed Section 1115 Comprehensive Demonstration Project Waiver in the Medi-Cal Program.

**SB 208**

SB 208 authorizes DHCS to continue to negotiate with the Centers for Medicare & Medicaid Services to finalize the details of a new waiver that will save up to $500 million per year by obtaining federal funds to offset General Fund expenditures. DHCS estimates this will save $250 million annually in the Medi-Cal program.

SB 208 also adds CHA-requested intent language that addresses the hospital financing component of the waiver. The language states that it is the intent of the Legislature for funding provided to designated public hospitals, private disproportionate-share hospitals and district hospitals, through a future hospital quality assurance fee and under a new waiver, to be implemented with the goal of providing balance and equity, and predictable and stable funding, and ensure hospitals have sufficient resources to move toward efficient care and health reform goals.

The bill requires DHCS to seek federal approval for a demonstration project for people who are Medi-Cal and Medicare eligible (dual eligibles) in up to four counties. It authorizes DHCS to require that dual eligibles be assigned as mandatory enrollees as part of the pilot project, which may begin March 1, 2011, but not sooner. SB 208 includes several critical amendments requested by CHA to clarify that dual eligibles are subject to mandatory enrollment in managed care only as to Medi-Cal benefits, and that managed care enrollment remains optional for Medicare.

SB 208 authorizes DHCS to require the mandatory enrollment of seniors and people with disabilities (SPDs) in a Medi-Cal managed care plan beginning June 1, 2011, or upon federal approval. It allows for a phase-in process only for Los Angeles County. The bill establishes contract, performance, quality and network adequacy measures and standards that must be met in order to implement mandatory enrollment.

It requires health plans to develop a mechanism to identify higher risk enrollees with complex health needs in consultation with individual plan member consumers and stakeholders, and requires DHCS to review and approve the mechanism.

SB 208 contains language to allow district hospitals that do not contract with the California Medical Assistance Commission to pursue intergovernmental transfers as a means to increase Medi-Cal funding. This language will require further clarification in future clean-up legislation.

SB 208 specifies that the elements of a medical home include providing referrals and assuring timely preventive, acute and chronic illness treatment in the appropriate setting.

It authorizes DHCS to contract with additional plans to provide services to SPDs in any county with less than two existing Medi-Cal managed health care plans, except in a county with a County Organized Health System.

SB 208 requires DHCS to establish organized health care delivery models for children eligible for California Children’s Services (CCS) and Medi-Cal by January 1, 2012. The model must be an enhanced primary-care case management model, provider-based Accountable Care Organization, specialty health care plan or Medi-Cal managed care plan that includes payment and coverage for CCS-eligible conditions.

DHCS had proposed language to allow for an alternative organized system of care, or County Alternative Model, but it was not included in SB 208 due to opposition by a number of stakeholders. It would have allowed the county and local stakeholders, in some managed care counties, to build on the existing managed care infrastructure and offer SPDs the choice to enroll in this alternative model in addition to existing managed care plans.

**AB 342**

AB 342 contains all the provisions that relate to the Coverage Expansion and Enrollment Demonstration (CEED) projects to provide scheduled health care benefits for uninsured adults 19 to 64 years old with incomes up to 133 percent of the federal poverty level, and upon federal approval between 134 percent and 200 percent of FPL, who are not otherwise eligible for Medi-Cal or Medicare. The bill requires CEED projects to be designed and implemented with the systems and program elements necessary to facilitate the transition of eligible individuals to the Medi-Cal program or, alternatively, to coverage through the health benefit exchange in 2014.

For more information on the FY 2010-11 state budget, contact Anne McLeod, CHA senior vice president, health policy, at (916) 552-7536 or amcleod@calhospital.org, or Barbara Glaser, CHA legislative advocate, at (916) 552-7559 or bglaser@calhospital.org.