INITIAL STATEMENT OF REASONS

Welfare and Institutions (W&I) Code Section 14124.5 authorizes the director of the Department of Health Care Services (the Department) to adopt, amend or repeal regulations as necessary and proper to carry out the purposes of and intent of the statutes governing the Medi-Cal program.

W&I Code Section 14105(a) requires the Department to adopt regulations that include the rates of reimbursement for non-contract services that the Medi-Cal program pays for within the Medi-Cal schedule of benefits set forth in W&I Code Section 14132. W&I Code Section 14105.15(e), specifically addresses reimbursement for acute care hospital inpatient services provided by out-of-state hospitals to Medi-Cal eligible beneficiaries.

On April 21, 2004, the City and County of San Francisco Superior Court issued a judgment pursuant to stipulation in the consolidated cases of Chandler Regional Medical Center, *et al*. v. California Department of Health Services; Diana M. Bontá, *et al*., City and County of San Francisco Case No. CGC-01-324400 and Arizona Burn Center, *et al*. v. California Department of Health Services; Diana M. Bontá, *et al*., City and County of San Francisco Case No. CGC-02-408260.

The plaintiffs in each of the above lawsuits challenged the validity of Medi-Cal rates for acute care hospital inpatient services, provided by out-of-state hospitals to Medi-Cal eligible beneficiaries. In accordance with the judgment that resolved the lawsuits, these regulations are necessary to implement rate changes for these services. The above judgment was based on a settlement entered into by the Department and the plaintiffs in the lawsuits.

This proposed regulatory action amends California Code of Regulations (CCR), Title 22, Section 51543 to comply with the court judgment by providing that out-of-state hospital inpatient services, which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained, shall be reimbursed the current statewide per diem average of contract rates for acute inpatient hospital services provided by California contract hospitals with at least 300 beds or the out-of-state hospital's actual billed charges, whichever is less.

Specifically, the contract rates are those negotiated by the California Medical Assistance Commission (CMAC). Pursuant to W&I Code Section 14165.9, CMAC annually reports to the California Legislature the average of such rates as of December 1 of the prior calendar year. The court judgment defines the term "current" to mean "the most recent per diem average as of December 1 of the prior calendar year of the contract rates for California hospitals with at least 300 beds that CMAC has reported to the Legislature." Therefore, the average per diem contract rate in effect on December 1

in a particular calendar year for California contract hospitals with at least 300 beds shall be the maximum rate paid to out-of-state hospitals for dates of service beginning January 1 of the following calendar year.

Basis for Amended Rate Methodology

The primary evidentiary basis for the change in regulations consists of the stipulated judgment ordering the Department to implement the agreed upon methodology. Specifically, the revised methodology is supported by the following considerations.

W&I Code Section 14105.15(e) provides for the reimbursement for out-of-state acute inpatient hospital services and was enacted in 1992. Section 14105.15(e) provides that:

> "Notwithstanding any other provision of law, reimbursement for out-of-state acute care inpatient hospital services provided to Medi-Cal beneficiaries shall not exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charges, whichever is less."

W&I Code Section 14165.9 was enacted in 1982. Subsection (d) directs CMAC to report annually to the Legislature the average per diem rate received by contract hospitals, as of December 1 of the preceding year, in the following categories:

(1) Statewide.
(2) By standard consolidated statistical area, as defined by the most recent United States Census.
(3) By that portion of the state not included within a standard consolidated statistical area.
(4) Statewide by hospitals with 1-99 beds, 100-299 beds, and over 300 beds.

When W&I Code Section 14105.15(e) was enacted in 1992, CMAC had already been annually reporting the latest statewide average of contract rates to the Legislature as required by W&I Code Section 14165.9. Moreover, when the Department implemented W&I Code Section 14105.15(e), it interpreted the phrase "current statewide average of contract rates" negotiated by CMAC to mean the most recent "statewide" average of contract rates that the Legislature had been receiving in annual reports from CMAC.

The statewide average per diem contract rate that CMAC annually reports to the Legislature is an unweighted average of each California contract rate in effect as of the prior December 1. In the lawsuits, the plaintiff out-of-state hospitals argued that the "statewide average of contract rates" pursuant to W&I Code Section 14105.15(e) should be a weighted statewide average of contract rates (i.e. weighted by volume of Medi-Cal patient days provided.) Data reviewed during the litigation indicated that the CMAC reported statewide average of contract rates for California contract hospitals with 300 beds or more is comparable to the weighted statewide average of contract rates for all

California contract hospitals. Thus, the parties stipulated to a court judgment resolving this litigation, which requires that the rate pursuant to W&I Code Section 14105.15(e) shall be based on the most recent CMAC reported statewide average of the contract rates for California contract hospitals with 300 beds or more.

To implement the Medi-Cal rate methodology required by the court judgment, the following changes are made to CCR, Title 22, Section 51543. Out-of-State Hospital Inpatient Services Reimbursement:

This section is amended to implement paragraph 3 on pages 3-4 of the judgment which states how the Department shall reimburse out-of-state hospitals for inpatient services. Specifically, the judgment requires that for days of service on or after January 1, 2004, "Medi-Cal covered acute care hospital inpatient services provided by out-of-state hospitals to Medi-Cal eligible beneficiaries shall be reimbursed the current statewide per diem average of contract rates for California hospitals with at least 300 beds or the out-of-state hospital's actual billed charges, whichever is less."

This section is also amended to include a reference to W&I Code Section 14165.9 that specifies CMAC's reporting requirements to the Legislature. This language is needed to clarify the origin of the "statewide per diem average of contract rates for California hospitals with at least 300 beds."

In accordance with the judgment, Section 51543 is also amended to define the term, "current," to mean "the most recent per diem average of the contract rates for California contract hospitals with at least 300 beds that CMAC has reported to the Legislature." For example, for calendar year 2004, the rate payable to out-of-state hospitals pursuant to the court judgment would be the average per diem contract rate in effect on December 1, 2003, for California contract hospitals with 300 or more beds as reported by CMAC to the Legislature.

Additionally, subsection (b) is being removed because the Department has determined that it is not necessary. This subsection was part of the payment methodology for out-of-state hospital rates that was in effect prior to October 1992. That payment methodology was more complicated (containing five alternative payment rate methodologies depending upon the information provided to the Department by an out-of-state hospital). Thus, there was an obvious need to have a process in which an out-of-state hospital could request an administrative adjustment if the hospital believed the Department had established the hospital's rates using the incorrect payment methodology among the five that existed prior to October 1992. When the Department changed to the current payment methodology, it apparently overlooked the fact that subsection (b) was no longer necessary.

Under the payment methodology that has been in effect since October 1992 and the new methodology enacted by this regulatory action, there is only one possible rate that the Department establishes. The provider will be paid the "current" CMAC rate, as

defined, unless the amount it bills the Department is less. Thus, there is no longer any need for requesting an administrative adjustment.

STATEMENTS OF DETERMINATION

ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this action is proposed, or would be as effective and less burdensome to affected private persons than this proposed action.

LOCAL MANDATE DETERMINATION

The Department has determined that the proposed regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code, nor are there other non-discretionary costs imposed.

ECONOMIC IMPACT STATEMENT

The Department has made an initial determination that the proposed regulations would not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the proposed regulations would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of exiting businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

DETERMINATION WHETHER REGULATION AFFECTS SMALL BUSINESSES

The Department has determined that the proposed regulations will not affect small businesses.

Provider participation in the Medi-Cal program is voluntary. These proposed regulation changes will not result in any new reporting, compliance or record keeping requirements for providers participating in the Medi-Cal program. This rate methodology will not alter the scope of Medi-Cal program benefits.

HOUSING COST IMPACT STATEMENT

The Department has determined that the proposed regulations will not affect housing costs.