FIRST HALF YEAR 2016
MEDI-CAL BENEFICIARIES' ACCESS TO GENERAL ACUTE CARE BEDS AND BEDS IN REHABILITATION-ONLY HOSPITALS

Introduction

California's Medicaid program, Medi-Cal, provides medically-necessary health care services for the State's low-income and disabled individuals. 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." In this bi-annual report, the California Department of Health Care Services (DHCS) uses a systematic approach for measuring access to Medi-Cal administered inpatient services to Fee-for-Service (FFS) Medi-Cal beneficiaries' access to hospitals reimbursed under the Diagnosis Related Group (DRG) methodology and to rehabilitation-only hospitals. The bi-annual report describing Short-Doyle (SD) Mental Health Medi-Cal beneficiaries' access to psychiatric hospitals will be provided under 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 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. Furthermore, the Medi-Cal Help Line provides a direct line of communication between DHCS and hospital providers to help them understand the Medi-Cal billing policies and procedures, correct completion of claim forms, claim denials, and provider manual information. DHCS has also established a DRG email box for provider inquiries.

To facilitate early detection of potential or emerging issues related to DRG reimbursement, DHCS closely tracks trends and themes from provider trainings and outreach, Medi-Cal Help Line calls, and DRG mailbox inquiries. From trainings, outreach, and education, Frequently Asked Questions (FAQs) have been developed and posted on DHCS's website. Webinar recordings, FAQs, DRG related bulletins and additional key resources are regularly accessed on DHCS's website at http://www.dhcs.ca.gov/provgovpart/pages/drg.aspx. Provider claiming and education issues are addressed on an ongoing basis by updating the FAQs or devising new provider trainings that address repetitive DRG-specific questions. Important updates are also made available through monthly provider bulletins and updates to the Medi-Cal provider manual available at http://www.medi-cal.ca.gov.

This constant and ongoing stakeholder-DHCS collaboration helps ensure that rates are set in a manner that does not jeopardize access and that issues with service provision and/or claiming are recognized. If possible, these issues should be resolved in a proactive manner.

DRG and Rehabilitation-Only Hospitals

In State Fiscal Year (SFY) 2015-16, 24.52[1] percent of all Medi-Cal beneficiaries were FFS eligible. Adequate access to inpatient services enables these typically more medically fragile individuals to have access to the care they need. As a result, 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 and rehabilitation-only hospitals.

Per the approved State Plan, DHCS reports on 23 access measures annually and a subset of four access measures quarterly. DHCS regularly compiles and reports on data pertaining to: physician supply, Medi-Cal beneficiary participation, service utilization rates per 1,000 member months, and beneficiary calls to the Ombudsman's Office to determine whether FFS Medi-Cal beneficiaries are able to access services in a timely manner.[2] DHCS' reports on inpatient hospital service days per thousand FFS Medi-Cal eligibles by aid code categories are measures of realized access. These reports are made available on DHCS' website and the public has the ability to provide feedback. In addition, these reports are provided to the Centers for Medicare and Medicaid Services (CMS) for review.

There is a formalized process whereby DHCS is notified of hospital closures/terminations. DHCS has an interagency agreement (IA) in place with the California Department of Public Health (CDPH). 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."/

CDPH notifies DHCS when health facilities are placed under temporary management or receivership and/or are fined or closed. This information is then shared throughout DHCS. As part of that process, the Provider Master File (PMF) is updated with pertinent information that appropriate Licensing and Certification Division employees

[1] Department of Health Care Services, "Estimated Monthly Certified Eligibles: November 2015", accessed March 16, 2016.
[2] For the most recent executive summary of this report, please refer to Medi-Cal Fee-for-Service Access to Care, Quarterly Monitoring Report #10 2014 Quarter 1 Executive Summary, accessed March 8, 2016.

have read-access to. The PMF is regularly used to inform program of provider activities including termination, closure, change of ownership and/or change of National Provider Identifier (NPI).

Upon receiving this information from CDPH, DHCS quarterly compiles a report that lists, by county, the number of active Medi-Cal DRG-reimbursed hospitals, and rehabilitation-only hospitals, and the number of providers that have been closed/terminated from the Medi-Cal program. A summary of this report is included as Appendices A, B, C and D[3]. DHCS analyzes the information for any impact to access using data available through the Office of Statewide Health Planning and Development (OSHPD), both for overall access and service line item access.

For hospitals reimbursed under the DRG methodology, DHCS monitors inpatient hospitals' utilization and payments to DRG hospitals by Medicaid Care Category (MCC) and applies policy adjustors when necessary. For example, 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 as shown in Table A. DHCS is currently monitoring whether this policy adjustor is positively impacting care in the obstetrics MCC.

[3] Please note that, beginning in FY 2014-15, DRG hospitals include non-designated public hospitals. As a result, there is additional bed capacity than was listed in the previous report but that does not necessarily mean that hospitals either opened in different counties or added bed capacity.

Table A: DRG Characteristics by MCC

Medicaid Care Category	DRG Stays[1]	DRG Avg Casemix[1]	DRG Pmt[1,2]	Baseline Avg Pmt[3]	FY 2013-14 DRG Avg Pmt[1]	FY 2014-15 DRG Avg Pmt[4]
OBSTETRICS	113,939	0.41	$ 383	$ 3,602	$ 3,362	$ 3,285
NEWBORNS						
NORMAL	103,092	0.12	$ 103	$ 1,259	$ 998	$ 1,000
NEONATE	17,809	2.97	$ 682	$ 32,316	$ 38,299	$ 39,861
Sub-Total	**120,901**		**$ 785**			
PEDIATRIC						
MISCELLANEOUS	42,877	1.39	$ 698	$ 11,856	$ 16,280	$ 16,234
RESPIRATORY	9,800	1.00	$ 111	$ 9,814	$ 11,331	$ 10,217
Sub-Total	**52,677**		**$ 809**			
ADULT						
MISCELLANEOUS	66,594	1.66	$ 1,000	$ 11,845	$ 15,023	$ 13,487
GASTROENTOLOGY	26,573	1.16	$ 251	$ 8,866	$ 9,464	$ 8,855
CIRCULATORY	20,616	1.34	$ 222	$ 8,185	$ 10,791	$ 10,608
RESPIRATORY	14,004	1.24	$ 148	$ 10,253	$ 10,563	$ 9,416
Sub-Total	**127,787**		**$ 1,622**			
OTHER	2,291	0.65	**$ 13**	$ 18,075	$ 5,537	$ 5,469
Grand Total	**417,595**	**0.88**	**$ 3,612**	**$ 6,636**	**$ 8,650**	**$ 8,754**

Note: [1]Data is for FY 2013-14 DRG admissions through paid date 3/21/2016 [2]Figures are in millions. [3]FY 2013-14 Baseline Payment is generated from Summary Analytical Dataset Table 4.2.2 posted on DHCS' website. [4]Data is for FY 2014-15 DRG admissions through paid date 3/21/2016.

DHCS regularly monitors whether hospital closures could have an adverse impact on FFS Medi-Cal beneficiaries' access to care. Saddleback Memorial Medical Center-San Clemente closed[4] on May 31, 2016. However, Saddleback Memorial, located at Laguna Hills, 14.2 miles away from the San Clemente location will remain open.

Saddleback Memorial Medical Center -San Clemente is a 73 licensed bed facility; 66 general acute and 7 critical care beds. DHCS analyzed the impact this closure could have on patient access by reviewing availability of general acute care (GAC) beds in nearby hospitals. The three hospitals close to Saddleback Memorial Center-San Clemente are Mission Hospital Regional Medical Center at approximately 9.2 miles and a driving time of 14 minutes, Saddleback Memorial Medical at approximately 14.2 miles and a driving time of 20 minutes, and Orange Coast Memorial Medical Center at approximately 26 miles and a driving time of 31 minutes. Based on the licensed bed

[4] Details of the closure are at http://www.memorialcare.org/saddleback-memorial-san-clemente

classification and occupancy rates shown in table B, it was determined that Mission Hospital Regional Medical Center and Saddleback Memorial Medical could absorb Saddleback Memorial Medical-San Clemente's general acute care and critical care services and that access would therefore not be impaired.

Table B: Bed Utilization among Saddleback Memorial Medical-San Clemente, Mission Hospital Regional Medical Center, Saddleback Memorial Medical, and Orange Coast Memorial Medical Center

2014	SADDLEBACK MEM MED CTR-SC			MISSION HOSP REG MED CTR			SADDLEBACK MEM MEDICAL			ORANGE COAST MEM MED CTR		
INPATIENT BED UTILIZATION License Bed Classification/Designation	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)
Medical/Surgical Acute[1]	4,688	24,090	19%	40,477	79,205	51%	31,276	59,495	53%	18,560	50,735	37%
Perinatal[2]	0	0	0%	7,845	15,695	50%	8,303	14,235	58%	5,068	18,980	27%
Pediatric Acute	0	0	0%	0	0	0%	0	0	0%	0	9,490	0%
Critical Care[3]	1,131	2,555	44%	12,188	22,995	53%	5,564	11,315	49%	6,803	15,330	44%
Acute Respiratory Care	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Burn Center	0	0	0%	0	0	0%	0	0	0%	1,107	2,555	43%
Intensive Care Newborn Nursery	0	0	0%	0	0	0%	2,908	6,935	42%	1,763	5,840	30%
Rehabilitation Center	0	0	0%	4,854	8,030	60%	0	0	0%	0	0	0%
Sub-Total	5,819	26,645	21.84%	65,364	125,925	51.91%	48,051	91,980	52.24%	33,301	102,930	32.35%

In November 2015, Tri-City Regional Medical Center (aka Garden Regional Hospital & Medical Center, aka GRHMC) communicated to DHCS that they had a cash flow problem and requested assistance in the amount of $3,862,104. GRHMC indicated that they may be forced to close if they did not receive the requested funds.

DHCS reviewed GRHMC's DRG utilization and payments. GRHMC had 416 FFS DRG-reimbursed Medi-Cal stays in State Fiscal Year (SFY) 2014-15, but are meeting the expected average reimbursement under DRG. It was determined additional DRG funds would be insufficient to resolve GRHMC's cash flow issues due to its relatively low FFS Medi-Cal utilization.

GRHMC received supplemental Hospital Quality Assurance Fee (HQAF) payment, with a projected benefit of $1,154,486 for SFY 2013-14 and $361,227 for SFY 2014-15. However, HQAF payments might not be made until program data has been reconciled.

GRHMC is the only community hospital in the City of Hawaiian Gardens. However, it is located in a densely populated urban area and there are two hospitals with equivalent services less than ten minutes' drive away: Los Alamitos Medical Center and La Palma Intercommunity Hospital. Based on the licensed bed classification and occupancy rates shown in Table C, it was determined that Los Alamitos Medical Center, La Palma

Intercommunity Hospital and west Anaheim Medical Center would be able to absorb GRHMC's general acute care and critical care services and that access would therefore not be impaired if GRHMC were forced to close.

Table C: Bed Utilization among Garden Regional Hospital and Medical Center (GRHMC), Los Alamitos Medical Center, La Palma Intercommunity Hospital, and West Anaheim Medical Center

2014	GRHMC			LOS ALAMITOS MED CENTER			LA PALMA INTERCOMMUNITY			WEST ANAHEIM MED CTR		
INPATIENT BED UTILIZATION License Bed Classification/Designation	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)
Medical/Surgical Acute[1]	15,694	32,485	48%	26,420	41,245	64%	5,602	38,325	15%	20,167	53,655	38%
Perinatal[2]	0	0	0%	3,306	4,380	75%	1,095	4,015	27%	0	0	0%
Pediatric Acute	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Critical Care[3]	2,589	6,570	39%	5,661	6,205	91%	1,500	2,920	51%	2,976	7,300	41%
Acute Respiratory Care	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Burn Center	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Intensive Care Newborn Nursery	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Rehabilitation Center	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Sub-Total	18,283	39,055	46.81%	35,387	51,830	68.28%	8,197	45,260	18.11%	23,143	60,955	37.97%

DHCS has since learned that GRHMC has filed for bankruptcy[5]. However, this does not necessarily mean that the hospital will close. DHCS is continuing to monitor the situation.

In April 2016, DHCS learned that Colusa Regional Medical Center was closing on April 22, 2016. Colusa Regional Medical Center in Colusa is a remote rural hospital licensed with 42 inpatient beds: 28 general acute, 6 critical care, and 8 perinatal. As Colusa Regional Medical Center is a remote rural hospital, the closest hospitals Medi-Cal beneficiaries will have access to general acute and critical care inpatient services including emergency rooms are more than half an hour away. Sutter Surgical Hospital in Yuba City and Rideout Memorial Hospital in Marysville are approximately 25 miles and 35 minutes away. Access for perinatal services is more greatly impacted as the closest hospital, Oroville Hospital, is 46.9 miles and 59 minutes away. The distance and time it takes for Medi-Cal beneficiaries to access needed inpatient services may result in an access issue. This access issue may be alleviated somewhat because in an article dated April 21, 2016, Becker's Hospital Review reports that Adventist Health

[5] The news article discussing GRHMC's bankruptcy can be found at http://www.beckershospitalreview.com/finance/los-angeles-hospital-files-for-bankruptcy-as-cash-collections-fall-short.html

has agreed to acquire Colusa Regional's three rural clinics although not all inpatient services can be diverted to outpatient rural clinics.

Based on the licensed bed classification and occupancy rates shown in table D, it was determined that although Sutter-Surgical and Rideout Hospital could absorb Colusa Regional Center's general acute care and critical care services while Oroville Hospital could absorb Colusa Regional Medical Center's perinatal services, access could nonetheless be impaired due to the time it takes to reach those hospitals.

DHCS has evaluated all remote rural providers in the State to determine whether there is any correlation between DRG rates and remote rural providers' financial viability and if there are any policy adjustors that can or should be applied. No correlation was found between DRG rates and a hospital's financial viability. It has, however, been found that DRG stays at remote rural hospitals, as a whole, have been steadily decreasing.

Table D: Bed Utilization among Colusa Regional Center, Sutter Surgical, Rideout Memorial, and Oroville Hospital

2014	COLUSA REGIONAL MED CTR			SUTTER SURGICAL			RIDEOUT MEMORIAL			OROVILLE HOSPITAL		
INPATIENT BED UTILIZATION License Bed Classification/Designation	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)	Patient Days	Licensed Bed Days	Lic. Bed Occupancy Rate (%)
Medical/Surgical Acute[1]	1,666	10,220	16%	1,309	5,110	26%	38,919	54,385	72%	35,906	41,245	87%
Perinatal[2]	491	2,920	17%	0	0	0%	0	0	0%	1,212	3,650	33%
Pediatric Acute	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Critical Care[3]	205	2,190	9%	0	0	0%	5,590	8,760	64%	2,595	3,650	71%
Acute Respiratory Care	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Burn Center	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Intensive Care Newborn Nursery	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Rehabilitation Center	0	0	0%	0	0	0%	0	0	0%	0	0	0%
Sub-Total	2,362	15,330	15.41%	1,309	5,110	25.62%	44,509	63,145	70.49%	39,713	48,545	81.81%

Looking at utilization and access, this report updates bed count and utilization by including non-designated public hospitals (NDPH) with active licenses for general acute care beds in the calculation of GAC bed availability as NDPHs began to be reimbursed under the DRG methodology on January 1, 2014. Appendix A presents the occupancy and vacancy rates for private and NDPH hospitals by county based on OSHPD data.

In addition to regularly utilizing OSHPD data sources for occupancy and vacancy information, DHCS monitors DRG provider reimbursement and availability on an

ongoing basis and annually publishes a hospital characteristics file[6]. The hospital characteristics file contains DRG rates for all DRG and non-DRG hospitals. Excluding non-DRG providers, the total DRG hospital count in FY 2013-14, FY 2014-15 and FY 2015-16 are relatively similar at 346, 348 and 348, respectively. The list of DRG hospitals in each FY are provided in Appendix D, under separate cover.

DHCS' overall findings indicate that overall availability of 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 can be found in Appendix A. A description of the data, methods and data's limitations can be found in Appendix C.

Vacancy Rates: DHCS used OSHPD Fiscal Year End (FYE) 2014 data on hospital bed utilization (the most recent utilization data available) and compared the FYE 2014 hospital bed utilization to SFY 2015-16 FFS Medi-Cal eligibles' potential need for inpatient GAC services. DHCS determined that the unweighted average vacancy rate[7] in GAC beds including rehabilitation beds at DRG hospitals was 50 percent in FYE 2014 and DRG bed day availability was 12,359,005. There were 2,559,468 FFS Medi-Cal eligibles in the first ten months of SFY 2015-16.

The ratio of vacant bed days to FFS Medi-Cal eligibles serves as an early gauge of access. If we divide the number of vacant DRG bed days by the average number of FFS Medi-Cal eligibles[8] in the first two Quarters of Federal Fiscal Year 2016 we find that there is an additional 4.83 bed days per FFS Medi-Cal beneficiary.

The current GAC bed day availability indicates that the system, as a whole, is capable of absorbing additional patients should there be an increase of Medi-Cal FFS eligible because the average length of stay for all of California's beneficiaries in State Fiscal Year 2015-16 is 3.99 bed days per beneficiary.

In FYE 2014, the last year for which utilization data is available, there were seven California inpatient facilities that are rehabilitation-only. A detailed breakdown of rehabilitation-only bed availability and utilization by county can be found in Appendix B. There are 135,126 total rehabilitation-only bed days. There is an overall occupancy rate

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[6] DHCS published Hospital Characteristics files for FY 2013-14, FY 2014-15, and FY 2015-16, i.e., every year that DRG has been implemented.

[7] The formula for the occupancy rate is taken from Johns, Merida, *Health Information Management Technology: An Applied Approach*, Chicago, Illinois: AHIMA Press, 2011, p. 551. The vacancy rate is derived by subtracting the occupancy rate from 100 percent.

[8] In FY 2012-13 there were 2,021,879 FFS Medi-Cal eligibles; in FY 2013-14 there were 2,363,365 FFS Medi-Cal eligibles; in FY 2014-15 there were 2,679,153; in the first 10 months of FY 2015-16 there were 2,559,468 FFS Medi-Cal eligibles.

of 69 percent and an overall vacancy rate of 31 percent in rehabilitation-only hospitals. There were 42,193 beds available rehabilitation-only hospitals in FYE 2014.

DHCS pays hospitals under the DRG payment methodology at the federal maximum upper payment limit, through the combination of DRG payments and multiple supplemental payments. Given that these payments are at the federal upper payment limits, DHCS cannot pay hospitals more than what is currently paid under the State Plan.

Conclusion: Based on this preliminary analysis of access, DHCS does not find that an access issue exists to GAC services, including rehabilitation services. This is due to various factors, among them: an increase in overall increase in GAC beds, an increase in hospital vacancy rates, as well as a concerted effort on the part of DHCS to enroll Medi-Cal beneficiaries into Medi-Cal managed care plans. Taken together, these factors appear to have more than offset the negative pressures on GAC access which include increased Medi-Cal enrollment as a result of the Affordable Care Act and increasing poverty rates. And finally, as noted above, hospitals are already paid at the federal upper payment limits.

DHCS will continue to monitor FFS Medi-Cal population's access to services, monitor utilization and payment, and apply policy adjustors when necessary to meet the goal of adequate access.

APPENDIX A: General Acute Care Utilization in Hospitals Reimbursed by DRG in FYE 2014[9][10]

County	Number of Hospitals	Number of Beds	Lic. Bed Days per Year	Patient Days per Year	Occupancy Rate	Vacancy Rate
Alameda	16	3,236	1,001,533	472,730	47%	53%
Amador	1	52	18,980	8,397	44%	56%
Butte	5	525	191,625	126,812	66%	34%
Calaveras	1	48	17,520	4,366	25%	75%
Colusa	1	42	15,330	2,362	15%	85%
Contra Costa	9	1,678	632,230	287,154	45%	55%
Del Norte	1	49	17,885	6,731	38%	62%
El Dorado	2	162	59,130	27,228	46%	54%
Fresno	9	1,703	618,443	377,692	61%	39%
Glenn	1	47	17,155	834	5%	95%
Humboldt	5	275	100,375	45,456	45%	55%
Imperial	2	268	97,820	36,616	37%	63%
Inyo	2	29	10,585	2,843	27%	73%
Kern	11	1,290	470,850	241,642	51%	49%
Kings	2	191	69,715	35,749	51%	49%
Lake	2	62	22,630	11,542	51%	49%
Lassen	1	38	13,870	3,978	29%	71%
Los Angeles	90	20,264	7,380,287	3,776,158	51%	49%
Madera	2	462	168,986	96,627	57%	43%
Marin	4	441	160,965	72,784	45%	55%
Mariposa	1	18	6,570	661	10%	90%
Mendocino	3	154	56,210	21,106	38%	62%
Merced	2	230	84,372	42,736	51%	49%
Modoc	2	20	7,300	436	6%	94%
Mono	1	17	6,205	654	11%	89%
Monterey	3	609	222,285	93,966	42%	58%
Napa	2	325	112,545	47,231	42%	58%
Nevada	2	139	50,735	22,296	44%	56%
Orange	35	5,757	2,117,789	966,735	46%	54%
Placer	3	740	265,600	162,894	61%	39%
Plumas	3	44	16,060	2,645	16%	84%
Riverside	17	3,056	1,115,440	592,877	53%	47%
Sacramento	10	2,316	837,586	466,087	56%	44%
San Benito	1	62	22,630	7,036	31%	69%
San Bernardino	24	3,645	1,399,080	724,971	52%	48%
San Diego	22	5,575	2,032,289	1,072,281	53%	47%
San Francisco	9	2,107	667,905	251,836	38%	62%
San Joaquin	7	997	363,961	160,860	44%	56%
San Luis Obispo	4	456	166,440	66,578	40%	60%
San Mateo	8	1,074	379,564	161,263	42%	58%
Santa Barbara	6	908	333,633	131,906	40%	60%
Santa Clara	11	2,953	1,087,436	583,560	54%	46%
Santa Cruz	3	359	131,035	67,871	52%	48%
Shasta	5	601	219,365	89,150	41%	59%
Siskiyou	2	61	22,265	7,162	32%	68%
Solano	5	672	245,280	125,439	51%	49%
Sonoma	9	898	293,438	134,405	46%	54%
Stanislaus	7	1,332	479,812	275,010	57%	43%
Sutter	2	74	27,010	6,757	25%	75%
Tehama	1	76	27,740	8,077	29%	71%
Trinity	1	25	9,125	1,633	18%	82%
Tulare	3	692	252,580	106,819	42%	58%
Tuolumne	2	84	30,660	19,636	64%	36%
Ventura	8	1,119	409,725	213,105	52%	48%
Yolo	2	125	45,625	17,460	38%	62%
Yuba	1	173	63,145	44,509	70%	30%
Grand Total	**394**	**68,355**	**24,694,354**	**12,335,349**	**50%**	**50%**

[9] The data includes NDPHs which did not participate in DRG reimbursement in CY 2013.
[10] As stated on page 8, GAC beds include rehabilitation beds.

APPENDIX B: Rehabilitation-Only Hospitals FYE 2014[11]

County	Number of Hospitals	Number of Beds	Licensed Bed Days per Year	Patient Days per Year	Occupancy Rate	Vacancy Rate
Butte	1	40	14,600	5,955	41%	59%
Kern	1	66	24,090	21,601	90%	10%
Los Angeles	1	68	24,820	21,788	88%	12%
Orange	2	86	31,466	24,265	77%	23%
San Bernardino	1	60	21,900	17,038	78%	22%
Grand Total	**6**	**320**	**116,876**	**90,647**	**78%**	**22%**

APPENDIX C: Study Data and Limitations

Study Data and Methods

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

Methods: The ratio of bed days to FFS Medi-Cal eligibles was based on OSHPD's total patient census days divided by the average number of eligibles over a ten-month period during calendar year (CY) 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 hospitalization. All other FFS Medi-Cal eligibles were included. The data on the FFS eligibles was extracted from the MIS/DSS system eight or more months after it was initially submitted to DHCS by the 58 counties, providing sufficient time for all counties to report the data and to make any corrections necessary. The number of individuals who are eligible for Medi-Cal hospital inpatient psychiatric services was derived by taking the total number of member months over a three-month period and dividing by three. The resulting figure was then modified by applying a

[11] The data includes only those hospitals that are rehabilitation-only; the other rehabilitation beds are included in Appendix A: General Acute Care Utilization in Hospitals Reimbursed by DRG in FY 2014-15.
[12] Population estimates for each county were obtained from the California Department of Finance, "Population and Housing Estimates for Cities, Counties, and the State, January 1, 2011-2016, with 2010 Benchmark" which was accessed on May 13, 2016.
[13] Poverty information for each county was obtained for the US Census Bureau, Small Income and Poverty Estimates tables which were accessed on June 8, 2015.
[14] The number of hospitals with licensed general acute care beds was downloaded from the Office of Statewide Health Planning and Development's Hospital Annual Utilization Data on March 8-10, 2016.
[15] The formula for the occupancy rate is taken Johns, Merida, *Health Information Management Technology: An Applied Approach*, Chicago, Illinois: AHIMA Press, 2011, p. 551. The vacancy rate is derived by subtracting the occupancy rate from 100 percent.

prevalence rate (i.e., the likelihood that individuals within a particular population would need hospital inpatient psychiatric services) to it.

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[16]. As a result, there is an annual lag in reporting and the last data set that was readily available to DHCS was for FYE 2014. The number of eligibles and the hospitals are from the State Fiscal Year 2015-16, the utilization rate is from calendar year 2014. Further, hospitals regularly place their GAC, rehabilitation and psychiatric beds "in suspense", either due to low demand or for other reasons. The data on beds placed in suspense is also lagging 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[17].

The calculation for vacancy rates assumes that those hospital beds are staffed and operated 24 hours per day, seven days per week during the reporting CY. This number may be overstated if hospital beds are not fully staffed during that time frame.

[16] 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. As a result, OSHPD's preliminary data does not constitute part of this report.

[17] 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, as a consequence, tend to report bed day availability by multiplying the number of beds by 365 or 366 in a leap year.