STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 323-4790

October 27, 1981

To: All County Welfare Directors

Letter No. 81-47

MEDICAID INPATIENT HOSPITAL REIMBURSEMENT

Federal regulations (CFR 42-447.205) require that any change in the Statewide method or level of reimbursement for Medicaid services by publicly noticed at least 60 days before the proposed effective date of the change. A local agency in each county must also be identified where copies of the proposed changes are available for public review.

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.

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

Expiration Date: December 31, 1981

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

STATE DEPARTMENT OF HEALTH SERVICES PUBLIC HEARING ON REGULATIONS

On January 5, 1982, commencing at 10:00 a.m., the State Department of Health Services will hold a public hearing in the Auditorium at 714 P Street, Sacramento, CA for the following agenda item:

(1)	Inpatient Hospital Reimbursement - 6% Limitation (R-54-81)	Arthur Chung (916) 323-4790	Title 22, Division 3 Emergency Regulation Filed October 1, 1981 Section 51538

The purpose of the hearing is to gather oral and/or written testimony from the public regarding the regulation changes under consideration. Attached you will find copies of recently published newspaper notices announcing the hearing and summarizing the regulation changes or containing the actual regulations. Also attached are copies of the actual regulation texts, arranged in the order in which they will be considered at the hearing. Additions to the existing regulations are indicated by underscoring and deletions have been ~~dashed-out~~.

The hearing will be chaired by a hearing officer delegated by the Director of Health Services to conduct the hearing in her behalf. Persons attending the hearing will be requested to complete a registration card at the door. Those persons wishing to present oral testimony will be requested to indicate on the card those agenda items to be addressed in their testimony.

Speakers will be called by the hearing officer as the appropriate agenda items are presented and everyone wishing to speak will be given the opportunity to do so. All testimony will be recorded by a certified shorthand reporter and each speaker will be asked to approach the microphone at the front of the hearing room and state for the record their name and the organization they represent, if any, prior to presentation of their testimony.

Although in most instances the hearing record will be closed at 5:00 p.m. on the day of the hearing, the record on individual agenda items may be held open for extended periods, at the discretion of the hearing officer, if it becomes evident that relevant written public testimony may be gathered by doing so.

Persons unable to attend the hearing or wishing to present testimony during a hearing extension period may submit written statements to:

State Department of Health Services
Office of Regulations
714 P Street, Room 1601
Sacramento, CA 95814

All testimony will be reviewed by the Department of Health Services prior to decision regarding final adoption of the regulation changes.

Any questions regarding the hearing may be addressed to the Department of Health Services at the above address or by phoning (916) 322-4990.

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

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

The Department of Health Services will hold a public hearing commencing at 10:00 a.m. on January 5, 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 October 1, 1981. Statements or arguments submitted in writing must be received by the Department by 5:00 p.m. on January 5, 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.

The emergency action taken is pursuant to the authority vested by Sections 14105, 14105.1 and 14124.5 of the Welfare and Institutions Code, Section 133.5, AB 251 (Ch. 102/81); Section 29, AB 1260, and is to implement, interpret or make specific Sections 14105, 14105.1, and 14106 of the Welfare and Institutions Code.

INFORMATIVE DIGEST

Current statutes and regulations require the Department of Health Services to reimburse hospitals for inpatient services rendered to Medi-Cal beneficiaries at the lower of customary charges, allowable costs determined in accordance with applicable Medicare standards and principles of reimbursement, or all-inclusive rate per discharge, as limited by a 55% hospital occupancy standard.

Recently enacted AB 251/1260 (Ch. 102, Stats. 1981 and Ch. 1163, Stats. 1981) added and amended Section 14105.1 of the Welfare and Institutions Code. Section 14105.1 limits reimbursable hospital cost increases in 1981-82 to 6% over the average amount paid, on a per discharge basis, during 1980-81. AB 251/1260 further provides that the Department shall adopt regulations implementing this 6% limitation as emergency regulations. Such regulations, however, shall only be implemented if the regulations are in conformity with federal statutes and regulations.

This regulation provides that reimbursement for inpatient hospital services rendered to Medi-Cal beneficiaries shall not exceed a rate of increase of 6 percent over the average payment per discharge at final settlement for services rendered during the comparable period of the prior year, but that the 6 percent limit shall not apply to services rendered prior to July 1, 1981 or after June 30, 1982. This regulation further provides for adjustments in interim payment rates consistent with the 6 percent limit, and provides for an adjustment to the allowable rate of increase for changes in case mix according to a specified methodology. The foregoing changes shall be effective on the effective date of federal approval of the change.

STATEMENT OF REASONS

The purpose of this regulation is to limit reimbursable hospital cost increases in 1981-82 to 6% over the average amount paid during 1980-81. These regulations implement the provisions and intent of AB 251/1260 (Ch. 102, Stats. 1981 and Ch. 1163, Stats. 1981) relating to health care services rendered to Medi-Cal beneficiaries by providers of inpatient hospital services.

As adopted and amended in AB 251/1260, Section 14105.1 of the Welfare and Institutions Code limits final settlements to a 6% increase over the prior base period's payment per discharge. Section 133.5 (d) of AB 251 also requires the Department to adopt regulations implementing AB 251's provisions "as emergency regulations in accordance with the provisions of the Administrative Procedure Act, Chapter 4.5 (commencing with Section 11371) of Part 1 of Divison 3 of Title 2 of the Government Code."

As a result of budget negotiations for the 1981-82 fiscal year, the State of California adopted a reimbursement policy for hospitals which 1) granted a flat 6% increase in allowable costs per discharge to all hospitals during 1981-82, and 2) authorized the State Department of Health Services to establish prospective reimbursement systems, on a pilot basis, for hospital services. These two actions were taken in response to the realization that without a fundamental change in the methods of reimbursing hospital costs, the State would be unable to ensure the continuation of the Medi-Cal program in its current form.

Although these actions were taken prior to the signing of the Omnibus Reconciliation Act of 1981 (P.L. 97-35), it is the State's feeling that the legislative action is consistent with both the letter and the intent of the Federal law. Specifically, it is our understanding that the State must pay hospitals rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. It is our contention that we certainly meet this criteria under our current State Plan, and given the particular situation in which California finds itself compared to other states, will continue to meet it under the proposed amendments. The conformance of our proposed amendments to the new Federal criteria is predicated upon two presumptions: 1) that the cost of goods and services purchased by hospitals in California will increase by approximately 12% during the coming year, and 2) that hospital expenditures in California currently exceed those necessary for the economical and efficient delivery of health services. Given this already inflated expenditure base for California hospitals, it is our contention that the 6% across the board increase in the allowable cost per discharge is more than adequate to meet the Federal criteria, and will in fact still leave California hospitals with base expenditures which exceed the national averages.

The first of these presumptions (i.e. that hospital input costs will increase by approximately 12%) is based upon the forecasts of Data Resources Inc.. Projections from this source are currently used by California in developing the allowable growth rate in hospital inpatient cost per discharge under our current State Plan. This rate is also consistent with the increases experienced in the past year in California hospitals.

In support of the presumption that the expenditure base in California hospitals is already inflated, several statistical measures of relative performance have been summarized in Table I. Each of these measures, which are derived from data submitted by the hospitals to the American Hospital Association, show that California exceeds the comparable national averages by from anywhere from 11.6 to 47.0 percent.

The measures used for this comparison are: 1) cost per day, 2) cost per admission, 3) full time labor equivalents (FTE's) per bed, and 4) assets per bed. The payroll cost per FTE is also included in the table so that adjustments can be made to the cost figures to reflect differences in the price and skill levels of hospital employees.

The largest disparity between California and the U.S. average for the performance indicators presented in Table I, is in the area of cost per day. This difference of 47% means that each patient day in a California hospital is, on average, almost one and one half times the national average.

One argument made by the hospitals in justifying this difference is that the State's higher cost per day is a reflection of the greater level of service intensity in California hospitals, and that this higher level of intensity has led to a reduction in California's length of stay compared to national averages. While there is certainly some validity to this argument, it does not explain the entire difference in costs. If, for example, we look at the cost per admission, a performance measure which takes into account the shorter length of stay in California, we find that State costs still exceed the national average by about 27%. Even after adjusting the cost per admission for difference in wage rates due to differences in both general salary levels and differences in skill levels, cost per admission in California exceeds the national average by 15.2%. [1]

As indicators of the relative labor and capital intensity of California hospitals compared to national averages, Table I also shows the FTE's per bed and the assets per bed. As seen in these statistics, California exceeds national norms on both measures, with FTE's per bed being 11.6% higher than the national average, and assets per bed being 12.5% higher.

Accepting the national norms as a criterion for "efficiently and economically operated facilities", it is apparent from Table I that California exceeds these amounts by far more than the difference between the anticipated rate of inflation for hospitals (12%) and the 6% allowance which has been granted by the legislature. It is therefore the contention of the State that rather than being parsimonious in its rate increase, California is instead being quite liberal vis-a-vis the federal requirements in granting 6%, when consideration is given to the inflated levels of base costs which already exist in California hospitals. We would therefore maintain that California does meet the letter and intent of the Budget Reconciliation Act and that our State Plan amendment should be approved as submitted.

1 This adjustment is made by decreasing the proportion of the cost per admission attributable to payroll costs by the percentage amount by which California's payroll cost per FTE exceeds the statewide average, and adding it to the proportion of the cost per admission not attributable to payroll costs. Specifically $.548(2091.69)(1 - .175) + (1 - .548)(2091.69) = 1891.10$
$1891.10 \div 1641.48 = 1.152$.

TABLE I

	California	U.S. Average	Percent Difference
Cost Per Day[1]	319.41	217.34	47.0
Cost Per Admission[1]	2091.69	1641.48	27.4
F.T.E. Per Bed[1]	3.09	2.77	11.6
Assets Per Bed[2]	$96,561	$85,837	12.5
Payroll Cost Per FTE[1]	$16.03	$13.64	17.5
Payroll cost as[1] a percentage of total	54.8%		

Sources:

1) Hospital Statistics. American Hospital Association, Chicago, 1980 Table 5A and 5C.

2) Hospital Fact Book 1980. California Hospital Association, 1980 Table 27.

Specifically this regulation change:

(1) Adopts new Section 51538 to limit reimbursable hospital cost increases in 1981-82 to 6% over the average amount paid during 1980-81.

Estimated 1981-82 savings to the Department: $50,829,000 (Gen. Fund $32,324,000)
Estimated 1982-83 savings to the Department: $141,696,000 (Gen. Fund $91,253,000)
Cost to any local agency or school district that is required to be reimbursed under Section 2231 of the Revenue & Taxation Code: None
Other nondiscretionary costs/savings imposed on local agencies : None
Annual/savings in federal funding to the State : 1981-82 $18,505,000 1982-83 $50,443,000

The Department has made copies of the regulation summarized above available for public review in the main office of each local county welfare agency. Individual copies may still be obtained by writing to the Office of Regulations, State Department of Health Services, 714 P Street, Room 1601, Sacramento, California 95814.

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

The express terms of the proposed 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 proposed action.

DEPARTMENT OF HEALTH SERVICES

R-54-81
5365

Dated: 10/14/81
October 14, 1981

Original signed by

Richard H. Koppes for
Beverlee A. Myers, Director

(1) Adopt new Section 51538 to read:

51538. Maximum Allowable Rate of Increase for Inpatient Hospital Services.

(a) To the extent permitted by federal law, reimbursement to hospitals for inpatient hospital services rendered to Medi-Cal program beneficiaries shall not exceed a rate of increase of 6 percent over the average payment per discharge at final settlement for services rendered during the comparable period of the prior year. The 6% reimbursement provision shall be implemented by adjusting the Hospital Cost Index specified in Section 51536 to meet the requirements of this section, but shall not apply to services rendered prior to July 1, 1981 or after June 30, 1982.

(b) Interim payment rates to hospitals shall be adjusted as soon as reasonably possible as consistent with federal law, to accomplish a rate of payment increase to hospitals for inpatient services which is consistent with the provisions of this section.

(c) The reimbursement principles employed by the Department in final settlement pursuant to this section will be the methods in effect prior to the effective date of federal approval, for any services rendered prior to that time, and 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) For cost reporting periods beginning on or after the effective date of federal approval, and after adjusting the Hospital Cost Index as specified in (c) above, an adjustment for changes in case mix shall be made to the Hospital Cost Index if the hospital's case mix in the final settlement year has materially changed from its prior year's case mix.

(1) The case mix adjustment shall be applied to the rate per discharge to adjust that rate for estimated changes in Medi-Cal costs resulting from changes in case mix according to the following method.

(2) For each Major Diagnostic Category (MDC), as specified in "Health Care Financing Grants and Contracts Report, AUTOGRP Patient Classification Scheme and Diagnosis Related Groups" by Robert B. Fetter, determination of the average Medi-Cal charge per MDC shall be as follows:

(A) Calculate the summation of the hospital's charges to the Medi-Cal program in the prior year for such MDC.

(B) Divide the result in (A) above by the number of Medi-Cal discharges in the prior year for such MDC.

(3) Calculate the summation of the average Medi-Cal charges per MDC in the prior year times the percentage of Medi-Cal discharges in the final settlement year for each MDC.

(4) Calculate the summation of the average Medi-Cal charge per MDC in the prior year times the percentage of Medi-Cal discharges in the prior year for each MDC.

(5) Divide the results to (3) by (4) above.

(6) Multiply the Hospital Cost Index as specified in (c) above by the results of (5) above.

(e) Exemptions to the case mix adjustment specified in (d) above may be granted if it is concluded by the Department and the hospital that there are an insufficient number of cases to validly determine the effect of the hospital's change in case mix. Such exemptions may include, but not be limited to, new hospitals, rural hospitals, and sole community hospitals as specified in Section 51537(f), (g) and (h).