ASSEMBLY BILL No. 366

Introduced by Assembly Member Bonta
(Principal coauthor: Senator Hernandez)

February 17, 2015

An act to amend Section 14105.28 of, and to add Sections 14105.194, 14105.196, and 14301.6 to, the Welfare and Institutions Code, relating to Medi-Cal and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 366, as introduced, Bonta. Medi-Cal: reimbursement: provider rates.

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law requires the department to develop and implement a Medi-Cal inpatient hospital reimbursement payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals, as specified. Existing law generally requires the diagnosis-related group-based payments to apply to all claims.

This bill would require claims for payments pursuant to the inpatient hospital reimbursement methodology described above to be increased by ___ percent for the 2015–16 fiscal year, and would require, commencing July 1, 2016, and annually thereafter, the department to increase each diagnosis-related group payment claim amount based on

increases in the medical component of the California Consumer Price Index.

(2) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, and provider payments for specified non-Medi-Cal programs to be reduced by 1%, for dates of service on and after March 1, 2009, and until June 1, 2011. Existing law requires, except as otherwise provided, Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011.

This bill would, instead, prohibit the application of those reductions for payments to providers for dates of service on or after June 1, 2011. The bill would also require payments for managed care health plans for dates of service following the effective date of the bill to be determined without application of some of those reductions. The bill would require the Director of Health Care Services to implement this provision to the maximum extent permitted by federal law and for the maximum time period for which the director obtains federal approval for federal financial participation for those payments.

(3) Prior law required, beginning January 1, 2013, through and including December 31, 2014, that payments for primary care services provided by specified physicians be no less than 100% of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

This bill, commencing January 1, 2016, would require, only to the extent permitted by federal law and that federal financial participation is available, payments for specified medical care services to not be less than 100% of the payment rate that applies to those services as established by the Medicare Program, for both fee-for-service and managed care plans. The bill would authorize the department to implement those provisions through provider bulletins without taking regulatory action until regulations are adopted, and would require the department to adopt those regulations by July 1, 2018. The bill would require, commencing July 1, 2016, the department to provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(4) Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

This bill would require, to the extent federal financial participation is not jeopardized, the department to pay Medi-Cal managed care plans

rate range increases at a minimum level of 100% of the rate range available with respect to all enrollees who are not subject to the rate range payment requirements that are applicable to all enrollees who are newly eligible beneficiaries assigned to county public hospital health systems.

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14105.28 of the Welfare and Institutions Code is amended to read:

14105.28. (a) It is the intent of the Legislature to design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups that more effectively ensures all of the following:

(1) Encouragement of access by setting higher payments for patients with more serious conditions.

(2) Rewards for efficiency by allowing hospitals to retain savings from decreased length of stays and decreased costs per day.

(3) Improvement of transparency and understanding by defining the "product" of a hospital in a way that is understandable to both clinical and financial managers.

(4) Improvement of fairness so that different hospitals receive similar payment for similar care and payments to hospitals are adjusted for significant cost factors that are outside the hospital's control.

(5) Encouragement of administrative efficiency and minimizing administrative burdens on hospitals and the Medi-Cal program.

(6) That payments depend on data that has high consistency and credibility.

(7) Simplification of the process for determining and making payments to the hospitals.

(8) Facilitation of improvement of quality and outcomes.

(9) Facilitation of implementation of state and federal provisions related to hospital acquired conditions.

(10) Support of provider compliance with all applicable state and federal requirements.

(b) (1) (A) (i) The department shall develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals in state and out of state, including Medicare critical access hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.

(ii) The payment methodology developed pursuant to this section shall be implemented on July 1, 2012, or on the date upon which the director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later.

(iii) Claims for payments pursuant to the payment methodology based on diagnosis-related groups established under this section shall be increased by ___ percent for the 2015–16 fiscal year.

(iv) Commencing July 1, 2016, and annually thereafter, the department shall increase each diagnosis-related group payment claim amount based on increases in the medical component of the California Consumer Price Index.

(B) The diagnosis-related group-based payments shall apply to all claims, except claims for psychiatric inpatient days, rehabilitation inpatient days, managed care inpatient days, and swing bed stays for long-term care services, provided, however, that psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay was in a distinct-part unit. The department may exclude or include other claims and services as may be determined during the development of the payment methodology.

(C) Implementation of the new payment methodology shall be coordinated with the development and implementation of the replacement Medicaid Management Information System pursuant to the contract entered into pursuant to Section 14104.3, effective on May 3, 2010.

(2) The department shall evaluate alternative diagnosis-related group algorithms for the new Medi-Cal reimbursement system for the hospitals to which paragraph (1) applies. The evaluation shall

include, but not be limited to, consideration of all of the following factors:

(A) The basis for determining diagnosis-related group base price, and whether different base prices should be used taking into account factors such as geographic location, hospital size, teaching status, the local hospital wage area index, and any other variables that may be relevant.

(B) Classification of patients based on appropriate acuity classification systems.

(C) Hospital case mix factors.

(D) Geographic or regional differences in the cost of operating facilities and providing care.

(E) Payment models based on diagnosis-related groups used in other states.

(F) Frequency of grouper updates for the diagnosis-related groups.

(G) The extent to which the particular grouping algorithm for the diagnosis-related groups accommodates ICD-10 diagnosis and procedure codes, and applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996.

(H) The basis for calculating relative weights for the various diagnosis-related groups.

(I) Whether policy adjusters should be used, for which care categories they should be used, and the frequency of updates to the policy adjusters.

(J) The extent to which the payment system is budget neutral and can be expected to result in state budget savings in future years.

(K) Other factors that may be relevant to determining payments, including, but not limited to, add-on payments, outlier payments, capital payments, payments for medical education, payments in the case of early transfers of patients, and payments based on performance and quality of care.

(c) The department shall submit to the Legislature a status report on the implementation of this section on April 1, 2011, April 1, 2012, April 1, 2013, and April 1, 2014.

(d) The alternatives for a new system described in paragraph (2) of subdivision (b) shall be developed in consultation with recognized experts with experience in hospital reimbursement,

economists, the federal Centers for Medicare and Medicaid Services, and other interested parties.

(e) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a particular hospital or hospital group, with demonstrated expertise in hospital reimbursement systems. The rate setting system described in subdivision (b) shall be developed with all possible expediency. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The department may adopt emergency regulations to implement the provisions of this section in accordance with rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the one readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other ~~provision of~~ law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, all-county letter, manual, or other similar instruction, at least five days prior to issuance. In addition, the

department shall provide a copy of any provider bulletin, all-county letter, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature.

SEC. 2. Section 14105.194 is added to the Welfare and Institutions Code, to read:

14105.194. (a) Notwithstanding Sections 14105.07, 14105.191, 14105.192, and 14105.193, payments to providers for dates of service on or after June 1, 2011, shall be determined without application of the reductions in Sections 14105.07, 14105.191, 14105.192, and 14105.193, except as otherwise provided in this section.

(b) Notwithstanding Sections 14105.07 and 14105.192, and except as otherwise provided in this section, for managed care health plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), payments for dates of service following the effective date of the act adding this section shall be determined without application of the reductions, limitations, and adjustments in Sections 14105.07 and 14105.192.

(c) The director shall implement this section to the maximum extent permitted by federal law and for the maximum time period for which the director obtains federal approval for federal financial participation for the payments provided for in this section.

(d) The director shall promptly seek all necessary federal approvals to implement this section.

SEC. 3. Section 14105.196 is added to the Welfare and Institutions Code, to read:

14105.196. (a) It is the intent of the Legislature to:

(1) Maintain the increased reimbursement rates for primary care providers in the Medi-Cal program upon expiration of the temporary increase provided for under Chapter 23 of the Statutes of 2012, as amended by Chapter 438 of the Statutes of 2012, in order to ensure adequate access to these providers.

(2) To increase reimbursement rates for other Medi-Cal providers to the amounts reimbursed by the federal Medicare program in order to ensure access to medically necessary health care services, and to comply with federal Medicaid requirements that care and services are available to Medi-Cal enrollees at least

to the extent that care and services are available to the general population in the geographic area.

(b) Beginning January 1, 2016, to the extent permitted by federal law and regulations, payments for medical care services shall not be less than 100 percent of the payment rate that applies to those services as established by the Medicare program, for both fee-for-service and managed care plans.

(c) Notwithstanding any other law, to the extent permitted by federal law and regulations, the payments for medical care services made pursuant to this section shall be exempt from the payment reductions under Sections 14105.191 and 14105.192.

(d) Payment increases made pursuant to this section shall not apply to provider rates of payment described in Section 14105.18 for services provided to individuals not eligible for Medi-Cal or the Family Planning, Access, Care and Treatment (Family PACT) Program.

(e) For purposes of this section, "medical care services" means the services identified in subdivisions (a), (h), (i), (n), and (q) of Section 14132.

(f) Notwithstanding any other law, the payment increase implemented pursuant to this section shall apply to managed care health plans that contract with the department pursuant to Chapter 8.75 (commencing with Section 14591) and to contracts with the Senior Care Action Network and the AIDS Healthcare Foundation, and to the extent that the services are provided through any of these contracts, payments shall be increased by the actuarial equivalent amount of the payment increases pursuant to contract amendments or change orders effective on or after January 1, 2016.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, clarify, make specific, and define the provisions of this section by means of provider bulletins or similar instructions, without taking regulatory action until the time regulations are adopted. The department shall adopt regulations by July 1, 2018, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning July 1, 2016, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a

semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(h) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 4. Section 14301.6 is added to the Welfare and Institutions Code, to read:

14301.6. To the extent federal financial participation is not jeopardized and consistent with federal law, the department shall pay Medi-Cal managed care plans rate range increases, as defined by paragraph (4) of subdivision (b) of Section 14301.4, at a minimum level of 100 percent of the rate range available with respect to all enrollees who are not subject to the rate range payment requirements described in Section 14301.5.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure, at the earliest possible time, access to medically necessary care for Medi-Cal beneficiaries, it is necessary that this act take effect immediately.

O