

AMENDED IN SENATE APRIL 13, 2015

**SENATE BILL**

**No. 243**

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**Introduced by Senator Hernandez**

(Principal coauthor: Assembly Member Bonta)

*(Coauthors: Senators Galgiani, Hertzberg, Pan, Pavley, Roth, Stone, Wieckowski, and Wolk)*

*(Coauthors: Assembly Members Achadjian, Campos, Cooper, Dababneh, Levine, Lopez, Low, Maienschein, Nazarian, Rendon, Santiago, Steinorth, Thurmond, Ting, and Waldron)*

February 17, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

SB 243, as amended, Hernandez. 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 ~~16~~ 16 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, *at a minimum*, on increases in the medical component of the California Consumer Price Index. *Commencing with the 2015–16 fiscal year, and annually thereafter, the bill would require managed care rates for Medi-Cal managed care health plans to be increased by a proportionately equal amount for increased payments for hospital services.*

(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, 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~~. *program for services rendered by fee-for-service providers, and would require rates paid to Medi-Cal managed care*

plans to be actuarially equivalent to payment rates established by the Medicare program. 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)~~

~~(4) This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

1 SECTION 1. Section 14105.28 of the Welfare and Institutions  
2 Code is amended to read:  
3 14105.28. (a) It is the intent of the Legislature to design a new  
4 Medi-Cal inpatient hospital reimbursement methodology based  
5 on diagnosis-related groups that more effectively ensures all of  
6 the following:  
7 (1) Encouragement of access by setting higher payments for  
8 patients with more serious conditions.  
9 (2) Rewards for efficiency by allowing hospitals to retain  
10 savings from decreased length of stays and decreased costs per  
11 day.  
12 (3) Improvement of transparency and understanding by defining  
13 the “product” of a hospital in a way that is understandable to both  
14 clinical and financial managers.

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

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

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

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

11 (8) Facilitation of improvement of quality and outcomes.

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

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

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

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

29 (iii) Claims for payments pursuant to the payment methodology  
30 based on diagnosis-related groups established under this section  
31 shall be increased by ~~16~~ 16 percent for the 2015–16 fiscal year.  
32 *Managed care rates to Medi-Cal managed care health plans shall*  
33 *be increased by a proportionately equal amount for increased*  
34 *payments for hospital services for the 2015–16 fiscal year.*

35 (iv) Commencing July 1, 2016, and annually thereafter, the  
36 department shall increase each diagnosis-related group payment  
37 claim amount based, *at a minimum*, on increases in the medical  
38 component of the California Consumer Price Index. *Commencing*  
39 *July 1, 2016, and annually thereafter, managed care rates to*  
40 *Medi-Cal managed care health plans shall be increased by a*

1 *proportionately equal amount for increased payments for hospital*  
2 *services.*

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

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

17 (2) The department shall evaluate alternative diagnosis-related  
18 group algorithms for the new Medi-Cal reimbursement system for  
19 the hospitals to which paragraph (1) applies. The evaluation shall  
20 include, but not be limited to, consideration of all of the following  
21 factors:

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

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

29 (C) Hospital case mix factors.

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

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

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

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

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

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

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

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

14 (c) The department shall submit to the Legislature a status report  
15 on the implementation of this section on April 1, 2011, April 1,  
16 2012, April 1, 2013, and April 1, 2014.

17 (d) The alternatives for a new system described in paragraph  
18 (2) of subdivision (b) shall be developed in consultation with  
19 recognized experts with experience in hospital reimbursement,  
20 economists, the federal Centers for Medicare and Medicaid  
21 Services, and other interested parties.

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

35 (f) (1) The department may adopt emergency regulations to  
36 implement the provisions of this section in accordance with  
37 rulemaking provisions of the Administrative Procedure Act  
38 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
39 Division 3 of Title 2 of the Government Code). The initial adoption  
40 of emergency regulations and one readoption of the initial

1 regulations shall be deemed to be an emergency and necessary for  
2 the immediate preservation of the public peace, health and safety,  
3 or general welfare. Initial emergency regulations and the one  
4 readoption of those regulations shall be exempt from review by  
5 the Office of Administrative Law. The initial emergency  
6 regulations and the one readoption of those regulations authorized  
7 by this section shall be submitted to the Office of Administrative  
8 Law for filing with the Secretary of State and publication in the  
9 California Code of Regulations.

10 (2) As an alternative to paragraph (1), and notwithstanding the  
11 rulemaking provisions of Chapter 3.5 (commencing with Section  
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
13 or any other law, the department may implement and administer  
14 this section by means of provider bulletins, all-county letters,  
15 manuals, or other similar instructions, without taking regulatory  
16 action. The department shall notify the fiscal and appropriate policy  
17 committees of the Legislature of its intent to issue a provider  
18 bulletin, all-county letter, manual, or other similar instruction, at  
19 least five days prior to issuance. In addition, the department shall  
20 provide a copy of any provider bulletin, all-county letter, manual,  
21 or other similar instruction issued under this paragraph to the fiscal  
22 and appropriate policy committees of the Legislature.

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

25 14105.194. (a) Notwithstanding Sections 14105.07, 14105.191,  
26 14105.192, and 14105.193, payments to providers for dates of  
27 service on or after June 1, 2011, shall be determined without  
28 application of the reductions in Sections 14105.07, 14105.191,  
29 14105.192, and 14105.193, except as otherwise provided in this  
30 section.

31 (b) Notwithstanding Sections 14105.07 and 14105.192, and  
32 except as otherwise provided in this section, for managed care  
33 health plans that contract with the department pursuant to this  
34 chapter or Chapter 8 (commencing with Section 14200), payments  
35 for dates of service following the effective date of the act adding  
36 this section shall be determined without application of the  
37 reductions, limitations, and adjustments in Sections 14105.07 and  
38 14105.192.

39 (c) The director shall implement this section to the maximum  
40 extent permitted by federal law and for the maximum time period

1 for which the director obtains federal approval for federal financial  
 2 participation for the payments provided for in this section.

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

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

7 14105.196. (a) It is the intent of the Legislature to:

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

13 (2) ~~To increase~~ *Increase* reimbursement rates for other Medi-Cal  
 14 providers to the amounts reimbursed by the federal Medicare  
 15 program in order to ensure access to medically necessary health  
 16 care services, and to comply with federal Medicaid requirements  
 17 that care and services are available to Medi-Cal enrollees at least  
 18 to the extent that care and services are available to the general  
 19 population in the geographic area.

20 (3) *Increase reimbursement rates for Denti-Cal providers to*  
 21 *the equivalent rate of the percentage increase for other Medi-Cal*  
 22 *providers to the amounts reimbursed by the federal Medicare*  
 23 *program in order to ensure access to medically necessary dental*  
 24 *services, and to comply with federal Medicaid requirements that*  
 25 *care and services are available to Medi-Cal enrollees at least*  
 26 *to the extent that care and services are available to the general*  
 27 *population in the geographic area.*

28 (b) ~~Beginning January 1, 2016, to the extent permitted by federal~~  
 29 ~~law and regulations, payments~~

30 (b) (1) (A) *Commencing January 1, 2016, payments for*  
 31 *medical care services rendered by fee-for-service Medi-Cal*  
 32 *providers, including dental providers, shall not be less than 100*  
 33 *percent of the payment rate that applies to those services as*  
 34 *established by the Medicare program, for both fee-for-service and*  
 35 ~~managed care plans.~~ *program for services rendered by*  
 36 *fee-for-service providers.*

37 (B) *Commencing January 1, 2016, rates paid to Medi-Cal*  
 38 *managed care plans shall be actuarially equivalent to the payment*  
 39 *rates established under the Medicare program.*



1 (2) *This subdivision shall be implemented only to the extent*  
2 *permitted by federal law and regulations.*

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

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

12 (e) For purposes of this section, “medical care services” means  
13 the services identified in subdivisions (a), (h), (i), (j), (n), ~~and (q),~~  
14 ~~and (w) of Section 14132.~~ *14132, and adult dental benefits*  
15 *provided pursuant to Section 14131.10.*

16 (f) Notwithstanding any other law, the *department shall*  
17 *implement the payment increase implemented pursuant to required*  
18 *by this section shall apply* to managed care health plans that  
19 ~~contract with the department~~ pursuant to Chapter 8.75  
20 (commencing with Section 14591) and to contracts with the Senior  
21 Care Action Network and the AIDS Healthcare ~~Foundation, and~~  
22 ~~Foundation in the following manner,~~ to the extent that the services  
23 are provided through any of these contracts, payments *by the*  
24 *department to managed care health plans* shall be increased by  
25 ~~the actuarial~~ *actuarially* equivalent amount of the payment  
26 increases pursuant to contract amendments or change orders  
27 effective on or after January 1, 2016.

28 (g) Notwithstanding Chapter 3.5 (commencing with Section  
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
30 the department shall implement, clarify, make specific, and define  
31 the provisions of this section by means of provider bulletins or  
32 similar instructions, without taking regulatory action until the time  
33 regulations are adopted. The department shall adopt regulations  
34 by July 1, 2018, in accordance with the requirements of Chapter  
35 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
36 Title 2 of the Government Code. Beginning July 1, 2016, and  
37 notwithstanding Section 10231.5 of the Government Code, the  
38 department shall provide a status report to the Legislature on a  
39 semiannual basis, in compliance with Section 9795 of the  
40 Government Code, until regulations have been adopted.

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

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

6 ~~14301.6. To the extent federal financial participation is not  
7 jeopardized and consistent with federal law, the department shall  
8 pay Medi-Cal managed care plans rate range increases, as defined  
9 by paragraph (4) of subdivision (b) of Section 14301.4, at a  
10 minimum level of 100 percent of the rate range available with  
11 respect to all enrollees who are not subject to the rate range  
12 payment requirements described in Section 14301.5.~~

13 ~~SEC. 5.~~

14 ~~SEC. 4. This act is an urgency statute necessary for the  
15 immediate preservation of the public peace, health, or safety within  
16 the meaning of Article IV of the Constitution and shall go into  
17 immediate effect. The facts constituting the necessity are:~~

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