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**PUBLIC HOSPITALS
AND HEALTH SYSTEMS**



Private
Essential
Access
Community
Hospitals

California's Community Safety Net Hospitals
Essential to Access, Essential to Health



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United Hospital Association

DISTRICT HOSPITAL LEADERSHIP FORUM



Alliance
of Catholic Health Care

Representing California's Catholic
Health Systems and Hospitals

April 20, 2020

Bradley Gilbert, MD, MPH
Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Sent Electronically to: Bradley.Gilbert@dhcs.ca.gov

RE: The Medi-Cal Response to COVID-19 for California's Hospitals

Dear Dr. Gilbert:

We want to acknowledge and extend our appreciation for the tremendous response so far by the Department of Health Care Services (DHCS) and that of all departments within the California Health and Human Services Agency. Although we are still amid the COVID-19 crisis, please know that hospitals stand beside you, focused on one thing: caring for patients.

When our state began its response to the unprecedented threat of COVID-19 in late February 2020, California's more than 400 hospitals quickly recognized and reacted to the gravity of a global pandemic that continues to threaten millions of lives around the world. Working closely with the state, hospitals immediately began suspending or canceling non-emergency surgeries, repurposing physical space to prepare for a surge of tens of thousands of COVID-19 patients, securing additional personal protective equipment, increasing staff capacity, and transitioning lower acuity patients to other settings, among other measures. **Hospitals estimate the impact over a six-month period will result in losses surpassing \$10 billion.**

The response to COVID-19 has strained California's health care system like never before — demanding more out of providers' clinical, administrative, operational, human and financial resources. While these immediate demands are putting most hospitals into a financially distressed state, this will pale in comparison to the long-term devastation that COVID-19 will wreak on California's health care systems and the work that will be required to collectively begin to rebuild.

Taking into consideration the immediate challenges and the growing uncertainty post the COVID-19 crisis, we urge DHCS to take the following actions to stabilize existing programs and predictability of vital funding sources for hospitals.

These requests are made considering a myriad of options that DHCS can take in the short-term to support our hospitals as they meet this challenge. Additionally, it is critical that hospitals have both immediate financial relief and longer-term financial support to ensure they can continue to care for patients. We are completing an analysis of the financial impact and will submit a request for additional direct support that could be provided in the current fiscal year.

Seek extension of existing 1115 Waiver Programs (Medi-Cal 2020) through December 31, 2021

Depending on the Medi-Cal 2020 waiver program, the current sunset date might be June 30, 2020, or December 31, 2020. Overall, the Medi-Cal 2020 Waiver has been a success — from implementing Whole Person Care pilots throughout the state, to transforming the delivery system through the efforts of PRIME and the Global Payment Programs. Even though the Centers for Medicaid & Medicare Services (CMS) released guidance in 2018 making the continuation of these programs under normal circumstances difficult through an 1115 Waiver Authority, ***we applaud DHCS in seeking the immediate extension of the existing waiver programs through December 31, 2021, with the waiving of budget neutrality.***

Continuing on the path of shifting these waiver programs into Medi-Cal managed care through California Advancing and Innovating Medi-Cal (CalAIM) efforts with Enhanced Care Management (ECM) and In-Lieu-Of-Services (ILOS) was no easy task under normal circumstances. Our safety net providers were working in close partnership with the state and managed care plans to adapt to the expiring programs, prepare in advance with the Medi-Cal managed care plans, and work toward predictability with their future revenue streams. However, given the current pandemic and recognizing the reality that all providers throughout the state are focused on treating patients, this is simply not an option. If safety net providers are forced into making these structural changes during the pandemic, this will lead to long-lasting negative impacts to the access of care and the overall safety net of California's health care delivery system.

Delay collection of the 2019-21 Hospital Quality Assurance Fee (HQAF) Children's Coverage

Across the state, hospitals are experiencing universally 20%-30% reductions in overall net patient revenue. Hospitals are seeing 50% reductions in emergency department utilization, and 100% cancellations of elective surgeries and outpatient procedures. Combining the significant decreases of revenue with the growing costs overall, many hospitals around the state are facing a financial uncertainty and determining whether they can make payroll and continue to operate during this crisis. Understanding that California's federal medical assistance percentages (FMAP) was increased temporarily by 6.2%, we believe the additional benefit from collecting more in federal funding will help relieve the state General Fund pressure to collect the Children's Coverage during this crisis. Existing statute provides the state with **discretion on when to collect** this portion of the program. For these reasons, ***we urge the state to delay the collection of the HQAF Children's Coverage until the managed care SFY 2019-20 passthrough cycle, and then to redistribute the collection of the Children's Coverage proportionally over all remaining FFS and managed care cycles.***

As the numbers of unemployed grow, so will the size of the Medi-Cal program and the uncompensated costs to hospitals in caring for these vulnerable patients. Unfortunately, because the Hospital Fee Program operates in such a retroactive manner, the shortfalls that exist today will not be mitigated for several years—until the multi-year look-back of utilization, network provider determinations, and then the calculations of supplemental payments can be performed by DHCS. Delaying the HQAF Children's Coverage would help hospitals at a time when resources are significantly limited.

Pursue Flexibility for Hospitals Unable to Pay the Hospital Fee Program Assessment

Between now and November 2020, hospitals will be required to advance \$3.57 billion in fees assessed by the Hospital Fee Program to receive \$5.52 billion in payments. These “advances” range from 20-days prior to receiving the fee-for-service (FFS) payments, to nearly 60-days prior to receiving the managed care directed payments. Given the current cash flow concerns, this delay between paying the fees to the state and receiving the payment is simply not feasible for many of the safety net hospitals. ***As such, we urge the state to use state General Funds in lieu of hospital quality assurance fees as the non-federal share of the supplemental payments*** and provide hospitals with a “net” payment of what their supplemental Medi-Cal payment would have been, but reduced by the fee assessment that was leveraged by the state General Fund.

Direct All Medi-Cal Managed Care Plans (MCPs) and their delegated entities to support hospitals

Specifically, we urge you to direct health plans and their delegates to do the following:

1. Resolve all unpaid claims to hospitals within 30 days.

Hospitals are currently owed billions of dollars in claims for care that remain unpaid by insurance companies and health plans. Some can take 90 days or more to pay hospital claims. Given hospitals have cancelled services and emptied to prepare for COVID-19 patients, there are far fewer claims for insurers to process. Directing Medi-Cal MCPs and their delegates to pay all outstanding hospital claims within 30 days, and to continue to pay new claims within 30 days, would immediately create much-needed cash flow.

2. Support hospitals by offering voluntary advance payment programs.

Following the model set by Medicare, other Medi-Cal MCPs and their delegates should offer options for hospitals to volunteer to receive accelerated or advance claims payments. This allows hospitals in need to receive payments in advance, smooth cash flow now and reconcile those claims at a later date.

Below is a proposed framework, already shared with the Medi-Cal MCPs: **The Managed Care Medi-Cal Periodic Interim Payment Program (MCMCPIP)**

- California's safety net hospitals are federally qualified as Disproportionate Share Hospitals (DSH) and treat most of all Medi-Cal patients in the state
- DSH hospitals generally lack the resources/reserves that other hospitals have because they don't treat large volumes of commercially insured patients for higher revenues
- Safety Net hospitals are now facing severe cash shortfalls, and many are concerned about making payroll and other integral payments
- Medi-Cal health plan partners have expressed a desire to provide support to the Medi-Cal safety net
- To the extent health plans can immediately adjudicate current hospital accounts receivable, and exercise administrative flexibility to accelerate cash payments, it would be financially lifesaving for many safety net hospitals
- One approach could be to distribute a periodic interim payment (PIP) every two weeks to hospitals, in the amount of 1/26th of the total amount of claims paid in 2019
- The start date for the MCMCPIP program could be March 15, 2020
- The first PIP could be paid by Friday, April 24, 2020 and could cover three (3) PIP periods (March 15 - April 17), or 3/26ths of the 2019 payment amount
- The second PIP could be processed two weeks later, on May 1 and cover the period April 18 - May 1, 2020

- The Medi-Cal DSH Eligibility List provides a good start in identifying hospitals that are high Medi-Cal providers, although other important providers may not be reflected on the list, they are integral in certain communities and for certain populations (children, etc.).
- The MCMCPIP Program will initially continue for six months, at which time hospitals and health plans will determine whether the program shall be extended
- The hospitals will have six months from the end of the program to reconcile actual claims paid against PIP received to determine the amount remaining that is due to/from the health plan
- The reconciliation will include provisions that remove administrative burdens such as examination of pre-authorizations, etc.

3. Remove administrative barriers to speed payment to hospitals.

Insurance companies and health plans can help by speeding or eliminating prior authorization requests and temporarily changing other administrative practices that are used to delay or deny hospital claims, such as the default request for a copy of medical records in all cases and lengthy, phone-based admission and post-stabilization notification requirements. All of these delay care to patients and slow payments to hospitals.

Increased Federal Medical Assistance Percentage should be shared with Providers

Enacted as part of the Families First Coronavirus Response Act on March 18th, California will receive increased federal funds to support the Medi-Cal program. The Centers for Medicaid & Medicare Services (CMS) during the time of the emergency declaration, will increase their contribution from 50% to 56.2% of Medi-Cal Costs. ***This new state General Fund savings should be immediately shared with providers who are at the frontlines responding to the pandemic through the issuance of direct grants in order to offset their immediate losses in revenue and increased costs.***

Advance Fee-for-Service Medi-Cal and California Children's Services Payments to Hospitals

Although Medi-Cal has transitioned to a predominantly managed care payment system over the past decade, some hospitals, such as children's hospitals, continue to receive a significant volume of reimbursement through FFS Medi-Cal and California Children's Services (CCS) payments. For example, Children's hospitals, all of which are high-volume Medi-Cal providers, have seen a substantial reduction in inpatient and outpatient utilization due to cancellations of elective procedures and surgeries. For these and other hospitals relying upon Medi-Cal FFS reimbursement, this is creating significant financial stress.

We ask that the State enable all private and district/municipal hospitals the ability to receive advanced Medi-Cal and CCS FFS payments based on their 2019 FFS claims volume. This would be analogous to the Medicare advance payment program set up by CMS. These advances could be reconciled after six months or a year, based on the hospital's billable claims during this hospital retention payment period.

Maintain the existing Private Hospital Supplemental Fund (PHSF) methodology and V35 Weights with the Diagnosis Related Group (DRG) payments

Since CMS announced the proposed Medicaid Fiscal Accountability Rule, hospitals around the state have expressed serious concerns with the predictability of funding for the Medi-Cal program. The importance of cash flow and revenue predictability is even more paramount during the current pandemic. As proposed, the changes to the PHSF methodology and the unknown effects by updating the DRG weights from V35 to

V37 will add to the uncertainty that many hospitals don't need right now. ***We urge DHCS maintain the status quo with these two programs for the next year, at least.***

Modernize the APR-DRG methodology to include a socioeconomic status adjustment

Joblessness and homelessness are major contributors to the socioeconomic status (SES) of individuals. While the number of homeless, and now and unemployed individuals, is growing the Medi-Cal program has not adjusted for the complexities that accompany this population. The 2018 data from the Office of Statewide Health Planning and Development (OSHPD) shows that – at a minimum – there were nearly 100,000 inpatient discharges of homeless adults. The preponderance of those discharges – more than 50% - were treated in California's safety net hospitals (those federally qualified as disproportional share hospitals – DSH). That's over half the adult homeless population treated in less than one-fourth of the hospitals. Further, as a result of the COVID-19 pandemic, the Medi-Cal program is expected to grow by about 15 percent because of job loss.

Research concludes that reimbursement mechanisms that fail to recognize the severity of SES impose a greater and disproportionate burden/penalties for safety net hospitals. Additionally, further research demonstrated that unadjusted reimbursement mechanisms may exacerbate disparities in care and that special attention should be devoted to safety net hospitals that are in a unique financial position and provide a disproportionate share of care to SES vulnerable adults.

The Medi-Cal APR-DRG formula fails to account for the social complexity of vulnerable SES patients, such as homeless or unemployed adults, resulting in a payment penalty incurred from treating patients that result in greater demand for hospital resources. Further, the Medi-Cal base rate for the APR-DRG has not increased in 8 years, since the implementation of the risk-based methodology in 2013.

To preserve access for the SES vulnerable adult population and to mitigate, in part, the financial disparities to safety net hospitals that care for this population, the state should consider an investment of \$50 million General Fund (\$120 million total funds) by directing the Department of Health Care Services to implement a SES adjustment factor to the APR-DRG formula on all claims paid to safety net hospitals that provide care for the Medi-Cal adults.

Administrative Fees Imposed on District/Municipal Hospitals

The significant decline in revenue for district/municipal hospitals coupled with increased costs has had a devastating impact on the cash flow of these hospitals, threatening, in some instances, the ability to make payroll and/or meet bond covenants.

The State imposes administrative fees on some of the intergovernmental transfer (IGT) programs in which district/municipal hospitals participate: the Non-Designated Public Hospital IGT Program (a 9 percent administrative fee) and the voluntary rate range program (a 20 percent administrative fee except in some instances). ***We urge you to allow for a delay in payment of these fees until such a time that the cash flow of affected hospitals is more stable than it currently is during the crisis.***

Adjust the Medi-Cal FFS Interim Per Diem Rates for Designated Public Hospitals

In preparation for the surge of COVID-19 admissions, Designated Public Hospitals (DPHs) have made huge changes to their operations, including upgrading units into intensive care units and reducing lower-level care admissions. As a result, DPHs' cost per day have significantly increased, beginning March 2020, and likely continuing through the rest of the calendar year. To provide immediate short term relief to provide the

necessary cash flow to support the costs associated with implementing these operational changes, as well as the financial impacts due to revenue losses, **we request that the State adjust the Medi-Cal FFS interim per diem rates paid to DPHs for inpatient hospital services, to increase the rates by 30% for SFY 2019-20, and by 50% for SFY 2020-21.** The current State Plan authorizes the State to make these adjustments to account for additional COVID-related costs due to changes in operations and circumstances.

Millions of Californians will be affected in one way or another by the COVID-19 pandemic. Through the actions we have outlined above, you can immediately make a difference in hospitals' ability to serve all Californians as effectively as possible. Moreover, these hospitals are integral to micro-economies throughout the state – often one of the largest employers in communities. This economic vitality helps build momentum for the state's economy to gain a foothold in these tumultuous and troubling times. To this end, we ask you to support the needs outlined above. Please call on us for any resources or technical advice you need to evaluate this important and urgent request.

Sincerely,



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