Legislative Rural Caucus

Medi-Cal Experience in Rural California

California State Rural Health Association

August 23, 2011

By Steve Barrow, Executive Director
California State Rural Health Association
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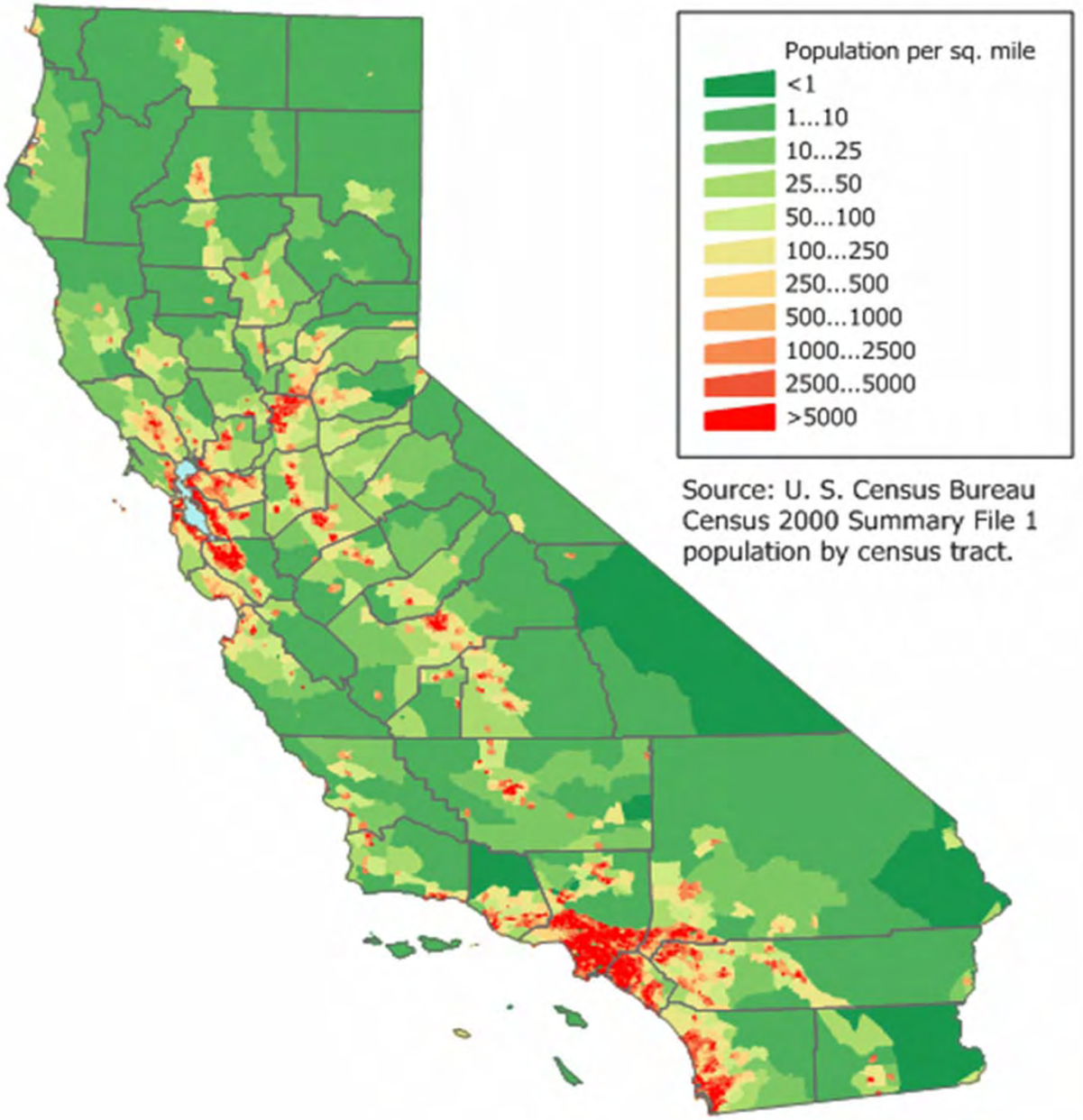
THE STORY OF RURAL HEALTH IN CALIFORNIA:

- **California is a HUGE state – grappling with the state's vast geography is a significant challenge**
- **California is also a very rural state**
- **85% of the state's land mass is rural**
- **44 of our 58 Counties are rural**
- **Rural CA is home to more than 5 million people, or 13.7% of the state's population**

CALIFORNIA STATE RURAL HEALTH ASSOCIATION

- Nearly 1 out of every 60 Americans live in rural CA
- Rural employment –
  11% health care
  9% agriculture



California State Rural Health Association's MISSION, VISION, PURPOSE

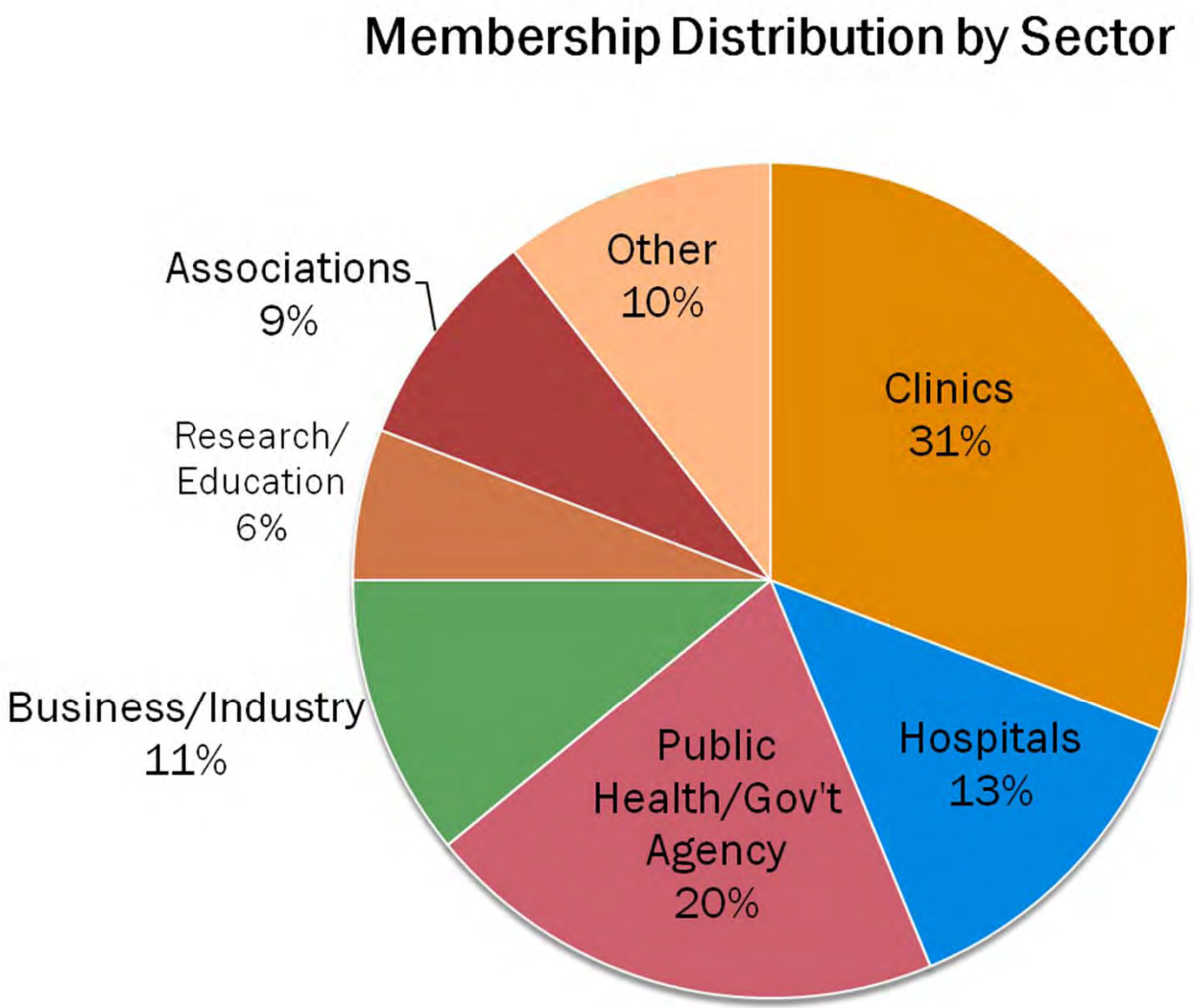
- Mission:
  Linking rural individuals and organizations together to facilitate information exchange, collaboration and advocacy to promote healthy rural communities.

- Vision:
  Empowered rural people creating healthy and sustainable rural communities

- Purpose:
  1. Facilitate information exchange, communication and collaboration among healthcare providers, government agencies, rural communities and others
  2. Educate rural communities and lawmakers about the effects of policy, legislation and regulation on the health of rural communities
  3. Advocate with rural stakeholders for rural-friendly policies

CALIFORNIA STATE
RURAL HEALTH
ASSOCIATION

MEMBERSHIP


Membership Distribution by Sector
Other 10%
Associations 9%
Clinics 31%
Research/ Education 6%
Business/Industry 11%
Public Health/Gov't Agency 20%
Hospitals 13%

Putting Rural In Perspective

- Some discount the need to focus on rural health due to its isolated and smaller population size vs. urban population in California
  - 5 million vs. 36 million
- Another perspective is to think of various rural regions as very very large neighborhood areas
  - Similarities include rate of poverty, unemployed, uninsured, struggling health care settings, disparities in services and health indicators, etc.
  - Differences distances to get to health care, rural populations lack multiple health care opportunities, physician recruitment/retention difficulties, access to nursing and auxiliary health staff, access to basic IT support, etc.

Rural Health Background Information

Rural California as MSSA

- The definition of a Rural Medical Service Study Area is a Medical Service Study Area (MSSA), as defined by the California Health Manpower Policy Commission, that have a population density of 250 persons or less per square mile and have no incorporated area greater than 50,000 persons.

- The definition of a Frontier Medical Service Study Area is an MSSA with population densities equal or less than 11 persons per square mile.

- 5,146,201 Californians live in rural MSSAs (OSHPD)

THE STORY OF RURAL HEALTH IN CALIFORNIA:

- There 935 residents per doctor in rural CA v. 460 in urban areas
- About 45% of rural Californians live in Health Professional Shortage Areas
- Higher rates of chronic diseases, including asthma, substance abuse (i.e. drug and alcohol, obesity, diabetes and heart disease)
- A greater proportion of rural residents have no health insurance (16.34% rural; 12.4% urban)

CALIFORNIA STATE
RURAL HEALTH
ASSOCIATION

Travel Important Factor in Rural Health

(According to OSHPD)

- Residents of rural areas travel a lot further for healthcare.
  - 75% of urban residents live an average of 10 miles away from a hospital
  - 90% of rural residents live an average of 25 miles away from a hospital – and due to lack of public transportation, nature of the narrow, and often time curvy roads, 25 rural miles can be different than 10 urban miles in time and effort to navigate

Rural California Providers Are:

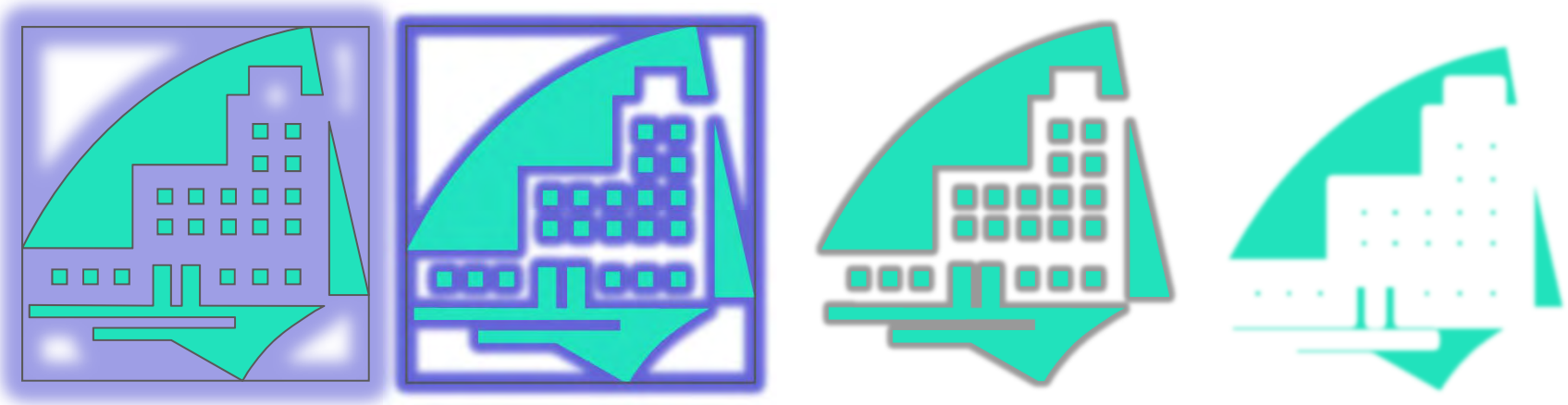
- Hospitals
  - General Acute Care Hospitals (GACH)
  - Critical Access Hospitals (CAH)
- Private Practices (individual and group)
- Licensed Primary Care Clinics
  - Federally Qualified Health Centers (FQHC)
  - Federally Qualified Health Center Look-Alikes (FQHC-LA)
  - Community clinics
- Rural Health Clinics (RHC)
  - Any legal medical provider who qualifies can be certified

Rural Health Background Information

Hospitals in Rural California

(OSHPD)

- Hospitals in rural areas are decreasing
  - 75 rural hospitals in California in October, 2000
  - Only 66 rural hospitals in California in July, 2010.



Rural Health Background Information

Clinics in Rural California

(CPCA)

- California has 825 community clinics and health centers (CCHC) - *235 are in rural & frontier areas*
- In California CCHCs provide 13 million encounters to 4 million patients - *3.6 million of these encounters to 1 million patients in rural & frontier areas*

Today's Hearing is About

Hearing from rural communities and healthcare providers about what is working and what is not working well regarding Medi-Cal in rural California

We are looking for the challenges with working with Medi-Cal

And

We are looking for suggested solutions to the identified Challenges

Who is in front of you today

We have structured the hearing so you can hear from:

Individual practice physicians

- *FQHC clinics*
- *Rural Health Clinics*
- *Rural hospitals and Critical Access Hospitals*
- *Community groups*
- *Think tanks that focus on health care*

These represent the vast majority of where healthcare and Medi-Cal is provided in rural California

SAVE THE DATE!

- 2011 Annual Rural Health Conference:
  Embracing Change for the Future of Rural Health
- November 15-16, 2011
  Hilton Arden West, Sacramento, CA
- More details at www.csrha.org
- Scholarships available for all PRIME students and others

CSRHA Contact Information

555 Capitol Mall, Suite 750

Sacramento, CA 95814

(916) 453-0780

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- President, Gail Nickerson, Director of Clinic Services, Adventist Health and Vice President of the Board of Directors, National Association of Rural Health Clinics - nickergw@ah.org
- Executive Director, Steve Barrow – sbarrow@csrha.org

History of Medi-Cal and Current Issues

Toby Douglas
Director

Department of Health Care Services

- DHCS finances and/or administers
  - Medi-Cal
  - California Children's Services Program (CHIP)
  - Genetically Handicapped Persons Program
  - Coverage for low-income individuals; pregnant women; elderly, blind, or disabled persons, and others
  - DHCS funding helps hospitals and clinics that care for uninsured populations

History of Medi-Cal

- State legislation establishing Medi-Cal enacted November 15, 1965; implemented March 1, 1966
- California's version of the Nation's major publicly financed health care program
- Funded jointly with federal and state funds- Approximately $45 billion per year
- Enrollment of 7.5 million; over 9 million including limited scope programs such as FPACT
- 51% of the population in Managed Care; 49% in fee-for-service (prior to the transition of SPDs)

Medi-Cal and Rural Health

1. Training and Technical Assistance programs
2. Managed Care expansion into rural areas
3. Budget actions
4. Challenges
5. Looking forward

Training and Technical Assistance Programs

- State Office of Rural Health (SORH)
  - Regional Extension Centers (CalHIPSO)
  - Workforce Development
- Trainings/Webinars
- Emergency Preparedness
- Small Rural Hospital Improvement Program (SHIP)—46 hospitals
- Medicare Rural Hospital Flexibility Program (FLEX/CAH)—31 hospitals

Managed Care Expansion Into Rural Areas

- Transition into managed care in rural areas
  - Functioning without disruption of services
    - -Santa Barbara County
    - -Fresno County
    - -Sonoma County
    - -Kings County
    - -Mendocino County
    - -Madera County
    - -Ventura County
- Telemedicine in rural areas
  - Podiatry -Dermatology -Ophthalmology

2011 State Budget Actions

- Changes to Medi-Cal
  - Co-pays
  - Provider rate reduction
    - Pending CMS SPA and waiver approval
  - Hospital fee
  - 7 visit soft cap on physician visits
    - exemptions
  - ADHC transition (December 1, 2011)
    - Transition Plan

Challenges

- Clinic Closures
  - 12 clinic closures
- Rural population disproportionately represented in Medi-Cal
  - 30% of Medi-Cal; 10% of State's population
- Proposed federal Medicare cut – 2%
- Physician and specialty services

Looking Forward

- Health Reform under ACA
  - Public program expansion and system reform
  - Health Insurance Exchange
  - Eligibility expansion of at least 2 million
  - Primary care rate increases to 100% of Medicare for primary physicians
  - Transition from FFS and cost-based care towards risk-based payments
  - Electronic Health Records incentive funding and technical assistance around Meaningful Use

1115 Waiver- Bridge to Health Care Reform

- Early enrollment of the newly Medicaid eligible group
  - LIHP/CMSP
- Prepare safety net and county systems for Medicaid expansion
- Provide better organized systems of care for vulnerable populations
- Maintenance of Efforts (MOE)
- Evaluating Health Home options for individuals with chronic conditions

QUESTIONS

Medi-Cal in Flux

Presentation to the Legislative Rural Caucus

State Capitol, Sacramento, CA
August 23, 2011

Albert Lowey-Ball
Health Economics and Medicaid Advisor
California Program on Access to Care
UC Berkeley School of Public Health

Background

- Experience with Medi-Cal, Hospitals, Clinics, Health Plans
- Helped Set Up a Number of Medi-Cal Managed Care Plans
- DHCS Doing Difficult Job Under Tough Conditions
- Role of UC Academics/CPAC and CaMRI
- CPAC: Nonpartisan Health Policy Advice and TA to Legislature and Administration

Medi-Cal: Brief Overview

- 7.5 Million Enrollees; $45 Bln; Largest in US
- Number of Eligibles/Enrollees Growing
- Provider Rates About 48th in US
- Only 56% of MDs Willing to Take New Medi-Cal
- 20% of MDs Handle 80% of Enrollees
- Healthy Families About 950,000 Enrollees
- 48% of Medi-Cal Enrollees in Managed Care
- May Rise to About 63% with SPD Expansion

Program Changes

- With ACA, by 2014-2018, Up to 3.6 Mln New Medi-Cal Eligibles/Enrollees
- May Be Folding Healthy Families into Medi-Cal
- Up to 2 Mln Commercial Lives Under C-HBEX
- LIHP/CMSP Expansion; Transition to Medi-Cal
- Possible Implementation of Basic Health Plan, Up to 700,000 Enrollees

Medi-Cal Rate Reductions-I

- Medi-Cal Provider Rates Increased About 1.7% Since 2002, Far Below CPI
- Provider Fees Influence Medi-Cal Managed Care Rates, Clinic Rates
- 10% Rate Reduction in Physician Fees, 2008; Hospital Freeze; Co-Pays
- Strenuously Opposed by Advocates, Provider Groups; Supported by Courts; Now at Supreme Court
- 2011 Budget, 10% Provider Rate Reductions, $5 MD Visit Copay, $50 ED Copay, 7 MD Visit Cap

Medi-Cal Rate Reductions II

- Budget Impacts of $631 Mln, $511 Mln and $41 Mln
- Reduction in Basic Office Visit Fee From $18 to $11.20
- Implications for MDs, Clinics, Hospitals
  - Reduced Access
  - Increased Visits Per Unit Time
  - Reduced MD Participation
  - Increased Use of EDs
  - Eventual Higher Medi-Cal Costs
  - Tightened Financials for Rural MDs, Clinics, Hospitals

ACA and Waiver: Opportunities

- Expanded Coverage of SPDs into Managed Care/Contracts with Managed Care
- Expanded Coverage in LIHPs/Contracts with Counties
- Coordination on Establishment of Medical Homes
- Coordination on Set-Up of ACOs
- Medi-Cal ACA Expansion/More Medi-Cal at Better Rates Than Indigent Rates
- Linkage Opportunities with C-HBEX-Qualified Plans for Medi-Cal and Commercial Enrollees (Indiv and SHOP)
- Participation in Possible Statewide Basic Health Plan

ACA and Waiver: Risks

- Recession and State Budget Stresses Continue/Possible Further Medi-Cal Cuts at State Level
- Reductions in Federal/CMS ACA Funding
- Termination of Parts of ACA by the Courts
- High Cost of Medical Home and ACO Set-Ups
- Lack of Preparedness to Handle SPDs, Indigents, Commercial Enrollees
- Reductions in DSH Program?
- Phase-Out of FQHC Rates?
- Severe Potential MD and Other Health Workforce Shortages

important first step, but in a sense it is a mere preliminary to the main game. In the long term, the only way for the economy to grow is through wealth creation. That means America needs to be thinking about entrepreneurship.

It's difficult to overestimate how much entrepreneurship marks America's economic culture as different from, for example, what we find in most of Western Europe. Survey after survey underscores that most Americans would prefer to work for themselves. Western Europeans, by contrast, crave security. Alexis de Tocqueville expressed his astonishment at "the spirit of enterprise" characterizing 19th-century America. "Almost all of them," Tocqueville scribbled in one of his notebooks, "are real industrial entrepreneurs."

We must rediscover the moral, legal, institutional, and cultural settings that allow entrepreneurship to flourish. We must also take practical steps, for instance liberalizing the labor-market regulations that bind large-scale entrepreneurs with inflexible union contracts. We should ease the process of hiring and firing employees, allowing entrepreneurs to take more and faster risks with new ideas, products, and services. An entrepreneur in the European Union must always think long and hard about hiring anyone, because once he has taken someone on, it is hard to remove that person, even for gross incompetence. With Obama's National Labor Relations Board growing ever more aggressive, we are moving in precisely the wrong direction for entrepreneurs.

Mr. Gregg is research director of the Acton Institute. His books include The Commercial Society *and* Wilhelm Röpke's Political Economy.

Help Wanted

KEVIN D. WILLIAMSON

When Washington talks about Social Security's funding, the problem is usually stated thus: "With the population aging, we have too few workers and too many retirees. The ratio of taxes paid in to benefits paid out is unsustainable." Thinking like this is what gives Washington its reputation for obtuseness: Politicians think workers exist to pay taxes, but workers really exist to *work*—to build things, to create things, to provide useful products and services. If you look at the historical growth rate of the U.S. economy, you'll see that GDP per capita has chugged along more or less steadily at 2 percent growth per year going all the way back to the Depression. But the real growth rate has averaged just over 3 percent; that additional growth has come from a growing work force. If you have an aging population and a relative decline in the number of people available to do productive work in the real economy, balancing the welfare books is not your biggest problem. You can cut those Social Security checks, but if that money is going to be exchanged for real goods and services, somebody has to provide them.

Immigration is not only an economic question, but to the extent that it is, our system is counterproductive: We send the Ph.D.s and engineers home to Taiwan and India but keep the illiterate Latin American farmhands, legal or illegal. At least one of those things should change, and probably both. **NR**

Entitlement BANDITS

How the Ryan plan would curb Medicare and Medicaid fraud

BY MICHAEL F. CANNON

The budget blueprint crafted by Paul Ryan, passed by the House of Representatives, and voted down by the Senate would essentially give Medicare enrollees a voucher to purchase private coverage, and would change the federal government's contribution to each state's Medicaid program from an unlimited "matching" grant to a fixed "block" grant. These reforms deserve to come back from defeat, because the only alternatives for saving Medicare or Medicaid would either dramatically raise tax rates or have the government ration care to the elderly and disabled. What may be less widely appreciated, however, is that the Ryan proposal is our only hope of reducing the crushing levels of fraud in Medicare and Medicaid.

The three most salient characteristics of Medicare and Medicaid fraud are: It's brazen, it's ubiquitous, and it's other people's money, so nobody cares.

Consider some of the fraud schemes discovered in recent years. In Brooklyn, a dentist billed taxpayers for nearly 1,000 procedures in a single day. A Houston doctor with a criminal record took her Medicare billings from zero to $11.6 million in one year; federal agents shut down her clinic but did not charge her with a crime. A high-school dropout, armed with only a laptop computer, submitted more than 140,000 bogus Medicare claims, collecting $105 million. A health plan settled a Medicaid-fraud case in Florida for $138 million. The giant hospital chain Columbia/HCA paid $1.7 billion in fines and pled guilty to more than a dozen felonies related to bribing doctors to help it tap Medicare funds and exaggerating the amount of care delivered to Medicare patients. In New York, Medicaid spending on the human-growth hormone Serostim leapt from $7 million to $50 million in 2001; but it turned out that drug traffickers were getting the drug prescribed as a treatment for AIDS wasting syndrome, then selling it to bodybuilders. And a study of ten states uncovered $27 million in Medicare payments to dead patients.

These anecdotes barely scratch the surface. Official estimates posit that Medicare and Medicaid lose at least $70 billion per year to fraudulent and otherwise improper payments, and that about 10.5 percent of Medicare spending and 8.4 percent of Medicaid spending was improper in 2009. Fraud experts say the official numbers are too low. "Loss rates due to fraud and abuse could be 10 percent, or 20 percent, or even 30 percent in some segments," explained Malcolm Sparrow, a mathematician, Harvard profes-

Mr. Cannon is director of health-policy studies at the Cato Institute and co-author of Healthy Competition: What's Holding Back Health Care and How to Free It.

sor, and former police inspector, in congressional testimony. "The overpayment-rate studies the government has relied on . . . have been sadly lacking in rigor, and have therefore produced comfortingly low and quite misleading estimates." In 2005, the *New York Times* reported that "James Mehmet, who retired in 2001 as chief state investigator of Medicaid fraud and abuse in New York City, said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal." And even these experts ignore other, perfectly legal ways of exploiting Medicare and Medicaid, such as when a senior hides and otherwise adjusts his finances so as to appear eligible for Medicaid, or when a state abuses the fact that the federal government matches state Medicaid outlays.

Government watchdogs are well aware of the problem. Every year since 1990, the U.S. Government Accountability Office has released a list of federal programs it considers at a high risk for fraud. Medicare appeared on the very first list and has remained there for 22 straight years. Medicaid assumed its perch eight years ago.

How can there possibly be so much fraud in Medicare and Medicaid that even the "comfortingly low" estimates have ten zeros? How can this much fraud persist decade after decade? How can it be that no one has even tried to measure the problem accurately, much less take it seriously? The answers are in the nature of the beast. Medicare and Medicaid, the two great pillars of Pres. Lyndon Johnson's "Great Society" agenda, are monuments to the left-wing ideals of coerced charity and centralized economic planning. The staggering levels of fraud in these programs can be explained by the fact that the politicians, bureaucrats, patients, and health-care providers who administer and participate in them are spending other people's money—and nobody spends other people's money as carefully as he spends his own. What's more, Medicare and Medicaid are spending other people's money in vast quantities. Medicare, for example, is the largest purchaser of medical goods and services in the world. It will spend $572 billion in 2011. Each year, it pays 1.2 billion claims to 1.2 million health-care providers on behalf of 47 million enrollees.

For providers, Medicare is like an ATM: So long as they punch in the right numbers, out comes the cash. To get an idea of the potential for fraud, imagine 1.2 million providers punching 1,000 codes each into their own personal ATMs. Now imagine trying to monitor all those ATMs.

For example, if a medical-equipment supplier punches in a code for a power wheelchair, how can the government be sure the company didn't actually provide a manual wheelchair and pocket the difference? About $400 million of the aforementioned fines paid by Columbia/HCA hospitals were for a similar practice, known as "upcoding."

And how does the government know that providers are withdrawing no more than the law allows? Medicaid sets the prices it pays for prescription drugs based on the "average wholesale price." But as the Congressional Budget Office has explained, the average wholesale price "is based on information provided by the manufacturers. Like the sticker price on a car, it is a price that few purchasers actually pay." Pharmaceutical companies often inflate the average wholesale price so they can charge Medicaid more. Teva Pharmaceuticals recently paid $27 million to settle allegations that it had overcharged Florida's Medicaid program by inflating its average wholesale prices, and the Department of Justice has accused Wyeth of doing the same. Merck recently settled a similar case.

Most ominously, how does the government know that people punching numbers into the ATMs are health-care providers at all? In his testimony, Malcolm Sparrow explained how a hypothetical criminal can make a quick million: "In order to bill Medicare, Billy doesn't need to see any patients. He only needs a computer, some billing software to help match diagnoses to procedures, and some lists. He buys on the black market lists of Medicare or Medicaid patient IDs." With this information in hand, Billy strides right up to the ATM, or several at a time, and starts punching in numbers. "The rule for criminals is simple: If you want to steal from Medicare, or Medicaid, or any other health-care-insurance program, learn to bill your lies correctly. Then, for the most part, your claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all." These schemes are sophisticated, so Billy might hire people within Medicare and at his bank to help him avoid detection.

Last year, the feds indicted 44 members of an Armenian crime syndicate for operating a sprawling Medicare-fraud scheme. The syndicate had set up 118 phony clinics and billed Medicare for $35 million. They transferred at least some of their booty overseas. Who knows what LBJ's Great Society is funding?

And there are other forms of fraud. An entire cottage industry of elder-law attorneys has emerged, for instance, to help well-to-do seniors appear poor on paper so that Medicaid will pay their nursing-home bills. Medicaid even encourages the elderly to get sham divorces for the same reason. It's all perfectly legal. It's still fraud.

Medicaid's matching-grant system also invites fraud. When a high-income state such as New York spends an additional dollar on its Medicaid program, it receives a matching dollar from the federal government—that is, from taxpayers in other states. Low-income states can receive as much as $3 for every additional dollar they devote to Medicaid, and without limit. If they're clever, states can get this money without putting any of their own on the line. In a "provider tax" scam, a state passes a law to increase Medicaid payments to hospitals, which triggers matching money from the federal government. Yet in the very same law, the state increases taxes on hospitals. If the tax recoups the state's original outlay, the state has obtained new federal Medicaid funds at no cost. If the tax recoups more than the original outlay, the state can use federal Medicaid dollars to pay for bridges to nowhere. As Vermont began preparations for its Obamacare-sanctioned single-payer system this year, it used a provider-tax scam to bilk taxpayers in other states out of $5.2 million. In his book *Stop Paying the Crooks*, consultant Jim Frogue chronicles more than half a dozen ways that states game Medicaid's matching-grant system to defraud the federal government.

Since 1986, the GAO has published at least 158 reports about Medicare and Medicaid fraud, and there have been similar reports by the HHS inspector general and other government agencies. In 1993, Attorney General Janet Reno declared health-care fraud America's No. 2 crime problem, after violent crime. Since then, Congress has enacted 194 pages of statutes to combat fraud in these programs, and countless pages of regulations.

Yet federal and state anti-fraud efforts remain uniformly lame. Medicare does almost nothing to detect or fight fraud until the

fraudulent payments are already out the door, a strategy experts deride as "pay and chase." Even then, Medicare reviews fewer than 5 percent of all claims filed. Congress doesn't integrate Medicare's myriad databases, which might help prevent fraud, nor does it regularly review the efficacy of most of the anti-fraud spending it authorizes. Many of the abuses noted above, such as those of the Brooklyn dentist, were discovered not by the government but by curious reporters poking through Medicaid records. The amateurs at the *New York Times* found "numerous indications of [Medicaid] fraud and abuse that the state had never looked into," but "only a thin, overburdened security force standing between [New York's] enormous program and the unending attempts to steal from it."

THE federal government's approach to fraud is sometimes so inept as to be counterproductive. Sparrow testified that a defect in the strategy of Billy, our hypothetical criminal, is that he doesn't know which providers and patients on his stolen lists are "dead, deported, or incarcerated." But Medicare's anti-fraud protocols help him solve this problem. When Medicare catches those claims, it sends Billy a notice that they have been rejected. "From Billy's viewpoint," Sparrow explained, "life could not be better. Medicare helps him 'scrub' his lists, making his fake billing scam more robust and less detectable over time; and meanwhile Medicare pays all his other claims without blinking an eye or becoming the least bit suspicious."

Efforts to prevent fraud typically fail because they impose costs on legitimate beneficiaries and providers, who, as voters and campaign donors respectively, have immense sway over politicians. At a recent congressional hearing, the Department of Health and Human Services' deputy inspector general, Gerald T. Roy, recommended that Congress beef up efforts to prevent illegitimate providers and suppliers from enrolling in Medicare. But even if Congress took Roy's advice, it would rescind the new requirements in a heartbeat when legitimate doctors—who are already threatening to leave Medicare over its low payment rates—threatened to bolt because of the additional administrative costs (paperwork, site visits, etc.).

Politicians routinely subvert anti-fraud measures to protect their constituents. When the federal government began poking around a Buffalo school district that billed Medicaid for speech therapy for 4,434 kids, the *New York Times* reported, "the Justice Department suspended its civil inquiry after complaints from Senator Charles E. Schumer, Democrat of New York, and other politicians." Medicare officials, no doubt expressing a sentiment shared by members of Congress, admit they avoid aggressive anti-fraud measures that might reduce access to treatment for seniors.

It's not just the politicians. The Legal Aid Society is pushing back against a federal lawsuit charging that New York City overbilled Medicaid. Even conservatives fight anti-fraud measures, albeit in the name of preventing frivolous litigation, when they oppose expanding whistle-blower lawsuits, where private citizens who help the government win a case get to keep some of the penalty.

Sparrow argued that when Medicare receives "obviously implausible claims," such as from a dead doctor, "the system should bite back. . . . A proper fraud response would do whatever was necessary to rip open and expose the business practices that produce such fictitious claims. Relevant methods include surveillance, arrest, or dawn raids." Also: "All other claims from the same source should immediately be put on hold."

Some of the implausible claims will be honest mistakes, such as when a clerk mistakenly punches the wrong patient number into the ATM. And sometimes the SWAT team will get the address wrong, or will take action that looks like overkill, as when the Department of Education raided a California home because it suspected one of the occupants of financial-aid fraud. How many times would federal agents have to march a handcuffed doctor past a stunned waiting room full of Medicare enrollees before Congress prohibited those measures?

"It seems extraordinary," Sparrow said, that the HHS Office of Inspector General recommends "weak and inadequate response[s] . . . to false claims and fake billings" and that Medicare "fail[s] . . . to properly distinguish between the imperatives of process management and the imperatives of crime control." Extraordinary? How could it be any other way? Anti-fraud efforts will *always* be inadequate when politicians spend other people's money. Apologists for Medicare and Medicaid will retort that fraud against private health plans is prevalent as well, but this only drives home the point: Since employers purchase health insurance for 90 percent of insured non-elderly Americans, workers care less about health-care fraud, and have a lower tolerance for anti-fraud measures, than they would if they paid the fraud-laden premiums themselves.

The fact that Medicare and Medicaid spend other people's money is why the number of fraud investigators in New York's Medicaid program can fall by 50 percent even as spending on the program more than triples. That is why, as Sparrow explained in an interview with *The Nation*, "The stories are legion of people getting a Medicare explanation of benefits statement saying, 'We've paid for this operation you had in Colorado,' when those people have never been in Colorado. And when you complain [to Medicare] about it, nobody seems to care."

THE Ryan plan offers the only serious hope of reducing fraud in Medicare and Medicaid. Its Medicare reforms, especially if they were expanded later, would make it easier for the federal government to police the program, and its Medicaid reforms would increase each state's incentive to curb fraud.

To see how the Ryan plan would reduce Medicare fraud,

imagine that the proposal really were what its critics claim it is: a full-blown voucher program, with each enrollee receiving a chunk of cash to spend on medical care, apply toward health-insurance premiums, or save for the future. Instead of processing 1.2 billion claims, Medicare would hand out just 50 million vouchers, with sick and low-income enrollees receiving larger ones. The number of transactions Medicare would have to monitor each year would fall by more than 1 billion.

Social Security offers reason to believe that a program engaging in fewer (and more uniform) transactions could dramatically reduce fraud and other improper payments. As a Medicare-voucher program would, Social Security adjusts the checks it sends to enrollees according to such variables as lifetime earnings and disability status. The Social Security Administration estimates that overpayments account for just 0.37 percent of Social Security spending. Overpayments are higher in the Supplemental Security Income (SSI) program (8.4 percent), a much smaller, means-tested program also administered by the Social Security Administration. But total overpayments across both programs still come to less than 1 percent of outlays.

In reality, the Ryan "voucher" is much closer to the current Medicare Advantage program, through which one in four Medicare enrollees selects a private health plan and the government makes risk-adjusted payments directly to insurers. Skeptics will rightly note that, judging by the official improper-payment rates, Medicare Advantage (14.1 percent) is in the same ballpark as traditional Medicare (10.5 percent). Therefore, the Ryan plan should be seen not as a solution to Medicare fraud in itself, but as a step toward a vastly simplified, Social Security–like program in which the task of policing fraud is less daunting.

The Ryan plan would also vastly increase the states' incentive to curb Medicaid fraud. Just as a state that increases funding for Medicaid gets matching federal funds, a state that reduces Medicaid fraud gets to keep only (at most) half of the money saved. As much as 75 percent of recovered funds revert back to the federal government. In a report for the left-wing Center for American Progress, former Obama adviser Marsha Simon noted that "states are required to repay the federal share . . . of any payment errors identified, even if the money is never collected." The fact that Albany splits New York's 50 percent share of the spending with municipal governments may explain why the Empire State is such a hot spot for fraud: No level of government is responsible for a large enough share of the cost to do anything about it. The result is that states' fraud-prevention efforts are only a tiny fraction of what Washington spends to fight Medicare fraud.

Ryan would replace Medicaid's federal matching grants with a system of block grants. Under a block-grant system, states would keep 100 percent of the money they saved by eliminating fraud. In many states, the incentive to prevent fraud would quadruple or more. Block grants performed beautifully when Congress used them to reform welfare in 1996. They can do so again.

The Ryan plan would not reduce Medicare and Medicaid fraud to tolerable levels, but neither would any plan that retains a role for government in providing medical care to the elderly and disabled. What the Ryan plan would do is reduce how much the fraudsters—many of whom sport congressional lapel pins—fleece the American taxpayer. And that is no small thing. **NR**

Law and Border

A Supreme Court victory for Arizona and the nation

BY KRIS KOBACH

On May 26, for the first time in 35 years, the United States Supreme Court issued an opinion on whether states may take action to stop illegal immigration. In *Chamber of Commerce v. Whiting*, the Supreme Court upheld the Legal Arizona Workers Act of 2007 against multiple challenges claiming that it was preempted by federal law. This act requires all employers in the state to use the E-Verify Internet system to check the work authorization of new hires, and it penalizes employers who knowingly hire unauthorized aliens by suspending their business licenses. (E-Verify, run by the federal government, checks data supplied by immigrants against Homeland Security and Social Security records to make sure they are eligible for employment.)

It was a 5–3 decision, with the conservative justices, plus Anthony Kennedy, siding with Arizona. Justice Elena Kagan recused herself because the Obama Justice Department had weighed in against Arizona when she was solicitor general.

The Justice Department urged the Supreme Court to take the case and participated in the oral argument on the losing side. The Obama administration has made no secret of its hostility toward Arizona and other states that want to use state powers to restore the rule of law in immigration. The Justice Department's pending lawsuit against Arizona's SB 1070, a 2010 law governing police procedures when officers encounter illegal aliens, is another example of this hostility.

Arizona's victory in the high court also gave an unmistakable green light to the other states. A week later, the Alabama legislature passed HB 56—the strongest law against illegal immigration that any state has enacted to date—and on June 9, Gov. Robert Bentley signed it into law. This measure, known as the Beason-Hammon Act after its main sponsors, includes everything that Arizona has done on the subject, plus a good deal more: prohibiting illegal aliens from attending public universities in the state, providing for civil forfeiture of vehicles used to knowingly transport illegal aliens, prohibiting landlords from knowingly harboring illegal aliens in apartments, and requiring public schools to count the number of illegal aliens receiving a free K–12 education at taxpayer expense.

Behind Alabama and Arizona are a growing number of other states that have taken significant steps down the same road, including Missouri, Mississippi, South Carolina, Georgia, Okla-

Mr. Kobach, the secretary of state of Kansas, is a co-author of Arizona's SB 1070 and Alabama's HB 56 and has defended numerous state and local laws concerning illegal immigration in court.

FRESNO HCAP

Fresno Healthy Communities Access Partners (FHCAP) is a seven-year-old nonprofit organization of thirteen health care and community organizations working together to improve access to health care for medically underserved communities in Fresno and the San Joaquin Valley.

Our partners are:

- Community Medical Centers
- Central California Faculty Medical Group
- Fresno Metro Ministry
- Central Valley Health Policy Institute
- Saint Agnes Medical Center
- Fresno County Department of Community Health
- Clinica Sierra Vista
- UCSF-Fresno, Medical Education Program
- Children's Hospital Central California
- Valley Health Team
- Fresno/Madera Medical Society
- Kaiser Permanente
- United Health Centers

Fresno HCAP provides leadership in the following collaborative projects:

- Program Administrator for One-e-App (a one stop shop for health insurance applications and referrals to other social services) in Fresno/Madera Counties
  - Improving services for low income financially challenged families by expanding application and referral programs, including adult Medi-Cal, CHDP, Food Stamps, Presumptive Eligibility, WIC, Medi-Cal for Children and Pregnant Women, Healthy Families, Kaiser Child Health Plan, Cancer Detection Program, FPACT, AIM, as well as low-income energy, auto insurance, utility assistance and tax credit programs for families
- Program Administrator for Fresno County Children's Health Initiative (CHI), a 17 member community and county coalition operating since 2005 to ensure that all children and their families living in Fresno County have access to health services
- Leader for OERU (Outreach, Enrollment, Retention and Utilization) services to low income populations working with 6 community-based partners:
  - Centro La Familia
  - Fresno Center for New Americans
  - Centro Binancional Para El Desarrollo Indigena Oaxaqueno
  - Clovis Unified School District
  - Clinica Sierra Vista
  - West Fresno Health Care Coalition
- Analyzed access to care issues surrounding the Fresno County MISP program, and partnering with the County and community stakeholders to develop new strategies through the Low Income Health Program (LIHP)
- Partnership with Joel Diringer of Diringer and Associates, to develop options for providing care and coverage to California's agricultural workers in three counties (Salinas, Ventura and Fresno) through consensus discussions with agricultural employers, workers and health providers.
- As the San Joaquin Valley Area Health Education Center (AHEC), improving access to healthcare for medically underserved populations of Fresno, Madera and Kings Counties through academic-community partnerships for training health professionals
- Improving and expanding the use of telemedicine in safety net organizations

For additional information contact Norma Forbes, Executive Director, Fresno HCAP, 2043 Divisadero Street, Fresno CA 93701; nforbes.hcap@phfe.org; 559-320-0240

Medi-Cal Health Care Access

Norma Forbes, Executive Director
Fresno Healthy Communities Access Partners

- The Maze
- What Works
- Challenges
- Technology Solutions

Maze of Referrals

Clinics

Hospitals
ER & Outpatient

Food Bank

Schools

Health Plans

Social Services

Legislative Rural Caucus Hearing

August 23, 2011

Carla Kakutani, MD

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Rural Medi-Cal Provider Perspective – Family Physician – Carla Kakutani, MD

Access to care for rural Medi-Cal patients is poor and is likely to get worse if proposed policies are adopted. The ratio of Californians per physician in rural areas is twice that in urban regions. With approximately 45 percent of rural Californians living in regions designated as Primary Care Health Professional Shortage areas, [1] access to care is severely limited. This, coupled with the 10 percent provider rate cut passed as part of the 2011-2012 state budget, will fall hard on rural Medi-Cal recipients and compound existing structural problems in the Medi-Cal program:

1) Medi-Cal recipients, especially those living in rural communities, have coverage but dwindling access to care due to limited primary care provider networks.
2) Many family physicians have difficulty finding subspecialists willing to take Medi-Cal patient referrals, making access to a medical home unachievable.
3) The contemplated transfer of Healthy Families children into Medi-Cal will have serious consequences for rural access to health care services.
4) The 10 percent provider cut and mandatory co-payments passed by the Legislature and signed by the Governor as part of the budget will exacerbate rural access problems.

Should the State Plan Amendment be granted to allow a 10 percent cut to Medi-Cal provider rates, it is important that policymakers are aware of the affect this action will have on rural communities and Medi-Cal recipients:

1) Access to care for patients will be adversely affected.
    a. Currently, less than half of California physicians participate in the Medi-Cal program, mainly due to woefully inadequate payment that doesn't meet the cost of care.[2]
    b. More than 55 percent of Medi-Cal beneficiaries reported difficulty finding physicians willing to treat them.[3]
2) Providers and health plans will leave the program because of lower rates and added administrative burdens: [4]
    a. California currently ranks 47 out of 50 states for Medi-Cal provider payment.

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[1] California State Rural Health Association, *Stats and Facts*, viewed August 22, 2011, http://www.csrha.org/2010stats_facts.html.

[2] Grumbach, K., Chattopadhyay, A., and Bindman, A. *The California Physician Supply Re-Count: Fewer and More Specialized.* University of California, San Francisco, 2009.

[3] Medi-Cal Policy Institute. *Physician Participation in Medi-Cal, 2001*. University of California, San Francisco, 2003.

[4] "Trends in Medicaid Physician Fees 2003-2008," Zuckerman, Williams, Stockley, *Health Affairs,* April 2009.

   b. California Medi-Cal rates are 20 percent lower than the national average Medicaid rate.
   c. California Medi-Cal rates are 44 percent below Medicare reimbursement rates.
   d. Medi-Cal primary care rates are 53 percent below Medicare rates.
   e. Medi-Cal pays $24 for an established patient visit; other payer rates are more than triple this amount.
3) Access problems will lead to lower quality of care.
4) The savings achieved by these cuts are short-term and short-sighted. Ultimately, the state will pay more for a sicker population that gets its care in the emergency room and hospital setting.

Should the cost sharing rules be waived allowing mandatory copayments, and patient visit limits be imposed, it is important that policymakers are aware of the effect these actions will have on rural communities and Medi-Cal recipients:

1) Out-of-pocket costs to Medi-Cal's impoverished enrollees will greatly increase.
   a. Collection of co-pays adds yet another expense to caring for Medi-Cal patients, punishing both the provider and the patient.
2) Higher co-pays and visit limits will create barriers to care for patients who need medically necessary care and medications.
3) Co-pays will discourage Medi-Cal patients from obtaining needed preventive and chronic condition care, leading to higher emergency room and hospital costs for the state.
   a. Underwriting of managed care plans for Medi-Cal patients has already factored in lower utilization, and rates already have been reduced. Further reductions will affect a plan's ability to retain providers.
4) Collecting co-pays from an indigent patient population puts physicians and other providers in the difficult, if not impossible, position takeoff accepting even lower payment or turning away patients who cannot afford a co-pay and have nowhere else to go.
   a. Mandatory copayments as proposed flagrantly violate limits imposed on Medicaid cost-sharing in the federal law.[5]
5) Monitoring the number of visits a patient makes has little to do with quality of care. This will create an administrative nightmare for physicians and other health care providers who would not be paid for services rendered if a patient had reached the allowed number of visits.
   a. Physician office administration of visit limits is impossible –one physician or practice will not know how many visits a patient has had with other providers.

[5] "Medicaid Program; Premiums and Cost Sharing; Final Rule." In *Federal Register*, Vol. 75, No. 103, May 28, 2010.

Medi-Cal and Rural Health Clinics

Presented to the Rural Legislative Caucus

August 23, 2011

CARHC
California Association of Rural Health Clinics

Rural Health Clinics (RHCs)

- RHC is a special Medicare certification of primary care providers in underserved, non-urbanized area; any eligible provider that qualifies can become certified
- At this point, most RHCs are owned by private medical providers or by hospitals

CARHC
California Association of Rural Health Clinics

Rural Health Clinics (RHCs)

- California has 275 RHCs that provide services to patients in need
- The majority of services are primary care, but some also provide specialty care, behavioral health, OB/perinatal, and dental
- According to CMS, in 2008, RHCs provided care to 353,696 Medi-Cal patients

CARHC
California Association of Rural Health Clinics

Current Issues

- Our RHC sometimes faces great difficulties finding specialty referrals for our Medi-Cal patients
- Cutting reimbursement for Medi-Cal services will only make this situation worse

CARHC
California Association of Rural Health Clinics

Current Issues

- We understand the state's financial dilemma, but think that limiting primary and specialty access will only mean more costs for care in emergency and other hospital departments down the road
- Decreasing Medi-Cal reimbursement will result in job loss or even elimination of some clinics

CARHC
California Association of Rural Health Clinics

Current Issues

- The “soft cap” on visits requires that additional visits be for “medically necessary” services only
- A requirement of any RHC visit is that it be “medically necessary” but we don’t know what Medi-Cal expects in this regard or whether we will end up having to pay back for services we provide
- We believe that cutting primary care visits will also mean more costs down the road

CARHC
California Association of Rural Health Clinics

Working Together for Improvement

- Please make sure we get educated about regulations and expectations, because we want to do the right thing
- Focusing on getting preventive care and early treatment to patients will help bring down costs in the long run

CARHC
California Association of Rural Health Clinics

Questions?

CARHC
California Association of Rural Health Clinics

CPCA
California Primary Care Association
Health Care Access for All

Legislative Rural Caucus Medi-Cal Hearing:
FQHC Perspective

Judith Shaplin, CEO
Mountain Health and Community Services

August 23, 2011

CPCA
California Primary Care Association
Health Care Access for All

Overview

- CPCA and rural membership
- What is an FQHC?
- Challenges
- Recommendations
- Contacts

CPCA
California Primary Care Association
Health Care Access for All

CPCA Membership

The California Primary Care Association represents over 800 community clinics and health centers across California

Clinic Types	Numbers
Total CCHCs	870
FQHC sites	478
FQHC look alikes	32
RHC sites	26

Demographics	Numbers
Patients	4,707,024
Medi-Cal patients	1,611,737
Encounters	14,423,190
Under 100% FPL	3,058,653
100-200%	774,636
Above 200%	657,448

Source: OSHPD, 2009

CPCA
California Primary Care Association
Health Care Access for All

Profile of Rural CCHCs

Clinic Types	
Total CCHCs	235
FQHC sites	159
FQHC look alikes	6
95-210 RHC sites	23

Age of Patients	
Less than 1 year	33,325
1-19	351,575
20-64	569,614
65+	73,004

Demographics	
Patients	1,027,518
Medi-Cal patients	434,638
Encounters	3,609,314
Medi-Cal encounters	1,570,439
Under 100% FPL	616,519
100-200%	181,363
Above 200%	80,623

Source: OSHPD, 2008

CPCA

California Primary Care Association

Health Care Access for All

CPCA
California Primary Care Association
Health Care Access for All

What is an FQHC?

- **Located in or serve a high need community** (designated Medically Underserved Area or Population).
- **Governed by a community board** composed of a majority (51% or more) of health center patients who represent the population served.
- **Provide comprehensive primary health care** services as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- **Provide services available to all** with fees adjusted based on ability to pay.
- **Meet other performance and accountability requirements** regarding administrative, clinical, and financial operations.

CPCA
California Primary Care Association
Health Care Access for All

Recommendations

- Challenge: Bureaucratic restrictions on eligibility like the **soft cap**
  - Seen as an impediment and will only deter providers from joining the program
  - Rural safety net cannot risk having to payback Medi-Cal for visits over 7
- Recommendation: Develop a computerized system with real time information

CPCA
California Primary Care Association
Health Care Access for All

Recommendations

- Challenge: Financial and bureaucratic barriers to patients receiving primary care like the **co-pays** and **re-certifications**
  - Co-pay: It will cost clinics more to impose and try and get the co-pay from the patient than just absorbing the cost
  - Recertification: Costly and time consuming and not appropriately executed
- Recommendation: Do not limit access to primary and preventive care services, rather provide incentives for patients to seek and receive primary care

CPCA
California Primary Care Association
Health Care Access for All

Challenges & Recommendations

- Challenge: Not enough providers to see Medi-Cal patients
  - Rates are too low
  - Many providers are aging out
- Opportunity: ACA will increase Medicaid payments in fee-for-service and managed care for primary care services provided by PCPs to 100% of the Medicare payment rates for 2013 and 2014.
  - States will receive 100% federal financing for the increased payment rates.
- Recommendation: After 2014 keep rates at the same level as the ACA increased rates

CPCA
California Primary Care Association
Health Care Access for All

Recommendations

- Challenge: Health information technology is absolutely necessary but also very expensive

- Recommendation: Support the roll out of the Medi-Cal Meaningful Use Incentives and Medi-Cal should form a partnership with the California Telehealth Network
  - Secure, medical grade broadband network
  - Connect rural, urban, safety net, private providers and institutions

CPCA
California Primary Care Association
Health Care Access for All

Contacts

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The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

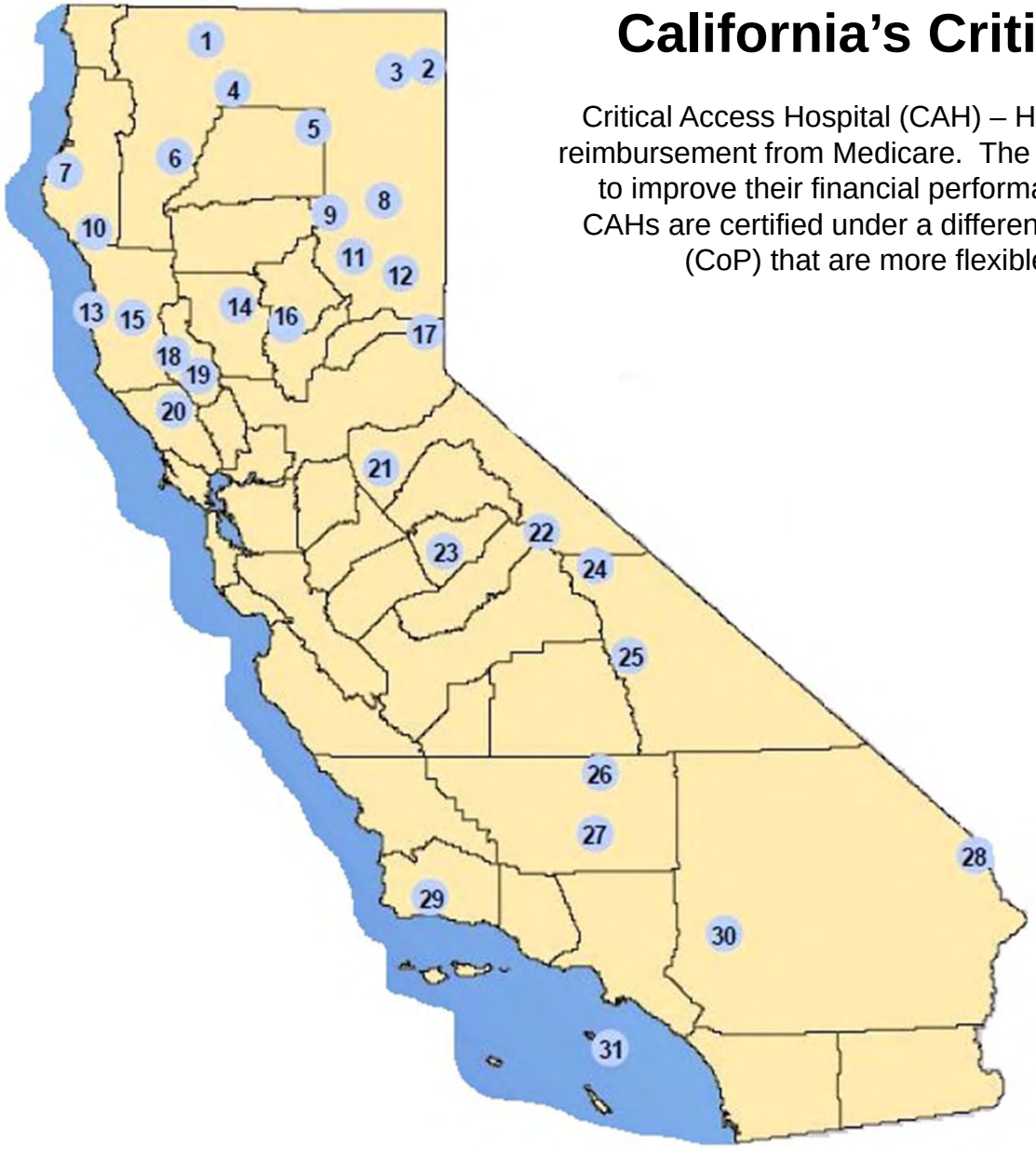
Raymond T. Hino, M.P.A., F.A.C.H.E.
Chief Executive Officer
Mendocino Coast District Hospital
Fort Bragg, California
and
Chairman, California Critical Access Hospital Network

California's Rural Hospitals

Rural Hospital Definition in accordance with: Chapter 67/88 (AB 2148) of the California Health and Safety Code and SB 1458, Section 12480 of the California Health and Safety Code, 1987

California's Critical Access Hospitals

Critical Access Hospital (CAH) – Hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures. CAHs are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital CoPs.



Label	Facility Name	City
1	Fairchild Medical Center	Yreka
2	Surprise Valley Community Hospital	Cedarville
3	Modoc Medical Center	Alturas
4	Mercy Medical Center, Mt. Shasta	Mount Shasta
5	Mayers Memorial Hospital	Fall River Mills
6	Trinity Hospital	Weaverville
7	Redwood Memorial Hospital	Fortuna
8	Banner Lassen Medical Center	Susanville
9	Seneca Healthcare District	Chester
10	Jerold Phelps Community Hospital	Garberville
11	Plumas District Hospital	Quincy
12	Eastern Plumas District Hospital	Portola
13	Mendocino Coast District Hospital	Fort Bragg
14	Glenn Medical Center	Willows
15	Frank R. Howard Memorial Hospital	Willits
16	Biggs-Gridley Memorial Hospital	Gridley
17	Tahoe Forest Hospital District	Truckee
18	Sutter Lakeside Hospital	Lakeport
19	St. Helena Hospital (Clearlake)	Clearlake
20	Healdsburg District Hospital	Healdsburg
21	Mark Twain St. Josephs Hospital	San Andreas
22	Mammoth Hospital	Mammoth Lakes
23	John C. Fremont Hospital	Mariposa
24	Northern Inyo Hospital	Bishop
25	Southern Inyo Healthcare District	Lone Pine
26	Kern Valley Hospital District	Lake Isabella
27	Tehachapi Valley Healthcare District	Tehachapi
28	Colorado River Medical Center	Needles
29	Santa Ynez Valley Cottage Hospital	Solvang
30	Mountains Community Hospital	Lake Arrowhead
31	Catalina Island Medical Center	Avalon

California Rural Hospitals and Critical Access Hospitals

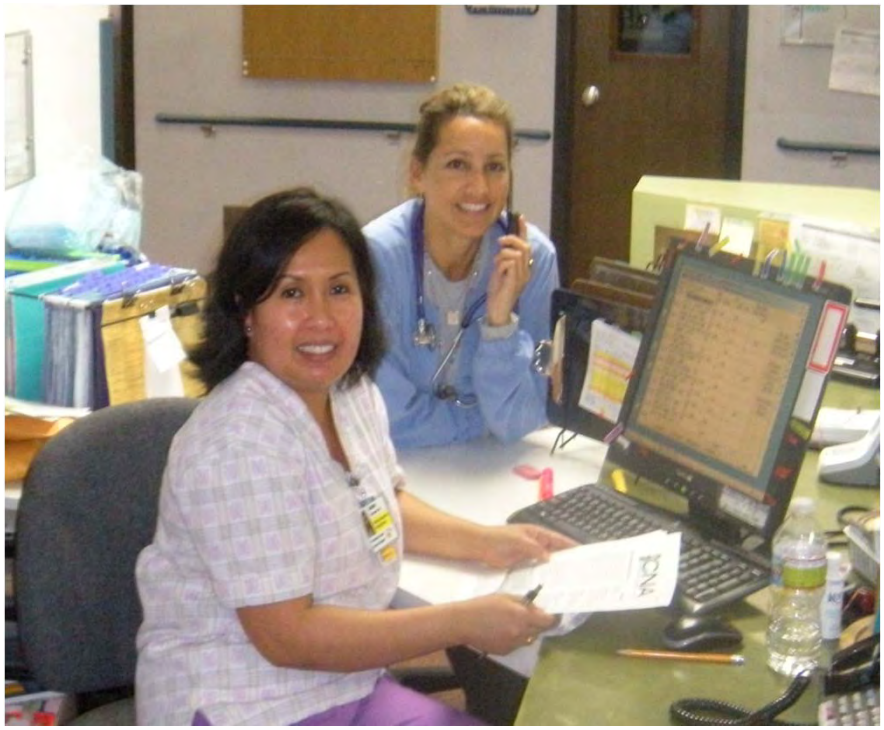
By the Numbers

- 352 California Community Hospitals (1)
- 69 Rural Hospitals (19% of all CA Hospitals) (2)
- 31 Critical Access Hospitals (Included with Rural Hospitals) (3)

(1) American Hospital Association AHA Hospital Statistics 2010 Edition
(2) California OSHPD ALIRTS 2008
(3) California State Office of Rural Health 2010

Mendocino Coast District Hospital
Fort Bragg, California

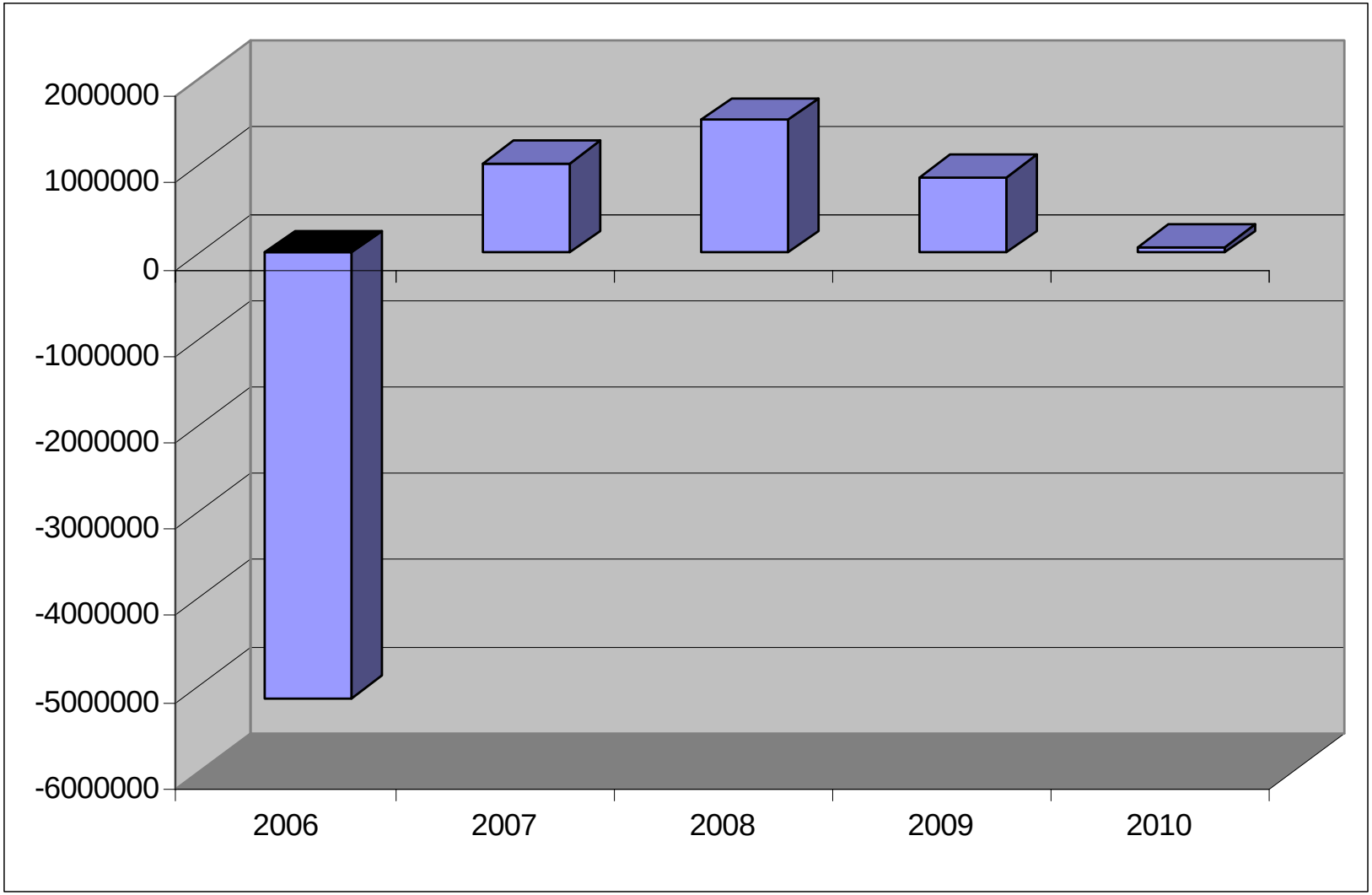
Mendocino Coast District Hospital Services



- Medical-Surgical Acute
- Intensive Care Unit
- Obstetrics
- Surgery
- Outpatient Surgery
- Emergency Room
- Ambulance
- Clinical Laboratory
- Imaging Services
- Hematology/ Oncology
- North Coast Family Health Center
- Home Health/ Hospice
- Healing Hospital and Wellness Center

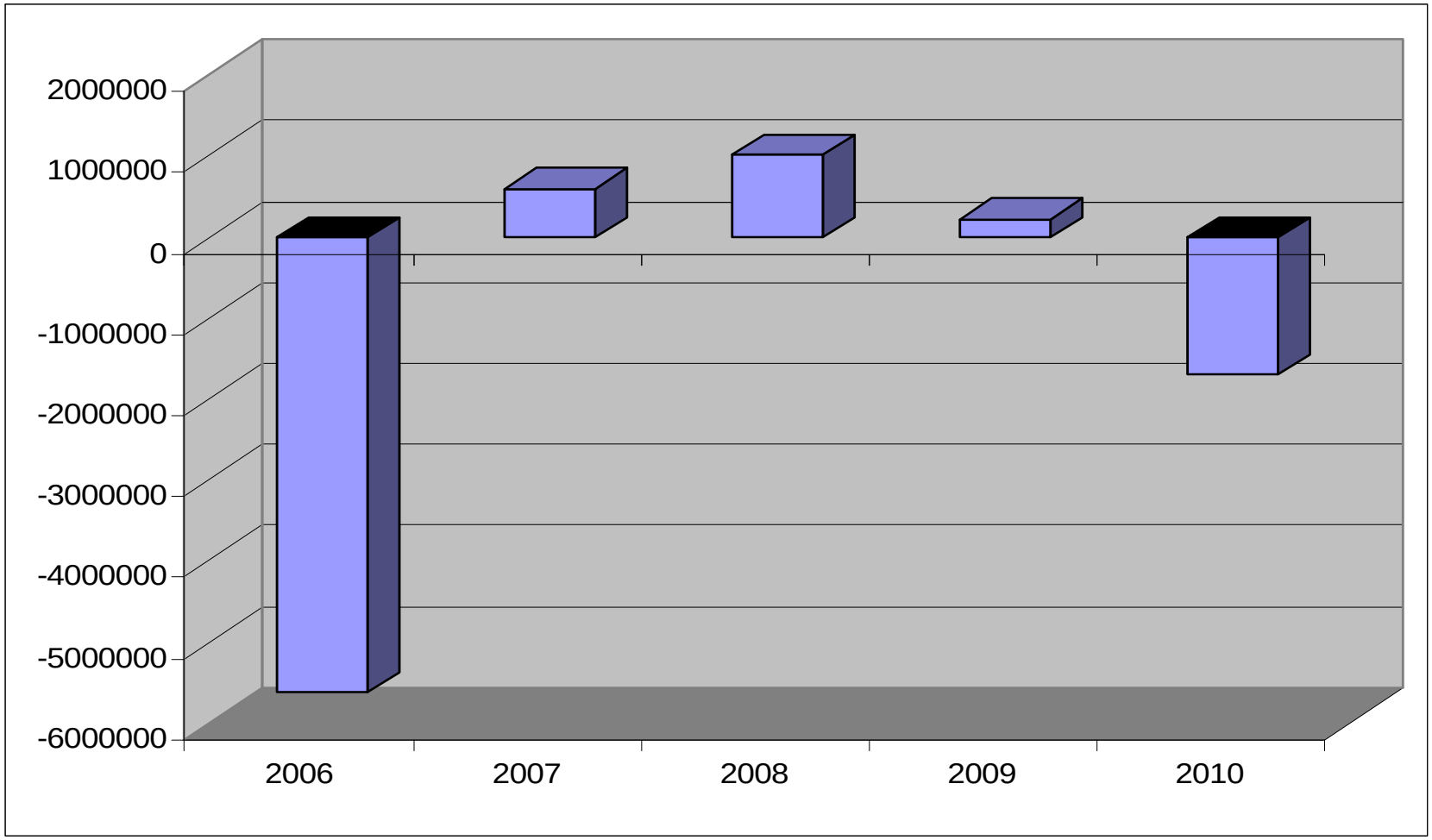
Fiscal Years 2006 – 2010

Total Net Income



Fiscal Years 2006 – 2010

Operating Income Only



Rural Hospitals and Critical Access Hospitals Key Issues

- Physician Recruitment and Employment
  - Access to Specialists/ Telemedicine
- Seismic Relief
- The State Budget/ Medi-Cal and Medicare Funding
- Health Information Technology Implementation
- National Health Reform

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

The State Budget
Medi-Cal Cuts

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

The Cuts:

- 10% Cuts for Hospital Fee for Service
- 2008-2009 Rates minus 10% Cuts for ICFs, SNFs, Rural Swing Beds, DPNFs, ADHCs, Pediatric Subacutes

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

The Cuts (Continued):

- $50.00 Co-Pay for each Emergency Dept Visit
- $100.00 Co-Pay for each Hospital Admission (up to a maximum of $200.00)
- $5.00 Co-Pay for each Physician Clinic Visit
- $5.00 Co-Pay for each Preferred Brand Prescriptions
- $3.00 Co-Pay for each Non-Preferred (Generic) Prescription
- Limit of 7 visits per year (soft cap)

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

Expected Outcomes:

- Transfer of Outpatient Clinic visits to Emergency Dept Visits
- Added Bad Debt for hospitals
- Patients delaying care, resulting in more costly interventions
- Rural Hospital Closures/ Skilled Nursing Facility Closures

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

The Eastern Plumas District Hospital (Portola, CA) Story:

- California's First Critical Access Hospital in 2000
- The hospital operates 60 DP SNF beds
- The 2008-2009 10% cut = 23% cut or a loss of $1.1 million, which will result in closure of all 60 beds
- 57 SNF patients will be moved out of the area
- 60 jobs will be eliminated

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

Medi-Cal Financing Relief for Rural Hospitals

<u>An Opportunity</u>

- The Current Proposal for a Hospital Fee Program
- A “Win-Win” for hospitals and for State of California

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

Health Information Technology – Meaningful Use

<u>Medi-Cal E.H.R. Incentive Program – More Work Needed</u>

- Positive Step to provide subsidies to help rural hospitals and rural health clinics to acquire electronic health records
- Current Medi-Cal Incentive formula penalizes rural hospitals with swing beds and DPSNFs that exceed the 25 day average length of stay limit

The Medi-Cal Experience in Rural California

Rural Hospitals and Critical Access Hospitals

Where do we go from here?

Thank You!