



An Examination of the Impact of Medi-Cal Reimbursement Cuts on Rural Hospitals and Clinics in California

Introduction

Healthcare providers across the state face severe difficulties when forced to provide services without adequate and timely reimbursement. This document outlines the ramifications of the 2008 budget cuts to rural communities, as well as long term solutions to avoiding such a crisis in the future.

Economic Consequences resulting from Funding Cuts to Healthcare:

Below are examples gathered from various sectors of the healthcare delivery system, including community clinics and health centers (CCHC), Rural Health Clinics (RHCs) and a very specific example from Sierra Kings District Hospital, a small rural hospital located in Reedley California.

Community clinics and health centers:

In the Spring of 2008, the California Primary Care Association (CPCA) surveyed over 675 of its clinic members regarding how the proposed June and August delay in Medi-Cal payments would impact their cash flow. Through the survey, CPCA found that:

- Over 80 percent of clinics will be forced to lay off employees, stop hiring, or ask staff to skip paychecks or take salary cuts. **These consequences will be felt hardest in rural areas, where workforce is already scarce.**
- 41 percent of clinics report that they will be able to cover operating expenses without Medi-Cal reimbursements for **30 days or less.**
- 50 percent of clinics surveyed reported that although they had access to a line of credit, **the interest rates on these lines of credit range as high as 14.5 percent, which increases their financial burden and extends repayment time.**

District and rural hospitals:

For many rural and district hospitals check write delays are especially challenging. Many district and rural hospitals have outstanding General Obligation (GO) bonds raised to cover infrastructure expenses due to seismic retrofit requirements, or just to cover operating expenses. The covenants of these bonds prohibit adding any other form of debt while in place, including lines of credit.

Sierra Kings District Hospital (SKDH) is a prime example highlighting the challenges typical small rural hospitals have faced due to past budget "solutions." During the past six years, the three closest regional hospitals to SKDH (Kingsburg, Sanger, Dinuba) have closed their Emergency Rooms or their

hospitals completely. These closures placed a greater burden on the 5-bed Emergency department at Sierra Kings, which saw 17,000 visits in the most recent calendar year. The majority of those visits were Medi-Cal eligible patients.

In addition, SKDH operates four Rural Health Clinics in impoverished communities of the lower San Joaquin Valley. These clinics offer extended service hours and weekend hours to permit low income patients access to primary care, and to reduce the costs of patient visits which would otherwise end up in the Emergency Room of the hospital. The clinics saw 43,954 visits in the most recent calendar year.

By delaying Medi-Cal payments:

- SKDH will have to find a way to cover the over \$1 million in monthly payroll expenses outside of seeking a line of credit. They do not have access to a line of credit to cover fixed expenses due to outstanding General Obligation (GO) bonds.
- Since SKDH operates in a Medi-Cal managed care county, the reduction also applies to those patients whom are enrolled in the plan. This represents an additional percentage of the patient population for which revenue will be reduced to the hospital.
- Due to a lack of financial alternatives, SKDH will not be able to meet payroll and other operating expenses. There is discussion of closing the entire hospital for a period of time.

If SKDH is forced to shut its doors, the potential costs to the Medi-Cal program in the next fiscal year will be significant:

- Patients seeking emergency services will have to be transported by ambulance to the next closest hospital (Community Regional Medical Center – 25 miles to Fresno).
- **Based on the E/R visits stated above, the cost to the Medi-Cal program for transportation alone would equal \$ 18.7 million.** Fresno area hospitals, including Community Regional Medical Center, currently face significant challenges due to overcrowding in their Emergency departments (average wait time ranges from 2 to 5 hours), and will be hard pressed to accommodate the increased demand resulting from the potential closure of SKDH.
- Furthermore, if the primary care facilities operated by SKDH (and across rural California) close temporarily, it is difficult to quantify the number of patients who will delay seeking care for issues that demand immediate attention. Past studies indicate the patients, especially low income and

non-English speaking patients, will delay seeking treatment until the health issue becomes chronic and/or requires emergency care.

- There is an enormous increased cost associated with treating patients in an ER setting versus a community clinic and health center setting, as it will result in increased billings at a higher level of acuity to the Medi-Cal program.

Policy Recommendations & Future Initiatives:

There are steps the Legislature can take to avoid a health care crisis in the future. The following is a collection of ideas gathered from participants of the recent CSRHA rural roundtable meetings across the state on cost-effective solutions to care for the low income and underserved populations in California.

CSRHA offers its expertise to help ensure the recommendations below are implemented.

1. Health Information Technology (HIT)

Health Information Technology (HIT) provides powerful tools to enhance health and health care in rural communities. It can bridge distances by providing immediate access to clinical knowledge, specialized expertise and services unavailable in rural areas. In its 2005 report, *Quality through Collaboration: The Future of Rural Health Care*, the Institute of Medicine (IOM) particularly noted as one of its key findings that telehealth warrants special attention to facilitate its use. **CSRHA recommends the following:**

- An expansion of approved services under the Medi-Cal program.
- An increase in reimbursement levels for those services, including the addition of a facility/site fee to offset site specific costs.
- New telemedicine policies that are more comprehensive, specific to the affected provider types, including FQHCs and RHCs, and easier to implement than the current policies.
- Financial assistance to rural providers for the hardware/software costs associated with initiating the program.
- Free training and assistance for rural providers to implement a telemedicine system.

2. Improve Access to Care at FQHCs and RHCs

The most efficient model for accessing primary care services is through the use of Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as an entry point. FQHCs and RHCs provide excellent patient care, carry on the tradition of providing information to patients for preventive healthcare, and reduce Medi-Cal program costs by keeping more patients from using the hospital emergency room. **CSRHA recommends the following:**

- Exclude FQHCs and RHCs from the check-write delays and other reductions in reimbursement that undermine their increasingly crucial role in the outpatient safety net.
- Do not require patient re-enrollment in the Medi-Cal programs on a quarterly basis (QSR), and rather, maintain

an annual enrollment process. QSRs are a tremendous administrative burden and an obstacle to care for eligible beneficiaries.

- Add more funding to the traditional clinic programs, including Expanded Access to Primary Care (EAPC). EAPC dollars are proposed to be cut under this Administration and have already been reduced during previous budget cutbacks. Such actions only trade dollars for dollars among programs at best, until the usual outcome of program elimination occurs.

3. Implement Policies that Promote Contracts Between Rural Hospitals and Prisons

Prison healthcare faces huge challenges due to cost and personnel issues. This is demonstrated in the current Federal court appointed receivership situation and the request to spend \$7 billion to build prison healthcare facilities. Prison costs for infirmary staff are extraordinarily high and extremely inefficient.

Senate Bill 260, authored by Senator Gloria Romero, was signed into law in 2004 to encourage such collaborations (Ch. 310, Stats 2004). When hospitals and local prison systems have cooperated with each other, the results always produce cost savings to the prison system. Currently there are a total of eight hospitals in rural communities that contract with prisons, including Pioneers Memorial Hospital in Brawley, Coalinga Hospital in Coalinga and Lompoc District Hospital in Lompoc. Each of these facilities has reduced prison system costs for transportation, length of prisoner stay, and officer's time in addition to the cost of healthcare services rendered. **CSRHA recommends the following:**

- Associations representing rural and district hospitals and the Secretary of the State Department of Corrections should negotiate a process to contract health care services, rather than competing for professional staff in rural areas already facing a shortage of qualified personnel.
- Prison wardens and hospital executives ought to be permitted to enter into agreements as needed without oversight by the State authorities. Local area communication will always create contracts which are favorable to both parties.
- Prisons should be permitted to assist area hospitals in the construction/remodeling of site space for secured rooms/units for handling inbound prisoner care, either through financial assistance or any other appropriate aid.

4. State-level 340B drug purchasing program

The current 340B program permits "covered entities" to purchase prescribed drugs at a contracted maximum rate for all outpatient needs. These provider types can contract with a single outside pharmacy as a dispensing agent to more efficiently purchase medications, or create a network of pharmacies for better patient servicing. The program as created in the Public Health Service Act applies only to certain provider types that are defined as safety net providers that participate in state Medicaid programs. The definition of a covered entity could be expanded to include all of the above referenced providers.

Certain state Medicaid programs have creatively used the 340B

program to reduce medication costs while attending to the needs of their patient populations through partnerships between state programs and covered entities. For example, Texas legislated that inmate drug purchases be contracted through the Texas state Medicaid program. In California AB 77 was passed in 2005, authorizing the Department of Corrections to set up a pilot program to purchase drugs through a partnership with the U.C. healthcare system. This was never implemented. However, purchasing drugs through a 340B type program benefits providers and patients in several ways:

- Patients receive prescribed medications at reduced cost, or in the case of sliding fee scales, at no cost.
- Providers purchase medications at price levels lower than traditional Medicaid program costs.
- Providers that bill private insurance plans for medication costs can charge plans at an arranged price that permits some profit.
- Patient populations can be increased by expanding the definitions used for safety net providers, thus increasing its cost effectiveness.
- Prison inmate populations can be included, creating an additional cost savings for the Department of Corrections.

CSRHA recommends that the Governor or the Legislature enact AB 77 to implement the stated pilot program to determine whether such a collaboration would prove cost effective. If proven successful, then we request a simple, streamlined process for providers to enroll in the program.

5. Rural healthcare providers need greater assistance from the CA Department of Healthcare Services (“CDHS”) and Department of Public Health (“CDPH”) on issues arising from licensing or certification of clinics, applying for various public health programs and requirements for receiving reimbursement for patient visits. The resulting multiplicity of forms and paperwork combined with department delays in processing result in reimbursement delays to the providers and increased administrative costs to both providers and the State budget for DHCS/CDPH.

Recommendations have been made in the past from various healthcare associations on streamlining the process and specific legislation has been passed to codify and define methodologies for improving the process. Many of these recommendations have been blatantly ignored and legislation has never been implemented. In addition, the split of DHS in 2007 into two departments also fragmented the licensing and certification application process into separate divisions. **CSRHA recommends the following:**

- **More effective communication between DHCS/CDPH licensing departments and Medi-Cal enrollment and other public health programs to ensure that a new provider is enrolled in available programs.** Currently there is little communication or understanding between departments on how the application process should function.
- **More effective communication and coordination between the Federal and State certification**

requirements of any application process. Neither side understands what the other does. *DHCS and CDPH are not even permitted to call CMS Region IX to obtain information on a pending application;* they must submit a written transmittal that rarely is answered.

- **Reduction in the quantity of application forms required for any enrollment process to eliminate redundant or unnecessary information.** For example, certification as a rural health clinic requires sixteen applications, not including additional applications required for Medi-Cal enrollment. Several forms are to be sent to CMS through CDPH for the Federal portion of certification and request the exact same information as several state certification forms. One state form was designed for skilled nursing facilities, but is requested with the rural health clinic package.
- **Simultaneous enrollment for licensure and enrollment in multiple Medi-Cal public health programs.** While AB 2307 was passed specifically to request implementation of simultaneous program enrollments, few clinics utilize this mechanism as a result of concerns about the long delays in the clinic license approval process and the continued failure of CDHP to implement prior law requiring the streamlining of the clinic license application.
- **Improved DHCS and CDPH staff training to understand the distinctions between provider types.** Currently there is no documentation to define the differences in function or regulation between primary care clinic licensure and rural health clinic certification. Staff do not appear to understand how to process applications, nor conduct required site surveys on the two distinct types. CSRHA can recommend consultants who routinely explain to department personnel how best to handle application issues and clinic site surveys.

Streamlining the provider application and eliminating unnecessary paperwork would product cost savings across multiple departments within DHCS and CDPH, leading to a more efficient use of personnel through reorganizing tasks.

Conclusion

The above solutions represent opportunities for the Administration and the Legislature to work together to create more effective use of limited financial resources in healthcare. While there has been improvements in some areas, particularly telemedicine, there is much more that could be accomplished to assist all parties involved in avoiding what appears to be an annual folly of cutting Medi-Cal reimbursement.

Please feel free to contact CSRHA if you require additional information on any of the above solutions.



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