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June 7, 2011

The Honorable Ed Hernandez
Chair, Senate Health Committee
State Capitol, Room 4085
Sacramento, CA 95814

Re: ***AB 1066 (Speaker Perez) as amended May 31, 2011***
Scheduled for Hearing in the Senate Health Committee June 15, 2011
Position: SUPPORT

Dear Senator Hernandez:

On behalf of the University of California, (UC), I am writing to respectfully offer our support for Assembly Bill (AB) 1066. UC owns and operates five academic medical centers at the Davis, Irvine, Los Angeles, San Diego, and San Francisco campuses, which are significantly impacted by AB 1066. Together our medical centers are the fourth largest healthcare delivery system and among the largest providers of care to Medicaid enrollees in California. We appreciate your leadership in ensuring that AB 1066 contains key implementation language for components of the Medi-Cal 1115 waiver approved in November 2010 and which governs for the UC Medical Centers are paid for Medicaid services

As you know, California's 19 public hospitals, including the UC Medical Centers, are the core of the state's health care safety net. Though just six percent of all California hospitals statewide, publicly owned hospitals serve 2.5 million Californians each year and provide nearly half of all hospital care to the state's 6.7 million uninsured residents. They deliver 10 million outpatient visits per year and operate more than half of the state's top-level trauma centers and almost half of the state's burn centers. They provide almost 30 percent of the care provided to California's Medi-Cal population within the hospital setting, and 35 percent of Medi-Cal visits in hospital outpatient settings. To a large extent, their patient population has complex and multiple medical needs. Forty-three percent of new doctors in the state are trained in public hospitals

The Medi-Cal Waiver funding is fundamental to the ability of our hospital system to continue to providing services to Medi-Cal and uninsured individuals and Californians overall. AB 1066 contains the technical language necessary to implement the vital reimbursement and funding components contained in the Waiver. While the federally approved terms and conditions of the Waiver lay out the overall allocation of funding to the State and public hospitals as a whole, they do not contain any specific hospital-level reimbursement detail. Therefore, as in the 2005 Waiver, technical implementing language is needed to outline the Waiver reimbursement for the designated public hospital systems.

The various components of the designated public hospital reimbursement included in AB1066 are:

- Regular Medi-Cal inpatient fee-for-service, including physician SPA payments, for inpatient services, which will continue to be through a direct CPE structure whereby the public hospital certifies the expenditures it has incurred for these services and receives the matching federal funds.

- Disproportionate Share Hospital (DSH) funding for designated public hospitals – reimbursement through this funding source is for uncompensated Medi-Cal and uninsured hospital services. Individual public hospital reimbursement will be based on a formula that considers the volume of services provided in the hospital, recognition of equity among the designated public hospitals, as well a hospital's proportionate share of hospital-specific DSH claiming ability which is based on the uncompensated cost.

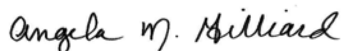
- Safety Net Care Pool (SNCP) for Uncompensated Care – reimbursement through this funding source is for uncompensated uninsured hospital and non-hospital services. This funding will be allocated based on a proportionate share of uncompensated uninsured costs.

- Delivery System Reform Incentive Pool (DSRIP) – funding through this pool is tied to achievement of hundreds of ambitious milestones related to improved patient health, experience, and clinical quality over five years. These milestones include reporting more than 20 population health measures, making dramatic improvements in patient safety, and implementing systemic reforms such as full-scale medical home and chronic care models. The funding allocation is based on the individual designated public hospital systems' DSRIP proposals submitted to DHCS/CMS.

Each of these Waiver components contains core funding for our medical centers and supports their ability to provide access to high quality care for low-income populations in California. AB 1066 is needed to ensure that these reimbursement and funding sources are equitably allocated among the public hospital systems. Additionally, AB 1066 contains needed language related to the coverage expansion provided for under the Waiver, consistent with the federally approved requirements.

For these reasons, we support AB 1066 when it is heard in the Senate Health Committee. We appreciate your commitment to public hospitals and would be happy to discuss our position with you and your staff. Thank you for your consideration.

Sincerely,



Angela M. Gilliard, JD
Legislative Director

cc: The Honorable John Peréz, Speaker of the Assembly
The Honorable Members of the Senate Health Committee
President Mark G. Yudof
Provost Lawrence Pitts
Executive Vice President Nathan Brostrom
Senior Vice President Daniel M. Dooley
Senior Vice President John Stobo
Associate Vice President Santiago Munoz
Associate Vice President and Director Steve Juarez

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