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June 12, 2017

Ms. Messina:

This letter presents our estimate of the potential costs to the Medi-Cal program that would result from the enactment of Senate Bill 349 (Lara), as amended on May 26, 2017.

Summary

We estimate annual costs beginning in 2019 of \$370 million to community dialysis clinics in California due to the staffing standards proposed by SB 349. For Medi-Cal to increase reimbursement rates to cover its share of these costs would cost \$60 million annually (\$30 million General Fund). Medi-Cal potentially would incur additional annual costs of \$270 million or more (\$135 million General Fund) for additional health care for patients whose access to clinic-based dialysis is reduced or eliminated.

Background

SB 349 establishes staffing standards and turn around minima for clinics¹ that provide renal dialysis services in California. Specifically, the bill requires, effective on January 1, 2019 that clinics maintain staffing levels of at least one nurse for every eight patients, one technician for every three patients and one social worker and one dietician for every 75 patients². It also requires that clinics allow at least 45 minutes of transition time per patient.

¹ The bill exempts in-patient and skilled nursing facilities from these requirements.

² Since each nurse and technician typically serve 3 different patients per day, the 8:1 and 3:1 ratios for patients being served at any given time equate to 24:1 and 9:1, respectively. However, the 75:1 ratios for social workers and dietitians apply to the total caseload.

In 2014 there were 63,457 dialysis patients served by clinics in California. Based on historical growth trends³, we project that this caseload will grow to 79,950 by 2019.

Costs to Dialysis Clinics

We estimate that the staffing standards mandated by SB 349 would increase the cost of the average clinic visit by \$29.60, which equates to an increased staffing cost (salary and benefits) of 35 percent. We estimated the costs at \$29.60 per visit based on data provided to us by a major dialysis provider⁴. Given our caseload estimate for 2019 and the fact that ideally each patient should receive 3 dialysis sessions per week, we estimate that the bill would increase the statewide staffing costs of all community dialysis clinics in California by at least \$370 million annually beginning in 2019.

Medi-Cal Covered Caseload

The Department of Health Care Services (DHCS) was not able to provide us with an estimate of the Medi-Cal caseloads served by community dialysis clinics. Therefore, we estimated these caseloads based on the average percent of the total caseloads of two major community dialysis providers. Based on these averages, we believe that a reasonable estimate of the Medi-Cal community Dialysis caseload in 2019 would be: 3,000 in Fee-For-Service Medi-Cal, 10,000 in managed care Medi-Cal and 30,000 Dual Eligibles for whom Medicare pays 80 percent and Medi-Cal pays 20 percent of dialysis costs⁵.

Medi-Cal Costs

The bill does *not* require the DHCS to increase its rate of reimbursement for dialysis. However, the Department ultimately raised its rates for both hospitals and nursing

³ The average annual increase in caseload between 2005 and 2014 was 4.7 percent, which is consistent with the 5-percent national growth rate for End Stage Renal Disease as reported by the University of California, San Francisco, Kidney Project.

⁴ Health Management Associates estimated the bill would increase the per-visit cost by \$22. However, that estimate did not include the costs of the dietitian staffing standard because that was only added to the bill in the March 26, 2017 amendment. We estimate that the dietitian standard adds \$3 to the per-visit cost of dialysis. So, our estimate equates to about \$4 per-visit more than the HMA estimate. Even so, we believe our estimate is conservative because of the other cost drivers in the bill for which neither we nor HMA have an empirical basis to provide a specific estimate: (1) neither estimate includes the costs to cover breaks for nurses, yet the staffing standards apply “at all times”, thus necessitating additional staff to cover times when nurses are on breaks (2) neither estimate includes the costs of the turn around minima, which would be potentially significant, (3) neither includes the pressure to increase wages that would result from the increased demand for dialysis workers, and (4) neither includes the potential costs for overhead associated with adding so many new workers.

⁵ These are rounded numbers reflecting 3.74 percent, 12.5 percent and 38 percent, of the total caseload, respectively.

homes after the enactment of legislation mandating staffing ratios for those facilities.⁶ If Medi-Cal rates were raised to cover the costs of SB 349, Medi-Cal costs would increase by \$14 million (\$7million General Fund) for fee-for-service patients and by \$46 million (\$23 million General Fund) for managed care patients — for a total Medi-Cal cost increase of \$60 million annually (\$30 million General Fund), beginning in 2019.

However, the Department does not set rates for Dual Eligibles. There is no reason to expect the federal government to raise its reimbursement rates for Medicare to cover the additional state mandated costs imposed by SB 349 and the Medi-Cal program simply pays 20 percent of the rates set by the Medicare program.

Potential Restriction in Supply of Community Dialysis

The staffing costs alone imposed by SB 349 represent about a 35-percent increase in staffing costs for community dialysis. Without some offsetting increases in the rates of reimbursement for these services, it is clear that such a substantial cost increase would ultimately reduce the supply. With supply constraints would come missed appointments, or even for some patients no access to community dialysis at all. Many of these patients develop complications that must be cared for in an emergent setting at the hospital, including dialyzing in a more expensive hospital setting.

While the exact number of patients whose access to dialysis would be limited due to the costs imposed by SB 349 cannot be predicted with certainty, the California Dialysis Council (CDC) has surveyed its members to estimate the number of clinics that would either close or reduce shifts should SB 349 become law without any increase in reimbursement rates to cover its costs. Based on this survey, the CDC estimates that 15,379 patients would have their access to dialysis either limited or eliminated by SB 349.

Potential Medi-Cal Costs Due to Supply Restrictions

A recent report by Health Management Associates (HMA) found that: “total costs of care for patients with access only to emergent dialysis was 3.7 times higher than for patients with access to a regular source of care...In addition, when patients miss dialysis appointments, they experience a sharply increased likelihood of hospitalization and need for emergent dialysis. With a single missed dialysis session, the 30-day increased mortality risk has been estimated at 30 percent and increased hospitalization risk at 13 percent...”

⁶ At the time hospital staffing was mandated, most Medi-Cal hospitals received rates based on negotiation. However, specific estimates of the costs were provided and taken into account during negotiations. W&I Code 14126.033 required the department to set nursing home rates to include funding for the costs of staffing standards.

Based on the same distribution of patients used above, and assuming that the at-risk clinics serve twice as many Medi-Cal patients as the average clinic⁷, we estimate that 5,000 Medi-Cal fee-for-service and Managed Care patients would have their access to dialysis limited in the event that SB 349 is enacted without any increase in the Medi-Cal reimbursement rate for community dialysis clinics. This equates to additional annual Medi-Cal health care costs of at least \$270 million (\$135 million General Fund)⁸.

There would also be significant access problems for Dual Eligibles since the federal government is not likely to increase its rate of reimbursement for dialysis to cover the added costs imposed by SB349. As a result these patients would likely have increased hospitalizations, morbidity and mortality, which is a significant policy problem of this bill. The Medicare program would cover the majority of hospitalization costs.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael C. Genest". The signature is fluid and cursive, with a large, stylized initial "M" and "G".

Michael C Genest
Chairman
Capitol Matrix Consulting

⁷ The Department of Health Care Services does not have an estimate of Medi-Cal FFS and managed care dialysis patients for each of the at-risk clinics in CDC's survey. We believe it is reasonable, however, given the geographic distribution of the at-risk clinics to assume that they serve twice as many Medi-Cal patients as the statewide average.

⁸ This is based on the current average annual cost of disabled Medi-Cal patients — \$20,082 — and assumes those costs would increase 3.7 times as a result of the health impacts of limiting access to dialysis. An alternative would be to use the costs of community dialysis alone, rather than total health care costs as the base for calculating the total health care cost increase. That would produce an estimate of \$330 million (\$165 million General Fund).