August 29, 2013

Hon. Kamala D. Harris
Attorney General
1300 I Street, 17th Floor
Sacramento, CA 95814

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed statutory initiative (A.G. File No. 13-0012) relating to the imposition of fees on community hospitals.

BACKGROUND

Medi-Cal: California's Medicaid Program

Medi-Cal Funding and Administration. The federal Centers for Medicare and Medicaid Services (CMS) oversees the federal Medicaid Program. In California, this federal program is administered by the state Department of Health Care Services (DHCS) as the California Medical Assistance Program, and is known more commonly as Medi-Cal. This program provides health care benefits to low-income persons who meet certain eligibility requirements for enrollment in the program.

The costs of the Medicaid Program are generally shared between states and the federal government based on a set formula. The federal government's contribution toward reimbursement for Medicaid expenditures is known as federal financial participation (FFP) or federal matching funds. The specified percentage of Medicaid costs paid by the federal government is known as the federal medical assistance percentage (FMAP). In general, the FMAP for Medi-Cal has been set at 50 percent. However, for certain populations and certain administrative activities the state receives a higher FMAP.

Federal Medicaid law permits states to finance the nonfederal share of Medicaid costs through the following sources:

- ***State General Funds.*** State general funds are revenues collected primarily through personal income, sales, and corporate income taxes.
- ***Certified Public Expenditures (CPEs).*** The CPEs are a funding mechanism in which public agencies (in California, primarily counties and the University of California [UC] system) certify that they have made expenditures eligible for FFP, and then are

reimbursed by the federal government for part of these expenditures, generally at the state's FMAP rate.

- ***Intergovernmental Transfers (IGTs).*** The IGTs are transfers of public funds between government entities, such as from counties to states.
- ***Charges on Health Care Providers.*** Certain charges levied on health care providers generate revenues which we describe later in more detail.

Medi-Cal Delivery System. Medi-Cal provides health care through two main systems: fee-for-service (FFS) and managed care. In the FFS system, a health care provider receives an individual payment for each medical service delivered to a beneficiary. (In a hospital setting, an individual "service" may consist of an inpatient day, an entire hospital stay, or specific services, supplies, and procedures.) In the managed care system, DHCS contracts with managed care plans to provide health care for Medi-Cal beneficiaries enrolled in these plans. Managed care enrollees may obtain services from providers—including hospitals—that accept payments from the plans. The plans are reimbursed with a predetermined amount per enrollee, per month (known as a capitation payment) regardless of the number of services each enrollee actually receives.

Medi-Cal Hospital Funding

About 400 California hospitals (general acute care hospitals licensed by the state) currently receive at least one of three types of payments Medi-Cal makes to pay for services for patients.

Direct Payments. Direct payments are payments for services provided to Medi-Cal patients through FFS. The nonfederal share of direct payments for hospital services provided to Medi-Cal patients depends on whether a hospital is privately owned or publicly owned and who operates the hospital.

- The nonfederal share of direct payments to public hospitals operated by municipalities and health care districts and hospitals operated by private corporations (known as private hospitals) is funded from the General Fund.
- The nonfederal share of direct payments to public hospitals operated by counties and UCs is generally provided through CPEs.

The state currently spends more than $1.9 billion General Fund annually on direct payments to private hospitals and hospitals operated by municipalities and health care districts.

Supplemental Payments. Supplemental payments are made in addition to direct payments. The state generally makes these payments to hospitals periodically on a lump-sum basis, rather than individual increases to reimbursement rates for specific services. There are various types of supplemental payments related to hospital services provided to Medi-Cal patients. Depending on the type of supplemental payment, the nonfederal share may be comprised of General Fund support, CPEs, IGTs, and/or revenues from charges levied on hospitals. Hospitals receive about $440 million in General Fund support from these supplemental payments.

Managed Care Payments. Managed care payments are payments from managed care plans to hospitals for services provided to Medi-Cal patients enrolled in these plans. The nonfederal share of capitation payments to managed care plans is comprised of General Fund support, IGTs,

and revenue from charges levied on hospitals. In recent years, plans used roughly $1.7 billion in General Fund support to reimburse hospitals for services provided to Medi-Cal patients.

Charges on Health Care Providers

Provider Charges Are Used to Draw Down Federal Matching Funds. Federal Medicaid law permits states to (1) levy various types of charges—including taxes, fees, or assessments—on health care providers and (2) use the proceeds to draw down federal matching funds to support their Medicaid Programs and/or offset some state costs. These charges must meet certain requirements and be approved by CMS for revenues from these charges to be eligible for FFP. A number of different types of providers can be subject to these charges, including hospitals, certain skilled nursing facilities, and certain intermediate care facilities for the developmentally disabled.

Medi-Cal Hospital Quality Assurance Fee. Chapter 286, Statutes of 2011 (SB 335, Hernandez) imposes a charge known as a "quality assurance fee" on certain private hospitals for the period of July 1, 2011, through December 31, 2013. (At the time of this analysis, a bill that would enact a new similar fee was under consideration by the Legislature.) The DHCS administers and collects the fee and deposits the proceeds into the Hospital Quality Assurance Revenue Fund. Once fully implemented, the fee is estimated to raise a total of as much as $7.1 billion in revenue from hospital fee payments over the term of the fee. Moneys in this fund—the proceeds of the fee and any interest earned on the proceeds—are available only for certain purposes, including the following:

- A portion of the moneys reimburses DHCS for the staffing and administrative costs related to implementing the fee.
- A certain amount of the moneys offsets General Fund costs for providing children's health care coverage, thereby achieving General Fund savings. The total amount of General Fund savings from using fee revenue to offset state costs for children's coverage is $1.2 billion.
- Most of the moneys provide the nonfederal share of (1) certain increases to capitation payments that plans are required to pass along entirely too private and public hospitals and (2) certain supplemental payments to private hospitals. Both types of payments receive FFP, so the fee revenues are used to draw down federal funds. The total amount of fee revenue that funds these types of payments is estimated to be $5.8 billion. The total amount of payments to hospitals using these fee revenues is therefore estimated to be $11.6 billion ($5.8 billion of fee revenue plus $5.8 billion of federal matching funds).
- A certain amount of the moneys fund direct grants to public hospitals. These grants, which total to $140 million, are not considered Medi-Cal payments and thus are not eligible for FFP.

The net benefit to the hospital industry from the Chapter 286 fee is estimated to be $4.6 billion—$11.7 billion in fee-related supplemental payments, increases to capitation payments, and direct grants minus $7.1 billion in total fee collections. In June 2012, the state

obtained approval from CMS to collect the fee and make fee-related supplemental payments, and shortly afterwards began implementing both activities. The state did not obtain CMS' approval to make fee-related capitation payment increases until June 2013.

PROPOSAL

This measure neither imposes any new fees on hospitals nor extends the existing fee imposed under Chapter 286. However, it would amend the State Constitution to prohibit the Legislature from imposing a new fee or continuing the imposition of an existing fee on community hospitals (defined as general acute care hospitals licensed by the state that are not owned or operated by the federal government) for the purpose of obtaining FFP in the Medicaid Program or any other similar program unless a series of requirements are met. The measure also dictates the use of the proceeds from such a fee. Below we describe specific restrictions that would be placed in the Constitution.

Requirements Related to Federal Approvals and Fee Requirements

The measure prohibits the Legislature from imposing a new fee or continuing the imposition of an existing fee on community hospitals for the purpose of obtaining FFP in the Medicaid Program or any other similar federal program unless the following requirements related to federal approvals and fee requirements are met.

- ***Federal Approval of All Fee-Related Payment Increases.*** The measure stipulates that before the state is authorized to collect the fee, the state is required to obtain all necessary approvals for the fee and related increase in Medi-Cal reimbursements from CMS.
- ***Rate of Fees Generally Limited.*** Under the measure, the rate of the fee could not exceed the maximum rate permitted by federal law for the purpose of obtaining FFP in the Medicaid Program or any other similar federal program.

Requirements Related to How Proceeds and Related Funds Could Be Spent

Funds Available Only for Hospitals, Administration, and Children's Coverage. The measure specifies how any proceeds of the fee, the amount of federal matching funds provided by the federal government, and all interest earned on such proceeds (hereafter collectively referred to as "fee-related moneys") would be spent. The fee-related moneys would be placed in a trust fund created in the State Treasury that would be subject to annual state audit. Apart from certain exceptions described below, fee-related moneys could only be used to supplement existing funding for hospital services provided by community hospitals to Medi-Cal patients. (Later we discuss how the measure defines "existing funding for hospital services.")

Aside from supplementing existing funding for hospital services, the measure allows the Legislature to allocate portions of the annual proceeds of the fees for the following purposes:

- Reimbursing the state for the actual cost of collecting the fee and administering the abovementioned trust fund.

- Providing health care coverage for children enrolled in Medi-Cal. The measure allows up to 20 percent of the annual proceeds of the fee to be used for this purpose.

Fee Proceeds and Interest Exempt From Proposition 98 Calculation. Proposition 98, a constitutional amendment adopted by voters in 1988 and amended in 1990, establishes a set of formulas that are used to annually calculate a minimum state funding level for K-12 education and the California Community Colleges. In many cases, additional state General Fund revenues result in a higher Proposition 98 requirement. This measure amends the Constitution to specify that the proceeds of the fee and all interest earned on such proceeds shall not be considered in calculating the Proposition 98 funding level required for schools.

Requirement Related to Maintenance of Existing Funding for Hospital Services

The measure prohibits the use of fee-related moneys to supplant existing funding for hospital services provided to Medi-Cal patients. The measure defines this existing funding as the amount of total funds expended—whether paid directly by the state or through managed care plans—from appropriations by the Legislature for hospital services provided to Medi-Cal patients in the fiscal year in which the fee was enacted or in any subsequent fiscal year, whichever is greater. The measure specifically exempts the following funds from being counted as existing funding for hospital services: (1) funds appropriated from the trust fund described above and (2) the total amount expended from appropriations by the Legislature arising from CPEs and IGTs. In other words, as long as a fee was imposed for the purpose of obtaining FFP, the state could not reduce total combined spending (existing funding as defined) from state General Fund, federal funds, and certain state special funds on Medi-Cal hospital services from the prior-year amount of spending. We estimate existing funding for hospital services as defined by the measure to be $8 billion in the 2012-13 state fiscal year—the sum of General Fund support and matching federal funds for direct, supplemental, and managed care payments to hospitals.

FISCAL EFFECTS

No Effect Under Current Law

Imposition of Type of Fee Affected by Measure Ends Before Measure Would Take Effect. Under Chapter 286, the imposition of the existing hospital quality assurance fee ends by December 31, 2013. Current law authorizes neither an extension of the existing Chapter 286 fee, nor the imposition of a new fee for the purpose of obtaining FFP. (However, as noted, there is a current legislative proposal to enact a new similar fee.) The earliest date this measure could take effect would be following the measure's adoption by voters in the November 4, 2014 election. Thus, under current law, this measure would not have any fiscal effect on state and local governments because there would be no fee in place that would be affected by the measure's requirements pertaining to certain fees.

Measure Could Have Fiscal Effects if Current Law Changed. It is possible that current law could change between the time of this analysis and when the measure would take effect. For example, to the extent that any future hospital fee enacted by the Legislature prior to the measure taking effect was broadly similar in structure to the existing Chapter 286 fee, the measure could have potential fiscal effects on state and local governments, some of which we describe below.

For example, as a result of the measure's requirement that the state obtain federal approval of any fee-related increases to capitation payments before collecting the fee, the state may experience greater delays than would otherwise occur in its ability to offset General Fund costs for children's coverage. As another example, the measure does not allow the state to use the proceeds of the fee to provide direct grants to public hospitals, in contrast to allowable uses of the Chapter 286 fee.

As yet another example, the measure could create state cost pressures from its requirements to maintain funding for hospital services. As noted earlier, this measure would not allow the state to use fee-related moneys to offset reductions in funding for hospital services provided to Medi-Cal patients. The requirement to maintain funding for hospital services could create greater pressures for additional General Fund spending than would otherwise occur, depending on a number of factors such as the future availability of various sources of funding for hospital services (including federal funding) and future changes in the amount and type of hospital services used by Medi-Cal patients.

Fiscal Summary

We estimate that the measure would have:

- No fiscal impact on state and local governments given that, under current law, no fee would be in place that would be affected by the measure's requirements pertaining to certain fees imposed on hospitals.

Sincerely,

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Mac Taylor
Legislative Analyst

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Ana J. Matosantos
Director of Finance