November 14, 2013

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

Attention: Ms. Ashley Johansson
Initiative Coordinator

Dear Attorney General Harris:

Pursuant to Elections Code Section 9005, we have reviewed the proposed constitutional and statutory initiative (A.G. File No. 13-0022) relating to conditions for amending, repealing, replacing, or rendering inoperative the Medi-Cal Hospital Reimbursement Improvement Act of 2013—current law that concerns the imposition of fees on certain private hospitals.

BACKGROUND

Overview of Medi-Cal

Medi-Cal Administration and Coverage. The federal Centers for Medicare and Medicaid Services (CMS) administers 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 currently provides health care benefits to about 7.9 million low-income persons who meet certain eligibility requirements for enrollment in the program (hereafter referred to as the currently eligible population). Under the Patient Protection and Affordable Care Act (ACA), also known as federal health care reform, the state will expand Medi-Cal to cover over one million low-income adults who are currently ineligible (hereafter referred to as the expansion population), beginning January 1, 2014.

Medi-Cal Financing. 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). The 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 costs associated with the currently eligible population has been set at 50 percent. (However, for certain currently eligible subpopulations and certain administrative activities, the state receives a higher FMAP percent.) As Figure 1 shows (see next page), for three years beginning January 1, 2014, the FMAP for nearly all Medi-Cal costs

associated with the expansion population will be 100 percent. Beginning January 1, 2017, the FMAP associated with the expansion population will decrease over a three-year period until reaching 90 percent on January 1, 2020, where it will remain thereafter under current federal law.

Figure 1
FMAP for Expansion Population

Calendar Year	FMAP
2014	100%
2015	100
2016	100
2017	95
2018	94
2019	93
2020 and thereafter	90

FMAP = federal medical assistance percentage.

Federal Medicaid law permits states to finance the nonfederal share of Medicaid costs through several sources, including (but not limited to):

- ***State General Funds.*** State general funds are revenues collected primarily through personal income, sales, and corporate income taxes.
- ***Charges on Health Care Providers.*** 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 FFP 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 to draw down FFP. A number of different types of providers can be subject to these charges, including hospitals.

Medi-Cal Delivery Systems. 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 directly from DHCS for each medical service delivered to a beneficiary. 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 DHCS reimburses plans 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 Financing

About 400 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. As follows, these hospitals are divided into three categories based on whether the hospital is privately owned or publicly owned, and who operates the hospital.

- ***Private Hospitals.*** These are hospitals owned and operated by private corporations.
- ***District Hospitals.*** These are public hospitals owned and operated by municipalities and health care districts.
- ***County Hospitals and University of California (UC) Hospitals.*** These are public hospitals owned and operated by counties or the UC system.

Below we describe the three types of payments—direct payments, supplemental payments, and managed care payments—that Medi-Cal makes for hospital services.

Direct Payments. Direct payments are payments for services provided to Medi-Cal patients through FFS. The nonfederal share of Medi-Cal direct payments to private and district hospitals is funded from the state General Fund, while the nonfederal share of direct payments to county and UC hospitals is self-funded.

Supplemental Payments. Supplemental payments (considered a type of FFS payment) are made in addition to direct payments. Medi-Cal generally makes supplemental 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, including a category of payments to private hospitals known as Disproportionate Share Hospital (DSH) replacement payments that we discuss further later in this analysis. Depending on the type of supplemental payment, the nonfederal share may be comprised of General Fund support, revenues from charges levied on hospitals, or other state and local funding sources.

Managed Care Payments. Managed care payments are payments from managed care plans to providers for services delivered to Medi-Cal patients enrolled in these plans. The capitation payments that plans receive from DHCS are meant to cover the expected costs to plans from making payments to providers, including hospitals. The nonfederal share of capitation payments to managed care plans is comprised of General Fund support, charges levied on hospitals, and other state and local funding sources.

Federal Limits on FFS Hospital Payments. Federal regulations specify that to be eligible for FFP, the total amount of Medi-Cal FFS payments to private hospitals—that is, the sum of all direct and supplemental payments for private hospital services—may not exceed a maximum amount known as the upper payment limit (UPL). (There are separate UPLs that apply to payments to hospitals owned and operated by local governments such as counties, and hospitals owned and operated by the state such as UC hospitals.) The UPL is a statewide aggregate ceiling on FFS payments to all private hospitals. This means there are no limits on FFS payments to individual private hospitals, as long as total FFS payments to all private hospitals do not exceed the UPL. In California, the UPL for hospital services has historically been between 5 percent to 10 percent above the total costs incurred by hospitals from providing these services, as defined under cost-reporting procedures approved by CMS.

Federal Limits on Managed Care Hospital Payments. The UPL does not apply to managed care payments for hospital services. However, federal Medicaid law requires qualified actuaries to certify capitation payments to managed care plans as being "actuarially sound" before these

payments may receive FFP. This certification involves the actuaries' assessment that capitation payments reflect "reasonable, appropriate, and attainable" costs to plans from making payments to providers, including hospitals. In practice, actuarial soundness requirements directly limit the total amount of capitation payments that DHCS may make to plans, and thus indirectly limit the total amount of payments that plans may make to hospitals.

Hospital Quality Assurance Fee

Chapter 657, Statutes of 2013 (SB 239, Hernandez), enacts the Medi-Cal Hospital Reimbursement Improvement Act of 2013 (hereafter referred to as the Act). The Act imposes a charge known as a quality assurance fee (hereafter referred to as the fee) on certain private hospitals beginning January 1, 2014.

If approved by CMS and implemented, the fee imposed by the Act will constitute the fourth consecutive hospital quality assurance fee program implemented in California since 2009 (each of the prior three programs had a statutory sunset date). The fee program authorized under the Act is broadly similar in structure to the prior three fee programs. The Act establishes a general structure for (1) how the fee is to be assessed and (2) how the proceeds from the fee are to be spent. We describe both components of this structure below.

Fee Assessment. Under the Act, the state will assess the fee for each inpatient day at each private hospital. The fee rate per inpatient day will vary depending on payer type, with the highest rates assessed on Medi-Cal inpatient days and lower rates assessed on days paid for by other payers, such as private insurance. The fee rate ranges from $145 for each inpatient day covered by a non-Medi-Cal payer to $618 per inpatient day covered by Medi-Cal. Private hospitals will pay the fee in quarterly installments.

Use of Fee Moneys to Offset State Costs. Under the Act, DHCS will administer and collect the fee from hospitals and deposit the proceeds into the Hospital Quality Assurance Revenue Fund. Moneys in this fund—the proceeds of the fee and any interest earned on the proceeds—are available only for certain purposes. These purposes include the following that serve to offset state costs (in order of descending priority):

- Up to $1 million of the moneys annually will be allocated to reimburse DHCS for the staffing and administrative costs related to implementing the fee.
- A certain portion of the moneys (determined by a formula) will offset General Fund costs for providing children's health care coverage, thereby achieving General Fund savings. Later we describe how the allocation for this General Fund offset is to be determined under the Act.

Use of Fee Moneys for Quality Assurance Payments. After moneys in the fund are allocated to offset state costs, the remaining moneys are available to support payment increases to hospitals, collectively known as quality assurance payments (in order of descending priority).

- A large portion of the moneys will provide the nonfederal share of certain increases to capitation payments to managed care plans, up to the maximum actuarially sound amount permitted by federal law. The plans are required to pass along these capitation increases entirely to private hospitals, county hospitals, and UC hospitals.

- A large portion of the moneys will provide the nonfederal share of certain supplemental payments to private hospitals, bringing total FFS payments to private hospitals as close as possible to the UPL.
- Some of the moneys may be used to fund direct grants to public hospitals. Any grant amounts retained by public hospitals are not considered Medi-Cal payments, and thus are not eligible for FFP.

At the end of this background discussion, Figure 2 (see page 7) displays our detailed projections of the annual amounts of fee moneys used to offset state costs and support quality assurance payments to hospitals under the Act.

Net Benefit and General Fund Offset for Children's Coverage. Under the Act, beginning July 1, 2014, the annual amount of moneys used to offset General Fund costs for children's health care coverage will equal 24 percent of the "net benefit" to hospitals, hereafter referred to as net benefit. (For the period between January 1, 2014 and June 30, 2014, the amount of General Fund offset is set at $155 million per quarter rather than a percentage of the net benefit.) The Act defines net benefit as total fee revenue collected from hospitals in each fiscal year, minus the sum of the following quality assurance payments:

- Fee-funded supplemental payments and direct grants.
- Fee-related capitation increases for hospital payments.

Fee-related capitation increases consist of (1) fee-funded increases related to hospital services for the currently eligible population and (2) increases related to hospital services for the expansion population. Due to the enhanced FMAP for the Medi-Cal expansion, the net benefit from a capitation increase for the expansion population is generally greater than the net benefit from an equal increase for the currently eligible population. For example, a capitation increase of $100 million for the currently eligible population would result in a net benefit of roughly $50 million, since hospitals would provide the nonfederal share for this increase through fee revenue. In contrast, the net benefit from a capitation increase of $100 million for the expansion population would be between $90 million and $100 million, depending on the FMAP in effect for the year in question.

Fee Program Periods. The Act (1) specifies the schedule of fee rates for the period between January 1, 2014 and December 31, 2016, and (2) requires DHCS to periodically redevelop the schedule of fee rates thereafter. Each schedule of fee rates will apply to separate and consecutive "program periods," each lasting no more than three years. While the schedules may differ by program period, each schedule will conform to the general structure for assessing the fee and using the proceeds as specified in the Act. That is, for each program period, DHCS will develop a schedule of fee rates that: (1) varies per inpatient day by payer type, with higher rates assessed on Medi-Cal days, and (2) enables the maximum amount of supplemental payments and capitation increases for hospital payments that receive FFP.

The Act designates the period of January 1, 2014 through December 31, 2016 as the first program period, and the period of January 1, 2017 through June 30, 2019, as the second program period. Under the Act, DHCS will determine the duration of subsequent program periods. During

the first program period, moneys in the Hospital Quality Assurance Revenue Fund will be continuously appropriated without further legislative action. In subsequent program periods, the Legislature will authorize expenditures from the fund in the annual budget act.

FFS Maintenance-of-Effort (MOE) for Hospital Services. The Act contains a provision to ensure that fee-related moneys are used to supplement and not supplant existing funding for hospital services provided to Medi-Cal patients. Specifically, the Act stipulates that for hospital services provided to Medi-Cal patients through FFS on or after January 1, 2014, the total amount of payments supported by General Fund expenditures shall not be less than the total amount that would have been paid for the same services on December 1, 2013. The Act specifically exempts DSH replacement payments from this MOE requirement. We estimate that for the 2012-13 fiscal year, the state provided $2 billion in General Fund expenditures for the types of FFS payments subject to the Act's MOE requirement.

Conditions Rendering Fee Inoperative. The Act includes several poison pill provisions specifying certain conditions that would render the Act inoperative, including, but not limited to:

- A judicial determination by the State Supreme Court or a State Court of Appeal that revenues from the fee must be included for purposes of calculating the Proposition 98 funding level required for schools. We describe the Proposition 98 funding requirement later in this analysis.
- A lawsuit related to the Act results in a General Fund cost of at least 0.25 percent of General Fund expenditures authorized in the most recent annual budget act (about $240 million in 2013-14).

Absent conditions that would trigger the Act's poison pill provisions and render the Act inoperative, the Act becomes inoperative by its terms as of January 1, 2017, due to a sunset provision. Therefore, under current law, the fee will be in place only through the first program period. (Moreover, authorization of the Hospital Quality Assurance Revenue Fund expires on January 1, 2018.) However, as noted, the Act prescribes a general structure for assessing the fee and using the proceeds that would apply to subsequent program periods if legislation were enacted to both extend the fee and maintain the fund.

Projected Fiscal Effects of the Act. Figure 2 provides our projections of (1) total fees collected as authorized by the Act, (2) uses of the fee revenues under the Act, and (3) fiscal effects on the state and hospitals of the Act.

Figure 2

Projected Fiscal Effects of Hospital Quality Assurance Fee Under the Act[a]

(In Millions)

	2013-14 (Half-Year Impact)	2014-15	2015-16	2016-17 (Half-Year Impact)
Total fees collected	$1,797	$4,103	$4,714	$2,553
Uses of Fee Revenues				
Direct grants to public hospitals	27	56	67	38
General Fund offset for children's coverage	310	745	863	460
Fee revenues used to draw down FFP	1,460	3,302	3,784	2,054
Payment Increases and Federal Match				
Medi-Cal payment increases to hospitals[b]	3,144	7,149	8,245	4,433
FFP[c]	1,685	3,847	4,461	2,379
Net benefit to hospitals[d]	1,374	3,102	3,598	1,918

[a] Medi-Cal Hospital Reimbursement Improvement Act of 2013.
[b] Sum of fee-related supplemental payments and capitation payment increases.
[c] Includes: (1) FFP leveraged by fee revenue, and (2) 100 percent federal funds for payment increases associated with the expansion population. During calendar years 2014, 2015, and 2016, the FMAP for the expansion population will be 100 percent.
[d] Sum of Medi-Cal payment increases to hospitals and direct grants to public hospitals less total fees collected.
FFP = federal financial participation; FMAP = federal medical assistance percentage.

PROPOSAL

This measure would amend the State Constitution to (1) restrict the Legislature's ability to amend, repeal, or replace the Act by statute, and (2) require voter approval to amend or replace the Act outside of these restrictions. The measure would also amend by statute the Act's poison pill provisions and remove the Act's sunset provision. The measure would also remove the Act's poison pill provision related to Proposition 98, and amend the Constitution to specify that revenues from the fee imposed by the Act and all interest earned thereon shall not be considered as revenues subject to the Proposition 98 funding requirement calculation. Below we describe the specific amendments that the measure would place in the Constitution, and then describe the statutory amendments that the measure would enact.

Constitutional Amendments

Requirements for Amending, Repealing, or Replacing the Act. This measure amends the Constitution to require two-thirds majorities in both houses of the Legislature to pass any statute that repeals the Act in its entirety. In addition, any statute that amends or replaces the Act requires voter approval in a statewide election before taking effect, unless both of the following conditions are met:

- The Legislature passes the statute with two-thirds majorities in both houses.

- The statute (1) is necessary for securing federal approval to implement the fee program, or (2) only changes the methodology used for developing the fee or quality assurance payments.

We note that under current law, the Legislature may pass legislation to broadly amend or repeal the Act with simple majorities in both houses, although some amendments could require passage by two-thirds majorities in both houses.

Fee Proceeds and Interest Exempt From Proposition 98 Calculation. Proposition 98, a constitutional amendment adopted by voters in 1988 and amended in 1990, established 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 funding 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.

Statutory Amendments

Changes to Poison Pill Provisions. The measure amends the Act's poison pill provisions in the following ways:

- The measure deletes the provision triggered by a state judicial determination that revenues from the fee are subject to the Proposition 98 calculation. As noted earlier in this analysis, the measure amends the Constitution to specify that proceeds and interest from the fee are not subject to the Proposition 98 calculation, thereby precluding such a judicial determination.
- The measure inserts a new poison pill provision that renders the Act inoperative if the Legislature does not appropriate moneys in the Hospital Quality Assurance Revenue Fund within 30 days following enactment of the annual budget act.
- The measure amends the provision triggered by a General Fund cost from a lawsuit related to the Act. Specifically, the measure redefines the threshold cost to be an overall net cost to the General Fund due to the Act remaining operative, rather than 0.25 percent of General Fund expenditures authorized in the budget act.

Removal of Sunset Provisions. The measure deletes the Act's sunset provision. The measure also nullifies the current-law sunset of the Hospital Quality Assurance Revenue Fund, and instead specifies that the fund shall remain operative as long as the Act remains operative. These combined changes permanently extend the fee program under the Act—starting with the second program period—absent one of the following conditions being met.

- An event occurs that triggers one of the Act's poison pill provisions (as amended by the measure).
- Additional statute that amends, repeals, or replaces the Act is adopted and takes effect in accordance with the measure's Constitutional requirements.

FISCAL EFFECTS

Significant Ongoing Fiscal Benefits to State and Local Governments in Future Years

Continuation of Fee-Related Fiscal Benefits. Under current law, the Act becomes inoperative on January 1, 2017. As a result, both the imposition of the fee and its related fiscal effects are currently scheduled to end with the first program period. By removing the Act's sunset provision, the measure provides the authority for implementation of the fee to continue without interruption through subsequent program periods. Implementation of the fee across program periods would be governed by the Act's general structure for assessing the fee and using the proceeds. Thus, following the first six months of 2016-17, the measure would maintain ongoing significant fiscal benefits to state and local governments that otherwise would cease to exist under current law.

Specifically, barring conditions that would trigger the Act's poison pill provisions, the measure would permanently extend the following fiscal benefits to the state and local governments.

- General Fund offset for children's coverage. Under the Act's current provisions (continued by this measure), annual state savings would be equal to 24 percent of the fee's net benefit.
- Direct grants, capitation increases, and other quality assurance payments that benefit counties, the UC system, health care districts, and other units of government that own and operate public hospitals.

Estimated Level and Growth of Fiscal Benefits. For each year, the exact amount of fiscal benefits to state and local governments would depend on the total amount of fee revenue collected, the amount of quality assurance payments made to hospitals, and the resulting calculation of net benefit. As these factors are currently unknown and their estimation subject to some uncertainty, to project the measure's fiscal impact, we rely on assumptions about the annual growth in federally allowable quality assurance payments to hospitals. Figure 3 (see next page) summarizes our multiyear projection of the measure's fiscal effect on the state General Fund by providing fee revenues that offset state General Fund costs for children's coverage. We estimate that the General Fund offset for children's coverage would be around $500 million during the last six months of 2016-17, reach more than $1 billion by 2019-20, and grow between 5 to 10 percent annually thereafter. We also estimate that quality assurance payments to state and local public hospitals would be around $90 million during the last six months of 2016-17, reach around $250 million by 2019-20, and grow between 5 percent to 10 percent annually thereafter. Below we discuss some considerations that affect our estimates.

Figure 3

Projected Additional General Fund Offset for Children's Coverage Under Measure

(In Billions)	
2016-17[a]	$0.5
2017-18	1.0
2018-19	1.1
2019-20	1.2

[a] Savings from continuing hospital quality assurance fee through last six months of 2016-17.

Federal Sources of Uncertainty

We briefly highlight potential federal decisions that, if implemented, could lead to significant deviations from our estimates of the measure's fiscal effects.

Allowable Rate of Provider Charges. Federal regulations currently discourage states from levying provider charges that exceed 6 percent of net patient revenue. Historically, hospital fee programs in California have approached this threshold by assessing fees as high as 5.5 percent of net patient revenue. We note that states have previously litigated and successfully blocked regulations promulgated by CMS that would have reduced the allowable rate of provider charges. If the federal government were to successfully reduce permissible provider charges—for example, to 3 percent rather than 6 percent of net patient revenue—this could significantly lower estimated annual savings within our multiyear projection. Such a change would also affect our estimate of savings growth beyond 2019-20.

Oversight of Quality Assurance Payments. Federal cost containment strategies could also affect the amount of quality assurance payments available under the fee. For example, changes in federal Medicaid policy governing UPL calculations would affect supplemental payments. As another example, CMS has expressed its intention to tighten its oversight of capitation payment development in Medicaid managed care and "look under the hood" of states' actuarial certification practices. Although it is difficult to quantify the overall impact of these scenarios on quality assurance payments given the varying forms such restrictions could take, they would generally lead to lower net benefits to hospitals under the fee program, and thus lower estimated savings to state and local governments from adopting the measure.

Summary of Fiscal Effects

We estimate that the measure would result in the following major fiscal impacts:

- State savings from increased revenues that offset state costs for children's health coverage of around $500 million beginning in 2016-17 (half-year savings) to over $1 billion annually by 2019-20, likely growing between 5 percent to 10 percent annually thereafter.

- Increased revenues to support state and local public hospitals of around $90 million beginning in 2016-17 (half-year) to $250 million annually by 2019-20, likely growing between 5 percent to 10 percent annually thereafter.

Sincerely,

_____
Mac Taylor
Legislative Analyst

_____
Michael Cohen
Director of Finance