Financing Medi-Cal's Future:
The Growing Role of Health Care-Related Provider Fees and Taxes

California HealthCare Foundation

ISSUE BRIEF

November 2009

Introduction

Taxes and fees assessed on health care providers have become a key component of Medicaid financing in 43 of 50 states. California currently imposes provider fees on nursing facilities and intermediate care facilities for the developmentally disabled (ICFs/DD) and, until it expired on September 30, 2009, also imposed a fee on Medi-Cal managed care organizations. In the final weeks of the 2009 legislative session, state lawmakers passed legislation that imposes a health care provider fee on hospitals (AB 1383, Jones) and that extends the state's existing gross premium tax on insurance to Medi-Cal managed care plans (AB 1422, Bass).

Revenues from these health care-related provider fees and taxes are used to increase Medi-Cal reimbursement to providers, to finance quality improvement efforts, and to maintain or expand health care coverage. The total amount made available by these assessments includes not only the fee or tax revenue itself but also the federal matching funds the state receives when it uses such fee or tax revenue for the non-federal share of Medi-Cal or Healthy Families expenditures.[1] Under current federal law, California receives approximately $1.60 (until 2011) in federal matching funds for every $1.00 in non-federal Medi-Cal expenditures to health care providers.[2]

This issue brief reviews federal requirements for health care-related provider fees and taxes and examines California's experience with provider fees under Medi-Cal. The brief also focuses on the recently enacted California health care-related hospital provider fee, and it concludes with a discussion of key issues, including unresolved matters concerning implementation of the new hospital provider fee.

Key findings discussed in this issue brief include:

- Among the 43 states with health care provider fees or taxes, these fees or taxes are most often imposed on nursing facilities (33 states) and ICFs/DD (29 states), followed by hospitals (21 states) and managed care organizations (14 states).
- In these states, the provider tax or fee revenues, along with matching federal funds, are used to increase Medicaid provider reimbursement, to fund expansion of Medicaid coverage for the uninsured, and/or to expand the scope of Medicaid benefits. The tax revenues benefit the state not only because they provide an alternative source of funds for the non-federal share of Medicaid expenditures but also because in some states a portion of the fees is retained in the state's general fund.
- California's fees on nursing facilities, ICFs/DD, and managed care organizations brought in over $500 million to the state in fiscal year 2008–09.[3]
- Extension of the state's gross premium tax on insurance to Medi-Cal managed care plans will provide over $653 million ($236 million tax and $417 million federal) in revenue for Medi-Cal and Healthy Families during fiscal year 2009–10 and the first half of fiscal

year 2010–11, and will avoid the loss of health care coverage for hundreds of thousands of children.[4]

- The newly enacted hospital fee will increase net annual reimbursements to all types of hospitals by nearly $2 billion dollars and provide $320 million annually to fund children's health coverage.[5]

The experience of California and other states demonstrates that the ability to sustain provider fees depends heavily on mutual agreement between lawmakers and the affected health care providers. The success of a provider fee can depend on the mix of winners (those that realize a net gain from the fee) and losers (those that incur a net loss from the fee) among providers who pay the fee, whether the losers believe they are nonetheless getting something of value in return, and whether providers are satisfied that the fee revenues are being used for their intended purposes.

The passage of AB 1422 demonstrates that, under certain circumstances, the California Legislature will adopt provider assessments that are classified as taxes, despite its current aversion to any new taxes. The lessons of AB 1383, the first health care provider fee in California to pass with a simple majority vote, are still unfolding. Federal approval of the hospital fee and payment structure is not certain, and much work remains to be done before the fee can be implemented. Whether implementation of AB 1383 is successful will inform and influence lawmakers as they consider other new taxes or fees on health care providers.

Tax or Fee?

Federal regulations refer to health care-related assessments on health care providers as "taxes," while California law refers to these assessments as "fees."[6] Consequently, this paper uses the term tax to refer to federal requirements and to programs in most other states, but uses the term fee when referring to existing Medi-Cal-related provider assessments in California.

Although the terms "tax" and "fee" are sometimes used interchangeably, there can be important distinctions between them, and opinions can differ about whether a particular health care-related provider assessment is a fee or a tax. Many federal and state statutes and court decisions have established or interpreted the meaning of these terms in their respective jurisdictions: Under most legal interpretations, a "tax" is a payment made to fund government operations (e.g., income taxes), while a "fee" is a payment made for the cost of services directly received (e.g., state park day use fees).[7] However, whether a Medicaid-related assessment on health care providers is a tax or a fee is also influenced by the extent to which providers who pay the fee benefit from distribution of the revenue generated (which would tend to make it a fee), and whether some portion of the revenue collected is used to benefit a state's general fund (which would tend to make it a tax).

Which term is used has important policy implications in California. Most taxes are subject to Proposition 98, which requires a minimum percentage of the state budget to be spent on education. To date, no Medi-Cal provider fees have been subject to Proposition 98. Another distinction is that fee-related bills require a simple majority vote of the state legislature, whereas taxes require a two-thirds majority vote. Given the current political sensitivity in California over taxes, financing proposals that rely on fees are much more likely to be adopted than those that rely on new taxes.

Until the hospital provider fee (AB 1383) was passed in 2009, every enacted bill imposing a health care-related provider fee in California had contained an urgency provision that meant the bill required a two-thirds majority vote. This meant that the distinction between a fee and tax was not central to determining how many votes the bills needed to pass. AB 1383, however, was adopted on a simple majority vote (although separate legislation, which did require a two-thirds majority vote, was later passed to add an urgency provision to the bill and to appropriate funds to administer the hospital fee).

Federal Provider Tax Requirements

Under federal law, health care-related provider taxes may only be imposed on 19 particular classes of health care items or services (see Appendix A). States may not impose health care-related taxes on provider classes that are not included on this list.

In addition to the restriction of provider taxes to these specific classes of health care, Section 1903(w) of the Social Security Act and federal regulations require that all state health care-related taxes meet certain requirements:

- Taxes must be broad-based, meaning that all "non-public" providers in the class must be taxed, not just those that participate in Medicaid. Also, states are prohibited from exempting specific members of the class without a specific waiver from the Center for Medicare and Medicaid Services (CMS).
- Taxes must be imposed at the same rate for all members in the class. Under this uniformity requirement, states are prohibited from varying tax rates based on volume, type of services, or any other factor.
- States may not guarantee, either directly or indirectly, that providers receive back from the state the money they paid as taxes. CMS has ruled that some state provider tax hold-harmless arrangements effectively repaid providers for the tax and thus improperly shifted a disproportionate share of the financial burden from the states to the federal government. CMS uses three tests to determine if a hold-harmless arrangement should be prohibited:
  - **Positive correlation test,** which determines whether a tax includes a direct or indirect non-Medicaid payment to the payers of that tax that is "positively correlated" to the tax amount or to the difference between the Medicaid payment and the tax amount;
  - **Medicaid payment test,** which determines whether any or all of a Medicaid provider's reimbursements vary based solely on the amount of the provider's tax payment; and
  - **Guarantee test,** which determines whether there is any direct or indirect guarantee that providers who pay the tax will be held harmless for any portion of their tax costs.
- The federal government discourages states from imposing a provider tax that exceeds 5.5 percent of aggregate net patient revenue. Relatively onerous requirements are imposed on the assessment program if that amount is exceeded. Prior to the Deficit Reduction Act (DRA) of 2005, this cap was set at 6 percent.

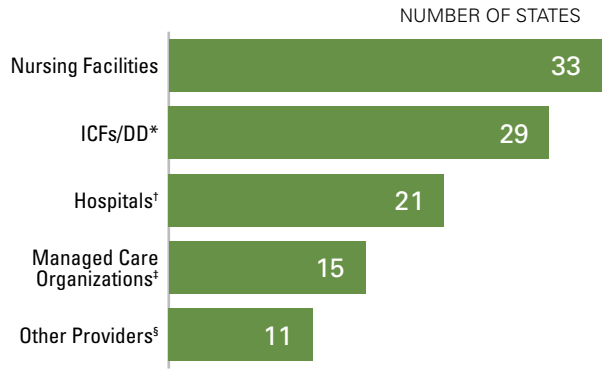
CMS is not permitted to waive requirements regarding permissible classes of health care services and hold-harmless arrangements. However, CMS may waive requirements related to the provider tax being broad-based and uniformly applied if a state meets complex statistical tests that measure the degree to which low-volume Medicaid providers contribute to the provider tax burden.

These various rules and requirements pertain only to health care-related taxes, defined by whether or not more than 85 percent of the tax revenue is paid by health care providers. If a tax is not health care-related (for example, a state's sales or income tax), these particular federal rules do not apply.

California's Experience with Medicaid Provider Fees

California is one of 43 states with one or more provider taxes or fees. As of 2008, more than half of states impose provider taxes on nursing facilities (33 states) and ICFs/DD (29 states). Many states also impose provider taxes on hospitals (21 states) and managed care organizations (15). Appendix B lists the types of provider taxes in each state.

Figure 1. Prevalence of Health Care-Related Provider Taxes (as of April 2009)



*This is the term used in California. The federal government and many states use the designation "Intermediate Care Facilities for the Mentally Retarded" (ICFs/MR) to refer to the same category of facility.

†Alabama, Arkansas, California, and Colorado have recently enacted hospital provider tax legislation, and are starting the process to request CMS approval to amend their state Medicaid plans.

‡Includes California, which permitted its fee on managed care organizations to sunset on September 30, 2009. Other states have also let their managed care organization taxes expire and some have replaced them with other taxes.

§Examples include pharmacies, residential care facilities, and physicians.

Source: Smith, V., K. Gifford, E. Ellis, R. Rudowitz, M. O'Malley, and C. Marks *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2007 and 2008,* Kaiser Commission on Medicaid and the Uninsured, October 2007. *Care Provider, Industry and Tobacco Taxes and Fees.* National Conference of State Legislatures, www.ncsl.org/programs/health/healthtaxes.htm. Updated April 13, 2009.

California's provider fees include a quality assurance fee (QAF) for free-standing skilled nursing facilities (SNFs) and a QAF for ICFs/DD. The state also had a quality improvement fee (QIF) for Medi-Cal managed care organizations until it expired on October 1, 2009. Unlike many other states, the revenue from these fees is deposited into the state General Fund rather than into a special account. Funds are then spent by the state according to each class of provider's reimbursement methodology as established by the state's relevant laws and regulations.

In state fiscal year 2008–09, revenues from California's three provider fees totaled $552.9 million (Table 1). In fiscal year 2009–10, revenues from the three provider fees and the extension of the states' gross premium tax to managed care organizations (discussed below) are projected to be $559.8 million. Revenue from the gross premium tax on managed care organizations does not fully offset the loss of revenue from the October 1, 2009 expiration of the fee on Medi-Cal managed care organizations.

Skilled Nursing Facilities

The enactment of Assembly Bill 1629 (2004) made possible the Skilled Nursing Facility Quality Assurance Fee Program[9] and the Medi-Cal Long Term Care Reimbursement Act. The new fee was approved by CMS

Table 1. Estimated Revenue from California's Medi-Cal Related Provider Assessments[8] (in millions)

	FY 2004–05	FY 2005–06	FY 2006–07	FY 2007–08	FY 2008–09	FY 2009–10
Fee on Skilled Nursing Facilities	$115. 6	$231.9	$247.4	$274.3	$282.4	$315.6
Fee on ICFs/DD	25.2	27.6	27.1	22.8	18.6	19.3
Fee on Managed Care Organizations		234.5	241.2	239.0	251.9	67.9
Premium Tax on Medi-Cal Managed Care Organizations						157.0
Total	**$140.8**	**$494.0**	**$515.7**	**$536.1**	**$552.9**	**$559.8**

Note: The hospital fee (AB 1383) is not shown in this chart as it still requires federal approval. These figures do not precisely reflect the fee revenue actually collected (because of late payments, provider non-payment, and other factors).

Source: Department of Health Care Services *May 2009 Medi-Cal Assumptions,* and Assembly Committee on Appropriations.

effective August 1, 2005. This fee expired on July 31, 2008 but was renewed through July 31, 2011.

The nursing facility fee was originally based on 6 percent of aggregate projected net revenue, excluding Medicare revenue.[10] Federal rules limit the fee to no more than 5.5 percent of all facility revenue, including Medicare. The fee is assessed based on resident days, for all days of a stay. Nursing facilities that operate as a distinct unit within a hospital, as part of a continuing care retirement community, or that are owned by the state or other public entity, are exempt from paying the fee.

Revenues from the nursing facility QAF have been used to significantly increase Medi-Cal reimbursement rates to free-standing SNFs. Implementation of the provider fee made possible a change in the Medi-Cal reimbursement rate methodology, from one in which all facilities are paid at the same rate, regardless of their costs, to one with a facility-specific rate based on each facility's costs. Without this provider fee, the Medi-Cal reimbursement change would have required a significant investment from the state General Fund to support those nursing facilities whose rates would have dropped with a facility-specific rate. Part of the intent of AB 1629 was to provide SNFs with annual cost-of-living increases. While the provider fee produces significant additional revenue for all SNFs, the "winners and losers" (meaning, the providers for whom fee-related revenue does or does not exceed the fee they pay) are largely determined by what percentage of a facility's patients are on Medi-Cal and how the facility spends its money. That is, if a facility spends more for certain costs, such as labor, the facility will receive additional funds through increased reimbursement rates two years after the expenditure. Expenditures on other costs, such as administration or capital, would not generate the same level of rate increases. Enabling legislation also provided for a cap on annual rate adjustment, most recently 5 percent per year. As a result of the fee, free-standing SNFs have received rate increases in some years when other Medi-Cal provider rates decreased.

Because the fee funds a portion of the cost-of-living increases to SNFs that previously was funded by the state General Fund, AB 1629 has also generated significant savings to the state. A report by the State Bureau of Audits estimated that the new reimbursement methodology produced net state General Fund savings of $33.7 million through fiscal year 2007–08.[11] This report factored in certain one-time costs that offset potential savings. A more recent report released by the California State Senate Office of Research estimates that savings through fiscal year 2008–09 will be as high as $505.6 million.[12]

During budget deliberations for 2009–10, the governor proposed and the legislature agreed to include Medicare revenues in the calculation of the maximum fee that could be collected. This will result in more revenue generated by the QAF, which will be used to offset General Fund spending. Budget action also eliminated the existing annual rate increase (of up to 5 percent) scheduled for free-standing SNFs. These types of changes alter the mix of winners and losers and shift fee revenues away from the providers who pay the fee and toward the funding of government operations. This fee comes up for renewal in 2010 and lawmakers will have to consider extending it in light of the fee increase, lack of an agreed-upon cost-of-living increase for SNFs, and the redirection of fee revenues to enable the covering of General Fund needs.

Intermediate Care Facilities for the Developmentally Disabled

A QAF for ICFs/DD was also established by AB 1629.[13] This fee is based on all gross receipts for each facility, minus charitable contributions, vendor rebates, bad debts, and return of overpayments. The state Department of Health Care Services (DHCS) has the discretion to make

retroactive adjustments to ensure that the fees collected do not exceed the cap of 5.5 percent of total facility revenues.

Of the fee revenue collected, approximately 22 percent is retained in the state General Fund, with the balance matched by federal funds to pay providers an amount that covers the tax and provides a slight increase in reimbursements. Because of the changes in federal law that decreased the maximum fee from 6 percent to 5.5 percent, the amount of revenue from this fee decreased in fiscal year 2008–09. Budget action also permanently eliminated the annual cost-of-living rate increase provided to these facilities.

These types of changes, which shift fee revenues from the providers who pay the fee to the funding of general government operations, can undermine provider support for the fee. In this case, however, the fee levied on ICFs/DD has broader support among these providers than fees on other provider types. That is because nearly all ICF/DD providers participate in Medi-Cal, and most facility clients with developmental disabilities are eligible for Medi-Cal services. Consequently, as long as more than half the fees collected, plus the federal matching funds they generate, are returned to the providers, very few of these providers will be net losers.

Managed Care Organizations

In 2005, California enacted a QIF imposed on Medi-Cal managed care organizations.[14] The fee was 5.5 percent of the total operating revenue of each organization. Based on federal rules, the fee was assessed on all premiums paid to legal entities providing comprehensive health coverage to Medi-Cal enrollees. However, four of the five county-organized health systems were not classified by the federal government as managed care organizations and so were not required to pay the QIF. The fee was assessed only on the legal entity contracting with the state for Medi-Cal services. Under federal rules, health plans could establish separate legal entities whose sole purpose was to contract with Medi-Cal. Many managed care organizations created such Medi-Cal-only entities, establishing a direct relationship between the fee paid by that entity and the amount of increased Medi-Cal revenue it received.

When the Medi-Cal managed care organizations fee was first established, 75 percent of the revenue generated was matched with federal funds and used for payments to the managed care organizations; the remaining 25 percent was retained by the state General Fund. Effective October 1, 2007, with implementation of the state's new managed care rate methodology, only half of the revenue generated is matched with federal funds and used for payments to the managed care organizations; the other half is retained by the state General Fund. While the amount managed care organizations pay is returned to them, they realize no net benefit.

Shortly after the Medi-Cal managed care organizations fee was enacted, the federal Deficit Reduction Act (DRA) of 2005 changed the definition of one of the approved classes of health care services from "Medicaid Managed Care Organizations" to "Managed Care Organizations," later defined by regulation to include health maintenance organizations and preferred provider organizations. States had until October 1, 2009 to bring their provider tax or fee laws into compliance with this new definition.

The Medi-Cal managed care organizations QIF expired on September 30, 2009. On September 2, 2009, the legislature passed AB 1422 (Bass), which replaces this fee by extending the 2.35 percent premium tax imposed on all types of insurance to include all comprehensive health plans contracting with Medi-Cal. Revenues from this tax, estimated at $157 million in fiscal year 2009–10, will be used to fund health care coverage for children through the Healthy Families program, provide a cost-of-living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates to health plans. These expenditures under Healthy Families and Medi-Cal qualify for federal matching funds, estimated at $277 million in fiscal year 2009–10. Because this tax, which

expires on December 31, 2010, also applies to non-health care insurance, it is not considered health care-related and therefore is not subject to federal Medicaid rules, as discussed in the section Federal Provider Tax Requirements, above.

The 2009 Hospital Quality Assurance Fee

AB 1383 (2009) requires hospitals that elect to participate in state-funded health insurance programs other than Medi-Cal to pay a hospital quality assurance fee. Certain hospitals are exempt from paying the fee, including all public hospitals (designated and non-designated), long term care hospitals, small and rural hospitals, and certain specialty hospitals. Hospitals not exempt are required to pay a fee of:

- $27.25 for every inpatient day of patients enrolled in a managed care plan, excluding Medi-Cal;
- $233.46 for every inpatient day of patients covered by fee-for-service, excluding Medi-Cal; and
- $293.00 for every inpatient day of patients covered by Medi-Cal, whether managed care or fee-for-service.

The bill's three-tier fee structure is intended to maximize the number of hospitals that benefit from it and minimize the number of hospitals that do not, while still meeting federal requirements. Specifically, the lower fee imposed on non-Medi-Cal managed care days and fee-for-service days is designed to prevent large financial losses from the fee among hospitals where Medi-Cal patients represent a small share of their overall inpatient days. While the fee's exact dollar amounts are set in the bill itself, DHCS may alter the fee amount slightly in order to obtain federal approval (see below). Therefore, the final fee amounts may be somewhat different than those prescribed in this legislation and shown above.

AB 1383 specifies that the fee is to be computed starting on the effective date of the bill and is to continue through December 31, 2010. Collection of the fee (to be deposited into a new state special fund) is conditioned upon the following: Reimbursement rates to hospitals under Medi-Cal managed care and fee-for-service must reflect the rate increases provided in the bill as of the effective date of federal approval; the fee is only to be used for the purposes provided in the bill; federal funding must be maintained; the courts must not interpret the fee to be a tax; and the fee must not result in a "financial disadvantage" to the state, as defined in the bill.

Distribution of Revenues

It is estimated that this health care-related fee on hospitals would, if approved by CMS, generate approximately $2 billion annually in fee revenue. Proceeds from the fee, including the fee revenues and associated federal matching funds, may only be used for the following purposes:

1. To increase Medi-Cal fee-for-service payments to private hospitals and non-designated public hospitals for inpatient and outpatient services;
2. To increase reimbursement to Medi-Cal managed care plans for supplemental payments to private hospitals, designated public hospitals, and non-designated public hospitals;
3. To provide $310 million annually for direct state grants to designated public hospitals;[15] and
4. To provide $320 million annually for health care coverage of children, either by creating a new coverage program or by helping to fund current children's coverage under such programs as Medi-Cal, Healthy Families, and the California Children's Services program.[16]

Of the $2 billion in annual fee revenue, approximately $1.4 billion would be used to increase Medi-Cal hospital payments. These payments would be matched with $2.3 billion of federal funds at California's Federal Medical Assistance Percentage (FMAP), for a total of

$3.7 billion annually available for additional Medi-Cal hospital payments.

The amount of payment and method of distribution of fee revenues and federal matching funds will vary based on whether a hospital is a private hospital, a non-designated public hospital, or a designated public hospital. If the fee is approved by CMS, funds will be distributed in accordance with a specific formula for each hospital category. These formulas for distributing proceeds are meant to maximize the number of hospitals that benefit from the fee and minimize the number of hospitals that do not, while still meeting federal requirements. With the exception of the direct grants to designated public hospitals, all payments will be matched by the federal government in accordance with California's FMAP.

Funds will be distributed to hospitals in three ways.

First, DHCS will pay hospitals directly, as follows:

- **Eligible private hospitals** will receive supplemental Medi-Cal payments for inpatient and outpatient hospital and subacute care services. Private hospitals will be reimbursed up to the maximum rates allowed by the federal government, called the upper payment limit. These supplemental payments are made in addition to the existing Medi-Cal per diem payments (i.e., payments per inpatient day). Private hospitals will receive the most new revenue, in part because they, unlike public hospitals, incur the cost of the new fee.
- **Non-designated public hospitals** will receive supplemental Medi-Cal payments for inpatient services. Reimbursement rates for these hospitals are on a per diem basis and are lower than those for private hospitals, in part because these hospitals do not incur the cost of the fee.
- **Designated public hospitals** will be paid direct grants in support of health care expenditures. These grants are not considered to be Medi-Cal payments and will not qualify for federal matching funds under Medi-Cal. In addition, these hospitals will receive supplemental Medi-Cal payments for acute inpatient psychiatric services that are not the financial responsibility of a mental health plan. Because designated public hospitals are now paid at the maximum amount that qualifies for federal matching funds (under terms of the state's Medicaid 1115 Hospital and Uninsured Waiver), these particular direct grants will not be matched with federal funds.

Second, DHCS will increase Medi-Cal payment rates to managed care organizations and require these health plans to pass-through all of these funds to hospitals. The amount a hospital will receive will be based on the number of total Medi-Cal managed care days it provides. Medi-Cal managed care plans will receive funds for hospitals that are located in the county the plan serves, as well as funds for hospitals in neighboring counties where there is no Medi-Cal managed care. As directed by DHCS, plans will then pay managed care supplemental payments to these hospitals. Payments will be made by plans to all designated hospitals regardless of whether the hospital has a contract with the plan, and plans are prohibited from considering this supplemental payment when negotiating the amount of other payments to hospitals.

Third, DHCS will make quarterly payments to county mental health plans so they may pass-through all of these funds to hospitals providing acute psychiatric services. The amount a hospital receives will be based on the number of total acute inpatient psychiatric days for which a mental health plan was financially responsible, at a per diem rate. Mental health plans will receive funds for hospitals and, as directed by DHCS, plans will then pay these hospitals their mental health supplemental payments. Alternatively, DHCS may also directly pay the hospitals.

Getting the Hospital Fee Bill Passed

The passage of AB 1383 by the legislature and its signing by the governor illustrates the considerable interest among lawmakers and many hospitals in finding ways to increase Medi-Cal hospital payments and to support health care coverage for children without requiring additional amounts from the General Fund. The sense of urgency that led legislators to enact the fee stemmed from concerns over the financial health of California's hospitals and recognition that prompt action would allow the state to take advantage of the enhanced FMAP available under the American Recovery and Reinvestment Act of 2009 (ARRA), which for California has increased from 50 percent to 61.59 percent. This increased matching rate—which reflects the federal share of Medi-Cal expenditures—ends on December 31, 2010.

Despite lawmakers' desire to identify revenue streams other than the General Fund for the state's safety-net hospitals, and acceptance by the bill's author of all amendments requested by the governor, AB 1383 failed to obtain passage with the required two-thirds majority vote on the last day of the 2009 legislative year. Rather than leave such a significant amount of potential revenue—including the enhanced federal matching funds—on the table, the author of AB 1383 amended the bill to require a simple majority vote. To do so, both the bill's appropriation and its urgency clause (making the bill effective upon signature by the governor, rather than on January 1, 2010) were removed. The bill was then adopted by the legislature by a simple majority. Subsequently, other legislation (AB 188, Jones) was passed to provide an appropriation and an urgency clause.

Passage of the hospitals fee establishes a significant precedent that this type of fee can be adopted by a majority vote. On the other hand, it also marks the first time the state will not have the retrospective protection of a two-thirds majority vote if a legal challenge results in a court classifying the assessment as a tax rather than a fee. The classification as a fee is supported, however, by the legal opinion of California's Legislative Counsel Bureau,[17] which concluded that the hospital assessment is a fee because it is imposed in response to a voluntary decision by participating hospitals to seek governmental privileges or benefits through participation in state-funded insurance programs other than Medi-Cal, such as the Major Risk Medical Insurance Program, the Healthy Families program, and the Access for Infants and Mothers program.

A hospital's payment of this fee as a condition of participation in state-funded insurance programs other than Medi-Cal is a major distinguishing factor of AB 1383 as compared to all other provider fees adopted by California. In all of the other such fees, payment is mandatory and non-exempt providers cannot chose to avoid paying the fee by electing not to participate in other state insurance programs.

The Road Ahead

The enactment of AB 1383 is a major step in resolving the obstacles to implementing a health care-related provider fee on hospitals. The hospital industry, the legislature, and the governor have come together to reach agreement on this significant change that will, if approved by the federal government, bring approximately $2.3 billion annually in new federal reimbursement to California hospitals and help pay for health care coverage for children in low-income families.[18] Supporters of the hospital fee overcame resistance from hospitals that do not benefit from the fee or that see competing hospitals benefiting to a greater degree. Supporters also overcame struggles between industry stakeholders and the state over how much of the fee goes to benefit the state General Fund, and they managed to reach agreement on protections and assurances that the fee be used only for the purposes enumerated in the legislation and that it limit the amount by which General Fund expenditures can increase because of the legislation.

Despite this achievement, numerous obstacles to successful implementation remain. These obstacles include the federal approval process and whether hospitals choose to pay the fee or opt out of state health insurance programs other than Medi-Cal. There are also several other unresolved issues, discussed below.

Federal Approval Is Uncertain

There are at least four federal approvals that must be obtained to implement AB 1383. First, DHCS must obtain federal approval to amend the state's Medicaid 1115 Hospital and Uninsured Waiver to allow a hospital fee, or receive assurances from CMS that it will not enforce a provision in the waiver that prohibits California from imposing a health care-related provider fee on hospitals or physicians as the source of the state's share (non-federal) of Medi-Cal funding.

Second, CMS must conclude that payment of the fee by hospitals is mandatory. If not, the fee could be classified as an impermissible voluntary provider donation. As discussed previously, California's Legislative Counsel Bureau concluded that payment of the fee is mandatory as a condition of participating in several state-funded health insurance programs other than Medi-Cal. Nevertheless, CMS may require California to demonstrate that hospitals will not opt out of these state-funded programs to avoid paying the fee.

Third, DHCS must obtain federal approval of the fee design. The federal government must find that the fee and rate structure does not violate federal requirements regarding hold-harmless arrangements and also must issue a waiver for a non-broad-based and non-uniform fee. DHCS is given some discretion to modify provisions of the bill in order to obtain federal approval, but must consult with the hospital community and not violate the spirit or intent of the legislation. AB 1383 restricts the authority of DHCS to change the fees paid by hospitals or the rates paid to hospitals to no more than 2 percent. However, DHCS, after consulting with hospitals, can change the per-day fees as follows, even if that change is greater than the 2 percent limit:

1. Increase or decrease the $27.25 fee for patients enrolled in a managed care plan, excluding Medi-Cal, by up to $5;
2. Decrease the $233.46 fee for patients covered by fee-for-service, excluding Medi-Cal, by $6; and
3. Increase the $293.00 fee for Medi-Cal managed care per-day and fee-for-service patients by up to $2.

Fourth, DHCS must obtain federal approval of the proposed increases to Medi-Cal fee-for-service payment rates and payment rates to managed care plans, as well as for the proposed methods for distributing payments to hospitals for Medi-Cal beneficiaries enrolled in managed care. DHCS and the California Medical Assistance Commission (CMAC) will need to execute numerous changes, orders, and amendments to their current hospital and health plan contracts, which must be approved by CMS. In some cases, federal waivers may need to be amended.

The timing of the federal review and approval process is uncertain. It might be completed relatively quickly, as was the case when CMS approved California's nursing facility fee in three months, or it could drag on for months or years, as was the case with CMS' approval of California's Medicaid 1115 Hospital and Uninsured Waiver and related federal claiming protocols. Complicating matters is that AB 1383 requires that the 2009–10 and 2010–11 fees and payments be negotiated concurrently with the hospital waiver despite different timeframes for implementation — the waiver expires on August 31, 2010, and the state is proposing a renewal that will be much larger than the current waiver.

Hospital Participation Is Critical

For some hospitals, the cost of paying the fee will be greater than the benefit derived from participating in the non-Medi-Cal state insurance programs. Yet any hospital

that chooses not to participate in these programs would still benefit from the Medi-Cal payment rate increases. It is unknown if any hospitals will choose to opt out of these programs and not pay the fee, but if this occurs it would reduce overall fee revenue and could lead to the end of the program if CMS withdraws its approval or if the opt-outs create a "financial disadvantage" to the state as defined in AB 1383.[19]

Some Issues Remain Unresolved

The enactment of AB 1383 leaves many questions unanswered about hospital provider fees in California, and raises new ones. Among these are:

- **What is the effective date for the fee and for rate increases?** AB 1383 states that DHCS will compute the fee starting on the effective date of the bill and directs DHCS to seek federal approval for an effective date that covers federal fiscal years 2008–09 through 2010–11. DHCS also published a public notice and placeholder state plan amendment preserving an effective date for the rate increases of July 2009 in order to maximize the benefit of the enhanced federal match available under the ARRA. It is unclear, however, if the legislation can impose a fee on a retroactive basis, especially as hospitals participated in state insurance programs without knowing that payment of the fee would be a condition of participation. It is also unclear what notice of this condition of participation these programs must give to hospitals.
- **What will be the role of CMAC?** Today CMAC's major role is to contract with hospitals for services to Medi-Cal fee-for-service enrollees. With implementation of AB 1383, the role of CMAC may dramatically change. First, the bill uses up most federal funding room available in the upper payment limit, which thereby restricts the amount of federal funds that CMAC has to use for hospital rate increases. Further, CMS may restrict the state's ability to do future contract negotiations so these new rates or supplemental payments do not later create a hold-harmless situation. CMS generally views contracting programs in conjunction with a provider fee as a way for states to hold hospitals harmless, since higher payments can be targeted to those hospitals that lose money from paying the fee.
- **What are the long-term implications if Congress passes health reform at the federal level?** The current national debate over the design of federal health reform presents a challenge to California's efforts regarding a hospital provider fee. By pursuing a hospital fee before the effect of federal health reform is known, the state may limit its options or lock in state or federal funding levels to its disadvantage. For example, the Medicare Part D program, which provides prescription drug coverage to Medicare beneficiaries, requires states to continue spending based on historical levels. It is conceivable that the state could lock itself into funding levels that include the fee. Such concerns about acting too quickly, however, must be weighed against the significant benefits of the hospital fee.

Conclusion

Current fiscal conditions in California, combined with enhanced federal matching rates under the ARRA, are motivating lawmakers and health care stakeholders to explore the use of health care provider fees to produce a greater share of non-federal Medi-Cal funding and reduce the rate of growth of General Fund support to Medi-Cal. In 2009, state lawmakers approved a health care provider fee on hospitals and a gross premium tax on Medi-Cal managed care organizations.

California's experience suggests that key elements of a successful health care-related provider fee or tax include the following:

- The fee is imposed on and benefits classes of health care providers threatened by recent or proposed Medi-Cal rate reductions and reductions to coverage.

- The fee is crafted to maximize the number of providers who would benefit from it and from any associated policy changes and to minimize the number of providers who would experience a loss in net revenue as a result of the fee.
- The fee is constructed with extensive input from entities—health plans or providers—that would pay the assessment. Those paying the assessment are assured that the revenue generated by the fee will be used largely to benefit the providers being assessed. While a guarantee that most revenue from the fee will be used exclusively and in perpetuity for the providers being charged may be unrealistic, provider support for such a fee is predicated on agreements that ensure that the providers will become and remain largely better off with a fee than without.

Significant obstacles remain to the successful implementation of California's hospital fee, including uncertain federal approval and hospital participation. Despite these obstacles, the enactments of AB 1383 and AB 1422 are expected to encourage lawmakers to consider new assessments on health care providers and the renewal of existing provider fees in 2010.

About the Authors

Brenda Klutz is a senior consultant with, and Stan Rosenstein is a principal advisor to, Health Management Associates, Inc., a national health policy consulting firm. They can be reached at bklutz@healthmanagement.com and srosenstein@healthmanagement.com.

Acknowledgments

The authors would like to thank the California Association of Health Facilities, California Association of Public Hospitals and Health Systems, the California Children's Hospital Association, the Department of Health Care Services, and the Private Essential Access Community Hospitals. In addition, the expertise of Kate Kirchgraber, Steve Perlin, Jim Frizzera, and Steve Scheer, with Health Management Associates, Inc., was particularly invaluable.

About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Appendix A: Classes of Health Care on Which States May Impose a Provider Tax under Federal Law

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Nursing facility services (other than services of intermediate care facilities for the mentally retarded);
4. Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915 (c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICFs/MRs prior to the grant of the waiver;
5. Physician services;
6. Home health care services;
7. Outpatient prescription drugs;
8. Services of managed care organizations (including health maintenance organizations, preferred provider organizations);
9. Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;
10. Dental services;
11. Podiatric services;
12. Chiropractic services;
13. Optometric/optician services;
14. Psychological services;
15. Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services and rehabilitative specialist services;
16. Nursing services, defined to include all nursing services including services of nurse midwives, nurse practitioners, and private duty nurses;
17. Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;
18. Emergency ambulance services; and
19. Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following: The fee must be broad based and uniform or the State must receive a waiver of these requirements; the payer of the fee cannot be held harmless; and the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

Source: 42 CFR 433.56

Appendix B: State-by-State Health Care-Related Provider Taxes or Fees

	CLASS TAXED				
	NURSING FACILITIES	ICFs/MR (ICFs/DD)	HOSPITALS*	MANAGED CARE ORGANIZATIONS	OTHERS†
AL	✔				✔
AR	✔				
AZ				✔	
CA	✔	✔			
CO		✔			
CT	✔				
DC	✔	✔			
FL			✔		
GA	✔			✔	
IA		✔			
ID			✔		
IL	✔	✔	✔		
IN	✔	✔			
KS			✔		
KY	✔	✔	✔	✔	✔
LA	✔	✔			✔
MA	✔	✔	✔		
MD	✔	✔		✔	
ME	✔	✔	✔		✔
MI	✔		✔	✔	✔
MN	✔	✔	✔	✔	✔
MS	✔	✔	✔		
MO	✔		✔	✔	✔
MT	✔	✔	✔		
NC	✔	✔			
ND		✔			

	CLASS TAXED				
	NURSING FACILITIES	ICFs/MR (ICFs/DD)	HOSPITALS*	MANAGED CARE ORGANIZATIONS	OTHERS†
NE		✔			
NH	✔		✔		
NJ	✔	✔		✔	
NM				✔	
NY	✔	✔	✔		✔
OH	✔	✔	✔	✔	
OK	✔				
OR	✔		✔	✔	
PA	✔	✔		✔	
PI					
RI	✔		✔		✔
SC		✔	✔		
SD		✔			
TN	✔	✔		✔	
TX		✔		✔	
UT	✔	✔			
VT	✔	✔	✔		✔
WV	✔	✔	✔		✔
WA	✔				
WI	✔	✔	✔		
TOTAL	**33**	**29**	**21**	**14**	**11**

*Alabama, Arkansas, California, and Colorado have recently enacted hospital provider tax legislation, and are requesting CMS approval to amend their state Medicaid plans.

†May include pharmacies, residential care facilities, physicians, etc.

Sources: Smith, V., K. Gifford, E. Ellis, R. Rudowitz, M. O'Malley, and C. Marks. *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2007 and 2008.* Kaiser Commission on Medicaid and the Uninsured, October 2007. *Health Care Provider, Industry and Tobacco Taxes and Fees.* National Conference of State Legislatures, www.ncsl.org/programs/health/healthtaxes.htm. Updated April 13, 2009.

Endnotes

1. Other sources of this non-federal share include state revenue, revenue from local governments (including counties, cities, school districts, and hospital districts), the University of California, and other governmental entities (as long as the state provides at least 40 percent of the non-federal share of the program).
2. As a part of the federal stimulus, states were provided with an enhanced federal matching assistance percentage (FMAP) for a period of nine quarters, thereby reducing each state's share of Medicaid expenditures. California's federal matching rate will return to 50 percent in January 2011, and the state will receive $1 in federal matching funds for every $1 in non-federal Medicaid expenditures.
3. The fees brought in this sum at the traditional federal matching percentage for Medi-Cal (50 percent). Expected revenues are even greater at the higher federal matching rate for Medicaid programs under the federal stimulus package, through 2010.
4. Assembly Committee on Appropriations. Fiscal Summary. September 3, 2009 hearing date.
5. Senate Appropriations Fiscal Committee. Fiscal Summary. September 11, 2009 hearing date.
6. State law does refer to an assessment on health plan premiums as a tax; however, this assessment is not Medicaid-related.
7. The Tax Policy Group of Joint Venture, Silicon Valley Network. *Tax Principles Workbook: A Tool for Critiquing Tax and Fiscal Proposals and Systems,* February 2003.
8. California Department of Health Care Services. *May 2009 Medi-Cal Assumptions.* Itemizes the amount of revenue expected to be deposited into the General Fund from the various provider fees.
9. The text of the SNF QAF can be found at California Health and Safety Code §§ 1324.20 – 1324.30.
10. Since the 6 percent cap does not include Medicare revenue, and the 5.5 percent federal test allows for the inclusion of Medicare revenue, the 6 percent fee is below the federal test level.
11. Bureau of State Audits. *Department of Health Services: It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities.* 21– 26, 2006 – 035, February 2007.
12. California State Senate Office of Research. *Inside California's Nursing Homes: A Primer for Evaluating the Quality of Care in Today's Nursing Homes.* 43, February 2009.
13. The text of the ICFs/DD QAF can be found at California Health and Safety Code §§ 1324 – 1324.14.
14. The text of the managed care organizations QIF can be found at California Welfare and Institutions Code § 14464.5.
15. Designated public hospitals include hospitals operated by the University of California and hospitals operated by counties. Non-designated public hospitals are those operated by health or hospital districts.
16. Senate Appropriations Fiscal Committee. Fiscal Summary. September 11, 2009 hearing date.
17. Legislative Counsel Bureau. *Hospitals: Quality Assurance Fee — Tax or Fee.* #0924432, October 6, 2009.
18. Senate Appropriations Fiscal Committee. Fiscal Summary. September 11, 2009 hearing date.
19. Financial disadvantage is defined as either the "loss of federal financial participation" or a "cost to the general fund that is equal or greater than one-quarter of a percent of the general fund expenditures authorized in the most recent annual Budget Act." This threshold is greater than $200 million a year.