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H.R. 1 Financing Impact on Medi-Cal Providers

PRESENTED TO: Assembly Budget Subcommittee No. 1 on Health
Hon. Dawn Addis, Chair

LEGISLATIVE ANALYST'S OFFICE

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Overview of Hospitals

What Are Hospitals?

- ***Provide Inpatient and Outpatient Services.*** Hospitals are licensed to provide 24-hour inpatient care (overnight care to patients). They also provide outpatient (same-day) services.
- ***Generally Focus on Acute Care.*** Many hospitals focus on acute care—short-term care for severe diseases requiring immediate attention. That said, some patients can have lengthy stays at the hospital, depending on their conditions.
- ***Hundreds Operate in California.*** There are over 400 licensed general acute care hospitals. These hospitals provide a general set of services, ranging from emergency care, maternity care, and surgery, among other areas. (There are also a couple hundred specialized hospitals, such as those focused on psychiatric care.)

Who Operates Hospitals?

- ***Three Key Kinds of Hospitals.*** For the purposes of Medi-Cal financing, there are three key kinds of hospitals.
  - ***Private Hospitals.*** Most hospitals in California are privately run. Of private hospitals, a majority are nonprofit. Some are for-profit. These hospitals are quite diverse, with some quite large and others fairly small.
  - ***County and University of California (UC) Hospitals.*** Also known as "designated public hospitals" in Medi-Cal, these are hospitals operated by counties or UC. These hospitals tend to be relatively large.
  - ***District Hospitals.*** These are hospitals operated by special health care districts. They tend to be relatively small.

Overview of Hospitals

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- ***Hospital Types Have Different Reimbursement Approaches…*** As with most providers, most Medi-Cal hospitals services are delivered under the managed care system. In this system, contracted health plans generally determine how to pay for services. For fee-for-service payments, Medi-Cal pays private and district hospitals for each visit using set rates. For county and UC hospitals, fee-for-service reimbursement is more cost-based.
- ***…And Financing Arrangements.*** Medi-Cal uses a mix of federal funds, state General Fund, and contributions from hospitals themselves to pay for Medi-Cal services. The state uses different mechanisms to use hospital contributions. For private hospitals, the state charges a fee (discussed later) that helps draw down federal Medicaid funds. Public hospitals generally use reported costs or fund transfers to draw down federal funds, as allowed under federal law.

What Are Safety Net Hospitals?

- ***Serve Disproportionate Number of Low-Income Patients.*** Some hospitals in California serve a disproportionate number of Medi-Cal and uninsured populations. These hospitals are known as safety net hospitals. (In Medi-Cal, they also are known as "Disproportionate Share Hospitals.")
- ***Receive Additional Federal Funds.*** Safety net hospitals qualify for additional federal Medicaid funds to help them cover the cost of uncompensated care—unpaid care to low-income populations.
- ***Include Many Hospitals in California.*** In California, many hospitals qualify as safety net. Under a longstanding policy, California allocates all of its federal safety-net funding to public safety net hospitals. Private safety net hospitals receive separate supplemental payments.

Overview of Provider Taxes and Directed Payments

What Are Provider Taxes?

- ***Specific Taxes on Health Care Services.*** Under federal law, provider taxes (also known as "health care-related taxes") are taxes specifically enacted on health care services. States most commonly charge provider taxes on hospitals and long-term facilities, but there are numerous other kinds.
- ***Typically Used to Support Medicaid.*** States typically use these taxes to support their Medicaid programs, resulting in federal matching funds. States also often use their Medicaid programs to pay providers back for some or all of the cost the tax, sometimes even providing them net funding increases through supplemental payments. As a result, much of the net cost of provider taxes tends to fall on the federal government, rather than states or providers.
- ***Federal Rules Regulate Provider Taxes.*** Because provider taxes can increase federal costs, federal law regulates how states structure their taxes. As the figure on the next page shows, the rules generally aim to make the taxes proportionate between Medicaid and non-Medicaid services and to limit how much funding providers receive back from Medicaid to cover the cost of the taxes. States can receive waivers to the proportionality rules under certain conditions. Waivers are for limited periods of time, often requiring states to periodically renew their federal approval.

Overview of Provider Taxes and Directed Payments

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Two Key Concepts Underpin Federal Rules

Federal Rules for Provider Taxes Before H.R. 1 Was Enacted

Proportionality

Requires charges:
- To be equal between Medicaid and non-Medicaid services.
- To broadly apply to all relevant providers.

Can be waived if tax redistributes funds from non-Medicaid services toward Medicaid services, as measured by mathematical tests.

Hold Harmless

Prohibits direct guarantees to pay providers back for the cost of tax.

Allows Medicaid to indirectly cover tax for providers, so long as either:
- Tax revenue is below specified limit (6 percent of providers' net patient revenue).
- Medicaid does not cover a certain amount of cost (75 percent or more) for a certain number of taxed providers (75 percent or more).

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What Are California's Provider Taxes?

- ***Two Key Taxes and Fees Affect Hospitals.*** Two of California's provider taxes specifically impact hospitals:
  - ***Health Plan Tax ("Managed Care Organization Tax").*** The state charges health plans a tax based on their Medi-Cal and commercial enrollment. Nearly all of the revenue comes from taxing Medi-Cal enrollment, as the Medi-Cal tax rate is more than 100 times larger than the commercial tax. Accordingly, California has needed to request a waiver from federal proportionality rules. The current tax generates between $7 billion and $8 billion in net revenue annually, with most of the funding to date (around 75 percent) offsetting General Fund spending in Medi-Cal. The smaller remaining share of funding (around 25 percent) supports certain programmatic augmentations, primarily Medi-Cal provider

Overview of Provider Taxes and Directed Payments

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rate increases. Some provider rate increases are for hospital services. Prior to H.R. 1, the current tax, including the waiver from federal proportionality rules, was approved through the end of December 2026.

- ***Private Hospital Fee ("Hospital Quality Assurance Fee").*** This fee is levied on each private hospital's inpatient days and outpatient visits. Like the health plan tax, the fee charges higher rates on Medi-Cal services than on non-Medi-Cal services, requiring a waiver from federal proportionality rules. The most recently approved version of the fee was in effect through 2024, generating $5.9 billion in fee revenue in that year. Relative to the health plan tax, a smaller share of revenue (around 25 percent) offsets General Fund spending in Medi-Cal, with a larger share (around 75 percent) used for rate increases to private hospitals.

- ***Voters Have Made Largest Provider Taxes Permanent in State Law.*** Proposition 52 (2016) made the private hospital fee permanent, while Proposition 35 (2024) made the health plan tax permanent. The two provider taxes are not permanent in federal law, however—periodic federal approval is still required to draw down federal funds. The two measures also include rules around how to structure the taxes and spend their associated revenues. For example, Proposition 35 generally limits the tax rate on commercial enrollment at roughly its current levels.
- ***State Also Has Two Smaller Provider Fees.*** The state also charges fees on long-term care facilities and private ground emergency medical transportation providers. These fees are much smaller, with the former raising around $700 million annually and the latter raising around $55 million annually.

Overview of Provider Taxes and Directed Payments

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What Are Directed Payments?

- ***State Direction to Health Plans on Medi-Cal Reimbursement.*** Federal law allows states to direct how contracted health plans pay for services in Medi-Cal, with certain limits. These are known as "directed payments." In practice, many directed payments work like supplemental reimbursement rates above what health plans already pay for services. Directed payments must receive federal approval each year.
- ***California Has One Key Directed Payment for Private Hospitals…*** The most significant directed payment for private hospitals in California is the Private Hospital Directed Payment Program. This program provides supplemental reimbursement rates for inpatient and outpatient services. The private hospital fee funds the nonfederal share of cost.
- ***…And Several for Public Hospitals.*** There are a few different public hospital directed payment programs that provide supplemental reimbursement. Public hospitals generally use local fund transfers for the nonfederal share—meaning that the net benefit of these payments comes from the additional federal funds.
- ***Federal Government Includes Limits on Medi-Cal Payments to Hospitals.*** Federal law and rules limit how much state Medicaid programs can spend on hospital services. In fee-for-service, the limit is tied to what Medicare pays for hospital services. Prior to H.R. 1, the federal government had a higher limit for managed care payments—the average rate paid by commercial health plans. Notably, these limits count total spending regardless of fund source for the nonfederal share. Thus, hospital contributions from local fund transfers or the private hospital fee count towards this limit.

Key H.R. 1 Changes

What Are the H.R. 1 Changes?

Three Key Changes. Among other changes, H.R. 1 prohibits states from adopting new provider taxes or increasing their existing ones. The legislation also includes three changes to federal approval rules:

- ***Proportionality.*** H.R. 1 tightens the existing rules around proportionality, generally prohibiting states from charging higher rates on Medicaid services than non-Medicaid services. This notably limits states' ability to obtain a waiver from proportionality rules. The new rules are already technically in effect, though the federal Department of Health and Human Services can grant states additional time to comply with the new rules.
- ***Revenue Limit.*** H.R. 1 gradually reduces the federal revenue limit on provider taxes beginning in federal fiscal year 2028 (roughly corresponding to California's 2027-28 fiscal year), until the limit reaches nearly half its current level by federal fiscal year 2032 (roughly corresponding to California's 2031-32 fiscal year). The reduction will require states that are near the current revenue limit, like California, to gradually reduce their provider taxes.
- ***Limit on Directed Payments.*** H.R. 1 also reduces an existing limit on payments directed to certain providers through Medicaid managed care plans. These payments will now be set at the comparable rate paid by Medicare, rather than the average rate paid by private health plans.

How Will the Changes Affect the Tax on Health Plans?

- ***No Change to Current Tax.*** Recent federal guidance suggests California's existing health plan tax will remain in effect through the end of December 2026, as originally authorized.
- ***More Proportionate Tax Beginning in 2027…*** If the state chooses to renew the health plan tax in 2027, the new tax will need to be more proportionate.

Key H.R. 1 Changes

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- ***…That Is Much Smaller.*** Though not required by H.R. 1 directly, California may have to adopt a much smaller health plan tax in 2027 compared to current levels. This is because Proposition 35 limits the tax rate on commercial enrollment to roughly current levels. Absent the Legislature or voters amending Proposition 35, the state can only reduce the Medi-Cal tax rate, resulting in less revenue. A smaller 2027 tax pursuant to Proposition 35's and H.R. 1's rules likely will raise tens of millions of dollars in revenue, rather than the billions under the existing tax.

How Will the Changes Affect the Private Hospital Fee?

- ***In Short-Run, Likely Similarly Sized Fee Program.*** According to the administration, federal administrators have signaled that the state could charge about the same size fee in 2025 as it did in 2024. (The state had submitted a much larger fee in 2025 for federal approval prior to H.R. 1, but is now in the process of revising it to comply with recent federal guidance.) The administration also indicates it may be able to qualify for an extension of a few years to the new proportionality rules.
- ***In Long-Run, Likely More Proportional and Smaller Fee.*** In the long-run, the state will need to make the fee more proportional between Medi-Cal and commercial services. The state also may need to gradually reduce the fee to comply with the lower revenue limit.

How Will the Changes Affect Directed Payments?

- ***Likely Reduced Payments…*** We understand that some health plan payments in Medi-Cal exceed what is paid in Medicare. As a result, the state likely will need to ratchet down directed payments over time to comply with the new limit.
- ***…Though Exact Size of Reduction Is Uncertain.*** The reduction to hospitals could be in the billions of dollars. Pinpointing the exact reduction is difficult, however, due to limited data. The administration does not publicly report how health plan payments in Medi-Cal compare to Medicare. Even with better data, there is still some uncertainty because federal guidance on the new limits is still forthcoming.