

Proposition 52:
Medi-Cal Hospital Fee Program.

Initiative Statutory and Constitutional Amendment

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I. EXECUTIVE SUMMARY

Proposition 52 seeks to permanently extend the Hospital Quality Assurance Fee (QAF) imposed on hospitals that allows the State to receive matching federal funding to pay for hospital care of Medi-Cal patients (California's Medicaid program for low-income individuals). The fee imposed under the Medi-Cal Hospital QAF program generates annual revenue of \$1 billion to offset Medi-Cal costs to the State's General Fund. The fee program also creates additional revenue that pays for hospital services for low-income Californians. This measure would also declare the fee revenues a "trust fund" that restricts uses of the funds and excludes the funds from the General Fund calculation for budgetary allocation purposes.

A **YES** vote means an existing charge imposed on most private hospitals that is scheduled to end on January 1, 2018, would be extended permanently. Revenue from the fee program will be placed in a trust fund, matched by federal funds and allocated to hospitals to pay for Medi-Cal services.

A **NO** vote on this measure means that the existing charge imposed, under the Medi-Cal Hospital Quality Assurance Fee program would end on January 1, 2018, absent legislative action extending the program. The program has been extended every time it has come before the Legislature and would likely be extended again if voters do not approve the proposition.

II. THE LAW

A. Path to the Ballot

The Legislature enacted Assembly Bill (AB) 1383¹ and AB 188² in 2009, creating the original framework for the Medi-Cal Hospital Quality Assurance Fee (QAF). The legislation imposed a charge on hospitals, created a general structure for assessment of fees, leveraged federal-matching grants, and allocated the funds to hospitals.³ Under AB 1383 the Department of Health Care Services (DHCS) was required to collect fees from hospitals and deposit the proceeds into the QAF.⁴ Fee rates were determined based on each day of care provided to a patient in a hospital.⁵ The rates were designed to meet federal approval and were developed in consultation with the hospital community.⁶ After its passage, however, it was determined by the federal Centers for Medicare and Medicaid Services that the fee and payment proposed in AB

¹ AB 1383, 2009 Leg., 2009–2010 Reg. Sess. (Cal. 2009).

² AB 188, 2009 Leg., 2009–2010 Reg. Sess. (Cal. 2009).

³ Cal. AB 1383, at 1.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

1383 did not meet federal requirements.⁷ In response, the Legislature passed and the Governor signed AB 1653 (2010) the following year, establishing a federally approved alternative mechanism for funding supplemental grants to hospitals.⁸ This allowed the State to retain the previously allocated funds to be used as intended by AB 1383 (2009).⁹

In 2011, Senate Bill (SB) 90 continued to impose the QAF on hospitals and used the revenue collected to leverage federal funds and provide supplemental payments to hospitals for treating Medi-Cal patients.¹⁰ The Medi-Cal services paid for by the fee revenue include Fee-For-Service, Managed Care Plans, acute psychiatric days, and children's health care coverage.¹¹ SB 90 also authorized DHCS to administer the fee.¹² The following year, SB 335 (2011) extended the QAF from June 2011 to December 2013.¹³ Again the resulting revenue from the fee created by SB 335 was used to leverage federal funds to allocate supplemental payments to hospitals in the Fee-For-Service category, Managed Care Plan services, and children's health coverage.¹⁴

In an effort to continue the Hospital QAF, the Legislature passed SB 239, the Medi-Cal Hospital Reimbursement Improvement Act of 2013.¹⁵ SB 239 sought to maintain a federally approved rate methodology and to ensure that the state and federal fees would be allocated toward supplemental Medi-Cal services and set to expire on to January 1, 2018.¹⁶

Since 2009, the Legislature has worked to extend the QAF four separate times to leverage matching federal funds to support Medi-Cal services.¹⁷ However, the Legislature has also diverted some of the hospital fee funds to the State's General Fund to close a budget shortfall in 2011–12.¹⁸ The Legislature took around \$260 million for the general fund, a much larger portion of the QAF program than the hospitals believed was appropriate.¹⁹ Proponents seek to remove possible threats of reallocation of the Medi-Cal fee revenues to the General Fund for purposes of closing future budget shortfalls.²⁰ The proponents of this measure intended to place this proposition on the ballot in 2014 but failed to submit voter signatures in time to meet the California Secretary of State's verification requirements that year.²¹

⁷ C. Duane Dauner, *California Hospitals Praise Governor Schwarzenegger*, CAL. HOSP. ASS'N, (Sept. 8, 2010), <http://www.calhospital.org/media-statement/california-hospitals-praise-governor-schwarzenegger>.

⁸ AB 1653, 2010 Leg., 2009–2010 Reg. Sess. (Cal. 2010).

⁹ Cal. AB 1383, at 1

¹⁰ SB 90, 2011 Leg., 2011–2012 Reg. Sess. (Cal. 2011).

¹¹ Cal. SB 90, at 7(g)-(j).

¹² Cal. SB 90, at 1.

¹³ SB 335, 2011 Leg., 2011–2012 Reg. Sess. (Cal. 2011).

¹⁴ Cal. SB 335, at 1(a); *see also* Cal. SB 90, at 7 (g)-(j).

¹⁵ SB 239, 2013 Leg., 2013–2014 Reg. Sess. (Cal. 2013).

¹⁶ *Id.*

¹⁷ *Proposition 52*, LEGISLATIVE ANALYST'S OFFICE (July 18, 2016), <http://www.lao.ca.gov/ballot/2016/Prop52-110816.pdf>.

¹⁸ Pauline Bartolone, *Hospital Finance Measures on California May Stump Voters*, KAISER HEALTH NEWS (July 14, 2016), <http://khn.org/news/hospital-finance-measure-on-california-ballot-may-stump-voters>.

¹⁹ Sophia Bollag, *California's 2012 Budget Crisis Sparked Prop. 52, A Measure To Generate Money For Medi-Cal*, L.A. TIMES (Oct. 5, 2016), <http://www.latimes.com/politics/la-pol-ca-medi-cal-proposition-52-20161005-snap-story.html>.

²⁰ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

²¹ *See* Bollag, *supra* note 19.

If approved by the voters Proposition 52 will make the Medi-Cal hospital fee program permanent unless the federal government denies approval of the fee or the Legislature does not appropriate such fees.²² Current law allows the Legislature to end the fee with a majority vote.²³ Proposition 58 seeks to make it harder for the Legislature to change or end the fee.²⁴ The proposal seeks to require a two-thirds vote of both houses of the Legislature to end the fee or make specific changes to the statute, such as obtaining federal approval or modifying the methodology used to determine the level of the fee or the payments made to the hospitals.²⁵

B. Existing Law

1. Federal Law

The Affordable Care Act resulted in a substantial expansion of federal Medicaid programs by providing federal incentives to states to provide insurance to low-income individuals and families.²⁶ The Medicaid program offers matching funds for many of the services states provide.²⁷ Medi-Cal is the California expansion of the federal Medicaid program and has enrolled over 2 million previously uninsured individuals since the Affordable Care Act passed in 2010.²⁸

2. State Law

a. Medi-Cal Overview

Medi-Cal currently provides insurance to over 13 million eligible low-income Californians, amounting to one-third of the State's population.²⁹ However, Medi-Cal does not cover undocumented immigrants because of federal requirements.³⁰ The benefits offered by Medi-Cal cover doctor's visits, emergency services, surgeries, and prescriptions.³¹ Spending on Medi-Cal services for 2015–16 totaled roughly \$93 billion, of which approximately \$23 billion was from the General Fund.³² The remainder of funding for Medi-Cal came from matching

²² See *Proposition 52*, *supra* note 17.

²³ Cal. SB 239.

²⁴ See *Proposition 52*, *supra* note 17.

²⁵ *Medi-Cal Overview. Hospital Quality Assurance Fee*, LEGISLATIVE ANALYST'S OFFICE (Nov. 14, 2013), <http://www.lao.ca.gov/ballot/2013/130602.aspx>.

²⁶ Shannon McConville, et al., *Health Coverage and Care for Undocumented Immigrants*, PUB. POLICY INST. OF CAL. (Nov. 2015), http://www.ppic.org/main/publication_quick.asp?i=1167.

²⁷ *Id.*

²⁸ *Id.*

²⁹ CAL. SEC'Y OF STATE, OFFICIAL VOTER INFORMATION GUIDE: CALIFORNIA GENERAL ELECTION, TUESDAY NOVEMBER 8, 2016, at 24, available at <http://vig.cdn.sos.ca.gov/2016/general/en/pdf/complete-vig.pdf> ["NOVEMBER 2016 VOTER GUIDE"].

³⁰ See McConville, *supra* note 26.

³¹ NOVEMBER 2016 VOTER GUIDE, at 24.

³² *Id.*

federal funds and other non-federal sources.³³ Other non-federal funds include certain expenditures and transfers by local governments and the Managed Care Organization tax, which collects taxes from Medi-Cal providers.³⁴

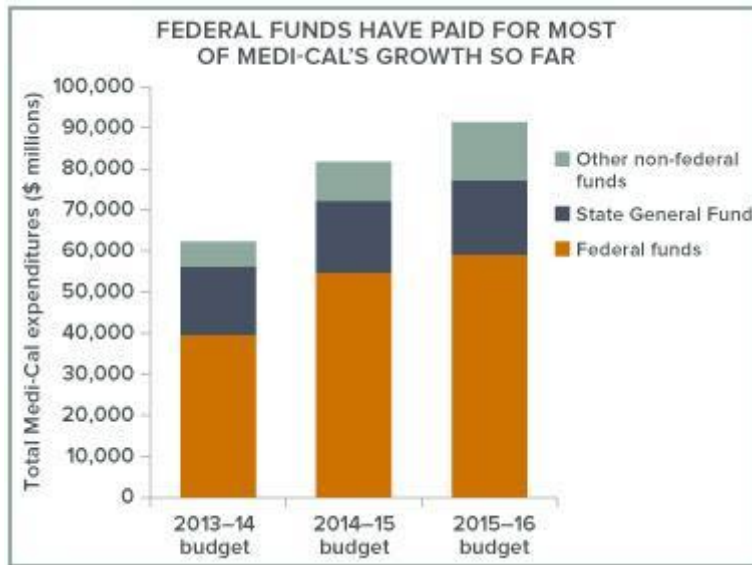


Chart provided by the Public Policy Institute of California http://www.ppic.org/main/publication_quick.asp?i=1167
http://www.ppic.org/main/publication_quick.asp?i=1167

b. Hospital Quality Assurance Fee Overview

Since 2009, hospitals have been charged a Hospital Quality Assurance Fee.³⁵ The fee averages from \$145 to \$618 per patient hospital stay and is paid to DHCS on a quarterly basis.³⁶ In 2015-2016, hospitals paid roughly \$4.6 billion dollars through the fee program. From the total revenues created by the fee, 24 percent are used to offset the overall cost of Medi-Cal to the General Fund.³⁷ In 2015-16, this offset of costs resulted in a total savings to the General Fund of \$850 million.³⁸ Additionally, public hospitals receive special grants totaling around \$300 million out of the revenues generated by the fee.³⁹

³³ See McConville, *supra* note 26.

³⁴ *Medi-Cal: Overview and Payment Issues*, LEGISLATIVE ANALYST'S OFFICE (July 9, 2015), <http://www.lao.ca.gov/handouts/health/2015/Medi-Cal-Overview-and-Payment-Issues-070915.pdf>

³⁵ NOVEMBER 2016 VOTER GUIDE, at 24.

³⁶ Victoria Collier, *Prop. 52, A Measure to Fund Medi-Cal, is its Own Worst Enemy*, S.F. CHRONICLE (Sept. 9, 2016), <http://www.sfchronicle.com/health/article/Prop-52-a-measure-to-fund-Medi-Cal-is-its-own-9213439.php>.

³⁷ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

³⁸ NOVEMBER 2016 VOTER GUIDE, at 24.

³⁹ *Id.*

The remaining 86 percent of the fees paid by hospitals, approximately \$3.1 billion in 2015–16, is then matched by the federal government.⁴⁰ Once DHCS receives the matching federal funds, it reimburses all the California hospitals for the treatment of Medi-Cal patients.⁴¹ The hospitals are reimbursed when DHCS funds Managed Care programs and directs the Managed Care programs to pay the appropriate portion of the funds to hospitals for treatment of Medi-Cal patients.⁴² DHCS directly reimburses the hospitals for treatment of patients covered under Fee-For-Service Medi-Cal.⁴³ The total amount that hospitals received from DHCS is in direct proportion to the number of Medi-Cal patients that a hospital treats.⁴⁴

DHCS’s payments to hospitals are retroactive and are designed to close the gap on the losses hospitals often take when treating Medi-Cal patients.⁴⁵ The payments made to hospitals through the fee program offset about 40 percent of the losses hospitals take by treating Medi-Cal patients.⁴⁶ However, some hospitals pay more into the QAF than they receive back from the State after the QAF funds are matched by federal funds.⁴⁷

Under this system, there are what are sometimes referred to as “winners” and “losers.”⁴⁸ The “winners” are the hospitals that are made whole when DHCS distributes the reimbursement payments or receive back the same amount they paid into the QAF. The “losers” are those hospitals that are not made whole or receive the full amount they paid into the QAF because they treat fewer Medi-Cal patients.⁴⁹ Under federal law, to receive matching federal funds there have to be “winners” and “losers” because the funding is proportional to the care for Medicaid (Medi-Cal) patients.⁵⁰ However, the fee system in the end results in a net benefit of \$3.5 billion for the California Hospital industry as a whole.⁵¹

⁴⁰ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

⁴¹ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

⁴² Interview with Amber Didier, Senior Fiscal & Policy Analyst, Legislative Analyst’s Office, Sacramento, CA (Sept. 27, 2016) (notes on file with the *California Initiative Review*).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Pauline Bartolone, *Here’s What You Need to Know About the Puzzling Medi-Cal Measure*, L.A. DAILY NEWS (Oct. 7, 2016), <http://www.sbsun.com/article/20161006/NEWS/161009619>.

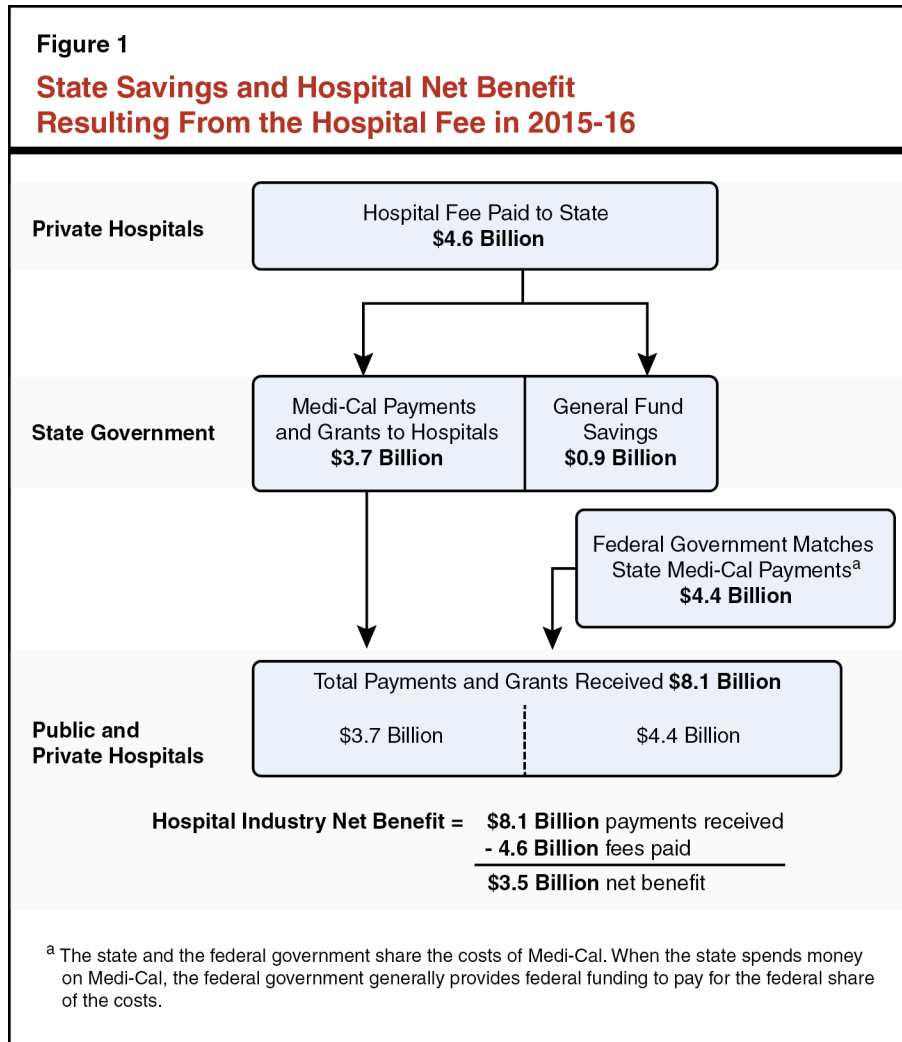
⁴⁷ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ NOVEMBER 2016 VOTER GUIDE, at 24.



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C. Proposed Law

1. Constitutional Amendment

Proposition 52 has been proposed to the voters as a constitutional amendment.⁵³ The proposal does not extend or repeal the sunset provision of the Medi-Cal Hospital Reimbursement Improvement Act of 2013 enacted by SB 239, and instead requires that the QAF remain operative as long as the Act continues to collect funds from the federal government.⁵⁴ The measure ensures that fees paid by hospitals to the State are placed into a trust fund and are allocated with the intended purpose of supporting Medi-Cal services and health care for low-income for children.⁵⁵ The portion of the proposition that amends the constitution says that the

⁵² *Id.*

⁵³ Cal. Proposition 52, § 2 (2016).

⁵⁴ *Id.* at § 4.

⁵⁵ *Id.* at § 3.5, amending CAL. CONST. art. XVI.

program, contained in the statute, shall not be amended except by a two-thirds vote of the Legislature.⁵⁶

2. *Requirements for Amending, Repealing, or Replacing the Act*

Currently, the Act allows the Legislature to broadly amend or repeal the Act with simple majorities in both houses.⁵⁷ Proposition 52 would amend the California Constitution to require a two-thirds majority in both houses of the Legislature to pass any statute that repeals the Act.⁵⁸ Any statute that amends or replaces the Act will require voter approval, unless both of the following conditions are met:

- The Legislature passes the statute with two-thirds majorities in both houses.⁵⁹
- The Legislature passes a statute that (1) is necessary for securing federal approval to implement the fee program, or (2) only changes the methodology used for developing the fee or the quality assurance payments.⁶⁰

3. *Fee Proceeds Exempt From Proposition 98 Calculation*

Proposition 98, a constitutional amendment adopted by voters in 1988, established a set of specific formulas used on an annual basis to calculate state minimum funding levels for K–12 education and the California Community Colleges.⁶¹ As a general matter, if the State receives additional General Fund revenues, this will result in a higher Proposition 98 funding requirement.⁶² Proposition 52 amends the Constitution to specify that the proceeds created by the fee are separate and are not calculated when determining the Proposition 98 funding level required for schools.⁶³

4. *Classifies Revenue as a Trust Fund*

Under the proposed constitutional amendment, the Hospital QAF and the matching federal funds will be placed into the Hospital Quality Assurance Revenue Trust Fund, and separate from the allocating of funds for education.⁶⁴ The purpose of the measure is to ensure that the fees paid by the hospitals to the State are made available to leverage federal matching funds.⁶⁵ The fees paid to the State are matched by the federal government and allocated to hospitals to support hospital care for Medi-Cal patients, health care for low-income children, and reimbursements for DHCS for the direct cost of administering the program.⁶⁶ Trust funds are a type of special fund. Trust funds can be created by statute, initiative, and the Constitution. In

⁵⁶ *Id.*

⁵⁷ See LEGISLATIVE ANALYST'S OFFICE, *supra* note 25.

⁵⁸ Cal. Proposition 52, §3.5, *amending* CAL. CONST. art. XVI (2016).

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Cal. Proposition 98 (1988); CAL. CONST. art. XVI, § 8.

⁶² Cal. Proposition 98 (1988); CAL. CONST. art. XVI, § 8(b)(2).

⁶³ See *Proposition 52*, *supra* note 17.

⁶⁴ *Id.*

⁶⁵ Cal. Proposition 52, § 2 (2016).

⁶⁶ *Hospital Quality Assurance Fee Program*, CAL. DEPT. OF HEALTH CARE SERV., <http://www.dhcs.ca.gov/provgovpart/Pages/HQAF.aspx>.

*Daugherty v. Riley*⁶⁷ the court said that funds collected for a regulatory purpose are special funds held in trust because they cannot be diverted for the purpose for which they are raised. If an initiative or the constitution creates a fund that has moneys that can only be used for a specified purpose, then a trust fund is created.⁶⁸

5. Trust Fund Revenues Would be Used to Offset State Costs

Since the trust fund revenue would be exempt from the Proposition 98 calculation, use of the funds would offset state costs.⁶⁹ Under the proposition, DHCS will administer and collect the fee from hospitals and deposit the proceeds into the Hospital Quality Assurance Revenue Trust Fund.⁷⁰

The following offset state costs:

- Up to \$1 million will be allocated from the trust fund on an annual basis to reimburse DHCS for the staffing and administrative costs related to implementing the fee.⁷¹
- Every year 24 percent of the fee revenue goes to offsetting the General Fund costs for providing children's health care coverage thereby achieving General Fund savings.⁷² This represents a continuation of the State's 24 percent net benefit as required in current law.⁷³ The net benefit is defined as the total fee revenue collected from hospitals in each fiscal year, minus the sum of the fee-funded supplemental payments and direct grants.⁷⁴

III. DRAFTING ISSUES

In the event that federal law changes, the Hospital Fee Program may need to be reformed to comply with federal law in order to receive the federal matching funds that result in revenue for the State. The language of Proposition 52 does allow for amendments by a two-thirds majority of both houses of the Legislature so long as the amendment obtains federal approval or furthers the purpose of the proposition.⁷⁵ Additionally, DHCS is granted latitude under the current statute and proposed measure to change methodology of the fee to comply with federal law.⁷⁶

⁶⁷ 1 Cal. 2d 298 (1934).

⁶⁸ *Id.*

⁶⁹ *See Proposition 52, supra* note 17.

⁷⁰ *See* CAL. DEPT. OF HEALTH CARE SERV., *supra* note 66.

⁷¹ *Id.*

⁷² Cal. SB 239, at 6.

⁷³ *Id.*

⁷⁴ *See Proposition 52, supra* note 17.

⁷⁵ CAL. CONST. art. II, § 10(c); Cal. Proposition 52, § 3.5(ii)(c), *amending* CAL. CONST. art. XVI (2016).

⁷⁶ Interview with Amber Didier, *supra* note 42.

Federal regulations concerning Managed Care Programs were issued in May that will affect the methodology of the fee program.⁷⁷ The new regulations regarding Managed Care Programs no longer allow the State to pay the hospitals back by directing a portion of the funds paid to Managed Care Plans towards the hospitals.⁷⁸ Previously, DHCS paid back the hospitals the year after collecting the hospital fee by requiring Managed Care Programs to pay hospitals in proportion to how many Medi-Cal patients they treated the year before.⁷⁹ DHCS will have to communicate with the federal government to determine how the fee program will need to be adjusted to comply with the federal changes.⁸⁰ But, DHCS likely has the authority to reform the methodology to comply with these changes without returning to a vote of the people or the Legislature.⁸¹

Additionally, the proposition contains language that automatically makes the Hospital Quality Assurance Fee program inoperative if certain requirements are not met.⁸² The proposition amends Section 14169.72 of the Welfare and Institutions Code, which states that the Act will become inoperative if any of the following conditions occur:

- A final judicial decision of appellate jurisdiction, the U.S. Department of Health and Human Services, or the federal Centers for Medicare and Medicaid services determines that the fee program cannot be implemented;⁸³
- The Legislature fails to appropriate the revenue from the fee program in the budget or a budget trailer bill;⁸⁴
- The federal government denies approval for the matching funds for the fee program and DHCS fails to modify the program to comply with federal requirements;⁸⁵ or
- The proceeds of the fee program are not deposited in the revenue fund or if the funds are not used for the specific purposes laid out in the Act.⁸⁶

⁷⁷ *Id.*; *HHS Issues Major Rule Modernizing Medicaid Managed Care*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (Apr. 25, 2016), <http://www.hhs.gov/about/news/2016/04/25/hhs-issues-major-rule-modernizing-medicare-managed-care.html>.

⁷⁸ Interview with Amber Didier, *supra* note 42.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*; *HHS Issues Major Rule Modernizing Medicaid Managed Care*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (Apr. 25, 2016), <http://www.hhs.gov/about/news/2016/04/25/hhs-issues-major-rule-modernizing-medicare-managed-care.html>.

⁸² Cal. Proposition 52, § 4 (2016).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

When a section of a proposition becomes inoperative, it is still included in the code but is not effective and does not impact current practices. There are no time constraints in the Proposition language for DHCS to adjust the procedures of the fee program to comply with federal law.⁸⁷ The fact that the Proposition is silent on the time DHCS has to adjust the program could mean that the Department has as long as it needs to adjust the fee program to ensure compliance with federal law and the matching federal funds.⁸⁸ DHCS will work with the federal government to adjust the fee program as soon as possible, to ensure the matching federal funds.⁸⁹ If the section becomes inoperative, then the legislature can create a new fee program by amending the sections of the Welfare and Institutions Code included in the fee program.⁹⁰

IV. CONSTITUTIONAL ISSUES

In order to receive the matching funds from the federal government the fee program must be approved by the federal government.⁹¹ If future circumstances require a change in the methodology then the provisions of the measure allow the Legislature and/or DHCS to work with the federal government to receive feedback and ascertain whether amendments are needed to further the intent of the QAF. If the federal government does not approve the fee program's procedures, then the funds the State receives from the federal government would decrease every year, over a 10-year period.⁹² It is likely that the state and federal government will work together so that the program's procedures comport with federal requirements.⁹³ Because the federal funds are given as an incentive program and not a mandated program,⁹⁴ there does not appear to be any conflicts between state and federal law, even if the program fails to gain federal approval. On its face, Proposition 52 appears to be constitutional.

⁸⁷ *Id.*

⁸⁸ Interview with Amber Didier, *supra* note 42.

⁸⁹ *Id.*

⁹⁰ See LEGISLATIVE ANALYST'S OFFICE, *supra* note 25.

⁹¹ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

⁹² Interview with Amber Didier, *supra* note 42.

⁹³ Interview with Amber Didier, *supra* note 42; *HHS Issues Major Rule Modernizing Medicaid Managed Care*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (Apr. 25, 2016), <http://www.hhs.gov/about/news/2016/04/25/hhs-issues-major-rule-modernizing-medicaid-managed-care.html>.

⁹⁴ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

V. PUBLIC POLICY CONSIDERATIONS

A. Proponents' Main Arguments

1. *Generate Revenue for Medi-Cal Budget*

The proponents of this proposition argue Proposition 52 will generate \$3 billion in revenue.⁹⁵ However, the Legislative Analyst's Office estimates that the revenue to the State is closer to \$1 billion.⁹⁶ This discrepancy results from the way the industry profits compared to how the State profits.⁹⁷ For the hospital industry, the Act results in a net profit of around \$3.5 billion after the federal government has matched the State funds and hospitals are paid back for the care they give to Medi-Cal patients.⁹⁸ The State keeps 24 percent of the fees collected from hospitals, which has resulted in about \$1 billion in revenue that is created to offset the cost of Medi-Cal to the State's General Fund.⁹⁹

2. *Prohibits Legislature From Diverting Funds*

The purpose of the measure is to ensure that the fees paid by the hospitals to the State are made available to leverage federal matching funds.¹⁰⁰ The fees paid to the State are matched by the federal government and paid to the hospitals are used to support hospital care for Medi-Cal patients and health care for low-income children.¹⁰¹ By reducing the losses that hospitals take when treating Medi-Cal patients and offsetting the costs of Medi-Cal, Proposition 52 ensures services for those in need will continue. The proposition requires that any changes to the fee program will have to be passed by the Legislature with a two-thirds majority.¹⁰² The proponents argue that this vote threshold will ensure that in economic downturns the Legislature is unable to divert the funds for other purposes.¹⁰³ Additionally, placing the revenues directly into a trust fund that requires the revenues only be spent for Medi-Cal purposes helps prevent the QAF from being diverted to other programs.¹⁰⁴ The vote threshold and the creation of the trust fund should secure funds from being redirected by the legislature.¹⁰⁵

⁹⁵ NOVEMBER 2016 VOTER GUIDE, at 24.

⁹⁶ *Id.*

⁹⁷ Interview with Amber Didier, *supra* note 42.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

B. Opponent's Main Arguments

1. The Legislature is better equipped to make a more flexible QAF program.

The United Health Care Workers branch of Service Employees International Union (SEIU-UHW) was originally opposed to Proposition 52, but has recently withdrawn its opposition.¹⁰⁶ The formal arguments against the measure no longer remain on the “No on Proposition 52” website, currently unpublished as of October 7, 2016,¹⁰⁷ but still listed in the voter guide that has gone out to California voters.¹⁰⁸

Prior to removing their opposition, SEIU-UHW argued that enacting a constitutional amendment through the ballot effectively reduces the ability of state lawmakers to act on issues that may impact fee methodology and federal government approval in the future.¹⁰⁹ Additionally, opponents argue that the sunset provision found in current law encourages stakeholder collaboration to extend the program and creates a more inclusive and up to date Medi-Cal hospital fee program.¹¹⁰ Opponents maintain that lawmakers are better suited to respond to an evolving health care system, but that if Californians vote directly on the proposal their vote will be harder to undo.¹¹¹

2. No Oversight

The opposition stated that the measure lacks accountability and allows program funds to be diverted from patients to corporations and hospital executives.¹¹² SEIU-UHW opposed the redistribution of matching federal funds, supporting statutory limitations on their use which they felt could be given to hospital CEOs without any audit requirements.¹¹³

Opposition includes a nurse practitioner from Los Angeles County stating in the official voter guide that Proposition 52 siphons resources meant for patients and communities and puts important resources into the pockets of CEOs and special interests.¹¹⁴ She states that there are no guarantees the fees are being spent on healthcare because the proposed trust fund lacks accountability.¹¹⁵

C. Fiscal Considerations

There are three possible scenarios that would determine the fiscal impact this proposition would have if passed.

¹⁰⁶ See COLLIER, *supra* note 36.

¹⁰⁷ *No on 52*, CALIFORNIANS FOR HOSPITAL ACCOUNTABILITY AND QUALITY CARE, <http://noon52.com>.

¹⁰⁸ NOVEMBER 2016 VOTER GUIDE, at 24.

¹⁰⁹ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

¹¹⁰ *Id.*

¹¹¹ See BARTOLONE, *supra* note 18.

¹¹² See CALIFORNIANS FOR HOSPITAL ACCOUNTABILITY AND QUALITY CARE, *supra* note 107.

¹¹³ *Id.*

¹¹⁴ NOVEMBER 2016 VOTER GUIDE, at 28.

¹¹⁵ *Id.*

1. If the Legislature does not extended the sunset provision

If the Legislature does not extend the sunset provision or repeals the sunset provision completely, then the revenue that is used to offset Medi-Cal costs in the General Fund will go away.¹¹⁶ The fee program generates \$1 to \$3 billion depending on how the revenue is categorized. Through the fee program, the State receives a little over \$4 billion from hospitals.¹¹⁷ Then \$1 billion of the fees collected go to a trust fund to offset the costs of Medi-Cal.¹¹⁸ Additionally, \$300 million of the fees go to grants by the State to hospitals.¹¹⁹ The remaining \$3 billion is then matched by federal funds and the State repays the hospital in direct proportion to the amount of Medi-Cal patients that the hospitals treat.¹²⁰ If the legislature does not extend the QAF, the Legislative Analyst's Office estimates that the proposition would result in \$1.3 billion revenue.¹²¹ It is highly unlikely that the fee program would not have been extended because it received bipartisan support every time the sunset provision was pending.

2. If the Legislature would have extended the sunset provision

If the legislature extended the sunset provision or repealed it to extend the fee program indefinitely this measure would have little to no fiscal impact because the program would have stayed in place.¹²² The Legislature most likely would have extended the fee program because every time the program has come up for renewal it has been extended with no opposition on record.¹²³ If this proposition fails, the Legislature has until January 1, 2018, to extend the fee program and will most likely do so.¹²⁴

3. If the Program Fails to Gain Federal Approval

If the federal government no longer approves the fee program and the State is unable to amend the program to comply with changes in federal law there would be a 10 year phase out of the federal funding.¹²⁵ The phase out of funds would begin one year after an official decision is made to no longer approve the program by decreasing the federal funding by 10 percent each year until it is eliminated, ending the federal revenue.¹²⁶

¹¹⁶ NOVEMBER 2016 VOTER GUIDE, at 24.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ JOINT COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF PROPOSITION 52 (May 25, 2016).

¹²⁰ NOVEMBER 2016 VOTER GUIDE, at 24.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *See Proposition 52, supra* note 17.

¹²⁴ *Id.*

¹²⁵ Interview with Amber Didier, *supra* note 42.

¹²⁶ *Id.*

VI. CONCLUSION

If passed, the Hospital Quality Assurance fee program will continue as long as matching federal funds are available and the revenue from the program is placed in the trust fund and spent on Medi-Cal services. The fee program allows the State to seek matching federal funds to pay for Medi-Cal services. By receiving matching federal funds the State benefits from a \$1 billion offset to the costs of Medi-Cal from the General Fund and \$3 billion goes to pay hospitals back for the care they give to Medi-Cal patients.

Proponents claim that extending the program will ensure the revenue to the general fund continues at 24 percent of the fees collected from hospitals. As the fees collected increase, the benefits to the General Fund will increase because it is based on the percentage. Additionally, the requirement that a two-thirds majority is necessary to amend the program will ensure it is harder to divert the funds in times of economic uncertainty. The arguments against extending the fee include that there will not be enough oversight and the program's flexibility is necessary