Health Care Reform

Federal health care reform (Affordable Care Act, ACA) increases access to both private and public health care coverage. The Governor's Budget continued implementation of federal health care reform in California, building on the early establishment of the California Health Benefit Exchange (Covered California) and the early coverage expansion through the "Bridge to Reform" waiver. It outlined the following principles for health care reform implementation: (1) it must be sustainable and affordable, (2) it must fairly allocate risk and clearly delineate responsibilities between the state and counties, (3) it must maintain a strong public safety net, and (4) it must support local flexibility. It outlined two approaches—county-based and state-based—to provide coverage to low-income adults without eligible children (optional expansion).

The May Revision proposes the state-based approach for expansion. Newly eligible individuals will receive the comprehensive benefits currently provided by Medi-Cal, including county-administered comprehensive specialty mental health services and county-supported substance use disorder services. Long-term care services will be covered, provided the federal government approves the retention of an asset test for these services. At a county option, beneficiaries, both existing enrollees and new eligibles, may receive an enhanced benefit package for substance use disorders.

Today, as the provider of last resort, counties are responsible for indigent health care. Under the 1991 realignment, the state provides roughly $1.5 billion to counties to assist them in meeting their obligations. To receive these funds, counties must spend a

required maintenance of effort of $343 million. Many counties spend additional funds on indigent care.

Under health care reform, county costs and responsibilities for indigent health care are expected to decrease. Under the state-based expansion and the eligibility simplification required by federal law, the state will bear the financial cost and risk of expanding coverage to currently uninsured adults. The state will be responsible for the bulk of indigent health care, providing coverage for nearly all low-income, uninsured individuals seeking health services. Given that health care costs have risen rapidly over the last few decades, generally outpacing revenue growth, and given that Medi-Cal is the second largest General Fund expense, the state cannot afford to both assume the cost of coverage, and continue its level of funding for county health care programs. Preserving a strong public safety net remains a priority.

While coverage will increase, thereby lessening county costs, uncertainty remains regarding how many people will enroll in coverage, where they will receive care, and what costs associated with services provided to uninsured individuals will remain. Counties play a key role in providing access to and delivery of health care services to both Medi-Cal beneficiaries and the uninsured. Given these factors, the May Revision proposes to determine county health care savings based on actual experience.

Mechanism to Preserve Access to the Safety Net

The state has an interest in maintaining a strong public safety net to ensure access to health care services as the safety net is the primary source of care for Medi-Cal beneficiaries and the uninsured. As part of the optional Medi-Cal expansion, the state will work with counties to support a viable patient base for county safety net providers, as well as adequate rates for services provided to the new population.

Given the increased coverage that will occur under the ACA, county responsibilities are expected to decrease, generating savings to counties. In recognition of the ongoing role of counties in delivering services to Medi-Cal and the uninsured, and the difficulty in projecting the specific impacts, a mechanism will be established to determine the level of county savings based on actual experience. Under this mechanism, each county's savings will be determined by measuring actual county costs for providing services to Medi-Cal and uninsured patients and the revenues received for such services. Revenues will include patient care revenues, federal funds, health realignment dollars, and net county contributions to health care services, which will be adjusted to reflect historic growth rates. The difference between total revenues and total costs will determine

the savings. These savings will be redirected to support human services programs at the local level. The May Revision estimates that $300 million in 2013-14, $900 million in 2014-15, $1.3 billion in 2015-16 and in 2016-17 will shift from local health programs to local human services programs. However, the actual amount of savings shifted will be based on the mechanism.

Because this mechanism is cost-based, it must include incentives for cost containment and maximizing enrollment in coverage, and it must also account for the remaining uninsured being served by the county, consistent with today's level of service. The Administration proposes a cap on the cost growth of county expenditures based on historic trends for purposes of determining savings. The mechanism will be in place until health care reform is fully implemented. This allows the state to determine savings that occur as a result of health care expansion and counties to retain funding for the costs—mostly related to outpatient services—that will remain for caring for uninsured individuals.

Given today's reimbursement structure and how it may change under the ACA, there is a risk of losing substantial federal funding and destabilizing local health care safety net systems—in particular, county-run public hospital and clinic systems. The state will seek to maximize federal funding through the development and procurement of a future Medicaid Waiver to replace the existing "Bridge to Reform" Medicaid Waiver that expires in 2015.

Delineation of Responsibilities for Health and Human Services Programs

Under the May Revision, the state will assume greater financial responsibility for health care programs. This builds on the Coordinated Care Initiative, which limited county contributions for In-Home Supportive Services program costs, transitioned collective bargaining for participating counties to the state, and expanded the state's financial responsibility in that program. Consistent with this expanded state responsibility for health care and long-term care services, the Administration proposes to, over time, shift responsibility to the state for California Children's Services—which provides specialized services for children with severe chronic health conditions, such as cystic fibrosis, hemophilia and cancer. Consideration will also be given to the appropriate role of counties in the Medical Therapy Program. Counties would retain responsibility for providing and funding public health programs—such as immunizations and communicable disease control activities.

The May Revision proposes to expand the counties' role in human services programs. Specifically, it proposes that, over time, counties assume greater financial responsibility for CalWORKs, CalWORKs-related child care programs and CalFresh (formerly Food Stamps) administration costs. Counties would be responsible for the coordination of all client services and would have opportunities to reinvest caseload savings and revenue growth in CalWORKs and related child care programs based on their local needs and priorities. Eligibility, grant levels and rates would continue to be set at the state level. The state would continue to provide funding for above-average costs that result from economic downturns or policy changes outside counties' control. Consideration would be given to balancing county flexibility and appropriate beneficiary protections.

Medi-Cal Optional Expansion — May Revision Adjustments

The May Revision includes $1.5 billion ($21 million General Fund, $1.5 billion federal funds) to implement the optional expansion in 2013-14. These figures assume that the state will receive 100 percent federal funding for the expansion population in the budget year, and reflect the following General Fund adjustments.

Significant Adjustments:

- *Services for Pregnant Women*—A decrease of $26.4 million in 2013-14 to reflect that pregnant women with income between 100 percent and 200 percent of the Federal Poverty Level who today are eligible for Medi-Cal will instead receive comprehensive coverage through Covered California beginning in 2014. To ensure health care coverage is affordable for this population, the May Revision proposes to cover all cost sharing not covered by the federal advance premium tax credits.
- *Services for Newly Qualified Immigrants Present Fewer than Five Years*—A decrease of $5.4 million in 2013-14 to reflect that individuals who would otherwise have been eligible under Medi-Cal as newly qualified immigrants will instead receive coverage through Covered California. To ensure health care coverage is affordable for this population, the May Revision proposes to cover all cost sharing not covered by the federal advance premium tax credits.
- *County Administration Costs*—An increase of $71.9 million in 2013-14 for increased county administration costs related to implementing the ACA. Additional resources are needed to process new applications and redeterminations, develop training and curriculum materials, train county eligibility workers, and support planning and implementation activities. The Administration proposes to base future appropriations on a time study of resource needs, beginning in 2015-16.