Thinking Through the State and County Options for Medi-Cal Expansion

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California State Association of Counties

INTRODUCTION

This document reviews the options for Medi-Cal expansion as outlined in the Governor's 2013-14 proposed budget and incorporates information from a number of sources, primarily at the county level. CSAC has committed to maintaining an ongoing dialogue with our membership, the Legislature, and the Administration to resolve issues of concern and move forward with a policy approach that allows for a timely and effective transition of the Medi-Cal expansion as put forth by the Affordable Care Act (ACA) in January 2014.

BACKGROUND

The Administration proposes to expand Medi-Cal to adults with incomes under 138% of the Federal Poverty Level (FPL) who are not currently Medicaid eligible, as allowed under the ACA. The Governor's budget document presents two options to expand Medi-Cal to these adults – a state-based approach and a county-based approach. In each case, the state is relying on the assumption that counties will achieve savings as a result of expanding eligibility for patients that are currently served by county indigent health programs. The Governor's budget anticipates utilizing these savings to offset state costs.

- **State-Based Approach.** Built upon the existing state-administered Medicaid program (called Medi-Cal in California) and managed care delivery system, the state would offer a standardized, statewide benefit package, excluding long-term care coverage.

  Under this option, the Administration would redirect existing 1991 health realignment funds to pay for new human services program responsibilities. The budget document specifically mentions subsidized child care; other options may include CalWORKs, CalFresh administration, child support, Supplemental Security Income (SSI), and In-Home Supportive Services (IHSS). The counties would fund those new responsibilities with savings resulting from the movement of indigent adults from county indigent health programs to Medi-Cal coverage.

- **County-Based Approach.** Under this option, the expansion would be built upon the existing Low Income Health Programs (LIHPs). Counties would maintain their current responsibilities for indigent health care services. Counties would need to meet statewide eligibility requirements and a statewide minimum package of health benefits consistent with benefits offered through Covered California. Counties could offer additional benefits, except for long-term care.

  Counties would act as the fiscal and operational entity responsible for the expansion and would build on their LIHPs as the basis for operating the expansion. Counties would be responsible for developing provider networks, setting rates (actuarial based or cost-based similar to the LIHP rates), and processing claims.

  The Administration still would like to engage counties in a discussion of savings and some diversion of 1991 health realignment funds under the county-based approach. Further, this option requires

federal approval and specified waivers. It is unclear if or when the federal government would consider a county-based approach for Medicaid expansion.

OVERARCHING COMMENTS

Remaining Responsibilities. Regardless of how the Medicaid expansion is implemented, counties will continue to have responsibilities to provide public health services and health services to indigent adults without private or public health care insurance coverage. The Administration's budget document makes it clear that counties will continue to provide public health services.

It is crucial for the health and welfare of all California residents that counties retain realignment funds to deliver public health and remaining indigent services.

Public Health. Under Health and Safety Code Section 101025, counties have a broad mandate to preserve and protect the public health of their communities. Traditional public health functions focus on the overall health of our communities in ways that are usually beyond the scope of health insurance, such as monitoring, investigating and containing communicable and food-borne disease outbreaks; planning for and responding to local disasters; ensuring our water supplies are safe; educating the public about emerging health risks and prevention measures and tracking the health status of our communities in order to develop community-based responses.

Indigent Health Care. Welfare and Institutions Code §17000 requires counties to provide health care to indigent adults. This law has been virtually unchanged since its inception in the 1930s. This Legislature has not expressed interest in making any changes.

Further, all counties will have indigent health responsibilities post-ACA implementation. In some counties, those obligations will decline but not disappear. In provider counties it is particularly difficult to predict the changes that will occur. Over 50 counties set their eligibility for indigent programs at 200% FPL or higher. The Medi-Cal expansion will cover adults up to 138% FPL. Additionally, not all residents are eligible for the Medi-Cal expansion, including legal immigrants who have been here less than five years and undocumented persons. Modeling suggests 3 to 4 million Californians will remain uninsured five years after implementation.

Adults with incomes between 138 and 400% FPL will be eligible for subsidized coverage through Covered California. However, unlike Medi-Cal, these adults will have limited windows to enroll in coverage. If an adult misses open enrollment, he or she will have to wait nine months for the next open enrollment period. In the meantime, that adult may qualify for a county indigent program.

Eligibility levels for county indigent programs generally take into account the costs of living in a particular county. Legal aid advocates have challenged counties on their income eligibility thresholds and prevailed. Issues under scrutiny include how income is calculated, including local cost of living, and to what degree the county should share in health costs for indigent adults. Changing eligibility thresholds proves to be difficult and will likely lead to legal challenges.

Additionally, counties may experience higher costs associated with the remaining uninsured population. For example, the remaining uninsured may utilize emergency services more frequently due to the nature of coverage available to this population.

Provider counties – those operating hospitals and clinics – are critical components of the health care system and must be maintained to ensure access as more Californians obtain health coverage. Today, county providers serve primarily uninsured individuals and Medi-Cal recipients. County hospitals also provide crucial community benefits, such as burn and trauma care and medical education training. For example, in San Bernardino, the county hospital provides 50% of trauma care in that county; 100% of burn care for Inyo, Mono, and San Bernardino counties; and graduates 70 physicians per year from resident training programs.

Stanislaus County – a clinic provider county – operates six primary care clinics and one specialty care clinic and is an essential provider in the county. The county also trains 12 family physicians a year, one-third of who stay in the San Joaquin Valley after the residency program.

For provider counties, particularly those with public hospitals, it is difficult to predict how patients will behave – how quickly they obtain coverage and whether once insured they continue to get care through county hospital and health systems. Additionally, we do not know today what the payment rates will be for services provided in county hospitals to the newly insured (Medi-Cal and Covered California). Both the patient mix and rates are key factors for a county hospital to determine whether the county hospital remains viable.

Additionally, federal funds for county hospitals are slated to decline – both Disproportionate Share Hospital funds and Safety Net Care Pool funds in the current Section 1115 Medicaid waiver. Counties with public hospitals will continue to care for the residually uninsured with declining federal funds; it is not clear that the ACA expansion will produce net savings to counties.

Fiscal Issues. Counties will have costs, like the state, associated with the mandatory changes to the Medi-Cal program. Counties pay the non-federal costs for specialty mental health services (mental health managed care carve out), Drug Medi-Cal, and fee-for-service inpatient days in county hospitals. Counties are estimating that the mental health costs associated with existing Medi-Cal eligibles who are not currently enrolled, but who obtain coverage due to mandatory enrollment changes and the so called "woodwork effect," will be $20 -$40 million annually.

Health realignment has grown modestly over the last 20 years ($400 million on a $941 million base), in part due to the inverse relationship between revenues that grow in a healthy economy and services that grow during economic downturns. The revenues in 2011-12 are the same as they were in 2000-01. Revenue growth has been modest in part because of the interaction with the caseload growth in the social services account – and the lack of general growth available. Additionally, Vehicle License Fees have declined 25% since 2006-07 and are recovering slowly.

The state historically utilized some federal Medicaid reimbursements to counties to cover state costs and this practice continues under the current Medicaid waiver. In light of this practice, counties are concerned about ensuring predictable and stable revenues and reimbursements and may not be able to nimbly adapt to funding changes that the state may impose.

Lastly, there is the question of timing and cash flow. It is difficult to proceed with a fiscal transaction in the middle of the fiscal year. Exchanging revenues or taking on new programs mid-year may destabilize existing services. For example, declines in 1991 health realignment funds have been budgeted for LIHPs in 2013-14. Changes to 1991 health realignment funds through 2013-14 will significantly disrupt current year services and programs. Additionally, counties pay provider claims up to six months after the date of service. Therefore, counties will need revenues to pay "tail claims" on the LIHP programs and indigent programs through at least June 2014 for those who transition into new coverage programs. Also, there is still no established mechanism to claim the administrative costs for the current LIHPs. Counties have been covering the administrative costs since the inception of the LIHPs.

Mental Health and Substance Use Disorder Issues. To date the federal government has not provided detail on mental health and substance use disorder parity within the Medi-Cal expansion, particularly in regards to compliance enforcement, specific benefits, discrimination standards and benchmark supplementation. Under either the state or county option, these details are important. Counties and the state need to know what the mental health and substance use disorder benefits will be in the expansion, the service delivery model, and projected acuity levels of the Medi-Cal expansion population.

Currently, California offers limited substance use disorder treatment services through the Drug Medi-Cal program. Most of the Drug Medi-Cal expenditures are for methadone services. Drug Medi-Cal does not cover a number of evidence based treatments, such as contingency management, continuing care and case management. Additionally, Drug Medi-Cal does not cover many residential and inpatient services or any alcohol treatment. It is unclear that the existing Drug Medi-Cal program will meet federal parity requirements and whether the state is contemplating changes to benefits for the Medi-Cal expansion.

Please recall that counties provide the entire non-federal match for both Drug Medi-Cal and mental health managed care benefits. To the extent that existing but not enrolled Medi-Cal eligible obtain behavioral health services through either carve out, counties will incur costs. Under Proposition 30, the counties are provided constitutional protections against new state legislation and federal law changes that increase costs.

Additionally, many of the childless adults who will obtain Medi-Cal coverage may have significant need for mental health and substance use disorder treatment services. For example, CMSP reports that behavioral health needs (both mental health and substance use disorders) drove $70 million in costs in 2004. Thirty percent of all drug formulary expenditures during that time period were on antipsychotic medications. Expanding the Medi-Cal system's capacity to deliver mental health and substance use disorder treatment should be a high priority heading into 2014.

According to the significant research in the behavioral health area, the vast majority of savings related to better coordination and integration of mental health and substance use disorder services with primary care are realized on the primary care side – in terms of reduced costs and improved health outcomes. In order for care coordination initiatives to be successful, it is imperative that this dynamic be recognized through shared savings arrangements between health plans and county mental health plans. Further exploration in the areas of incentive payments and shared savings pools is critical to support strong care coordination between systems.

Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings. The aim of the ACA is to ultimately reduce the cost of health care delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

Formal mechanisms to coordinate emergency and outpatient behavioral health coverage with managed care organizations are needed to assure that beneficiary risk and services costs are efficiently managed by both sectors.

THINKING THROUGH THE STATE OPTION

Counties have identified a number of benefits to a state administered Medi-Cal program, including economies of scale, better success at maintaining broad networks, and ability to ensure consistency statewide. We also note that all state and county ACA implementation efforts have rested upon the assumption of a state-based Medicaid expansion. With less than 10 months to go before ACA implementation, changing course from the known state-based model may cause significant challenges for consumers, providers and health plans.

Further, the state is well positioned to ensure statewideness and uniformity of programs and services under federal Medicaid requirements. For example, under the county-run LIHPs there is variation of services for mental health and substance use disorder treatment services (please recall that LIHPs were allowed to offer non-parity compliant mental health services, and offered substance use disorder treatment at their option because the federal government did not require any such services in the LIHP).

Under the state option, counties are pleased to continue the existing partnership in regards to determining Medi-Cal eligibility at the local level.

Program Realignment. The proposed program realignment portion of the state option presents a number of challenges for counties, many of which are outlined in the financial considerations section of this document. In 1991 and 2011 realignments, the state attempted to match revenues – and how those revenues would grow – with programs. In some cases, the state realigned programs that allowed counties significant flexibility to design programs – which helps counties manage when revenues change. In other cases, counties assumed fixed shares of costs or entire shares of cost for inflexible federal programs. The 1991 and 2011 realignments taught the counties that predicting and matching revenues with programs is difficult. However, it is significantly easier than projecting savings to programs and then trying to match those savings with new service responsibilities (as currently contemplated in the state option).

Because there are so many unknowns with how ACA implementation will impact individual counties – and how and when savings will occur – it suggests the need for flexibility and nimbleness. Locking in a new permanent set of programs through a realignment while the ACA is still being implemented appears to be a complex challenge. Moreover, both the state and counties are legitimately concerned about future risk.

The Governor's budget document specifically contemplates subsidized child care programs as an example of a program suitable for realignment. There are number of issues with the program that make it a very risky program for counties:

1. Recent budget cuts to child care programs have been significant, eroding the ability of the programs to meet the need for services:

- Based on the 2013-14 Governor's Budget proposal, funding for all child care (both CalWORKs and non-CalWORKs) will have been cut by about $947 million in total funds since 2008-09, a 31 percent reduction.
- The funding cut described above will result in the loss of over 98,000 child care slots since 2008-09, a 23 percent reduction.

2. High unmet demand for services puts pressure on programs to expand:
   - Recent funding cuts to child care programs were not precipitated by lack of demand or need for services; rather they were in response to the state's dire budget situation. Furthermore, as the state's economy improves and more people are able to find jobs, the need and demand for child care will increase.
   - Statewide, the availability of licensed child care meets the demand for only about 25 percent of children with parents in the labor force. County-by-county, availability ranges from 15 percent to 78 percent.
   - The number of child care slots overestimates the actual quantity of child care that is available due to shortages of qualified staff and other issues.
   - The waiting list for child care as of April 2011 was 200,000 children.

3. Cost drivers exist in current state statute with unknown fiscal implications:
   - Funding for CalWORKs child care is at an historic low due to previous statutory changes that exempted a number of clients from work participation requirements (therefore those clients did not need child care). Those statutory exemptions expired in January 2013, and the need for child care will dramatically increase as previously exempted clients are reengaged in work activities.
   - There were also significant programmatic changes enacted to CalWORKs in 2012-13 that are just beginning to be implemented that will require the availability of more child care for CalWORKs recipients. The ultimate need is currently unknown, but will likely be much greater than is currently proposed to be funded in 2013-14.

4. Prospect of collective bargaining and the demand for wage increases will increase costs:
   - Child care workers' average annual salary is less than $25,000.
   - Setting aside any potential implications of an organized child care workforce on quantity, quality, and availability of child care, the establishment of collective bargaining will put significant upward pressure on wages and overall costs of the program.

5. Administration of child care programs is bifurcated and complex
   - Two different state departments currently administer and oversee a complex local system of child care programs. There are different regulations between the two departments and for the various programs, different eligibility requirements, different terms and conditions for payment, excessive paperwork and reporting requirements, as well as complex contract requirements and funding from dozens of federal, state, local, and private sources.

- There would need to be major simplification of the administration of the child care system before counties could viably assume responsibility for such programs; yet there are vested interests within the child care system that make simplification politically extremely difficult to achieve.

6. Likelihood of meaningful local control over child care programs slim:
   - The provision of child care generally and the specific question of which governmental entity administers child care programs is politically extremely sensitive.
   - Notwithstanding the assertion that child care is not an entitlement, given the demand for services and the priority placed on child care programs by many interest groups, some counties will find it difficult to reduce programs or services even if adequate funding not available.
   - There is also significant Legislative interest in child care programs, which will likely result in continued legislation in this area. Given this interest, it is also not clear that counties would be allowed to retain local flexibility in prioritizing services or setting rates as contemplated by the Administration if realigned.

The modest growth in the revenues within the 1991 health realignment subaccount suggests that child care demand would outstrip resources over the long term. Furthermore, the legislative interest in child care programs would suggest that changes at the state level will be very difficult. Constitutional protections appear to be the only remedy to protect against future state law changes, such as collective bargaining.

THINKING THROUGH THE COUNTY OPTION

As the Administration's budget document presented the county option, it is an all or nothing proposal, meaning all 58 counties must proceed with the Medi-Cal expansion via a LIHP. Currently, five counties do not operate or plan to operate a LIHP – Fresno, Merced, San Luis Obispo, Santa Barbara, and Stanislaus. Given the significant time it takes to start a LIHP – upwards of 12 months to establish a network of provider, erect billing systems, and ensure adequate cash flow to provide services – it appears that the county option would extremely difficult to implement on a statewide basis by January 2014. Additionally, nine LIHPs, representing a total of 43 counties, currently have eligibility levels below 133% FPL and would need to be significantly expanded to meet the higher income threshold.

The budget does has not address how to start LIHPs in those five counties or to assure that all the existing LIHPs are brought up to the higher income and network capacity requirements. The Administration acknowledges that they cannot require a county to start or to continue to operate a LIHP. State officials suggest that other counties could partner and operate the LIHP in counties that decline to either start or continue to operate a LIHP. However, for one county to operate a LIHP for another county, there would likely need to be significant protections for the host county. It is unclear whether a host county will contribute capacity to create another county's LIHP at the same time the host county would be focused on expanding its LIHP to 138% FPL.

Administrative Issues. Counties with existing LIHPs identify a number of concerns about their ability to expand and sustain their LIHPs.

- Smaller and medium sized counties indicate that they have limited resources and capacity to dedicate to network development, compliance and regulatory oversight. These matters are complex and require expertise and infrastructure, neither of which smaller and medium size counties possess – particularly if they do not operate hospitals or clinics. This includes the counties that participate in CMSP.
- The infrastructure to develop and negotiate numerous contracts with vendors, hospitals, and out-of-network providers, and develop an appropriate rate structure will be a challenge.
- Creating upwards of 20 systems across the state to manage claims payments, administration and oversight is duplicative.
- Urban counties indicate that the network expansion would necessitate the creation of billing systems. For a an urban county building a billing system for a comprehensive provider and specialty care network will take significant resources and is a long-term information technology (IT) investment. Using Los Angeles County as an example, the IT system required would need to include managed care functions that can handle benefits, claims, hospital and ancillary contracts, enrollment and eligibility functions as well as member services, provider network and utilization management modules. Based on a typical county procurement process, it will take over a year to develop, solicit and review bids, significant time to negotiate the contract and

then well-over six months to customize, install and train staff. The system will easily cost around $10-15 million for Los Angeles County; this cost does not include the significant administrative infrastructure to operate the system and program at a county level. The costs for such an endeavor would likely be subject to the 50/50 federal match.

- Even urban counties have diverse issues. For example, urban counties have rural areas. In San Bernardino, portions of the county remain fee-for-service within the Medi-Cal system. This diversity makes it difficult to manage programs.
- Only a very limited number of hospital counties, mostly urban, believe they can meet the administrative and network obligations by January 2014.

Network Obligations. Counties – rural, urban and suburban – report numerous difficulties in developing contracts and service agreements for primary and specialty health care services for their LIHPs.

The current LIHP provider base is not adequate to provide timely access to the new, substantially larger Medi-Cal expansion population. Expanding LIHPs from 100% FPL to 138% FPL would double or triple the size of the LIHPs in some counties. For example, San Joaquin estimates the number of LIHP enrollees could increase tenfold. Path to Health (CMSP's LIHP) would need to accommodate an additional 100,000 enrollees. Counties are not prepared to manage contracts, billing systems, and claims processes while maintaining adequate networks at the expansion levels.

For example, San Joaquin Valley counties and CMSP counties point to a shortage of physicians in their regions that makes it unlikely to meet network adequacy standards and be compliant with federal requirements – thus the county option exposes these and other counties to new legal risks. Please recall that three of the five counties that did not create LIHPs are in the San Joaquin Valley – and Tulare is one of the last counties to implement a LIHP. Many medical specialties are not evenly distributed throughout the state. In San Joaquin County, with a population of almost 700,000, there are two neurosurgeons in the entire county. Dermatologists, orthopedists, ENTs, allergists, and psychiatrists are in short supply in San Joaquin.

Having an inadequate provider network (i.e. specialists) increases the cost of providing services. Merced County recently sent a client in their indigent adult program to UC Davis hospital for treatment not provided by the local hospital. UC Davis was ready to release the patient, but only after arrangements for home infusion services were secured. The only provider of these services within Merced County refused to accept county indigent clients. The difficulty in securing this service extended the patient's stay in the hospital for almost a week until an agreement could be reached between the local provider and the county. The extended stay resulted in significant increases to the county's medical care costs.

Specialist shortages are pervasive statewide. For example, San Diego County reports ongoing challenges with shortages of specialists in orthopedics, pain management, neurosurgery and urology in their LIHP.

The LIHPs need patient volume to attract and retain providers, particularly specialists. This is challenging in smaller and medium sized counties and the rural areas of urban counties. Even under a Medicaid

expansion, individual counties will face significant challenges in building and maintaining provider networks. Counties have no leverage with providers, hospitals or ancillary services to join their networks or accept certain rates. Counties cannot bring any other "book of business" to the table to offset the rates likely to accompany a Medi-Cal contract.

The best opportunity for effective contract negotiation and provider network development will occur with the greatest number of covered individuals. Rural and county plans with smaller covered populations will be uniquely vulnerable to having insufficient market clout to develop provider networks and favorable rate agreements.

Health Issues Span Counties. Health care utilization crosses county borders; provider networks will need to span multiple counties, which increase the administrative requirements and issues for counties.

Regional consistency is also important, particularly for benefits. Since LIHPs continue to offer different services, benefit consistency would be best accomplished with the state option.

State, federal and legal risks.

- Counties lack administrative control; the federal and state governments will set the rules.
- Counties have no ability to negotiate with the federal government.
- The current rate of Medi-Cal growth exceeds most revenue sources available to counties. Further, a Medi-Cal share of cost is a long term financial risk. Non-hospital counties are particularly concerned about taking on a share of cost of the Medi-Cal program.
- Although the Legislature could devise "poison pill" provisions for the Medi-Cal expansion related to federal cost sharing, future legislatures would still retain the ability to change state law.

Issues with the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). There have been a number of implementation issues with the existing LIHPs that are cause for concern among counties during expansion discussions.

DHCS and CMS continued to negotiate on details of the LIHPs even after implementation was underway in many counties. For example, counties committed to participate in the LIHP – full implementation was underway in some counties – before CMS decided to require that HIV positive individuals enrolled in the Ryan White program be covered by LIHPs, which resulted in significant cost increases for several LIHPs. The predecessor to the LIHP – the Coverage Initiative – did not require coverage of Ryan White/HIV positive individuals; thus, this was an unanticipated new cost. Orange County is projecting to spend $8 million in the current year on HIV medications, which is 31% of the LIHP pharmacy expenditure this year. Three hundred clients transitioned from Ryan White to the Orange LIHP. To date, San Diego has incurred $8.6 million in current year expenditures on medical and pharmacy costs associated with Ryan White clients.

The existing LIHPs are required by CMS to contract with at least one Federally Qualified Health Center and pay PPS rates. In some counties the PPS rate is three times higher than non-FQHC payments,

making LIHP costs high. It is unclear whether under the county option, LIHPs would now be required to contract with all FQHCs, consistent with federal Medicaid law.

DHCS has been slow to provide guidance and directions to counties; it has been unable to produce claiming protocols and claims payment within a reasonable timeframe. Please recall that some of the LIHPs have been operational since July 2011 and still cannot claim for administrative costs back to that date. For example, Orange County is owed approximately $7 million in administrative claims, covering both the original Coverage Initiative and LIHP. San Diego is owed approximately $8.6 million since October 2011. The inability for counties to be reimbursed for the LIHP administrative costs has affected cash flow within counties. In turn, some counties were forced to slow payments to providers, and some providers responded by threatening to turn away LIHP clients.

Counties are very concerned that the above DHCS administrative issues associated with the LIHP will plague an expansion and put counties at further risk, particularly if counties have to make large investments in administrative activities – like billing systems.

Counties also have questions about the CMS approval process for the county option.

- How long will it take CMS to approve?
- Will it be like LIHP with rule changes occurring during implementation?
- Will CMS waive the requirement that a statewide expansion occur all on the same day? This seems contrary to the federal guidance issued on December 10, 2012.
- Will CMS waive out-of-network emergency and post-stabilization services, including the payment rate at 100%? While the LIHPs are reimbursing at 30%, it seems unlikely CMS would allow the full Medi-Cal expansion at such a rate.
- Will CMS waive standard FQHC contracting and payment requirements? This also seems unlikely given political pressure at the federal level.
- Will CMS approve a waiver for network adequacy, including the use of limited networks and alternative time/access standards? This seems politically difficult. The existing LIHP requirements increase the network adequacy requirements over time. Additionally, federal alternative time and access standards do not take into account issues in rural California. The LIHP requirements are exceedingly difficult for CMSP to meet.
- Will CMS continue to allow LIHPs' standards for hearing and appeals? This also seems like a difficult proposal for CMS to approve.

Cash Flow. Counties have experienced significant cash flow issues with the administrative claiming of the LIHPs. Under federal rules, Medicaid programs first must incur costs and then claim for them before receiving reimbursement. Under the county option, counties will incur 100% of the Medi-Cal expansion costs, submit claims to the state, the state will submit claims to CMS. Once federal approval is received, the state will reimburse counties. This process could take months – or years (as with the administrative cost of the LIHPs). Counties need to be able to plan for cash flow and be assured of full reimbursement for costs and services. Also, will counties be fronting hundreds of

millions of dollars in the first year of the county option? Given the challenge of cash flow within the LIHPs and at the county level generally, this scenario is infeasible.

Continuity of Care. Under the county option, continuity of health plans between Medi-Cal and Covered California may be a significant challenge as most LIHPs are not run through existing Medi-Cal managed care plans.

Further, children have better access to health care if parents and children have the same coverage plan. Under the county option children may have a Medi-Cal managed care plan and their parents may have coverage through a LIHP. The county option will likely lead to coverage gaps within families. The county option could also result in unnecessary confusion and decreased compliance as individual and families attempt to navigate multiple fragmented programs resulting in negative health outcomes, increased costs and avoidable suffering.

OTHER FINANCIAL CONSIDERATIONS

The fundamental premise of the Governor's budget proposals to implement the mandatory and optional Medi-Cal expansions is that counties will achieve savings associated with the movement of a certain portion of the indigent population (i.e. those that receive health services from the county via programs for the medically indigent or Welfare and Institutions Code §17000) to the newly expanded Medi-Cal program. There are other financial considerations for the counties that inform our analysis of the state versus county options.

Counties review these options under the existing constitutional and statutory frameworks of 1991 realignment, Proposition 1A, Proposition 22, and 2011 realignment, all of which will serve to inform our response.

Constitutional Mandate Protections (Proposition 1A). Proposition 1A (2004) prohibits the state from transferring complete or partial financial responsibility for a required program for which the state previously had complete or partial financial responsibility. Under either the state or county option, the Medi-Cal expansion represents a transfer of complete or partial financial responsibility: under the county option, the newly expanded Medi-Cal population and under the state option, a new share of cost and/or programmatic responsibility for human services programs. In both options, the Administration assumes utilizing 1991 realignment funds to avoid a successful mandate claim. This creates complexities for achieving a transfer of responsibility without running afoul of the provisions of Proposition 1A.

First, federal government is still issuing regulatory direction about the implementation of the Medi-Cal expansion. This creates significant challenges to estimating the cost of the expansion and the resultant savings to counties on a statewide basis. This challenge is magnified when considering the county-by-county obligations associated with either option: because counties provide indigent health care services in a variety of ways, savings associated with the expansion are variable, as will be costs associated with the expansion or with a share of cost of a new human services program. Therefore, there is great uncertainty regarding timing/extent of county savings.

Second, 1991 realignment includes a so-called "poison pill" that statutorily unwinds the revenues directed to 1991 realignment upon a successful mandate claim. At that time, there was an abiding mutual interest in achieving and sustaining the revenue and responsibility transfer associated with realignment. Given the scope of the Medi-Cal expansion and uncertainty involved in its effectuation, counties are concerned about the efficacy of the 1991 poison pill; simply put, we anticipate that there may not be the same interest in avoiding a successful mandate claim under the county option for expansion or with a new share of cost/new programmatic responsibility under the state option.

Third, Proposition 22 limits the state's ability to utilize VLF revenues for mandated programs. This constitutional provision underscores our concern about counties' willingness to avoid mandate claims.

Lessons Learned from 1991 and 2011 Realignments. Counties' concerns with the Medi-Cal expansion are informed by lessons learned from both 1991 and 2011 realignments. Primarily, the constitutional protections contained in Proposition 30 guide our response to the Administration's proposals for Medi-Cal expansion.

First, counties should be wary of relying on existing resources to fund realigned programs without a limitation on the ability of the state to change realigned programs and impose costs. The same goes for federal law changes and changes imposed by the courts. This concept is particularly critical in 2013 under the county option, as the federal government has yet to release the full regulatory scheme for the expansion.

In 1991-92, the state provided $941 million for health programs (public health, indigent health, etc.) as part of the 1991 realignment. In 2011-12, those revenues produced $1.3 billion for the health subaccount. Health funds have grown $400 million over 20 years. The modest growth in the revenues make it difficult to foresee how the revenues will match new program responsibilities for Medi-Cal or human services – not to mention how the programs may change over time due to state or federal law changes or court decisions.

Second, 1991 realignment funds serve as the primary funding source for indigent health care. After the expansion, most, if not all, counties will continue to have ongoing obligations for the indigent population, as well as ongoing local public health obligations. Further, those counties with physical infrastructure must continue to maintain the viability of those systems.

Third, 1991 and 2011 realignment have resulted in inter-county equity concerns that will add to the complexity of achieving changes to the financing of indigent health care.

Remaining issues:

Timing. A county's obligation to arrange and pay for indigent health care for county residents will gradually decline as Medi-Cal and Covered California enrollment uptake occurs. Counties will be responsible for payment of all outstanding indigent health care claims submitted by contracted providers for services delivered to covered county residents. Thus, the savings to a county are related to the efficiency and stability of the Medi-Cal expansion and the Covered California enrollment process and the timing of payments to providers. Key questions must be addressed: when are these indigent health savings actually experienced at the county level? How efficiently will the transfer of health care coverage responsibilities occur? When should transfers of responsibilities occur? How will this transfer of financial obligations be phased in?

Savings. How to estimate county savings (statewide and by county)? What is an appropriate proxy for savings? How should savings be redirected?

Counties approach these questions with a focus on maintaining sufficient funding for existing obligations, avoiding mandates, and ensuring protections from future changes that increase costs.

CONCLUSION

Based on the analysis presented in this document and conversation with our members, it is clear that counties continue to have significant concerns regarding the implementation of the Affordable Care Act in a timely and sustainable manner. County concerns include:

- Residual responsibilities for health services. All counties will have remaining responsibilities for public health and indigent adults. It is crucial for the health and welfare of all California residents that counties retain sufficient realignment funds to deliver public health and remaining indigent services. To date, neither option provides assurances about how much 1991 health realignment will be available for local health purposes.

- Timing. Counties believe the county option is unlikely to ensure coverage for the Medi-Cal expansion on January 1, 2014. Significant technical, administrative and fiscal issues at the local level present very significant challenges to the timely implementation of the ACA.

- Program realignment. The realignment of additional programs to counties is a risky proposition. If counties are to take on new risks associated with new programs, counties may need constitutional protections from future actions of the state legislature, federal government, and courts. Additionally, counties need assurances that revenues will grow concurrently with program mandates and costs. Counties also believe that child care is a particularly difficult program for realignment.

Counties remain committed to working with the Administration and the Legislature to implement the Affordable Care Act and expand Medicaid coverage to millions of Californian on January 1, 2014.

APPENDIX A

COUNTY DELIVERY SYSTEMS

COUNTIES THAT OWN AND OPERATE HOSPITAL SYSTEMS (12)

Alameda	San Bernardino
Contra Costa	San Joaquin
Kern	San Francisco
Los Angeles	San Mateo
Monterey	Santa Clara
Riverside	Ventura

Note: All of these counties operate/plan to operate a Low Income Health Program (LIHP). San Joaquin and Monterey have limited LIHP enrollment.

COUNTY MEDICAL SERVICES PROGRAM (35) – The County Medical Services Program (CMSP) provides health coverage for low-income, indigent adults in 35, primarily rural California counties. The CMSP Governing Board , established by California law in 1995, is charged with overall program and fiscal responsibility for the program.

Alpine	Lake	Shasta
Amador	Lassen	Sierra
Butte	Madera	Siskiyou
Calaveras	Marin	Solano
Colusa	Mariposa	Sonoma
Del Norte	Mendocino	Sutter
El Dorado	Modoc	Tehama
Glenn	Mono	Trinity
Humboldt	Napa	Tuolumne
Imperial	Nevada	Yolo**
Inyo	Plumas	Yuba
Kings	San Benito	

*Note: CMSP operates one LIHP on behalf of these 35 counties.**Yolo joined CMSP in July 2012 and has a different financial arrangement than the other 34 counties.*

NON-CMSP, NON-HOSPITAL COUNTIES (11)

Contract-only counties	**Counties that operate a clinic(s)**
Fresno	Placer*
Merced	Sacramento*
Orange*	Santa Barbara
San Diego*	Santa Cruz*
San Luis Obispo	Stanislaus
	Tulare*

**Operate or are planning to operate a LIHP.*

APPENDIX B

COUNTY INDIGENT CARE ELIGIBILITY AND LIHP ELIGIBILITY

NON-CMSP COUNTIES (23)

COUNTY	Indigent FPL	LIHP FPL
Alameda	200	200
Contra Costa	200	200
Kern	200	100
Fresno*	114	
Los Angeles	133	133
Merced	100	
Monterey	250	100
Orange	200	200
Placer	100	100
Riverside	200	133
Sacramento**	67	67
San Bernardino	200	100
San Diego*	165	133
San Francisco	500	25
San Joaquin	200	80
San Luis Obispo	250	
San Mateo	200	133
Santa Barbara	200	
Santa Clara	200	133
Santa Cruz	100	100
Stanislaus	223	
Tulare	275	75
Ventura	200	200

* Under specified circumstances certain individuals with higher incomes may qualify for services with a share of cost.

**Mirrors Medi-Cal. Share-of-cost is required for income over the Medically Needy Level. This begins at 68% FPL.

CMSP COUNTIES (35)

COUNTY	Indigent FPL	LIHP FPL
Alpine	200	100
Amador	200	100
Butte	200	100
Calaveras	200	100
Colusa	200	100
Del Norte	200	100
El Dorado	200	100
Glenn	200	100
Humboldt	200	100
Imperial	200	100
Inyo	200	100
Kings	200	100
Lake	200	100
Lassen	200	100
Madera	200	100
Marin	200	100
Mariposa	200	100
Mendocino	200	100
Modoc	200	100
Mono	200	100
Napa	200	100
Nevada	200	100
Plumas	200	100
San Benito	200	100
Shasta	200	100
Sierra	200	100
Siskiyou	200	100
Solano	200	100
Sonoma	200	100
Sutter	200	100
Tehama	200	100
Trinity	200	100
Tuolumne	200	100
Yolo*	200	100
Yuba	200	100