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May 17, 2013

The Honorable Holly Mitchell
Chair, Assembly Budget Subcommittee No. 1
State Capitol, Room 2163
Sacramento, California 95814

Re: Budget Item 4260: Department of Health Care Services – Medi-Cal Expansion

Dear Assembly Member Mitchell:

The California State Association of Counties (CSAC) is writing to share our analysis of the Governor's May Revision proposal for implementing the Medi-Cal expansion.

Counties strongly support the goal of enrolling millions of uninsured Californians in Medi-Cal by January 1. We appreciate Governor Brown's continued commitment to timely implementation in California and his recognition that a state-based approach to Medi-Cal expansion is the correct course. Further, we appreciate that the Governor's May Revise acknowledged that the redistribution of funds should be based on actual savings generated by the Affordable Care Act (ACA) rather than an arbitrary number.

While the May Revision is an improvement over the January budget, counties have a number of outstanding concerns.

Administration's Formula for Determining Costs and Savings - Oppose

Overall, counties are supportive of developing a formula for determining state ACA costs and county costs and savings that is based on real data, However, CSAC is opposed to the formula presented by the Administration. First, the formula seeks would reach into all county revenues, not just 1991 health realignment funds. Second, the mechanism presented would begin taking health realignment revenue in 2013-14, before the ACA is implemented and before any evidence of county savings is produced. Third, beginning in 2014-15 and thereafter, the formula provides a mechanism for the state to annually withhold all health realignment funding and leave counties with little if any resources for provision of health care services to the remaining uninsured and public health services.

The ACA is a transformational change to the health care system and many unknowns remain, including how quickly people will enroll in Medi-Cal and Covered California, whether the Covered California products are affordable, how many people continue to access county indigent programs, how many people remain uninsured, and how many people continue to access county hospital and clinic systems. Due to the large number of unknowns, a data-based formula is both reasonable and appropriate. Unfortunately, the manner in which the Administration has constructed the formula provides a recipe for taking all county health realignment funding. The formula does not adequately recognize ongoing indigent health and public health responsibilities counties will have post ACA.

As described in the May Revision, the Administration's formula appears focused on assumptions related to only hospital counties. CSAC only supports a solution that works for all 58 counties, including counties that contract for services, counties that operate

clinics but not hospitals, and rural counties in the County Medical Services Program (CMSP). CSAC is committed to working with the Legislature and Administration to develop a formula that is fair and responsible for all counties and the state.

Only the State Benefits from County Savings

Under the Administration's proposal, only the state would benefit from county savings. County health care systems would not share in any savings resulting from health care reform in any manner. Counties believe the state must recognize the ACA's goal of improving health care outcomes. Therefore, counties advocate that it is essential that certain of these savings be reinvested in the health care safety net, in public health and in behavioral health services that will improve delivery systems and outcomes, as well as, decreasing health care costs.

Evidence-based health interventions will assist the state with Medi-Cal affordability and sustainability. Counties support investing savings locally in:

- Public health, such as prevention, public health/primary care intersection, chronic disease prevention, communicable disease mandates, and addressing health disparities. Investments in prevention can help reduce overall health care costs, including Medi-Cal rates.
- Provider capacity. Investments in provider capacity, particularly in rural areas, would also help the Medi-Cal program in the long-term to maintain a robust pool of providers and decrease rate pressure.
- County hospital investments, such as health information technology and electronic medical records, expansion of primary care and outpatient care, including hiring more providers and expanding sites.
- Behavioral health investments, such as care coordination, crisis response, behavioral health/primary care integration, information technology and improving data reporting systems.

Timing and Size of Fiscal Transaction – Oppose

As described in the May Revision, the Administration is proposing to redirect 1991 county health realignment funds as follows:

- 2013-14: $300 million
- 2014-15: $900 million
- 2015-16: $1.3 billion

The Administration proposes a true-up process with the formula mentioned above to alter those projections in future years. Counties do not anticipate data being available to inform the formula before January 2015, at the earliest. That means the Administration will redirect $1.2 billion in county funds before there is sufficient data to support such a redirection. It is too much, too soon.

Counties oppose a redirection of any 1991 health realignment funds in 2013-14. There will be no data to support a transfer of that much money that early. It is vitally important to the health care system that county services – indigent programs, county hospitals, county

clinics, and community health, including public health – remain stable during the first years of ACA implementation.

If $1.2 billion is redirected in 2013-14 and 2014-15 and another $1.3 billion in 2015-16, counties will be forced to make cuts in safety net health care systems that will harm critical health infrastructure and community health. Californians will be impacted by such a large redirection of health funds.

Though the Administration affirms that public health is an ongoing county responsibility, the redirection within their May Revision document will cause great harm to 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. Compromising these services will compromise community health and will harm prevention efforts that reduce overall health care costs.

County Share of Cost for New Eligible – Drug Medi-Cal and Specialty Mental Health Services – Oppose

The Administration is proposing that counties pay the non-federal share of cost for services provided through the Drug Medi-Cal and Specialty Mental Health carve outs for the Medi-Cal expansion population. As part of 2011 Realignment, counties have 100 percent of the financial responsibility and risk for these programs for existing Medi-Cal eligibles. Concerned about future state law changes, counties negotiated provisions within Proposition 30 of 2012, to require the state to cover the costs of future law changes associated with these programs. Counties believe that the share of cost is a violation of the provisions of Proposition 30 and, therefore, unconstitutional.

Realignment of Human Services Programs – Oppose

The proposed program realignment of CalWORKs, CalWORKs child care, and CalFresh administration presents a number of insurmountable challenges, and counties remain opposed to additional programmatic realignment of state responsibilities.

There are a number of existing constitutional and statutory frameworks within 1991 realignment, Proposition 1A, Proposition 22, and 2011 realignment that make additional programmatic realignment complicated.

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. The Administration assumes utilizing 1991 realignment funds to fund additional human services at the county level to avoid a successful mandate claim. This creates

complexities for achieving a transfer of responsibility without running afoul of the provisions of Proposition 1A.

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 with a new share of cost/new programmatic responsibility under the state option.

Third, Proposition 22 limits the state's ability to utilize vehicle license fee (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 additional realignment are also 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 proposal.

First, counties are 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.

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 – not to mention how the realigned programs may change over time due to state or federal law changes or court decisions.

Realignment is Unworkable and Unnecessary. First, the way the Administration has proposed to effectuate realignment is contradictory and unworkable. The Administration has not provided detail about when and how the share of costs would be altered. The May Revision suggests the program realignment would go into effect in 2016-17. However, in subsequent comments, the Administration states it will use the true-up mechanism for eight to ten years. It is unclear how the true-up mechanism reconciles with a permanent fixed new share of cost for these human services programs.

Locking in a new permanent set of programs through realignment while the ACA is still being implemented is a complex challenge. The CalSIM model predicts take-up over a five year period – through 2019-20. It appears there will continue to be instability in 2016-17, making the realignment of a number of fixed human services programs impossible.

Further, it is unnecessary to include realignment of these programs to counties to make the Medi-Cal expansion work. The Legislative Analyst has suggested other approaches for a fiscal transaction to achieve General Fund savings.

Specific CalWORKs/CalFresh Concerns.

- The Administration is not proposing any flexibility in how CalWORKs is structured should it be realigned – the state will still set eligibility, rates, and grant levels. The realignment of state and federally-controlled programs leaves no room for local control over programs.
- The 1991 realignment revenue sources – sales tax and Vehicle License Fees – are countercyclical. The highest demand for CalWORKs and CalFresh services will be at the exact time that revenues are at their lowest. Additionally, the modest growth in the revenues within the 1991 health realignment subaccount suggests that CalWORKs, child care, and CalFresh demand would outstrip resources during downturns.
- In the May Revision document, the Administration says that the state will provide above-average costs during economic downturns. The state did not provide additional funding during the Great Recession. Additionally, such a promise would be statutory and therefore subject to change by future legislatures and governors.

Counties remain committed to successful implementation of the Medi-Cal expansion on January 1, 2014 and to ensuring the health of our communities. Counties will continue to work with the Legislature and Administration on the Medi-Cal expansion proposal to find a sustainable solution that does not harm the local safety net and access to care for all Californians.

Please do not hesitate to contact me if you have additional questions about our positions.

Sincerely,

Kelly Brooks-Lindsey
Senior Legislative Representative

cc: Assembly Speaker John A. Peréz
Members, Assembly Budget Subcommittee No. 1
Chris Woods, Chief Fiscal Advisor, Speaker Peréz
Christian Griffith, Budget Director, Assembly Budget
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