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Rethinking the State-Local Relationship: Health Care

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Summary

Federal health reform offers California an opportunity to transform its health care safety net system. Health care services for uninsured and low-income Californians are provided through a complex patchwork of programs, with responsibility shared among the federal, state, and local government. As many uninsured Californians become eligible for comprehensive health insurance through coverage expansions included in the Affordable Care Act (ACA), the state's current safety net structure comes into question. Other changes ushered in by the ACA—including standardized eligibility and enrollment processes, delivery system reforms, and shifts in financing—will also affect the system. Taken together, these reforms invite if not compel policymakers to revisit the long-standing division of responsibility between state and local governments in the financing, administration, and delivery of health services to the state's low income residents.

California's existing safety net is fragmented and varies considerably across counties. The policy changes advanced by the federal government in the ACA have the potential to improve health care services available to low-income Californians across the state. Several state-level implementation decisions will have important implications for the impact of ACA reform in California, particularly in relation to the roles and responsibilities of state and local governments.

Unlike California's realignment efforts in other areas, which have focused on shifting responsibilities from the state to the counties, the ACA could result in the state assuming responsibilities now borne by county government, such as coverage for low-income, uninsured adults through an expanded Medi-Cal program and certain aspects of the eligibility and enrollment process. State fiscal imperatives may well define this reconsideration, but many unknowns signal caution. Policymakers will need to consider a number of issues—including the scope of the ACA and the complexity of county indigent care financing—as they re-evaluate California's long-standing division of responsibilities between local and state government.

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Abbreviations

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIM	Access to Infants and Mothers
CalHEERS	California Healthcare Eligibility, Enrollment and Retention System
CCS	California Children's Services
CHDP	Child Health and Disability Program
CMS	Centers for Medicare and Medicaid Services
CMSP	County Medical Services Program
DHCS	Department of Health Care Services
DSH	Disproportionate Share Hospital
DSRIP	Delivery System Reform Incentive Pool
EWC	Every Woman Counts
FPL	Federal Poverty Level
FPACT	Family Planning, Access, Care, and Treatment
HFP	Healthy Families Program
LIHP	Low-Income Health Program
MAGI	Modified Adjusted Gross Income
MIA	Medically Indigent Adult
MISP	Medically Indigent Services Program
MOE	Maintenance of Effort
MN	Medically Needy
SAWS	Statewide Automated Welfare System
SCHIP	State Children's Health Insurance Program
SNAP	Supplemental Nutrition Assistance Program
SNCP	Safety Net Care Pool
TANF	Temporary Assistance to Needy Families

Introduction

Health care services for uninsured and low-income Californians currently are provided through a complex patchwork of programs, with responsibility shared among federal, state, and local governments. Depending on the program and population served, different levels of government play different roles in the financing, administration, and provision of coverage and care. The distribution of roles and responsibilities has varied over time, determined more by the evolving fiscal and policy considerations of state policymakers than by a guiding set of governance principles.

The federal Affordable Care Act (ACA) has the potential to dramatically change how health care to low-income populations is financed, administered, and delivered. The ACA contains various provisions intended to increase insurance coverage and reduce the number of uninsured. The two main provisions are the expansion of Medicaid —the public insurance program for low-income families and qualified adults—and the creation of state insurance exchanges with income-based federal subsidies.[1] In the California context, the ACA's sweeping reforms invite policymakers to reconsider state and county responsibilities for indigent health care. Indeed, the governor's proposed 2013–2014 budget requires this reconsideration by offering two alternative options for expanding Medi-Cal (California's Medicaid program)—a state-based approach and a county-based approach. The state-based approach would build upon the current state-run Medi-Cal program and the county-based approach would build upon existing county health programs.

The result of a state-based approach would shift responsibility for providing care to many low-income, uninsured adults from the counties to the state, which would be a departure from California's realignment efforts to date. The county-based approach, while consistent with increasing program responsibilities for local government, would represent a substantial undertaking for counties and introduce many unknowns. Regardless of the approach, ACA implementation will prompt an assessment of state and county responsibilities for financing and administering expanded Medi-Cal coverage as well as other functions that could shift from county government to the state including eligibility determination for public insurance programs. Policymakers will need to understand the provisions and implications of federal health reform as implementation moves forward in 2013 and takes effect in 2014.

The ACA offers California policymakers an opportunity to focus on promoting the efficient and effective administration and delivery of health care services. But state budget constraints could narrow the focus to financing new costs associated with implementation. The way state policymakers frame the issues will have important implications for how indigent care responsibilities are defined and what the health care safety net will look like after 2014.

To help inform these discussions, this report describes the current programs that serve the state's low-income and uninsured residents with a focus on the roles of state and local governments. It then outlines key provisions of the ACA and the changes they could bring to California's health care safety net programs. It next offers a detailed discussion of the implications of important ACA implementation decisions for the evolving role of state and local government in the provision of services to low-income residents. It concludes by cataloging important questions and decisions that can help guide policymakers as they grapple with ACA implementation in California.

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[1] Other provisions to increase insurance coverage include tax incentives to encourage small businesses to offer coverage to their employees and allowing young adults to stay on their parent's insurance until age 26. The other key component to coverage expansion is the requirement that most U.S. citizens and legal residents have health insurance, referred to as the individual mandate.

California's Health Care Safety Net Programs

Since its creation in 1966, Medi-Cal has been the primary public insurance program for low-income Californians. At one time, low-income, uninsured residents with no children or qualifying disability—known as medically indigent adults (MIAs)—were covered by Medi-Cal and jointly funded by state and county dollars. Changes to the county-state fiscal relationship following the passage of Proposition 13 and the recession of the early 1980s precipitated a restructuring of the Medi-Cal program in 1982. Responsibility for MIAs reverted to counties with a certain percentage of Medi-Cal spending going to counties to cover the costs.

This shift in responsibility for indigent care provision from the state to the counties prompted lawsuits with counties arguing that the shift in responsibility represented a reimbursable mandate. The state constitution requires that if state government mandates a local government to provide a new service or higher level of service that the state must provide reimbursement. Most counties, however, dropped their legal action in 1991, when the State again restructured the financing of county indigent care by allocating a certain portion of sales tax and vehicle license fees to fund health care, mental health, and social services provided by county governments. The 1991 restructuring and its associated financing, known as realignment, continue to provide the major source of state funding for county indigent care programs.[2]

The health care services currently available to low-income and uninsured residents in California are provided through a diverse, uncoordinated mix of programs with federal, state, and local governments all playing a role. Eligibility restrictions for comprehensive public insurance programs exclude many low-income, uninsured residents. As a result, more than seven million Californians currently lack health insurance. This section describes the patchwork of safety net programs and funding sources that provide coverage and services to California's low-income populations.

Medi-Cal and Healthy Families

The state operates two primary public insurance programs that offer comprehensive coverage to low-income Californians: Medi-Cal and Healthy Families. Medi-Cal, the most significant program, serves roughly eight million low-income Californians who meet income and categorical requirements related to age, disability, and family composition. Generally speaking, Medi-Cal's income eligibility requirements are 100 percent of the federal poverty level (FPL)—or $23,050 for a family of four.[3] In addition to the income requirement, adults must have either dependent children or a qualifying disability in order to enroll. California policymakers have adopted optional Medicaid categories to serve low-income individuals who otherwise would not be eligible for coverage. Some examples of optional coverage programs include the 1931(b) program and the medically needy (MN) program, both of which extend Medi-Cal coverage to people who would not be eligible based on categorical income level limits.[4] The state also finances full-scope Medi-Cal coverage for legal

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[2] For a more complete description of the history of medically indigent programs in California, see California HealthCare Foundation report "Caring for Medically Indigent Adults in California: A History."

[3] For children under age 1 and pregnant women eligibility is 185 percent of FPL, and for children age 1–5 eligibility is 133 percent. Other specific eligibility categories may have slightly different income eligibility requirements.

[4] The 1931(b) program enables low-income parents and caretakers to receive Medi-Cal benefits even if their income exceeds the eligibility threshold by allowing certain amounts and types of income, referred to as income disregards, to not be included in eligibility determinations thus reducing monthly income to qualifying levels. The Medically Needy (MN) program also extends Medi-Cal coverage to people whose income exceeds

immigrants who have resided in the United States for less than five years and are ineligible for federally supported services.

California's Healthy Families Program—its version of the State Children's Health Insurance Program (SCHIP)—provides comprehensive, low-cost coverage to nearly 900,000 children with family incomes below 250 percent of FPL, about $57,625 for a family of four, who are not eligible for Medi-Cal. The Healthy Families program requires families to contribute a small monthly amount for premiums and, in some cases, co-payments for services. Children covered under the Healthy Families program are in the process of transitioning to Medi-Cal over the next 12 months.[5]

Medi-Cal and Healthy Families are both state-federal programs for which the federal government provides at least half of the total financing in addition to legal and regulatory frameworks and program oversight. The state's standard funding responsibility is 50 percent for Medi-Cal and 33 percent for Healthy Families. It also ensures compliance with federal regulation, oversees services delivered through private and county-run managed care plans, determines the scope of benefits offered under optional categories, and sets reimbursement rates for providers.

County government is responsible for the administration of Medi-Cal and HFP, along with other public assistance programs such as CalWORKs (California's TANF program) and CalFresh (California's SNAP program). Eligibility determination and enrollment for these and other safety net programs is carried out by county welfare departments, which employ roughly 27,000 workers and utilize three information technology systems that comprise the Statewide Automated Welfare System (SAWS). A product, in part, of federal rules and requirements, the current Medi-Cal enrollment process requires a significant amount of paper documentation and relies on a face-to-face and mail-in approach. But many counties are working to take advantage of online technologies to simplify and improve the enrollment process. In fiscal year 2010–11, counties received roughly $1.3 billion in federal and state funds for Medi-Cal administration, which contributes a large share of the total administration costs for other public assistance programs including CalWORKs and CalFresh (Rosenstein et al. 2012).

State Limited-Benefit Programs

In addition to Medi-Cal and Healthy Families, the state administers a patchwork of programs that target particular population groups, most of which are tied to certain diseases or services (Table 1). These limited-benefit programs, also known as "state-only" programs, target specific populations (e.g., pregnant women are covered through the Access for Infants and Mothers program), services (e.g., the Family PACT program provides family planning services), and diseases (e.g., breast cancer screening is provided through the Every Woman Counts program). In most cases, limited-benefit programs serve low-income individuals who have no other insurance coverage. But there are a few programs that provide additional or "wrap-around" health care services to groups that are insured through Medi-Cal (e.g., California Children's Services provide specialized care for children with specific health conditions) or commercial coverage (e.g., persons with HIV/AIDS can get expanded medication coverage through the AIDS Drug Assistance Program).

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qualifying levels by allowing amounts spent on medical expenses to not be included in eligibility determinations. California policy allows these individuals to become Medi-Cal eligible with a monthly share of cost, something akin to a deductible.

[5] The shift of children from Healthy Families to Medi-Cal was part of the 2012–13 state budget agreement and is estimated to reduce state spending by $73 million annually once the transition is complete. The transition, which has been approved by the U.S. Centers for Medicare and Medicaid Services, will occur in four phases throughout 2013.

Services are financed principally by state and federal dollars, with the bulk of funding for many programs coming from the federal government. Some programs also receive funding from other sources, such as Proposition 99 (tobacco tax) revenue for AIM and Every Woman Counts. The California Children's Services (CCS) program also relies on county funding for the state-only and Healthy Families portions of the caseload.[6] Counties are responsible for providing important services—such as case management and clinical assessment—for a few of these programs, including Child Health Disability Prevention Program (CHDP) and CCS.

TABLE 1
State limited-benefit programs

Program	Target population	Individuals served	Funding source	Program expenditures (FY 2011–12)
Access for Infants and Mothers (AIM)	Low-income pregnant women (200–300% of FPL)	10,739	State General Fund; Federal Funds; Prop 99; Premiums	State: $57.5M Federal: $71.1M
California Children's Services (CCS)	Children with specific health conditions, family income less than $40,000 or medical costs more than 20% annual income	43,227	State General Fund; Federal Funds; County Funds	State: $25.9M Federal: $240M
Child Health and Disability Program (CHDP)	Low-income children, provides screenings and referrals to necessary services	45,178	State General Funds	State: $2.8 M
Family Planning Access Care and Treatment (Family PACT)	Low-income (less than 200% of FPL)with family planning needs	1,820,000	State General Funds; Federal Funds; Drug rebates	State: $141M Federal: $441M
Every Woman Counts Program (EWC)	Low-income women (less than 200% of FPL), provides screenings for breast and cervical cancer	319,000	State General Funds, Federal Funds (CDC); Prop 99 Funds, Breast Cancer Control Account	State: $5.7M Federal: $4.5M Other: $35M
AIDS Drug Assistance Program (ADAP)	Low-income individuals (less than $50,000 annual income) with AIDS/HIV positive, provides prescription drug coverage	40,988	State General Funds; Federal funds (Ryan White); ADAP special funds (drug rebates)	State: $4.7M Federal: $118.8M Other: $356.7M
Genetically Handicapped Persons Program	Adults with specific genetic disorders, enrollment fee based on income level	830	State General Fund; Federal Funds; enrollment fees	State: $21.1M Federal: $55.0M Other: $8.5M

SOURCES: California Department of Health Care Services, Family Health May 2012 Local Assistance Estimates (CCS, CHDP, GHPP). California Department of Public Health, Aids Drug Assistance Program (ADAP) May 2012 Estimate Package. California Department of Public Health, Every Women Counts May 2012 Estimate Package. UCSF Bixby Center for Global Reproductive Health, Family PACT Program Report, Fiscal Year 2010–2011.

NOTES: All enrollment totals and program expenditures are for FY 2011–12, unless otherwise noted. CCS program enrollment totals and program expenditures only include the State-only and HFP portions of the caseload, which constitute roughly 30 percent of total enrollment. The remaining 70 percent of CCS program enrollment is covered under the Medi-Cal program and those costs are not reflected in the expenditure totals included in the table. In addition, State general fund spending for CCS in FY 2011–12 was considerably lower than the appropriation due to the availability of funds from other sources such as the Safety Net Care Pool. The 2012–13 program allocation for General Fund spending on CCS is much higher at $68 million. CHDP enrollment and program expenditures only include the number of screenings and costs for the State-only portion of the program. Family PACT enrollment reflects FY 2010–11 clients served reported in UCSF Family PACT Program Report and program expenditures come from DHCS May 2012 Medi-Cal Estimate. For the EWC program, a unique caseload total is not available and so the enrollment total is based on a projection by the CDPH. For ADAP program expenditures, the state general fund expenditure reflects a $76.8M decrease from the Budget Act appropriation due to one-time funding available in FY 2011–12 from the DHCS Safety Net Care Pool fund. GHPP enrollment and program expenditures include only the State-only caseload—the remaining caseload (715 individuals) is covered under the Medi-Cal program.

[6] More than 70 percent of the CCS caseload is covered under the Medi-Cal program, with one study indicating that the CCS expenditures for children covered by Medi-Cal account for nearly 90 percent of total program spending. The State-only portion of the program (10% of caseload) provides coverage to children who are not eligible for either Medi-Cal or Healthy Families most often due to immigration status, and expenditures for this part of the caseload are disproportionately lower (Health Management Associates 2009).

County Indigent Care Programs

Counties play an important role in providing health care for low-income Californians through the operation of county indigent care programs. These programs serve uninsured adults who meet county-determined eligibility standards but are not eligible for Medi-Cal—most often because their incomes are too high, they are unauthorized immigrants, or they do not meet categorical eligibility requirements, such as having dependent children or a qualifying disability.[7] California Welfare and Institutions Code Section 17000,[8] enacted by the state legislature in 1933, established the statutory requirement that counties function as providers of last resort for their indigent populations and continues to be the legal framework governing county responsibility for providing health care to the medically indigent. Section 17000 allows counties latitude in serving the medically indigent, the result being that case law prescribes the boundaries of county responsibility relative to eligibility standards, cost-sharing, and covered benefits. As a result, there is significant variation across counties in the scope of services provided to the medically indigent.

The 24 largest counties in the state operate independent Medically Indigent Services Programs (MISPs). The remaining 34 counties provide indigent care services through the County Medical Services Program (CMSP), which contracts with a private vendor to administer the program. There is considerable variation among programs operated in MISP counties, reflecting different approaches taken by counties to fulfill their indigent care obligations. The CMSP, on the other hand, establishes standard eligibility requirements, benefit coverage, and provider networks for all participating counties.

Half of the counties that operate MISPs are referred to as provider counties because they operate public hospitals and outpatient clinics that provide the bulk of indigent care services.[9] These counties, with nearly two-thirds of the state's non-elderly, adult uninsured population, play an essential safety net role; their public hospitals provide nearly half of all hospital-based care to the state's uninsured population and they also serve many Medi-Cal beneficiaries as well as those covered by other public or private insurance (California Association of Public Hospitals 2011). In addition, public hospitals offer critical services—such as trauma and burn care—to all Californians. There are six counties (known as "payer" counties) that do not operate hospitals or clinics and instead contract with private providers—typically nonprofit hospitals and community clinics—to provide care to those eligible for the county indigent program.[10] About one in five non-elderly adults who are currently uninsured reside in payer counties. Another six counties (known as "hybrid" counties) operate public outpatient clinics but not public hospitals and so, like payer counties, must contract with private hospitals to provide inpatient care.

Table 2 summarizes the eligibility standards, covered benefits, and provider networks across the different types of county organizational structures. Provider counties generally offer more generous coverage than payer and hybrid counties—more inclusive income eligibility, fewer restrictions on basic medical services, and fewer restrictions based on immigration status. For example, one-third of provider counties have income eligibility cutoffs above 300 percent of FPL and two-thirds offer full services to unauthorized

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[7] Counties are able to determine the income thresholds and other eligibility requirements, such as immigration status and asset tests, to be eligible for services under county indigent care programs. As a result, not all uninsured are eligible for county indigent care programs. Unauthorized immigrants are eligible for limited services under the Medi-Cal program including emergency-only services and pregnancy-related services.

[8] Section 17000 reads, in part, "Every county… shall relieve and support all incompetent, poor indigent persons … lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

[9] Los Angeles County operates outpatient clinics, but also contracts with several non-county health clinics through the Public-Private Partnership (PPP) program to provide additional capacity to care for the large population of the medically indigent in the county.

[10] Hospitals operated by the University of California are also considered public hospitals. Three UC hospitals—UC Irvine, UC San Diego, and UC Davis—operate in counties that are not designated as provider counties. Orange and San Diego are payer counties, while Sacramento is classified as a hybrid county.

immigrants. In comparison, none of the payer or hybrid counties provides services to those over 300 percent of FPL and only two cover unauthorized immigrants.

TABLE 2
County indigent care programs

	Medically indigent services programs			County medical services programs
	Provider counties	Payer counties	Hybrid counties	
Number of counties	12 counties	5 counties	6 counties	35 counties
% of California uninsured adults	64	20	8	8
County program descriptions				
Income requirement				
Up to 100% of FPL	0	1	2	–
Up to 200% of FPL	5	2	3	35
Up to 300% of FPL	3	2	1	–
Above 300% of FPL	4	0	0	–
Services for unauthorized immigrants				
None	4	4	5	–
Emergency only	0	0	1	35
Full services	8	1	0	–
Ages served				
All ages	5	0	1	–
Adults, 19–64	3	0	0	–
Adults, 21–64	4	5	5	35
Covered services				
Limited inpatient/outpatient	3	2	5	–
No limits on basic medical services	9	3	1	35

SOURCES: CHCF County Indigent Care Profiles, October 2009; U.S. Census Bureau, American Community Survey, 2011, 3-year estimates.

NOTES: Provider counties include Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura. Payer counties include Fresno, Merced, Orange, San Diego, and San Luis Obispo. Hybrid counties include Placer, Sacramento, Santa Barbara, Santa Cruz, Stanislaus, and Tulare. Covered Services refers to county indigent care programs in operation prior to the creation of county Low-Income Health Programs, which must meet certain requirements on medical services provided and thus do not limit inpatient or outpatient services. Percent of uninsured adults by counties is based on authors' calculations of the American Community Survey.

County indigent care is funded by multiple sources that have varied over time and across counties. State realignment funds constitute the major source of state financing, totaling roughly $1.2 billion in fiscal year 2011–12.[11] Health realignment funds are distributed to counties based on historical allocation formulas that do not necessarily reflect current need and also represent a declining revenue source in recent years due to the

[11] This total reflects the new base reported by the State Controller's Office for the 2012–13 fiscal year, which is based on the program allocations for the 2011–12 fiscal year. This total does not include any funds that may be transferred between realignment accounts nor any monies from growth subaccounts.

economic downturn because they are raised through vehicle license fees and sales tax.[12] Tobacco settlement monies provide another $380 million dollars (FY 2011–12) available for county indigent health services. County general funds also provide support for indigent health services. State realignment funding requires a county maintenance of effort to access indigent health service funds and counties may contribute additional general funding as necessary and available.[13] Finally, a few counties—principally larger, "provider counties"—have enacted local revenue measures to finance indigent care.[14]

Federal funding is also a significant source of money for county health services, particularly for counties that operate public hospitals. The state's 1115 Medicaid Waiver, California's Bridge to Reform, provides approximately $10 billion in federal funds over the five-year period from 2010 to 2015 to support additional coverage for low-income populations, investments in the public hospital system, and financial offsets for uncompensated care provided in safety net hospitals. Under the waiver, all counties had the opportunity to create Low-Income Health Programs (LIHPs), an optional local program to provide care to those with incomes up to 138 percent of FPL who will be eligible for Medi-Cal in 2014 as a result of ACA coverage expansions.[15] The other federal funding provided by the waiver is available only to public hospitals.

The federal funds available through the waiver, as well as additional federal monies, most notably Disproportionate Share Hospital (DSH) payments for Medi-Cal and uninsured patients, require a "match"—county funds and public hospital contributions to both the Medi-Cal program and indigent care. In fiscal year 2011–12, about $4 billion in county funds leveraged a like amount of federal resources to support an array of critical services, including Medi-Cal inpatient care, public hospital delivery system improvements, and county-based LIHPs.

Other County Health Programs and Responsibilities

In addition to their indigent care responsibilities, counties provide substance abuse and mental health services to low-income residents. Beginning with the state's 1991 realignment, counties became responsible for the financing and delivery of specialty mental health care services required by Medi-Cal beneficiaries with severe mental illness[16] and, resources permitting, community mental health services for uninsured residents (Watson and Klurfeld 2011). Counties rely on a variety of funding sources, including another pot of realignment funding designated for mental health, state general funds allocated to Medi-Cal mental health managed care, federal Medicaid and SCHIP funds, and revenue generated from the Mental Health Services Act. (California Health Care Foundation 2011).

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[12] State realignment funding allocations to the counties were based on county program allocations just prior to the 1991 realignment, however, for some programs, including indigent health services, those program allocations were rooted in historical formulas and spending patterns that dated back to the 1970s and 1980s (LAO 2001).

[13] County's maintenance of effort (MOE) represents a county match of funds and establish minimum county spending levels. County MOE requirements for the sales tax portion of state realignment funding for health is based on statute (Welfare and Institutions Code Section 17608.10) and totals $343 million. Statutory language in 17608.10(b) also suggests counties must contribute a 1:1 match for the vehicle license fee portion of realignment funding provided for health, although it is not clear if this is done.

[14] One example is Alameda County's Measure A, a sales tax measure adopted by county voters in 2004 to support health care services to medically indigent residents. Los Angeles County has also sponsored local initiatives to support county indigent care.

[15] Counties had the option to include individuals up to 200 percent of FPL under their LIHPs, but most chose to set the income eligibility limit at 138 percent of FPL or lower. A few counties—including Fresno, Merced, and San Luis Obispo—have chosen not to participate in the LIHP. In addition, as of August 1, 2012, LIHP implementation was still pending in Santa Barbara and Stanislaus counties.

[16] Mental health services for patients with chronic and severe mental illnesses such as schizophrenia are carved out of the Medi-Cal health program, meaning that services are provided outside the Medi-Cal managed care or fee-for-service structure, and instead fall under the purview of county mental health programs.

Counties are also tasked with operating public health programs. All counties, as well as three cities (Long Beach, Pasadena, and Berkeley), run public health programs that focus on population-based health promotion. Core public health activities include communicable disease control, environmental health, health education, and emergency preparedness.

Clearly, state and local government play primary roles in administration and delivery of the programs and health care services available to low-income and uninsured adults in California, but the federal government also serves a critical role in terms of financing and establishing broad parameters for several safety net programs. With the passage of the ACA, the federal government will be even more involved in the financing and programmatic oversight of the health care safety net services available to low-income Californians.

The Affordable Care Act and California

The patchwork of health care safety net programs described in the previous section evolved out of recognition for the need of a health care safety net to provide care to low-income populations, many of whom could not afford health insurance coverage. Although these programs are administered largely through state and local agencies, the federal government supplies guiding principles and funding. The ACA expands the federal government's involvement in the health care programs available to low-income residents. An understanding of the ACA's major components is an essential foundation for considering the practical effect of its implementation on California's uninsured adults, state budget, county indigent care programs, and county-operated public hospital systems. In this section, we provide a brief overview of the ACA's primary provisions and their expected impact on indigent care and state and county roles in California.

Coverage

Many of the uninsured served today by county indigent programs and state limited-benefit programs will become eligible for comprehensive insurance coverage as a result of ACA provisions that allow states to expand their Medicaid programs to cover more low-income residents and establish a health benefit exchange where individuals and small businesses can shop for qualified health plans starting in January 2014.[17] California policymakers have been actively planning for these expansions,[18] though the U.S. Supreme Court's June 2012 ruling effectively renders the Medicaid expansion for adults optional,[19] which means that state policymakers can decide whether to expand Medi-Cal to the full extent outlined by the ACA.

According to the governor's proposed 2013–2014 budget, California will expand the Medi-Cal program, making roughly two-thirds of California's current uninsured population—approximately 4.7 million people—eligible for subsidized coverage through either Medi-Cal or the state's health benefits exchange, recently renamed Covered California. The remaining one-third will be ineligible for subsidized coverage either because their incomes are too high, in which case they can still purchase coverage through Covered California but receive no subsidies, or prohibited from Medi-Cal or Covered California due to their immigration status (Lavarreda and Cabezas 2011).[20] Despite the expanded eligibility for subsidized insurance, it is not clear how many Californians will enroll in available coverage. Extensive modeling to estimate the size and distribution

[17] States can expand their Medicaid programs to all low-income adults with incomes up to $32,000 or 138 percent of FPL for a family of four. Federal tax credits for coverage in an exchange are available to citizens with incomes between 100–400 percent of FPL, or $23,050 to $92,000 for a family of four and legal immigrants who have resided in the United States less than five years below 138 percent of FPL who are not eligible for the Medicaid expansion. Certain small businesses will also be eligible for tax credits to offset insurance costs. States can choose to operate independent health benefit exchanges and the federal government will operate an exchange to serve the residents of states that choose not to create their own.

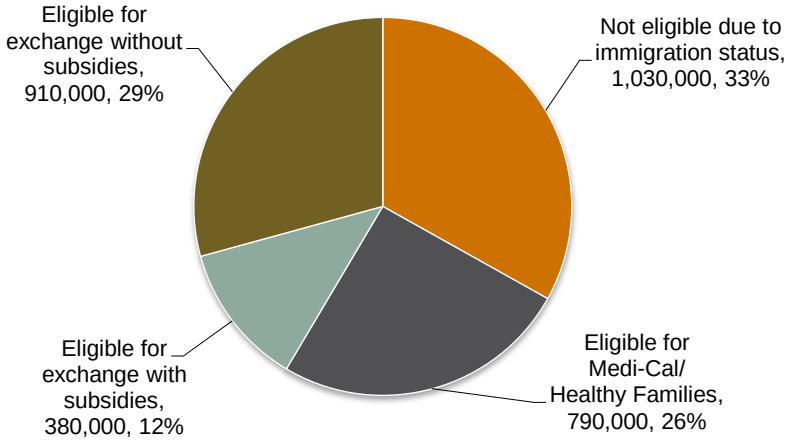
[18] Two examples of the state's preparation are the state's Section 1115 Bridge to Reform Medicaid waiver and the creation of the Low-Income Health Programs and the creation of the California Health Benefits Exchange.

[19] For more information on the Supreme Court decision, *National Federation of Independent Business v. Sebelius,* and its implications for state Medicaid expansions refer to the Kaiser Family Foundation report "Implementing the ACA's Medicaid-Related Health Reform Provisions after the Supreme Court's Decision."

[20] Of the 7 million Californians who were uninsured for all or part of 2009, 3 million are estimated to be eligible for Medi-Cal and 1.7 million are estimated eligible for subsidized coverage in Covered California. Of the remaining 2.3 million not eligible for subsidized coverage, 1.2 million are estimated to be ineligible for subsidized coverage because their incomes are too high or they have an offer of affordable employer coverage, and 1.1 million are estimated to be ineligible for all coverage programs due to their immigration status.

of coverage changes resulting from the ACA underscores this uncertainty.[21] Available California-specific estimates indicate that the Medi-Cal program will see an increase of between 1.0 and 1.4 million new enrollees by 2019 and another 1.7 to 2.1 million Californians will likely enroll in subsidized coverage through Covered California (Lucia et al. 2012). Notwithstanding the ACA's promise of near universal coverage, federal exclusions guarantee that some populations will remain outside the ACA's coverage provisions. Upwards of three million Californians could remain uninsured in 2019, even under an aggressive outreach and enrollment scenario, and nearly four in ten of those remaining uninsured could be eligible for subsidized coverage (Figure 1).[22] An important difference is that the remaining uninsured who are eligible for but not enrolled in Medi-Cal could enroll if they need medical services due to retroactive eligibility for the Medi-Cal program.[23] This will not be a feature of coverage secured through Covered California, which will have a standard open enrollment period.

FIGURE 1
Eligibility of uninsured Californians in 2019 (enhanced outreach scenario)



SOURCE: UC Berkeley-UCLA CalSIM Model, version 1.8 from Lucia et al. (2012).

NOTE: Total = 3.1 million.

Financing

The federal government will finance the vast majority of the costs associated with the coverage expansions prescribed by the ACA. For the first three years of implementation (2014 through 2016), the federal government will bear 100 percent of the cost of expanding Medi-Cal coverage to those made *newly* eligible by the ACA; after that, the federal contribution will gradually decrease, dropping to 90 percent by 2020. However, the state will be responsible for 50 percent of the costs for residents who were eligible for Medi-Cal under pre-ACA rules but

[21] These estimates are based on micro-simulation models (MSMs) which are constructed from a variety of data sources and contain many built-in assumptions regarding the behaviors of both firms and individuals in order to predict how insurance coverage decisions will be made in light of the changes brought about by the ACA. In this paper, we present findings from an MSM developed specifically for California by researchers at the University of California, Berkeley and University of California, Los Angeles, which is referred to as CalSIM. Other sources for these estimates include the Urban Institute Health Policy Simulation Model (Holahan and Headon 2010 and Buetggens, Holahan, and Carroll 2011); Long and Gruber (2011); and Lewin Group (2010).

[22] The CalSIM model provides estimates for a base scenario, which relies more heavily on current behavior and take-up rates for programs, and an enhanced scenario, which assumes a higher take-up rate due to increased outreach and enrollment strategies. The numbers provided here are based on the enhanced scenario.

[23] Medi-Cal will cover medical services received during any of the three calendar months immediately preceding the month of application for the program providing the applicant would have qualified for the program during the month they received services.

were not enrolled before 2014. The tax credits available to subsidize coverage purchased through Covered California will be financed entirely by the federal government.

Despite this significant federal financing, the state will face additional direct costs and financial pressures as implementation moves forward, and policymakers will need to consider possible financing options. The largest source of new state costs will come from increased enrollment in the Medi-Cal program. The share of costs for those made newly eligible will accrue to either state or county government depending on the approach chosen for the optional Medi-Cal expansion, though these costs will not be borne until after 2016 and will vary depending on take-up rates.[24] The state will experience increased costs associated with what is popularly known as the "woodwork effect"—the enrollment of individuals who are eligible under existing Medi-Cal rules but are not enrolled—although their take-up rates are projected to be much lower than those of the newly eligible.[25] Although these costs are for existing state obligations, they are an anticipated result of ACA provisions, including enhanced outreach and education, a simplified application, and streamlined enrollment processes. The state will also incur increased administrative costs associated with expanding governmental capacity to administer Medi-Cal, including the upgrade of enrollment and eligibility systems.[26]

In addition to direct costs, the state will experience financial pressure as a result of other policy changes included in the ACA. Two of these changes could be particularly costly. First, the state may need to maintain higher primary care physician rates for the Medi-Cal program; in 2013 and 2014, these ACA-prescribed rate increases will be fully funded by the federal government. California's Medi-Cal provider reimbursement rates are among the lowest in the nation, and it may be very difficult for the state to roll back these higher rates in 2015 and maintain physician participation in the Medi-Cal program. A second looming fiscal pressure relates to the ACA's reduction in federal Disproportionate Share Hospital (DSH) funds by nearly $19 billion between 2014 and 2020. DSH provides additional payments to hospitals treating large numbers of Medicaid and uninsured patients, contributing $1.1 billion a year to the state's hospitals.[27] These reductions will be phased in and will vary across states, depending on the size of the residually uninsured population and the care provided to the uninsured.[28] In California, the impact of these reductions will vary across counties because of the differential effects of the ACA's coverage provisions and the distribution of the residually uninsured.

The ACA also provides opportunities for state savings. A 23 percent increase in the federal match for Healthy Families is a projected source of state savings, as is a change in prescription drug rebates available through Medicaid. These savings are expected to be relatively modest compared to the potential savings from the modification or elimination of state and county services for the uninsured once these residents become eligible for federally supported coverage through Medi-Cal and Covered California. The issues and implications of scaling back state support for these programs are examined in the next section.

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[24] Take-up rates among those made newly eligible for Medi-Cal range between 61 and 75 percent in the CalSIM model. One estimate of the state costs associated with covering newly eligible Medi-Cal enrollees ranges from $1.7–$2 billion over the six year period from 2014–19 (Holahan and Headon 2010).
[25] The CalSIM model estimates this population to be approximately 1.3 million with take-up rates ranging from 10 to 40 percent.(Kominski et al. 2012). Again, state cost projections vary, with one estimate providing a range of $1.25–$4.5 billion over the 2014–19 period, depending on participation rates (Holahan and Headon 2010).
[26] General Medi-Cal administrative costs will be shared 50-50, though the federal government will cover the bulk of costs for new eligibility and enrollment systems at a 90 percent match rate.
[27] Kaiser statehealthfacts.org (www.statehealthfacts.org/comparetable.jsp?ind=185&cat=4).
[28] Despite California continuing to have a sizable uninsured population post-ACA, one estimate suggests the state could lose $1.2 billion by 2020 as the result of DSH reductions (Lewin Group 2010).

Program Administration

The ACA calls for simplified and coordinated eligibility determination and enrollment processes for public insurance coverage programs,[29] which will have significant implications for actual enrollment levels and the number of Californians who remain uninsured. The ACA directs states to establish consumer-centered and computer-supported processes that offer multiple pathways to insurance for the millions of individuals who will become newly eligible for coverage.[30] California's health benefit exchange, Covered California, will play a role in screening and, potentially, in determining Medi-Cal eligibility for those seeking coverage. Finally, to facilitate simplified, real-time eligibility determination, enhanced federal funding is available to modernize the state's information systems. Covered California, the California Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB) have procured the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS), which will determine eligibility in real time for most Medi-Cal and Covered California applicants and provide consumers with a Web portal to compare plans, and select and enroll in the coverage of their choice.[31]

Delivery Systems

The ACA also calls for significant changes to the organization and delivery of health care. New incentives and requirements for health plans and providers designed to move from a volume-based model that rewards increased utilization to a value-based model that rewards care management and prevention could have significant implications for California's public hospital and clinic systems. County-operated public hospital systems offering episodic care will need to compete for patients in an environment of consumer choice, while maintaining their capacity to serve the uninsured. The state's "Bridge to Reform" waiver is intended to help county systems position themselves as providers of choice for newly covered populations and become efficient, high quality partners for integrated provider networks that are developing.[32]

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[29] For example, federal law institutes fundamental changes to the method used to determine eligibility for new coverage options, including Medi-Cal and subsidized coverage through Covered California. Most notably, a new income-only eligibility standard will be instituted for many applicants that is based on Modified Adjusted Gross Income (MAGI), which can be obtained and verified electronically through tax returns and other sources as necessary.

[30] Such pathways include an online application, customer service center support, and in-person assistance through community-based organizations and agents and brokers as well as traditional social services agencies.

[31] Federal approval of CalHEERS requires that automated Medi-Cal eligibility for the MAGI eligible population be "done solely by CalHEERS," which should facilitate timely eligibility determinations, a more uniform consumer experience, and continuous coverage (Centers for Medicare & Medicaid Services letter to Toby Douglas, Director of the California Department of Health Care Services, June 8, 2012). Earlier federal approvals direct California to move towards a single automated system for health and human services program administration by 2020 (Centers for Medicare & Medicaid Services letter to Toby Douglas, Director of the California Department of Health Care Services, April 5, 2012).

[32] The Delivery System Reform Incentive Pool (DSRIP), a component of the state's Bridge to Reform waiver, provides up to $3.3 billion to support the capacity of public hospital systems to provide more coordinated, integrated care, and to improve patient experience as well as clinical outcomes.

State Implementation Decisions and the State-County Relationship

The ACA calls for major changes to California's health care safety net system, but decisions by state policymakers will shape several aspects of ACA implementation. Chief among them will be whether the optional Medi-Cal expansion follows a state-based or county-based approach as outlined in the governor's budget proposal. These implementation decisions will shape and define the evolution of state and county roles and responsibilities related to health care for low-income Californians. Many of the uninsured served under existing county indigent care programs and state limited-benefit programs will become eligible for comprehensive coverage through the Medi-Cal expansions or subsidized coverage through Covered California. Moreover, eligibility determination for public coverage programs could be streamlined and largely centralized at the state level. Delivery system reforms already under way in the marketplace will accelerate under the ACA's provisions, providing both opportunities and challenges for the state's health care safety net.

The re-evaluation of state and local health care responsibilities may well be driven by state fiscal imperatives. But given the scope of the ACA, the complexity of indigent care financing, and many unknowns, policymakers will need to consider a number of issues as they redefine California's long-standing division of responsibilities for indigent health care and explore new opportunities to promote the effective administration and delivery of health services.

Maximizing Enrollment among Eligible Populations

Projections indicate that millions of Californians will remain uninsured even several years after the ACA coverage expansions have been implemented, but this is not a pre-ordained outcome. Enrollment levels among eligible populations will be shaped by state and local decisions and actions.

Outreach and Enrollment

Outreach and public education campaigns will be needed before coverage is expanded. More than half of the adults expected to remain uninsured after coverage expansions despite being eligible for Medi-Cal or subsidized coverage through Covered California are estimated to have limited English proficiency, which underscores the importance of culturally sensitive and language appropriate materials and strategies, including community-based models (Lucia et al. 2012). Simplified eligibility determination and "no wrong door" enrollment procedures that screen individuals seeking coverage for all available programs and take them through to enrollment will also be essential to increasing take-up rates among those eligible for Medi-Cal and facilitating enrollment in Covered California. Pre-enrollment strategies for seamless transition of those participating in county-based LIHPs to the Medi-Cal program will also be important.

Fortunately, many groups are working to lay the groundwork for this effort, including Covered California, the California Department of Health Care Services (DHCS), county agencies, as well as foundations and nonprofit organizations. Their decisions regarding the amount of funding and the logistics of media and community-based outreach, messaging, and branding will have implications for the state's ability to connect millions of newly eligible Californians to health coverage.

Transitions in Coverage and Program Eligibility

State policy decisions can also influence the degree to which individuals cycle in and out of coverage as their incomes and/or families change. This phenomenon—known as "churning"—not only contributes to individuals falling through the cracks of coverage but also increases administrative costs. National patterns suggest that as many as 50 percent of individuals with income below 200 percent of FPL will cycle between eligibility for Medicaid and subsidized exchange coverage due to income fluctuations over the course of a year (Sommers and Rosenbaum 2011). Policymakers need to find ways to promote continuity of coverage and care, such as common Medi-Cal and Covered California plans and provider networks, and the eligibility systems and processes required to facilitate continuous coverage. The Medicaid Bridge Program proposed in the governor's budget is an example of a policy option to address some of these issues. The program would provide very low-cost or no-cost health plan options that contract with Medi-Cal managed care plans through Covered California and would be available for those with incomes up to 200 percent of FPL.

Affordability

The cost of health plan options offered through Covered California will affect low-income individuals' decision to purchase coverage, which in turn will affect the size of the uninsured population. Despite federal tax credits for purchasers of insurance with incomes between 100 and 400 percent of FPL, low- and moderate-income individuals and families will have to cover the gap between premium amounts and the tax credits as well as any cost-sharing for services. At this point, the cost of health plans and benefit levels available through Covered California is unknown. Some early research suggests that low-income families should have enough room in their budgets to afford the expected costs of subsidized coverage (Gruber and Perry 2011), but it is difficult to predict how uninsured individuals will respond.

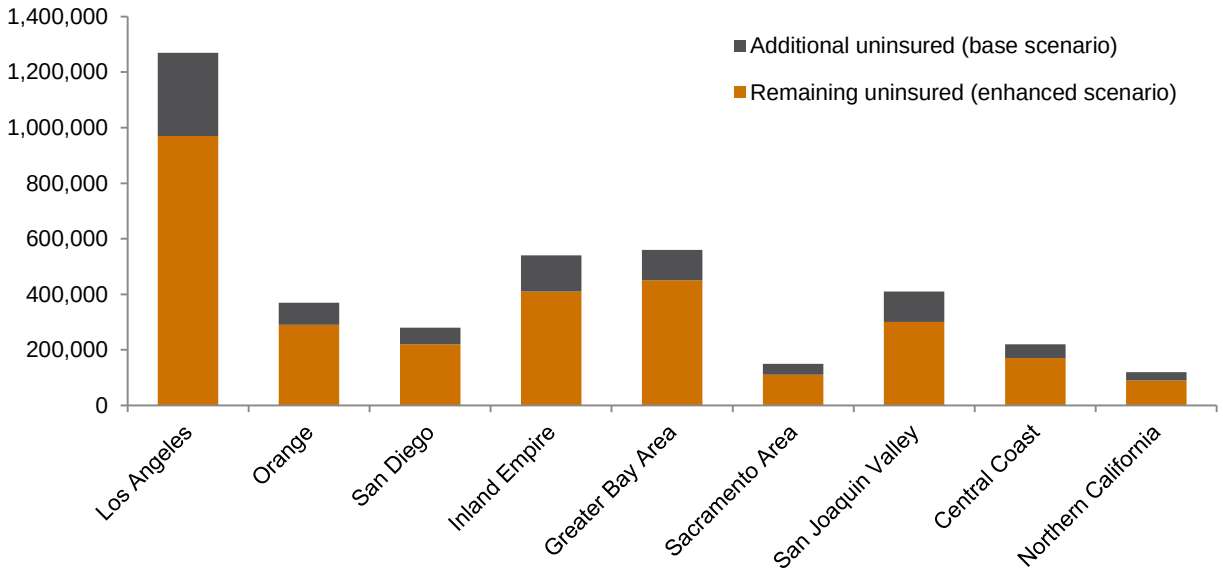
Determining the Continued Need and Responsibility for Safety Net Services

Any reassessment of county responsibility for indigent care or elimination and/or modification to state limited-benefits programs will require a careful analysis of the number, nature, and distribution of Californians who remain uninsured after implementation of health care reform. Policymakers will need to factor in this ongoing need as they grapple with questions about responsibility for indigent care.

County Indigent Care Programs and Section 17000

Based on available estimates, all counties will continue to have sizable uninsured populations even after ACA coverage expansions (Figure 2).The numbers will depend on the extent that state and local polices are able to maximize enrollment levels, but the projected size of the remaining uninsured population suggests a continued need for a safety net of health care services throughout California and quite possibly a continuing role for county indigent care programs. Understanding the actual size and distribution of the remaining uninsured and determining the financial responsibility for providing health care for this group could prove difficult in the short-term given the uncertainty around so many ACA implementation decisions.

FIGURE 2
Distribution of uninsured Californians in 2019 according to two scenarios by county and region



SOURCE: UC Berkeley-UCLA CalSIM Model, version 1.7 from Jacobs et al. (2012).

NOTES: The CalSIM model generates two sets of estimates for projecting the impacts of the ACA coverage expansions in California. The base scenario assumes take-up rates for insurance coverage will reflect current take-up rates. The enhanced scenario uses higher take-up rates that account for increased outreach, enrollment, retention processes than currently exist and therefore produce estimates of fewer remaining uninsured compared to the base scenario estimates.

If policymakers opt for the state-based approach to the Medi-Cal expansion, the state will assume financial responsibility for many uninsured adults currently served under indigent care programs, relieving counties of much of their Section 17000 obligations and the state of its financial responsibilities to counties to support that care. The retroactive coverage provisions for Medi-Cal protect counties to a certain extent from financial exposure, since the remaining uninsured who are eligible for Medi-Cal can be enrolled at the time of service. But state policymakers will need to consider whether to shift some or all of state funding previously used to support county indigent care responsibilities, and what, if any, residual county obligations and funding requirements remain after 2014. It is not clear if state policymakers will need to clarify county obligations under Section 17000 under the state-based approach to Medi-Cal expansions, given the residual nature of county responsibility for indigent care. While some counties and stakeholders will look to state policymakers for direction, state officials historically have been reluctant to tinker with Section 17000. To the extent that the past is prologue, litigation and case law could determine the division of responsibility for providing this care.[33]

In the absence of state direction, Section 17000 may be redefined on a county-by-county basis. The current variation among county indigent care programs suggests that ACA coverage expansions could play out differently across counties and state policy will need to reflect this development. The ACA may enable some counties—particularly payer and CMSP counties—to scale back if not eliminate indigent care programs. Given their ability under current statute and case law to set eligibility requirements for indigent care programs at or

[33] Several court decisions have addressed issues related to the county obligation to provide health care to the medically indigent under Section 17000. Two important decisions include *County of San Diego v. The State of California* in 1997, which found that the state transfer of medically indigent adults to counties was a reimbursable mandate and *Hunt v. Superior Court of Sacramento* in 1999, which ruled that counties cannot limit their indigent care programs to cover only residents eligible for General Assistance.

below the new ACA eligibility standard for the Medi-Cal program, counties that do not serve undocumented immigrants can create eligibility requirements that effectively dismantle the program by excluding everyone not eligible for Medi-Cal.

Provider counties that operate public hospitals and clinic systems, on the other hand, are in a very different position. County-operated public hospital systems are significant providers of care to all Californians, including those who are uninsured and those in public coverage programs including Medi-Cal. While the payer mix of public hospitals will change as many uninsured patients secure coverage, these safety net providers are expected to play an important—and likely growing—role in meeting the demand for services after ACA implementation by the remaining uninsured and newly insured alike. Policymakers will need to ensure that any redirection of county indigent care financing does not disrupt the state's safety net hospital infrastructure, which is already under financial pressure from government budget shortfalls.

State Limited-Benefit Programs

Policymakers need to consider carefully the implications of modifying or eliminating state limited-benefit programs such as Access for Infants and Mothers, Family PACT, or Every Woman Counts. While the comprehensive coverage options made available through the ACA offer an opportunity to streamline the fragmented limited-benefit network, these programs offer critical services to those who will remain uninsured. Most provide some level of service regardless of immigration status and will be important for unauthorized immigrants who are largely left out of ACA coverage expansions. In addition, a number of limited-benefit programs provide specialized services and supports not easily accessible under other insurance coverage and requiring no or limited cost sharing. Political considerations may also need to be factored in, since all of these programs have their constituencies and supporters, which include the populations they serve and the professionals that provide care and administer services.

Financing New State Costs

The impact of federal health reform on the state budget will focus attention on options for financing new costs. Actual state costs in 2014 and beyond will be the product both of ACA requirements and of state implementation decisions and policy choices yet to be made, in particular, whether to proceed with the optional Medi-Cal expansion under a state-based or county-based approach. With a state-based approach, policymakers will have a number of options for financing new state costs, although each comes with important tradeoffs that will need careful consideration.

Repurposing Health Realignment Funds

Currently, state spending on care for the medically indigent comes predominantly from the 1991 health realignment funding provided to support county health services. Under the state-based approach for Medi-Cal expansions, the governor's proposed budget calls for "capturing" county savings that result from the state assuming responsibility for many of the uninsured currently served under county indigent care programs. The captured savings would come from shifting health realignment funds to finance expanded county responsibilities for human services programs.[34] Policymakers will need to consider a number of issues to

[34] The majority of health realignment funds come from Vehicle License Fees (VLF), which are a constitutionally protected source of funding that must go to counties. As a result, any captured funding would need to be in the form of increasing responsibility for counties in other areas, rather than taking the money into the state's General Fund.

ensure that such a shift of health realignment funds is not done prematurely and does not erode support for the state's safety net system that will continue to serve potentially large numbers of uninsured residents.

County indigent care financing is complex and defies a simple accounting, making estimates of expected county savings associated with the ACA's coverage expansions difficult to quantify. Lack of information about total expenditures for county indigent care by funding source has been highlighted in the past as a major barrier to effective health financing policies and budgets (LAO 2001). The absence of reliable data systems to track spending on county health services continues to hinder the state's ability to evaluate the implications of important fiscal decisions. Policymakers will need to work with counties to unpack county indigent care funding sources and expenditures as accurately and consistently as possible. This baseline analysis is a critical starting point for considering the amount of county indigent care savings resulting from ACA coverage expansions and also for understanding variations by county.

A decision to shift realignment funds away from county health services will need to factor in continuing county responsibility (under Section 17000) for providing care to those that remain uninsured and account for the variation among different types of county indigent care programs. Specifically, state and local policymakers will need to consider the percentage of residents currently receiving services through county indigent programs who will remain uninsured and the realignment funding associated with their care. For planning purposes, county Low-Income Health Programs can provide some helpful insights, to the extent LIPH enrollees represent a subset of a county's indigent population likely to enroll in Medi-Cal or Covered California in 2014. For example, roughly 80 percent of the population served by county indigent care programs operated by CMSP is enrolled in Path2Health, the LIHP administered by the CMSP Governing Board, suggesting that about 20 percent of the current population served will continue to rely on county indigent care services after ACA coverage expansions (County Medical Services Program 2012). County-specific data regarding the size and distribution of the residually uninsured—and the financing associated with that care—will be important factors in state financing decisions. This is particularly true for provider counties that operate public hospital systems, which are expected to face continued demands to care for the remaining uninsured, as well as newly insured residents. State policy will need to align responsibility with financial resources, either by ensuring that counties are able to retain sufficient realignment funding to meet the costs of providing care to those remaining uninsured or by establishing alternative state financing mechanisms.

Finally, it will be important for policymakers to disentangle two important aspects of realignment's complex financing structure. First, any redirection of health realignment funding will need to ensure adequate funding for ongoing county public health responsibilities, such as population-based communicable disease control. Second, policymakers need to consider the importance of county funding for Medi-Cal broadly and the financial viability of safety net providers in particular. Health realignment funds contribute to the larger pot of money used by counties to support health care services beyond their indigent care programs. Most notably, counties combine realignment funds with other funds to draw down federal dollars that support public hospitals and services to Medi-Cal beneficiaries and the uninsured alike. Counties may also use realignment dollars to contribute to the county share of cost for the California Children's Services (CCS). Any state repurposing of health realignment funding to offset new state costs will need to take these county responsibilities into account.

Establishing a County Share of Cost

One alternative to recouping some or all of county indigent care funding, aside from the county-based approach where counties would take full responsibility for the optional expansion population, is enacting a county share of cost for the Medi-Cal program—an approach for which there is precedent. Throughout

Medi-Cal's history, counties have covered the costs of Medi-Cal to varying degrees. In 1971, for example, the state expanded Medi-Cal to some low-income adults who were not otherwise eligible for the program and established a county share of Medi-Cal costs (Kelch 2005). In the context of the ACA's Medi-Cal coverage expansion, a county share of cost would effectively build from the county-based LIHPs, which utilize county funds to match federal resources and provide coverage to indigent adults who become Medi-Cal eligible in 2014. Moreover, a county share of cost could be structured to encourage county-level activity that advances the ACA's enrollment, delivery system, and health outcome goals.

Modifying State Limited-Benefit Programs

Another potential source of funding for new state ACA costs could come from state limited-benefit programs. Certainly, scaling back or eliminating some or all of these programs would provide general fund savings that could be directed to new state ACA costs. Current General Fund expenditures for these programs, presented in Table 1, total in the hundreds of millions of dollars, with some programs (such as AIM and Family PACT) requiring higher expenditures than others. Several factors described in the previous section should be considered, including the continued need of those who remain uninsured and the extent to which limited-benefit programs provide additional, wrap-around benefits not offered by traditional insurance products. Moreover, given that most of these programs rely on federal financial support and guidelines, federal policy decisions will also influence the future of these programs.[35]

Reducing State Medi-Cal Spending

The ACA includes a "maintenance of effort" (MOE) requirement that precludes states from reducing Medicaid eligibility before they have established health benefit exchanges. Once the MOE is lifted, California policymakers can consider drawing a bright line between Medi-Cal and Covered California eligibility compelling individuals with incomes above 138 percent of FPL to secure coverage through Covered California.

Relatedly, state policymakers could eliminate optional Medicaid categories covering populations that will be eligible for federally funded tax credits through Covered California. Two such programs include the 1931(b) eligibility category and the Medically Needy (MN) program, which extend Medi-Cal coverage to individuals who may have incomes above ACA eligibility standards. California policymakers could decide to change program rules to shift these individuals from Medi-Cal to Covered California in order to maximize federal funds.[36] While the majority of state MN costs are associated with long-term care, services that will not be provided through Covered California, the MN program also serves families with significant medical expenses. State policymakers could consider changing the MN standard to focus this optional program on long-term care services and shift MN families to the federally subsidized Covered California. Before it could make a decision, the state will need more information, including clarity on what is federally allowable, the number of 1931(b) and MN recipients with incomes in excess of 138 percent of FPL, implications on recipient coverage and access to services, and anticipated state savings and administrative costs.

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[35] As an example, in 2011 the Obama Administration concluded that state HIV/AIDS clients were ineligible to receive services through discrete, federally-funded medical services for HIV/AIDS (Ryan White program) or drug assistance (ADAP) if they are eligible for more comprehensive care through a county LIHP.

[36] On March 16, 2012, the Centers for Medicare and Medicaid Services (CMS) released the final rule on Medicaid eligibility under the Affordable Care Act. The ruling clearly states that new MAGI eligibility rules do not apply to medically needy eligibility categories and that the option to spend-down to medically needy coverage remains part of the law. It is unclear whether this is also true for those eligible through the 1931(b) program, although it appears that states can continue to offer coverage to this group at higher levels but it will not be supported by enhanced federal funds.

Phasing in Costs

Although efforts to facilitate early enrollment and maximize the number of Californians ready to enroll in Medi-Cal and Covered California on January 1, 2014, are under way, previous state coverage expansions demonstrate that new programs take time to ramp up. Consequently, new costs are likely to be phased in over a period of several years after ACA implementation in January 2014. Given the federal government's significant financial contributions in the early stages of ACA implementation, most projections suggest that significant state costs will not materialize for several years. Most modeling efforts anticipate state budget implications through and after 2019, when federal financial support drops to 90 percent of Medicaid costs for those who become eligible under the ACA expansion.

It will also take time for actual savings to materialize, given the issues associated with ramping up new coverage programs and expansions. Policymakers might want to consider a phased-in approach, whereby any state recoupment of realignment indigent care funding or county share of Medi-Cal cost is based on actual enrollment of eligible uninsured county residents.

Defining State and County Roles in Program Administration

Increased enrollment in Medi-Cal could add significantly to county workloads. At the same time, the standardized rules, streamlined processes, online applications, and electronic verifications offer an opportunity to re-envision eligibility systems and processes and transform the enrollment process for consumers and county workers alike. Changes already under way are beginning to affect state and county enrollment responsibilities. The procurement of the CalHEERS system can help facilitate enrollment of those newly eligible for coverage, promote a consistent consumer experience across counties, and enable county workers to focus their expertise to support more complex health coverage and human services cases. To this end, new state-county relationships are developing, with some counties expected to assume an expanded role to help consumers enroll in Medi-Cal or Covered California through the new customer service center established by Covered California. This state-county partnership will incorporate unprecedented performance, reporting, and accountability measures.

The procedures that will govern business processes and responsibilities among Covered California, DHCS, and county welfare offices for determining Medi-Cal eligibility for most applicants have not been finalized. However, the Brown administration expects that counties will continue to be responsible for all Medi-Cal eligibility determinations, including new Medi-Cal applicants whose initial contact is through Covered California, and for case management of newly eligible individuals within county SAWS systems (California Health Benefit Exchange Board 2012a). This policy direction introduces complexities that will need to be navigated carefully to minimize costs, risks, and consumer impact, and also to ensure federal financial support.

While the federal vision of a first-class customer experience and streamlined processes is powerful, it bumps up against such practical considerations as California's long-standing reliance on multiple systems to support the state's county-based approach to program administration. Moreover, given the way Medi-Cal costs are shared with other public assistance programs, a more efficient and less costly approach to Medi-Cal administration could affect county staffing as well as the allocation of county funds for administration. State and county protocols—and politics—will largely determine the extent to which the ACA's promise of streamlined and consistent enrollment systems and processes across counties becomes a reality for millions of Californians newly eligible for coverage.

Integrating Health Coverage with Other Safety Net Programs

ACA implementation deadlines compel policymakers to focus on the complex integration of eligibility and enrollment for most health coverage programs. But the groundwork is being laid for future integration that could include other health and human services programs. Looking beyond 2014, state policymakers may want to consider opportunities to leverage the statewide CalHEERS system to reach additional populations, such as the Medi-Cal disabled population, and other human services programs such as CalFresh and CalWORKs. The CalHEERS platform provides a functional and federally funded foundation for such a horizontal integration of human services programs. Consolidating IT systems and streamlining business operations could help achieve economies of scale, reduce costs, and promote a more uniform consumer experience across counties and different health and human services programs. At the same time, broad centralization of administrative responsibilities runs counter to realignment's historic devolution of responsibility to local government and to the Brown administration's support of local control. Moreover, the prospect of social services realignment and expanded county responsibilities for human services programs could complicate efforts to centralize eligibility and enrollment systems more broadly, given complex cost allocation, business process, and technology issues.

Delivery System Improvements

Leveraging State Purchasing Power

While the state is not a provider of health care services, it is a major purchaser of coverage and services, and that role will be enlarged with the coverage expansions brought about by the ACA. Currently, the state purchases coverage for more than 8 million individuals enrolled in Medi-Cal and HFP. The state also purchases health benefits for 1.3 million active and retired state and local employees and their dependents through the CalPERS program, making it the largest employer purchaser of health coverage in California. In 2014, the state will become an even bigger purchaser, as many individuals and small businesses buy coverage through Covered California. In total, state government could become the purchaser of health care for 13 million Californians. The ACA provides new opportunities for policymakers to leverage state purchasing power to have a broader impact on the health care system. Quality measurement, payment and delivery reform, and consumer engagement are examples of areas where aligned contracting strategies among public and private purchasers can help foster delivery system improvements that result in better quality and lower costs.

Supporting Traditional Safety Net Providers

As state policymakers deploy new tools to meet broader delivery system and quality goals, they will need to consider safety net providers, who will be an important source of care for both the newly covered and remaining uninsured. On the one hand, policymakers will need to encourage the meaningful participation of safety net providers—particularly county-operated public hospital systems—in more-integrated delivery systems while also supporting their financial capacity to care for the uninsured. Public hospital systems will have the challenge of competing in an environment of expanded coverage and consumer choice, a marketplace that increasingly emphasizes outpatient care delivery, and a reimbursement protocol based on patient outcomes rather than volume of services. In short, public systems will be compelled to operate more like private institutions, while at the same time retaining their mission and capacity to serve the uninsured.

California's Bridge to Reform waiver devotes significant resources to strengthen the state's public hospital systems by advancing two principal goals: first, to improve the quality of care, patient experience, and outcomes through more coordinated, integrated delivery strategies; and second, to position public hospital

systems as attractive providers of choice for newly covered populations and effective partners for developing provider networks. Covered California has made a number of decisions that promote safety net provider participation in the qualified health plans it contracts with - for example, by defining "essential community providers" and network adequacy standards (California Health Benefit Exchange Board 2012b).

But new models of care and the ACA coverage expansion do not address the expectation that county-operated public hospitals and health systems will continue to serve the large number of people expected to remain uninsured. While public hospital systems can expect to generate new revenue from the ACA's coverage expansion, they are also slated to experience reductions in offsetting disproportionate share hospital (DSH) payments. Further research and analysis can help state policymakers assess anticipated safety net hospital revenue gains and losses under full ACA implementation and the resource needs to care for the residually uninsured.[37] Such information can help the state ensure that the federal distribution of DSH reductions does not disadvantage California's safety net hospitals.

Integrating Systems of Care

By advancing new health care delivery models that emphasize care coordination and integration and providing new tools and resources to catalyze innovation, the ACA offers state policymakers an opportunity to explore a more comprehensive approach to health improvement. ACA reforms will contribute to local discussions already occurring regarding the coordination of mental health, substance abuse, and other services to low-level inmates for whom counties assumed responsibility as a part of the 2011 public safety realignment. Relatedly, counties have been testing an array of innovative strategies to coordinate physical and behavioral health care across providers and systems. These county-based efforts can help inform policymaker and practitioner understanding of the opportunities for and barriers to integrating systems of care for physical health, mental, health, and substance abuse services in the ACA context.

California largely separates substance abuse and mental health services from physical health care and principally vests counties with responsibility for the financing and treatment of severely mentally ill Med-Cal and uninsured patients. This approach creates barriers to integration of care within local systems and results in gaps in treatment provided and populations served (Technical Assistance Collaborative 2012). The county responsibility for these services will need to be reassessed in the ACA context of significant Medi-Cal growth and the integration of mental health and substance abuse services as essential health benefits, which includes the requirement of parity in the coverage of medical and behavioral health care. In this same context, policymakers will need to assess the ability of county financing to provide the non-federal share of Medi-Cal support for the newly eligible Medi-Cal enrollees. This issue is particularly urgent for counties that currently contribute little in support of mental health services to the indigent (Wulsin 2012).

Policymakers may be reluctant to revisit the division of state and county responsibilities for behavioral health services, even though the ACA provides a context for clarifying the county role in delivering and financing these services and the state role in assuring uniform Medi-Cal benefits and performance standards. If policymakers decide not to undo the separation between physical and mental health/substance abuse services, they will need to consider how the state in its role as purchaser of care can help align financial incentives across systems to improve care coordination and health outcomes (Technical Assistance Collaborative 2012).

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[37] Research pending, Katherine Neuhausen, M.D., Robert Wood Johnson Foundation Clinical Scholar, Department of Family Medicine University of California Los Angeles.

Conclusion

The ACA fundamentally changes California's health care landscape, particularly for low-income residents. Under the ACA, the state Medi-Cal program and Covered California could extend coverage to upwards of four million lower-income individuals who today may only have access to a patchwork of state and county programs to meet their healthcare needs. Simplified and standardized rules for eligibility, along with multiple pathways to coverage, including a self-service online application, contrast sharply with today's complex eligibility rules and enrollment processes that rely on in-person visits to county welfare offices. New ACA reimbursement and delivery models will help promote coordinated and integrated care that emphasizes and rewards health improvement. This too will be important for Medi-Cal and uninsured populations, many of whom have complex medical needs, and for the safety net providers that have traditionally served these populations.

At the same time, ACA implementation comes at a time of economic uncertainty and budget restraint. Federal reform's coverage expansions will impose new state costs. Moreover, notwithstanding the ACA's promise of "near-universal coverage," upwards of 3 million Californians will remain uninsured as a result of federal exclusions, state policy and practice decisions, and individual choice. And while Medi-Cal eligibility simplification and a new statewide enrollment portal offer the potential to re-create eligibility and enrollment processes for health as well as other social services programs, the new paradigm offered by the ACA runs counter to traditional state and county administrative relationships.

The changes ushered in by the ACA invite if not compel policymakers to revisit long-standing policy and practice and the apportionment of responsibilities for the administration, financing, and delivery of medically indigent health care services. There are several critical policy questions.

- Will state and local government deploy the comprehensive education, outreach, and enrollment strategies required to maximize the number of insured residents?
- How will the state finance new costs associated with populations previously supported through county indigent programs if the Medi-Cal expansion follows a state-based approach? Will the state also assume responsibility for the financing of care to all low-income populations, including those who remain uninsured? If county indigent care funding is recouped to support the expanded state role, will Section 17000 be repealed or modified commensurate with reduced state funding, or will such funding no longer be required in light of the ACA Medi-Cal expansion?
- What is the future of county indigent care programs, and where does responsibility lie for the residually uninsured? If counties retain their role as providers of last resort, what service models can most effectively serve those who remain uninsured and how will their care be financed?
- Under the county-based approach for Medi-Cal expansions, will counties be able to build upon their existing county indigent care programs and LIHPs to offer comprehensive Medi-Cal coverage to the expansion population that meets federal and state requirements? How will this differ across counties, particularly counties that have more restrictive indigent care programs and/or have chosen not to implement LIHPs? Will counties have the opportunity to opt-out of the expansion?
- Should state limited-benefit programs be maintained as a residual safety net of services or scaled back to encourage those newly eligible to enroll in more comprehensive coverage options?

- How can the state most effectively leverage its expanded role as a purchaser of health care to advance broader health care system improvement goals of better health, better care, and lower costs? How can state policy ensure the meaningful participation of safety net providers in a reformed health care system?
- Does a centralized model work better than a distributed model to optimize the operational efficiency of public health program eligibility, enrollment, and case management functions?
- Given the constitutionally protected nature of Vehicle License Fees, which comprise the majority of current state funding for county indigent care, what new or expanded responsibilities could counties assume to offset new state costs anticipated by the ACA's coverage expansions? What opportunities does such a swap provide to better align and integrate services to improve outcomes for low-income Californians?

To fully address these and other questions, policymakers will need more complete information than is currently available. Policymakers need federal guidance in a number of areas, including the extent of state flexibility in the Medicaid expansion, enhanced financial support for administrative systems changes, and federal support for state limited-benefit programs. State and county policymakers will need to work together to come up with other information, such as a complete and consistent accounting of current county indigent care funding sources and expenditures, and county-specific data regarding the size, characteristics, and distribution of the residually uninsured, as well as the resources associated with their care needs. Still other informational needs—for example, an analysis of financial projections for DSH hospitals after ACA coverage expansions and anticipated DSH reductions—could be addressed by independent research.

Unlike state-county discussions in other policy areas, the realignment conversation sparked by federal health reform is not exclusively about devolving responsibility from the state to county governments. Rather, the ACA calls for an expanded role for both the state—as a provider of coverage—and the counties (particularly provider counties)—as deliverers of care. Unless the state decides to assume full responsibility for low-income populations, including those who remain uninsured, it is likely that a shared governance model for the financing and delivery of care for the residually uninsured will be devised. And, given the complex interplay between health coverage and human services programs, future eligibility systems and business processes might evolve to reflect a new partnership, with the state assuming responsibility for a consolidated automated system for public insurance—and also, potentially, for human services—programs, and the counties assuming responsibility for business processes.

State fiscal considerations are likely to play an important role in the implementation of federal health reform. But the ACA offers policymakers an opportunity to marry the transactional discussion around financing new state costs with the policy conversation around aligning the financing, delivery and administration of indigent health care to improve coverage, access to care, and health outcomes.

References

Buettgens, Matthew, John Holahan, and Caitlin Carrol. 2011. *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid*. Washington DC: Urban Institute.

California Association of Public Hospitals. 2011. *The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems*. Policy Brief. Oakland, CA.

California Health Benefit Exchange Board. 2012a. September 18, 2012 Minute Meetings.

California Health Benefit Exchange Board. 2012b. August 23, 2012 Minute Meetings.

California HealthCare Foundation. 2009. *California County Indigent Care Program Profiles.* Available at www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20ProfilesIndigent2009.pdf.

County Medical Services Program. "CMSP Eligibility All Counties by Aid Code by Month." Available at www.cmspcounties.org/pdf_files/data/CMSP-1112.pdf.

Gruber, Jonathan, and Ian Perry. 2011. *Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable?* New York: Commonwealth Fund.

Health Management Associates. 2009. *Considerations for Redesign of the California Children's Services Program.* Available at www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Considerations%20for%20Redesign%20of%20the%20CCS%20Program.pdf.

Holahan, John, and Irene Headen. 2010. *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.* Washington DC: Kaiser Family Foundation.

Jacobs, Ken, Dave Graham-Squire, Gerald F. Kominski, Dylan H. Roby, Nadereh Pourat, Christina M. Kinane, Greg Watson, Daphna Gans and Jack Needleman. 2012. *Remaining Uninsured in California under the Affordable Care Act: Regional and County Estimates.* UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research.

Kaiser Family Foundation. 2012. *Implementing the ACA's Medicaid Related Health Reform Provisions After the Supreme Court's Decision.* Washington DC.

Kelch, Deborah. 2005. *Caring for Medically Indigent Adults in California: A History*. Oakland: California HealthCare Foundation.

Kelch, Deborah. 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. Oakland: California HealthCare Foundation.

Kominski, Gerald F., Ken Jacobs, Dylan H. Roby, Dave Graham-Squire, Christina M. Kinane, Greg Watson, Daphna Gans, and Jack Needleman. 2012. *Health Insurance Coverage in California under the Affordable Care Act: Presentation to the California Health Benefit Exchange Board.* UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research.

Lavarreda, Shana Alex, and Livier Cabezas. 2011. *Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform.* Health Policy Research Brief. Los Angeles: UCLA Center for Health Policy Research.

Legislative Analyst's Office. 2001. *Realignment Revisited: An Evaluation of the 1991 Experiment in State-County Relations.* Available at www.lao.ca.gov/2001/realignment/020601_realignment.html.

Lewin Group. 2010. "The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending." Staff Working Paper #12. Available at www.lewin.com/~/media/Lewin/Site_Sections/Publications/Lewin_Impact_of_Medicaid_Expansions_on_State_Spending.pdf.

Long, Peter, and Jonathan Gruber. 2011. "Projecting the Impact of the Affordable Care Act on California." *Health Affairs* 30 (1): 63–70.

Lucia, Laurel, Ken Jacobs, Miranda Dietz, Dave Graham-Squire, Nadereh Pourat, and Dylan H. Roby. 2012. *After Millions of Californians Gain Health Coverage Under the Affordable Care Act, Who Will Remain Uninsured?* UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research.

Rosenstein, Stan, Caroline Davis, and David Fosdick. 2012. *Financing County Medi-Cal Eligibility and Enrollment in California*. Oakland: California HealthCare Foundation.

Sommers, Benjamin, and Sara Rosenbaum. 2011. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs* 20 (2): 228–36.

Technical Assistance Collaborative and Human Services Research Institute. 2012. *California Mental Health and Substance Use System Needs Assessment, Final Report.* Available at www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf.

Watson, Sara, and Alison Klurfeld. 2011. *California's Mental Health System.* Los Angeles: Insure the Uninsured Project.

Wulsin, Lucien. 2012. *Mental Health and Substance Abuse In California's Public Health Programs*. Los Angeles: Insure the Uninsured Project.

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