



CALIFORNIA
HEALTHCARE
FOUNDATION

Financing County Medi-Cal Eligibility and Enrollment in California

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

by

Stan Rosenstein

Caroline Davis

David Fosdick

HEALTH MANAGEMENT ASSOCIATES

July 2012

About the Authors

Stan Rosenstein, MPA, is a principal advisor with **Health Management Associates (HMA)**, a national health policy research and consulting firm. Prior to joining HMA in 2009, Rosenstein was the longtime director of Medi-Cal, the California Medicaid program, with responsibility for all aspects of Medi-Cal policy, financing, and operations. Caroline Davis, MPP, is a senior consultant with HMA. Prior to joining HMA, Davis was a member of the California Medicaid leadership team and worked with counties on eligibility and enrollment issues. David Fosdick is a consultant with HMA who worked previously as a fiscal analyst at the nonpartisan Michigan Senate Fiscal Agency, focusing on Medicaid and human services budget issues.

Acknowledgments

The authors particularly wish to thank staff at the California Department of Health Care Services, the California Department of Social Services, and the County Welfare Directors Association of California for their assistance with this project.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Contents

2 I. Executive Summary

7 II. Introduction

Coming Changes to Program Administration
Scope of This Paper

9 III. Current Funding Sources and Structures for the Administration of Public Assistance Programs

Medi-Cal Administration Funding
CalWORKs Administration Funding
CalFresh Administration Funding

18 IV. Shared Administrative Budgeting Among Public Assistance Programs

Medi-Cal's Impact on Shared Administrative Costs
Effect of State Budget Reductions on Administrative Spending
Impact of Budget Cuts on County Staffing Levels

21 V. Impending Changes to Medi-Cal Administration

Changes in Medi-Cal Budgeting Methodology
Future of the Healthy Families Program
ACA Implementation

26 VI. Conclusion

28 Endnotes

I. Executive Summary

IN CALIFORNIA, COUNTY SOCIAL SERVICE offices serve as the primary point of contact for individuals applying for Medi-Cal (Medicaid) and other public assistance benefits for low-income residents, including cash assistance and the Supplemental Nutrition Assistance Program (SNAP) (formerly the food stamps program). A combination of state, federal, and county-appropriated funds (a total of \$3.1 billion in state fiscal year 2010–2011) supports program eligibility determination, program enrollment, and case maintenance. County staff generally perform many administrative activities across all of these programs, so changes in administration or budgets affecting one program are likely to affect others as well.

Scope of This Paper

This report focuses on California's three largest county social service agency-administered programs with income-based eligibility: Medi-Cal; the Temporary Assistance for Needy Families (TANF) program, known as California Work Opportunity and Responsibility for Kids (CalWORKs); and SNAP, known as CalFresh, along with the related state-funded California Food Assistance Program (CFAP).

The first part of this report examines how California finances county administration of these programs and explores recent budget impacts. The second part considers the likely impact of certain changes under the Affordable Care Act (ACA) and new state laws. The report is based on state and federal statutory requirements, Medi-Cal estimates, state and county budget documents, information from the California Department of Social

Services, and interviews with staff at the California Department of Health Care Services, the County Welfare Directors Association of California, and a former county social service director.

Current Funding Sources

The state, counties, and federal government jointly support the county administration of income-based public assistance programs through a combination of funding streams:

- For Medi-Cal, the federal government, for the most part, matches the state's contribution (50% each).
- For CalWORKs, a federal block grant covers services and administrative costs, as well as state and county Maintenance-of-Effort funding.
- For CalFresh, federal funding for administrative costs is set at 50%; the non-federal share is divided between the state (70%) and the counties (30%); funding for CFAP administrative costs comes solely from the state.

Because of these funding methodologies, counties have an incentive to use Medi-Cal as much as possible (within federal and state rules) to support common county administrative costs. However, due to California's ongoing budget crisis, the state has reduced funding for county Medi-Cal administration, which therefore affects the other two programs as well.

Medi-Cal Administration Funding

County social service agencies handle most eligibility and enrollment functions for Medi-Cal. In 2010–2011, counties received nearly \$1.3 billion in federal and state funds for Medi-Cal administration. The federal government covers 50% of most Medi-Cal administrative expenditures, and more for eligible information technology systems. The non-federal share is paid entirely through the state’s General Fund. To control these expenditures, however, the state has recently implemented cost control measures that have meant a 20% reduction in available funding to counties.

The state calculates payments to counties for Medi-Cal administration by establishing a base allocation, then two years later reconciling that initial allocation with actual county administrative expenses for that fiscal year. A new methodology is being developed in which cases will be grouped based on the time and resources needed to conduct eligibility determinations.

CalWORKs Administration Funding

CalWORKs provides cash assistance plus employment and support services to eligible low-income families with children. County social service offices handle eligibility determination, enrollment, and case maintenance. Administrative costs are covered by combined federal (60%) and state (40%) funds, but because California expends its federal block grant each year, any program cost increases are paid from the state General Fund. Counties may move funds between administrative and service needs, and may allocate additional funding to meet growing caseloads.

CalFresh Administration Funding

Food benefits are provided to eligible low-income individuals under CalFresh and CFAP. Administration of CalFresh is funded through a combination of federal, state, and county funds, while CFAP administration is completely state-funded. In recent years, the state has reduced financing for CalFresh administration, and no inflation adjustment has been provided since 2000–2001, though the state did provide funding to address caseload growth of 35% between May 2009 and May 2011. The state passed legislation in 2011 intended to provide administrative simplifications and workload reductions for counties administering CalFresh, which may reduce some administrative costs.

Shared Administrative Budgeting Among Public Assistance Programs

Using a variety of methods, counties pool state and federal funding for each program to cover shared administrative costs. Since the Medi-Cal case volume is by far the largest of these programs, and all CalWORKs and most CalFresh beneficiaries also are enrolled in Medi-Cal, Medi-Cal funds a large share of administration for all three programs. Also, federal funding for Medi-Cal administration is not capped, while CalWORKs is provided a fixed amount of federal funding and CalFresh requires counties to fund a portion of its administrative costs.

Effect of State Budget Reductions on Administrative Spending

State budget woes mean counties cannot count on the reconciliation process to make them whole if they spend over their allocation, and some counties have reduced administrative spending rather than risk exceeding this amount. This results in difficulty maintaining customer service levels. Fewer eligibility

workers and larger caseloads can cause backlogs and other delays that make it more difficult for new applicants to enroll and for counties to process redeterminations. No comprehensive analysis has been conducted of the impact of administrative budget cuts on Medi-Cal applicants and enrollees or on total Medi-Cal caseload. As a result, the state does not know the net impact of these budget reductions on the overall cost of Medi-Cal and whether the reductions have contributed to the large Medi-Cal caseload increases.

Impact of Budget Cuts on County Staffing Levels

This report presents data on social services staffing levels in the state's five largest counties. From 2004–2010, the state's largest counties other than Los Angeles experienced significant increases in Medi-Cal, CalWORKs, and CalFresh caseloads, but decreases or only small increases in staffing. This suggests that changes in eligibility staffing levels have not kept pace with county caseload growth. However, policy changes and greater automation have simplified programs such as CalFresh, so that not all increased caseloads translate into increased staff workloads.

Significantly, during the same period, Los Angeles County experienced a small increase in overall staffing and only a slight increase (and a recent decrease) in its Medi-Cal caseload. Los Angeles County's relatively small caseload change is not consistent with the experience of other counties. As over one-third of the state's Medi-Cal population resides in Los Angeles, further analysis is needed to determine the underlying reasons for the decline in enrollment in the county compared to the significant caseload growth in other large counties.

Impending Changes to Medi-Cal Administration

Three sets of impending changes to the benefit programs examined in this paper may significantly affect their administrative budgets.

Revised Budgeting Methodology

A new budgeting methodology for determining Medi-Cal administrative payments to counties is being developed. Assembly Bill 102 (2011) requires that counties be reimbursed for the time and resources necessary for eligibility determination or redetermination.¹ The state is to work with counties to identify and consider changes that would align workload responsibilities with available funding if the state fails to fully fund allocations based on the new methodology. The impact of this new methodology is unclear, although in the current economic crisis it is unlikely the state would increase overall funding.

Future of Healthy Families Program

Under the state fiscal year 2012–2013 California Budget, the state will close the Healthy Families Program (HFP) and move health coverage for nearly 900,000 children from HFP to Medi-Cal, beginning no earlier than January 1, 2013. When these children become eligible for Medi-Cal, responsibility for determining individual eligibility for this group will shift from a private entity (under HFP) to county social service offices, although a vendor will continue to screen applications received at the Single Point of Entry and collect premiums. As a result, county workloads will increase to accommodate applications received at the county. In response, Medi-Cal funding to counties for eligibility and enrollment activities will rise, the amounts depending on the size of the caseload increase and the level of state reimbursement. This will relieve some pressure

on counties to shift costs to other programs (e.g., CalWORKs and CalFresh).

ACA Implementation

- **Realignment of Health Care Programs.** The governor's proposed state fiscal year 2012–2013 budget discusses changing state and county responsibilities for the funding and delivery of certain health care services. These changes would respond to the movement of eligible low-income uninsured Californians out of county-provided health care programs and into Medi-Cal or other coverage to be made available through the ACA-mandated insurance exchange.² In particular, the governor's proposal indicates that the counties' financial responsibility for some health care programs may be changed as part of the implementation of federal health reform. While not being enacted as part of the state's 2012–2013 budget, the governor is expected to include in his 2013–2014 budget a proposal to address state and county funding if the state implements the ACA's Medicaid expansion.
- **Medicaid Expansion and Eligibility Simplification.** If California expands Medi-Cal coverage as allowed and encouraged by the ACA, Medi-Cal enrollment is estimated to grow by 1.4 million people beginning in 2014, with some estimates significantly higher. At the same time, the ACA requires significant simplification of many aspects of the Medicaid eligibility process (e.g., elimination of complex asset and deprivation eligibility tests and use of electronic eligibility verification processes). Also, federal regulations are streamlining the Medicaid redetermination process to synchronize it with the ACA's reliance on electronic verifications. States will be required to redetermine eligibility no more frequently than every 12 months for most Medicaid eligibility groups. If California expands Medi-Cal, the overall increase in enrollees could significantly increase county workloads, but some of the increase will be offset by these eligibility simplifications.
- **Role of California's Health Benefit Exchange.** Under the ACA, health insurance exchanges are required to play a role in Medicaid eligibility determination, and California's exchange-implementing legislation requires its exchange to enroll eligible individuals into Medi-Cal if they apply via the exchange. Recent federal regulations, however, leave it up to each state to decide whether final eligibility for most Medicaid applicants will be determined by the exchange or by Medicaid. The California exchange board continues to explore its options, which makes it unclear exactly how local county social service offices will interact with the state's exchange and whether they will retain responsibility for all Medicaid eligibility determinations and redeterminations.
- **Eligibility Determination System Upgrades.** The federal government has extended enhanced funding for ACA-related upgrades to Medicaid eligibility determination systems until December 31, 2015, and permanently for related, ongoing systems maintenance. However, the enhanced funding may only be available for one eligibility determination system per state, and California has three. State officials have indicated that they will soon consolidate its three systems into two, but it is unclear whether federal officials will consider this sufficient to qualify California for any of the available enhanced funding.

- **Basic Health Program.** Under the ACA, states can elect to create a Basic Health Program (BHP) to provide coverage to eligible individuals with incomes under 200% of the federal poverty level who do not qualify for Medicaid. In the absence of a BHP, these individuals would be eligible for subsidized coverage through the state's health benefit exchange. California is currently considering legislation that would create a BHP which could provide coverage for an estimated 725,000 to 948,000 individuals. County workloads could increase if counties are responsible for eligibility determination and ongoing case maintenance for BHP enrollees, although it is possible that DHCS could contract with the state's insurance exchange for these activities or perform them itself.

Conclusion

In recent years, efforts to reduce state General Fund expenditures for Medi-Cal, CalWORKs, and CalFresh administration have affected county performance of eligibility determination and enrollment, leaving counties to manage greater caseloads with fewer staff. Because county staff work with clients across a range of programs, reductions in administrative funding for one program affect other programs as well. The sources of funding — federal, state, and county — that support administrative costs for different programs also play an important role. The differences in funding may affect cost and staff levels as counties shift resources between programs to limit their fiscal exposure and to maximize state and federal funding.

Looking ahead, California is moving toward a new budgeting methodology for county administration of Medi-Cal at the same time as more funding cuts are possible. State policymakers will need to assess the impact of budget reductions on

services provided to clients and the overall impact of these reductions on Medi-Cal caseloads and costs. Further, policymakers will need to analyze the underlying causes for Los Angeles County's relatively flat Medi-Cal caseload growth at the same time as caseloads in other large counties have been growing at a significant rate.

The federal ACA will alter the landscape as well. Some of its changes are likely to reduce county workloads while others could increase the burden on counties. State policymakers, the counties, and other stakeholders must create eligibility and enrollment processes that are efficient and that minimize the burden on individuals seeking coverage. How this is accomplished may greatly affect ongoing county administrative costs and could affect other county-administered programs. If counties incur additional costs, it is unclear how they will be funded given the state's budget crisis. On the other hand, the ACA provides counties with the opportunity to reshape their role in the Medi-Cal eligibility process.

II. Introduction

IN CALIFORNIA, COUNTY SOCIAL SERVICE offices serve as the primary point of contact for individuals applying for Medi-Cal (Medicaid) and other public assistance benefits for low-income residents, including cash assistance and the Supplemental Nutrition Assistance Program (SNAP) (formerly known as the food stamps program). For state fiscal year (SFY) 2010–2011, the California Budget appropriated nearly \$3.1 billion to counties to support eligibility determination, program enrollment, and case maintenance associated with these public assistance programs. These funds, which include county-appropriated amounts, are used to support eligibility caseworkers and staff, information technology (IT) systems, and other associated overhead.

County staff generally perform administrative activities across these programs. Eligibility rules between the programs are similar (sometimes identical), and beneficiaries often seek access to multiple programs at a single county social service office. Consequently, changes in program administration or budgets intended to affect one program, such as Medi-Cal, are likely to affect county administration of the other programs as well.

Coming Changes to Program Administration

Under national health reform, Medi-Cal enrollment is projected to grow by an estimated 1.8 million people, beginning in 2014, and potentially by as many as 3 million people, significantly increasing the burden of program administration.³ Moreover, implementation of the Patient Protection and Affordable Care Act (ACA) is likely to result in major

changes to the Medi-Cal eligibility determination process and its funding. The ACA aims to simplify the Medi-Cal application, eligibility determination, and renewal processes for families and children, including the automation of many data verification functions.

Additionally, the ACA and California's implementing legislation both require the new California Health Benefit Exchange to determine Medi-Cal eligibility under the ACA's simplified income-eligibility rules for those applications it receives, if it is possible to do so, and to coordinate with counties, among other entities, for eligibility determination purposes. Under current state law, counties will then be responsible for case maintenance for anyone determined eligible for Medi-Cal. To the extent counties are asked to assume greater or fewer responsibilities, state funding will need to be adjusted to ensure that counties are adequately and appropriately compensated for their costs. It will also be important to consider the secondary effect any change in Medi-Cal administrative funding could have on other programs administered by the counties.

Historically, the state has allocated administrative payments to counties based upon a projection of the actual county costs to administer public assistance programs. In recent years, however, state budget cuts have resulted in significant reductions in state support for county administrative activities. In addition, state law now mandates the development of a revised budgeting methodology for determining Medi-Cal administrative payments to counties.⁴ This new methodology must account for the costs, time, and resources necessary for eligibility determinations

and redeterminations by county. The new budgeting methodology, when implemented, could have a significant impact on counties, depending on the final proposal submitted by the California Department of Health Care Services (DHCS) and adopted by the legislature. For example, while it is unlikely in this budget environment that the state would increase the total funding available, if the methodology changes how funds are distributed among the counties, it could result in meaningful changes on a county-by-county basis in how counties perform Medi-Cal administrative activities. Further, a new methodology could bring greater transparency to county allocations and require the state to work with the counties in determining changes in county workloads due to reductions in state funding.

Finally, the state fiscal year 2012–2013 California Budget will move health coverage for nearly 900,000 children from California’s Children’s Health Insurance Program, known as the Healthy Families Program (HFP), to Medi-Cal. This will shift responsibility for eligibility determination, program enrollment, and case maintenance for these children to the counties. State law requires Medi-Cal to consider the counties’ increased cost in determining state budget allocations for this workload. Accordingly, this shift will result in increased state funding to the counties for Medi-Cal administrative activities, some of which could offset costs that are shared among Medi-Cal, CalWORKs, and CalFresh.

The state and counties will have to account for all of these changes during a time when the infrastructure used to support the administration of public benefit programs is experiencing uncommon stress. High unemployment and other financial woes in many regions is driving higher program caseloads at a time when tax revenue available to the state and counties has fallen sharply.

Scope of This Paper

While the counties administer a number of public benefit programs, this report focuses on three:

- Medi-Cal
- Temporary Assistance for Needy Families (TANF), known as California Work Opportunity and Responsibility for Kids (CalWORKs)
- SNAP, in California called CalFresh, and the solely state-funded California Food Assistance Program (CFAP)

These are the largest county-administered programs for which eligibility is determined based on income and assets, and all of them are administered by county social service agencies. The first part of this report examines how California finances county administration of these programs and explores recent budget decisions that have affected county administrative funding.

The second part of the report considers the likely impact on counties of some of the major changes required under the ACA and new state laws, as well as other proposed changes, with an emphasis on county administrative activities related to Medi-Cal eligibility and enrollment. The report is based on a comprehensive review of state and federal statutory requirements, Medi-Cal local assistance estimates, recent state and selected county budget documents, and information provided by the California Department of Social Services (CDSS). Also, interviews were conducted for the report with staff at DHCS, the County Welfare Directors Association of California (CWDA), and a former county social service director.

III. Current Funding Sources and Structures for the Administration of Public Assistance Programs

THE STATE, COUNTIES, AND FEDERAL government jointly support the county administration of health and social service public assistance programs through a combination of funding streams. For a comparison of funding for the three programs examined in this paper, see Table 1.

Funding for these programs is governed by federal claiming and cost allocation rules as well as by a wide variety of state and federal regulations that affect both the amount of available funding and the mix of state, federal, and county dollars available to each program.⁵

Table 1. Enrollment and Budgeted Funding for County Administration of Public Benefits, SFY 2010–2011

	MEDI-CAL	CALWORKS	CALFRESH	TOTAL
Enrollment (in millions)				
Average monthly enrollees	6.1	1.5	3.6	N/A*
Share of total	54%	13%	32%	N/A*
Funding (in millions)				
Federal	\$632	\$360	\$574	\$1,566
State	\$632	\$243	\$491	\$1,366
County	\$0	\$0	\$143	\$143
Total	\$1,264	\$603	\$1,208	\$3,075
Share of total	41%	20%	39%	100%

NOTES REGARDING ENROLLMENT:

*The enrollment figures reflect duplicated counts across programs.

Medi-Cal. Authors’ calculation of Medi-Cal enrollment, less those eligible for Medi-Cal through receipt of Supplemental Security Income benefits. Supplemental Security Income-Medi-Cal beneficiaries identified via the Public Assistance Aged, Public Assistance Blind, and Public Assistance Disabled aid code categories. Supplemental Security Income enrollees automatically qualify for Medi-Cal benefits. As a result, counties are not responsible for determining Medi-Cal eligibility for these individuals.

Share of total. Reflects sum of enrollment in each program, including duplicates.

NOTES REGARDING FUNDING:

CalWORKS. Counties are provided a single allocation to support CalWORKS services and the administrative costs associated with providing services. Within this allocation, it is possible for counties to shift some funding between administration and services. As a result, expenditures for administration could be larger or smaller than the allocated amounts documented in Table 1.

CalFresh. Funding data provided by California Department of Social Services via personal communication (February 11, 2011).

Share of total. The authors note the significant differences in the cost per case between Medi-Cal, CalWORKS, and CalFresh. To date, no analysis has been completed that compares the costs across these programs or analyzes the reasons for the differences.

Sources: State of California, Department of Health Care Services, *Trend in Medi-Cal Program Enrollment — Most Recent 24 Months, 12/2009–11/2011*, November, 2011, www.dhcs.ca.gov. State of California, Department of Social Services (CDSS), *CalWORKS Cash Grant Caseload Movement Report* (CA 237 CW, Lines 8a3 and 8b3, all columns, www.cdss.ca.gov) and *Food Stamp Program Participation and Benefit Issuance Report* (DFA 256), www.cdss.ca.gov. CDSS calculation of fiscal year average of monthly reports, July 2010 through June 2011. The data include total individuals in CalFresh federal, state, and federal/state combined households.

The methodology used to determine each county's allocation for program administrative costs has several components:

- Current year funding is adjusted to reflect assumed cost changes associated with program caseload and policy changes.
- The base funding may be adjusted for inflation.⁶
- The administrative allocation is adjusted to reflect any inconsistency between prior year allocations and actual spending.
- The final allocations also are influenced by formal arrangements and legal settlements between counties, the state, and clients.

Contributions to the programs' administrative budgets come from a mix of sources. For Medi-Cal, the federal government matches the state's contribution (50% each). For CalWORKs, the federal contribution is fixed as part of a block grant that covers California's cash grant program, services, child care, and administrative costs. For CalWORKs to receive a federal grant, there must be a set level of state and county Maintenance-of-Effort funding. For the CalFresh program, federal funding for administrative costs is set at 50%. The non-federal share is divided between the state (70%) and the counties (30%). Funding for CFAP administrative costs comes solely from the state.

The sources and structure of funding for each program's administrative costs are discussed in greater detail in the immediately following sections. However, before entering those individual discussions, it is important to understand key elements of how eligibility determination, enrollment, and administration for the three programs intersect with each other:

- Of the three programs, Medi-Cal has the largest caseload and accounts for the most funding for county administration. The caseload for CalFresh is 40% less than for Medi-Cal but spending for county administration of the two programs is about the same. Caseload and administrative spending for CalWORKs is considerably smaller than for either of the other two programs.⁷
- Within the bounds of federal cost-allocation rules, counties can and do share state and federal administrative funding across a number of programs and shift staff or costs as needs and/or available funding levels change.
- Federal funding for county administration of Medi-Cal is not capped, and funding is divided equally between the federal and state governments. Federal funding for CalFresh is likewise uncapped, but it requires a contribution (15%) from the county. By contrast, federal funding for CalWORKs is capped, so any additional funding for administration would require either additional state General Fund support or an offsetting reduction in benefit payments.
- Because of these different funding methodologies, counties have an incentive to use Medi-Cal as much as possible (within the rules) to support common county administrative costs. However, due to California's ongoing budget crisis, the state has reduced General Fund support for county Medi-Cal administration. These cuts have effectively de-linked the amount budgeted for administrative activities from actual county costs, and counties are potentially at-risk for the non-federal share (i.e., half) of any costs that exceed the amount budgeted by the state.

Medi-Cal Administration Funding

Medi-Cal is the main source of public-sector health coverage in California. Medi-Cal benefits are available to a wide range of people with low income and assets, including families, children, pregnant women, individuals in need of long-term care services, the elderly and disabled, and people with breast or cervical cancer.

The Medi-Cal eligibility determination process is extremely complicated and its rules continually evolve through changes in state and federal law and regulations, as well as through litigation. In California, county social service agencies are responsible for eligibility and enrollment functions associated with most of the Medi-Cal program.⁸

Sources of Funding for Medi-Cal Administration

In SFY 2010–2011, counties received nearly \$1.3 billion in federal and state funds to support the administration of Medi-Cal. This included human resources costs for staff associated with the program, operation of IT systems, and additional overhead costs (e.g., a portion of the costs associated with the offices of the auditor-controller, county counsel, and/or the county administrator).

The federal government contributes 50 cents of every dollar for most eligible Medi-Cal administrative expenditures.⁹ For IT systems that are part of the Medicaid Management Information System (MMIS), however, the federal government contributes a larger percentage. The MMIS includes the Medicaid claims processing system and its related subsystems, part of which is the Medicaid eligibility reference system (known in California as the Medi-Cal Eligibility Data System, or MEDS). The federal government contributes 90 cents of every dollar of the cost of design, development, and implementation of the state’s MMIS, and 75 cents of every dollar toward

operating costs, including staff. California’s three automated eligibility determination systems, known collectively as the Statewide Automated Welfare Systems (SAWS), are not considered part of the MMIS and therefore receive only the general 50% federal administrative matching rate. However, as discussed in Section V of this paper, recent federal regulations provide states with the ability to claim the 90% MMIS match for a limited time for certain ACA-related eligibility system changes. ACA-related changes to eligibility systems also qualify for a 75% MMIS match rate for ongoing maintenance costs. The various Medi-Cal administrative matching rates are summarized in Table 2.

Table 2. Federal Matching Rates for Medi-Cal Administration, by Category

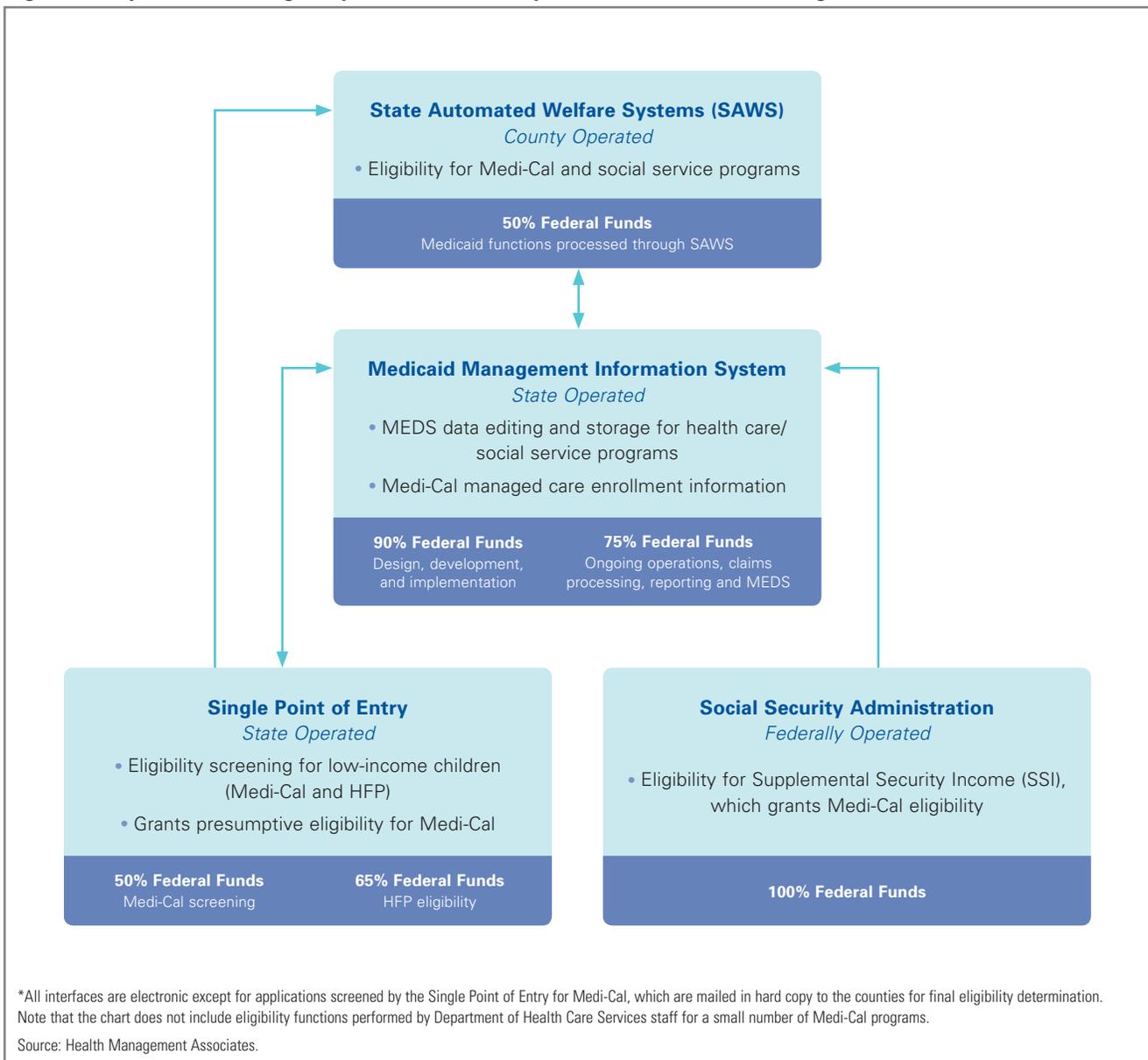
	FEDERAL SHARE	STATE SHARE
Non-IT Administrative Costs		
General Medi-Cal administration (including eligibility determination)	50%	50%
MMIS Costs (includes MEDS)		
Design, development, and implementation	90%	10%
Ongoing maintenance and operations (including staff costs)	75%	25%
SAWS Costs (non-ACA-related)		
Design, development, and implementation	50%	50%
Ongoing maintenance and operations	50%	50%
SAWS Costs (ACA-related)		
Design, development, and implementation (expires December 31, 2015)	90%	10%
Ongoing maintenance and operations	75%	25%

Source: Social Security Act, Title XIX.

The relationships between the major Medi-Cal eligibility and enrollment IT systems (with their associated matching rates) are shown by the flow chart in Figure 1. While not specifically discussed in this paper, the state’s Single Point of Entry is included in this chart because of its role in screening children’s applications for Medi-Cal and HFP, and to further illustrate the variety of federal funding support

provided for health care eligibility and enrollment functions. The chart also includes the federal Social Security Administration, which determines eligibility for the Supplemental Security Income (SSI) program and thus categorical eligibility for Medi-Cal. Also, once California’s ACA-mandated insurance exchange is operational, it also will interface with the MMIS, MEDS, and SAWS.

Figure 1. Major Medi-Cal Eligibility and Enrollment Systems and Federal Matching Rates*



The non-federal share of the costs of county Medi-Cal eligibility determination, enrollment, and case management is established and budgeted by the state and paid entirely through the state's General Fund, with the total matched by the federal government. Table 3 summarizes the Medi-Cal administrative allocation provided to counties in SFY 2010–2011.

Table 3. Medi-Cal County Administrative Allocation, SFY 2010–2011 (in millions)

	FEDERAL	STATE	TOTAL
Total Salary and Benefit Cost	\$441	\$441	\$882
Total Support Cost*	\$200	\$200	\$400
Total Staff Development Cost	\$10	\$10	\$19
Assumed Policy Changes	— \$19	— \$19	— \$38
Total†	\$632	\$632	\$1,265

*Includes overhead costs, such as equipment, rent, and IT. IT costs shown include only those county costs that qualify for the regular federal Medicaid administrative matching rate of 50%.

†Figures may not match due to rounding.

Source: State of California, Department of Health Care Services, County Administration, Fiscal Forecasting and Data Management Branch, *Medi-Cal May 2011 Local Assistance Estimate for Fiscal Years 2010–11 and 2011–12*, www.dhcs.ca.gov.

Medi-Cal Payment Methodology

The state calculates payments to counties for Medi-Cal administration using a two-step process. Initially, each county receives a base allocation which reflects its share of the total funding included in the state's budget for these activities. Then two years after the completion of each fiscal year, the state reconciles the initial budget allocations with actual county administrative expenses for that year. This recalculation is subject to a limitation that total expenditures statewide cannot exceed the budgeted amount.

Calculation of base allocation. Under California law, county administrative allocations are determined using a formula that reflects actual, county-specific staff costs, adjusted for anticipated changes in policy and program caseload. These allocations are intended to reflect the best understanding of the likely Medi-Cal eligibility costs that will be incurred by the counties. Each county's base allocation is calculated using county-submitted workload and spending data regarding three elements:

- **Staff costs.** This element of the base allocation uses a two-step process to estimate costs for eligibility workers, eligibility supervisors, clerical support staff, and administrative staff. First, the state estimates the average monthly eligibility determination levels for the intake and maintenance of Medi-Cal cases based on the previous fiscal year. Second, the state estimates the staff levels that will be needed to meet this Medi-Cal activity. Cost per worker is based on the average annual salary and benefits for each worker.
- **Staff development costs.** The base allocation also provides reimbursement to counties for staff development costs associated with training new caseworkers regarding Medi-Cal eligibility procedures. This allocation explicitly accounts for salary and benefits costs of employed trainers, supplies, and travel reimbursement.
- **Support costs.** County allocations reflect the overhead costs associated with supporting Medi-Cal administrative activities. This includes county-incurred operating support costs (e.g., equipment and rent) and the cost of IT systems used by county caseworkers to determine program eligibility. Counties are reimbursed for these costs across several assistance programs that share common resources.

Adjustments to base allocation. The state adjusts base allocations to counties to reflect matters that will change the cost of Medi-Cal eligibility and enrollment activities, including an inflationary adjustment (when provided), estimated changes in program caseload, and the impact of other policy changes implemented by the state:

- **Cost of doing business adjustment.** The base allocation is adjusted to reflect inflationary changes in personnel costs. This is known as the Cost of Doing Business (CODB) adjustment and is tied to the California Necessities Index (a state-specific measure of inflation) or to increases in state employee salaries, whichever is greater. As discussed below, however, the state has not funded the CODB adjustment since SFY 2007–2008.
- **Changes in Medi-Cal caseload.** The base allocation is also adjusted to reflect projected changes in the county’s Medi-Cal caseload. Medi-Cal caseloads have grown steadily for most of the last decade, increasing by 11% statewide between 2004 and 2010.¹⁰ Full funding for anticipated caseload growth, however, has not always been provided in recent years (e.g., the state did not fund Medi-Cal caseload growth for SFY 2008–2009).¹¹
- **Policy changes.** Each county’s base allocation is adjusted to reflect the impact of policy changes that will affect administrative expenditures. Examples of policy adjustments to county allocations include expected savings or costs related to: process changes, upgrades in IT, changes in state or federal policies, changes in Medi-Cal eligibility standards, and reductions mandated by the legislature. Each of these changes is separately accounted for in the

DHCS and Counties Developing New Medi-Cal Administrative Budgeting Methodology

California Assembly Bill (AB) 102 directs the California Department of Health Care Services (DHCS) to work with the counties to develop a new budgeting methodology for county Medi-Cal administrative costs associated with eligibility determinations, case maintenance, and renewals for different groupings of Medi-Cal beneficiaries.¹² Cases are to be grouped based on the time and resources necessary to conduct eligibility determinations, taking into account the complexity of the eligibility rules, ongoing eligibility requirements, and other factors to be determined by DHCS. This new methodology is intended to replace the current base allocation estimate. If the allocations developed under the new methodology are not fully funded in the state budget, DHCS must work with the counties to identify and consider changes to align funding levels with workload responsibilities.

Under AB 102, DHCS can phase in the new methodology. A report regarding the new methodology was due to the legislature by March 1, 2012. The report has not been submitted as of this writing, however, and the earliest the new methodology could be implemented is July 2013.

budget, along with associated assumptions about workload impacts.

Reconciliation process. Two years after the end of each fiscal year, DHCS uses data from CDSS to reconcile reported county administrative expense claims (following federal standards for the reporting of administrative costs) against the initial budget allocations. This reconciliation leads to the following:

- Counties that report actual Medi-Cal administrative costs below their allocation may have future administrative allocations reduced to reflect the difference.

- Counties that report actual Medi-Cal administrative costs above their allocation may be provided sufficient funding to support the overage, paid out of unexpended administrative funds from counties that have not used their full allocation.

Over the last decade, DHCS has been able to use the reconciliation process to fully compensate every county for its reported actual Medi-Cal administrative expenditures. Consistent reductions in available Medi-Cal administrative funding, however, jeopardize this full compensation and make counties increasingly vulnerable to bearing the non-federal share of any administrative expenses that exceed their initial state allocation.

Recent Reductions to the Allocation of Medi-Cal Administrative Costs

In an effort to control its General Fund expenditures, the state has implemented a number of cost control measures that have significantly affected county Medi-Cal administrative allocations. Taken together, these have meant a 20% reduction in available funding to counties over four years.¹³ Specifically, California made across-the-board reductions to county Medi-Cal allocations. Combined federal and state funding was reduced by \$42 million in SFY 2008–2009 and by \$121 million in SFY 2009–2010, with half of these savings accrued to the state General Fund. In addition, the state has not appropriated funding for the CODB adjustment since SFY 2007–2008. The lack of a CODB adjustment affects not only a county’s administrative allocation for a single year but also the county’s base allocation going forward, as the absence of CODB funding in one year is reflected in the county’s base for the following year. As shown in Table 4, if the CODB had been fully funded and counties had

expended their allocations between SFY 2008–2009 and SFY 2011–2012, the SFY 2011–2012 allocation would have been \$149.6 million higher.

Table 4. Budgeted Savings from Averted CODB Adjustments, by State Fiscal Year (in millions)*

	COUNTY IMPACT	
	ANNUAL	CUMULATIVE
SFY 2008–2009	\$64.6	\$64.6
SFY 2009–2010	\$46.4	\$111.0
SFY 2010–2011	\$21.7	\$132.6
SFY 2011–2012	\$17.0	\$149.6
Total	\$149.6	N/A

*Combined federal and state savings.

Source: State of California, Department of Health Care Services, *Medi-Cal Local Assistance Estimates*, state fiscal years 2008–2009 through 2011–2012, www.dhcs.ca.gov.

CalWORKs Administration Funding

CalWORKs provides cash assistance plus employment and supportive services to eligible low-income families with children. CalWORKs also provides state-only funding for certain non-citizen legal residents who are ineligible for the federal TANF program which largely funds CalWORKs. County social service offices are responsible for eligibility determinations for CalWORKs and are required to ensure that applicants meet income, resource, employment status, and family composition standards. Counties are also responsible for enrollment in the program and for monitoring of enrollee status to ensure continued eligibility.

CalWORKs program funding is provided to counties through the CalWORKs Single Allocation, which includes eligibility administration, Welfare-to-Work employment services, and subsidized child care. Administrative costs are covered by a combination of federal and state funds. In SFY 2010–2011, this totaled \$603 million, with federal TANF

grant dollars accounting for 60% (\$360 million) and California's General Fund accounting for the remaining 40% (\$243 million). Unlike Medi-Cal, the federal government does not contribute matching funds toward eligible non-federal expenditures. Rather, federal participation consists of a block grant — approximately \$3.7 billion in SFY 2010–2011 — for both services and administrative costs. Because California fully expends its TANF block grant, and uses state General Fund dollars to support any additional CalWORKs costs, increases in CalWORKs costs reduce the state General Fund whereas decreases in CalWORKs costs result in state General Fund savings.

Federal rules specify that states may not spend more than 15% of their federal TANF funds, or of federally-mandated state expenditures for TANF program activities, on administrative costs.¹⁴ Administrative costs in a TANF-supported program are defined as costs for general administration, coordination, and overhead, including:

- Salaries and benefits for staff performing activities related to eligibility determinations
- Budget preparation
- Program monitoring
- Fraud units
- Services related to accounting, litigation, payroll, and personnel
- Goods and services required for program administration (e.g., supplies, equipment, utilities, rental and maintenance of office space)

To determine CalWORKs county budget allocations, the state estimates future year costs and adjusts them for a variety of factors, including projected changes in caseload, staff development expenditures, automated systems costs, and contract costs. Under the Single Allocation, counties have the flexibility to move funds between components, as necessary, to meet the county's administrative and service needs (e.g., funds allocated for employment services or child care may be used to cover administrative costs).

The state has not funded CODB adjustments for CalWORKs administrative costs since SFY 2000–2001. This means annual changes in CalWORKs administrative payments to counties do not account for inflation or the impact that adjustments in caseworker salary and health coverage costs have upon human resources expenses. However, caseload adjustments are budgeted to provide counties with additional funding to meet the increased needs associated with growing caseloads or to provide less funding when caseloads are declining.

Counties report their actual administrative expenses for CalWORKs, as they do for other social service and assistance programs. Counties report direct costs associated with administration of the program and pool shared costs across assistance programs. State and federal administrative funding is allocated across pooled costs using ratios established through county-administered caseworker time studies conducted according to federal cost allocation principles.

CalFresh Administration Funding

Food benefits are provided to eligible low-income individuals under the federal Supplemental Nutrition Assistance Program (SNAP), called CalFresh in California. Eligibility for CalFresh is largely established by federal law, with state and local governments making eligibility determinations that consider income, resources, and benefit limits. Under federal law, some legal resident non-citizens are ineligible for SNAP benefits. However, California provides food assistance to legal residents, who would otherwise be eligible for SNAP, through the California Food Assistance Program (CFAP), which is entirely supported by state funds. County social service offices are tasked with determining eligibility for both CalFresh and CFAP and with administering and maintaining enrolled cases.

CalFresh benefits are fully federally funded, while CFAP benefits are funded solely by the state General Fund. Administration of CalFresh is funded through a combination of federal, state, and county funds, while the cost of administering CFAP is fully state-funded. (See Table 5.)

Table 5. Food Program Administrative Costs, SFY 2010–2011 (in millions)

	FEDERAL	STATE	COUNTY	TOTAL
CalFresh	\$574	\$491	\$143	\$1,208
CFAP	\$0	\$3	\$0	\$3
Total	\$574	\$494	\$143	\$1,211

Note: Figures do not include costs associated with Food Nutrition Education, Outreach, or Employment and Training Program.

Source: State of California, Department of Social Services, "2010–2011 May Revision."

County administrative funding for CalFresh is based on historical allocations adjusted annually for changes in caseload and other factors (e.g., policy changes). Allocations for CalFresh administration are compared with quarterly expenses reported by individual counties, and future payments are adjusted to reflect actual incurred administrative costs.

As with other public assistance programs in the current economic climate, the state has reduced financial resources available to counties for the administration of CalFresh benefits, and no annual CODB inflation adjustment has been provided since SFY 2000–2001. The SFY 2008–2009 appropriation reduced CalFresh county administrative payments by \$20.9 million (about 3%), a reduction that has not been restored in subsequent years. However, the state has provided funding in response to caseload growth of 35% between May 2009 and May 2011.¹⁵ In addition, the state passed legislation in 2011 intended to provide administrative simplifications and workload reductions for counties administering CalFresh. These changes include moving from quarterly to semi-annual reporting and eliminating the fingerprint imaging requirement.¹⁶

Interestingly, CDSS data show that, for the last three state fiscal years, the counties' actual administrative expenditures have only been approximately 87% of the administrative allocation provided for CalFresh.¹⁷ While the reasons the counties have not spent their full allocations have not been determined, they may reflect the inability of the counties to provide the county share to support new CalFresh staff, the challenge of hiring additional staff quickly to address the large CalFresh caseload increase, or the fact that county costs are actually below the allocation level.

IV. Shared Administrative Budgeting Among Public Assistance Programs

COUNTY SOCIAL SERVICE AGENCIES IN California administer eligibility determination and enrollment activities for multiple public assistance programs, including Medi-Cal, CalWORKs, and CalFresh. A single county caseworker may work with an individual or family to obtain benefits through any one or a combination of these programs, depending on the person's or family's needs. Many counties also have shared facilities and operations, such as call centers, that serve all the programs they administer. These facilities and operations represent significant fixed costs that are shared across all the programs based on federally-established cost allocation methods and a state-developed cost allocation plan. Under these methods, counties pool the funding they receive from the state and federal governments for each program to cover shared customer service costs (e.g., office space and utilities). Accordingly, Medi-Cal funds not only those costs directly attributable to operating the program but also the Medi-Cal portion of shared operations and overhead at the county level. Depending on the county, shared costs may be allocated across more programs than just the three discussed in this paper, such as the In-Home Supportive Services program, child welfare services, and adult protective services.

Medi-Cal's Impact on Shared Administrative Costs

Costs of the state's SAWS eligibility determination systems are shared across a number of health and social service programs, based on each program's caseload, as required by cost allocation rules. The volume of Medi-Cal cases is much larger than that of any other public assistance program, and all CalWORKs and most CalFresh beneficiaries also are enrolled in Medi-Cal. Therefore, Medi-Cal plays a large role in funding the SAWS for all three programs. All federal Medicaid funding for SAWS is included in the DHCS budget, while the state General Fund portion of Medi-Cal funding for these systems is divided between the DHCS and CDSS budgets.¹⁸

Over time, changes in relative workload and funding levels across Medi-Cal, CalWORKs, and CalFresh result in changes to staff deployment, which in turn lead to shifts in how fixed costs and overhead are allocated among the programs pursuant to federal rules. As cuts in state funding have made it more difficult for the counties to fund their administrative costs, the counties have shifted resources to secure as much federal and state funding as possible under federal and state rules. To this end, county Medi-Cal allocations fund a significant portion of local social service agencies' shared administrative activities because Medi-Cal is the largest of the three programs, its federal funding is uncapped, and counties do not have a contribution or share of cost. A program such as Medi-Cal tends to be used as much as possible to support common county administrative costs rather than programs that provide a fixed funding amount

(such as CalWORKs) or that require counties to fund a portion of these costs (such as CalFresh).

Effect of State Budget Reductions on Administrative Spending

The methodology for county Medi-Cal administrative funding allocation was constructed to reflect the projected costs of Medi-Cal eligibility activities incurred by counties for caseload and administrative costs. However, recent spending reductions by the state have effectively de-linked the methodology from the county projections. To date, the reconciliation process has fully funded counties for their reported Medi-Cal expenditures through the shift of available funds from counties that have underspent their allocations to counties that have exceeded their allocations. Even so, recent significant state budget reductions have prompted some counties to reduce administrative spending rather than risk exceeding their budget allocations. Counties cannot assume they will continue to be made whole through the reconciliation process as over-expenditures by most or all counties would exceed the amount available from the state.

Also in response to these state budget reductions, many counties have pursued strategies to become more efficient. Nonetheless, many counties indicate they are having difficulty maintaining historical levels of customer service. Reductions in administrative budgets often result in fewer eligibility workers and larger caseloads for remaining workers, which can cause backlogs and delays that make it more difficult for new applicants to enroll and for counties to process status reports and redeterminations for current enrollees. State Medi-Cal officials report an increase in complaints from clients and consumer advocates about the timeliness of application and redetermination processing as a result of county efforts to reduce administrative costs in response

to the lower levels of state funding. In addition, interviews with a former county social service director and CWDA for this report suggest that some counties have closed social service offices, requiring applicants and existing enrollees to travel further to apply for benefits. A study from 2008 reported that reductions in state appropriations to counties to support the administration of assistance programs were at that time already leading to reductions in program staff, elimination of contracts with community organizations, and longer wait times for clients to apply for and receive benefits.¹⁹

Impact of Budget Cuts on County Staffing Levels

No comprehensive analysis has been conducted of the impact of administrative budget cuts on Medi-Cal applicants and enrollees, the counties, total Medi-Cal caseload, or overall Medi-Cal expenditures. However, Table 6 provides a summary of human services staffing levels in the five largest California counties (by population), which provides some insight into the counties' response to reductions in administrative funding levels. (See page 20.) Together, these five counties account for 54% of California's population, 55% of total Medi-Cal caseload in 2010, and more than 50% of the combined total caseload in 2010 for Medi-Cal, CalWORKs, and CalFresh.²⁰ Table 6 compares changes in staffing levels and county caseloads between 2004 and 2010 for Medi-Cal, CalFresh and CalWORKs.

Between 2004–2005 and 2009–2010, Orange, Riverside, San Bernardino, and San Diego Counties experienced significant increases in Medi-Cal and CalWORKs caseloads and even greater increases in CalFresh caseloads coupled with decreases or only relatively small increases in staffing. Los Angeles County, on the other hand, showed only a small increase in overall staffing and only a slight overall

Table 6. Changes in Budgeted Social Services Staff, Selected Counties, 2004–2010

COUNTY	STAFFING LEVELS						PERCENTAGE CHANGE IN...				
	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	STAFF LEVELS	MEDI-CAL CASELOAD	CALWORKS CASELOAD	CALFRESH CASELOAD	ALL CASELOADS
Los Angeles	13,361	13,389	14,365	14,550	14,492	13,866	3.8%	0.8%	4.3%	50.7%	6.0%
San Diego	2,664	2,674	2,600	2,658	2,656	2,438	-8.5%	22.4%	28.7%	151.6%	32.8%
Orange	3,894	4,041	4,111	4,201	4,201	4,005	2.9%	19.2%	36.1%	123.8%	27.7%
Riverside*	N/A	N/A	3,393	3,551	3,769	3,323	-2.1%	26.3%	56.0%	149.6%	39.1%
San Bernadino	2,151	2,148	2,059	2,064	2,059	2,248	4.5%	23.6%	46.9%	133.8%	37.3%

*For Riverside County, percentages reflect the period 2006–2010.

†Medi-Cal caseload includes those individuals eligible for Medi-Cal through receipt of Supplemental Security Income benefits whose eligibility is determined by the federal Social Security Administration.

Sources:

STAFFING LEVELS: Los Angeles County Department of Public Social Services count of administrative staff, www.ceo.lacounty.gov; San Diego County Health and Human Services Agency count of regional operations staff, www.sdcounty.ca.gov; Orange County Social Services Agency count of staff, bos.ocgov.com; Riverside County Department of Public Social Services count of staff, www.countyofriverside.us; San Bernardino County Department of Transitional Assistance count of staff, www.sbcounty.gov.

CASELOAD INFORMATION: State of California, Department of Health Care Services, Medi-Cal Enrollment Statistical Tables, www.dhcs.ca.gov; State of California, Department of Social Services, Food Stamp Program Participation and Benefits Issuance Report, July 2005, www.cdss.ca.gov and July 2010, www.cdss.ca.gov; Department of Social Services, CalWORKs Cash Grant Caseload Movement Report (CA 237 CW, Line 8, all columns), July 2005, www.cdss.ca.gov and July 2010, www.cdss.ca.gov.

increase and even a recent decrease (between 2008–2009 and 2009–2010) in Medi-Cal caseload.²¹ With the exception of Los Angeles, this suggests that changes in staff allocated for eligibility work have not kept pace with sizeable changes in county caseloads. It should be noted, however, that a number of policy changes coupled with increased automation have simplified programs such as CalFresh (e.g., through the use of online applications and waiver of the face-to-face interview requirement), which means that not all increased caseloads translate into increased workload for staff.

The relatively small change in the reported Medi-Cal caseload in Los Angeles County between 2005 and 2010 is not consistent with the Medi-Cal caseload figures reported in other large counties or statewide. According to DHCS, much of the decline in the Medi-Cal caseload in Los Angeles County is due to a significant reduction in enrollment by undocumented residents (who would qualify for a limited set of Medi-Cal benefits). DHCS’s analysis of

Medi-Cal data, however, has not yielded a definitive specific cause (or causes) of the caseload decline.²² As over one-third of the state’s Medi-Cal population resides in Los Angeles, further analysis is needed to determine the underlying reasons for the decline in enrollment in the county as well as for the significant caseload growth in other large counties.

V. Impending Changes to Medi-Cal Administration

A NUMBER OF ISSUES ASSOCIATED WITH a change in the Medi-Cal budgeting methodology, the governor's proposed SFY 2012–2013 budget, and implementation of the federal ACA may impact the level of county administrative funding for public assistance programs and, in turn, customer service and operations for those programs.

Changes in Medi-Cal Budgeting Methodology

Assembly Bill 102 (2011) requires DHCS to develop a new budgeting methodology to reimburse counties for the administration of Medi-Cal cases. The new rate will reflect the time and resources necessary to complete an eligibility determination (for applicants) or redetermination (for enrollees) based on different groupings of cases.²³ This law does not specify whether the new methodology must be budget neutral, generate savings, or result in recommended funding levels. Rather, the new law requires DHCS to work with the counties to better align county workload responsibilities with available funding if the state fails to fully fund the allocations arrived at through the new methodology. As a result, the impact of the new methodology on county administrative funding levels is unclear, although given the current budget environment it is unlikely the state would be able to increase funding from current levels. Because the county administrative budgets are intertwined across Medi-Cal, CalWORKs, and CalFresh, if the new methodology significantly alters Medi-Cal budgets for county administration, it could also have a ripple effect on these other programs.

Future of the Healthy Families Program

The SFY 2012–2013 California Budget eliminates the HFP and shifts nearly 900,000 children to Medi-Cal.²⁴ HFP-eligible individuals will be enrolled in Medi-Cal beginning no earlier than January 1, 2013.²⁵ Currently, HFP eligibility determinations are conducted by a private vendor. When HFP is closed and HFP-enrolled children become eligible for Medi-Cal, this responsibility will shift to county social service offices although it is anticipated that a vendor will continue to screen applications received at the state Single Point of Entry (SPE) before sending them to the counties for a final eligibility determination. The vendor also will continue to collect any required premiums.

As a result of the HFP shift, county workloads will increase to accommodate children's applications received at the county. Even if the vendor at the state SPE screens applications, counties will make the final Medi-Cal eligibility determination and take on the responsibility for case maintenance and redeterminations for these children, as well as any state-mandated status reporting required beginning in 2014. State Medi-Cal administration funds will increase, the amount depending on the magnitude of the caseload increase and the ability of the state to fund reimbursement for county Medi-Cal administrative costs.

ACA Implementation

The ACA enacted a number of significant changes in Medicaid policy, including the potential for a major increase in the number of Medicaid-eligible individuals as well as adjustments in how Medicaid eligibility is determined. These changes, which

will impact counties' administrative workload and the costs of Medi-Cal administration, include the following.

Realignment of Health Care Programs

The governor's proposed SFY 2012–2013 budget briefly discussed changing state and county responsibilities for the funding and delivery of certain health care services. These changes would respond to eligible low-income uninsured Californians moving out of county-provided health care programs and into Medi-Cal or other coverage available through the ACA-mandated insurance exchange.²⁶ In particular, the proposed budget indicates that the counties' financial responsibility for some health care programs may be changed as part of the implementation of federal health reform. While it is clear that the counties will continue to have a significant role in determining Medi-Cal eligibility, the realignment could impact county responsibilities and related financing. For example, if California implements the ACA's Medicaid expansion in 2014, the state could take over responsibility for most or all Medi-Cal-funded health services and, in their place, give counties responsibility for some state programs that are currently county-administered (e.g., social services or criminal justice programs). Counties would then be required to use current health care funding to support these "realigned" programs. While not enacted as part of the state's SFY 2012–2013 budget, the governor is expected to include a proposal in his SFY 2013–2014 budget on county and state responsibilities related to the potential Medi-Cal expansion.

Medicaid Expansion and Eligibility Simplification

Beginning in 2014, the ACA sets the Medicaid income level for most enrollees at 138% of the federal poverty level and extends coverage to non-disabled adults without minor children. If this expansion is adopted in California, Medi-Cal enrollment will increase by an estimated 1.4 million individuals (with some estimates as high as 3 million).²⁷ However, as a result of the June 2012 United States Supreme Court ruling, states can choose not to expand Medicaid up to ACA-permitted levels without the threat that the federal government will cut off all federal Medicaid funding.²⁸ Under this ruling, California could expand Medi-Cal statewide up to ACA levels or choose not to expand coverage. Alternatively, the state may propose to continue with the expansion of Medi-Cal-like coverage on a county-by-county basis now underway as part of the state's Medicaid waiver. Each of these options has implications for county workloads and responsibilities. Under the waiver, in many counties the social service office does not make final eligibility determinations for this population. As discussed below, however, if the state implements the Medicaid expansion statewide, either the state's insurance exchange or the counties could assume eligibility responsibility for the new enrollees.

At the same time, the ACA requires significant simplification for many aspects of the Medicaid eligibility process. Complex Medicaid eligibility rules, such as the asset and deprivation tests, will be eliminated for many Medicaid eligibility groups, and eligibility verification processes currently conducted manually (e.g., through review of hard-copy pay stubs or tax forms) will be largely replaced by electronic verifications. In addition, federal Medicaid regulations provide that as long as information provided by an individual is "reasonably compatible"

with information obtained by the state via electronic data matches, the state will be required to determine or redetermine Medicaid eligibility without requesting additional information from the client.²⁹

Recent federal regulations also streamline the Medicaid redetermination process to synchronize it with the ACA's reliance on electronic data verifications for the initial eligibility process.³⁰ In particular, states will be required to implement administrative renewals for Medicaid enrollees. Specifically, states will review information available electronically to determine whether sufficient data exists to continue an enrollee's eligibility without contacting the enrollee. If not, the state will be required to send a pre-populated renewal application to the enrollee to request any necessary additional information. Further, states will be required to redetermine eligibility no more frequently than every 12 months for most Medicaid eligibility groups.

If the state adopts the Medicaid expansion, the overall increase in Medi-Cal enrollees could significantly increase county workloads, although some of the increase will be offset by these eligibility simplifications. While final state eligibility determination rules have not yet been issued, these ACA-driven changes could simplify the eligibility determination and redetermination processes and thus reduce county workload related to eligibility. Health care services provided to the expansion population initially are 100% federally funded, decreasing to a 90% matching rate, while administrative services for the expansion are funded at the general 50% federal administrative matching rate.

Basic Health Program

Under the ACA, states can elect to create a Basic Health Program (BHP) to provide coverage to eligible individuals with incomes under 200% of

the federal poverty level who do not qualify for Medicaid. In the absence of a BHP, these individuals would be eligible for subsidized coverage through the state's health benefit exchange. Current legislation (Senate Bill 703) to establish a BHP in California is pending. If enacted, an estimated 725,000 to 948,000 Californians could qualify for coverage under the BHP.³¹ If the state moves forward with the BHP, county workloads could increase if the counties are made responsible for eligibility determination and ongoing case maintenance for BHP enrollees, although it is possible that DHCS could contract with the state's insurance exchange for these activities or perform them itself.

Role of California's Health Benefit Exchange

Under the ACA, states have the option of creating insurance exchanges: a public, private, or quasi-public entity that will serve as a mechanism for the purchase of individual or small group insurance coverage. Alternatively, states can choose to use the federally-operated exchange. In September, 2010, California enacted legislation authorizing the creation of a state-based exchange as a separate state department. Under the ACA, exchanges are required to play a role in Medicaid eligibility determination, and California's exchange-implementing legislation requires its exchange to enroll eligible individuals into Medi-Cal if they apply for coverage via the exchange. The final federal regulations governing exchanges, however, leave it up to each state to decide whether final eligibility for most Medicaid applicants will be determined by the state exchange or by Medicaid, and the California exchange board continues to explore its options in this area.³²

It therefore remains unclear exactly how local county social service offices will interact with California's exchange and whether they will retain responsibility for all Medicaid eligibility

determinations, though counties and the exchange will need to work together closely. Further, it remains unknown whether California will adopt the Medicaid expansion or a BHP. If the state adopts a BHP, it is unclear whether the counties would be responsible for BHP-related eligibility and enrollment. As a result of these uncertainties, it is difficult to predict how county responsibilities and caseloads may change in 2014. Implementation of the ACA will simplify Medi-Cal eligibility and lead to an estimated enrollment of 400,000 more people who are currently eligible but not enrolled in Medi-Cal. If California expands Medi-Cal and the counties are responsible for all Medi-Cal eligibility determinations, their caseloads would increase by an estimated 1.4 million people.³³ If, on the other hand, California does not expand Medi-Cal coverage or the state exchange can make final Medi-Cal eligibility determinations, county workloads might not increase and could even decrease, depending on the number of currently eligible or newly eligible people seeking Medi-Cal enrollment through the exchange. As many as 70% of current “Medi-Cal only” enrollees (i.e., those who apply at the county for Medi-Cal and who are eligible through neither CalWORKs nor SSI eligibility) could apply for Medi-Cal at the exchange.³⁴ Similarly, if the state implements the BHP and counties are responsible for eligibility, county workloads would increase, but the exchange also could assume responsibility for these activities. Regardless, the ACA requires all states to create a statewide web portal for enrollment. If California creates an effective portal, the number of individuals seeking Medi-Cal and BHP coverage through the exchange could be sizeable, which would reduce county responsibility for initial eligibility and enrollment activities.

Enhanced Federal Funds for Eligibility Determination System Upgrades

The federal government has extended the MMIS matching rate (90% federal funds/10% non-federal funds) to provide enhanced federal funding for upgrades to Medicaid eligibility determination systems due to health care reform.³⁵ This 90% matching rate will be available until December 31, 2015. Enhanced match funding for ongoing maintenance (75% federal funds/25% non-federal funds) would also continue to be available.

This enhanced federal funding is intended to cover expenditures related to eligibility streamlining across Medicaid, the health benefit exchanges, and the Children’s Health Insurance Program (CHIP), including case maintenance and forthcoming requirements for eligibility and enrollment reporting. Federal officials have indicated the enhanced funding may only be available for one eligibility system per state, which is problematic for California which has three different Medi-Cal eligibility determination systems. State officials have indicated that the short timeframe for ACA implementation will not allow California to completely rework its SAWS but have stated their intention to consolidate the three state SAWS into two.³⁶ While SAWS consolidation would simplify how Medi-Cal eligibility is determined, it is unclear whether federal officials will consider this sufficient for California to receive any of the available enhanced funding. Additional federal clarification regarding the enhanced funding is needed before the impact on county workloads can be assessed.

The federal government has also issued formal guidance that provides states with the option to integrate eligibility determination functions for social service programs (including TANF and SNAP) into systems designed specifically to determine eligibility for Medicaid, CHIP, and the exchange’s cost-sharing and premium tax credits. Significantly,

social service programs would not need to share in the costs of any common system development (e.g., client portals, business rules engine and operating systems, user interfaces) necessary to develop the exchange, Medicaid, and CHIP systems. Essentially, this would allow California to include these programs in the exchange's eligibility determination system and therefore to use federal exchange funding to pay for much of the development costs.

Overall, the impact of the ACA on county workloads and funding remains difficult to anticipate. Counties could experience an increase in program caseloads as some uninsured individuals seek coverage through their local social service agencies. However, the caseload impact associated with the potential Medi-Cal expansion and the BHP could be offset by simplified rules and procedures, if the exchange processes a significant number of Medi-Cal and/or BHP applications or state law is changed to give the exchange responsibility for case maintenance.

VI. Conclusion

FOR MILLIONS OF CALIFORNIANS, THE county is the front door to public assistance benefits, including Medi-Cal. In recent years, efforts to reduce state General Fund expenditures for the administration of these programs have had an impact on counties' performance of their eligibility determination and enrollment responsibilities. In general, counties now have to manage greater caseloads with fewer staff. In response, counties have sought to be more efficient and have increased their reliance on automation. For individual program applicants, the budget reductions may result in enrollment delays. It may also take counties longer to complete the redetermination and reporting processes, which could increase state costs to the extent that counties are unable to expedite the identification of current enrollees who are no longer eligible for benefits.

Many county staff work with clients across a range of public assistance programs. As a result, reductions in administrative funding for one program will affect the other programs administered by the counties as staff are shifted between programs in response to state budget cuts. The sources of funding — federal, state, and county — that support administrative costs for the different programs also play an important role in the county-level impacts of budget cuts. For Medi-Cal, federal funding for administrative costs is not capped and the non-federal share is provided solely by the state General Fund. However, some programs (such as CalFresh) rely on both state and county funding for the non-federal share of administrative costs. Other programs, such as CalWORKs, have capped federal funding. These differences may affect costs and staff levels

allocated to programs as counties shift resources, based on budget and workload, to limit their fiscal exposure and maximize state and federal funding.

Looking ahead, the landscape for county administration of Medi-Cal and other public assistance programs is changing. California has adopted legislation that will move the state toward the creation of a new budgeting methodology for county administration of Medi-Cal, and additional funding cuts are possible to address the state's continuing budget deficits. State policymakers will need to assess the impact of budget reductions on services provided to clients and the overall impact of these reductions on Medi-Cal caseloads and costs. Further, policymakers will need to analyze the underlying causes for Los Angeles County's relatively flat Medi-Cal caseload growth at the same time as caseloads in other large counties have been growing at a significant rate.

The federal ACA also will alter the landscape, but the overall impact of these changes on county funding and workload is still unknown: Some changes are likely to reduce county workloads (e.g., some Medi-Cal eligibility work will shift from the counties to the new state health benefit exchange, and forthcoming Medicaid eligibility simplifications will reduce the amount of county effort required to determine eligibility for many applicants), while other changes could increase county workloads (e.g., Medicaid expansion could increase the total Medi-Cal caseload and counties could assume responsibility for BHP eligibility, enrollment, and ongoing case maintenance).

State policymakers, the counties, and other stakeholders working to implement the ACA and

connect Californians with health insurance must create eligibility and enrollment processes that are as efficient as possible and that minimize the burden on individuals seeking coverage. To do so, the state and counties will need to develop a new paradigm for determining eligibility and managing Medi-Cal cases. How this is accomplished may greatly affect ongoing county administrative costs and could also affect other programs administered by the counties. If the counties incur additional costs, it is unclear how they will be funded, given the likelihood of continuing state budget deficits. On the other hand, the ACA provides counties with the opportunity to rethink their role in the Medi-Cal eligibility process given the ACA's new pathways into coverage coupled with the streamlined and automated processes envisioned in the federal law.

Endnotes

1. Assembly Bill 102, Chapter 29, Statutes of 2011, June 29, 2011. Modifies California Welfare and Institutions Code, §14154.
2. State of California, *2012–13 Governor’s Budget Summary*, January 5, 2012, www.ebudget.ca.gov.
3. Projected enrollment from analysis by the California Department of Health Care Services. See also John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL*, Kaiser Family Foundation, Commission on Medicaid and the Uninsured, Table 1 and Table 2, www.kff.org. California HealthCare Foundation, *Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal*, October 2011, www.chcf.org.
4. Assembly Bill 102 (2011).
5. States use the U.S. Office of Management and Budget Circular A-87 guidance to determine allowable costs for which federal funding can be claimed.
6. Considerations for inflation adjustments to payments for administration of both CalWORKs and CalFresh require collaboration between the state, County Welfare Directors Association of California, and other stakeholders, as well as changes to the current county administrative budgeting methodology and/or statute.
7. The authors are not aware of any completed analysis that compares the costs across these programs or analyzes the reasons for the significant differences in the cost per case among Medi-Cal, CalFresh, and CalWORKs.
8. Counties do not determine Medi-Cal eligibility for the Breast and Cervical Cancer Treatment Program, the Family Planning, Access, Care and Treatment program, or state correctional inmates. Eligibility determination for the Low Income Health Program, created under California’s Medicaid Section 1115 Waiver, is performed by counties. Counties may use either their social services or health agency to complete Low Income Health Program eligibility determinations, and funding is shared equally between the county and the federal government.
9. The administrative matching rate is the same for all states and is unrelated to the Federal Medical Assistance Percentage, which varies by state.
10. State of California, Department of Health Care Services, Research and Analytical Studies Section, *Medi-Cal Enrollment Population*, state fiscal years 2004–2005 through 2009–2010, www.dhcs.ca.gov.
11. State of California, Department of Health Care Services, County Administration, Fiscal Forecasting and Data Management Branch, *Medi-Cal May 2008 Local Assistance Estimate for Fiscal Years 2007–08 and 2008–09*, www.dhcs.ca.gov.
12. Assembly Bill 102 (2011).
13. The state fiscal year 2011–2012 Medi-Cal County Administration allocation is assumed to be \$1,264,964,778. If California had provided Cost of Doing Business adjustments between state fiscal years 2008–2009 and 2011–2012, and had not implemented any across-the-board reductions, the allocation would be \$1,577,728,778. This represents a 19.8% difference.
14. The federal Personal Responsibility and Work Opportunity Act of 1996 established the Temporary Assistance for Needy Families block grant program to support state assistance programs for low-income residents. A state must demonstrate a minimum level of state expenditures for programs benefiting low-income individuals in order to fully access its federal Temporary Assistance for Needy Families block grant. This requirement is defined in federal law as the state’s Maintenance-of-Effort requirement.

15. State of California, Department of Social Services, *Public Assistance Facts and Figures*, May 2009 and May 2011, www.cdss.ca.gov and www.cdss.ca.gov.
16. Assembly Bill 6, Chapter 501, Statutes of 2011.
17. Author's personal communication with California Department of Social Services staff, February 16, 2012.
18. The state General Fund portion of the costs for Los Angeles County's Eligibility, Automated Determination, Evaluation and Reporting system is included in the California Department of Health Care Services budget, and the state funding for the other two systems is included in the DSS budget.
19. California Budget Project, *Stretched Thin 2008: State Budget Cuts Undermine California's Human Services Programs*, August 2008, www.cbp.org.
20. State of California population information from State of California, Department of Finance, *E-1 Population Estimates for Cities, Counties and the State – January 1, 2010 and 2011*, www.dof.ca.gov; Caseload information from State of California, Department of Health Care Services, Medi-Cal Enrollment Statistical Tables, www.dhcs.ca.gov; State of California Department of Social Services, Food Stamp Program Participation and Benefits Issuance Report, July 2010, www.dss.cahwnet.gov; State of California Department of Social Services, CalWORKs Cash Grant Caseload Movement Report (CA 237 CW, Line 8 all columns), July 2010, www.cdss.ca.gov.
21. County-level data from Los Angeles County Department of Public Social Services count of administrative staff, www.ceo.lacounty.gov; California, Department of Health Care Services, Medi-Cal Enrollment Statistical Tables, www.dhcs.ca.gov.
22. California Department of Health Care Service, Research and Analytics Studies Branch, DHCS External Request for Information, March 2012.
23. Assembly Bill 102 (2011).
24. The HFP shift could be revisited when the legislature takes up the extension of a gross premium tax on Medi-Cal managed care plans that expired on June 30, 2012, which was established to fund the HFP. A two-thirds vote is required to approve any tax legislation and it is unclear whether there is sufficient support in the legislature to extend the tax, given the elimination of the HFP. This would lead to an increase in the state's budget deficit as the shift of children from HFP to Medi-Cal produces less budgetary savings than the tax generates in revenue.
25. For current HFP enrollees, the state will phase in the shift of the HFP to Medi-Cal. Beginning no earlier than January 1, 2013, HFP enrollees who are enrolled in an HFP managed care plan that also participates in Medi-Cal managed care will be enrolled in the same plan. No earlier than April 1, 2013, individuals enrolled in an HFP managed care plan that is a subcontractor to a Medi-Cal managed care plan will be enrolled, if possible, into the managed care plan that includes the individual's HFP managed care plan. No earlier than August 1, 2013, individuals enrolled in an HFP plan that is not a participating Medi-Cal managed care plan or subcontracting plan will be enrolled into a Medi-Cal plan in the individual's county of residence. No earlier than September 1, 2013, individuals who reside in a county that is not part of the Medi-Cal managed care program will receive services through the Medi-Cal fee-for-service system until such time as the state converts the county to Medi-Cal managed care.
26. State of California, *Governor's Budget Summary, 2012–13*, January 5, 2012, www.ebudget.ca.gov.
27. This 1.4 million would be the direct result of Medi-Cal expansion. It is also estimated that another 400,000 currently eligible but not enrolled people might enroll due to eligibility and enrollment simplification.

28. Supreme Court of the United States, *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.*, Case Number 11-393, decided June 28, 2012.
29. 77 Fed. Reg. 17144 (March 23, 2012).
30. Ibid.
31. Mercer Health Benefits, LLC, *Exploring the Financial Feasibility of a Basic Health Program in California*, California HealthCare Foundation, May 12, 2011, www.chcf.org. Gerald Kominski and Nancy Wise, *The Basic Health Program: What Would It Mean for California?*, California HealthCare Foundation, April 27, 2012, www.chcf.org.
32. 77 Fed. Reg. 18310 (March 27, 2012).
33. Note that this would require a change in California's health benefit exchange statute.
34. Authors' calculation based on data from the California Health Care Foundation, *Medi-Cal Facts and Figures*, September 2009.
35. 76 Fed. Reg. 21950 (April 19, 2011).
36. Letter from Toby Douglas and Will Lightbourne to the Centers for Medicare and Medicaid Services, July 29, 2011, www.cdss.ca.gov.



**CALIFORNIA
HEALTHCARE
FOUNDATION**

1438 Webster Street, Suite 400
Oakland, CA 94612
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org