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TO DIANA S. DOOLEY
Secretary

FROM: **Jennifer Kent, Director**
Department of Health Care Services

Mari Cantwell, Chief Deputy Director & State Medicaid Director
Department of Health Care Services

SUBJECT: SUMMARY AND PRELIMINARY FISCAL ANALYSIS OF THE MEDICAID PROVISIONS IN THE FEDERAL AMERICAN HEALTH CARE ACT

PRELIMINARY ANALYSIS AND COMMENTS:

The Department of Health Care Services, in collaboration with the Department of Finance, have reviewed the provisions contained within the proposed *American Health Care Act (AHCA)* as introduced on March 6, 2017 (and amended through March 21, 2017) and have identified preliminary programmatic and fiscal concerns. Please note that this analysis contains assumptions and, when possible, the use of our internal enrollment, cost and utilization data. The current federal proposal represents a significant shift of costs from the federal government to states resulting in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027. The General Fund share is estimated to be $4.3 billion in 2020, increasing to $18.6 billion in 2027.

Our most significant concerns are listed and detailed below:

1. Imposes a new Medicaid funding methodology for nearly all enrollees and expenditures in Medi-Cal to a per capita spending limit based on 2016 data, trended by the Medical Consumer Price Index (CPI) or an adjusted Medical CPI.

This funding formula represents a fundamental change in the federal-state partnership that has existed since the Medicaid program's inception over fifty years ago. Under AHCA, if a state exceeds its spending limits, it must repay the federal share of the excess spending the following fiscal year on a quarterly basis. In spite of continued efforts to run a cost-effective program, we expect Medi-Cal expenditures to exceed the

expenditures allowed under the proposed cap. Consequently, we estimate California will be responsible for a state share of approximately $680 million in 2020, growing to $5.3 billion by 2027.

	Per Capita Impact	
	FY 2020	FY 2027
Total Expenditures Subject to the Cap	$ 94,888,686,184	$ 155,848,068,021
Total Allowed Expenditures Under the Cap	$ 93,819,883,742	$ 146,753,343,274
Total Expenditures Over the Cap	$ 1,068,802,442	$ 9,094,724,747
Federal Repayment Above Cap	**$ 679,192,987**	**$ 5,284,654,126**

To the extent that state Medicaid programs are subject to an aggregate spending limit, this will have a devastating and chilling effect on provider or plan rate increases or any future supplemental payments (including quality assurance fees) because these additional costs will almost always be guaranteed to exceed the allowed trend factors and require states to fund these additional costs at 100%.

2. Sets per capita spending limits, as noted above, and reduces the amount of federal funds available for new enrollees after 2019. This includes enrollees who have a break in coverage for more than one month. Therefore, the majority of individuals will be covered at the "traditional" 50% cost-sharing ratio instead of the 90% funding promised to states under the Affordable Care Act.

In addition to reducing federal funding for states that chose to expand Medicaid coverage to individuals below 138% of the federal poverty level, the AHCA requires these adult beneficiaries be subject to a 6-month redetermination to remain eligible for coverage. This additional administrative barrier will cause individuals to lose their coverage and shift the cost burden to states in an expedited manner. The Congressional Budget Office's assumption that 42% of this population will shift annually was used to determine the impact to Medi-Cal because it is a reasonable approach given both traditional changes in Medi-Cal enrollment and the new shorter redetermination periods. Under this assumption, with over 3.8 million individuals projected to be covered under the expansion category (as defined in the AHCA), by 2027 nearly all of these and any new expansion enrollees, over 4.8 million individuals, will not be eligible for enhanced federal funding. Costs for these enrollees would be subject to the 50-percent state/50-percent federal cost-sharing ratio. This change represents the most significant cost shift to states, especially those that have expanded their Medicaid programs. We estimate that this will cost $4.8 billion in 2020, and grow to over $18.5 billion in 2027. The General Fund share would be about $3.3 billion in 2020, increasing to $13 billion in 2027.

	ACA Expansion FMAP Shift	
	FY 2020	**FY 2027**
Total ACA Expansion Enrollees	3,888,109	4,814,477
ACA Expansion Enrollees at 90% FMAP	2,187,297	1,839
ACA Expansion Enrollees at 50% FMAP	1,700,812	4,812,638
Total ACA Expansion Expenditures	$ 27,365,301,087	$ 46,454,019,990
ACA Expansion Expenditures at 90% FMAP	$ 15,394,640,767	$ 17,739,684
ACA Expansion Expenditures at 50% FMAP	$ 11,970,660,320	$ 46,436,280,306
Lost FFP Due to Shift to 50% FMAP	**$ 4,788,264,128**	**$ 18,574,512,122**

Note: The General Fund share of the FMAP shift is approximately 70%.

3. Eliminates enhanced federal funding of 6% for specific In-Home Supportive Services (IHSS) program costs beginning in 2020. California's IHSS program is the largest in the country, and is the core of our home-and-community-based system that allows the elderly and disabled to remain in their homes rather than be placed in a more costly institutional care setting. Serving over 480,000 beneficiaries today, this reduction in funding is estimated to increase state costs by about $400 million in 2020, growing annually.

4. Institutes a one-year freeze on any federal payments to specified providers who provide abortion services. California has a long history of providing coverage and services for family planning. Established in 1997, the Family Planning, Access, Care and Treatment Program (FPACT) has been a model in delivering family planning services to low-income individuals and reducing our state's teen pregnancy rates to near-historic lows as well as reducing unintended pregnancy and the associated costs.

The federal proposal does not permit any Medicaid, CHIP or block grant program funds to be provided to any provider who offers abortion services in addition to primary services of family planning. In California, this definition appears to only apply to the Planned Parenthood Affiliates of California. They currently provide services to more than 600,000 Medi-Cal and Family PACT beneficiaries. We estimate the one-year federal prohibition on these providers represents over $400 million.

5. Removes the expanded presumptive eligibility program for hospitals. Approximately 25,000 individuals each month are offered coverage through this process in California. Due to the nature of presumptive eligibility and the removal of this provision, costs will shift to hospitals and individuals that will no longer be found eligible for Medi-Cal. In 2017-18, state expenditures on hospital presumptive eligibility is nearly $400 million ($192 million state General Fund).

SUMMARY:

The current federal proposal, as detailed in the *American Health Care Act*, represents a massive and significant fiscal shift from the federal government to states. Given our state's significant population of low-income individuals, in addition to Medi-Cal's historic coverage for populations of children, seniors and persons with disabilities, this proposal will negatively impact the state by abandoning our traditional state/federal partnership and shifting billions in additional costs to California. It will also increase the fiscal burden on our state's safety net health care providers as they are also forced to live within the proposed aggregate cost limitations and potentially see increases in uncompensated care in the hundreds of millions, if not billions annually.