

# AB 85 – County Savings and Realignment Redirection under ACA

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- Enacts formulae to redirect a portion of Health Realignment funding for indigent care to fund social services programs, while accounting for the uncertainty involved and the need to maintain a viable county safety net and public health services.
- Redirection calculations vary by county type, broadly broken into three county groups:
  - CMSP Counties (34): Single option - 60% of health realignment and health realignment MOE are redirected.
  - Counties with county public hospital systems (12): 2 options
  - Non-CMSP counties without county public hospital systems (12): 2 options



# Determination of Redirected Amount

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- Non-CMSP counties have two options for determining their redirected amount:
  1. 60% of 1991 Health Realignment Funds + 60% of Maintenance of Effort (MOE), with specified limits.
  2. The County Savings Formula that determines whether available revenue exceeds county costs for providing services. If so, 80% of that “savings” is redirected, up to the limit of the indigent health realignment. (Cost and revenues included differ by county type.)



# Designated Public Hospital Counties

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## Revenues

- Medi-Cal and uninsured revenues (including Waiver, managed care, FFS, hospital fee, etc)
- Any special local health funds (e.g. tobacco settlement, county assessments)
- Historical percentage of health care realignment used for indigent care
- Historical county general fund spending for indigent care
- Historical profits from other payors

## Costs

- Medi-Cal Costs (including specified IGTs for other providers)
- Uninsured Costs
- Costs are subject to a cost containment limit



# LA County

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- Similar to the other public hospital counties, except that revenues and costs are inclusive of their entire health care services, not just limited to Medi-Cal and the uninsured.
- Also includes the cost containment cap.



# Non-CMSP/Non-Hospital Counties (Article 13)

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## Revenue

- Indigent Program Revenues (if applicable)
- Any special local health funds (e.g. tobacco settlement, county assessments)
- Historical percentage of health care realignment used for indigent care
- Historical county general fund spending for indigent care

## Costs

- Indigent health care costs
- Costs are subject to a cost containment limit



# Timeline

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## FY 2013/14

- **10/31/13** – Counties submitted tentative decisions regarding formula versus 60/40.
- Counties electing or potentially interested in the formula must provide data elements to state in historical period:
- **12/15/13** – State must notify county of agreement or disagreement with data provided
- **1/22/14** – Counties must adopt final board resolutions confirming formula or 60/40
- **1/31/14** – Department must issue determination of the historical amounts and percentages. If no agreement has been reached, DHCS shall use the county's determination until a decision is made. The County Health Care Funding Resolution Committee issue their determination within 45 days.
- **By 6/30/15** – Counties submit final data to state for the FY 2013/14
- **By 12/31/15** – State provides final FY 2013/14 calculations to counties



## Timeline (*Cont'd*)

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### **FY 2014/15 and future years**

- **November** - 5 months after the end of each fiscal year, counties using the formula submit reports on all revenue and cost data to DHCS.
- **January** - DHCS completes the interim calculation the January prior to the starting fiscal year, using the most current/accurate data available.
- **May** – DHCS updates the interim calculation in May before the start of the fiscal year.
- **June** - 12 months/by June 30th of the year after subject fiscal year, counties submit final data to DHCS.
- **July - December** – DHCS completes the final calculation and submits to counties by December 31<sup>st</sup> of the fiscal year following the receipt of the final data – one and a half years after the subject fiscal year.



# County Tentative Decisions

<b>Public Hospital County</b>	
<b>County</b>	<b>Tentative Decision</b>
Alameda	Formula
Contra Costa	Formula
Kern	Formula
Los Angeles	Formula
Monterey	Formula
Riverside	Formula
San Bernardino	Formula
San Francisco	Formula
San Joaquin	Formula
San Mateo	Formula
Santa Clara	60/40
Ventura	Formula

<b>Article 13 County</b>	
<b>County</b>	<b>Tentative Decision</b>
Fresno	Formula
Merced	Formula
Orange	Formula
Placer	60/40
Sacramento	60/40
San Diego	Formula
San Luis Obispo	Formula
Santa Barbara	60/40
Santa Cruz	Formula
Stanislaus	60/40
Tulare	Formula
Yolo	60/40



# AB 85 – Managed Care Requirements

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## Reimbursement Provisions

- Plans will be required to pay county public hospital systems at no less than cost for services provided to newly eligible Medi-Cal expansion population.
- Plans will be required to pay at least 75% of the rate range between the lower and upper bound for the newly eligible population to county public hospital systems. DHCS will pay plans rates higher in the range to accomplish this requirement.

## Primary Care Provider Default Assignment Provisions

- For the first three years, 75% of newly eligible population that does not otherwise select a primary care provider will be assigned to county public hospital systems.
  - Up to the point that the county system has either reached its enrollment target or has notified the plan it is at capacity.
  - Drops to 50% after the first three years.
  - Nothing in this requirement precludes a beneficiary from changing primary care providers.



# Questions?

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Additional information, including more detailed presentations on the methodologies can be found on the DHCS website at:

<http://www.dhcs.ca.gov/provgovpart/Pages/AB%2085.aspx>

Once final historical calculations are determined for each county, these will also be available on this website, as well final county selection information on 60/40 or formula.

For AB 85-related questions, comments and concerns, please email us at [AB85@dhcs.ca.gov](mailto:AB85@dhcs.ca.gov).

