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**DATE:** June 27, 2017

**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 BETTER CARE RECONCILIATION 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 *Better Care Reconciliation Act (BCRA)* draft from the U.S. Senate available on June 26, 2017. We have identified significant programmatic and fiscal concerns, consistent with our prior analysis of the House American Health Care Act (AHCA). Please note that this analysis contains assumptions and, when possible, the use of our internal enrollment, cost and utilization data.

The long-term impacts of the BCRA on the Medi-Cal program go beyond the devastating impacts in the AHCA as the cost shift from the federal government to states substantially increases over time under the BCRA. The current proposal represents a significant shift of costs from the federal government to states resulting in nearly \$3.0 billion in costs to California in 2020, growing to \$30.3 billion by 2027. The General Fund share is estimated to be \$3.0 billion in 2020, increasing to \$24.3 billion in 2027. Cumulatively over the period from 2020 through 2027, the impact to California is \$114.6 billion, or \$92.4 billion state General Fund.

Our most significant concerns are listed and detailed below:

1. **Shift in Federal Financing to Per Capita Limit:** Similar to the AHCA, the BCRA imposes a new Medicaid funding methodology for nearly all enrollees and

expenditures in Medi-Cal to a per capita spending limit based on historical data. The per capita limits are similar to the AHCA through FY 2024 in that they are trended by the Medical CPI or adjusted Medical CPI. However, starting in 2025 the allowed cost trend under the BCRA is reduced further by linking it to the general CPI-U.

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 and a pure **cost-shift** from the federal government to the states. Under BCRA, if a state exceeds its spending limits, it must repay the federal share of the excess spending the following fiscal year.

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, particularly given that many health care costs are not within the state's control, such as the increasing costs of new drugs. Since the BCRA cost cap trend is significantly lower beginning in FY 2025, the impact to California is even more catastrophic. We estimate California will be responsible for an increased state share of approximately \$2.6 billion in 2020, growing to \$11.3 billion by 2027. Cumulatively over the course of 2020 through 2027, the impact to California is estimated to be \$37.3 billion.

	Per Capita Impact		
	FY 2020	FY 2027	FY2020-FY2027
Total Expenditures Subject to the Cap	\$ 96,874,240,713	\$ 159,026,709,846	
Total Allowed Expenditures Under the Cap	\$ 93,009,818,706	\$ 139,730,358,720	
Total Expenditures Over the Cap	\$ 3,864,422,007	\$ 19,296,351,126	
<b>Federal Repayment Above Cap</b>	<b>\$ 2,641,997,864</b>	<b>\$ 11,328,558,369</b>	<b>\$ 37,306,688,112</b>

While the BCRA does contain the possibilities for adjustments for states that have spending well below the national average, it is not possible to assess the potential impacts of such adjustments at this time. It should be noted that these adjustments could be positive or negative.

To the extent that state Medicaid programs are subject to an aggregate spending limit, this will have a deeply 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. **Phase Out of the Enhanced Federal Funding for Expansion:** In addition to the per capita limits on federal funding noted above, the BCRA also phases out the enhanced federal funding under the ACA for the Medicaid expansion

population. California has over 3.8 million individuals who have been enrolled through the Medicaid expansion, one of the major reasons the rate of uninsured in the state has dropped by more than fifty percent. However, the decision to expand to this population was premised on the availability of federal funding at the enhanced level of at least 90% federal matching for fiscal years 2020 and beyond.

The BCRA phases out the enhanced federal funding, beginning in 2021 with five percentage point reductions each year for three years. Beginning in 2024, the federal matching rate will be reduced to a state's traditional federal matching rate, which for California is 50%. This means that in order to maintain the expansion (notwithstanding the effects of the per capita limits) California would need to spend **five times** as much as originally estimated.

The costs for the reduced federal matching for the expansion don't begin to occur until 2021, so there are no costs in 2020, however by 2027 the cost to California is \$18.0 billion (\$12.6 billion state general fund), and cumulatively from 2021 through 2027 it is \$74.1 billion (\$51.9 billion state general fund).

	ACA Expansion FMAP Impact		
	FY 2020	FY 2027	FY2020-FY2027
Total ACA Expansion Expenditures	\$ 26,552,122,873	\$ 45,073,607,735	
FFP at ACA 90% FMAP	\$ 23,896,910,586	\$ 40,566,246,962	
FFP at BCRA FMAP	\$ 23,896,910,586	\$ 22,536,803,868	
<b>Lost FFP Due to Shift Reduced FMAP</b>	\$ -	\$ 18,029,443,094	\$ 74,133,865,418
<b>State GF Share of Lost FFP</b>	\$ -	\$ 12,620,610,166	\$ 51,893,705,793

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

- 3. Elimination of Enhanced Funding for IHSS:** 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. One-Year Ban on Planned Parenthood Participation in Medicaid:** 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 and receive nearly \$250 million in total funding.

5. **Eliminates Hospital Presumptive Eligibility:** Removes the expanded presumptive eligibility program for hospitals effective in 2020. 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).
6. **Reduces Levels of Provider Fees:** The BCRA contains a provision to phase down the maximum level of allowable provider fees that are used by states to fund their Medicaid programs. The current maximum is 6% of net patient revenue, the proposal phases that down to 5% in 2025. Provider fees/assessment have been a significant source of non-federal revenue in the Medi-Cal program for many years. We anticipate an immediate impact to at least California's provider fee on skilled nursing and other long-term care facilities. We anticipate at full implementation, this reduction could result in the need for increased state general fund of nearly \$150 million. The impact is potentially greater if this reduction also impedes the state's ability to fully assess the hospital provider fee, although no impact is estimated at this time.

#### **SUMMARY:**

The current federal proposal, as detailed in the *Better Care Reconciliation 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. The impacts noted above of this magnitude will be devastating to California and our Medi-Cal program. If the BCRA becomes law, California will be faced with tens of billions of dollars in new costs that could necessitate difficult decisions to be made regarding the populations and benefits we choose to cover and how much we pay providers and plans for the services they provide.