FACT SHEET

Medi-Cal Explained: Medi-Cal Financing and Spending

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Introduction

California's Medicaid program, Medi-Cal, is an important source of health insurance coverage for millions of Californians and their families. In fiscal year (FY) 2021–22, the Medi-Cal program spent $121.9 billion of federal, state, and local funds providing a wide range of core health benefits — including primary, specialty, acute, and behavioral health care services; prescription drugs; and long-term care — for nearly 15 million Californians with low incomes.[1] This issue brief illustrates how California's Medicaid program is financed and the factors that impact total spending on health services through the program.

Overview of Medicaid Financing and the Medi-Cal Budget

Medicaid, a federal program administered by states, provides coverage for a wide range of core health benefits to people who meet certain criteria, most of which are based on family income. California's Medicaid program is administered by the Department of Health Care Services (DHCS) and is known as Medi-Cal and, like all Medicaid programs, is financed using federal and state dollars.

The federal share of a state's Medicaid budget is based on a formula called the Federal Medical Assistance Percentage (FMAP), which varies based on the type of enrollee (e.g., Affordable Care Act expansion population) and other criteria determined by federal law.[2] California's FMAP is generally 50%, meaning the federal government pays half of the cost of providing coverage to an enrollee, with no preset spending limit. The federal government may, however, finance a larger share of costs through an "enhanced," or increased, FMAP rate for certain populations and services, and during certain periods. For example, California received an enhanced FMAP rate with a temporary increase of 6.2 percentage points in federal match funding to address the COVID-19 public health emergency (PHE).[3]

States are responsible for the share of the overall Medicaid budget not financed by the federal government, often called the "state share" or "nonfederal share" of costs. This includes both the state proportion of the FMAP and the entire proportion of costs for populations and services not eligible for FMAP funds (e.g., immigrants without documentation, abortion services). Within California, most of this funding comes from the state general fund, the predominant source of financing for most state operations. California also uses other state and local funding sources — including revenue from a statewide tax on tobacco products, financing

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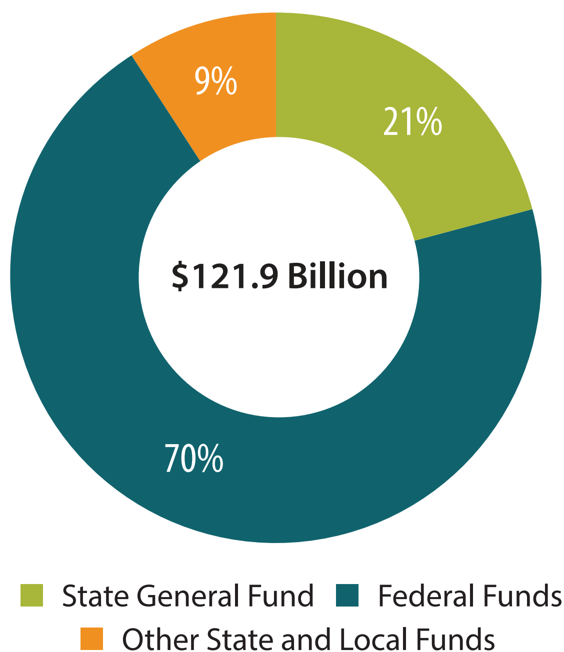
from cities and counties, and fees and taxes on providers, health plans, and health systems — to finance its share of the Medi-Cal program.

Medi-Cal Funding Sources

In FY 2021–22, California spent $121.9 billion on the Medi-Cal program, financed 70% by the federal government, 21% from the state general fund, and 9% using other state and local funds (Figure 1).[4]

Over time, these proportions have changed markedly; following the enactment of the Affordable Care Act, increases in federal funding for the Medi-Cal program vastly outpaced state funding growth. For example, from FY 2016–17 to FY 2021–22, the federal share of Medi-Cal spending increased by 5 percentage points as a proportion of total spending (from 65% to 70%), while the proportion attributed to the state general fund remained relatively flat (note that recent budget estimates indicate state general fund spending for Medi-Cal is expected to increase).[5] Other state and local spending sources have fluctuated as a proportion of total spending, from a high of 18%, or $17 billion, in FY 2017–18 to a low of 9%, or $11 billion, in FY 2021–22 (Figure 2, page 3).[6]

Figure 1. FY 2021–22 Medi-Cal Funding Sources



Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 24, 2023.

Medi-Cal Benefit Spending

Each year, California state officials prepare an overall Medi-Cal budget by examining spending in three categories: on medical benefits for enrollees, by counties to determine enrollee eligibility and administrative aspects of the program, and by the state or fiscal intermediary associated with processing claims.

In FY 2021–22, $116.4 billion was spent on medical care for Medi-Cal enrollees, $5.0 billion was spent on county administration, and $447.0 million was spent on the fiscal intermediary (Figure 3, page 3).[7] Spending on medical care for Medi-Cal enrollees can be further broken down into spending through the Medi-Cal managed care program and spending through the Medi-Cal fee-for-service program.

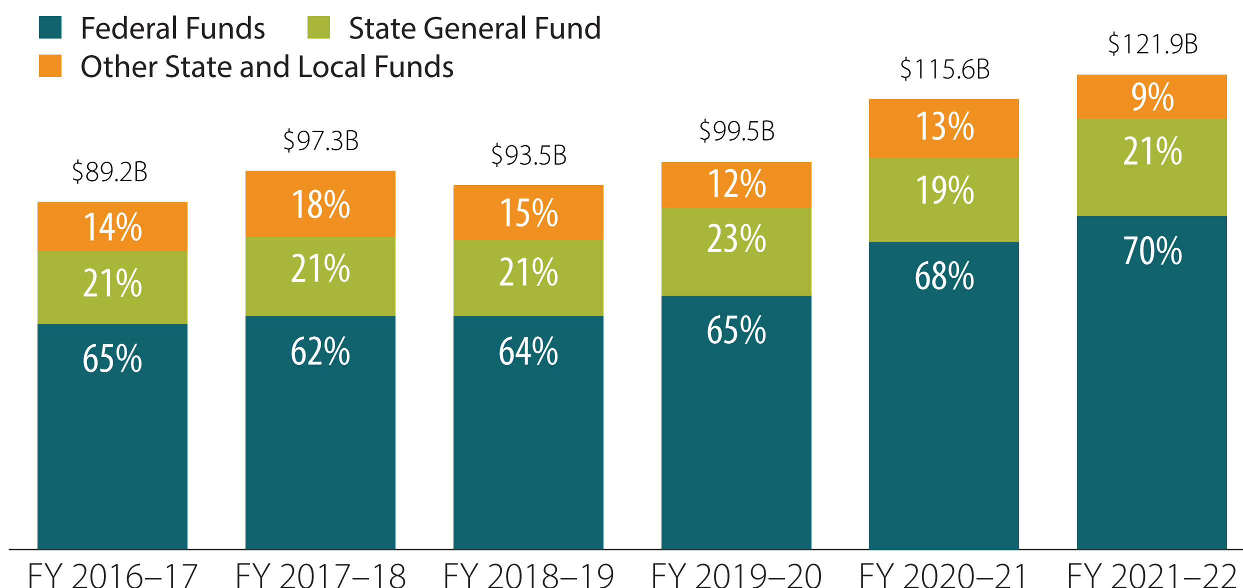
Medi-Cal Benefit Spending by Managed Care and Fee-for-Service Program

In FY 2021–22, nearly half (48%), or $55.5 billion, of Medi-Cal spending on medical care for enrollees went to Medi-Cal managed care plans (Figure 4, page 4).[8] Costs grouped in the "Other" category were the next largest spending category, at 13% of total Medi-Cal spending, and were driven largely by spending on miscellaneous services ($15 billion). Fee-for-service inpatient hospital costs followed closely behind, at 12% of total Medi-Cal spending ($14 billion).

Medi-Cal Managed Care

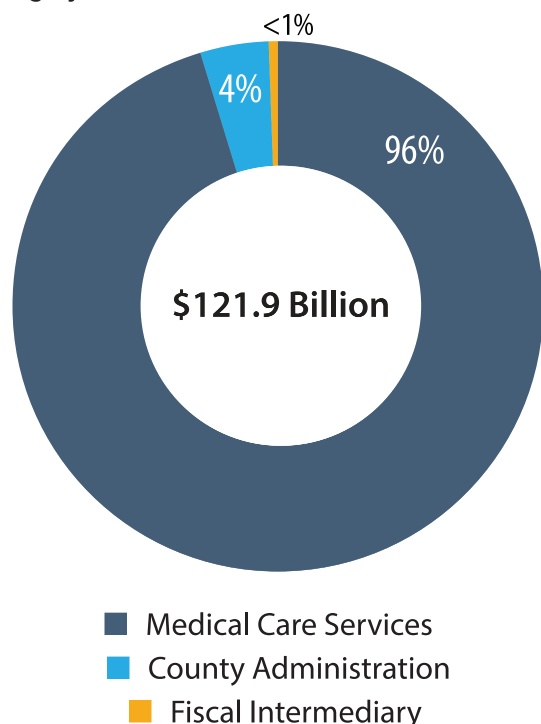
Under the Medi-Cal managed care program, the state pays a Medi-Cal managed care plan (MCP) a per-member per-month (PMPM) payment for all the contracted services provided to a Medi-Cal enrollee. PMPM payment rates to health plans are publicly available through the California Health and Human Services Open Data Portal and on the DHCS website.[9] As of September 2022, MCPs covered 13 million enrollees, or 86% of total Medi-Cal enrollment, across all 58 counties in California.[10]

Figure 2. FY 2016–17 to FY 2021–22 Medi-Cal Spending by Funding Source



Source: Author calculation based on "Local Assistance Estimates," California Department of Health Care Services, last modified May 12, 2023. See the Medi-Cal May 2017–22 Local Assistance Estimates for Fiscal Years 2016–17, 2017–18, 2018–19, 2019–20, 2020–21, and 2021–22.

Figure 3. FY 2021–22 Medi-Cal Spending by Budget Category



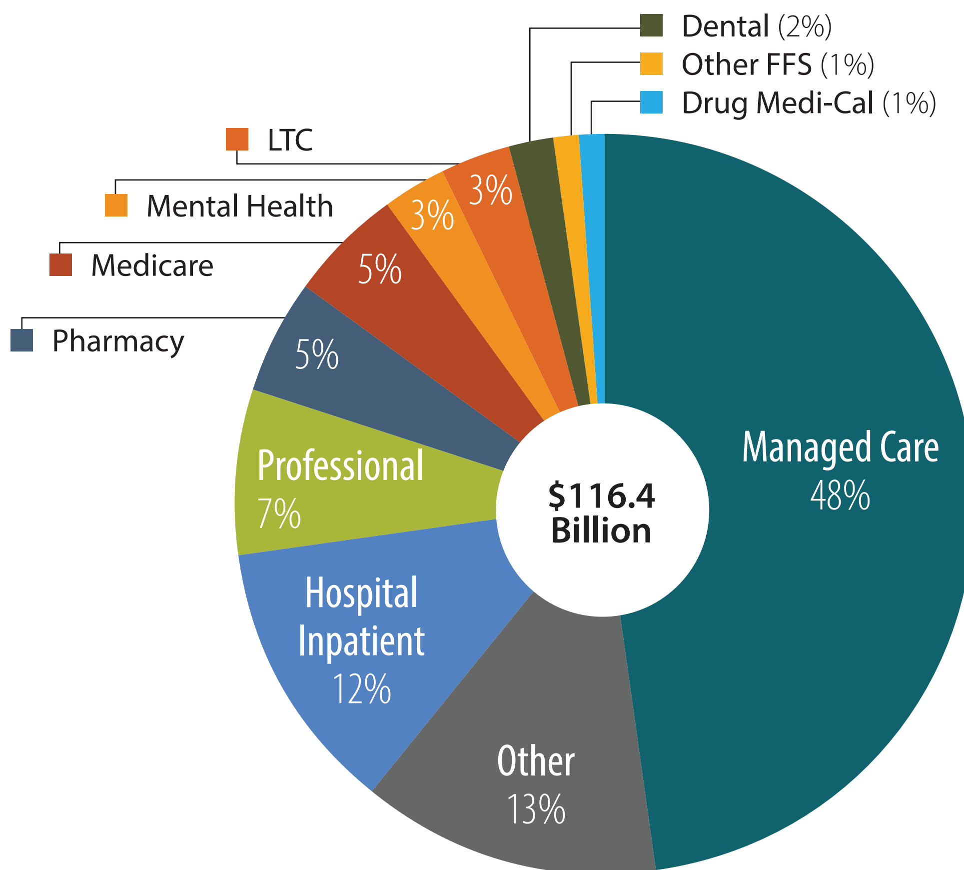
Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 24, 2023.

Detailed data on MCP categories of spending, payment rates to health care providers, and utilization data are often considered proprietary by managed care plans and are not generally reported by DHCS. However, scattered spending data may be available in reporting on specific programs or in individual plan documents for MCPs run by public agencies or as publicly traded companies. The Department of Managed Health Care, which regulates and licenses health plans in California, also publishes some utilization and financial reports.

Medi-Cal FFS

Under the Medi-Cal FFS program, the state pays health care providers directly for each service a Medi-Cal enrollee receives.[11] While Medi-Cal has increasingly covered more services and populations through Medi-Cal managed care, about 2.2 million enrollees received care through the state FFS program in FY 2021–22. The FFS program delivers several significant benefit "carve-outs," which refer to services paid and covered separately from a payer contract, including specialty mental health services, substance use disorder services,

Figure 4. FY 2021–22 Medi-Cal Spending by Service Category



Notes: *Other FFS* is fee-for-service and includes medical transportation, home health, and other services; *LTC* is long-term care and includes nursing facilities and intermediate care facilities for people with developmental disabilities (ICF-DD); *Other* includes audits/lawsuits, state hospitals/development centers, recoveries, and miscellaneous services.

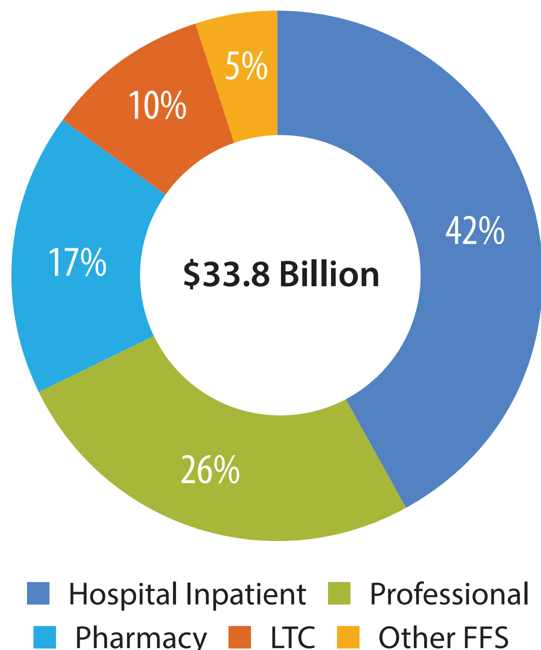
Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 25, 2023.

and dental services.[12] In FY 2022–23, spending on prescription drugs for all Medi-Cal enrollees will be covered through the FFS program.

California has significant discretion in determining provider payment rates in the FFS program as long as the payments follow "efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population."[13] California has generally had some of the lowest FFS rates compared with other states and the national average. For example, FFS payment rates for office visits in California are 19% below the national Medicaid average, while Oklahoma pays 29% above the average.[14] However, FFS payments are typically just one of several revenue streams flowing to providers for the care of Medi-Cal enrollees.

DHCS regularly reports spending by specific service category within the FFS program, which totaled $33.8 billion in FY 2021–22 (Figure 5, page 5). Of that amount, $8.7 billion, or 26% of overall FFS spending on medical benefits, was allocated for professional services (e.g., doctors and other medical providers), while $14.2 billion, or 42% of overall FFS spending, was spent on hospital inpatient care. Other significant service categories included long-term care ($3.5 billion), pharmacy ($5.7 billion), and ancillary or other FFS services (e.g., transportation, home health) at $1.7 billion.[15]

Figure 5. FY 2021–22 Medi-Cal FFS Spending by Service Category



Notes: *Other FFS* is fee-for-service and includes medical transportation, home health, and other services; *LTC* is long-term care and includes nursing facilities and intermediate care facilities for people with developmental disabilities (ICF-DD).

Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 25, 2023.

Factors Impacting Medi-Cal Benefit Spending

Spending on medical care through the Medi-Cal program depends on several factors that may increase or decrease the overall Medi-Cal budget in any fiscal year. These include factors that change the quantity of services delivered, which can often be attributed to eligibility expansions or contractions, the addition or removal of specific benefits, and changes in care patterns or utilization among enrollees. In addition, the prices paid for medical goods and services — either directly to providers in the FFS program or indirectly through the PMPM payment rates to managed care plans — can impact total benefit spending and the overall Medi-Cal budget.

Eligibility expansions and contractions also have an outsized impact on the overall Medi-Cal budget. California has used state funds to incrementally expand comprehensive Medi-Cal coverage to include, according to the Office of Governor Newsom, "individuals who do not have satisfactory immigration status or are unable to establish satisfactory immigration status," including children under age 19, adults over age 49, and (effective by January 2024) adults age 26–49.[16] The expansion of full-scope Medi-Cal coverage to adults age 26–49 is estimated to cost $613.5 million in state general funds in 2023–24 and $2.2 billion yearly at full implementation.[17]

Medi-Cal is a countercyclical program impacted by the economy: Enrollment surges when unemployment increases. During the economic slowdown brought about by the COVID-19 pandemic, Medi-Cal enrollment between March 2020 and October 2021 increased by 14% to over 14.2 million.[18] While the PHE generated significant state general fund savings due to enhanced federal funding, it also raised total fund costs by increasing Medi-Cal caseload levels due to the "continuous coverage requirement," which stipulated that states provide continuous enrollment for Medicaid members.[19] The expiration of the PHE will likely result in net general fund costs due to the loss of enhanced federal funding and the unwinding of PHE-related policies, but these costs will be partially offset by declines in the Medi-Cal caseload.[20]

In addition to enrollment growth, caseload patterns (cost of services and utilization) differ across Medi-Cal enrollment categories (e.g., children, seniors and people with disabilities, and childless adults). Seniors and people with disabilities typically have higher acuity and costs, accounting for about half of total Medi-Cal spending, a trend estimated to increase as this group becomes a larger share of Medi-Cal's overall caseload.[21]

The addition and removal of covered benefits within the Medi-Cal program impacts the overall Medi-Cal budget significantly. While federal statute mandates that Medi-Cal cover a core set of essential health benefits, states have flexibility to cover optional benefits. California currently offers dental, vision, transportation, and long-term services and supports in addition to the mandated benefits.[22] These optional benefits are often targets for elimination during tight budget times, and over the years benefits such as dental, podiatry care, and acupuncture have been cut as one strategy to reduce state spending.

Changes in the prices paid to health providers directly through the Medi-Cal FFS program and indirectly through PMPM payments to managed care plans have an intuitive and linear impact on the overall Medi-Cal budget. For example, an increase in payments to primary care providers was financed through a 2016 statewide ballot proposition that increased taxes on tobacco products by $2. This primary care provider payment supplement increased overall Medi-Cal spending by $908 million in FY 2021–22.[23]

Looking Ahead: Medi-Cal Spending and Value

California recently established an Office of Health Care Affordability, which, among other responsibilities, will set and enforce underlying cost growth targets across California's entire acute care finance and delivery system, including the parts of the system related to the provision of services to Medi-Cal enrollees. The office will begin analyzing data on utilization trends and underlying cost drivers in the second half of 2024.[24]

Historically, states have often turned to cost containment approaches such as reductions in provider payment rates and benefit eligibility when trying to mitigate underlying growth in Medicaid spending. Alternatively, states have looked to deploy longer-term strategies that improve value through payment and delivery system reforms, including incentives to reduce unnecessary or wasteful care (e.g., NTSV [nulliparous, term, singleton, vertex] c-sections), increase the provision of high-value care (e.g., primary and preventive services), provide access to enhanced care coordination and social services for enrollees with complex needs, or some combination.

More data on where spending flows within the acute care delivery system, along with detailed information on enrollees' access to and experience with that care, will likely prove useful as policymakers continue to deploy these and other strategies to improve value in the Medi-Cal program over the near and longer term.

About the Authors

Athena Chapman, MPP, is president and Samantha Pellón, MPH, is senior director of policy and strategy at Chapman Consulting, which provides strategic planning, meeting facilitation, organizational support, market research, and regulatory and statutory analysis to organizations in the health care field.

Endnotes

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