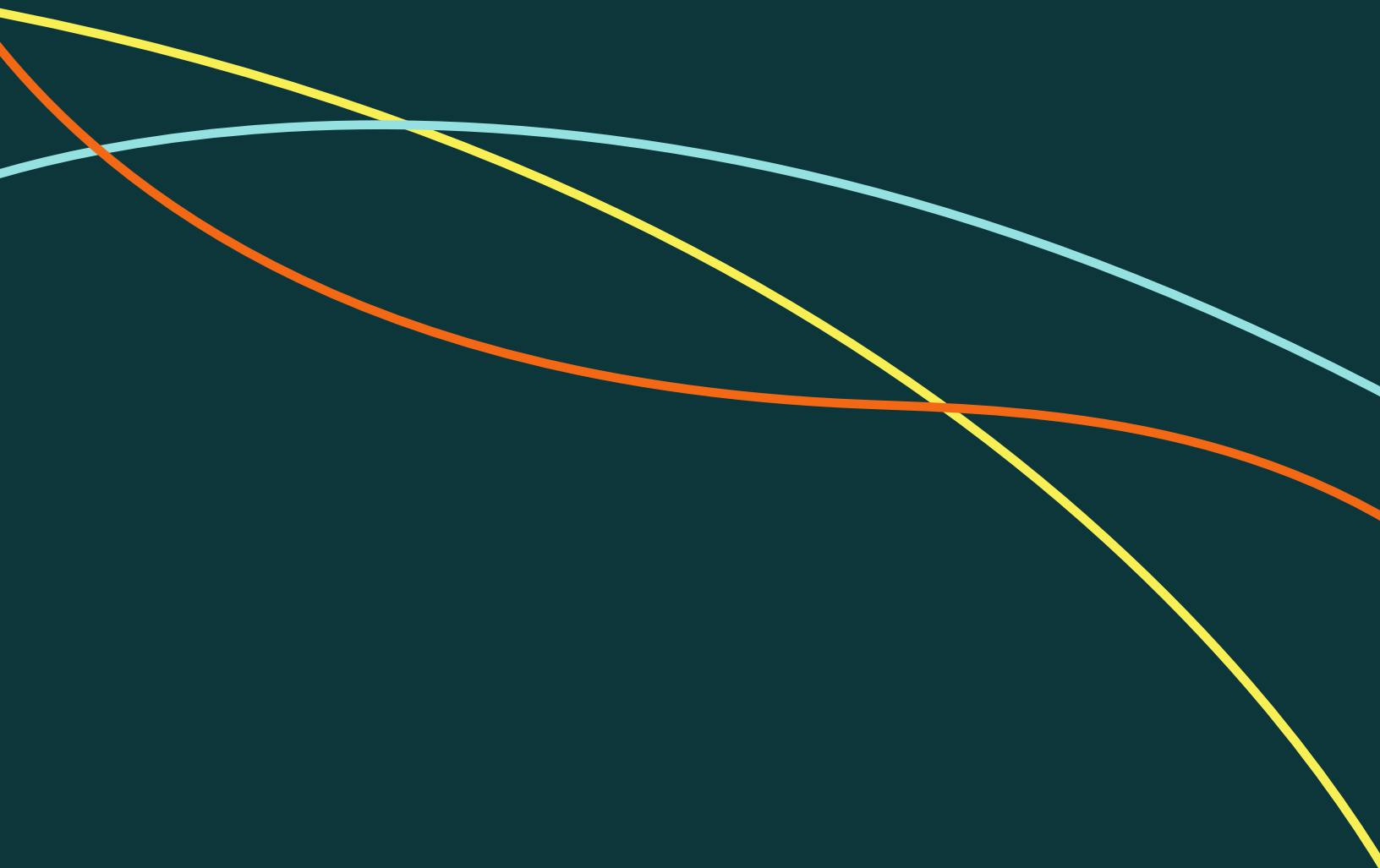


A Per Capita Cap for Medi-Cal

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Executive Summary

The Problem

Medi-Cal faces a dual threat of rising health care costs and constrained funding mechanisms. As expenditures outpace revenues, the current system creates dangerous financial instability for the state and for counties. This uncertainty trickles down, threatening health plans, providers, and the millions of Californians who rely on the Medi-Cal program. With federal, state, and county budget pressures mounting, Medi-Cal's current financial model is not sustainable.

The Bold Idea: A Per Capita Cap

California should consider a fundamental shift in Medi-Cal financing: **a federal per capita cap**. Under this model, as part of a Section 1115 demonstration waiver, California would negotiate with the US Centers for Medicare & Medicaid Services (CMS) to have the federal government provide a fixed amount of funding per enrollee rather than the traditional open-ended Medicaid matching funds. Since the state would retain unspent funds and be on the hook for additional expenses, this per capita cap approach would incentivize the state to control cost growth and focus on high-value innovations, such as chronic disease management, primary care transformation, public health investments, and preventive services. Other states have successfully implemented similar approaches with clearly defined federal financing contributions for Medicaid programs under Section 1115 waivers.

Keys to Success

For a Medi-Cal per capita cap approach to work, the details matter. California must negotiate a cap that reflects the true costs of care, hedges against cost growth and inflation, and provides room for innovation. The California Department of Health Care Services (DHCS) must also have sufficient administrative resources to implement and monitor this approach.

Stakeholders — including Medi-Cal enrollees, consumer advocates, counties, managed care plans, and providers, including but not limited to physicians, hospitals, and Federally Qualified Health Centers — may naturally fear that capped funding means funding cuts. To succeed, DHCS must develop a well-designed per capita approach and build buy-in by effectively engaging stakeholders, considering their input, and communicating the risks of the status quo and the advantages of a new financing approach.

The Bottom Line

Changing political climates, unaffordable health care cost growth, and shifting federal priorities have yielded funding cuts. A per capita cap approach offers a pathway to protect Medi-Cal. By stabilizing funding and gaining flexibility to innovate, California can ensure Medi-Cal remains affordable and available going forward.

The Problem: Preserving Medi-Cal in a Changing Fiscal Landscape

Medi-Cal is the cornerstone of California's safety net, providing health care coverage to nearly 15 million people, including more than half of the state's children, nearly one in five working adults, and 2.2 million seniors and people with disabilities.¹

However, Medi-Cal faces a critical juncture, and its current financing path is not sustainable. In the past decade, while enrollment has grown by 17%, total Medi-Cal expenditures have more than doubled, reaching \$179 billion in state fiscal year (SFY) 2024-25.² Medi-Cal coverage expansions, increased provider payments, and new restrictions on non-federal funding mechanisms have strained state finances. In 2025, facing a \$6.2 billion Medi-Cal budget shortfall, the state was forced to make difficult cuts, including reducing coverage for people without satisfactory immigration status, restricting access to certain pharmaceuticals, and reinstating asset tests for specific populations.³

A core problem lies in how Medi-Cal is financed. Currently, the state relies on a complex mix of state, county, and federal funding sources. The federal share of Medi-Cal is paid through an open-ended matching system, and it comes with extensive federal oversight and administrative burdens. For most Medi-Cal populations and expenditures, California receives a 50% federal match; for some populations, the match is as high as 90%.⁴ In SFY 2024–25, the federal government provided funding for approximately 61% of total Medi-Cal expenditures.⁵

To pay for the non-federal share of Medi-Cal, California uses revenues from the state General Fund, county funds, and various taxes and fees. However, the mechanisms used to generate some of these non-federal funds are at risk. H.R. 1, 119th Congress (2025), and other federal policy changes, including those related to provider and managed care organization taxes and state-directed payments, could severely limit California's ability to generate its required share of funding.⁶ Furthermore, the current Medi-Cal funding model creates tension and inconsistency across the state's 58 counties, which face vastly different health care markets and economic realities.

Without a reformed Medi-Cal financing strategy, California will likely face continued pressure to reduce Medi-Cal benefits, limit eligibility, and cut provider rates. Individuals without satisfactory immigration status will likely be impacted first, as California pays for all services except emergency services with state-only dollars for this group of enrollees. Populations with the most complex needs — such as enrollees requiring specialized behavioral health services, long-term care, and significant medical care and interventions — and those with health-related social needs will likely be next to face new limitations to important Medi-Cal services.

California must explore alternative Medi-Cal funding mechanisms to stabilize and rationalize financing, reduce federal administrative oversight, and drive innovation to improve health outcomes for all Californians.

The Bold Idea: Per Capita Caps

A per capita cap approach with a clearly defined federal investment could be a solution to Medi-Cal's uncertain financial future. Under this approach, the federal government would provide a fixed amount of funding per Medi-Cal enrollee rather than an open-ended match. While the federal and state governments would continue to share risk regarding Medi-Cal enrollment volume, the state would assume risk for costs of care in excess of the defined federal investment. If the state can deliver high-quality care for less than the cap, it retains the savings and has flexibility to reinvest those resources; if Medi-Cal expenditures exceed the negotiated cap during the waiver period, the state is responsible for the difference.⁷

A per capita cap approach has the potential to be transformative for several reasons. First, it **incentivizes value** by creating a powerful financial imperative for the state and its partners to control costs by improving population health and system efficiency. It therefore rewards investments in primary and preventive care, public health, chronic disease management, and social determinants of health that prevent expensive downstream utilization of the health care system. Second, it **provides budgetary clarity**, requiring more transparent and strategic decisionmaking regarding program affordability by providing state legislators with unambiguous financial targets. Finally, it **unlocks program flexibility**. By establishing a fixed federal contribution, California may be able to negotiate for relief from complex federal reporting and compliance requirements that increase costs and stifle innovation and customization — hurdles that can be especially inhibiting in a state as large and diverse as California. A per capita cap approach may allow California to combine federal, state, and county funds more creatively, simplifying how Medi-Cal providers are paid and tailoring benefits and managed care approaches to local health care infrastructure and needs.

How a Per Capita Cap in California Would Work in Practice⁸

The mechanics of a per capita cap are familiar. The state currently uses similar per-member per-month (PMPM) capitation rates to set and pay actuarially sound rates to Medi-Cal managed care plans.⁹

The US Centers for Medicare & Medicaid Services (CMS) uses similar calculations to establish Section 1115 waiver budget neutrality and Medicaid spending caps included in Section 1915(b) Home and Community-Based Service waivers. States like Oregon, Rhode Island, Tennessee, and Vermont have successfully negotiated and implemented capped federal Medicaid financing approaches through their 1115 waivers.¹⁰

Implementing a per capita cap for Medi-Cal is both a significant financial adjustment and a major operational shift that requires close collaboration between the state, the federal government, and local stakeholders. This transition involves three overlapping phases.

Phase 1: Designing the Cap to Protect the State and Its Medi-Cal Enrollees

The most critical work involves designing the per capita cap to reflect the anticipated costs of health care for Medi-Cal enrollees. The California Department of Health Care Services (DHCS) must make several key design decisions.

Agreeing on the Goal of the Cap

Because a per capita cap requires CMS approval, the first step is for DHCS and CMS to agree on the overall goal. Having a shared vision of what California wants to accomplish and demonstrate by implementing a per capita cap is essential. Box 1 lists potential goals of a per capita cap.

Unlike a block grant, a per capita cap approach does not put the state at financial risk in the case of increased enrollment. Under a per capita cap approach, if the economy falters and more Californians become eligible for Medi-Cal, the state continues to receive federal financial contributions for each enrollee.

Box 1: Potential Per Capita Cap Goals

- Defined federal contribution
- Reduced Medi-Cal cost growth
- Increased state flexibility
- Reduced administrative burden
- Improved quality and value
- Enhanced innovation

Deciding Between an Overall Per Capita Cap or Caps by Population Group

Under a per capita cap approach, the federal government would provide a fixed amount of funding per Medi-Cal enrollee. With an **overall per capita cap** (i.e., one cap applied to the total number of enrollees), California would receive the same level of federal funding for each enrollee regardless of that person's health care needs or eligibility category. Using this approach, the state may benefit from the additional enrollment of lower-cost Medi-Cal enrollees based on a set rate that presumes higher average levels of medical need. However, California may struggle with an overall cap if the Medi-Cal enrollment mix changes.

With **separate per capita caps by population group**, the state is not at risk for different proportions of Medi-Cal enrollment and thus is not negatively affected by an increased proportion of enrollees in higher-cost population groups. For example, if the proportion of an expensive population enrolled in Medi-Cal, like seniors, increases, and the proportion of an inexpensive group, like children without disabilities, decreases, an overall per capita cap across all enrollees increases the state's financial liability, while separate caps do not.

While there are pros and cons to each approach, establishing separate caps for specific population categories better protects the state and vulnerable enrollees by ensuring federal funding adjusts over time based on the mix of populations actually enrolled in Medi-Cal. The potential for more Medi-Cal enrollees in higher-cost categories over time is a particular risk

given the aging demographics in California.¹¹ As shown in **Table 1**, according to CMS, the 2023 Medi-Cal per capita expenditure for seniors age 65 and older was over four times the per capita expenditure across the five identified eligibility groups.¹² Similarly, CMS reports

the per capita expenditure for enrollees eligible under a Medi-Cal disability category as just over \$35,000 per year, which is about \$27,000 higher than the overall per capita expenditure for all Medi-Cal enrollees (approximately \$8,420).

Table 1. Average Annual Medicaid Expenditures Per Enrollee for Five Eligibility Groups, 2023

MEDI-CAL METRIC	TOTAL	CHILDREN	ADULTS: NON-EXPANSION, NON-DISABLED, UNDER AGE 65	SENIORS (AGE 65+)	PEOPLE WITH DISABILITIES	ADULTS: ACA MEDICAID EXPANSION
California Per Capita Expenditures	\$8,420	\$3,570	\$4,490	\$17,310	\$35,440	\$7,030
Percentage of Total Enrollee Per Capita Expenditure	100%	42%	53%	206%	421%	83%
Difference from Total Enrollee Per Capita Expenditure	\$0	\$(4,850)	\$(3,930)	\$8,890	\$27,020	\$(1,390)

Notes: Per capita expenditures were rounded to the nearest 10.
Source: “[Medicaid Per Capita Expenditures](#),” US Centers for Medicare & Medicaid Services, accessed March 17, 2026.

Recommended Population Groups for a Per Capita Cap Approach

At a minimum, DHCS should consider five broad population groups for per capita caps:

- Children (excluding children who are Medi-Cal eligible due to a disability)
- Traditional adults (non-disabled, non-expansion, under age 65)
- People with disabilities
- Medicaid expansion adults
- Seniors (age 65 and older)

In addition to these five population groups, DHCS could consider a separate per capita cap for pregnant women or for sub-categories within these groups, such as individuals with third party coverage, including those dually eligible for Medi-Cal and Medicare. DHCS could consider creating even more specific groups, mirroring categories used in its Medi-Cal managed care rate

development process. However, the more Medi-Cal population categories for which the state utilizes a separate per capita cap, the more complex tracking and managing the cap becomes.

Developing the Per Capita Cap

To calculate a per capita cap for each population group, DHCS must collect and analyze detailed historical Medi-Cal program expenditures by population group category. DHCS would likely require enhanced data and infrastructure capacity to ensure complete confidence in its enrollment projections and expenditure forecasts. The historical expenditure and enrollment data should span several years to allow DHCS to understand cost and utilization trends, medical spend fluctuations, and per capita expenditure growth within the Medi-Cal program and among categories of enrollees. The analysis should include consideration of each population category’s acuity mix and consider differences in Medi-Cal spend based on geographical region, including varying workforce issues and health system infrastructure that may impact future expenditures. DHCS should also

consider which administrative expenses or Medi-Cal benefits (if any) to exclude from the negotiated per capita cap approach. For example, DHCS may want to exclude Medicare premium payments made by Medi-Cal on behalf of dually eligible beneficiaries as these premium payments are set by Medicare and the state cannot control premium growth, nor pharmacy spend due to unpredictable trends.

There are two key pieces to a Medi-Cal per capita cap approach:

- 1. The initial per capita cap(s):** Using historical data to determine a base year, DHCS and CMS would negotiate the initial per capita cap(s). In selecting the base year, DHCS would need to consider whether it has complete data, whether it would need to develop completion estimates for the most recent year, and whether to use a calendar year, state fiscal year, or federal fiscal year.
- 2. The growth rate:** Health care expenditures typically rise every year. If the annual growth rate for the per capita cap is lower than actual inflation for Medi-Cal covered services (e.g., the cap grows by 3.5%, but Medi-Cal expenditures grow by 10%), the state and counties would be forced to absorb the difference or make coverage changes.

Consideration of Federal Payment Formulas, Administrative Costs, and Excluded Services

The federal government pays a percentage of Medi-Cal costs through a matching system known as the Federal Medical Assistance Percentage (FMAP). States with Medicaid demonstration funding approaches with similar limits on federal spending have generally maintained existing FMAP differentials for different population groups and expenditures. However, the state may choose to negotiate with CMS for a single FMAP across all Medi-Cal populations. This may reduce administrative complexity. Alternatively, maintaining existing FMAP rates for each population would allow the state to receive an enhanced rate if Medi-Cal

populations with higher FMAP rates grow faster than those at a 50% FMAP.

DHCS would also need to consider whether to include state and county Medi-Cal administrative costs within the per capita cap or continue to claim for these expenditures separately. By rolling administrative costs into the per capita cap, DHCS may limit some of the administrative burden that comes with claiming federal match dollars for administrative expenditures under Medi-Cal. Within the per capita cap, the administrative component could be calculated similarly to that of Medi-Cal's PMPM rates. Alternatively, it could be limited to a percentage of the cap similar to the 10% administrative cost limit on the state's annual Children's Health Insurance Program (CHIP) allotment.¹³ Further, DHCS would need to consider whether and how to address Medi-Cal Disproportionate Share Hospital and supplemental payments (both of which provide additional financial support to safety net hospitals) and whether to exclude from the cap people receiving limited Medi-Cal services (e.g., family planning services only) or those populations for whom DHCS only receives federal funding for emergency services.

Level of Annual Growth Under the Per Capita Cap by Population Group Category

DHCS would negotiate the annual growth rate for the per capita cap with CMS. Depending on negotiations, the growth rate may be consistent across Medi-Cal population categories or may be negotiated separately by population group category. In order for a per capita cap to be feasible for California, it is essential that the allowed annual growth rate is reasonable and achievable.

Between SFY 2023-25, Medi-Cal enrollment declined while overall and per capita expenditures grew (see **Table 2**). As shown in Tables 2 and 3, since SFY 2022-23, the estimated annual Medi-Cal per capita growth rate has outpaced measures of affordability like the California gross domestic product (GDP) and the California Consumer Price Index for All Urban Consumers (CPI-U).

Table 2. Estimated Medi-Cal Per Capita Growth, SFY 2023–2025

SFY	TOTAL MEDI-CAL ENROLLMENT	TOTAL MEDI-CAL EXPENDITURES (IN BILLIONS)	ESTIMATED PER CAPITA MEDI-CAL EXPENDITURES	PER CAPITA EXPENDITURE GROWTH FROM PREVIOUS SFY
2022–23	15,586,929	\$137.7	\$8,834	+5.4%
2023–24	15,115,639	\$157.5	\$10,420	+18.0%
2024–25	14,896,006	\$179.0	\$12,017	+15.3%

Notes: Enrollment figures reflect total Medi-Cal enrollment as of December of each fiscal year. Estimated per capita Medi-Cal expenditure and growth rates are calculated by the authors for illustration purposes only and may differ from per-member per-month expenditure calculations. SFY is state fiscal year.

Sources: [Medi-Cal Monthly Eligible Fast Facts](#) (PDF), California Department of Health Care Services (DHCS), January 2026; [Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23](#) (PDF), DHCS, May 2022; [Medi-Cal May 2023 Local Assistance Estimate for Fiscal Years 2022-23 and 2023-24](#) (PDF), DHCS, May 2023; [Medi-Cal May 2024 Local Assistance Estimate for Fiscal Years 2023-24 and 2024-25](#) (PDF), DHCS, May 2024; and [Medi-Cal May 2025 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26](#) (PDF), DHCS, May 2025.

Table 3. California Annual GDP and CPI-U Growth, 2022–2025

CALENDAR YEAR	GDP GROWTH FROM PREVIOUS YEAR (CALIFORNIA)	CPI-U GROWTH FROM PREVIOUS YEAR (CALIFORNIA)
2022	+5.9%	+7.3%
2023	+5.8%	+3.9%
2024	+5.8%	+3.1%
2025	N/A	+3.1%

Notes: Growth rates calculated by authors. California annual GDP data for calendar year 2025 were not available. GDP is gross domestic product. CPI-U is Consumer Price Index for All Urban Consumers.

Sources: [“GDP by State,”](#) Bureau of Economic Analysis, US Department of Commerce, updated January 23, 2026; and [California Consumer Price Index \(1955-2025\)](#) (PDF), State of California Department of Industrial Relations, accessed February 12, 2026.

As California grapples with health care affordability overall, the California Office of Health Care Affordability (OHCA) set its annual per capita growth target at 3.5% for 2025 and aims to reduce the rate to 3% by 2029.¹⁴ The estimated growth in per capita Medi-Cal expenditures in recent years is well above that target, as shown in **Table 2** above.¹⁵

In negotiating a growth rate for a per capita cap approach, DHCS would need to provide CMS with evidence for why a specific rate is appropriate (particularly if it is higher than the national Medicaid growth rate and/or the GDP or CPI-U growth rates), proof that the rate maintains federal budget neutrality, and ideas for how DHCS aims to constrain Medi-Cal cost growth. DHCS also would need to identify how often the base

year and growth rate would be re-negotiated and under what circumstances they would be modified (e.g., due to a national emergency, a new medical technology, or a blockbuster drug with an exorbitant price).

Phase 2: Authorization and Legal Framework

Before any Medi-Cal funding changes occur, the state must secure legal authority to implement per capita caps. This phase requires action from two main bodies:

The federal government (i.e., CMS): DHCS must negotiate a Section 1115 Demonstration waiver with CMS, which will serve as the contract defining the federal terms and conditions of the per capita cap approach.

The state: California must enact legislation to authorize the new funding structure.¹⁶ This legislation must also explain what happens if Medi-Cal expenditures exceed a cap, outline how potential excess costs would be covered using state General Funds or other non-federal sources, and indicate how DHCS could use program savings.

Phase 3: Implementation and Monitoring

Moving to a per capita cap requires the development and implementation of new federal and state oversight approaches. Since the federal financial contribution would be fixed, DHCS should negotiate with CMS for

reduced federal oversight. This would relieve some of the current administrative burden and mitigate expected increases in CMS oversight due to concerns about Medicaid fraud, waste, and abuse and state use of health care-related taxes and state-directed payments.¹⁷ DHCS would need to negotiate with CMS to clarify the level of flexibility allowed to the state as well as the state funding and reporting requirements that would remain. For example, CMS would likely continue to require DHCS to submit quality performance data relative to the Medicaid core measure set but may reduce some requirements regarding Medi-Cal managed care rate certifications and state and local financing, as federal expenditures would no longer be impacted.

Monitoring Spending Against the Per Capita Cap

Under a per capita cap, the state must strictly monitor Medi-Cal spending by population group category and in the aggregate. DHCS and CMS would need to agree on how and when that occurs. As a starting point, DHCS should negotiate an approach consistent with existing Section 1115 waiver budget neutrality calculations that allows the state to meet an overall combined aggregate spending cap that recognizes that spending for particular populations may vary from the individual per capita caps. DHCS should also ensure that if spending is below the negotiated per capita cap overall it would retain savings and the ability to utilize the additional “cap room” for future years. In the design of the per capita cap approach, DHCS should clarify and negotiate with CMS the state’s options for reducing Medi-Cal spending if the state anticipates exceeding the cap. It is expected that DHCS would be required to continue coverage of Medicaid entitlements but able to reduce optional services and/or limit populations if the cap is exceeded.

Implementation Approach and Timeline

Prior to implementing a per capita cap, DHCS would need both federal and state authority. Once these authorities have been obtained, a per capita cap could

be imposed all at once or in a phased capacity by population (e.g., children, Medicaid Expansion) or geographic area (e.g., Los Angeles County). The state may also initially leave certain services out of the per capita cap (e.g., county behavioral health services).

The Path Forward: Data is Key

Successfully designing and moving to a Medi-Cal per capita cap approach requires a significant investment in data infrastructure. Just as the state currently calculates actuarially sound rates for managed care, DHCS would need rigorous data to set the per capita caps accurately. This process would build on data and tools the state utilizes to calculate managed care plan rates, including Medi-Cal expenditure data by population group as well as health care affordability and market analysis data from OHCA and the California Legislative Analyst’s Office (LAO). By grounding the Medi-Cal per capita cap approach in robust data, California can design and move toward a financing system that is more sustainable, transparent, and focused on value.

Risks, Tradeoffs, and Unintended Consequences

Implementing a per capita cap approach is a high-stakes policy shift. While it offers the potential for stability and flexibility, it carries significant risks. Whether this approach succeeds depends on the design details; the terms and conditions of a Section 1115 waiver (specifically, how the initial cap is set and how it grows over time); and whether the state can take advantage of the need for efficiency and reform Medi-Cal in a way that truly contains cost growth. To make an informed decision on the per capita cap approach, California policymakers must weigh two distinct categories of risk: financial and operational.

1. Financial Risk: Can California Live Within the Negotiated Per Capita Cap?

The primary danger is negotiating a cap or growth rate that is too low to cover actual Medi-Cal expenditures

from one year to the next. Estimating the financial impact of a per capita cap approach depends entirely on the assumptions used. National analyses of per capita caps often paint a grim picture because they assume the goal is to cut federal Medicaid spending. Several organizations have completed analyses of per capita caps for Medicaid expansion populations based on recent federal policy discussions. The 2024 Congressional Budget Office analysis of Medicaid per capita caps utilizes CPI-U and limits federal growth to 3.1%, forecasting an overall reduction in federal spending of \$761 billion from 2025–2034 with an overall cap in federal spending, and a reduction of \$971 billion with a per-enrollee spending cap.¹⁸

Given current year-over-year increases in Medi-Cal per capita expenditures, a growth rate tied to the CPI-U would likely be disastrous for the state. If California's actual per capita Medi-Cal spending rises faster than the negotiated cap due to higher-than-expected cost growth, a new expensive drug, or a national emergency, the state would be responsible for the difference unless DHCS negotiated provisions to account for certain exceptions in the waiver terms and conditions. This could force difficult decisions, such as freezing provider payment rates or cutting optional Medi-Cal benefits, which might reduce access to care. It may also force the state to divert funds from other critical priorities.

Between state funding constraints and changing federal policies and budgetary scenarios, California is already facing difficult decisions when it comes to Medi-Cal.¹⁹ A well-designed per capita cap approach would formalize these existing Medi-Cal budget constraints by making the incentives, tradeoffs, and urgent need for action more transparent while also adjusting for possible changes in Medi-Cal enrollment. If developed using historical Medi-Cal trends or growth rates from the President's Budget, as is now required for Section 1115 waivers, the per capita cap would likely exceed the CPI-U.²⁰ This would provide California with workable caps that would allow the state to maintain access to Medi-Cal covered services for enrollees while improving administrative efficiency and fostering innovation.

This scenario would have limited negative impact on enrollees, providers, and managed care plans. Still, there would likely be strong resistance from stakeholders who may fear that capped funding means Medi-Cal budget cuts and political risk. Specifically, Medi-Cal enrollees and advocates may fear that a per capita cap could lead to reduced Medi-Cal benefits, stricter eligibility rules, or barriers to access. Counties and local governments may worry that if the state runs out of federal funds, the financial burden could shift to them. Health plans, hospitals, and safety-net clinics may fear that the state would manage the cap by freezing or cutting payment rates. However, a per capita cap approach would force the state and its partners to better align incentives and more efficiently and effectively manage Medi-Cal. And the change doesn't need to be permanent. As a safety mechanism, DHCS should include language within any Section 1115 waiver allowing DHCS to end the waiver at any point and revert to the traditional open-ended approach to federal Medi-Cal funding.

2. Operational Risk: The Efficiency Imperative

A per capita cap provides the state and its health care system with strong motivation to innovate and operate efficiently. The state, counties, Medi-Cal managed care plans, health systems, and providers would all need to work together to support innovation and constrain cost growth. To ensure that the cap is appropriately monitored and that there are early warning signs if it will be exceeded, the state would likely need to increase oversight through the following pathways:

Administrative investment. The state must invest in monitoring systems to track expenditures against the cap in real time.

Program alignment. DHCS would need to consider new investments and programs to improve quality and outcomes for enrollees and reduce cost growth, while also refining existing programs such as CalAIM (California Advancing and Innovating Medi-Cal) and value-based payment models.

Financial incentives to state partners. DHCS must consider what financial incentives and triggers should flow to counties, managed care plans, health systems, and providers, depending on overall financial performance relative to the caps.

Mitigation Strategies

If California pursues this path, it needs a comprehensive strategy to protect the Medi-Cal program and build consensus. The following strategies could support that effort:

Implement rigorous modeling and transparency.

Before agreeing to any waiver, DHCS must model various economic scenarios. The state should only proceed if the data show that the per capita cap offers a viable alternative to the current model. This modeling should be shared transparently with stakeholders to build trust.

Include stakeholders in the design of a per capita cap.

To address political risks and stakeholder concerns, DHCS could convene a working group early in the process. By involving advocates, counties, and providers in the design phase, the state can address fears and gain stakeholder buy-in to this approach.

Consider phased implementation (i.e., pilots).

Rather than flipping a switch for the entire program, DHCS could implement the cap as a pilot. For example, the state could begin by only applying the cap to specific populations (e.g., the expansion population) or services (e.g., managed care benefits) while leaving county-funded behavioral health services outside the cap initially. This would allow the state to test the mechanism without risking the entire safety net.

Strategic communication. The state must articulate a clear narrative: This is not about cutting costs, but about stabilizing funding. The message must demonstrate how a per capita cap protects Medi-Cal from federal uncertainty and preserves the flexibility needed to innovate through programs like CalAIM.

Conclusion: Why Per Capita Caps, Why Now

Now is the time to consider a per capita cap for Medi-Cal. As California grapples with unsustainable increases in Medicaid expenditures, the federal government is restricting state financing options; ramping up its focus on reducing fraud, waste, and abuse; and denying federal matching funds for Medicaid expenditures. Without a new Medi-Cal financing strategy, California faces a future of reactive budgeting and eroding access to care.

A Medi-Cal per capita cap offers California a path to financial stability and an imperative for efficiency. The approach also supports the state's overall objectives to rein in per capita health care expenditures across all markets and populations. For California and its counties, a per capita cap approach offers a clear picture of available federal funding for Medi-Cal.

The success of this per capita cap approach for Medi-Cal depends on the details. Under the right circumstances, with reasonable caps and growth rates, a per capita cap may allow California the flexibility to invest in its health care system and programs with an eye toward containing expenditures and improving quality and outcomes for Medi-Cal enrollees. This approach allows California to take control of its own fiscal future and to continue its legacy of innovation.

The alternative to a per capita cap is not a continuation of Medi-Cal's status quo, but rather a future of uncertainty. Without this bold structural change to Medi-Cal financing, the state, counties, plans, providers, and enrollees will remain vulnerable to program cuts. California may continue to be squeezed by new fiscal limitations, federal Medicaid oversight approaches, and changes in the political climate. A per capita cap, if designed correctly, offers a way to secure the Medi-Cal program's foundation before those pressures become insurmountable.

Endnotes

1. [“Medi-Cal Basics,”](#) California Health Care Foundation, updated May 2025.
2. Percentage calculated by authors based on data from between December 2015 and December 2025. [Table 1A: Medicaid and CHIP: December 2015 and January 2016 Monthly Enrollment](#) (PDF), Centers for Medicare and Medicaid Services (CMS), updated March 2016; [“Medi-Cal Enrollment and Renewals Dashboard: December 2025,”](#) California Department of Health Care Services (DHCS), accessed March 9, 2026; Governor’s Budget Summary – 2015–16: Health and Human Services (PDF), California Department of Finance, accessed February 9, 2026; and [The 2025–26 California Spending Plan: Health](#), California Legislative Analyst’s Office (LAO), October 16, 2025.
3. Ana Ibara, [“California’s Medi-Cal Shortfall Hits \\$6.2 Billion with ‘Unprecedented’ Cost Increases,”](#) *CalMatters*, March 18, 2025.
4. [“Federal Medical Assistance Percentage \(FMAP\) for Medicaid and Multiplier: FY2026,”](#) KFF, accessed February 9, 2026; and Medicaid’s Federal Medical Assistance Percentage (FMAP) (PDF), Congressional Research Service, updated April 2, 2025.
5. Percentage calculated by authors. The 2024–2025 total Medi-Cal spending was \$179.0 billion. Federal funds accounted for \$108.6 billion, General Funds accounted for \$37.4 billion, and other funds accounted for \$32.9 billion. [2025–26 California Spending Plan](#), LAO, October 16, 2025.
6. [An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No 119-21, \(2025\); 42 C.F.R. part 433, February 2, 2026; and Dan Brillman \(deputy administrator, CMS\), “Section 71116 of the Working Families Tax Cuts Legislation on State Directed Payments,”](#) February 2, 2026.
7. For example, in 2021, CMS approved a Tennessee Medicaid demonstration with an aggregate cap for federal funding and opportunities for the state to share in savings for 10 years. Under this waiver, Tennessee was required to provide actual expenditure data, recalculate the base year amount, and adjust the aggregate cap based on the first five years of their demonstration. See: [“TennCare III \(subsumes TennCare II\),”](#) CMS, accessed March 16, 2026.
8. The authors reviewed and drew from two main sources in discussing design considerations for per capita caps: [Medicaid Per Capita Caps: Design Considerations and Policy Implications](#) (PDF), American Academy of Actuaries, March 2025; and [Design Issues in Medicaid Per Capita Caps: An Update](#) (PDF), Medicaid and CHIP Payment and Access Commission, July 2017.
9. [2025–2026 Medicaid Managed Care Rate Development Guide](#) (PDF), CMS, August 2025.
10. For information on capped federal Medicaid financing approaches implemented under Section 1115 waivers, see [“OHP 1115 Waiver Documents and Reports,”](#) Oregon Health Authority, accessed February 19, 2025; [Request to Extend the Rhode Island Comprehensive Section 1115 Demonstration Waiver](#) (PDF), Rhode Island Executive Office of Health & Human Services, September 30, 2022; [“CMS Approves Tennessee Block Grant Waiver: A Summary and Analysis From Your Editors,”](#) Foley Hoag, January 11, 2021; Andrea Casart (director, CMS Division of Eligibility and Coverage Demonstrations) to Stephen Smith (director, TennCare), [“TennCare III Medicaid Section 1115 Demonstration”](#) (PDF), award letter, January 20, 2021; [Global Commitment to Health Section 1115 Demonstration Waiver Authority](#) (PDF), CMS, amended January 2, 2025; and [Vermont’s Global Commitment Waiver: Implications for the Medicaid Program](#), KFF, April 29, 2006.
11. Hans Johnson et al., [California’s Aging Population: Anticipating Dramatic Growth in the Number of Older Californians](#), Public Policy Institute of California, January 2025.
12. [“Medicaid Per Capita Expenditures,”](#) CMS, accessed March 17, 2026.
13. [Social Security Act § 2105\(c\)\(2\)\(A\).](#)
14. Spending targets are set by the California Office of Health Care Affordability (OHCA). For detailed information, see [“Slow Spending Growth,”](#) California Department of Health Care Access and Information, accessed February 12, 2026.
15. [2026–27 Governor’s Budget: Department of Health Care Services Highlights](#) (PDF), DHCS, January 9, 2026.
16. While beyond the scope of this paper, the state authorizing legislation may also include changes to state and county funding approaches for Medi-Cal. For more information on funding alignment, see Scott Graves and Nishi Nair, [Understanding Realignment: California’s Shifts in State and County Responsibilities](#), California Budget & Policy Center, July 2025; Jacey Cooper, [Beyond Realignment: Options for Modernizing California’s Behavioral Health System](#), CHCF, January 2026; and Meredith Wurden et al., [The Crucial Role of Counties in the Health of Californians](#), CHCF, January 2026.
17. 42 C.F.R. part 433, February 2, 2026; [Request for Information Related to Comprehensive Regulations To Uncover Suspicious Healthcare](#), 42 C.F.R. part 424, February 27, 2026; and Mehmet Oz (administrator, CMS) to California Governor Gavin Newsom, [Letter requesting information on Medi-Cal](#), January 27, 2026.
18. [Options for Reducing the Federal Deficit: 2025–2034](#) (PDF), Congressional Budget Office, December 2024; Phillip Swagel (director, Congressional Budget Office) to Honorable Ron Wyden (ranking member, Committee on Finance and Honorable) and Frank Pallone (junior ranking member, Committee on Energy and Commerce), [“Estimates on Medicaid Policy and State Responses,”](#) May 7, 2025.
19. Constantouros, [2026–27 Medi-Cal Fiscal Outlook](#), LAO.
20. Daniel Tsai (deputy administrator and director, CMS) to all state Medicaid directors, [“Budget Neutrality Policies for 1115\(a\) Medicaid Demonstration Projects,”](#) State Medicaid Director Letter 24-003, August 22, 2024. The Budget Reconciliation Act of 2025 added a new budget neutrality provision requiring the CMS chief actuary to certify that each Section 1115 waiver is not expected to increase federal expenditures above ‘without waiver’ expenditures. Pub. L. No 119-21, (2025).