Medi-Cal Explained FACT SHEET

The Medi-Cal Budget Process

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Introduction

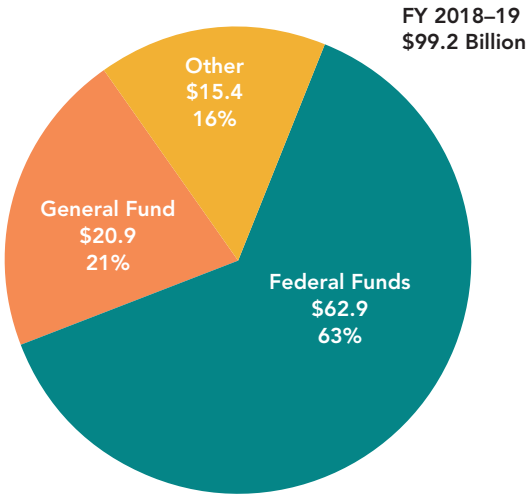
MEDI-CAL IS JOINTLY FUNDED by the state and federal governments as an entitlement program, meaning that there is no cap on federal or state spending and the amount of funding is based on expenditures needed to cover care for eligible beneficiaries.

The total budget for the Medi-Cal program in FY 2018-19 is over $99 billion (Figure 1).[1] State General Fund spending for Medi-Cal ($20.9 billion) represents 15% of the General Fund budget, second only to K–12 education.

The federal government provides federal matching funds for Medicaid based on a Federal Medical Assistance Percentage (FMAP), which varies by state and by population. For every dollar that the state expends on allowable Medicaid costs, the federal government matches those funds at the applicable FMAP.

The state share of Medi-Cal funding is drawn from multiple sources, including the state General Fund (GF), local matching funds, provider fees, and health plan taxes. These other funding sources allow California to draw down additional federal matching funds for Medi-Cal while reducing the impact on the GF. Over a third of the state financing for Medi-Cal comes from these other sources. Counties and the public hospital systems are the main sources of local matching funds and have a significant impact on Medi-Cal financing and the ability of the state to support the program.

Figure 1. Medi-Cal Budget FY 2018-19



Source: *Governor's Budget Summary 2019 – 20*: Health and Human Services, California Dept. of Finance, www.ebudget.ca.gov.

The Budget Process

The Department of Health Care Services (DHCS) develops detailed estimates of the overall costs of the Medi-Cal program twice a year —once in November to inform the development of the governor's initial budget proposal for the upcoming

fiscal year (released in January), and again in May to reflect changes to the budget outlined in the May Revision to the governor's budget proposal. The Medi-Cal estimate forecasts the current and budget year expenditures for the Medi-Cal program. Those expenditures fall into three categories:

- Benefits, or expenditures for the care of Medi-Cal beneficiaries;
- County administration, or expenditures for the counties to determine Medi-Cal eligibility and administer aspects of the program; and,
- Fiscal intermediary, or expenditures associated with the processing of claims.

The Medi-Cal estimate is prepared by DHCS' Fiscal Forecasting Division. Development of the estimate involves extensive consultation and coordination among DHCS, Health and Human Services Agency, Department of Finance (DOF) and Legislative Analyst's Office.

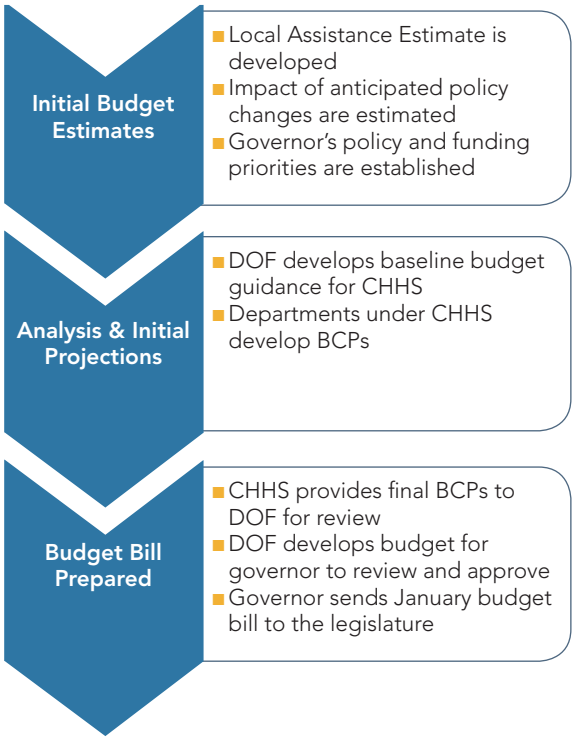
Once the estimate has been approved within the executive branch, it is used as the basis for the development of individual budget change proposals. A Budget Change Proposal (BCP) is a proposal to change the level of service or funding sources for activities, to implement a new state or federal requirement, or to propose new program activities not currently authorized. Budget change proposals accompany the governor's overall budget package (including the estimate) and are the basis of budget hearings held by the legislature to review, discuss, and approve or reject each component of the governor's proposal.

January Budget

On or before January 10 of each year, the governor must submit a budget bill to the legislature for the following state fiscal year, after which the Senate Budget and Fiscal Review Committee and the Assembly Budget Committee conduct budget hearings. Budget issues related to Medi-Cal are assigned to the Health and Human Services subcommittees in both the assembly and the senate. Hearings typically start in March, and the subcommittees provide recommendations to the full budget committee in each house at the end of this process. A conference committee sends a single version of the budget bill back to each house for a vote before its goes to the governor for signature. Since proposed budget changes often require changes to state statute if implemented, separate budget trailer bills are typically introduced by February 1 and heard by the legislature as part of the budget process.

The Legislative Analyst's Office (LAO) provides an analysis of the budget bill for the legislature and other stakeholders to consider. Stakeholders, including lobbyists and the public, have an opportunity to provide input to the governor and the legislature on policy and budget priorities during the budget process. California Health and Human Services (CHHS) and its departments' directors are often required to testify in front of the legislature on spending levels and requested budget changes or increases.

Figure 2. Steps to the January Budget



May Budget Revision

The input received on the January budget from stakeholders and legislators and an update of the state's overall fiscal condition is considered by the governor and DOF throughout the spring. An updated Medi-Cal estimate, overall state budget, and the required budget bill, with details on individual department spending, are released by the executive branch in May.

This process, known as the "May Revise," results in another round of legislative hearings.

Adoption of the Budget

The legislature reviews and approves its final version of a budget bill by June 15; the new budget year begins on July 1. The package of "trailer bills" that contain the statutory changes needed to implement the budget actions are approved by the legislature concurrent with or in the weeks following approval of the budget bill.

The final budget bill (and trailer bills) are sent to the governor for his review and action. The governor has line-item veto power and can reduce or eliminate any appropriation contained in the budget. The legislature can override any vetoed item by a two-thirds vote in both houses.

Process for Program Changes

Program changes and legislative mandates that impact cost and utilization often require adjustments to the Medi-Cal budget that result in changes to both fee-for-service (FFS) and Medi-Cal managed care rates and services. Program changes may include an addition, modification, or elimination of a benefit or service; a provider FFS rate change; an eligibility change; or an additional administrative requirement placed on health plans. While many program changes align with the budget year, they can also result in adjustments that must be made mid-year.

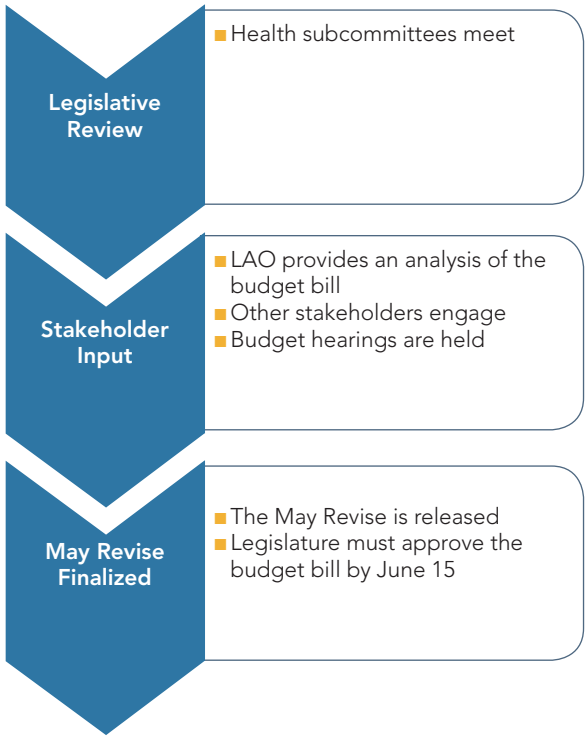
These mandates and program changes are normally itemized on the capitation rate sheets that plans receive from DHCS, with the adjustments developed by the actuary from information provided by DHCS on the estimated impact on costs and utilization. Contract changes are also often required in order to implement changes to benefits or populations covered. Program adjustments may take effect immediately (requiring a retroactive adjustment and contract update) or on a specified future date in the fiscal year. Plans and providers are often informed of these changes via All Plan Letters (APLs) (for the health plans) and provider bulletins (for FFS changes).[2,3]

Looking Ahead

The Medi-Cal program faces a great deal of uncertainty at the federal level, with a continuing threat of funding reductions.[4] Because Medi-Cal is an entitlement program, any significant decrease in federal funding results in the state bearing the additional cost of providing the benefits required under state law, or the state can eliminate or reduce covered services and/or populations. There are several other uncertainties that could have a significant impact on the Medi-Cal budget, including:

- **Section 1115 Waiver Expiration.** California's Section 1115 waiver, called Medi-Cal 2020, has provided $6.2 billion in federal funding over five years and will expire on December 31, 2020.[5]

Figure 3. Steps to the May Revise and Final Budget



The Section 1115 waiver includes numerous payment and delivery system reform initiatives, all of which were expected to generate savings to both the state and the federal government. The entire waiver and the amount of federal funding will have to be renegotiated with CMS starting in 2019.

- **Reduced ACA Funding.** Federal matching funds for the optional expansion population, which is the eligibility group created under the Affordable Care Act (ACA) that allowed states to cover non-elderly adults without dependent children if they meet Medicaid income requirements, will continue to be reduced. This population was fully funded by the federal government for several years. However, the state's share for this population will increase again in 2020, which is projected to increase General Fund (GF) costs by $1 billion.
- **MCO Tax Renegotiation.** For many years, California has used the managed care organization (MCO) tax, which is a tax on health plans that is specifically earmarked to fund the Medi-Cal program. Once the tax is collected, the funds can be used like any other state funds, and California receives the applicable federal matching dollars. The most recent federal approval of matching funds, which resulted in a $1.8 billion state GF offset for FY 2017-18, required significant negotiation with the federal government and included a requirement that California implement a broader tax to include plans that are not contracted with Medi-Cal. The MCO tax expires again in July 2019. This loss of federal funding is estimated to result in increased state GF expenditures of $1.3 to $1.8 billion per year.[6]
- **Prop 55 Funding.** Proposition 55, a voter-approved continuation until December 31, 2030 of a personal income tax increase on high-income earners (the top 1%) in California, primarily funds public schools but allocates 50% of any excess revenues to the Medi-Cal program.[6] However, the amount of funding actually available to Medi-Cal is subject to broad interpretation by the DOF. It is unknown at this time how significant the excess funds will be.
- **Prop 56 Funding.** Proposition 56 increased taxes on tobacco products effective April 1, 2017, and requires that the majority of these funds be used to supplement provider payments for specific services and to fund the growth in the Medi-Cal budget.[7] For FY 2017-18, this provided $1.4 billion for provider payment increases and $880 million in GF offsets. However, the legislature and governor have the authority each year to determine how the provider payments are structured and the amount that is available for provider increases rather than GF offsets, so the effect on the overall Medi-Cal budget can change from year to year.
- **Economic Downturn.** An economic downturn could significantly reduce the amount of general fund revenue available to finance the program. While the state is projected to hold nearly 10% of its overall budget in a "rainy day fund" by the end the current fiscal year, the simultaneous increase in Medi-Cal enrollment as tax revenue declines has led to deep cuts in eligibility and benefits during previous recessions.

Endnotes

1. *Governor's Budget Summary 2019 – 20*: Health and Human Services, California Dept. of Finance, www.ebudget.ca.gov.
2. "Medi-Cal Managed Care All Plan, Policy, and Dual Plan Letters," California Department of Health Care Services, last modified November 28, 2018, www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx.
3. "DMC Regulations and Provider Bulletins," California Department of Health Care Services, last modified July 18, 2016, www.dhcs.ca.gov/provgovpart/Pages/Regulations_and_Provider_Bulletins.aspx.
4. "Fiscal Outlook: Medi-Cal," Legislative Analyst's Office, November 15, 2017, https://lao.ca.gov/Publications/Report/3715.
5. "Medi-Cal 2020 Progress Reports," California Department of Health Care Services, last modified October 23, 2018, www.dhcs.ca.gov/provgovpart/Pages/medi-cal2020progressreports.aspx.
6. *Proposition 55: Should California Maintain Higher Taxes on the Wealthiest to Fund Education, Health Care, and Other Services?* September 2016, California Budget & Policy Center. https://calbudgetcenter.org/resources/proposition-55-california-maintain-higher-taxes-wealthiest-fund-education-health-care-services/
7. *Proposition 56: Should California Voters Increase the State Excise Tax on Cigarettes and Other Tobacco Products?* October 2016, California Budget & Policy Center. https://calbudgetcenter.org/blog/proposition-56-california-voters-increase-state-excise-tax-cigarettes-tobacco-products/

Acknowledgments

About Health Management Associates

Health Management Associates (HMA) is an independent national research and consulting firm in the healthcare industry. HMA helps clients stay ahead of the curve in publicly funded healthcare by providing technical assistance, resources, decision support and expertise.

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About Chapman Consulting

Chapman Consulting provides strategic planning, meeting facilitation, organizational support, and regulatory and statutory analysis, to a variety of health care related organizations.

Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.