California Health Care Foundation

Medi-Cal: A State-Federal Partnership

How California and the Federal Government Jointly Administer and Fund Medi-Cal

March 2025

Authors: Liz Stein, Catherine Gekas Steeby, and Kate Johnson, Aurrera Health Group

Table of Contents

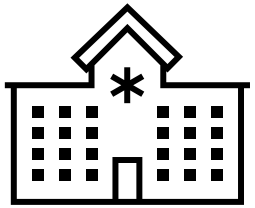
Medicaid Overview

Medicaid Overview

- Medicaid was created by Title XIX of the Social Security Act in 1965
- Medicaid provides health care coverage and services for children, for older adults, and for people with disabilities or low income
  - The Affordable Care Act (ACA), which passed in 2010 and was implemented in 2014, enabled states to expand Medicaid eligibility to adults with low income. As of 2024, 41 states, including California, have expanded Medicaid
- In 2024, approximately 79.4 million Americans and 14.8 million Californians were covered by Medicaid

Sources: 42 C.F.R. part 431; "October 2024 Medicaid & CHIP Enrollment Data Highlights," CMS, 2024; and *Medi-Cal Monthly Eligible Fast Facts* (PDF), DHCS, Oct. 2024.

Medicaid Overview

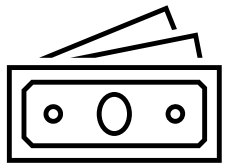


Medicaid is **jointly administered** by states and the federal government

- At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the US Department of Health and Human Services, oversees the program
- The California Department of Health Care Services (DHCS) oversees the program at the state level. DHCS is the state Medicaid single payer

Sources: 42 C.F.R. part 431; and MACPAC.

Medicaid Overview



Medicaid is **jointly financed** by the state and federal government*

- Federal Medicaid funding — also called the federal share or federal financial participation (FFP) — is based on state-specific Federal Medical Assistance Percentages (FMAPs)
  - The federal government reimburses each state for a portion of its Medicaid program costs based on its FMAP
  - In California, the federal government pays 50% of most costs, and the state pays the remainder
- State Medicaid funding — also called the state share or nonfederal share — comes from a range of sources including state general funds, local government funding, and health care–related taxes

*Additional information on Medicaid financing begins on slide 26.

Sources: 42 C.F.R. part 431; and MACPAC.

Medicaid Delivery Systems

State Medicaid services are delivered to enrollees on a **fee-for-service (FFS)** basis, through **managed care organizations (MCOs)**, or both

Fee-for-Service
• The state pays providers directly for each service delivered to a Medicaid enrollee • Payments must follow certain federal requirements to ensure efficiency and quality of care

Managed Care
• The state contracts with MCOs to deliver Medicaid services for enrollees • The state pays the MCOs based on the number of people enrolled in the plan, and the MCO then pays providers for services delivered • Nearly all states use a form of managed care, as it allows them to better control health care costs and improve access to high-quality services

Nationally, **74% of all Medicaid enrollees** receive benefits through managed care; in **California, 94% (PDF) of Medicaid members** are enrolled in managed care

Source: 42 U.S.C. 1396a.

California Medicaid: Governance

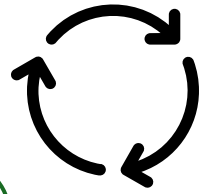
In California, Medi-Cal (the state Medicaid program) is a collaboration between **federal**, **state**, and **county** partners

Federal

CMS oversees state Medicaid programs and establishes federal rules and regulations

County

County Health and Social Service Departments conduct eligibility assessments and oversee enrollment



State

- The **California Department of Health Care Services**, or DHCS, is the state's Medicaid agency and administers Medi-Cal
- The **legislature** passes legislation to modify the Medi-Cal program within federal law, conducts hearings and audits, and approves the overall budget

Source: *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, CHCF, June 2024.

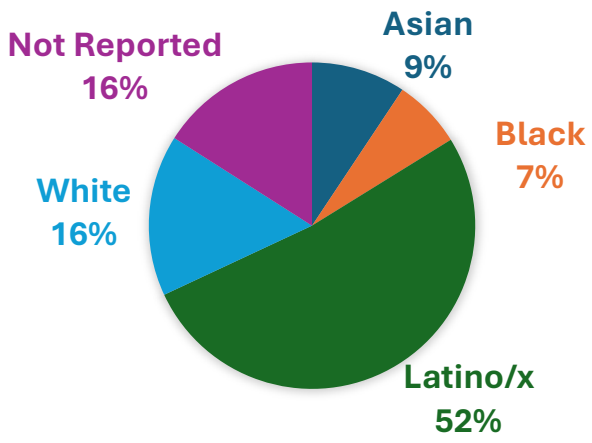
Medi-Cal Enrollment

Medi-Cal covers approximately **14.8 million people** across the state

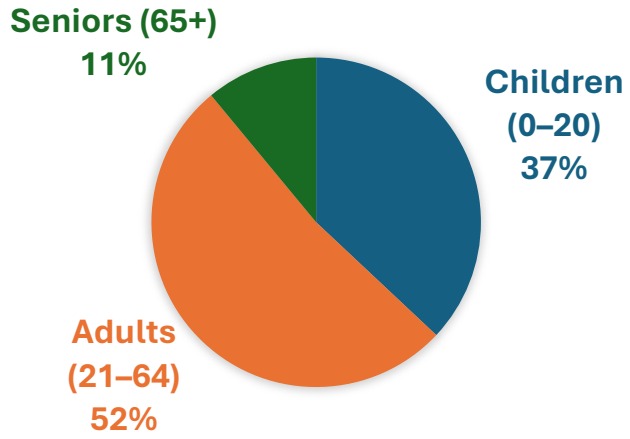
- See Medi-Cal enrollment by county and district

Nearly 70% of Medi-Cal members are people of color

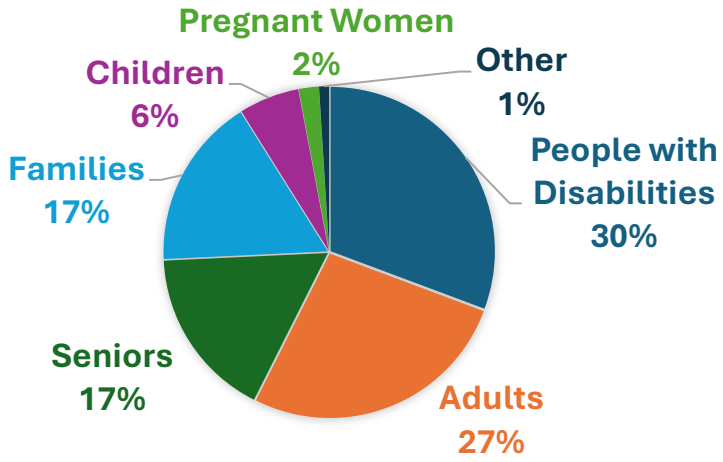
Medi-Cal Coverage by Race/Ethnicity



Medi-Cal Coverage by Age



Medi-Cal Spending by Enrollment Group



Sources: *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, CHCF, June 2024; *Medicaid in California* (PDF), KFF, 2024; and *Medi-Cal Monthly Eligible Fast Facts* (PDF), DHCS, Oct. 2024.

Federal Medicaid Requirements and State Flexibility

Mandatory Federal Medicaid Requirements

To comply with federal laws and receive federal funds, state Medicaid programs must meet certain requirements, including coverage of mandated:

- **Populations or "eligibility groups,"** such as children from families with low income, pregnant women, and people with disabilities
- **Benefits**, such as hospital, nursing facility, and children's preventive health care services

However, CMS also allows states to cover other optional populations and services

Learn more:

- List of mandatory eligibility groups (PDF)
- List of mandatory Medicaid benefits

Source: 42 U.S.C. 18022.

Medicaid State Plan

A Medicaid State Plan is an **agreement between the state and federal government** detailing how a state will administer its Medicaid program and what will be included

- Medicaid services included in a State Plan must be the same in amount, duration, and scope for all enrollees

California's Medicaid State Plan can be found on the DHCS website

State Plans typically outline:

- How a state will pay for services and provider types, including fee schedules
- Any optional groups, services, or programs that are covered
- Relevant state administrative activities

Sources: 42 U.S.C. 1396a; and 42 C.F.R. 430.

State Flexibility

- States have the flexibility to design many aspects of their Medicaid programs
- For example, states have the option to cover additional **populations** or **benefits** and establish specific **provider payment rates (PDF)**

California's Medi-Cal:

- Covers a **range of optional benefits**, like chiropractic services and adult dental services
- Covers **additional population groups**, like nonelderly adults with incomes under 138% of the federal poverty level (ACA Medicaid expansion)
- Establishes **provider fee schedules** and **offers supplemental funding** for certain services and providers, like hospitals that serve many Medi-Cal patients

Sources: 42 U.S.C. 18022, and "California State Plan," DHCS.

Federal Medicaid Authorities

- States **must receive CMS approval** to tailor their Medicaid programs
- There are federal authorities that states can use to modify their Medicaid programs, including:
  - State Plan Amendments
  - Medicaid waivers
- These options allow additional flexibility and sometimes additional funding
- This presentation reviews the **following federal Medicaid authorities**:

1. State Plan Amendments
2. Section 1915(b) Waivers
3. Section 1115 Demonstration Waivers

Medicaid State Plan Amendments

- To change or update their State Plan, states **must submit a State Plan Amendment (SPA)** to CMS for approval
  - SPAs may be initiated by changes in federal law/regulation, state law, or state policy
  - SPAs may aim to change the state's Medicaid eligibility, optional benefits, allowable providers, or reimbursement rates
- SPAs **must apply statewide**, to all Medi-Cal members and in all 58 counties
- There is **no limit** to the number of SPAs a state may submit
- Approved SPAs are posted to the CMS website
- Proposed, pending, and submitted SPAs in California can be found on the DHCS website

Examples of SPAs in California:

- SPA (PDF) to bring the California State Plan into compliance with new federal requirements (2024)
- SPA (PDF) to increase provider reimbursement rates for primary care, obstetric, and mental health services (2023)
- SPA (PDF) to add community health worker services to the Medi-Cal program (2022)

Source: 42 C.F.R. 430.

SPA Submission and Approval Process

1. SPAs are **submitted by the state Medicaid Agency** (DHCS) to CMS for approval

2.
   - CMS has **90 days** to approve, disapprove, or request more information on the SPA; otherwise, the proposed changes automatically go into effect
   - CMS can **pause or "stop the clock"** once per SPA if more information is needed
   - States may need to submit a revised SPA if it is not in compliance with the law

3. Approved changes **can take effect retroactively** to the first day of the calendar quarter in which the state submitted the amendment

Sources: 42 C.F.R. 430, and "State Plan," MACPAC, August 14, 2019.

SPAs: Key Characteristics

Financial Implications

SPAs **do not need to meet budgetary targets** but must describe expected costs for the state and federal governments

Duration

- Once approved, SPAs usually **do not expire** unless requested by the state
- CMS can also terminate a SPA if it no longer meets federal requirements

Public Notice

Public notice **is required** before submission of certain SPAs

Medicaid Waiver Authorities

Federal waivers allow states to **waive certain Medicaid program requirements**, allowing for greater flexibility and for testing new approaches to program eligibility, benefits, delivery systems, or financing

- Different types of waivers are available*
- States can operate multiple waivers at a time

States must apply to CMS when seeking a waiver

- Approved state waiver applications are posted to the CMS website

Terms of the waiver are outlined in Special Terms and Conditions, or STCs, that govern the programs authorized by the waiver

* Visit the CMS website to learn more about waiver types, including 1915(a), 1915(c), and more

Source: 42 U.S.C. 1315.

Medicaid Waiver Authorities

Federal waivers are primarily used to modify the following three core principles of the Medicaid program

Statewideness

Medicaid programs must provide the same benefits to enrollees in all counties throughout the state

Comparability

Medicaid enrollees are eligible for an equal amount, duration, and scope of services

Freedom of choice of provider

Medicaid enrollees can obtain services from any qualified provider

This presentation focuses on two common waiver types: **Section 1915(b) waivers** and **Section 1115 demonstration waivers**

Section 1915(b) Waivers

Section 1915(b) waivers allow states to modify how they deliver Medicaid services to enrollees and are commonly used to:

- Require Medicaid participants to enroll in managed care
- Limit the number or type of providers who can provide specific Medicaid services

These waivers **do not have to apply statewide** and may focus on select populations or geographic regions

Examples of Section 1915(b) waivers in California include:*

- Authorizing the state's Medi-Cal managed care program
- Authorizing California's specialty mental health program to require beneficiaries to receive services through their county mental health plan

* Learn more at DHCS's 1915(b) waiver home page.

* California operates several other types of 1915 waivers; visit the CMS waiver page for a full list.

Sources: 42 U.S.C. 1396n; and 42 C.F.R. 431.55.

1915(b) Waiver Submission and Approval Process

1. 1915(b) waivers are **submitted by the state Medicaid Agency** to CMS for approval

2.
   - CMS has **90 days** to approve, disapprove, or request more information on the waiver, otherwise the proposed change automatically goes into effect
   - CMS can **pause or "stop the clock,"** once per waiver if there is a need for additional information

3. Generally approved for an **initial three-year period** and can be extended

Sources: 42 U.S.C. 1396n; and "1915(b) Waivers," MACPAC, May 9, 2022.

1915(b) Waivers: Key Characteristics

Financial Implications

1915(b) must **demonstrate cost-effectiveness** through an accounting of all expenses, including administrative-related expenses, involved in managing the waiver

Duration

- 1915(b) waivers are **time-limited**, generally approved for three years with up to a five-year renewal period
- States can terminate waivers with CMS approval, and CMS can terminate waivers if a state is not adhering to the waiver terms

Public Notice

No public notice requirements

Source: 42 C.F.R. 431.55.

Section 1115 Demonstration Waivers

- Section 1115 waivers are **broad in scope** and can be **very expansive**, allowing states to implement experimental, pilot, or demonstration projects
- 1115 waivers may also permit states to **draw down federal Medicaid funding** to cover services and populations not included in their Medicaid State Plan
- These waivers **do not have to apply statewide** and may focus on select populations or geographic regions
- State Medicaid agencies and CMS **negotiate the terms of the waiver**, including the financial implications

Examples of Section 1115 waivers in California include:

- Prerelease Medicaid services to justice-involved populations (a CalAIM initiative)
- Coverage of residential substance use disorder treatment

Learn more at DHCS's 1115 waiver home page.

Source: 42 U.S.C. 1315.

1115 Waiver Submission and Approval Process

1. **Public notice is required** before waiver submission
2. 1115 waivers are **submitted by the state Medicaid Agency** to CMS for approval
3.
   - There is **no required time frame** for CMS review or approval
   - Negotiations between states and CMS can take **months or years** to complete
4. Generally approved for an **initial five-year period** and can be extended

Sources: 42 C.F.R. 430; Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended; and 42 U.S.C. 1315.

1115 Waivers: Key Characteristics

Financial Implications

1115 waivers must **demonstrate** budget-neutrality (PDF) **to the federal government**, meaning federal expenditures during the approval period cannot be greater with the waiver than without the waiver

Duration

- 1115 waivers are **time-limited**, generally approved for five years with a three-year renewal period
- States can terminate waivers with CMS approval, and CMS can terminate waivers if it doesn't believe the demonstration will achieve its goals or purpose

Public Notice

States must **notify the public** through two public hearings and provide a 30-day comment period before submitting the waiver proposal to CMS

Medicaid SPAs and Waivers: Key Similarities and Differences

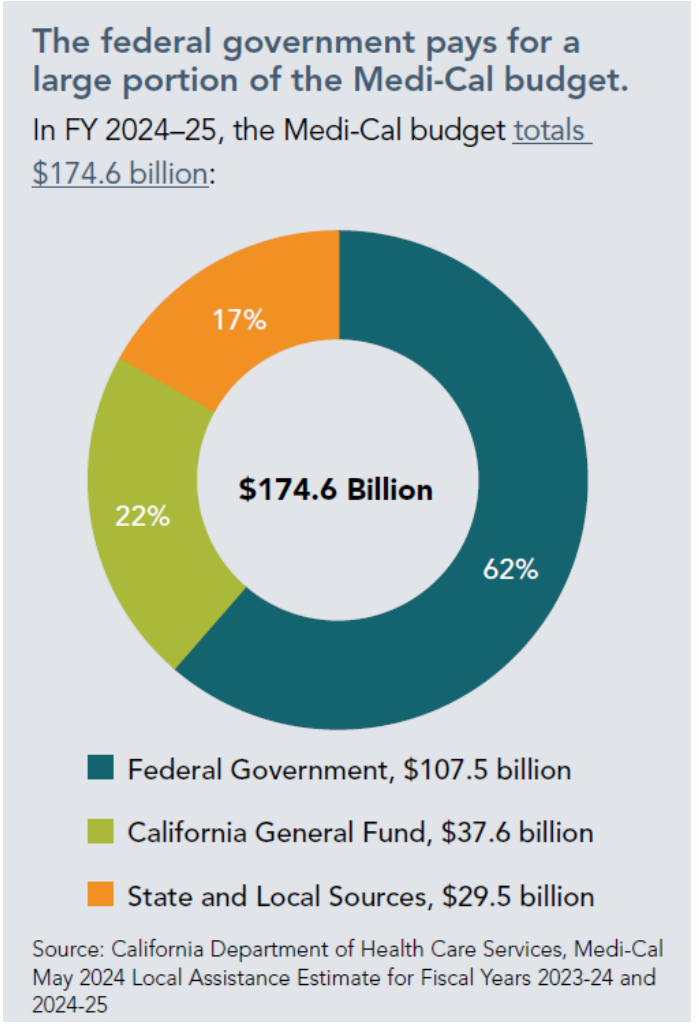
SPAs and waivers allow states to change their Medicaid program following a submission and approval process with CMS

SPAs	1915(b) Waivers	1115 Waivers
• Used to alter or update a component of the Medicaid State Plan • Usually not time-limited • Do not need to demonstrate budget neutrality or cost-effectiveness • Apply statewide to all Medi-Cal members	• Used to waive statutory requirements, often to modify delivery systems • Time-limited • Must be cost-effective • May apply to only certain populations or locations	• Used to test an innovative programmatic or policy change • Time-limited • Must be budget neutral to the federal government • May apply to only certain populations or locations

Medicaid Financing

Medicaid Financing

- Medicaid financing is shared by states and the federal government — commonly referred to as the "federal share" and "state share"
- In California, total Medi-Cal expenditures were $174.6 billion in FY 2024-25
- The federal share of Medi-Cal expenditures was 62%



Sources: Social Security Act of 1935, Pub. L. No. 74-271.49 Stat. 620 (1935), §§ 1903, 1905(b), 1902(a)(2)

Medicaid Financing: Federal Share

The federal share of Medicaid expenditures, known as federal financial participation (FFP), is based on the federal medical assistance percentage (FMAP) (PDF) or federal matching rate

- FMAP is based on a **formula in federal Medicaid statute** set by Congress
- **FMAP varies across states** based on a state's average per capita income relative to the national average
  - Per federal statute, no state receives an FMAP less than 50%
- **FMAP also varies for different Medicaid services and populations within a state**
  - For Medicaid to adults with incomes up to 138% of the federal poverty level under the ACA receive 90% FMAP for medical services for that population

States are guaranteed to receive federal matching payments with no limit on expenditures

- example, states, including California, that expanded

FMAP in California:

- Standard FMAP for most populations and services is 50%
- FMAP for the Children's Health Insurance Program and the Breast and Cervical Cancer Treatment Program is 65%
- FMAP for the ACA expansion population is 90%

Sources: Social Security Act of 1935, Pub. L. No. 74-271.49 Stat. 620 (1935), §§ 1903, 1905(b), 1902(a)(2).

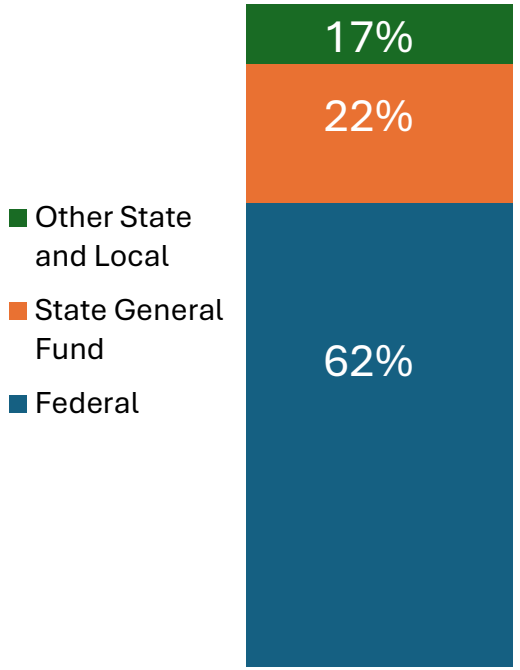
Medicaid Financing: State Share

States fund their share of Medicaid expenditures through a variety of sources, including:

- State general fund
- Local funds
  - Certified public expenditures (CPEs)
  - Intergovernmental transfers (IGTs)
- Health-related taxes and fees

At least 40% of the state's share must be financed by the state, and up to 60% may come from local governments

Total Medi-Cal Spending in FY 2024-25 is $174.6 Billion



Sources: California Department of Health Care Services, Medi-Cal May 2024 Local Assistance Estimate for Fiscal Years 2023-24 and 2024-25; and, *Medicaid: An Overview* (PDF), R43357, Congressional Research Service, last updated February 8, 2023.

Medicaid Health Care-Related Taxes

Health care–related taxes, also referred to as provider taxes and fees, are a **common mechanism used by states to finance their share of Medicaid expenditures**

- Using revenue from health care–related taxes as the state share of Medicaid expenditures allows **states to receive federal matching or FMAP payments**

Health-care related taxes may be imposed on a range of providers and services and are **used in a variety of ways to support Medicaid programs**, such as:

- Provider rate increases, specific program or coverage expansion, or administrative costs

Health-care related taxes across states are commonly imposed on:

- Hospitals
- Nursing facilities
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IDDs)
- Managed care organizations (MCOs)

Source: *Medicaid Provider Taxes* (PDF), RS22843, Congressional Research Service, 2016.

Medicaid Health Care–Related Taxes: Requirements

To be used for the state share of Medicaid expenditures, health care–related taxes must meet three requirements:*

1

Be broad-based

- The tax must be imposed on all providers within a class of providers
- There are 19 classes of providers used to ensure taxes are broad-based

2

Be imposed uniformly

- The tax must be imposed in the same way on all providers in a class
- For example, taxes may not be limited solely to Medicaid providers

3

Not hold providers harmless

- There cannot be a guarantee that providers will have tax revenue returned to them
- This does not apply if the tax is less than 6% of net patient service revenues received by the taxpayer

* CMS can waive the requirements that health care–related taxes be broad-based, uniform, or both if certain conditions are met.

Source: *Medicaid Provider Taxes* (PDF), RS22843, Congressional Research Service, 2016.

Medicaid Health Care–Related Taxes: Use

Health care–related taxes have become a growing source of state Medicaid funds

- In 2019, 49 states and the District of Columbia (PDF) imposed at least one health care–related tax
- State Medicaid funds from health care–related taxes grew from 7% in FY 2008 to 17% in FY 2018

While taxes on nursing facilities, hospitals, and intermediate care facilities are most prevalent across states, MCO taxes have become more common in recent years

- The number of states with MCO taxes in place grew from 12 in 2018 to 20 in 2024

Medicaid Health Care-Related Taxes: California Examples

Hospital Quality Assurance Fee (HQAF) Program. Established by DHCS in 2010, this program assesses a fee on certain hospitals. Fees are based on Medicaid utilization rates, federal upper payment limits, and various other data elements.

- Revenue from the fee provides funding for supplemental payments to California hospitals, children's health care coverage, direct grants to public hospitals, and direct costs of administering the program

MCO Tax. The MCO tax has existed in California since 2005. DHCS imposes a tax on MCOs based on the number of members they served.

- Revenue from the tax provides funding for provider rate increases and other investments to help secure access, quality, and equity in the Medi-Cal program

Additional Resources

For more information on Medicaid SPAs and waivers and how these authorities are used in California, please visit:

- Medi-Cal Explained
- Medi-Cal State Plan Amendments and Waivers Comparison Chart
- CalAIM Authorities Chart
- Medi-Cal Facts and Figures Almanac — 2024 Edition

About the Authors

Liz Stein, Catherine Gekas Steeby, and Kate Johnson are consultants at Aurrera Health Group, a mission-driven national health policy and communications firm based in Sacramento.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

Appendix

Abbreviations

ACA	Affordable Care Act
CalAIM	California Advancing and Innovating Medi-Cal
CMS	Centers for Medicare & Medicaid Services
CPE	Certified Public Expenditure
DHCS	California Department of Health Care Services
FFP	Federal Financial Participation
FFS	Fee for Service

FMAP	Federal Medical Assistance Percentage
HQAF	Hospital Quality Assurance Fee
ICF/IDD	Intermediate Care Facility for Individuals with Developmental Disabilities
IGT	Intergovernmental Transfer
MCO	Managed Care Organization
SPA	State Plan Amendment
STC	Special Terms and Conditions