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Medi-Cal Budget: Lessons Learned from a Review of Policy Changes with Significant Budgetary Impact, 2007–2017

Introduction

A tumultuous environment with many proposed changes to federal health policies being debated throughout 2017 led state policymakers to contemplate the potential impact of such changes on their respective Medicaid programs. In an extreme scenario, such changes would have dramatically reduced or capped federal funds, requiring policymakers to either cut expenditures or find alternative revenue sources to maintain this federal-state program. Even in the absence of federal reforms, California governor Brown's January 2018 budget message to the legislature noted the importance of budgetary oversight in general, and the need to prepare for the cyclical nature of the economy, stating that "We must remain vigilant and not let rosy statistics lull us into believing that economic downturns are a relic of the past. Fiscal restraints are needed more than ever as California approaches the peak of a business cycle."[1]

This analysis seeks to inform future decisions about the state's Medicaid program, known as Medi-Cal, by examining the significant decisions of California policymakers from 2007 to 2017, that when signed into law, were projected to have a significant impact on the Medi-Cal budget. The impetus for these changes varied — some were state-initiated, some were implemented in response to opportunities made available by the federal government, and others resulted from ballot initiatives. The past decade included periods of both severe recession and recovery expansion and can therefore provide valuable lessons. Although steeped in the realities of money matters, budgetary policy decisions ultimately involve trade-offs in values negotiated among federal and state policymakers, beneficiaries, and other stakeholders. This paper seeks to provide insights for a variety of audiences including state and federal policymakers and staff, state agency staff, health policy analysts and researchers, health care advocates, and beneficiary representatives.

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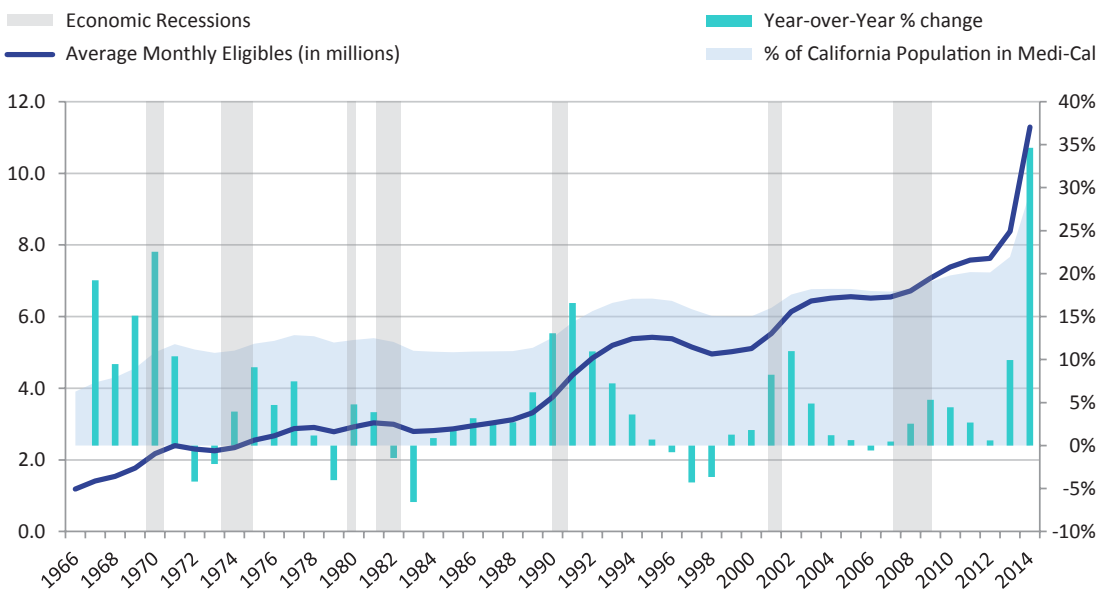
— Governor Jerry Brown

Background

Medi-Cal is a core public program, currently providing health insurance coverage to nearly one of every three Californians, or 13.5 million people,[2] and also affecting the many people employed in the health care sector who serve them. Financing of the program is shared between the federal and state government, with generally a 50/50 split, where the federal government matches each of California's dollars. Prior analyses show that Medi-Cal enrollment is countercyclical to the economy; in other words, when there is a downturn in the economy, Medi-Cal enrollment increases (see Figure 1 on page 2). Prior to the Great Recession of 2008, for example, average monthly Medi-Cal enrollment declined slightly from FY2007–08 to FY2008–09; in FY 2009–10, however, Medi-Cal enrollment increased by 9%. After the federal Affordable Care Act (ACA) was implemented with expanded eligibility categories,

Figure 1. Medi-Cal Enrollment Trend, 1966–2014



Notes: Gray bars represent economic recessions and illustrate the countercyclical nature of program enrollment. By the end of 2014, more than 12 million beneficiaries were enrolled in the Medi-Cal program.

Source: *Medi-Cal's Historic Growth: A 24-Month Examination of How the Program has changed since 2012*, Medi-Cal Statistical Brief, California Department of Health Care Services, Research and Analytic Studies Division, August 2015.

Over the last 10 years the proportion of the Medi-Cal budget funded by the state's general fund declined, from a high of 39% in FY 2007–08 to 18% in FY 2017–18.

Medi-Cal enrollment increased substantially in each year from FY 2013–14 through FY 2016–17. Medi-Cal is the costliest state government program in total dollars (including federal), with expenditures budgeted to be $110 billion in FY 2017–18.[3] Medi-Cal accounts for about 16% of California's general fund (GF) expenditures.[4]

Medi-Cal Financing Sources with a Focus on the General Fund

In FY 2007–08, Medi-Cal was funded primarily by federal dollars and state GF dollars. Over the last 10 years, however, the proportion of the Medi-Cal budget funded by the state's GF declined, from a high of 39% in FY 2007–08 to 18% in FY 2017–18 (see Table 1 on page 3). Beginning in FY 2010–11, "other funds," such as state special funds and local funds, began to serve as a significant source of dollars for Medi-Cal, growing to $18.8 billion and representing about 18% of the total Medi-Cal budget in FY 2017–18.

California has a history of greater volatility in its GF compared to the economy overall, making budgeting difficult.[5] In an economic downturn, if the GF declines significantly, or other revenue sources decline or sunset, California's ability to provide stable funding for state programs may be particularly challenged. This analysis assesses some of the budget impacts of key Medi-Cal policies on the state's GF, with a goal of providing insights that policymakers can take into consideration in future budget planning.

Table 1. Medi-Cal Beneficiary and Expenditure Trends, FY 2007–08 to FY 2017–18

	AVERAGE MONTHLY ENROLLMENT	AVERAGE ANNUAL TOTAL EXPENDITURE PER ENROLLEE†	MEDI-CAL BUDGET* (IN BILLIONS)				
			TOTAL	FEDERAL	OTHER FUNDS	GF	GF AS % OF TOTAL†
FY 2007–08	6,602,900	$5,543	$36.6	$21.9	$0.7	$14.1	38.5%
FY 2008–09	6,586,700	$6,118	$40.3	$26.6	$0.8	$12.9	32.0%
FY 2009–10	7,185,700	$5,970	$42.9	$29.6	$1.1	$12.1	28.2%
FY 2010–11	7,538,700	$6,659	$50.2	$31.1	$5.5	$13.6	27.1%
FY 2011–12	8,007,600	$5,682	$45.5	$28.8	$2.1	$14.7	32.3%
FY 2012–13	8,246,300	$7,191	$59.3	$36.0	$8.9	$14.4	24.3%
FY 2013–14	9,117,000	$7,623	$69.5	$42.7	$10.8	$16.1	23.2%
FY 2014–15	11,500,500	$7,852	$90.3	$58.6	$14.4	$17.3	19.2%
FY 2015–16	12,434,100	$7,319	$91.0	$58.9	$14.1	$18.0	19.8%
FY 2016–17	14,117,700	$6,396	$90.3	$57.8	$14.8	$17.8	19.7%
FY 2017–18	13,688,100	$7,839	$107.3	$68.9	$18.8	$19.5	18.2%
Ratio (2018/2007)	2.1	1.4	2.9	3.1	26.9	1.4	

*Components may not add to total due to rounding.
† Calculated.

Source: California Department of Health Care Services Local Assistance Estimates, May 2008 to November 2017.

Methods

Analyzing historical Medi-Cal budgets requires piecing together information from various sources that represent differing time frames, categorizations, levels of detail, descriptive language, and perspectives. These complexities are compounded by additional nuances best understood in hindsight. For example, some state policies intended to generate substantial GF savings were subsequently disapproved by the federal government,[6] or delayed, stopped, or altered by the courts.[7]

A variety of print and online sources were used for this analysis, as described in detail in Appendix B. The major sources include state budgets, as well as reports from the Department of Health Care Services (DHCS), which administers the Medi-Cal program, the Legislative Analyst's Office (LAO), and the Senate Committee on Budget and Fiscal Review.

An advisory committee composed of current and former budget staff experts from the legislature, LAO, Department of Finance, and California Budget & Policy Center (see sidebar) was convened to review a draft list of major budget policies and discuss what information may prove most useful given the purpose of and audience for the analysis. Advisory committee members recommended emphasizing long-term structural changes rather than policies that generate one-time savings to achieve a balanced budget in a given year. They also recommended using a threshold of significance for key policies of at least a $50 million impact on the GF and eliminating "art of budgeting" items, such as delays in check

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writing, as well as certain programmatic policies, such as an expansion of antifraud programs or drug rebates. To manage the breadth of budget sources examined, several services associated with the Medi-Cal program that are not included in the Medi-Cal GF budget, such as payments to in-home supportive service (IHSS) workers, were excluded.

Analysis: Five Types of Policy Changes

California deployed five major types of policy changes to manage Medi-Cal program costs over the past decade. These include three that are often cited:

1. Changes in benefits,
2. Eligibility changes, and
3. Changes to provider/health plan payments.

Two additional types of policy changes also were used:

4. Delivery system changes and
5. Other revenue augmentations.

These major types of policy changes and examples of each are shown in Figure 2 (see page 5). More detailed descriptions of select key policy changes from Figure 2 are described below, and where feasible, the magnitude of their respective budget impact.

1. Changes in Benefits

One approach used to manage program costs in lean years was the reduction or elimination of optional Medi-Cal benefits, which are not federally required. Conversely, in more prosperous years such as after the passage of the ACA, benefits were added. As one example, adult day health care (ADHC) services were reduced from five days a week to no more than three days in 2009 and then eliminated altogether in FY 2011–12. The decision to cease covering these services was contested by Medi-Cal beneficiaries in a class action suit, and ultimately in 2012, the ADHC benefit was replaced with the more restrictive Community-Based Adult Services (CBAS) program. This change was designed to save over $500 million GF between FY 2009–10 and FY 2012–13,[8] but the actual savings are difficult to track since the transition to the CBAS program was delayed due to the lawsuit. The legislature appropriated $85 million GF in FY 2012–13 to help transition enrollees receiving ADHC services to other appropriate services.[9]

Another example of changing benefits relates to dental services for adults, which were eliminated on July 1, 2009, partially reinstated on May 1, 2014, and fully reinstated on January 1, 2018. While the GF savings of eliminating dental benefits were estimated to be $74 million for FY 2008–09 and $104 million for FY 2009–10,[10] the GF costs of reinstating this benefit over time were difficult to ascertain. Per DHCS reports, GF costs were estimated to be $445,000 for FY 2013–14;[11] GF versus total funds were not clearly broken out for subsequent years. For the full restoration of benefits beginning January 1, 2018, a DHCS report showed GF costs estimated to be $32 million for FY 2017–18 and $80 million for FY 2018–19.[12]

At the same time some benefits were being cut, the ACA required coverage for a variety of services; treatment of mental health conditions and substance use disorders was required, for example, so these benefits were expanded for Medi-Cal beneficiaries. Beginning in 2014, Medi-Cal was also required to cover behavioral health treatment for individuals under age 21 with autism.[13]

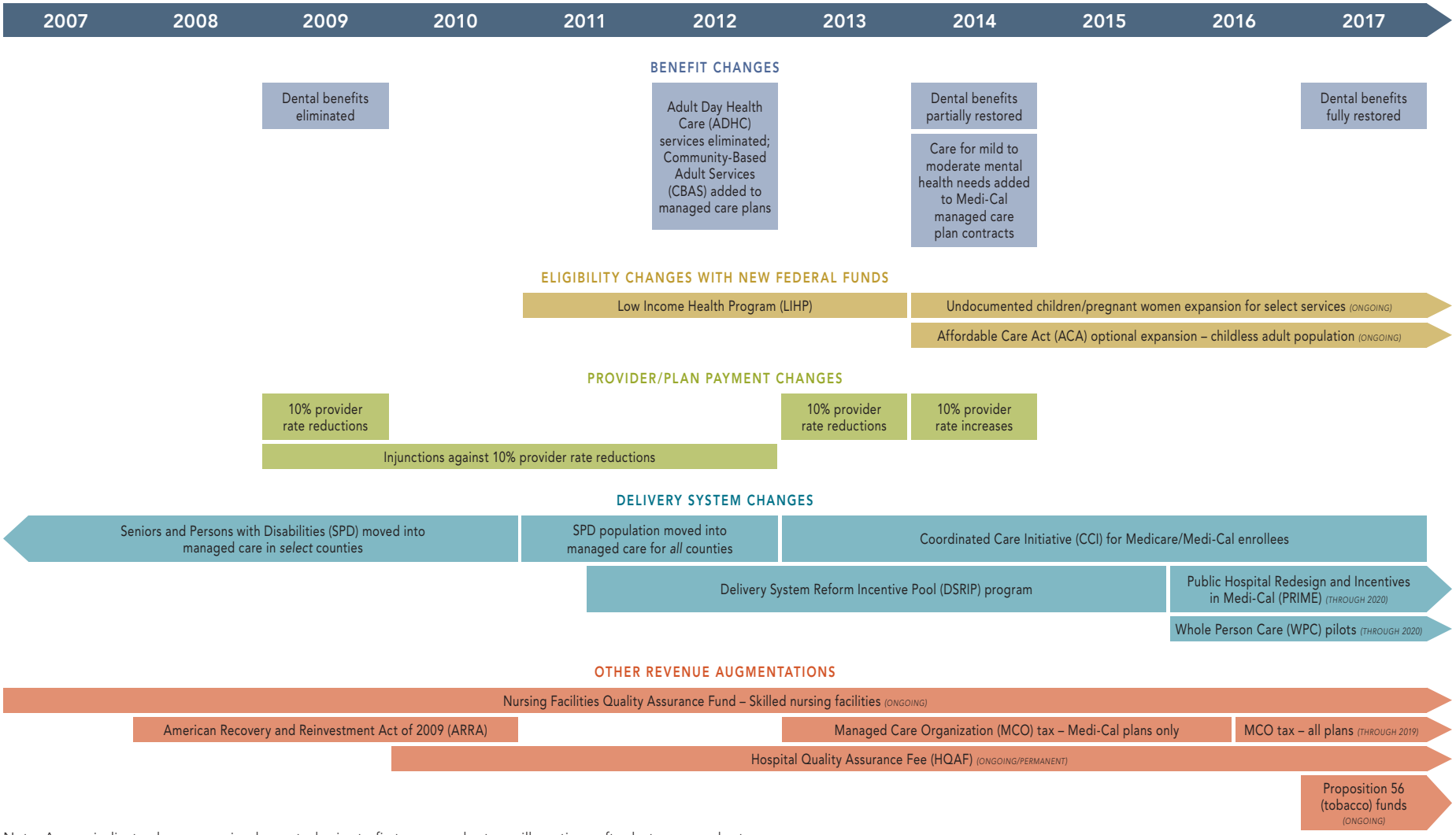
2. Eligibility Changes

Due to an influx of federal funds, the most noteworthy changes in Medi-Cal eligibility over the past decade have been expansions. Beginning in FY 2013–14, the ACA provided federal matching funds to cover low-income, childless adults, who were not previously eligible for Medi-Cal. In addition to an influx of federal funds, which until January 1, 2017, covered 100% of the costs for the expansion population, using state-only funds California has expanded coverage to immigrant children and pregnant women as well as undocumented children. The GF costs of expanding Medi-Cal to all children under age 19 regardless of immigration status, which was implemented in May 2016, for example, were estimated to be $986 million in FY 2016–17 and $901 million in FY 2017–18.[14]

3. Changes to Provider / Health Plan Payments

In lean financial times, notably following the Great Recession of 2008, health care providers, including physicians, pharmacists, dentists, hospitals, and nursing homes, as well as health plans, were on the receiving end of proposed reductions in payments

Figure 2. Medi-Cal Policy Changes with Major Budget Impact, by Implementation Date, FY 2007–08 to FY 2017–18



Note: Arrows indicate change was implemented prior to first year on chart or will continue after last year on chart.

Sources: Medi-Cal Local Assistance Estimates, May 2008 to November 2017, California Department of Health Care Services (DHCS), www.dhcs.ca.gov.
Dental: "Restoration of Adult Dental Services," DHCS, www.dhcs.ca.gov. Note: Full restoration of dental benefits effective January 1, 2018.
ADHC/CBAS: "Community-Based Adult Services (CBAS)," DHCS, www.dhcs.ca.gov.
Mental health, autism, SPDs: *Medi-Cal Managed Care: An Overview and Key Issues*, Kaiser Family Foundation, Issue Brief, 2016.
CCI: *The 2017–18 Budget: The Coordinated Care Initiative: A Critical Juncture*, Legislative Analyst's Office, 2017.
LIHP: "About the Low Income Health Program," UCLA Center for Health Policy Research, healthpolicy.ucla.edu.

for services provided to Medi-Cal beneficiaries. With Medi-Cal provider rates for fee-for-service enrollees among the lowest in the nation, provider payments may seem an unlikely source of program savings.

Legislation was passed effective July 2008 implementing a 10% reduction in most provider reimbursement rates and managed care capitation payments. GF savings in FY 2008–09 were expected to total $624 million as a result of cuts in payments to providers and managed care plans.[15] Almost immediately, however, some providers questioned the legality of these cuts, and a federal judge issued an injunction on August 18, 2008, blocking some of the reductions for ADHC, dental, physicians, optometry, and clinics. This issue played out in the courts over several years, with other injunctions restoring payments including: (1) an April 6, 2009, injunction restoring payments for ADHC services, pharmacy services, some nursing facilities, and certain hospital services; (2) a November 18, 2009, injunction restoring payments to 17 plaintiff hospitals; and (3) a February 25, 2010, injunction restoring payments for some nursing facilities and some small/rural hospitals. DHCS received federal approval for another 10% cut to provider and managed care plan payments that was enacted in 2011 during a state budget crisis, but another injunction delayed implementation until late 2013 / early 2014 based on the type of providers.[16]

Not being able to implement planned payment reductions was estimated to cost the state more than $1.5 billion between 2008 and 2015.[17] In more prosperous recent years, prior cuts to dental providers and long-term care facilities were reversed, and provider payments to primary care physicians increased in 2013 and 2014 as required by the ACA. In FY 2017–18, about $546 million of the $1.3 billion going to Medi-Cal in new Proposition 56 tobacco tax funds will be used to increase provider payments.[18]

4. Delivery System Changes

The federal government offers states flexibility in the way services are provided to Medicaid beneficiaries, and California has embraced this flexibility, seeking and receiving several waivers during the past decade that are designed to improve care while reducing costs. Several programs have been implemented to encourage the enrollment of all Medi-Cal beneficiaries including the population of seniors and persons with disabilities in managed care plans, with 82% enrolled in managed care plans in 2017.[19]

One program that was part of a waiver, the Coordinated Care Initiative (CCI), was implemented in FY 2012–13 and enrolled beneficiaries dually eligible for Medicare and Medi-Cal in managed care. The CCI was implemented in seven counties and included:

1. Cal MediConnect, a voluntary program where dually eligible people could receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services, and
2. Integration of Long-Term Supports and Services (LTSS) into Medi-Cal managed care, with most of these enrollees being required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wraparound benefits.

Over five fiscal years, DHCS reports showed projected GF costs in three years and savings in two others.[20] The CCI was formally discontinued in FY 2017–18 after California's Department of Finance determined that CCI increased GF costs rather than achieving anticipated GF savings;[21] however, several substantive CCI program components, including Cal MediConnect, were retained.[22]

The most recent five-year 1115 waiver (Medi-Cal 2020) makes available more than $7 billion in federal matching funds through programs that shift the focus away from hospital-based and inpatient care, and toward outpatient, primary, and preventive care.

The most recent five-year 1115 waiver[23] (Medi-Cal 2020) makes available more than $7 billion in federal matching funds through programs that shift the focus away from hospital-based and inpatient care, and toward outpatient, primary, and preventive care. Components of this waiver are designed to improve the health outcomes of vulnerable Medi-Cal beneficiaries who are high utilizers of the health care system yet have poor outcomes; integrate substance use, mental health, and primary care; improve dental care for children; and move toward value-based payments for public hospitals and hospitals serving the uninsured.

One key component of the current waiver — Public Hospital Redesign and Incentives in Medi-Cal (PRIME) — is a pay-for-performance delivery system transformation program that seeks to maximize health care value and move toward alternative payment models such as capitation, risk-pool payments, and other risk-sharing arrangements. Hospitals participating in PRIME may receive up to $3.7 billion in federal Medicaid matching funds along with $3.7 billion contributed by public hospitals over five years for implementing clinical projects that change the way care is delivered. PRIME builds on the Delivery System Reform Incentive Payment (DSRIP) component of the prior five-year 1115 waiver. There is no direct GF impact expected, however, since funding for PRIME comes from the federal government and public hospitals.

5. Other Revenue Augmentations

Over the past decade, the Medi-Cal program and California's GF have benefitted tremendously from various sources of revenue augmentations. Taxes and fees on health care providers and plans have been used to generate additional federal funds and are the source of billions of dollars used to support the Medi-Cal program over the past decade. The two largest of these are the hospital quality assurance fee (HQAF) and the managed care organization (MCO) tax.

Initially implemented in FY 2009–10, the HQAF is the state's largest provider fee and is paid by general acute care hospitals to DHCS; it was made permanent under state law (subject to periodic federal review) following voter approval of Proposition 52 in 2016. It is estimated that hospitals have paid into the HQAF in excess of $2 billion most years and a total of almost $22 billion since enactment;[24] the amount of these funds "used to generate state GF savings is based on a formula in state law."[25] In FY 2015–16, for example, hospitals paid about $4.6 billion to the state, of which about $850 million was GF savings.[26]

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When first introduced in FY 2009–10, the MCO tax was a sales tax imposed on Medi-Cal managed care plans only. To comply with federal requirements, the third MCO tax passed in 2016 for a three-year period applies to *all* managed care plans and is expected to generate $1.8 billion in GF savings in FY 2017–18.[27] Prior to the 2017–18 fiscal year, the MCO tax is estimated to have saved the GF a total of at least $1.5 billion.[28] Established in 2004 through AB 1629, skilled nursing facilities and intermediate care facilities also pay a quality assurance fee that is estimated to contribute several hundreds of millions of savings to the state's GF annually.[29]

In addition, two major federal policy changes have resulted in billions of dollars of GF savings over the past decade. The first and largest of these is the American Recovery and Reinvestment Act of 2009 (ARRA), which provided about $7.7 billion in federal matching funds to the Medi-Cal program between FY 2008–09 and FY 2010–11.[30] The second relates to California's federal match (the Federal Medical Assistance Percentage or FMAP) for the Children's Health Insurance Program (CHIP), which temporarily increased from 65% to 88%, resulting in about $100 million to $600 million annually in GF savings beginning in FY 2015–16.[31]

Other Administrative / Structural Changes

In addition to the five major types of policy changes described above, a variety of programmatic and administrative changes have been implemented over the past decade. The magnitude of expected or actual GF savings associated with these changes is difficult to ascertain, however. One major change involved the transition of 750,000 enrollees in the previously freestanding Healthy Families program (California's CHIP) into Medi-Cal. Scheduled to occur in four phases over a one-year period beginning January 1, 2013, the GF costs related to administrative changes were estimated to be $10 million in FY 2012–13 and $12 million in subsequent years.[32] While the administrative costs can be identified, it is not possible to assess whether the transition reduced GF costs, since expenditures for this population were incorporated into the total for all Medi-Cal enrollees after the transition. Another programmatic change involved the transfer of responsibility for behavioral health treatment for people under age 21 from regional centers into Medi-Cal. Similarly, subsequent expenditures from this transition were folded into total program costs.

California has twice used a budgeting tool known as realignment, in which responsibilities for programs and funding are shifted from the state to local governments — first in 1991 and most recently in 2011. The 2011 realignment resulted in a total of $368 million being allocated to the counties for mental health managed care and substance use treatment programs.[33] Another $579 million was allocated to the counties for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, a federally mandated program requiring the state to provide medically necessary physical and mental health services to Medi-Cal beneficiaries under age 21.

Various other administrative/structural changes have occurred as well, including the transfer of two agencies into DHCS — the former Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (ADP).

Limitations

Some major changes to the Medi-Cal program such as moving almost all enrollees into managed care and expanding enrollment and coverage as part of the ACA are not described in detail in this paper because they were not included in budget documents describing changes in state GF dollars relative to the Medi-Cal budget. In addition, because it was challenging to precisely quantify most of the policy changes that were proposed or implemented, the numbers included are best considered as order-of-magnitude estimates of the various changes.

Reflections / Lessons Learned

Considering all the Medi-Cal policy changes over the past decade, it is important to step back and look at several measures of effectiveness. One measure is the *expenditure per Medi-Cal enrollee* over the decade as compared to the rate of medical inflation, private health insurance premiums, or Medicaid expenditures in other states. The average expenditure per Medi-Cal enrollee increased about 40% from approximately $5,500 to $7,800 during the 2007–17 period (see Table 1, page 3), while overall medical inflation increased by about 35% and the average family premium for private health insurance increased 55%.[34] Despite its higher rate of growth, the private sector uses approaches unavailable to Medi-Cal, such as increased enrollee cost sharing, to constrain the rate of growth. Average annual expenditure increases for Medicaid programs in several other western states — Colorado, Nevada, Oregon, and Washington, all of which also expanded Medicaid under the ACA — were greater than for Medi-Cal during the 2007–10 period and similar or greater during the 2010–14 period.[35]

From 2007 to 2017, program enrollment more than doubled, from 6.6 million to 13.7 million, and the total Medi-Cal budget almost tripled, from $37 billion to $107 billion. Reliance on California's GF did not keep pace with these increases, however, as there was only a 38% increase in state GF to support Medi-Cal. Rather, California relied more heavily on federal funds, which increased by approximately 215%, and on other funds, such as county funds, beginning in FY 2010–11 (see Table 1, page 3). In other words, policymakers successfully kept GF growth well below that of overall program growth and generally in line with or below expenditures of other western states and the private sector. By relying more heavily on these other sources of funds rather than contributing state GF dollars at the FY 2007–08 rate of 39% of total Medi-Cal program funds throughout the period, the state saved an estimated $108 billion GF.[36] Given the volatility of the state GF dollars, it may be fiscally prudent for the state to leverage other revenue sources to support the Medi-Cal program, even though those funds also may fluctuate over time.

Policymakers successfully kept general fund growth well below that of overall program growth and generally in line with or below expenditures of other western states and the private sector.

This constraint in GF growth was achieved while instituting many long-term structural changes to Medi-Cal, including covering an additional 3.7 million enrollees; migrating many beneficiaries, notably those who are seniors and persons with disabilities, into managed care plans; realigning mental health services from the state to the counties; and implementing two five-year 1115 waivers. A variety of

innovative revenue-generation and cost-reduction approaches were used to support the program during this period. On the revenue-generation side, the program and state's GF greatly benefitted from an infusion of federal dollars such as those from ARRA and the ACA. Other significant sources of program support and GF savings include taxes and fees, particularly the HQAF and the MCO tax, and beginning in the FY 2017–18 budget, Proposition 56 tobacco tax funds. Cost-moderation/reduction approaches included several that are also designed to improve care, such as the CCI and various waiver programs such as DSRIP/PRIME and Whole Person Care, as well as those that are attributable to harsh budget realities such as provider fee cuts and reduced benefits.

Policy changes such as the plan and provider taxes/fees are innovative and have been very successful in securing funds for the Medi-Cal program and freeing up state GF dollars for other purposes. Some other changes — either enacted or proposed — had unintended and/or undesired outcomes. These include provider rate cuts that resulted in lawsuits, proposed beneficiary cost sharing that was not approved by the federal government, the discontinuation of the CCI because it did not meet targeted savings, and challenges with access when benefits are discontinued and then reinstated.

This brief has focused on the budget impacts of various revenue-generation and expenditure-reduction policies to support the Medi-Cal program, but the task of assessing the broader impacts of these policy changes on quality, health outcomes, and beneficiary experiences will take more time. Evaluations that will help to answer these questions are underway for initiatives facilitated by the ACA and the state's 1115 Medi-Cal 2020 waiver that emphasize preventive services, whole person care, and integrated behavioral health and primary care. It is envisioned that these changes will not only help keep people healthier but also help the state manage ever-escalating costs.

While policymakers will likely continue to avail themselves of the five major types of policy changes described above, the specific policy changes going forward may look quite different given the long-term and/or one-time nature of most of the changes over the last decade and given the continued evolution of health care in California. As the state seeks to address future budget challenges, whether it can retain some flexibility rather than having to comply with federal or other requirements will be an important consideration. Since Medi-Cal covers one-third of California's population, it offers the state a great opportunity to leverage its size and importance to drive changes and improve health and health care delivery.

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Appendix A. Methods

Analyzing historical Medi-Cal budgets requires piecing together information from various sources that represent differing time frames, categorizations, levels of detail, descriptive language, and perspectives. The formatting and degree of detail within one annual source of documentation, such as the Department of Health Care Services (DHCS) Medi-Cal Local Assistance Estimates (LAEs), may mention a policy in one year but not provide specific information on the policy in subsequent years. Sometimes this is due to analyst reporting. Program or departmental consolidation is another reason it is hard to track a given policy change over time. For example, when a program such as Healthy Families (HF) transitions into the Medi-Cal program (as it did in 2013), the costs for the HF population were merged with costs for other Medi-Cal beneficiaries. Those costs overall may go up or down depending on various factors such as the number of newly eligible people enrolling, whether utilization of high-cost drugs was contributing, etc. Therefore, it is unclear whether more or less was paid for the HF enrollees before and after the transition to Medi-Cal. Moreover, some policy changes are simply titled, "Unspecified Budget Reduction."[37]

Overall, this analysis required reviewing and crosswalking multiple documents and consulting with many experts to verify what actually transpired to identify the most significant policy decisions during the 10-year period under study.

Annual sources examined for this analysis include gubernatorial proposed January budgets; DHCS May LAEs that include Management Summary reports; gubernatorial revised May budgets; June enacted budgets passed by the legislature; Senate Committee on Budget and Fiscal Review Final Action Reports published in July–November depending on the year; and Legislative Analyst Office (LAO) California Spending Plans on the Budget and Related Legislation that are published between August and November. The LAO reports are particularly important because there is often significant language in the trailer bill that accompanies the enacted budget, along with other legislative actions. Health Trailer bills that follow enactment of the budget were not examined.

Unsurprisingly, an initial comparison of January and May revised gubernatorial and enacted budgets showed many significant changes, primarily deletions that occurred as proposals were considered and rejected or modified by the legislature and other stakeholders. Therefore, the LAO Spending Plans were used to create an initial picture of annual enacted *significant* policy changes. *Significant* was defined as policies that generated a minimum cost or savings of $50 million to total funds or $25 million to the GF. Over the decade reviewed, there were 63 budget policies that met these criteria (see Table A1 on page 11). These budget items were further grouped into 10 policy categories that either augmented or generated GF savings or costs. Augmentations and savings include drawing down additional federal funds, imposing new or increasing existing taxes, or reducing benefits or payments. New costs to the GF may come from policies such as increasing provider payments or enhancing benefits.

An advisory committee composed of current and former budget staff experts from the legislature, LAO, Department of Finance, and California Budget and Policy (see sidebar on page 3) was convened to review a major budget policies list and discuss what information may prove most useful, given the project's purpose and goals. Advisory committee members recommended that the analysis emphasize long-term structural changes, not policies that generate one-time savings to achieve a balanced budget in a given year. Services associated with the Medi-Cal program that are not included in the Medi-Cal GF budget, such as payments to in-home supportive service (IHSS) workers, were excluded from this analysis.

Advisory committee members also recommended various sources for piecing together the details of the analysis. Finding the appropriate level of detail meant excluding lengthy, detailed sources, such as the Department of Finance's Change Reports, that included changes in appropriations for various programmatic components. By contrast, DHCS's LAEs/Management Summaries provided more policy details than the LAO Spending Plans for line items that together add up to at least $50 million for one

of the 10 broad categories. Figures from the LAEs, which come out in May and are based on actual program implementation figures through approximately February of that year, are the most reliable budget numbers for that year.

For several major GF changes, including some that generated revenue and others that reduced expenses, the LAEs were reviewed to identify the start and end dates and the budget impacts of each change. The analysis of the major changes generating revenue, such as provider taxes and fees, was much more straightforward than the analysis of changes to either benefits or provider/plan payments, which were often subject to lawsuits and subsequent court injunctions or lack of approval by the federal government. As a result, planned changes such as provider cuts were often delayed or reduced or eliminated altogether (e.g., planned copayments for Medi-Cal beneficiaries). When it was difficult to assess the budget impacts of a specific policy change using the LAEs, other data sources were reviewed for inclusion in the analysis.

Table A1. Major Medi-Cal Policy Changes, FY 2007–08 to FY 2017–18

	POLICY CHANGE (PROJECTED BUDGET IMPACT >= $25 MILLION GF)	PROJECTED GF EFFECT (IN MILLIONS)
FY 2007–08	Increase rates for managed care plans to reflect new rate-setting methodology	$54
	Reduce reimbursement rates for drug ingredients	$39
	Increase funding for county administration to comply with new federal eligibility law	$25
	Governor's veto to reduce funding for managed care plans	–$53
	Governor's veto to reduce program spending	–$332
FY 2008–09	Eliminate payment of Medicare Part B premiums for certain beneficiaries	–$48
	Reduce funding to the counties for program administration	–$53
	Reduce payment rates for physicians and other providers	–$291
	Adjustment to reflect recent spending trends	–$323
FY 2009–10	Suspend cost-of-living adjustment for county administration (February)	–$25
	Impose limits on Adult Day Health Care	–$28
	Expand antifraud efforts	–$47
	Redirect Proposition 99 funds to Medi-Cal from various health programs	–$50
	Governor's veto of county administration funding	–$60
	Implement changes to reduce prescription drug costs	–$66
	Freeze long-term care rates	–$90
	Reduce payments to hospitals ($54.2 million in February)	–$109
	Eliminate certain optional benefits for adults (February)	–$122
	Continue unspecified reduction to reflect past program spending trends	–$323
	Assume federal actions to reduce program funding requirements	–$1,000
FY 2010–11	Expand antifraud efforts	–$26
	Extend existing 1115 waiver for two months	–$29
	Reduce county funding for eligibility processing	–$44
	Redirect Proposition 99 funds to Medi-Cal from various health programs	–$47
	Freeze hospital rates at January 2010 levels	–$85
	Adopt additional checkwrite delay for institutional providers	–$120
	Delay checkwrite related to mandatory enrollment of seniors/disabled into managed care	–$187
	Dedicate revenues from hospital provider fee to pay for Medi-Cal children's coverage	–$560
FY 2011–12	Provide funds to transition ADHC beneficiaries to other services	$85
	Collect state share of intergovernmental transfers	–$34
	Impose "soft cap" on physician and clinic visits	–$41
	Collect additional drug rebates	–$64
	Adopt fund shifts and one-time funding sources	–$128

Table A1. Major Medi-Cal Policy Changes, FY 2007–08 to FY 2017–18, *continued*

	POLICY CHANGE (PROJECTED BUDGET IMPACT >= $25 MILLION GF)	PROJECTED GF EFFECT (IN MILLIONS)
FY 2011–12, *continued*	Eliminate adult day health care benefit	–$170
	Implement unallocated reduction	–$345
	Impose mandatory copayments on Medi-Cal beneficiaries	–$511
	Impose provider payment reduction of up to 10%	–$623
FY 2012–13	Transition Long-Term Supports and Services from fee-for-service to managed care	$115
	Temporarily increase rates for primary care services	$39
	Eliminate payments for certain potentially preventable whospital admissions	–$30
	Use First 5 (Proposition 10) monies to fund Medi-Cal	–$40
	Change payment structure for retroactive services in certain counties	–$48
	Nursing home payment changes	–$88
	Hospital payment changes	–$387
	Defer payments to providers and managed care plans	–$711
FY 2013–14	Assume costs from increased enrollment from currently eligible populations	$104
	Provide funding for county administration costs	$87
	Enhance mental health and substance use disorder services	$67
	Shift certain Medi-Cal enrollees to Covered California	–$29
	Redirect 1991 Health Realignment Funds to offset state General Fund costs	–$300
	Assume savings from hospital fee extension	–$310
	Impose a tax on Medi-Cal managed care organizations	–$340
FY 2015–16	Expand full-scope coverage to undocumented children	$40
	Restore rates previously reduced for dental providers	$30
FY 2016–17	Rate adjustments for certain long-term care providers	$135
	Changes to asset recovery	$26
	Savings from new federal limits on generic drug prices	–$130
	Savings resulting from revised MCO tax	–$1,100
FY 2017–18	Assume reduction in federal Children's Health Insurance Program funding	$369
	Repeal scheduled transition of Newly Qualified Immigrants into Covered California	$48
	Restore full adult dental benefits	$35
	Abolish Major Medical Risk Insurance Fund	–$47
	Use Proposition 56 monies to pay for year-over-year program growth	–$711

Source: Legislative Analyst's Office Spending Plans, FY 2007–08 to FY 2017–18.

Endnotes

1. Governor's budget summary, 2018–19, www.ebudget.ca.gov (PDF).
2. California January 2018 proposed budget, www.ebudget.ca.gov.
3. California 2017 enacted budget, www.ebudget.ca.gov.
4. A state's general fund is the primary fund for financing its operations, and in California, it includes three core taxes: personal income tax, sales and use tax, and corporation tax. It does not include federal dollars that pay for a substantial portion of the Medi-Cal program, nor state Special Funds. Information for general fund calculation (Medi-Cal GF as percentage of total GF for 2017–18) available at www.ebudget.ca.gov (PDF).
5. *Funding the Medi-Cal Program*, Public Policy Institute of California, March 2017.
6. For example, the 2011–12 LAO Spending Plan indicated that the state budget assumed $511 million in GF savings by imposing mandatory copayments for physician and clinic visits, dental visits, prescriptions, emergency room visits, and hospital inpatient visits. However, the 2012–13 LAO Spending Plan notes that this savings was not realized because the federal government did not approve the proposed copayments.
7. For example, the FY 2008–09 LAO Spending Plan notes that legislation enacted as part of a February 2008 special legislative session reduced most Medi-Cal provider reimbursement rates by 10% as of July 1, 2008. However, in response to legal challenges raised by some Medi-Cal provider groups, a federal judge issued an injunction on August 18, 2008, blocking enforcement of the reductions for certain types of services provided on or after that date.
8. DHCS May 2009 Medi-Cal Estimate, PC p. 178; DHCS May 2010 Medi-Cal Estimate, PC p. 178; DHCS May 2011 Medi-Cal Estimate, PC p. 200; DHCS May 2012 Medi-Cal Estimate, PC p. 77.
9. DHCS May 2012 Medi-Cal Estimate, PC p. 40.
10. DHCS May 2008 Medi-Cal Estimate, PC p. 166; DHCS May 2009 Medi-Cal Estimate, PC p. 157.
11. DHCS May 2014 Medi-Cal Estimate, OA pp. 64–65. Benefit partially restored for only two months of fiscal year.
12. DHCS November 2017 Medi-Cal Estimate, PC pp. 86–87.
13. DHCS, *Behavioral Health Treatment (BHT) Frequently Asked Questions*, www.dhcs.ca.gov (PDF).
14. DHCS May 2017 Medi-Cal Estimate, PC pp. 26–28; DHCS November 2017 Medi-Cal Estimate, PC pp. 22–23.
15. DHCS May 2008 Medi-Cal Estimate, PC pp. 155, 159, 167, 168, and 182. The $624 million includes $326 million in cuts to providers other than hospital inpatient departments, nursing homes, health clinics, and ADHC providers; $49 million in cuts to nursing home and ADHC providers; $50 million in cuts to certain hospitals; and $198 million in cuts to managed care plan payments.
16. DHCS, *Implementation of AB 97 Reductions*, www.dhcs.ca.gov (PDF).
17. David Siders, "Supreme Court ruling limits Medi-Cal lawsuits," *Sacramento Bee*, March 31, 2015.
18. California voters approved Proposition 56 in November 2016; it increases excise taxes on tobacco products. The 2017–18 LAO Spending Plan estimates that about $1.3 billion in Proposition 56 funds will go to Medi-Cal, with $546 million used for increased provider payments and $711 million to pay for year-over-year program growth.
19. *DHCS Medi-Cal Monthly Enrollment Fast Facts*, November 2017, www.dhcs.ca.gov (PDF).
20. DHCS May 2014 Medi-Cal Estimate, PC p. 237; DHCS May 2015 Medi-Cal Estimate, PC p. 230; DHCS May 2016 Medi-Cal Estimate, PC p. 216; DHCS May 2017 Medi-Cal Estimate, PC p. 217; DHCS November 2017 Medi-Cal Estimate, PC p. 206.
21. California Department of Finance, Letter re: Estimated General Fund Impact for the Coordinated Care Initiative, January 10, 2017.
22. *The 2017–18 Budget, The Coordinated Care Initiative: A Critical Juncture*, LAO, February 27, 2017.
23. 1115 waiver proposals are submitted to the federal government for review; they typically involve a demonstration project and give states additional flexibility to design and improve their Medicaid programs by implementing state-specific policy approaches that better serve the state's population.
24. DHCS May 2011 Medi-Cal Estimate, PC pp. 133–34; DHCS May 2012 Medi-Cal Estimate, PC pp. 215–16; DHCS May 2013 Medi-Cal Estimate, PC pp. 292–93; DHCS May 2014 Medi-Cal Estimate, PC pp. 316–20; DHCS May 2015 Medi-Cal Estimate, PC pp. 315–19; DHCS May 2016 Medi-Cal Estimate, PC pp. 297–98, 301–3; DHCS May 2017 Medi-Cal Estimate, PC pp. 324–27, 356–58.
25. *Proposition 52: State Fees on Hospitals. Federal Medi-Cal Matching Funds. Initiative Statutory and Constitutional Amendment*, LAO, July 18, 2016.
26. Ibid.
27. DHCS November 2017 Medi-Cal Estimate, PC pp. 246–48.
28. DHCS May 2011 Medi-Cal Estimate, PC p. 218; DHCS May 2013 Medi-Cal Estimate, PC pp. 396–97; DHCS May 2014 Medi-Cal Estimate, PC pp. 270–71; DHCS May 2015 Medi-Cal Estimate, PC pp. 265–66; DHCS May 2016 Medi-Cal Estimate, PC pp. 246–47; DHCS May 2017 Medi-Cal Estimate, PC pp. 240–41.
29. *Funding the Medi-Cal Program*, Public Policy Institute of California, March 2017.
30. DHCS May 2009 Medi-Cal Estimate, PC p. 170; DHCS May 2010 Medi-Cal Estimate, PC p. 171; DHCS May 2011 Medi-Cal Estimate, PC p. 156.
31. DHCS May 2016 Medi-Cal Estimate, PC pp. 359–61; DHCS May 2017 Medi-Cal Estimate, PC pp. 441–42.
32. DHCS May 2013 Medi-Cal Estimate, CA pp. 19–20.
33. *2011 Realignment: Addressing Issues to Promote Its Long-Term Success*, LAO, August 19, 2011.

34. *Employer Health Benefits: 2017 Annual Survey*, Kaiser Family Foundation, September 2017.

35. *Average Annual Growth in Medicaid Spending*, Kaiser Family Foundation, www.kff.org.

36. Total estimated Medi-Cal GF expenditures for FY 2007–08 through FY 2017–18 were $170 billion; if GF had represented 39% of total Medi-Cal expenditures during this period (assuming no other changes), Medi-Cal GF expenditures would have totaled $279 billion.

37. Example from the DHCS May 2009 Medi-Cal Estimate (Local Assistance Estimate/LAE) for FY 2008–09 and FY 2009–10: PC 35 Unspecified Budget Reduction: The FY 2008–09 and FY 2009–10 Appropriations both included an unspecified reduction in the Medi-Cal budget of $323.3 million GF. There were no specific changes in policy associated with these budget reductions. The May 2009 Estimate is the final estimate for FY 2008–09 based on the latest available data, and indications were that the unspecified reduction would not be achieved for FY 2008–09. Therefore, in the May 2009 Estimate the unspecified budget adjustment was not included. This results in an increase in cost of $323.3 million GF for this policy change in FY 2008–09 relative to the Appropriation and the November Estimate. The May 2009 Estimate continued to include an unspecified budget reduction of $323.3 million GF for FY 2009–10, so there was no change from the FY 2009–10 Appropriation.