PUBLIC POLICY INSTITUTE OF CALIFORNIA

Funding the Medi-Cal Program

Technical Appendices

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Appendix A: Revisiting the FMAP

The federal share for Medicaid programs—the Federal Medical Assistance Percentage, or FMAP—varies by state. The standard average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82 %). FMAPs are adjusted for each state on a three-year cycle to account for fluctuations in the economy and published annually in the Federal Register. See the ASPE FMAP 2017 Report for additional details.

Several of our expert interviews mentioned California's low FMAP as a constraint on Medi-Cal financing in California. There have been calls to revisit the FMAP formula so that it better reflects differences in the need for Medicaid services across states and the ability of states to adequately fund the program. Several GAO reports have expressed concern that per-capita income as the sole measure used in the FMAP formula to determine state need and resources is incomplete and a poor proxy for the size of the state's population in need of Medicaid services. This may be particularly true in a state like California, which has high levels of income inequality, resulting in high per capita income but a disproportionate share of residents living in poverty—especially when cost of living is accounted for.

A 2016 GAO report describes alternative methods for determining FMAP including using federal surveys to develop measures of the demand for Medicaid services, geographic cost differences, and state resources to provide a basis for allocating funds more equitably among states. However, it is difficult to assess how the federal government and Congress will respond given the current policy landscape.

Appendix B: Health Care and the State-County Relationship

Counties in California are charged with providing health care and mental health services to the medically indigent. Counties are also responsible for providing specialty mental health services to Medi-Cal beneficiaries with severe mental health needs and coordinating substance use disorder services. In addition, local governments—primarily counties, but in a few cases, cities—are tasked with providing public health services which include infectious disease monitoring and health education.

AB 8

In the wake of Proposition 13—passed by voters in 1978 to limit property taxes—local governments faced a substantial and immediate loss of billions of dollars in revenues. In response, the state passed legislation—Assembly 8 (AB 8)—to relieve fiscal pressures on local governments. AB 8 accomplished this in part by shifting county cost sharing requirements for some health and human services programs to the state. The state assumed all costs for Medi-Cal—prior to Proposition 13 counties paid a share of Medi-Cal costs—and the State Supplementary Program (SSP) of the SSI/SSP and also increased the state share of costs for the state's cash assistance program (formerly AFDC, now TANF/CalWORKs). It also created a state block grant for county indigent health programs.

1991 Realignment

The two primary revenue sources—which the state collects and allocates to counties—that support county health programs are sales tax and vehicle license fees (VLF). This funding structure is the result of a major change to the state-county relationship that occurred in 1991—commonly referred to as 1991 Realignment. To support the "realignment" of programmatic and fiscal responsibility from the state to the counties for certain health and social service programs, half a cent of state sales tax and a portion of VLF collections were dedicated to counties.

The 1991 health realignment funding continues to provide the bulk of funds available to counties to meet their health obligations—including both the provision of indigent care and public health programs. With the Medi-Cal expansion under the ACA, most, if not all, county residents once served by county indigent care programs now qualify for Medi-Cal with costs borne largely by the state and federal government rather than counties. This is particularly true in the majority of California counties that do not operate public hospital systems.

Changes in the Wake of the ACA

With the state expansion to Medi-Cal under the ACA, legislation (AB 85) was passed to redirect some 1991 health realignment funds to support state costs and also to reflect the lowered county obligation to provide indigent care. The mechanism to determine how much funds should be shifted from the counties to the state relied on detailed formulas to calculate county savings. Adding to the complication, VLF funds are constitutionally protected local funds, so the county savings generated from reduced indigent care responsibilities goes towards increasing CalWORKs grant amounts paid for by counties, rather than directly going to support Medi-Cal program costs.

In recent budget years, the amount redirected to the state under AB 85 has been less than anticipated—in the current fiscal year nearly $200 million less. When the legislation was passed in 2013, there was still considerable uncertainty as to the impact of the state's Medi-Cal expansion on remaining county indigent responsibilities and county hospital systems. Now that we are a few years into the expansion—which did exceed most expectations in terms of reducing the number of low-income, uninsured residents—we have some grounding and actual cost figures on which to base decisions. Particularly among counties that do not operate county hospitals, there would appear to be valid reasons that the state may seek to adjust the share of 1991 health realignment funding that continues to go to counties. Indeed, the Governor's January budget for fiscal year 2017-2018 includes provisions to recoup county savings from previous budget years.

2011 Realignment

Counties also provide specialty mental health services to Medi-Cal beneficiaries with severe mental health needs. The 1991 realignment provided a separate pot of funds to counties to support community mental health systems operated by counties to meet their responsibilities to provide mental health services to Medi-Cal beneficiaries as well as the uninsured.

In 2011, the state instituted another major 'realignment' which shifted responsibility for certain correctional populations from the state to the counties. Referred to as Public Safety Realignment, this shift was also accompanied by dedicated funding for counties to support their new correctional responsibilities—and this included additional funds for mental health services. Under the 2011 realignment, counties received additional dedicated sales tax revenues to support the provision of county mental health systems. And in 2012, with the passage of Proposition 30, the sales tax revenue dedicated to county mental health has become a constitutionally protected source of local funds.

Program Administration

Counties are also responsible for managing eligibility and enrollment in means-tested programs, including Medi-Cal, CalFresh, and CalWORKs. While counties shoulder a share of the cost for administering CalFresh and CalWORKs, the state and federal government provides the majority of funding related to program administration. With the large investments made under the ACA to streamline eligibility systems and processing along with the new IT system—CalHEERs, which determines eligibility for subsidies in Covered California, but also screens for Medi-Cal eligibility—it may be possible to reevaluate the role that counties play in administering Medi-Cal eligibility and enrollment in a way that could lead to cost savings down the road.

Appendix C: Data Sources and Methodology

Sources of Fiscal Information

We use several sources of information to examine Medi-Cal financing. Major revenue, expenditure, and budget data sources used in the report come from state and federal sources and are listed in Table C1. For much of the analysis of recent Medi-Cal state spending trends we rely on the Medi-Cal Local Assistance Estimates produced by the Department of Health Care Services in May and November each year. For longer trend analyses, we utilize Medicaid data the state submits to the federal government, which is published by the Centers for Medicare and Medicaid Services, sometimes referred to as form CMS-64. Because these come from two different data sources there are sometimes minor discrepancies in total amounts, although these do not change any of the interpretations or discussion.

TABLE C1

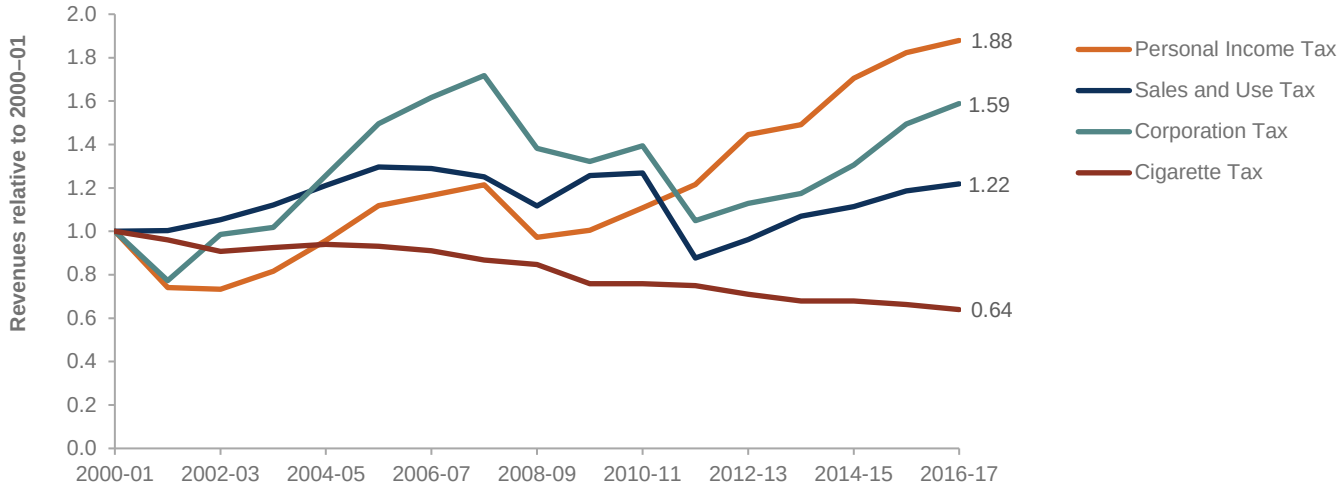
Major data sources for state revenues and federal and non-federal expenditures

Source	Description
California Legislative Analyst's Office	General and Special Fund Revenues
California Department of Finance	May Revision summaries
California Department of Health Care Services	Historical Trends and Most Recent 24 Months; California Spending Plan Annual Reports; Medi-Cal Local Assistance Estimates
Centers for Medicare and Medicaid Services	Medicaid Financial Management Reports

For all of the figures included in the main body of the report, we adjust dollar amounts for inflation using the CPI-U for the western region. Figure C1 below shows nominal changes in major tax revenues, using 2000–01 as the comparison year. Figure 2 in the report shows the same trends, but in inflation-adjusted terms. With no adjustment, for example, the Personal Income Tax increased by 1.88 times in nominal terms (as compared to 1.33 times shown in Figure 2) and revenue from sales and use tax increased by 1.22 times.

FIGURE C1

Nominal change in California's major tax revenues



SOURCES: Legislative Analyst's Office, General and Special Funds Revenues (accessed at lao.ca.gov/ PolicyAreas/state-budget/historical-data) and Department of Finance May Revision Summary, 2015–16 and 2016–17.

NOTES: Figure shows the relative increase in state revenues generated by each source relative to fiscal year 2000–2001 as the base. Revenues are not adjusted for inflation.

We examine changes over time in revenues and expenditures using 2000–01 as the comparison or base year. The choice of base year is somewhat arbitrary, although changing the base year does not alter the overall trends in major revenue sources that we discuss in the report; no matter the choice of base year, Sales and Use Tax revenues are flat or declining, while the Corporation Tax has grown moderately and the Personal Income Tax has grown more substantially. Table C2 shows that the choice of base year is most consequential for trends in Personal Income Tax. Even in inflation-adjusted terms, the Personal Income Tax grew by a far greater amount if we use 1995 or 1996 as the base year of comparison instead of 2000. The other sources of revenue are not as sensitive to choice of base year.

TABLE C2

Real change in California's major tax revenues, various base years

	2016 vs. 1995	2016 vs. 1996	2016 vs. 1997	2016 vs. 1998	2016 vs. 1999	2016 vs. 2000
Personal Income Tax	2.49	2.29	1.96	1.80	1.44	1.33
Sales and Use Tax	1.02	1.00	0.96	0.91	0.84	0.86
Corporation Tax	1.16	1.20	1.22	1.27	1.12	1.12
Cigarette Tax	0.29	0.31	0.33	0.36	0.42	0.45

SOURCES: Legislative Analyst's Office, General and Special Funds Revenues (accessed at lao.ca.gov/ PolicyAreas/state-budget/historical-data) and Department of Finance May Revision Summary, 2015–16 and 2016–17.

NOTES: Figure shows the relative increase in state revenues generated by each source compared to the indicated state fiscal years. Revenues are adjusted for inflation using the CPI-U west, but do not account for changes in tax rates or population growth.

Expert Interviews

In September and October of 2016, PPIC researchers conducted semi-structured interviews with several people identified as experts or key stakeholders in issues related to Medi-Cal financing. Below is a list of the individuals who were interviewed for this project along with the interview protocol. The protocol was provided to each participant and used as a guide to all of the interviews we conducted.

Interview Participants

Diane Cummins, Governor Brown's Office

Craig Cornett, Senate President Pro Tem Office

Seren Taylor, State Senate Republican Caucus

Adam Dorsey, Department of Finance

Jason Sisney, Legislative Analyst's Office

Farrah McDaid Ting, California State Association of Counties

Fred Silva, California Forward

Jennifer Ito, member of Parsky Commission and California State Controller's Council of Economic Advisors

Kim Reuben, Urban Institute and member of California State Controller's Council of Economic Advisors

Stan Dorn, Urban Institute

Melissa Stafford Jones, U.S. Department of Health and Human Services, Region 9, former President of California Association of Public Hospitals

Deidre Gifford, National Medicaid Directors Association

Charles Bacchi and Athena Chapman, California Association of Health Plans

Felix Su, Blue Shield of California Medicaid Plans, former LAO Medi-Cal analyst

Interview Protocol

Thank you for agreeing to participate in our project. We appreciate your taking the time to speak with us.

The interview will last about an hour and be semi-structured: We will propose some general topics and questions and then let the conversation develop from there. If it is acceptable to you, we would like to audio tape the interviews, as it will provide an accurate record to which we can later refer and will also allow us to more fully engage during the discussion itself. We will not keep any of the audio recordings.

We are planning on including a list of the people and organizations that we interview in an appendix of the report, so the information you provide will not be confidential. However, we will not attribute any specific comment(s) to an individual or organization; rather the information you provide will be synthesized by researchers to inform our analysis and conclusions. The second page of this document provides information about your rights as a participant in this research project.

We envision discussing four broad areas:

1. The capacity of the General Fund to absorb increased spending in the Medi-Cal program;
2. The feasibility of counties and provider fees to provide large shares of non-federal funds;
3. The pros and cons of other revenue sources that could potentially be dedicated to health; and
4. The need to situate Medi-Cal spending needs within a broader discussion of California's tax system.

Examples of specific questions include:

What are the most significant sources of cost pressure facing the Medi-Cal program over the next 5–10 years? For example, pressure to raise rates, new federal managed care regulations, reductions in federal funding. In your opinion, how much can the General Fund be expected to cover increases in program spending needs?

How does the division of responsibilities between the state and the counties affect the program's fiscal base? Are there more effective ways to structure financing with local entities and partners to improve program goals such as improving access, coordinating care, and controlling costs? What are the barriers/challenges to changing the state/local finance structure? Any potential solutions?

Based on your knowledge of Medi-Cal financing issues, can the current share of program funding derived from non-federal sources (counties, plans, hospitals) be maintained or expanded? What will be the largest impacts of the new federal managed care rules on the program's financing structure and spending? What areas could be most affected –General Fund, revenue for safety net hospitals, Drug Medi-Cal ODS?

Can you discuss some of the advantages and disadvantages of creating additional dedicated revenue streams for the Medi-Cal program, i.e. tobacco taxes, taxes on high-income earners? Are there other sources of additional revenue the state should consider or pursue?

In your opinion, what strategies is (or can) the state employ to address anticipated shortfalls (fiscal gaps) between Medi-Cal spending needs and available revenue over the next 5–10 years? For example, rainy day fund, better aligning Medi-Cal with other public purchasers, changes to the state-local relationship.

Are there other states or policy areas that you feel offer examples of forward-looking or innovative strategies that could inform Medi-Cal financing moving forward?

Can developing stable and adequate funding for Medi-Cal be achieved without examination of California's broader revenue system which relies so heavily on high-income earners and capital gains?

Appendix D: Tax Expenditure Estimates

The Department of Finance (DOF) is required by law to produce annual reports describing the impacts of various tax expenditures on state and local revenues as well as the number of entities that are affected (taxpayers or corporations). Table D1 below provides a list of their estimates of tax expenditures in California in the most recent fiscal year for personal income tax and corporation taxes. We only include tax expenditures with estimates of at least $500 million, although the DOF provides estimates for any tax expenditures projected to results in $5 million or more in lost state revenues.

TABLE D1

Major identifiable tax expenditures

	State General Fund Revenue Lost (in millions)		
Personal income Tax Provisions	2016–17	2017–18	2018–19
Exclusion of employer contributions to health plans	$6,000	$6,400	$6,200
Exclusion of employer pension contributions	6,500	7,500	7,500
Home mortgage interest deduction	4,200	4,500	4,600
Exclusion of social security benefits1	3,600	3,800	3,700
Exclusion of capital gains on sale of principal residence	3,000	3,200	2,900
Basis step-up on inherited property	2,500	2,600	2,400
Charitable contributions deduction	2,660	2,850	2,940
Real estate, personal property and other taxes deduction	1,840	1,940	1,840
Exclusion of benefits provided under cafeteria plans	1,500	1,600	1,500
Dependent exemption in excess of personal exemption credit	1,400	1,500	1,500
Employee business and miscellaneous expenses deduction	1,400	1,400	1,400
Exclusion of investment income on life insurance and annuity contracts	1,300	1,300	1,200
Head-of-household and qualifying widower filing status	1,100	1,200	1,200
Exclusions for individual retirement accounts	850	900	900
Medical and dental expenses deduction	550	600	600
Exclusions for self-employed retirement plans	500	500	550
Personal Income Tax Total (including provisions not shown)	41,530	44,510	43,644
Corporate Tax Provisions			
Water's edge election	2,300	2,400	2,600
Research and development credit	1,600	1,700	1,700
Enterprise Zone And Similar Areas	410	310	250
Like-kind exchanges	750	800	750
Corporate Tax Total (including provisions not shown)	6,195	6,462	6,655

SOURCE: California Department of Finance.

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