Protect Medi-Cal Funding 2025: Federal Threats

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California's Medicaid program (Medi-Cal) provides a critical investment in the health of Californians. Medi-Cal coverage and services are tailored to meet the unique needs of low-income individuals and families, and provides the most affordable coverage. If Medicaid cuts are enacted, states like California will lose billions of dollars in federal Medicaid funding, shifting financial responsibility for Medicaid services to the states and to enrollees. The loss of billions of dollars in federal Medicaid funding will invariably lead to cuts in services and the loss of affordable coverage. This issue brief explains why Medi-Cal is so critical to helping low-income people afford health care, and it explains how low-income Californians would be harmed by Medicaid funding caps and cuts.

Background

Medicaid is the nation's largest public health coverage program. In California, approximately 14.8 million people are enrolled in Medi-Cal and CHIP; Medi-Cal is the largest state Medicaid program in the U.S.[1] State Medicaid programs are jointly administered between the federal government and the state. Federal dollars make up the bulk of Medi-Cal's budget, last year funding 62% of Medi-Cal.[2] Medi-Cal covers a wide range of health services for low-income people of all ages. Cutting federal funding will certainly harm the Medi-Cal program. This issue brief details how the various potential cuts could impact the Medi-Cal program. Please visit NHeLP's updated "Protect Medi-Cal Funding 2025" series to learn more about the threats to Medi-Cal applicants and beneficiaries.

Potential Threats

Work Requirements

Advocates expect that Congress may revive work requirements as a strategy to cut Medicaid dollars despite past failed attempts and legal challenges in court by NHeLP and many other partners that ended these illegal demonstrations.[3] Implementing work requirements in the Medi-Cal program would create a significant barrier in access to coverage and widen health inequities. Work requirements fail to take into account that there are many reasons why

beneficiaries cannot work, including: disabilities and/or chronic conditions; lack of economic opportunities or the availability to work; lack of access to childcare; and/or lack of transportation, and more. Proposed work requirements also include reporting requirements, which only adds more bureaucratic red tape for beneficiaries to comply with. In a state as large and diverse as California, many beneficiaries would be at risk of losing their Medi-Cal coverage because of work requirements, including older adults, persons with disabilities, students, and residents of the many rural counties across the state. These barriers are underscored by the ongoing local county Medi-Cal office and call center barriers that persist throughout the state.[4]

Most Medicaid (Medi-Cal) beneficiaries who can work do so.[5] The most current data shows that approximately 3.4 million California workers (nearly one in five) age 19 to 64 were enrolled in Medi-Cal.[6] Medi-Cal beneficiaries working in high-enrollment industries have a higher rate of Medi-Cal enrollment because they have no option of employer-sponsored insurance (ESI).[7] Inequities in rates of job-based coverage show up across race, class, citizenship status, age, and conditions of employment. California adults between ages 19 to 64 years old who are Latino or Black, low-income, immigrants, and young adults show lower rates of ESI.[8]

Loss of Medi-Cal coverage due to work requirements will certainly increase California's uninsured rate and increase expenses for households that might need to purchase marketplace coverage. To date, most California residents have health insurance because of the years-long achievements to expand access to affordable coverage through Covered California and the Medi-Cal program. As of 2023, California's uninsured rate of 6.4% remains below the national average of 7.4%.[9] Individuals who would otherwise qualify for Medi-Cal, would lose coverage, because of barriers to access employment or barriers to comply with burdensome reporting criteria and red tape.

Changes to the Federal Medical Assistance Percentage (FMAP)

The current financial structure of the Medicaid program uses the Federal Medical Assistance Percentage (FMAP) to finance a portion of Medicaid costs. The FMAP can increase for specific beneficiaries and covered services. In California, the "minimum matching rate," or regular FMAP, for Medi-Cal is 50%, which is the lowest regular FMAP for a state. However, the FMAP for beneficiaries enrolled under Medicaid expansion programs, such as adults ages 19 to 64, is at 90%.[10] The FMAP can also change and increase during disasters or public health emergencies (PHEs). For example, during the COVID-19 PHE, Congress passed legislation that increased the FMAP so that California could coordinate its COVID-19 response on the condition that the state maintain coverage for Medi-Cal beneficiaries.[11] As millions of people lost their

jobs or income sources during the PHE, Medi-Cal enrollment grew to almost 16 million beneficiaries in May 2023 when the PHE ended and the requirement to maintain coverage began to phase out.[12] This increased FMAP allowed the Medi-Cal program to maintain low-income Californians' health coverage, while responding to the urgent needs of the pandemic without running out of the necessary funding to cover the costs.

Reducing or eliminating the current enhanced FMAPs would devastate the Medi-Cal program. Less federal financial assistance would shift the heavy burden of the costs of benefits and services to California. Changes to the FMAPs would inevitably force California to make cuts to the Medi-Cal program. While it is unclear today which specific cuts would be made, potential ones could include: ending the expansion for all Californians regardless of immigration status, re-imposing Medi-Cal premiums, cuts to innovative benefits under CalAIM, and more. Even more devastating, reducing or eliminating the Medicaid expansion FMAP could put pressure on California to drop it altogether, resulting in the loss of coverage for low-income individuals and families ages 19 to 64. Changes to the regular FMAP would also have a similar impact and result in cuts to Medi-Cal benefits and services to compensate for the losses.

Block Grants

Block granting Medicaid would cause significant problems for the Medi-Cal program. As explained above, current federal financing of Medi-Cal is based on the actual costs to provide eligibility, services, and provider payments through federal matching funds. However, block grants are a single, limited payment to the states based on a preset formula to finance the Medi-Cal program.[13] It is not based on actual costs and California would not get additional payments if enrollment increases or if the costs of services or provider payments increases. Block grants would pressure California to make cuts to the Medi-Cal program, because the initial allotment would be based on expected, not actual, costs. Any increases in subsequent years would not keep up with the pace of rising, or unanticipated, health care costs. For example, during the COVID-19 PHE, the rapid spread of the virus overwhelmed the entire health care system throughout California, especially because of the disproportionate impacts on many underserved communities such as lower-wage workers and BIPOC individuals.[14] Medi-Cal was a lifeline, because the federal and state response led to increased federal matching dollars and additional protections. The increased funding allowed the Medi-Cal program to cover the costs for COVID-19 related testing, treatment, and vaccine coverage to mitigate the spread of the virus. It also provided health coverage because of the economic downturn when many Californians lost their jobs. A block grant funding structure would have left California without the resources to adequately respond to such a health crisis, because it is inflexible and does not account for the actual costs and needs demanded by a disaster or an emergency.

Per Capita Caps

Similar to block grants, per capita caps are financing mechanisms that cut Medicaid funding by capping federal payments, but *per beneficiary*. Per capita caps are also based on a preset formula instead of the actual costs for benefits and services.[15] Current federal funding for Medi-Cal is based on actual costs and continues regardless of whether enrollment or program costs go up, because of the federal matching funds that the state receives. Per capita caps are problematic by design. In the first year when a per capita cap amount is established, the initial allotment for the preset formula is based on expected, not *actual*, costs. This estimated, one-size-fits-all approach does not account for the realistic and actual needs of California and would likely underestimate the actual costs for Medi-Cal. Because per capita caps fail to account for increased health care costs and increase much more slowly than actual state spending, California would have to shoulder the burden of increased costs, even within the same year of implementation. The cost-shifting burden would force California to make cuts to Medi-Cal eligibility and services in order to sustain the program.

Even if a proposed per capita cap rate increased per year, such increases are based on a preset growth index, which also does not keep up with the actual rate of costs.[16] No matter how you slice it, per capita caps would leave California to absorb higher, unanticipated costs, which would destabilize the resources of the Medi-Cal program. Using the COVID-19 PHE as an example, per capita caps would likely have left the state to pay the higher costs of the Medi-Cal program for testing, treatment, and vaccine coverage, especially taking into account the deadliness of the virus, as well as the multiple strains of the virus, and reinfection rates.

Changes to State Use of Provider Taxes

Federal law gives California wide flexibility in how it finances the Medi-Cal program with its portion of the costs. Revenues from provider taxes, which can include hospitals, nursing homes, and managed care plans, is a common source of Medicaid funding, including for Medi-Cal.[17] Currently, California has provider taxes on hospitals, nursing homes, intermediate care facilities for individuals with intellectual disabilities, managed care plans, and ambulance providers.[18] Last year, California made the existing Managed Care Organization Tax permanent, which requires the state to spend the revenue on Medi-Cal health care costs.[19] If federal cuts are enacted to eliminate or inhibit the use of provider taxes, this could put the state in a difficult position to generate revenue and result in the state making cuts to the program, or needing to raise state taxes, in order to compensate for the cost-shifting burden from the loss of the revenue source.

Conclusion

The Medicaid program is designed to give California wide flexibility in designing and implementing its own Medi-Cal program to meet the particular health needs of its residents. The potential threats to the program on the federal level will not only result into devastating impacts on low-income individuals and families across the state, these threats will also make it necessary for California to impose additional cuts and erect barriers to access life-sustaining care in the future. While it remains unclear what the current 2025 Congress and Trump Administration will do with respect to the Medicaid program, such federal funding cuts or barriers to deter enrollment must be rejected so low-income individuals and families have the access to quality affordable and comprehensive health care they need.

ENDNOTES

[1] CMS, *October 2024 Medicaid & CHIP Enrollment Data Highlights* (Jan. 15, 2025), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.; Cal. Dep't Health Care Servs., *October 2024 Medi-Cal Continuous Coverage Unwinding Dashboard*, https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Continuous-Coverage-Eligibility-Unwinding-Dashboard-October2024.aspx (last visited Feb. 4, 2025).
[2] Cal. Dep't of Health Care Servs., *Medi-Cal May 2024 Local Assistance Estimate for Fiscal Years 2023-24 & 2024-25* (July 24, 2024), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx.
[3] *See* Mara Youdelman, Nat'l Health L. Prog., *Who is Harmed by Medicaid Work Requirements?* (Jan. 6, 2025), https://healthlaw.org/resource/who-is-harmed-by-medicaid-work-requirements/.
[4] *See* The Children's Partnership, *Medi-Cal Call Wait Times Study* (July 2024), https://childrenspartnership.org/research/medi-cal-call-wait-times-survey-report/.
[5] *See* Rolonda Donelson et al., Nat'l Health L. Prog., *Medicaid Work Requirements Hurt the U.S. Workforce*, (Sept. 2024), https://healthlaw.org/wp-content/uploads/2024/09/013-PMF-Low-Wage-Workers.pdf.; Rolonda Donelson et al., Nat'l Health L. Prog., *Medicaid Work Requirements Hurt State Economies* (Sept. 2024), https://healthlaw.org/wp-content/uploads/2024/09/014-PMF-State-Budgets.pdf.
[6] *See* Cal. Health Care Found., *Medi-Cal and the Federal Government – Policy at a Glance* (Jan. 22, 2025), https://www.chcf.org/publication/medi-cal-federal-government/#related-links-and-downloads.
[7] Rebecca Catterson et al., Cal. Health Care Found., *Working Californians Enrolled in Medi-Cal Share Their Voices* (Oct. 2020), https://www.chcf.org/wp-content/uploads/2020/10/WorkingCaliforniansMediCalShareStories.pdf. Based on the American Community Survey, the three industries with the highest Medi-Cal enrollment rates are: (1) agriculture, forestry, fishing, and mining at 32%; (2) restaurants, bars, and food services at 31%; and (3) "other services" which included auto mechanics, hair salon workers, workers in private households, and more at 27%. Additional industries with large representations of Medi-Cal beneficiaries include: administrative and building services at 26%; retail at 22%; transportation and warehousing at 21%; and construction at 19%.; *See* Kevin Lee et al., UC Berkeley Labor Ctr., *Job-based coverage is less common among workers who are Black or Latino, low-wage, immigrants, and young adults* (Nov. 22, 2019), https://laborcenter.berkeley.edu/job-based-coverage-is-less-common-among-workers-who-are-black-or-latino-low-wage-immigrants-and-young-adults/.
[8] Kevin Lee et al., UC Berkeley Labor Ctr., *supra* note 7.
[9] U.S. Census Bureau, *2023 American Community Survey, 1-Year Estimates, S2701 Selected Characteristics of Health Insurance Coverage in the United States*, https://data.census.gov/table/ACSST1Y2023.S2701?g=040XX00US06 (last visited Feb. 4, 2025).; Kaiser Family Found., *Health Insurance Coverage for the Total Population (2023)*, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Feb. 4, 2025).

[10] *See* Cal. Health Care Found., *supra* note 6.
[11] Families First Coronavirus Response Act [hereinafter FFCRA], Pub. L. No. 116-127, 134 Stat. 178 § 6008(a) (2020), **https://www.congress.gov/116/bills/hr6201/BILLS-116hr6201enr.pdf**.; 42 U.S.C. 1396d; CMS, *Families First Coronavirus Response Act - Increased FMAP FAQs* (Apr. 13, 2020), **https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf**.
[12] Cal. Dep't of Health Care Servs., *Medi-Cal Continuous Coverage Unwinding Dashboard* (May 2023), **https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx**.
[13] Mara Youdelman, Nat'l Health L. Prog., *What Is a Block Grant and How Would It Impact Medicaid?* (Dec. 18, 2024), **https://healthlaw.org/resource/what-is-a-block-grant-and-how-would-it-impact-medicaid/**.
[14] Don Bambino Geno Tai et al., *Disproportionate Impact of COVID-19 on Racial and Ethnic Minority Groups in the United States: a 2021 Update* (2022), **https://pmc.ncbi.nlm.nih.gov/articles/PMC8513546/**.; *See* Samantha Artiga et. al., Kaiser Family Found., *Communities of Color at Higher Risk for Health and Economic Challenges Due to Covid-19* (Apr. 7, 2020), **https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/**.
[15] Mara Youdelman, Nat'l Health L. Prog., *What Is a Per Capita Cap and How Would It Impact Medicaid?* (Dec. 18, 2024), **https://healthlaw.org/resource/what-is-a-per-capita-cap-and-how-would-it-impact-medicaid/**.
[16] Shameek Rakshit et al., Petersen-Kaiser Family Found., Health System Tracker, *How does medical inflation compare to inflation in the rest of the economy?* (Apr. 2, 2024), **https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/**.
[17] Anne Dwyer et al., Georgetown Univ. McCourt School of Pub. Pol'y Ctr. for Children and Families, *How Medicaid Works and What's at Stake in 2025* (Dec. 10, 2024), **https://ccf.georgetown.edu/wp-content/uploads/2024/12/How-Medicaid-Works-Whats-at-Stake-in-2025_-Presentation-Slides.pdf**.
[18] *See* Medi-Cal: Managed Care Organization Provider Tax (AB 119); CMS letter to Dir. Michelle Baass, Cal. Dep't Health Care Services (Dec. 19, 2023), **https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-23-0035-Approval.pdf** (federal approval of State Plan Amendment 23-0035, effectuating approval of targeted Medi-Cal provider rate increases); *See also* Cal. Dep't Health Care Servs., *Medi-Cal Targeted Provider Rate Increases and Investments*, **https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx** (last visited Feb. 4, 2025).; Anne Dwyer et al., Georgetown Univ. McCourt School of Pub. Pol'y Ctr. for Children and Families *supra* note 17 at 34.
[19] *See* Kristen Hwang, *CalMatters, California voters give Medi-Cal doctors a raise by passing Prop. 35* (Nov. 7, 2024), **https://calmatters.org/politics/elections/2024/11/election-result-proposition-35/**.; *Supra* note 18.