Informational Hearing

Forecasts and Estimates: Crafting the Budget for California's Health Programs

BACKGROUND

INTRODUCTION

The 2025 Budget Act includes total expenditures of $306.2 billion ($87.4 billion General Fund) for California's health and human services (HHS) programs in 2025-26. Nearly two-thirds of HHS expenditures, or $202.7 billion, are for the Department of Health Care Services (DHCS), which administers the Medi-Cal program. The Department of Social Services (CDSS), which administers CalWORKs and CalFresh, as well as In-Home Supportive Services and other public benefit programs, is projected to spend $56.1 billion on its programs in 2025-26. The Department of Developmental Services (DDS), which administers Lanterman Act services for individuals with developmental disabilities, is projected to spend $18.7 billion on its programs in 2025-26. The next largest HHS expenditures are for the California Department of Public Health (CDPH) and the Department of State Hospitals (DSH), which are projected to spend $5.2 billion and $3.2 billion, respectively, in 2025-26. While these programs comprise the largest total fund expenditures for HHS programs, each has its own unique combination of state funds, federal funds, and other funds that support its state operations and delivery of services or benefits.

OVERVIEW – MEDI-CAL CASELOAD AND LOCAL ASSISTANCE ESTIMATES

The 2025 Budget Act includes expenditure authority of $185.5 billion ($38.3 billion General Fund, $109.8 billion federal funds, and $37.4 billion special funds and reimbursements) in 2024-25 and $202.7 billion ($45.6 billion General Fund, $120.7 billion federal funds, and $36.4 billion special funds and reimbursements) in 2025-26 to support the Department of Health Care Services (DHCS), which administers the Medi-Cal program. Of these amounts, $1.5 billion ($474.5 million General Fund, $590.4 million federal funds, and $429.1 million special funds and reimbursements) in 2024-25 and $1.4 billion ($320.6 million General Fund, $642.7 million federal funds, and $395.1 million special funds and reimbursements) in 2025-26 are allocated for state operations cost for DHCS to administer Medi-Cal and a few other state health-related health programs. The budget for state operations is generally driven by personnel costs (salaries, wages, and benefits), contract costs, and operating expenses. New state operations expenditures are generally reflected in the department's budget change proposals (BCPs) submitted for consideration by the Legislature during the annual budget process.

Medi-Cal Local Assistance Estimate. The largest expenditure category for DHCS is for the Medi-Cal program, as reflected in the semi-annual Medi-Cal Local Assistance Estimates. After adoption of the 2025 Budget Act, the Medi-Cal Estimate reflects total expenditure authority of $194.5 billion ($44.6 billion General Fund, $118.8 billion federal funds, and $31.1 billion special funds and reimbursements) in 2024-25, and $196.7 billion ($44.9 billion General Fund, $119.7 billion federal funds, and $32.1 billion special funds and reimbursements) in 2025-26.

Caseload Projections. The budget estimates total Medi-Cal caseload of 15 million beneficiaries in 2024-25 and 14.9 million in 2025-26. Of these totals, 14 million beneficiaries or 93.6 percent, in 2024-25, and 13.9 million beneficiaries or 93.4 percent, in 2025-26, will receive their Medi-Cal services through a managed care plan. 962,000 beneficiaries or 6.4 percent, in 2024-25, and 979,000 beneficiaries or 6.6 percent, in 2025-26, will receive their Medi-Cal services through the fee-for-service delivery system. Medi-Cal caseload estimates in the past five years have been impacted by several external factors, most significantly the impacts of the COVID-19 pandemic, but also several important changes to eligibility for the program. During the pandemic, a combination of economic conditions and federally mandated continuous coverage requirements during the public health emergency led to a sharp increase in Medi-Cal caseload projections to more than 15 million Californians. After the expiration of the public health emergency, the federal government required states to "unwind" the continuous coverage provisions adopted during the pandemic, and restart annual redeterminations of eligibility for beneficiaries. As the "unwinding" process concluded, the Medi-Cal program experienced fewer disenrollments of individuals than were expected, with Medi-Cal caseloads projected to be just under 15 million beneficiaries in 2025-26.

As the pandemic "unwinding" process was occurring, the state made two key changes to eligibility for Medi-Cal, both beginning in January 2024, that impacted caseload in specific populations. First, the state completed its two-phase elimination of the asset test for Medi-Cal eligibility for seniors and persons with disabilities. In 2022, the state increased the asset limit to $130,000 for an individual and $65,000 for each additional individual in the household. Although the vast majority of income-eligible individuals are unlikely to possess this level of assets, an often cumbersome asset verification process prevented many from taking advantage of their eligibility for the program. In January 2024, the state eliminated the asset limit entirely, relieving beneficiaries and county eligibility workers of the burden of asset verification, resulting in a spike in Medi-Cal enrollment for seniors and persons with disabilities. The Legislative Analyst's Office estimated in a March 2025 report that around 225,000 additional seniors had enrolled in Medi-Cal compared to a pre-pandemic baseline, with at least 165,000 enrolled due to eligibility expansions, and 60,000 still on the program due to the pandemic continuous coverage requirements and federal "unwinding" flexibilities authorized during the Biden Administration[1]. Due to a General Fund shortfall, the 2025 Budget Act included a return to the previous asset limit of $130,000 for an individual and $65,000 for additional individuals in the household, which is estimated to result in General Fund savings of $45 million in 2025-26, $343 million in 2026-27, and $510 million annually thereafter, due primarily to fewer individuals successfully navigating the asset verification process and enrolling in Medi-Cal.

In addition, on January 1, 2024, California expanded eligibility for full-scope Medi-Cal coverage to all income-eligible individuals, regardless of immigration status. Previous expansions to income-eligible individuals, regardless of immigration status, included children under 19 (2016), young adults under 26 (2020), and older adults over 50 (2022). The 2024 expansion included all remaining adults ages 26 to 49. Due to increased costs for this population estimated in the Governor's May Revision, the 2025 Budget Act imposed several changes to eligibility and other

[1] Legislative Analyst's Office. "Understanding Recent Increases in the Medi-Cal Senior Caseload". March 6, 2025. http://lao.ca.gov/Publications/Report/5010

costs for this population, including: 1) a freeze on new enrollment beginning January 1, 2026; 2) monthly premiums for individuals with unsatisfactory immigration status (UIS) beginning July 1, 2027; 3) elimination of dental benefits for the UIS population beginning July 1, 2027; 4) elimination of clinic per-visit payments for the UIS population beginning July 1, 2027; and 5) implementing pharmacy rebates for utilization by the UIS population. Combined, these provisions are estimated to result in General Fund savings of more than $6 billion annually when fully implemented, primarily due to reduction in caseloads for the expansion and UIS populations.

Estimating Managed Care Delivery System Costs in the Medi-Cal Program. The most significant expenditure category in the Medi-Cal program is for costs related to payments to Medi-Cal managed care plans, who provide health care services to more than 93 percent of Medi-Cal beneficiaries. The 2025 Budget Act estimates total expenditures of $89.4 billion in 2024-25 and $98.6 billion in 2025-26 for the Medi-Cal managed care delivery system. Capitation payments to Medi-Cal managed care plans are developed separately for each Medi-Cal category of aid, county, and plan.

Capitation payments for Medi-Cal managed care are required by federal Medicaid regulations to be actuarially sound, providing for all reasonable, appropriate, and attainable costs that are required under the terms of the plan contract.[2] DHCS contracts with Mercer to develop actuarially sound capitation payments for Medi-Cal managed care plans annually. Mercer uses retrospective managed care plan encounter or claims data to develop prospective rates for the upcoming calendar year, taking into account program or policy changes, changes in population mix, and other factors. Mercer uses these data to develop a rate range for each rate cell (category of aid, county, plan), and the final, contracted rate falls within that rate range.

OVERVIEW – CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PROGRAMS

The 2025 Budget Act includes expenditure authority of $5.2 billion ($799.4 million General Fund, $2.3 billion federal funds, and $2.1 billion special funds and reimbursements) in 2025-26 for programs administered by the California Department of Public Health (CDPH). CDPH administers a variety of different public health programs within the following major program division: 1) Center for Preparedness and Response; 2) Center for Health Communities; 3) Center for Infectious Disease; 4) Center for Family Health; 5) Center for Health Statistics and Informatics; 6) Center for Environmental Health; 7) Center for Healthcare Quality; and 8) Center for Laboratory Science. Many of the programs administered by CDPH are supported by special funds that derive from user and other fees, as well as grants of federal funds through a variety of programs. The primary caseload-driven programs administered by CDPH include the AIDS Drug Assistance Program (ADAP), the Genetic Disease Screening Program (GDSP), and the Women, Infants, and Children (WIC) Program.

AIDS Drug Assistance Program (ADAP). The 2025 Budget Act includes expenditure authority of $356.3 million ($241.1 million ADAP Rebate Fund and $115.2 million federal funds) in 2024-25 and $411.7 million ($301.4 million ADAP Rebate Fund and $110.3 million federal funds) in 2025-26 to support medication and health care coverage for individuals living with, or at risk of,

[2] 42 Code of Federal Regulations Section 438.4

HIV/AIDS in ADAP. ADAP provides direct medication assistance, as well as assistance with health care premiums or cost-sharing for individuals covered by Medicare, Medi-Cal, or private insurance. ADAP also provides pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications to HIV-negative individuals who are at risk of HIV infection.

The 2025 Budget Act assumes ADAP caseload of 31,522 in 2024-25 and 36,744 in 2025-26, in the following categories:

Caseload by Client Group	2024-25	2025-26
Medication-Only	8,493	7,763
Medi-Cal Share of Cost	103	138
Private Insurance	9,826	10,451
Medicare	6,715	6,646
PrEP Assistance Program	6,385	11,746
TOTAL	**31,522**	**36,744**

According to CDPH, the ADAP Estimate uses a Cost per Client methodology to estimate expenditure and revenue associated with the program. The methodology estimates expected number of clients serviced per month and expected cost per client per month to arrive at an expenditure forecast for the program. Forecasts of ADAP revenue derived from drug manufacturer rebates are based on expected expenditures, historical rebate amounts, and the timing of medication dispensing and receipt of rebate payments from manufacturers.

Genetic Disease Screening Program (GDSP). The 2025 Budget Act includes expenditure authority from the Genetic Disease Screening Fund of $173.5 million ($37.6 million state operations and $136 million local assistance) in 2024-25, and $174.5 million ($36.4 million state operations and $138.1 million local assistance) in 2025-26 to support newborn and prenatal screening in the Genetic Disease Screening Program. The GDSP Local Assistance Estimate forecasts costs for two programs: the Newborn Screening (NBS) Program, a mandatory program that screens all infants born in California for genetic and congenital diseases, and the Prenatal Screening (PNS) Program, an opt-in program for pregnant individuals to screen for neural tube defects (NTD) or chromosome aneuploidies through its cell-free DNA (cfDNA) screening.

Newborn Screening (NBS) Caseload Estimate. The 2025 Budget Act estimates NBS program caseload of 404,023 in 2024-25 and 402,104 in 2025-26. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

Prenatal Screening (PNS) Caseload Estimate. The 2025 Budget Act estimates PNS program caseload of 201,875 cfDNA specimens in 2024-25 and 200,911 cfDNA specimens in 2025-26. These estimates are based on state projections of the number of live births in California, with 50 percent projected to opt-in to participate in PNS in 2024-25 and 50 percent in 2025-26.

Women, Infants, and Children (WIC) Program. The 2025 Budget Act includes expenditure authority of $1.4 billion ($1.2 billion federal funds and $192.7 million WIC Manufacturer Rebate Fund) in 2024-25 and $1.5 billion ($1.3 billion federal funds and $186.3 million WIC Manufacturer Rebate Fund) in 2025-26 to support food and nutrition programs through the WIC program. The federal funds include state operations costs of $69.5 million in 2024-25 and $71.1 million in 2025-26.

The 2025 Budget Act assumes 1,004,181 average monthly WIC participants in 2024-25 and 1,013,240 average monthly WIC participants in 2025-26. According to CDPH, caseload and expenditure estimates are based primarily on expected participation in each of the five categories of eligibility for WIC: 1) pregnant, 2) breastfeeding, 3) non-breastfeeding, 4) infants, and 5) children. Participation for each of these categories is estimated separately using population growth rates, as well as the upper limit of possible participants in the program, to project future participation.

PANELIST PRESENTATIONS

Subcommittee Questions. The subcommittee has requested panelists respond to the following:

DHCS:

1. Please provide a brief overview of the overall budget for DHCS, including major programs, funding sources, positions and expenditures for state operations, and expenditures for local assistance.

State Operations

2. How does DHCS evaluate its state operations needs for its program areas, including number of positions and the need for contract resources?

3. How does DHCS determine whether workload should be managed by state civil service positions or by contract staff? What types of workload typically fall into each category?

Medi-Cal Local Assistance

4. Please describe in detail how DHCS arrives at its forecasts for caseload in the Medi-Cal program, as reflected in the Medi-Cal Local Assistance Estimate, including sources for assumptions on population growth, impact of policy changes, and other factors.

5. Please provide some examples of how major policy changes can impact caseload estimates (e.g. undocumented freeze/premiums, asset test) as well as expenditures (e.g. provider rate changes, benefit expansions, pharmacy changes).

6. Please describe in detail how DHCS develops capitated rates for Medi-Cal managed care plans, including actuarial soundness requirements, the use and timing of encounter data, policy-related adjustments, and policies that protect the state and plans from deviations from those estimates (e.g. risk corridors, medical-loss ratio, etc..).

7. Aside from base managed care rates, what are some examples of other major cost drivers in the Medi-Cal program? How are those programs funded?

8. Please describe the role of provider taxes in funding for the Medi-Cal program, including the different types of provider taxes (e.g. MCO, HQAF, SNF QAF), how they support the non-federal share of Medi-Cal expenditures, and how those funds are used to improve the program. In addition, please briefly describe how DHCS is approaching future federal challenges to the state's current and future provider taxes.

CDPH:

1. Please provide a brief overview of the overall budget for CDPH, including major programs, funding sources, positions and expenditures for state operations, and expenditures for local assistance.

State Operations

2. How does CDPH evaluate its state operations needs for its program areas, including number of positions and the need for contract resources?

3. How does CDPH determine whether workload should be managed by state civil service positions or by contract staff? What types of workload typically fall into each category?

Program Estimates/Local Assistance

4. Please provide an overview of how CDPH centers arrive at caseload and expenditure forecasts for the AIDS Drug Assistance Program (ADAP), the Genetic Disease Screening Program (GDSP), and the Women, Infants, and Children (WIC) Program, including sources for assumptions on population growth, impact of policy changes, and other factors.

5. Please provide some examples of how major policy changes can impact caseload estimates (e.g. ADAP eligibility changes, coverage changes) as well as expenditures (e.g. food/pharmacy costs, expansion of covered screening tests in GDSP).

6. Please describe how CDPH is managing fiscal and programmatic impacts to its programs related to recent federal actions.

DOF:

1. Please provide an overview of the DOF budget development process for the state's health programs.

2. How does DOF evaluate requests for state operations resources from state health programs like DHCS and CDPH?

3. How does DOF interact with DHCS, CDPH, or other caseload driven department programs to evaluate and refine caseload and expenditure estimates for inclusion in the Governor's January budget?

4. When confronted with a General Fund shortfall, how does DOF evaluate options for expenditure reductions to address the shortfall, particularly in the state's health programs? What factors are considered and how does the department and Administration prioritize among all expenditures in the budget?

5. Conversely, when confronted with a General Fund surplus, how does DOF evaluate proposals from state departments, particularly health-related departments, for investments in new programs, or expansions of existing programs?

6. How is DOF approaching the fiscal threats from the new federal administration to ensure health programs, and the beneficiaries who rely on them, are protected?

LAO:

1. Please provide a presentation of the findings in the recent LAO report, 'Considering Medi-Cal in the Midst of a Changing Fiscal and Policy Landscape", particularly how they relate to the fiscal risks to the Medi-Cal budget in the coming fiscal year.

2. Please describe the most significant challenges to the Medi-Cal budget posed by the provisions of House Resolution (HR) 1, including changes to provider taxes, eligibility processes, and impacts on caseload and expenditures, as well as how the state might address those challenges.

3. Given the projected shortfalls in the state's General Fund condition over the next few fiscal years, what types of tradeoffs will the Administration and the Legislature need to consider when evaluating potential reductions in the Medi-Cal budget?

4. How should the Administration and the Legislature evaluate the non-budgetary impacts on the state's health system stemming from Medi-Cal programmatic changes related to HR 1 or state budget actions, including impacts on financial stability of hospitals and clinics, potential cost shifts to county indigent programs, and changes to healthcare utilization patterns due to reductions in access to preventive services.

5. Absent significant changes in the growth of health care costs, what strategies could the Administration and the Legislature consider to ensure the long-term fiscal stability and sustainability of the Medi-Cal program?