

## THE 2026-27 BUDGET: MEDI-CAL AT THE MAY REVISION

Below is our initial analysis of the May Revision proposals for Medi-Cal. Given the late release of the budget back-up information this year, the Legislature was afforded little time to fully assess the proposals ahead of next week's hearings (even compared to previous May Revisions). Accordingly, we focus on providing key questions for the Legislature to pursue in budget hearings and subsequent discussions with the administration.

We first provide an overview of the Medi-Cal budget at the May Revision. We then assess the Medi-Cal base spending estimates at May Revision. We then provide a lengthier analysis of two key proposals—(1) the MCO tax proposal and (2) the county administration funding proposal related to H.R. 1 implementation. We conclude by providing brief analyses of various other proposals and budget adjustments, including those related to the asset test, individuals with unsatisfactory immigration status (UIS), and planned operational efficiencies. For your convenience, a summary of our analyses and recommendations is provided immediately below.

### SUMMARY

We recommend treating the baseline estimates (before considering policy changes) in the May Revision as a reasonable starting point.

Regarding the MCO tax, we find the administration's proposal to create a new tax outside of Proposition 35 novel but worth considering. That said, we recommend the Legislature weigh its trade-offs with other approaches, such as pursuing legislative amendments of Proposition 35 as allowed by the measure. We also recommend the Legislature direct the administration to provide key information to help it weigh its options.

Regarding the county administration funding proposal, we recommend the Legislature balance near-term H.R. 1 implementation needs against broader budget constraints. The Legislature could consider pairing one-time funding with workload reporting and provisional authority to adjust funding if workload exceeds assumptions. We also recommend seeking more information on the surge staffing model and trailer bill language related to county performance penalties.

We are still reviewing the administration's estimates for several key policy changes, including those related to individuals with UIS and the asset test. We recommend caution in assuming much of the administration's projected savings from operational efficiencies.

### OVERVIEW

***Medi-Cal's Overall Budget Is Down in May Revision.*** The May Revision provides \$217 billion total funds for Medi-Cal in 2026-27. While this would reflect an all-time high for the program, it is \$6 billion (3 percent) lower than what the administration proposed in the Governor's budget. Estimated spending is also lower in the current year. As Figure 1 shows, spending generally is down across most fund sources and programs, with some exceptions. For example, General Fund spending is higher in the current year.

Figure 1

**Medi-Cal's Budget Is Down, With Some Variation by Fund Source**

In Billions

	2025-26			2026-27		Change From		Year-to-Year
	Budget Act	Governor's Budget	May Revision	Governor's Budget	May Revision	Governor's Budget 2025-26	2026-27	Change at May Revision
<b>Totals</b>	\$196.0	\$196.7	\$194.4	\$222.4	\$216.7	-\$2.3	-\$5.7	\$22.3
<b>By Fund Source</b>								
Federal Funds	\$119.7	\$119.4	\$117.0	\$137.5	\$132.5	-\$2.5	-\$5.0	\$15.5
General Fund	44.2	46.4	48.6	48.8	44.9	2.2	-3.9	-3.7
Other Funds	32.1	30.9	28.8	36.2	39.3	-2.1	3.1	10.4
<b>By Program</b>								
Managed Care	\$100.4	\$99.0	\$98.2	\$123.2	\$113.7	-\$0.8	-\$9.5	\$15.6
Fee For Service	45.6	44.8	40.1	43.5	44.9	-4.7	1.4	4.8
Other Services	43.3	44.8	48.6	48.0	49.6	3.8	1.5	0.9
Local Administration	8.4	8.0	7.5	7.7	8.5	-0.5	0.8	1.1

**Current-Year General Fund Spending Is Higher...** In 2025-26, the May Revision estimates \$2.2 billion (5 percent) more General Fund for Medi-Cal relative to the Governor's budget. The Governor's budget already assumed another \$2.2 billion increase above the 2025-26 Budget Act, meaning that General Fund Medi-Cal spending would be \$4.4 billion (10 percent) higher than last year's expectations. About half of the \$2.2 billion revision over Governor's budget is from a delay in federal approval of the state's private hospital fee (the Hospital Quality Assurance Fee), requiring a partial backfill from the General Fund. Most of the remainder is from higher base spending (mostly higher per-enrollee costs) and additional federal funding deferrals.

**...Requiring a Short-Term Loan to Medi-Cal.** When Medi-Cal costs notably exceed expectations in the budget act, the department can run the risk of lacking enough budget capacity to cover expenses before the Legislature can increase its appropriation authority. State law creates a mechanism to loan additional cash to Medi-Cal in the short run through the Medi-Cal Provider Interim Payment (MPIP) Fund. A few days before the May Revision, Department of Finance approved a \$4.3 billion MPIP loan in 2025-26 to Medi-Cal. The May Revision assumes this amount is repaid from a supplemental General Fund appropriation in the final budget package. (There is another \$4.4 billion in outstanding MPIP loans—including around \$1 billion in 2025-26—due to the state deferring repayment as a budget solution in the 2025-26 Budget Act. The administration states that it does not intend to pursue such an approach for this year's \$4.3 billion loan.)

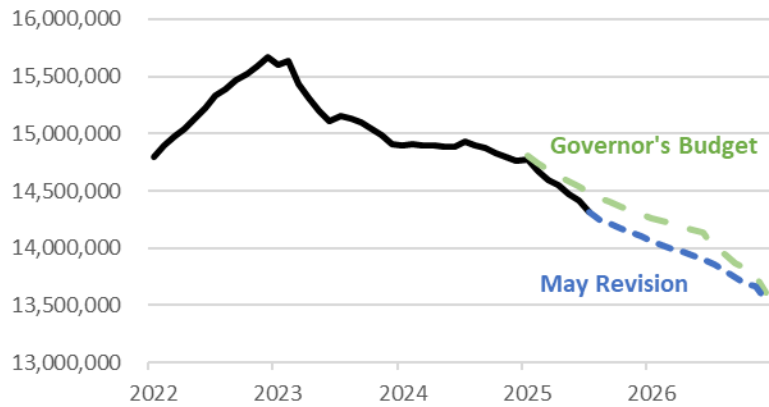
**Budget-Year General Fund Spending Is Down.** In contrast to General Fund spending in 2025-26, proposed General Fund spending in 2026-27 is down from the Governor's budget by \$3.9 billion (8 percent). Of this amount, \$2.8 billion is from proposed budget solutions (described later). Most of the remainder generally is from lower base spending. The Governor's proposal to move all UIS individuals to the fee-for-service (FFS) delivery system (described later) appears to be a key reason for the decline in base spending.

**Medi-Cal Caseload Is Down Slightly.** The May Revision estimates Medi-Cal enrolls 13.9 million people in 2026-27. As Figure 2 shows, this amount is slightly lower than the estimates in the Governor's budget. The reduction is the result of both underlying trends and certain proposed budget solutions.

Figure 2

## Caseload Is Down At May Revision

Monthly Medi-Cal Caseload



***Governor Proposes Expanded Package of Budget Solutions.*** The Governor's budget included two budget solutions related to people with UIS. The May Revision includes additional solutions. As Figure 3 shows, the largest solutions involve Proposition 35 and the MCO tax. The May Revision also modifies some of the previously proposed solutions, such as by delaying their timing. Most of the proposed budget solutions are ongoing.

Figure 3

**May Revision Notably Expands List of Medi-Cal Budget Solutions**

Proposed Budget Solutions in Medi-Cal

	2026-27	2027-28	2028-29	2029-30
<b>Governor's Budget</b>				
<b>People with UIS</b>				
End of comprehensive coverage for new UIS populations <sup>a</sup>	\$786	\$1,100	\$1,100	\$1,100
Work requirements and six-month renewals <sup>a</sup>	125	2,000	2,500	2,900
<b>Totals</b>	<b>\$911</b>	<b>\$3,100</b>	<b>\$3,600</b>	<b>\$4,000</b>
<b>May Revision</b>				
<b>Proposition 35 and MCO Tax</b>				
Proposition 35 support for provider rate increases	\$1,700	\$150	—	—
New managed care organization tax	575	2,300	2,300	1,725
Proposition 35 support for behavioral health initiatives	122	—	—	—
<b>People with UIS</b>				
End of comprehensive coverage for new UIS populations <sup>a</sup>	—	\$1,300	\$1,300	\$1,300
Work requirements and six-month renewals <sup>a</sup>	60	1,200	1,900	2,100
Increase in premiums	—	427	426	314
<b>Other</b>				
Lower asset limit for seniors and disabled adults	\$216	\$321	\$321	\$321
Restructured Enhanced Care Management benefit	41	99	99	146
Rate reduction for PACE providers	34	81	85	85
Restructured Community Supports services	27	59	51	51
Medical loss ratio remittance redirection	—	25	25	25
Opioid Settlement Fund offsets	35	35	35	35
Managed Care Performance Guarantee deposit	—	15	30	
End of acupuncture benefit	5	13	13	13
<b>Totals</b>	<b>\$2,810</b>	<b>\$6,012</b>	<b>\$6,572</b>	<b>\$6,102</b>
<b>Difference</b>	<b>\$1,899</b>	<b>\$2,912</b>	<b>\$2,972</b>	<b>\$2,102</b>

<sup>a</sup> Reflects LAO estimates.

UIS = unsatisfactory immigration status. MCO = managed care organization. PACE = Programs of All-Inclusive Care for the Elderly.

**BASE SPENDING ESTIMATES**

**Baseline Caseload Projected to Decline More Steeply...** The May Revision projects that baseline Medi-Cal caseload—that is, caseload before considering the effects of major new policy changes—will decline from about 14.4 million average monthly enrollees in 2025-26 to 14.2 million in 2026-27. This represents a steeper decline than the administration assumed in the Governor’s budget, primarily due to lower projected enrollment among childless adults, families, and seniors. Our office’s caseload projections are nearly identical to those of the administration in 2025-26, but lower by about 300,000 enrollees in 2026-27. This difference is mainly because we project enrollment to continue moving closer to pre-pandemic levels in the absence of continuous coverage and related federal flexibilities.

**...With Per-Enrollee Costs Still Driving Growth in Base Spending.** While Medi-Cal caseload is projected to decline, base spending in many areas is expected to continue growing due to rising per-enrollee costs. This is consistent with our office's earlier finding that per-enrollee costs, rather than caseload, have explained most of the Medi-Cal base spending growth over the past decade. In managed care, capitation rates are projected to grow by 6 percent to 7 percent in 2026-27 depending on the care model, somewhat higher than the 4.6 percent long-term annual growth rate we have estimated. Net pharmacy spending per Medi-Cal beneficiary—after accounting for federal and state drug rebates—is projected to grow by more than 15 percent, reflecting increases in the number of users, utilization per user, and drug prices. Average Medicare premium payments for dual eligible Medi-Cal beneficiaries are projected to grow by about 8 percent, above the roughly 5 percent long-term average. These trends suggest that underlying cost pressures in Medi-Cal remain significant, even as caseload declines.

**Second Consecutive Year of Sizable Cost Overruns.** This is the second consecutive May Revision where Medi-Cal costs are coming in notably higher than originally budgeted, requiring the administration to access the maximum allowable cash loan for Medi-Cal. With a program as large and complex as Medi-Cal, revised estimates are to be expected in a given year. Some of this year's cost overrun also is due to unforeseen events (such as delayed federal approval of the private hospital fee). That said, higher base spending—specifically, higher per-enrollee costs—remain a key driver of the cost overruns. Medi-Cal's large size also means that sizable adjustments can create significant fiscal challenges for the Legislature. This risk is particularly heightened in the context of the state's projected structural deficits over the multiyear period.

**Recommend Treating Base Spending Estimates as Reasonable Starting Point.** Though our own modeling has some differences from the administration, we view these differences as modest and well within the reasonable margin of uncertainty with Medi-Cal budgeting. In light of this, we recommend treating the administration's estimates as a starting point.

**Legislature Could Explore Needed Refinements to Medi-Cal Budgeting.** Over the longer term, the Legislature may wish to work with the administration to better understand the key reasons why Medi-Cal costs have been exceeding budgeting expectations in recent years. Identifying the underlying causes could help refine budget modeling over time, reducing the risk of substantial cost overruns in the future.

## **MCO TAX PROPOSAL**

### **Background**

**State Tax on Health Plans Helps Pay for Medi-Cal.** The MCO tax is a specific tax on health plans in California (such as Kaiser Permanente and Anthem Blue Cross). It has worked differently over time, but more recent iterations were based on health plans' enrollment levels. The tax has supported the Medi-Cal program, historically helping to pay for existing costs in lieu of the General Fund.

**Tax Historically Resulted in More Federal Funding.** Though a tax on health plans, nearly all of the MCO tax revenue (over 99 percent) comes from more federal funding. The way this works is complex, but it is because most of the tax falls on plans' Medi-Cal enrollment. Medi-Cal is partly funded by federal funds, and the program basically covers the cost of the tax for the

plans. There also is a tax on private health plan enrollment, but it is relatively small—less than 1 percent the size of the tax on Medi-Cal enrollment.

***Voters Recently Enacted Rules Around Tax.*** The Legislature never permanently approved the MCO tax. Instead, it approved it for limited periods of time, generally renewing it at the end of each cycle. This dynamic changed when voters approved Proposition 35 in 2024. Under the measure, the state could permanently charge the tax without legislative approval. The measure also placed new rules on the tax. For example, the tax on private health plan enrollment cannot exceed its then-existing, relatively low levels. The measure also requires much of the revenue to be spent on *expanded* Medi-Cal services (such as provider rate increases) in addition to existing services.

***Congress Recently Changed Federal Rules Around Tax.*** The state must also receive federal approval to draw down federal funds with the MCO tax. In 2025, Congress enacted H.R. 1, which included certain policy changes affecting the MCO tax. Most notably, future taxes must now be proportionate between Medi-Cal and private health plan enrollment, effectively shifting more cost burden onto private plans. H.R. 1 also effectively prohibits the state from increasing the MCO tax or adopting new taxes beyond its existing one.

***Due to State and Federal Policy Changes, Next Tax Was Expected to Be Small.*** The state's current MCO tax, which raises around \$7 billion to \$8 billion annually to the state, is scheduled to expire at the end of 2026. In 2027, the state will charge a new MCO tax pursuant to Proposition 35's and H.R. 1's rules. Due to the interaction of these two laws, the 2027 version was expected to be very small, raising just tens of millions of dollars annually. This is because Proposition 35 limits what the state can charge private health plan enrollment, while H.R. 1 requires the tax to be proportionate between Medi-Cal and private plans. Absent amending Proposition 35, the state can only scale back the Medi-Cal tax to comply with both laws.

## **Proposal**

***Proposes Additional Moderately-Sized, Proportionate MCO Tax.*** The May Revision assumes federal approval of an MCO tax in 2027. The assumed tax would raise around \$2 billion in annual revenue to the state, notably smaller than the state's current tax. In compliance with H.R. 1, the new tax would be proportionate between Medi-Cal and private health plan enrollment, with an average monthly charge of \$8.85 per enrollee.

***Uses Resulting Funds as a Budget Solution.*** The May Revision proposes using all of the MCO tax's net revenue to help pay for *existing* costs in Medi-Cal. This would create General Fund savings, because the MCO tax would cover costs in lieu of the General Fund. When factoring in the timing of federal approval and Medi-Cal's cash-budgeting system, the administration estimates initial General Fund savings of \$575 million in 2026-27, ramping up to around \$2 billion in subsequent years.

***Proposes Two-Part Approach to Comply With Proposition 35 and H.R. 1.*** According to the Department of Finance, the proposal involves a single tax that would be submitted for federal approval, with two different components. According to public statements by the administration, the first component would be largely similar to the existing tax structure. The second component, which would be H.R. 1 compliant, would be in addition—and therefore not subject—to Proposition 35. In this way, the administration argues it can still pursue federal approval for meaningfully large MCO tax while still complying with Proposition 35 and H.R. 1.

***Includes Certain Other Proposition 35-Related Budget Solutions.*** According to the Department of Finance, it also is shifting existing Proposition 35 funds used for provider rate increases to further help offset General Fund spending. Similar to a solution in the *2025-26 Budget Act*, the shift would support provider rate increases that already occurred and were covered by the General Fund. Proposition 35 technically allows the state to count increased service levels and rates since 2024 as provider rate increases.

## **Assessment**

***State Is at Crossroads With Proposition 35 Implementation.*** Proposition 35 was crafted and approved by voters before Congress enacted H.R. 1. With the enactment of H.R. 1, the measure's many provisions increasingly appear to be in conflict. For example, as we have noted elsewhere, notably reducing the Medi-Cal tax rate to comply with Proposition 35 and H.R. 1 means that the state will no longer have a reliable source of support for provider rate increases. While potentially compliant with Proposition 35, such an action would counter the measure's goals of having a meaningfully large MCO tax. Other implementation options raise similar trade-offs. With so many competing goals, any implementation decision likely will run counter to some of Proposition 35's original goals, maintaining others.

***Governor's Proposal Aims to Ensure Large MCO Tax...***The Governor's proposal presents a novel approach to preserve a meaningful MCO tax, one of Proposition 35's key objectives.

***...at Higher Cost to Private Health Insurance Consumers...*** On the other hand, this proposal comes with a key trade-off of creating higher costs on health plans, which likely will try to recover at least some of this cost by raising premiums on their consumers. As a rough rule of thumb, private health premiums average around \$600 per month. If health plans shift all of the tax onto consumers, the \$8.85 per member, per month would reflect around a 1.5 percent increase in average costs for consumers. Whether or not this level of increase is acceptable is a policy consideration for the Legislature.

***...and With No Funding for Medi-Cal Provider Rate Increases.*** The proposal also allocates no MCO tax funding for provider rate increases—a fundamental objective of Proposition 35. Allocating more funding for provider rate increases arguably would align better with the intent of the measure. Doing so, however, would require the Legislature to find additional budget solutions to address the state's structural imbalance.

***Proposal Raises Some Legal Questions.*** With so many complex provisions in Proposition 35, any approach taken by the state regarding the MCO tax poses some legal questions and uncertainties. Based on our initial review of the Proposition 35 text, we could identify a reasonable argument for the Governor's proposed approach. That said, there is no guarantee that the courts would concur with our understanding. It also is uncertain how federal administrators would view the two-part approach for obtaining federal approval.

## **Recommendations**

***Weigh Proposal Against Other Approaches.*** Given the implementation challenges ahead, we recommend the Legislature seriously consider the Governor's proposal. In doing so, however, the Legislature could contemplate alternative approaches. Examples of alternatives include:

- ***Amending Proposition 35.*** Proposition 35 allows the Legislature to amend the measure with a three-fourths vote in each house, provided the amendments further the

measure's purpose and intent. One provision specifically allows the Legislature to use this approach to amend the limit on the private health plan enrollment tax rate. Amending the measure could allow the Legislature to meaningfully preserve Proposition 35. That said, this approach would require more funding for provider rate increases and less support for existing Medi-Cal costs—requiring the Legislature to find corresponding budget solutions elsewhere.

- ***Creatively Restructuring MCO Tax.*** The Legislature also could take time to find other creative ways to restructure the MCO tax. For example, the tax would no longer fall under federal rules if more than 15 percent of its cost falls on other entities than health care providers. Expanding the tax's scope in this way likely would result in costs on California entities, but potentially still allow for a tax that draws down federal funds.

***Inquire With Administration on Key Issues.*** To better inform legislative decision making, we also recommend asking the administration the following questions at budget hearings:

- How large of an MCO tax can the state pursue and remain under the federal revenue limit? What would be the associated tax rate under a maximized health plan tax?
- If the Legislature desired to allocate more funding for provider rate increases, how quickly could the department implement them?
- What is the administration's legal reasoning for how this proposal complies with Proposition 35?
- What risks are associated with federal approval of this proposal? How can the state minimize these risks?

***Direct Administration to Provide More Information on Proposal.*** We further recommend the Legislature direct the administration to release more key information on the tax, including its structure, tax burden by health plan, proposed duration, and the multiyear spending plan.

## **COUNTY ADMINISTRATION FUNDING PROPOSAL**

### **Proposal**

***Proposed One-Time Funding Augmentation.*** The May Revision proposes a one-time augmentation to Medi-Cal county administration to support implementation of H.R. 1 eligibility changes, including work requirements and more frequent renewals for certain adults. The augmentation includes \$228.8 million (\$57.2 million General Fund) for direct county administration support in 2026-27 and \$33.3 million (\$16.7 million General Fund) in each of 2026-27, 2027-28 and 2028-29 for optional surge staffing capacity. The surge staffing would be provided through state-contracted vendors and could support counties with activities such as reviewing application and renewal materials for completeness, data entry, and call center inquiries. The administration indicates this surge staffing could be available more immediately, as need arises, to help counties respond to higher workload. The administration has also signaled plans to revisit appropriate funding levels with counties as implementation proceeds.

***Trailer Bill Language Related to Annual Cost-of-Living Adjustment (COLA), Performance Measures, and Penalties.*** The administration has additionally proposed [language](#)

that would update existing law on performance measurement and penalties related to county administration of Medi-Cal. While we continue to learn more about this proposal, the language appears to remove an existing requirement that performance-related penalties may not be imposed on counties in years that no COLA is provided for county administrative funding. Instead, the language would allow penalties when counties receive funding above a “base allocation.” In recent years, COLAs have been routinely suspended, and we are not aware of an instance in which penalties have been imposed on counties. The language also would make changes to performance measures and how penalties are applied.

## **Assessment**

***“Right” Level of Funding Is Difficult to Determine.*** The administration has stated that the proposed augmentation was informed by discussions with County Welfare Directors Association of California (CWDA) about counties’ expected workload needs. The administration also has indicated that partially funding counties’ request reflects prior experience that counties need time to recruit and train new workers. However, there is still limited information on the specific assumptions behind the augmentation, including the amount of additional workload assumed and how the final funding level was determined. This uncertainty is compounded by the fact that the underlying county administration budget is not based on a clear workload methodology, as we described in our [earlier analysis on H.R. 1 county administration](#). County workload will also depend on uncertain caseload effects from H.R. 1 and other policies, including the undocumented adult enrollment freeze and asset limit changes.

***Legislature Faces Trade-Off Between Budget Constraints and Readiness.*** Additional funding may help counties reduce avoidable coverage losses due to administrative barriers, but the augmentation would compete with other funding priorities in a constrained budget environment, particularly in 2027-28 and later years. The near-term risk that counties will be overwhelmed by H.R. 1-related workload is somewhat mitigated by implementation timing. The first six-month renewals—a major source of new workload under H.R. 1—would occur in September 2027. For work requirements, about half of renewing enrollees would first be assessed in the 2027-28 budget year, and individuals who fail to renew would have a 90-day cure period. These timing factors suggest the largest H.R. 1 workload and coverage effects will occur in 2027-28. This provides some room for the Legislature to hold off on committing to longer-term funding as implementation proceeds and more information about workload becomes available. That said, waiting until next year to adjust funding could leave counties without enough time to hire and train staff.

***Could Preserve Flexibility on Funding Levels as Workload Develops.*** One option could be to approve one-time funding that is available starting in 2026-27, paired with reporting requirements and provisional authority to adjust funding upward based on workload indicators. These indicators could include, for example, renewal volume, manually processed renewals, and call center demand. Comparing these indicators in the months leading up to H.R. 1 implementation with pre-H.R. 1 levels could help the Legislature assess emerging workload pressures and determine whether counties should access provisional funding.

***Surge Staffing Could Provide Flexible Capacity, but Raises Questions.*** In theory, the proposed surge staffing approach could help address timing concerns by providing flexible, short-term capacity. However, the Legislature may want more detail on how surge staff would be trained, what quality controls would apply, and what level of statewide capacity the proposed

funding would purchase. In addition, the proposal appears to assume 50 percent federal funding, likely because surge staffing is treated as general administrative support. If similar activities could instead be funded through county eligibility systems eligible for the 75 percent enhanced federal match, relying on surge staffing could forgo some federal support.

***Trailer Bill Language Raises Broader County Administration Issues.*** At this time, we are continuing to learn about the administration’s proposed trailer bill language. Pending additional information, we offer the following suggested questions for the Legislature to pose to the administration as it considers the language:

- What goals does the administration seek to accomplish with changes to performance measures and the application of penalties?
- What is the intent of the language with respect to the current COLA requirement? The language removes the requirement that counties receive a COLA before penalties can be imposed. However, the language also appears to reserve penalties for counties receiving funding above a “base allocation.”
- How would the base allocation be defined? This matters because if the base allocation or any augmentation is not sufficient to support core eligibility activities, penalties alone may not address the underlying problem. In some cases, reducing county funding for missed standards could worsen performance challenges, particularly during a critical period such as H.R. 1 implementation.

***Recommend Adopting Requirement and Definite Timeline for Methodology Update.*** The May Revision does not address shortcomings in the underlying Medi-Cal administration budgeting methodology that we identified in our earlier analysis. Given the many competing priorities facing the department at this time, developing a comprehensive update to the budgeting methodology is not feasible in the near term. We recommend that the Legislature update statute to require a revised methodology that would clearly link workload and funding by a specified future date. That date should take into account that it may take time to fully understand and incorporate the impacts of H.R. 1 into an administrative funding methodology.

## **OTHER PROPOSALS AND BUDGET ADJUSTMENTS**

### **Asset Test**

***State Eliminated, and Then Reinstated, Asset Test in Recent Years.*** Prior to July 2022, the state limited how many assets seniors and persons with disabilities could have to be eligible for Medi-Cal (\$2,000 per individual and \$3,000 per couple, excluding a primary residence and vehicle). In recent years, the Legislature has changed the limit, first raising it (\$130,000 for individuals and \$195,000 for couples) between July 2022 and December 2023, then eliminating it altogether beginning January 2024. The state then reinstated the higher limit as a budget solution beginning January 2026. Our office [previously found](#) that the asset test elimination was particularly effective at extending Medi-Cal coverage to seniors, resulting in about 100,000 additional seniors enrolling in Medi-Cal by January 2025, but also was more costly than originally anticipated.

***May Revision Proposes to Return to Original Asset Test.*** The Governor’s May Revision proposes to reduce the asset limit for seniors and persons with disabilities to the pre-July 2022

limit (\$2,000 per individual and \$3,000 per couple) beginning January 2027. The administration estimates that this will save \$215 million General Fund in 2026-27 and \$321 million General Fund in 2027-28 and ongoing. The administration estimates that Medi-Cal caseload would decrease by about 26,000 enrollees in 2026-27 due to this policy change.

***Savings Amount Reasonable, but Proposal Raises Trade-offs.*** We find the estimated savings from the proposal to be generally reasonable at this time. That said, the proposal raises trade-offs in terms of access to care for seniors and persons with disabilities. Should the Legislature wish to prioritize access for this population, alternative solutions of at least this magnitude would be needed in other areas of Medi-Cal or other areas of the budget.

***Key Issues to Consider.*** As the Legislature considers this proposal, below are some questions the Legislature may want to ask the administration at budget hearings:

- How did the administration arrive at its estimate of about 30,000 Medi-Cal enrollees disenrolling in 2026-27 due to this proposal?
- How would the proposal affect workload for county Medi-Cal eligibility workers?
- How would the department communicate this change in eligibility policy to affected enrollees?
- Would a different asset limit mitigate some access impacts while also achieving needed budget savings?

### **Shift of People With UIS to Fee-for-Service**

***Federal Guidance Limits State's Ability to Cover UIS Individuals in Managed Care.*** Following the passage of H.R. 1, the Centers for Medicare and Medicaid Services (CMS) released guidance that restricted federal reimbursement for emergency services in Medi-Cal for UIS individuals. The new policy would only provide federal reimbursement for actual services rendered and that reimbursements would not be available for services paid for by risk-based payments. To meet this requirement, the administration determined it would need to pay for emergency services in the FFS delivery system for UIS enrollees.

***May Revision Shifts People With UIS to FFS.*** The administration has proposed moving all UIS individuals to the FFS delivery system (including those receiving full-scope Medi-Cal) due to the technical and administrative challenges of only carving out emergency services from managed care. The administration estimates that this shift will result in \$470 million General Fund savings in 2026-27 and \$1.2 billion General Fund savings ongoing. The administration has stated the savings are a result of three factors: (1) reduced administrative costs, (2) UIS individuals no longer being eligible for Enhanced Care Management or Community Supports Services under CalAIM, and (3) savings associated with lower UIS utilization across managed care that would be realized sooner by the state (compared to a scenario in which UIS members had remained in the managed care delivery system).

***Key Questions Around Fee-For-Service Transition.*** This proposal raises several issues that warrant further investigation. There is uncertainty about the amount of potential savings, as well as issues regarding programmatic implications (described below). As the Legislature continues to consider this proposal, below are some additional questions the Legislature may want to ask the administration at budget hearings:

### ***Questions on Savings Estimates:***

- The administration stated that there will be savings realized from managed care plans no longer performing administrative functions for UIS enrollees. What is the associated amount of savings from this component of the transition, and how did the administration arrive at this estimate? What is the estimated annual cost to the state to take on these administrative functions for UIS enrollees in the FFS delivery system going forward?
- The May Revision reflects expenditure authority of up to \$25 million General Fund in 2026-27 to support administrative costs to implement the transition. How did the department arrive at this estimate? Will the department need to add any positions to implement the transition? If not, how will the department accomplish this task using its existing positions?
- The Medi-Cal Local Assistance Estimate also reflects \$33.3 million General Fund in 2026-27 for “system costs” to implement the transition. What is the distinction between the \$25 million for administrative costs and the \$33.3 million for system costs?

### ***Questions on Programmatic Implications:***

- Does the department intend to provide care coordination services for UIS enrollees once they are transitioned to the FFS delivery system? If so, how will the department provide this service, which is traditionally provided by managed care plans?
- The managed care system is intended to reduce volatility in the Medi-Cal budget. How will the department help prevent future budget volatility after UIS enrollees transition to the FFS delivery system?
- The department stated that, as of May Revision, utilization for UIS enrollees in the managed care system has been lower than anticipated. Does the department anticipate that the shift to the FFS delivery system could change utilization trends? If so, how? If no, why not?
- As part of the 2025-26 May Revision, the administration stated that utilization among UIS enrollees was higher than projected. As part of the 2026-27 May Revision, the administration stated that utilization among UIS enrollees is now lower than projected. Can the department describe changes in utilization trends among UIS enrollees from 2024 (when the final expansion regardless of immigration status went into effect) through the present?

### **Other UIS-Related Proposal**

***May Revision Proposes to Increase Recently Enacted Premiums for UIS in Full-Scope Medi-Cal...*** As a part of the 2025-26 budget package, the Legislature enacted several budget solutions impacting UIS individuals enrolled in Medi-Cal, including a \$30 per month premium for all adults (aged 19-59) who remain in full-scope Medi-Cal beginning July 1, 2027. At May Revision, the administration proposes increasing the monthly premium to \$50 and estimates a savings of about \$420 million General Fund in 2027-28.

*...But Savings May Be Less Than Estimated.* The estimated savings associated with the premium level established last year are already subject to inherent uncertainty. Additionally, existing research suggests that premium increases beyond a certain threshold may have a diminishing marginal impact on additional disenrollments. Taken together, it is unclear the extent to which the proposed increase in premiums will result in additional savings above the current policy.

## Medi-Cal Efficiencies

*Governor’s Budget Assumed Savings From Operational Efficiencies in 2026-27.* The administration has an existing contract with a third-party consultant to develop recommendations to improve departmental (DHCS) operations and realize savings from operational efficiencies. According to the contract, the potential activities associated with DHCS include strengthened oversight over managed care organizations, enhanced fraud and improper claims detection, and improved hospital payment methodologies. At budget enactment in June 2025, savings from these operational efficiencies were not anticipated to begin until 2027-28. The Governor’s January proposed budget added \$120 million in General Fund savings in 2025-26 for this item, increasing to \$435 million annually by 2029-30.

*May Revision Updates Projected Savings...* The Governor’s May Revision revises the estimated savings from 2025-26 through 2028-29 and ongoing. Specifically, administration provided the savings amounts from each activity in the contract, shown in Figure 4 below.

**Figure 4**

### Administration's Savings Estimates from Operational Efficiencies

Boston Consulting Group's Medi-Cal Activities (In Millions)

	Savings Assumed at May Revision				
	2025-26	2026-27	2027-28	2028-29	Ongoing
Drug rebate aggregator <sup>a</sup>	\$120	\$435	\$580	\$580	\$580
Utilization management practices	—	68	107	107	107
Managed care oversight	—	—	—	45	45
Other <sup>b</sup>	—	—	—	200	400
<b>Totals</b>	<b>\$120</b>	<b>\$503</b>	<b>\$687</b>	<b>\$932</b>	<b>\$1,132</b>

<sup>a</sup> Was initially enacted in the 2025-26 Budget Act as a separate solution from the Medi-Cal operational efficiencies. The administration now considers this as part of Boston Consulting Group’s work to identify Medi-Cal efficiencies.

<sup>b</sup> Department of Finance states this reflects placeholder estimates.

*...And Provides More Detail on Some Planned Activities.* As part of May Revision, the administration indicates that the operational efficiencies in DHCS include the use of a drug rebate aggregator, a budget solution that was adopted in the 2025-26 budget package. Specifically, the administration plans to contract with a pharmacy rebate aggregator to negotiate rebates with manufacturers on drugs provided to UIS members. This is a population for which the state did not previously receive drug rebates. Additionally, DHCS proposes implementing utilization management controls for two Medi-Cal services: applied behavior analysis/behavioral health treatment and transportation (non-emergency medical transport and non-medical transport). DHCS states that utilization patterns for these services are consistent with overuse and misuse. The proposed utilization management controls are therefore intended to prevent inappropriate use of services.

***Legislature Needs More Details to Evaluate Planned Activities.*** As we have noted in a [previous post](#) on the contract to achieve operational efficiencies, the Legislature will want to ensure that it understands the assumptions that form the basis of the administration's estimates to ensure that they are realistic. Additionally, the Legislature will want to understand the activities underway with the contractor to ensure that the proposed actions align with legislative priorities. We also recommend (1) the Legislature adopt quarterly updates on the contract and (2) view unallocated savings proposals skeptically. Below, we provide questions that the Legislature could ask the administration at budget hearings on the proposed activities in Medi-Cal.

- To date, to what extent has the department successfully negotiated rebates with drug makers? For what amount of time do these negotiated agreements generally remain in place?
- Will the proposed budget solutions affecting UIS enrollees alter the potential savings from drug rebates for this population? If so, to what extent? If no, why not?
- How did the department arrive at the estimated amount of savings for utilization controls in applied behavior analysis/behavioral health treatment and transportation?
- How will the department ensure that the utilization management controls are applied in a way that is consistent statewide across managed care plans?
- Has the department considered whether utilization management controls for applied behavior analysis/behavioral health treatment could affect utilization of other state-funded services, such as developmental services coordinated by regional centers?