Introduction to Medi-Cal Managed Care Financing

Medi-Cal — California's Medicaid program — provides health care to approximately 15 million Californians, or about one-third of the state population. Medi-Cal expenditures typically exceed $100 billion annually. With such enormous costs, how is Medi-Cal funded? And how are Medi-Cal managed care plans paid?

How Medi-Cal is Funded

Medi-Cal is a joint federal-state program funded with federal and state dollars:

1. **Non-Federal Share.** The State's share of funding — called the "non-federal share" — comes from various sources, including the General Fund, provider and other taxes, special funds and local funds.
2. **Federal Share.** California's non-federal share is matched by federal funds according to a federal medical assistance percentage (FMAP) or "match rate." California's base FMAP match rate is typically 50 percent — meaning for every $1 California provides, the federal government matches $0.50. However, FMAP varies by Medi-Cal population (i.e., children, adults), service or program. Key match rates are shown in Table 1.

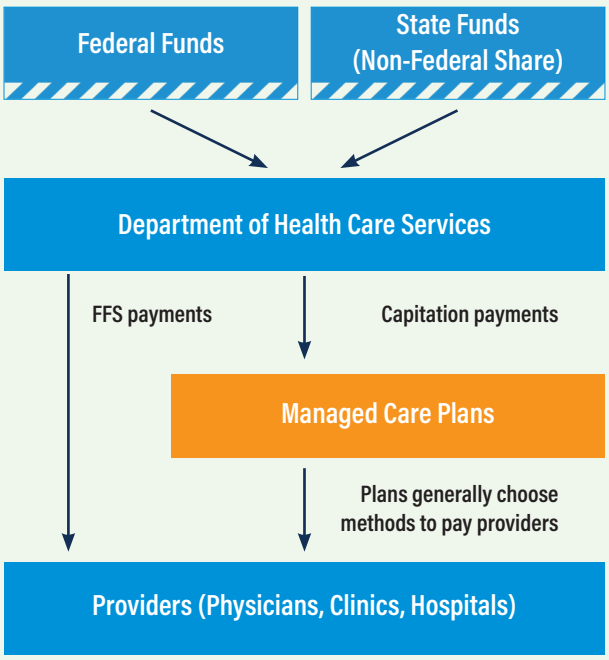
Table 1.

California's Key FMAP Rates for 2023	
Regular[1]	56.2%
ACA Adult Expansion	90%
Children's Health Insurance Program	69.3%[2]

1. Regular base program includes low-income parents, children and people with disabilities. Figure includes additional 6.2% due to the Families First Coronavirus Response Act and will end with expiration of the federal Public Health Emergency.
2. Will reduce to 65% once the federal Public Health Emergency expires. Through Sept. 30, 2023.

How Medi-Cal Managed Care Plans are Paid

Figure 1. Flow of Funds



More than 85 percent of Medi-Cal beneficiaries are enrolled in **managed care** and have their benefits coordinated and managed by a managed care plan (MCP). The state Department of Health Care Services (DHCS) pays MCPs a monthly **capitation rate** — a fixed dollar amount per member per month — to provide services to individuals enrolled in their plan. Capitation payments are **risk-based,** which means MCPs assume the financial risk that the payments will be adequate to cover their costs and the utilization of services for their enrollees. Capitation offers predictability and budget certainty, and aligns fiscal incentives to provide high-quality, efficient care. This is in contrast to DHCS' volume-driven **fee-for-service (FFS)** payment system, which pays providers directly for each service performed.

How DHCS Develops Capitation Rates

Capitation rates paid to Medi-Cal MCPs are the product of a robust rate-setting process, federal rules, review and approval. In order for DHCS to receive federal approval and the federal share of funding, its capitation rates must be **actuarially sound** — meaning that, in general, they reasonably account for the costs of the services to be provided. The goal of rate setting is to match payment to the contract risk.

The capitation rate-setting process involves several steps (see Figure 2):

1. **Rate Build-Up.** The annual process begins with robust data collection. Several sources of data are used, but MCP-reported data is the most significant. MCP data is collected by specific beneficiary groups or categories of aid groupings, such as child or adult, and similar categories of service, such as inpatient hospital or emergency room care. Typically, base data used is two to three years old to ensure complete health care claims information and to aid the state in prospective rate setting.
2. **Adjustments to Base Data.** Collected base data is then adjusted for reasonableness with:
   - **Smoothing,** which is the process of making adjustments for small numbers, or extraordinary utilization or costs
   - Industry **trend factors** to update the base data for changes in cost and utilization
   - **Program change impacts,** such as for changes in Medi-Cal benefits, price or eligibility
   - Managed care **efficiency adjustments,** such as for potentially preventable hospital admissions
   - Assumptions for **non-medical load** or additions, such as for administration.
3. **Risk Adjustment.** In order to better match payment to risk, risk adjustment is used in counties (or rating regions) with more than one plan. This process helps account for differences in the underlying health status of the population and distributes capitation across plans based on health risk. Risk adjustment is applied to rates that are averaged across the county (or rating region). These risk adjusted county-averaged rates are then blended with plan-specific rates to establish a final health plan rate.

Figure 2. Rate-Setting Process

4. **Supplemental Rates.** MCPs also receive supplemental rates (also known as kick payments), or payments made separately from and in addition to the regular base capitation payment. Supplemental payment mechanisms can help mitigate against cost risks that emerge, for example, with a new benefit or blockbuster drug not assumed in the original rate setting.
5. **Review and Approval.** The rate build-up process produces distinct rates for each MCP by county (or rating region) and category of aid groupings. DHCS is required to provide each MCP with its draft rates and information about the build-up, as well as offer the MCP an opportunity to provide supplemental information. After this process is complete, DHCS submits certified capitation rates and contract amendments for review and approval by the federal government. Once federal approval is received, the capitation rates are considered final.

Looking ahead. As part of CalAIM, DHCS will move to a regional rate-setting methodology, which will significantly impact how capitation rates are calculated. MCPs should remain abreast of such developments and evaluate their impact on plan operations.