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ISSUE BRIEF

Too Big, Too Broken: Restoring Integrity to Medi-Cal

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Executive Summary

Medi-Cal, the state of California's name for the federal government's jointly-funded Medicaid program, has become one of the largest government-administered healthcare programs in the United States. Nearly 15 million Californians are covered by the program,[1] and annual spending has climbed to more than $200 billion across all fund sources.[2] What was once a targeted safety-net program increasingly functions as a vast public entitlement system with growing fiscal and administrative challenges.

As Medi-Cal has expanded, the program has become more expensive, more complex, and more difficult to oversee. California's shortage of healthcare providers, long wait times, and low physician participation rates leave many beneficiaries struggling to access timely care despite possessing insurance coverage. At the same time, mounting evidence of fraud, improper payments, and oversight failures has raised urgent concerns regarding the program's integrity and long-term sustainability.

What was once a targeted safety-net program increasingly functions as a vast public entitlement system with growing fiscal and administrative challenges.

Medi-Cal's problems are not isolated administrative failures. They are the predictable consequences of a policy agenda that prioritized expanding enrollment while neglecting access to care, fiscal discipline, and program integrity.

To restore Medi-Cal's effectiveness and preserve its core safety-net function, policymakers should:

- Strengthen eligibility verification and redeterminations.
- Improve oversight of managed care organizations.
- Increase transparency around emergency Medicaid financing.
- Prioritize limited resources for vulnerable populations.

Without reform, Medi-Cal will consume a growing share of state and federal resources while failing to deliver timely, accountable, and sustainable care to vulnerable Californians.

Introduction

Medicaid was created by Congress more than 60 years ago, as part of President Lyndon Johnson's "War on Poverty."[3] It was designed to be an insurer of last resort for the poor and the disabled. In the 1980s, Medicaid was expanded to cover low-income pregnant women.[4]

Medicaid is jointly administered by the federal government and the states. The federal government and the states also split the costs. The federal government provides at least one dollar—and often, much more than that—for every dollar a state government spends on its Medicaid program.

Over time, federal policy changes, expanded eligibility rules, and a host of perverse incentives have caused the program to drift far from its original mission. No state illustrates this transformation more clearly than California.

Over the last decade, California policymakers have pursued one of the nation's most aggressive Medicaid growth strategies. Following passage of the Affordable Care Act, signed into law by President Obama on March 23, 2010, the state dramatically expanded eligibility for able-bodied adults while relying heavily on enhanced federal reimbursement rates to finance enrollment increases. California later became the first state in the nation to offer full Medicaid coverage to all low-income, undocumented adults regardless of age.[5]

Healthcare resources are finite. As enrollment has grown, access has increasingly suffered.

More than one-third of Californians now have coverage through Medi-Cal.[6] But access to coverage is not the same as access to care.

Healthcare resources are finite. Expanding Medicaid enrollment increases demand for care. But Medi-Cal's low reimbursement rates make it difficult to attract enough physicians and specialists to meet that demand. As enrollment has grown, access has increasingly suffered.

Consequently, patients wait longer for appointments. Provider shortages worsen. Oversight becomes more difficult. And fiscal pressures intensify.

Medi-Cal is one of the largest programs in the state budget, accounting for 40% of spending across all sources.[7] State officials are now confronting the fiscal consequences of expansion policies that proved significantly more expensive than anticipated.

These problems reflect deep structural incentives embedded within the modern Medicaid system. Federal reimbursement rules reward states for growing enrollment while placing comparatively little emphasis on access to care, long-term affordability, or program integrity.

California's experience demonstrates that these challenges are not simply the result of administrative mistakes or poor execution. They are the predictable consequence of a policy framework that prioritizes expanding coverage while neglecting the capacity, oversight, and fiscal discipline needed to sustain it.

The result is a Medi-Cal program that has grown ever more expensive and administratively complex while struggling to fulfill its original safety-net mission.

I. Medi-Cal's Rapid Growth and Fiscal Exposure

Medi-Cal's expansion has occurred gradually over decades but accelerated sharply following passage of the Affordable Care Act (ACA). The law extends Medicaid eligibility to adults earning up to 138% of the federal poverty level,[8] or just over $22,000 for an individual.[9]

In 2026, nearly 4.9 million Californians between the ages of 19 and 64 were enrolled through the ACA's expansion of the program, accounting for more than one-third of total Medi-Cal enrollment.[10]

This enrollment surge has coincided with a massive increase in program costs. Medi-Cal spending is expected to exceed $219.7 billion across all fund sources in fiscal year 2026–2027, including $46.9 billion from the state General Fund.[11] Medi-Cal now consumes nearly one-fifth of General Fund spending, a significant increase from historical norms.[12]

Medi-Cal Spending Has More Than Doubled over the Last Decade

Fiscal Year	Total Medi-Cal Spending (All Funds)
2014-15	$83 billion[13]
2017-18	$102.6 billion[14]
2020-21	$115.4 billion[15]
2021-22	$121.9 billion[16]
2026-27	$219.7 billion[17]

This rapid spending growth has several causes. First, healthcare costs nationwide continue to rise due to demographic pressures, increased utilization, labor shortages, and inflation in medical services. Second, California policymakers have repeatedly expanded eligibility and benefits. Third, the structure of Medicaid financing itself strongly encourages enrollment expansion because the federal government assumes a large share of program costs.

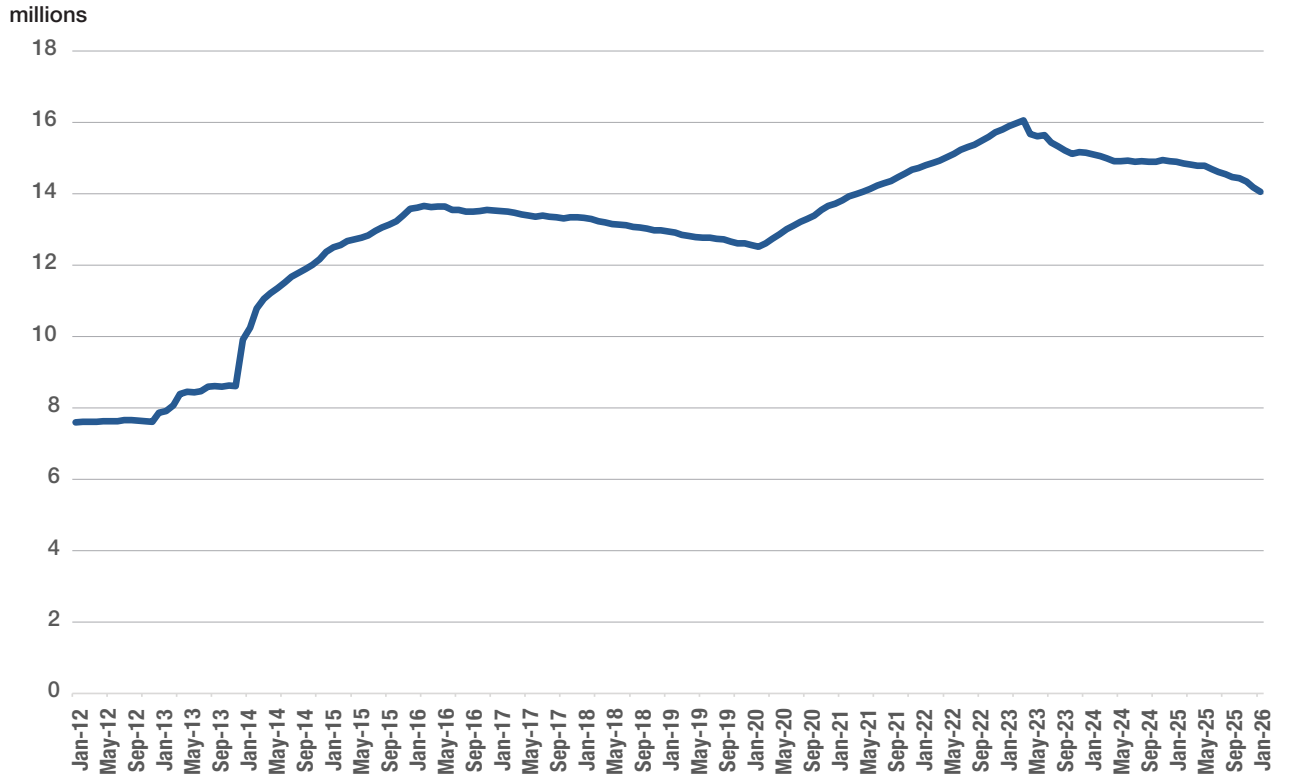
Under the ACA, the federal government covers 90% of the cost of Medicaid coverage for the expansion population—a far more generous reimbursement rate than it provides for the legacy Medicaid population.[18] This enhanced federal match creates powerful incentives for states to maximize enrollment among the expansion population.

California's recent experience demonstrates how quickly Medi-Cal spending can spiral. Following the COVID-19 pandemic, Medi-Cal enrollment has increased significantly around the country due in part to continuous coverage requirements that temporarily prevented states from removing ineligible beneficiaries from Medicaid rolls.[19]

This put enormous strain on the state's finances. In 2025, the Newsom administration sought approximately $6.2 billion in additional funding for Medi-Cal—including a $3.4 billion General Fund loan—to keep the program solvent through the end of the fiscal year in June.[20]

These fiscal pressures are not merely temporary post-pandemic distortions. They reflect a structural reality. Medi-Cal has become so large that even modest changes in enrollment or utilization now carry multibillion-dollar budget consequences.

Medi-Cal Enrollment Growth, 2012 - present[21]



Source: California Health Care Foundation, Medi-Cal Enrollment Tracking Tool

II. Expanding Access to Coverage Did Not Expand Access to Care

Much of California's Medi-Cal policy over the last decade has prioritized increasing enrollment while focusing too little on building sufficient capacity to care for these millions of additional beneficiaries.

As Medi-Cal enrollment surged, provider participation failed to keep pace. One of the primary reasons is reimbursement. Medi-Cal generally reimburses physicians and providers at rates substantially below private insurance and often below Medicare reimbursement levels.[22] These lower reimbursement rates create strong incentives for providers to limit the number of Medi-Cal patients they accept or avoid participating in the program altogether.

California's provider shortages did not begin with Medicaid expansion. Many parts of the state, particularly rural communities, struggled for years to attract enough physicians and specialists. But adding millions of new beneficiaries to an already strained system intensified those pressures.

The result has been worsening access to care. The California Health Care Foundation has reported that some Medi-Cal beneficiaries wait six to nine months for a preventive appointment with a gastroenterologist.[23]

Nationwide, Medicaid recipients are 1.6 times less likely to successfully schedule a primary care appointment—and 3.3 times less likely to secure specialty care—than individuals with private insurance.[24]

The strain is particularly acute in rural California, where many counties already face shortages of physicians and specialists willing to accept Medi-Cal patients.[25] In these areas, beneficiaries may travel long distances or turn to overcrowded emergency departments for necessary care.

III. Expansion Beyond Medi-Cal's Traditional Mission

California's decision to expand Medi-Cal to undocumented immigrants is one of the most consequential healthcare policy shifts in the state's recent history. Proponents framed the expansion as a humanitarian and public-health initiative. But it substantially increased Medi-Cal's fiscal exposure while intensifying existing concerns regarding provider capacity, administrative oversight, and program integrity.

Gov. Jerry Brown expanded Medi-Cal eligibility to undocumented children in 2015.[26] Gov. Gavin Newsom extended eligibility to additional undocumented immigrants in stages according to age. By January 1, 2024, California had become the first state in the nation to offer full Medicaid coverage to all low-income, undocumented adults.[27]

The state estimates that roughly 1.7 million undocumented immigrants ultimately enrolled in Medi-Cal.[28] By 2025, the state said the expansion would cost approximately $8.5 billion annually.[29]

These costs were substantially larger than initially projected.[30] Facing significant Medi-Cal shortfalls, Governor Newsom froze[31] new enrollment for undocumented adults and imposed monthly premiums on certain beneficiaries that will take effect in 2027.[32]

These reversals amounted to an admission that California's expansion strategy had become fiscally unsustainable.

Federal law generally prohibits federal funds from underwriting Medicaid benefits for undocumented immigrants. California therefore finances much of the undocumented expansion using funds nominally provided by the state.

But money is fungible. California's ability to finance coverage for undocumented immigrants depends in part on maximizing federal Medicaid reimbursement for other beneficiaries.

This is especially true in the case of emergency Medicaid spending, which permits federal reimbursement for medical services provided to certain individuals who would otherwise be ineligible for traditional Medicaid benefits because of their immigration status. Historically, this category was intended to cover emergency conditions such as life-threatening injuries or urgent labor and delivery services.

In recent years, however, states have dramatically expanded their use of emergency Medicaid reimbursement. The Foundation for Government Accountability estimates that California has claimed billions of dollars in federal reimbursement through emergency Medicaid-related expenditures connected to undocumented immigrants—some $4.5 billion in 2024 alone.[33]

These arrangements not only undermine the spirit of federal Medicaid restrictions—they create incentives for states to shift growing healthcare costs onto federal taxpayers.

IV. Scale and Complexity Increase Fraud Vulnerability

Large government programs inevitably face oversight challenges. But as Medi-Cal has expanded into one of the largest publicly financed healthcare systems in the nation, concerns regarding improper payments, eligibility errors, and fraud have become difficult to ignore.

The problem is not simply that a few bad actors exploit the system. Rather, Medi-Cal's enormous size and administrative complexity create structural conditions that make effective oversight nearly impossible.

Today, Medi-Cal operates through a multi-layered system involving federal funding streams, state agencies, managed care organizations, and provider networks.

Millions of beneficiaries move in and out of eligibility categories over time. Multiple funding streams overlap across federal and state programs. Eligibility determinations often depend on fluctuating income, household composition, immigration status, disability classifications, and other variables that require continual verification.

Medi-Cal's enormous size and administrative complexity create structural conditions that make effective oversight nearly impossible.

As complexity increases, so does the risk of improper payments. Federal law defines improper payments broadly.[34] Some constitute fraud. Others result from administrative mistakes, incomplete documentation, duplicate payments, or payments made on behalf of ineligible individuals.

Regardless of intent, the fiscal consequences are substantial. Researchers at the Paragon Health Institute and the Economic Policy Innovation Center estimate that cumulative federal Medicaid improper payments may have exceeded $1 trillion over the last decade.[35]

Federal auditors have repeatedly scrutinized California for its efforts to verify eligibility, its reimbursement practices, and its oversight of managed care contractors. In 2024, the U.S. Department of Health and Human Services Office of Inspector General concluded that California improperly claimed approximately $52.7 million in federal Medicaid reimbursement tied to capitation payments made on behalf of certain noncitizens.[36]

The most glaring evidence of inadequate Medi-Cal oversight can be seen in the extent and frequency of outright fraud within the program. In one recent federal case, a California man pleaded guilty to orchestrating a $270 million medication reimbursement scheme involving drugs that were never provided, medically unnecessary, or improperly coded to maximize reimbursement.[37]

Authorities have also uncovered widespread hospice fraud in Los Angeles, where operators allegedly established sham hospice agencies, used stolen identities to enroll patients, and billed government programs for care that was never delivered.[38]

So far, regulators have struggled to keep pace with the rapid growth of questionable hospice providers throughout the state. California officials recently announced they had revoked more than 280 hospice licenses over the previous two years and were actively investigating hundreds of additional providers.[39] Meanwhile, the California Department of Justice says it has recovered more than $2.8 billion in fraud over the past decade. The agency has conducted more than 2,300 fraud investigations, including 294 hospice fraud investigations, and secured 51 convictions.[40]

These dishonest practices have become so widespread within Medi-Cal that, in 2025, the U.S. Department of Justice announced the creation of a West Coast Health Care Fraud Strike Force—an effort targeting fraudulent billing schemes, kickback arrangements, and organized healthcare fraud operations throughout the region.[41]

Large healthcare entitlements are attractive targets for fraud because they involve massive flows of public money processed through highly decentralized administrative systems. The resulting scandals and oversight failures erode confidence not only in Medi-Cal but in publicly financed safety-net programs more broadly.

The growing scale of Medi-Cal presents California policymakers with a fundamental governance challenge. A program of such complexity that serves millions of state residents requires robust verification systems, transparent oversight, and strict accountability measures.

V. Restoring Medi-Cal's Safety-Net Mission

Millions of low-income Californians depend on Medi-Cal. Preserving its long-term viability requires policymakers to restore accountability and refocus resources on those most in need. The state can do so in the following ways.

Strengthen Eligibility Verification and Redeterminations

Effective eligibility verification is one of the most important safeguards against improper payments, enrollment errors, and deliberate fraud. Yet Medicaid programs nationwide—including Medi-Cal—have struggled to maintain accurate eligibility systems, particularly following the pandemic-era suspension of normal redeterminations.

California should strengthen eligibility verification procedures by increasing data-matching across state and federal systems, conducting more frequent eligibility reviews, and improving documentation standards where appropriate. The state must also ensure that post-pandemic redeterminations are completed accurately and consistently.

Increase Transparency and Oversight in Managed Care

Today, managed care organizations administer coverage for nearly all Medi-Cal beneficiaries. Yet the complexity of capitation payment systems and subcontracted provider networks can make oversight difficult for regulators and policymakers alike.

This makes stronger auditing and reporting requirements for managed care organizations participating in Medi-Cal absolutely essential. To that end, policymakers should require greater transparency regarding:

- Provider network adequacy
- Appointment wait times
- Beneficiary access metrics
- Denied claims and referrals
- Capitation payment practices

More rigorous oversight would help reduce improper payments while improving access and accountability for beneficiaries.

Refocus Limited Resources on the Poor

Medi-Cal was not created to put the state on the path to universal, publicly financed coverage. It was created as a safety-net for the poor. State policymakers must recommit to that original intent.

They can start by taking steps to rigorously and fairly implement the Medicaid work requirements established under the One Big Beautiful Bill Act, which Congress passed and President Trump signed into law in 2025.[42] The policy conditions Medicaid eligibility for able-bodied working-age patients without dependent children on participation in a job, job training, education, or community engagement activities. These requirements do not apply to pregnant women, the disabled, or those with legitimate barriers to employment.[43] They do, however, focus program resources on patients who rely on Medi-Cal the most, while reducing a form of waste that is less visible than fraud but no less egregious.

Restore Fiscal Sustainability

Finally, California policymakers must acknowledge the broader fiscal reality confronting Medi-Cal. The program already consumes an enormous share of California's budget. Future spending pressures are likely to intensify due to demographic changes, rising healthcare costs, and continued demand for publicly financed coverage.

California's experience demonstrates the risks of treating Medi-Cal as a vehicle for universal coverage rather than a targeted safety-net program. Policymakers should reject further eligibility expansions and instead focus on strengthening access to care, improving oversight, and directing limited resources toward the state's most vulnerable residents.

California's experience demonstrates the risks of treating Medi-Cal as a vehicle for universal coverage rather than a targeted safety-net program.

Medi-Cal cannot simultaneously function as an insurer of last resort and a pathway toward government-financed healthcare for ever-larger segments of the population. Attempting to make it serve both purposes has weakened its ability to fulfill either.

Conclusion

Medi-Cal's rapid growth in recent years has produced mounting fiscal pressures, provider shortages, and administrative oversight challenges that have left the program open to fraud. At the same time, many beneficiaries struggle to obtain timely access to care.

California has become a case study in the limits of expansion-first healthcare policy. Loosening eligibility requirements is politically easier than ensuring long-term fiscal sustainability. Increasing enrollment is easier than expanding the supply of care. Building massive public healthcare systems is easier than supervising them effectively.

Today, Medi-Cal struggles to fulfill its original safety-net purpose. Meaningful reform will require stronger eligibility verification, improved oversight, better policing of improper payments and fraud, and a redirection of resources toward vulnerable populations.

Restoring Medi-Cal's integrity will require stronger eligibility verification, more aggressive oversight, greater transparency, and a renewed commitment to the program's original safety-net mission.

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