CALIFORNIA

Health Care Almanac

CHCF

FEBRUARY 2019

Medi-Cal Facts and Figures:

Crucial Coverage for Low-Income Californians

Executive Summary

Medi-Cal, California's Medicaid program, is the state's health insurance program for low-income Californians, including 40% of all children, half of all people with disabilities, over a million seniors, and nearly 4 million adults. It also pays for more than 50% of all births in the state and 58% of all patient days in long-term care facilities.* In total, 13 million, or one in three, Californians rely on the program for health coverage. Medi-Cal pays for essential primary, specialty, acute, behavioral health, and long-term care services.

The Patient Protection and Affordable Care Act (ACA) allowed states the option to expand Medicaid to low-income adults, and California has been an enrollment leader among the 37 states expanding their programs. In the spirit of advancing coverage, California also expanded Medi-Cal to low-income undocumented children and youth using only state resources in 2015.

Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians presents data on the Medi-Cal program based on the most recent data available.

KEY FINDINGS INCLUDE:

- Nearly two-thirds of Medi-Cal enrollees are composed of children and their parents/caretakers, children in the Children's Health Insurance Program (CHIP), and seniors and people with disabilities.
- In fiscal year 2018–19, Medi-Cal is projected to bring in more than $59 billion in federal funds and account for nearly 17% of state general fund spending.
- Eighty percent of all Medi-Cal beneficiaries were enrolled in one of six managed care models.
- Medi-Cal plays a crucial role in the California health care system. Its initiatives and demonstrations contribute to transforming the way health care is delivered to all Californians.

Medi-Cal has numerous initiatives and innovations focused on improving the quality and outcomes of care for its enrollees with complex chronic diseases, as well as reducing costs. Upcoming changes may bring new challenges and opportunities to Medi-Cal: Two of Medi-Cal's waivers expire in 2020, prompting the need for decisions about which initiatives should continue and what new initiatives would best serve beneficiaries.

*Fee-for-service only. Does not include patient days paid through Medi-Cal managed care contracts.

Note: See the current and past editions of *Medi-Cal Facts and Figures* at www.chcf.org/collection/medi-cal-facts-figures-almanac.

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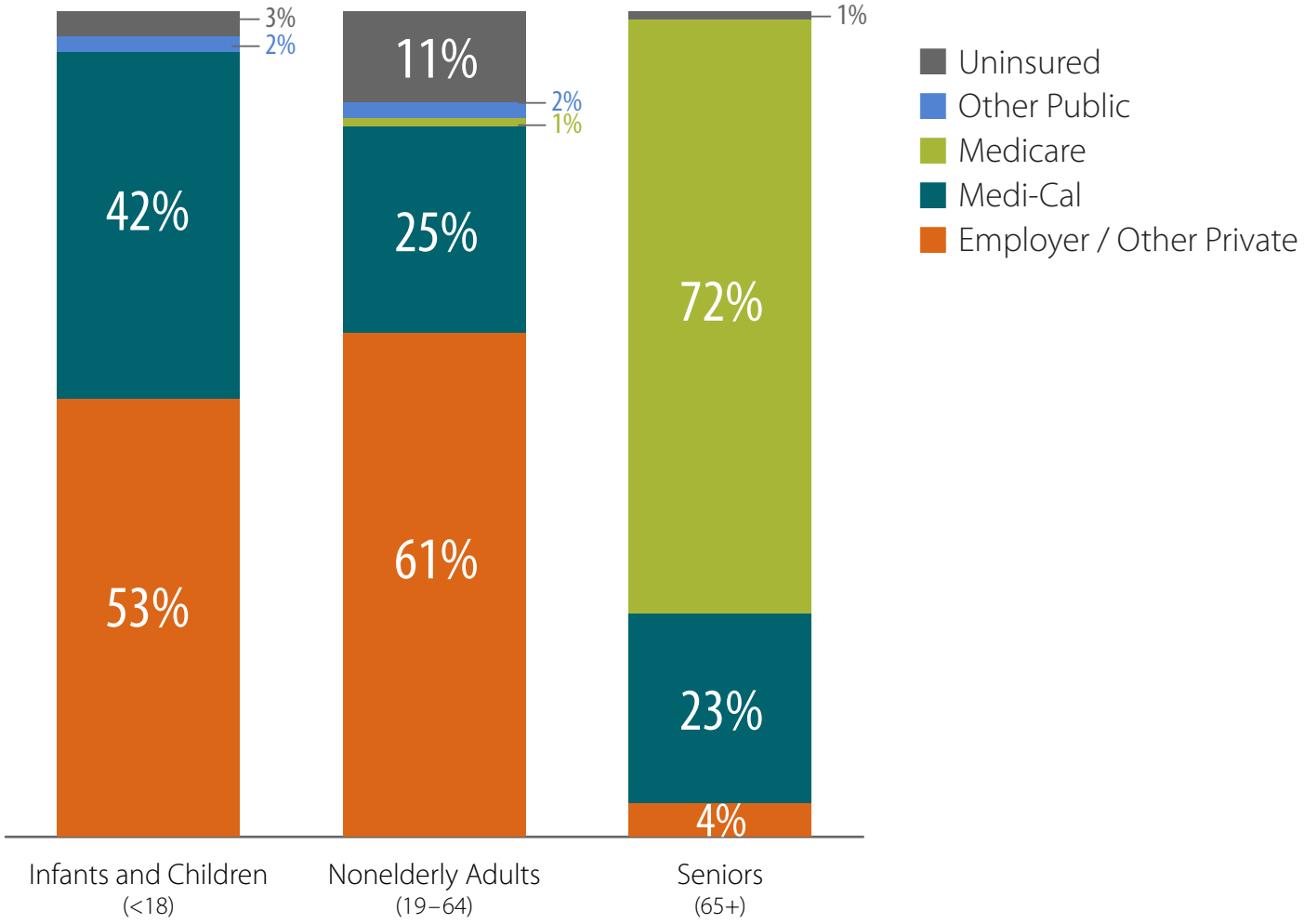
Sources of Insurance Coverage, by Age Group

California, 2017



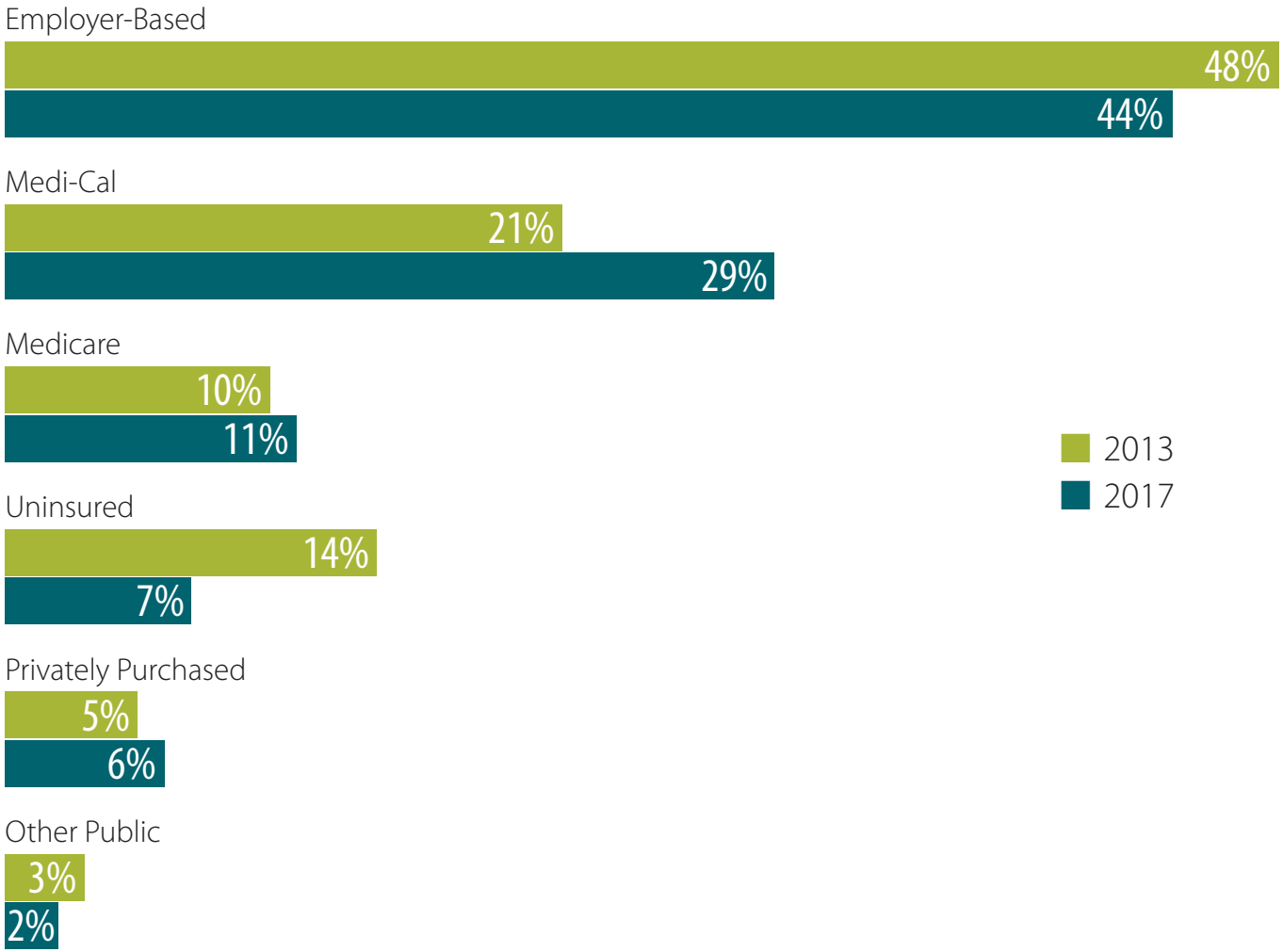
Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported that they have both Medi-Cal and Medicare coverage and may include those with restricted scope benefits. See About the Data on page 63 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other (not Medi-Cal). *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents (among nonelderly adults).

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., **ask.chis.ucla.edu**.

Medi-Cal is an important source of health care coverage for Californians of all ages. Medi-Cal provides coverage for nearly half (42%) of all children in the state, and one-quarter of adult Californians. Even though most seniors are eligible for Medicare, nearly one-quarter of Californians over age 65 are also covered by Medi-Cal (known as "dual eligibles"*).

* For more information, see *Dual Eligible Beneficiaries Under Medicare and Medicaid*, **www.cms.gov** (PDF).

Health Insurance, by Source of Coverage
California, 2013 and 2017



Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported that they have both Medi-Cal and Medicare coverage (dual eligibles) as well as Healthy Families (2013) and may include those with restricted scope benefits. See About the Data on page 63 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other (not Medi-Cal). *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents (among nonelderly adults).

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

The implementation of the Affordable Care Act in 2014 changed the California health insurance landscape. The largest of these changes was the significant increase in Medi-Cal enrollment and the corresponding decline in the uninsured population.

About Medicaid

- Federal program created in 1965 by Title XIX of the Social Security Act. In California the program is called Medi-Cal.
- Provides health care coverage to 66 million Americans, including low-income children, parents, seniors, people with disabilities, and low-income adults.
- Each state administers its program within federal rules, and financing is shared between state and federal governments. It is an entitlement program that must provide benefits to certain mandatory groups meeting eligibility requirements.
- Medicaid programs vary significantly across the nation, as states have the option to cover additional groups and use waivers to amend some eligibility requirements, use different care delivery and payment models, and develop other innovations.
- Eligibility was expanded to low-income adults under the Patient Protection and Affordable Care Act (ACA), passed in 2010 and implemented in 2014. Enrollment has grown significantly in the 37 states that chose this option.
- Medicaid is the nation's largest purchaser of health care services, collectively spending more than $582 billion in federal and state dollars in fiscal year 2017.

The Affordable Care Act gave states the option to expand the program significantly, resulting in an additional 14.5 million people enrolled in Medicaid nationally by the end of 2016. Medicaid served 66 million people nationwide in 2018.

Sources: "Program History," Centers for Medicare & Medicaid Services (CMS), n.d., **www.medicaid.gov**; *November 2018 Medicaid and CHIP Application, Eligibility Determinations, and Enrollment Report*, CMS, last modified February 7, 2019, **www.medicaid.gov**; *October – December 2016 Medicaid MBES Enrollment*, CMS, last modified November 2018, **www.medicaid.gov**; "Medicaid Expansion Enrollment: FY 2016," Kaiser Family Foundation, n.d., **www.kff.org**; and "NHE [Natl. Health Expenditures] Fact Sheet," CMS, last modified December 6, 2018, **www.cms.gov**.

About Medi-Cal

- A source of health care coverage for:
  - One in three Californians
  - 40% of the state's children
  - 50% of people with disabilities
- Pays for:
  - More than 50% of all births in the state
  - 58% of all patient days in long-term care facilities*
- Medi-Cal accounts for over two-thirds of net patient revenues in California's city/county hospitals and primary care clinics.
- Medi-Cal's waiver initiatives and demonstration projects contribute to transforming the way health care is delivered in the state.
- Medi-Cal is expected to bring in $59 billion in federal funds in FY 2018–19.

Providing insurance for one-third of all Californians, Medi-Cal plays a major role in the health care system. California has the nation's largest Medicaid program.

*Medi-Cal patient days cited here are fee-for-service only and do not include patient days paid through Medi-Cal managed care contracts.

Sources: *July 2018 Medicaid and CHIP Application, Eligibility Determinations, and Enrollment Report*, Centers for Medicare & Medicaid Services, last modified November 30, 2018, www.medicaid.gov; *Medicaid in California*, Kaiser Family Foundation, November 2018, kff.org (PDF); *Medi-Cal Births for 2007–2011*, California Dept. of Health Care Services (DHCS), July 2014, www.dhcs.ca.gov (PDF); *2016 Long-Term Care Facilities Utilization Data - (updated)*, California Health and Human Services Agency (CHHS), last modified April 2018, data.chhs.ca.gov; *2016 Pivot Table - Primary Care Clinic Utilization Data*, CHHS, last modified May 8, 2018, data.chhs.ca.gov; *2017 Pivot Table - Hospital Annual Selected File (September 2018 Extract)*, CHHS, last modified November 5, 2018, data.chhs.ca.gov; *Medi-Cal November 2018 Local Assistance Estimate for Fiscal Years 2018–19 and 2019–20*, DHCS, last modified December 21, 2018, www.dhcs.ca.gov; and "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Comparison to Medicare

	MEDI-CAL	MEDICARE
Population	Low-income children and adults, including, but not limited to: • Pregnant women • People with disabilities • Seniors (65+) • Children, regardless of immigration status	• Seniors (65+) • People with permanent disabilities
Enrollment	13.2 million Californians	6.1 million Californians
Services Covered	Primary, specialty, and acute care; long-term care; mental health and substance use disorder services; prescription drugs	Primary, specialty, and acute care; prescription drugs
Cost Sharing	No premiums or copayments for lowest-income beneficiaries	Beneficiaries must pay premiums and deductibles
Funded by	Federal and California state and county governments	Federal government and beneficiaries
Administered by	California with oversight by CMS	Federal government through CMS

Medi-Cal and Medicare provide coverage to different populations, cover different services, and are administered separately. However, 1.4 million California seniors and people with disabilities are eligible for both Medi-Cal and Medicare; this population is referred to as "dual eligibles."*

Sources: *Medi-Cal Monthly Enrollment Fast Facts, May 2018*, California Dept. of Health Care Services (DHCS), September 2018, www.dhcs.ca.gov (PDF); "Medicare Enrollment Dashboard," Centers for Medicare & Medicaid Services (CMS), last modified August 2018, www.cms.gov; "Number of Dual Eligible Beneficiaries, FY 2013," Kaiser Family Foundation, n.d., www.kff.org; *Dual Eligible Beneficiaries Under Medicare and Medicaid*, CMS, May 2018, www.cms.gov (PDF); and *Medi-Cal at a Glance*, DHCS, May 2018, www.dhcs.ca.gov (PDF).

* For more information, see *Dual Eligible Beneficiaries Under Medicare and Medicaid*, www.cms.gov (PDF).

Legislative History, Selected Milestones

FEDERAL

- **1965** Passed Medicaid law
- **1972** Required states to extend Medicaid to Supplemental Security Income (SSI) recipients and to seniors and disabled
- **1980** Created Disproportionate Share Hospital (DSH) program
- **1988** Expanded coverage to low-income pregnant women and families with infants
- **1996** Unlinked Medicaid and welfare
- **1997** Established State Children's Health Insurance Program and limited DSH payments
- **2006** Required individuals to provide proof of citizenship to obtain coverage
- **2009** Expanded coverage to legal immigrants for up to five years
- **2010** Under ACA, state option to provide Medicaid coverage for all individuals under 133% FPL at enhanced federal matching rate
- **2012** Supreme Court upholds ACA and rules Medicaid expansion is optional for states
- **2016** Final Managed Care Rule to align Medicaid with other insurance regulations and to strengthen consumer protections
- **2018** CHIP funding reauthorized through FY 2027

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- **1966** Created Medi-Cal
- **1973** Established first Medi-Cal managed care plans
- **1982** Created hospital selective contracting program
- **1993** Required most children/parents with Medi-Cal to enroll in managed care plans
- **1994** Began consolidation of mental health services at county level
- **1997** Expanded access to family planning services*
- **1998** Created Healthy Families program for children
- **2000** Extended Medi-Cal to families with incomes at or below 100% FPL
- **2004** Expanded coverage for home and community-based services
- **2010** Under ACA, expanded coverage for uninsured adults, and required seniors and people with disabilities to enroll in managed care (excluding those with Medicare)
- **2012** Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties
- **2013** Expanded Medi-Cal under ACA state option
- **2015** Expanded full-scope Medi-Cal to eligible undocumented children using state funds

*Family Planning, Access, Care and Treatment (Family PACT) Program

Note: *FPL* is federal poverty level.

Medi-Cal has evolved in response to changing federal and state policies.

Sources: *Medicare & Medicaid Milestones, 1937–2015*, Centers for Medicare & Medicaid Services (CMS), **www.cms.gov**; *Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget*, Committee on Budget and Fiscal Review, January 6, 2009, **sbud.senate.ca.gov** (PDF); "California's Medicaid State Plan (Title XIX)," California Dept. of Health Care Services (DHCS), last modified September 26, 2018, **www.dhcs.ca.gov**; *Description of Medi-Cal Waivers Chart*, DHCS, August 1, 2008, **www.dhcs.ca.gov** (PDF); *California Bridge to Reform: A Section 1115 Waiver Fact Sheet*, DHCS, November 2010, **www.dhcs.ca.gov** (PDF); *Legislative Summary 2011*, DHCS, n.d., **www.dhcs.ca.gov** (PDF); *The Affordable Care Act: An Implementation Timeline for California*, California Health Care Foundation, November 2011, **www.chcf.org**; *State Children's Health Insurance Program (CHIP) Fact Sheet*, Medicaid and CHIP Payment and Access Commission, February 2018, **www.macpac.gov** (PDF); Ashley Kirzinger et al., "Kaiser Health Tracking Poll - September 2017: What's Next for Health Care?," Kaiser Family Foundation, September 22, 2017, **www.kff.org**; and Cal. Welf. & Inst. Code § 14007.8.

Medi-Cal Governance

FEDERAL

Federal Centers for Medicare & Medicaid Services (CMS)

- Provides regulatory oversight
- Reviews and monitors waivers to program rules

COUNTY

County Health and Social Services Department

- Conducts eligibility determination
- Oversees enrollment and recertification

STATE

California Department of Health Care Services (DHCS)

- Administers Medi-Cal
- Sets eligibility and benefits, contracts with managed care plans and other providers, and determines payments

California Legislature

- Passes legislation enabling programs, eligibility requirements, waivers, and benefits within federal law
- Provides oversight through hearings and audits
- Approves overall budget

Medi-Cal is governed by the federal, state, and county governments. The California legislature provides important oversight and approves the budget.

The Affordable Care Act (ACA) and Medi-Cal

Eligibility Expansions

- In 2010, the ACA allowed states to expand eligibility to low-income adults under 65. In 2018, California covered 3.8 million "expansion" adults, which accounted for nearly 30% of all enrollees.
- Starting in 2011, California prepared for expansion with the "Bridge to Health Reform" 1115 Medicaid waiver. In January 2014 the state transitioned over one million newly eligible low-income adults into Medi-Cal. Over half had been enrolled previously through Low Income Health Programs, which were funded by counties and federal waiver funds.
- The ACA raised the income eligibility threshold for parent and adult caretaker relatives. In addition, eligibility for foster youth enrolled in Medicaid was extended from age 18 up to age 26.

Benefit Expansions

- California expanded benefits to include mild-to-moderate mental health services and substance use disorder services.
- Starting In 2019, California will implement the ACA's Health Homes provision to provide enhanced care management and coordination for beneficiaries with multiple chronic conditions.

Eligibility and Enrollment Simplification

- The ACA simplified and streamlined eligibility requirements. California also improved its "no wrong door" enrollment system, creating a single online portal to initiate applications for insurance affordability programs.

Impact on California

- The Medi-Cal expansion contributed significantly to reducing the number of uninsured people in California, which declined from 14% in 2013 to 7% in 2017.*
- While Medi-Cal's share of the state budget has remained the same, increased federal matching contributions have financed most of the eligibility and enrollment expansions in California.

*Self reported.

Sources: Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010), www.govinfo.gov (PDF); "Summary of the Affordable Care Act," Kaiser Family Foundation (KFF), April 25, 2013, www.kff.org; "Status of State Action on the Medicaid Expansion Decision," KFF, last modified November 26, 2018, www.kff.org; "The ACA and Medi-Cal: What's at Stake?," Insure the Uninsured Project, May 23, 2017, www.itup.org; "Interim Evaluation Report on California's Low Income Health Program (LIHP)," UCLA Center for Health Policy Research, July 29, 2013, healthpolicy.ucla.edu; *2018–19 Governor's May Revision: Highlights*, California Dept. of Health Care Services (DHCS), May 11, 2018, www.dds.ca.gov (PDF); "Health Homes Program," DHCS, November 26, 2018, www.dhcs.ca.gov; and *California's Uninsured: Progress Toward Universal Coverage*, California Health Care Foundation, August 6, 2018, www.chcf.org; and "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

The ACA allows states the option to expand Medicaid to low-income adults previously ineligible. California, which has the largest number of adults enrolled through this expansion, has been an enrollment leader among the 37 states expanding their programs.

Financing the Medi-Cal Program

Medi-Cal is paid for with a mix of federal, state, and local funds.

Source of Funds

- The federal government contributes a percentage of every dollar that states spend on qualified Medicaid expenditures. This federal medical assistance percentage (FMAP), also known as the federal share, varies by state and is calculated using the average per capita income in the state. California's standard FMAP is 50%.
- California's nonfederal share of Medi-Cal expenditures is financed through the state general fund, county revenues, and taxes and fees on managed care organizations, hospitals, and tobacco products.

FMAP Enhancement

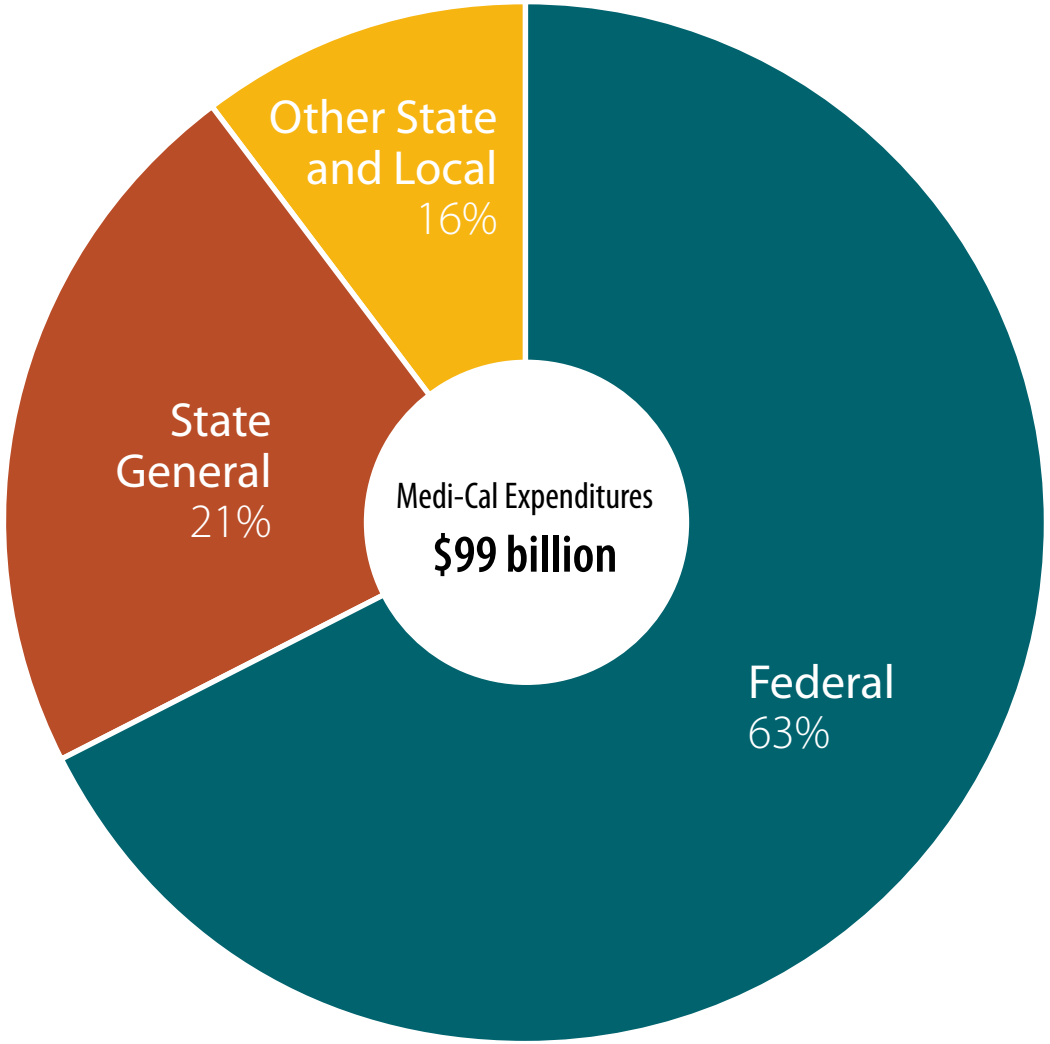
- The FMAP may be "enhanced," or increased, for specific services. For example, the FMAP is 90% for family planning services and health homes. Other services with enhanced FMAPs include breast and cervical cancer treatment, and Indian Health Services and Tribal Facility Services.
- The FMAP is enhanced for specific populations such as refugees, pregnant women, and children.

Affordable Care Act (ACA) Effects on FMAP

- The ACA enhanced the FMAP for newly eligible low-income adults under age 65 to 100% from 2014 to 2016, but it declines to 90% by 2020.
- The FMAP for pregnant women and newborns covered by the Children's Health Insurance Program was increased to 88% through September 2019 and declines to 65% thereafter.

Sources: Laura Snyder and Robin Rudowitz, "Medicaid Financing: How Does it Work and What Are the Implications?," Kaiser Family Foundation, May 20, 2015, www.kff.org; Aid Code Master Chart, California Dept. of Health Care Services, October 18, 2017, www.dhcs.ca.gov (PDF); and "The 2018–19 Budget: Analysis of the Health and Human Services Budget — Medi-Cal," Legislative Analyst's Office, February 2018, lao.ca.gov.

Medi-Cal Funding Sources
FY 2018–19

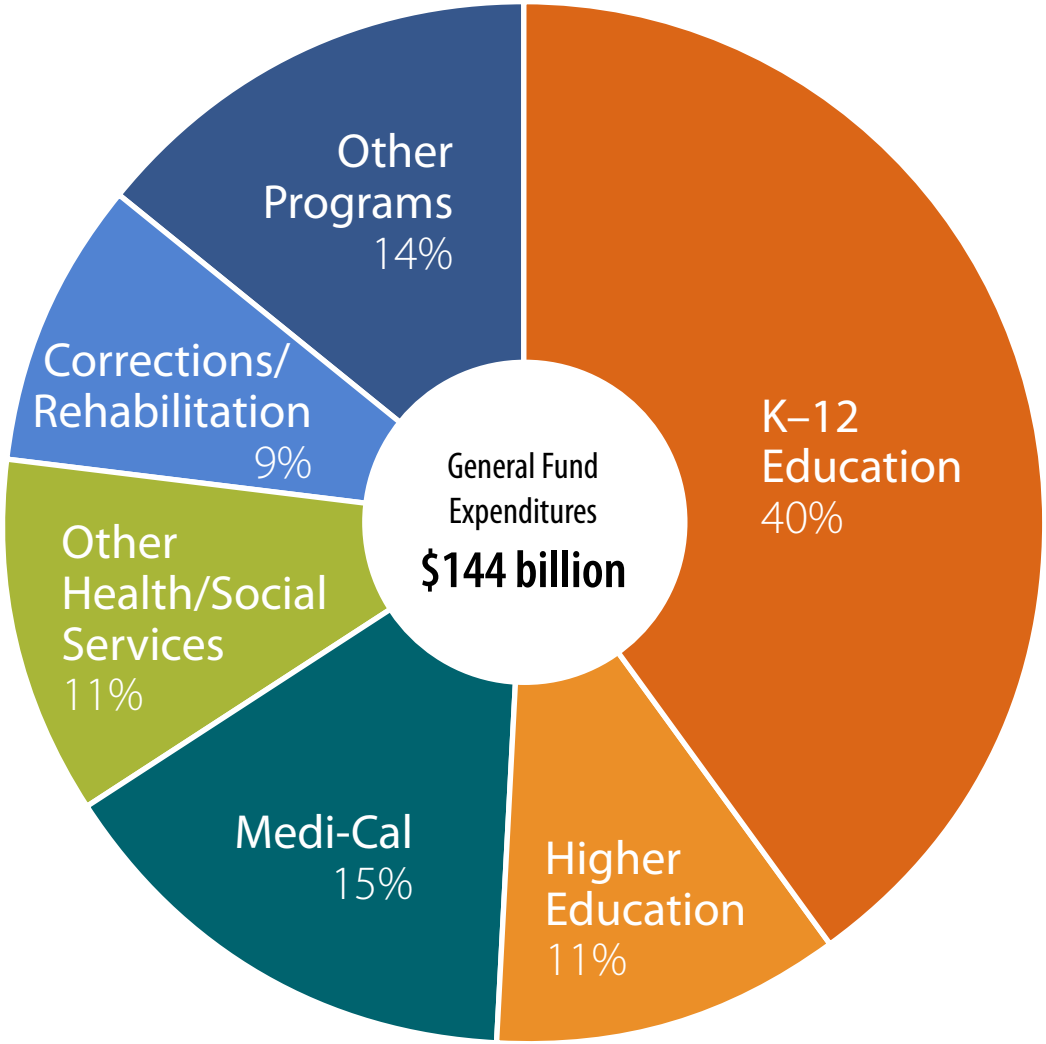


Note: 2018–19 estimated general fund expenditures as reported in the governor's 2019–20 budget.

Source: *Governor's Budget Summary 2019–20 : Health and Human Services*, California Dept. of Finance, www.ebudget.ca.gov (PDF).

The federal government provides nearly two-thirds of total Medi-Cal funding. The estimated state general fund contribution to Medi-Cal is 21%, while other state and local funds compose the remaining 16%.

General Fund Distribution
FY 2018–19

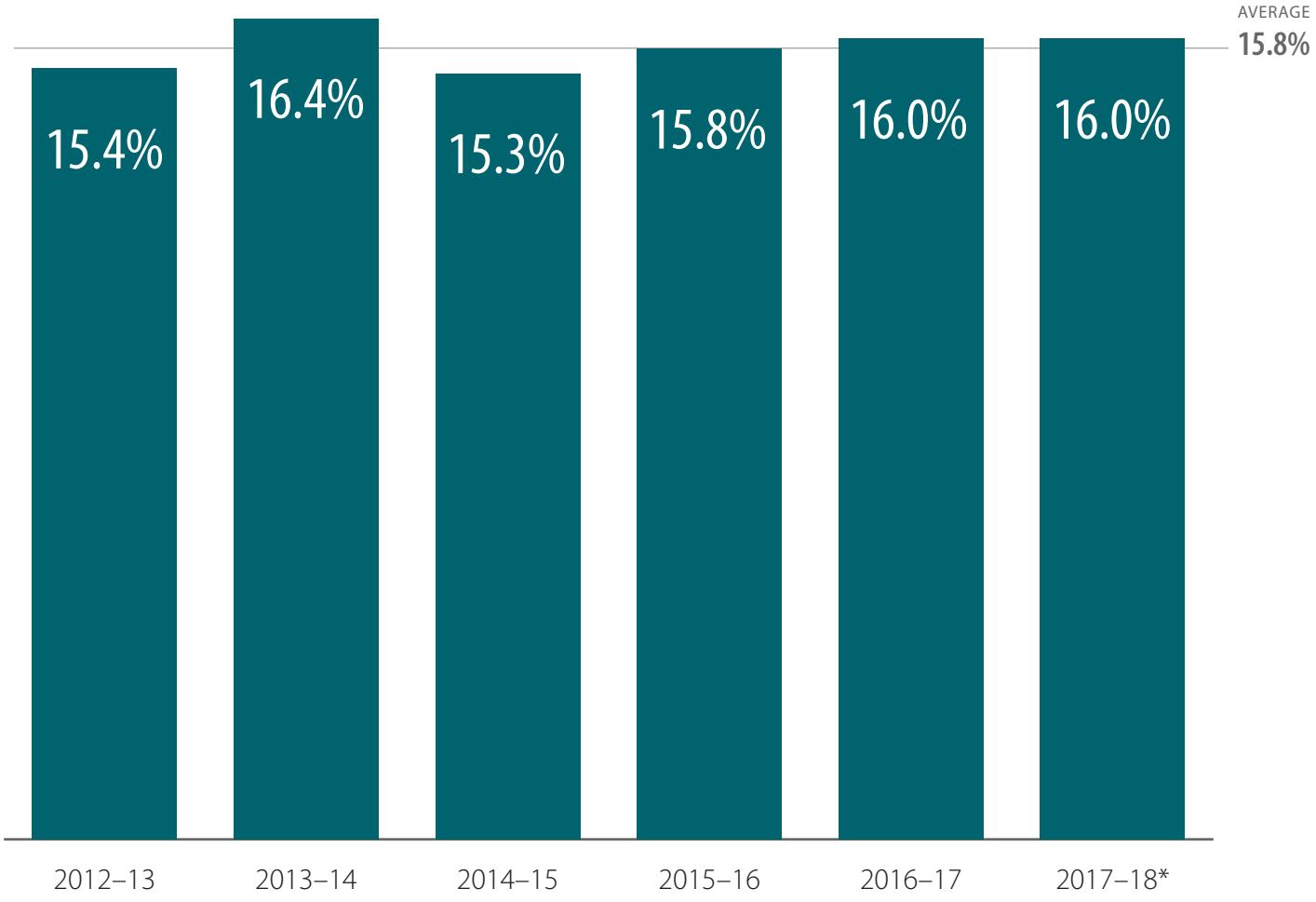


Notes: 2018–19 estimated general fund expenditures as reported in the governor's 2019–20 budget. Includes expenditures for medical care services, eligibility (county administration), fiscal intermediary management, and benefits (medical care and services). Segments do not total 100% due to rounding.

Source: *Governor's Budget Summary 2019–20*, California Dept. of Finance, www.ebudget.ca.gov.

California invests more than $20 billion annually in the Medi-Cal program, making Medi-Cal the second-largest category of state general fund spending after K–12 education.

Share of General Fund for Medi-Cal
FY 2013 to FY 2018



*Estimate

Sources: Estimates for 2016–17 and 2017–18 are from *Governor's Budget Summary, 2018–19*, California Dept. of Finance (DOF), January 10, 2018, www.ebudget.ca.gov (PDF); estimates for 2015–16 are from *2017–18 Governor's Budget Summary*, DOF, January 10, 2017, www.ebudget.ca.gov (PDF); estimates for 2014–15 are from *Governor's Budget Summary, 2016–17*, DOF, January 7, 2016, www.ebudget.ca.gov (PDF); estimates for 2013–14 are from *2015–16 Governor's Budget Summary*, DOF, January 9, 2015, www.ebudget.ca.gov (PDF); and estimates for 2012–13 are from *Governor's Budget Summary, 2014–15*, DOF, January 10, 2014, www.ebudget.ca.gov (PDF).

Over the past six years, Medi-Cal has, on average, accounted for 15.8% of all general fund expenditures.

Eligibility Requirements

Medi-Cal eligibility is based on household income and other finances, citizenship and immigration status, and enrollment in other public assistance programs.

- **Income.** Household incomes must be below certain thresholds of the federal poverty guidelines. Income threshold calculations vary by eligibility group (see page 16).
- **Property.** Enrollees in specific aid categories must pass an asset test and demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than $3,300 for a family of four). Some types of property, such as a principal residence, are exempt.
- **Citizenship and immigration status.** US citizenship or satisfactory immigration status (e.g., lawful permanent resident) is required. Residents without lawful status may be eligible for *restricted-scope* benefits that cover limited services such as pregnancy-related and emergency care. California allows undocumented children meeting eligibility requirements to receive *full-scope* benefits. Full-scope Medi-Cal provides medical, dental, mental health and vision care. It also covers alcohol and drug use treatment and prescription drugs.
- **Residence.** Enrollees must reside in California.
- **Public assistance program enrollment.** Eligibility for Medi-Cal is automatic for enrollees in the following public assistance programs: CalFresh, Supplementary Security Income / State Supplemental Payment, CalWORKS, Refugee Assistance, Foster Care / Adoption Assistance Program.

For most beneficiaries, Medi-Cal eligibility is based on household income.

Notes: The ACA created a streamlined financial eligibility test based on federal tax rules to determine gross income for all insurance affordability programs. The modified adjusted gross income (MAGI) standard eliminated the asset test for most adults, parents, children, and pregnant women. In 2018, the 138% of federal poverty level for a single adult was $16,754.

Sources: "Poverty Guidelines," US Dept. of Health and Human Services, 2018, aspe.hhs.gov; *Medi-Cal General Property Limitations*, California Dept. of Health Care Services (DHCS), April 2014, www.dhcs.ca.gov (PDF); *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates,* March 2016, Western Center on Law and Poverty, wclp.org; *Explaining Health Reform: The New Rules for Determining Income Under Medicaid in 2014*, Kaiser Family Foundation, June 2011, kaiserfamilyfoundation.files.wordpress.com (PDF); "Medi-Cal Eligibility and Covered California - Frequently Asked Questions," DHCS, last modified September 28, 2018, www.dhcs.ca.gov; and "Do You Qualify for Medi-Cal Benefits?," DHCS, September 27, 2018, www.dhcs.ca.gov.

Eligibility Groups

MANDATORY GROUPS – *REQUIRED BY FEDERAL LAW*	INCOME THRESHOLD	NOTES
Children under age 26 receiving adoption assistance or foster care	None	
Children under age 19	138% FPL cap	Income threshold is below 142% FPL for children age 1 to 5.
People in long-term care	100% FPL cap	Subject to asset test*
Parents and caretaker relatives	109% FPL cap	
Aged, blind, and people with disabilities	Must receive SSI	Subject to asset test*
Pregnant women, newborns, and infants under age 1	213% FPL cap	
Low-income Medicare beneficiaries	135% FPL cap	Three categories: Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualifying Individual
OPTIONAL GROUPS – *NOT REQUIRED BY FEDERAL LAW*	**INCOME THRESHOLD**	**NOTES**
ACA "expansion" adults under age 65	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA.
Parents and caretaker relatives	110% – 138% FPL	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA.
Qualifying state and county inmates	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA. Medi-Cal pays for inpatient hospital services.
Children under age 19	139% – 266% FPL	Title XXI funded Optional Targeted Low-Income Children†
Children under age 19 in specific counties†	267% – 322% FPL	Title XXI funded with county match (C-CHIP)‡
Pregnant women, newborns, and infants under age 2	213% – 322% FPL	Title XXI funded Optional Targeted Low-Income Children
Undocumented children under age 19	266% FPL cap	State-only funding
Undocumented adults in long-term care	100% FPL cap	State-only funding
Aged, blind, and people with disabilities — FPL program	100% FPL cap	State option in Title XIX§; subject to asset test*
Working disabled	250% FPL cap	State option in Title XIX§; subject to asset test*

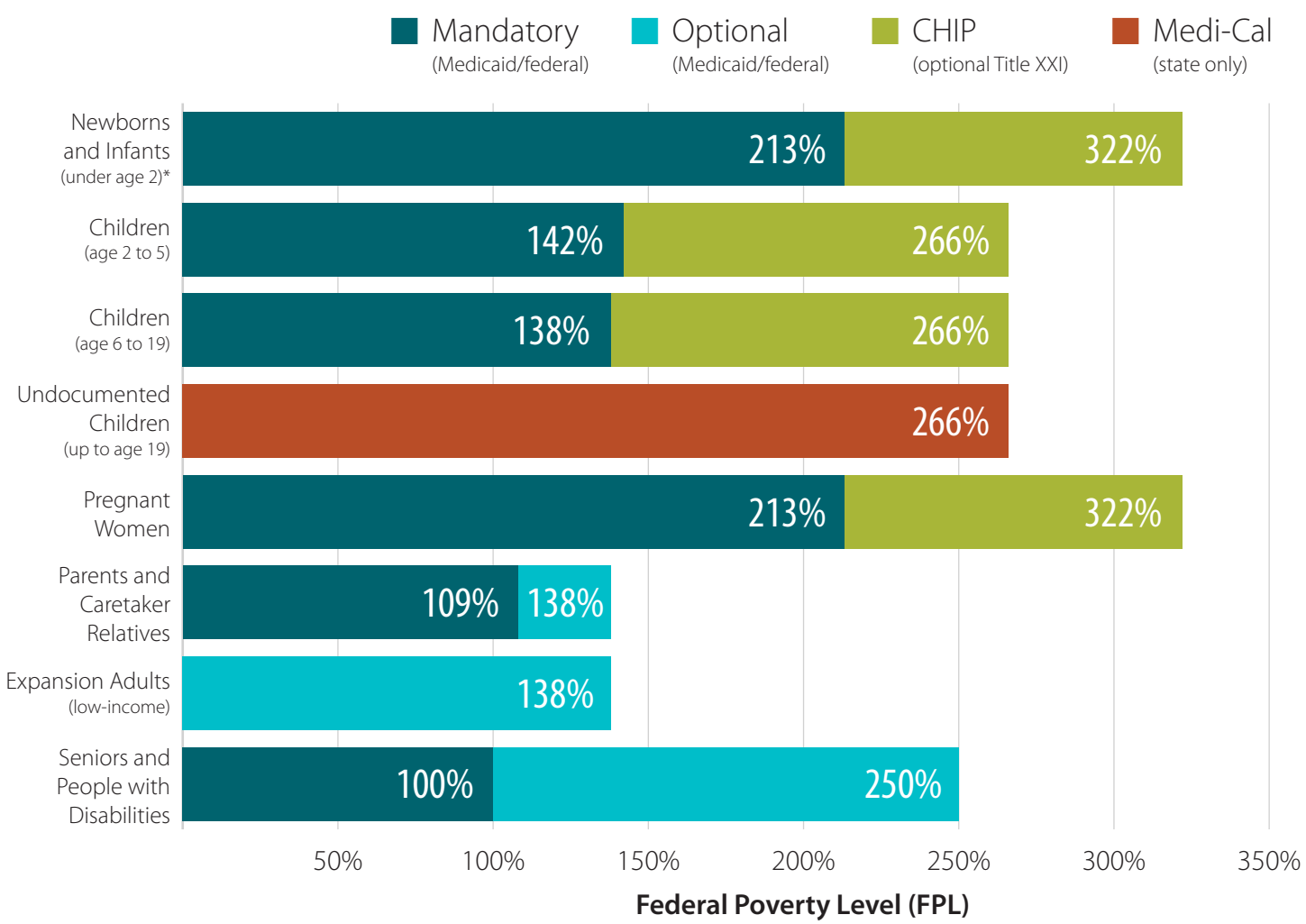
* Some people must demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than $3,300 for a family of four). This is commonly referred to as the "asset test." Some real and personal properties are exempt (e.g., principal residence). This requirement applies only to specific aid categories such as the aged, blind, and disabled.
† Title XXI of the Social Security Act passed in 1997, also known as the State Children's Health Insurance Program, allows states the option to provide coverage to uninsured pregnant women, infants, and children in families with household incomes higher than Medicaid thresholds and who cannot afford private insurance. States can create standalone programs, expand their Medicaid programs, or create a hybrid program. Originally, California created the Healthy Families program but transitioned enrollees into Medi-Cal in 2012–13 and uses the Title XXI funds to expand Medi-Cal eligibility thresholds. ‡ C-CHIP in San Mateo, Santa Clara, and San Francisco Counties only. § Social Security Act, Title XIX, Section 1902(a)(10)(A)(ii)(X), www.ssa.gov.

Note: The federal poverty level (*FPL*) in 2018 was $12,140 for an individual and $25,100 for a family of four.

Federal law requires all state Medicaid programs to cover certain (mandatory) groups, and allows states to receive federal matching funds for certain other (optional) groups. As allowed under the ACA, California expanded eligibility to low-income adults without disabilities or dependent children with incomes up to 138% FPL, and to parents and caretaker relatives with incomes from 110% to 138% FPL.

Sources: Aid Codes and Coverage Groups, custom data request, California Dept. of Health Care Services (DHCS), August 2018; Sandra Williams (chief, Medi-Cal Eligibility Div., DHCS) to all county welfare directors et al., letter 18-03, January 30, 2018, **www.dhcs.ca.gov** (PDF); *List of Medicaid Eligibility Groups*, Centers for Medicare & Medicaid Services, **www.medicaid.gov** (PDF); *Medi-Cal General Property Limitations*, DHCS, April 2014, **www.dhcs.ca.gov** (PDF); Sandra Williams (chief, Medi-Cal Eligibility Div., DHCS) to all county welfare directors et al., letter 17-03, January 25, 2017, **www.dhcs.ca.gov** (PDF); "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults," Kaiser Family Foundation, March 2018, **www.kff.org**; and *State Children's Health Insurance Program (CHIP) Fact Sheet*, Medicaid and CHIP Payment and Access Commission, February 2018, **www.macpac.gov** (PDF).

Income Thresholds, by Funding Source



Notes: *CHIP* is Children's Health Insurance Program and is part of the Medi-Cal program. See page 16 for details on optional groups.

*Medicaid requires mandatory coverage of newborns and infants up to age 1 to 213% FPL. Title XXI allows the states the option to cover newborns and infants under age 2 and up to 322% FPL.

Sources: Sandra Williams (chief, Medi-Cal Eligibility Div., California Dept. of Health Care Services) to all county welfare directors et al., letter 18-03, January 30, 2018, www.dhcs.ca.gov (PDF); *Program Eligibility by Federal Poverty Level for 2019*, Covered California, October 2018, www.coveredca.com (PDF); "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults," Kaiser Family Foundation, March 2018, www.kff.org; and *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates*, March 2016, Western Center on Law and Poverty, wclp.org.

Medi-Cal income thresholds vary. In 2018, a single, childless adult with annual income below 138% of the federal poverty level, or $16,754, would be eligible for Medi-Cal. A pregnant woman would be eligible if her annual income was below 322% of the federal poverty level, or $39,091.

Immigration Status and Eligibility

Immigrants who are not citizens may be eligible for Medi-Cal if they meet categorical, financial, and residency requirements. There are two main groups who are eligible:

Qualified Immigrants

- Legal permanent residents, asylees, refugees, and other qualifying categories.
- Eligible for full-scope benefits.
- Federal FMAP funds available if they've resided in US more than five years.

Nonqualified Immigrants

- Permanently Residing Under Color of Law (PRUCOL): entitled to full-scope Medi-Cal with state-only funding and no FMAP. The ACA recognizes Deferred Action for Childhood Arrivals (DACA) status as "lawfully present" under PRUCOL.
- Undocumented adults: entitled only to restricted-scope — emergency and pregnancy-related — services. These services qualify for federal matching.
- Undocumented children: entitled to full-scope benefits with state-only funding and no FMAP.
- Other nonqualified, but lawfully present, include tourists, students, and those with temporary protected status.

Some noncitizen immigrants are eligible for full-scope Medi-Cal, while others may be eligible for emergency and pregnancy-related services.

Notes: Other qualified groups include (1) those paroled into the US under specific conditions; (2) those granted conditional entry pursuant to specific conditions; (3) Cuban or Haitian entrants; (4) battered spouses and children with a pending or approved: (a) self-petition for an immigrant visa or visa petition by a spouse or parent who is either a US citizen or LPR, or (b) application for cancellation of removal/suspension of deportation, where the need for the benefit has a substantial connection to the battery or cruelty (parent/child of such a battered child/spouse are also "qualified"); and (4) Victims of Severe Forms of Trafficking. California passed SB 75 in 2015, which provides full-scope benefits to undocumented children up to age 19 who meet all other eligibility requirements. There is no federal medical assistance percentage (*FMAP*) for these children. FMAP funds available for emergency or pregnancy-related services if residing in US less than five years. Permanent Residence Under Color of Law (PRUCOL) is not an immigration status but a public benefits eligibility category; PRUCOL individuals are not US citizens, but they are considered to have the same rights as legal residents for welfare eligibility purposes. See 42 CFR § 435.408 for the federal definition and 22 CCR § 50301.3 for the state definition.

Sources: *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates,* March 2016, Western Center on Law and Poverty, wclp.org; *Medi-Cal's Non-Citizen Population*, California Dept. of Health Care Services, October 2015, www.dhcs.ca.gov (PDF); Cal. Welf. & Inst. Code § 14007.8; and "Lessons From CA: Expanding Full-Scope Medi-Cal to All Children," National Health Law Program, May 31,2016, healthlaw.org.

Individual Application Process

In person. May apply for Medi-Cal at local county social services office or at hospitals and clinics where county eligibility workers and certified application assisters are located. Medi-Cal applications, paper or electronic, can be submitted with the assistance of trained certified application assisters, many of whom work at community-based organizations.

Mail in. The paper version of the single streamlined application can be submitted to county offices or Covered California.

Online. Medi-Cal applications can be initiated electronically using the Covered California portal and benefitscal.org website, which links applicants to county eligibility systems. Most applicants will be required to follow up in person or by phone with county eligibility offices.

Presumptive eligibility. Participating providers in the Presumptive Eligibility Program for Pregnant Women or the Hospital Presumptive Eligibility program can request immediate 60-day temporary, no-cost Medi-Cal coverage for qualified individuals. During the 60-day period, those receiving this temporary coverage apply for permanent Medi-Cal or other health coverage.

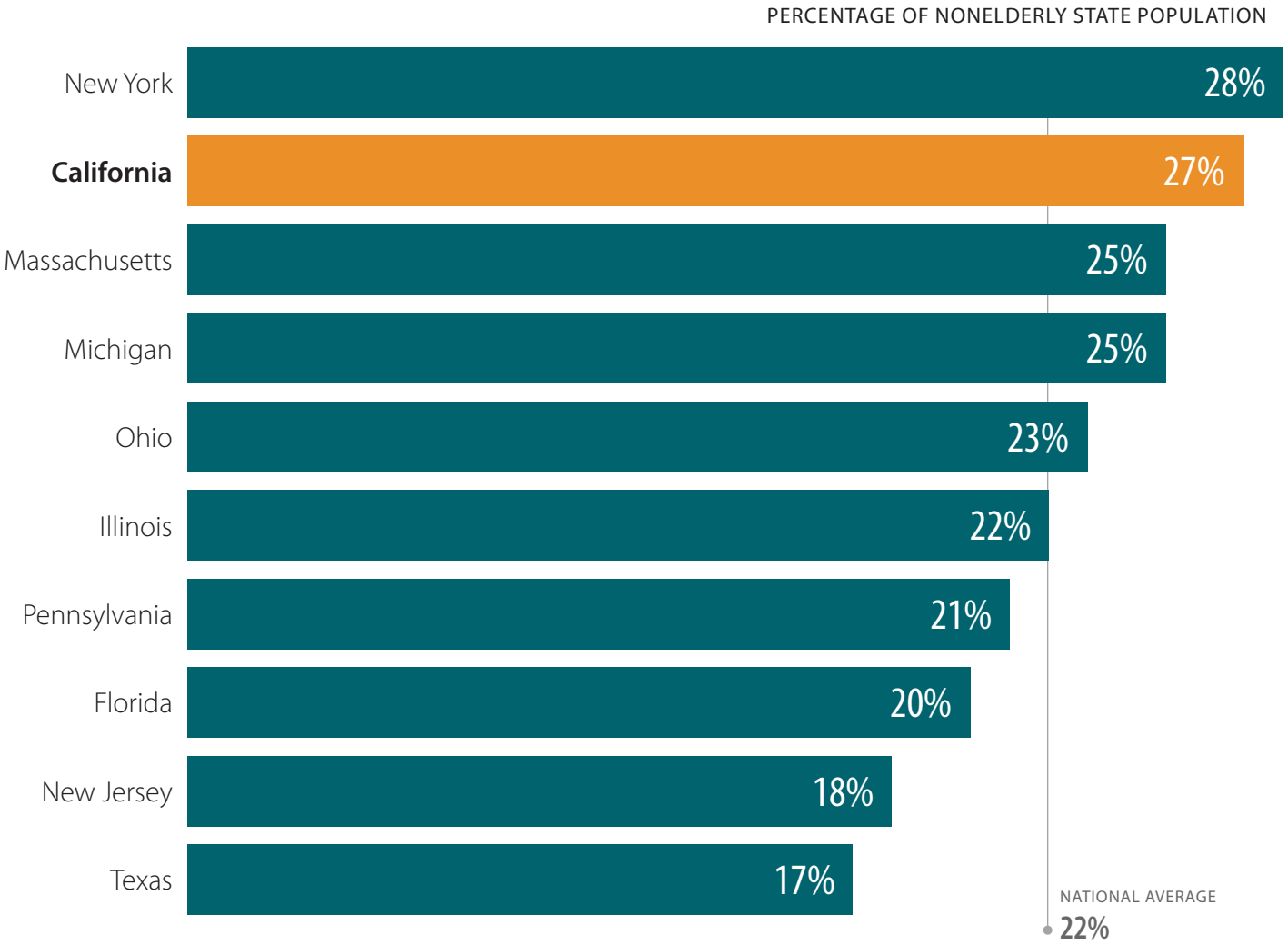
To comply with the ACA, California created a single streamlined application for Medi-Cal and Covered California, the state's health care exchange.

Notes: People eligible for temporary coverage through presumptive eligibility are pregnant women, foster youth age 18 to 26, children under 19, parents and caretaker relatives, and low-income adults under 65. People must meet income and residency requirements and not have received presumptive eligibility benefits in the last 12 months. CalWORKs is a public assistance program that provides cash aid and services to eligible families that have children in the home.

Sources: "Steps to Medi-Cal," California Dept. of Health Care Services (DHCS), last modified September 27, 2018, www.dhcs.ca.gov; and "Hospital Presumptive Eligibility (HPE) Program," DHCS, last modified November 2, 2018, www.dhcs.ca.gov.

Medicaid Enrollment

Selected States, 2017

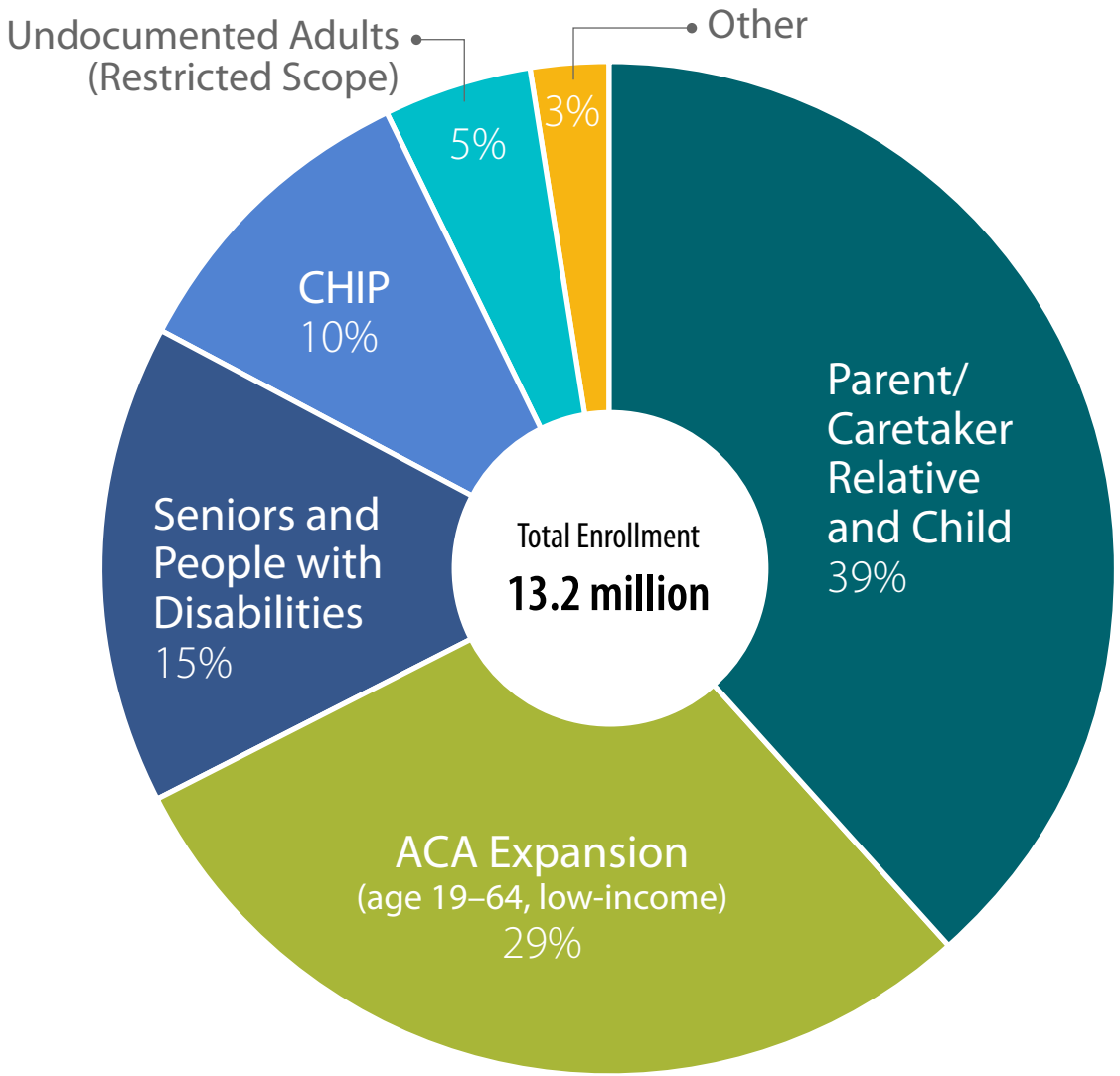


Notes: States with the 10 largest Medicaid expenditures in FY 2017 are represented. *Nonelderly* is under age 65. Medicaid enrollment is self-reported and includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Sources: "Health Insurance Coverage of Nonelderly 0–64," Kaiser Family Foundation (KFF), www.kff.org; and "Total Medicaid Spending," KFF, www.kff.org.

California had more Medicaid enrollees in total but New York had a slightly higher percentage of the state's nonelderly population enrolled in Medicaid. Texas and Florida did not expand their Medicaid programs under the Affordable Care Act.

Enrollment, by Aid Category, 2018



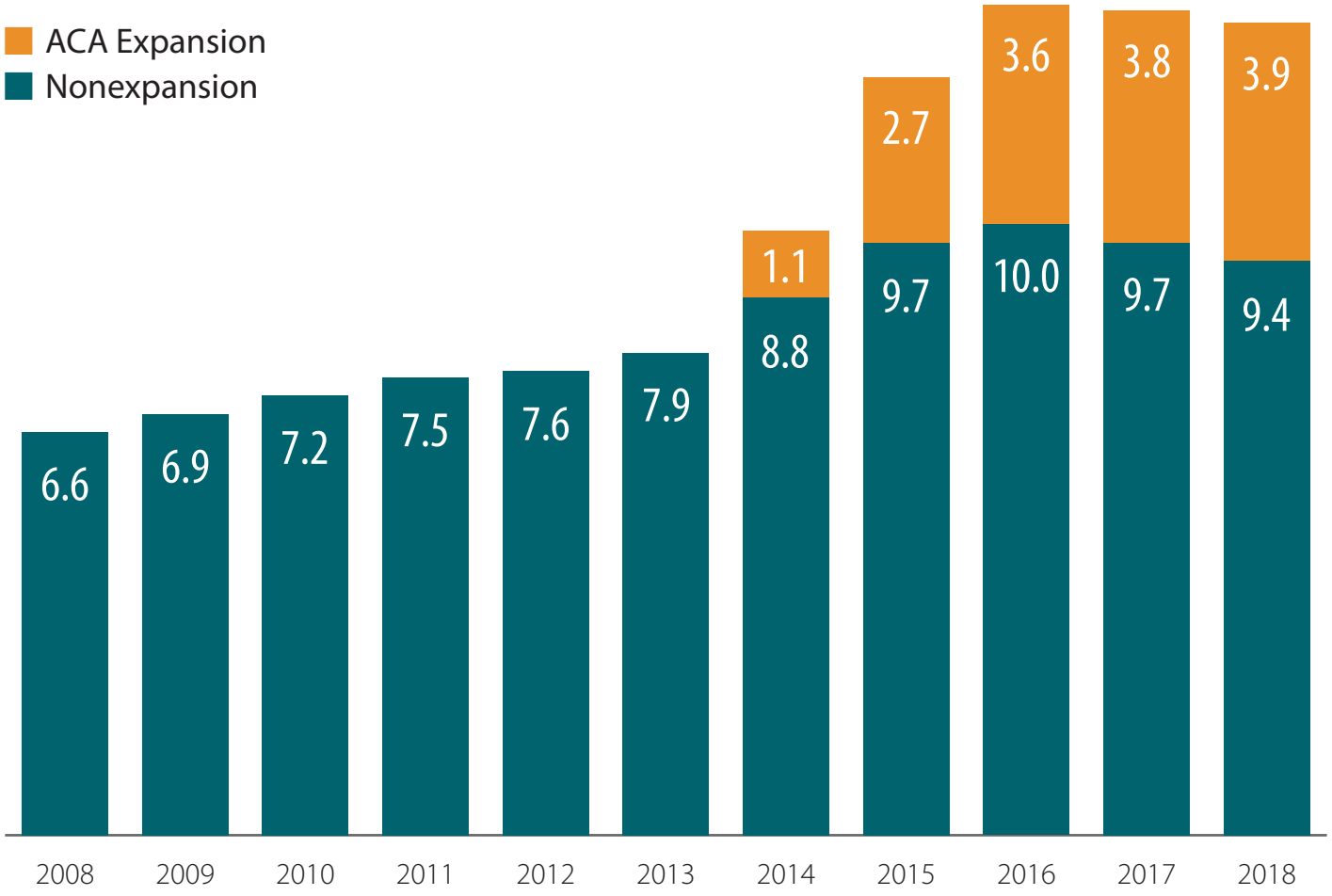
Notes: *CHIP* is Children's Health Insurance Program. *Undocumented adults* is a California Dept. of Health Care Services (DHCS) classification that includes aid categories restricted to only pregnancy-related, long-term care and emergency services for adults who do not have satisfactory immigration status, also known as restricted-scope benefits. *Other* includes long-term care and aid categories including Refugee Medical Assistance / Entrant Medical Assistance, Breast and Cervical Cancer Treatment Program, Abandoned Baby Program, Minor Consent Program, Accelerated Enrollment in the Children Health and Disability Prevention Program (CHDP), Trafficking and Crime Victims Assistance Program, and state and county inmates. Segments do not total 100% due to rounding.

Sources: *Medi-Cal Monthly Enrollment Fast Facts*, DHCS, May 2018, www.dhcs.ca.gov (PDF); and *Aid Code Master Chart*, DHCS, October 18, 2017, www.dhcs.ca.gov (PDF).

Nearly two-thirds of Medi-Cal enrollees are composed of children and their parents/caretakers, children in CHIP, and seniors and people with disabilities. The ACA expansion group — low-income adults — is the second-largest group of Medi-Cal enrollees.

Medi-Cal Enrollment, ACA Expansion and Nonexpansion
2008 to 2018

IN MILLIONS



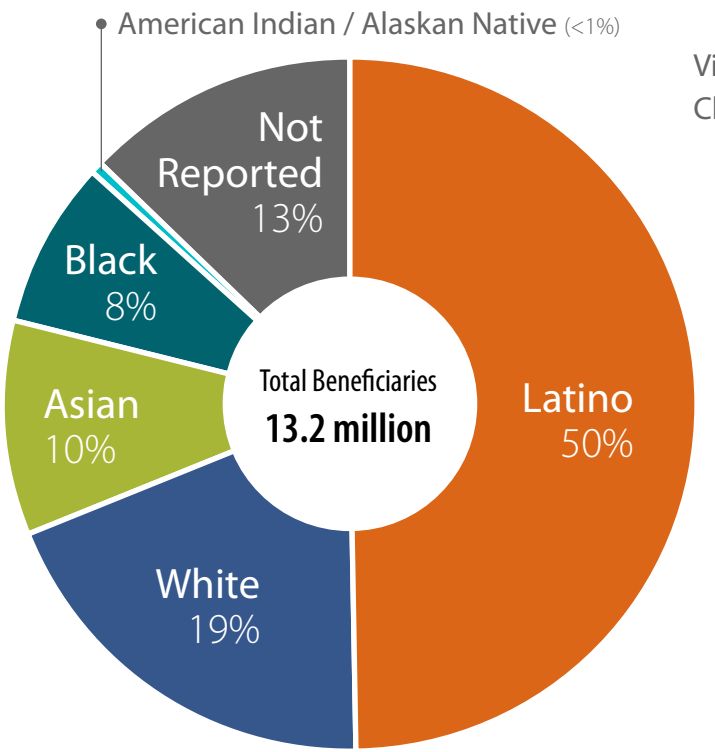
Sources: *Trend in Medi-Cal Program Enrollment – January Month of Enrollment for 2000–2013*, California Dept. of Health Care Services (DHCS), July 2013, www.dhcs.ca.gov (PDF); *Medi-Cal Monthly Enrollment Fast Facts, December 2016*, DHCS, April 2017, www.dhcs.ca.gov (PDF); and *Medi-Cal Monthly Enrollment Fast Facts, June 2018*, DHCS, October 2018, www.dhcs.ca.gov (PDF).

Medi-Cal enrollment has increased significantly since 2013, largely due to the ACA expansion. In 2014, the first year of the expansion, traditional Medi-Cal enrollment also increased sharply due to the inclusion of beneficiaries from the former Healthy Families program. Since 2016, enrollment increases have tapered off.

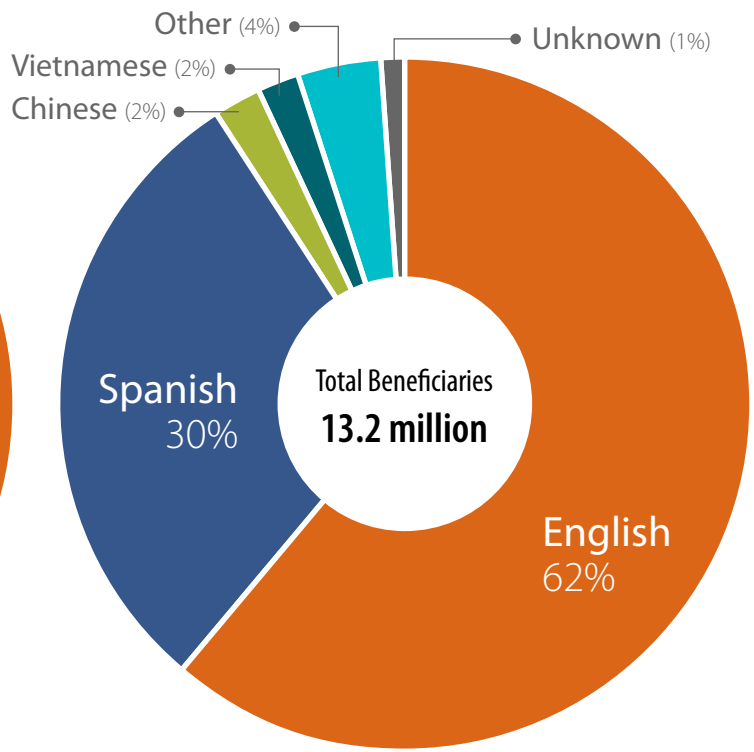
Beneficiary Profile

by Race/Ethnicity and Primary Language Spoken, 2018

Race/Ethnicity



Primary Language Spoken

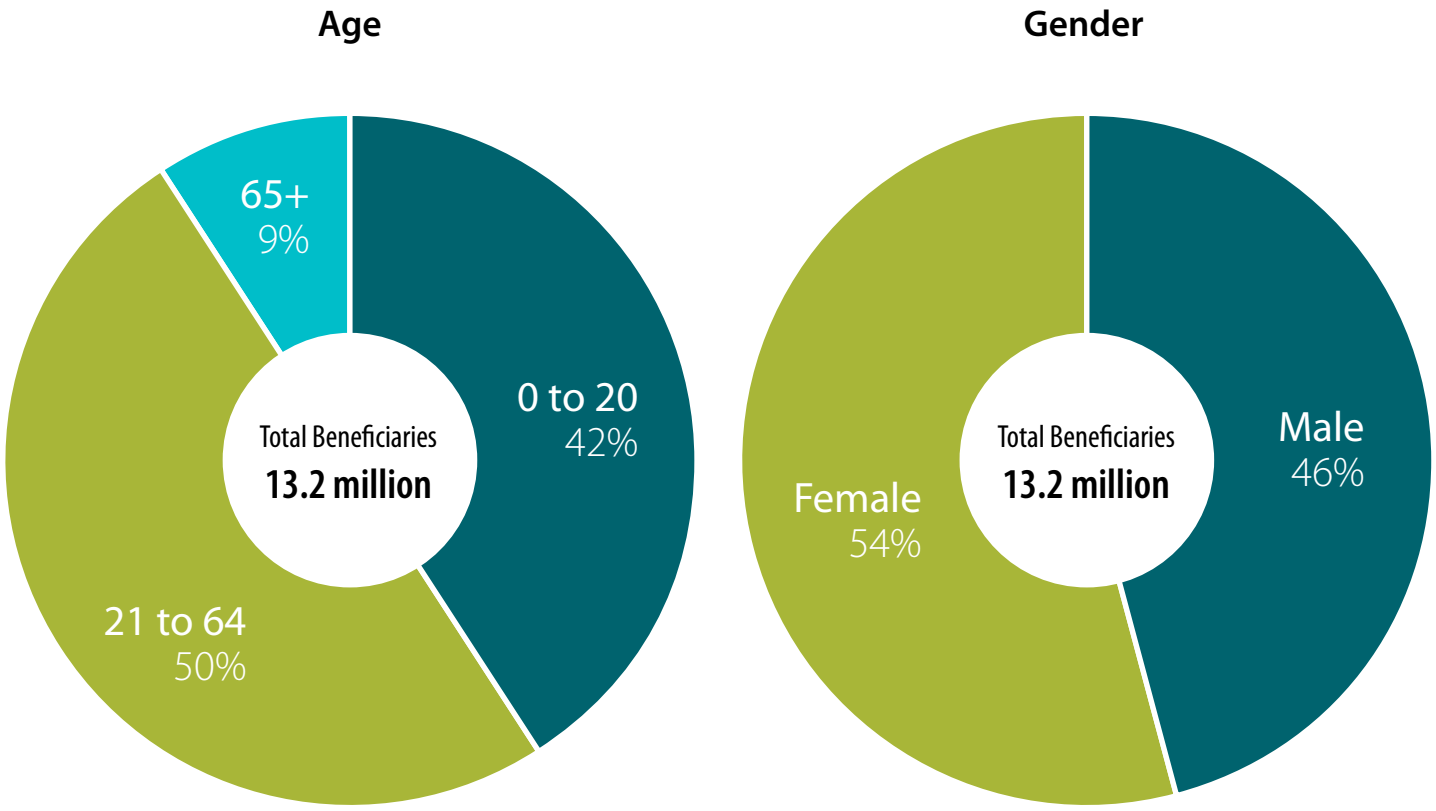


Medi-Cal serves a large and diverse population, with Latinos accounting for 50% of all enrollment. English is the most common language spoken, (62% of enrollees), and Spanish is the primary language spoken for 30%.

Notes: *Asian* includes Pacific Islander. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Enrollment Fast Facts, May 2018*, California Dept. of Health Care Services, September 2018, www.dhcs.ca.gov (PDF).

Beneficiary Profile
by Age and Gender, 2018



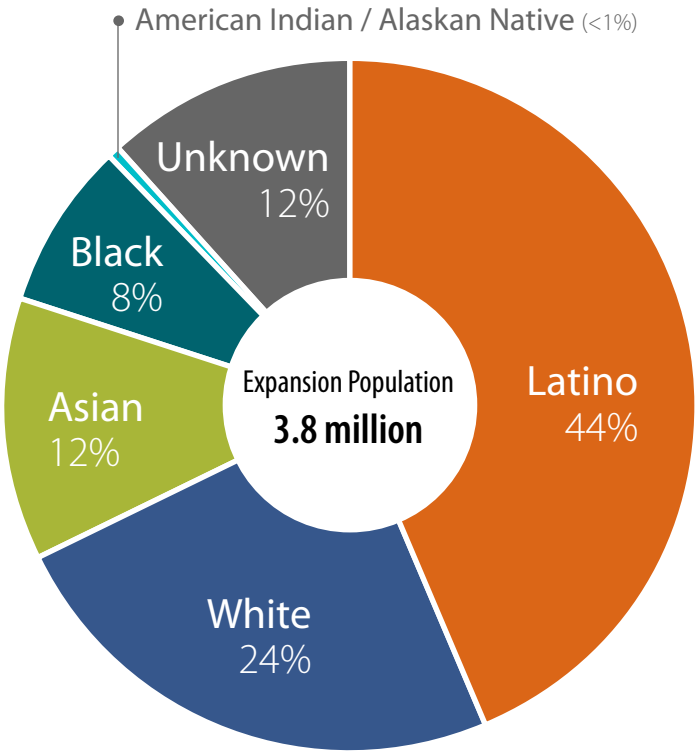
Half of Medi-Cal enrollees are adults; children and youth (age 0 to 20) account for 42% of enrollment. Medi-Cal enrollees are somewhat more likely to be female (54%) than male (46%).

Note: Segments may not total 100% due to rounding.

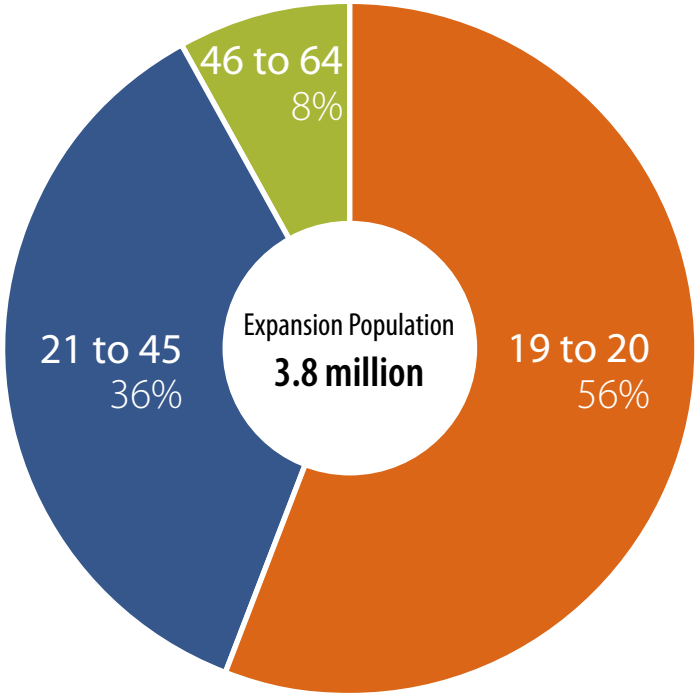
Source: *Medi-Cal Monthly Enrollment Fast Facts, May 2018*, California Dept. of Health Care Services, September 2018, www.dhcs.ca.gov (PDF).

Expansion Population
by Race/Ethnicity and Age, 2018

Race/Ethnicity



Age



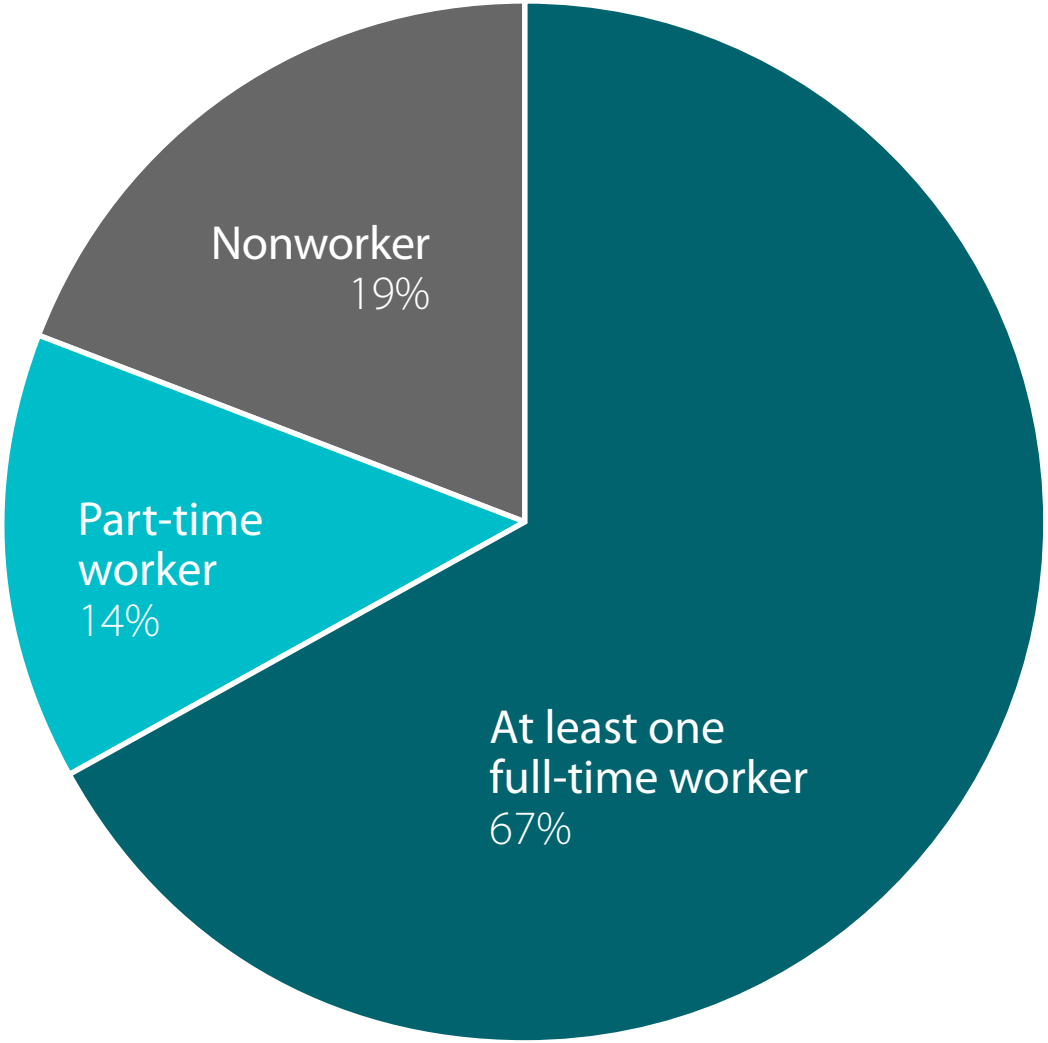
Those enrolling in Medi-Cal as a result of the ACA in many ways are similar to the overall Medi-Cal population. Latinos represent the largest racial/ethnic group (44% of beneficiaries), followed by whites (24%). All beneficiaries in the expansion population are adults, with those age 21 to 45 representing the largest segment, at 56%.

Notes: *Asian* includes Pacific Islander. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Enrollment Fast Facts, May 2018*, California Dept. of Health Care Services, September 2018, www.dhcs.ca.gov (PDF).

Enrollment, by Family Work Status

Nonelderly Population, 2017



Source: "Distribution of the Nonelderly with Medicaid by Family Work Status," Kaiser Family Foundation, www.kff.org.

Two out of every three Medi-Cal beneficiaries have at least one family member that works full time.

Medi-Cal Benefits

ESSENTIAL HEALTH BENEFITS	OPTIONAL SERVICES
• Ambulatory services	• Dental for adults
• Emergency services	• Vision services for adults
• Prescription drugs	• Nonemergency medical transportation services
• Rehabilitative and habilitative services and devices	• Long-term services and supports
• Hospitalization	
• Preventive and wellness services, chronic disease management	
• Mental health and substance use disorder (SUD) services, including behavioral health treatment	
• Maternity and newborn care	
• Pediatric services, including oral and vision care	
• Laboratory services	

Sources: "State Plan Section 3 – Services," California Dept. of Health Care Services, last modified December 19, 2018, www.dhcs.ca.gov; and *Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary*, DHCS, October 2017, www.dhcs.ca.gov (PDF).

The Affordable Care Act ensures that all Medi-Cal health plans offer 10 essential health benefits. In addition, California provides other services that are not required by the federal government.

Premiums and Cost Sharing, by Eligible Group

	REQUIREMENTS
Children >160% FPL	• Children age 1 to 19 in families with incomes between 160% and 266% of the FPL have a monthly premium. • Premiums are $13 for each child but cannot exceed $39 per family per month.
250% Working Disabled Program	• People with a medical determination of physical or mental impairment lasting or proposed to last for one year and whose countable monthly income is below 250% FPL. • Working disabled individuals with monthly income under 250% FPL. Disability income is excluded from income calculation. • Monthly premiums range from $20 to $250 for a single person depending on income.
Aged, Blind, and Disabled — Medically Needy Program Share of Cost*	• People over age 65, blind, or who have a disability with income above $1,242 per month (after numerous deductions). • People with a medical determination of a physical or mental impairment lasting or proposed to last for one year.

**Share of cost* is the amount of health care costs the beneficiary must incur before Medi-Cal will pay for medically necessary goods and services. It is calculated as the monthly family income less a Maintenance Need Allowance based on family size.

Notes: *FPL* is federal poverty level. American Indian / Alaskan Native children may be eligible to have the premiums waived.

Sources: *Program Eligibility by Federal Poverty Level for 2019*, Covered California, October 2018, www.coveredca.com (PDF); "Medi-Cal Premium Payments for the 'Medi-Cal for Families' Program – Frequently Asked Questions," California Dept. of Health Care Services, September 28, 2018, www.dhcs.ca.gov; and *Community-Based Medi-Cal Programs Fact Sheet*, California Advocates for Nursing Home Reform, May 2, 2018, canhr.org (PDF).

While Medi-Cal is a no-cost program for most beneficiaries, there are some who pay small premiums or who are responsible for a share of the cost.

Waivers

States may use statutory authority to waive certain Medicaid rules, subject to federal approval. Medi-Cal operates 12 waiver programs, including the Medi-Cal 2020 demonstration waiver.

1915(B) FREEDOM OF CHOICE

PURPOSE

Permits states to implement service delivery models that restrict choice of providers, such as managed care. States may also use these to waive statewide requirements (e.g., limited geographic area) and comparability requirements.

EXAMPLE

Specialty Mental Health Services. Waives freedom of choice and creates county mental health plans to deliver specialty mental health services.

1915(C) HOME AND COMMUNITY-BASED SERVICES

PURPOSE

Authorize states to provide home and community-based services as an alternative to placement in a nursing home, hospital, or other long-term care facility.

EXAMPLES

HCBS for the Developmentally Disabled. For beneficiaries of any age with developmental and intellectual disabilities, including autism, assists with living in the community rather than an institution.

Nursing Facility / Acute Hospital Waiver. Provides case management, habilitation services, home health nursing, and other services for medically fragile and technology-dependent people of any age.

HIV/AIDS Waiver. Provides care coordination, respite care, personal care, expressive therapies, family counseling and training, and other services for medically fragile and technology-dependent people up to age 20.

Other 1915(c) waivers. Include Multipurpose Senior Services Program, Assisted Living, and In-Home Operations.

1115(A) RESEARCH AND DEMONSTRATION PROJECTS

PURPOSE

Gives broad authority to waive certain provisions of the Medicaid statutes related to state program design for "any experimental, pilot, or demonstration project likely to assist in promoting the objectives" of the programs.

EXAMPLES

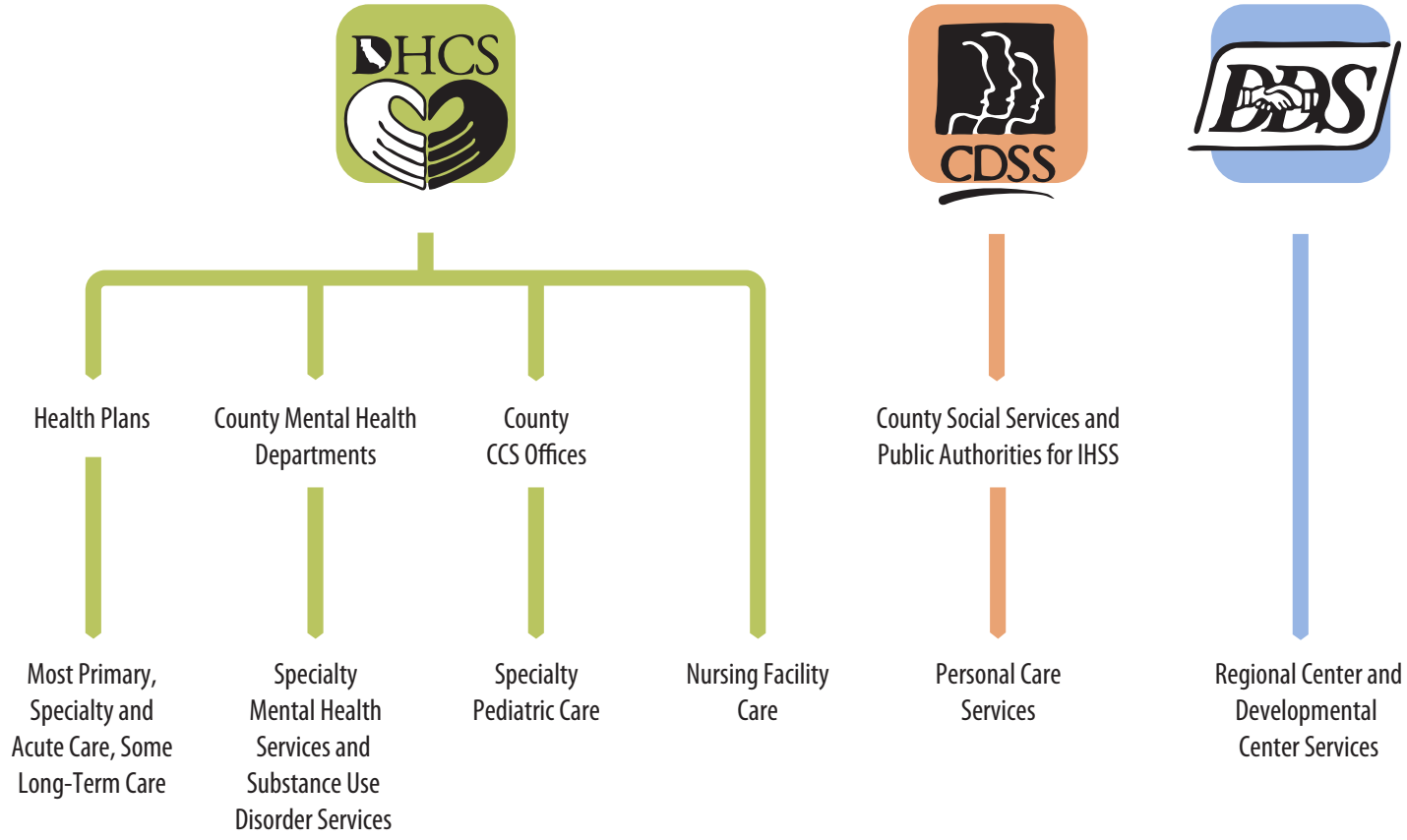
Medi-Cal 2020. Composed of five main programs:

- ***Public Hospital Redesign and Incentives in Medi-Cal.*** Changes care delivery to maximize health care value and strengthens ability to perform under risk-based alternative payment models.
- ***Global Payment Program.*** Establishes a statewide pool of funding for the remaining uninsured and provides incentives for primary and preventive care services.
- ***Whole Person Care pilot program.*** Coordinates physical health, behavioral health, and social services for high-risk, high-cost beneficiaries with poor health outcomes.
- ***Dental Transformation Initiative.*** Provides incentives to improve access to preventive services and continuity of care for dental services for Medi-Cal children.
- ***Drug Medi-Cal Organized Delivery System.*** Aims to demonstrate how organizing substance use disorder services along a continuum of care increases beneficiaries' success while decreasing system health care costs.

Sources: "Waivers," Medicaid and CHIP Payment and Access Commission, n.d., www.macpac.gov; and "Medi-Cal Waivers," California Dept. of Health Care Services, last modified November 9, 2018, www.dhcs.ca.gov.

Multiple Delivery Systems

Medi-Cal services are financed and administered through an array of state departments and local intermediaries.



Notes: *DHCS* is the California Department of Health Care Services. *CDSS* is the California Department of Social Services. *DDS* is the California Department of Developmental Services. *CCS* is the California Children's Services program for children with special health care needs. Public authorities are the employers of record and maintain a provider registry for those eligible for personal care services through the In-Home Supportive Services (IHSS) program. Developmental centers (for facility-based care) and regional centers (for community-based care) serve individuals with developmental disabilities. This is not a complete list of services provided by Medi-Cal. The budgets of other departments (e.g., aging, corrections, public health) also include some general fund spending for Medi-Cal services.

Managed Care vs. Fee-for-Service, May 2018

	MANAGED CARE	FEE-FOR-SERVICE
Availability	All 58 counties	All 58 counties
Market Share	82% of all beneficiaries	18% of all beneficiaries
Enrollment Population	**Mandatory** • Children • Pregnant women • Parents/caretaker relatives • Adults without dependents • Seniors and people with disabilities (not also in Medicare) **Voluntary** • Seniors and people with disabilities (dual eligibles) • Foster children and youth • All beneficiaries in San Benito County	• Dual eligibles, or those with Medicare • Foster children and youth • Long-term care • Those with other health insurance • Family PACT • Share of Cost Medi-Cal • Other beneficiaries without full-scope Medi-Cal • Beneficiaries who have received a medical exemption
Expenditures	49%	30%*
Covered Services	All essential health benefits required by the ACA, including: • Ambulatory services • Emergency services • Mental health and substance use disorder services • Hospitalization • Pediatric services • Prescription drugs	• Most long-term care • Specialty mental health • Substance use disorder services • Dental services • California Children's Services (CCS) for the seriously ill and disabled children and youth in certain counties†
Payment	The state pays plans a fixed monthly capitation rate for each member, also known as a per-member-per-month payment. Plans negotiate payment rates with most contracted network providers.	The state pays providers according to a fee schedule.
Carve-Outs	• California Children's Services for the seriously ill and disabled children and youth in certain counties† • Specialty mental health • Substance use disorder services • Most long-term care • Dental services	N/A

*Fee-for-service expenditures reported in the *Medi-Cal Estimate* does not include most of the "carved out" services — dental, mental health, and Drug Medi-Cal. These are reported as separate service category line items along with Medicare payments and other miscellaneous services. †CCS children enroll in managed care plans, which provide non-CCS services. For their CCS-related needs, they use fee-for-service CCS providers typically outside of the managed care plan. However, all CCS services will be delivered by the five County Organized Health Systems to CCS children in 21 counties. This CCS Whole Child Model is rolling out in two phases starting in July 2018 and January 2019.

Notes: *Family PACT* is the Family Planning, Access, Care, and Treatment Program. Medi-Cal beneficiaries in San Benito County may elect not to enroll in the single managed care plan and instead have all services provided to them by FFS providers.

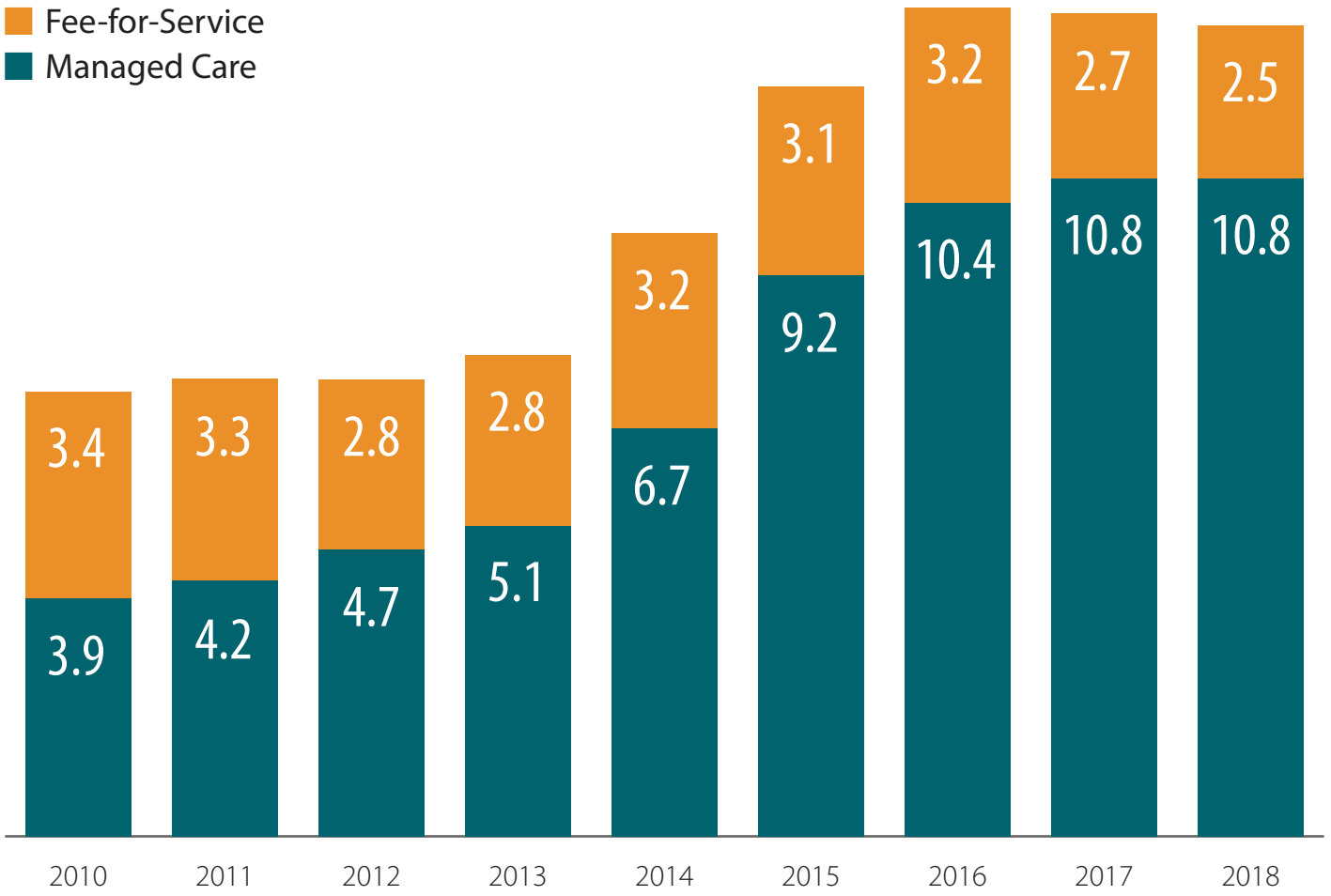
Sources: *Medi-Cal at a Glance: Most Recent Reported Month — May 2018*, California Dept. of Health Care Services (DHCS), n.d., www.dhcs.ca.gov (PDF); *Medi-Cal May 2018 Local Assistance Estimate for Fiscal Years 2017–18 and 2018–19*, DHCS, May 8, 2018, www.dhcs.ca.gov (PDF); "MMCD - Seniors & Persons with Disabilities (SPD)," DHCS, last modified January 21, 2015, www.dhcs.ca.gov; and "California Children's Services (CCS) Whole Child Model (WCM)," DHCS, last modified November 27, 2018, www.dhcs.ca.gov.

Eight in 10 beneficiaries are enrolled in managed care plans that account for nearly half of all Medi-Cal expenditures. The State determines mandatory or voluntary managed care enrollment, subject to federal approval.

Fee-for-Service and Managed Care Enrollment

January 2010 to January 2018

IN MILLIONS

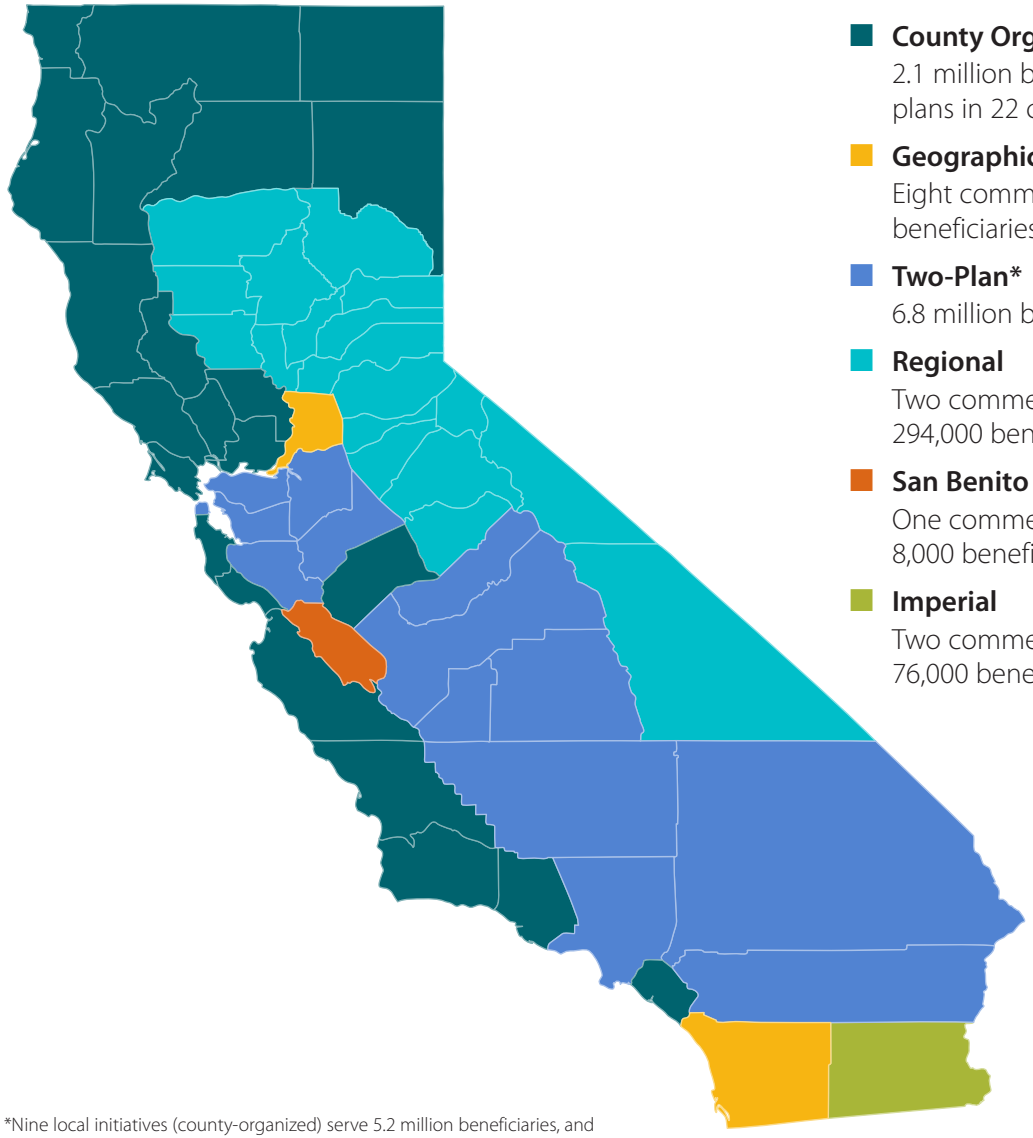


Note: Figures include restricted-scope Medi-Cal.

Sources: Medi-Cal Certified Eligibles Statewide Pivot as of June 2018, California Dept. of Health Care Services (DHCS), November 2018, www.dhcs.ca.gov; *Medi-Cal Monthly Enrollment Fast Facts, February 2016*, DHCS, May 2016, www.dhcs.ca.gov (PDF); and *Trend in Medi-Cal Program Enrollment by Managed Care Status – for Fiscal Year 2004–2012*, DHCS, July 2013, www.dhcs.ca.gov (PDF).

Most Medi-Cal beneficiaries are enrolled in managed care. Fee-for-service enrollment accounts for a shrinking share of the total.

Managed Care Models, by County, December 2018



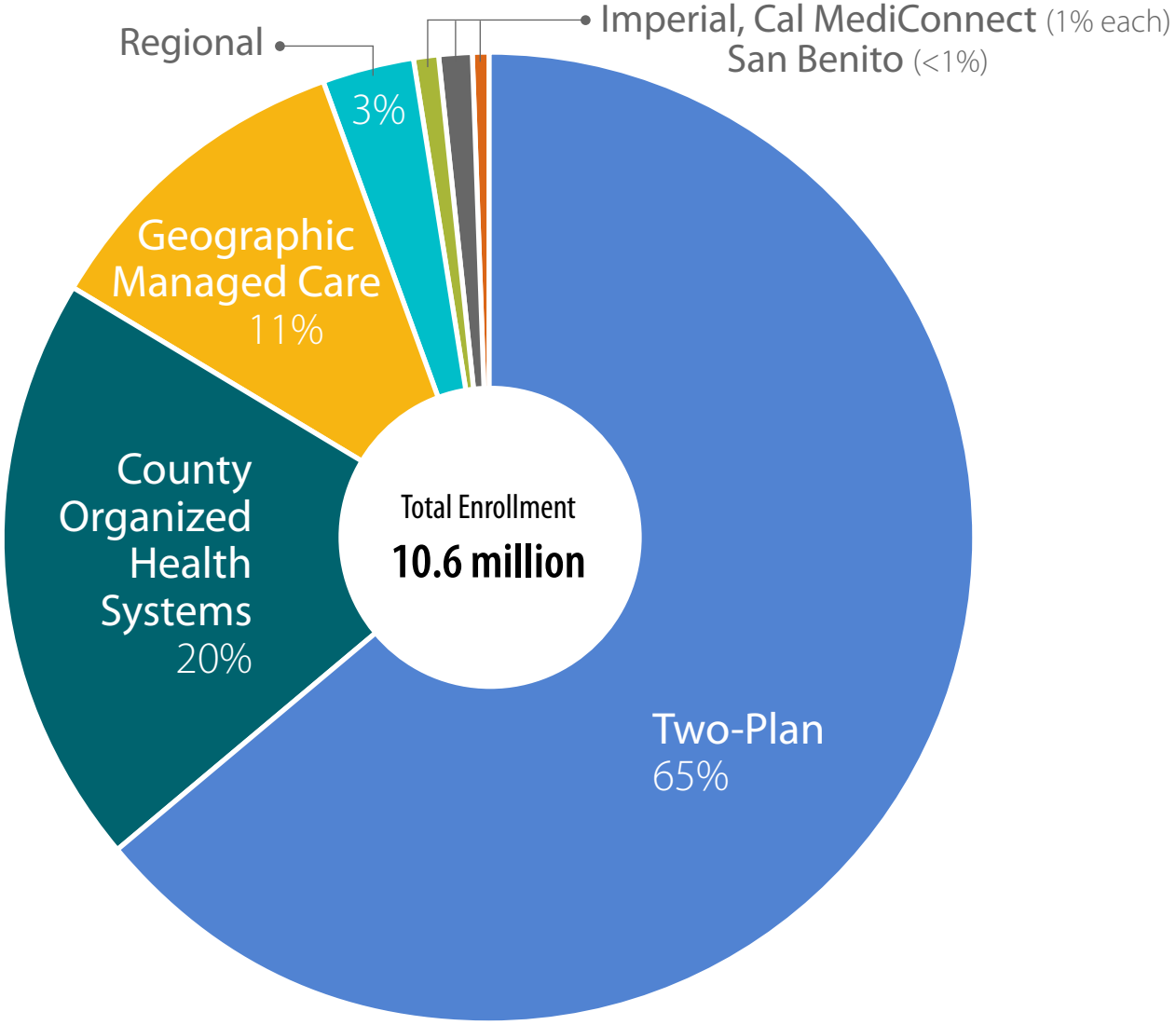
- **County Organized Health Systems (COHS)**
  2.1 million beneficiaries served by six health plans in 22 counties.
- **Geographic Managed Care (GMC)**
  Eight commercial plans serve 1.1 million beneficiaries in 2 counties.
- **Two-Plan***
  6.8 million beneficiaries in 14 counties
- **Regional**
  Two commercial plans serve about 294,000 beneficiaries in 18 counties.
- **San Benito**
  One commercial plan serves about 8,000 beneficiaries.
- **Imperial**
  Two commercial plans serve about 76,000 beneficiaries.

*Nine local initiatives (county-organized) serve 5.2 million beneficiaries, and three commercial plans serve 1.6 million beneficiaries. While Tulare is a two-plan model county, there is no local initiative and instead, beneficiaries choose between two commercial plans.

Sources: *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models*, California Dept. of Health Care Services (DHCS), n.d., www.dhcs.ca.gov (PDF); and *Medi-Cal Managed Care Enrollment Report – December 2018*, DHCS, January 2, 2019, www.dhcs.ca.gov (PDF).

In California, there are six models of managed care. The state expanded managed care into rural areas in September 2013.

Managed Care Enrollment, by Plan Type
December 2018



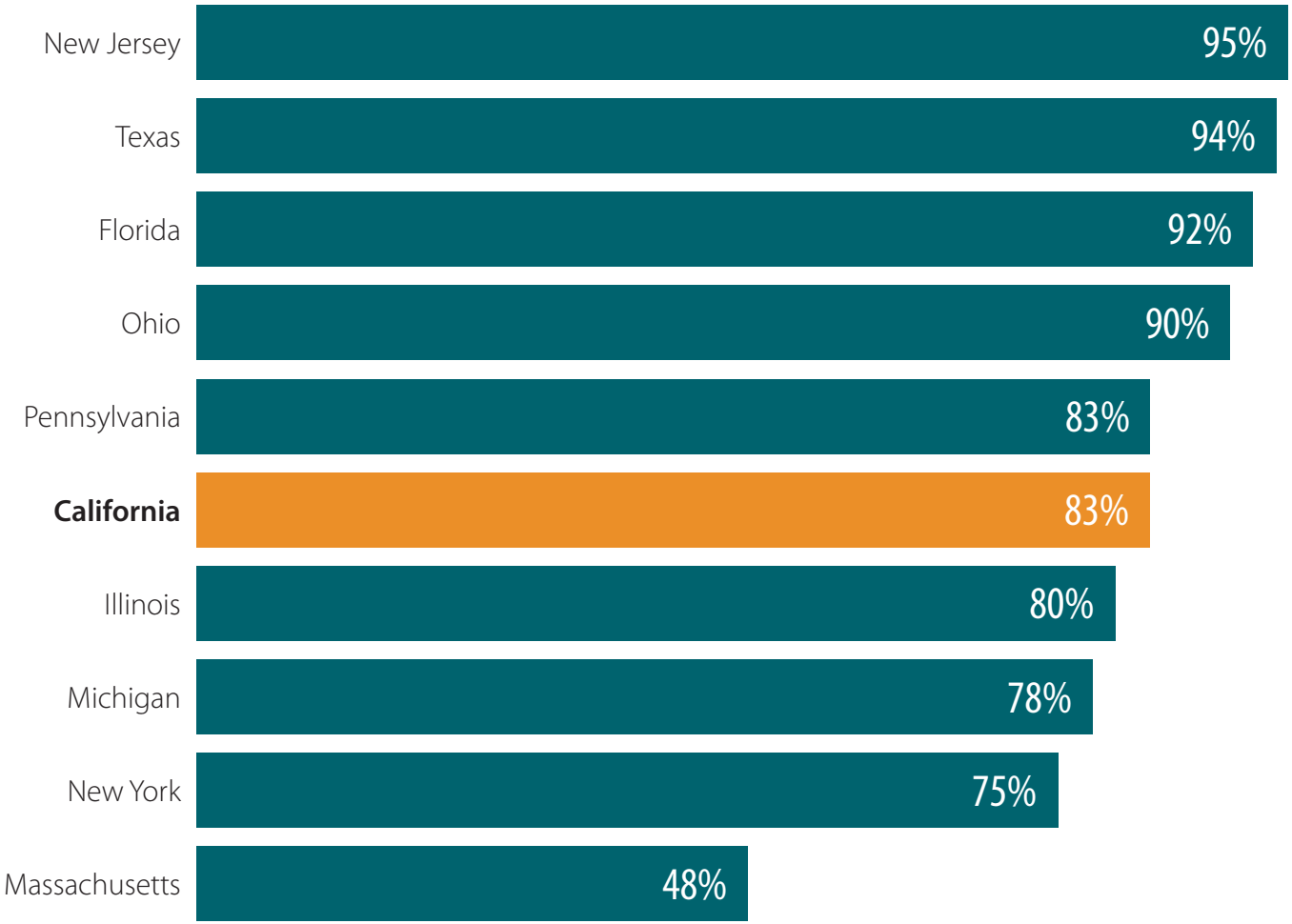
Notes: Primary Care Case Management (PCCM), which had 0.008% enrollment, is not shown. Segments do not total 100% due to rounding.

Source: *Medi-Cal Managed Care Enrollment Report – December 2018*, California Dept. of Health Care Services, January 2, 2019, www.dhcs.ca.gov (PDF).

The Medi-Cal program uses a variety of managed care models; some rely on county health plans, some rely on private health plans, and others use a combination of the two. The two-plan model, in which a government-run local initiative competes with a private health plan, had the largest enrollment.

Managed Care Penetration Rates

Selected States, as of July 1, 2018



Notes: States with the 10 largest Medicaid expenditures in FY 2017 are represented. The share reported may include some adults receiving limited Medicaid benefits, such as those receiving only family planning services.

Source: "Medicaid Managed Care Penetration Rates by Eligibility Group," Kaiser Family Foundation, last modified July 1, 2018, www.kff.org.

Enrollment in managed care has increased in California, especially since 2014 (see page 32). Many states with large Medicaid expenditures, however, have an even greater share of their Medicaid population enrolled in managed care.

Coordinated Care Initiative

- California enacted the Coordinated Care Initiative (CCI) in 2012 to provide better coordinated care to people with both Medicare and Medi-Cal, who are known as "dual eligibles."
- The goals of CCI are to:
  - Coordinate state and federal benefits to improve continuity of care.
  - Maximize the ability of dual eligible beneficiaries to remain in their homes and communities.
  - Increase the availability of and access to home- and community-based alternatives.
  - Preserve and enhance the ability of consumers to self-direct their care.
  - Optimize the use of Medicare, Medi-Cal, and other state and county resources.
- Cal MediConnect, part of the CCI and launched in April 2014, creates a single health plan covering all Medi-Cal and Medicare benefits and nine managed care plans in seven counties.* Dual eligible beneficiaries can choose to enroll in a Cal MediConnect plan and receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services.
- Of the 1.4 million dual eligible beneficiaries in California in September 2018, 111,717 were enrolled in Cal MediConnect plans. The demonstration has been extended for two years, until December 31, 2020.

The Coordinated Care Initiative is California's demonstration program designed to better coordinate care for dual eligibles (those eligible for both Medicare and Medi-Cal) via Cal MediConnect plans in seven counties.

*This applies to Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara Counties.

Sources: "Medi-Cal's Coordinated Care Initiative (CCI): The Duals Demonstration," California Dept. of Health Care Services (DHCS), October 12, 2015, www.dhcs.ca.gov; and *Medi-Cal Managed Care Enrollment Report – September 2018*, DHCS, October 1, 2018, www.dhcs.ca.gov (PDF).

Managed Care Carve Outs

Certain Medi-Cal services are "carved out." Carved-out services have separate funding mechanisms and delivery systems.

Services that are offered under Medi-Cal but not provided by the managed care plan are referred to as "carve outs," and include the following services:

- **Specialty Mental Health Services (SMHS)** are provided by county mental health plans to adults with a serious mental illness and to children with a serious emotional disturbance. SMHS include targeted case management, partial hospitalization, and outpatient and inpatient mental health services.
- **Substance use disorder** services are provided through the Drug Medi-Cal program, which provides on-demand treatments, including outpatient drug-free services, intensive outpatient services, detoxification services, medication-assisted treatment, and residential recovery services.
- **Dental services** are available on a fee-for-service basis through the Denti-Cal program. Denti-Cal provides preventive, diagnostic, restorative, and periodontal services. In Los Angeles and Sacramento Counties, dental services are provided through dental managed care plans.
- **Long-Term Services and Supports (LTSS)** include the use of home- and community-based services intended to keep beneficiaries out of long-term care facilities such as nursing homes. LTSS are carved out of managed care, except for plans operating in Coordinated Care Initiative counties where services are part of a Managed Long-Term Services and Supports (MLTSS) benefit.
- **Long-term care services** are provided under most managed care contracts for only two months. A beneficiary requiring a longer stay in the long-term care facility is disenrolled from the plan and moved to fee-for-service, where DHCS is responsible for all covered services.*
- **California Children's Services (CCS)** program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. The CCS Whole Child Model program will be implemented in 21 counties and five health plans in two phases starting in July 2018 and January 2019.

*One exception is that long-term care is covered in most County Organized Health System plans and for plans operating in the Coordinated Care Initiative. These health plans maintain responsibility for all long-term care costs and are paid a per-member-per-month rate as described above for a long-term care category of aid.

Sources: *California Medi-Cal Dental Services: 2018 Beneficiary Handbook*, California Dept. of Health Care Services (DHCS), May 2018, www.denti-cal.ca.gov (PDF); "Medi-Cal Specialty Mental Health Services," DHCS, last modified December 18, 2017, www.dhcs.ca.gov; Sarah C. Brooks (chief, Managed Care Quality and Monitoring Div., DHCS) to all Medi-Cal managed health care plans, all-plan letter 14-017, December 12, 2014, www.dhcs.ca.gov (PDF); and "California Children's Services (CCS) Whole Child Model (WCM)," DHCS, last modified November 27, 2018, www.dhcs.ca.gov.

Long-Term Care

- Long-term care typically refers to intermediate care facilities for the developmentally disabled and nursing homes.
- State Medicaid programs are the principal funders of long-term care services for low-income seniors and people with disabilities. A majority of California nursing home residents are on Medi-Cal, and most using long-term care are dually eligible for Medi-Cal and Medicare.
- Eligibility requirements for Medi-Cal long-term care services are based on income and having limited personal property and savings (asset test). Some people with higher incomes are eligible but may pay a share of the cost.
- Medi-Cal uses benefits and programs that serve as alternatives to placement in long-term care facilities. These include home- and community-based services (HCBS), in-home supports and services (IHSS), the Community First Choice (CCT) Option, the Multipurpose Senior Services Program (MSSP), and the Program for All-Inclusive Care for the Elderly (PACE).
- Medi-Cal spending on in-home support and community-based services is greater than on institutional placement. In FY 2017–18, Medi-Cal spent $3.2 billion on long-term care facilities but spent $4.2 billion on programs including HCBS, IHSS, CCT, and MSSP.

Medi-Cal prioritizes keeping seniors and people with disabilities living in the community with in-home support and services.

Sources: *If You Think You Need a Nursing Home: A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility*, California Advocates for Nursing Home Reform, January 2019, www.canhr.org (PDF); "Integrated Care: What Options Exist for Californians with Medicare and Medi-Cal?," The SCAN Foundation, June 2017, www.thescanfoundation.org; and *Medi-Cal May 2017 Local Assistance Estimate for Fiscal Years 2016–17 and 2017–18*, California Dept. of Health Care Services, May 5, 2017, www.dhcs.ca.gov (PDF).

Behavioral Health Services Delivery

Managed Care Plans

- Medi-Cal managed care plans are responsible for individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management, as required by the ACA's essential health benefits.
- Services addressing mild-to-moderate behavioral health needs are delivered on an outpatient basis.

County Mental Health Plans

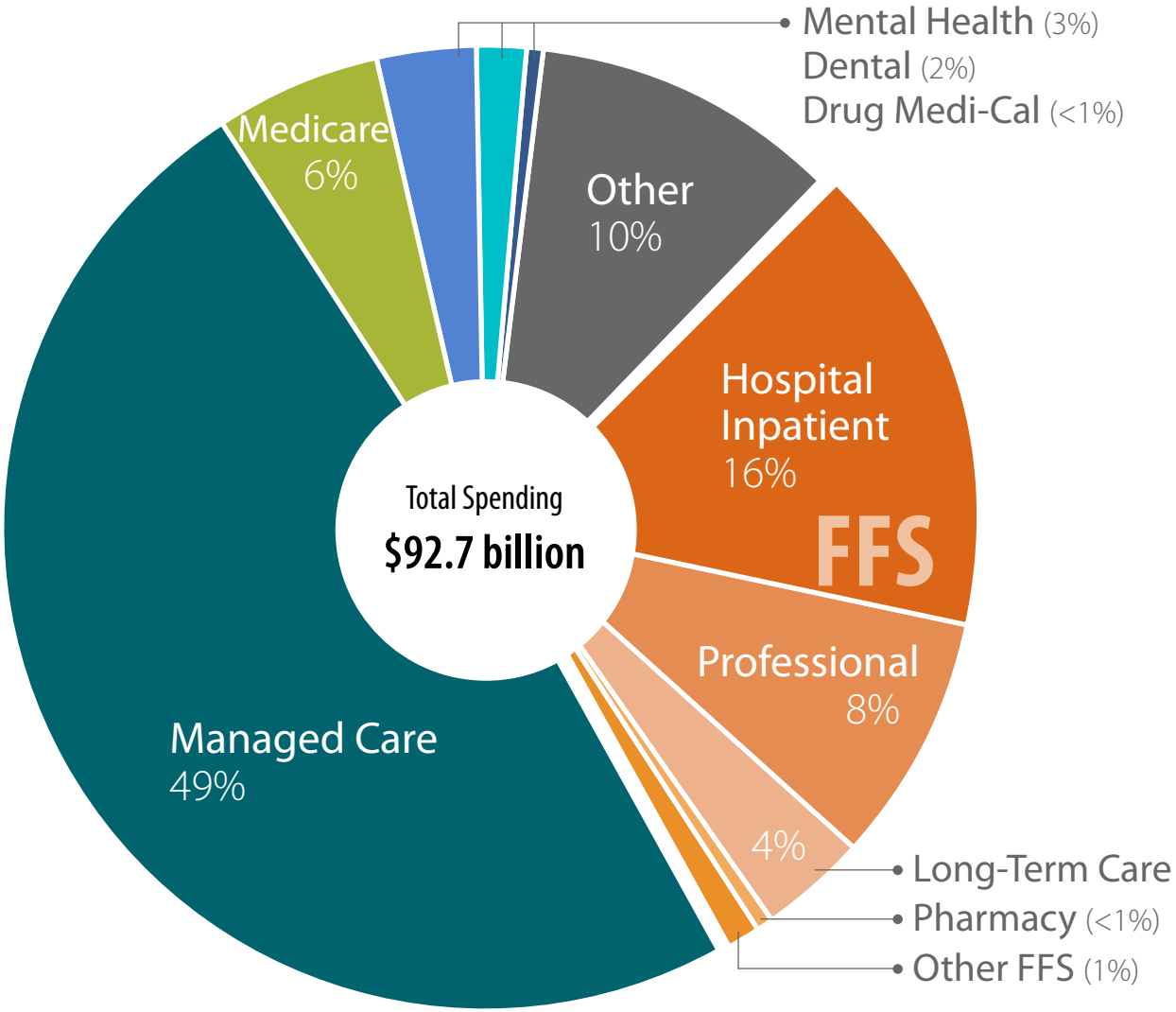
- County mental health plans are responsible for the assessment and treatment of beneficiaries with serious mental illness or substance use disorder needs.
- Adults with a serious mental illness and children with a serious emotional disturbance can receive specialty mental health services, which include crisis intervention, rehabilitation, targeted case management, partial hospitalization, and outpatient and inpatient mental health services.
- Substance use disorder services are also delivered by county mental health plans through the Drug Medi-Cal program. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program aimed at improving care, increasing efficiency, and reducing societal and health care costs associated with substance use. Twenty-two counties have launched DMC-ODS pilots, and 18 others are pending.
- In FY 2016–17, about 4% of beneficiaries (259,870 children and youth and 341,362 adults) used a specialty mental health service.

The California Department of Health Care Services requires managed care plans and county mental health plans to have memorandums of understanding that specify policies and procedures for screening, referral, care coordination, information exchange, and dispute resolution in each county.

Sources: *Statewide Aggregate Specialty Mental Health Services Performance Dashboard*, California Dept. of Health Care Services, March 13, 2018, www.dhcs.ca.gov (PDF); and Don Kingdon, Molly Brassil, and Erynne Jones, "The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions," California Health Care Foundation, August 2016, www.chcf.org.

Medi-Cal benefits include mental health and substance use disorder services. Service delivery is bifurcated between managed care plans and county mental health plans depending on a beneficiary's needs. This often results in poorly coordinated care, as beneficiaries must move between systems as their mental health needs change.

Distribution of Medi-Cal Spending
by Service Category, FY 2017–18

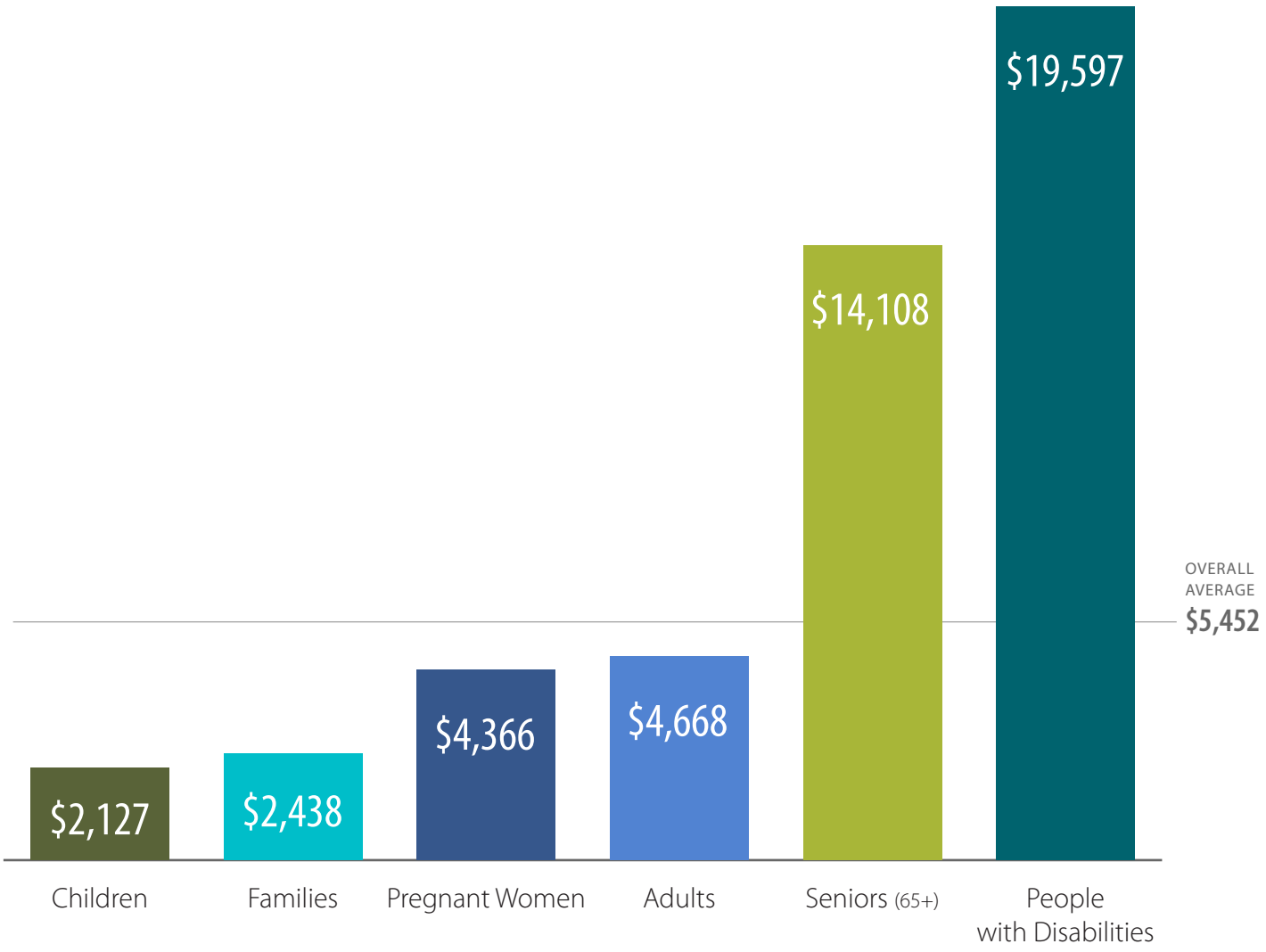


Notes: Figures presented are estimates for FY 2017–18, as of May 2018 and presented in the Medi-Cal estimate. *Drug Medi-Cal* is a program that provides services to treat beneficiaries with substance use disorders. *Other* includes medical transportation; home health; audits/lawsuits; Early and Periodic Screening, Diagnostic, and Treatment screens; state hospitals / developmental centers; recoveries; and other miscellaneous services. *FFS* is fee-for-service. Segments may not total 100% due to rounding.

Source: "Medi-Cal Expenditures by Service Category, FY 2017–18," in *Medi-Cal May 2018 Local Assistance Estimate for Fiscal Years 2017–18 and 2018–19*, California Dept. of Health Care Services, May 8, 2018, www.dhcs.ca.gov (PDF).

Managed care organizations were the largest service category in the Medi-Cal program, accounting for nearly half of all service payments. Hospital inpatient services was the next largest category, accounting for 16% of Medi-Cal spending.

Medi-Cal Annual Spending per Beneficiary
by Eligibility Category, FY 2017–18

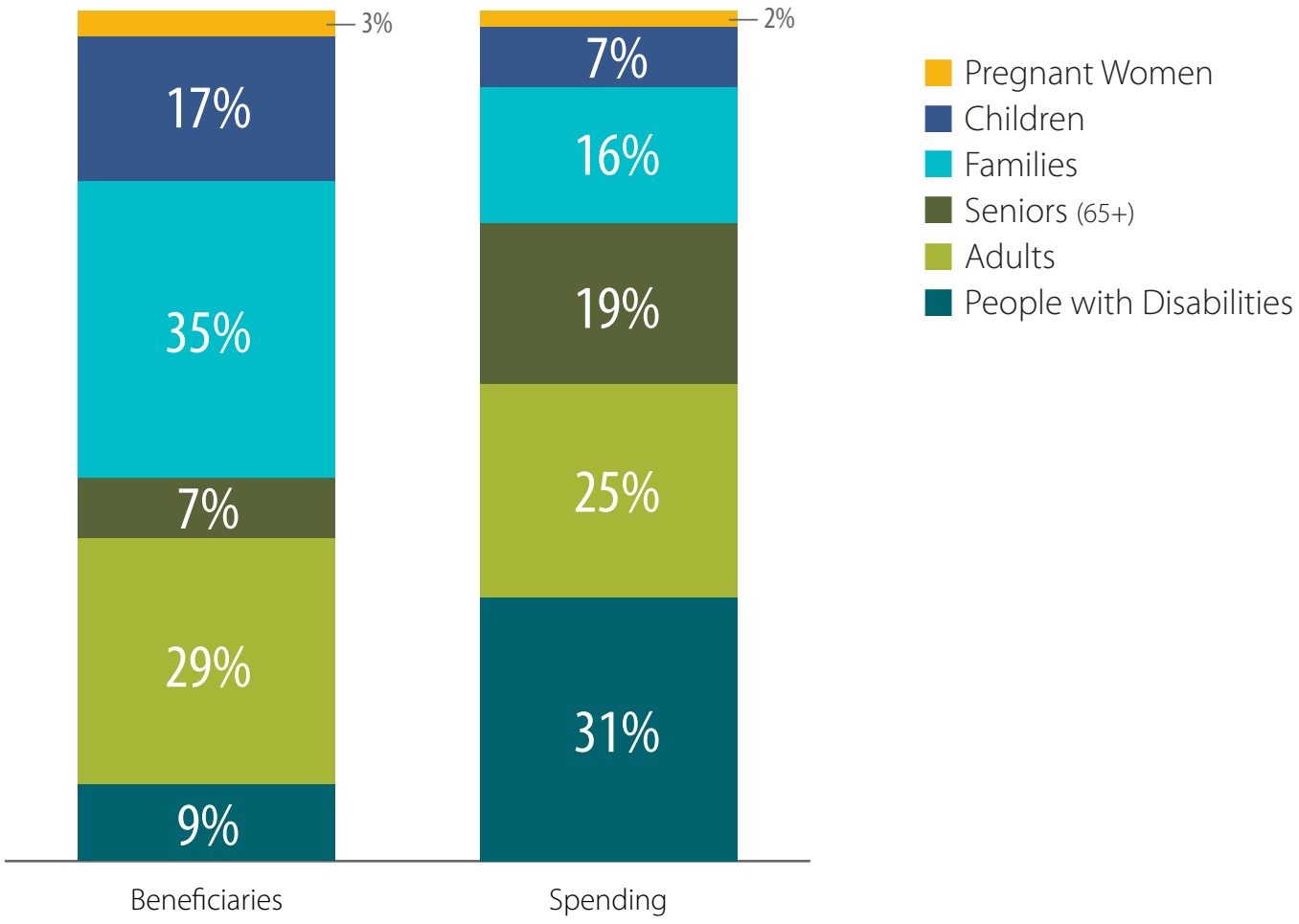


Note: Figures presented are estimates for FY 2017–18, as of May 2018.

Source: "Fiscal Year 2017–18 Cost per Eligible Based on May 2018 Estimate," in *Medi-Cal May 2018 Local Assistance Estimate for Fiscal Years 2017–18 and 2018–19*, California Dept. of Health Care Services, May 8, 2018, www.dhcs.ca.gov (PDF).

Medi-Cal spending per beneficiary varied by eligibility category. Medi-Cal spent about $2,000 annually per child. The program spent almost $20,000 annually per beneficiary for people with disabilities.

Beneficiaries and Spending
by Eligibility Category, FY 2017–18



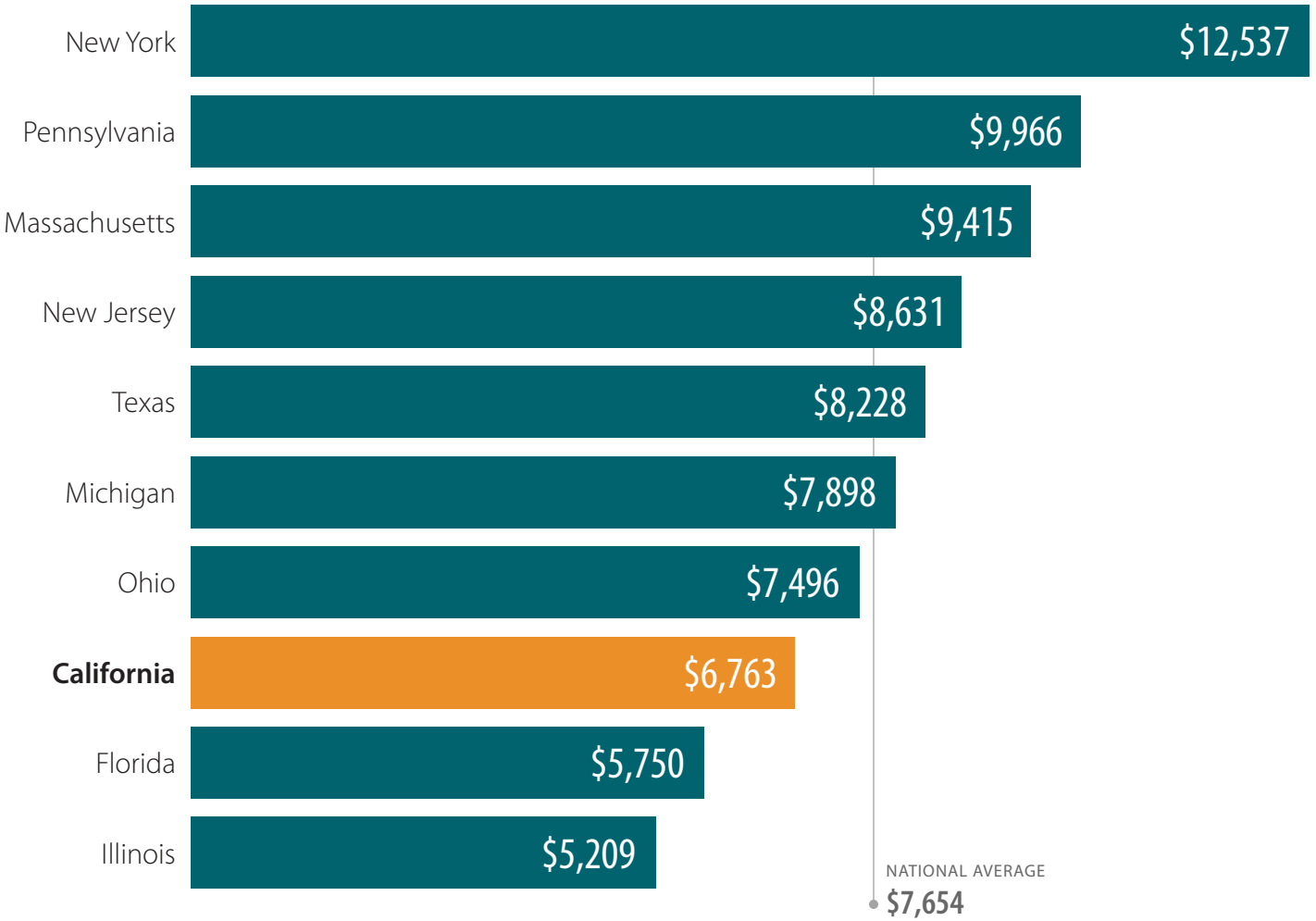
Notes: Figures presented are estimates for FY 2017–18, as of May 2018. Reported values exclude Hospital Presumptive Eligibility and other aid codes totaling 0.2% of beneficiaries.

Source: "Fiscal Year 2017–18 Cost per Eligible Based on May 2018 Estimate," in *Medi-Cal May 2018 Local Assistance Estimate for Fiscal Years 2017–18 and 2018–19*, California Dept. of Health Care Services, May 8, 2018, www.dhcs.ca.gov (PDF).

People with disabilities composed 9% of Medi-Cal beneficiaries, but accounted for 31% of spending. In comparison, children and families accounted for 52% of beneficiaries, but just 23% of spending.

Medicaid Benefit Spending per Full-Year Equivalent Enrollee

Selected States, FY 2017



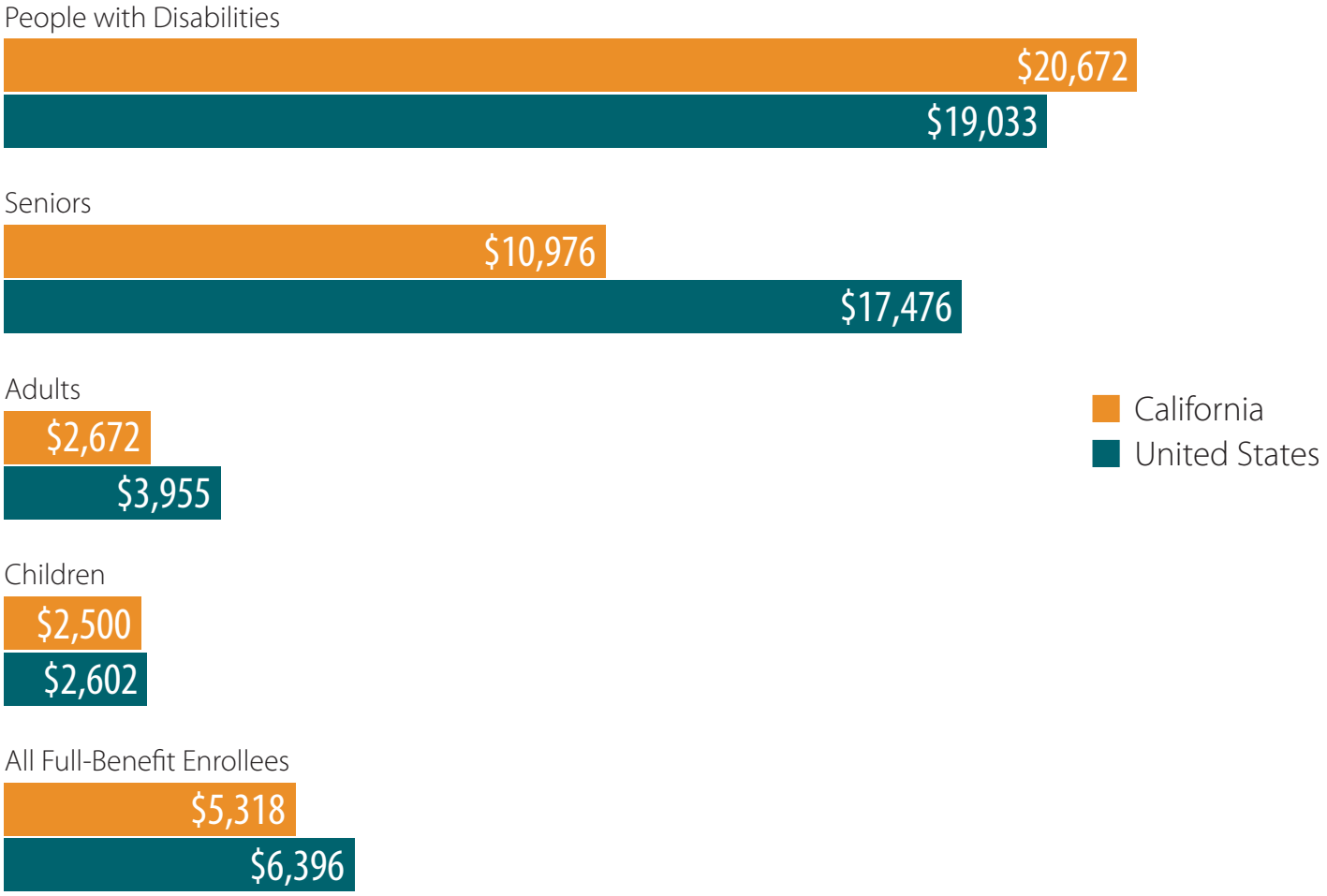
Notes: States with the 10 largest Medicaid programs based on FY 2017 expenditures are represented. *Full-year equivalent* may also be referred to as average monthly enrollment. Includes spending for disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority.

Source: *MACStats: Medicaid and CHIP Data Book*, Medicaid and CHIP Payment and Access Commission, December 2018, www.macpac.gov (PDF).

California spends less per full-year equivalent enrollee than both the national average and most other large states.

Medicaid Spending per Full-Benefit Enrollee

California vs. United States, FY 2014

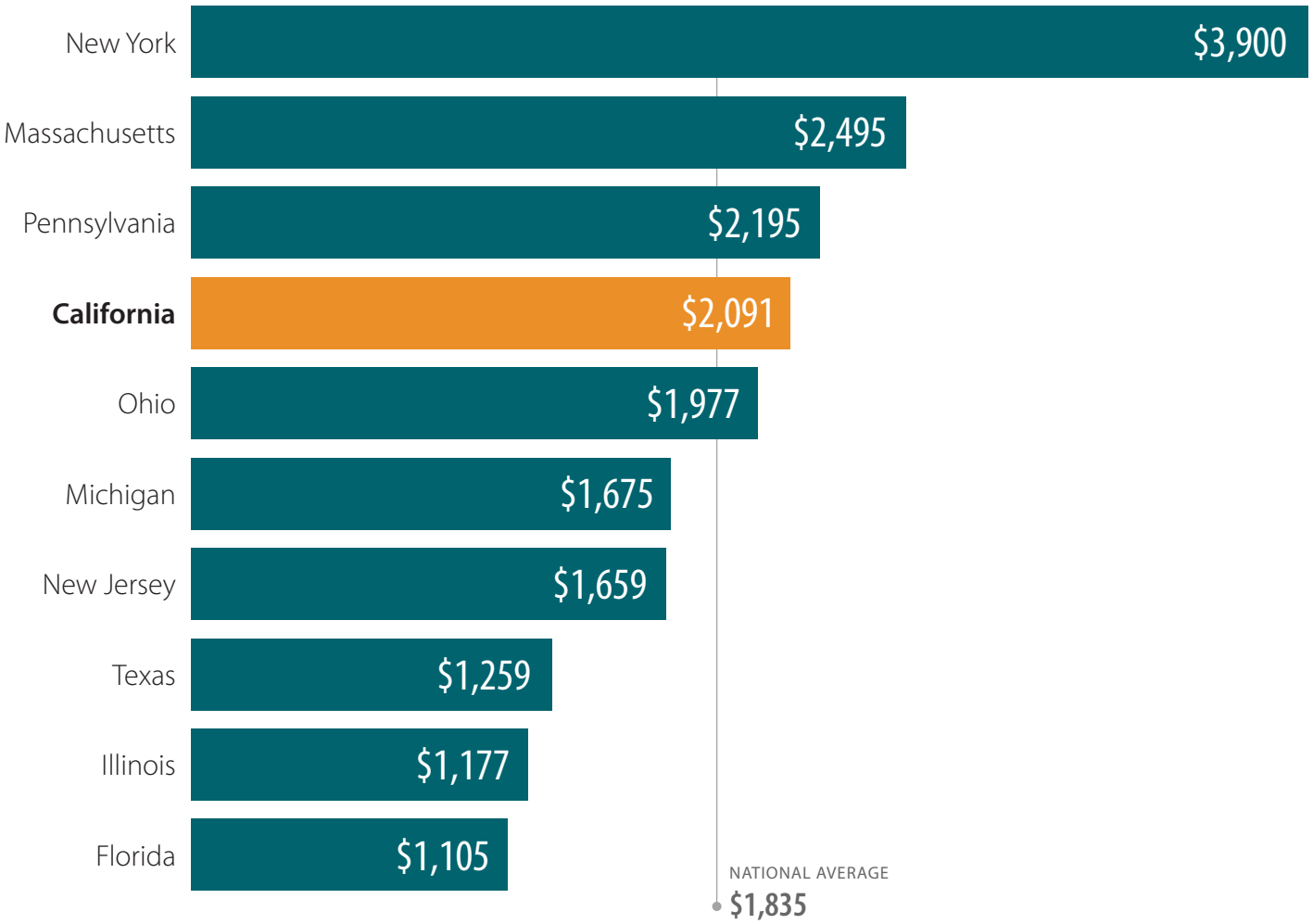


With the exception of people with disabilities, California's per enrollee spending is lower than the national average.

Notes: Figures represent the average level or payments across full-benefit enrollees only during fiscal year 2014, based on date of payment. Enrollees are identified as full benefits if for each month they were enrolled in Medicaid they also received full benefits or received Medicaid benefits through an alternative package of benchmark equivalent coverage.

Source: "Medicaid Spending per Full-Benefit Enrollee," Kaiser Family Foundation, www.kff.org.

Spending per State Resident
Selected States, FY 2017



Note: States with the 10 largest Medicaid programs based on FY 2017 expenditures are represented.

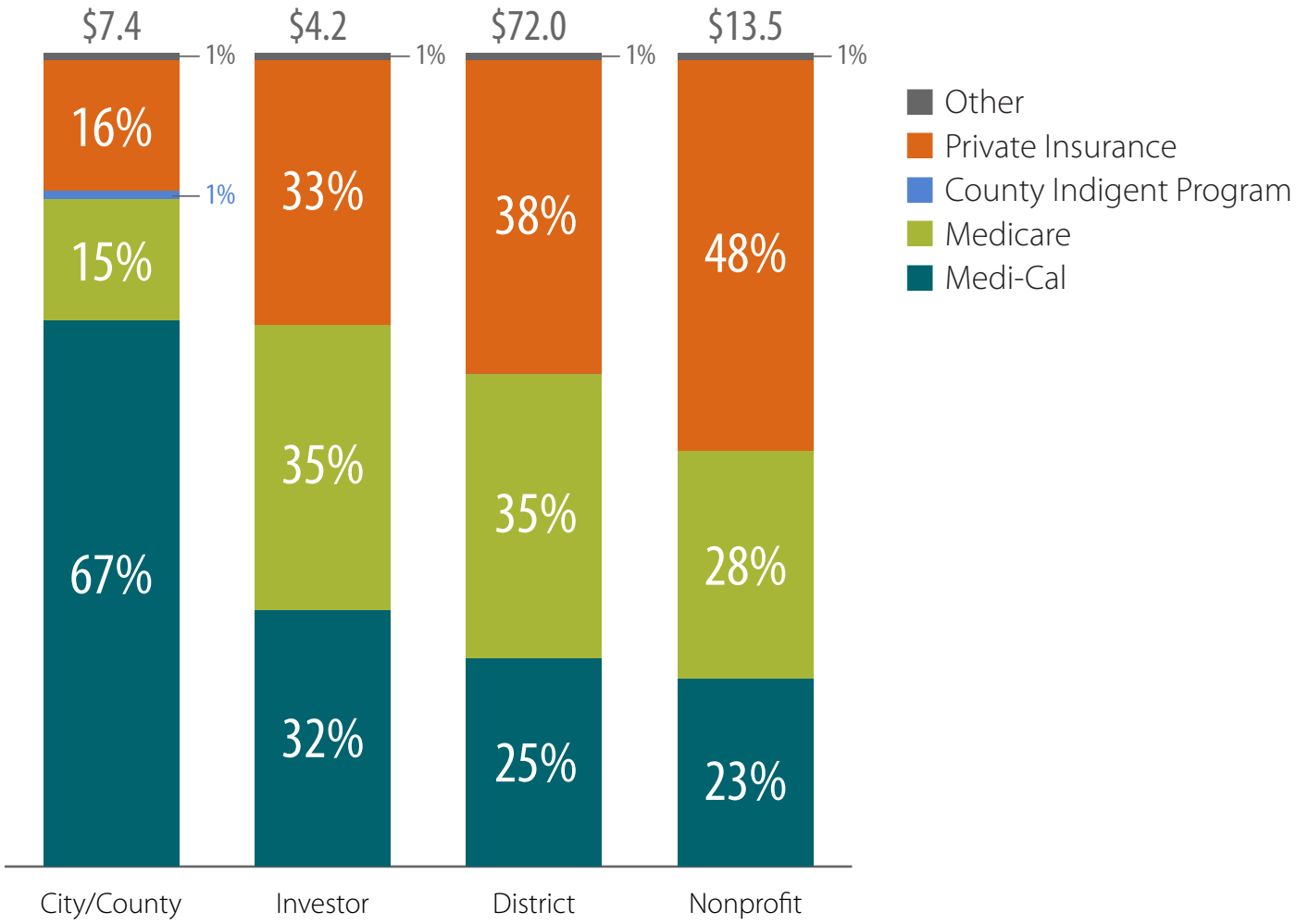
Sources: Author calculations based on "Exhibit 23," in *MACStats: Medicaid and CHIP Data Book*, Medicaid and CHIP Payment and Access Commission, December 2018, www.macpac.gov (PDF); and *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2017*, US Census Bureau, www.census.gov.

While California's Medicaid program has the largest enrollment in the nation, spending per state resident ($2,091) was lower than New York ($3,900), Massachusetts ($2,495) and Pennsylvania ($2,195).

Net Patient Revenues

by Hospital Ownership Type and Payer, 2016

IN BILLIONS



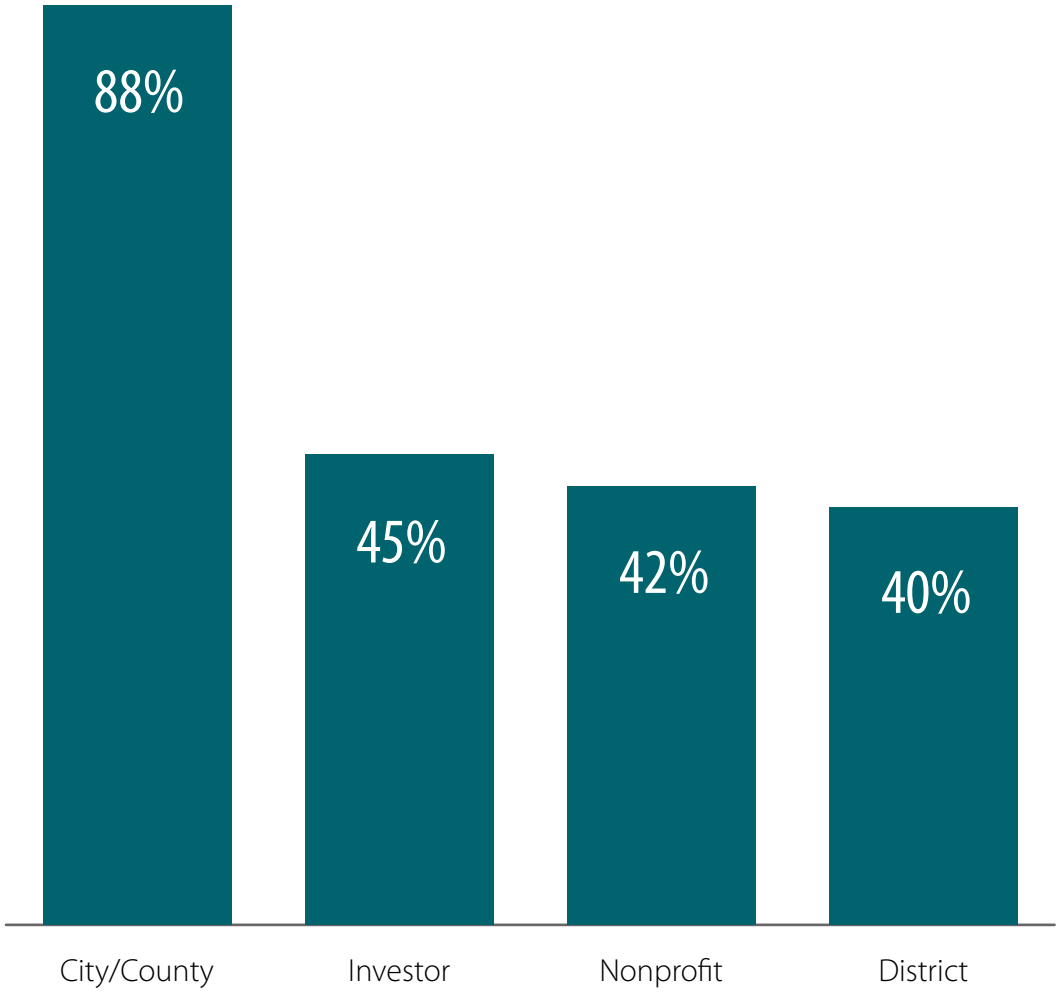
Notes: Data are only for hospitals classified as comparable by the Office of Statewide Health Planning and Development (OSHPD) and thus do not include state-run and Kaiser hospitals or facilities classified as psychiatric or long-term care. Segments may not total 100% due to rounding.

Source: *2016 Pivot Table - Hospital Annual Selected File (September 2018 Extract)*, California Health and Human Services Agency, last modified September 25, 2018, data.chhs.ca.gov.

Medi-Cal Facts and Figures
Role in the System

Medi-Cal is a key source of funding for hospitals. Medi-Cal was the primary revenue source for city/county hospitals, making up two-thirds (67%) of the net patient revenue. For investor-owned hospitals, Medi-Cal made up nearly a third of the net patient revenue (32%).

Change in Medi-Cal Net Patient Revenue
by Hospital Ownership Type, 2013 to 2017

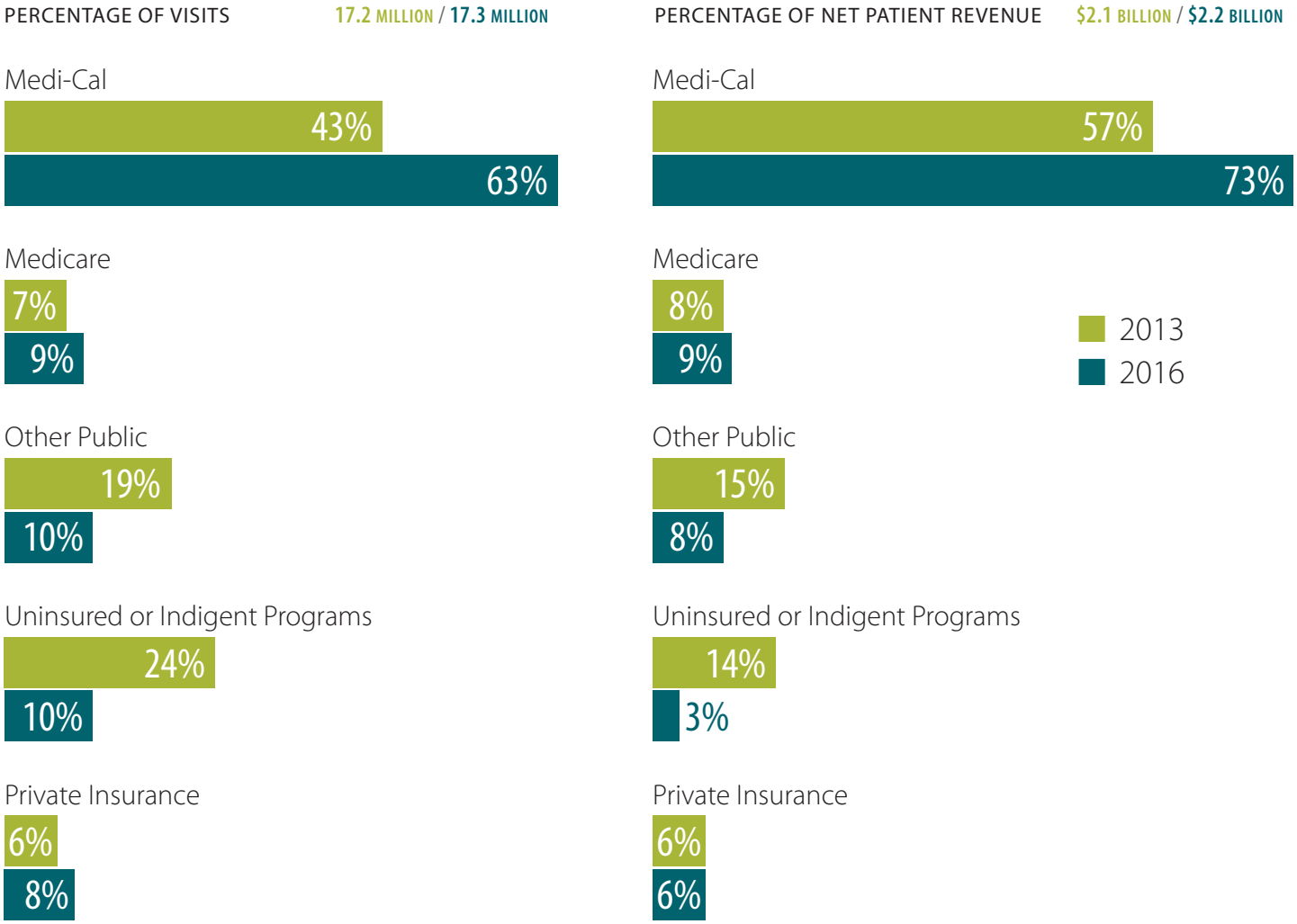


Note: Data are only for hospitals classified as comparable by the Office of Statewide Health Planning and Development (OSHPD) and thus do not include state and Kaiser hospitals or facilities classified as psychiatric or long-term care.

Sources: Author calculations based on *2017 Pivot Table - Hospital Annual Selected File (September 2018 Extract)*, California Health and Human Services Agency (CHHS), last modified September 25, 2018, and *2013 Pivot Table Hospital Annual Selected File*, CHHS, last modified September 15, 2015, data.chhs.ca.gov.

All hospital types experienced a growth in Medi-Cal revenue between 2013 and 2017, likely a result of the ACA expansion in 2013. Investor and City/county hospitals experienced the largest growth in Medi-Cal net patient revenue (88%).

Primary Care Clinic Visits and Net Patient Revenue
by Payer, 2013 and 2016

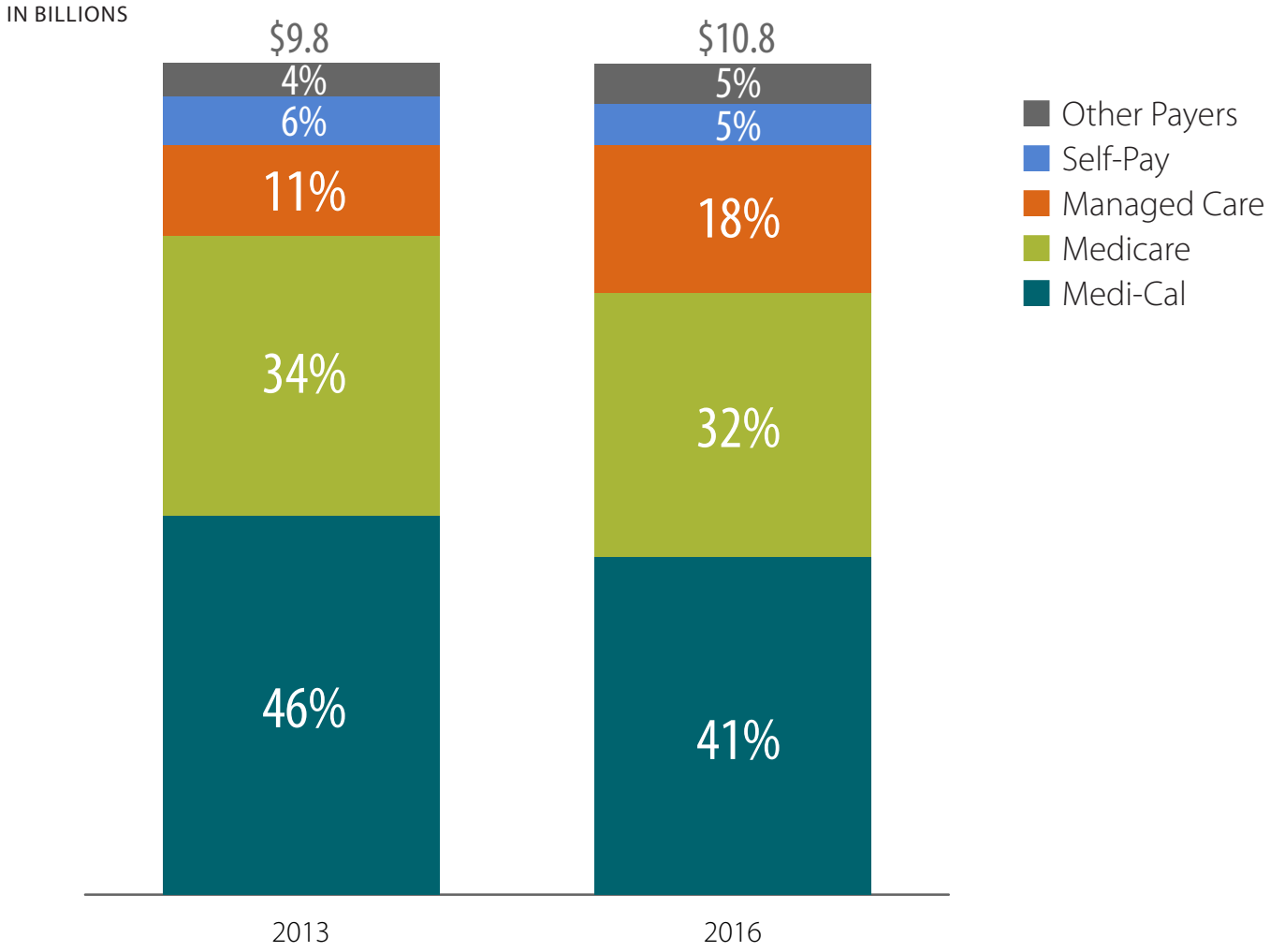


Notes: Includes Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and other clinic types. Excludes clinics with no patient encounters and dental clinics (those with >90% of procedures for dental services). Uninsured and indigent coverage are combined due to data-reporting inconsistencies, and include self-pay/sliding scale, free, and county indigent program patients. *Other public* includes Alameda Alliance for Health, Family PACT, and all other payers. Excludes county-run clinics. Segments may not total 100% due to rounding.

Sources: Blue Sky Consulting Group analysis of *2016 Pivot Table - Primary Care Clinics Annual Utilization Data* and *2013 Pivot Table Primary Care Utilization Data*, California Health and Human Services Agency, data.chhs.ca.gov.

The percentage of Medi-Cal visits and net patient revenues in primary care clinics increased significantly since 2013, just before the implementation of the Affordable Care Act in 2014. Medi-Cal visits increased from 43% of visits in 2013 to 63% in 2016. Both visits and revenue from uninsured patients declined as more patients were enrolled in Medi-Cal.

Long-Term Care Facilities Revenue
by Payer, 2013 and 2016



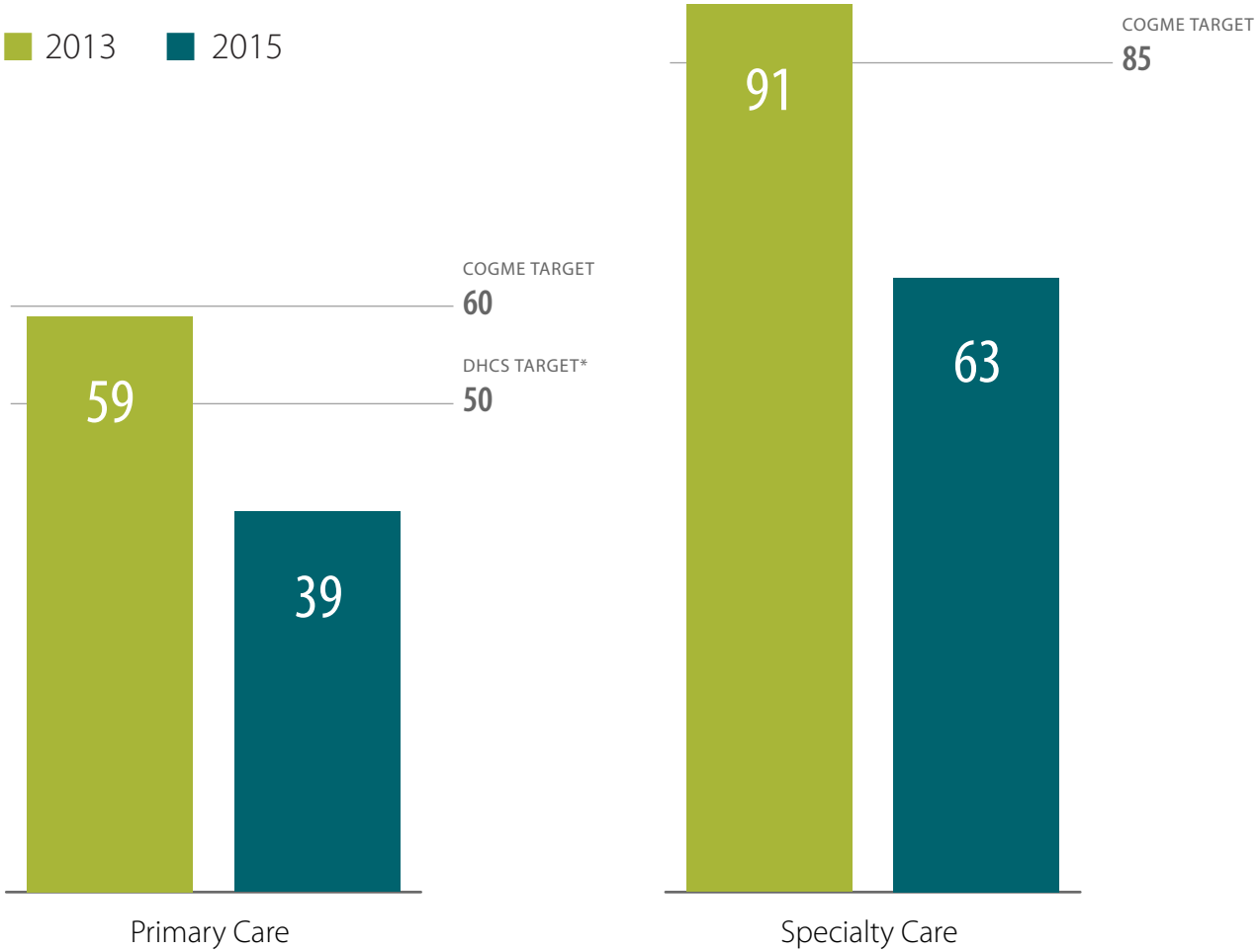
Notes: *Long-term care* includes those facilities providing sub-acute and intermediate care, skilled nursing, and facilities for the developmentally disabled. *Managed care* patients are patients enrolled in a managed care health plan who receive all or part of their health care from providers on a prenegotiated or per diem basis, usually involving utilization review. This includes health maintenance organizations (HMOs), HMOs with point-of-service option, preferred provider organizations (PPOs), exclusive provider organizations (EPOs), EPOs with point-of-service option, etc. Also includes patients enrolled in Medicare and Medi-Cal managed care health plans. Segments do not total 100% due to rounding.

Sources: *2016 Pivot Table – Long-Term Care Facilities Utilization Data* and *2013 Pivot Table – Long-Term Care Facilities Utilization Data*, California Health and Human Services Agency, chhs.ca.gov.

Medi-Cal provided an important source of revenue for long-term care facilities. Even though the share of revenues from Medi-Cal was down slightly from 2013, Medi-Cal accounted for 41% of all long-term care facilities revenues in 2016.

Full-Time Equivalent Physicians Participating in Medi-Cal
California, 2013 and 2015

PER 100,000 FULL-SCOPE BENEFICIARIES



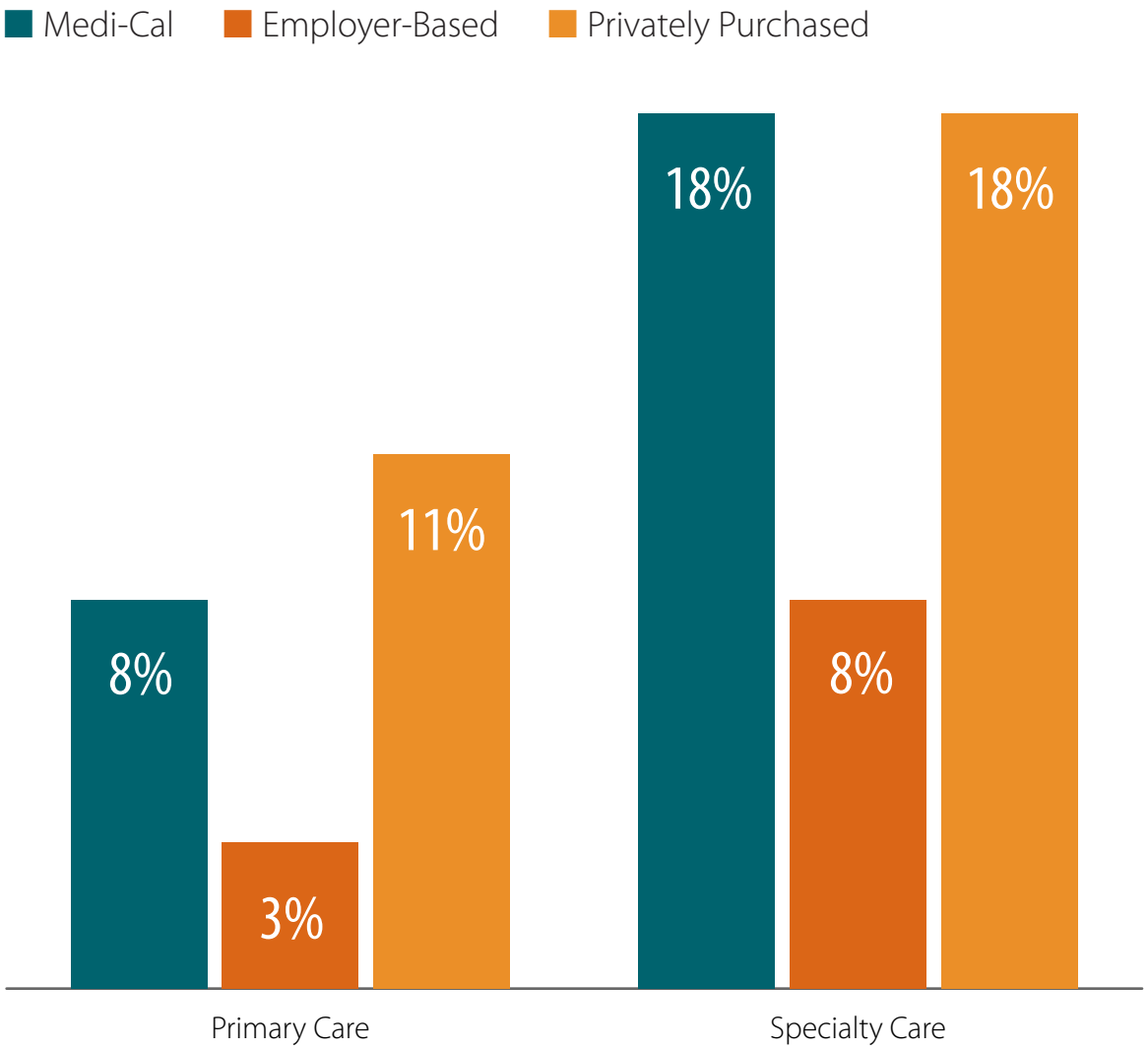
*N/A for specialty care.

Notes: The California Department of Health Care Services (DHCS) and the Council on Graduate Medical Education (COGME) establish targets for the adequate number of physicians to provide care. COGME is a federal advisory committee.

Source: Janet Coffman and Margaret Fix, *Physician Participation in Medi-Cal: Is Supply Meeting Demand?*, California Health Care Foundation, June 28, 2017, www.chcf.org.

After implementation of the ACA in 2014, Medi-Cal enrollment expanded, but the number of physicians accepting Medi-Cal did not keep pace. From 2013 to 2015, the number of FTE physicians participating in Medi-Cal increased by 9%, while the number of Medi-Cal enrollees with full-scope benefits grew by 60% (not shown). The number of physicians participating in Medi-Cal per 100,000 beneficiaries decreased between 2013 and 2015 from 59 to 39 for primary care and from 91 to 63 for specialty care. These rates are below the standards set by the DHCS and the Council on Graduate Medical Education.

Insurance Not Accepted by Provider
Adults, 2017

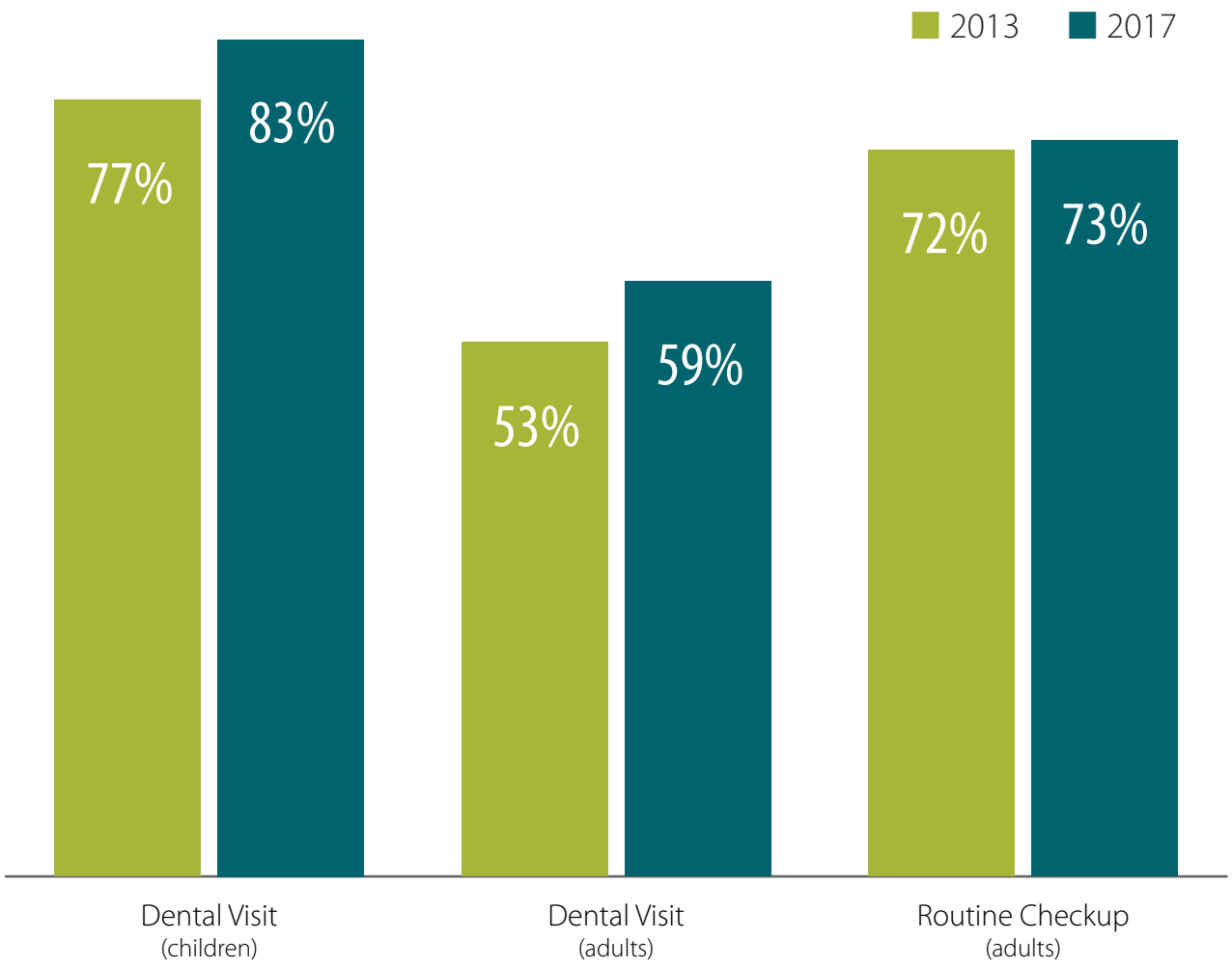


Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Medi-Cal beneficiaries were more than twice as likely to report difficulty finding a provider that accepted their insurance than those with employer-based coverage. This pattern held for both primary and specialty care.

Preventive Care Visits
2013 and 2017

PERCENTAGE OF MEDI-CAL BENEFICIARIES WHO HAD THE FOLLOWING PREVENTIVE CARE WITHIN THE PAST YEAR



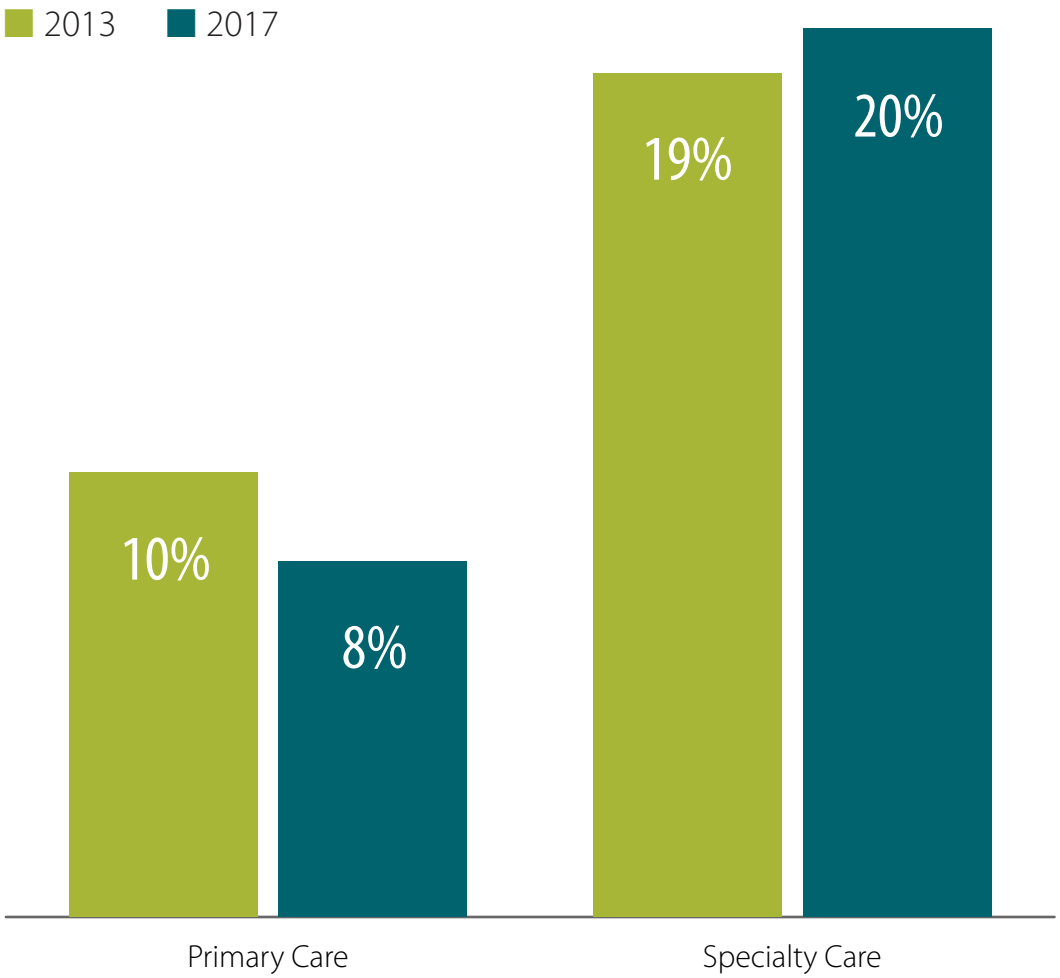
Note: *Medi-Cal beneficiaries* includes dual eligibles and Healthy Families enrollees.

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Although enrollment significantly increased between 2013 and 2017, a majority of beneficiaries were able to access important health care services. A slightly larger proportion of children and adults with Medi-Cal coverage had a dental care visit in 2017 than in 2013.

Difficulty Finding Primary and Specialty Care
2013 and 2017

PERCENTAGE OF ADULT MEDI-CAL BENEFICIARIES



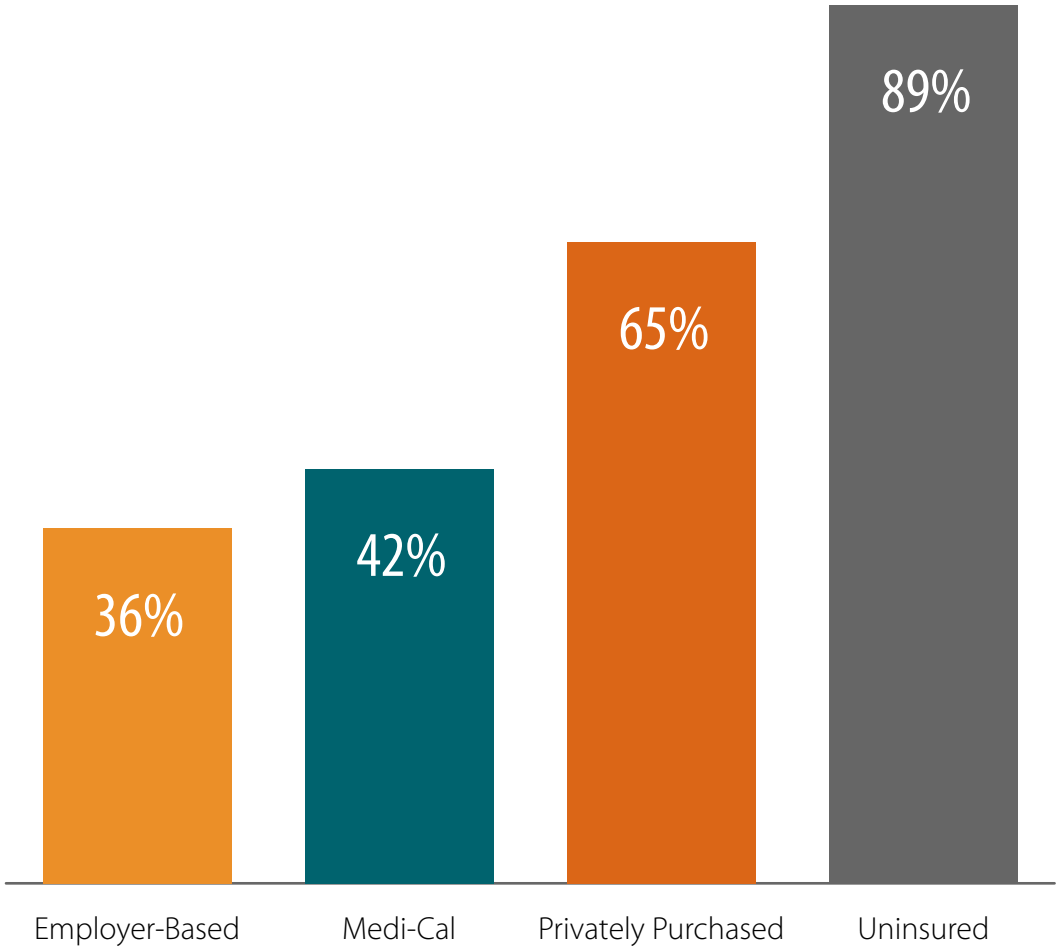
Note: *Medi-Cal beneficiaries* includes dual eligibles and Healthy Families / CHIP enrollees.

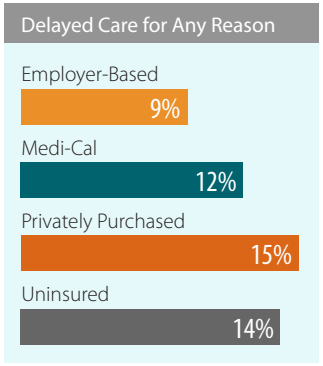
Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

The percentage of adult Medi-Cal beneficiaries reporting difficulty finding a primary care provider decreased slightly from 2013 to 2017, while the percentage reporting difficulty accessing specialty care remained relatively flat.

Delay of Care
by Source of Coverage, 2017

AMONG ALL WHO DELAYED CARE, PERCENTAGE WHO REPORTED THE REASON AS COST OR LACK OF INSURANCE





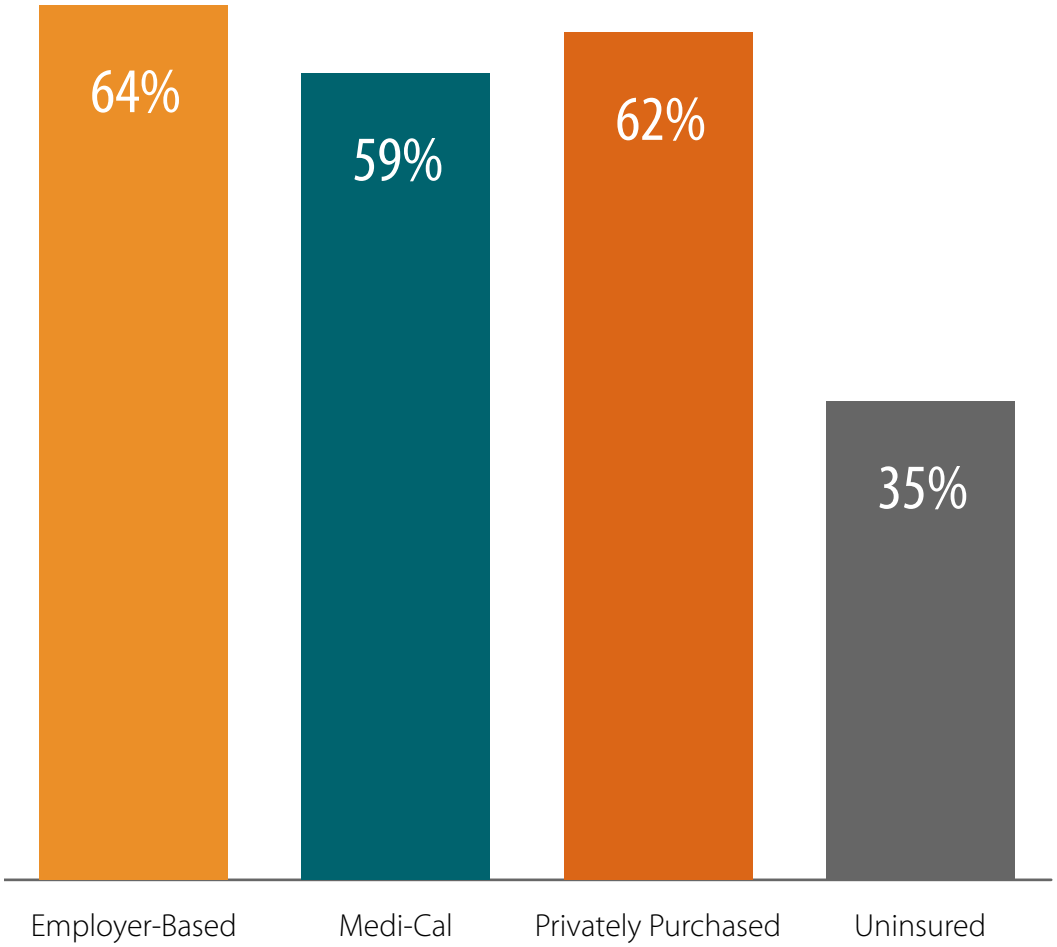
Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported having both Medi-Cal and Medicare coverage (dual eligibles) and may include those with restricted scope benefits.

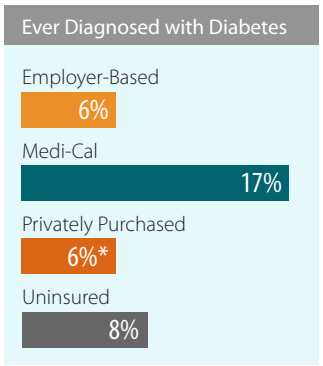
Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

One in eight Medi-Cal beneficiaries reported delaying care, roughly the same percentage as Californians overall (not shown). Among all those who delayed care, Medi-Cal beneficiaries were much less likely to report cost or lack of insurance as reasons for delaying care, compared with the uninsured or those with privately purchased insurance.

Diabetes Care
by Source of Coverage, 2017

ADULTS EVER DIAGNOSED WITH DIABETES WHO REPORTED THEY WERE VERY CONFIDENT IN THEIR ABILITY TO CONTROL/MANAGE IT





*Statistically unstable due to a small sample size which resulted in a wide confidence interval. Estimate is unreliable and, therefore, comparisons should not be made.

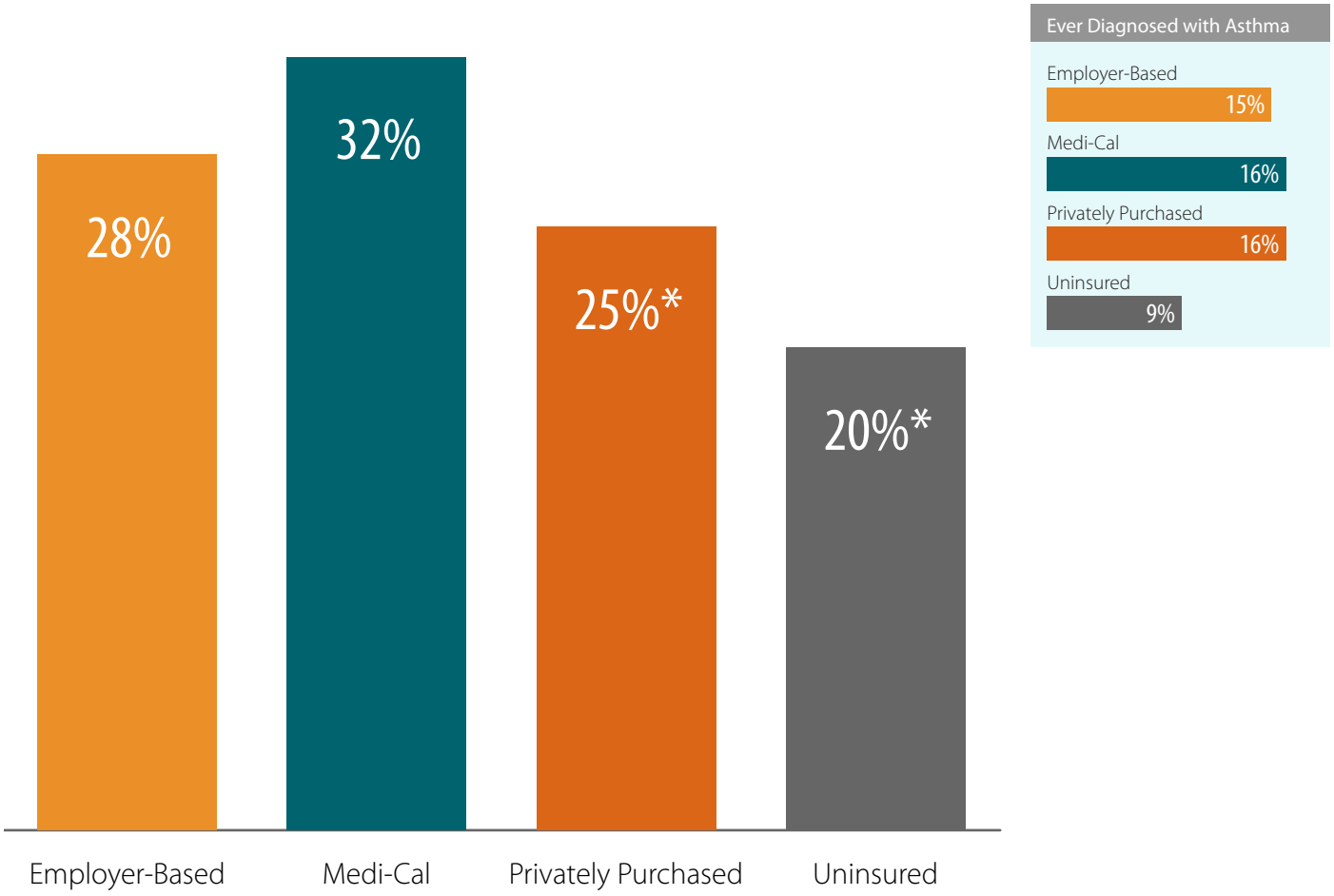
Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported having both Medi-Cal and Medicare coverage (dual eligibles) and may include those with restricted scope benefits.

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Among Medi-Cal patients ever diagnosed with diabetes, confidence to control their diabetes was similar to patients with employer-based insurance as well as to those with privately purchased coverage in 2017.

Asthma Care Measures
by Source of Coverage, 2017

POPULATION EVER DIAGNOSED WITH ASTHMA WHO HAD AN ATTACK IN THE PAST 12 MONTHS



*Statistically unstable due to a small sample size which resulted in a wide confidence interval. Estimate is unreliable and, therefore, comparisons should not be made.

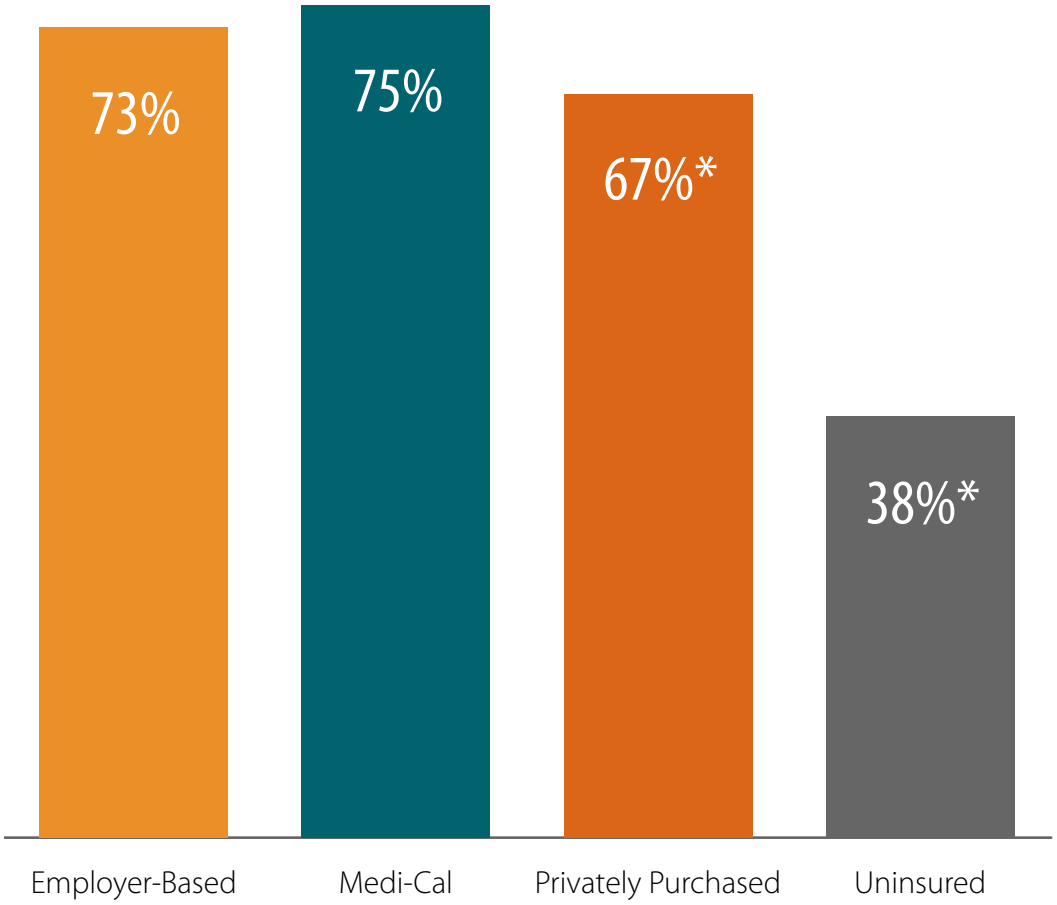
Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported having both Medi-Cal and Medicare coverage (dual eligibles) and may include those with restricted scope benefits.

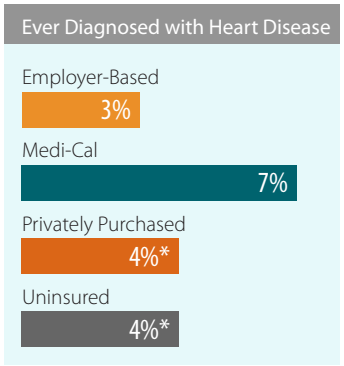
Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Well-controlled chronic conditions can be an indicator of accessible and effective primary care. In 2017, one in three Medi-Cal enrollees ever diagnosed with asthma reported having an attack in the prior 12 months.

Heart Disease Management Plan
by Source of Coverage, 2017

SHARE OF ADULTS DIAGNOSED WITH HEART DISEASE WITH A MANAGEMENT PLAN





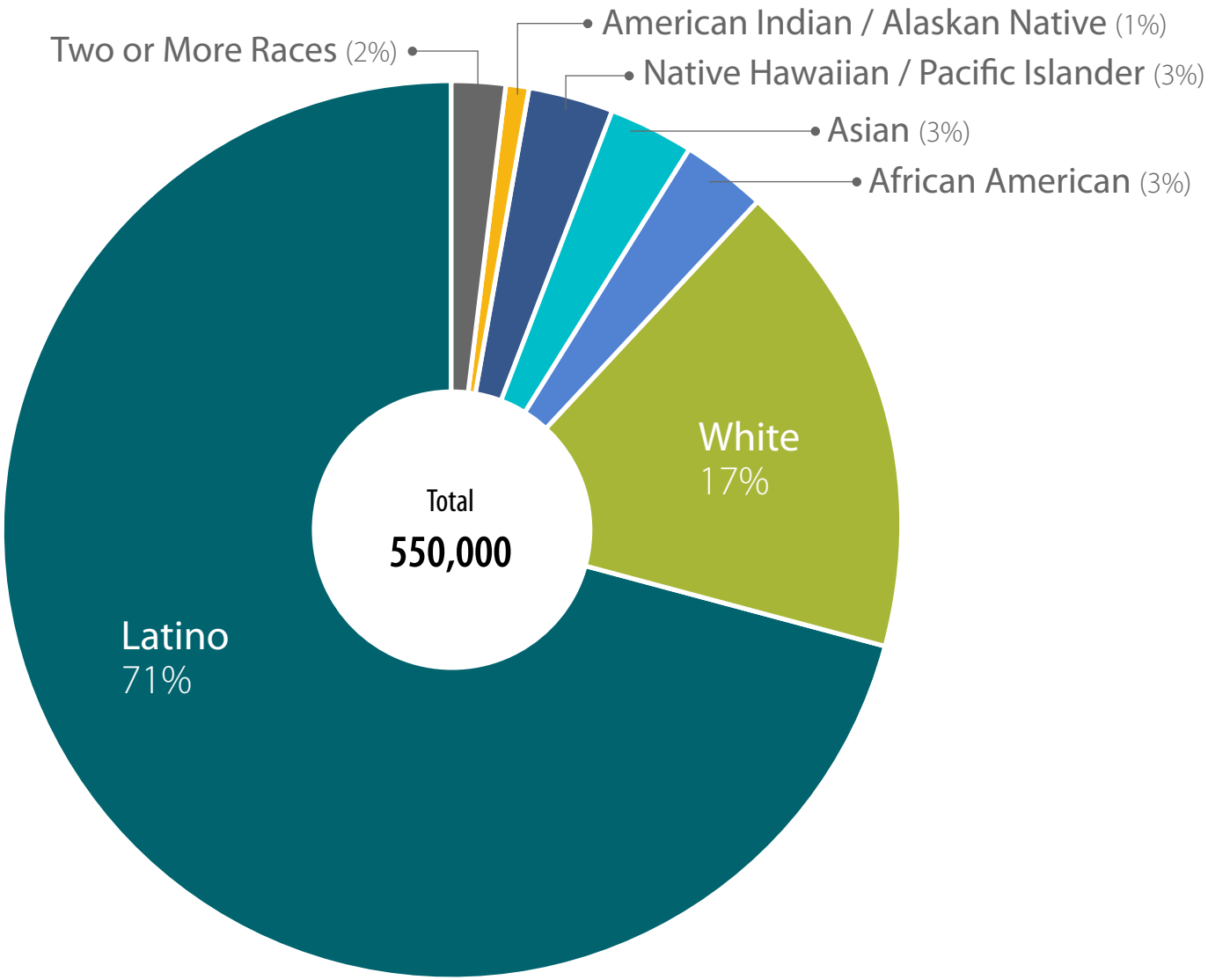
*Statistically unstable due to a small sample size which resulted in a wide confidence interval. Estimate is unreliable and, therefore, comparisons should not be made.

Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported having both Medi-Cal and Medicare coverage (dual eligibles) and may include those with restricted scope benefits.

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

Management plans help patients control chronic conditions like heart disease. The percentage of Medi-Cal beneficiaries with heart disease who were provided a heart disease management plan was similar to those with employer-based coverage in 2017.

Eligible for Medi-Cal but Not Enrolled
by Race/Ethnicity, 2017

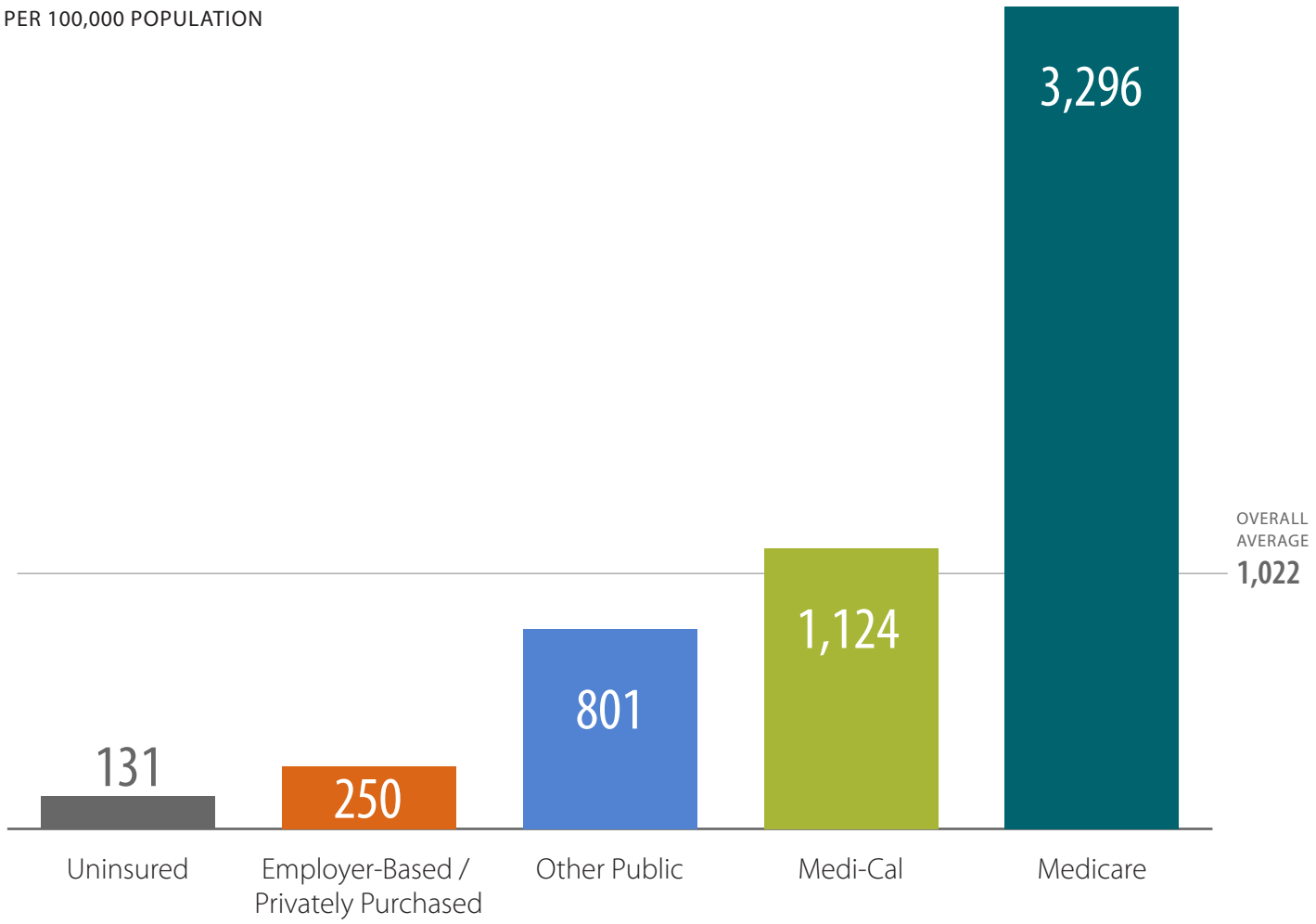


Notes: Race/ethnicity category used is OMB/Department of Finance. All groups, other than Latino, are non-Latino.

Source: "Ask CHIS [California Health Interview Survey]," UCLA Center for Health Policy Research, n.d., ask.chis.ucla.edu.

In 2017, 2.8 million Californians under 65 remained uninsured, 550,000 of whom were eligible for but not enrolled in Medi-Cal. Of these, 71% were Latino.

Preventable Hospitalizations
by Source of Coverage, 2016



Notes: The rate of avoidable hospitalizations was calculated as the number of hospitalizations for a particular payer category divided by the corresponding adult population according to the California Health Interview Survey (CHIS). Rates presented are overall rates, not adjusted for age, gender, or other demographic characteristics. For additional information about this measure, see oshpd.ca.gov.

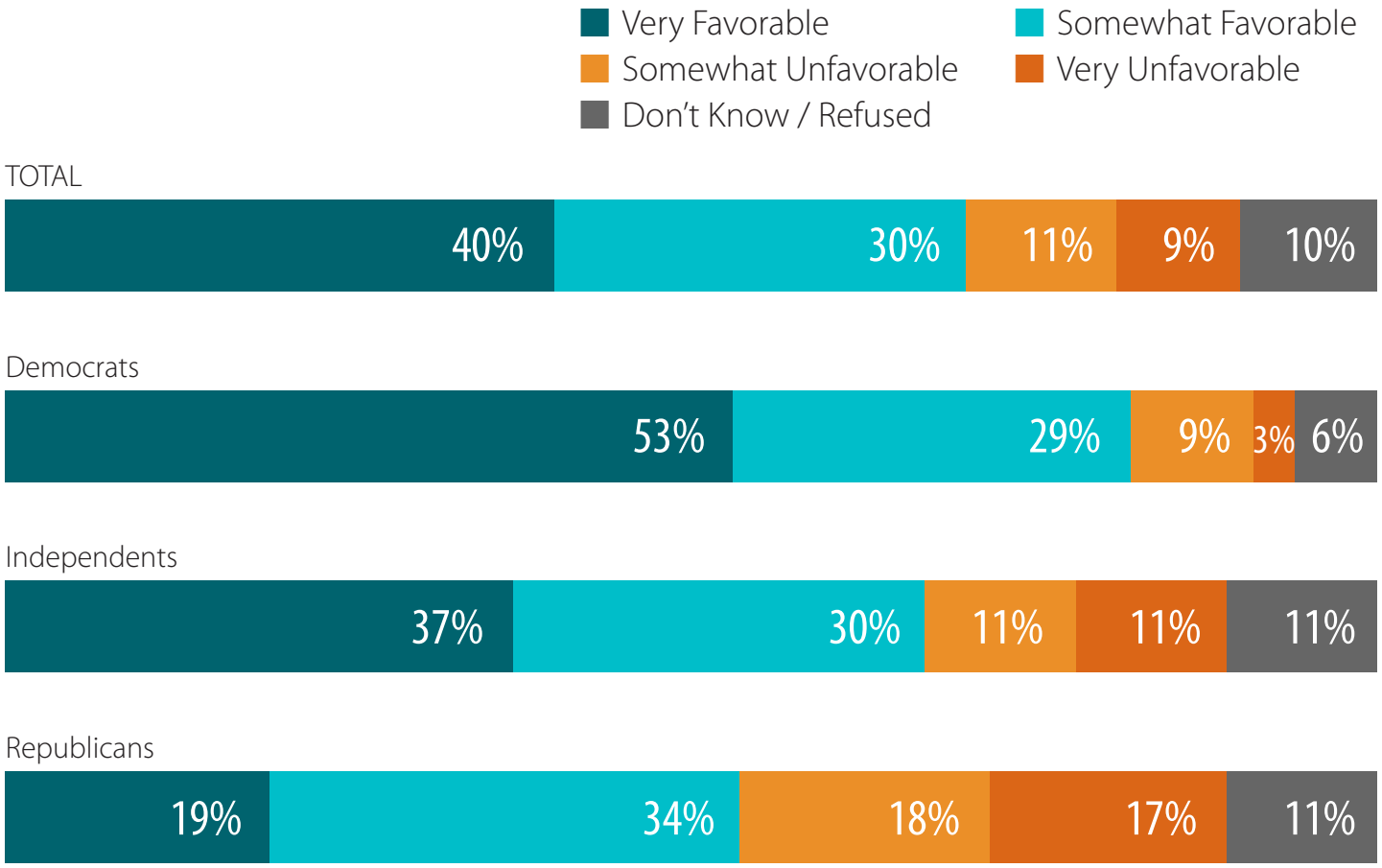
Sources: Blue Sky Consulting Group analysis of Prevention Quality Indicators Overview module v5.0, Agency for Health Research and Quality, www.qualityindicators.ahrq.gov, applied to 2016 Hospital Inpatient Discharge data, Office of Statewide Health Planning and Development, oshpd.ca.gov and 2016 CHIS, UCLA Center for Health Policy Research, healthpolicy.ucla.edu.

Rates of avoidable hospitalizations for ambulatory care–sensitive conditions (including diabetes complications, adult asthma or other lung diseases, hypertension, heart failure, and other conditions) are widely used as a marker of access to primary care, in addition to reflecting the underlying health status of the patients. Those receiving care paid for by public coverage programs, including Medi-Cal and Medicare, experienced a higher rate of avoidable hospitalizations when compared to the uninsured or those with private or employer-based coverage.

View of Medi-Cal
by Political Party, California, 2018

Most California residents have a favorable view of Medi-Cal.

In general, do you have a favorable or an unfavorable opinion of Medi-Cal, the government health insurance and long-term care program for low-income adults and children?

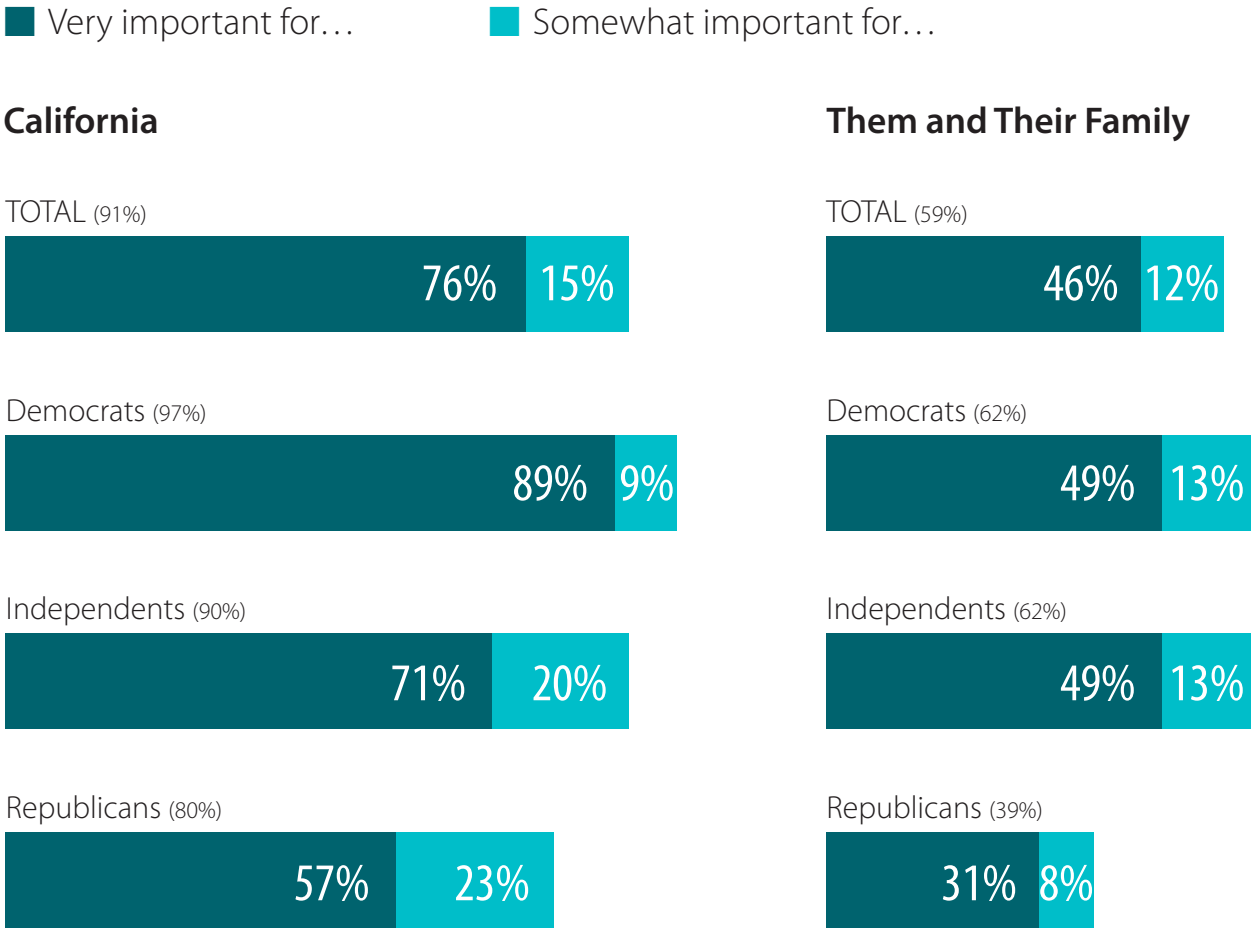


Note: Segments may not total 100% due to rounding.

Source: KFF/CHCF California Heath Policy Survey (November 12 to December 27, 2018). See topline for full question wording and response options.

Importance of Medi-Cal
by Political Party, California, 2018

PERCENT WHO SAY MEDI-CAL IS *VERY IMPORTANT* OR *SOMEWHAT IMPORTANT* FOR EACH OF THE FOLLOWING:



Notes: Net figures are shown in parentheses. Segments may not total net values due to rounding.

Source: KFF/CHCF California Heath Policy Survey (November 12 to December 27, 2018). See topline for full question wording and response options.

Across parties, strong majorities say Medi-Cal is important for California, many say it is important personally.

Looking Ahead

Medi-Cal has undergone a historic expansion since 2014. While new beneficiaries have experienced better access to care than when uninsured, access to care for some beneficiaries remains a challenge.

Upcoming changes may bring new challenges and opportunities to Medi-Cal. Two of Medi-Cal's waivers expire in 2020, prompting the need for decisions about which initiatives should continue and what new initiatives would best serve beneficiaries. While difficult to forecast, an economic downturn could bring general fund budgetary pressures and potentially force a reassessment of California's optional coverage groups and benefits.

A turbulent federal policy environment presents unique challenges to Medi-Cal. With a large federal budget deficit, Congress may target Medicaid spending with block grants, per capita spending caps, or reductions in FMAP shares. Proposed "public charge" regulations, if enacted, would lead to disenrollments in the Medi-Cal program and increase the number of uninsured in California. In addition, a recent federal court ruling on the ACA will likely bring the law's constitutionality before the US Supreme Court once again.

California priorities for Medi-Cal should include:

- Enrolling and retaining low-income Californians eligible for coverage.
- Fostering greater innovation and accountability among health plans and providers for providing timely access to high quality care and improving patient outcomes.
- Improving care coordination and quality of care for beneficiaries with multiple complex physical and behavioral health needs.
- Managing the growth in health care costs and expenditures.
- Testing and scaling approaches to address social determinants of health, such as homelessness, food insecurity, trauma, and social exclusion.
- Identifying sustainable sources of funding to support Medi-Cal into the future.

Medi-Cal has undergone a historic expansion since 2014. While new beneficiaries have experienced better access to care than when uninsured, access to care for some beneficiaries remains a challenge.

Note: *FMAP* is federal medical assistance percentages.

Source: Samantha Artiga, Rachel Garfield, and Anthony Damico, "Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid," Kaiser Family Foundation, October 11, 2018, www.kff.org.

About the Data

The survey data used in this publication rely on self-reported insurance status. When asked by survey researchers about health coverage, some undocumented immigrants who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage. Restricted-scope Medi-Cal, which covers only emergency and pregnancy-related services, is not comprehensive coverage. If these undocumented adults reporting Medi-Cal were instead considered uninsured, the number of Californians without insurance would be higher.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

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