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.

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”*).

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).


* 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

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-Based</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Medicare</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Privately Purchased</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Other Public</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

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).

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.

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.

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

Comparison to Medicare

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

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

### Legislative History, Selected Milestones

<table>
<thead>
<tr>
<th>FEDERAL</th>
<th>CALIFORNIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1965</strong> Passed Medicaid law</td>
<td><strong>1966</strong> Created Medi-Cal</td>
</tr>
<tr>
<td><strong>1972</strong> Required states to extend Medicaid to Supplemental Security Income (SSI) recipients and to seniors and disabled</td>
<td><strong>1973</strong> Established first Medi-Cal managed care plans</td>
</tr>
<tr>
<td><strong>1980</strong> Created Disproportionate Share Hospital (DSH) program</td>
<td><strong>1982</strong> Created hospital selective contracting program</td>
</tr>
<tr>
<td><strong>1988</strong> Expanded coverage to low-income pregnant women and families with infants</td>
<td><strong>1993</strong> Required most children/parents with Medi-Cal to enroll in managed care plans</td>
</tr>
<tr>
<td><strong>1996</strong> Unlinked Medicaid and welfare</td>
<td><strong>1994</strong> Began consolidation of mental health services at county level</td>
</tr>
<tr>
<td><strong>1997</strong> Established State Children’s Health Insurance Program and limited DSH payments</td>
<td><strong>1997</strong> Expanded access to family planning services*</td>
</tr>
<tr>
<td><strong>2006</strong> Required individuals to provide proof of citizenship to obtain coverage</td>
<td><strong>1998</strong> Created Healthy Families program for children</td>
</tr>
<tr>
<td><strong>2009</strong> Expanded coverage to legal immigrants for up to five years</td>
<td><strong>2000</strong> Extended Medi-Cal to families with incomes at or below 100% FPL</td>
</tr>
<tr>
<td><strong>2010</strong> Under ACA, state option to provide Medicaid coverage for all individuals under 133% FPL at enhanced federal matching rate</td>
<td><strong>2004</strong> Expanded coverage for home and community-based services</td>
</tr>
<tr>
<td><strong>2012</strong> Supreme Court upholds ACA and rules Medicaid expansion is optional for states</td>
<td><strong>2010</strong> Under ACA, expanded coverage for uninsured adults, and required seniors and people with disabilities to enroll in managed care (excluding those with Medicare)</td>
</tr>
<tr>
<td><strong>2012</strong> Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties</td>
<td><strong>2012</strong> Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties</td>
</tr>
<tr>
<td><strong>2013</strong> Expanded Medi-Cal under ACA state option</td>
<td><strong>2013</strong> Expanded Medi-Cal under ACA state option</td>
</tr>
<tr>
<td><strong>2015</strong> Expanded full-scope Medi-Cal to eligible undocumented children using state funds</td>
<td><strong>2015</strong> Expanded full-scope Medi-Cal to eligible undocumented children using state funds</td>
</tr>
<tr>
<td><strong>2016</strong> Final Managed Care Rule to align Medicaid with other insurance regulations and to strengthen consumer protections</td>
<td><strong>2015</strong> Expanded full-scope Medi-Cal to eligible undocumented children using state funds</td>
</tr>
<tr>
<td><strong>2018</strong> CHIP funding reauthorized through FY 2027</td>
<td><strong>2018</strong> CHIP funding reauthorized through FY 2027</td>
</tr>
</tbody>
</table>

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

Note: FPL is federal poverty level.

Medi-Cal Governance

FEDERAL
Federal Centers for Medicare & Medicaid Services (CMS)
- Provides regulatory oversight
- Reviews and monitors waivers to program rules

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

COUNTY
County Health and Social Services Department
- Conducts eligibility determination
- Oversees enrollment and recertification

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.

Financing the Medi-Cal Program

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.

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%.

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

Medi-Cal Facts and Figures

Overview

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.

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General Fund Distribution
FY 2018–19

General Fund Expenditures
$144 billion

- K–12 Education: 40%
- Medi-Cal: 15%
- Higher Education: 11%
- Other Health/Social Services: 11%
- Corrections/Rehabilitation: 9%
- Other Programs: 14%

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](http://www.ebudget.ca.gov)
Medi-Cal Facts and Figures

Overview

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

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

*Estimate

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 Supplementation Payment, CalWORKS, Refugee Assistance, Foster Care / Adoption Assistance Program.

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.

## Eligibility Groups

### MANDATORY GROUPS – REQUIRED BY FEDERAL LAW

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Income Threshold</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under age 26 receiving adoption assistance or foster care</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children under age 19</td>
<td>138% FPL cap</td>
<td>Income threshold is below 142% FPL for children age 1 to 5.</td>
</tr>
<tr>
<td>People in long-term care</td>
<td>100% FPL cap</td>
<td>Subject to asset test*</td>
</tr>
<tr>
<td>Parents and caretaker relatives</td>
<td>109% FPL cap</td>
<td></td>
</tr>
<tr>
<td>Aged, blind, and people with disabilities</td>
<td>Must receive SSI</td>
<td>Subject to asset test*</td>
</tr>
<tr>
<td>Pregnant women, newborns, and infants under age 1</td>
<td>213% FPL cap</td>
<td></td>
</tr>
<tr>
<td>Low-income Medicare beneficiaries</td>
<td>135% FPL cap</td>
<td>Three categories: Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualifying Individual</td>
</tr>
</tbody>
</table>

### OPTIONAL GROUPS – NOT REQUIRED BY FEDERAL LAW

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Income Threshold</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA “expansion” adults under age 65</td>
<td>138% FPL cap</td>
<td>Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA.</td>
</tr>
<tr>
<td>Parents and caretaker relatives</td>
<td>110% – 138% FPL</td>
<td>Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA.</td>
</tr>
<tr>
<td>Qualifying state and county inmates</td>
<td>138% FPL cap</td>
<td>Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA. Medi-Cal pays for inpatient hospital services.</td>
</tr>
<tr>
<td>Children under age 19</td>
<td>139% – 266% FPL</td>
<td>Title XXI funded Optional Targeted Low-Income Children†</td>
</tr>
<tr>
<td>Children under age 19 in specific counties†</td>
<td>267% – 322% FPL</td>
<td>Title XXI funded with county match (C-CHIP)‡</td>
</tr>
<tr>
<td>Pregnant women, newborns, and infants under age 2</td>
<td>213% – 322% FPL</td>
<td>Title XXI funded Optional Targeted Low-Income Children</td>
</tr>
<tr>
<td>Undocumented children under age 19</td>
<td>266% FPL cap</td>
<td>State-only funding</td>
</tr>
<tr>
<td>Undocumented adults in long-term care</td>
<td>100% FPL cap</td>
<td>State-only funding</td>
</tr>
<tr>
<td>Aged, blind, and people with disabilities — FPL program</td>
<td>100% FPL cap</td>
<td>State option in Title XIX‡; subject to asset test*</td>
</tr>
<tr>
<td>Working disabled</td>
<td>250% FPL cap</td>
<td>State option in Title XIX‡; subject to asset test*</td>
</tr>
</tbody>
</table>

*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.

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**Medi-Cal Facts and Figures**

**Eligibility and Enrollment**

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.

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Income Thresholds, by Funding Source

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.

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.

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.

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.

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 benefitsca.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.

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.


To comply with the ACA, California created a single streamlined application for Medi-Cal and Covered California, the state’s health care exchange.
Medicaid Enrollment
Selected States, 2017

Per Cent of Nonelderly State Population

- New York: 28%
- California: 27%
- Massachusetts: 25%
- Michigan: 25%
- Ohio: 23%
- Illinois: 22%
- Pennsylvania: 21%
- Florida: 20%
- New Jersey: 18%
- Texas: 17%

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.


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.
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 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.

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.

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.
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%.
Enrollment, by Family Work Status
Nonelderly Population, 2017

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

## Medi-Cal Benefits

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

### Premiums and Cost Sharing, by Eligible Group

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

*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.

Waivers

<table>
<thead>
<tr>
<th>1915(B) FREEDOM OF CHOICE</th>
<th>1915(C) HOME AND COMMUNITY-BASED SERVICES</th>
<th>1115(A) RESEARCH AND DEMONSTRATION PROJECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE</strong></td>
<td>Authorizes states to provide home and community-based services as an alternative to placement in a nursing home, hospital, or other long-term care facility.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>EXAMPLES</strong></td>
<td><strong>HCBS for the Developmentally Disabled.</strong> For beneficiaries of any age with developmental and intellectual disabilities, including autism, assists with living in the community rather than an institution.</td>
<td><strong>EXAMPLES</strong></td>
</tr>
<tr>
<td><strong>Specialty Mental Health Services.</strong> Waives freedom of choice and creates county mental health plans to deliver specialty mental health services.</td>
<td><strong>Nursing Facility / Acute Hospital Waiver.</strong> Provides case management, habilitation services, home health nursing, and other services for medically fragile and technology-dependent people of any age.</td>
<td><strong>Medi-Cal 2020.</strong> Composed of five main programs:</td>
</tr>
<tr>
<td></td>
<td><strong>HIV/AIDS Waiver.</strong> 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.</td>
<td>• <strong>Public Hospital Redesign and Incentives in Medi-Cal.</strong> Changes care delivery to maximize health care value and strengthens ability to perform under risk-based alternative payment models.</td>
</tr>
<tr>
<td></td>
<td><strong>Other 1915(c) waivers.</strong> Include Multipurpose Senior Services Program, Assisted Living, and In-Home Operations.</td>
<td>• <strong>Global Payment Program.</strong> Establishes a statewide pool of funding for the remaining uninsured and provides incentives for primary and preventive care services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Whole Person Care pilot program.</strong> Coordinates physical health, behavioral health, and social services for high-risk, high-cost beneficiaries with poor health outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Dental Transformation Initiative.</strong> Provides incentives to improve access to preventive services and continuity of care for dental services for Medi-Cal children.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Drug Medi-Cal Organized Delivery System.</strong> Aims to demonstrate how organizing substance use disorder services along a continuum of care increases beneficiaries’ success while decreasing system health care costs.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability</strong></td>
<td>All 58 counties</td>
</tr>
<tr>
<td><strong>Market Share</strong></td>
<td>82% of all beneficiaries</td>
</tr>
<tr>
<td><strong>Enrollment Population</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mandatory</strong></td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Pregnant women</td>
</tr>
<tr>
<td></td>
<td>Parents/caretaker relatives</td>
</tr>
<tr>
<td></td>
<td>Adults without dependents</td>
</tr>
<tr>
<td></td>
<td>Seniors and people with disabilities (not also in Medicare)</td>
</tr>
<tr>
<td><strong>Voluntary</strong></td>
<td>Seniors and people with disabilities (dual eligibles)</td>
</tr>
<tr>
<td></td>
<td>Foster children and youth</td>
</tr>
<tr>
<td></td>
<td>All beneficiaries in San Benito County</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td>49%</td>
</tr>
<tr>
<td><strong>Covered Services</strong></td>
<td>All essential health benefits required by the ACA, including:</td>
</tr>
<tr>
<td></td>
<td>• Ambulatory services</td>
</tr>
<tr>
<td></td>
<td>• Emergency services</td>
</tr>
<tr>
<td></td>
<td>• Mental health and substance use disorder services</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Carve-Outs</strong></td>
<td>California Children's Services for the seriously ill and disabled children and youth in certain counties'</td>
</tr>
<tr>
<td></td>
<td>Specialty mental health</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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. ¹ 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.

Fee-for-Service and Managed Care Enrollment
January 2010 to January 2018

IN MILLIONS

Fee-for-Service
Managed Care

3.4 3.3 2.8 2.8 3.2 3.1 3.2 2.7 2.5

Note: Figures include restricted-scope Medi-Cal.

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](http://www.dhcs.ca.gov) (PDF); and Medi-Cal Managed Care Enrollment Report – December 2018, DHCS, January 2, 2019, [www.dhcs.ca.gov](http://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

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.

Notes: Primary Care Case Management (PCCM), which had 0.008% enrollment, is not shown. Segments do not total 100% due to rounding.
Managed Care Penetration Rates
Selected States, as of July 1, 2018

<table>
<thead>
<tr>
<th>State</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey</td>
<td>95%</td>
</tr>
<tr>
<td>Texas</td>
<td>94%</td>
</tr>
<tr>
<td>Florida</td>
<td>92%</td>
</tr>
<tr>
<td>Ohio</td>
<td>90%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>83%</td>
</tr>
<tr>
<td>California</td>
<td>83%</td>
</tr>
<tr>
<td>Illinois</td>
<td>80%</td>
</tr>
<tr>
<td>Michigan</td>
<td>78%</td>
</tr>
<tr>
<td>New York</td>
<td>75%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>48%</td>
</tr>
</tbody>
</table>

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.

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.

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

Managed Care Carve Outs

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.

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.

Sources:
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.

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

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.

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.

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.

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

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.

Medicaid Benefit Spending per Full-Year Equivalent Enrollee
Selected States, FY 2017

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

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).
Medicaid Spending per Full-Benefit Enrollee
California vs. United States, FY 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>California</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with Disabilities</td>
<td>$20,672</td>
<td>$19,033</td>
</tr>
<tr>
<td>Seniors</td>
<td>$10,976</td>
<td>$17,476</td>
</tr>
<tr>
<td>Adults</td>
<td>$2,672</td>
<td>$3,955</td>
</tr>
<tr>
<td>Children</td>
<td>$2,500</td>
<td>$2,602</td>
</tr>
<tr>
<td>All Full-Benefit Enrollees</td>
<td>$5,318</td>
<td>$6,396</td>
</tr>
</tbody>
</table>

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.


With the exception of people with disabilities, California’s per enrollee spending is lower than the national average.
Spending per State Resident
Selected States, FY 2017

- New York: $3,900
- Massachusetts: $2,495
- Pennsylvania: $2,195
- California: $2,091
- Ohio: $1,977
- Michigan: $1,675
- New Jersey: $1,659
- Texas: $1,259
- Illinois: $1,177
- Florida: $1,105

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

### 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%).

---

### Net Patient Revenues
by Hospital Ownership Type and Payer, 2016

IN BILLIONS

<table>
<thead>
<tr>
<th></th>
<th>City/County</th>
<th>Investor</th>
<th>District</th>
<th>Nonprofit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>16%</td>
<td>15%</td>
<td>67%</td>
<td>32%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>33%</td>
<td>35%</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>County Indigent Program</td>
<td>32%</td>
<td>35%</td>
<td>35%</td>
<td>23%</td>
</tr>
<tr>
<td>Medicare</td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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.
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**

**PERCENTAGE OF VISITS 17.2 MILLION / 17.3 MILLION**

- Medicare: 7% (2013) → 9% (2016)
- Other Public: 19% (2013) → 15% (2016)
- Uninsured or Indigent Programs: 24% (2013) → 10% (2016)
- Private Insurance: 6% (2013) → 8% (2016)

**PERCENTAGE OF NET PATIENT REVENUE $2.1 BILLION / $2.2 BILLION**

- Medi-Cal: 57% (2013) → 73% (2016)
- Medicare: 8% (2013) → 9% (2016)
- Other Public: 15% (2013) → 8% (2016)
- Uninsured or Indigent Programs: 14% (2013) → 3% (2016)
- Private Insurance: 6% (2013) → 6% (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.

**Medi-Cal Facts and Figures**

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

IN BILLIONS

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Payers</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>11%</td>
<td>18%</td>
</tr>
<tr>
<td>Medicare</td>
<td>34%</td>
<td>32%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>46%</td>
<td>41%</td>
</tr>
</tbody>
</table>

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 Facts and Figures

Role in the System

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 42% of all long-term care facilities revenues in 2016.
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.

* 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.

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

<table>
<thead>
<tr>
<th>Preventive Care Visit</th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visit (children)</td>
<td>77%</td>
<td>83%</td>
</tr>
<tr>
<td>Dental Visit (adults)</td>
<td>53%</td>
<td>59%</td>
</tr>
<tr>
<td>Routine Checkup (adults)</td>
<td>72%</td>
<td>73%</td>
</tr>
</tbody>
</table>

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


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.
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.

Note: Medi-Cal beneficiaries includes dual eligibles and Healthy Families / CHIP enrollees.
Delay of Care
by Source of Coverage, 2017

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

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.

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.

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

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Very Confident in Ability to Control/Monitor Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-Based</td>
<td>64%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>59%</td>
</tr>
<tr>
<td>Privately Purchased</td>
<td>62%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>35%</td>
</tr>
</tbody>
</table>

*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.


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

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Ever Diagnosed with Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-Based</td>
<td>15%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>16%</td>
</tr>
<tr>
<td>Privately Purchased</td>
<td>16%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>9%</td>
</tr>
</tbody>
</table>

*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.

Heart Disease Management Plan by Source of Coverage, 2017

SHARE OF ADULTS DIAGNOSED WITH HEART DISEASE WITH A MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Ever Diagnosed with Heart Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-Based</td>
<td>3%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>7%</td>
</tr>
<tr>
<td>Privately Purchased</td>
<td>4%*</td>
</tr>
<tr>
<td>Uninsured</td>
<td>4%*</td>
</tr>
</tbody>
</table>

*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.


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.
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.

Notes: Race/ethnicity category used is OMB/Department of Finance. All groups, other than Latino, are non-Latino.
Preventable Hospitalizations by Source of Coverage, 2016

PER 100,000 POPULATION

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.


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

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?

**TOTAL**
- Very Favorable: 40%
- Somewhat Favorable: 30%
- Somewhat Unfavorable: 11%
- Very Unfavorable: 9%
- Don’t Know / Refused: 10%

**Democrats**
- Very Favorable: 53%
- Somewhat Favorable: 29%
- Somewhat Unfavorable: 9%
- Very Unfavorable: 3%
- Don’t Know / Refused: 6%

**Independents**
- Very Favorable: 37%
- Somewhat Favorable: 30%
- Somewhat Unfavorable: 11%
- Very Unfavorable: 11%
- Don’t Know / Refused: 11%

**Republicans**
- Very Favorable: 19%
- Somewhat Favorable: 34%
- Somewhat Unfavorable: 18%
- Very Unfavorable: 17%
- Don’t Know / Refused: 11%

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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 **SOMEWHA T IMPORTANT** FOR EACH OF THE FOLLOWING:**

- **Very important for…**
- **Somewhat important for…**

### California

<table>
<thead>
<tr>
<th>Party</th>
<th>Very Important</th>
<th>Somewhat Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>76%</td>
<td>15%</td>
</tr>
<tr>
<td>Democrats</td>
<td>89%</td>
<td>9%</td>
</tr>
<tr>
<td>Independents</td>
<td>71%</td>
<td>20%</td>
</tr>
<tr>
<td>Republicans</td>
<td>57%</td>
<td>23%</td>
</tr>
</tbody>
</table>

### Them and Their Family

<table>
<thead>
<tr>
<th>Party</th>
<th>Very Important</th>
<th>Somewhat Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>46%</td>
<td>12%</td>
</tr>
<tr>
<td>Democrats</td>
<td>49%</td>
<td>13%</td>
</tr>
<tr>
<td>Independents</td>
<td>49%</td>
<td>13%</td>
</tr>
<tr>
<td>Republicans</td>
<td>31%</td>
<td>8%</td>
</tr>
</tbody>
</table>

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.

## Medi-Cal Facts and Figures

Public Opinion

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.

Note: FMAP is federal medical assistance percentages.
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.