CHCF

Medi-Cal Explained

The Medi-Cal Program **An Overview**

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Acknowledgment

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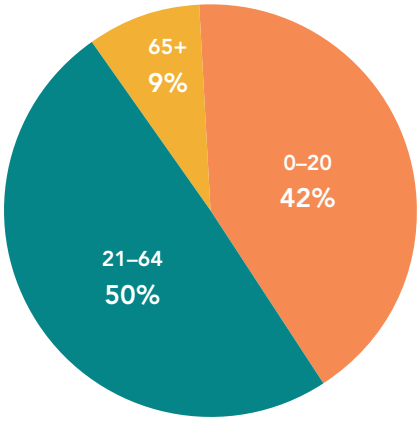
Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.

Contents

Medi-Cal, California's Medicaid program, provides health coverage for low-income Californians, including children and their parents, pregnant women, seniors, people with disabilities, and non-elderly adults. Medi-Cal is a vital source of coverage for a significant portion of the state's population. It covers nearly 40% of California's children, half of those with disabilities, over a million seniors, and about one in five California workers.[1, 2]

Figure 1. Medi-Cal Population by Age*



* Percentages in pie may not equal 100% due to rounding.

Source: *Medi-Cal at a Glance: Most Recent Reported Month — May 2018*, California Department of Health Care Services, accessed November 30, 2018, www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_at_a_Glance_May2018_ADA.pdf.

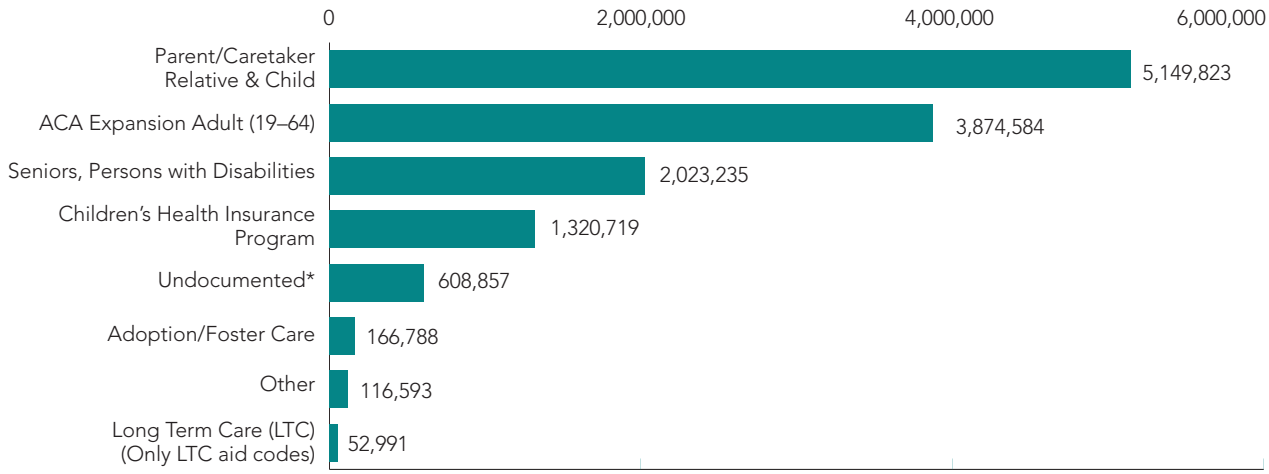
Medi-Cal enrollment increased by 5.6 million people between 2013 and 2017, largely due to the Affordable Care Act (ACA) expansion of Medicaid coverage to low-income adults. These expansion adults account for approximately 30% (3.9 million people) of current Medi-Cal enrollees.

Who Does Medi-Cal Serve?

Federal law mandates the inclusion of certain populations in Medicaid, referred to as mandatory Medicaid eligibility groups, including children, pregnant women, and seniors and persons with disabilities. Each state can opt to add additional population groups defined by statute. In California, some of these include low-income adults under age 65, those in the Breast and Cervical Cancer Treatment Program (BCCTP), and those who receive care in a nursing facility or receive long-term support services.

Medi-Cal eligibility is determined by financial, categorical, and nonfinancial factors. Financial requirements include income, and for some groups, assets, that fall within the program limits. Categorical requirements include being a member of a specific group, such as being a child under 21 years of age, a parent, a person with a disability, or a low-income adult under age 65. Nonfinancial factors include state residency and immigration status.

Figure 2. Medi-Cal Enrollment by Eligible Population, 2018



Source: Medi-Cal Monthly Enrollment Fast Facts: Characteristics of the Medi-Cal Population as Captured by the Medi-Cal Eligibility Data System, California Department of Health Care Services, April 2018.

* Restricted scope coverage (pregnancy and emergency services) for adults only. Children with undocumented immigration status are eligible for full scope coverage and are dispersed throughout other aid categories.

Table 1. Medicaid Eligibility Groups

MEGs or Medi-Cal Population(s)	Federal Statutory Authority	% of FPL[3]	% of Total
ACA expansion adult — adults ages 19-64 (MCE)	§1902(a)(10)(A), §1905(y)(2)	≤138%	29%
Adoption/foster care	§1902(a)(10)(A)	None	1%
Children's Health Insurance Program (CHIP)	§2103	≤322% (children) <100% (adults)	10%
Long-term care	§1919(a)	≤300% FBR	<1%
Other	Various	N/A	1%
Parent/caretaker relative and child	§1902(e)(5)	[TK]	39%
Seniors and persons with disabilities (SPDs)	§1902(a)(10)(a), §1619(a)&(b)	≤133%	15%
Undocumented*	State-only program	≤138%	5%
Total enrollment (as of Jan. 2018)			100%

FBR = 2018 Federal Benefit Rate = $2,250; FPL = federal poverty level; MCE = Medicaid covered expansion.

* Restricted scope coverage (pregnancy and emergency services) for adults only. Children with undocumented immigration status are eligible for full scope coverage and dispersed throughout other aid categories.

Source: California Department of Health Care Services, April 2018.

Populations

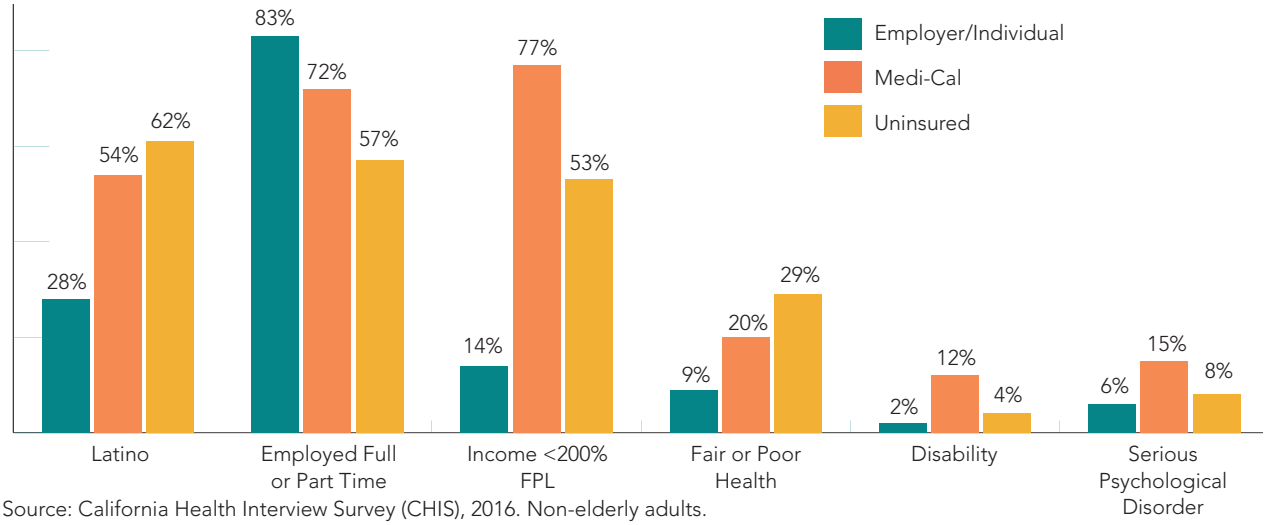
The Medi-Cal program has eight primary Medicaid eligibility groups (MEGs). Eligible Medi-Cal enrollees must fall into one of these MEGs to qualify for coverage, as identified in Table 1.

When compared to the population that has health insurance either through their employer or the individual market (where the individual buys insurance directly), the nonelderly adult Medi-Cal population experiences much higher rates of poverty and reports higher rates of fair or poor health, disabilities, and serious psychological distress. The uninsured population has significantly higher rates of reported fair or poor health compared to both the Medi-Cal and employer-based population.

Dual Eligibles

Dual eligibles are those beneficiaries eligible for both Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing. Medicare pays covered medical services first for dual-eligible beneficiaries because Medicaid is generally the payer of last resort. Medicaid may cover medical costs that Medicare does not cover or partially covers (such as nursing home care, personal care, and home- and community-based services). In certain California counties, dual eligibles have access to Cal MediConnect, a program that combines their Medicare and Medi-Cal benefits under a single Medicare-Medicaid Plan.

Figure 3. Population Characteristics by Source of Coverage



Source: California Health Interview Survey (CHIS), 2016. Non-elderly adults.

What Is the Application Process for Medi-Cal?

Individuals and families can apply for Medi-Cal online, over the phone, or in person at a county eligibility office. California uses a Single Streamlined Application,[4] which allows people to apply for both Medi-Cal and plans offered through Covered California, the state marketplace for private insurance coverage created under the Affordable Care Act.[5] Another pathway to enrollment is presumptive eligibility (PE),[6] whereby hospitals and clinics provide temporary eligibility for Medi-Cal on-site. The PE program provides qualified persons with immediate access to temporary, no-cost Medi-Cal while they are applying for permanent Medi-Cal coverage or other health coverage. During the period of PE coverage, the individual must apply to enroll and maintain ongoing Medi-Cal coverage.

How Are Enrollees Covered?

As of 2018, 82% of Medi-Cal beneficiaries received Medi-Cal coverage from Medi-Cal managed care plans (MMCPs). A traditional fee-for-service (FFS) delivery system covers the remaining population, which includes beneficiaries who have limited-scope coverage, those with a share-of-cost plan,* dual eligibles (except in the Coordinated Care Initiative counties, explained below), and a limited number of beneficiaries in special categories who have full-scope coverage but are not required to enroll in managed care. In certain counties, beneficiaries may also apply for a Medical Exemption Request (MER), which, if approved by the California Department of Health Care Services (DHCS), provides continuity of care with FFS providers to continue or finish a specified course of treatment (for example, to stay with the same FFS doctor for an entire pregnancy). MERs can be approved for up to 12 months, and at the end of the approved period the beneficiary can apply for a new MER or enroll in managed care. Beneficiaries who are required to enroll in an MMCP but have not yet selected their plan remain in FFS until the enrollment is complete (which is generally done within 90 days). This population represents about 60% of FFS enrollment in any given month.

If a Medi-Cal beneficiary who is required to enroll in managed care does not select a health plan within 30 days of enrollment, DHCS assigns the beneficiary to a plan. Once enrolled, members have the option to change their plan if they are not satisfied, except in counties in California that have only one plan available.

Once a year every beneficiary receives a Medi-Cal redetermination notice from DHCS, which begins a process to verify continuing eligibility. If a beneficiary does not complete the redetermination process, DHCS is required to terminate coverage. A beneficiary who loses eligibility can reapply at any time but may experience a gap in coverage. If a beneficiary is determined ineligible in the redetermination process, he or she may apply for coverage through Covered California during a special enrollment period, which runs for 60 days following the loss of coverage.

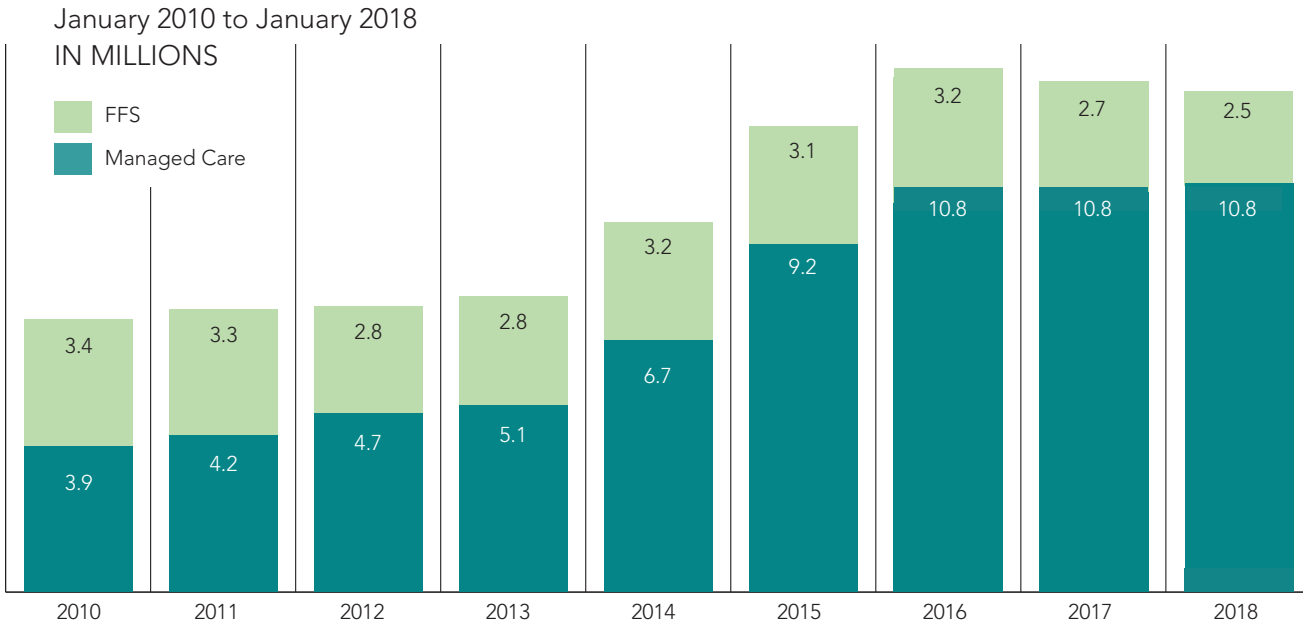
Managed Care vs. Fee-for-Service

Under managed care, the state contracts with health plans and pays a fixed amount each month per member enrolled in the plan. The health plan is then responsible for providing all Medi-Cal services included under the contract. Plans are required under state and federal law to maintain an adequate Medi-Cal provider network to ensure that each member has a primary care physician and must report on quality and access measures.

Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal enrollees. It is the enrollee's responsibility to find a physician who accepts Medi-Cal.

* Share-of-cost (SOC) Medi-Cal is available to some beneficiaries who have too much income to qualify for coverage. Each month they are required to spend a certain amount of money, which is determined based on how much income they have, on medical care. Once the beneficiary meets their "share of cost," Medi-Cal pays for the remaining covered medical expenses for that month.

Figure 4. Medi-Cal Enrollment by Type



Source: "Medi-Cal Certified Eligibles — Recent Trends," California Department of Health Care Services, last modified September 24, 2018, www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx.

Figure 5. FFS Beneficiaries by Category of Aid

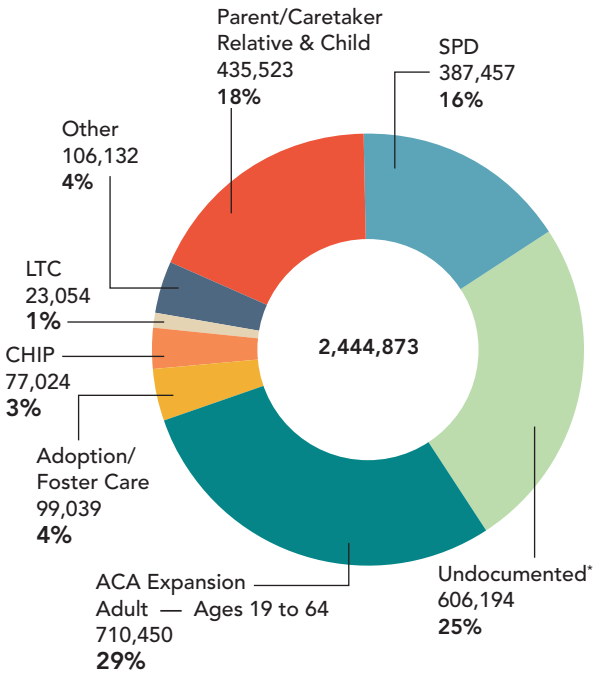
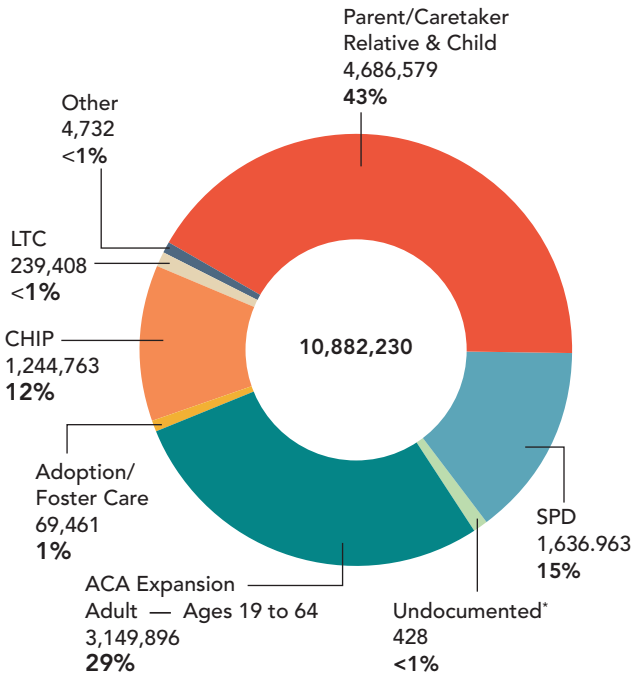


Figure 6. Managed Care Beneficiaries by Category of Aid



*Restricted scope coverage (pregnancy and emergency services) for adults only. Children with undocumented immigration status are eligible for full scope coverage and dispersed throughout other aid categories.

Source: *Medi-Cal Monthly Enrollment Fast Facts, California Department of Health Care Services*, March 2018, www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_March2018_ADA.pdf.

How Do State Policymakers Expand or Reduce Eligibility?

Expanding Medi-Cal eligibility to a new population requires funding from the state and/or the federal government. There are statutory restrictions on what populations the federal government will provide funding for, and these expansions must be approved — either through the State Plan Amendment (SPA) process or through a Medicaid waiver (detail on both processes is provided below) — by the Centers for Medicare & Medicaid Services (CMS). If the state is not eligible for any federal dollars, then it has the option to cover the entire cost.

Once financing for the expansion is determined, state legislation must be introduced to make the corresponding statutory and budgetary changes to define the eligible population, the estimated costs to the state and/or federal government, and the funding source(s). In the event that California wanted to reduce eligibility for Medi-Cal, it would have to get approval from CMS and the legislature would have to amend state law. A transition plan would have to be established to reduce the harm to impacted members, and the details of that would vary based on the scope and type of beneficiaries.

During the 2017-18 legislative cycle, there was a proposal to extend full-scope Medi-Cal to the undocumented adult population. Federal statute prohibits the use of federal Medicaid funds to cover the undocumented adults, so any such expansion would have to have been funded entirely by the state; the estimated cost for the 2018-19 state fiscal year was $3 billion.[7] When California expanded eligibility for undocumented children under age 19 in 2016, the state budget included $279.5 million for a full year's costs.[8]

What Benefits and Services Are Covered by Medi-Cal?

Full-scope Medi-Cal–covered services include primary, specialty, and acute care; home- and community-based services that help with activities of daily living and allow people to remain in their homes; institutional care (such as nursing homes); pediatric and adult dental services; comprehensive behavioral health coverage, including behavioral health treatment for children with autism spectrum disorders; and substance use disorder (SUD) treatment services.

The scope of these services is negotiated in the Medicaid State Plan, an agreement between the federal government (Centers for Medicare and Medicaid Services, or CMS) and the state (DHCS) that also governs how the program is administered, which populations are covered, how providers are reimbursed, and what administrative functions are required of the state. Full-scope Medi-Cal covers a wide array of health benefits, outlined in Figure 7.

Figure 7. Medi-Cal Covered Benefits and Services

Ambulatory Care: ■ Physician services ■ Hospital outpatient ■ Outpatient surgery ■ Podiatry ■ Chiropractic ■ Allergy care ■ Treatment therapies ■ Dialysis/hemodialysis	**Emergency Services:** ■ Emergency room services ■ All inpatient and outpatient services necessary for the treatment of an emergency medical condition, including dental services ■ Ambulance services	**Early and Periodic Screening, Diagnostic, and Testing (EPSDT) Services:** ■ Periodic screenings to determine health care needs and extended services as medically necessary for children under 21
Hospitalization: ■ Inpatient hospital services ■ Anesthesiologist services ■ Surgical services (bariatric, reconstructive surgery, etc.) ■ Organ and tissue transplantation	**Rehabilitative & Habilitative Services:** ■ Physical therapy ■ Speech therapy ■ Occupational therapy ■ Acupuncture ■ Cardiac rehabilitation ■ Pulmonary rehabilitation ■ Skilled nursing facility services (90 days) ■ Medical supplies/equipment/ appliances ■ Durable medical equipment ■ Orthotics/prostheses ■ Hearing aids ■ Home health services	**Dental/Vision:** ■ Emergency dental services ■ Dentures ■ Dental implants and implant-retained prostheses ■ Basic preventive, diagnostic, and repair services ■ Extended dental benefits for EPSDT and pregnant women ■ Routine eye exam once in 24 months ■ Eyeglasses for eligible individuals under 21 and pregnant women through postpartum
Mental Health and Substance Use Disorder (SUD) Services: ■ Outpatient mental health services ■ Outpatient specialty mental health ■ Inpatient specialty mental health ■ Outpatient SUD services ■ Residential treatment services ■ Voluntary inpatient detoxification	**Maternity and Newborn Care:** ■ Prenatal care ■ Delivery and postpartum care ■ Breastfeeding education ■ Nurse midwife services ■ Licensed midwife services	**Transportation:** ■ Transportation to and from appointments for services covered by Medi-Cal ■ Nonemergency transportation services ■ Nonmedical transportation services
Prescription Drugs: ■ Coverage at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class ■ Beneficiaries may receive up to a 100-day supply of many medications	**Preventive and Wellness Services:** ■ USPSTF A & B preventive services ■ Advisory Committee for Immunization Practices recommended vaccines ■ HRSA Bright Futures recommendations ■ Preventive services for women ■ Family planning services ■ Smoking cessation services ■ Behavioral health treatment under 21	**Long-term Services and Supports:** ■ Skilled Nursing Facility services (91+ days) ■ Personal Care Services ■ Self — Directed Personal Assistance Services ■ Community First Choice Option ■ Home and Community Based Services

Source: California Department of Health Care Services, 2017, www.dhcs.ca.gov/services/medi-cal/pages/medi-cal_ehb_benefits.aspx.

How Do State Policymakers Add a New Medi-Cal Benefit?

The legislature must pass a bill that is signed into law by the governor for a new Medi-Cal benefit to be added. DHCS and other stakeholders provide input on proposed changes to Medi-Cal benefits. Some of the more recently added benefits include nonmedical transportation and treatment for autism spectrum disorders.

When a new benefit or service is added to the Medi-Cal program, if it is funded using any federal dollars, the state must go through the State Plan Amendment (SPA) process. There is a 90-day review by CMS once an SPA is submitted, but it can often take much longer as CMS has the authority to "stop the clock" one time during a review process by requesting additional information from the state. A new 90-day review clock starts once the requested information is submitted.

The state plan authority is strictly limited under current federal statutes governing the Medicaid program. If a state wants to cover additional services or populations using any federal dollars, or use managed care to cover certain populations, it must request a waiver as described below. If the state opts to fund the additional services or populations with state-only funds, no federal waivers are required.

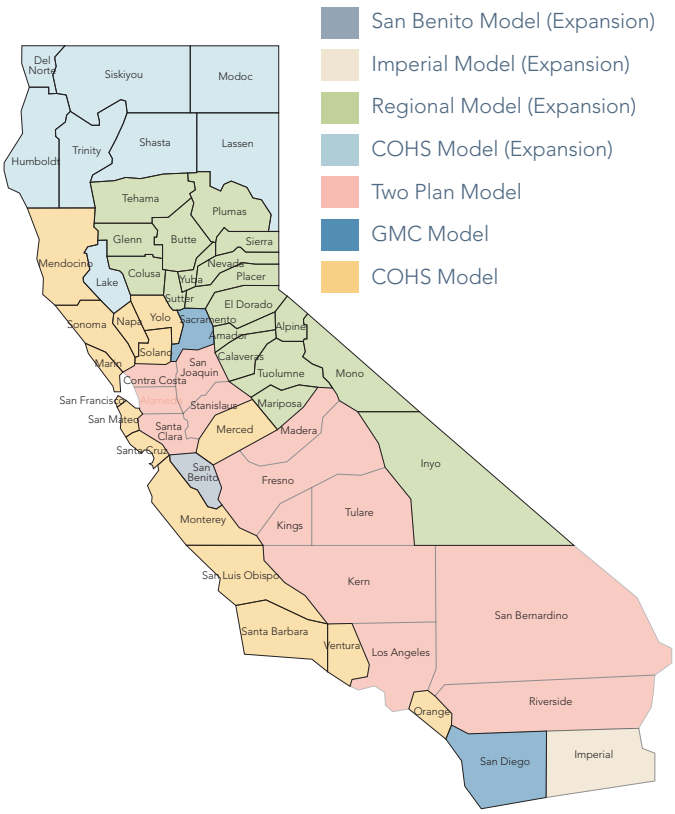
What Is Medi-Cal Managed Care?

Currently, 82% of Medi-Cal beneficiaries receive their coverage through managed care plans contracted with the state, while the remaining 18% are enrolled through fee-for-service Medi-Cal.[9]

There are six managed care models in Medi-Cal managed care:

- **County Organized Health System (COHS).** A health plan created and administered by a county board of supervisors. Within a COHS county, all managed care enrollees are in the same plan. (22 counties)
- **Two-Plan Model.** This model comprises a publicly run entity (a local initiative) and a commercial plan.† (14 counties)
- **Geographic Managed Care (GMC).** A mix of commercial and nonprofit plans that compete to serve Medi-Cal beneficiaries. (2 counties)

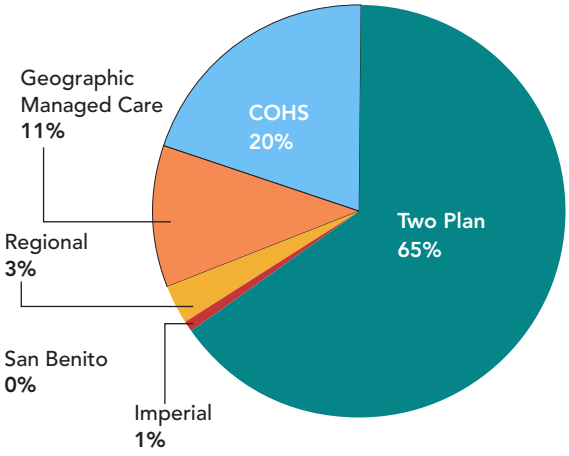
Figure 8. Medi-Cal Managed Care Models



Source: *Medi-Cal Managed Care Program Fact Sheet — Managed Care Models*, California Department of Health Care Services, February 2018, www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf.

† With the exception of Tulare County, which has two commercial plans.

Figure 9. Medi-Cal Enrollment by Managed Care Model, December 2018



Source: *Medi-Cal Managed Care Enrollment Report — December 2018* (Sacramento: California Department of Health Care Services, January 2019).

- **Regional Expansion Model.** Two commercial plans in each county. (18 counties)
- **Imperial Model.** This model only operates in Imperial County, with two commercial plans.
- **San Benito (Voluntary) Model.** One commercial plan.

The geographic distribution of the models, and the percent of Medi-Cal managed care enrollees in each model, are displayed in Figures 8 and 9.

What Services Are Excluded, or "Carved Out," of Managed Care?

While managed care plans cover most primary and acute care benefits for managed care enrollees, some Medi-Cal–covered services are excluded from managed care, or "carved out." These carved-out services are administered and accessed outside of the managed care plan. Major carve-outs include:

- **Specialty Mental Health Services**. Currently, mental health service delivery is split between Medi-Cal managed care plans, which provide mental health services to Medi-Cal beneficiaries with mild to moderate mental health conditions, and county mental health plans (MHPs), which provide specialty mental health services (SMHS) to people with serious mental

illness (SMI).[10] SMHS are provided through the county MHPs using the 1915(b) waiver authority (described in the section on Medicaid waivers). SMHS may include, but are not limited to, individual and group therapy, medication services, crisis services, case management, residential and hospital services, and specialized services for children and youth.

- **Substance Use Disorder (SUD) Services.** SUD services are provided through the Drug Medi-Cal Organized Delivery System (DMC-ODS), which provides on-demand treatment (no referral from Medi-Cal or the managed care plan is required) for the treatment of SUDs, including outpatient addiction treatment services, intensive outpatient services, detox services, medication-assisted treatment, and residential recovery services.
- **Dental Services.** Denti-Cal provides dental care to Medi-Cal members on a FFS basis, except in Los Angeles and Sacramento Counties, where dental managed care plans are available.[11] Denti-Cal provides basic coverage for cleaning and preventive care along with some medically necessary treatments.
- **Long-Term Services and Supports (LTSS).** LTSS include Home- and Community-Based Services (HCBS), which are intended to keep beneficiaries in their homes and out of long-term care facilities such as nursing homes. LTSS are carved out of the managed care contract, except for the plans operating in Coordinated Care Initiative (CCI) counties, where these services are provided as part of a Managed Long-Term Services and Supports (MLTSS) benefit that is only available within the managed care delivery system. (LTSS are described in more detail in the waivers section. For detailed discussion of the CCI program, see "What Are Medi-Cal Pilot Programs and How Are They Designed?" on page 13) Examples of LTSS include In-Home Supportive Services (IHSS),[12] which is administered by the county and overseen by the California Department of Social Services. IHSS provides personal care and domestic services that allow seniors and persons with disabilities to remain in their homes. The Multipurpose Senior Services Program (MSSP), which is administered by the California Department of Aging,[13] provides comprehensive case management to Medi-Cal beneficiaries over the age of 65. The community-based adult services (CBAS)[14] benefit is administered by centers that provide an array of services including nursing services and personal care.
- **Long-Term Care**. Coverage for long-term care services is provided under most managed care contracts for the month of admission to a long-term care facility plus an additional month. If the beneficiary requires a longer stay, the plan will disenroll the member into FFS, under which DHCS assumes responsibility for all covered services, including the cost to Medi-Cal for the member's long-term care stay. One exception is that long-term care is covered in most COHS plans and in plans operating in the CCI.
- **California Children's Services (CCS).** The 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, which include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries. CCS was carved out of managed care statewide until SB 586 authorized DHCS to implement the Whole Child Model (WCM) program in 21 specified COHS counties. Under the WCM, starting in 2018, several counties transitioned coverage for CCS into their COHS plans, with more in line to transition in the near future.[15]

How Is Payment Structured for Medi-Cal Managed Care?

Payment Rates for Plans

Under managed care, DHCS pays each MMCP a specific amount per member per month (PMPM) to cover the services provided under the health plan contract, which varies by model and county.[16] Rates are based on categories of aid (COA) that correspond to Medi-Cal–eligible populations. The specific rate for each COA varies by county and plan.

A PMPM rate for each aid category is calculated by DHCS and its contracted actuaries based on historical data, projected use of services, and

other programmatic or coverage changes. The actuarially certified rates are then submitted to CMS for review and approval. Once DHCS receives approval from CMS on the final rates, the plans are paid monthly based on the number of plan enrollees in each aid category.

The ACA established a medical loss ratio (MLR) for the adult Medicaid expansion population. This MLR requires plans to demonstrate that at least 85% of spending on this population goes directly to medical costs and allowable administrative expenses. If a Medi-Cal managed care plan does not meet this threshold, it must return the excess funds to DHCS, which, in turn, will repay CMS. Starting in 2019, Medi-Cal managed care plans are required to collect and report MLR data for all COAs, and beginning in 2023, the plans will be required to return excess funds across all COAs and not just for the Medi-Cal expansion population. This information will be made publicly available by DHCS.

Payment Rates for Doctors and Hospitals

Each MMCP establishes its own payment rates for providers, which are confidential. The rates that are negotiated with providers reflect the state budget and decisions about funding levels for Medi-Cal. This generally results in provider payments being lower than commercial or Medicare reimbursement rates.

Many plans and providers have moved from FFS payment to capitated arrangements to simplify the system and reduce risk. Under a capitated arrangement, the provider accepts a monthly payment from the health plan for the number of enrollees assigned to that provider (individual provider or provider groups). The provider then agrees under its contract to deliver a set of defined services to its assigned enrollees for that payment amount. This transfers some of the risk to the provider because it must appropriately manage utilization and costs to maintain a financially sustainable relationship with the health plan.

Which Agencies Provide Oversight for Medi-Cal?

Centers for Medicare & Medicaid Services (CMS). Medicaid is a shared program, with financing, regulation, and oversight split between the federal government and each state. CMS administers the federal share of Medicaid financing, sets program parameters through regulations and formal guidance, and oversees state Medicaid programs, including review and approval of state Medicaid waivers and other programs unique to each state.

California Health and Human Services Agency. CHHS is the umbrella agency that includes state departments that oversee health and human services programs in California.

California Department of Health Care Services. DHCS, which is part of CHHS, directly administers Medi-Cal. DHCS implements federal Medicaid policy and regulations, provides state regulation and program guidance governing Medi-Cal, oversees the Medi-Cal fee-for-service program, and contracts with and oversees performance of Medi-Cal managed care plans.

California Department of Managed Health Care (DMHC). DMHC is a regulatory agency that licenses managed care plans in California. DMHC oversees compliance of Knox-Keene licensed managed care plans and products, conducts enforcement actions, and processes complaints from health care consumers.

California Department of Social Services (CDSS). CDSS administers public programs that are part of the social safety net in California, such as CalWORKs, which provides cash aid to low-income families; CalFresh (the Supplemental Nutrition Assistance Program [SNAP]); foster care and adoption assistance; and In-Home Supportive Services (IHSS), among others.

California Department of Aging (CDA). CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities. CDA contracts with Area Agencies on Aging (AAA), which

manage federal- and state-funded services. CDA also administers the Community-Based Adult Services (CBAS) program and the Multipurpose Senior Services Program (MSSP).

California Department of Developmental Services (DDS). DDS provides services and supports to individuals with developmental disabilities, including intellectual disabilities, cerebral palsy, epilepsy, autism, and related conditions. DDS oversees and operates developmental centers and community facilities, and contracts with 21 nonprofit regional centers that serve as a local resource to help beneficiaries find and access the services and supports.

How Is Medi-Cal Performance Monitored?

DHCS is responsible for monitoring and reporting on Medi-Cal care delivery, quality, and access. For the FFS system, DHCS compiles the Access Monitoring Plan, which reports on eligibility, enrollment, and use of services.[17] For managed care, DHCS is required by federal law to contract with an external quality review organization (EQRO), which provides detailed reports to monitor and assess health plan performance, including compliance with DHCS quality strategy, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and encounter data validation studies. Additionally, the EQRO uses the Healthcare Effectiveness Data and Information Set (HEDIS), a national standard set of quality measures, to assess each health plan. DHCS and its EQRO use this information to provide plan-specific reports and develop performance improvement project requirements.

DHCS also monitors Medi-Cal enrollees' grievances and appeals and other activities that may indicate a quality or access issue. This information is compiled into a Medi-Cal Managed Care Performance Dashboard,[18] which is released quarterly on the DHCS website. DHCS also conducts medical and quality audits and surveys each year and makes public selected information about health plan compliance, enrollment, and quality.[19] Health plans that are not in compliance with access or quality requirements may be placed under a corrective action plan (CAP) or face financial sanctions. DHCS maintains a Medi-Cal Managed Care Monitoring website, where the public can access information on audits and surveys, quality improvement and performance measure reports, and administrative and financial sanctions.

How Is the Medi-Cal Program Financed?

Medi-Cal is jointly funded by the state and federal governments as an entitlement program, meaning that there is no cap on federal or state spending and the amount of funding is based on expenditures needed to cover care for eligible beneficiaries. The total cost for the Medi-Cal program in FY 2018-19 is over $99 billion (see Figure 10).[20] General Fund spending for Medi-Cal ($20.9 billion) represents 15% of the total General Fund budget, second only to spending on K–12 education.[21] The federal government provides federal matching funds for Medicaid based on a Federal Medical Assistance Percentage (FMAP), which varies by state and by population. For every dollar that the state expends on allowable Medicaid costs, the federal government matches those funds at the applicable FMAP. California's 2019 FMAPs are as follows[22]:

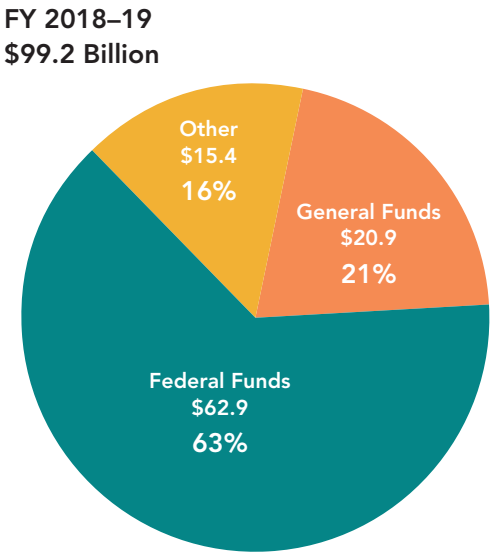
- 50% for the pre-ACA Medi-Cal population, which includes families, SPDs, and pregnant women
- 88% for the Children's Health Insurance Program (CHIP)
- 93% for the expansion adult population, which includes adults without dependent children below 138% of the FPL (this FMAP will decrease to 90% in 2020 and beyond)

In addition to these standard FMAPs, the federal government provides enhanced funding (more than 50% FMAP) for certain other activities and services, such as family planning and information technology investments.

The state share of Medi-Cal funding is drawn from multiple sources, including the state General Fund (GF), local matching funds, provider fees,[23] and health plan taxes. These other funding sources

allow California to draw down additional federal matching funds for Medi-Cal while reducing the impact on the GF. Over a third of the state financing for Medi-Cal is from these other sources. Counties and the public hospital systems are the main sources of local matching funds and have a significant impact on Medi-Cal financing and the ability of the state to support the program.

Figure 10. Medi-Cal Funding Sources



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

What Is the Role of Waivers in the Medi-Cal Program?

The federal Medicaid program provides states with considerable flexibility, much if which is provided through waivers of federal law. California uses three types of Medicaid waivers:

1. Section 1915(b) Managed Care Freedom-of-Choice Waivers

A Section 1915(b) waiver is often referred to as a "freedom-of-choice" waiver because the usual requirement that a Medicaid beneficiary can receive services from any provider in the state is waived. California's Medi-Cal Specialty Mental Health Services Section 1915(b) waiver requires Medi-Cal beneficiaries that meet medical necessity criteria for specialty mental health services to receive those services through their County Mental Health Plan (MHP).[24] Within the MHP, beneficiaries have a choice of providers. California's current Medi-Cal Specialty Mental Health Services 1915(b) waiver runs through June 30, 2020.

2. Section 1915(c) Home- and Community-Based Services (HCBS) Waivers

Section 1915(c) waivers allow state Medicaid programs to cover long-term care services to be delivered in community settings instead of solely in institutions such as nursing homes. HCBS waiver programs can provide a combination of both traditional medical services (e.g., dental care, skilled nursing care) and nonmedical services (e.g., respite care, case management, environmental modifications). States have the flexibility to determine how many beneficiaries they will serve through each HCBS waiver program. California has several HCBS waivers serving seniors and persons with disabilities and individuals with HIV/AIDS.[25, 26, 27, 28, 29, 30, 31]

3. Section 1115 Waivers

Section 1115 of the Social Security Act allows states to propose projects that test policy innovations likely to further objectives of the Medicaid program. Section 1115 waivers have been used by states to implement sweeping Medicaid program reforms, including Medicaid managed care programs, Medicaid expansion alternatives, Medicaid work requirements, and many other program reforms.[32] A key feature of Section 1115 waiver authority is that it allows CMS to permit states to use program savings to pay for services, programs, or populations that would not otherwise be eligible for federal matching funds.

California's current Section 1115 waiver, Medi-Cal 2020, builds upon previous reforms and furthers the goals of system-wide integration and transformation. It includes:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME).** The successor to the Delivery System Reform Incentive Payment (DSRIP) program, PRIME aims to change care delivery and promote risk-based alternative payment models (APMs).

- **Global Payment Program (GPP).** Assists designated public hospitals and public health care systems in providing health care for the uninsured.
- **Whole Person Care (WPC) Pilot Programs.** County-based pilot programs that provide support to integrate care for the highest-risk, highest-cost beneficiaries to address poor health outcomes.
- **Dental Transformation Initiative.** Incentive to expand access to dental services for Medi-Cal beneficiaries.

The Drug Medi-Cal Organized Delivery System program (discussed separately below) is also included in the Medi-Cal 2020 waiver. The waiver expires on December 31, 2020.

What Are Medi-Cal Pilot Programs and How Are They Designed?

California has implemented several pilot programs to test new approaches to integrating care across the health care system, with the broader goals of improved quality and increased efficiency. Major initiatives are outlined below.

Coordinated Care Initiative (CCI)

The Coordinated Care Initiative (CCI) was enacted in 2012 and implemented in seven counties (San Mateo, Santa Clara, Los Angeles, Orange, Riverside, San Bernardino, and San Diego). The first component of the CCI is a mandatory Managed Long Term Services and Supports (MLTSS) program. Through MLTSS, Medi-Cal beneficiaries, including dual eligibles, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including long-term care services and Medicare wraparound benefits. The second component is a demonstration program for dual eligibles. This program component is called Cal MediConnect and creates a single health plan that covers all Medi-Cal and Medicare benefits. Eleven managed care plans participate in Cal MediConnect in the seven program counties, and 111,330 dual eligibles are currently enrolled. Through the demonstration program, dual eligibles can choose to enroll in a Cal MediConnect plan and receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services. The initial demonstration has ended, but California will continue the program through December 31, 2020.

Health Homes Program

The Health Homes program (HHP), established by the Affordable Care Act, provides resources for enhanced care management across physical health, behavioral health, and community-based long-term services and supports needed by beneficiaries with chronic conditions.[33] HHP will be administered through Medi-Cal managed care plans and will include six core services: (1) comprehensive care management; (2) care coordination (physical health, behavioral health, community-based LTSS); (3) health promotion; (4) comprehensive transitional care; (5) individual and family support; and (6) referral to community and social support services. HHP implementation is being phased in between 2018 and 2020. Each managed care plan will coordinate with community-based care management entities (CB-CMEs) and other community-based organizations (CBOs) to link members to community and social supports as part of a whole-person care approach. CB-CMEs serve as the single coordinating entity that ensures each HHP participant receives access to HHP services.

Whole Person Care Pilot Program

The Whole Person Care (WPC) Pilot program[34] was established as part of the Medi-Cal 2020 waiver and aims to provide integrated services to some of Medi-Cal's most vulnerable beneficiaries. WPC pilot programs were proposed by counties in partnership with providers and managed care plans over two application rounds. There are 25 pilot programs in place today across the state, with a total five-year budget of $3 billion. Entities participating in WPC pilots are responsible for increasing integration among county agencies, health plans, providers, and other entities within the county that serve high-risk, high-need beneficiaries, and for developing infrastructure to ensure collaboration among the participating entities over the long term.

Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) was authorized and financed under the authority of the state's Section 1115 Bridge to Reform waiver and was then carried over into the Medi-Cal 2020 waiver. Counties voluntarily participate in DMC-ODS. The waiver program created an organized delivery system through which counties that opt in contract with a SUD provider network and provide coordinated services to all full-scope Medi-Cal beneficiaries. The continuum of care used in the program is modeled after the American Society of Addiction Medicine (ASAM) criteria. The goals of the DMC-ODS pilot program are as follows[35]:

- Test a new paradigm for the organized delivery of health care services for Medi-Cal enrollees with an SUD.
- Demonstrate how organized SUD care improves outcomes for DMC beneficiaries while decreasing other health care costs.
- Promote both systemic and practice reforms to develop a continuum of care that effectively treats the multiple dimensions of SUDs.
- Design an SUD benefit that guarantees a full continuum of evidence-based practices to address the immediate and long-term physical, mental, and care needs of the beneficiary.

Looking Ahead

Medi-Cal is the largest Medicaid program in the country in both its total enrollment and its budget. The Medi-Cal program provides coverage of primary, specialty, acute, and dental services for one-third of Californians. With billions of federal and state dollars allocated to this program — and millions of Californians relying on it for their health care — it has a prominent role in state budget and policy discussions. Medi-Cal has long been a leader and an innovator among state Medicaid programs. California was an early adopter of Medicaid managed care, has taken advantage of federal waiver and pilot opportunities, and has embraced the expansion of coverage under the ACA.

Trends in Medicaid nationally include ACA eligibility expansions among some states; increased use of managed care delivery systems; expansion of home- and community-based services, housing supports and services, long-term care, provider rates and taxes, and integrated behavioral health (including addressing SUD and opioid abuse); and connecting formally incarcerated individuals to health care. California is implementing programs in all of these areas.

California relies heavily on federal funding and could not maintain its current Medi-Cal program under the funding scenarios that have been proposed at the federal level, including block grants. Another major concern is the impact of an economic downturn, which would result in a surge in Medi-Cal enrollment at a time when state revenues are declining.

Moreover, while the state has had several ambitious 1115 waivers leading up to and following the implementation of the ACA, it is widely expected that the next 1115 waiver renewal in 2021 will be more limited in scope. Previously, California has been able to generate significant projected savings under budget neutrality requirements of the 1115 waiver to fund programs such as Whole Person Care and the early transition of members eligible under the ACA expansion under the Low-Income Health Program (LIHP). However, the federal government has indicated that it does not expect to continue to approve large-scale demonstration programs under California's next 1115 waiver. Specifically, the baseline used to calculate the "without waiver costs" will be updated to reflect more recent state experience with managed care rather than using a FFS basis. This is expected to significantly reduce the program savings that are available under the demonstration.

Medi-Cal provides a vital safety net for low-income Californians and plays an important role in the state, providing vulnerable populations with access to needed care across the care continuum. It also provides a vehicle for California to implement health care transformation and to further the goals of achieving the Triple Aim: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

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