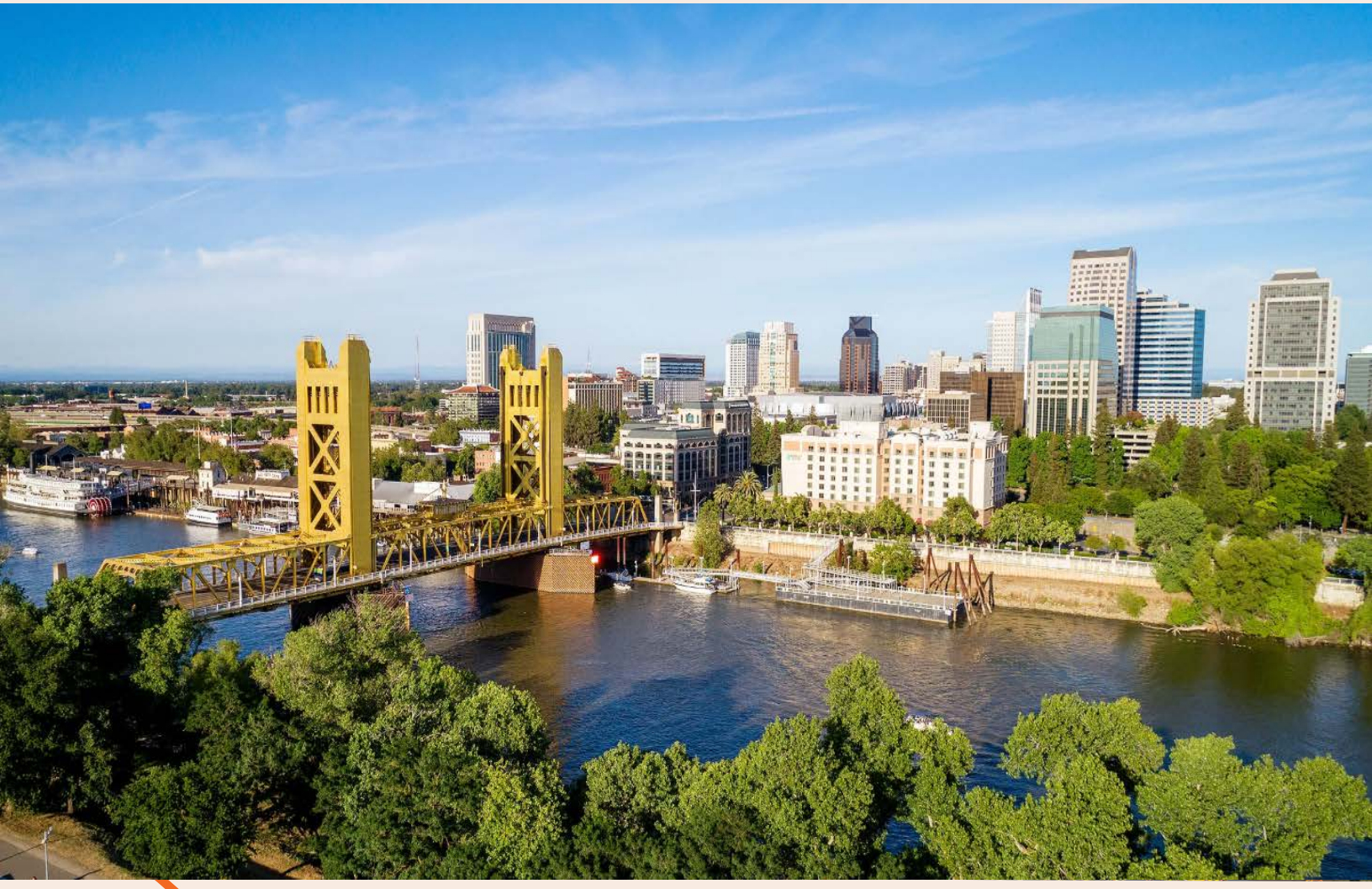
California Health Care Foundation

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Regional Market Report 2026: Sacramento Area



California Health Care Almanac
Regional Markets Series

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California Health Care Foundation

Sacramento Area: As Health Systems Chase Population Growth, Medi-Cal Access Problems Persist

Summary of Findings

The Sacramento area — spanning El Dorado, Placer, Sacramento, and Yolo Counties — is among the fastest growing regions in California and is now home to more than 2.4 million people. Together, the four counties include about 5,100 square miles, including an urban core in Sacramento County and a mixture of suburban and rural areas in the other counties. Anchored by the state capital, Sacramento County constitutes about two-thirds of the regional population. Historically reliant on government, health care, education, tourism, and agriculture, the region's economy is diversifying with growth in the life sciences and tech sectors, including semiconductor manufacturing. As younger, higher-income, and commercially insured people move to fast-growing suburbs, the major health systems are building new hospitals, outpatient facilities, and medical office buildings to meet demand. At the same time, lower-income Medi-Cal and uninsured patients rely primarily on community health centers (CHCs) for outpatient care and experience significant challenges accessing specialty services.

The region has experienced a number of changes since the previous study in 2020–21 (see page 23 for more information about the Regional Markets Study).[1] Key developments include the following:

- **Medi-Cal has expanded to cover more than 1 in 3 people regionally, but federal and state cuts threaten coverage gains.** Medi-Cal coverage increased 6.7 percentage points in the region between 2019 and 2023, reaching 35.6% of the population. However, federal House Resolution 1 (HR 1), also known as the One Big Beautiful Bill, is expected to significantly reduce Medi-Cal enrollment statewide and regionally, resulting in more uninsured people. Reduced availability of premium subsidies for people enrolled in Covered California, the state's health insurance marketplace, will compound the problem. At the same time, state budget shortfalls prompted a Medi-Cal enrollment freeze statewide for undocumented adults and others with unsatisfactory immigration status (UIS).
- **Placer and El Dorado Counties launched new Medi-Cal managed care models in 2024, requiring about 50,000 people to switch plans and, in some cases, providers.** Commercial plans exited and new public plans entered the counties. The transition disrupted care for some Medi-Cal enrollees as the new plans struggled to establish or expand provider networks. In Sacramento County, where the number of commercial Medi-Cal managed care plans declined from five to four, providers still report challenges related to different administrative infrastructure and policies, including prior authorization, billing requirements, referral networks, and quality incentive programs.

- **Health systems build new facilities to meet population growth.** The region's four major health systems — Dignity Health, Kaiser Permanente, Sutter Health, and UC Davis Health — continue to expand, especially in the fast-growing Sacramento suburbs where younger, higher-income, and commercially insured people are moving. State seismic safety requirements are also contributing to the construction boom as Kaiser and UC Davis Health build new hospitals in Sacramento to replace aging infrastructure.
- **Access to specialty care remains challenging, with long waits for appointments, especially for Medi-Cal patients.** As physicians continue to align with the major health systems or join larger independent practice associations (IPAs), access to specialists for Medi-Cal patients has become more challenging. Despite the region having more primary care and specialty physicians, including psychiatrists, per 100,000 population than statewide, access challenges reportedly affect commercially insured people as well.
- **CHCs across the four-county Sacramento region have expanded facilities, added new sites or mobile units, or merged to improve access to care.** CHCs provide access to vital primary and specialty care, dental services, and behavioral health services. Despite expansions, CHCs regionally still see fewer patients and provide fewer visits per capita than CHCs on average statewide.

Market Background

The Sacramento area — spanning El Dorado, Placer, Sacramento, and Yolo Counties — is among the fastest growing regions in California. Home to more than 2.4 million people, the region's population has grown 4.2% since 2019, compared to a -0.2% population decline statewide during the same time (Table 1). Anchored by the state capital, Sacramento County comprises about two-thirds of the region's population, including more than 535,000 residents in the city of Sacramento. Placer and El Dorado Counties lie to the east of Sacramento and include more affluent suburbs near their western borders and semirural areas stretching east to the Nevada border and Lake Tahoe. Roseville, with a population of about 160,000, is the largest city in Placer County and lies roughly 20 miles northeast of the city of Sacramento. In El Dorado County, the unincorporated El Dorado Hills area, with a population of about 50,000, also borders Sacramento County and is the county's largest community. Yolo County lies to the west of the capital, on the other side of the Sacramento River. Yolo's largest city, Davis, with a population of about 67,000, is home to the University of California, Davis; however, the UC Davis Medical Center is in Sacramento.

The region's economy relies heavily on government, health care, education, tourism, and agriculture,[2] but the Sacramento area is experiencing growth in the life sciences and tech sectors, including semiconductor manufacturing.[3] The unemployment rate regionally is lower than statewide — 4.3% versus 4.8% — and nearly a quarter of households (24%) can afford to buy a median-priced home, compared to 13.6% of households statewide. About 1 in 9 people (10.9%) regionally had incomes below the federal poverty level in 2023 — or $30,000 for a family of four[4] — compared to 1 in 8 statewide (12.0%). People regionally are more likely to have a high school diploma than statewide — 90.1% versus 84.6% — but the share of people regionally with a college bachelor's degree or higher is about the same as statewide — 36.3% versus 36.5%.

The Sacramento region is less racially diverse than California overall, with Latino/x residents accounting for 23.0% of the population — much lower than the statewide share (40.4%). White residents account for nearly half of all people regionally (48.3%), compared to 34.3% statewide. The region has a slightly higher proportion of Black residents than statewide

and about the same share of Asian residents as in California overall. People regionally also are less likely to have been born outside the United States than statewide — 19.8% versus 27.3%.

TABLE 1. Population Characteristics,
Sacramento Four-County Region vs. California, 2023 Unless Noted

	Sacramento	California
POPULATION STATISTICS		
Total population (2024)	2,463,127	39,431,263
Share of state population	6.2%	100%
Five-year population growth	4.2%	-0.2%
AGE OF POPULATION, IN YEARS		
Under 18	21.9%	21.7%
18 to 64	60.9%	62.1%
65 and older	17.2%	16.2%
RACE/ETHNICITY		
Latino/x	23.0%	40.4%
White (non-Latino/x)	48.3%	34.3%
Asian (non-Latino/x)	15.3%	15.8%
Black (non-Latino/x)	7.0%	5.6%
Other (non-Latino/x)	6.4%	3.8%
BIRTHPLACE		
Outside the United States	19.8%	27.3%
EDUCATION (AMONG THOSE AGE 25 AND OLDER)		
High school diploma or higher	90.1%	84.6%
College bachelor's degree or higher	36.3%	36.5%
ECONOMIC INDICATORS		
Income below 100% federal poverty level	10.9%	12.0%
Household income $100,000+ (%)	47.2%	48.4%
Median household income*	$94,847	$96,334
Average (mean) household income	$123,767	$136,730
Unemployment rate	4.3%	4.8%
Households able to afford median-priced home (2024)	24.0%	13.6%

* A weighted blend of county-level median household income figures.

Sources: *Annual Estimates of the Resident Population for Countries in the United States: April 1, 2020 to July 1, 2024* (CO-EST2024-POP), *County Population by Characteristics: 2020–2023* (CC-EST2023-ALLDATA-06 and CC-EST2023-AGESEX-06), *Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019* (CO-EST2019-ANNRES-06), "US Census, American Community Survey (ACS) 1-Year Supplemental Estimates, K200503, Place of Birth in the United States" (2019 and 2023), "ACS 5-Year Estimates Subject Tables, S1501, 2023, Educational Attainment by County" (2023), "US Census, ACS 5-Year Estimates Subject Tables, S1901, Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars), 2023 and (in 2019 Inflation-Adjusted Dollars), 2019," US Census Bureau; "Current Industry Employment and Unemployment Rates for Counties," California Employment Development Department; and "Housing Affordability Index – Traditional (Q2 2024)," California Association of Realtors.

Infant Mortality, Overdose Deaths Higher Than Statewide

While a smaller share of Sacramento area residents reported being in fair or poor health (13.8%) than statewide (15.5%), the region experienced worse outcomes on several physical and behavioral health indicators (Table 2). For example, the infant mortality rate regionally is 4.7 deaths per 1,000 live births, compared to 4.1 statewide. Similarly, the region fares worse on drug-related overdose deaths — 32.9 per 100,000 population versus 29.1 statewide — and drug-related emergency department (ED) visits — 151.0 per 100,000 population versus 137.4 statewide. Suicide rates also are higher in the Sacramento region than statewide — 11.8 deaths per 100,000 population compared to 10.1 statewide.

TABLE 2. Health Status,
Sacramento Four-County Region vs. California, 2023 Unless Noted

	Sacramento	California
PHYSICAL HEALTH STATUS		
Fair/poor*	13.8%	15.5%
Adults with an independent living difficulty†	6.3%	5.8%
Diabetes prevalence‡	10.6%	11.3%
High blood pressure prevalence‡	23.0%	21.9%
Infant mortality rate (deaths per 1,000 live births), 2019–21	4.7	4.1
BEHAVIORAL HEALTH		
Anxiety prevalence‡	11.1%	10.3%
Depression, bipolar, or other depressive mood disorders prevalence‡	11.6%	10.5%
Opioid and other drug-related emergency department visits (per 100,000 population)	151.0	137.4
All drug-related overdose deaths (per 100,000 population)	32.9	29.1
Suicide deaths (per 100,000 population), 2020–22, age-adjusted	11.8	10.1

* Fair/poor health status reflects Sacramento County only due to small cell sizes.

† An independent living difficulty refers to, for example, difficulty doing errands alone, visiting a doctor's office, or shopping because of a physical, mental, or emotional condition.

‡ Prevalence reported from the Healthcare Payments Data (HPD) source reflects data from claims and encounter records, which capture instances of a condition treated during the specified time. Results may differ from prevalence rates obtained by other methods — for example, surveys or record sampling. HPD reporting of measures data suppresses counts from any group (age, sex, payer, and county-specific) with fewer than 30 people; caution is advised when interpreting results for geographic areas with fewer than 30,000 residents.

Sources: "AskCHIS," UCLA Center for Health Policy Research; "American Community Survey, 2023 5-Year Estimates, S1810, Disability Characteristics," US Census Bureau; *HPD Measures Data (2018–2023)*, California Department of Health Care Access and Information; "Infant Mortality," California Department of Public Health (CDPH); *County Health Status Profiles, 2024: Tables 1–29*, CDPH, last updated August 8, 2024; "California Overdose Surveillance Dashboard," CDPH, last updated May 19, 2025.

Medi-Cal Coverage Expands

More than a third of Sacramento area residents (35.6%) in 2023 had Medi-Cal coverage, including those dually eligible for Medicare, compared to 40.1% statewide (Table 3). Medi-Cal coverage regionally increased 6.7 percentage points between 2019 and 2023, marking the greatest increase among coverage categories. The share of area residents with commercial health insurance also increased, growing from 54.5% in 2019 to 56.3% in 2023, compared to 50.8% statewide in 2023. Reflecting the region's older population, 18.7% of Sacramento area residents had Medicare coverage in 2023, including those dually eligible for Medi-Cal, compared to 17.3% statewide. The share of people regionally without health insurance decreased slightly to 4.6% in 2023, compared to 6.4% statewide.

TABLE 3. Sources of Health Insurance,
Sacramento Four-County Region vs. California, 2019 and 2023

Coverages as Share of Population (Totals > 100%)*	2019		2023	
	Sacramento	California	Sacramento	California
Uninsured	5.3%	7.7%	4.6%	6.4%
Medi-Cal and Medicare dually eligible	3.4%	3.7%	4.0%	4.5%
Medi-Cal (no Medicare)	25.5%	28.6%	31.6%	35.6%
Medicare (no Medi-Cal)	14.2%	12.1%	14.7%	12.8%
Commercial	54.5%	50.6%	56.3%	50.8%

* Percentages may sum to more than 100% due to people being included in more than one category.

Sources: *MA State/County Penetration* (July 2019 and July 2023), US Centers for Medicare & Medicaid Services; "American Community Survey, 1-Year and 5 Year Estimates, S2701, Selected Characteristics of Health Insurance Coverage in the United States," US Census Bureau; "By Medicare Dual Status, Certified Eligibles," California Health and Human Services Agency; and Katherine Wilson, *California Health Insurers, Enrollment Almanac — 2025 Edition*, California Health Care Foundation, February 2025.

Covered California accounted for 4.0 and 4.3 percentage points of commercial enrollment in the region and state, respectively, in 2023 — up slightly from 2019 (data not shown). In 2025, the average monthly Covered California premium for the lowest-cost silver plan was nearly 14% higher regionally ($536) than statewide ($472) for a 40-year-old person, assuming no premium subsidy (Table 4). In 2025, almost all Covered California enrollees in the Sacramento area (93.3%) received a premium subsidy that reduced the monthly cost of coverage, making the average net premium paid $130. By comparison, 89.4% of enrollees statewide received a premium subsidy and paid an average net $134 monthly premium. Enhanced federal premium subsidies enacted during the COVID-19 pandemic expired on January 1, 2026, making premiums significantly less affordable for about 100,000 Sacramento area residents who received premium subsidies in 2025. Moreover, for 2026, the unsubsidized monthly Covered California premium for a 40-year-old with the lowest-cost silver plan increased 14%, from $536 to $611.[5] To replace a portion of these lost federal funds, the California legislature appropriated $190 million in the 2026 plan year and another $300 million for the 2027 plan year to support premium subsidies. These subsidies are available to Covered California members with household incomes below 200% of the federal poverty level.[6]

TABLE 4. Covered California Monthly Premiums,
Sacramento Four-County Region vs. California, 2020 and 2025

Covered California Premiums*	2020		2025	
	Sacramento	California	Sacramento	California
Lowest-cost silver monthly premium, 40-year-old	$468	$398	$536	$472
Percentage higher/lower than California average	17.6%		13.6%	
Average annual premium increase, 2020–2025			2.8%	3.5%
Per-hour wage amount needed to pay monthly premium†	$2.70	$2.29	$3.09	$2.72
Monthly premium as share of state minimum wage, full time†	20.8%	17.6%	18.7%	16.5%
Percentage of members who receive premium subsidy			93.3%	89.4%
Average net monthly premium paid by those receiving subsidy			$130	$134
Median net monthly premium paid by those receiving subsidy			$54	$57

* California premiums are weighted averages across all Covered California rating regions. Similarly, regional premiums are weighted averages for the counties that make up the region. Weighting is by enrollment.

† Assumes person pays the entire premium (i.e., no subsidy to offset cost).

Sources: *2025 Covered California Data: 2025 Individual Product Prices*, Covered California; *2020 Covered California Data: 2020 Individual Product Prices for All Health Insurance Companies*, Covered California; and *Active Member Profiles: June Profile* (2020 and 2025), Covered California.

The prevalence of medical debt in the Sacramento area, at 10.4% in 2022–23, remained virtually unchanged from 10.3% four years earlier and is similar to the statewide rate (Table 5). However, among those with medical debt regionally, 64.2% owed more than $2,000 — a sizable jump from 47.5% four years prior and a larger share than statewide.

TABLE 5. Medical Debt,
Sacramento Four-County Region vs. California, 2018–19 and 2022–23

	2018–19 POOLED*		2022–23 POOLED*	
Medical Debt	**Sacramento**	**California**	**Sacramento**	**California**
Prevalence (% of adults with medical debt)†	10.3%	10.8%	10.4%	10.2%
AMOUNT OF MEDICAL DEBT THEY ARE HAVING TROUBLE PAYING‡				
Less than $2,000	52.5%	45.1%	35.8%	43.7%
More than $2,000	47.5%	54.9%	64.2%	56.3%

* Data are pooled across two years to increase data stability; confidence intervals on the amount of debt are broad in multiple regions.

† Prevalence figure is the percentage of people who answered yes to the question "Ever had problems paying for self or household family's medical bills in past 12 months?"

‡ The amount of medical debt reflects the responses of those who said they had experienced problems paying medical bills in the past 12 months.

Source: "AskCHIS," UCLA Center for Health Policy Research.

Medicare Managed Care Grows

More than 450,000 Sacramento area residents are Medicare beneficiaries, and the share of the population covered by Medicare has increased both regionally and statewide in recent years (Table 6). A higher share of the population regionally is enrolled in Medicare than are Californians overall — 18.8% versus 17.5% in 2024 — reflecting the Sacramento area's older population. A larger share of Sacramento area Medicare beneficiaries (57.3%) is enrolled in private Medicare Advantage (MA) health plans, compared to about 51.2% of California Medicare beneficiaries overall. Kaiser remained the dominant insurer regionally in 2024, covering 59% of MA enrollees — a sizable decline from 66% in 2019 (Table 7). UnitedHealthcare (United) also lost MA market share, dropping from 13% in 2019 to 9% in 2024. During the same time, Sierra Health, a wholly owned subsidiary of UnitedHealthcare, saw a slight increase to 9%, with two plans — Blue Cross of California and Alignment — entering the market, each with 4% market share by 2024.

TABLE 6. Medicare Enrollment Overview,
Sacramento Four-County Region vs. California, 2019 and 2024

	SACRAMENTO		CALIFORNIA	
	2019	**2024**	**2019**	**2024**
Total Medicare enrollment	417,151	463,705	6,239,477	6,899,496
Medicare as share of population	17.6%	18.8%	15.8%	17.5%
SHARE OF TOTAL MEDICARE				
Medicare Advantage	48.2%	57.3%	44.1%	51.2%
Original Medicare	51.8%	42.7%	55.9%	48.8%

Source: *MA State/County Penetration* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

TABLE 7. Largest Medicare Advantage (MA) Health Plans and Market Share,
Sacramento Four-County Region, 2019 and 2024

Health Plan	2019	2024
Kaiser Foundation Health Plan	66%	59%
UnitedHealthcare of California	13%	9%
Sierra Health and Life Insurance Company	7%	9%
Blue Cross of California Partnership Plan	0%	4%
Alignment Health Plan	0%	4%

Source: *Monthly MA Enrollment by State/County/Contract* (July 2019 and July 2024), US Centers for Medicare & Medicaid Services.

Coverage options for people dually eligible for Medicare and Medi-Cal in the Sacramento area have changed recently in response to a California Department of Health Care Services (DHCS) mandate requiring all Medi-Cal managed care plans to offer an MA Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (EAE D-SNP) product, known as a "Medi-Medi plan" in California. People eligible for both Medicare and Medi-Cal can enroll in a D-SNP or another MA plan, or stay in original Medicare. If they enroll in an EAE D-SNP, the state automatically enrolls the member into the same Medi-Cal plan to align Medicare and Medi-Cal coverage. A key feature of the DHCS policy change is that among D-SNPs, only the EAE D-SNPs can enroll new members. Commercial plans that offer nonaligned D-SNP products cannot enroll new members in those products (though they can enroll dually eligible people into other MA products). Medi-Medi plans were available in Sacramento County starting in 2025 and launched in El Dorado, Placer, and Yolo Counties in 2026.[7]

As Medi-Cal Managed Care Expands, Two Counties Try New Models

Reflecting California's continued expansion of managed care within Medi-Cal, nearly all (94%) of the more than 825,000 Sacramento region residents with Medi-Cal in 2024 were enrolled in managed care plans (Table 8).

TABLE 8. Medi-Cal Enrollment Overview,
Sacramento Four-County Region vs. California, 2019 and 2024

	SACRAMENTO		CALIFORNIA	
	2019	2024	2019	2024
Total Medi-Cal enrollment	683,766	828,288	12,778,575	14,796,389
Medi-Cal as share of population	29%	34%	32%	38%
Share of Medi-Cal in managed care	81%	94%	82%	94%

Source: "Certified Eligibles by Delivery System and Plan" (August 9, 2024), California Department of Health Care Services.

In 2024, the four-county Sacramento region had three of the five state-approved models of Medi-Cal managed care:[8] the County-Organized Health System (COHS) model in Yolo and Placer Counties; the Geographic Managed Care (GMC) model in Sacramento County; and the Two-Plan model in El Dorado County. In addition to these three models and the plans serving in them, Kaiser established a direct contract with DHCS in 2024 to serve Medi-Cal enrollees. With new plan contracts starting in January 2024, the mix of plans serving these counties changed, with some plans entering and some plans leaving these markets.

GMC and the Sacramento County Health Authority Commission

In Sacramento County, with four plans serving the GMC model, the market shares for each plan remained largely the same after contract changes that went into effect in 2024 (Table 9). Anthem Blue Cross had the largest share with 41.4%, followed by the Centene subsidiary Health Net Community Solutions and Kaiser with 24.2% and 22.0% market share, respectively. Molina served the remaining Medi-Cal managed care enrollees with 12.2% market share. Aetna Better Health, which had a 2.1% share of enrollment in 2019, exited the market at the end of 2023.

TABLE 9. Medi-Cal Managed Care Plans,
Sacramento Four-County Region, 2019 and 2024

		MARKET SHARE BY COUNTY*	
County	Plan	2019	2024
El Dorado	Anthem Blue Cross Partnership Plan	29.4%	67.9%
El Dorado	Mountain Valley Health Plan	0.0%	21.8%
El Dorado	Kaiser Permanente	7.4%	10.2%
El Dorado	California Health & Wellness	63.2%	0.0%
Placer	Partnership HealthPlan of California	0.0%	77.5%
Placer	Kaiser Permanente	18.1%	22.5%
Placer	Anthem Blue Cross Partnership Plan	60.7%	0.0%
Placer	California Health & Wellness	21.2%	0.0%
Sacramento	Anthem Blue Cross	41.3%	41.4%
Sacramento	Health Net Community Solutions	24.6%	24.2%
Sacramento	Kaiser Permanente	20.5%	22.0%
Sacramento	Molina Healthcare of California	11.5%	12.2%
Sacramento	Aetna Better Health	2.1%	0.0%
Yolo	Partnership HealthPlan of California	100.0%	90.4%
Yolo	Kaiser Permanente	0.0%	9.6%

* Plan level Medi-Cal managed care market share is as of December 2019 and December 2024.
Source: *Medi-Cal Managed Care Enrollment Report* (data through January 2025), California Department of Health Care Services.

According to study respondents, the GMC model in Sacramento County remains complex and burdensome to both providers and Medi-Cal enrollees, even with the reduction to four plans. Providers reported having to wrestle with each plan's different administrative infrastructure and policies, including prior authorization, billing requirements, referral networks, and quality incentive programs. A managed care plan respondent observed, however, that the Sacramento region has more provider consolidation than other regions, contributing to better administrative alignment across Medi-Cal plans.

The simultaneous implementation of CalAIM (California Advancing and Innovating Medi-Cal) initiatives and statewide behavioral health changes added to administrative burdens for providers and plans (see "CalAIM Implementation: 'Flying the Plane While Building It,'" page 18). Furthermore, several CHC and legal advocate respondents reported that because health system medical groups limit participation in Medi-Cal, plan provider networks are "anemic" and members have difficulty accessing specialty care (see "Independent Practice Declines, Specialty Access Worsens," page 11).

The Sacramento County Health Authority Commission, created in December 2020 by the Sacramento County Board of Supervisors, is tasked with proposing strategies to Medi-Cal managed care plans to improve the quality, cost, and accessibility of services.[9] The commission is analyzing selected health plan quality measures to study variation among subgroups of enrollees and their geographic locations.[10] While commission recommendations are advisory only, if plans do not make meaningful improvements, the commission can escalate requests to DHCS and the board of supervisors to take more action. Notably, a separate county committee provides oversight of Medi-Cal dental service delivery.[11]

Commission members include CHCs, hospitals, Medi-Cal enrollees, advocates, a member of the board of supervisors, and the Sacramento County Department of Health Services. Managed care plans are nonvoting members. Several respondents observed that the commission has struggled to find a unified view of the group's mission and strategic priorities. One respondent noted that while many have long aspired to change Sacramento County from the GMC model to a Two-Plan model, other respondents voiced little confidence that a public local initiative managed care plan could operate successfully in the county.

Bumpy Transition to New Medi-Cal Plans

After many years of advocacy by providers, consumer groups, and elected officials, El Dorado and Placer Counties in 2024 transitioned away from the Regional model of managed care with two commercial health plans. The board of supervisors in each county had to pass an ordinance and seek approval for the model change from DHCS.[12] El Dorado and Placer County respondents noted that providers had been frustrated with Anthem Blue Cross and Centene subsidiary California Health & Wellness, particularly around staff turnover and timely payment issues.

With plans exiting and entering El Dorado and Placer Counties under the model changes, some 50,000 Medi-Cal enrollees transitioned from one managed care plan to another. The transition created continuity of care issues for many, which were addressed by state policies that allow Medi-Cal enrollees to keep using providers no longer in-network for a period of time.[13] El Dorado County moved to the Two-Plan model, with Mountain Valley Health Plan (operated by the Health Plan of San Joaquin) entering the market and serving as the county-authorized local initiative plan and Anthem Blue Cross serving as the commercial plan. Placer County changed to the COHS model of managed care, with Partnership HealthPlan of California entering the market. In both counties several observers noted that the new plans had to sort through building provider networks, which one observer described as a "jumble," particularly with specialty physicians. Since the somewhat bumpy transition, several respondents shared that access to services has improved and that the new plans are working hard to build trust in the community.

Four Large Health Systems Dominate Market

Sixteen acute care hospitals serve the four-county Sacramento region, with 13 affiliated with four large health systems: Dignity Health, Kaiser, Sutter Health, and UC Davis

Health. In addition, two small independent hospitals operate in El Dorado County, and Shriners Children's Northern California, a Sacramento-based pediatric specialty hospital, draws patients from across Northern California. There are no city- or county-owned hospitals in the region; consequently, Medi-Cal inpatient admissions are shared across area hospitals. Together, the 16 hospitals have over 4,000 available beds, representing 168 beds per 100,000 population, less than the statewide average of 198 beds (Table 10).

Several hospital and CHC respondents observed that hospitals were struggling with high labor and other expenses, which rose during the COVID-19 pandemic and have remained high. Nonetheless, the region's hospitals were faring better financially than hospitals statewide in 2023, with an average net income (profit) margin of 5.7% compared to 4.5% statewide. The average operating expenses per adjusted patient day in the Sacramento region, at $6,111, were higher than the statewide average.

TABLE 10. Acute Care Hospitals Overview,
Sacramento Four-County Region vs. California, 2023

Acute Care Hospitals*	Sacramento	California
Number of facilities	16	334
Beds (available) per 100,000 population	168	198
Number of discharges	210,918	3,148,191
Net income margin	5.7%	4.5%
Operating expenses per adjusted patient day	$6,111	$5,117

* *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Operating expenses per adjusted patient day* equal total gross patient revenue divided by gross inpatient revenue times the number of inpatient days.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

Sutter Health, a nonprofit system based in Sacramento, operates 21 hospitals across Northern and Central California, including four in the Sacramento area. Sutter Medical Center in Sacramento, with 523 beds, is the largest in the region, followed by 382-bed Sutter Roseville Medical Center and 64-bed Sutter Auburn Faith Hospital, both in Placer County, and 48-bed Sutter Davis Hospital in Yolo County. Sutter Health is the largest system regionally with almost a third (31%) of inpatient discharges in the market (Table 11). Medicare accounted for 43% of Sutter discharges regionally, while commercial payers accounted for 29% of discharges and Medi-Cal for 26%. Sutter's net income margin in 2023 was 10.5%, the highest in the region and more than double the 4.5% statewide average. Sutter Health recently announced plans to expand outside California and is exploring the acquisition of Minnesota-based Allina Health.[14]

Dignity Health, with hospitals across California, Arizona, and Nevada, is part of CommonSpirit Health, one of the largest nonprofit Catholic health systems in the country. In the Sacramento region, Dignity Health operates four hospitals in Sacramento County — 384-bed Mercy San Juan Medical Center, 329-bed Methodist Hospital, 313-bed Mercy General Hospital, and 106-bed Mercy Hospital Folsom — and 105-bed Woodland Memorial Hospital in Yolo County. Collectively, Dignity Health accounted for 27% of all inpatient discharges regionally, with 46% of discharges covered by Medicare, 33% by Medi-Cal, and 21% by commercial payers. Dignity's net income margin in 2023 was 6.0%.

Kaiser, a nonprofit multistate integrated delivery system that combines a health plan, hospitals, and tightly aligned employed physicians, operates two hospitals in Sacramento County: 287-bed Sacramento Medical Center and 241-bed South Sacramento Medical Center. The largest Kaiser hospital regionally is 383-bed Roseville Medical Center in Placer County. The three Kaiser hospitals accounted for 24% of the region's discharges, with 47% of discharges covered by Medicare, 38% by commercial payers, and 14% by Medi-Cal. Collectively, the Kaiser hospitals had a 7.1% net income margin.

UC Davis Health operates a 628-bed academic medical center in Sacramento, including a Level I trauma center, a burn center, and a children's hospital. The trauma and burn

TABLE 11. Hospital Systems, by Number of Hospitals,
Sacramento Four-County Region, 2023

Hospital System	Number of Hospitals	Number of Available Beds	Occupancy (Avail Beds)	Share of Discharges in Region	DISTRIBUTION OF DISCHARGES BY PAYER TYPE (HEALTH SYSTEM)			Net Income Margin	Current Ratio	Operating Expenses per Adjusted Patient Day
					Medicare	Medi-Cal	Commercial			
Dignity Health	5	1,237	69%	27%	46%	33%	21%	6.0%	1.8	$4,391
Sutter Health	4	1,017	80%	31%	43%	26%	29%	10.5%	8.4	$5,495
Kaiser	3	911	68%	24%	47%	14%	38%	7.1%	n/a	$6,417
UC Davis	1	628	92%	15%	34%	38%	28%	1.6%	1.2	$9,539
No system affiliation	3	271	46%	3%	48%	28%	21%	-4.4%	1.7	$4,301
Sacramento	**16**	**4,064**	**74%**	**100%**	**43%**	**27%**	**29%**	**5.7%**	**1.8**	**$6,111**
California	**334**	**77,339**	**64%**	**n/a**	**42%**	**31%**	**25%**	**4.5%**	**1.6**	**$5,117**

Notes: *Net income margin* is net income divided by the sum of net patient revenue, other operating revenue, and nonoperating revenue. *Adjusted patient day* equals total gross patient revenue divided by gross inpatient revenue times the number of inpatient days. *Current ratio* is current assets divided by current liabilities. This ratio shows the dollar amount of current assets per dollar of current liabilities. It is a gross indicator of the facility's liquidity. Usually, a ratio of 2.0 or more indicates a healthy liquidity position. *Distribution of discharges by payer type* may not add to 100% because "Other indigent" and "Other payers" are excluded.

Source: *2023 Pivot Table - Hospital Annual Selected File*, California Department of Health Care Access and Information.

centers are the only ones in Northern California outside of the San Francisco Bay Area. UC Davis Health accounted for 15% of the region's total discharges, with 38% of discharges covered by Medi-Cal, 34% by Medicare, and 28% by commercial payers. In 2023, UC Davis Health reported a net income margin of 1.6%.

Beyond the four large health systems, Sacramento-based Shriners Children's Northern California is part of a global nonprofit system of 26 hospitals and satellite clinics providing pediatric specialty care.[15] The 50-bed Sacramento facility had about 1,100 discharges in 2023, with 56% of discharges covered by Medi-Cal (data not shown). UC Davis Health and Shriners Children's have had a formal relationship for over 20 years, and the Shriners hospital is on the UC Davis Medical Center campus, where they jointly built the Institute for Pediatric Regenerative Medicine. Many pediatric specialty physicians at Shriners also serve on the faculty of the UC Davis School of Medicine.

Independent Hospitals Amid the Large Systems

Two nonprofit hospitals, both in El Dorado County, remain independent. Barton Memorial Hospital, with 111 beds in South Lake Tahoe, accounted for less than 1% of regional discharges, serving primarily patients covered by Medicare and commercial insurance; 22% of discharges were covered by Medi-Cal (data not shown). Similarly, 110-bed Marshall Hospital in Placerville accounted for 2% of regional discharges, with 23% of discharges covered by Medi-Cal (data not shown). Barton Memorial Hospital reported a 0% net income margin, and Marshall Hospital a 5.6% net income margin in 2023 (data not shown).[16] Marshall is affiliated with UC Davis Health for cancer care, while Barton Health is affiliated with Cleveland Clinic Connected, a program that provides access to the Cleveland Clinic's clinical and operational experts to enhance patient care and improve quality. Marshall Hospital operates two Rural Health Clinics and Barton Health operates one.

Health System Construction Follows Population Growth

All the major systems — Dignity, Kaiser, Sutter, and UC Davis — have strategic plans to expand clinical capacity, especially in the fast-growing Sacramento suburbs to the south in Elk Grove and east along the Interstate 80 and Highway 50 corridors into Folsom, Roseville, Placerville, and El Dorado Hills. As younger, higher-income, and commercially insured people move to these areas, the systems are building new hospitals, clinics, and medical office buildings. Additionally, to meet state seismic safety requirements, Dignity, Kaiser, and UC Davis are replacing aging hospitals with new facilities in Sacramento.[17]

With a goal of becoming a regional system of care, UC Davis Health is investing $3.7 billion to build a 14-story hospital tower at its flagship Sacramento campus that will include 334 inpatient beds, operating rooms, an imaging center, and burn care units.[18] Several wings of the old hospital will be demolished, resulting in a modest overall increase in inpatient beds to about 700 by 2030. In August 2025, UC Davis Health opened the Folsom Medical Care Clinic, about 30 minutes east of Sacramento. Consolidating three UC Davis Health clinics, the new site is also scheduled to add a surgical center and a small hospital in the future. UC Davis Health also announced the purchase of a 20-acre site in March 2023 to expand the health system's current Elk Grove clinics south of Sacramento to offer additional primary care and comprehensive specialty care services.

Sutter Health's Destination 2030 expansion plan calls for adding 76 new ambulatory care sites and over 160 hospital beds across Northern California.[19] In the Sacramento region, Sutter is spending over $400 million to expand facilities, including adding 36 beds in 2025 to Sutter Roseville Hospital in Placer County. At the end of 2023, Sutter also added nine inpatient beds to Sutter Davis Hospital in Yolo County and expanded space for the ED, birthing center, and medical-surgical unit. Sutter also is expanding a multispecialty ambulatory center in Elk Grove and has plans to build a new care center in Folsom. In Sacramento, Sutter renovated a multispecialty medical office in 2025 and will add 42 inpatient beds to Sutter Medical Center by the end of 2026. As of mid-2026, Sutter Health hospitals in the region did not yet have approved plans to meet seismic compliance requirements by the 2030 deadline.[20]

Dignity Health has opened several outpatient facilities in recent years and has plans for others in the coming years, spending over $300 million regionally. In September 2024, Dignity Health opened a cardiovascular center next to Mercy General Hospital in East Sacramento. Dignity also opened express primary care clinics in Elk Grove and Roseville in 2025 to meet demand for same-day care, given the shortage of primary care capacity. By summer 2027, Dignity will complete construction of an ambulatory care center in Folsom Ranch, offering outpatient surgery, imaging, and specialty services. The system also plans to replace the aging and seismically noncompliant Methodist Hospital in South Sacramento with a new 100-bed hospital and medical office building on a new Elk Grove campus, but no opening date has been publicized. As of mid-2026, Mercy General, Mercy San Juan, and Woodland Memorial hospitals did not yet have approved seismic compliance plans, and only Mercy Hospital in Folsom will meet seismic requirements by 2030.

In March 2025, Kaiser broke ground on a $1 billion, 18-acre medical center in the Railyards section of downtown Sacramento. When completed in 2029, the campus will include a 310-bed full-service hospital, outpatient medical offices, and a parking garage. The new facility will replace Kaiser's South Sacramento Medical Center, which does not meet seismic safety standards. The Railyards campus is part of Kaiser's regional expansion plan, which also includes adding 138 beds to Roseville Medical Center and building a new medical office building in Folsom next to an existing

Kaiser ambulatory surgery center.[21] Kaiser Roseville has an approved plan to meet seismic compliance by 2030.

The independent hospitals also are expanding as the population grows. In August 2025, Marshall opened a new medical facility in El Dorado Hills with numerous specialty services, including family medicine and orthopedics. A hospital respondent observed that Marshall feared its patients would be "cannibalized" by other providers expanding in the area, so Marshall adapted by expanding capacity and differentiating service offerings. The current Marshall Hospital does not have an approved plan to meet seismic compliance by 2030. In November 2022, Barton Health's board approved construction of a hospital in Stateline, Nevada, to replace Barton Memorial Hospital in South Lake Tahoe, which will not meet seismic requirements by 2030. The new hospital is still in the planning and approval phase. Lastly, private, for-profit California Northstate University in Elk Grove, whose College of Medicine received full accreditation in July 2025, plans to build a teaching hospital in North Natomas, with plans to break ground in 2026 and open in 2029.

Independent Practice Declines, Specialty Access Worsens

Access to medical groups and IPAs in the Sacramento region is generally bifurcated, with Medicare and commercially insured patients seen by the large health system–affiliated medical groups, and Medi-Cal patients seen by the smaller independent medical groups and IPAs. Medi-Cal managed care members are served primarily by four IPAs — Vivant Health, Imperial Medical Group, Hill Physicians Medical Group, and Nivano Physicians. The health system–affiliated groups and IPAs — Mercy Medical Group (Dignity), UC Davis Medical Group, Sutter Medical Group, and Sutter Independent Physicians — serve primarily commercially insured patients. Several regional observers noted that the ongoing decline of independent physician practices has contributed to problems accessing outpatient specialty care, particularly for Medi-Cal patients but also for commercially insured (see "A Closer Look at Medi-Cal Specialty Care Access in Sacramento County," page 13).

There are nine principal risk-bearing medical groups and IPAs in the region that contract with commercial, MA, and Medi-Cal managed care plans:[22]

Hill Physicians Medical Group is the largest IPA in Northern California, with more than 6,000 providers caring for people across 14 counties, including the four-county Sacramento area. Hill Physicians contracts with commercial, MA, and Medi-Cal managed care plans.

Imperial Health Holdings, an IPA operating across the four-county Sacramento area as well in 45 counties in Northern, Central, and Southern California, primarily serves Medi-Cal and MA patients. Imperial also operates the Imperial Health Plan, offering MA plans.

Mercy Medical Group, part of the Dignity Health Medical Foundation, has a presence across Central and Northern California, including Sacramento and Yolo Counties. The group contracts with many health plans to serve Medi-Cal, MA, and commercial patients, as well as beneficiaries with original Medicare.

Nivano Physicians, an IPA with a presence in 11 counties in Northern California, operates in the Sacramento area except for Yolo County. Nivano contracts with managed care plans to serve Medi-Cal, MA, and commercial patients.

Permanente Medical Group is a multispecialty medical group of some 10,000 physicians in an exclusive contract with the Kaiser Foundation Hospitals serving Kaiser members in Northern and Central California. The Kaiser Greater

Sacramento region includes Yolo, Amador, El Dorado, Sutter, Nevada, and Yuba Counties.

Sutter Independent Physicians includes about 600 primary care and specialist physicians in Sacramento, Yolo, and Placer Counties. Like Sutter Medical Group, the IPA largely serves commercially insured and MA patients and some Medi-Cal enrollees.

Sutter Medical Group is part of the Sutter Valley Medical Foundation, affiliated with Sutter Health. Sutter Medical Group has a presence across the four-county Sacramento region and serves another six counties in Northern and Central California. The group serves primarily commercially insured and MA patients and some Medi-Cal enrollees. Together, Sutter Medical Group and Sutter Independent Physicians form Sutter Physicians Alliance, a regional physician network formed for coordination and clinical integration.

UC Davis Medical Group is part of UC Davis Health and employs over 1,200 faculty physicians in 150 specialty areas and 30 pediatric subspecialties. UC Davis Medical Group largely serves commercially insured and Medicare patients and has a small panel of Medi-Cal enrollees for primary care services and through a partnership with WellSpace Health. Medi-Cal enrollees may also be served by UC Davis specialists for inpatient services.

Vivant Health, formerly River City Medical Group, serves over 200,000 people through managed care contracts with eight health plans primarily serving Medicare and Medi-Cal enrollees. Vivant Health only serves Sacramento County and operates an MA plan and a Medicare accountable care organization.

WellSpace Nexus, a subsidiary of the Federally Qualified Health Center (FQHC) WellSpace Health, became a registered risk-bearing organization with the state in 2022. The nonprofit takes delegated financial risk for professional services for 22,000 Medi-Cal enrollees from Health Net and Molina. It partners with WellSpace Health and has the goal to partner with other FQHCs and IPAs to increase access to health care, including primary and specialty care.

A Closer Look at Medi-Cal Specialty Care Access in Sacramento County

Many respondents reported frustration with inadequate specialty care access for Medi-Cal patients in Sacramento County — a long-standing and documented problem.[23] The following specialties were particularly difficult to access, according to respondents: orthopedics, obstetrics/gynecology (ob/gyn), urology, rheumatology, gastroenterology, psychiatry, and physical, occupational, and speech therapy. To monitor patient access, the state assesses Medi-Cal managed care plans annually for provider network adequacy.[24] Medi-Cal plans must meet provider-to-member ratios for primary care providers, selected specialists, and certain mental health providers while meeting travel time or distance standards. Plans must make good faith efforts to exhaust reasonable contracting options with providers within the time or distance standards. If plans cannot meet required ratios within the time or distance standards, they can request an exception known as an alternative access standard. In 2024, the four Medi-Cal managed care plans in Sacramento County contracted with required providers and met provider-to-member ratios.[25] However, for 19 adult specialties and 18 pediatric specialties, all four plans were granted exceptions for time or distance standards.

Additionally, the California Department of Health Care Services conducts an annual survey to measure compliance with in-person appointment wait time standards to see primary care and specialty physicians. For nonurgent appointments, the standard is 15 business days. For urgent appointments requiring prior authorization, the standard is 96 hours (or 4 days). In 2024, three Medi-Cal plans in Sacramento County — Anthem, Health Net, and Molina — performed well below statewide averages for both adult and pediatric nonurgent and urgent specialty appointment wait times (Table 12).

TABLE 12. Share of In-Person Specialty Appointments That Meet Wait Time Standards,
by Plan, 2024

	SACRAMENTO COUNTY	STATEWIDE
Nonurgent (15 Days) — Adult		
Anthem Blue Cross Partnership	59.7%	70.4%
Health Net Community Solutions	44.0%	62.8%
Molina Healthcare	54.6%	58.6%
Kaiser Permanente	90.7%	92.3%
All Medi-Cal managed care plans	n/a	70.5%
Nonurgent (15 Days) — Pediatric		
Anthem Blue Cross Partnership	45.6%	64.5%
Health Net Community Solutions	52.4%	64.3%
Molina Healthcare	53.6%	61.7%
Kaiser Permanente	93.0%	90.9%
All Medi-Cal managed care plans	n/a	74.0%
Urgent (4 Days) — Adult		
Anthem Blue Cross Partnership	16.4%	50.1%
Health Net Community Solutions	18.8%	47.3%
Molina Healthcare	19.7%	35.5%
Kaiser Permanente	77.8%	79.9%
All Medi-Cal managed care plans	n/a	54.4%
Urgent (4 Days) — Pediatric		
Anthem Blue Cross Partnership	6.5%	44.9%
Health Net Community Solutions	30.2%	54.7%
Molina Healthcare	19.6%	37.5%
Kaiser Permanente	79.1%	79.5%
All Medi-Cal managed care plans	n/a	60.4%

Source: *Medi-Cal Managed Care Physical Health External Quality Review Technical Report, Contract Year 2023–24: Timely Access Study Results,* California Department of Health Care Services, April 2025.

Multiple factors contribute to the specialist access challenges. Availability of specialists within the provider network is a key issue: Even when specialists accept Medi-Cal patients, they may decline appointments for Medi-Cal patients due to limited capacity or restrict the conditions they will treat. One IPA reported that although it contracts with health system medical groups, the IPA is prohibited from publicizing physician names in its provider network directory.

Another factor is that the specialty referrals process is laborious and time consuming, according to FQHCs and advocates. Staff must navigate out-of-date specialist lists, expiring referrals, and specialist denials. If no specialist is available, staff work with the IPA and managed care plan to identify out-of-network providers. The plan and IPA must determine who is responsible for paying the out-of-network provider and then obtain a onetime letter of agreement with the provider. At times, patients must travel as far as the Bay Area to see a specialist, and while Medi-Cal covers non-medical and non-emergency medical transportation, respondents noted transportation can be difficult to arrange. Another respondent observed that Medi-Cal members admitted to inpatient

care via the ED will receive needed care from health system hospitalists and sometimes post-discharge care from other health system specialists. But this care may also require onetime letters of agreement.

Several regional experts also noted that access to maternity care could be particularly challenging for Medi-Cal enrollees. The experts cited shortages of ob/gyns and the few remaining independent ob/gyn practices in the region. A hospital expert observed that maternity care access was "stable for now," adding that ob/gyns were difficult to recruit and retain. A hospital respondent noted that payment rates from managed care plans and IPAs were low, making maternity care services financially tenuous. Marshall Hospital in Placerville has committed to keeping labor and delivery services available to address community need despite fluctuating delivery volumes. One regional expert noted that Medi-Cal enrollees at CommuniCare+OLE clinics in Yolo County have access to Sutter Davis Hospital physicians and maternity services.

Amid specialty care access challenges, there are bright spots. Managed care plans have supported providers' expanded use of telehealth as well as eConsults for specialty care, enabling primary care physicians to manage some specialty needs within their scope of practice. In addition, an innovative partnership between a CHC and a large academic medical center has expanded access to specialty services for Medi-Cal patients.

After a great deal of planning and overcoming logistical hurdles, WellSpace Health signed an agreement with UC Davis Health to create Specialty Connect to improve access to selected specialty services for Medi-Cal members.[26] Launched in January 2023, the program allows WellSpace Health to use its cost-based prospective payment system revenue to pay UC Davis Health specialists a flat fee for seeing patients at a WellSpace clinic.[27] This flat fee is higher than the fee-for-service rate the specialists would have received from a Medi-Cal managed care plan, making participation more viable. The program started with rheumatology and added cardiology and neurology, with plans to expand further.

CHCs Expand Access to Services

CHCs across the four-county Sacramento region have expanded facilities, added new sites or mobile units, or merged with other CHCs to improve patient access to care. The region's CHCs provide vital primary care, dental services, specialty care, and behavioral health services. Despite expansions, CHCs regionally still see fewer patients and provide fewer visits per capita than CHCs statewide (Table 13).

In the Sacramento region, CHCs provided more than 1.2 million patient encounters in 2023 across 35 sites. Most are certified as FQHCs and organized into five large organizations (Table 14). Principal CHC systems in the Sacramento area include the following:

TABLE 13. Community Health Centers Overview,
Sacramento Four-County Region vs. California, 2023

	Sacramento	California
Number of sites	35	1,139
Patients with incomes under 100% federal poverty level	66%	70%
Patients per capita	0.15	0.21
Encounters per capita	0.50	0.69
Medi-Cal as share of net patient revenue	70%	78%

Notes: Sites may include multiple physical locations. Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024), California Department of Health Care Access and Information, last updated October 31, 2024.*

WellSpace Health, the largest FQHC regionally, provided more than 315,000 patient encounters in 2023 in Sacramento and Placer Counties. Along with more than 20 locations in Sacramento County, WellSpace opened a third location in Roseville, a rapidly growing area in Placer County,

in September 2025. WellSpace worked with Sutter Health to open the location, and the two will partner on an ob/gyn residency program to increase access to women's health services. As noted previously, the CHC in 2022 created WellSpace Nexus as a risk-bearing organization to take professional risk for Medi-Cal patients.

Elica Health Centers operates eight locations and two mobile units in Sacramento County and two locations and two mobile clinics in West Sacramento in Yolo County. Elica provided over 230,000 patient encounters in 2023. In 2024, Elica expanded a clinic in the Sacramento Arden Arcade neighborhood.

Health and Life Organization has 11 clinic locations across the cities of Sacramento, North Highland, and Rancho Cordova and provided over 190,000 patient encounters in 2023.

One Community Health has three locations and a mobile clinic in the city of Sacramento and provided nearly 100,000 patient encounters in 2023. One Community Health expanded its midtown Sacramento clinic space and plans to add another in the Arden Arcade neighborhood of Sacramento, with construction slated to start in 2026.

CommuniCare+OLE has 15 clinics in seven locations across the cities of Davis, West Sacramento, and Woodland, all in Yolo County, and provided over 80,000 patient encounters in 2023. The CHC also serves Solano and Napa Counties. In 2023, CommuniCare clinics in Yolo County merged with OLE Health in Napa and Solano Counties to become CommuniCare+OLE.

Other CHCs in the region. Other CHCs operate regionally, including the county-run Sacramento County Health Center, which has one main clinic site, a mobile unit, and a satellite clinic to serve people experiencing homelessness. Other CHCs include Peach Tree Health with one Sacramento clinic, Winters Healthcare Clinic in Yolo County, Shingle Springs Health and Wellness Center with one site in El Dorado County, and El Dorado Community Health Centers with three sites in El Dorado County. Three American Indian clinic organizations also operate in the region: Sacramento Native American Health Center, with two sites in Sacramento; Chapa-De Indian Health, with a clinic in Placer County; and Northern Valley Indian Health, with two sites and mobile services in Yolo County. Both Chapa-De and Northern Valley have clinics in other counties as well.

TABLE 14. Largest Community Health Center Systems,
Sacramento Four-County Region, 2023

Community Health Center System	Encounters	Patient Income Under 100% Federal Poverty Level	Medi-Cal as Share of Net Patient Revenue
WellSpace Health	315,458	64%	93%
Elica Health Centers	234,426	88%	87%
Health and Life Organization	193,214	n/a*	95%
One Community Health	96,977	67%	81%†
CommuniCare + OLE	80,604	84%	76%†
Sacramento	1,203,234	66%	70%
California	26,871,453	70%	78%

Notes: Excludes 30 sites statewide that report 100% of their revenue from California's Program of All-Inclusive Care for the Elderly. Excludes county-owned and -operated FQHCs in the region, as this information is not reported to the California Department of Health Care Access and Information.

* Incomplete data reported.

† Reported to the author by the clinic.

Source: *2023 Primary Care Clinic Annual Utilization Data (November 2024), California Department of Health Care Access and Information, last updated October 31, 2024.*

Some CHCs Struggle with Higher Costs and Inconsistent Revenue

Despite expanding sites and services, some CHCs have faced financial challenges more recently, with one CHC leader noting, "We are stretched very thin." In July 2024, WellSpace Health closed sites in Amador, Folsom, and South Sacramento and laid off 135 employees, attributing the cutbacks in part to higher labor costs from the state minimum wage requirements for health care workers, delays in CalAIM payments from managed care plans, and cuts to federal public health and substance use disorder (SUD) funding. Several other CHC

respondents noted that mandated minimum wage increases for lower-wage staff created tensions with other staff who expected raises as well. In January 2026, another minimum wage increase took effect. Another CHC recorded a large loss in 2024 due to declines in pharmacy revenue and the loss of several clinicians. Other CHC leaders reported that reduced revenues have forced staffing cuts. The Sacramento County Health Center has typically operated at a loss with subsidies from the county general fund. Elica Health reported a modestly positive operating margin while noting that rising labor costs were outpacing Medi-Cal prospective payment system (PPS) rates.

CHCs Expand Behavioral Health Capacity

CHCs regionally typically provide some level of behavioral health services, and state CalAIM and behavioral health initiatives have enabled CHCs to expand services and care teams by adding clinical psychologists, community health workers, and other staff. CHCs usually have staff psychiatrists, and some contract with medical groups for part-time psychiatrists or telepsychiatry services. Some CHCs provide services only for patients with mild-to-moderate mental health conditions and coordinate with county behavioral health departments for specialty mental health and SUD services. Others, like WellSpace Health, provide a broader spectrum of services, including specialty mental health and SUD services.

Despite Workforce Training Infrastructure, Concerns About Supply

While the supply of physicians and nurses per 100,000 population in the Sacramento region exceeds statewide numbers, the region has fewer advanced practice providers and behavioral health providers per 100,000 population than statewide (Table 15). When examining physicians working 20 or more hours weekly, the region has more primary care and specialty physicians, including psychiatrists, per 100,000 population than statewide. These provider figures, while greater per 100,000 when compared to statewide averages, only tell part of the access-to-care story. As noted earlier, the supply of physicians and other providers doesn't translate into easy access to services, particularly for Medi-Cal patients.

TABLE 15. Health Care Workforce Supply,
Sacramento Four-County Region vs. California, 2024

	Sacramento (Percentage of Statewide Average)	California
LICENSED PROVIDERS PER 100,000 POPULATION		
License group*		
Physicians	392 (109%)	358
Advanced practice providers	124 (96%)	128
Nurses	1,570 (116%)	1,353
Behavioral health providers	355 (92%)	384
PHYSICIAN DETAIL BY SPECIALTY AND HOURS WORKED†		
Physicians per 100,000 Population		
Physicians working 20+ hours/ week	325 (111%)	294
Primary care	129 (109%)	118
Specialty	196 (112%)	176
Psychiatry	20 (109%)	18

* License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians are MDs and DOs; advance practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.*

† Allocation of physicians into specialties and hours of practice used the HCAI Physicians by Specialty and Patient Care Hours, as of April 3, 2024.

Source: 2024 license renewal survey data representing active licenses as of December 3, 2024, custom data request, HCAI, received April 14, 2025.

Compared to the 23% of the population in the region identifying as Latino/x, the share of health professionals identifying as Latino/x is much lower (Table 16). Only 7.2% of physicians identify as Latino/x and only 11% of physicians speak Spanish. This Latino/x race/ethnicity and language mismatch with the overall population is the same for advanced practice providers, nurses, and behavioral health providers. This mismatch occurs for those identifying as White in the region as well. There is a higher percentage of health professionals across all categories identifying as Asian than the 15.3% of the region's population. For the 7.0% of the region's population identifying as Black, there is generally closer concordance with health

professionals also identifying as Black. One clinic expert reported that hiring bilingual or multilingual staff to work with their non-English-speaking patients was challenging.

TABLE 16. Physician and Health Workforce Characteristics,
Sacramento Four-County Region vs. California, 2024

	Physicians	Advanced Practice Providers	Nurses	Behavioral Health Providers	Population
RACE/ETHNICITY OF PROVIDERS*					
Latino/x, any race	7.2%	11.5%	10.8%	10.8%	23.0%
White, non-Latino/x	48.7%	52.9%	44.9%	44.9%	48.3%
Asian, non-Latino/x	36.4%	22.9%	31.5%	31.5%	15.3%
Black, non-Latino/x	3.4%	6.0%	5.8%	5.8%	7.0%
LANGUAGES SPOKEN†					
English only	62%	63%	62%	82%	
Spanish	11%	12%	6%	9%	

Notes: License groups based on information reported to the California Department of Consumer Affairs and the methods used by the California Department of Health Care Access and Information (HCAI). *Physicians are MDs and DOs; advanced practice providers are nurse practitioners and physician assistants; nurses are licensed vocational nurses and registered nurses; behavioral health providers are all licenses in the following types: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, licensed clinical social worker, licensed educational psychologist, licensed marriage and family therapist, licensed professional clinical counselor, psychiatric mental health nurse, psychiatric technician, psychologist, and registered psychological associate.*

* Not shown: Other, non-Latino/x.

† Spoken fluently/well enough to provide direct services to clients. Some providers speak multiple non-English languages (e.g., 8% of physicians statewide); these languages are not captured here.

Sources: 2024 license renewal survey data representing active licenses as of December 3, 2024, custom data request, HCAI, received April 14, 2025; and *Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2023 (CC-EST2023-ALLDATA) (2023), US Census Bureau.*

Recruiting and Retaining Some Providers Challenging

Several CHC and hospital respondents reported difficulties recruiting and retaining physicians, especially in less urban areas in Placer and El Dorado Counties, and cited factors like older physicians retiring and clinician burnout as contributing to the problem. To address physician shortages, hospitals and CHCs increasingly rely on advanced practice providers — nurse practitioners (NPs) and physician assistants (PAs) — to fill critical clinical and primary care "gatekeeping" roles. Several respondents in El Dorado and Placer Counties said federal policy changes like the new $100,000 price tag for an H-1B visa, which started in September 2025, may make sponsoring international medical graduates prohibitively expensive and worsen shortages. Changes in federal education loans also will affect the supply of health care professionals.

Significant Health Professions Education and Training Infrastructure

The region has many education and training programs for health professionals, ranging from physicians and dentists to advanced practice providers to medical assistants. UC Davis has both medical and nursing schools, and UC Davis Medical Center offers a wide range of physician residencies and fellowship programs for physicians, NPs, and PAs in both primary care and medical specialties with an emphasis on rural and safety-net settings. California Northstate University also offers a range of health professional education opportunities across colleges of medicine, nursing, dentistry, pharmacy, and psychology, along with undergraduate health sciences.

There are a dozen nurse training programs in the region for licensed vocational and registered nurses at four-year and two-year colleges, including Sacramento State University and American River College in Sacramento and Sierra College in Placer County. These colleges and several private technical training institutes have programs for medical assistants, dental hygienists, imaging technologists, and other allied health occupations. Marshall partners with a private adult education program to run the Marshall School of Medical Assisting in El Dorado County and may expand to include pharmacy technicians.

Hospitals in the region also support accredited graduate medical education and nursing residency programs. Sutter Health Roseville in Placer County supports about 100 nurses in training and residents rotating in four specialties. In 2025, Sutter Roseville and WellSpace Health launched a joint ob/gyn residency program to address provider shortages. Sutter Health will also launch a new neurology residency in 2026. Kaiser trains four medical specialties in Sacramento and Roseville as well as nursing, pharmacy, and postdoctoral psychology trainees. Dignity Health has family medicine training at Methodist hospital and nursing residencies in all four hospitals in the region. Marshall Hospital supports training

for nurses and a limited number of physician residents. The Sacramento Veteran's Administration Medical Center has residency training programs for pharmacists, mental health professionals, NPs, dentists, and nurses.

CHCs also support health professional training. CommuniCare+OLE, One Community Health, and the Sacramento County Health Center all host UC Davis medical students and residents at clinics, notably family and internal medicine. Elica Health and WellSpace Health also host medical students and physicians in training from UC Davis. All five also serve as training rotation sites for NPs, PAs, nursing, behavioral health, and other allied health professionals. These CHCs developed training opportunities without designation as federally funded Teaching Health Center sites, which exist in five of the other study regions.[28]

Moreover, public Medi-Cal managed care plans support local workforce development through grants.[29] For example, Mountain Valley Health Plan provides grants to safety-net provider organizations to recruit clinicians, especially ob/gyns, NPs and PAs, and behavioral health providers, and invests in nursing and physician training programs locally.

CalAIM Implementation: 'Flying the Plane While Building It'

The state launched CalAIM in 2022, an ambitious transformation of Medi-Cal through multiple initiatives implemented over several years.[30] Two foundational aspects of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS) services. A new Medi-Cal benefit, ECM provides resources for care coordination and care management for the highest-risk, highest-cost Medi-Cal managed care members with the most complex medical, behavioral health, and social needs, including those experiencing homelessness. Medi-Cal has specific ECM eligibility definitions for both adult and child populations.[31] CS services, which are optional for managed care plans to offer, expand Medi-Cal beyond traditional health care services, adding services for health-related social needs such as housing supports, medically tailored meals, and sobering centers. Medi-Cal managed care plans are responsible for implementing and coordinating CS services.

In the Sacramento region, in the fourth quarter of 2024, about 11,000 members, or 1.4% of Medi-Cal members, were enrolled in ECM, compared to 1.5% of members enrolled statewide (Table 17). Enrollment in CS services, at 1.2% of Medi-Cal members or just over 9,500 people, also was below the statewide enrollment of 1.9%. The most-used CS service was housing transition navigation (4,030 enrollees, or nearly half of those using CS services), followed by medically tailored meals (1,949 enrollees) and housing tenancy and sustaining services (1,001 enrollees).[32]

TABLE 17. Medi-Cal and CalAIM's Enhanced Care Management and Community Supports,
Sacramento Four-County Region vs. California, 2024

	Sacramento	California
ENHANCED CARE MANAGEMENT (ECM) ENROLLMENT*		
ECM enrollment	11,119	206,501
Share of Medi-Cal managed care enrollees receiving ECM	1.4%	1.5%
COMMUNITY SUPPORTS (CS) ENROLLMENT†		
CS enrollment	9,558	258,141
Share of Medi-Cal managed care enrollees receiving CS	1.2%	1.9%

** ECM enrollment is the number of unique members who received ECM in the last 12 months of the reporting period ending September 30, 2024.*

† CS enrollment is the number of members receiving services in the 12 months of the reporting period ending September 2024.

Source: *ECM and Community Supports Quarterly Implementation Report (data through September 30, 2024), California Department of Health Care Services, last updated March 2025, data tables for charts 1.7.1 and 3.9.1.*

To support ECM and CS implementation, DHCS provided nearly $1.66 billion statewide through Providing Access and Transforming Health Capacity and Infrastructure Transition, Expansion and Development grants to build capacity and infrastructure among CHCs, behavioral health providers, hospitals, county agencies, and tribes.[33] During four rounds

of grants between 2023 and 2025, dozens of organizations across the region received awards.[34] These included Marshall Hospital, nine CHC systems, two county agencies, two medical groups, and Pacific Clinics, a large multicounty behavioral services provider. In 2024, seven FQHCs in the region received over $4 million.

Numerous providers and managed care plans observed that while the aims of ECM and CS services are laudable, implementation felt rushed and faced many challenges. Policy and administrative requirements for both programs are complex, and the back-to-back operational rollouts by DHCS consumed tremendous amounts of staff time. A community-based provider respondent characterized CalAIM implementation as "flying the plane while building it."

One managed care plan leader remarked that building networks for ECM and CS services took time and much "handholding" for small inexperienced community-based organizations (CBOs) to become enrolled providers and deliver services. Other respondents said that ECM required new training for care managers and medical assistants. In Sacramento County, providers and advocates reported that each of the four managed care plans and their delegated IPAs approached ECM and CS implementation differently and that CS services were not uniform across plans. Some criticized DHCS for issuing unclear and inconsistent regulations that contributed to differences across plans, leading to administrative burdens from navigating different workflows, referral networks, billing systems, and data sharing platforms.

ECM payment approaches also differ across plans, with some paying fixed per-member, per-month amounts, or capitated payments, while others use fee-for-service payments. Plan documentation required to process claims also varies across plans. Along with long delays in initial payments, several providers reported that early ECM rates were insufficient. Given the implementation challenges, the Sacramento County Health Authority Commission has prioritized reviewing ECM and CS outcomes and providing feedback to plans about identifying and resolving payment and other provider concerns.

Several ECM provider respondents said some CBOs from outside the region had entered the local market and were attempting to "poach" their clients or provide duplicate services to them. A behavioral health provider expressed surprise that these newcomer providers could even get referrals, remarking that "CalAIM is strangely competitive." Another expressed frustration with the CalAIM "Wild West" and said outsiders were siphoning resources and not providing valuable services, and that DHCS was finally identifying this through audits. Despite implementation and operational challenges, provider respondents generally believed ECM and CS services were making a difference for people. However, some noted that fundamental questions remained unanswered about impact.

Behavioral Health Infrastructure and Capacity Improvements

The delivery of Medi-Cal behavioral health services is divided between managed care plans and county behavioral health departments and has long been poorly coordinated and administratively burdensome. Medi-Cal managed care plans provide non-specialty mental health services, while specialty mental health and SUD services are the responsibility of county behavioral health plans. During the 2020–21 regional study, respondents cited the need for additional inpatient and outpatient mental health and SUD treatment capacity in the Sacramento region. Additionally, a 2022 RAND study of Sacramento County identified an urgent need for psychiatric beds at subacute levels of care, notably mental health rehabilitation centers, and for SUD beds to serve Medi-Cal patients.[35]

For this study, numerous respondents reported that access to behavioral health services regionally had improved modestly. They attributed the improvement in part to multiple state behavioral health transformation initiatives — especially the Behavioral Health Continuum Infrastructure Program (BHCIP), which has provided billions of dollars to cities and counties statewide to increase inpatient and outpatient behavioral health capacity.[36]

The initial BHCIP funding focused on planning, children and youth facilities, and mobile crisis services. Across the four-county Sacramento region, more than 400 inpatient beds and over 650 outpatient slots have been or will be added at residential psychiatric treatment facilities, mental health rehabilitation centers, community wellness centers, and peer respite centers. Through bond-backed BHCIP grants issued in May 2025, over $170 million was awarded for projects across the region. With facilities scheduled to open between spring 2027 and winter 2029, the capital infusion will support over 3,000 outpatient slots and more than 150 inpatient beds, including inpatient psychiatric facilities in Sacramento and El Dorado Counties; behavioral health urgent care centers in El Dorado, Placer, and Sacramento Counties; an adult residential SUD treatment facility in Placer County; and peer respite in Yolo County. Most grant dollars and added capacity went to Sacramento County. In the second round of bond BHCIP grants announced in March 2026, a for-profit provider in Sacramento County was awarded over $20 million to build a social rehabilitation facility with 32 residential beds.

While positive about behavioral health infrastructure expansions, many CHC and legal advocate respondents noted wide variation in service availability by county and a need for more timely access to care. In El Dorado County, for example, there are currently no inpatient psychiatric beds, and patients are often sent to Southern California. One advocate reported that youth residential services are currently in short supply. Another advocate observed that county eligibility requirements for behavioral health services can be inflexible, resulting in denied care for some patients who then spiral into crisis. One respondent reported "lackluster" DHCS oversight of managed care and county behavioral health plans, leading advocates and families to appeal care denials through the state fair hearing process, which can take months.

Other Behavioral Health Initiatives

Along with infrastructure investments, statewide CalAIM efforts to improve access to Medi-Cal behavioral health care include the Children and Youth Behavioral Health Initiative, improvements to the Drug Medi-Cal Organized Delivery System, a "no wrong door" policy to improve access to services regardless of where a person seeks care, administrative integration, and behavioral health payment reform. One regional leader noted that there were so many initiatives that "it's hard to wrap my head around all of them." Provider respondents also noted challenges with the number and complexity of behavioral health changes. One county leader remarked that new services and benefits added complexities, increasing work for staff already operating at capacity and contributing to staff turnover.

In Sacramento County, Medi-Cal behavioral health payment reform also brought a significant change in business models, moving county behavioral health plans and their contracted providers from cost-based reimbursement to fee-for-service rates based on a fee schedule. To support navigating these changes, the county hired an actuarial firm to assist with rate setting and provide technical assistance to providers about how to adapt their business models. Another reported that the county had hired additional staff just to manage new administrative requirements associated with new benefits, billing, and payment.

County behavioral health departments also were planning for the July 2026 implementation of the Behavioral Health

Services Act (BHSA), passed by voters through Proposition 1 in March 2024. The BHSA redirects how Mental Health Services Act funding, established by voters in November 2004 through Proposition 63, can be spent by counties. This redirection increases the focus on serving people experiencing homelessness who also have serious mental health or SUD needs. Several county behavioral health provider respondents said that the redirection and loss of local control diverted resources away from prevention and children's services and upended existing budgets and provider contracts. Another remarked that while the focus on housing is laudable, the community "still hadn't fixed the affordable housing crisis," making this goal a challenge.

Federal Medicaid Cuts and State Budget Shortfalls Threaten Coverage Gains

Over 10 years, HR 1 will cut Medicaid spending nationally by more than $900 billion, resulting in an estimated 10.3 million people losing Medicaid coverage.[37] In California, as many as 3.4 million people may lose Medi-Cal coverage, which will in turn reduce health care access and increase household financial burdens.[38] Consistent with these national forecasts, HR 1 provisions were widely expected to adversely affect the financial stability of Sacramento area health care providers. Beyond HR 1, other federal policies threaten health care access and affordability and the financial viability of providers. For example, the expiration of enhanced federal premium subsidies will reduce Covered California enrollment.

At the state level, in response to budget shortfalls, California froze new full-scope Medi-Cal enrollment in January 2026 for undocumented adults and others with UIS aged 19 and older.[39] Starting in July 2027, CHCs will no longer receive PPS rates for visits by patients with UIS. Also in July 2027, adults with UIS enrolled in Medi-Cal will be required to pay a monthly premium of up to $50 and will no longer receive dental benefits other than emergency dental services.[40]

Respondents predicted significant reductions regionally in patients covered by Medi-Cal and Covered California and increases in uninsured patients. Most feared their organizations would suffer financially from decreased revenue and increased demand for uncompensated care. A hospital respondent remarked that the organization would only be able to do what is financially sustainable and was already identifying how to manage costs. Others expressed concern that disparities in access to care would worsen after years of progress in closing gaps. Another regional leader predicted that rural hospitals could face severe financial distress and closure, saying, "This is a sad way to end my career."

County health leaders were already exploring how to ramp up county programs for medically indigent patients to prepare for Medi-Cal and Covered California enrollees losing coverage. Over the last decade, many county programs for medically indigent people fell dormant as federal and state expansions of Medicaid reduced the number of uninsured people, including those with UIS.[41] Counties are statutorily required to be the "providers of last resort" for medical care in California, though they are not required to provide services to those with UIS.[42] In Sacramento County, health agency leadership projected increases in the uninsured and prepared cost estimates for indigent programs with different eligibility requirements, benefit packages, and patient cost sharing.[43] County supervisors voted in January 2026 to reduce the income eligibility and age thresholds for the county indigent program and to retain the existing Healthy Partners program for those with UIS. Similarly, El Dorado and Yolo Counties, which participate in the County Medical Services Program for uninsured indigent adults who are ineligible for other public coverage, expected to face increased financial demands as the ranks of the uninsured rise. In June 2026, the Placer County Board of Supervisors voted to join the County Medical Services Program, which organizes and delivers services to medically indigent adults in 35 small and rural counties with populations under 300,000.

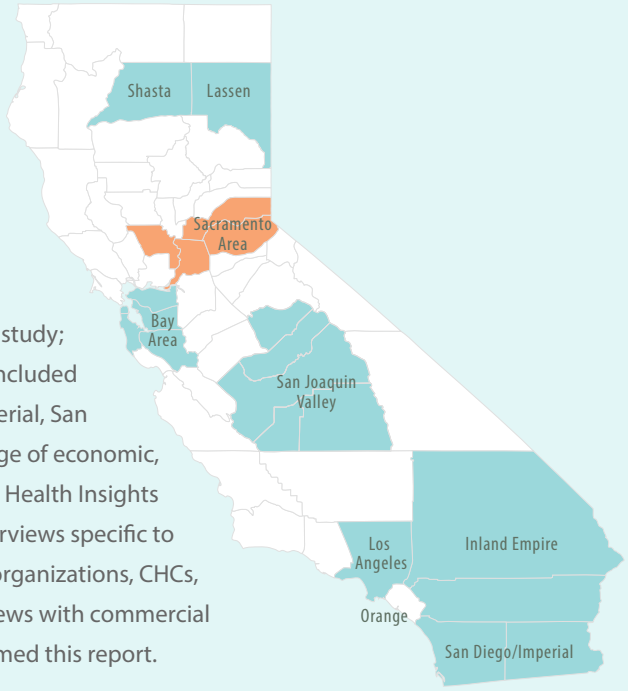
Facing these cuts and changes, many regional leaders reaffirmed their commitments to providing services and working collaboratively with other providers and county agencies. Some respondents reflected on their experiences with the cyclical nature of the California state budget, Medi-Cal expansions and contractions, and the many federal policy changes over the years. Some predicted their organizations would weather the storm. Others, however, observed that the scope of federal changes was unprecedented, leading to uncharted waters ahead.

Issues to Track

- Will the rapid Sacramento area population growth continue, and if so, how will health systems, CHCs, and other providers respond to rising demand? Or will the health care building boom lose steam as providers seek to limit capital spending as revenues decline?
- How will reductions in Medi-Cal and Covered California enrollment affect hospital and health system financial performance?
- Will the small independent hospitals in the region maintain their independence?
- Will access to specialty care continue to decline for Medi-Cal members? What solutions will evolve to improve access to specialty care?
- How will CHCs weather Medi-Cal enrollment declines? Can CHCs handle an increase in self-pay and uninsured patients?
- Will Sacramento County move to change the Medi-Cal managed care model to a Two-Plan model and put a local initiative health plan in place?
- How much will the region's counties build out capacity for their indigent care programs? Will financing be available to provide services to the uninsured?
- Will new behavioral health inpatient and outpatient capacity have an impact on timely access to needed services?

Background on Regional Markets Study

Between September 2025 and January 2026, researchers from Yegian Health Insights, LLC, conducted interviews with health care leaders in the Sacramento area counties of El Dorado, Placer, Sacramento, and Yolo to study the market's local health care system. The Sacramento area is one of seven markets included in the Regional Markets Study funded by the California Health Care Foundation. The purpose of the study is to gain key insights into the organization, financing, and delivery of care in communities across California and over time. This is the fifth round of the study; the first set of regional reports was released in 2009. The seven markets included in the project — Inland Empire, Los Angeles, Sacramento, San Diego/Imperial, San Francisco Bay Area, San Joaquin Valley, and Shasta/Lassen — reflect a range of economic, demographic, care delivery, and financing conditions in California. Yegian Health Insights interviewed over 200 respondents for the overall study, with 25 to 30 interviews specific to each region. Respondents included executives from hospitals, physician organizations, CHCs, Medi-Cal managed care plans, and other local health care leaders. Interviews with commercial health plan executives and other respondents at the state level also informed this report.



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ABOUT THE FOUNDATION

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system.

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