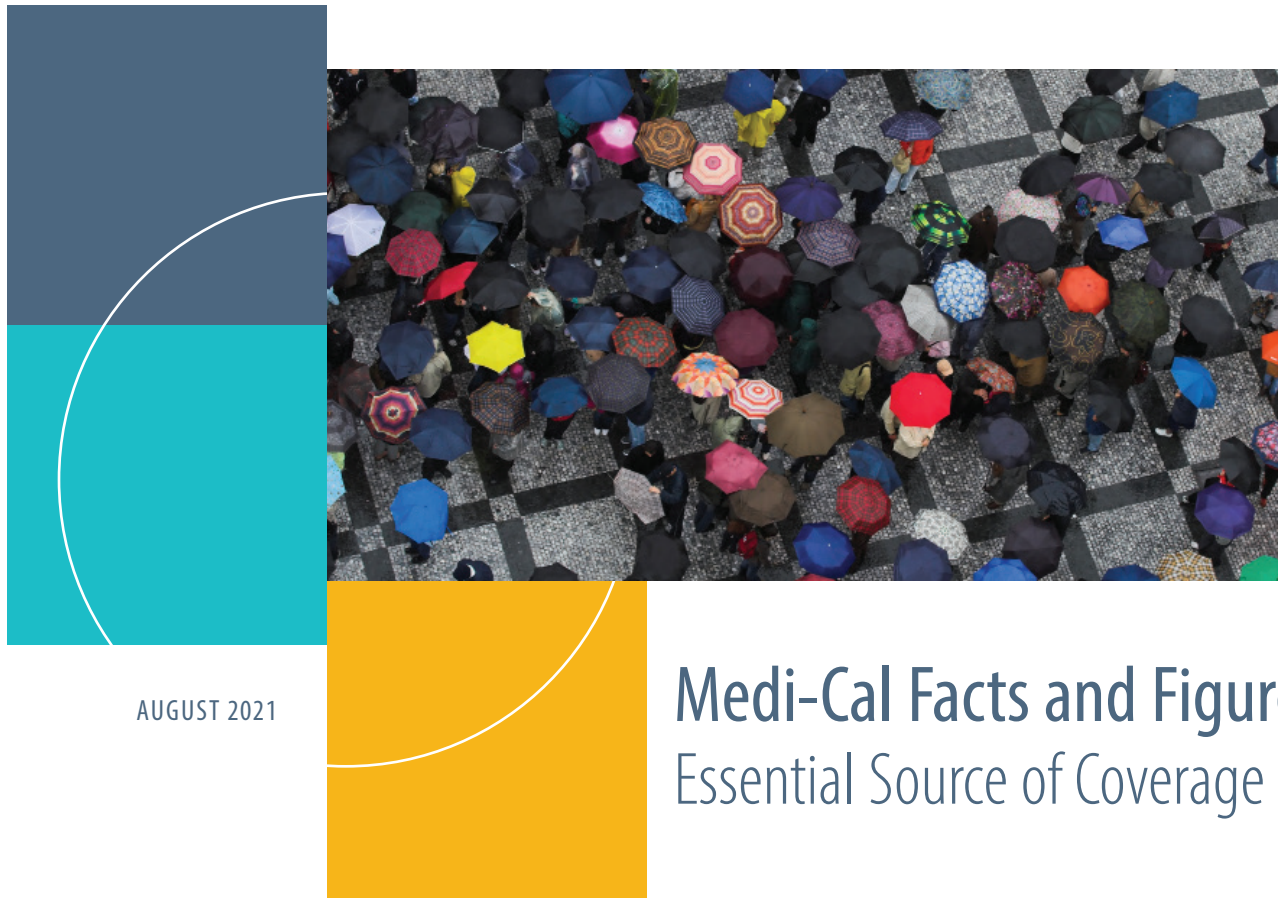


CALIFORNIA Health Care Almanac



AUGUST 2021

Medi-Cal Facts and Figures: Essential Source of Coverage for Millions

Executive Summary

Medi-Cal, California’s Medicaid program, is the state’s health insurance program for Californians with low income, including nearly 4 in 10 children, one in five nonelderly adults, and two million seniors and people with disabilities. It also pays for more than 50% of all births in the state and 55% of all patient days in long-term care facilities.* In total, over 13 million Californians — one in three — rely on the program for health coverage. Medi-Cal pays for essential primary, specialty, acute, behavioral health, and long-term care services.

The Affordable Care Act allowed states the option to expand Medicaid, and California added over four million adults with low income to the program. Using only state resources, California also expanded Medi-Cal to cover three groups in households with low income regardless of immigration status: children, adults under 26, and in 2022, adults age 50 and over.

Medi-Cal Facts and Figures: Essential Source of Coverage for Millions presents findings about the Medi-Cal program based on the most recent data available.

KEY FINDINGS INCLUDE:

- In fiscal year 2019–20, Medi-Cal brought in more than \$65 billion in federal funds and accounted for nearly 16% of all state general fund spending.
- People with disabilities composed 9% of Medi-Cal enrollees, but accounted for 31% of spending. Meanwhile, children accounted for 17% of enrollees, but just 6% of spending.
- 85% of people served by Medi-Cal were enrolled in one of six managed care models.
- More than three out of four Medi-Cal enrollees are in households where they or another family member works part- or full-time.
- Starting in March 2020, the COVID-19 pandemic, ensuing economic downturn, and related policy changes resulted in hundreds of thousands of people enrolling in, or retaining, Medi-Cal coverage.
- The state has proposed innovations and changes aimed at improving care for Medi-Cal members.

The Medi-Cal program faces numerous changes in the coming years, including procuring new contracts with managed care plans, which provide services to 11 million Medi-Cal enrollees in all 58 counties, and transitioning pharmaceutical benefits from managed care plans to the centralized Medi-Cal Rx program. Medi-Cal will also address the needs and costs of an aging population and implement strategies to address disparities in access, quality, and outcomes of care for enrollees of color.

* Fee-for-service only. Does not include patient days paid through Medi-Cal managed care contracts.
Note: See the current and past editions of *Medi-Cal Facts and Figures* at www.chcf.org/collection/medi-cal-facts-figures-almanac.

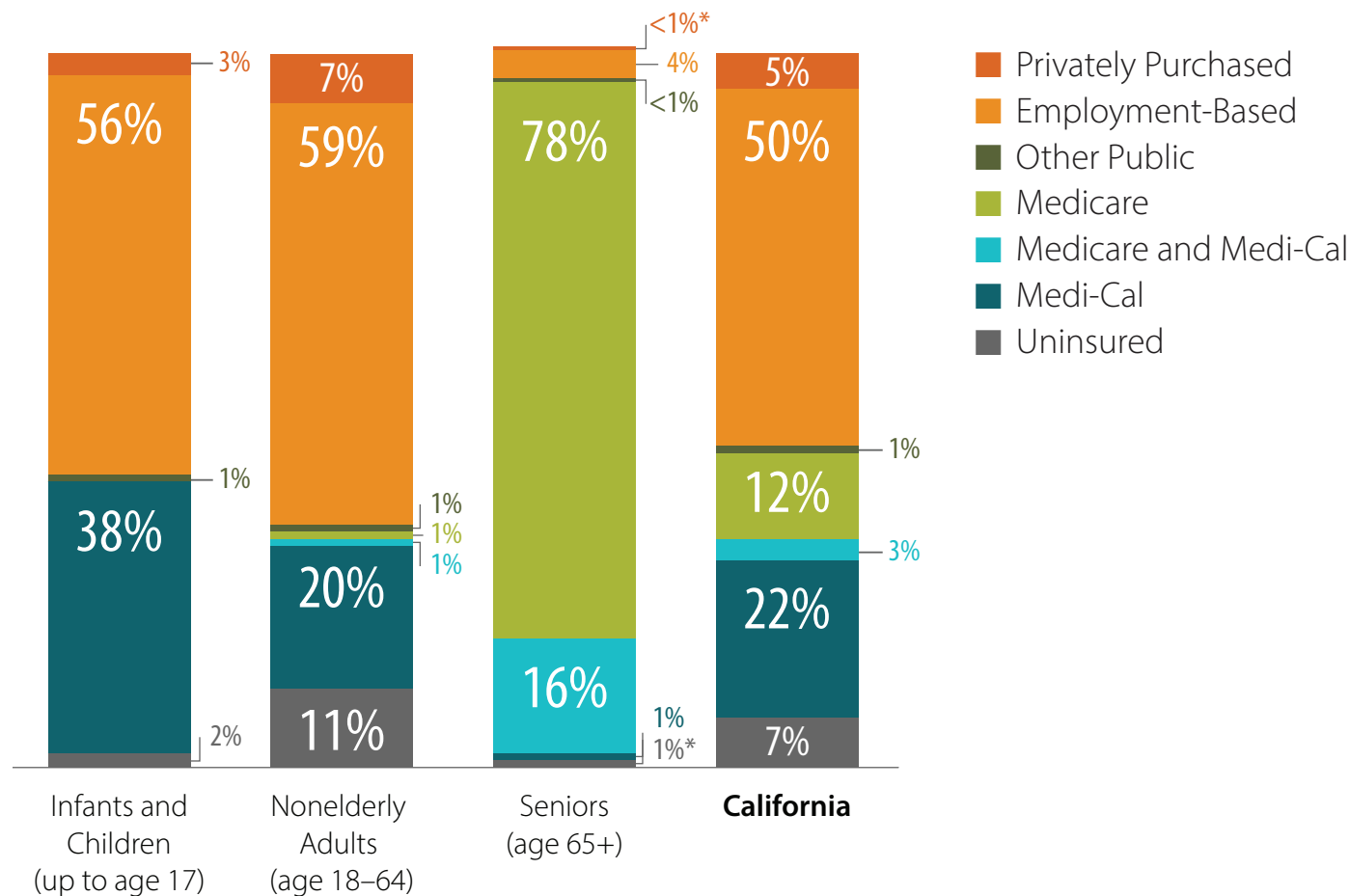
Medi-Cal Facts and Figures

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Sources of Insurance Coverage, by Age Group

California, 2019



* Indicates that results are statistically unstable.

Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported they have Medi-Cal coverage only, and may include those with restricted-scope benefits. See “About the Data” on page 69 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other. *Privately purchased* includes those that purchased health insurance directly from an insurance company or HMO, or through Covered California. *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents. Percentages may not add to 100% due to rounding.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal Facts and Figures

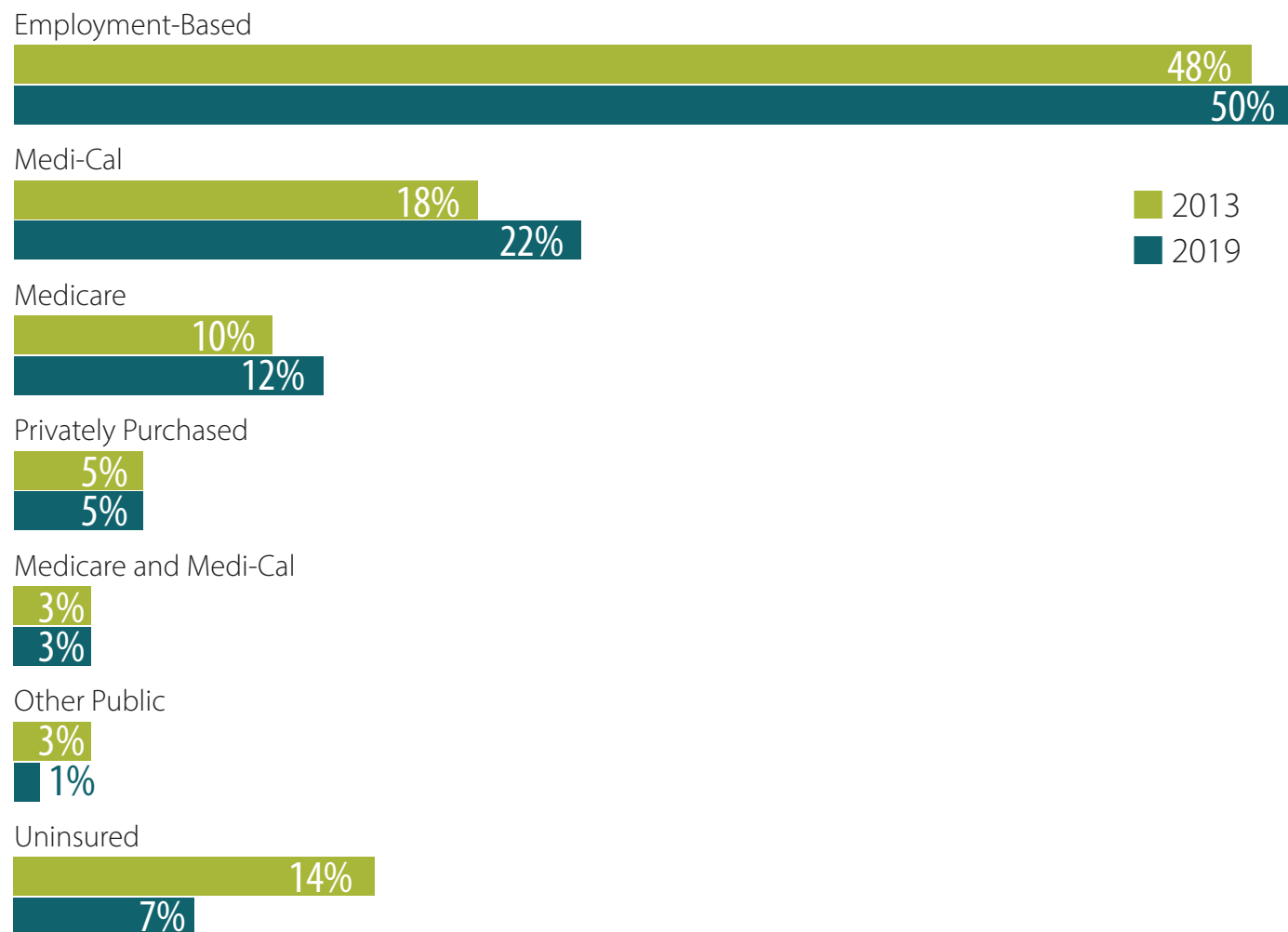
Overview

Medi-Cal is an important source of health care coverage for Californians of all ages. According to the California Health Interview Survey, nearly 40% of all children in the state, and one in five nonelderly adults, were covered by Medi-Cal. Almost all seniors are eligible for Medicare, and 16% of Californians over age 65 are reportedly also covered by Medi-Cal (known as “dually eligible enrollees”).

For more information, see *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.

Health Insurance, by Source of Coverage

California, 2013 and 2019



Medi-Cal Facts and Figures

Overview

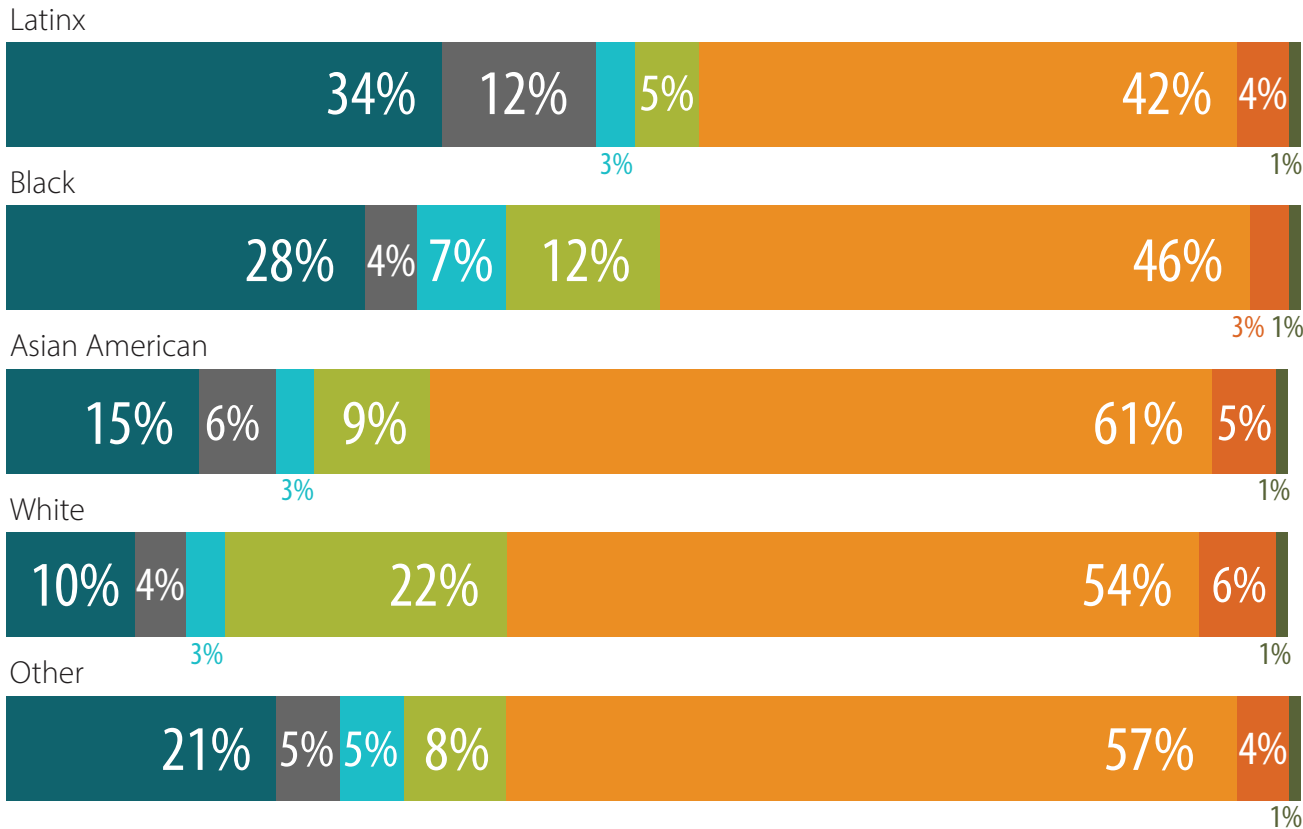
Between 2013 and 2019, the distribution of health insurance coverage shifted, due in part to the implementation of the Affordable Care Act in 2014. The percentage of Californians who reported being enrolled in Medi-Cal increased from 18% to 22%, while the percentage of Californians who were uninsured decreased from 14% to 7%.

Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported they had Healthy Families (2013) and may include those with restricted-scope benefits. See "About the Data" on page 69 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other (not Medi-Cal). *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents.

Source: 2019 and 2013 California Health Interview Survey, UCLA Center for Health Policy Research.

Health Insurance Coverage, by Race/Ethnicity, 2019

■ Medi-Cal
 ■ Uninsured
 ■ Medicare and Medi-Cal
 ■ Medicare
■ Employment-Based
 ■ Privately Purchased
 ■ Other Public



Medi-Cal Facts and Figures

Overview

Medi-Cal provided health insurance coverage for about one-third of Latinx Californians. Similarly, 28% of Black Californians were covered by Medi-Cal.

Notes: Insurance coverage is self-reported. See "About the Data" on page 69 for a full explanation of how this could impact findings. *Other* includes those of two or more races, Native Hawaiian / Pacific Islander, and American Indian / Alaska Native. Source uses *Black or African American* and *Asian*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

About Medicaid

- Federal program created by Title XIX of the Social Security Act in 1965. In California, the program is called Medi-Cal.
- Provides health care coverage to 69 million Americans, including children in families with low incomes, parents, seniors, people with disabilities, and adults with low incomes.
- Each state administers its program within federal rules, and financing is shared between state and federal governments. The program must provide benefits to certain mandatory groups meeting eligibility requirements.
- Medicaid programs vary significantly across the nation, as states have the option to cover additional groups and use waivers to amend some eligibility requirements, use different care delivery and payment models, and develop other innovations.
- Eligibility was expanded to adults with low incomes under the Patient Protection and Affordable Care Act (ACA), passed in 2010 and implemented in 2014. Enrollment has grown by 14.8 million in the 39 states that chose this option.
- Nationwide Medicaid expenditures, including both federal and state funds, totaled \$604 billion in 2019.

Medi-Cal Facts and Figures

Overview

The Affordable Care Act gave states the option to expand the program significantly. Medicaid served 69 million people nationwide in 2020.

Sources: "Program History," Centers for Medicare & Medicaid Services (CMS); "Medicaid Expansion Enrollment" (June 2019), KFF; "Updated July 2020 Applications, Eligibility, and Enrollment Data," CMS, last updated April 2, 2021; "Status of State Medicaid Expansion Decisions: Interactive Map," KFF, last updated May 10, 2021; and "Total Medicaid Spending" (FY 2019), KFF, accessed October 29, 2020.

About Medi-Cal

- A source of health care coverage for:
 - Nearly one in three Californians
 - Nearly 40% of the state's children
 - 43% of people with disabilities
 - About one in six of all California workers age 19 to 64
- Pays for:
 - More than 50% of all births in the state
 - 55% of all patient days in long-term care facilities*
- Medi-Cal accounts for nearly two-thirds of net patient revenues in California's city/county hospitals and nearly 75% of net patient revenues for primary care clinics.
- Medi-Cal brought in \$65 billion in federal funds in FY 2019–20.
- Medi-Cal enrollment increased by more than 700,000 between March and December 2020 during the COVID-19 pandemic and economic downturn.

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

Sources: "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Dept. of Health and Human Services (CHHS), last updated April 27, 2021; *Medicaid in California* (PDF), KFF, October 2019; *Medi-Cal Explained Fact Sheets: Maternity Care and Paying for Maternity Services*, California Health Care Foundation, September 2020; "Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data & Pivot Tables" (2019), CHHS; "Hospital Annual Financial Data - Selected Data & Pivot Tables" (2019), CHHS; "Primary Care Clinic Annual Utilization Data" (2019), CHHS; and *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), DHCS, accessed August 6, 2020.

Medi-Cal Facts and Figures

Overview

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

Medi-Cal vs. Medicare

	MEDI-CAL	MEDICARE
Population	<p>Children in families with low incomes and adults with low incomes, including but not limited to:</p> <ul style="list-style-type: none"> • People who are pregnant • People with disabilities • Seniors (65+) with low incomes • Children, regardless of immigration status 	<ul style="list-style-type: none"> • Seniors (65+) • People with permanent disabilities • People with end-stage renal disease
Enrollment	13.6 million Californians	6.4 million Californians
Services Covered	Primary care, specialty care, acute care, long-term care, and mental health and substance use disorder services	Primary, specialty, and acute care
Cost Sharing	No premiums or copayments for enrollees with the lowest incomes	Enrollees must pay premiums and deductibles
Funded By	Federal, state, and county governments	Federal government and enrollees
Administered By	California with oversight by CMS	Federal government through CMS

Medi-Cal Facts and Figures

Overview

Medi-Cal and Medicare provide coverage to different populations, cover different services, and are administered separately. However, 1.4 million California seniors and people with disabilities are eligible for both Medi-Cal and Medicare; they are referred to as “dually eligible enrollees.”*

Note: CMS is Centers for Medicare & Medicaid Services.

Sources: *Medi-Cal Monthly Eligible Fast Facts, January 2021*. (PDF), California Dept. of Health Care Services, April 2021; and “Total Number of Medicare Beneficiaries” (2020), KFF.

* For more information, see *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.

Medi-Cal and the COVID-19 Pandemic

As of March 2021, a year after a state of emergency was declared, more than 3.5 million Californians have been diagnosed with COVID-19, and over 54,000 have died from the disease. The pandemic dramatically reduced economic activity, resulting in increased unemployment. Unemployment skyrocketed from 4.3% in February 2020 to 16.4% in May 2020. It has since declined but remained high at 9.0% in December 2020. The Medi-Cal program played a critical role in providing health services to those Californians most affected by the pandemic.

As of April 2021, Latinx Californians represented 56% of cases and 47% of deaths. Medi-Cal provides health insurance coverage to 34% of all Latinx Californians.

Black Californians represent 4% of cases and 6% of deaths, and 28% of Black Californians are enrolled in Medi-Cal.

Nursing home residents represent 24% of all deaths from COVID-19 in the state, and Medi-Cal paid for 55% of patient days in long-term care facilities.

Between March and December 2020, Medi-Cal enrollment increased 8% or just over 1 million.* During the same period in 2019, enrollment decreased by 2%.

* It is likely that most of this enrollment increase has resulted from suspending eligibility redeterminations for current enrollees as directed by Executive Orders N-29-20 and N-71-20 during the COVID-19 public health emergency. DHCS assume that about 104,000 enrollees lose eligibility each month and would continue on Medi-Cal due to the redetermination suspension.

Sources: "COVID-19: California Case Statistics," California Dept. of Public Health, accessed March 9, 2020; "Tracking the Coronavirus in California Nursing Homes," *Los Angeles Times*, accessed March 9, 2021; *Medi-Cal Enrollment Update* (PDF), California Dept. of Health Care Services (DHCS), April 8, 2021; Exec. Order N-29-20 (PDF), State of California, March 17, 2020; Exec. Order N-71-20 (PDF), State of California, June 30, 2020; and *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21*, DHCS, accessed July 8, 2021.

Medi-Cal Facts and Figures

Overview

The COVID-19 pandemic has had deep social, public health, and economic impacts on California. Medi-Cal provides health services for those disproportionately impacted by the pandemic: Latinx Californians and residents of long-term care facilities.

Medi-Cal and the COVID-19 Pandemic (continued)

Federal COVID-19 emergency resources and regulatory relief has allowed the Medi-Cal program to temporarily:

- Provide free COVID-19 testing and treatment to those without insurance
- Pay for services delivered via telehealth at the same rates to those delivered in person
- Ease some eligibility and enrollment processes and place a moratorium on redetermining current enrollees' eligibility
- Increase payment rates for some services, notably clinical laboratories and skilled nursing facilities
- Ease limitations on specific services, such as telehealth and substance use disorder services
- Waive requirements such as pre-authorizations and utilization controls

Federal COVID-19 funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act has provided emergency resources to Medi-Cal providers, including those that provide health care services to patients with Medi-Cal.

Federal regulatory flexibilities and funding have allowed Medi-Cal to play an important role in the COVID-19 pandemic response.

Sources: "Federal COVID-19-Related Funding to California," California Legislative Analyst's Office, April 28, 2020; State Plan Amendment #20-0024 (PDF), California Dept. of Health Care Services (DHCS), May 13, 2020; *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* (PDF), Centers for Medicare & Medicaid Services, last updated January 6, 2021; *Request for Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency* (PDF), DHCS, March 16, 2020; "CARES Act Provider Relief Fund: For Providers," US Dept. of Health and Human Services, last reviewed May 7, 2021; "The 2021-22 Budget: Medi-Cal Fiscal Outlook," Legislative Analyst's Office, November 18, 2020. Department of Health Care Services 2020; and *Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)*, DHCS, January 5, 2021.

The Affordable Care Act (ACA) and Medi-Cal

Eligibility Expansions

- Starting in 2014, the ACA allowed states to expand Medicaid eligibility to adults under 65 with low incomes. In 2020, California covered four million “expansion” adults, which accounted for 30% of all enrollees. Forty-four percent of expansion adults were Latinx, and over one-third were between age 46 and 64.
- The ACA raised the income eligibility threshold for parent and adult caretaker relatives. In addition, eligibility for youth in foster care who are enrolled in Medicaid was extended from age 18 up to age 26.
- The ACA included a “maintenance of effort” (MOE) provision prohibiting states from reducing eligibility for children to levels prior to March 2010, imposing new or increased waiting periods, or increasing premiums. The MOE expired in September 2019.

Benefit Expansions

- California expanded benefits to include mild-to-moderate mental health services and substance use disorder services.
- California implemented the ACA’s Health Homes provision in 12 counties to provide enhanced care management and coordination for enrollees’ complex medical needs and chronic conditions.

Eligibility and Enrollment Simplification

- The ACA simplified and streamlined eligibility requirements for people without disabilities. California also improved its enrollment system, creating a single online portal to initiate applications for insurance affordability programs, in addition to existing ways to apply.

Impact on California

- The Medi-Cal expansion contributed significantly to reducing the percentage of Californians without insurance, which declined from 14% in 2013 to 7% in 2019.*
- While Medi-Cal’s share of the state budget has remained the same, increased federal matching contributions have financed most of the eligibility and enrollment expansions in California.

* Self-reported. See “About the Data” on page 69 for a full explanation of how this could impact findings.

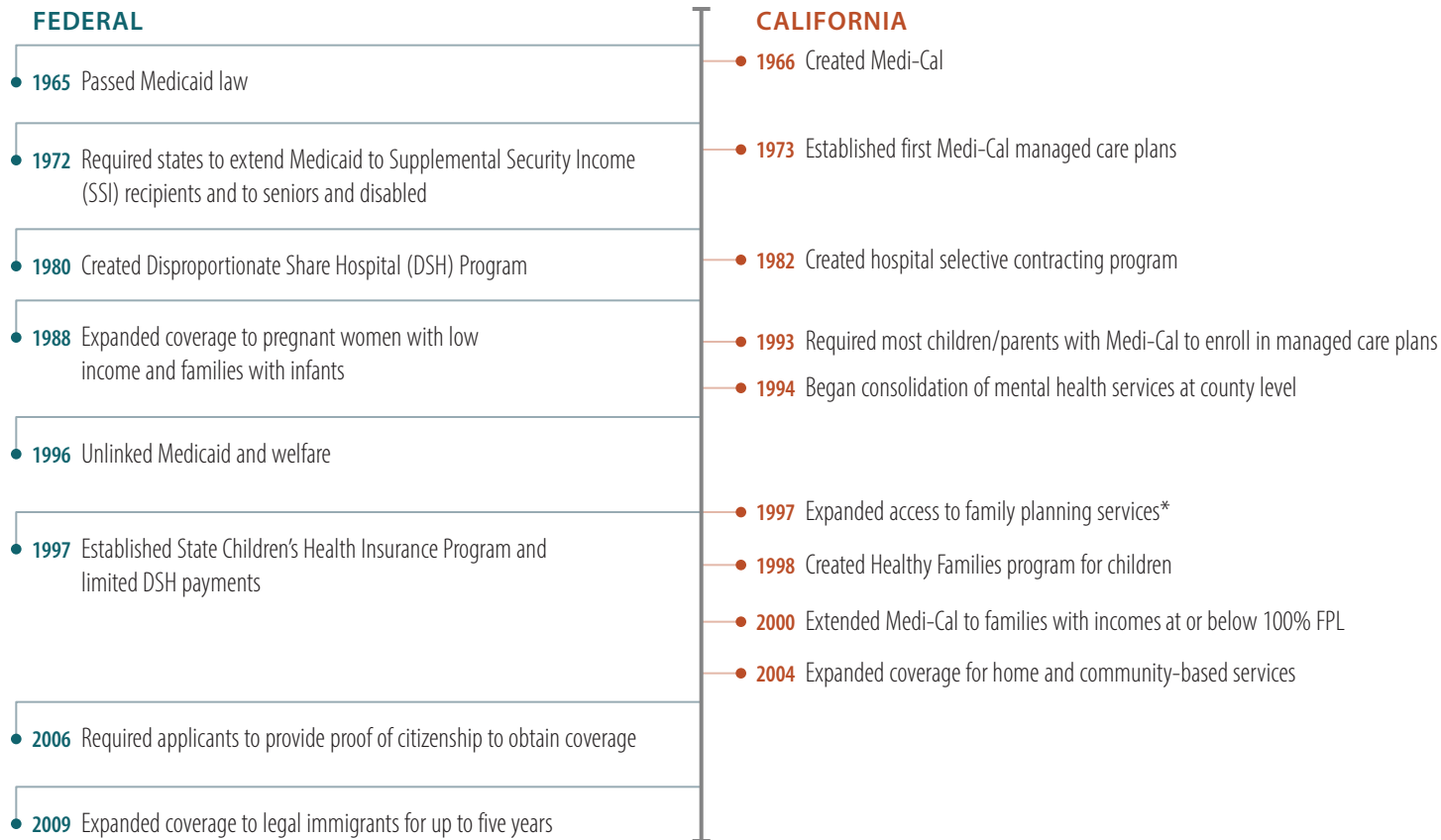
Sources: *Medi-Cal Monthly Eligible Fast Facts* (Sept. 2020) (PDF), California Dept. of Health Care Services (DHCS), December 2020; *Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, § 1101, 124 Stat. 119, 141-43 (2010); *Summary of the Affordable Care Act*, KFF, April 25, 2013; *The Maintenance of Effort (MOE) Provision in the Affordable Care Act* (PDF), Georgetown Health Policy Institute, May 2017; *California Health Homes Program: September 2020 Update* (PDF), DHCS; California Health Interview Survey, UCLA Center for Health Policy Research; and “Status of State Medicaid Expansion Decisions: Interactive Map,” KFF, last updated May 13, 2021.

The ACA allows states the option to expand Medicaid to adults with income levels that made them previously ineligible. In 2019, California had the largest number of adults enrolled through this expansion and has been a leader in enrollment among the 39 states and the District of Columbia that expanded their programs.

Medicaid Legislative History, Selected Milestones

Medi-Cal Facts and Figures

Overview



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

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

Note: FPL is federal poverty level.

Source: "Program History," Centers for Medicare & Medicaid Services, accessed July 27, 2021.

Medicaid Legislative History, Selected Milestones (continued)

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

FEDERAL

- **2010** Under ACA, state option to provide Medicaid coverage for all individuals under 133% FPL at enhanced federal matching rate
- **2012** Supreme Court upholds ACA and rules that Medicaid expansion is optional for states
- **2016** Final Managed Care Rule to align Medicaid with other insurance regulations and to strengthen consumer protections
- **2017** Tax overhaul legislation reduced the penalty for not having insurance to \$0
- **2018** CHIP funding reauthorized through FY 2027

CALIFORNIA

- **2010** Under ACA, expanded coverage for uninsured adults, and required seniors and people with disabilities to enroll in managed care (excluding those with Medicare)
- **2012** Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties
- **2013** Expanded Medi-Cal under ACA state option
- **2015** Expanded full-scope Medi-Cal to eligible children regardless of immigration status using state funds starting May 16, 2016
- **2019** Created financial penalty for failure to maintain health coverage starting January 1, 2020
Medi-Cal eligibility extended to adults 19–25 regardless of immigration status starting January 1, 2020
Expanded income eligibility up to 138% FPL for seniors and people with disabilities starting December 1, 2020
Extended Medi-Cal coverage by 12 months after delivery for women with a maternal mental health condition starting August 1, 2020
Executive order moved pharmacy benefit from managed care to statewide administration
- **2021** Expanded full-scope Medi-Cal to eligible adults age 50 and over regardless of immigration status starting no earlier than May 2022
State will seek federal approval to eliminate the asset test as an eligibility requirement
With newly allowable federal matching funds, extended Medi-Cal eligibility from 60 days to 12 months for eligible postpartum individuals, targeted to start April 2022

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

Note: FPL is federal poverty level.

Sources: Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget (PDF), Committee on Budget and Fiscal Review, January 6, 2009; "California's Medicaid State Plan (Title XIX)," California Dept. of Health Care Services, last modified May 5, 2020; "The Affordable Care Act in California," California Health Care Foundation, June 28, 2012; *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, March 2021; S.B. 78 (Cal. 2019); S.B. 104 (Cal. 2019–20); H.R. 1, 115th Cong. (2017–18); and H.R. 1319 - American Rescue Plan Act of 2021, 117th Cong. (2021), 5, 2020; A.B. 133 (Cal. 2021–22).

Medi-Cal Governance

FEDERAL

Centers for Medicare & Medicaid Services (CMS)

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



COUNTY

County Health and Social Services Department

- Conducts eligibility determination
- Oversees enrollment and recertification

STATE

California Department of Health Care Services (DHCS)

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

California Legislature

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

Medi-Cal Facts and Figures

Overview

Medi-Cal is governed by the federal, state, and county governments.

The California legislature provides oversight and approves the overall budget.

Financing the Medi-Cal Program

Source of Funds

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

FMAP Enhancement

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

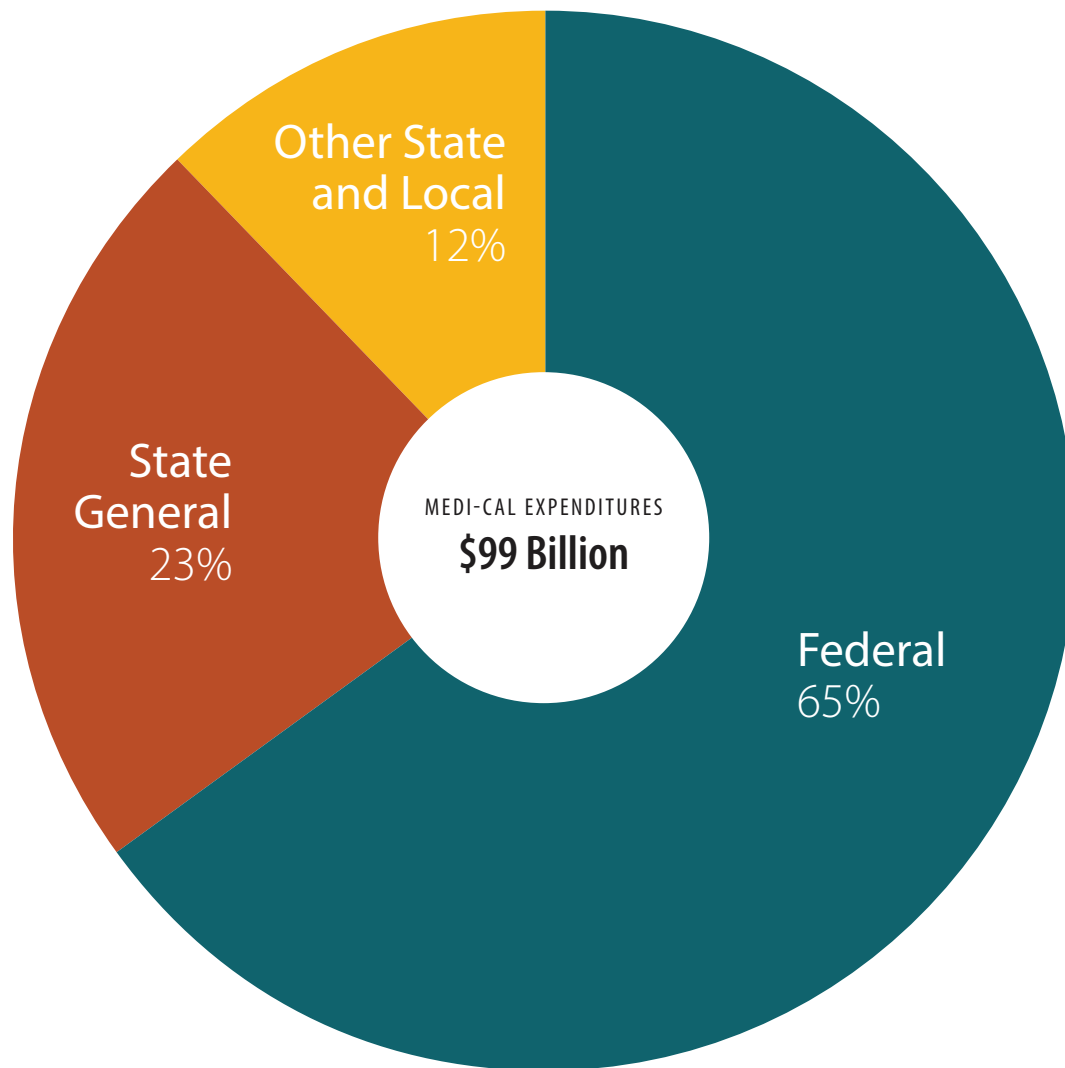
Affordable Care Act (ACA) Effects on FMAP

- The ACA enhanced the FMAP for the expansion to nonpregnant, childless adults under age 65. From 2014 to 2016, the federal share was 100% and was reduced to 90% in 2020.
- The ACA enhanced the FMAP to 88% for pregnant women and newborns covered by the Children's Health Insurance Program through September 2019 and is reduced to 65% thereafter.

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

Medi-Cal Funding Sources

FY 2019–20



Medi-Cal Facts and Figures

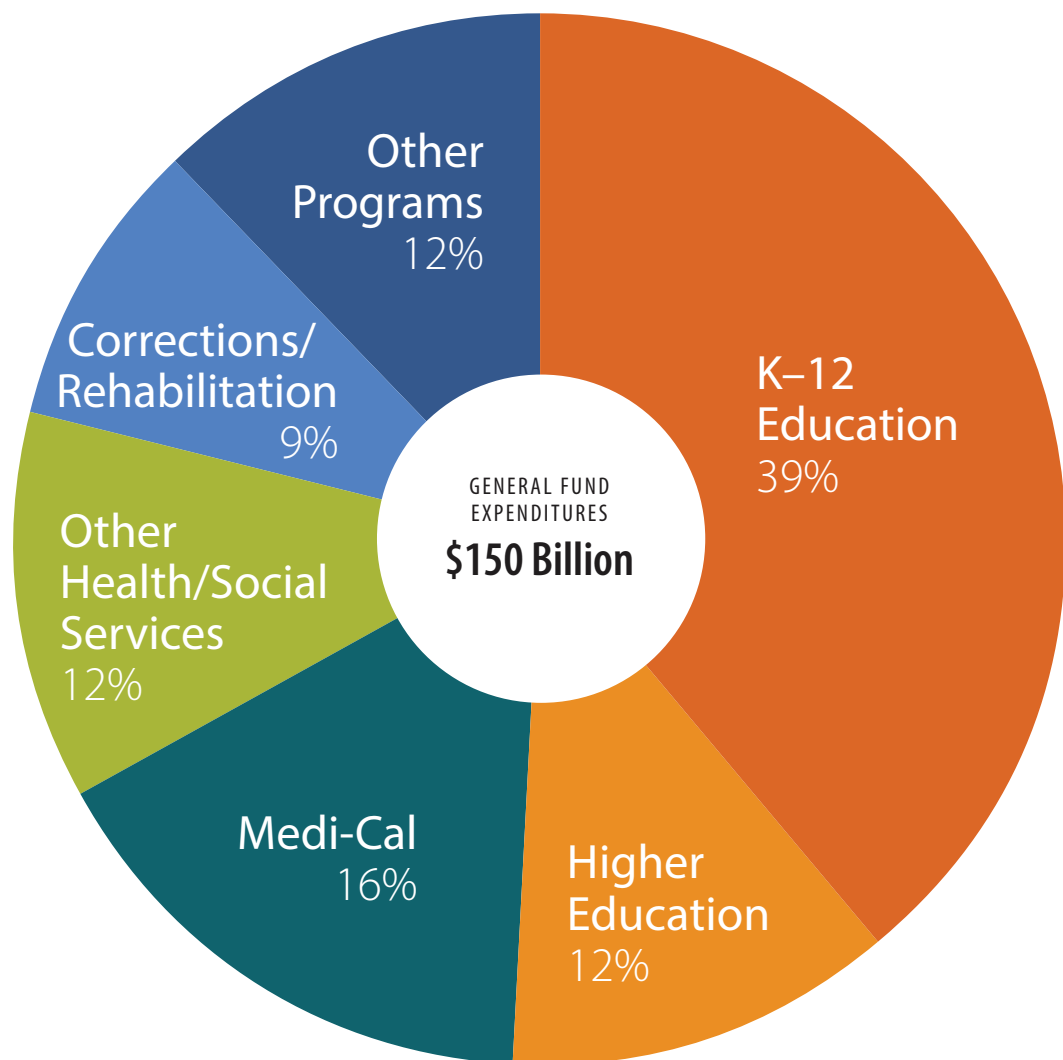
Overview

The federal government provided nearly two-thirds of total Medi-Cal funding. The state contribution to Medi-Cal was 23%, while other state and local funds composed the remaining 12% of the total.

Source: Author calculation based on *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health of Health Care Services, accessed August 6, 2020.

General Fund Distribution, California

FY 2019–20



Medi-Cal Facts and Figures

Overview

California invested more than \$23 billion from its general fund annually in the Medi-Cal program, making Medi-Cal the second-largest category of general fund spending after K–12 education.

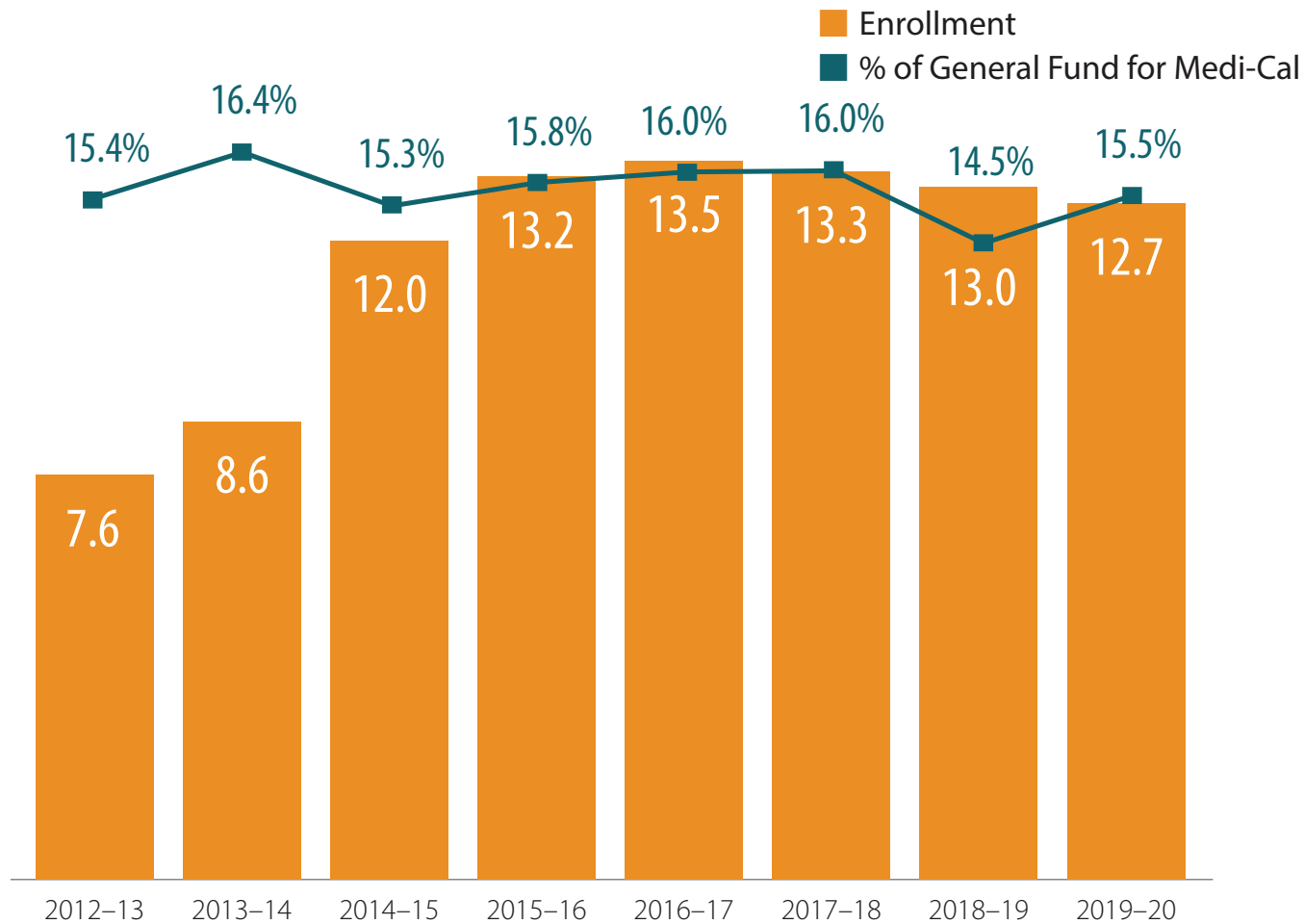
Notes: 2019–20 general fund expenditures as reported in the 2020–21 budget. Includes expenditures for medical care services, eligibility (county administration), fiscal intermediary management, and benefits (medical care and services).

Sources: Estimates for 2019–20 Medi-Cal spending are from *2020–21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF) and total general fund spending from *Governor's Budget Summary 2020–21: Summary Charts* (PDF), DOF.

Medi-Cal Enrollment and Share of General Fund

FY 2013 to FY 2020

ENROLLMENT IN MILLIONS



Sources: Estimates for 2019-20 Medi-Cal spending are from *2020-21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF) and total general fund spending from *Governor's Budget Summary 2020-21: Summary Charts* (PDF), DOF; estimates for 2018-19 Medi-Cal spending are from *2019-20 Governor's Budget: 4260 State Department of Health Care Services* (PDF), DOF, and total general fund spending from *Governor's Budget Summary 2019-20: Summary Charts* (PDF), DOF; estimates for 2016-17 and 2017-18 are from *Governor's Budget Summary, 2018-19* (PDF), DOF; estimates for 2015-16 are from *Governor's Budget Summary, 2017-18* (PDF), DOF; estimates for 2014-15 are from *Governor's Budget Summary, 2016-17* (PDF), DOF; estimates for 2013-14 are from *Governor's Budget Summary, 2015-16* (PDF), DOF; and estimates for 2012-13 are from *Governor's Budget Summary, 2014-15* (PDF), DOF.

Medi-Cal Facts and Figures

Overview

Over the past eight years, Medi-Cal has, on average, represented 16% of all general fund expenditures.

Medi-Cal Eligibility Requirements

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

- **Income.** Household income must be below certain thresholds of the federal poverty guidelines. Income thresholds, and factors used in calculating income, vary by eligibility group (see page 21) and take household size into account.
- **Property.** Enrollees in some aid categories must pass an asset test and demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than \$3,300 for a family of four). Some types of property, such as a principal residence, are exempt.*
- **Citizenship and immigration status.** For adults, US citizenship or “qualifying immigration status” (e.g., lawful permanent resident) is required to be eligible for full-scope benefits. California allows children, teens, young adults under 26, and in 2022, adults age 50 and older who are undocumented and meet other eligibility requirements to also receive full-scope benefits. Full-scope Medi-Cal provides medical, dental, mental health, and vision care. It also covers alcohol and substance use disorder treatment and prescription drugs. Other residents without qualifying immigration status may be eligible for restricted-scope benefits that cover only pregnancy-related and emergency services. (See Immigration Status and Eligibility on page 22 for more information.)
- **Residence.** Enrollees must reside in California.
- **Public assistance program enrollment.** Eligibility for Medi-Cal is automatic for enrollees in the following public assistance programs: CalFresh, Supplementary Security Income / State Supplemental Payment, CalWORKS, Refugee Assistance, Foster Care / Adoption Assistance Program.

* AB133 in 2021 directs the state to seek federal approval to eliminate the asset test as an eligibility requirement.

Notes: The ACA created a streamlined financial eligibility test based on federal tax rules to determine gross income for all insurance affordability programs. The modified adjusted gross income (MAGI) standard eliminated the asset test for most adults, parents, children, and pregnant women.

Sources: “Poverty Guidelines” (2020), US Dept. of Health and Human Services; *Medi-Cal General Property Limitations* (PDF), California Dept. of Health Care Services (DHCS), April 2014; Jen Flory et al., *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; “Medi-Cal Eligibility and Covered California - Frequently Asked Questions,” DHCS, last modified March 23, 2021; and “Do You Qualify for Medi-Cal Benefits?,” DHCS, last modified March 23, 2021.

Medi-Cal Facts and Figures

Eligibility and Enrollment

For most enrollees, Medi-Cal eligibility is based on household income and size.

Eligibility Groups

MANDATORY GROUPS – REQUIRED BY FEDERAL LAW	INCOME THRESHOLD	NOTES
Children and youth under age 26 receiving adoption assistance or foster care	None	
Children under age 19	133% FPL cap	Income threshold is below 142% FPL for children age 1 to 5.
People in long-term care	100% FPL cap	Subject to asset test*
Parents and caretaker relatives	108% FPL cap	
Aged, blind, and people with disabilities	Must receive SSI	Subject to asset test*
Pregnant women, newborns, and infants under age 1	213% FPL cap	
Medicare enrollees with low incomes	FPL cap varies	Three categories: Qualified Medicare Beneficiary (100% FPL), Specified Low-Income Medicare Beneficiary (120% FPL), Qualifying Individual (135% FPL)
OPTIONAL GROUPS – NOT REQUIRED BY FEDERAL LAW	INCOME THRESHOLD	NOTES
ACA "expansion" adults under age 65	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA [†]
Parents and caretaker relatives	109%–138% FPL	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA [†]
Qualifying state and county inmates	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA. Medi-Cal pays for inpatient hospital services
Children under age 19	134%–266% FPL	Title XXI funded Optional Targeted Low-Income Children [‡]
Children under age 19 in specific counties [§]	267%–322% FPL	Title XXI (C-CHIP) [‡]
Pregnant women, newborns and infants under age 2	213%–322% FPL	Title XXI funded Optional Targeted Low-Income Children
Children and youth under age 19 regardless of immigration status	Below 266% FPL	State-only funding
Young adults age 19–25 regardless of immigration status	138% FPL cap	State-only funding
People in long-term care regardless of immigration status	100% FPL cap*	Subject to asset test*
Aged, blind, and people with disabilities — FPL program	138% FPL cap	Subject to asset test*
Working disabled	250% FPL cap	Subject to asset test*
Adults age 50 and older regardless of immigration status**	138% FPL cap	State-only funding

* People qualifying under specific aid categories must demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than \$3,300 for a family of four). This is commonly referred to as the "asset test." Some real and personal properties are exempt (e.g., principal residence). This requirement applies only to specific aid categories such as the aged, blind, and disabled. Those in long-term care may also have to pay a share of cost. AB 133 (2021) directs the state to seek federal approval to eliminate the asset test as an eligibility requirement.

[†] While the Supreme Court made it the state's option to implement this expansion, states opting to do so must implement the expansion group as written in statute.

[‡] Title XXI of the Social Security Act passed in 1997, also known as the Children's Insurance Program, allows states the option to provide coverage to uninsured pregnant women, infants, and children in families with household incomes higher than Medicaid thresholds and who cannot afford private insurance. States can create stand-alone programs, expand their Medicaid programs, or create a hybrid program. Originally, California created the Healthy Families program but transitioned enrollees into Medi-Cal in 2012–13 and uses the Title XXI funds to expand Medi-Cal eligibility thresholds.

[§] C-CHIP in San Mateo, Santa Clara, and San Francisco Counties only.

** Effective in 2022

Medi-Cal Facts and Figures

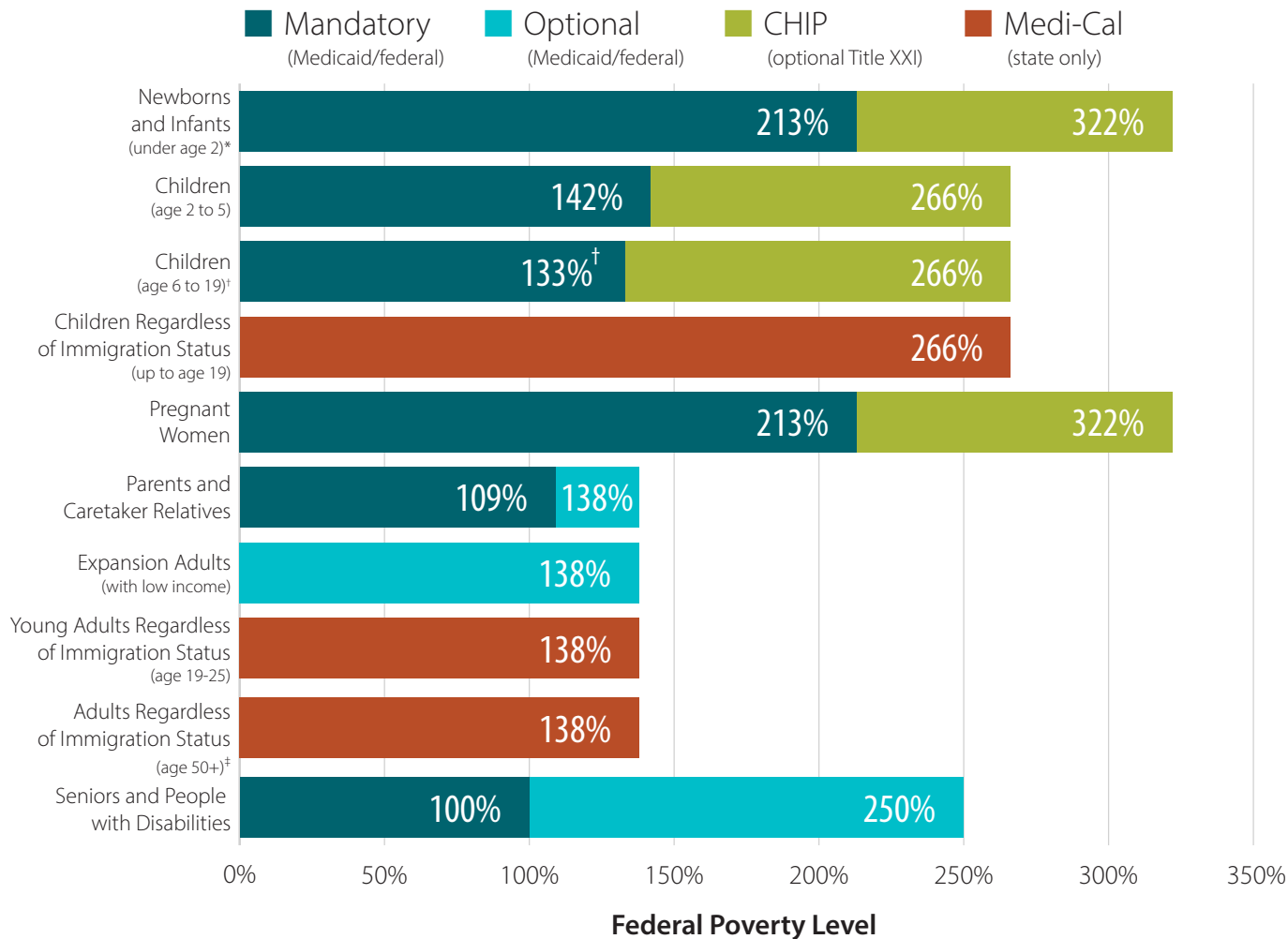
Eligibility and Enrollment

Federal law requires all state Medicaid programs to cover the mandatory groups, and allows states to receive federal matching funds for the optional groups. Under the ACA, California expanded eligibility to adults with low incomes and without disabilities or dependent children, and to parents and caretaker relatives. Using state funds, California also expanded Medi-Cal to cover three groups in households with low income regardless of immigration status: children, adults under 26, and in 2022, adults age 50 and over.

Note: The 2021 federal poverty level (FPL) for a single person is \$12,760; 138% FPL is \$17,609.

Sources: "California Medicaid Eligibility Groups by Medi-Cal Aid Code," California Health and Human Services Agency, accessed October 22, 2020; *All-County Letter Welfare Letter 20-03* (PDF), California Dept. of Health Care Services (DHCS), February 5, 2020; *List of Medicaid Eligibility Groups* (PDF), Centers for Medicare & Medicaid Services, accessed October 18, 2020; *Medi-Cal Eligibility Division Informational Letter 19-15* (PDF), DHCS, May 30, 2019; Tricia Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," KFF, March 26, 2020; *Fact Sheet: Children's Health Insurance Program* (CHIP) (PDF), Medicaid and CHIP Payment and Access Commission, February 2018; *Young Adult Full Scope Expansion: Eligibility and Enrollment Plan* (PDF), DHCS, November 4, 2019; *Program Eligibility by Federal Poverty Level for 2021* (PDF), Covered California, accessed October 18, 2020; and AB 133 (Cal. 2021-22).

Medi-Cal Income Thresholds



Note: *CHIP* is Children's Health Insurance Program and is part of the Medi-Cal program.

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

† 5% income disregard doesn't apply.

‡ Effective in 2022.

Sources: "California Medicaid Eligibility Groups by Medi-Cal Aid Code," California Health and Human Services Agency, accessed October 22, 2020; *All-County Letter Welfare Letter 20-03* (PDF), California Dept. of Health Care Services, February 5, 2020; *Program Eligibility by Federal Poverty Level for 2021* (PDF), Covered California, accessed October 18, 2020; and "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," KFF, March 26, 2020.

Medi-Cal Facts and Figures

Eligibility and Enrollment

Medi-Cal income eligibility thresholds vary. In 2021, a single, childless adult with annual income below 138% of the federal poverty level (FPL), or \$17,609, would be eligible for Medi-Cal. A pregnant person would be eligible if their annual income were below 322% of FPL, or \$41,088.

Immigration Status and Eligibility

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

Qualified Immigrants

- Legal permanent residents (LPRs), asylees, refugees, and other qualifying categories: Eligible for full-scope benefits and Federal Medical Assistance Percentage (FMAP) if they have resided in the US for more than five years (referred to as the “five-year bar”).

Nonqualified Immigrants

- Permanently Residing Under Color of Law (PRUCOL): Entitled to full-scope Medi-Cal with state-only funding and no FMAP. The ACA recognizes Deferred Action for Childhood Arrivals (DACA) status as “lawfully present” under PRUCOL.
- Children who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP.
- Young adults age 19–25 who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP.
- Adults age 26–49 who are undocumented: Entitled only to restricted-scope (emergency and pregnancy-related) services. These services qualify for federal matching.
- Adults age 50 and older who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP, effective in 2022.

Notes: Other qualified groups include those (1) paroled into the US under specific conditions; (2) granted conditional entry pursuant to specific conditions; (3) Cuban or Haitian entrant; (4) battered spouses and children with a pending or approved: (a) self-petition for an immigrant visa or visa petition by a spouse or parent who is either a US citizen or LPR, or (b) application for cancellation of removal/suspension of deportation, where the need for the benefit has a substantial connection to the battery or cruelty (parent/child of such battered child/spouse are also “qualified”); (5) Victims of Severe Forms of Trafficking. The date someone receives their qualified status triggers the beginning of the “five-year bar.” Some qualified immigrants are exempt from the five-year bar. Permanent Residence Under Color of Law (PRUCOL) is not an immigration status but a public benefits eligibility category; PRUCOL individuals are not US citizens but are considered to have the same rights as legal residents for welfare eligibility purposes. See 42 CFR § 435.408 for the federal definition and 22 CCR § 50301.3 for the state definition.

Sources: *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; Cal. Welf. and Inst. Code § 14007.8; “An Advocate’s Guide to Medi-Cal Services,” National Health Law Program, February 11, 2020; AB 133 (Cal. 2021-22); and *Young Adult Full Scope Expansion: Eligibility and Enrollment Plan* (PDF), California Dept. of Health Care Services, November 4, 2019.

Medi-Cal Facts and Figures

Eligibility and Enrollment

Some immigrants who are not citizens are eligible for full-scope Medi-Cal, while others may be eligible only for restricted-scope emergency and pregnancy-related services.

Medi-Cal Individual Application Process

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

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

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

By phone. Interested people can call the Covered California service center or county social services office to initiate an application with a customer service representative or county eligibility worker. These applications require in-person follow-up with the county eligibility worker.

Presumptive eligibility. Participating providers in the Presumptive Eligibility Program for Pregnant Women, the Child Health and Disability Prevention Program, the Breast and Cervical Cancer Treatment and Prevention program, or the Hospital Presumptive Eligibility program can request immediate 60-day temporary, no-cost Medi-Cal coverage for qualified applicants. During the 60-day period, those receiving this temporary coverage apply for permanent Medi-Cal or other health coverage. During the COVID-19 public health emergency, the federal government expanded the use of presumptive eligibility.

Applications during the COVID-19 pandemic. In April 2019, 37% of applications were online and 38% were in-person. In April 2020 at the start of the COVID-19 Public Health Emergency, online applications rose dramatically to 72% and in-person applications dropped to 5%.

Notes: People eligible for temporary coverage through presumptive eligibility are pregnant women, foster youth age 18–26, children under 19, parent and caretaker relatives, and adults under 65 without dependent children. People must meet income and residency requirements and not have received presumptive eligibility benefits in the last 12 months. CalWORKs is a public assistance program that provides cash aid and services to eligible families that have children in the home.

Sources: “Medi-Cal Eligibility and Covered California - Frequently Asked Questions,” California Dept. of Health Care Services (DHCS), accessed October 18, 2020; *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; and *Medi-Cal Enrollment Update* (PDF), DHCS, April 8, 2021.

Medi-Cal Facts and Figures

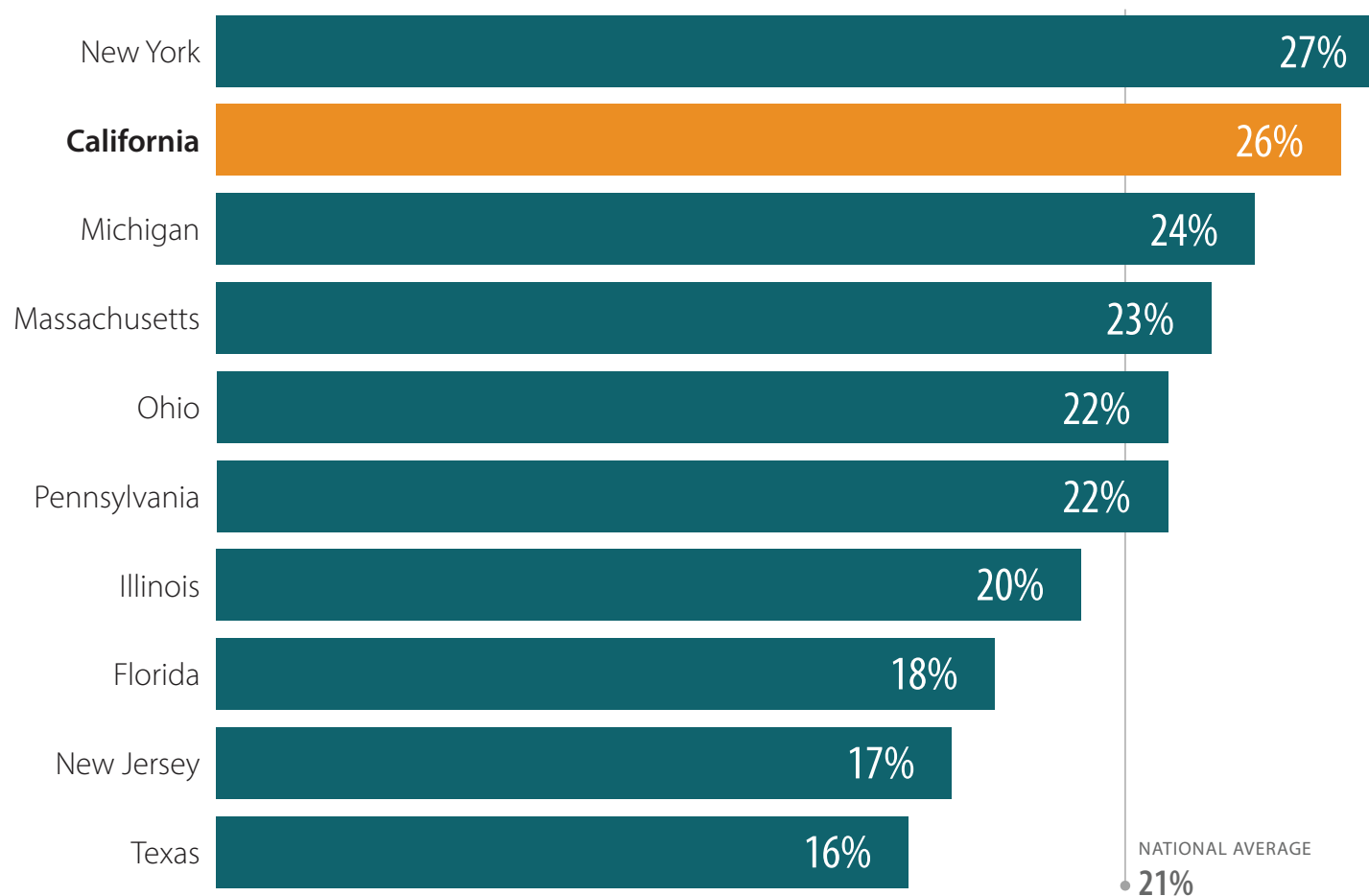
Eligibility and Enrollment

To comply with the ACA, California created a single streamlined application for Medi-Cal and Covered California, the state’s health care exchange. There are numerous pathways to submit an application.

Medicaid Enrollment

Selected States, 2019

PERCENTAGE OF NONELDERLY STATE POPULATION



Notes: States with the 10 largest Medicaid expenditures in FY 2019, based on KFF's "Total Medicaid Spending (FY 2019)," are represented. *Nonelderly* is under age 65. Medicaid enrollment is self-reported and includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan, or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage such as dually eligible enrollees also covered by Medicare.

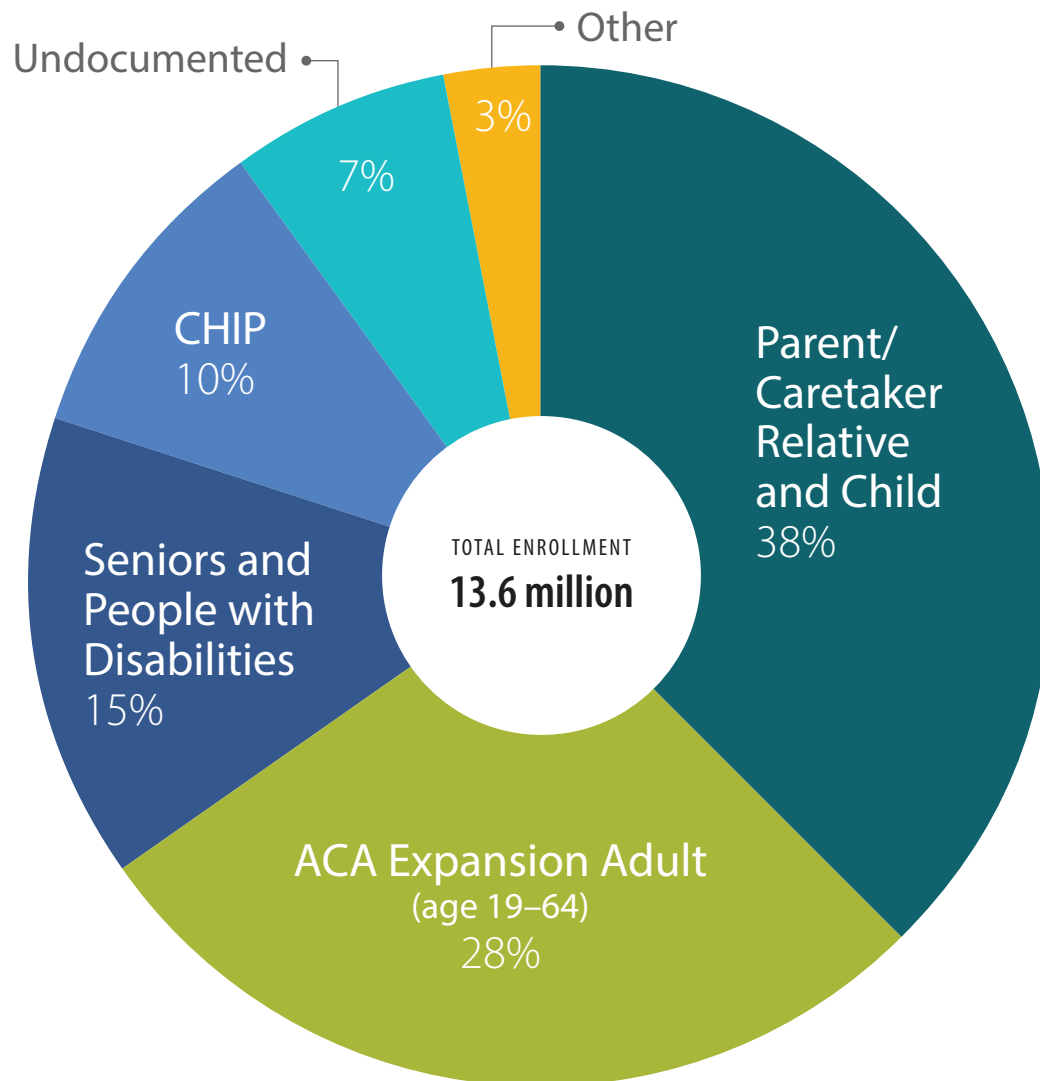
Source: "Health Insurance Coverage of Nonelderly 0-64" (2019), KFF.

Medi-Cal Facts and Figures

Eligibility and Enrollment

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

Enrollment, by Aid Category, 2021



Notes: Enrollment month is January 2021. *CHIP* is Children’s Health Insurance Program. *Undocumented* includes aid categories restricted to only pregnancy-related, long-term care, and emergency services for adults who do not have satisfactory immigration status, also known as restricted-scope benefits. *Other* includes long-term care and aid categories including Adoption/Foster Care, Refugee Medical Assistance / Entrant Medical Assistance, Breast and Cervical Cancer Treatment Program, Abandoned Baby Program, Minor Consent Program, Accelerated Enrollment in the Children Health and Disability Prevention Program (CHDP), Trafficking and Crime Victims Assistance Program, and state and county inmates. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

Medi-Cal Facts and Figures

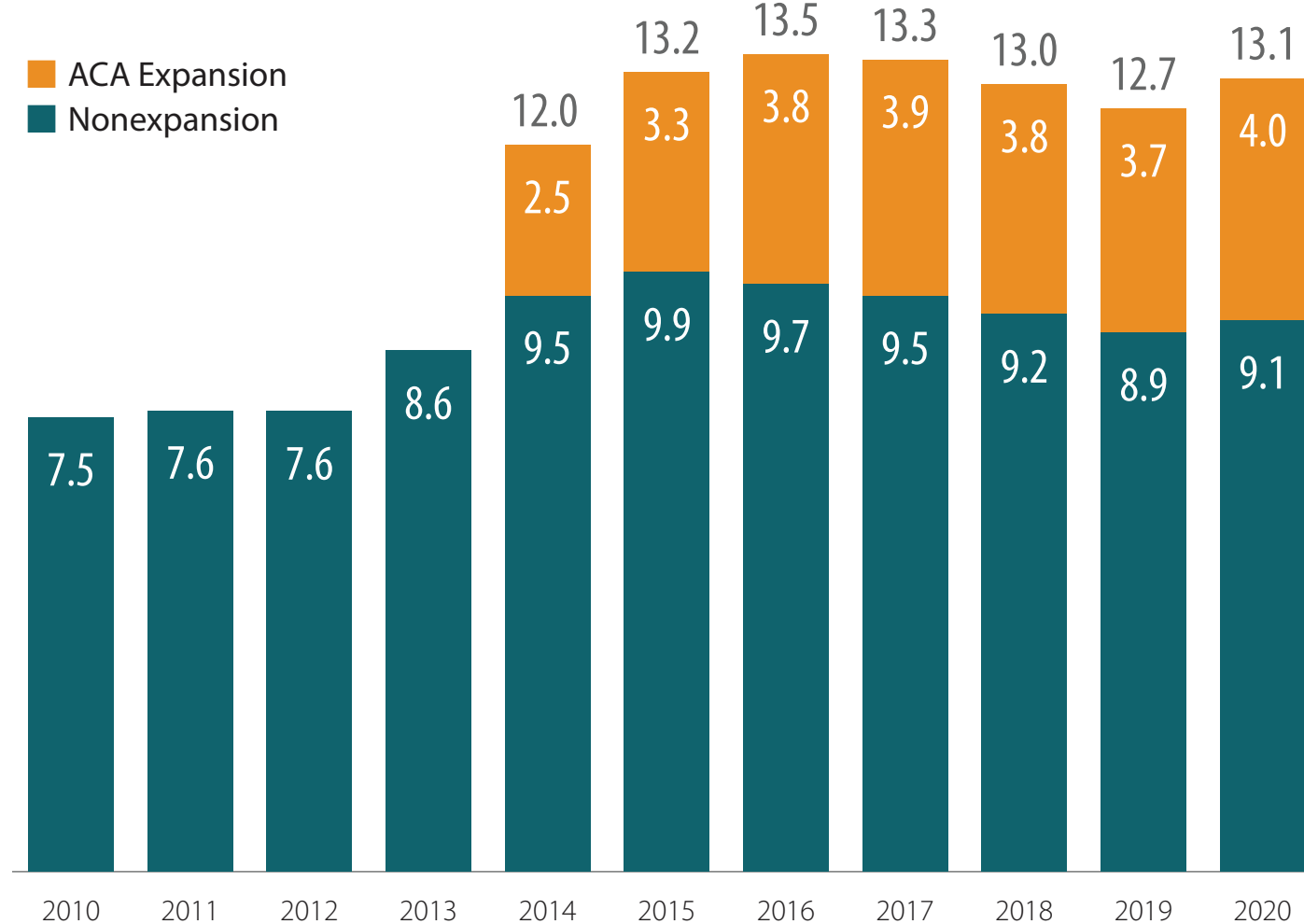
Eligibility and Enrollment

Nearly half of Medi-Cal enrollees were children and their parents/caretakers and children in CHIP. Nearly one in six enrollees was a senior or person with a disability. The Affordable Care Act (ACA) expansion group — adults under 65 with low incomes and no dependent children — was the second-largest group of Medi-Cal enrollees.

Medi-Cal Enrollment

2010 to 2020

IN MILLIONS



Note: Enrollment month is November of each year.

Sources: *Month of Eligibility, Aid Category by County, Medi-Cal Certified Eligibility*, California Dept. of Health Care Services (DHCS), November 25, 2020; and *Medi-Cal Enrollment Update* (PDF), DHCS, April 8, 2021.

Medi-Cal Facts and Figures

Eligibility and Enrollment

Medi-Cal enrollment has increased significantly since 2013, largely due to the ACA expansion. In 2014, nonexpansion enrollment increased sharply when Healthy Families enrollees were moved to Medi-Cal. Between 2016 and 2019 enrollment declined. In 2020, enrollment increased amid the COVID-19 pandemic, increased unemployment, and suspended eligibility redeterminations.

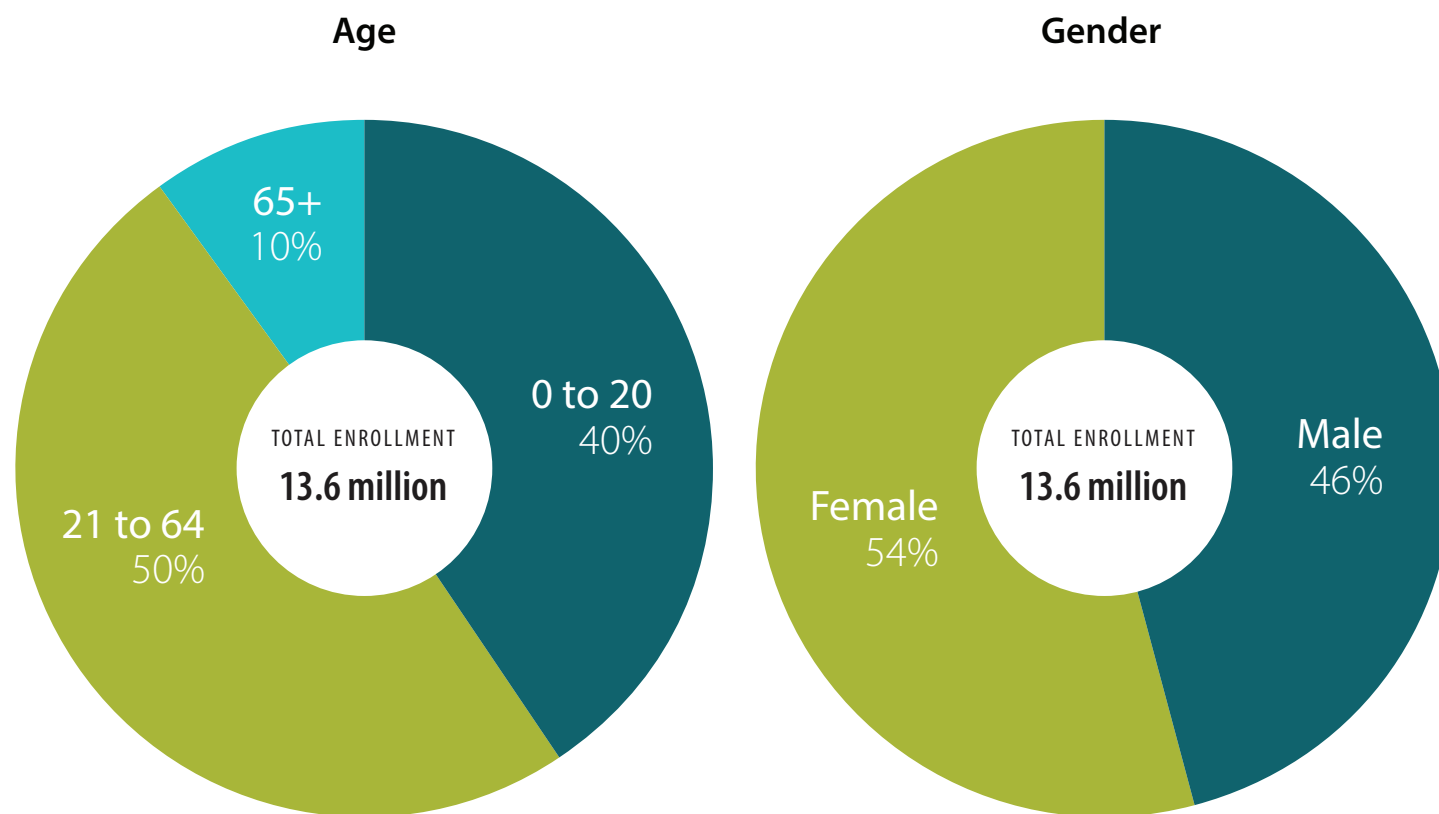
Medi-Cal Enrollee Profile

by Age and Gender, 2021

Medi-Cal Facts and Figures

Eligibility and Enrollment

Half of Medi-Cal enrollees are adults; children and youth (age 0–20) account for about 41% of enrollment. Medi-Cal enrollees are somewhat more likely to be female (54%) than male (46%).



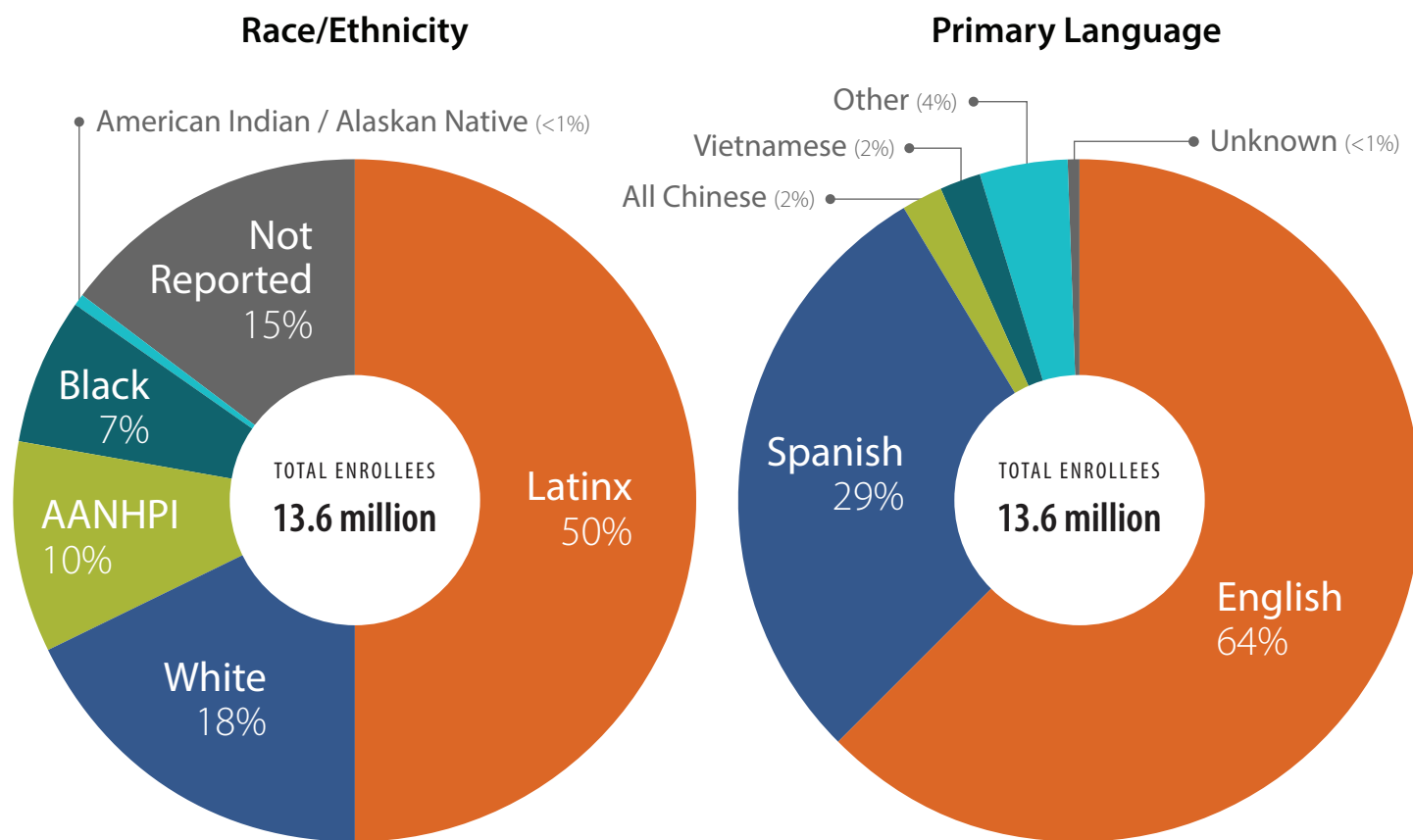
Note: Enrollment month is January 2021.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

Medi-Cal Enrollee Profile

by Ethnicity and Primary Language, 2021

Medi-Cal serves a large and diverse population, with Latinx Californians accounting for 50% of all enrollment. English is the most common language spoken (64% of enrollees). Spanish is the primary language spoken for 29% of enrollees.

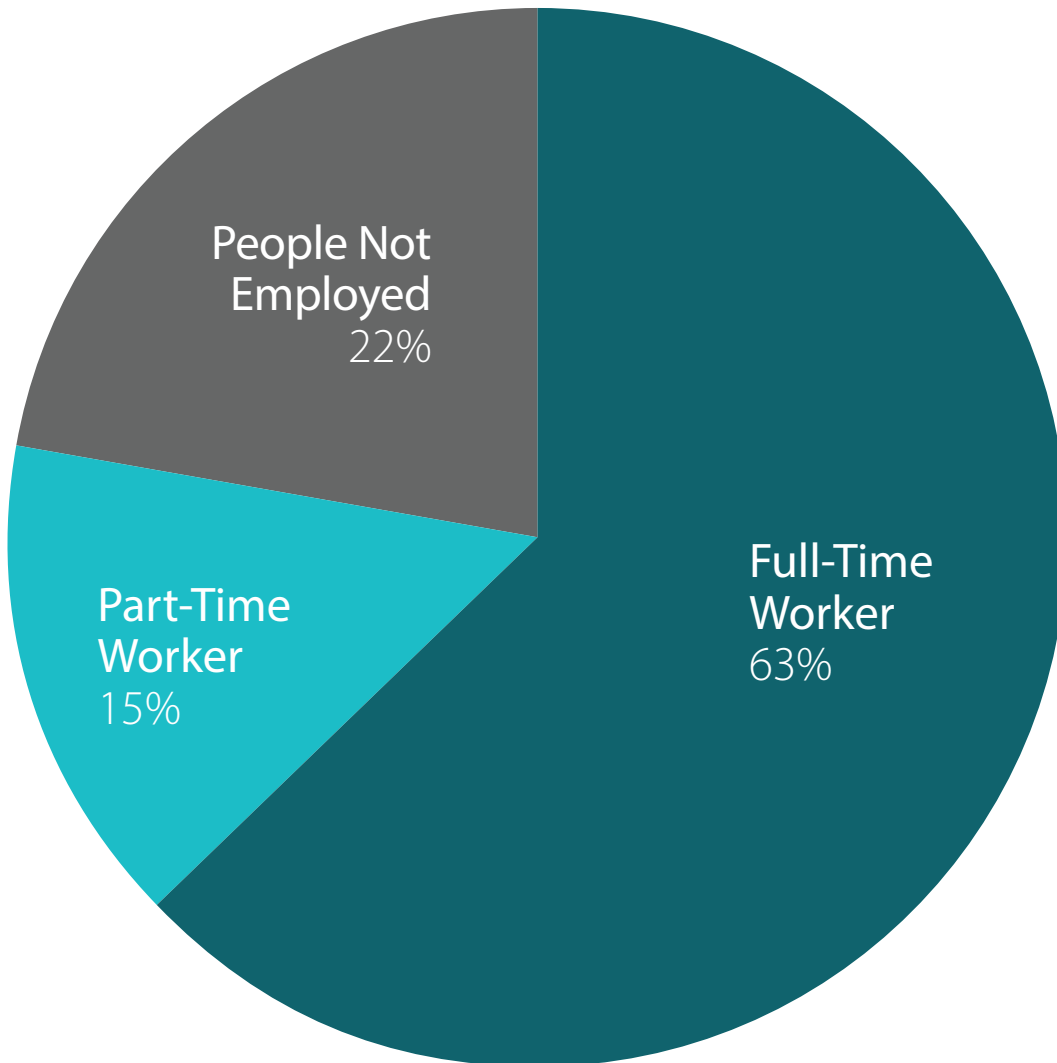


Notes: AANHPI is Asian American / Native Hawaiian and Pacific Islander. Enrollment month is January 2021. Source uses *Hispanic*, *African American*, and *Asian / Pacific Islander*. All Chinese includes Mandarin, Cantonese, and Other Chinese. Other includes American Sign Language, Arabic, Armenian, Cambodian, Farsi, French, Hebrew, Hmong, Ilocano, Italian, Japanese, Korean, Lao, Mien, Other Non-English, Other Sign, Polish, Portuguese, Russian, Samoan, Tagalog, Thai, and Turkish. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

Medi-Cal Enrollment

by Family Work Status, Nonelderly Population, 2019



Medi-Cal Facts and Figures

Eligibility and Enrollment

About three out of four nonelderly Medi-Cal enrollees are in households where they or another family member work part- or full-time.

Note: Source uses *Non Workers*.

Source: "Distribution of the Nonelderly with Medicaid by Family Work Status" (2019), KFF, accessed October 9, 2020.

Medi-Cal Benefits

ESSENTIAL HEALTH BENEFITS	OPTIONAL SERVICES
<ul style="list-style-type: none">• Ambulatory services• Emergency services• Prescription drugs• Rehabilitative & habilitative services and devices• Maternity and newborn care• Hospitalization• Preventive & wellness services and chronic disease management• Mental health and substance use disorder services, including behavioral health treatment• Pediatric services, including oral and vision care• Laboratory services	<ul style="list-style-type: none">• Dental services for adults• Vision services for adults• Nonemergency medical transportation services• Long-term services and supports

Medi-Cal Facts and Figures

Benefits and Cost Sharing

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

Sources: "State Plan Section 3 - Services," California Dept. of Health Care Services (DHCS), last modified March 23, 2021; "Essential Health Benefits," DHCS, accessed October 25, 2020; and *Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary* (PDF), DHCS, January 2020.

Medi-Cal Pharmacy Benefit Management Transition

In January 2019, Governor Newsom directed the California Department of Health Care Services (DHCS) to transition the administration of pharmaceutical benefits from managed care plans to the state on January 1, 2022. The existing scope of Medi-Cal's pharmacy benefits does not change.

The new program, Medi-Cal Rx, aims to:

- Improve access to pharmacy services for Medi-Cal members
- Standardize the pharmacy benefit under one delivery system
- Apply statewide utilization protocols to all outpatient drugs
- Strengthen the state's ability to negotiate drug rebates with drug manufacturers

DHCS has contracted with Magellan Medicaid Administration, a national pharmacy benefit management firm, to administer Medi-Cal Rx.

DHCS estimates the transition will reduce state general fund expenditures by \$238 million in FY 2021–22.

Medi-Cal Facts and Figures

Benefits and Cost Sharing

Starting in 2021, Medi-Cal will standardize and centralize pharmacy benefits and services across the state. Previously, managed care plans were responsible for administering pharmacy benefits.¹

Sources: Exec. Order N-01-19 (PDF), State of California, January 7, 2019; *Medi-Cal November 2020 Local Assistance Estimate for Fiscal Years 2020-21 and 2021-22* (PDF), California Dept. of Health Care Services (DHCS), accessed March 11, 2021; "Medi-Cal Rx: Transition," DHCS; *Medi-Cal Rx Monthly Bulletin* (PDF) DHCS, accessed August 16, 2021; and "Medi-Cal Rx Background," DHCS, accessed October 25, 2020.

¹ Medi-Cal Rx will not apply to Programs of All-Inclusive Care for the Elderly (PACE) plans, Senior Care Action Network (SCAN) and Cal MediConnect health plans, or the Major Risk Medical Insurance Program (MRMIP).

Premiums and Cost Sharing, by Eligible Group

	PREMIUM OR COST SHARING
Children >160% FPL	<ul style="list-style-type: none"> • Children age 1 to 19 in families with incomes between 160% and 266% of the FPL have a monthly premium. • The premiums are \$13 for each child but cannot exceed \$39 per family per month.
250% Working Disabled Program	<ul style="list-style-type: none"> • People with a medical determination of physical or mental impairment lasting or proposed to last for one year whose countable monthly income is below 250% FPL. • Working people with disabilities and monthly income under 250% FPL. Disability income is excluded from income calculation. • Monthly premiums range from \$20 to \$250 for a single person depending on income.
Aged, Blind, and Disabled — Medically Needy Program Share of Cost*	<ul style="list-style-type: none"> • People over age 65 or who have a disability, with income above \$1,596 per month (after numerous deductions). • People with a medical determination of a physical or mental impairment lasting or proposed to last for one year.

Medi-Cal Facts and Figures

Benefits and Cost Sharing

While most enrollees pay nothing for Medi-Cal, about 200,000 pay small premiums or are responsible for a share of the cost.*

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

Sources: *All-County Welfare Letter 20-03* (PDF), California Dept. of Health Care Services (DHCS), February 5, 2020; "Medi-Cal Premium Payments for the 'Medi-Cal for Families' Program - Frequently Asked Questions," DHCS, accessed October 25, 2020; *Fact Sheet: Aged & Disabled Medi-Cal Program* (PDF), California Advocates for Nursing Home Reform, last updated July 30, 2019; and "Population Distribution for Medi-Cal Enrollees by Share of Cost (SOC)," California Health and Human Services Agency, accessed January 26, 2021.

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

Medi-Cal Waivers

Medi-Cal Facts and Figures

Benefits and Cost Sharing

1915(B) FREEDOM OF CHOICE	1915(C) HOME AND COMMUNITY-BASED SERVICES	1115(A) RESEARCH AND DEMONSTRATION PROJECTS
<p>PURPOSE Permits states to implement service delivery models that restrict choice of providers, such as managed care. States may also use these to waive statewide requirements (e.g., limited geographic area) and comparability requirements.</p> <p>EXAMPLE Specialty Mental Health Services. Waives freedom of choice and creates county mental health plans to deliver specialty mental health services.</p>	<p>PURPOSE Authorizes states to use home and community-based services as an alternative to placement in a nursing home, hospital, or other long-term care facility.</p> <p>EXAMPLES HCBS for the Developmentally Disabled. For enrollees of any age with developmental and intellectual disabilities, including autism, to assist with living in the community rather than in an institution. Nursing Facility / Acute Hospital Waiver. Provides case management, habilitation services, home health nursing, and other services for medically fragile and technology-dependent people of any age. HIV/AIDS Waiver. Provides care coordination, respite care, personal care, expressive therapies, family counseling and training, and other services for medically fragile and technology-dependent people up to age 20. Other 1915(c) waivers. Include Multipurpose Senior Services Program, Assisted Living, and In-Home Operations.</p>	<p>PURPOSE Gives broad authority to waive certain provisions of the Medicaid statutes related to state program design for “any experimental, pilot, or demonstration project likely to assist in promoting the objectives” of the programs. These waivers must be “budget neutral” (i.e., require no additional federal spending).</p> <p>EXAMPLES Medi-Cal 2020. Composed of five main programs:</p> <ul style="list-style-type: none"> • Public Hospital Redesign and Incentives in Medi-Cal. Changes care delivery to maximize health care value and strengthens ability to perform under risk-based alternative payment models. • Global Payment Program. Establishes a statewide pool of funding for the remaining uninsured and provides an incentive for primary and preventive care services. • Whole Person Care pilot program. Coordinates physical health, behavioral health, and social services for enrollees with poor health outcomes who are high risk and have high costs. • Dental Transformation Initiative. Provides incentives to improve access to preventive services and continuity of care for dental services for Medi-Cal children. • Drug Medi-Cal Organized Delivery System. Aims to demonstrate how organizing substance use disorder services along a continuum of care increases enrollees’ success while decreasing system health care costs.

States may use statutory authority to waive certain Medicaid rules, subject to federal approval. As of January 2021, California has 12 waiver programs. Due to the COVID-19 pandemic, Medi-Cal received an extension to the end of 2021 for the Medi-Cal 2020 demonstration waiver and the 1915(b) waiver.

Sources: Jennifer Ryan and Julie Stone, *Medi-Cal Explained Fact Sheet: Medicaid Waivers in California*, California Health Care Foundation, October 2019; and “Medi-Cal Waivers,” California Dept. of Health Care Services, accessed October 25, 2020.

California Advancing and Innovating Medi-Cal (CalAIM)

Section 1115 and 1915(b) waivers, under which many Medi-Cal benefits and initiatives are delivered, are scheduled to expire at the end of 2021. A new proposal, California Advancing and Innovating Medi-Cal (CalAIM), provides a framework for new waivers and future reforms. Importantly, CalAIM envisions moving away from demonstration waivers and making systemic programmatic changes focused on population health improvement.

The CalAIM goals over six years are to:

- Identify and manage member risk and need through whole-person care approaches and addressing social determinants of health.
- Work toward a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

CalAIM proposes to:

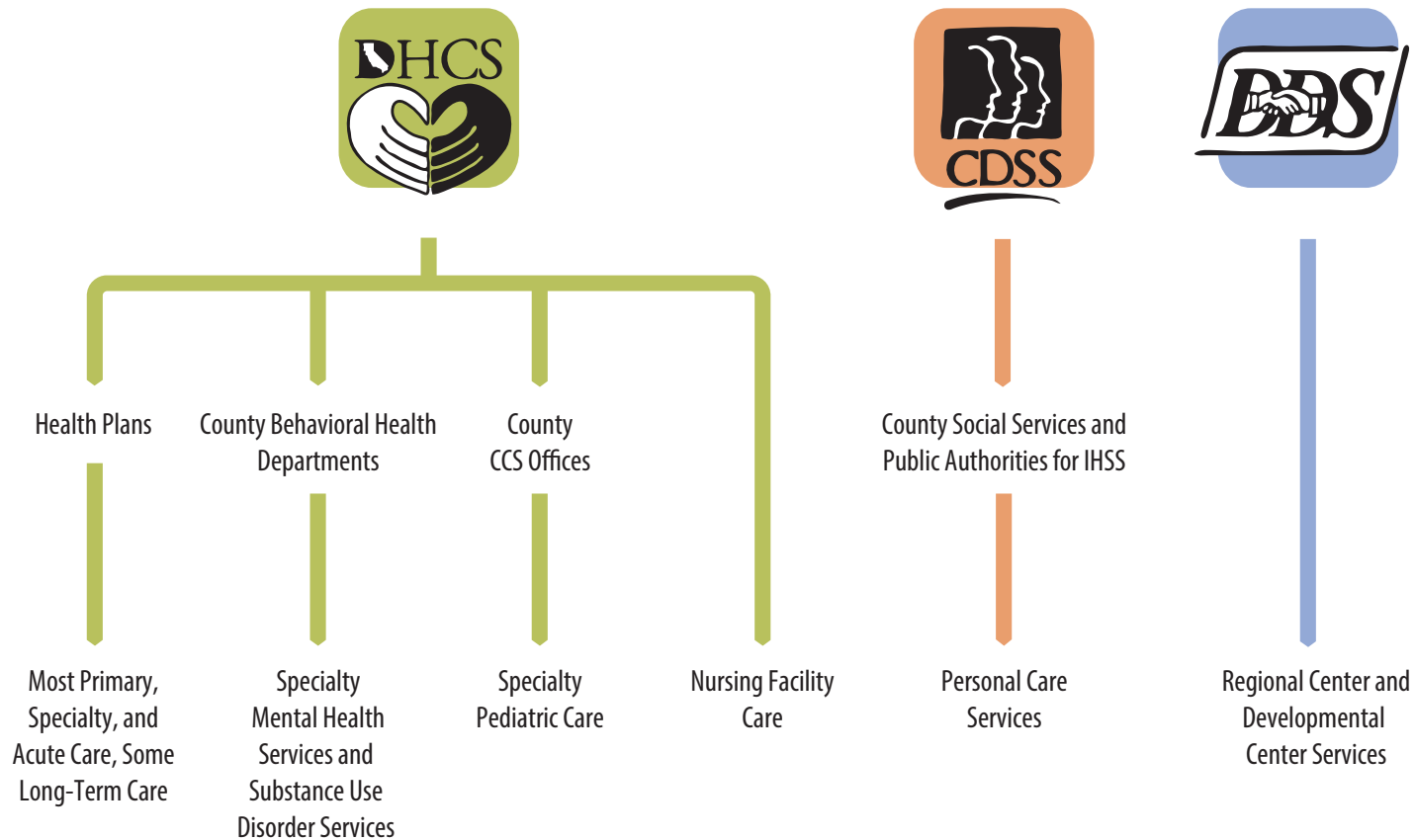
- Create new benefits — Enhanced Care Management and In Lieu of Services — which would be delivered by managed care plans. These benefits demonstrated their effectiveness in the Whole Person Care pilots and Health Homes Program.
- Increase managed care plans' responsibility for care delivery and allow pilots wherein plans would manage and integrate services across multiple benefits (e.g., physical and behavioral health).
- Streamline county behavioral health services reimbursement, contracting, and program administration.

While the launch has been postponed to January 2022 due to the COVID-19 pandemic, DHCS has affirmed its commitment to CalAIM. The FY 2021–22 budget includes \$1.6 billion for implementation.

Sources: *California Advancing and Innovating Medi-Cal (CalAIM)* (PDF), Insure the Uninsured Project, February 2020; *California Advancing and Innovating Medi-Cal: Executive Summary and Summary of Changes* (PDF), California Dept. of Health Care Services (DHCS), accessed January 26, 2021; and *2021-22 Governor's Budget: Department of Health Care Services Highlights* (PDF), DHCS, January 8, 2021.

The state has proposed innovations and changes aimed at improving care for Medi-Cal members.

Systems for Delivering Care



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

Medi-Cal Facts and Figures

Delivery Systems

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

Medi-Cal and Telehealth

Many Medi-Cal enrollees report difficulty accessing specialty services, a problem exacerbated by the COVID-19 pandemic. Telehealth can improve access to care by decreasing wait times between a referral and subsequent visit.

Telehealth is a collection of methods or means for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

Telehealth technologies can be used for diagnostic and monitoring activities as well as education across most health services disciplines, including medicine, dentistry, counseling, occupational and physical therapy, and chronic disease management.

Telehealth is particularly valuable to deliver care to residents of rural areas.

The COVID-19 public health emergency forced swift action by federal and state governments to support telehealth during the pandemic, including increased flexibility and enhanced payment to providers for telehealth visits.

From March to September 2020 during the COVID-19 pandemic, the average monthly rate of outpatient telehealth visits per 100,000 Medi-Cal enrollees increased to 8,587 from 287 during the same period in 2019.*

Nearly 7 in 10 Californians reported receiving care via telehealth in 2020.

* Outpatient telehealth visits per 100,000 enrollees provided by both managed care and fee-for-service providers. Visits by phone or video. Does not include mental health visits.

Sources: "What Is Telehealth," Center for Connected Health Policy, accessed October 24, 2020; *The State of Telehealth in Medi-Cal Managed Care: Taking Stock in the Era of COVID-19*, California Health Care Foundation (CHCF), April 2020; Shira H. Fischer et al., "Prevalence and Characteristics of Telehealth Utilization in the United States," *JAMA Network Open* 3, no. 10 (Oct. 26, 2020): e2022302; Rebecca Catterson, Lucy Rabinowitz, and Emily Alvarez, *The 2021 CHCF California Health Policy Survey*, CHCF, January 2021; and *Stakeholder Advisory Committee Meeting* (PDF), California Dept. of Health Care Services, February 11, 2021.

The use of telehealth by Medi-Cal providers increased dramatically during the COVID-19 pandemic.

Managed Care vs. Fee-for-Service, November 2020

Medi-Cal Facts and Figures

Delivery Systems

	MANAGED CARE	FEE-FOR-SERVICE
Availability	All 58 counties	All 58 counties
Market Share	85% of all enrollees	15% of all enrollees
Enrollment Categories	<p>Mandatory</p> <ul style="list-style-type: none"> Children Pregnant people Parents / caretaker relatives Adults without dependents Seniors and people with disabilities (not also in Medicare) <p>Voluntary</p> <ul style="list-style-type: none"> Seniors and people with disabilities (dually eligible for Medicare) Foster children and youth All enrollees in San Benito County 	<ul style="list-style-type: none"> Dually eligible enrollees Foster children Long-term services and supports Those with other health insurance Share of Cost (SOC) Medi-Cal Family PACT Other enrollees without full-scope Medi-Cal Enrollees who have received a medical exemption Those receiving restricted-scope benefits
Expenditures	50%	28%*
Covered Services	<p>All essential health benefits required by the ACA, including:</p> <ul style="list-style-type: none"> Ambulatory services Emergency services Mental health and substance use disorder services Hospitalization Pediatric services Prescription drugs 	<ul style="list-style-type: none"> Most long-term services and supports Specialty mental health Substance use disorder services Dental services[†] California Children's Services for the seriously ill and disabled children and youth in certain counties[†]
Payment	The state pays plans a fixed monthly capitation rate for each member, also known as a per-member per-month payment. Plans negotiate payment rates with most contracted network providers.	The state pays providers according to a fee schedule.
Carve-Outs	<ul style="list-style-type: none"> Pharmaceuticals[§] Specialty mental health Substance use disorder services Most long-term services and supports Dental services[†] California Children's Services for the seriously ill and disabled children and youth in certain counties[†] 	N/A

More than 8 in 10 Medi-Cal enrollees are enrolled in managed care plans, and account for 50% of all Medi-Cal expenditures. The state determines mandatory or voluntary managed care enrollment, subject to federal approval.

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

Sources: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency, accessed December 11, 2020; *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health Care Services (DHCS), accessed August 6, 2020; *Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes* (PDF), DHCS, December 3, 2018; "California Children's Services Whole Child Model," DHCS; "Medi-Cal Dental Managed Care," DHCS, accessed December 19, 2020; and "Medi-Cal Rx: Medi-Cal Rx Background," DHCS, accessed October 25, 2020.

* Fee-for-service expenditures include "carved-out" services received by managed care enrollees such as dental and specialty mental health.

[†] Dental services are provided by Dental Managed Care (DMC) plans in Sacramento and Los Angeles Counties. In Sacramento County, enrollment is mandatory, with few exceptions. In Los Angeles County, an enrollee must opt in to participate in the DMC program.

[‡] CCS children enroll in managed care plans that provide non-CCS services. For their CCS-related needs, they use fee-for-service CCS providers typically outside of the managed care plan. CCS services are delivered by the five County Organized Health Systems to CCS children in 21 counties under a model called "CCS Whole Child Model."

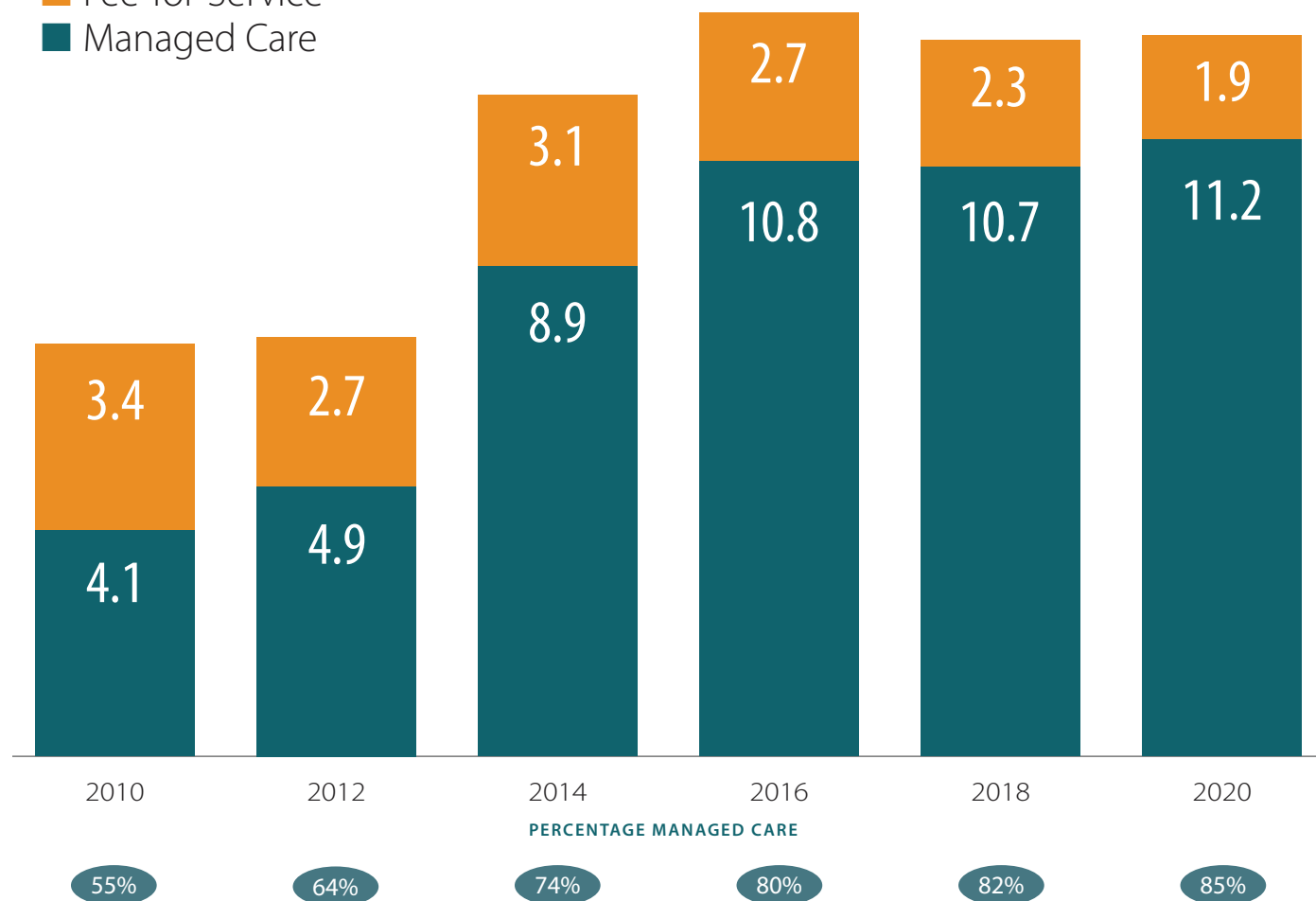
[§] Medi-Cal intends to transition the pharmaceutical benefit responsibility away from managed care plans in 2022 and centralize benefit administration within DHCS and a contracted pharmacy benefit management vendor.

Medi-Cal Managed Care and Fee-for-Service Enrollment Trends

2010 to 2020, Selected Years

IN MILLIONS

■ Fee-for-Service
■ Managed Care



Note: Enrollment is from November of each year.

Source: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Dept. of Health Care Services, accessed December 11, 2020.

Medi-Cal Facts and Figures
Delivery Systems

The majority of Medi-Cal members are enrolled in managed care plans. The share of members enrolled in fee-for-service Medi-Cal has decreased from 2010 to 2020.

Medi-Cal Managed Care Models by Model and County, November 2020



- **County Organized Health Systems (COHS)**
 2.2 million enrollees served by six health plans in 22 counties.
- **Two-Plan**
 7.2 million enrollees in 14 counties. Nine local initiatives (county-organized) serve 5.3 million enrollees, and three commercial plans serve 1.8 million enrollees.
- **Geographic Managed Care (GMC)**
 Eight commercial plans serve 1.1 million enrollees in 2 counties.
- **Regional**
 Two commercial plans serve 315,000 enrollees in 18 counties.
- **Imperial**
 Two commercial plans serve about 80,000 enrollees.
- **San Benito**
 One commercial plan serves 8,800 enrollees.

In California, there are six models of managed care.

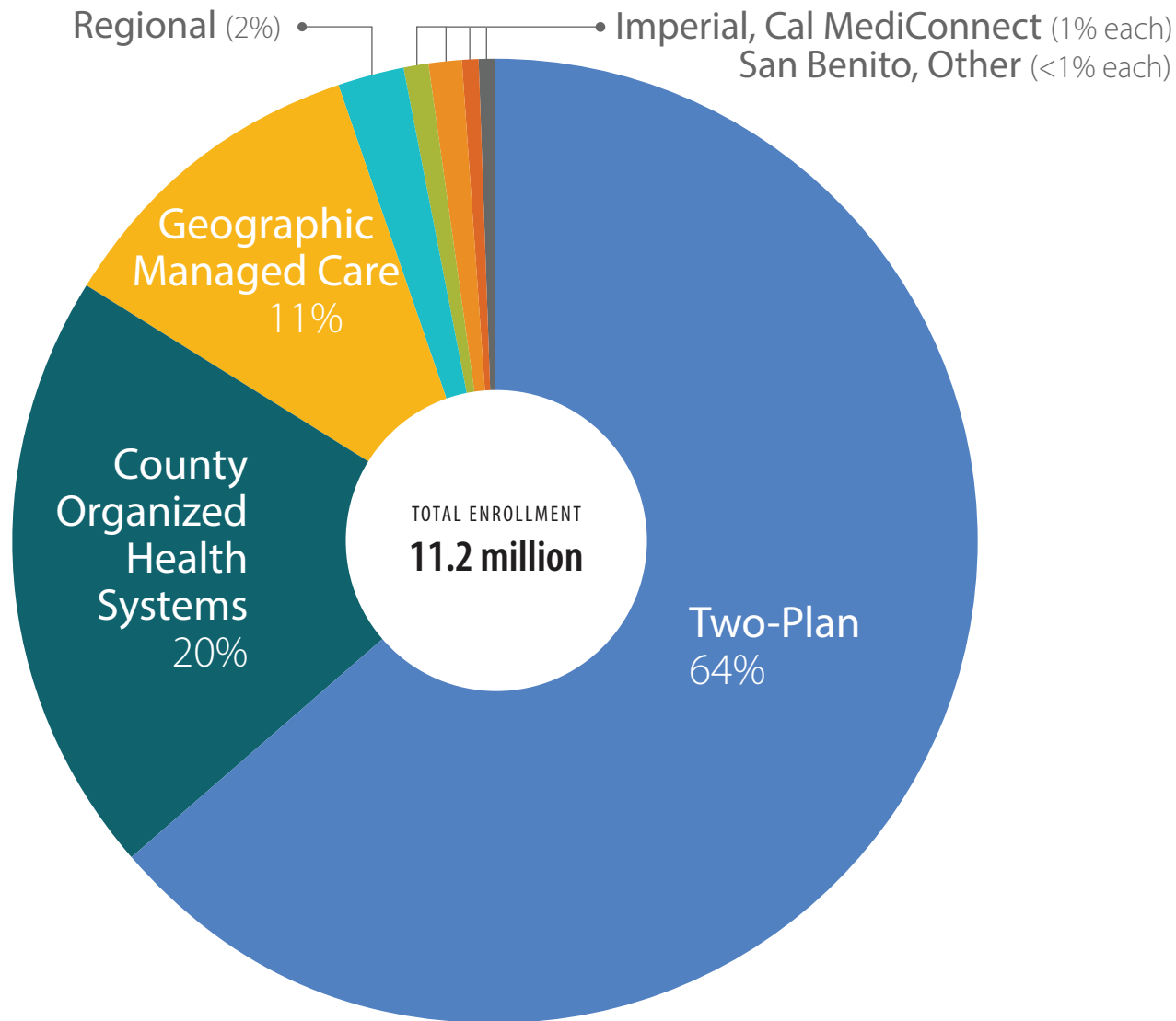
Notes: The figures above include Cal MediConnect enrollees but exclude SCAN, Primary Care Case Management, Special Project, and PACE plan enrollees. While Tulare is a Two-Plan Model county, there is no county-run local initiative and instead the county contracts with Anthem Blue Cross as the local initiative. Tulare's enrollment is included in commercial plans.

Sources: *Medi-Cal Managed Care Program Fact Sheet - Managed Care Models* (PDF), California Dept. of Health Care Services, January 2, 2020; and "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed December 15, 2020.

Managed Care Enrollment, by Plan Type

November 2020

The Medi-Cal program uses a variety of managed care models, including county health plans and private health plans. The Two-Plan Model, in which a government-run local initiative competes with a private health plan, had the largest enrollment.



Notes: *Other* includes Primary Case Management, PACE, and SCAN plans. Segments do not total 100% due to rounding.
Source: "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed December 15, 2020.

Medi-Cal Managed Care Carve-Outs

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

- **Specialty Mental Health Services (SMHS)** are provided by county mental health plans to adults with a serious mental illness and to children with a serious emotional disturbance. SMHS include targeted case management, partial hospitalization, and outpatient and inpatient mental health services.
- **Substance use disorder services** are provided through the Drug Medi-Cal program, which provides on-demand treatments, including outpatient drug-free services, intensive outpatient services, detoxification services, medication-assisted treatment, and residential recovery services.
- **Dental services** are available on a fee-for-service basis through the Denti-Cal program. Denti-Cal provides preventive, diagnostic, restorative, and periodontal services. In Los Angeles and Sacramento Counties, dental services are provided through dental managed care plans.
- **Long-term services and supports (LTSS)** include the use of home and community-based services intended to keep enrollees out of long-term care facilities. LTSS are carved out of managed care except for Community-Based Adult Services and the nursing home benefit in County Organized Health System (COHS) counties.* For the Coordinated Care Initiative, 11 Medi-Cal managed care plans refer and coordinate LTSS, but the services remain carved out except the nursing facility home benefit.
- **Institutional long-term care services** are provided under most managed care contracts for only two months. A member requiring a longer stay in the long-term care facility is disenrolled from the plan and moved to fee-for-service, where DHCS is responsible for all covered services. DHCS has proposed a statewide carve-in of this benefit into managed care under its CalAIM initiative.
- **California Children’s Services (CCS)** provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Five COHS plans will manage these children’s benefits in 21 counties in a program called the CCS Whole Child Model.
- **Prescription drug** benefit in managed care plans will transition to Medi-Cal Rx in 2021. (See page 31 for details.)

* Health Plan of San Mateo, a County-Organized Health System, has also fully integrated Multipurpose Senior Services Program benefits.

Sources: *2019 Medi-Cal Dental Services Member Handbook* (PDF), California Dept. of Health Care Services (DHCS), accessed October 26, 2020; “Medi-Cal Specialty Mental Health Services,” DHCS, accessed October 26, 2020; “California Children’s Services Whole Child Model,” DHCS, accessed October 26, 2020; and Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, California Health Care Foundation, September 2020.

Certain Medi-Cal services are “carved out” of managed care plan contracts. Carved-out services have separate funding mechanisms and delivery systems.

Medi-Cal Long-Term Services and Supports

Medi-Cal enrollees who have a disability or chronic illnesses may need services to support their daily living. They may receive these services in an institutional setting, at home, or in the community. These services are referred to as long-term services and supports (LTSS).

The majority of California skilled nursing facility residents are Medi-Cal enrollees, and most using long-term services and supports are dually eligible for Medicaid and Medicare.

There are nearly a dozen LTSS programs for which Medi-Cal coordinates benefits, financing, and oversight with four other state agencies. This patchwork creates challenges for providers and Medi-Cal enrollees.

Qualifying enrollees are entitled to receive these LTSS benefits:

- Skilled nursing facility services
- Personal care services
- Self-directed personal assistance services
- Community first choice option (in-home supportive services)
- Home and community-based services

Eligibility requirements for Medi-Cal support of LTSS are based on income and having limited assets. Some enrollees with higher incomes may pay a share of the cost.

Additional benefits may include case management, private duty nursing, home health aides, community transition services, and respite care for caregivers. However, these may not be available statewide.

Medi-Cal spent \$3.3 billion on skilled nursing facilities in FY 2019–20.

Sources: Athena Chapman and Elizabeth Evenson, *Long-Term Services and Supports in Medi-Cal* (PDF), California Health Care Foundation, October 2020; *If You Think You Need a Nursing Home: A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility* (PDF), California Advocates for Nursing Home Reform, revised January 2021; "Integrated Care: What Choices Exist for Californians with Medicare and Medi-Cal?," SCAN Foundation, last updated October 16, 2019; and *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health of Health Care Services, accessed August 6, 2020.

Medi-Cal Facts and Figures

Delivery Systems

Medi-Cal prioritizes keeping seniors and people with disabilities living in the community with in-home and other services and supports. Medi-Cal spends three out of four long-term services and supports dollars on home health and personal care.

Medi-Cal Coordinated Care Initiative

The Coordinated Care Initiative (CCI) was enacted in 2012 and implemented in seven counties.* The goal is to better serve the state's seniors with low incomes, people with disabilities, and enrollees dually eligible for Medi-Cal and Medicare.

The first component of the CCI is a mandatory Managed Long-Term Services and Supports (MLTSS) program. Through MLTSS, Medi-Cal enrollees, including those who are dually eligible, must enroll in a Medi-Cal managed care plan to receive their benefits, including long-term care services and Medicare wraparound benefits.

The second component, a demonstration project for dually eligible members called Cal MediConnect (CMC), creates a single plan covering all Medi-Cal and Medicare benefits. Eleven managed care plans participate in CMC. Dually eligible enrollees voluntarily enroll in a CMC plan and receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services. As of February 2021, 112,968 members were enrolled in CMC plans.

The initial CMC demonstration has ended but California received extensions through December 31, 2022.

Medi-Cal Facts and Figures

Delivery Systems

The Coordinated Care Initiative is a demonstration project to better serve seniors with low incomes, people with disabilities, and enrollees who are dually eligible for Medi-Cal and Medicare. The demonstration has laid the groundwork for proposed statewide changes.

* Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara

Sources: "Coordinated Care Initiative Overview," California Dept. of Health Care Services (DHCS), accessed October 29, 2020; *Cal MediConnect Performance Dashboard Metrics Summary* (PDF), DHCS, September 2020; Amber Christ, *Advocates Guide to California's Coordinated Care Initiative* (PDF), Justice in Aging, December 2017; and "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed March 16, 2021.

Behavioral Health Services in Medi-Cal

Managed Care Plans

- Medi-Cal managed care plans are responsible for individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management, as required by the ACA's essential health benefits.
- These outpatient services, which address lower-acuity behavioral health conditions, are also referred to as “mild-to-moderate” services.

County Mental Health Plans

- County mental health plans are responsible for the assessment and treatment of enrollees with serious mental illness or substance use disorder needs.
- Adults with a serious mental illness and children with a serious emotional disturbance can receive specialty mental health services, which include crisis intervention, rehabilitation, targeted case management, partial hospitalization, and outpatient and inpatient mental health services. In FY 2017–18, about 4% of Medi-Cal enrollees (341,710 adults and 267,991 children and youth) received specialty mental health services.

County Substance Use Disorder Programs

- Substance use disorder (SUD) services are delivered by county mental health plans through the Drug Medi-Cal program. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program aimed at improving care, increasing efficiency, and reducing societal and health care costs associated with substance use.* Thirty-seven of California's 58 counties have implemented the DMC-ODS pilot.
- The California Department of Health Care Services requires managed care plans and county mental health plans to have memorandums of understanding that specify policies and procedures for screening, referral, care coordination, information exchange, and dispute resolution in each county.

*The Drug Medi-Cal Organized Delivery System pilot is part of the Medi-Cal 2020 Section 1115 waiver.

Sources: “Behavioral Health Services,” California Dept. of Health Care Services, accessed December 19, 2020; Don Kingdon, Molly Brassil, and Erynne Jones, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*, California Health Care Foundation (CHCF), August 2016; Allison Valentine, Patricia Violet, and Molly Brassil, *How Medi-Cal Expanded Substance Use Treatment and Access to Care: A Close Look at Drug Medi-Cal Organized Delivery System Pilots*, CHCF, August 2020; and “Performance Dashboard AB 470 Report Application,” California Health and Human Services Agency, accessed January 26, 2021.

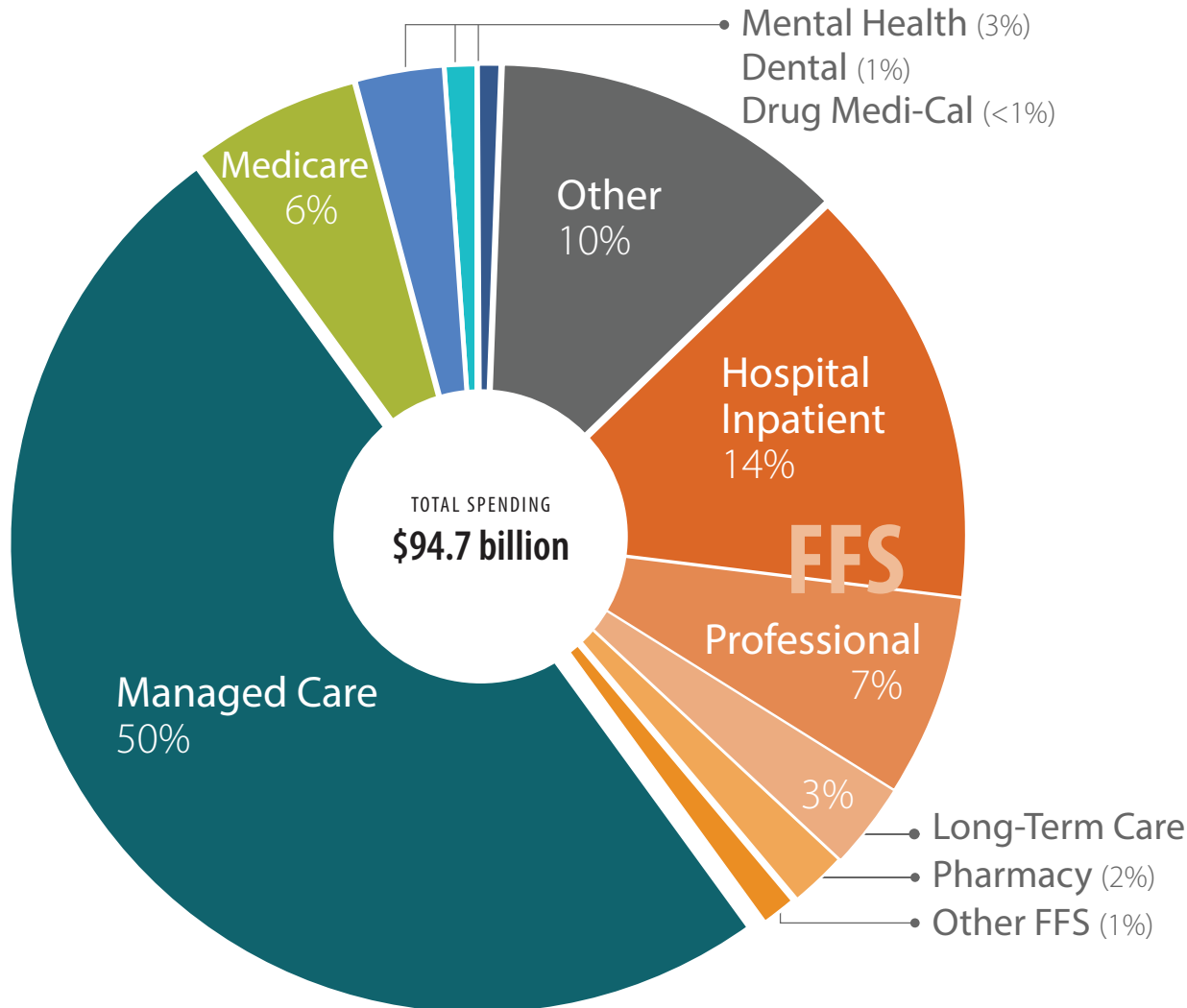
Medi-Cal Facts and Figures

Delivery Systems

Medi-Cal benefits include mental health and substance use disorder services. Service delivery is bifurcated between managed care plans and county mental health plans depending on an enrollee's needs. The CalAIM initiative proposes to integrate speciality mental health and SUD services into one system, making access and use easier for enrollees.

Medi-Cal Expenditures

by Service Category, FY 2019–20



Medi-Cal Facts and Figures

Spending

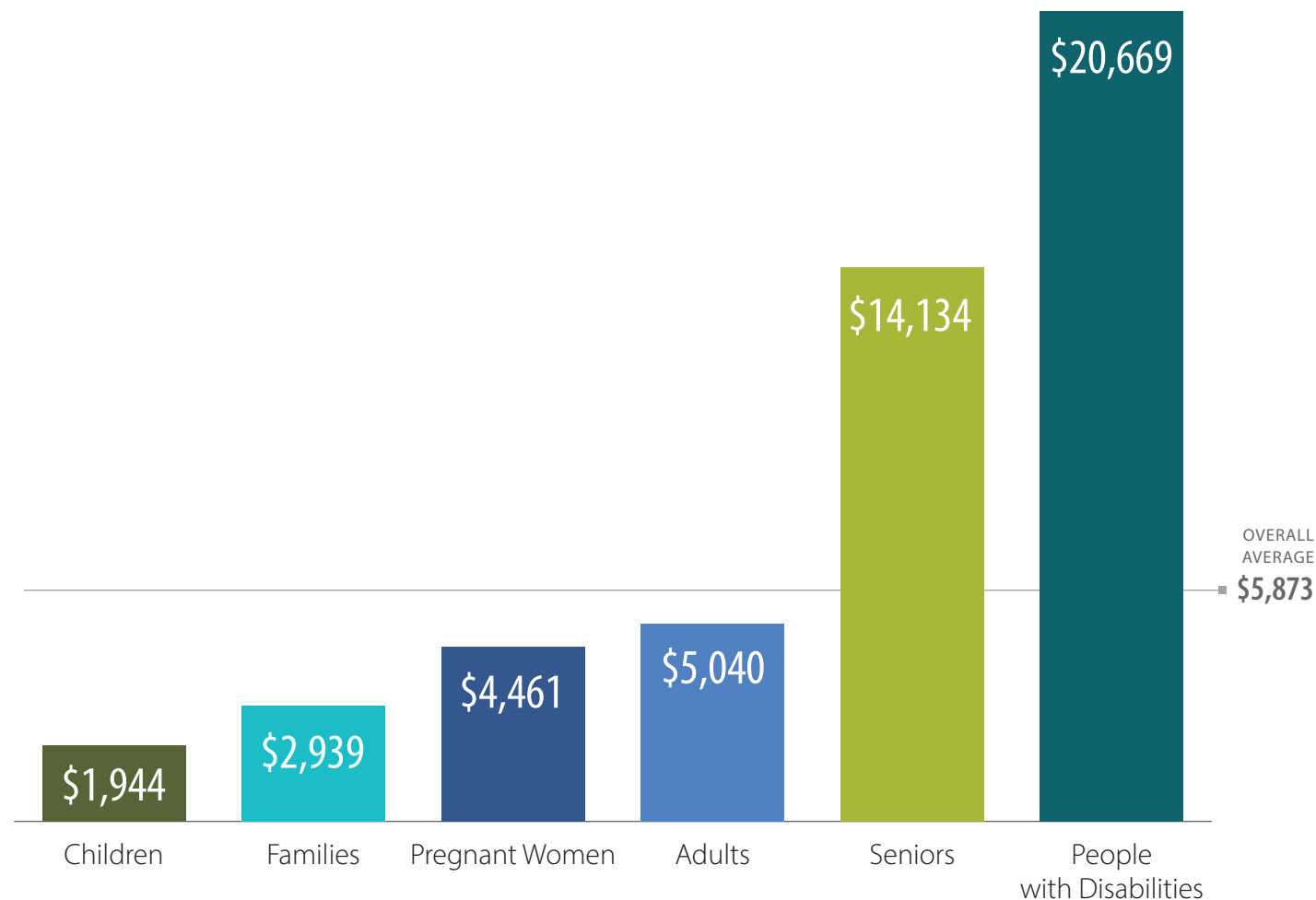
Managed care organizations were the largest category of service providers to the Medi-Cal program, accounting for half of all service payments. Hospital inpatient services, paid on a fee-for-service basis, were the next largest category, accounting for 14% of Medi-Cal spending.

Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020 and reflect annual spending. The Drug Medi-Cal program provides services to treat enrollees with substance use disorders. *FFS* is fee-for-service. *Other FFS services* includes medical transportation, home health, and other services. *Other* includes audits/lawsuits, state hospitals / developmental centers, recoveries, and miscellaneous services. Segments may not total 100% due to rounding. Hospital services are FFS.

Source: *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health Care Services, accessed August 6, 2020.

Medi-Cal Annual Spending per Eligible Enrollee

FY 2019–20



Medi-Cal Facts and Figures

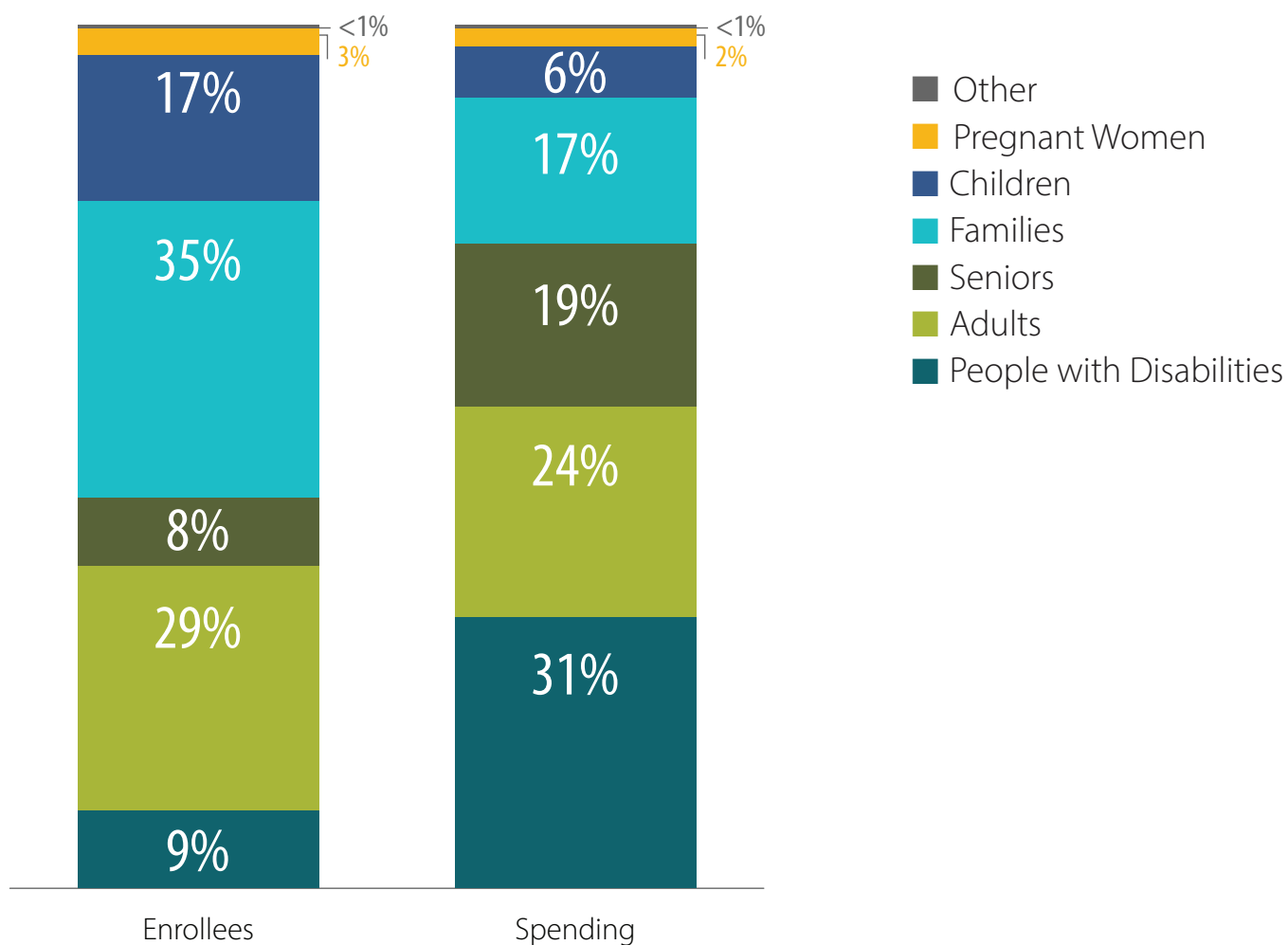
Spending

Medi-Cal spending per enrollee varied by eligibility category. Medi-Cal spent about \$2,000 annually per child. The program spent over \$20,000 annually per enrollee with disabilities.

Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020 and reflect annual spending. Reported values exclude Hospital Presumptive Eligibility and other aid codes totaling 0.3% of enrollees. For additional information about Medi-Cal spending on maternity care, please see CHCF's report *Maternity Care and Paying for Maternity Services*.

Source: "Fiscal Year 2019-20 Cost per Eligible Based on May 2020 Estimate," in *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019–20 and 2020–21* (PDF), California Dept. of Health Care Services.

Medi-Cal Enrollees and Spending by Eligibility Category, FY 2019–20



Medi-Cal Facts and Figures

Spending

People with disabilities represented 9% of Medi-Cal enrollees, but accounted for 31% of spending. Children accounted for 17% of enrollee, but just 6% of spending.

Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020. *Other* includes Hospital Presumptive Eligibility and other aid codes. For additional information about Medi-Cal spending on maternity care, please see CHCF's report *Maternity Care and Paying for Maternity Services*.

Source: "Fiscal Year 2019-20 Cost per Eligible Based on May 2020 Estimate," in *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019–20 and 2020–21* (PDF), California Dept. of Health Care Services.

Medicaid Spending per Full-Year Equivalent Enrollees

California vs. United States, FY 2018

Seniors



People with Disabilities



Other Adult



New Adult Group



Children



All Full-Benefit Enrollees



California
United States

Medi-Cal Facts and Figures

Spending

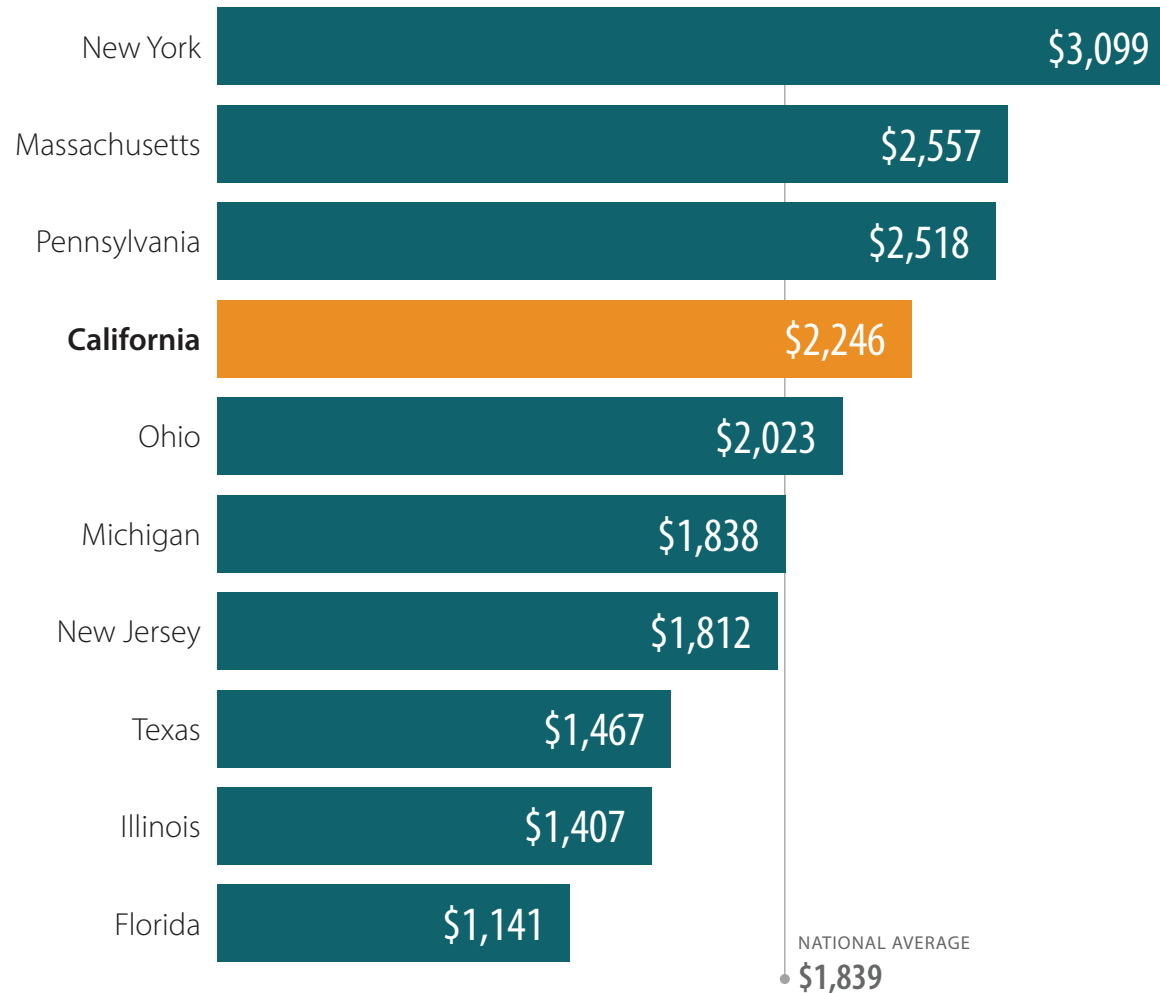
Across all enrollee groups, California's per enrollee spending is lower than the national average.

Notes: Full-year equivalent (FYE) may also be referred to as average monthly enrollment. Data are for full-benefit enrollees and exclude those receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. *Other adult* includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant people). *New adult group* is the ACA "expansion" population.

Source: "Exhibit 22. Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2018," in *MACStats: Medicaid and CHIP Data Book*, Medicaid and CHIP Payment and Access Commission.

Medicaid Spending per Resident

Selected States, FY 2019



Note: The 10 states chosen for comparison had the largest Medicaid expenditures in FY 2019.

Sources: "Total Medicaid Spending" (FY2019), KFF, accessed October 24, 2020; and *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2019* (NST-EST2019-01), US Census Bureau, accessed October 30, 2020.

Medi-Cal Facts and Figures

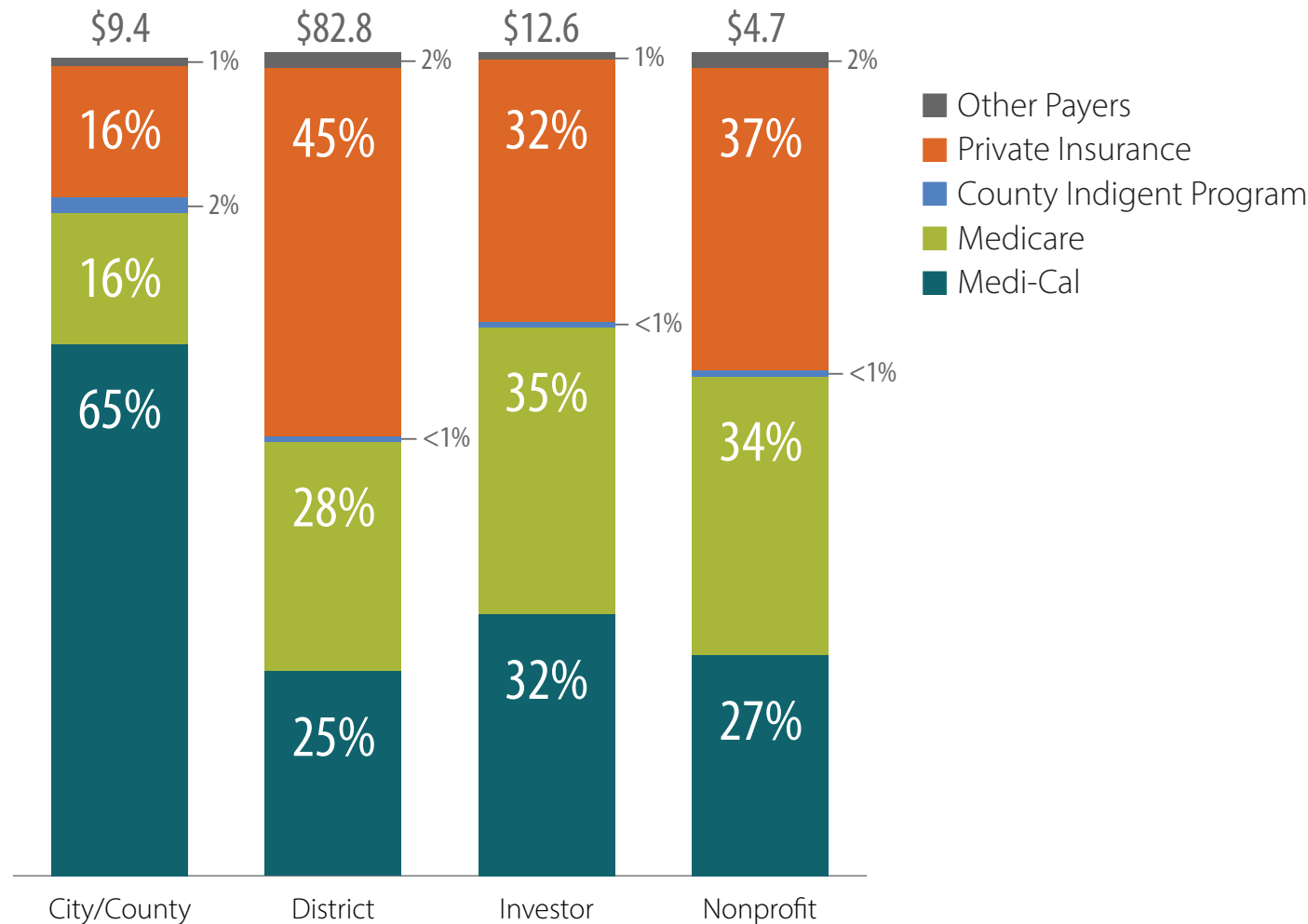
Spending

While California's Medicaid program has the largest enrollment in the nation, spending per resident (\$2,246) was lower than in New York (\$3,099), Massachusetts (\$2,557), and Pennsylvania (\$2,518). The national average Medicaid spending per resident was \$1,839 in 2019.

Net Patient Revenues

by Hospital Ownership Type and Payer, California, 2019

IN BILLIONS



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

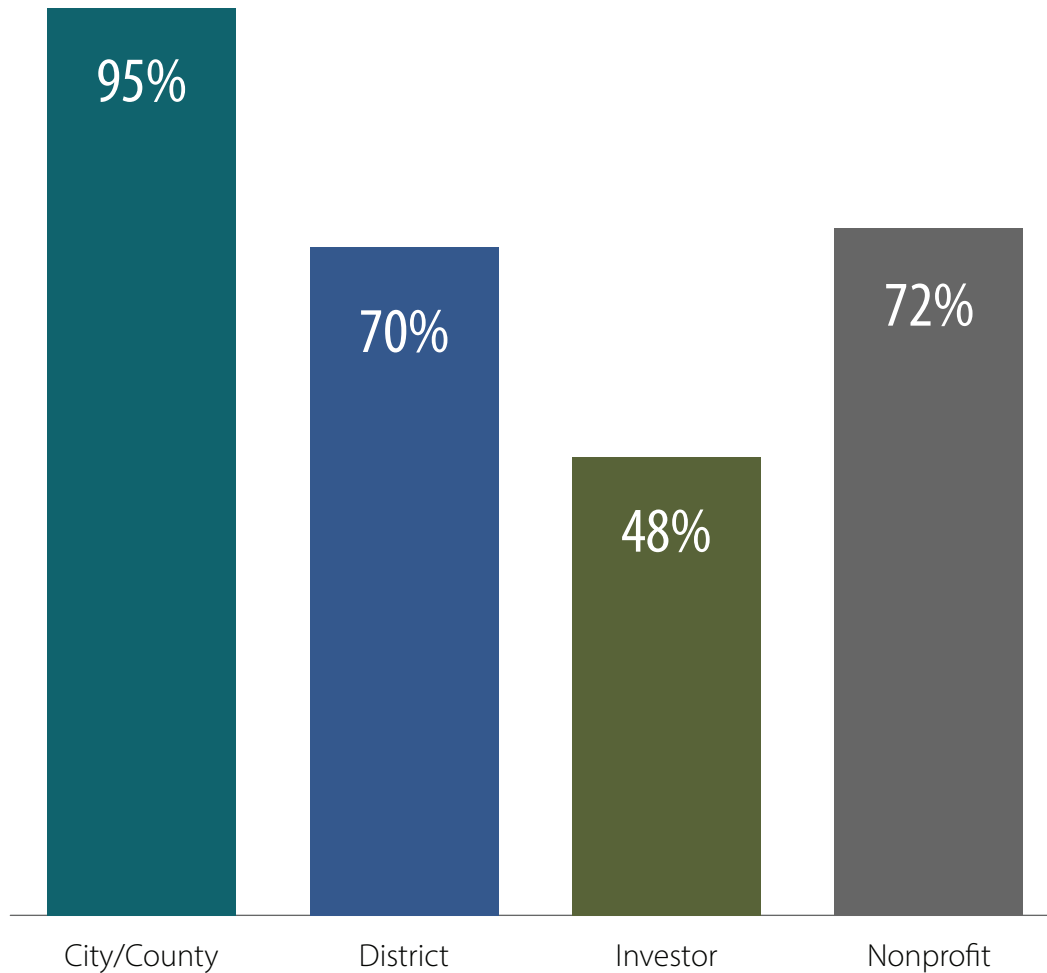
Source: 2019 Pivot Table - Hospital Annual Selected File (November 2020 Extract), California Health and Human Services Agency, December 10, 2020.

Medi-Cal Facts and Figures

Role in the System

Medi-Cal is a key source of funding for hospitals. Medi-Cal provided nearly two-thirds (65%) of the net patient revenue for city/county hospitals and nearly a third (32%) for investor-owned hospitals.

Change in Medi-Cal Net Patient Revenue by Hospital Ownership Type, 2013 to 2019



Note: Data are only for hospitals classified as comparable and thus do not include state-run and Kaiser hospitals or facilities classified as psychiatric or long-term care.

Source: 2019 Pivot Table - Hospital Annual Selected File (November 2020 Extract), California Health and Human Services Agency, December 10, 2020.

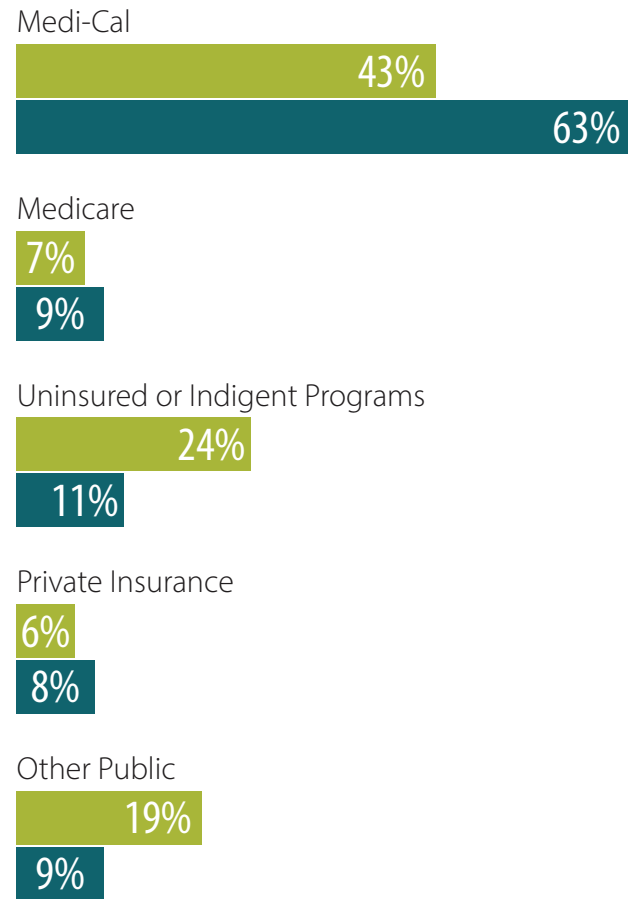
Medi-Cal Facts and Figures

Role in the System

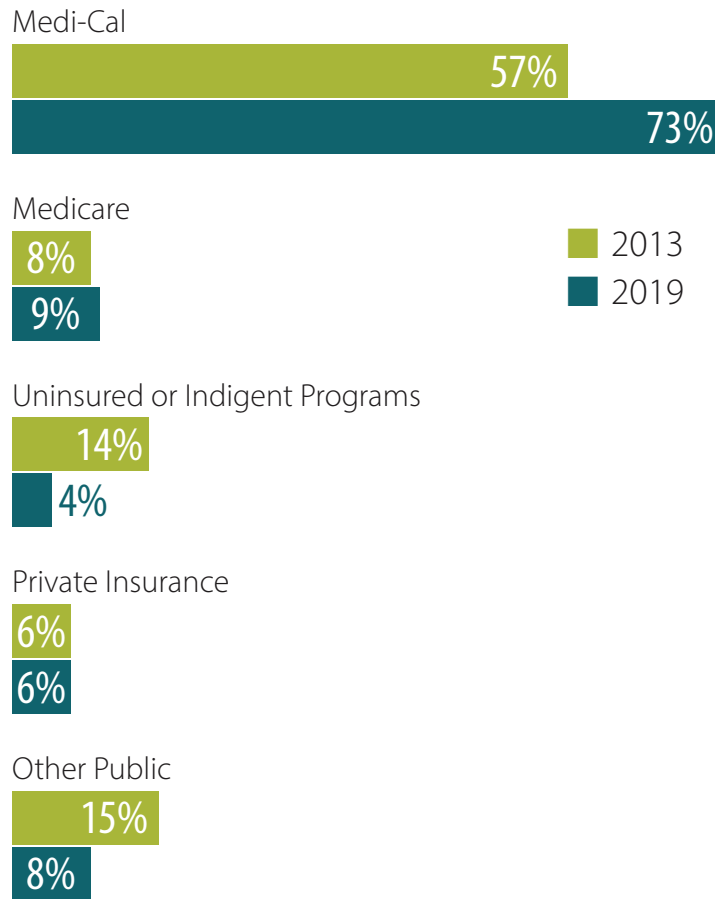
All hospital types experienced a growth in Medi-Cal net patient revenue between 2013 and 2019, likely as a result of the ACA expansion in 2014. Net patient revenue from Medi-Cal grew by 95% at city/county hospitals.

Primary Care Clinic Visits and Net Patient Revenue by Payer, 2013 and 2019

PERCENTAGE OF VISITS **17.2 MILLION / 23.3 MILLION**



PERCENTAGE OF NET PATIENT REVENUE **\$2.1 BILLION / \$4.3 BILLION**



Medi-Cal Facts and Figures

Role in the System

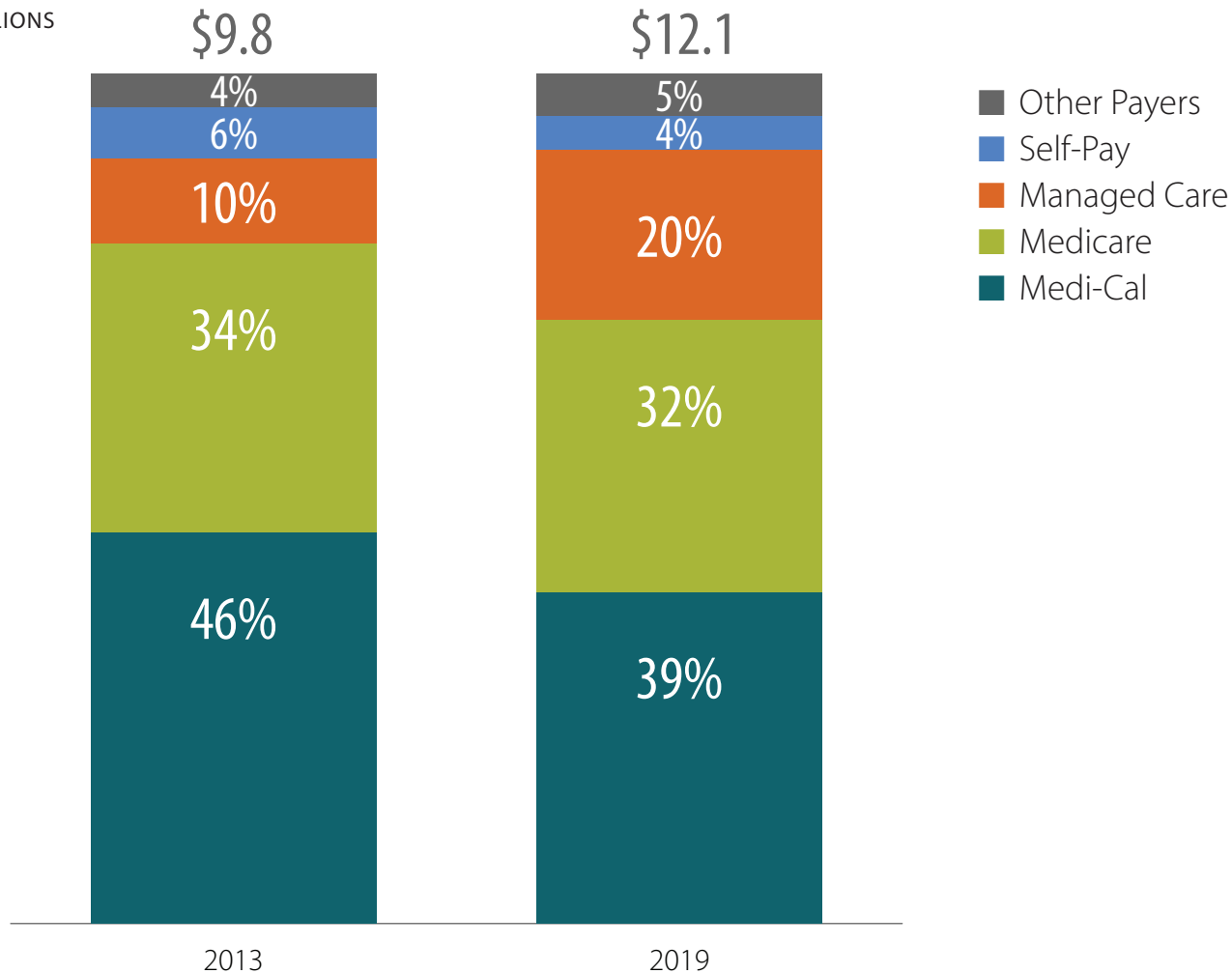
Primary care clinics experienced significant growth in Medi-Cal visits and net patient revenue since the implementation of the Affordable Care Act. Medi-Cal visits increased from 43% of visits in 2013 to 63% of visits in 2019. Both visits and revenue from uninsured patients declined as more patients were enrolled in Medi-Cal and private insurance.

Notes: Includes Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and other clinic types. Uninsured and indigent coverage are combined due to data-reporting inconsistencies, and include self-pay/sliding scale, free, and county indigent program patients. *Other public* includes Alameda Alliance for Health, Family PACT, and all other payers, except for the PACE program, which is excluded from all categories. Excludes county-run clinics. Segments may not total 100% due to rounding.

Source: Blue Sky Consulting Group analysis of 2019 *Pivot Table - Primary Care Clinic Utilization Data*, California Health and Human Services Agency (CHHS), last updated December 4, 2020, and 2013 *Pivot Table - Primary Care Utilization Data*, CHHS, last updated May 8, 2018.

Net Patient Revenues, Long-Term Care Facilities by Payer, 2013 and 2019

IN BILLIONS



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

Sources: 2019 - *Pivot Profile - Long-Term Care Annual Financial Data (December 2020)*, California Health and Human Services Agency (CHHS), last updated December 14, 2020; and 2013 - *Pivot Profile - Long-Term Care Annual Financial Data*, CHHS, last updated May 3, 2018.

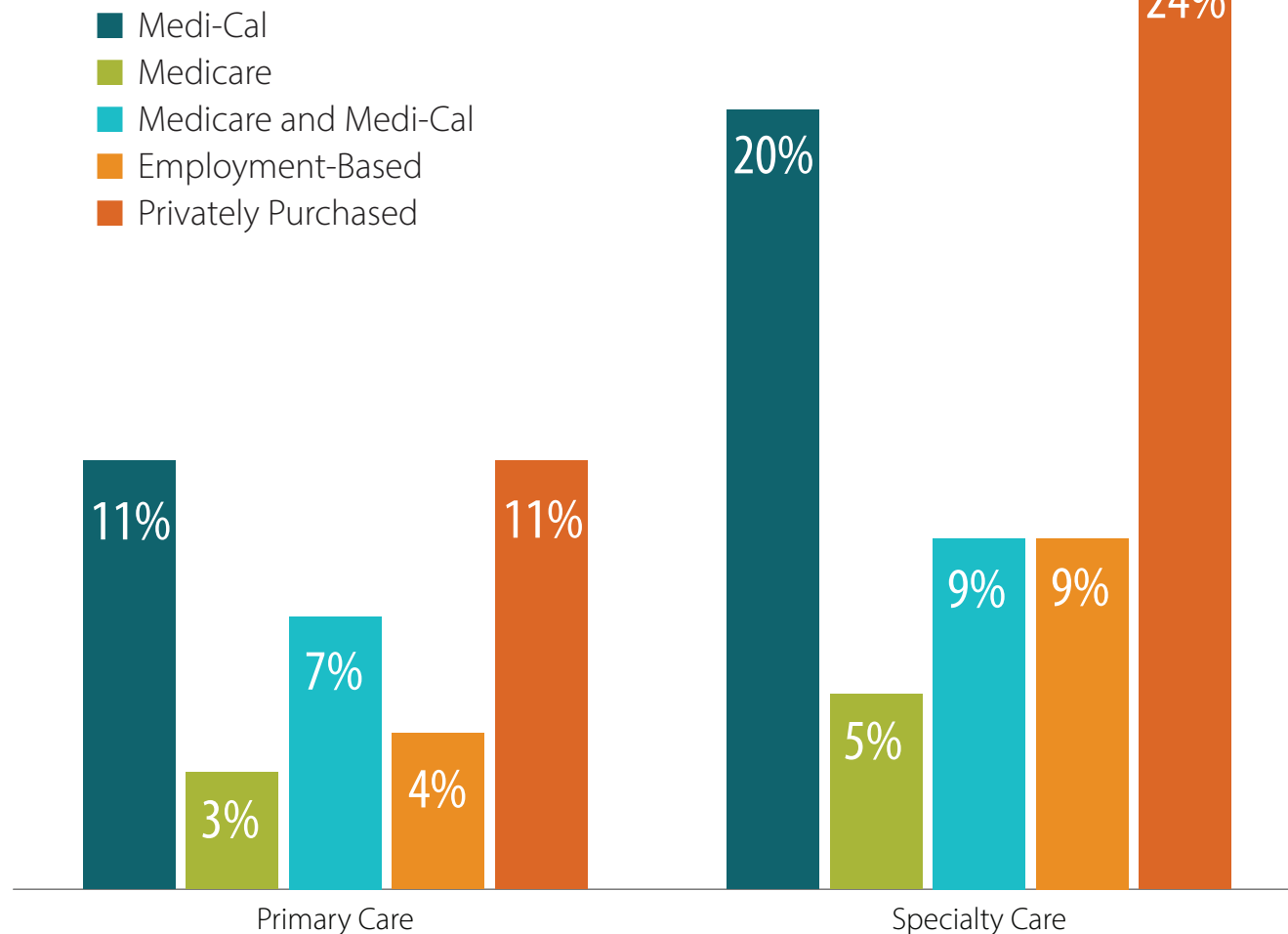
Medi-Cal Facts and Figures

Role in the System

Medi-Cal provided an important source of net patient revenue for long-term care facilities. Even though the share of revenues from Medi-Cal was down from 2013, Medi-Cal accounted for 39% of all long-term care facilities' net patient revenues in 2019.

Insurance Not Accepted by Provider by Source of Coverage, Adults, California, 2019

SHARE OF ADULTS WHOSE INSURANCE WAS NOT ACCEPTED BY THEIR PROVIDER



Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

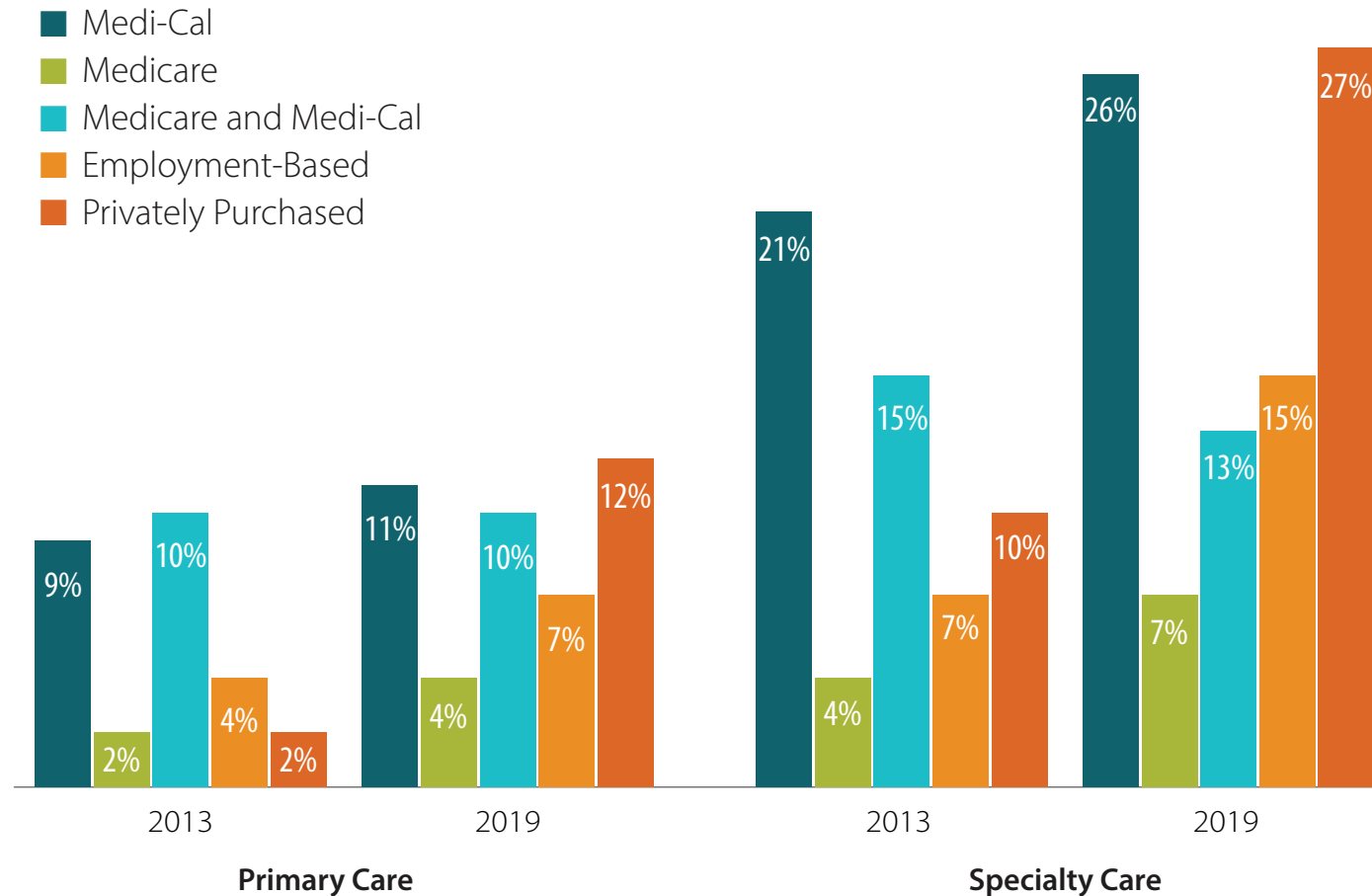
Medi-Cal Facts and Figures

Access and Utilization

Adults enrolled in Medi-Cal were more than twice as likely to report difficulty finding a provider that accepted their insurance when compared to those with employer-based insurance or Medicare. This pattern held for both primary and specialty care.

Difficulty Finding Primary and Specialty Care by Source of Coverage, 2013 and 2019

PERCENTAGE OF ADULTS WHO HAD DIFFICULTY FINDING PRIMARY AND SPECIALTY CARE



Medi-Cal Facts and Figures

Access and Utilization

Of all adults enrolled in Medi-Cal, the percentage reporting difficulty finding primary care increased slightly, while the percentage reporting difficulty finding specialty care increased from 21% in 2013 to 26% in 2019.

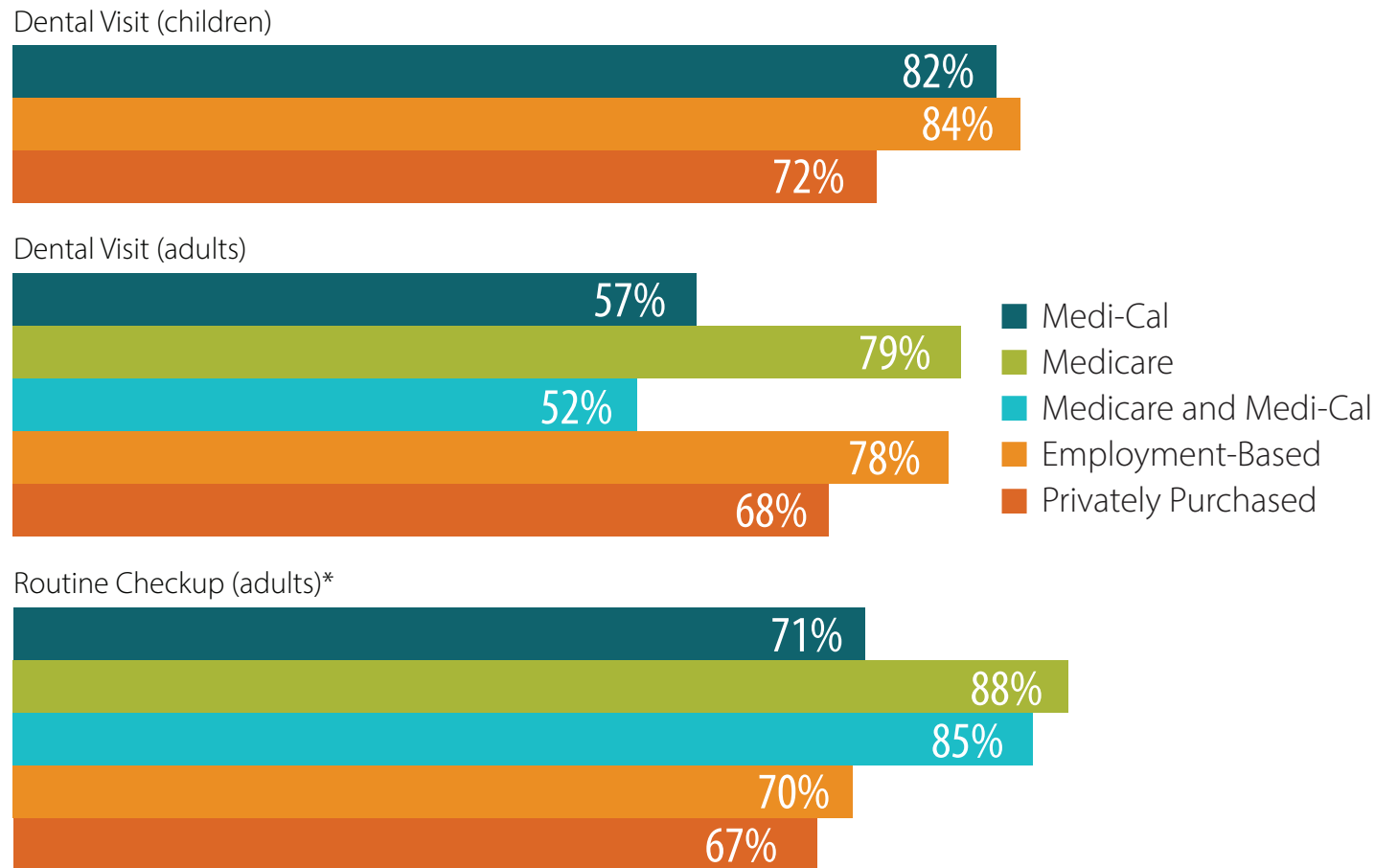
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2013 and 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Preventive Care Visits

by Source of Coverage, California, 2019

PERCENTAGE WHO HAD THE FOLLOWING PREVENTIVE CARE WITHIN THE PAST YEAR



* With a doctor or medical provider.

Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal Facts and Figures

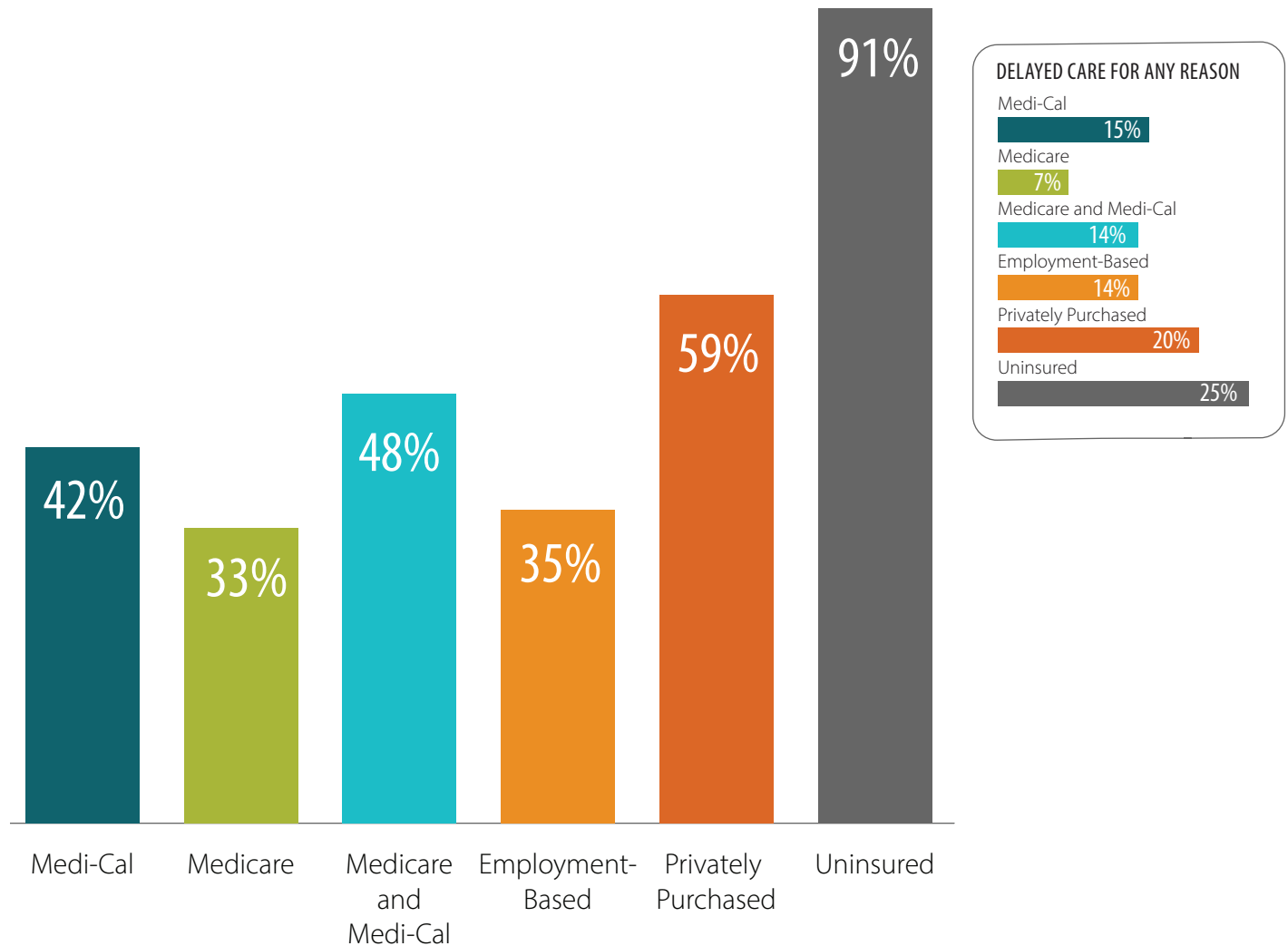
Access and Utilization

Medi-Cal enrollees reported having a routine checkup at the same rates as people with employer-based or private insurance. Adult enrollees were less likely to have visited a dentist during the past 12 months, compared to those with employer-based or private insurance.

Delay of Care

by Source of Coverage, California, 2019

SHARE OF POPULATION THAT DELAYED CARE DUE TO COST OR LACK OF INSURANCE, BY INSURANCE TYPE



Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal Facts and Figures

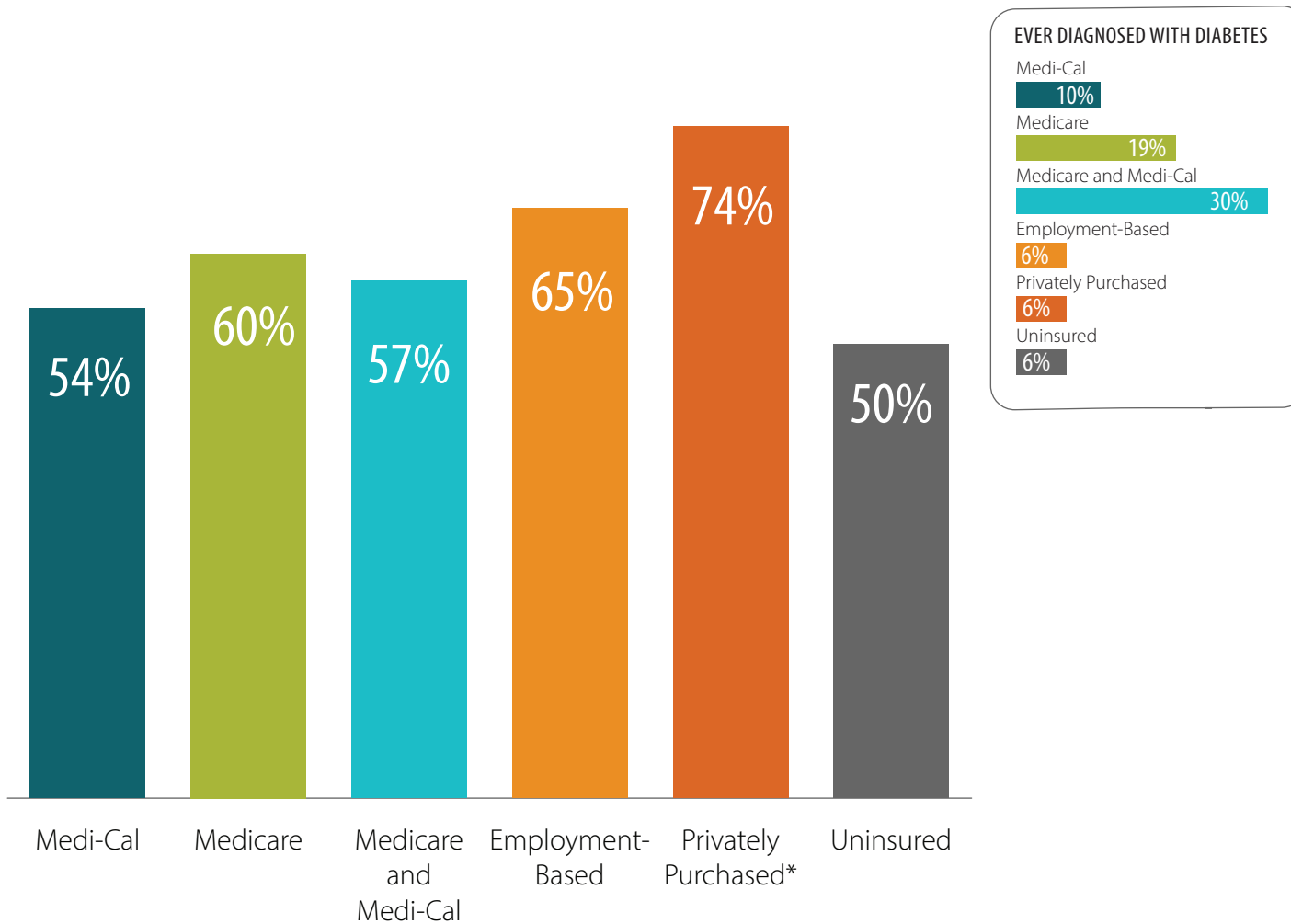
Access and Utilization

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

Diabetes Care

by Source of Coverage, California, 2018

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



* Statistically unstable.

Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal Facts and Figures

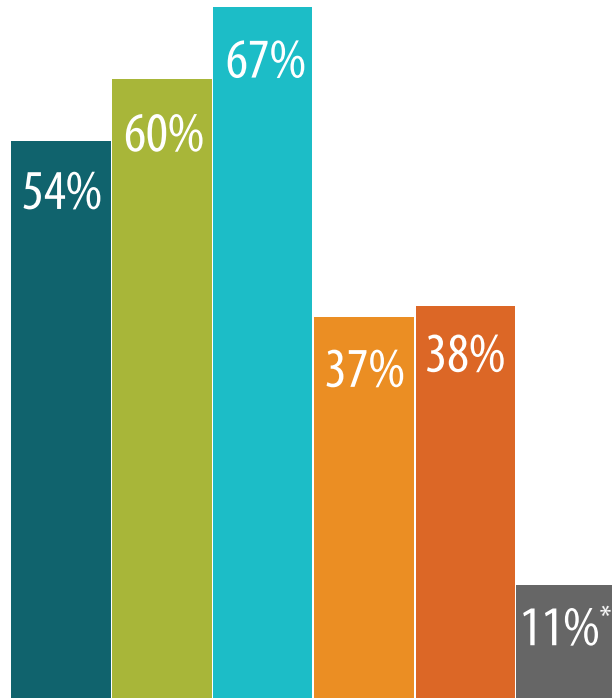
Access and Utilization

Medi-Cal enrollees were less likely than those with other types of insurance to report that they were confident that their diabetes was under control.

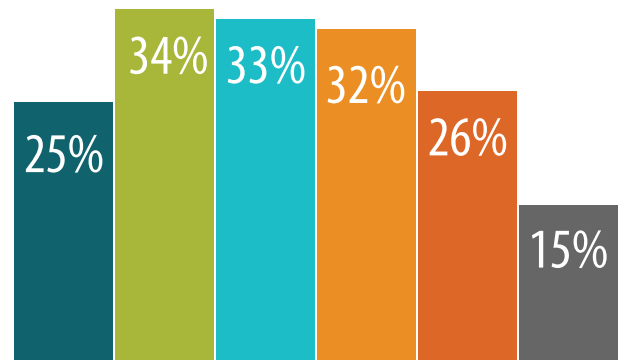
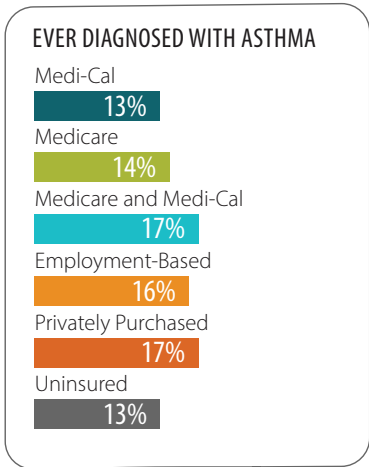
Asthma Care

by Source of Coverage, California, 2019

- Medi-Cal
- Medicare
- Medicare and Medi-Cal
- Employment-Based
- Privately Purchased
- Uninsured



Population with Asthma Who Take Daily Medication to Control It



Population Ever Diagnosed with Asthma Who Had an Attack in the Past 12 Months

* Statistically unstable

Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

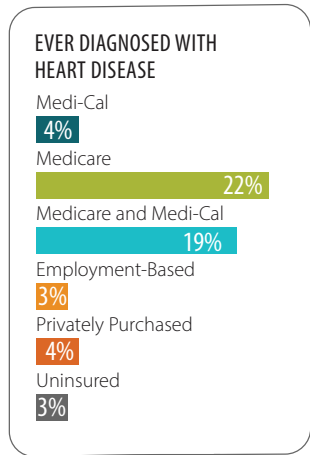
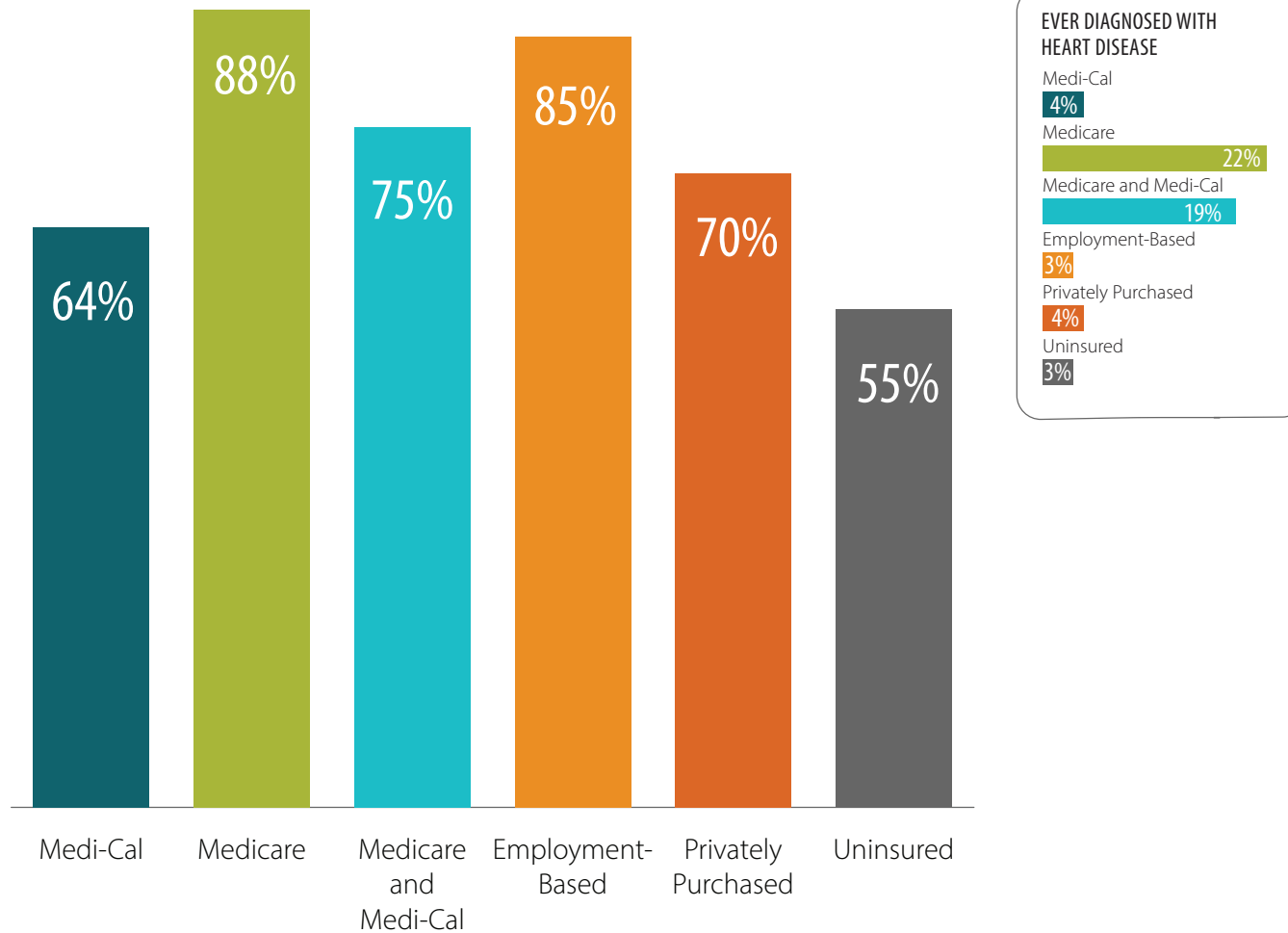
Medi-Cal Facts and Figures

Access and Utilization

One in four Medi-Cal enrollees diagnosed with asthma reported they had an asthma attack in the past 12 months, and one in two took daily medication to control their asthma.

Heart Disease Care by Source of Coverage, 2018

SHARE OF ADULTS DIAGNOSED WITH HEART DISEASE WITH A MANAGEMENT PLAN



Medi-Cal Facts and Figures

Access and Utilization

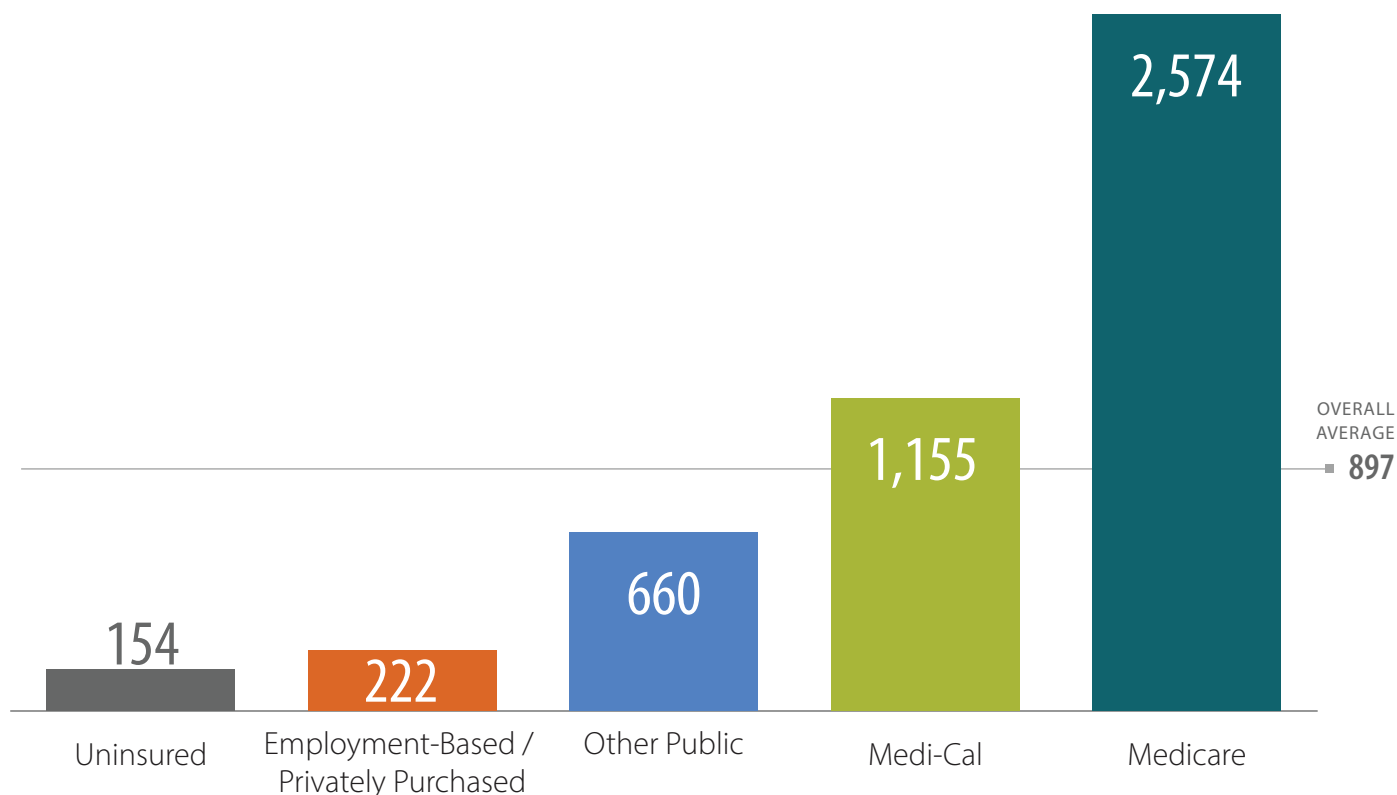
Slightly more than 6 in 10 Medi-Cal enrollees diagnosed with heart disease were provided a heart disease management plan by their provider.

Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

Preventable Hospitalizations by Source of Coverage, California, 2018

PER 100,000 POPULATION



Notes: PQI 90 (Prevention Quality Indicator 90) is an overall composite measure of avoidable hospitalizations. The rate of avoidable hospitalizations was calculated as the number of hospitalizations for a particular payer category divided by the corresponding adult population according to the California Health Interview Survey. Rates presented are overall rates, not adjusted for age, gender, or other demographic characteristics. For additional information about this measure, see www.oshpd.ca.gov.

Sources: Blue Sky Consulting Group analysis of Agency for Healthcare Research and Quality PQI applied to custom data request, Office of Statewide Health Planning and Development Hospital Inpatient Discharge data; and the 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal Facts and Figures

Quality

Rates of avoidable hospitalizations for ambulatory care–sensitive conditions (including diabetes complications, adult asthma or other lung diseases, hypertension, heart failure, and other conditions) are widely used as a marker of access to primary care. Those with public coverage experienced higher rates of avoidable hospitalizations when compared to those without insurance or those with private or employment-based coverage.

Antidepressant Medication Management

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019

EFFECTIVE ACUTE PHASE TREATMENT

American Indian / Alaska Native

53%

Asian American

60%

Black

52%

Latinx

54%

Native Hawaiian / Other Pacific Islander

53%

Other

61%

White

62%

MINIMUM PERFORMANCE LEVEL ■

Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Effective acute phase treatment* measures the percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 60%. Source uses *Asian, Black or African American, and Hispanic or Latino*.

Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

Medi-Cal Facts and Figures

Quality

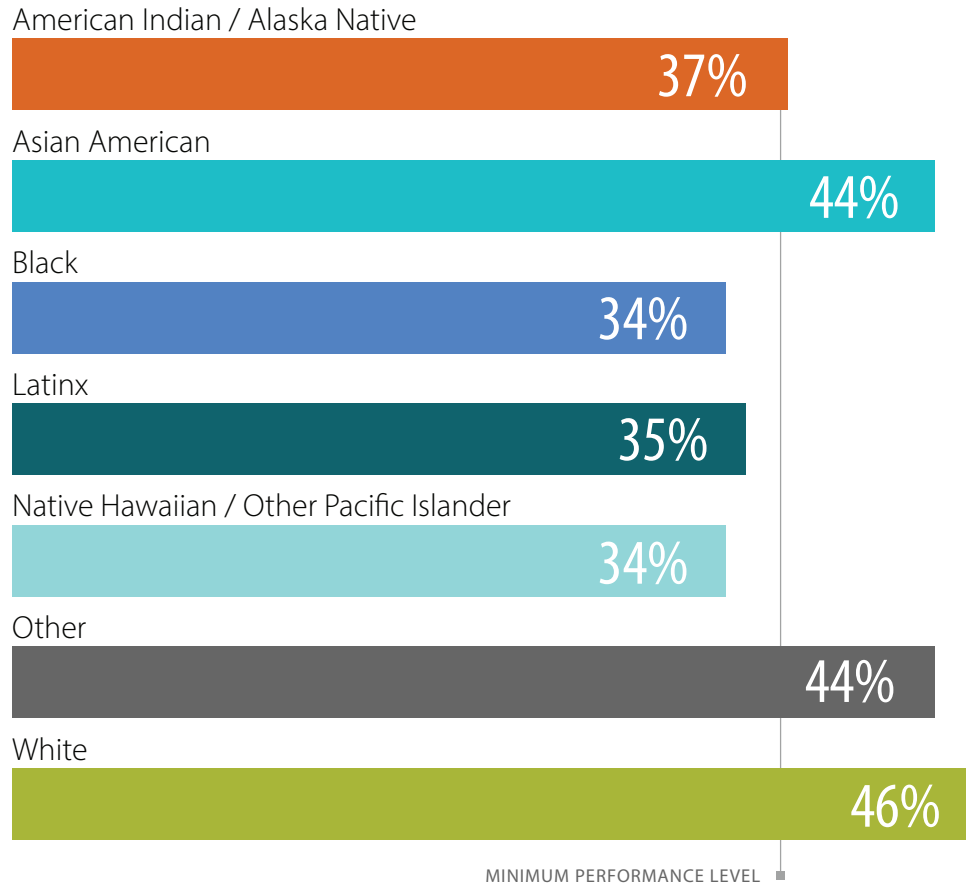
Medi-Cal managed care enrollees reporting their race/ethnicity as Latinx, Black, American Indian / Alaska Native or Native Hawaiian / Other Pacific Islander had slightly lower rates of remaining on antidepressant medication for at least 84 days than other races/ethnicities. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.*

*Antidepressant Medication Management (AMM), National Committee for Quality Assurance.

Antidepressant Medication Management

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019

EFFECTIVE CONTINUATION PHASE TREATMENT



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Effective continuation phase treatment* measures the percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 43%. Source uses *Asian, Black or African American, and Hispanic or Latino*.

Source: 2019 Health Disparities Report, California Dept. of Health Care Services, December 2020.

Medi-Cal Facts and Figures

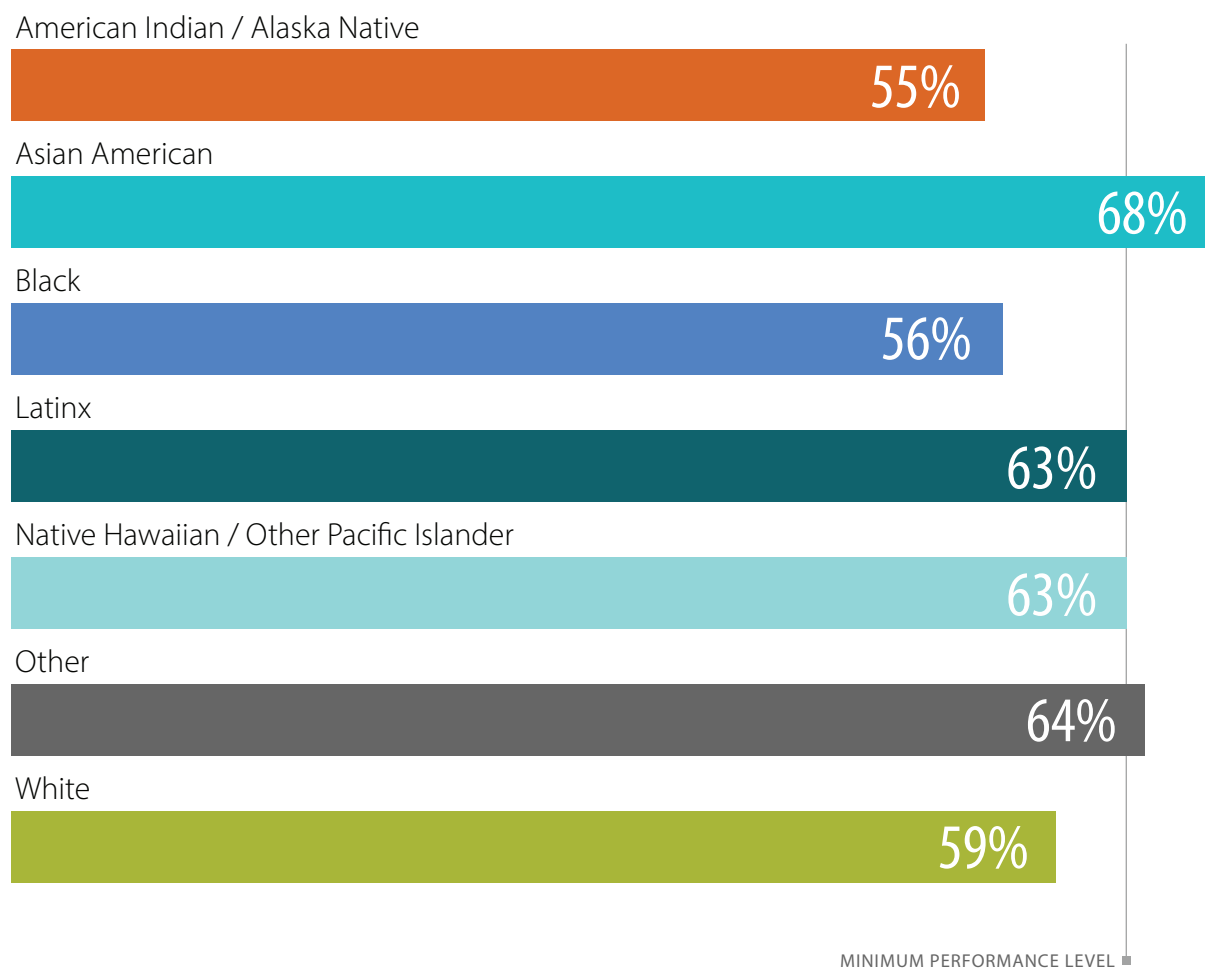
Quality

Medi-Cal managed care enrollees reporting their race/ethnicity as Latinx, Black, or Native Hawaiian / Other Pacific Islander had lower rates of continuing antidepressant medication for at least 180 days than other races/ethnicities. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.*

*"Antidepressant Medication Management (AMM)," National Committee for Quality Assurance.

Asthma Medication Ratios

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Asthma medication ratio* measures the percentage of members age 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 69%. Source uses *Asian, Black or African American, and Hispanic or Latino*.

Source: 2019 Health Disparities Report, California Dept. of Health Care Services, December 2020.

Medi-Cal Facts and Figures

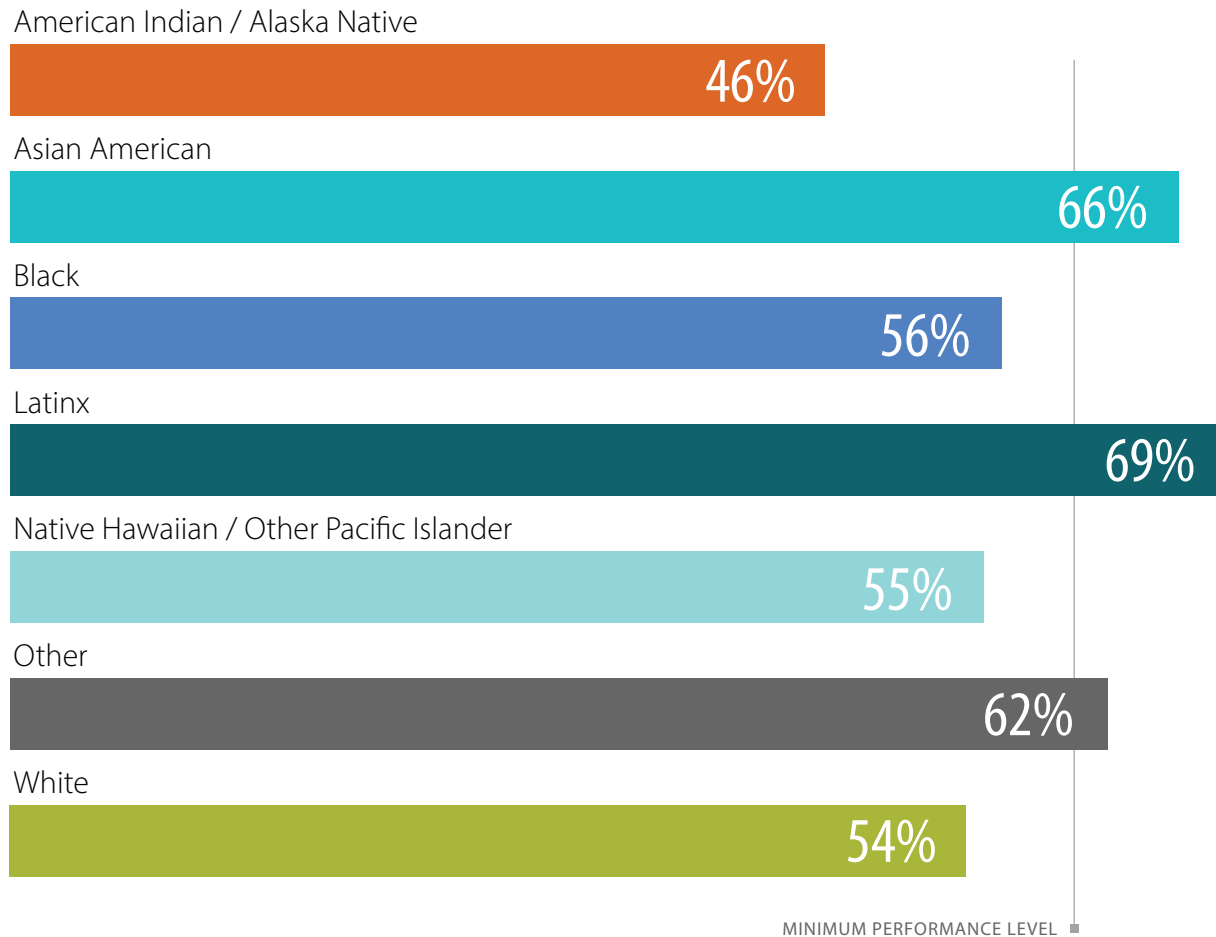
Quality

Black and American Indian / Alaska Native managed care enrollees with persistent asthma had the lowest rates for receiving medications to control their condition. Appropriate medication management for patients with asthma could reduce the need for rescue medication as well as the costs associated with emergency room visits, inpatient admissions, and missed days of school and work.*

* "Medication Management for People with Asthma and Asthma Medication Ratio (MMA, AMR)," National Committee for Quality Assurance.

Breast Cancer Screening

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Breast cancer screening* measures the percentage of women age 50 to 74 who had a mammogram to screen for breast cancer. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 57%. Source uses *Asian, Black or African American, and Hispanic or Latino*.

Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

Medi-Cal Facts and Figures

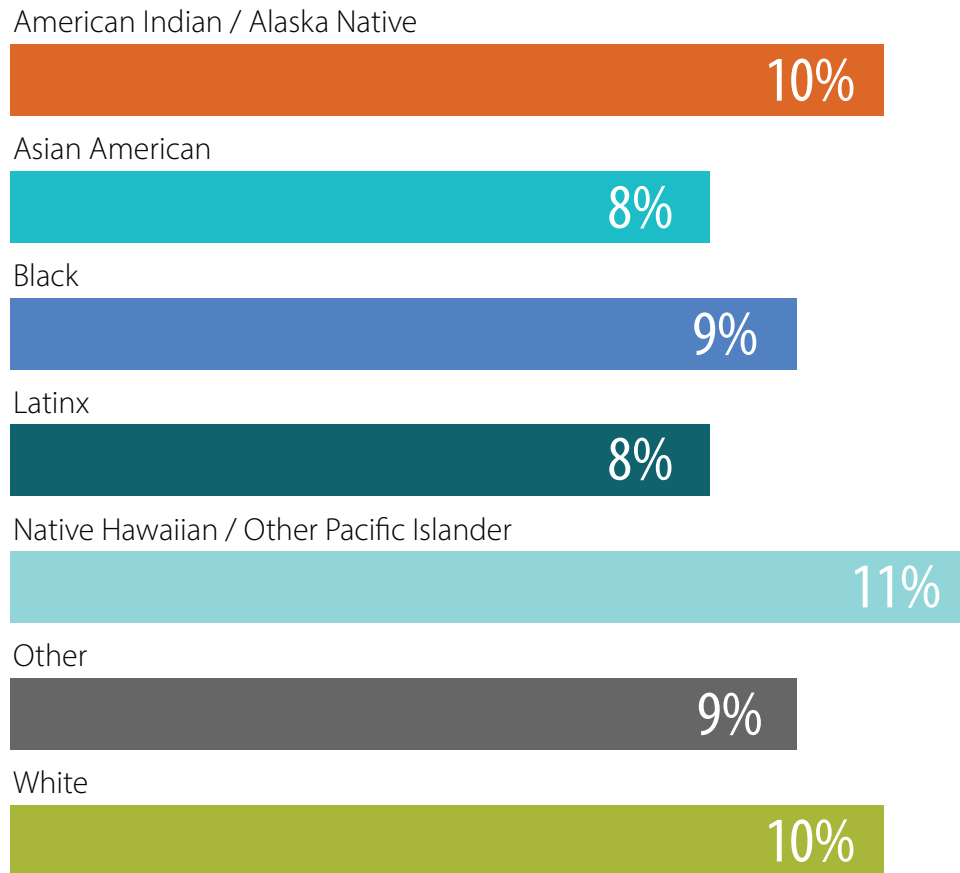
Quality

While Latinx and Asian American women enrolled in Medi-Cal managed care plans had the highest rates of breast cancer screening, American Indian / Alaska Native enrollees had the lowest rates. Early detection can reduce the risk of dying from breast cancer and can lead to a greater range of treatment options.*

*"Breast Cancer Screening (BCS); National Committee for Quality Assurance.

Plan All-Cause Readmissions

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Plan all-cause readmissions-observed readmission rate-total* measures the percentage of members age 18 and older who had an acute inpatient and observation stay during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 of discharge. The rate for unknown/missing race/ethnicity was 9%. Source uses *Asian, Black or African American, and Hispanic or Latino*.

Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

Medi-Cal Facts and Figures

Quality

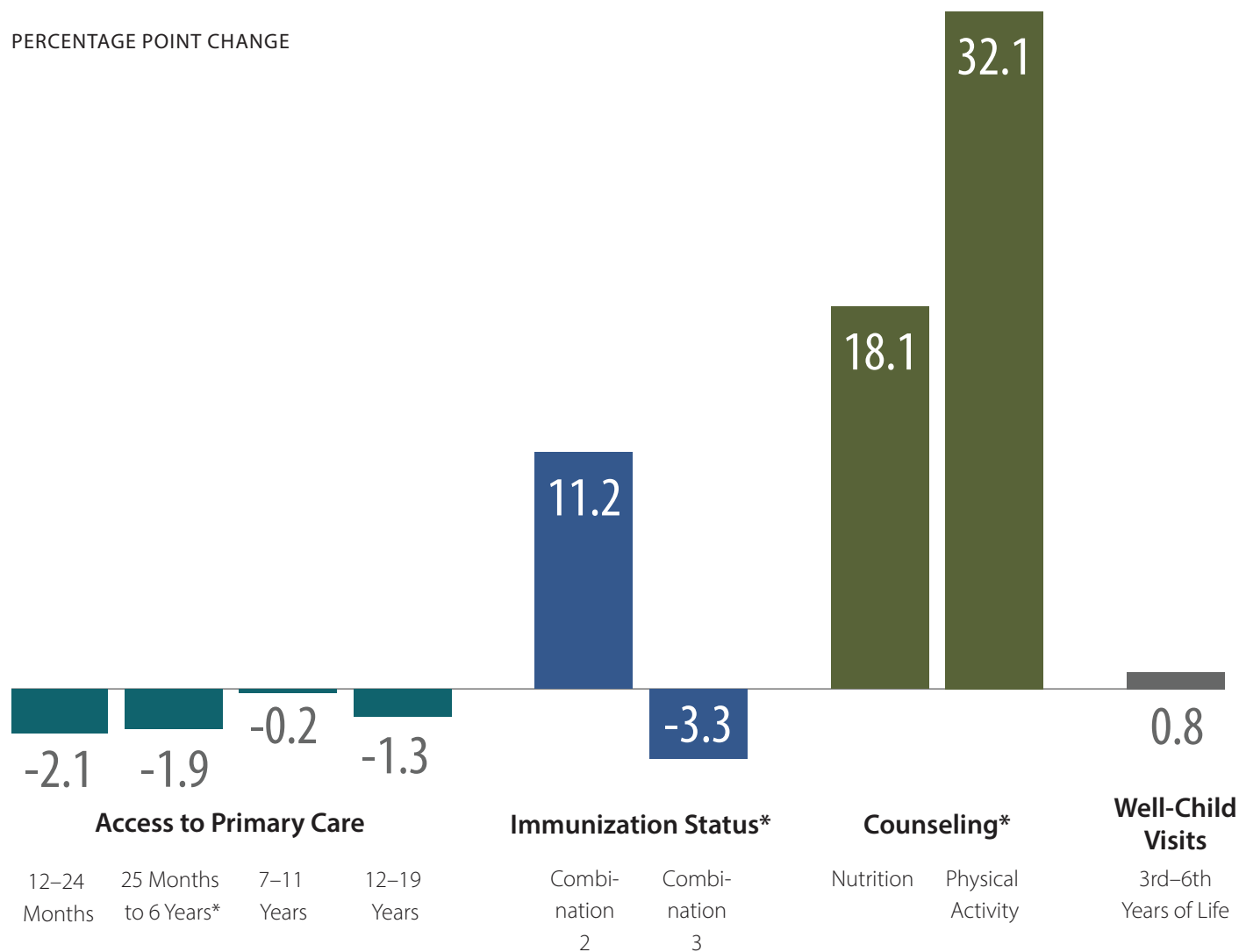
Native Hawaiian / Other Pacific Islanders had a slightly higher rate of readmission to the hospital than Medi-Cal managed care enrollees of other races/ethnicities. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.*

*“Plan All-Cause Readmissions (PCR);” National Committee for Quality Assurance.

Medi-Cal Managed Care Quality, Childhood Measures

2009 to 2018

PERCENTAGE POINT CHANGE



* Change is statistically significant.

Notes: Not every measure was reported every year. *Change over time* represents percentage points.

Source: Andrew Bindman et al., *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, California Health Care Foundation, September 2019.

Medi-Cal Facts and Figures

Quality

From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant on over half of 41 measures (not shown). Among the nine quality measures currently in use for children, six declined or stayed the same.

Looking Ahead

The Medi-Cal program faces numerous changes in the coming years. Some of this change is driven by leadership decisions from the executive branch and also from the California legislature. DHCS will:

- Continue to support Medi-Cal enrollees, providers, and Californians who are undocumented during the COVID-19 public health emergency, working with waivers provided by the federal government.
- Accommodate increased enrollment in 2021 due in part to the COVID-19 pandemic.
- Seek CalAIM approval from the federal government and then prepare for implementation of several initiatives in January 2022. See page 34 for more information on CalAIM.
- Begin the process to procure contracts for all commercial health plans providing services and to recontract with local plans. Starting in 2024, this may bring a change of health plans to some portion of the 11 million Medi-Cal enrollees in managed care in 58 counties.

- Assess the outcome of a planned transition to carved-out pharmacy benefits with the Medi-Cal Rx program.
- Possible expansion of full-scope coverage of adults with low incomes regardless of immigration status if the legislature continues to pursue this goal.

In addition, DHCS will have to address:

- An aging enrollee population as California's over-60 population increases at a rate three times faster than overall population growth. This will likely increase Medi-Cal's spending on long-term services and supports.
- Disparities in access, quality of care, and health outcomes for enrollees of color.

Medi-Cal Facts and Figures

Looking Ahead

The Medi-Cal program faces numerous changes and challenges in the coming years as it evolves in response to new policies and unprecedented funding approved by the governor and legislature, to health care inequities laid bare by the COVID-19 pandemic, and to a growing desire for the program to contribute more to addressing longstanding health disparities and social determinants of health.

Sources: *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type* (PDF), California Dept. of Health Care Services, last updated February 27, 2020; and "Facts About California's Elderly," California Dept. of Aging, accessed March 18, 2021.

About the Data

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

Medi-Cal Facts and Figures

ABOUT THIS SERIES

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

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