CALIFORNIA

Health Care Almanac

CHCF

JUNE 2024

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 three in seven children, two in nine nonelderly adults, and two in five people with disabilities. It also paid for 39% of all births in the state. In total, over 15 million Californians relied on the program for health coverage in 2022.

Using only state resources, California has expanded Medi-Cal to all income-eligible immigrants, regardless of immigration status.

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

KEY FINDINGS INCLUDE:

- In fiscal year 2021–22, Medi-Cal brought in more than $85 billion in federal funds and accounted for nearly 15% of all state general fund spending.
- People with disabilities composed 8% of Medi-Cal enrollees and accounted for 31% of spending. Meanwhile, children accounted for 16% of enrollees and just 6% of spending.
- In 2022, 86% of people served by Medi-Cal were enrolled in one of six managed care models.
- Three of four Medi-Cal enrollees were in households where they or another family member worked part- or full-time.
- CalAIM (California Advancing and Innovating Medi-Cal) is a multiyear program intended to transform the Medi-Cal delivery system.

The Medi-Cal program faces numerous changes in the coming years, including the implementation of CalAIM, and assessing the outcome of transitioning pharmaceutical benefits to the 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.

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

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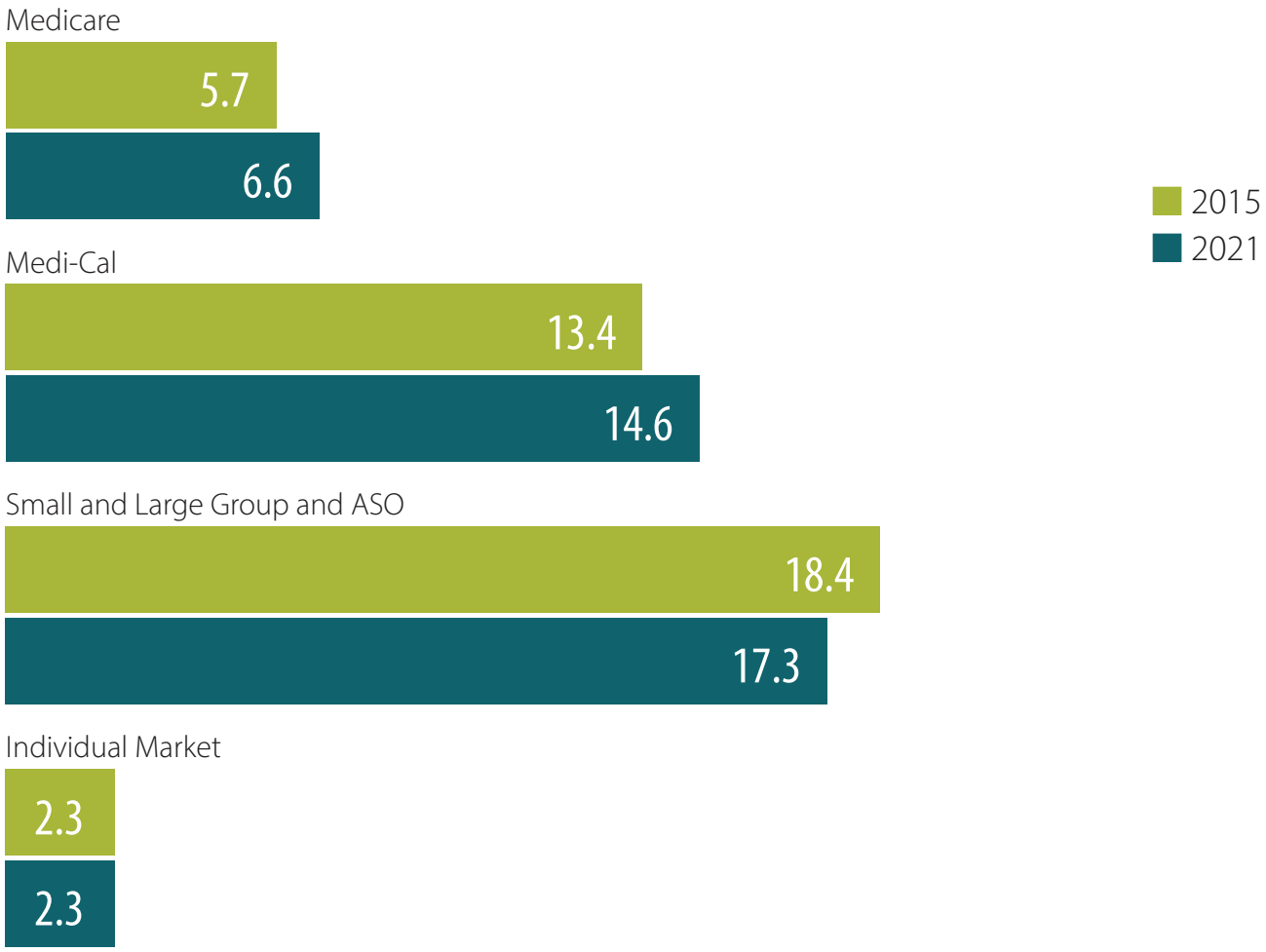
Health Insurance, by Source of Coverage

California, 2015 and 2021

IN MILLIONS



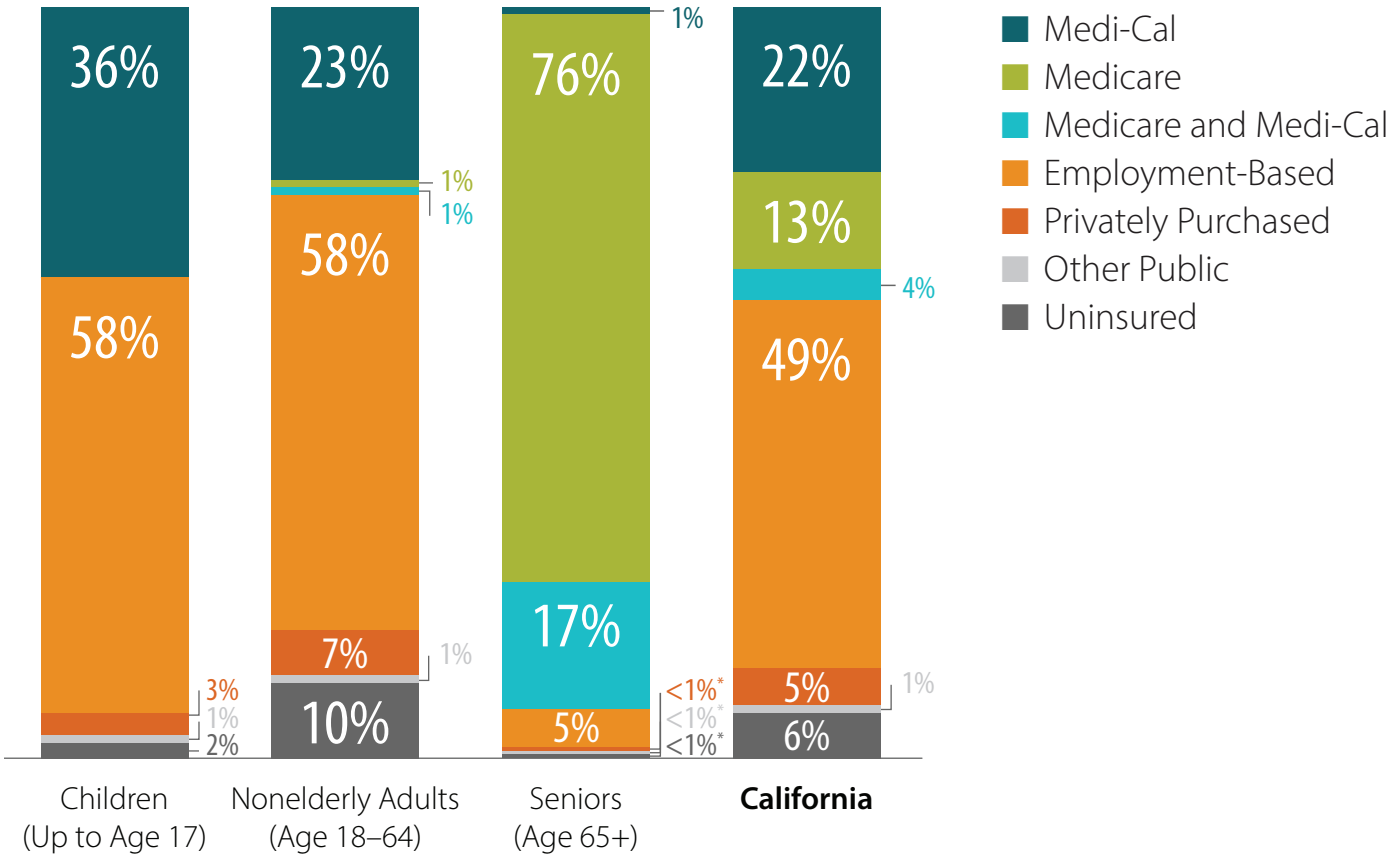
Notes: Enrollment as of December. *Medicare* includes traditional Medicare, Medicare Advantage, and other health plans (not Medi-Cal). *Medi-Cal* includes enrollees who have both Medicare and Medi-Cal coverage ("dual enrollees"). *ASO* is administrative services only. Those with other forms of public insurance or no insurance are not shown.

Sources: "CMS Program Statistics - Medicare Total Enrollment" (2015 and 2021), Centers for Medicare & Medicaid Services, accessed April 10, 2023; "Medi-Cal Certified Eligible Tables, by County from 2010 to Most Recent Reportable Month" (2021), California Health and Human Services Agency, accessed March 1, 2023; and Katherine Wilson, *California Health Insurance Enrollment in 2021: Strong Medi-Cal Growth Offset by Decline in Employment-Sponsored Insurance*, California Health Care Foundation, December 2022.

Between 2015 and 2021, Medi-Cal enrollment increased by more than one million. During this period, the number of Californians with employer-sponsored insurance (small group, large group, and administrative services only) declined.

Sources of Insurance Coverage, by Age Group

California, 2021



* Statistically unstable

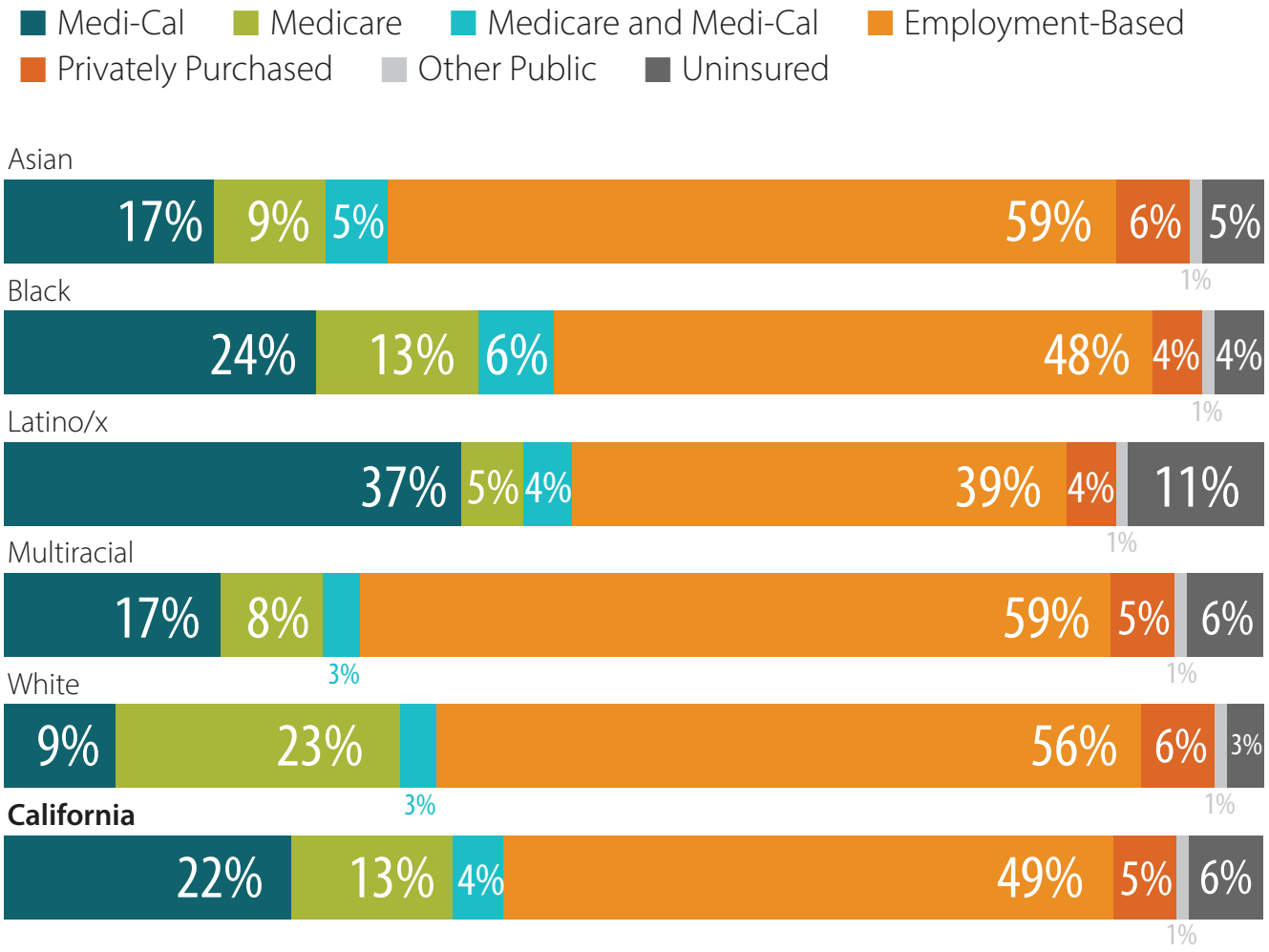
Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*. Figures may not sum due to rounding.

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

Medi-Cal Facts and Figures
Overview

According to the California Health Interview Survey, Medi-Cal provided coverage for 36% of all children, and 23% of nonelderly adults in California in 2021. Almost all seniors were covered by Medicare, and 17% of Californians over age 65 reported also being covered by Medi-Cal (known as "dually eligible enrollees").

Health Insurance Coverage, by Race/Ethnicity, 2021



Notes: Insurance coverage is self-reported. *American Indian / Alaska Native* and *Native Hawaiian / Pacific Islander* are not shown because the data are statistically unstable. Source uses *Black or African American*, *Latino*, and *Two or more races*. *Medicare* includes *Medicare only* and *Medicare* and *other*. Figures may not sum due to rounding.

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

In 2021, 37% of Latino/x Californians and 24% of Black Californians reported Medi-Cal as their source of insurance coverage.

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 more than 86 million Americans, including children in families with low incomes and their parents, adults with low incomes, seniors, and people with disabilities.
- 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 to 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, passed in 2010 and implemented in 2014. Enrollment has grown by 22.7 million in the 39 states that have implemented this option.
- Nationwide Medicaid expenditures, including both federal and state funds, totaled $728 billion in 2021.

Medicaid served over 86 million people nationwide in 2022.

Sources: "Program History," Centers for Medicare & Medicaid Services (CMS); "Medicaid Expansion Enrollment" (Sept. 2022), KFF; *February 2023 Medicaid and CHIP Enrollment Trend Snapshot*, CMS; and "Total Medicaid Spending" (FY 2021), KFF, accessed June 21, 2023.

About Medi-Cal

- A source of health care coverage for:
  - 14.2 million Californians
  - Three in seven of the state's children (under 18)
  - Two in five people with disabilities
  - Two in nine Californians age 19 to 64
  - 39% of all births in the state
- Medi-Cal accounted for about two-thirds of net patient revenues at California's city/county hospitals and primary care clinics in 2021.
- Medi-Cal brought in $85 billion in federal funds in FY 2021–22, up from $65 billion in FY 2019–20. The increase was due in part to an increase in federal assistance during the COVID-19 pandemic.
- Hundreds of thousands of people retained Medi-Cal coverage during the COVID-19 pandemic as a result of continuous coverage requirements imposed by the federal government. (The continuous coverage requirement ended in March 2023.)

Sources: *Medicaid in California* (PDF), KFF, June 2023; "Hospital Annual Financial Data - Selected Data & Pivot Tables" (2021), Calif. Health and Human Services Agency (CalHHS); "2021 Primary Care Clinic Utilization Data" (October 2022), CalHHS; "Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data & Pivot Tables" (2021), CalHHS; and *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), DHCS, accessed March 7, 2023.

Medi-Cal plays a major role in the health care system. California has the nation's largest Medicaid program.

Medi-Cal vs. Medicare

	MEDI-CAL	MEDICARE
Population	Most people in households with low income, subject to income limitations that vary by age, documentation status, and other factors (see page 18)	• Seniors (65+) • People with permanent disabilities • People with end-stage renal disease
Enrollment	15.4 million Californians	6.6 million Californians
Services Covered	Primary, specialty, and acute care services; prescription drugs; long-term care; mental health and substance use disorder services	Primary, specialty, and acute care; prescription drugs
Cost Sharing	No premiums or copayments*	Enrollees must pay premiums and deductible
Funded By	Federal, state, and county governments	Federal government and enrollees
Administered By	California with oversight by CMS	Federal government through CMS

* A limited number of enrollees received Medi-Cal with a share of cost, which acts as a monthly deductible before their coverage starts.

Note: *CMS* is Centers for Medicare & Medicaid Services.

Sources: *Medi-Cal Monthly Eligible Fast Facts* (October 2022) (PDF), California Dept. of Health Care Services, January 2023; and "Monthly Enrollment by State" (October 2022), Centers for Medicare & Medicaid Services.

Medi-Cal and Medicare provide coverage to different populations, cover different services, and are administered separately. However, in 2022, 1.7 million California seniors and people with disabilities were eligible for both Medi-Cal and Medicare; they are referred to as "dually eligible enrollees."†

† For more information, see: Amber Christ and Georgia Burke, *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

- Millions of Californians maintained Medi-Cal coverage during the COVID-19 pandemic, due in part to the federal government temporarily waiving annual eligibility redeterminations.
- The continued coverage requirement ended March 31, 2023.
- The Families First Coronavirus Response Act (FFCRA), passed in March 2020, increased the Federal Medical Assistance Percentage (FMAP) for each included service (subject to limited exceptions) by 6.2 percentage points.
- The increased FMAP will be lowered in phases between March 1 and December 31, 2023.
- Effective January 1, 2024, there will no longer be an enhanced FMAP under FFCRA.

In response to the COVID-19 pandemic, eligibility requirements for the Medi-Cal program were changed, resulting in an increase in enrollment. Many of these changes have been reversed with the end of the COVID-19 public health emergency.

Sources: Gabriel Petek, *The 2023-24 Budget: Analysis of the Medi-Cal Budget* (PDF), Legislative Analyst's Office, February 2023; and *Medi-Cal Covid-19 Public Health Emergency and Continuous Coverage Operational Unwinding Plan* (PDF), California Dept. of Health Care Services, September 18, 2023.

Medi-Cal and the COVID-19 Pandemic: Lasting Changes

Federal COVID-19 emergency resources and regulatory relief allowed the Medi-Cal program to temporarily expand coverage and to waive certain enrollment and eligibility requirements. Many of these changes have become permanent, even as the public health emergency triggered by the pandemic expired.

Some of these changes include the following:

- Telehealth and in-person services are paid at the same rates
- Suspension of premiums and cost sharing in Medi-Cal and the Children's Health Insurance Program
- Expansion of hospital presumptive eligibility to those age 65 and older and people with disabilities (including blindness)*
- Increased reimbursement rates for some services, notably clinical laboratories and long-term care facility types

Many of the changes to the Medi-Cal program that were adopted as emergency measures during the pandemic have been made permanent.

* The California Department of Health Care Services (DHCS) expanded the use of presumptive eligibility (PE) to include those age 65 and older and people with disabilities. DHCS has made the expansion of PE policies permanent, with one PE period allowed every 12 months.

Source: "*Hospital Presumptive Eligibility Program*," California Dept. of Health Care Services, accessed May 14, 2024.

Medicaid Legislative History, Selected Milestones

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

FEDERAL

- **1965** Passed Medicaid law
- **1972** Required states to extend Medicaid to Supplemental Security Income (SSI) recipients and to seniors and disabled
- **1980** Created Disproportionate Share Hospital (DSH) Program
- **1988** Expanded coverage to pregnant women with low income and families with infants
- **1996** Unlinked Medicaid and welfare
- **1997** Established State Children's Health Insurance Program and limited DSH payments
- **2006** Required applicants to provide proof of citizenship to obtain coverage
- **2009** Expanded coverage to legal immigrants for up to five years

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- **1966** Created Medi-Cal
- **1973** Established first Medi-Cal managed care plans
- **1982** Created hospital selective contracting program
- **1993** Required most children/parents with Medi-Cal to enroll in managed care plans
- **1994** Began consolidation of mental health services at county level
- **1997** Expanded access to family planning services*
- **1998** Created Healthy Families program for children
- **2000** Extended Medi-Cal to families with incomes at or below 100% FPL
- **2004** Expanded coverage for home and community-based services

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

Sources: *Medicare & Medicaid Milestones, 1937–2015* (PDF), Centers for Medicare & Medicaid Services, July 2015; *Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget* (PDF), Senate Budget and Fiscal Review Committee, January 6, 2009; "California's Medicaid State Plan (Title XIX)," California Dept. of Health Care Services (DHCS), last modified May 5, 2020; "The Affordable Care Act in California," California Health Care Foundation, June 2012; *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, March 2021; S.B. 78 (2019–20); S.B. 104 (2019–20); Pub. L. No. 115-97 (2017); American Rescue Plan Act of 2021, Pub. L. No. 117-2 (2021); "Ages 26 Through 49 Adult Full Scope Medi-Cal Expansion," DHCS, accessed June 1, 2023; "Asset Limit Changes for Non-MAGI Medi-Cal," DHCS, last updated May 31, 2023; *Asset Limit Changes for Non-MAGI Medi-Cal: Eligibility and Enrollment Plan* (PDF), DHCS, accessed June 1, 2023; and Sandra Williams (chief, Medi-Cal Eligibility Div., DHCS), "American Rescue Plan Act Postpartum Care Extension" (PDF), All County Welfare Directors Letter 22-23, October 17, 2022.

Medicaid Legislative History, Selected Milestones (Continued)

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

2018 Children's Health Insurance Program funding reauthorized through FY 2027

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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

2020 Full-scope Medi-Cal eligibility extended to adults age 19–25 regardless of immigration status

2022 Full-scope Medi-Cal eligibility extended to adults age 50 and over regardless of immigration status; state law passed to extend this coverage to adults age 26–49 starting January 1, 2024. Medi-Cal launches CalAIM (see page 33)

2023 Expanded mandatory enrollment in Medi-Cal managed care to the dually eligible population statewide

Sources: *Medicare & Medicaid Milestones, 1937–2015* (PDF), Centers for Medicare & Medicaid Services, July 2015; *Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget* (PDF), Senate Budget and Fiscal Review Committee, January 6, 2009; "California's Medicaid State Plan (Title XIX)," California Dept. of Health Care Services (DHCS), last modified May 5, 2020; "The Affordable Care Act in California," California Health Care Foundation, June 2012; *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, March 2021; S.B. 78 (2019–20); S.B. 104 (2019–20); Pub. L. No. 115-97 (2017); American Rescue Plan Act of 2021, Pub. L. No. 117-2 (2021); "Ages 26 Through 49 Adult Full Scope Medi-Cal Expansion," DHCS, accessed June 1, 2023; "Asset Limit Changes for Non-MAGI Medi-Cal," DHCS, last updated May 31, 2023; *Asset Limit Changes for Non-MAGI Medi-Cal: Eligibility and Enrollment Plan* (PDF), DHCS, accessed June 1, 2023; and Sandra Williams (chief, Medi-Cal Eligibility Div., DHCS), "American Rescue Plan Act Postpartum Care Extension" (PDF), All County Welfare Directors Letter 22-23, October 17, 2022.

Medi-Cal has expanded to include coverage options for virtually all Californians that meet income requirements as part of a broader state effort to significantly reduce the uninsured rate. The Medi-Cal program has also expanded its benefits to address social determinants of health and transitioned almost entirely to a managed care model.

Medi-Cal Governance

FEDERAL

Centers for Medicare & Medicaid Services

- 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

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

California Legislature

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

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

Financing the Medi-Cal Program

Source of Funds

- California's Medicaid program is known as Medi-Cal. The federal government contributes a percentage of every dollar California spends on qualified Medi-Cal expenditures. California's Federal Medical Assistance Percentage (FMAP), also known as the federal financial participation, is 50% for most services and populations. The FMAP is calculated using the state's average per capita income relative to the national average.
- California's nonfederal share of Medi-Cal expenditures is financed through the state general fund, county funds, and a variety of other taxes and fees.

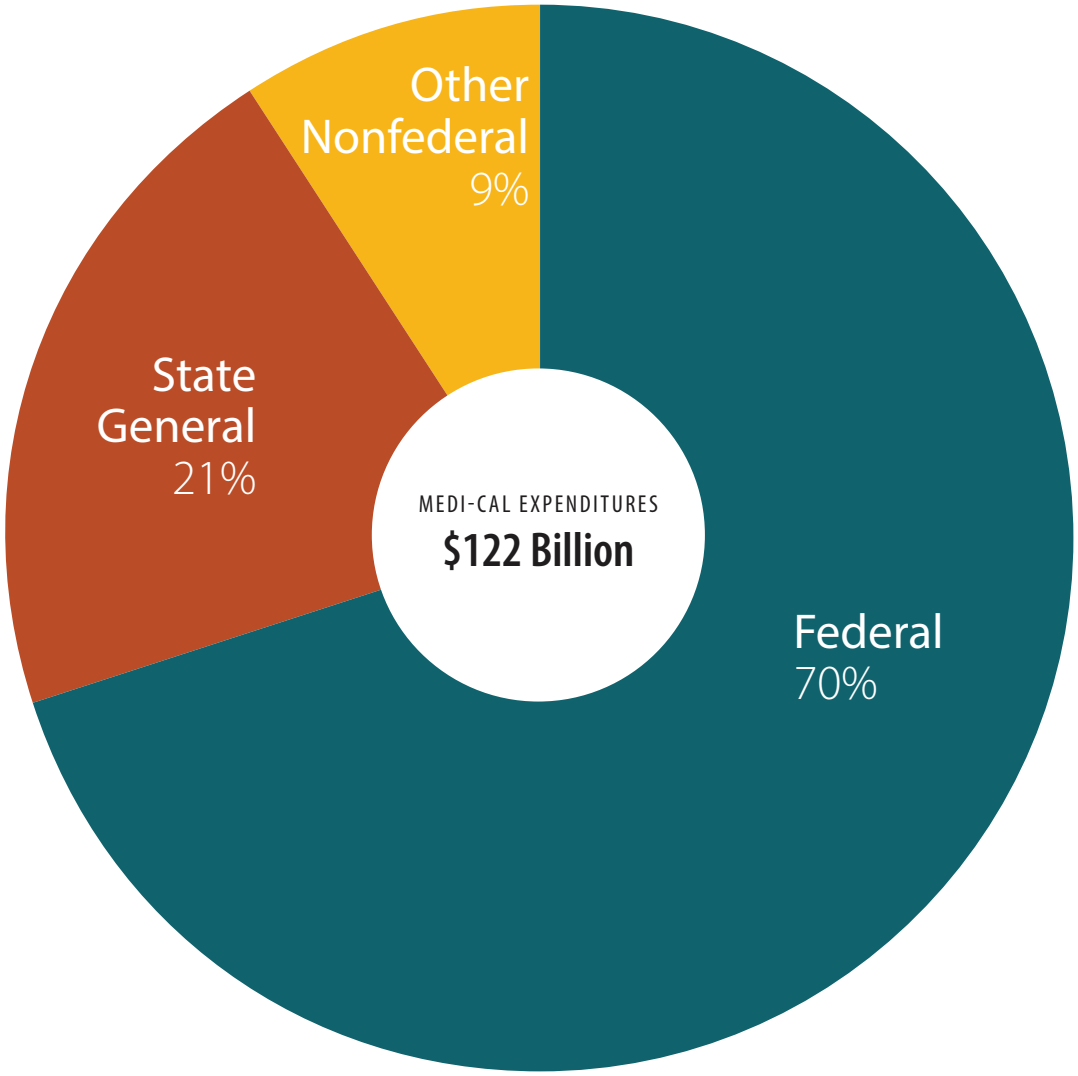
FMAP Enhancement

- The FMAP may be "enhanced," or increased, for specific services. For example, the FMAP is enhanced for specific populations such as refugees, pregnant women, and children. Other services with enhanced FMAPs include breast and cervical cancer treatment, and Indian Health Services and Tribal Facility Services.
- Temporary, or time-limited, FMAP increases are used to incentivize coverage or expansion by states or to address an increase in the financial burden on state Medicaid programs.
- The Affordable Care Act (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 gradually reduced to 90% in 2020.
- Through the Families First Coronavirus Response Act the federal government increased the FMAP in response to the COVID-19 pandemic by 6.2 percentage points effective January 1, 2020. This enhancement ended December 31, 2023.

Medi-Cal is paid for with a mix of federal, state, and local funds. The amount of federal funding available to states is based on a national formula and is increased for certain populations or circumstances.

Sources: "Matching Rates," Medicaid and CHIP Payment and Access Commission, accessed April 7, 2023; "Financial Management," Centers for Medicare & Medicaid Services, accessed April 7, 2023; *Medi-Cal Managed Care Plans: Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes — 2023 Forward* (PDF), California Dept. of Health Care Services, updated June 1, 2023; and "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," KFF, accessed April 3, 2023.

Medi-Cal Funding Sources
FY 2021–22

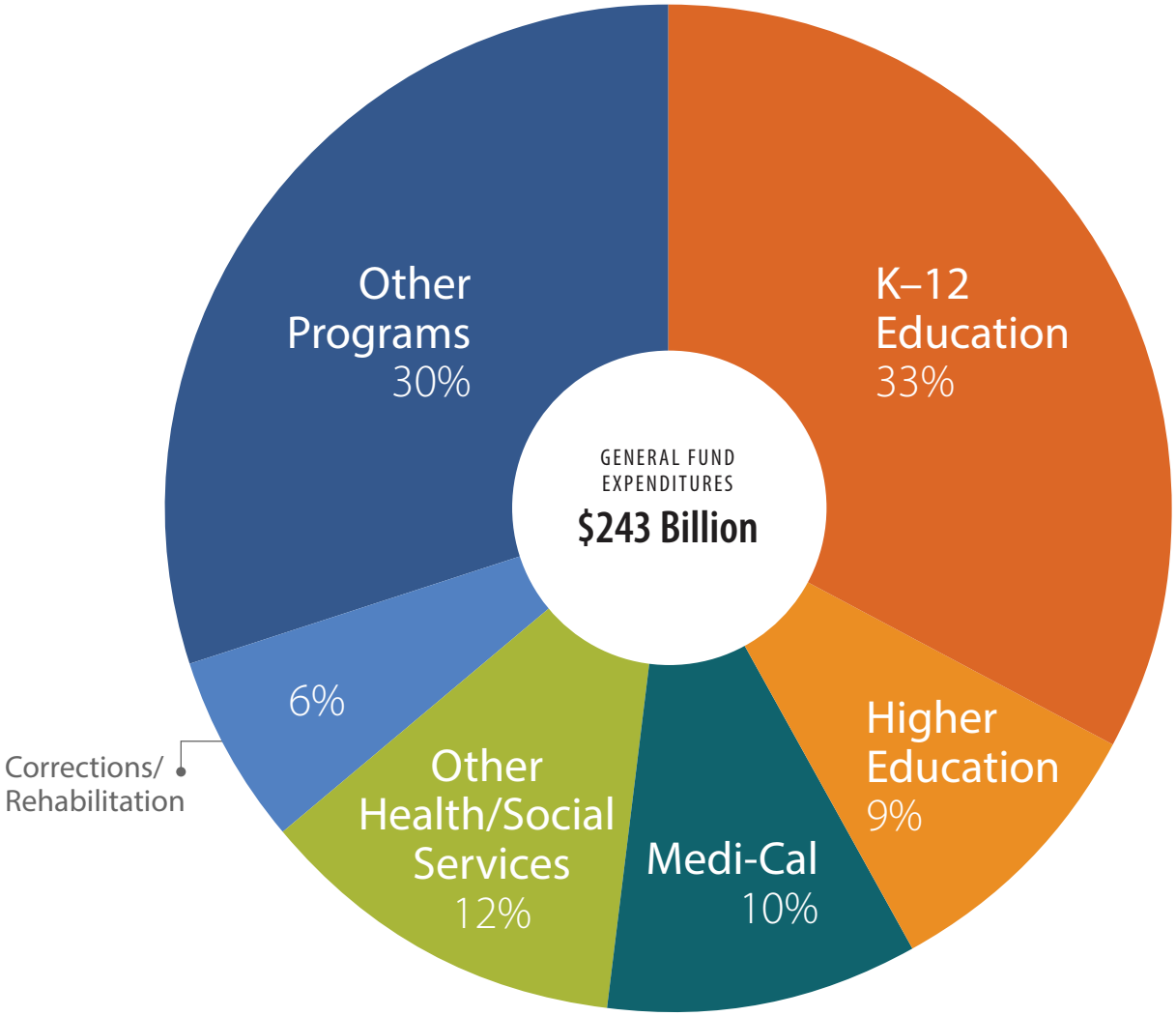


Note: Figures may not sum due to rounding.

Source: *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Dept. of Health Care Services, accessed March 15, 2023.

The federal government provided 70% of total Medi-Cal funding in FY 2021–22. The state's general fund contribution to Medi-Cal accounted for an additional 21%, while other nonfederal funds composed the remaining 9%.

General Fund Distribution, California
FY 2021–22



Notes: 2021–22 general fund expenditures as reported in the 2022–23 budget. *Medi-Cal* includes expenditures for medical care services, eligibility (county administration), fiscal intermediary management, and benefits (medical care and services). Figures may not sum due to rounding.

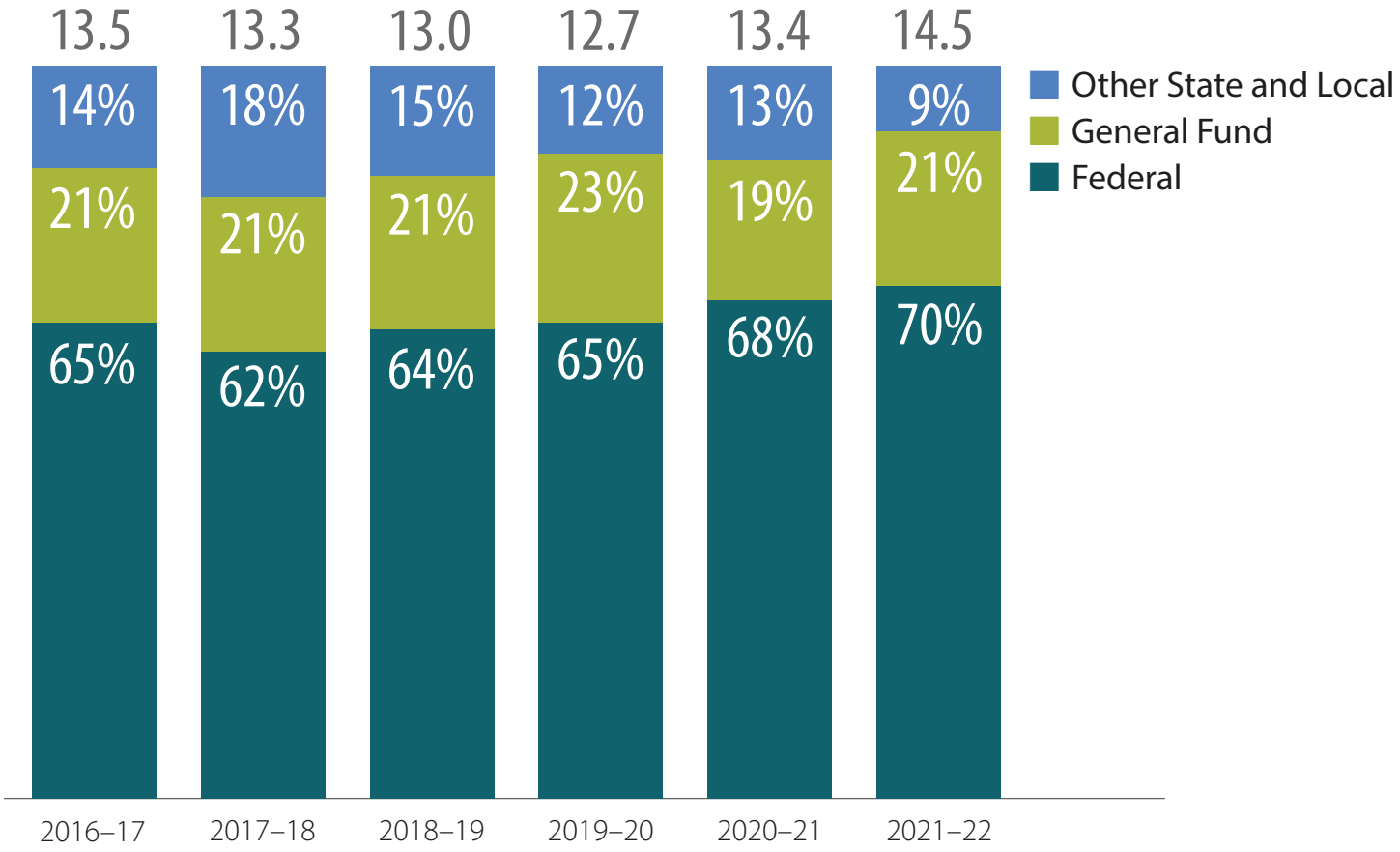
Sources: *2023–24 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF); and *California State Budget — 2022-23: Summary Charts* (PDF), DOF.

In FY 2021–22, California invested $25 billion in the Medi-Cal program, making it one of the largest categories of general fund spending.

Medi-Cal Enrollment and Funding

FY 2016–17 to FY 2021–22

ENROLLMENT IN MILLIONS



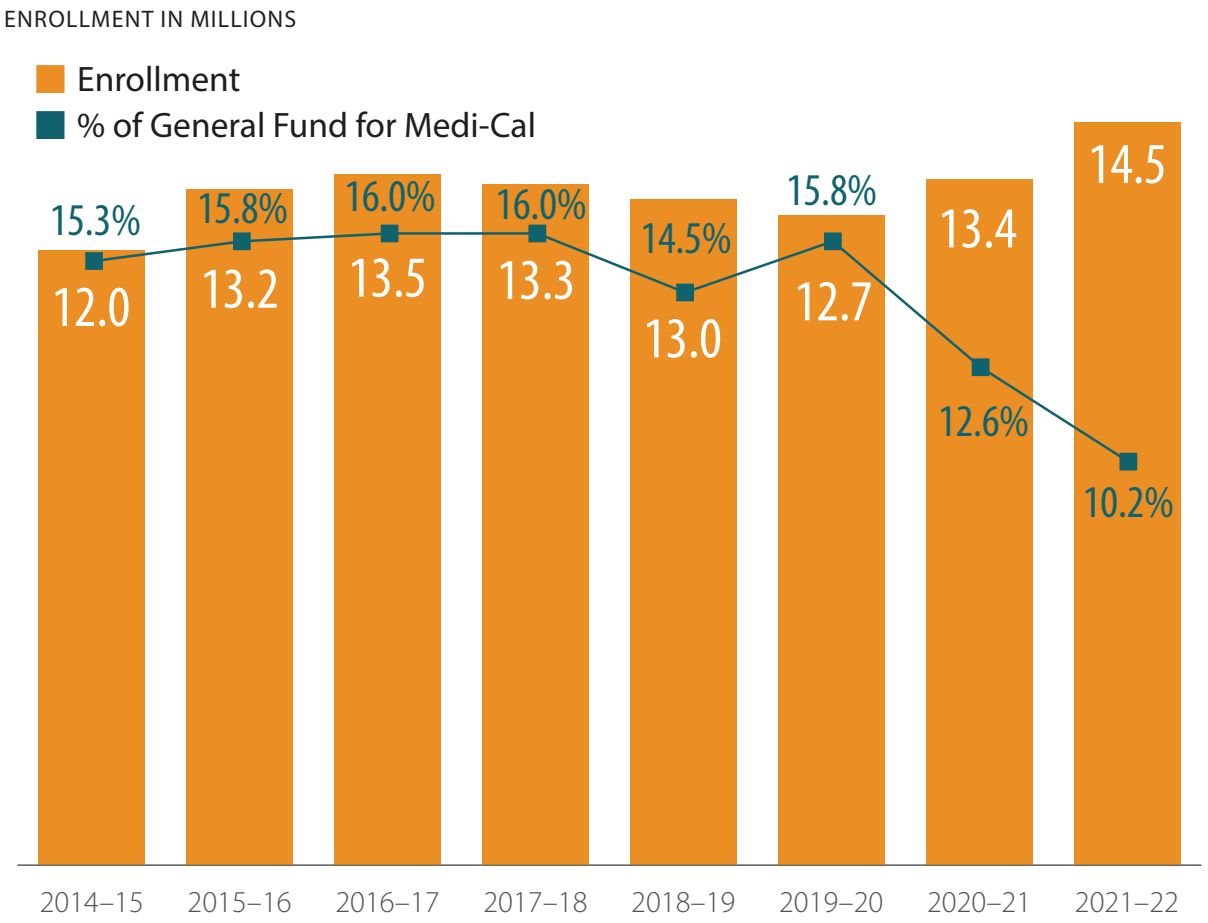
Notes: Enrollment figures as of November of each fiscal year. Figures may not sum due to rounding.

Sources: Enrollment is from "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency; estimates for 2021–22 Medi-Cal spending are from *2023-24 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF), and total general fund spending from *California State Budget — 2022-23: Summary Charts* (PDF), DOF; estimates for 2021–22 Medi-Cal spending are from *2022-23 Governor's Budget: 4260 State Department of Health Care Services* (PDF), DOF, and total general fund spending from *California State Budget — 2021-22: Summary Charts* (PDF), DOF; estimates for 2019–20 Medi-Cal spending are from *2020-21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), 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; and estimates for 2016–17 and 2017–18 are from *Governor's Budget Summary, 2018-19* (PDF), DOF.

Federal funds accounted for a growing share of total Medi-Cal funding, increasing from 65% of total funding in FY 2019-20 to 70% in FY 2021–22. During the same time, enrollment increased by 14% due in part to the continuous coverage provisions enacted during the COVID-19 public health emergency.

Medi-Cal Enrollment and Share of General Fund

FY 2014–15 to FY 2021–22



Note: Enrollment figures as of November of each fiscal year.

Sources: Enrollment is from "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency; estimates for 2021–22 Medi-Cal spending are from *2023-24 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF), and total general fund spending from *California State Budget — 2022-23: Summary Charts* (PDF), DOF; estimates for 2020–21 Medi-Cal spending are from *2022-23 Governor's Budget: 4260 State Department of Health Care Services* (PDF), DOF, and total general fund spending from *California State Budget — 2021-22: Summary Charts* (PDF), DOF; estimates for 2019–20 Medi-Cal spending are from *2020-21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), 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 2015–16 are from *Governor's Budget Summary, 2017-18* (PDF), DOF; and estimates for 2014–15 are from *Governor's Budget Summary, 2016-17* (PDF), DOF.

Medi-Cal's share of total general fund spending fell from 16% in FY 2019–20 to 10% in FY 2021–22. During this time Medi-Cal expenditures increased by $2 billion while total general fund expenditures increased by $96 billion (not shown).

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 20) 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. Some types of property, such as a principal residence, are exempt. In 2022 the Medi-Cal asset limit was $130,000 for an individual and $65,000 for each additional family member; the asset test was eliminated in 2024.
- **Citizenship and immigration status.** Proof of satisfactory immigration status (e.g., lawful permanent residence) is required to receive federal funding for full-scope Medi-Cal benefits. Residents without satisfactory 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.) California allows children, teens and young adults under 26, and those over 50 who are undocumented and who meet other eligibility requirements to receive full-scope Medi-Cal benefits through coverage funded entirely with state funds.
- **Residence.** Enrollees must reside in California.
- **Public assistance program enrollment.** Eligibility for Medi-Cal is automatic for enrollees in the following public assistance programs: CalFresh, Supplementary Security Income / State Supplemental Payment, CalWORKS, Refugee Assistance, Foster Care / Adoption Assistance Program.

For most enrollees, Medi-Cal eligibility is based on household income and size. The Affordable Care Act created a streamlined financial eligibility test, known as the modified adjusted gross income (MAGI) standard, for most children, adults, parents, and pregnant women / birthing people.*

Sources: "Older Adult Expansion," California Dept. of Health Care Services (DHCS), accessed on April 7, 2023; "Young Adult Expansion," DHCS, accessed on April 7, 2023; "Do You Qualify for Medi-Cal Benefits?," DHCS, accessed on April 7, 2023; "Ways to Apply for Medi-Cal," DHCS, accessed on April 7, 2023; and "Presumptive Eligibility (PE) Programs," DHCS, accessed on April 7, 2023.

* *Birthing people* is used to recognize that not all people who become pregnant and give birth identify as women or mothers.

Medi-Cal 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 1	266% FPL cap	208%–266% FPL covered by CHIP
Children age 1–5	266% FPL cap	142%–266% FPL covered by CHIP
Children age 6–18	266% FPL cap	108%–266% FPL covered by CHIP
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	322% 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 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, and 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 and adults age 50 and older regardless of immigration status#	138% FPL cap	State-only funding.
Persons who are undocumented in long-term care	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"*

Notes: The 2023 federal poverty level (FPL) for an individual is $14,580 and $30,000 for a household of four; 138% of FPL is $20,120 for an individual and $41,400 for a household of four. *CHIP* is Children's Health Insurance Program.

Sources: Theresa Hasbrouck (director, Policy Dev. Branch, California Dept. of Health Care Services [DHCS]) to all county welfare directors et al., "2023 Federal Poverty Levels" (PDF), Letter 23-03, January 26, 2023; *List of Medicaid Eligibility Groups: Mandatory Categorically Needy* (PDF), Centers for Medicare & Medicaid Services, accessed April 7, 2023; Tricia Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Prepare for the Unwinding of the Pandemic-Era Continuous Enrollment Provision," KFF, April 4, 2023; *California Medicaid Eligibility Groups by Medi-Cal Aid Code,* California Health and Human Services Agency, last updated February 1, 2023; *Program Eligibility by Federal Poverty Level for 2023* (PDF), Covered California, March 2023; *2023 Poverty Guidelines: 48 Contiguous States (All States Except Alaska and Hawaii)* (PDF), US Dept. of Health and Human Services, last updated January 2022; *Medi-Cal Managed Care Plans: Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes — 2023 Forward (2023)* (PDF), DHCS, last updated March 9, 2023; and Alison Mitchell et al., *Medicaid: An Overview* (PDF), Congressional Research Service, last updated February 8, 2023.

Federal law requires all state Medicaid programs to cover mandatory groups, and allows states to receive federal matching funds for certain optional groups. Using state funds, California expanded Medi-Cal to cover certain people in households with low income regardless of immigration status: children, adults under 26, adults 50 and over, and adults 26 to 49.

* Under the "asset test," some recipients must demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than $130,000 for an individual and $65,000 for each additional family member). The Medi-Cal asset test was eliminated in 2024.

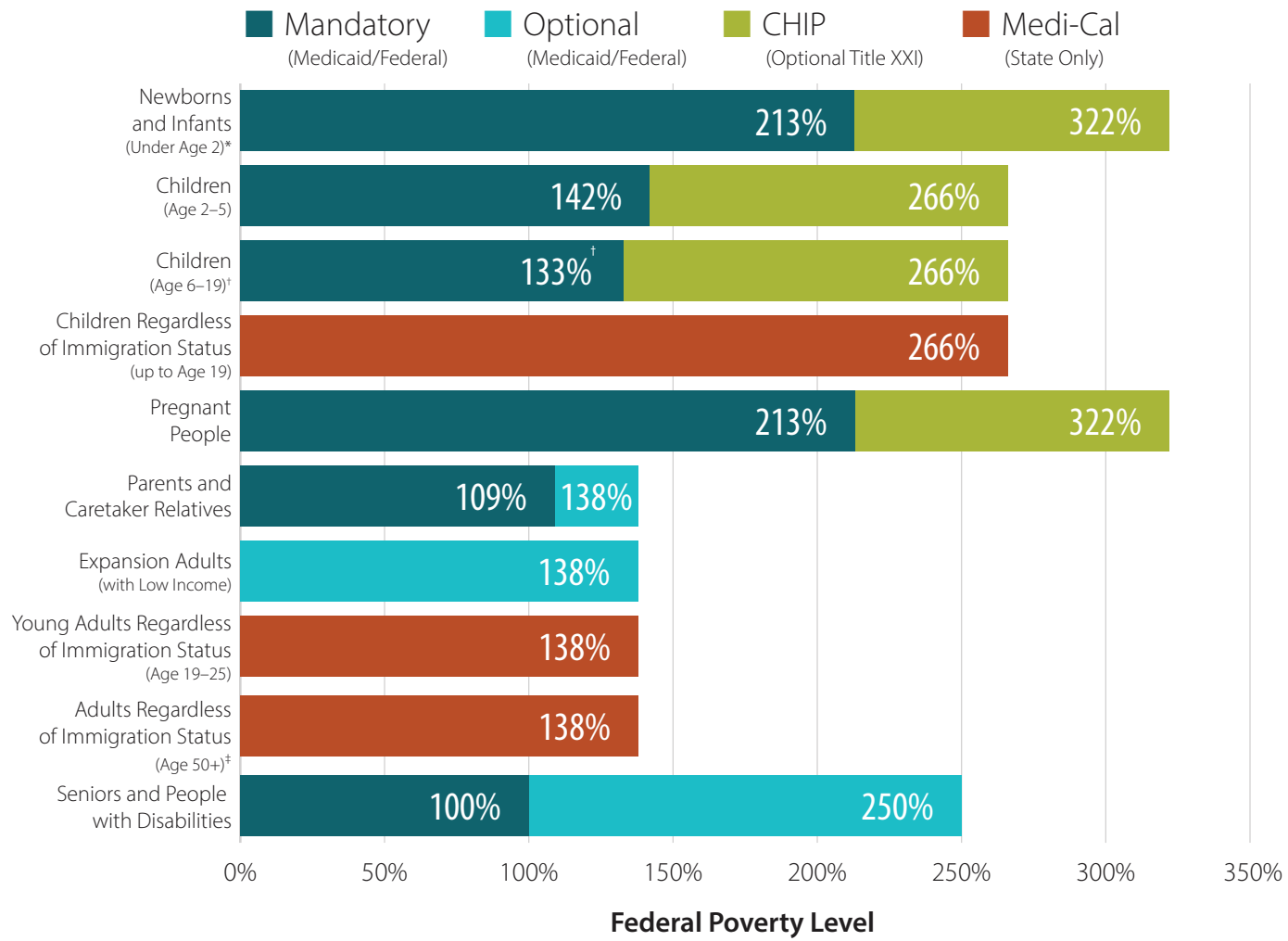
† The Supreme Court made it the state's option to implement this expansion.

‡ Title XXI of the Social Security Act, also known as the Children's Health Insurance Program, allows states to provide coverage to uninsured pregnant women, infants, and children in families with household incomes higher than Medicaid thresholds. 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 Francisco, San Mateo, and Santa Clara Counties only.

California has used state funds to expand eligibility to undocumented children and young adults, and those over age 50, and expanded coverage to all income-eligible adults, regardless of immigration status, starting January 1, 2024.

Medi-Cal Income Thresholds



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

† 5% income disregard does not apply.

‡ This includes a broad group eligible for Medi-Cal through various aid codes and up to 250% FPL under the Working Disabled Program. In 2020 California expanded coverage for seniors and people with disabilities, known federally as aged, blind, and disabled, up to 138% of FPL.

Notes: *CHIP* is Children's Health Insurance Program, part of the Medi-Cal program. Although Medi-Cal is a no-cost program for most enrollees, some enrollees with higher incomes may qualify for coverage under share of cost. These enrollees have a set amount in health care costs they must pay before Medi-Cal will pay for medically necessary goods and services. Source uses *pregnant women*.

Medi-Cal income eligibility thresholds vary. For example, in January 2023, a single, childless adult with annual income below 138% of the federal poverty level, or $20,120, would be eligible for Medi-Cal, and a pregnant person would be eligible if their annual income was below 322% of the federal poverty level, or $46,948.

Sources: Theresa Hasbrouck (California Dept. of Health Care Services) to all county welfare directors et al., "2023 Federal Poverty Levels" (PDF), Letter 23-03, January 26, 2023; *California Medicaid Eligibility Groups by Medi-Cal Aid Code*, California Health and Human Services Agency, last updated February 1, 2023; *Program Eligibility by Federal Poverty Level for 2023* (PDF), Covered California, March 2023; *Medi-Cal Managed Care Plans: Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes — 2023 Forward* (2023) (PDF), DHCS, last updated March 9, 2023; "Ages 26 through 49 Adult Full Scope Medi-Cal Expansion," DHCS, accessed on April 7, 2023; "Older Adult Expansion," DHCS, last modified March 23, 2023; "Working Disabled Program," DHCS, accessed on April 7, 2023; and "Aged, Blind and Disabled Federal Poverty Level Expansion Program," DHCS, last modified December 15, 2021.

Immigration Status and Eligibility

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

Qualified Immigrants

- Legal permanent residents, asylees, refugees, and those in 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 (the "five-year bar").

Nonqualified Immigrants

- Permanently Residing Under Color of Law (PRUCOL): Eligible for full-scope Medi-Cal with state-only funding and no FMAP. The Affordable Care Act recognizes Deferred Action for Children Arrivals status as "lawfully present" under PRUCOL.
- Children who are undocumented: Eligible for full-scope benefits with state-only funding and no FMAP.
- Young adults age 19–25 who are undocumented: Eligible for full-scope benefits with state-only funding and no FMAP.
- Adults age 26–49 who are undocumented: Eligible for restricted-scope (emergency and pregnancy-related) services. These services qualify for FMAP. Starting January 1, 2024, this population became eligible for full-scope benefits with state-only funding and no FMAP.
- Adults age 50 and over who are undocumented: Eligible for full-scope benefits with state-only funding and no FMAP.

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. Effective January 1, 2024, all income-eligible immigrants, regardless of immigration status, are eligible for full-scope benefits.

Notes: Other qualified groups include those who are (1) paroled into the US under specific conditions; (2) granted conditional entry pursuant to specific conditions; (3) a 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 legal permanent resident (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"); or (5) Victims of Severe Forms of Trafficking. The date someone receives their qualified status (e.g., LPR) triggers the beginning of the "five-year bar" requirement. Some qualified immigrants are exempt from the five-year bar (e.g., refugees, asylees, and qualified immigrants who are veterans and their spouse and children). Permanent Residence Under Color of Law (PRUCOL) is not an immigration status but a public benefits eligibility category; PRUCOL individuals are not US citizens, but they are considered to have the same rights as legal residents for welfare eligibility purposes. See 42 CFR § 435.408 for the federal definition and 22 CCR § 50301.3 for the state definition.

Sources: Jen Flory et al., "Overarching Eligibility for Medi-Cal," chap. 1 in *Getting and Keeping Health Care Coverage for Low-Income Californians: A Guide for Advocates*, Western Center on Law and Poverty March 2016; Cal. Welf. & Inst. Code § 14007.8; "Overview of Medicaid and Medi-Cal," chap 1. in *An Advocate's Guide to Medi-Cal Services*, Natl. Health Law Program, January 2020; and "Ages 26 through 49 Adult Full Scope Medi-Cal Expansion," California Dept. of Health Care Services, accessed on April 7, 2023.

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 single streamlined paper version of the application can be submitted to county offices or to 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 people. 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 (see page 10 for additional detail).

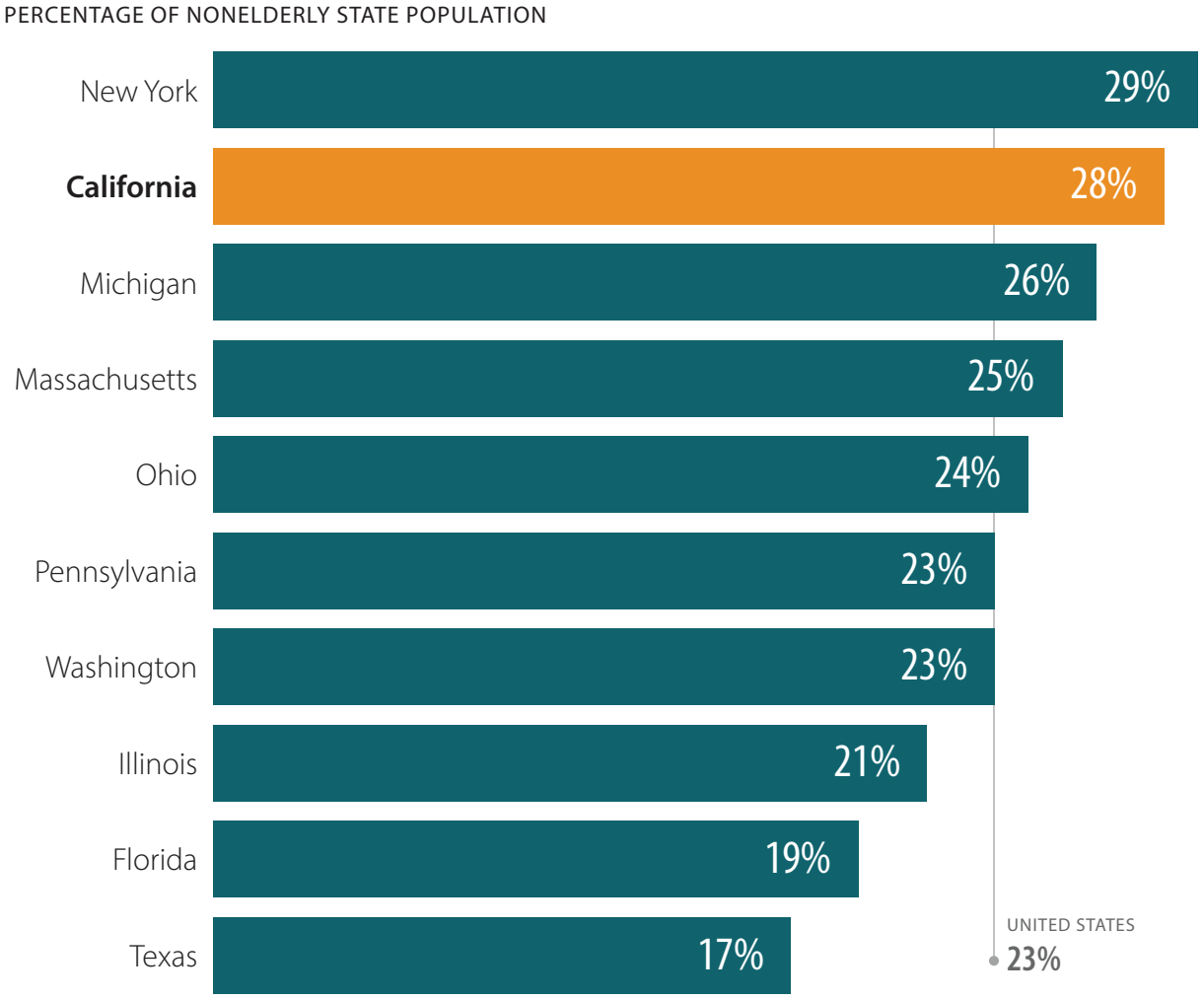
Public assistance automatic program enrollment. Eligibility for Medi-Cal is automatic for enrollees in the following public programs: CalFresh, CalWORKS, Foster Care / Adoption Assistance Program, Refugee Assistance, Supplementary Security Income / State Supplemental Payment.

To comply with the Affordable Care Act, 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.

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

Sources: "Medi-Cal Eligibility and Covered California - Frequently Asked Questions," California Dept. of Health Care Services (DHCS), last modified March 23, 2021; "CHDP Program Overview," DHCS, accessed June 28, 2022; "Welcome to the Breast and Cervical Cancer Treatment Program," DHCS, last modified June 1, 2023; and "Overarching Eligibility for Medi-Cal," chap. 1 in *Getting and Keeping Health Care Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; and "Hospital Presumptive Eligibility Program," DHCS, February 16, 2021.

Medicaid Enrollment
Selected States, 2021



Notes: The 10 states with the highest Medicaid expenditures in FY 2021 based on KFF's "Total Medicaid Spending," FY 2021. *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.

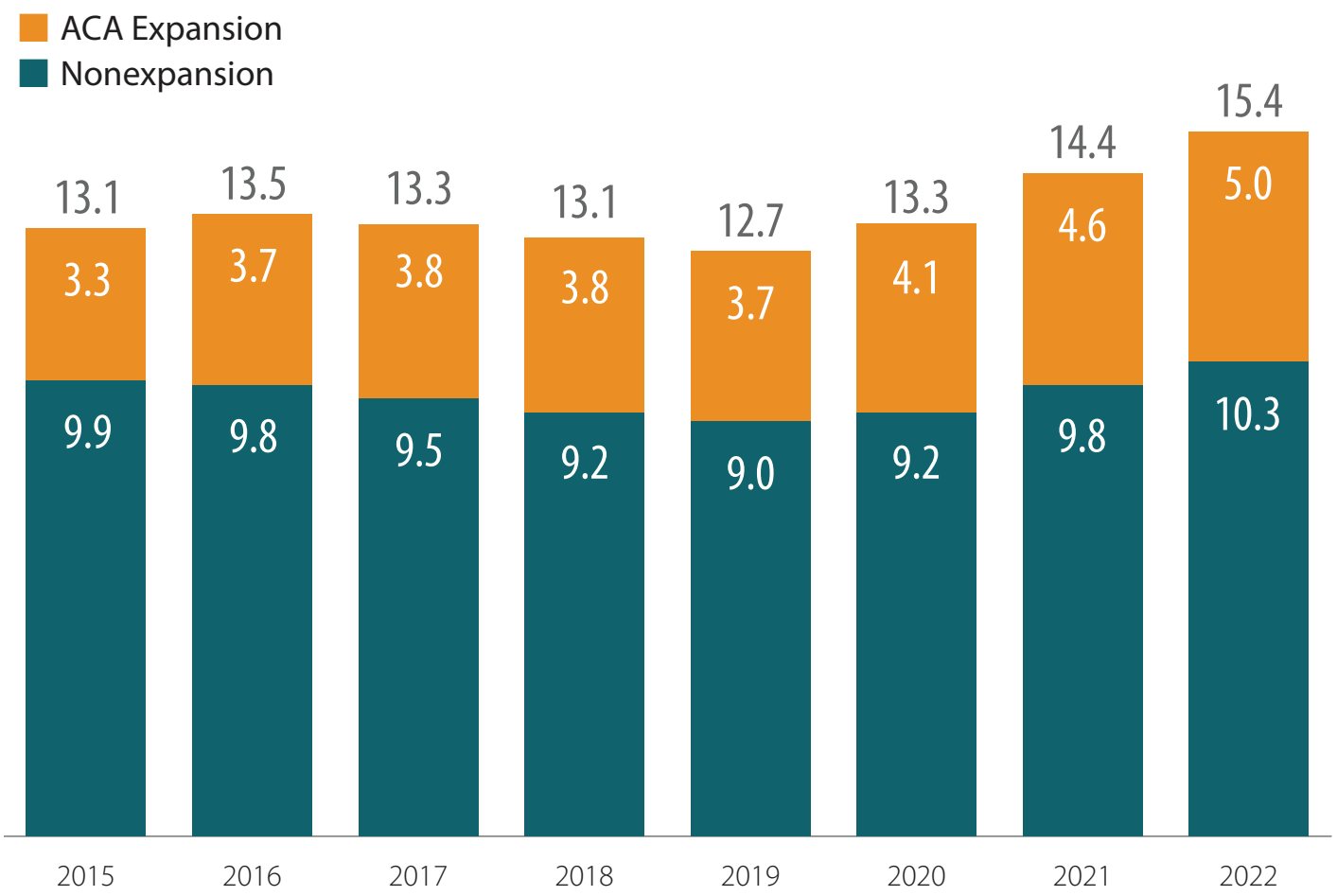
Source: "Health Insurance Coverage of Nonelderly 0-64" (2021), KFF.

Of the 10 largest states by population, only New York has a higher percentage of the state's nonelderly population enrolled in Medicaid. California, however, has nearly twice the number of Medicaid enrollees as New York (not shown).

Medi-Cal Enrollment

2015 to 2022

IN MILLIONS

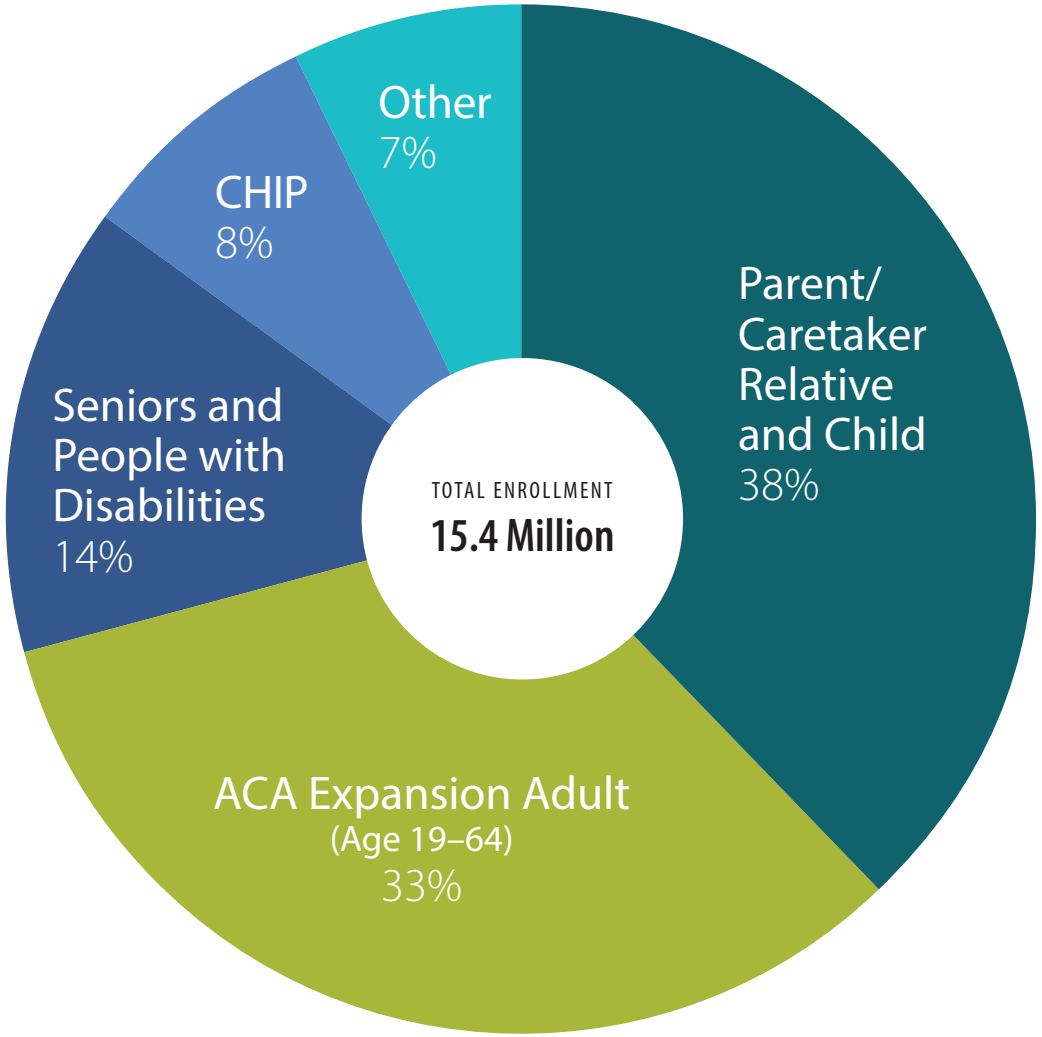


Notes: Enrollment as of October of each calendar year. Figures may not sum due to rounding.

Source: *Month of Eligibility, Aid Category by County, Medi-Cal Certified Eligibility*, California Health and Human Services Agency, last updated April 10, 2023.

Medi-Cal enrollment peaked in 2016 and then steadily declined for several years due to the state's strong economic growth. The COVID-19 pandemic starting in 2020 resulted in a substantial increase in enrollment, with the suspension of eligibility redeterminations pushing enrollment higher.

Medi-Cal Enrollment, by Aid Category, 2022



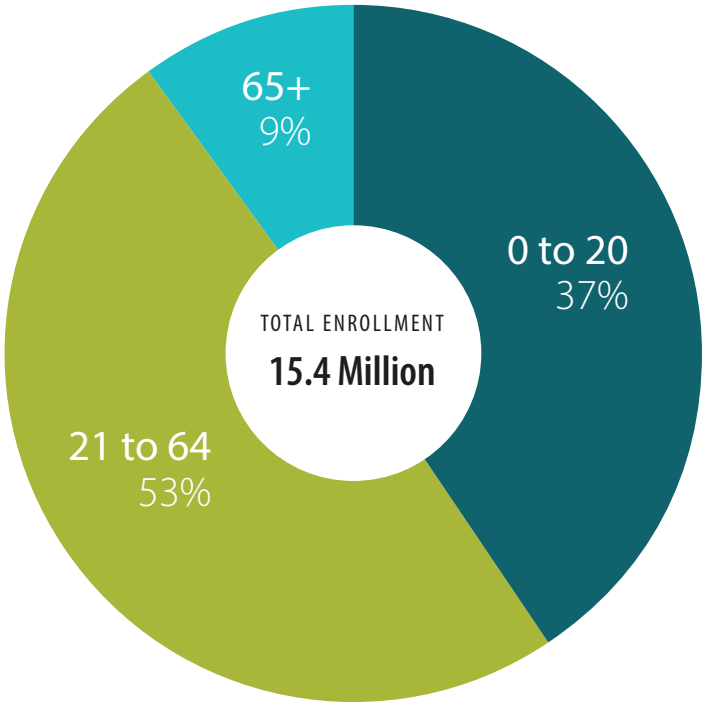
Notes: Enrollment month is October 2022. *CHIP* is Children's Health Insurance Program. *Other* includes long-term care and other aid categories including Undocumented, Adoption/ Foster Care, Refugee Medical Assistance / Entrant Medical Assistance, Breast and Cervical Cancer Treatment Program, Abandoned Baby Program, Minor Consent Program, Accelerated Enrollment in the Children Health and Disability Prevention Program, Trafficking and Crime Victims Assistance Program, and state and county inmates. Figures may not sum due to rounding.

Source: *Medi-Cal Monthly Eligible Fast Facts* (October 2022) (PDF), California Dept. of Health Care Services, January 2023.

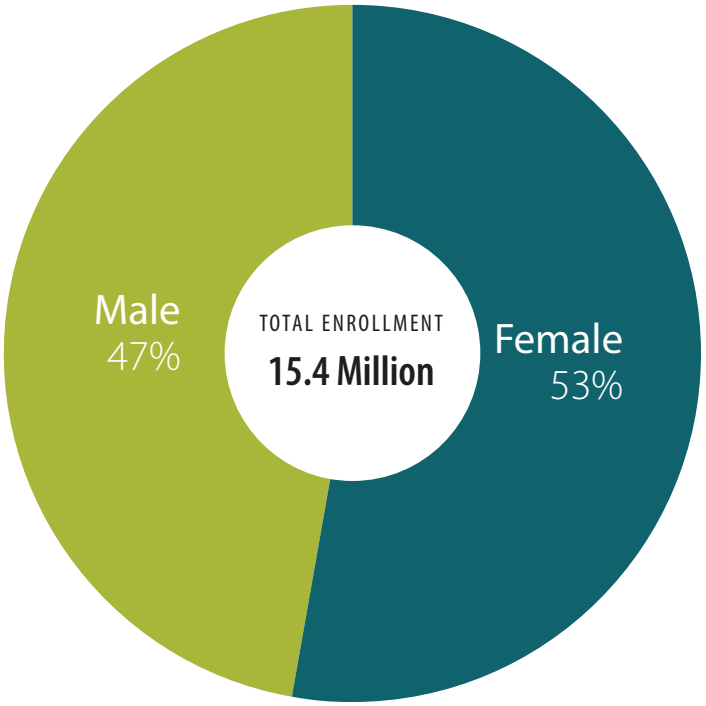
In 2022, nearly 40% of Medi-Cal enrollees were children and their parents/caretakers. The Affordable Care Act expansion group — adults under 65 with low incomes and no dependent children — was the second-largest group of Medi-Cal enrollees.

Medi-Cal Enrollee Profile
by Age and Gender, 2022

Age



Gender



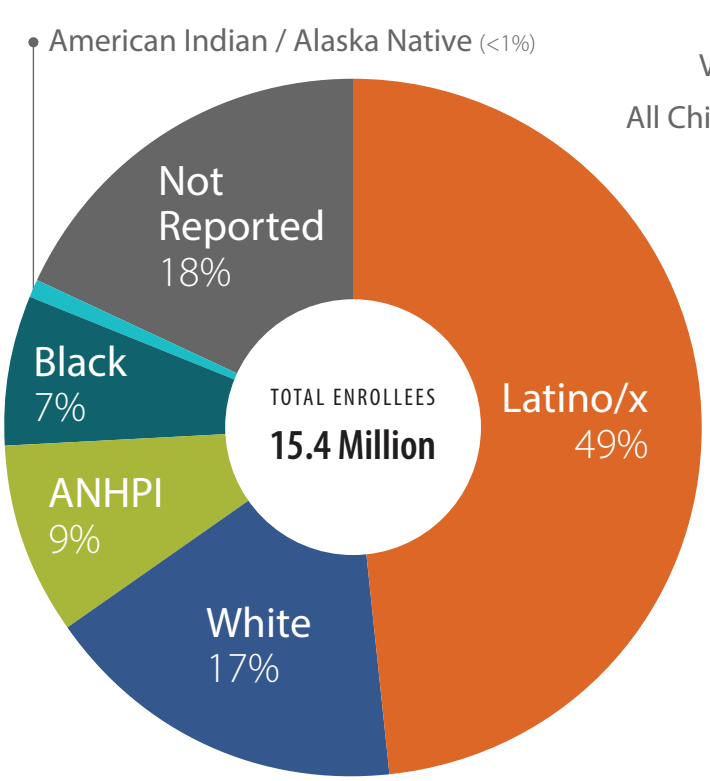
Just over 60% of Medi-Cal enrollees were adults. Children and youth (age 0–20) accounted for 37% of enrollment. The percentage of female Medi-Cal enrollees (53%) was slightly higher than the percentage of males (47%).

Notes: Enrollment as of October 2022. Figures may not sum due to rounding.

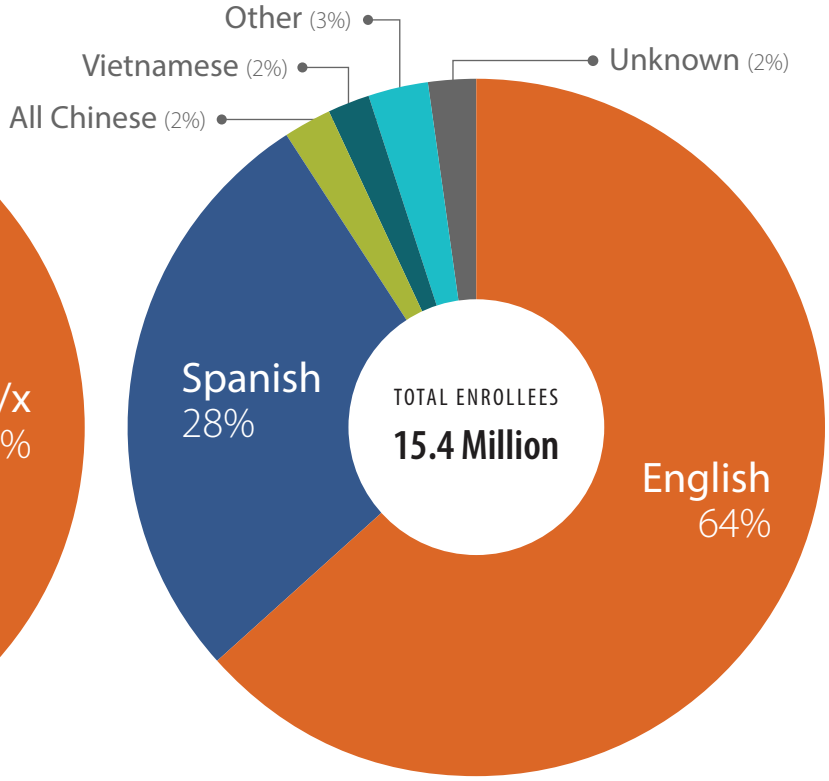
Source: *Medi-Cal Monthly Eligible Fast Facts* (October 2022) (PDF), California Dept. of Health Care Services, January 2023..

Medi-Cal Enrollee Profile
by Ethnicity and Primary Language, 2022

Race/Ethnicity



Primary Language



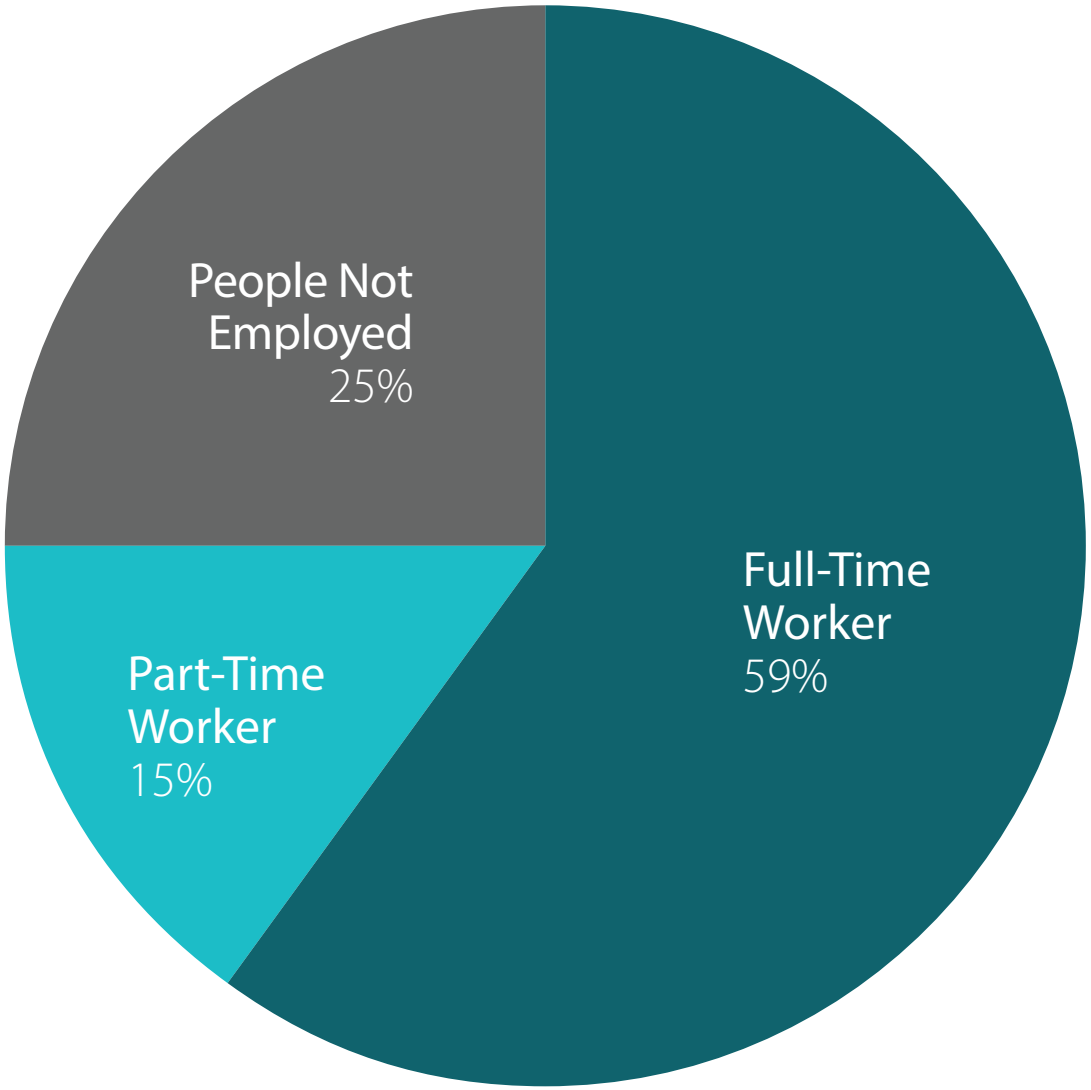
Notes: Source uses *African American, Asian / Pacific Islander*, and *Hispanic*. *All Chinese* includes Cantonese, Mandarin, and Other Chinese. *ANHPI* is Asian, Native Hawaiian, and Pacific Islander. *Other* includes American Sign Language, Arabic, Armenian, Cambodian, Farsi, French, Hebrew, Hmong,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

Source: *Medi-Cal Monthly Eligible Fast Facts* (October 2022) (PDF), California Dept. of Health Care Services, January 2023.

Medi-Cal serves a large and diverse population, with enrollees who identify as Latino/x accounting for nearly 50% of all enrollees and nearly 60% of enrollees reporting their race and ethnicity (not shown). Almost 20% of enrollees did not report a race or ethnicity. English was the most common language spoken (64% of enrollees). Spanish was the primary language spoken for 28% of enrollees.

Medi-Cal Enrollment

by Family Work Status, Nonelderly Population, 2021



Notes: Source uses *Non workers*. *Full-time workers* are those who work 35 hours per week or more. Figures may not sum due to rounding.

Source: "Distribution of the Nonelderly with Medicaid by Family Work Status" (2021), KFF, accessed March 10, 2023.

Three of four nonelderly Medi-Cal enrollees were in households where they or another family member worked part- or full-time.

Medi-Cal Benefits

ESSENTIAL HEALTH BENEFITS	ADDITIONAL MANDATORY MEDICAID BENEFITS	OPTIONAL SERVICES*
• Ambulatory services	• Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)	• Dental services for adults
• Emergency services	• Nursing facility services	• Vision services for adults
• Prescription drugs	• Home health services	• Nonemergency medical transportation services
• Rehabilitative & habilitative services and devices	• Rural Health Clinic services	• Long-term services and supports
• Maternity and newborn care	• Federally Qualified Health Center services	• Enhanced Care Management†
• Hospitalization	• Family planning services	• Community Supports‡
• Preventive & wellness services and chronic disease management	• Nurse midwife services and Freestanding Birth Center services (when licensed or otherwise recognized by the state)	
• Mental health and substance use disorder services, including behavioral health treatment	• Transportation to medical care	
• Pediatric services, including oral and vision care	• Tobacco cessation counseling for pregnant women	
• Laboratory services		

* Eligible for Federal Medicaid Assistance Percentage (FMAP).

† Enhanced Care Management is a new benefit established under CalAIM and provided solely through Medi-Cal managed care plans (MCPs).

‡ Community Supports include a predefined list of cost-effective alternatives to more traditional medical treatments that, per federal regulation, are optional for the MCP to offer and for the enrollee to accept.

Sources: "State Plan Section 3 - Services," California Dept. of Health Care Services (DHCS), accessed June 1, 2023; "Essential Health Benefits," DHCS, last modified May 11, 2023; "Mandatory & Optional Medicaid Benefits," Centers for Medicare & Medicaid Services, accessed June 1, 2023; "Health Insurance Benefits," California Dept. of Insurance, accessed June 1, 2023; "What Are the Medi-Cal Benefits?," DHCS, accessed August 16, 2022; and *Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary* (PDF), DHCS, January 2020.

Medi-Cal is required to cover a set of mandatory benefits and has the option to provide additional benefits eligible for federal matching dollars under the Medicaid program. Medi-Cal health plans are required to cover 10 essential health benefits as outlined in the Affordable Care Act.

"Medi-Cal Rx" Management Transition

In January 2019 Governor Newsom directed the California Department of Health Care Services to transition the administration of pharmaceutical benefits from Medi-Cal managed care plans (MCPs) to a fee-for-service system (Medi-Cal Rx). The transition occurred on January 1, 2022. The scope of Medi-Cal's pharmacy benefits did not change. Physician-administered drugs (e.g., those administered directly by a doctor in a hospital or a facility) remain under the MCP.

The Medi-Cal Rx program aims to:

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

The state expects Medi-Cal Rx implementation will result in increased savings over time. Estimates for FY 2022–23 show a decrease of $868 million over the previous year for spending on prescription drugs and related medical supplies. These savings are based on a combination of Medi-Cal Rx implementation and increased rebate revenue.

Medi-Cal Rx administers the pharmacy benefit through a fee-for-service system. The state maintains responsibility for implementing policies for drug coverage, supplemental drug rebates, prior authorization requirements, the state fair hearing process, pharmacy reimbursement methods, and maintaining the pharmacy network.*

Sources: "Medi-Cal Rx," California Dept. of Health Care Services (DHCS), accessed June 21, 2023; "Medi-Cal Rx: Education & Outreach," DHCS, accessed April 8, 2023; Gabriel Petek, *The 2022-23 Budget: Analysis of the Medi-Cal Budget* (PDF), Legislative Analyst's Office, February 2022; and "Medi-Cal Rx Frequently Asked Questions," DHCS, accessed April 5, 2023.

* Medi-Cal Rx does not apply to Programs of All-Inclusive Care for the Elderly plans, Senior Care Action Network and Cal MediConnect health plans, or the Major Risk Medical Insurance Program.

Medi-Cal Waivers

1915(B) FREEDOM OF CHOICE	1915(C) HOME AND COMMUNITY-BASED SERVICES	1115(A) RESEARCH AND DEMONSTRATION PROJECTS
PURPOSE Permits states to implement service delivery models that restrict choice of providers, such as managed care. States may also use these to waive statewide requirements (e.g., limited geographic area) and comparability requirements. EXAMPLE **Specialty Mental Health Services.** Waives freedom of choice and creates county mental health plans to deliver specialty mental health services. **Medi-Cal Managed Care.** Waives statewideness, comparability, and freedom of choice to authorize the Medi-Cal managed care delivery system programs including Medi-Cal Managed Care, Dental Managed Care, and Drug Medi-Cal Organized Delivery System.	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. 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. **Home and Community-Based Alternatives (HCBA) 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 with HIV/AIDS up to age 20. **Multipurpose Senior Services Program.** Provides care for Medi-Cal enrollees age 65 and older who quality for a nursing facility level of care and provides case management, personal care services, respite care, and other services to help people stay in the community. **Assisted Living Waiver.†** Provides care for Medi-Cal enrollees age 21 and older residing in certain counties who qualify for a nursing facility level of care but are able to reside in a lower-level care setting and assists with that transition. **Self Determination Program.** Provides enrollees and their families with more freedom, control, and responsibility in choosing services and supports to help meet objectives in their individual program plan. Available to all eligible people receiving services from a regional center.	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). EXAMPLES **California Advancing and Innovating Medi-Cal (CalAIM).** Includes limited coverage for certain services provided to certain incarcerated people for up to 90 days immediately before their expected date of release, funds for the Designated State Health Program, funds for the Providing Access and Transforming Health program, authorization for the Community-Based Adult Services program, reimbursement of optional chiropractic services provided by Indian Health Services, renewal of the Global Payment Program, and permits required to align the Medi-Cal managed care plan with the Medicare plan choice for a dually eligible enrollee in specified circumstances. See page 34 for more information on CalAIM.

* On February 2, 2023, the Centers for Medicare & Medicaid Services (CMS) approved the renewal of the HCBA waiver for five years (January 1, 2023–December 31, 2027).

† On January 7, 2022, CMS approved an amendment to add 7,000 slots to the Assisted Living Waiver (ALW) to eliminate the current waitlist and expand waiver capacity. This amendment is retroactive to July 1, 2021. DHCS amended the current HCBA waiver to integrate ALW services effective March 1, 2024.

States may use statutory authority to waive certain Medicaid rules, subject to federal approval. California uses a combination of federal waivers to implement and maintain its managed care program, home and community-based services, and behavioral health. For example, the components of Medi-Cal reforms under CalAIM are authorized through several federal waivers.

Sources: "Medi-Cal Waivers," California Dept. of Health Care Services (DHCS), accessed April 5, 2023; Courtney Miller (director, Medicaid and CHIP Operations Group, Centers for Medicare & Medicaid Services [CMS]) and Alissa Mooney DeBoy (director, Disabled and Elderly Health Programs Group, CMS) to Jacey Cooper (chief deputy director, Health Care Programs, DHCS), "CalAIM 1915(b) Approval Letter" (PDF), December 29, 2021; "CalAIM 1115 Demonstration and 1915(b) Waiver," DHCS, accessed April 5, 2023; Daniel Tsai (deputy administrator and director, CMS) to Jacey Cooper, "CalAIM 1115 Approval Letter and STCs" (PDF), December 29, 2021; Daniel Tsai to Jacey Cooper, "California Reentry Demonstration Initiative Amendment Approval" (PDF), CMS, January 26, 2023; Athena Chapman and Elizabeth Evenson, Long-Term Services and Supports in Medi-Cal, California Health Care Foundation, October 2020; and "Assisted Living Waiver," DHCS, accessed April 8, 2023.

CalAIM (California Advancing and Innovating Medi-Cal)

CalAIM is a broad and bold multiyear plan intended to transform the Medi-Cal delivery system.

In 2021 DHCS received federal approval for CalAIM — a significant overhaul of the Medi-Cal program. The federal approval included authorization of both Section 1115 and consolidated 1915(b) waivers.

CalAIM is intended to:

- Identify and manage comprehensive needs through whole-person care approaches and social drivers of health
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform
- Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility

Sources: "Medi-Cal Transformation," California Dept. of Health Care Services (DHCS), accessed June 21, 2023; and "CalAIM 1115 Demonstration & 1915(b) Waiver," DHCS, accessed June 21, 2023; and *2022-23 Budget Act: Department of Health Care Services* (PDF), DHCS, accessed June 21, 2023.

CalAIM Implementation: New and Expanded Benefits

CalAIM includes new or expanded benefits for Medi-Cal enrollees aimed at using whole-person care approaches to improve health outcomes and to address the social drivers of health.

Enhanced Care Management (ECM). ECM is person-centered care management provided to Medi-Cal enrollees with the highest needs.

Community Supports (also known as "In Lieu of Services"). A set of 14 preapproved alternatives to more traditional medical treatments that health plans may choose to offer to enrollees. Alternatives include housing transition and navigation services, home modifications, medically tailored meals, and respite services.

New Dental Benefits. CalAIM expands key dental benefits, including a tool to identify risk factors of dental decay. Statewide pay-for-performance initiatives will reward dental providers for focusing on preventive services and continuity of care.

Justice-Involved Adults and Youth. Targeted Medi-Cal services to address poor health outcomes and disproportionate risk of illness and accidental death among Medi-Cal eligible adults and youth as they reenter their communities.

Integrated Care for Dually Eligible Enrollees. The statewide expansion to Medicare Medi-Cal Plans (MMPs, or Medi-Medi Plans), a special kind of Medicare Advantage Plan that coordinates Medicare and Medi-Cal benefits for enrollees eligible for both programs. Also known as Exclusively Aligned Enrollment Dual Eligible Special Needs Plans.

Managed Institutional Long-Term Care. This institutional long-term care benefit, provided through health plans statewide, provides a consistent set of services under managed care.

Statewide Managed Long-Term Services and Support. Moving toward a delivery system where the health plans would serve as the single point of accountability for referral, coordination, and delivery of all Medi-Cal covered long-term services and supports.

Note: *CalAIM* is California Advancing and Innovating Medi-Cal.

Sources: "Medi-Cal Transformation," California Dept. of Health Care Services (DHCS), accessed June 21, 2023; "CalAIM 1115 Demonstration & 1915(b) Waiver," DHCS, accessed June 21, 2023; and *2022-23 Budget Act: Department of Health Care Services* (PDF), DHCS, accessed June 21, 2023.

CalAIM Implementation: New Policies and Funding

CalAIM includes a series of new policies and investments intended to make a more consistent and seamless system for Medi-Cal enrollees.

Providing Access and Transforming Health (PATH). PATH is a five-year, $1.85 billion initiative to build the capacity of partners, such as community-based organizations, public hospitals, county agencies, tribes, and others, to successfully participate in the Medi-Cal delivery system. This initiative will build on the Whole Person Care and Health Homes pilots to address the gaps in local organizational capacity and infrastructure.

Population Health Management (PHM). Managed care plans will need to adopt a whole-system, person-centered strategy that includes assessments of each enrollee's health risks and health-related social needs. DHCS will also develop a PHM Service, which will be designed to collect and integrate information across the continuum of care and provide risk stratification functions.

Behavioral Health Delivery System Transformation. CalAIM will streamline policies to improve access to behavioral health services, simplify how these services are funded, and support administrative integration of mental illness and substance use disorder treatment.

Expanded Managed Care Enrollment. Expands the use of managed care plans to deliver care including for dually eligible enrollees and other populations previously enrolled on a voluntary basis.

Full Integration Pilot. Explores the integration of physical health, behavioral health, and dental health in one managed care plan through a few test sites.

National Committee for Quality Assurance Accreditation. Requirement that managed care plans be accredited by NCQA.

Note: *CalAIM* is California Advancing and Innovating Medi-Cal.

Sources: "Medi-Cal Transformation," California Dept. of Health Care Services (DHCS), accessed June 21, 2023; "CalAIM 1115 Demonstration & 1915(b) Waiver," DHCS, accessed June 21, 2023; and *2022-23 Budget Act: Department of Health Care Services* (PDF), DHCS, accessed June 21, 2023..

CalAIM Major Initiatives Launch Timeline as of February 2023

DATE	INITIATIVE
January 2022	• Dental (new benefits and pay for performance) • Enhanced Care Management (ECM) for several populations of focus in first-phase counties • Community Supports in first-phase counties • Mandatory managed care enrollment for non-dually eligible populations
July 2022	• ECM for several populations of focus in remaining counties
January 2023	• Long-term care (LTC) skilled nursing facility transition to Medi-Cal managed care • Mandatory managed care enrollment for dually eligible populations and those in LTC • Providing Access and Transforming Health initiatives (ECM, Community Supports, Justice-Involved) and Technical Assistance Marketplace • Transition the Exclusive Aligned Enrollment Dual Eligible Special Needs Plan (EAE D-SNP) model* in seven Coordinated Care Initiative counties • ECM for the Individuals Transitioning from Incarceration and the Birth Equity populations of focus
January 2024	• Intermediate Care Facility / Developmentally Disabled (ICF/DD) facilities, ICF-DD/Habilitative, ICF-DD/Nursing and Subacute Care (adult and pediatric) facilities transition to Medi-Cal managed care • Launch of the Population Health Management program
April 2024	• Justice-Involved Initiative: pre-release Medi-Cal services
January 2026	• Transition to statewide Managed Long-Term Services and Supports (MLTSS) and EAE D-SNP model • NCQA accreditation for managed care plans required • Implementation of statewide MLTSS
January 2027 or Beyond	• Final phase of administrative integration of specialty mental health and substance use disorder services • Full integration of plans pilot

* The EAE D-SNP is also referred to as Medicare Medi-Cal Plans (MMPs, or Medi-Medi Plans).

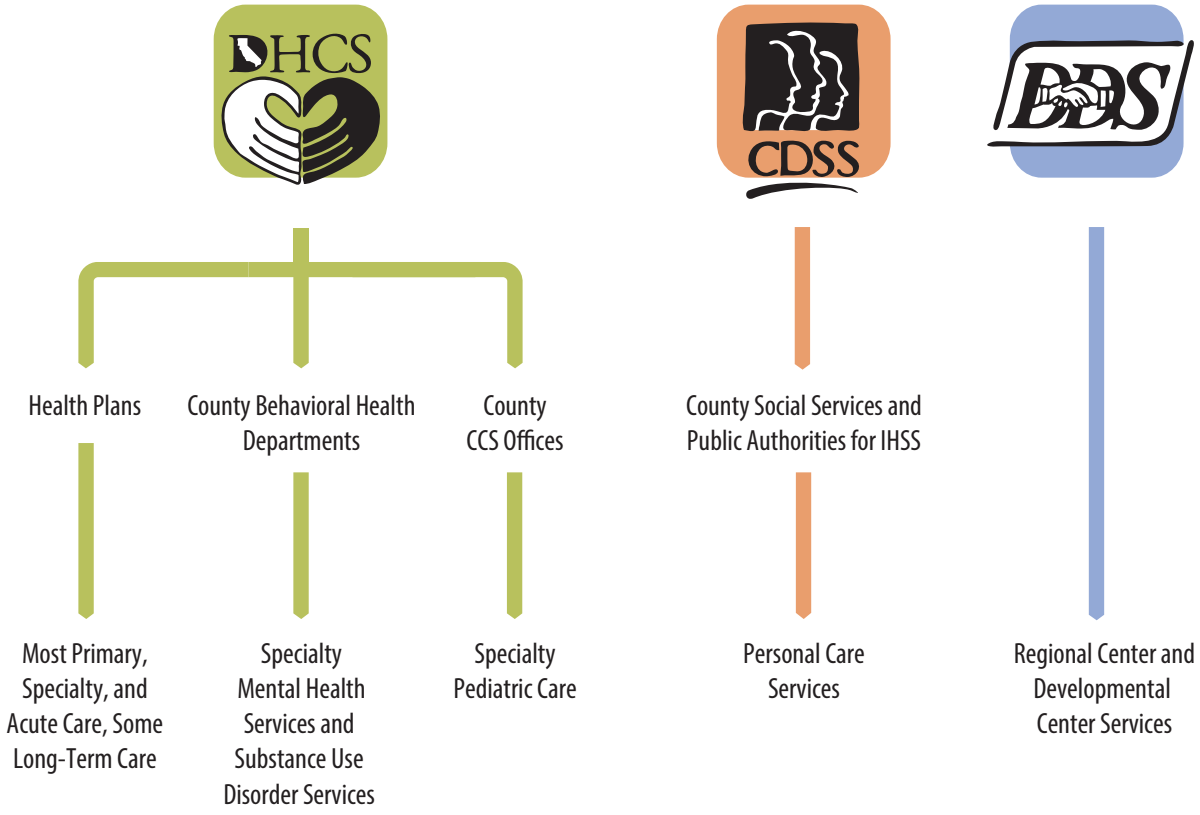
Note: *CalAIM* is California Advancing and Innovating Medi-Cal.

Sources: *CalAIM Initiatives Launch Timeline as of February 2023* (PDF), California Dept. of Health Care Services (DHCS), accessed May 31, 2023; "CalAIM Population Health Management Initiative," DHCS, accessed May 31, 2023; and "Cal MediConnect Transition," DHCS, accessed May 31, 2023.

Multiple CalAIM initiatives and programs are proposed to be implemented over the coming years.

Systems for Administering Care

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



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

Medi-Cal and Telehealth

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.

Recent legislation implemented several Medi-Cal telehealth policies that clarify and expand the use of telehealth by providers, including updates to reimbursement policies to allow visits to be conducted via telephone, video, or asynchronous telehealth modalities; establishment of payment parity for telehealth with services provided in person; and allowing the establishment of new patients via video telehealth.

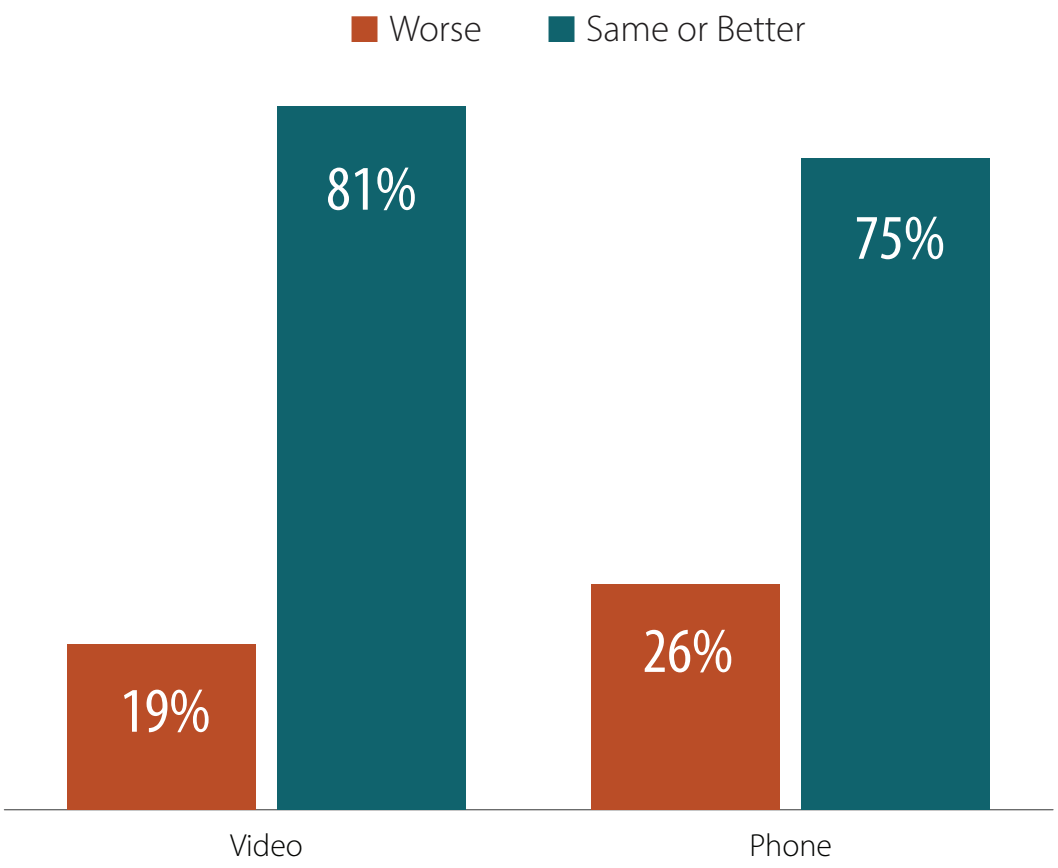
In 2021, 46% of Medi-Cal enrollees reported accessing telehealth services, up from just 9% in 2018. Statewide, 49% of all patients reported receiving telehealth services.

Current Medi-Cal telehealth policies aim to ensure patients have choice in telehealth modality and in-person access. The California Department of Health Care Services established a research and evaluation plan that will monitor telehealth access, outcomes, quality, cost, and equity.

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 Bailey, and Emily Alvarez, *The 2021 CHCF California Health Policy Survey*, CHCF, January 2021; *Stakeholder Advisory Committee Meeting* (PDF), California Dept. of Health Care Services (DHCS), February 11, 2021; *DHCS Telehealth Policy: Executive Summary*, DHCS, accessed April 5, 2023; *DHCS Telehealth: Research and Evaluation Plan* (PDF), DHCS, December 19, 2022; and "AskCHIS," (2021), UCLA Center for Health Policy Research.

Telehealth Visits, Medi-Cal Enrollees, 2021

RATING OF TELEHEALTH VISIT COMPARED TO IN-PERSON VISIT



Note: Asked only of enrollees who had a telehealth visit.

Source: "AskCHIS," (2021), UCLA Center for Health Policy Research.

In 2021, almost half of Med-Cal enrollees (46%) had received care via telehealth, a significant increase from the 9% of enrollees who reported a telehealth visit in 2018 (not shown). Of those enrollees who had a telehealth visit, 75% or more rated the visit the same or better than an in-person visit. Medi-Cal policies aim to ensure patients have choice in telehealth modality and in-person access.

Managed Care vs. Fee-for-Service, 2023

	MANAGED CARE	FEE-FOR-SERVICE
Availability	All 58 counties	All 58 counties
Market Share	85% of all enrollees	15% of all enrollees
Enrollment Categories	**Mandatory** • Children • Pregnant people • Parents / caretaker relatives • Adults without dependents • Seniors and people with disabilities • Enrollees in long-term care • HCBS waiver enrollees • Those dually eligible for Medicare • Those with other health insurance • American Indians / Alaska Natives in County Organized Health System (COHS) counties **Voluntary** • American Indians / Alaska Natives (in non-COHS counties) • Foster children and youth	• Foster children • Share of cost (SOC) Medi-Cal enrollees (except institutional) • Family PACT enrollees • Other enrollees without full-scope Medi-Cal • Enrollees who have received a medical exemption • Enrollees with presumptive eligibility • Non-citizen pregnancy-related enrollees • All enrollees in San Benito County*
Expenditures	48%	29%
Covered Services	All essential health benefits required by the ACA, including: • Ambulatory services • Emergency services • Mental health and substance use disorder services • Hospitalization • Pediatric services • Skilled nursing facilities	Some services are carved out of managed care, including: • Pharmacy benefits (other than physician-administered drugs) • Specialty mental health • Substance use disorder services • Dental services† • California Children's Services, for seriously ill and disabled children and youth in certain counties‡ • Most long-term services and supports (other than skilled nursing facilities)
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.

* In 2024 San Benito County will transition to a COHS model with mandatory enrollment into managed care.

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

‡ Children in California Children's Services (CCS) enroll in managed care plans, which provide non-CCS services. For their CCS-related needs, they use fee-for-service CCS providers typically outside of the managed care plan. CCS services are delivered by the five COHS to CCS children in 21 counties under the CCS Whole Child Model.

Notes: *Family PACT* is the Family Planning, Access, Care, and Treatment Program. Enrollees with restricted-scope benefits are all in fee-for-service Medi-Cal. *ACA* is Affordable Care Act. *HCBS* is home and community-based services.

More than eight in 10 enrollees were in managed care plans and accounted for nearly 50% of all Medi-Cal expenditures. The state determines mandatory or voluntary managed care enrollment, subject to federal approval.

Sources: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency, accessed April 10, 2023; *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Dept. of Health Care Services (DHCS), accessed March 10, 2023; *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, accessed March 10, 2023; "Medi-Cal Dental Managed Care," DHCS, accessed April 8, 2023; "Medi-Cal Rx: Medi-Cal Rx Background," DHCS, accessed April 8, 2023; Michelle Retke (chief, Managed Care Operations Division, DHCS) to All Medi-Cal managed care health plans, "Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative" (PDF), All-Plan Letter 21-015, October 18, 2021; and *All Plan Letter 21-015, Attachment 1: Mandatory Managed Care Enrollment (MMCE) Requirements* (PDF), DHCS, October 18, 2021.

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:

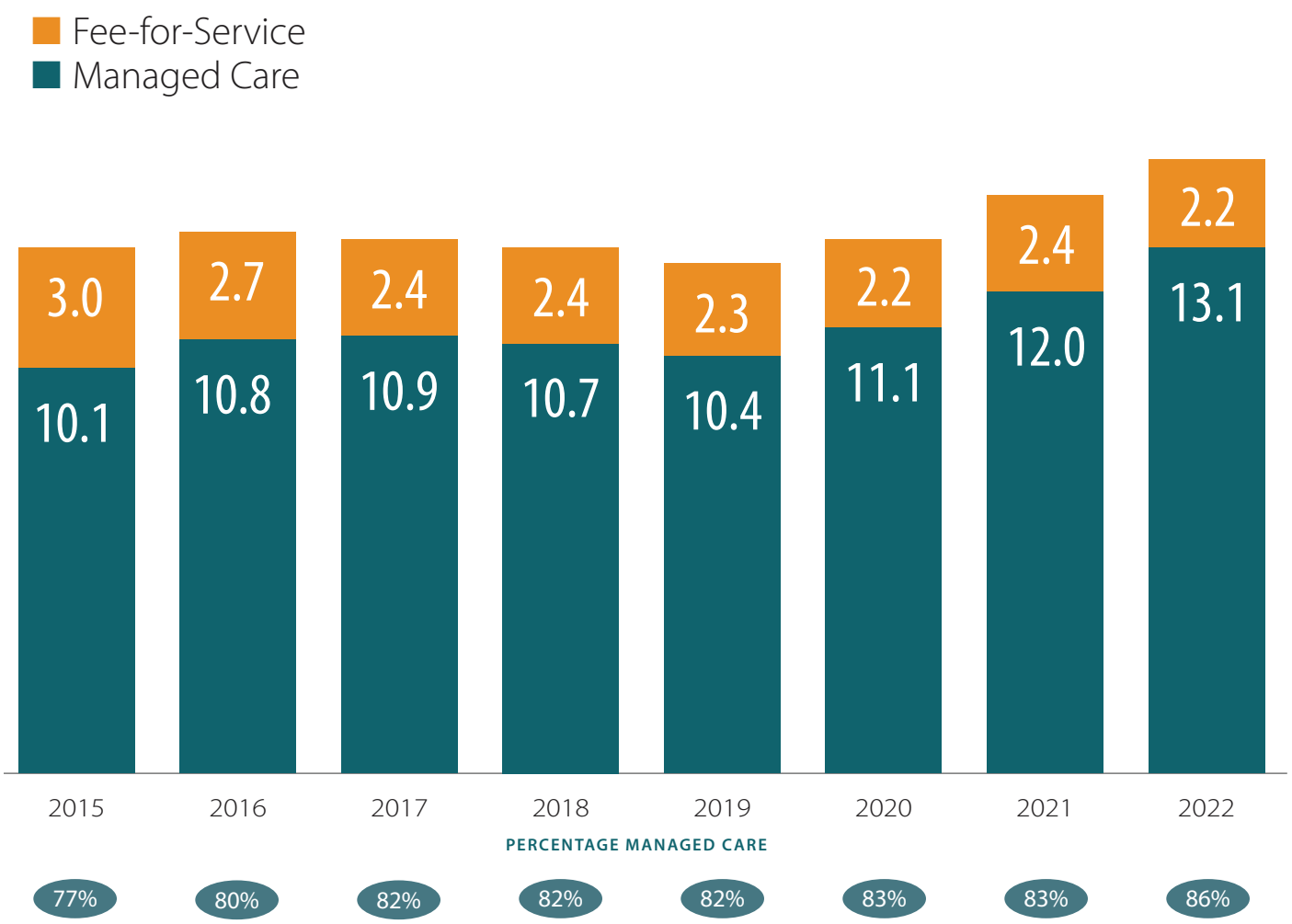
- **Specialty mental health services** (SMHS) are provided by county mental health plans to adults with a serious mental illness and to children with a serious emotional disturbance. SMHS include targeted case management, partial hospitalization, and outpatient and mental health services.
- **Substance 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 institutional long-term care.
- **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 County Operated Health System plans manage these children's benefits in 21 counties in a program called the CCS Whole Child Model.
- **Pharmacy benefit**, through the Medi-Cal Rx transition that occurred on January 1, 2022, was carved out from managed care plans and centralized purchasing, claims, and member services within the California Department of Health Care Service and its contracted administrative vendor (see page 31 for more detail).

Certain Medi-Cal services are "carved out" of the managed care benefit and have separate reimbursement structures and delivery systems. Medi-Cal managed care plans are generally required to refer and coordinate these carved-out services.

Sources: *Medi-Cal Dental Member Handbook, 2023* (PDF), California Dept. of Health Care Services (DHCS); "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.

Medi-Cal Enrollment
2015 to 2022

IN MILLIONS

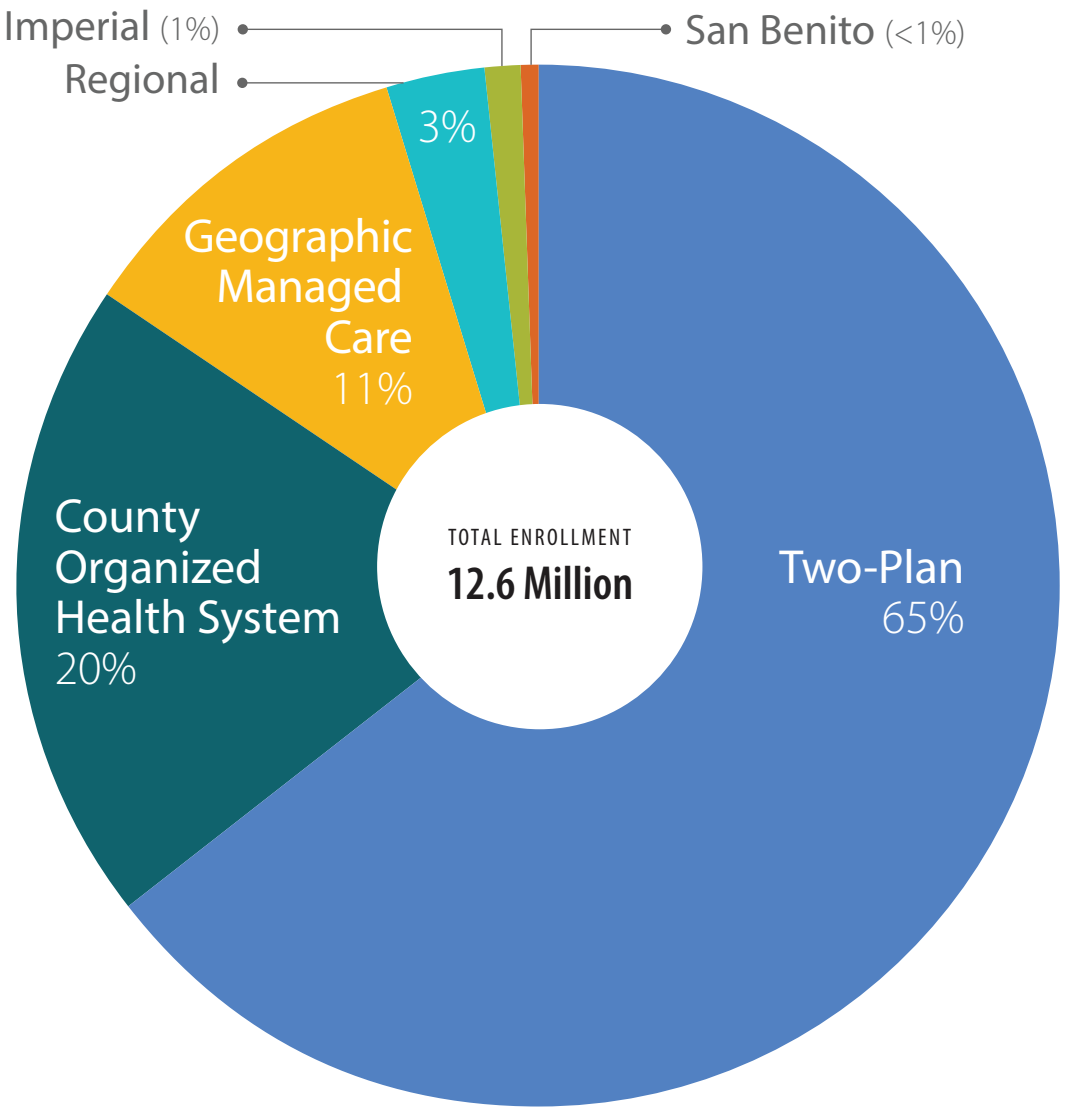


Note: Enrollment is as of October of each year.

Source: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency, accessed March 10, 2023.

The majority of Medi-Cal enrollees were in managed care plans. The share of enrollees in fee-for-service Medi-Cal decreased between 2015 and 2022.

Medi-Cal Managed Care Enrollment, by Model, 2022



Notes: Enrollment as of June. Figures may not sum due to rounding. For more information on plan models, see *Medi-Cal Managed Care Plan Model Fact Sheet*, California Dept. of Health Care Services (DHCS).

Source: *Medi-Cal Managed Care Enrollment Report*, DHCS, accessed June 21, 2023.

The Medi-Cal program offers a variety of managed care models. The Two-Plan Model, in which a government-run local initiative competes with a private plan, accounted for 65% of managed care enrollment.

Medi-Cal Long-Term Services and Supports

Medi-Cal prioritizes keeping seniors and people with disabilities living in the community with various long-term services and supports programs.

Medi-Cal enrollees who have a disability or chronic illness 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).

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

Some enrollees with higher incomes may pay a share of the cost of a stay in a skilled nursing facility.

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 managed care plans are responsible for some LTSS, including institutional long-term care (stays in a skilled nursing facility), Community-Based Adult Services (CBAS), Enhanced Care Management, and optional Community Supports. The remaining LTSS are covered under waiver programs. Under the CalAIM Managed Long-Term Services and Support initiative, the managed care plan is the single point of accountability for referral, coordination, and delivery of LTSS.

Medi-Cal spent $23.2 billion on long-term care in FY 2020–21, including more than $3 billion on long-term care in skilled nursing facilities.

Sources: Athena Chapman and Elizabeth Evenson, *Long-Term Services and Supports in Medi-Cal*, California Health Care Foundation (CHCF), 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, last revised January 2021; "Integrated Care: What Choices Exist for Californians with Medicare and Medi-Cal?," SCAN Foundation, last updated October 16, 2019; "Distribution of Fee-for-Service Medicaid Spending on Long Term Care" (FY 2021), KFF, accessed June 22, 2023; and Athena Chapman and Elizabeth Evenson, *Medi-Cal Managed Care and Long-Term Services and Supports: Opportunities and Considerations Under CalAIM*, CHCF, March 2023.

Coordinating Care for Enrollees in Medi-Cal and Medicare

The Coordinated Care Initiative (CCI) was adopted in July 2012 and implemented in seven counties* beginning in 2014 to better serve the state's seniors with low incomes and people with disabilities. CCI began the process of integrating delivery of medical, behavioral, and long-term care services for this population. This program laid the groundwork for statewide changes now being implemented under CalAIM.

Effective January 1, 2023, enrollees dually eligible for Medi-Cal and Medicare must enroll in a Medi-Cal managed care plan.

DHCS intends to implement Managed Long-Term Services and Support statewide by 2027, including the institutional long-term care carve-in and long-term services and supports benefits provided by managed care plans under Enhanced Care Management and Community Supports.

DHCS has established an Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (EAE D-SNP), also referred to as Medicare Medi-Cal Plans (MMP, or Medi-Medi Plans). The EAE D-SNPs replaced the plans in the seven counties that initially participated in the CCI program on January 1, 2023. Under CalAIM, all contracted Medi-Cal managed care plans must have an EAE D-SNP by January 1, 2026.

Having to navigate both Medicare and Medi-Cal can confuse dually eligible enrollees about available benefits and provider networks. Current reform efforts aim to provide them more coordinated care.

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

Notes: *DHCS* is California Department on Health Care Services. DHCS conducted an EAE D-SNP feasibility study in 2022 and indicated that some plans may be eligible to request a three-year waiver from implementation of this requirement, but to date no formal delays have been announced. Some managed care plans have indicated early interest, and the EAE D-SNP model is scheduled to go live in Fresno, Kings, Madera, Sacramento, and Tulare Counties in 2024.

Sources: "Coordinated Care Initiative and Cal MediConnect," California Dept. of Health Care Services (DHCS), last modified October 3, 2022; "CalAIM Long-Term Care Carve-In Transition," DHCS, accessed on April 11, 2023; "CalAIM 1115 Demonstration & 1915(b) Waiver," DHCS, accessed on April 11, 2023; "Integrated Care for Dual Eligible Beneficiaries," DHCS, accessed on April 11, 2023; and *Medi-Cal D-SNP Feasibility Study* (PDF), DHCS, June 2022.

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 2020–21, about 4% of Medi-Cal enrollees (339,000 adults and 243,700 children and youth) received specialty mental health services.

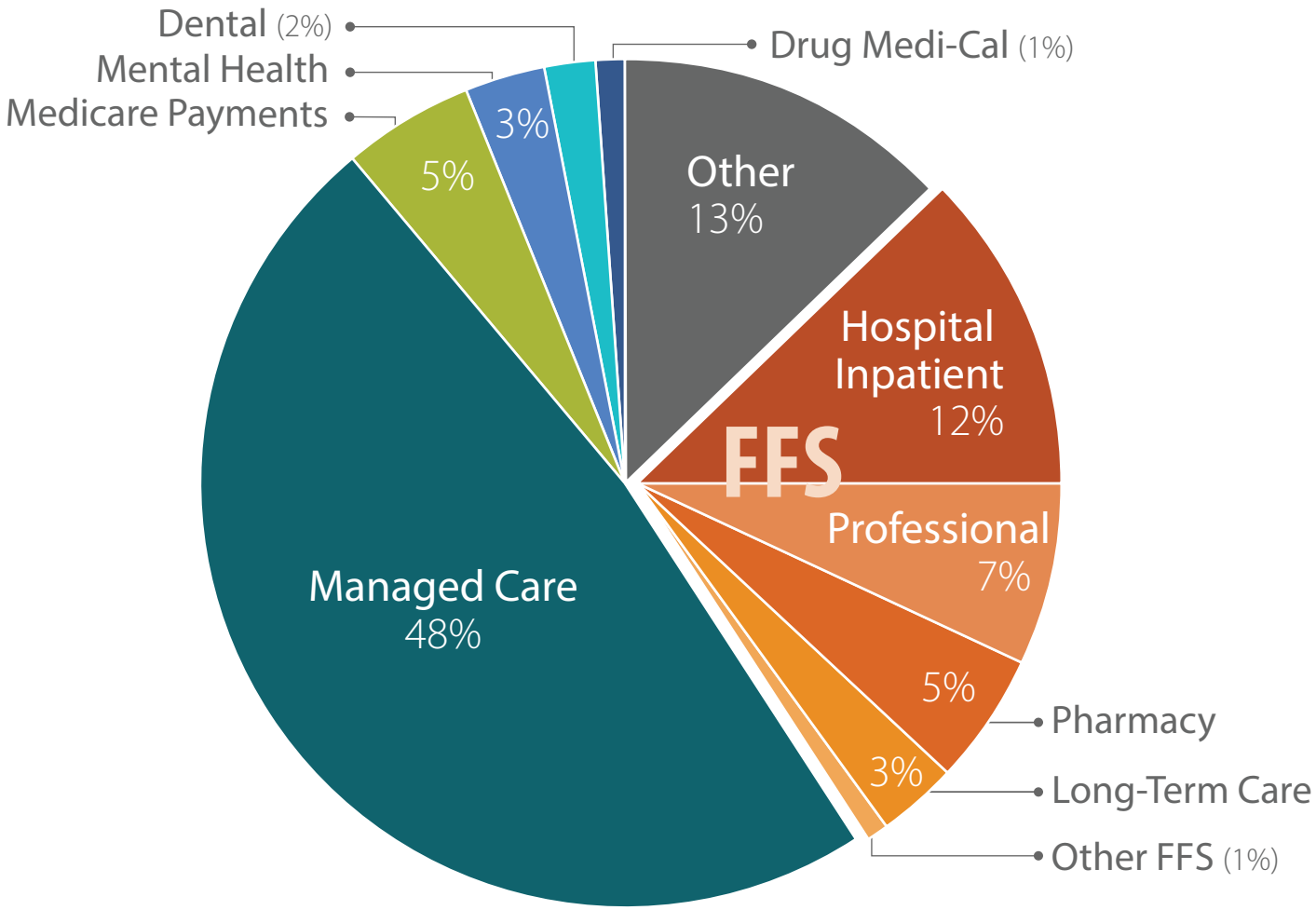
County Substance Use Disorder Programs

- Substance use disorder services are delivered by county mental health plans through the Drug Medi-Cal program. The Drug Medi-Cal Organized Delivery System (DMC-ODS), authorized as part of the CalAIM Section 1915(b) waiver and CalAIM Section 1115 demonstration, is aimed at improving care, increasing efficiency, and reducing societal and health care costs associated with substance use.
- 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.

Medi-Cal enrollees can receive mental health care from two different systems: a Medi-Cal managed care plan or a county mental health plan. In 2022, DHCS implemented a "no wrong door" policy so enrollees can receive mental health care regardless of where they seek care (e.g., via county mental health or their Medi-Cal managed care plan).

Sources: "Drug Medi-Cal Organized Delivery System," California Dept. of Health Care Services (DHCS), accessed on April 11, 2023; and "Mental Health Services Performance Dashboard," DHCS, accessed February 13, 2023.

Medi-Cal Expenditures
by Service Category, FY 2021–22



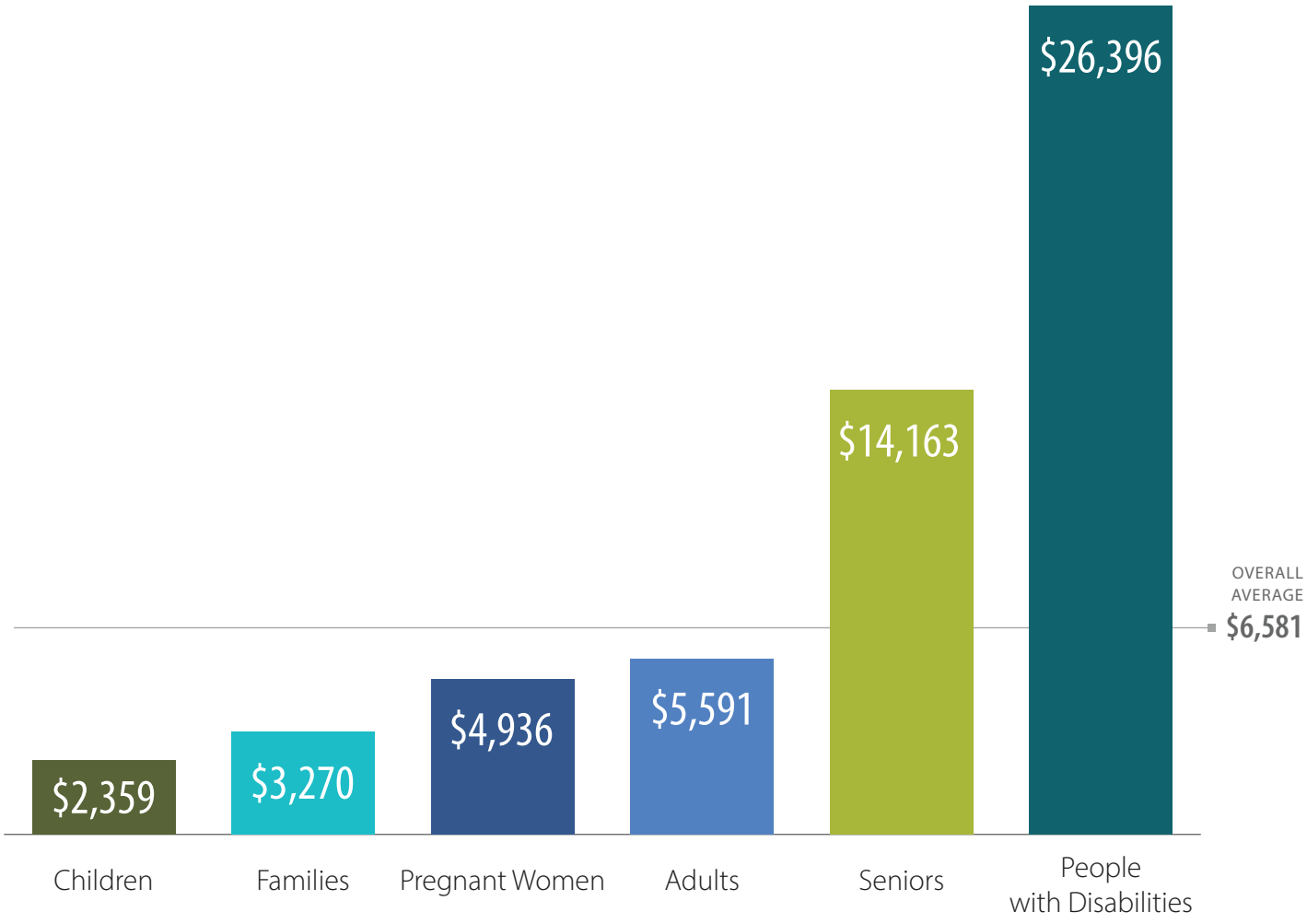
Notes: Figures presented are estimates for the 2021–22 fiscal year calculated as of May 2022 and reflect annual spending. *Drug Medi-Cal* provides services to treat enrollees with substance use disorders. *FFS* is fee-for-service. *Other FFS* services includes medical transportation, home health, and other FFS services. *Other* includes audits, lawsuits, state hospitals / developmental centers, recoveries, and miscellaneous services. Figures may not sum due to rounding.

Source: *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Dept. of Health Care Services, accessed March 10, 2023.

Managed care was the largest service category for the Medi-Cal program, accounting for nearly half of all expenditures. Hospital inpatient services, paid on a fee-for-service basis, was the next largest category, accounting for 12% of Medi-Cal spending.

Medi-Cal Annual Spending per Eligible Enrollee

FY 2021–22

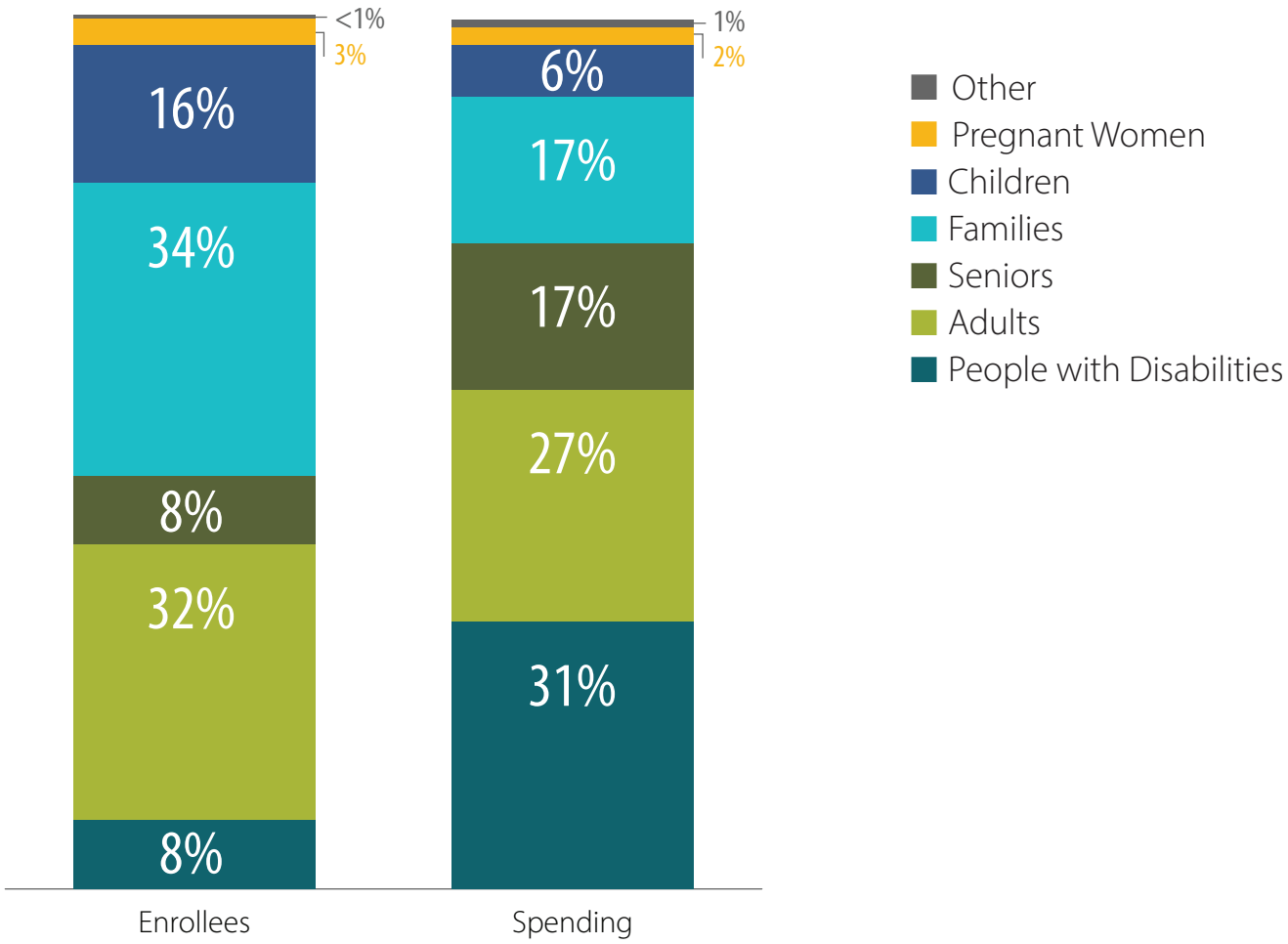


Notes: Figures are estimates for the fiscal year 2021–22 calculated as of May 2022. Reported values exclude Hospital Presumptive Eligibility and other aid codes totaling 0.3% of enrollees.

Source: *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Dept. of Health Care Services, accessed March 10, 2023.

Medi-Cal spending per enrollee varied by eligibility category. In FY 2021–22, Medi-Cal spent about $2,400 annually per child and over $26,000 per enrollee with disabilities.

Medi-Cal Enrollees and Spending
FY 2021–22



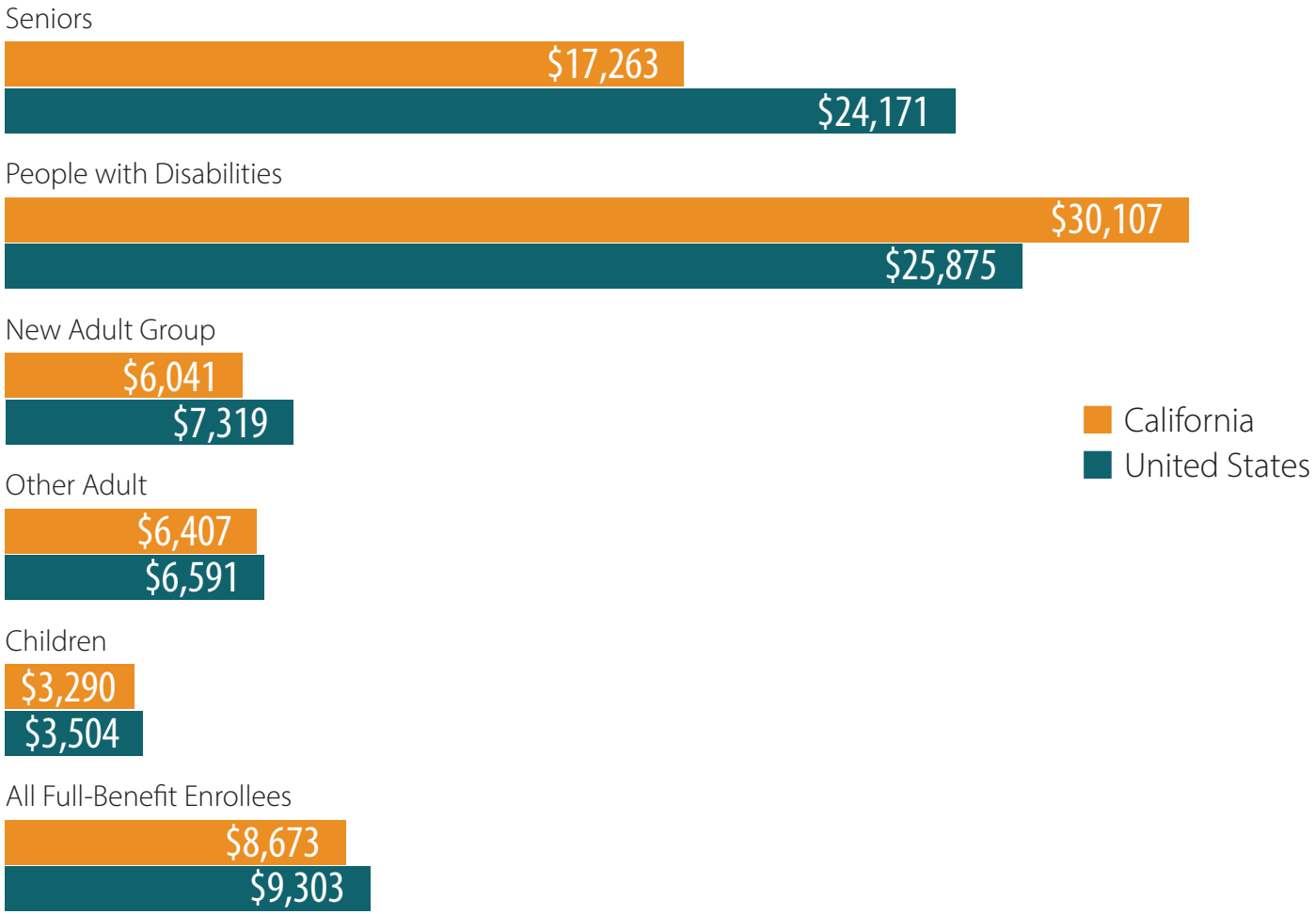
Notes: Figures are estimates for fiscal year 2021–22 calculated as of May 2022. Figures may not sum due to rounding. *Other* includes Hospital Presumptive Eligibility and other aid codes. For additional information about Medi-Cal spending on maternity care, please see CHCF's report *Maternity Care and Paying for Maternity Services*.

Source: Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23 (PDF), California Dept. of Health Care Services, accessed March 10, 2023.

People with disabilities represented 8% of Medi-Cal enrollees yet accounted for 31% of spending. Meanwhile, children accounted for 16% of enrollees and just 6% of spending.

Medicaid Spending per Full-Year Equivalent Enrollees

California vs. United States, FY 2020



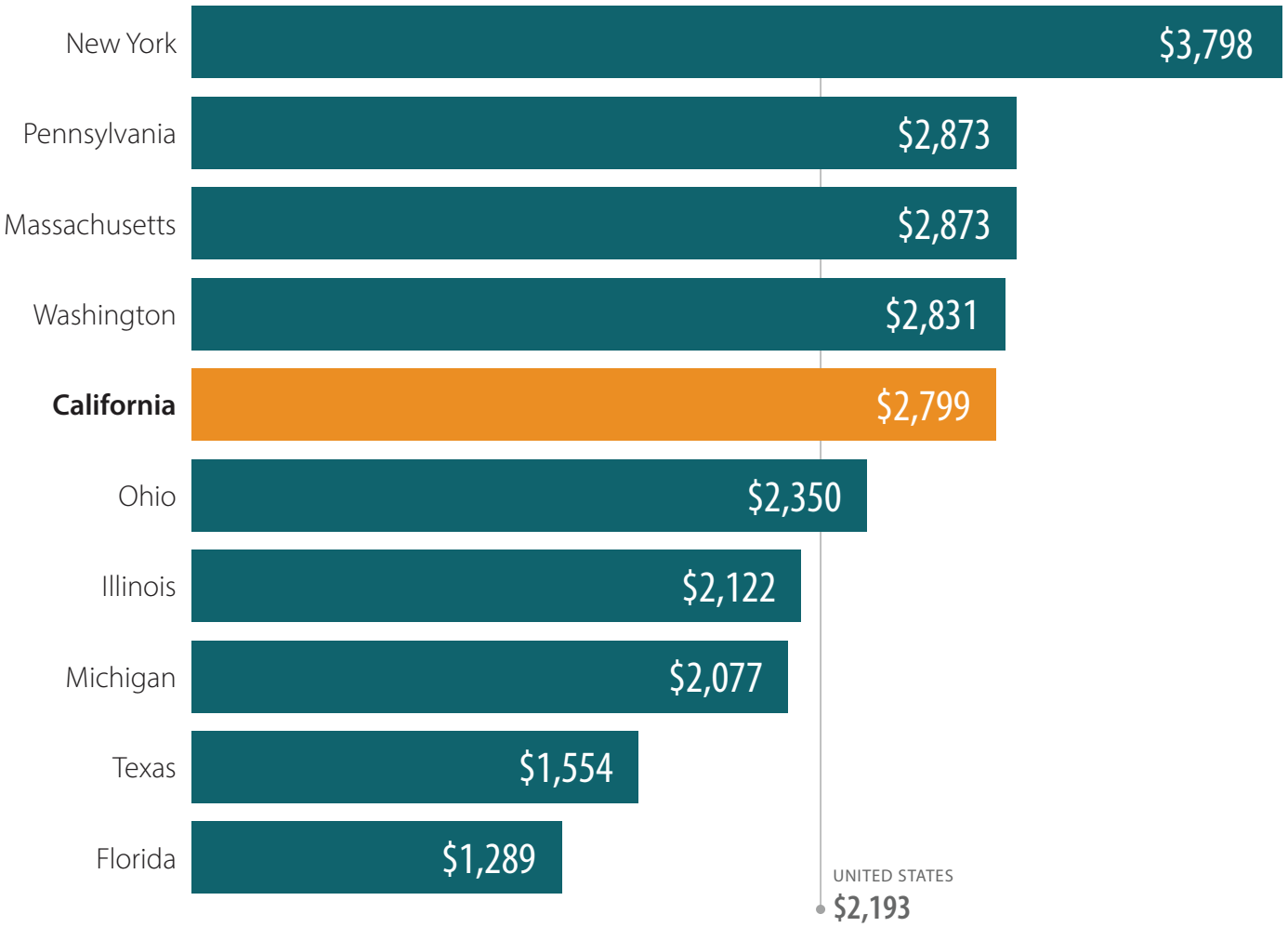
Notes: Full-year equivalent may also be referred to as average monthly enrollment. Data are for full-benefit enrollees and exclude those receiving coverage for only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. *New adult group* is the ACA expansion population. *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 women).

Source: "Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2020," exhibit 22 in *MACStats: Medicaid and CHIP Data Book*, Medicaid and CHIP Payment and Access Commission.

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

Medicaid Spending per Resident

Selected States, FY 2021



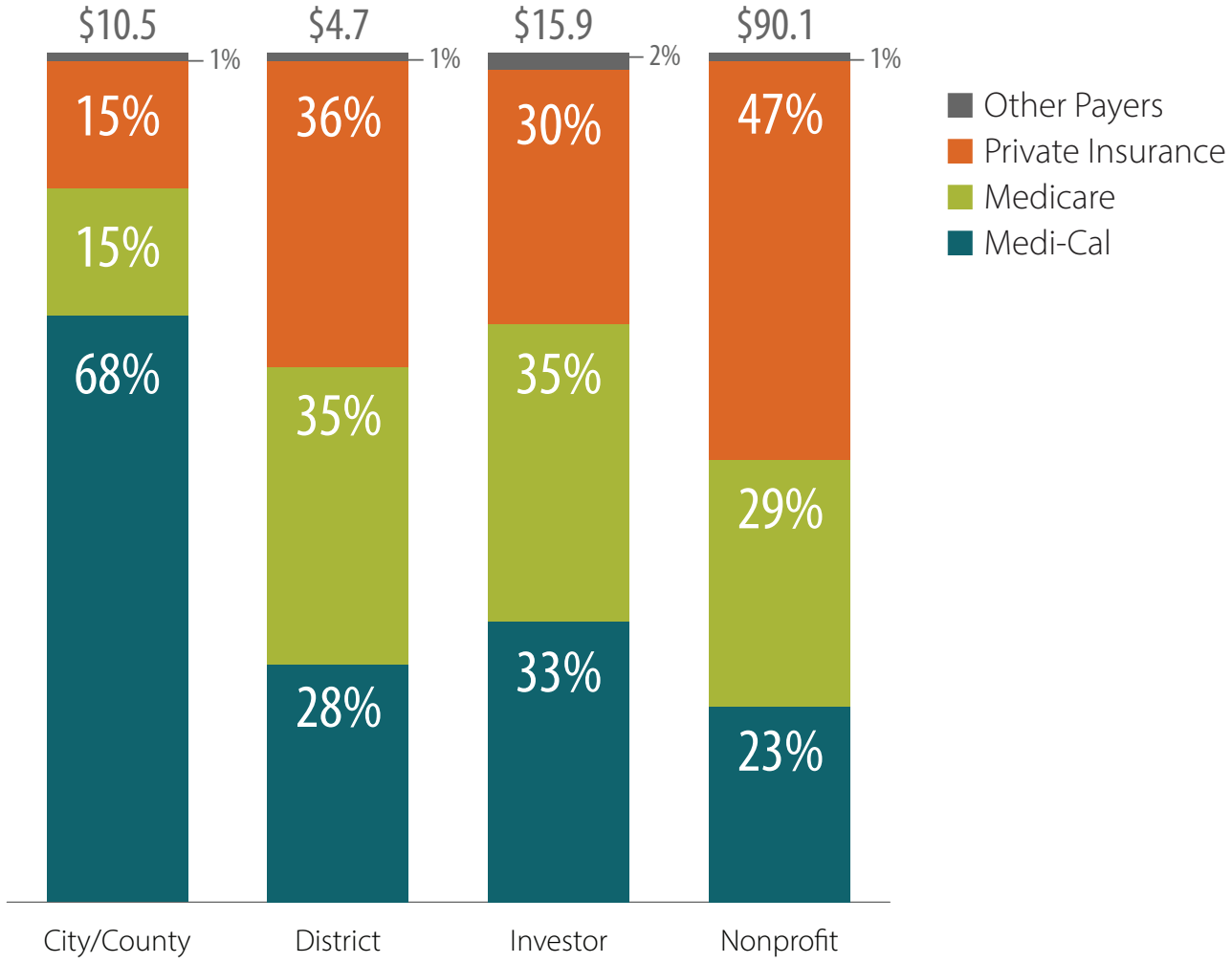
Note: Data are for states with the largest Medicaid expenditures in FY 2021.

Sources: Author calculation based on "Total Medicaid Spending" (FY 2021), KFF, accessed March 10, 2023; and "State Population Totals and Components of Change: 2020-2022," US Census Bureau, accessed March 10, 2023.

California's Medicaid spending per resident ($2,799) was higher than the national average ($2,193).

Net Patient Revenues
by Hospital Ownership Type and Payer, 2021

DOLLARS IN BILLIONS

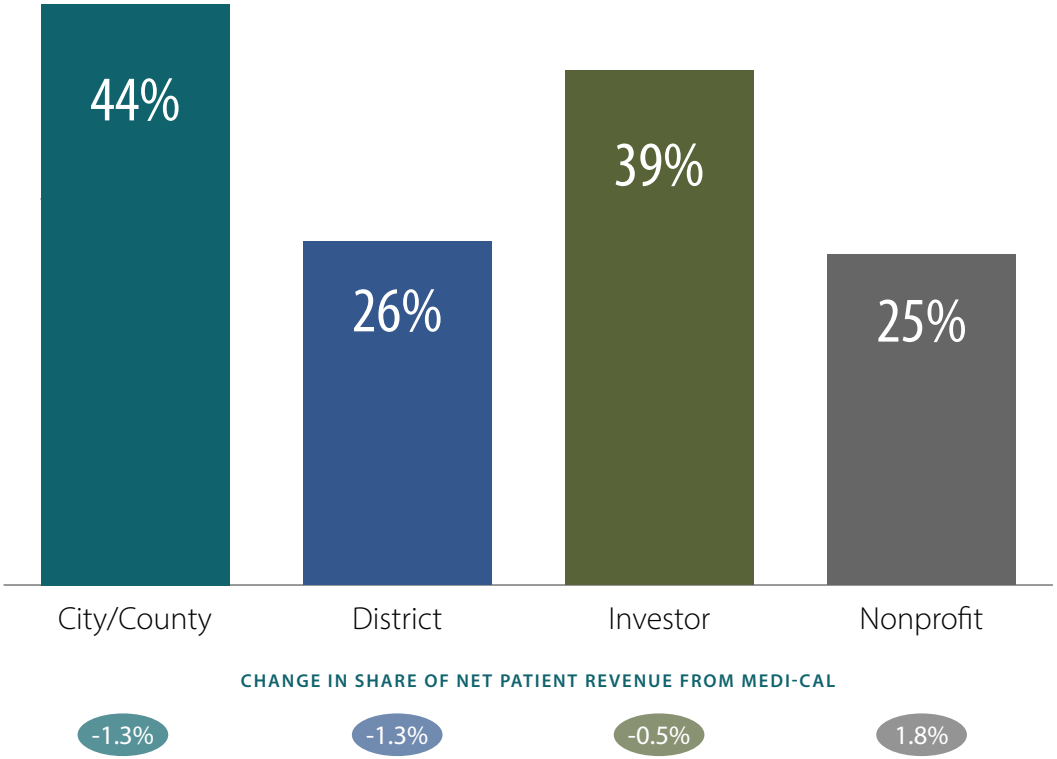


Notes: Includes fee-for-service and managed care. Data are only for hospitals classified as comparable and thus do not include state-run and Kaiser hospitals or facilities classified as psychiatric or long-term care. Traditional and managed care are included. *Private insurance* is *other third party* in the source. *Other payers* includes county indigent programs and other payers. Figures may not sum due to rounding.

Source: *2021 Pivot Table - Hospital Annual Selected File (April 2023 Extract)*, California Health and Human Services Agency, last updated April 28, 2023.

Medi-Cal is a key source of funding for hospitals. Medi-Cal accounted for two-thirds of net patient revenues for city/county hospitals and one-third for investor-owned hospitals.

Change in Medi-Cal Net Patient Revenue
by Hospital Ownership Type, 2015 to 2021



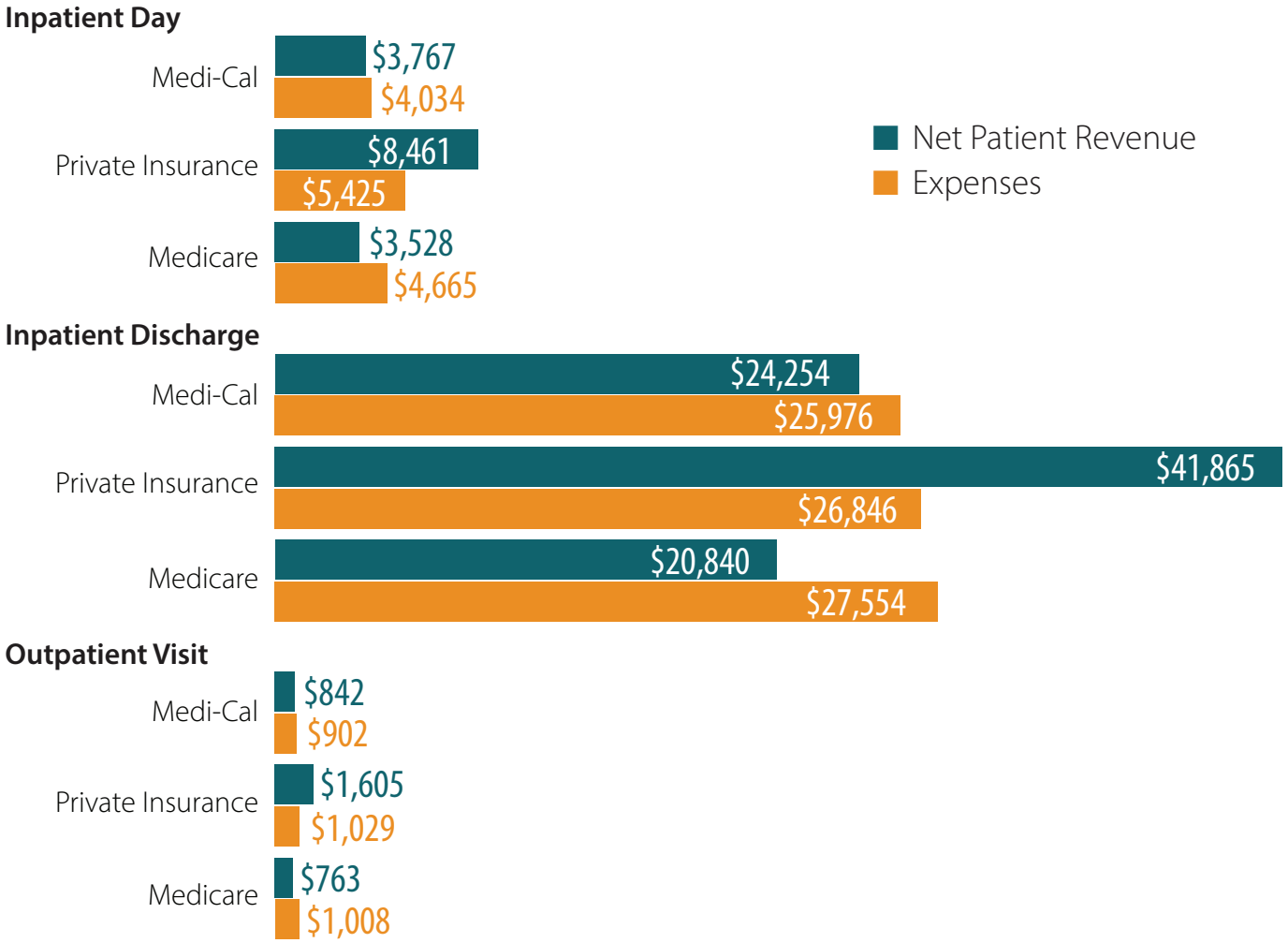
All hospital types experienced growth in Medi-Cal revenue between 2015 and 2021. City/county hospitals experienced the largest increase in Medi-Cal revenue (44%). During the same time, Medi-Cal's share of total net patient revenues across all hospitals was relatively unchanged.

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.

Sources: *2015 Pivot Table Hospital Annual Selected File*, California Health and Human Services Agency (CalHHS), last updated May 3, 2018; and *2021 Pivot Table - Hospital Annual Selected File (April 2023 Extract)*, CalHHS, last updated April 28, 2023.

Net Patient Revenue and Expenses
by Payer, 2021

NET PATIENT REVENUE AND EXPENSES PER...



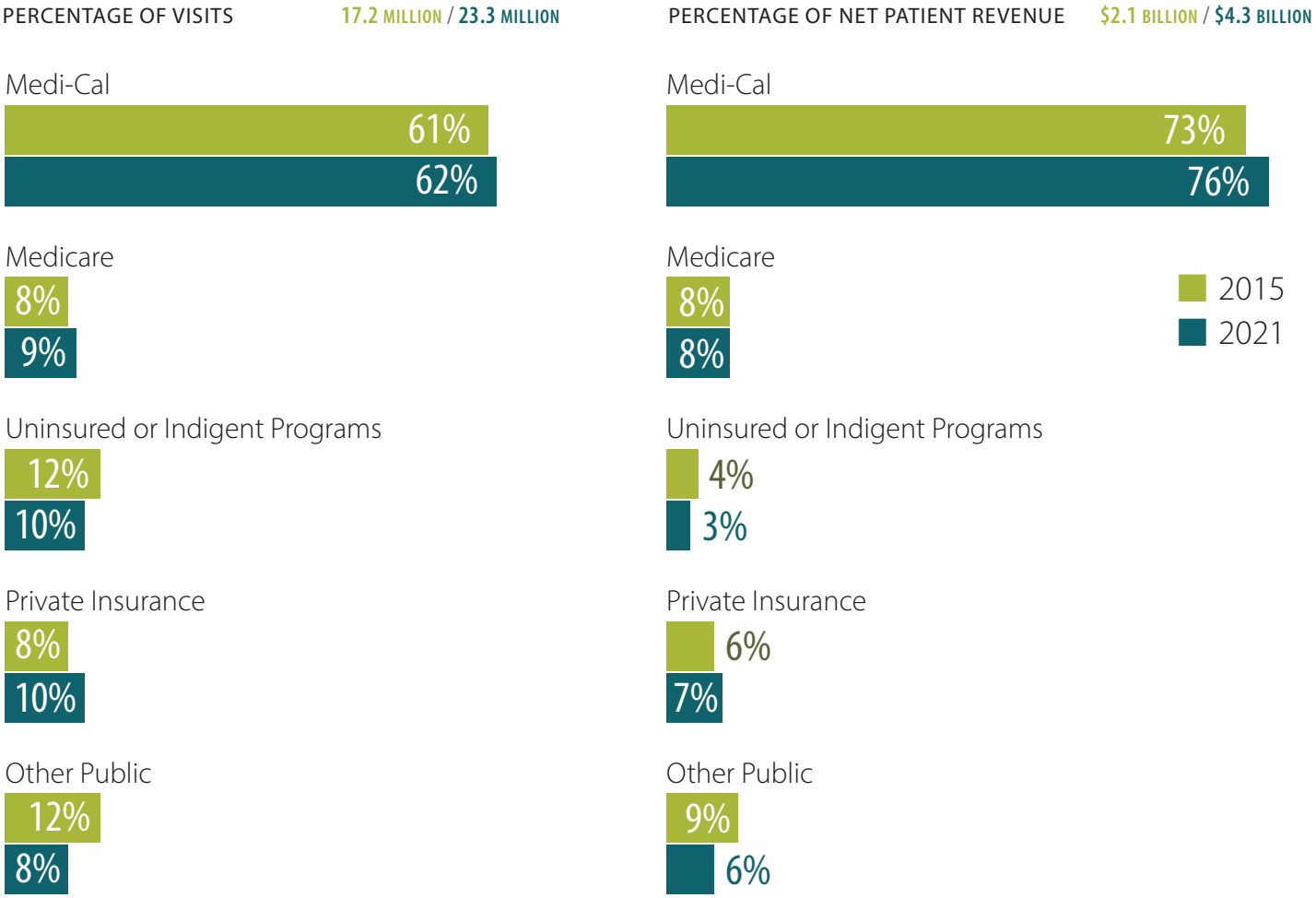
Notes: Data include only hospitals classified as "general acute." *Net patient revenue* is net patient revenue and excludes "other operating" and "other revenues," such as supplemental grants from federal, state, or local governments or private institutions. Net patient revenues per inpatient day, discharge, and outpatient visit are reported by the California Health and Human Services Agency. Inpatient expenses were calculated by multiplying the share of gross inpatient revenue by the operating expenses. Outpatient expenses were calculated by multiplying the share of gross outpatient revenue by the operating expenses. Private insurance is *Other third party* in the source.

Source: Blue Sky Consulting Group analysis of *2021 Pivot Table - Hospital Annual Selected File (April 2023 Extract)*, California Health and Human Services Agency, last updated April 28, 2023.

Net patient revenue per patient day was lower for Medi-Cal than for private insurance. Medi-Cal net revenue per outpatient visit was about half that of private insurance. Although hospitals' net revenues from private insurance exceeded related expenses, net patient revenues from both Medi-Cal and Medicare were less than expenses incurred.

Primary Care Community Clinic Visits and Net Patient Revenue
by Payer, 2015 and 2021

Medi-Cal accounted for the majority of primary care clinic visits and revenue.

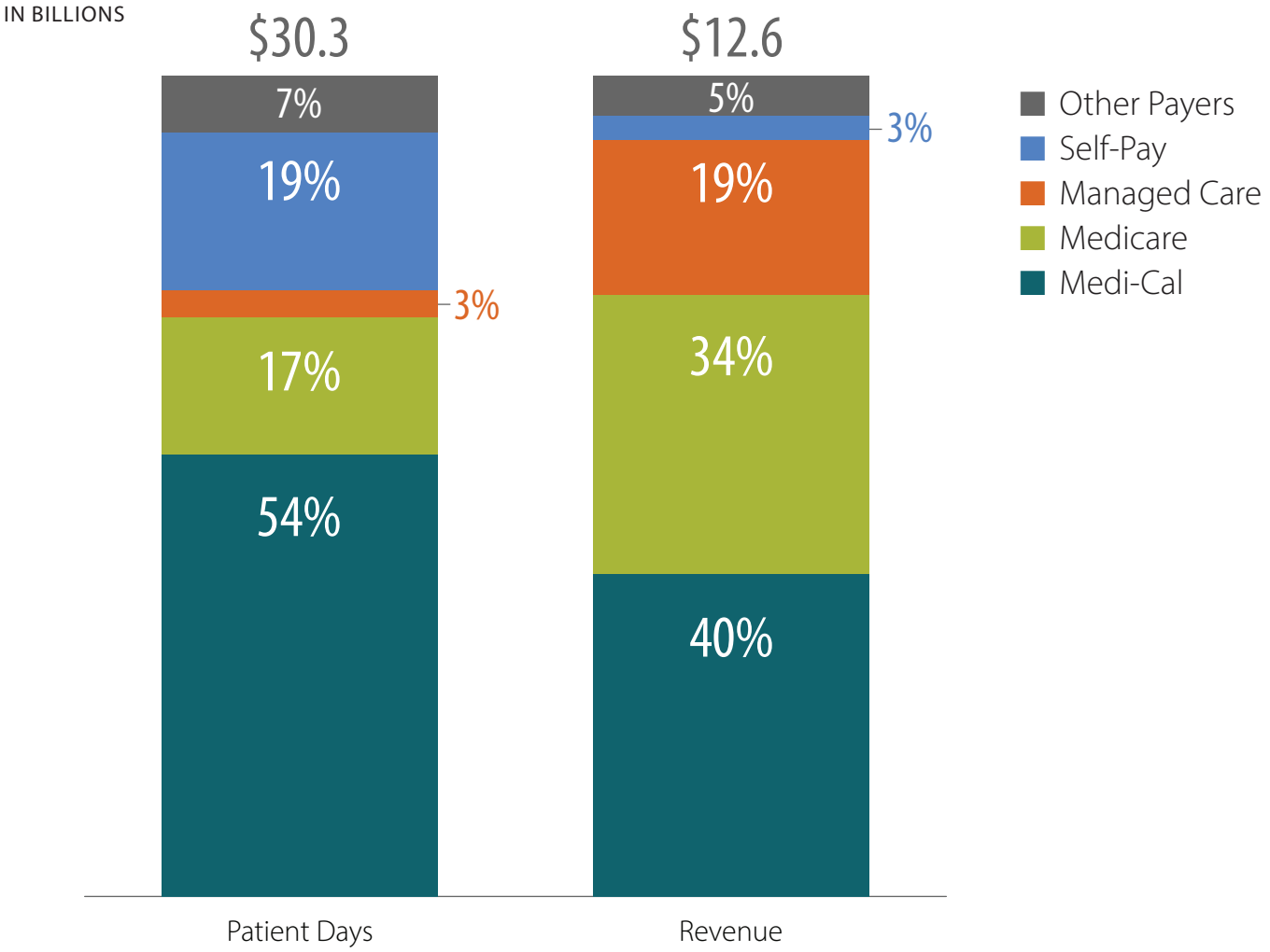


Notes: Includes Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and other clinic types. Uninsured and indigent coverage are combined due to data-reporting inconsistencies, and include self-pay / sliding scale, free, and county indigent program patients. *Other public* includes Family PACT and all other payers, except for Program of All-Inclusive Care for the Elderly, which is excluded from all categories. Excludes county-run clinics and clinics with 90% or more dental visits. Segments may not sum due to rounding.

Source: Blue Sky Consulting Group analysis of *2021 Pivot Table - Primary Care Clinic Utilization*, California Health and Human Services Agency (CalHHS), December 1, 2022, and 2015 Pivot Table - Primary Care Utilization Data, CalHHS, May 8, 2018.

Net Patient Revenue and Patient Days, Long-Term Care Facilities
by Payer, 2021

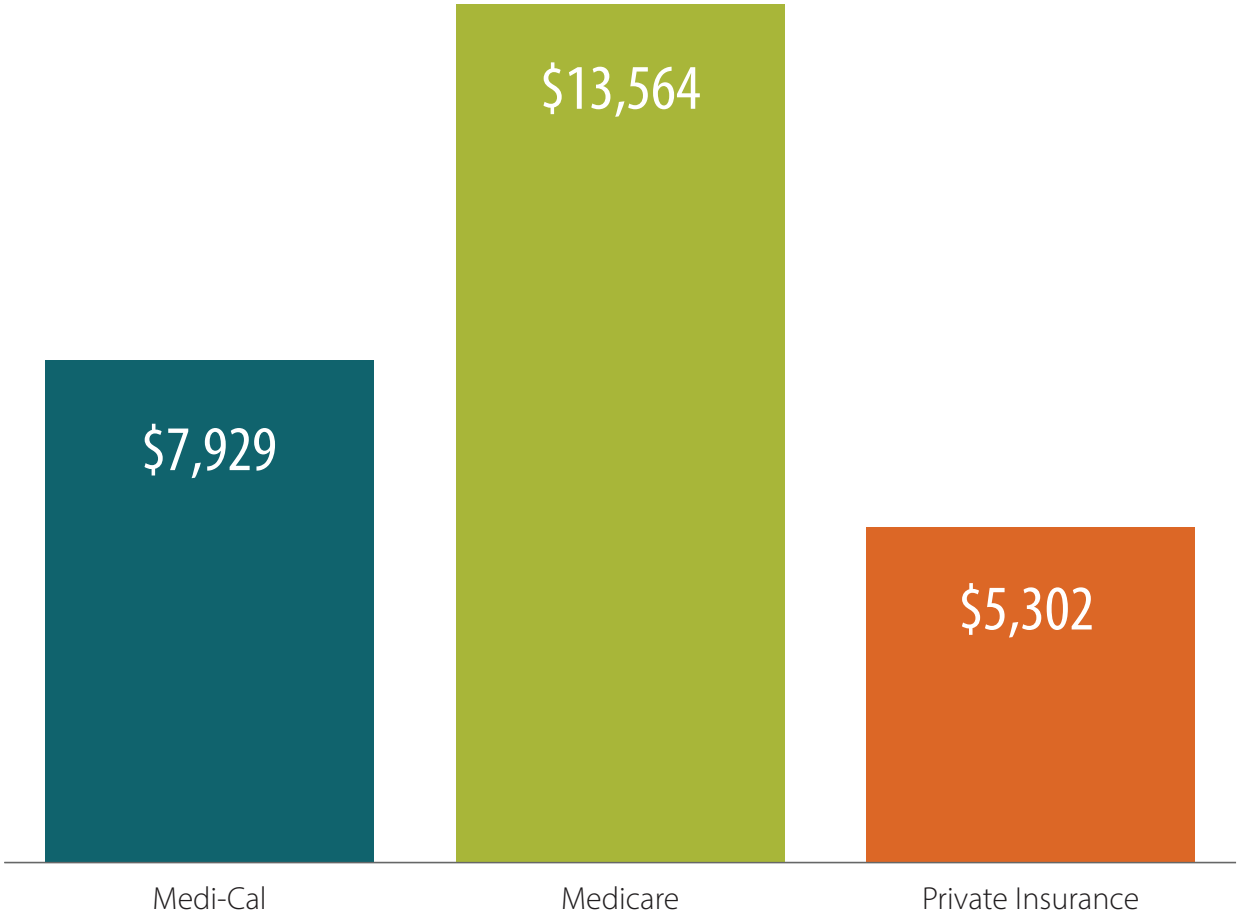
Medi-Cal accounted for 54% of patient days and nearly 40% of net patient revenue at long-term care facilities in 2021.



Notes: *Long-term care facilities* includes those facilities providing subacute and intermediate care, skilled nursing, and facilities for the developmentally disabled. *Managed care* includes health maintenance organizations, HMOs with point-of-service option, preferred provider organizations, exclusive provider organizations (EPOs), EPOs with point-of-service option, Medicare, and Medi-Cal managed care. Figures may not sum due to rounding.

Source: *2021 Pivot Profile (As Submitted) - Long-Term Care Annual Financial Data (September 2022 Extract)*, California Health and Human Services Agency, last updated October 4, 2022.

Health Care Spending per Enrollee
by Payer, California, 2020

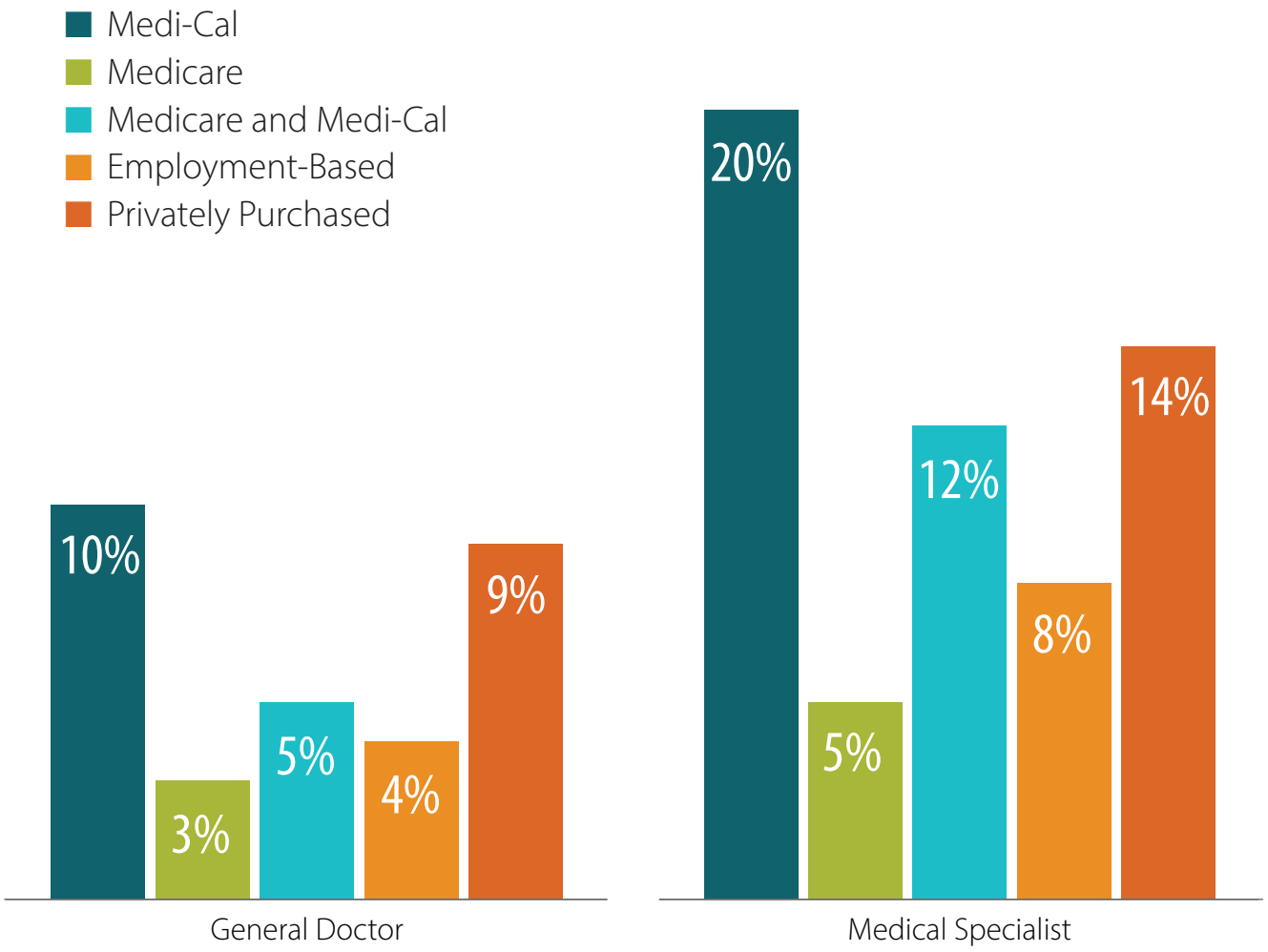


In 2020, annual health spending per Medi-Cal enrollee was 40% lower than health spending per Medicare enrollee and 50% higher than health spending per private insurance enrollee.

Source: "Health Expenditures by State of Residence, 1991-2020," Centers for Medicare & Medicaid Services, accessed March 13, 2023.

Insurance Not Accepted by Provider
by Source of Coverage, Adults, California, 2021

SHARE OF ADULTS WHOSE INSURANCE WAS NOT ACCEPTED BY THEIR PROVIDER



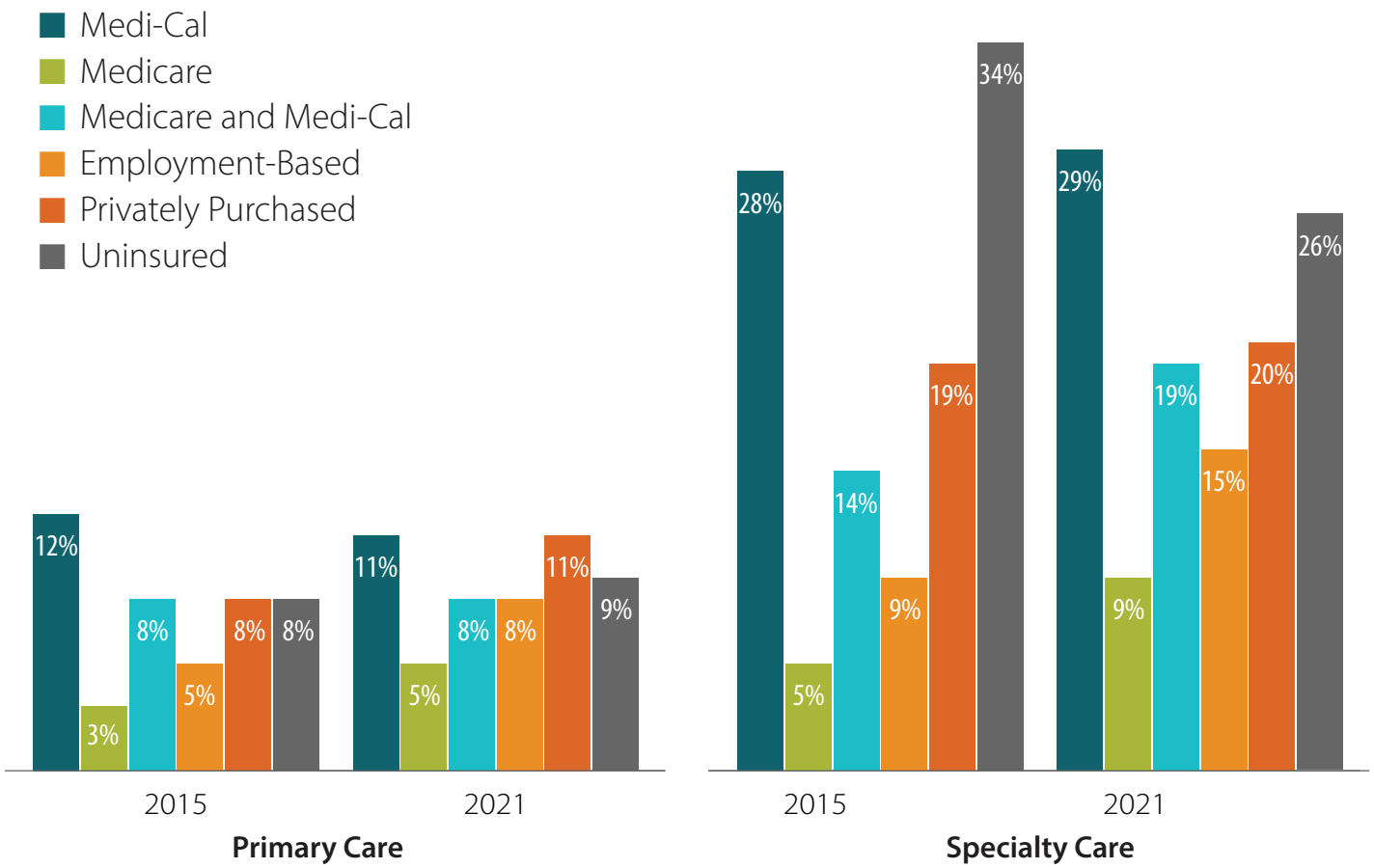
Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*. *Specialist* results are for currently insured respondents who needed to see a medical specialist in the past year.

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

Adults enrolled in Medi-Cal were more than twice as likely to report difficulty finding a provider that accepted their insurance compared to those with employment-based insurance or Medicare. This pattern held for both general doctors and medical specialists.

Difficulty Finding Primary and Specialty Care
by Source of Coverage, 2015 and 2021

PERCENTAGE OF ADULTS WHO HAD DIFFICULTY FINDING PRIMARY AND SPECIALTY CARE



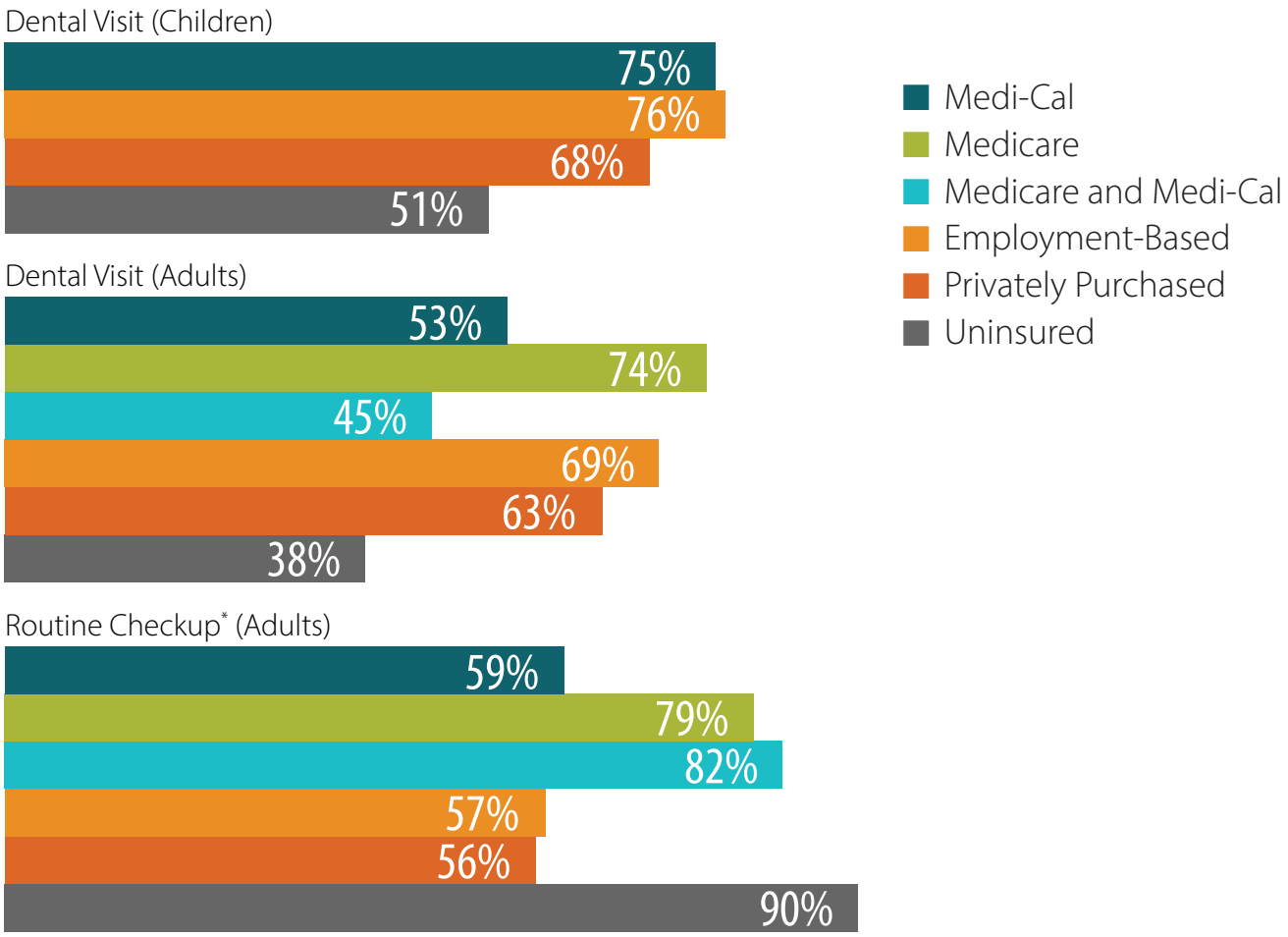
Notes: Insurance status is self-reported. *Specialist* results are for currently insured respondents who needed to see a medical specialist in the past year. *Medicare* includes *Medicare only* and *Medicare and other*.

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

Between 2015 and 2021, most respondents across all insurance types reported more difficulty finding both primary care and specialty care providers. In 2021, more than one in 10 Medi-Cal enrollees had difficulty finding primary care and more than one in four had difficulty finding a specialist. Medi-Cal enrollees continue to report the greatest difficulty finding a primary care provider or specialist.

Preventive Care Visits
by Source of Coverage, California, 2021

PERCENTAGE WHO HAD THE FOLLOWING PREVENTIVE CARE WITHIN THE PAST YEAR



Medi-Cal enrollees reported having a routine checkup at roughly the same rate as those with employment-based or private insurance. Adult Medi-Cal enrollees were less likely to have visited a dentist within a 12-month period, compared to those with employer-based or privately purchased insurance.

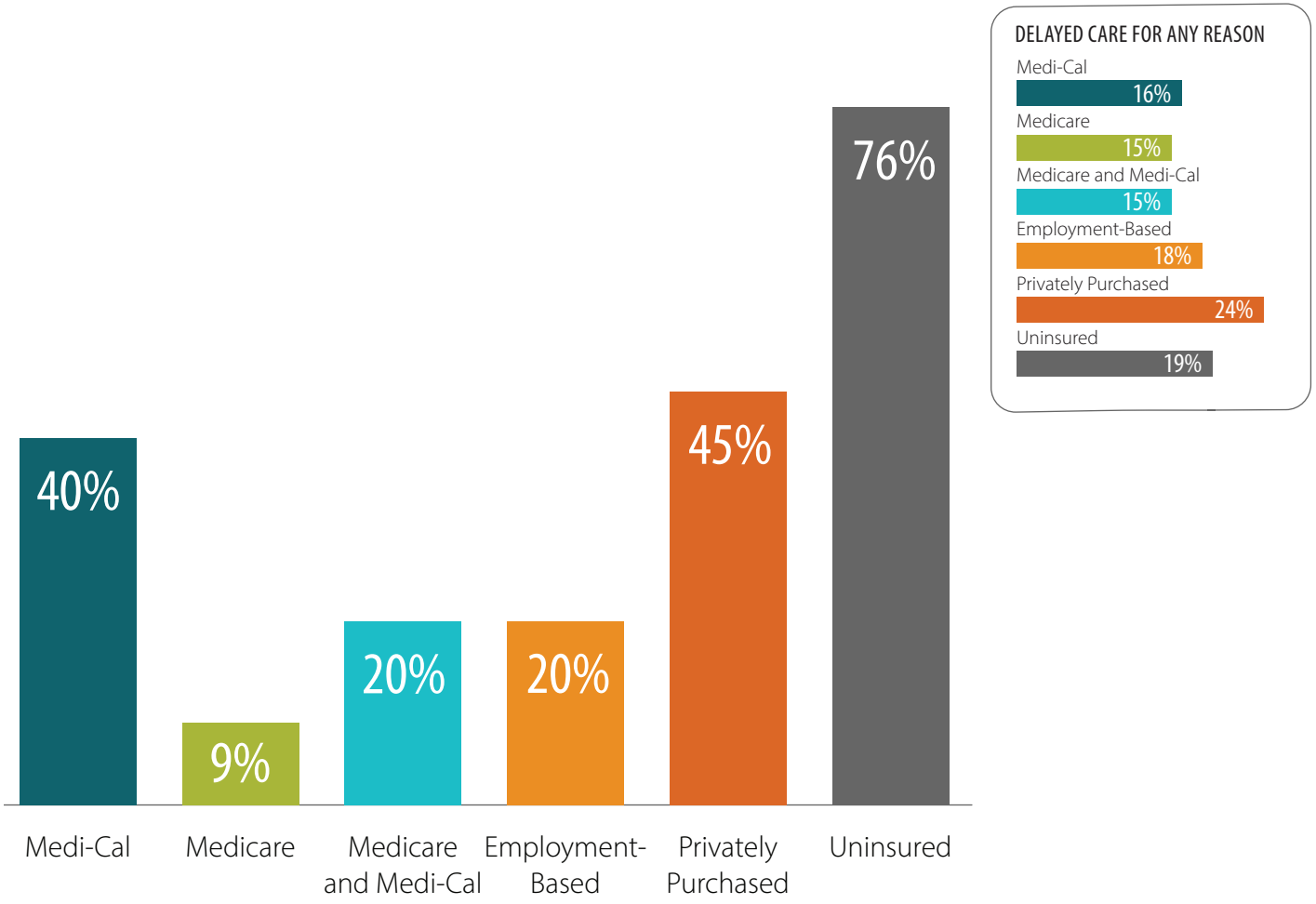
* With a doctor or medical provider.

Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

Delay of Care
by Source of Coverage, California, 2021

OF THOSE THAT DELAYED CARE, SHARE WHO CITED COST OR LACK OF INSURANCE AS THE REASON



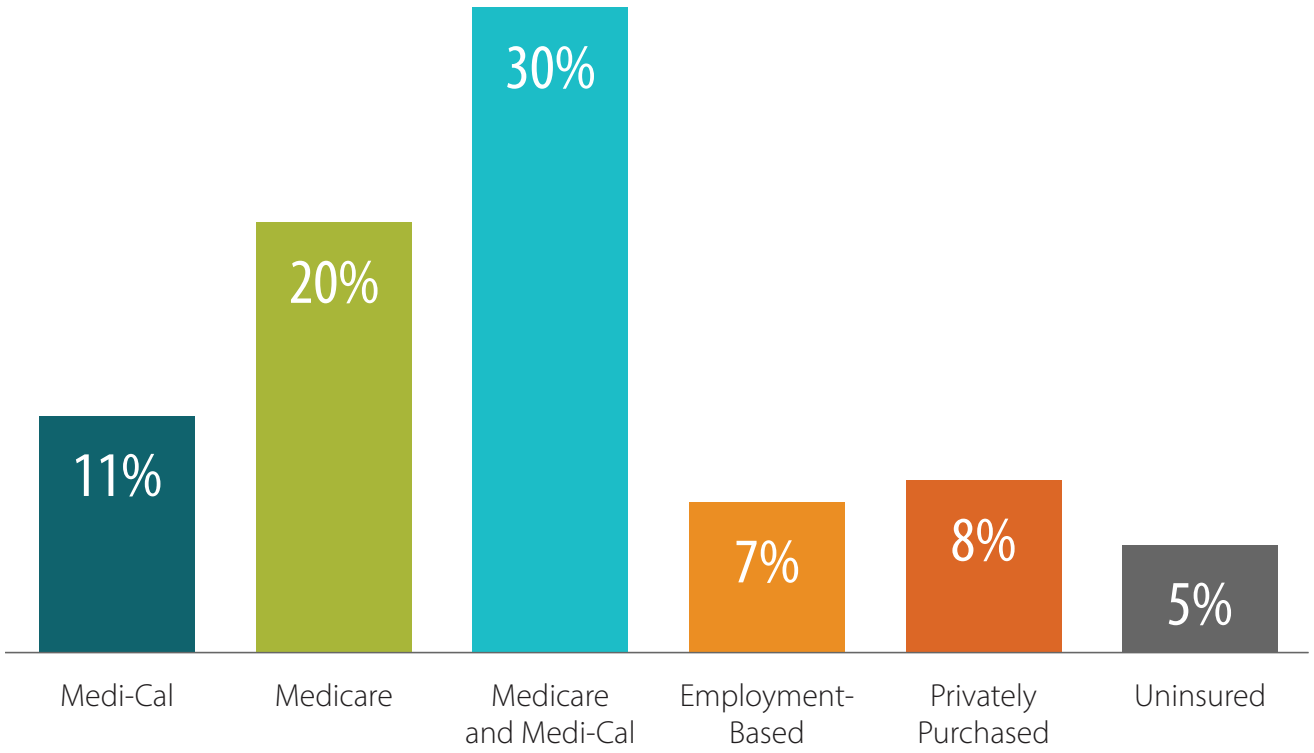
Notes: Delayed care due to cost or lack of insurance question was asked only of respondents who delayed or did not get other needed medical care in the past 12 months. Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

Sixteen percent of Medi-Cal enrollees reported delaying care. Among those who delayed care, 40% of Medi-Cal enrollees reported cost or lack of insurance as reasons for delaying care.

Diabetes
by Source of Coverage, California, 2021

ADULTS EVER DIAGNOSED WITH DIABETES



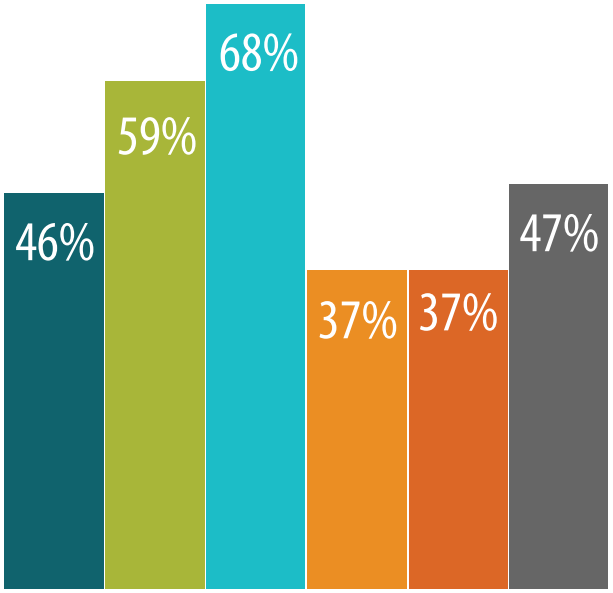
Notes: Adults only. Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

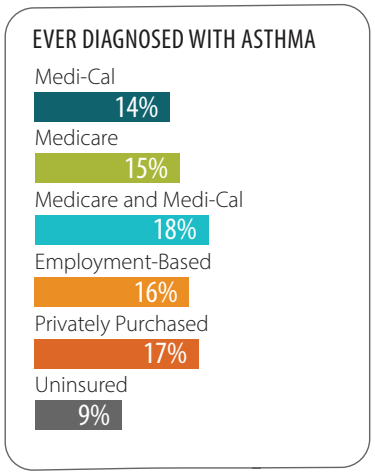
About one in nine Medi-Cal enrollees reported having diabetes.

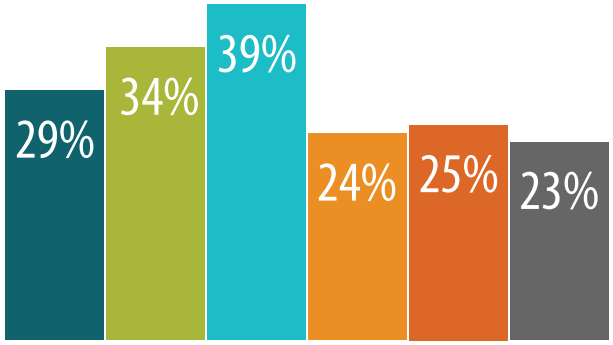
Asthma
by Source of Coverage, California, 2021

- 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

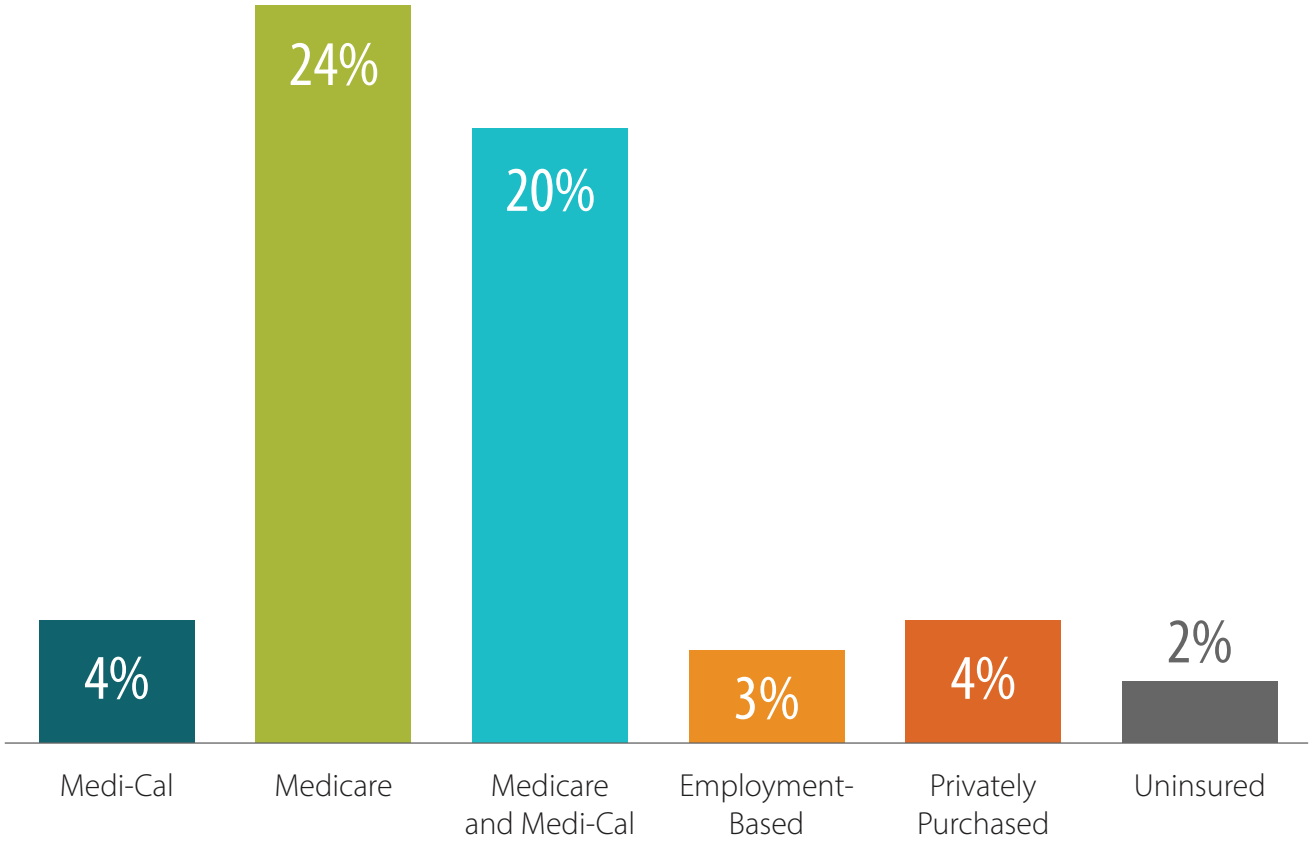
Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

Nearly one in two Medi-Cal enrollees diagnosed with asthma took daily medication, and more than one in four reported they had an asthma attack in the past 12 months.

Heart Disease
by Source of Coverage, 2021

ADULTS EVER DIAGNOSED WITH HEART DISEASE



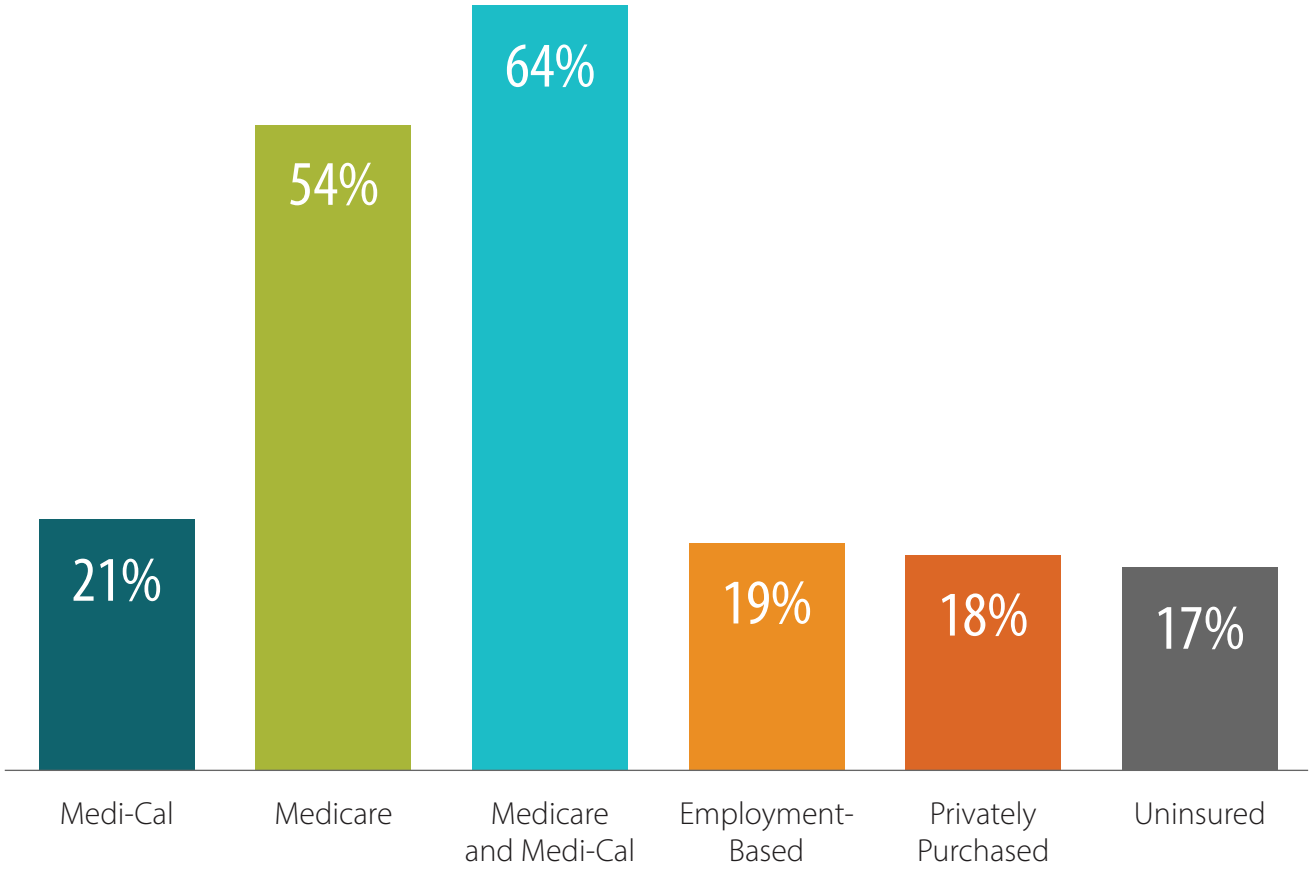
Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

Medi-Cal enrollees were diagnosed with heart disease at roughly the same rate as those with employment-based or privately purchased health insurance.

High Blood Pressure
by Source of Coverage, 2021

ADULTS EVER DIAGNOSED WITH HIGH BLOOD PRESSURE



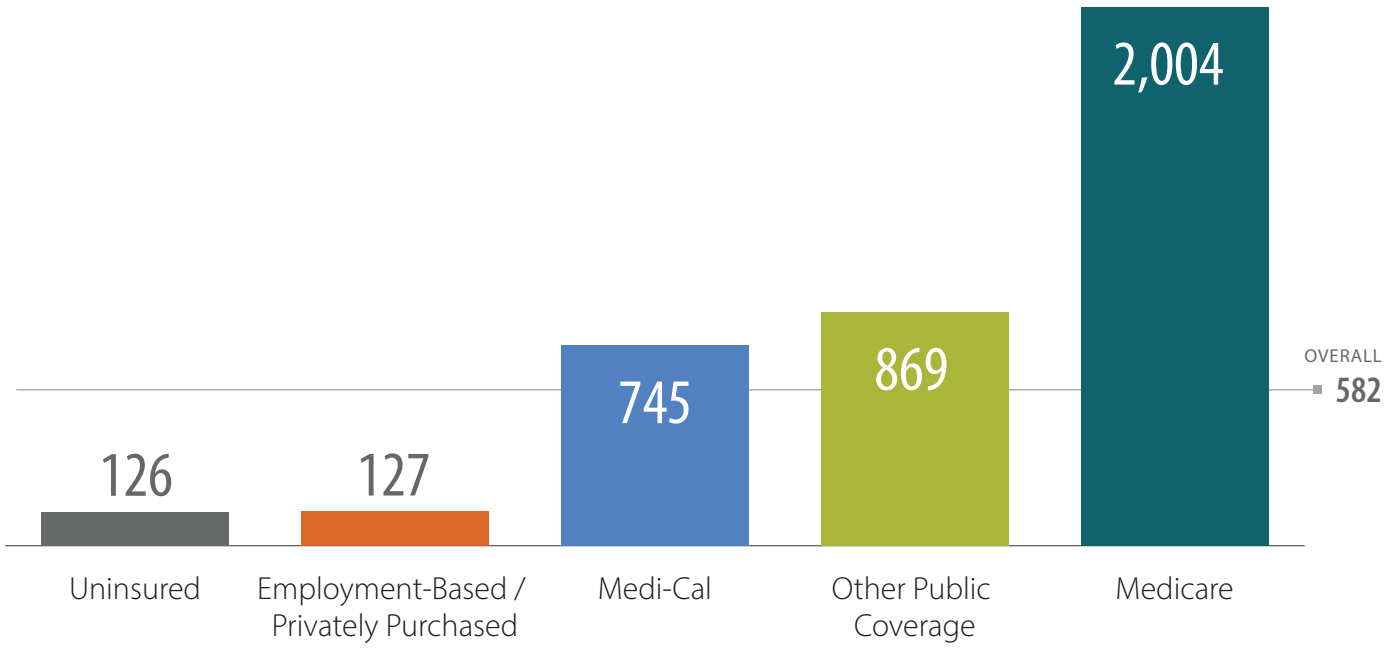
Notes: Insurance status is self-reported. *Medicare* includes *Medicare only* and *Medicare and other*.

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

About one in five Medi-Cal enrollees reported having been diagnosed with high blood pressure.

Preventable Hospitalizations
by Source of Coverage, California, 2021

PER 100,000 POPULATION



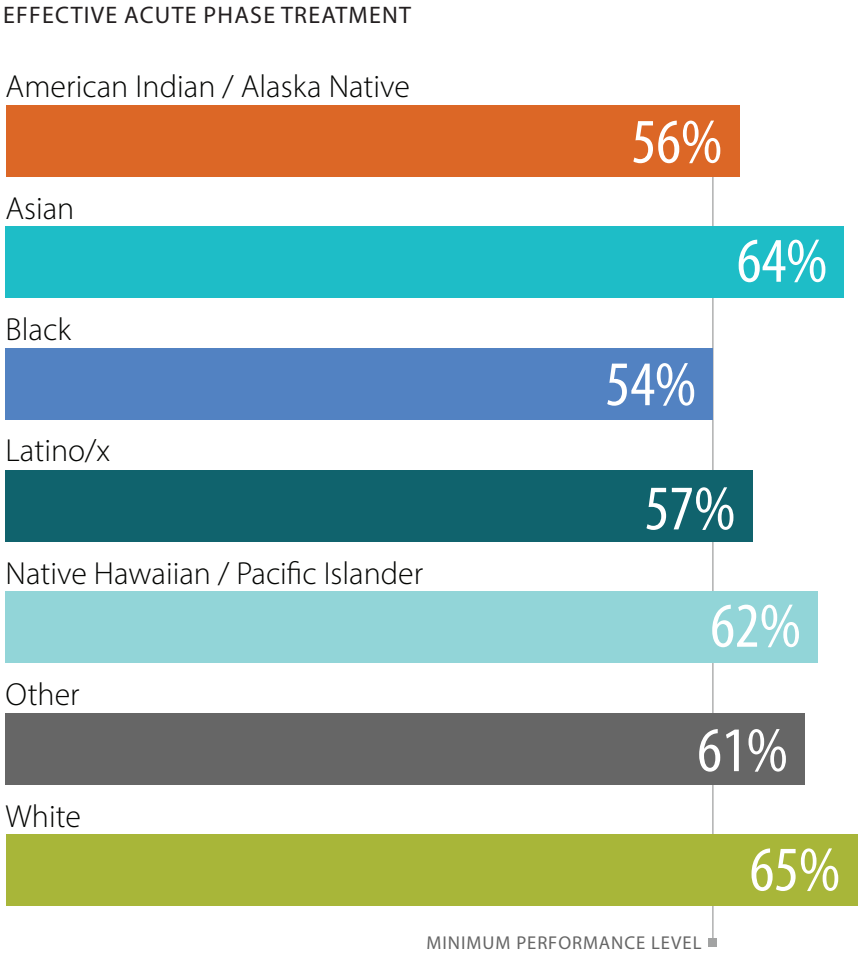
Notes: PQI (Prevention Quality Indicator) is an overall composite measure of avoidable hospitalizations. The rate of avoidable hospitalizations was calculated as the number of hospitalizations for a particular payer category divided by the corresponding adult population according to the California Health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

Sources: Blue Sky Consulting Group analysis of Agency for Healthcare Research and Quality PQI applied to HCAI Hospital Discharge data (provided by special request from the California Dept. of Health Care Access and Information); and "AskCHIS," UCLA Center for Health Policy Research.

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 Medicare, Medi-Cal, and other 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

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



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 remained on an antidepressant medication for at least 84 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator. It 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 63%. Source uses *Black or African American* and *Hispanic or Latino*.

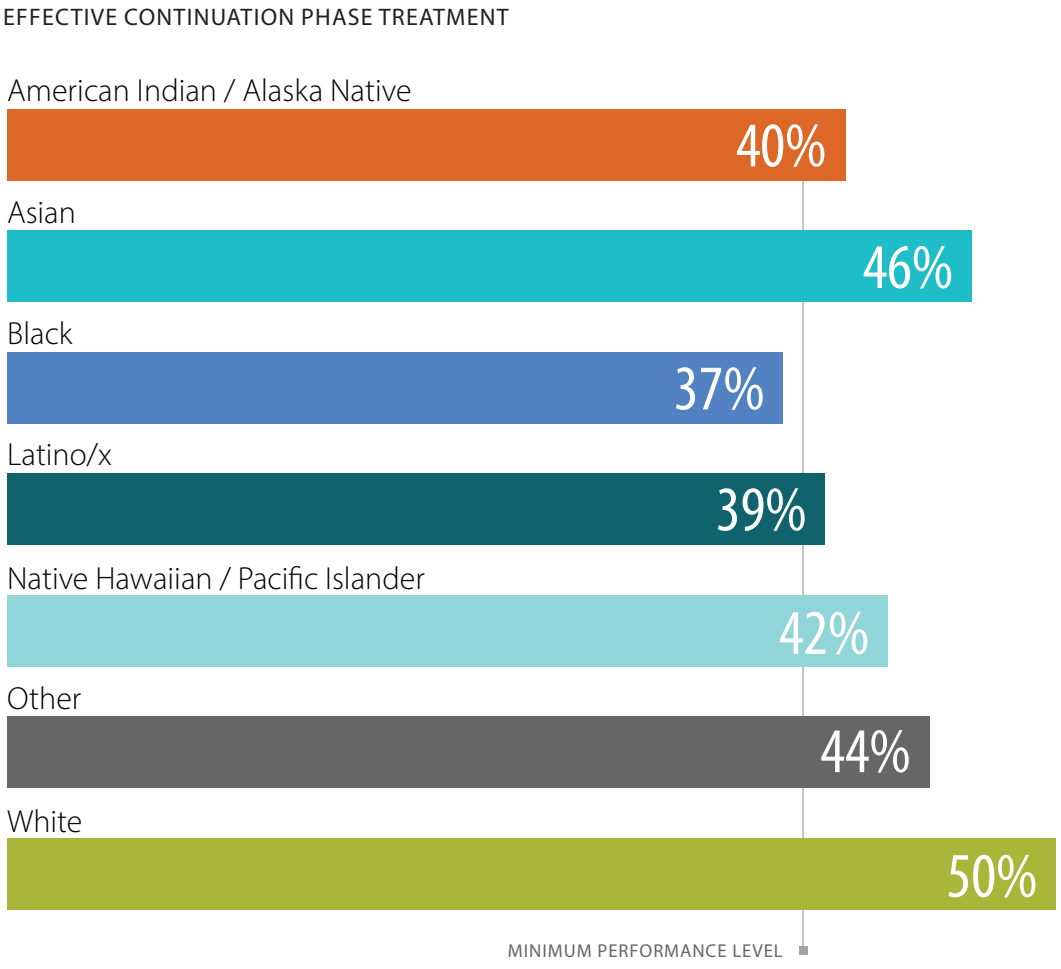
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

The percentage of Medi-Cal managed care enrollees who reported remaining on antidepressant medication for at least 84 days ranged from 54% for Black enrollees to 65% for White enrollees. 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)," Natl. Committee for Quality Assurance.

Antidepressant Medication Management

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



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 remained on an antidepressant medication for at least 180 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator. It 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 46%. Source uses *Black or African American* and *Hispanic or Latino*.

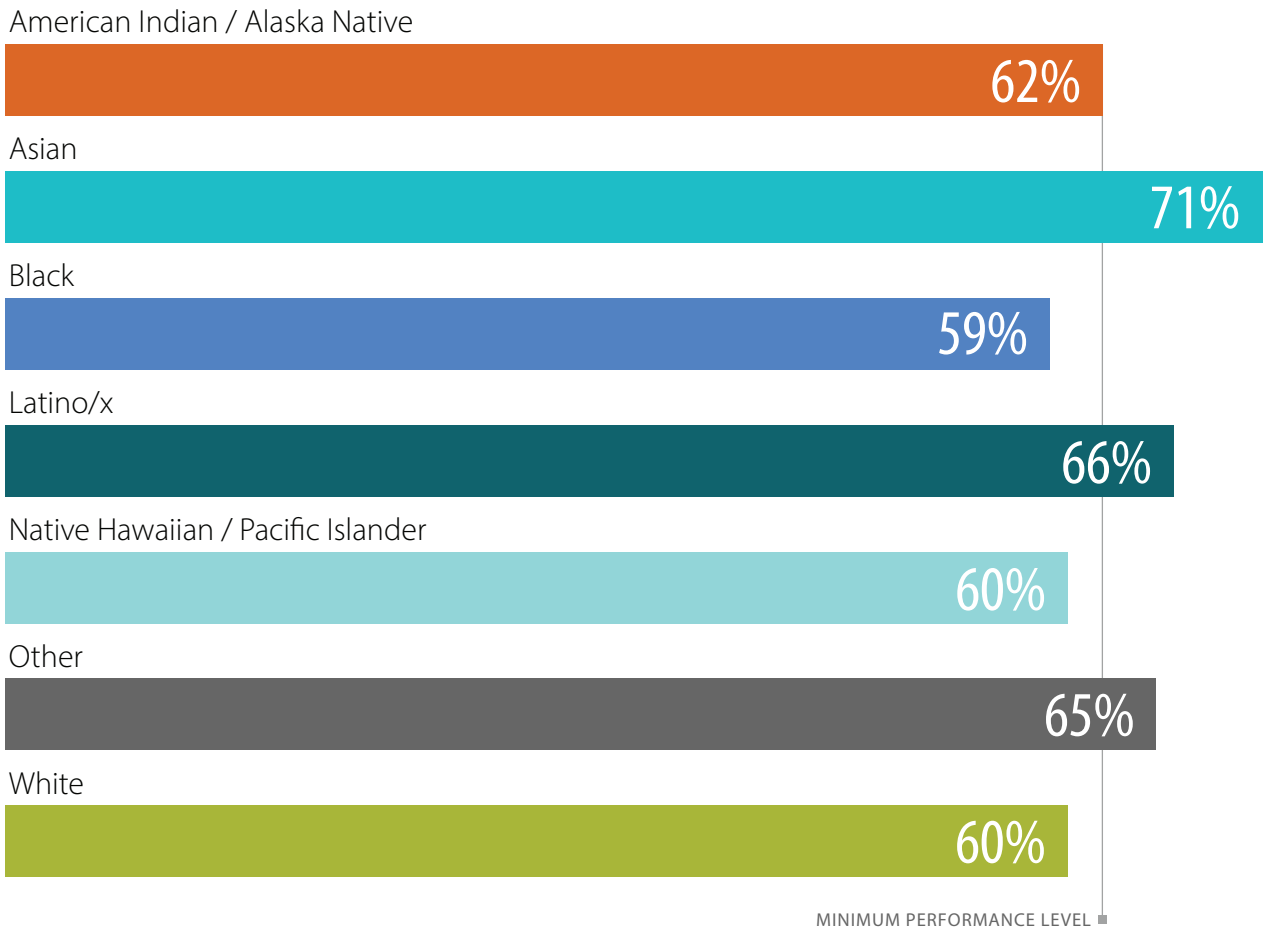
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

Medi-Cal managed care enrollees reporting their race/ethnicity as Black had a lower rate of continuing antidepressant medication for at least 180 days compared to those in 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)," Natl. Committee for Quality Assurance.

Asthma Medication Ratios

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



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 identified as having persistent asthma and who 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. It 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 66%. Source uses *Black or African American* and *Hispanic or Latino*.

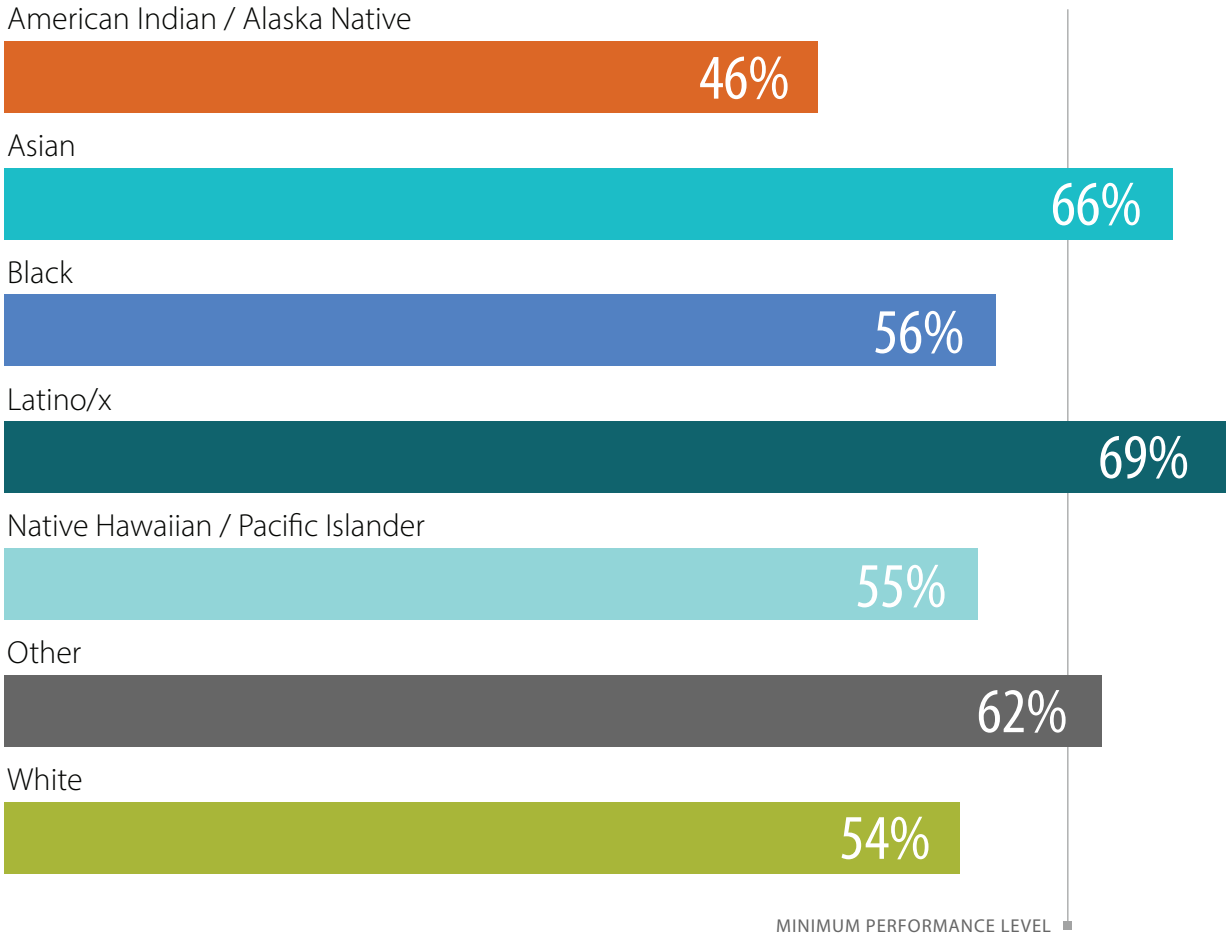
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

Black, Native Hawaiian / Pacific Islander, and White Medi-Cal 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, admissions, and missed days of school and work.*

* "Asthma Medication Ratio (AMR)," Natl. Committee for Quality Assurance.

Breast Cancer Screening

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



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. It 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 52%. Source uses *Black or African American* and *Hispanic or Latino*.

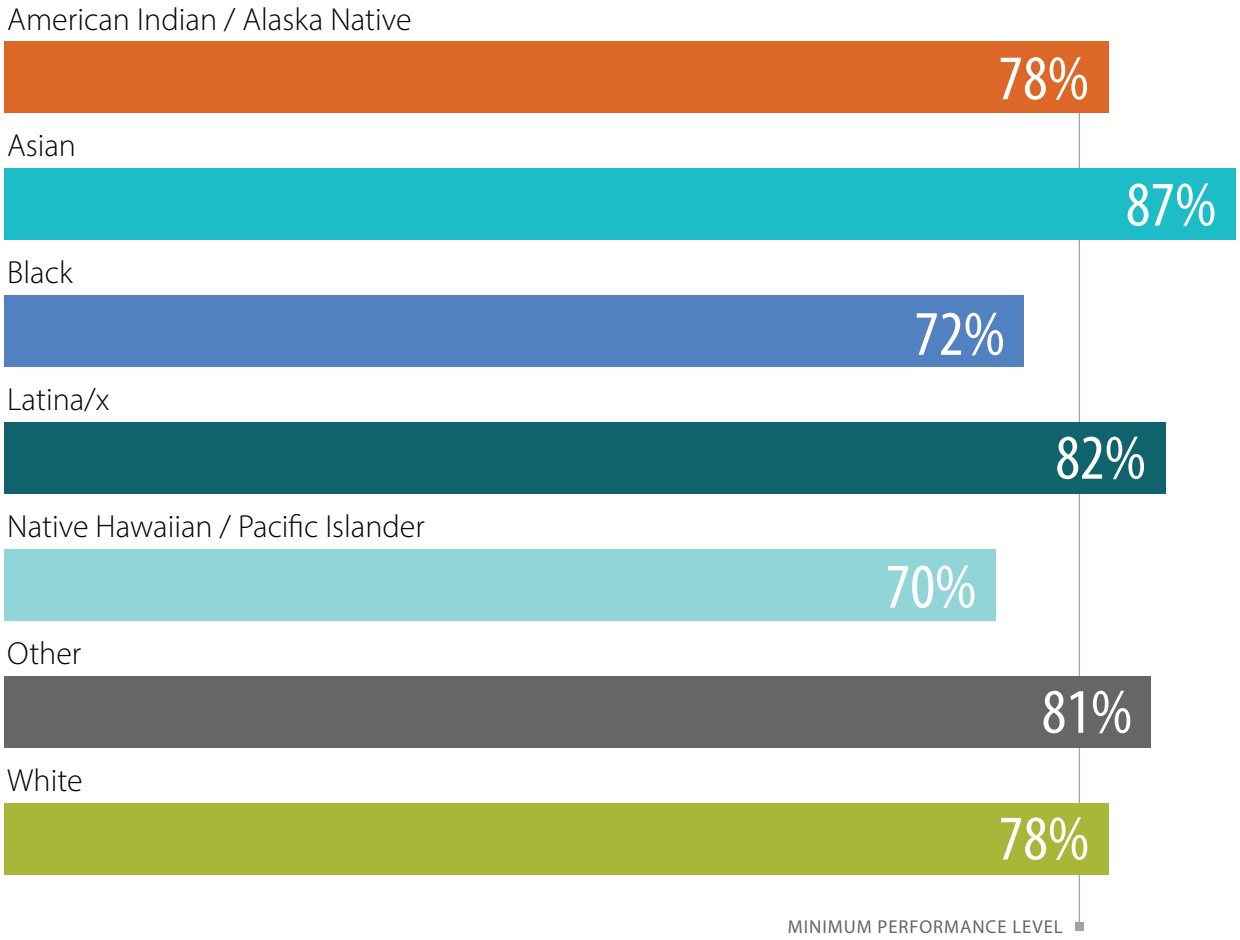
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

While Latina/x women enrolled in Medi-Cal managed care plans had the highest rate of breast cancer screening, American Indian / Alaska Native enrollees had the lowest rate. 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)," Natl. Committee for Quality Assurance.

Postpartum Care

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Postpartum care* measures the percentage of live birth deliveries followed by a postpartum visit on or between 7 and 84 days after delivery. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator. It 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 80.5%. Source uses *Black or African American* and *Hispanic or Latino*.

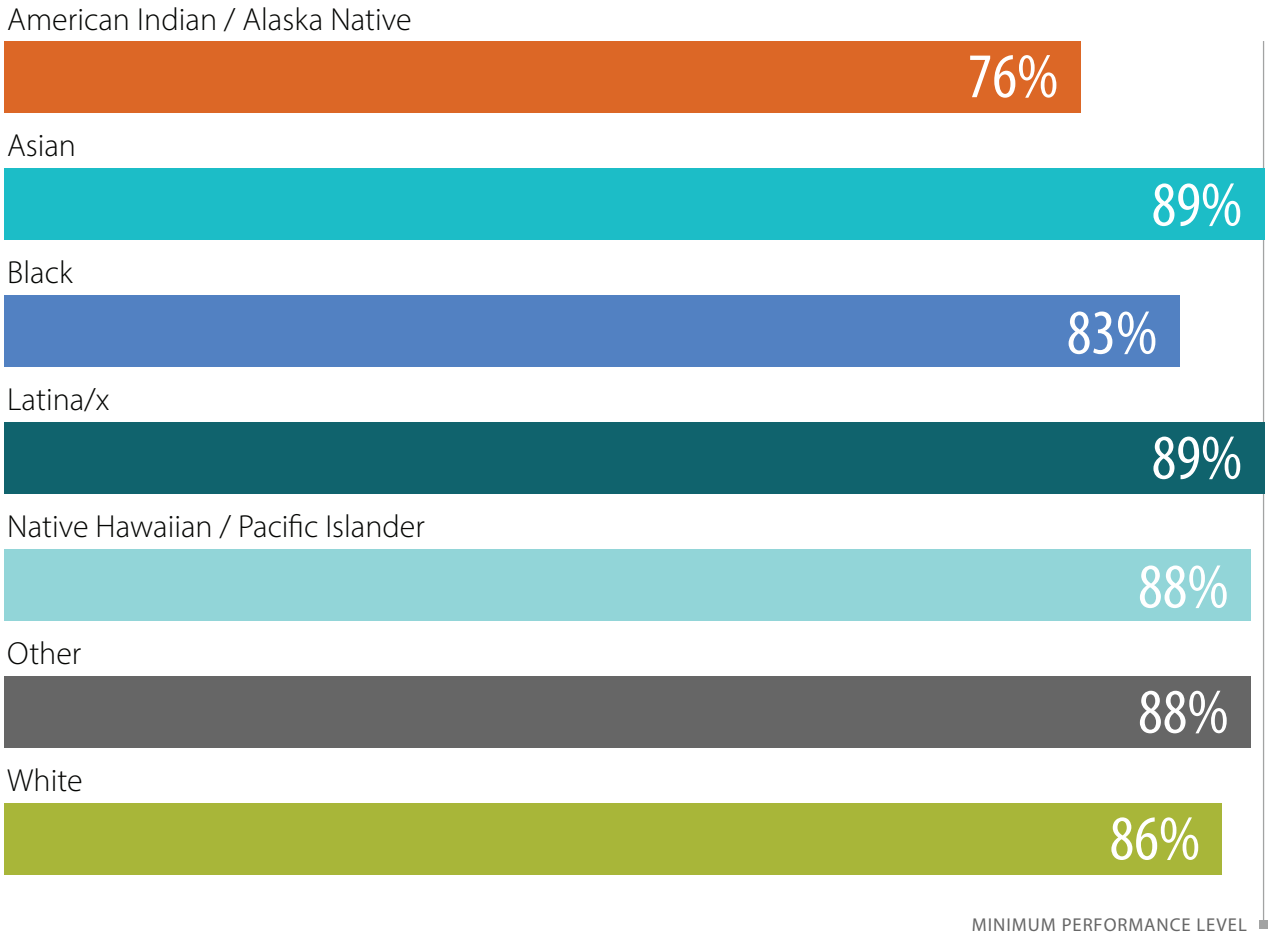
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

While Asian women / birthing people* enrolled in Medi-Cal managed care plans had the highest rate of postpartum visits, Black and Native Hawaiian / Pacific Islander women / birthing people had the lowest rates and were the only groups that did not meet the minimum performance level.

* *Birthing people* is used to recognize that not all people who become pregnant and give birth identify as women.

Timeliness of Prenatal Care

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Timeliness of prenatal care* measures the percentage of live birth deliveries preceded by timely prenatal care. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator. It 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 87.6%. Source uses *Black or African American* and *Hispanic or Latino*.

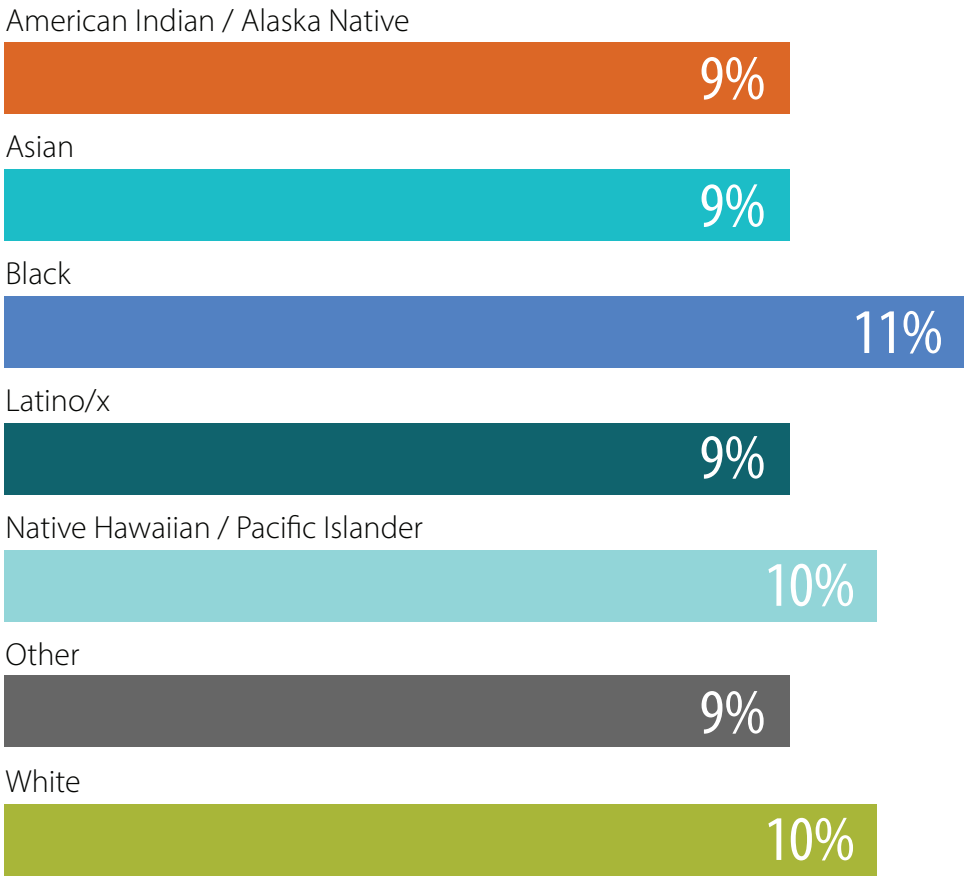
Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

While Asian and Latina/x women / birthing people* enrolled in Medi-Cal managed care plans had the highest rates of births receiving timely prenatal care, American Indian / Alaska Native enrollees had the lowest rate.

* *Birthing people* is used to recognize that not all people who become pregnant and give birth identify as women.

Plan All-Cause Readmissions

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020



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 and observation stay during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days of discharge. The rate for unknown/missing race/ethnicity was 9%. Source uses *Black or African American* and *Hispanic or Latino*.

Source: *2020 Health Disparities Report*, California Dept. of Health Care Services, December 2021.

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)," Natl. Committee for Quality Assurance.

Children's Health

Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2020

	CALIFORNIA	AIAN	ASIAN	BLACK	LATINO/X	NHPI	OTHER	WHITE
Child and Adolescent Well-Care Visits	41%	29%	45%	31%	43%	33%	42%	36%
Childhood Immunization Combination 10	40%	29%	57%	22%	44%	33%	41%	33%
Adolescent Immunization Combination 2	41%	32%	48%	30%	46%	41%	38%	29%
Developmental Screening	23%	16%	26%	19%	23%	23%	29%	23%
Well-Child Visits								
• First 15 Months	38%	31%	45%	26%	39%	30%	38%	37%
• 15 to 30 Months	66%	52%	76%	48%	69%	56%	67%	63%

In 2020, less than half of children enrolled in Medi-Cal managed care had their childhood or adolescent immunizations.

Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Child and adolescent well-care visits* measures the percentage of children age 3 to 21 years who had at least one comprehensive well-care visit with a primary care physician (PCP) or an ob/gyn practitioner. *Childhood immunization combination 10* measures the percentage of children age 2 who had four diphtheria, tetanus, and acellular pertussis: three polio, one measles, mumps and rubella, three haemophilus influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday. *Adolescent immunization combination 2* measures the percentage of adolescents age 13 who had one one dose of meningococcal vaccine; one tetanus, diphtheria toxoids, and acellular pertussis vaccine; and have completed the human papillomavirus vaccine series by their 13th birthday. *Developmental screening* is the percentage of children who were screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on the child's first, second, or third birthday. *First 15 months* is the percentage of children who turned 15 months old during the measurement year who had six or more well-child visits with a PCP. *Fifteen to 30 months* measures the percentage of children who turned 30 months old during the measurement year who had two or more well-child visits. Source uses *Black or African American* and *Hispanic or Latino*. *AIAN* is American Indian and Alaska Native. *NHPI* is Native Hawaiian and Pacific Islander.

Source: *2020 Health Disparities Report* (PDF), California Dept. of Health Care Services, December 2021.

Looking Ahead

The Medi-Cal program faces numerous challenges in the coming years as a result of changing demographics, policy changes, and the implementation of CalAIM. The California Department of Health Care Services (DHCS) will:

- Continue to support Medi-Cal enrollees, providers, and undocumented Californians through implementation of the CalAIM series of reforms.
- Work to maintain Medi-Cal enrollment in 2023 and beyond as eligibility redeterminations resume following the end of the COVID-19 public health emergency.
- Assess the outcome of a transition to carved-out pharmaceutical benefits with the Medi-Cal Rx program.

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 the overall population. This shift will likely increase Medi-Cal's spending on long-term services and supports, as well as other services.
- Disparities in access, quality of care, and health outcomes for Medi-Cal enrollees of color and other enrolled Californians.

The Medi-Cal program faces numerous changes and challenges in the coming years.

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 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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