ITUP Insure the Uninsured Project

ACA Watch

Highlighting Issues and Events Affecting Health Reform in California

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About ACA Watch

Under the Affordable Care Act (ACA), California cut the number of uninsured in the state by half and embarked on reforms and system transformations touching all aspects of the state's health care delivery system.

California's reform progress, and progress around the country, is at risk. As the federal repeal and replace debate unfolds, ITUP's ***ACA Watch*** will periodically highlight emerging federal proposals, congressional and administrative actions and potential impacts for health care and health reform in California.

About ITUP

Insure the Uninsured Project is a nonprofit, independent health policy institute located in Sacramento, California.

ITUP advances creative and workable policy solutions that expand health care access and improve the health of Californians.

ITUP conducts policy focused research and convenes broad-based stakeholders on health policy topics. To assist with health reform in California, ITUP hosts an annual statewide conference and facilitates regional and issue workgroups on topics affecting health and health care in California.

The ACA and Medi-Cal: What's at Stake?

The Patient Protection and Affordable Care Act (ACA) includes an expansion of Medicaid eligibility for low-income childless adults at a higher federal matching rate to support states in implementing the expansion. Beyond the familiar ACA Medicaid expansion for adults, the ACA also includes many other Medicaid program changes and improvements.

California embraced the ACA adult expansion in the state's Medicaid Program (Medi-Cal) to address long-standing affordability barriers that contributed to the state's historically high uninsured rates. In the decade preceding ACA, the uninsured rate for California adults under 64 years of age and under 138 percent of the federal poverty level (FPL) hovered around ***40 percent***.[1] The increase in Medi-Cal enrollment among this previously uninsured group is a primary contributing factor to the 10 percent decrease in California's uninsured rate under ACA.[2]

In November 2013, Medi-Cal covered 8.6 million low-income Californians.[3] According to the Governor's January 2017-18 proposed budget, Medi-Cal is projected to serve 14 million beneficiaries in the next fiscal year.

These improvements are in jeopardy as federal policymakers debate potential repeal or rollback of the ACA. The American Health Care Act (AHCA), recently passed by the U.S. House of Representatives, coupled with dramatic additional Medicaid cuts proposed in President Trump's 2018 federal budget, could reverse the gains in coverage California made.

This issue of **ACA Watch** highlights program and population changes that re-shaped Medi-Cal under ACA. In addition to expanding coverage for some of the state's most disenfranchised residents, the ACA dramatically altered the demographic profile and scope of the Medi-Cal program.

The ACA Expanded and Improved Medi-Cal for Beneficiaries

The ACA expansion of Medicaid eligibility to non-pregnant, childless adults under 138 percent FPL added nearly 4 million Californians to Medi-Cal. While childless adults are the largest new group to be covered in Medi-Cal under the ACA, it is often not as well known that the ACA also secured and improved Medi-Cal coverage for other low-income, vulnerable populations.

Streamlined eligibility and enrollment processes, presumptive eligibility at key points of service, and expanded eligibility for parents and foster children are just some of the ACA changes with a positive impact on health care coverage for low-income Californians.

The ACA Adult Expansion Population in California

Most adults obtain health insurance coverage through their employers. Nationally, ***nearly 8 in 10 Medicaid adults are in working families*** because workers in low-wage jobs often are employed in industries or working for employers that do not provide job-based coverage.[4] The ACA recognized this long-standing gap in employment-based coverage and expanded Medicaid to support low-wage employees and other low-income adults.

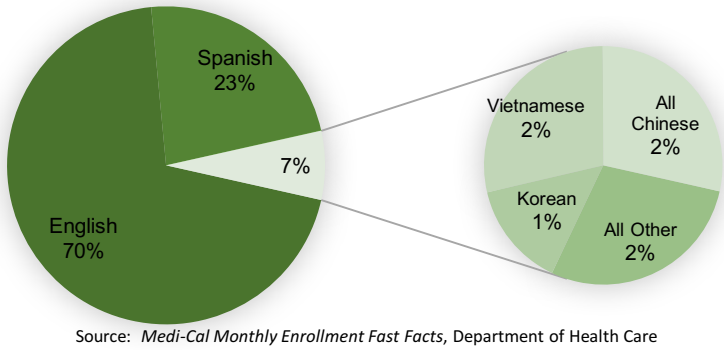
On January 2014, the first month of the ACA implementation in California, over 1 million newly eligible adults transitioned into Medi-Cal with over half (655,695) enrolled through county Low Income Health Programs, established under California's Bridge to Health Reform 1115 Medicaid Waiver.[5] By November 2016, the number of adults newly enrolled through the Medi-Cal adult expansion grew to ***3.7 million*** or approximately 9.5 percent of the California population.[6]

Demographics of the ACA Adult Expansion Population in Medi-Cal

California's newly eligible adults are 51 percent male and 49 percent female,[7] which differs significantly from the largest Medi-Cal (non-elderly / non-disabled) eligibility group – Parents, Caretaker Relatives, and Children. This group is 70 percent female and only 30 percent male.[8]

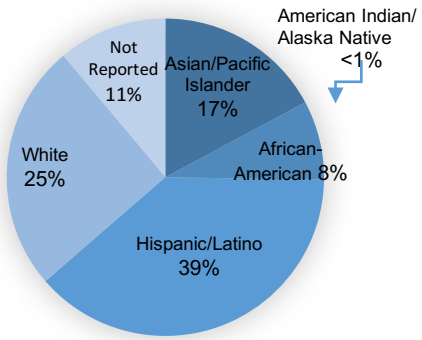
Seven percent of newly eligible adults are 20 and under and 93 percent are between 21-64 years old.[9]

Figure 1. ACA Adult Expansion Language



Source: *Medi-Cal Monthly Enrollment Fast Facts*, Department of Health Care Services, Research and Analytic Studies Division, November 2016.

Figure 2. ACA Adult Expansion Race/Ethnicity



The ACA transformed Medi-Cal coverage for adults in rural California. The top 10 California counties with the highest percentage of enrollment of newly eligible adults are rural counties:[10]

1. Humboldt 14%
2. Mendocino 14%
3. Lake 13.8%
4. Trinity 12.8%
5. Merced 12.2%
6. Fresno 12.2%
7. Tulare 12.1%
8. Siskiyou 11.9%
9. Imperial 11.8%
10. Stanislaus 11.8%

Other Newly-Eligible Medi-Cal Beneficiaries under ACA

Former Foster Care Youth

The ACA expanded Medicaid coverage for young adults previously in the foster care system. Before the ACA, former foster youth were eligible for Medi-Cal until they age out of the foster care system generally at age 18. Former foster youth up to age 26 became eligible for Medi-Cal under the ACA, providing they were Medi-Cal enrolled prior to aging out of foster care. This provision ensures that young adults previously in the foster care system have the same ability to access health care coverage as other young adults, who under the ACA can remain on their parents' health plans until they turn 26. To more directly parallel the experiences of former foster care young adults and adults covered by their parents, income is not a factor in eligibility for foster youth.

In December 2016, ***18,823*** young Californians formerly in foster care were newly insured because of this ACA Medicaid expansion.

Parents, Caretaker Relatives and Children on Medi-Cal

For parents and adult caretaker relatives, the ACA expanded income eligibility from 100 percent FPL to 138 percent FPL and eliminated the "asset test" for eligibility. The asset test restricted Medi-Cal eligibility if the value of an individual or family's personal property was above a specified limit. For example, a family of two with over $3,000 in the bank were ineligible for Medi-Cal. In addition to the eligibility expansion and elimination of the assets test, the state conducted extensive outreach to enroll both newly eligible Medi-Cal beneficiaries and individuals that were previously eligible, but had yet to enroll.

From January 2013 to November 2016, this Medi-Cal eligibility group grew from approximately 4.3 million individuals to 5.4 million beneficiaries.[11,12] This increase represents the total growth in the Medi-Cal aid codes associated with the Parent, Caretaker Relatives and Child aid category. (Medi-Cal beneficiaries are grouped by aid codes which specify income eligibility thresholds and levels of benefit by category.) Based on the pre-ACA Medi-Cal growth trends for these aid codes, it is reasonable to attribute much of this enrollment growth to the ACA and the extensive outreach conducted in California to enroll eligible beneficiaries.[13]

The ACA added approximately ***1 million*** parents, caretaker relatives and children to Medi-Cal.

ACA Enhanced Funding for CHIP-eligible Children

Pre-ACA, Medi-Cal covered infants and children (0-19 years of age) up to 250 percent FPL. Beginning in January 2013, California transitioned into Medi-Cal 751,293 children previously in the Healthy Families Program, the California version of the Children's' Health Insurance Program (CHIP).[14] According to the Department of Health Care Services (DHCS) the transition to Medi-Cal was intended to: (1) simplify eligibility and coverage for children and families – families could be covered under just one program; (2) improve coverage through retroactive benefits, increase access to vaccines, and expand mental health coverage; and (3) eliminate premiums for lower income beneficiaries – those under 150 percent FPL. Medi-Cal uses CHIP funds to cover costs for children at the higher eligibility income levels. For example, in 2016 CHIP funds covered Medi-Cal children ages 1-5 between 142-261 percent FPL and children ages 6-18 between 108-261 percent FPL.[15] Medi-Cal children at lower incomes are supported by state and federal Medicaid funds.

California also uses CHIP funding to cover unborn children, their pregnant mothers and newborns until age two up to 322 percent FPL.

The use of CHIP funding to cover low and moderate income children and pregnant women in Medi-Cal has been in place since before the ACA. The ACA extended this funding through fiscal year 2015 and imposed a "maintenance of effort" (MOE) requirement on Medi-Cal and CHIP-funded Medi-Cal programs. Under the MOE, states are required to maintain pre-ACA Medi-Cal and CHIP eligibility levels in place until *September 2019*.

The ACA also provided an enhanced federal match for children covered under CHIP if the CHIP program was reauthorized after 2015. The pre-ACA CHIP federal match for California was 65 percent and the ACA increased this to 88 percent for federal fiscal years 2016 and 2017. CHIP funding, including the enhanced CHIP match rate enacted in the ACA, is scheduled to sunset in October 2017 if not reauthorized by Congress before then.

As of November 2016, the ACA enhanced federal match for CHIP Medi-Cal covered ***1.3 million*** children, pregnant women, unborn children and infants in low and moderate income families.

President Trump's budget proposes a two-year CHIP reauthorization but at the lower, non-enhanced federal match of 65 percent. Given the uncertainties surrounding the CHIP reauthorization and federal funding, the 2017-2018 proposed Governor's budget includes $536.1 million state general fund to cover reduced federal matching funds for CHIP. Because California's eligibility levels for CHIP-funded Medi-Cal were in place when the ACA was implemented, the MOE requirement safeguards low and moderate income children from losing Medi-Cal coverage until 2019 regardless of federal funding levels for the program. The President's budget proposes ending the MOE requirement in 2017 and eliminating this safeguard.

New ACA Options for Medi-Cal Beneficiaries Needing Long-Term Services and Supports

- ***Community First Choice Option.*** The ACA created the Community First Choice state option (CFCO) which allows states to provide statewide home and community-based attendant support and services to individuals who would otherwise require an institutional level of care. States choosing to implement this option receive a six percent increase in their federal match rate for funds spent on CFCO services. California was well-positioned to implement the new ACA CFCO because of the existing Medi-Cal In-Home Support Services (IHSS) infrastructure. The Medi-Cal IHSS benefit covers attendant and chore services to support beneficiaries safely in their own homes and avoid the need for out-of-home care. In March 2013, California became the first state to secure federal approval to implement the new CFCO. For the first two years of implementation, California received $573 million in additional federal funding under the CFCO for IHSS.[16]

  Upon receipt of federal CFCO resources, 41 percent of existing IHSS beneficiaries were transitioned to the Community First Choice IHHS program, approximately ***183,680*** individuals.[17]

- ***Cal MediConnect***. In addition to ongoing support for IHSS, the ACA is also responsible for California's Coordinated Care Initiative, which among other things includes Cal MediConnect. The ACA created the Center for Medicare and Medicaid Innovation (CMMI) with new demonstration authority to test payment and service delivery innovations. CMMI utilized this demonstration authority to develop the Financial Alignment Demonstration. In March 2013, the federal Department of Health and Human Services announced California's partnership with CMS to test a new financial alignment model for providing dually eligible Medicare-Medicaid enrollees with more coordinated, person-centered care, along with access to new services. Under Cal MediConnect, Medicare-Medicaid managed care plans in seven California counties conduct a comprehensive assessment of dual eligible enrollees, support the development of an individualized care plan under the oversight of a multi-disciplinary care team, and coordinate service delivery, including long term services and supports.

  As of March 2017, enrollment in Cal MediConnect plans included ***115,613*** dual eligible individuals.

ACA Provisions for Medi-Cal Beneficiaries Needing Mental Health and Substance Use Disorder Services

The ACA adopted a national standard to ensure health plans cover basic benefits, or essential health benefits (EHBs). The 10 categories of EHBs in the ACA need to be covered in a state's Medicaid program or an "alternative benefit plan" offered to the ACA newly eligible adults. The ACA explicitly includes mental health and substance use disorder treatment services among the 10 EHB categories that must be

offered under the alternative benefit plan. California expanded Medi-Cal benefits to include EHB coverage for all Medi-Cal beneficiaries, not just newly eligible adults, and ensured its existing Medi-Cal delivery system met the alternative benefit plan requirements.

The mental health benefit expansion focuses on services for individuals with mild to moderate mental health impairments including:

1. individual/group mental health evaluation and treatment (psychotherapy),
2. psychological testing when clinically indicated to evaluate a mental health condition,
3. outpatient services for monitoring medication treatment,
4. psychiatric consultation, and
5. outpatient laboratory, medications, supplies and supplements.[18]

According to utilization data from Medi-Cal managed care plans, seniors, persons with disabilities and dual Medicare/Medi-Cal eligible beneficiaries have benefitted the most from the ACA mental health expansion.[19]

The substance use disorder services expansion applies to all beneficiaries and lifted previous restrictions on the following services:

1. intensive outpatient treatment,
2. residential substance use disorder services, and
3. elective inpatient detox.[20]

In addition to EHB requirements that added mental health and substance use disorder services for all Medi-Cal beneficiaries, the ACA also requires state Medicaid programs to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). This means Medi-Cal managed care plans cannot charge higher rates or place more restrictions on mental health or substance use disorder services than other types of health services. California must fully implement mental health parity in Medi-Cal by October 2, 2017.

ACA Policies Supporting Medi-Cal Enrollment of Low-Income Beneficiaries

In addition to the expanded programs and eligibility policies highlighted above, the ACA also improved beneficiary enrollment and retention in Medi-Cal by streamlining and simplifying eligibility processes, including the following program changes:

- ***Determining Income Eligibility***. The ACA requires states to use the modified adjusted gross income (MAGI) of an individual or household to simplify income eligibility determinations for most Medi-Cal populations. MAGI is generally the amount of income reported on annual federal tax forms and can be easily verified through electronic sources. The ACA also includes a 5 percent across-the-board "income disregard" for those using the MAGI process, which increases the number of income eligible individuals by effectively raising the income eligibility threshold. All other prior Medi-Cal income disregards are not included in a MAGI eligibility determination. MAGI is used for both Medi-Cal and Covered California income eligibility determinations to facilitate individuals moving between these programs as they experience changes in income and circumstances. The use of a simplified, standardized income eligibility process for different state programs eases the enrollment process for most Medi-Cal beneficiaries.

  The number of Medi-Cal beneficiaries determined or redetermined income eligible for Medi-Cal using the simplified MAGI process increased from 905,449 beneficiaries, or 9 percent of enrollees in January 2014, to ***9,125,389 beneficiaries*** or 68 percent of enrollees, by November 2016.[21]

- ***Annual Redeterminations***. Medi-Cal is required to verify eligibility, or redetermine eligibility, periodically. The ACA created a new annual redetermination process for individuals deemed eligible through MAGI. The new process requires less information from applicants and requires county eligibility workers to use information already available through existing sources to initiate redeterminations. For any information that is unavailable, a redetermination form is prepopulated for the beneficiary and a reasonable timeframe to return the remaining information is provided. States may use similar processes for non-MAGI eligibility determinations, as of yet California has not moved in this direction.

- ***Presumptive Eligibility***. Presumptive eligibility allows specified providers to presume Medicaid eligibility for specific populations after a preliminary eligibility screen and before a full application is completed. The provider is reimbursed for services until a full determination of Medi-Cal eligibility is made. Pre-ACA, presumptive eligibility was available for low-income children and pregnant women and states, including California, allowed providers to make presumptive eligibility determinations for those populations. The ACA allows states that adopt presumptive eligibility for children and pregnant women, such as California, to expand the scope of presumptive eligibility to include newly eligible adults and parents, as well as other populations. The ACA also authorizes hospitals that are Medicaid providers to conduct presumptive eligibility determinations even in states without pre-ACA presumptive eligibility programs.

  In California as of April 2017, 335 hospital sites were qualified to conduct presumptive eligibility determinations. Each month, approximately 1 percent of newly eligible adults or ***20,000-25,000 individuals*** are included in the hospital presumptive eligibility (HPE) Medi-Cal aid code. In general, these adults remain in the HPE aid code until they submit a complete application and their eligibility for Medi-Cal is finalized.

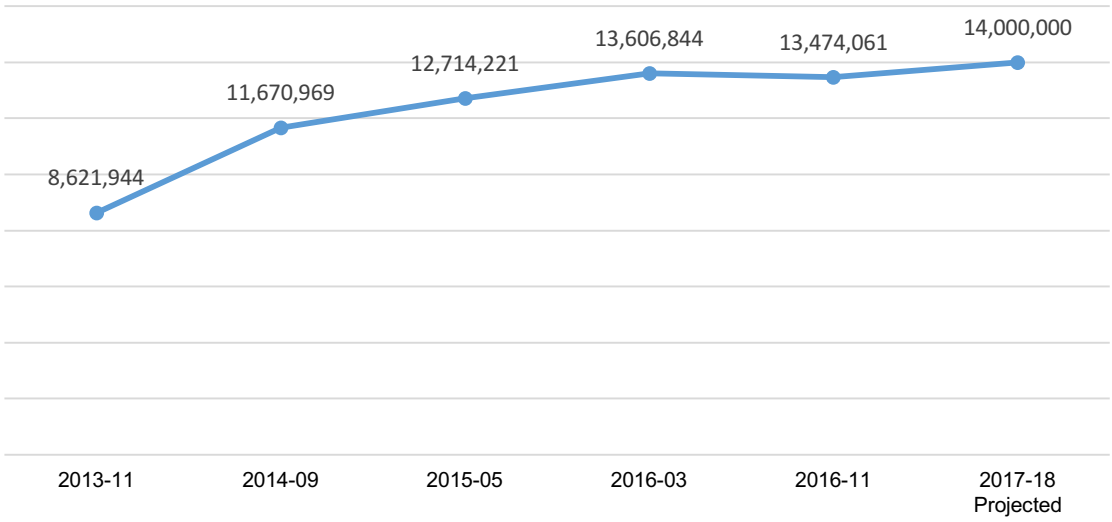
- ***Attestations***. Except for citizenship and legal residency status, ACA allows states to accept attestations (verbal statements without paper verification) by applicants or beneficiaries in Medicaid eligibility determinations, reducing the need for extensive document submission and verification.

- ***Coordination with State Exchange***. In implementing ACA, California adopted a no-wrong-door approach for Medi-Cal and Covered California applications, allowing applicants to apply for either program through Covered California or at county Medi-Cal eligibility offices. Applicants can apply online, via telephone, by mail, or in person. If an individual or a household is above the MAGI standard for Medi-Cal, eligibility workers must determine whether the individual qualifies for another non-MAGI Medi-Cal program or Covered California and facilitate their enrollment into these programs.

Medi-Cal Pre-ACA and Today

The passage of the ACA brought about sweeping changes for the Medi-Cal program. Pre-ACA, the Medi-Cal program primarily served low-income children, their parents, seniors and people with disabilities. ACA Medicaid expansions added other low-income groups and reshaped the Medi-Cal program. As Figure 3 illustrates, the growth in Medi-Cal enrollment since the state's ACA implementation has been dramatic, with state projections estimating Medi-Cal will grow to approximately 14 million enrollees in 2017-18.

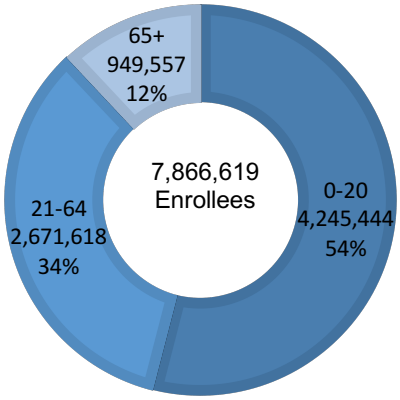
Figure 3. Medi-Cal Enrollment



Source: *Medi-Cal Monthly Enrollment Fast Facts*, Department of Health Care Services, Research and Analytic Studies Division, November 2016.

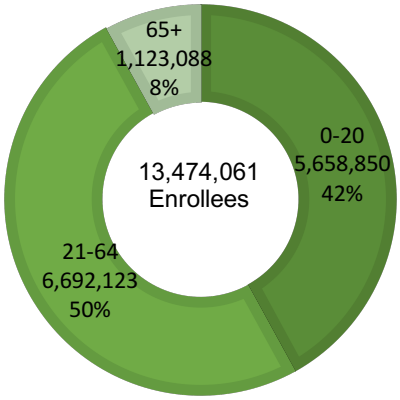
With the ACA Medi-Cal expansions described above, the age demographics of the Medi-Cal population changed and became more evenly split between children and adults. Prior to the ACA, adults without children working for employers that did not provide health insurance coverage, and other low-income adults, had few coverage options and were mostly uninsured. As Figures 4 and 5 illustrate, Medi-Cal now supports slightly more low-income adults than low-income children.

Figure 4. Pre-ACA Medi-Cal Age Groups



Source: *Population Distribution by Ethnicity*, Department of Health Care Services, January 2013

Figure 5. Nov 2016 Medi-Cal Age Groups

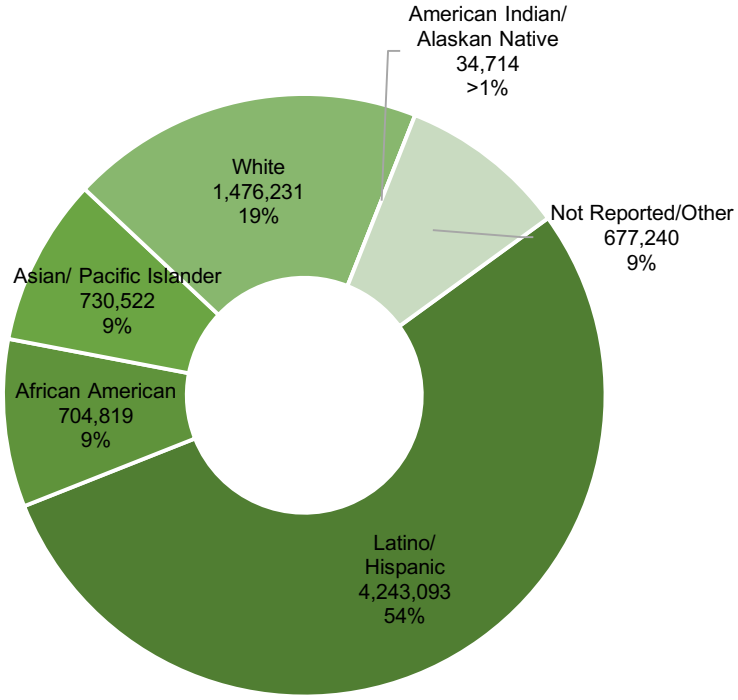


Source: *Medi-Cal Monthly Enrollment Fast Facts*, Department of Health Care Services, Research and Analytic Studies Division, November 2016.

The race/ethnicity of Medi-Cal enrollees has also changed under ACA, with the largest increases in the Asian/Pacific Islander and Latino/Hispanic communities. Under ACA, Medi-Cal enrollment grew for all race and ethnic groups. As illustrated in Figures 6 and 7, from 2013 to 2016, Medi-Cal enrollment for the Latino/Hispanic community grew by 2 million individuals. In this same period, Medi-Cal enrollment grew by over one million individuals among Asian/Pacific Islanders and Whites.

Pre-ACA, the Latino/Hispanic community represented over half (54 percent) of the Medi-Cal population and the Asian/Pacific Islander community represented approximately 9 percent (Figure 6). As of 2016, the Latino/Hispanic community represents less than half (47 percent) of the Medi-Cal population. Asian/Pacific Islanders in Medi-Cal increased from 9 percent to 13 percent (See Figure 7 on page 9).

Figure 6. Race/Ethnicity - January 2013



Source: *Population Distribution by Age/Gender*, Department of Health Care Services, January 2013

The AHCA Could Reverse Progress in Medi-Cal

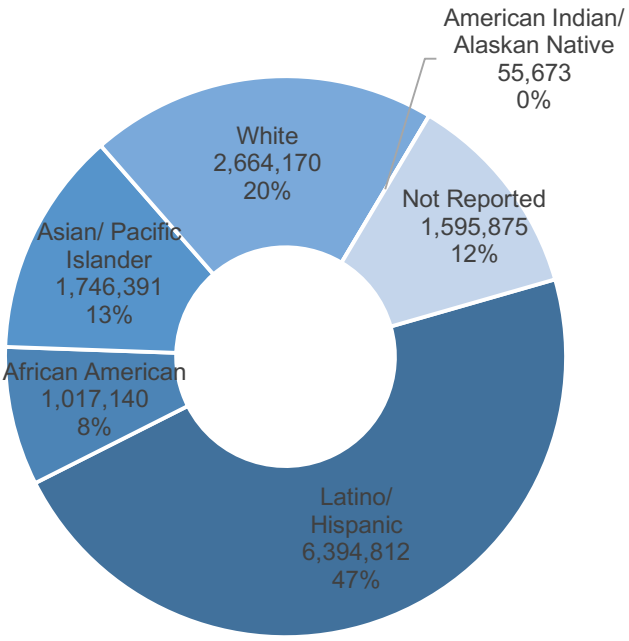
The House-passed AHCA gradually rolls back the enhanced federal funding for the adult expansion and, in addition, also goes beyond the ACA Medicaid provisions to push for a complete transformation of the Medicaid program. AHCA threatens the progress California made to improve and expand Medicaid under the ACA.

- ***Medicaid Per Capita Cap/Block Grant***. Medicaid is administered as a state/federal partnership with shared accountability for the entire program. Medicaid is an entitlement program where the state and federal government share the responsibility to guarantee coverage/services for everyone that qualifies. The AHCA ends Medicaid as an entitlement that guarantees coverage to all those eligible. Beginning in 2020, the AHCA seeks to transition Medicaid to a per capita cap model where states are reimbursed based on a per-beneficiary allocation.

In general, in a per capita cap program, the per-beneficiary allocation is based on a state's total expenditures on its Medicaid population in a chosen base year and adjusted annually based on the consumer price index medical component. Under the AHCA, states can also choose to receive a block grant or "lump sum" payment to serve its Medicaid population in lieu of the per capita cap model.

According to DHCS estimates, under the AHCA's per capita cap model, California would be responsible for $680 million more in Medi-Cal costs in the first year of implementation. This amount grows to $5.3 billion after seven years. As the funding gap grows, ensuring coverage and essential health services for all Medi-Cal beneficiaries becomes increasingly difficult.

Figure 7. Race/Ethnicity - November 2016



Source: *Medi-Cal Monthly Enrollment Fast Facts*, Department of Health Care Services, Research and Analytic Studies Division, November 2016.

- ***Medicaid Adult Expansion***. Beginning in 2020, AHCA seeks to eliminate the federal Medicaid enhanced match rate states receive for covering adults newly eligible under ACA. AHCA continues the higher rate for non-pregnant, childless adults enrolled as of the end of 2019 who do not experience a break in coverage of more than one month. However, AHCA eliminates the annual redetermination of eligibility for this population and instead, imposes a six-month redetermination period.

  AHCA maintains the state option to cover childless adults for states, such as California, that took advantage of this option and maintains the ACA enhanced match for those adults that do not have a lapse in coverage. However, AHCA also reinstates previous practices that lead to coverage lapses, such redeterminations every six-months versus annually. According to DHCS estimates, implementing a six-month redetermination process results in 42 percent of newly enrolled adults experiencing a lapse in Medi-Cal coverage in the first year.[22] DHCS estimates that loss of the enhanced federal match for newly eligible adults would cost California $4.8 billion in the first year of implementation presenting a tremendous challenge for the state to make up the shortfall.

- ***Medicaid Child Expansion***. AHCA also eliminates the ACA Medicaid expansion for children ages 6-19. Because California's eligibility levels for CHIP-funded Medi-Cal programs were in place when the ACA was implemented, the MOE requirement, discussed previously, safeguards low and moderate income children from losing Medi-Cal coverage until 2019. Beyond 2019, California's ability to continue coverage for children up to 261 percent FPL will depend on other policies still in flux, such as the nature of future CHIP reauthorizations and imposition of the per capita cap model of federal Medicaid funding.

- ***Presumptive Eligibility, Stricter Citizenship Verification and Community First Choice Option***. Instead of facilitating Medicaid enrollment of eligible individuals, AHCA reestablishes eligibility and enrollment barriers. AHCA repeals hospital presumptive eligibility provisions and presumptive eligibility for the adult expansion population. AHCA eliminates the ability for states to be reimbursed for services during the time an applicant is obtaining necessary documentation to verify citizenship and residency status. AHCA also repeals the enhanced federal match rate for the Community First Choice Option.

California embraced and successfully implemented the ACA, dramatically reducing the number of uninsured in the state and reshaping the Medi-Cal program through coverage expansions, streamlined eligibility and delivery system improvements. Medi-Cal is now the primary source of health coverage for almost 14 million Californians. Federal proposals would significantly reduce federal Medicaid funding, potentially wiping out the gains under the ACA and going further to fundamentally alter the state-federal partnership in Medicaid. The Congressional Budget Office (CBO) found that AHCA would reduce federal Medicaid funding by an estimated $880 billion, leaving the states to make up the shortfall. The President's proposed 2018 federal budget follows the Congressional lead in AHCA by proposing the per capita cap and a $610 billion cut in federal Medicaid funding. The magnitude of the federal reductions will put enormous fiscal pressure on states and most states, including California, may be unable to replace the lost revenues. The proposed rollbacks in federal Medicaid support could reverse California's progress in covering the uninsured and eliminate access to health care for millions of Californians.

ITUP gratefully acknowledges Len Finocchio of Blue Sky Consulting who provided data analysis and research support for this project.

Notes

[1] AskCHIS data query, UCLA Center for Health Policy Research, http://ask.chis.ucla.edu/ask/SitePages/AskChisLogin.aspx?ReturnUrl=%2fAskCHIS%2ftools%2f_layouts%2fAuthenticate.aspx%3fSource%3d%252FAskCHIS%252Ftools%252F%255Flayouts%252FAskChisTool%252Fhome%252Easpx&Source=%2FAskCHIS%2Ftools%2F%5Flayouts%2FAskChisTool%2Fhome%2Easpx.
[2] Paul Fronstin, Employee Benefit Research Institute, "California's Uninsured: As Coverage Grows, Millions Go Without," 2, *California Health Care Almanac,* California Health Care Foundation, December 2016, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaUninsuredDec2016.pdf.
[3] Department of Health Care Services (DHCS) Research and Analytic Studies Division (RASD), "Medi-Cal Monthly Enrollment Fast Facts," 1, November 2016, http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Nov_2016.pdf.
[4] MaryBeth Musumeci, "Medicaid and Work Requirements," 3, Kaiser Family Foundation, March 2017, http://files.kff.org/attachment/Issue-Brief-Medicaid-and-Work-Requirements.
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[6] DHCS RASD, November 2016, 4.
[7] DHCS RASD, November 2016, 6.
[8] DHCS RASD, March 2017, 7.
[9] DHCS RASD, November 2016, 8.
[10] DHCS RASD, March 2017, 8.

[11] DHCS RASD, "Population Distribution by Detail Aid Category," January 2013, http://www.dhcs.ca.gov/dataandstats/statistics/Documents/3_2_Population_Distribution_Aid_Category.pdf.
Note: The Parent, Caretaker Relative and Child category did not exist in January 2013. ITUP used the analytical notes included in the January 2013 report to cross reference 2013 aid code categories with the current Parent, Caretaker Relative and Child aid codes to prepare this estimate. ITUP used the following 2013 aid code categories for this estimate: 1931(b) Families – Non-CalWORKS and No Share of Cost, Public Assistance – Families, Medically Needy – Families, and Medically Indigent – Child.
[12] DHCS RASD, November 2016, 2.
[13] DHCS RASD, "Trend in Medi-Cal Program Enrollment by Aid Category – for Fiscal Year 2004-2012", July 2013, http://www.dhcs.ca.gov/dataandstats/statistics/Documents/1_5_Annual_Historic_Trend.pdf.
Note: To evaluate the growth trend for 2013 aid codes associated with the Parent, Caretaker Relative and Child category, ITUP reviewed the enrollment trends for the 1931(b) Families and Families aid categories. These categories reflected relatively flat growth from 2004 – 2008. The recession in 2008 did result in increased enrollment across all Medi-Cal aid categories. This growth returned to a relatively flat trend between 2011 – 2013, with enrollment in these aid codes hovering between 4.2 – 4.3 million.
[14] DHCS, "Healthy Families Transition to Medi-Cal: Final Comprehensive Report," 2, February 4, 2014, http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF.
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