SACRAMENTO COUNTY HEALTH AUTHORITY COMMISSION

General Meeting

October 14, 2025

Agenda Item #1:
Welcome/Opening Remarks & Updates

Agenda Item #2: Agenda Review

1. Welcome/Opening Remarks and Updates

2. Agenda Review

3. Action: Approval of Meeting Minutes

4. Presentation, Discussion & Action: Approval of Chair Recommendation Process – CPC Commissioners, Nick Capistrano & Margarita Dodatko
5. Presentation & Discussion: County's Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program – Cortney Maslyn, Sacramento County Department of Health Services
6. Public Comment

7. Closing Comments and Adjournment

Agenda Item #3:

Approval of Meeting Minutes

Agenda Item #4

Presentation, Discussion & Action: Approval of Chair Recommendation Process – CPC Commissioners, Nick Capistrano & Margarita Dodatko

Agenda Item #5

Presentation & Discussion: County's Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program – Cortney Maslyn, Sacramento County Department of Health Services

County’s Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program

Department of Health Services

October 14, 2025

Agenda

Background

- California Statutory Requirements/Indigent Programs
- Sacramento County CMISP/Healthy Partners

Impacts on Sacramento County

- State and Federal Statutory Changes Timeline
- Impacted Populations

Framing the Path Forward

- Policy Decisions

Background

Statutory Requirements

- **Welfare and Institutions Code (WIC) § 17000:** Obligates counties to provide coverage for indigent individuals, and gives counties broad flexibility, subject to certain conditions.
- **WIC § 10000**: Imposes a minimum standard of care, and gives counties discretion re how to meet this standard, subject to certain conditions.

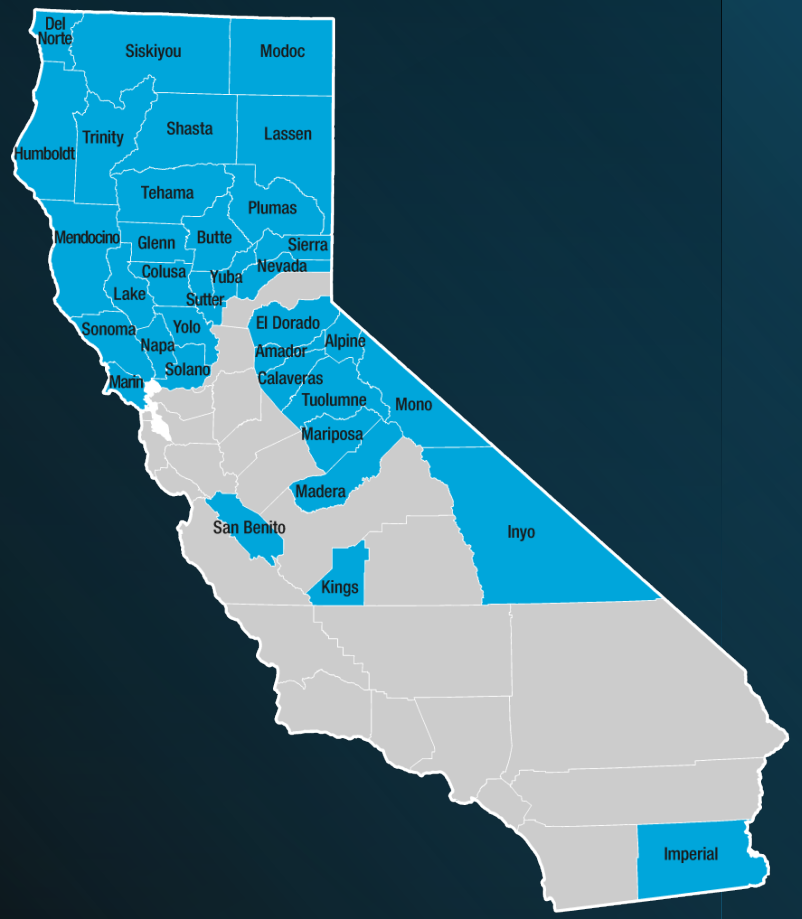
California's Indigent Programs

- **34 counties fulfill statutes via County Medical Services Program (CMSP):** Uniform eligibility criteria & benefits, administered by state, managed by contracted health plans.
- **24 counties fulfill statutes via County Medically Indigent Services Program (CMISP)**: Variety of eligibility criteria & benefits, variety of administration and management models.

See Appendix, slide 22 for more details.

Background: CMISP VS. CMSP

- **CMSP Counties** (in blue)
  - Administered by a state-level program, CMSP.
  - Follows a standardized rules set by CMSP.
  - Offer a uniform set of benefits, in a similar way to Medi-Cal.
  - Only available to counties with a population of less than 300,000
  - Counties contract with agencies (e.g., Anthem Blue Cross) to manage CMSP.
- **CMISP Counties** (in gray), Sacramento County's Program
  - Each county manages its own program independently.
  - Counties set their own rules for eligibility, benefits, and services.
  - Offer a wide range of service delivery strategies, including:
    - Provider counties (owning and operating hospitals/clinics),
    - Payer counties (contracting for services), or
    - Hybrid counties (public clinics and private hospital contracts).



Sacramento's History: Changing Over Time

2010 Affordable Care Act

Before 2009: CMISP

- Avg annual enrollment ~ 50K
- Avg # of Monthly Claims ~10K

February 2009

CMISP services for undocumented cut, due to budget

June 2013

AB 85 required funding formula changes for CMISP- Sacramento County optioned for 60/40 formula resulting in the funding for CMISP being eliminated.

March – June 2015

Board reviews CMISP program to include undocumented population, **creates Healthy Partners** to cover undocumented

January 2016

Healthy Partners program launched including undocumented population with **enrollment cap of 3,000**

January 2018

Healthy Partners Program expanded with enrollment cap to 4,000 and over 65 population, limited to 200

January 2024

Medi-Cal expansion for undocumented, ages 26-49, **membership in Healthy Partners drops to 0** (not needed)

Sacramento County CMISP

➢ Purpose: Fulfills statutory requirements

Benefits and Services

- Medically necessary primary and specialty care
- Emergency and hospital care
- Pharmacy and ancillary services
- Subject to limitations

Eligibility
(rules have changed over time)

- Residents with no other options
- Apply at time of medical service/Rx
- Subject to exclusions
- Up to 12 months
- Cost sharing 138-400% FPL
- No asset test

Enrollment, Cost & Utilization

- Pre-2014: ~50K enrolled, $50M budget*
- Post-2014: zero enrollment

*Partially paid for by state funding

See Appendix, slide 23 for more details.

Sacramento County Healthy Partner's Program

- Purpose: Created by the Board of Supervisors to provide primary and preventive health care for low-income, undocumented immigrants at the County Health Center

Eligibility
(rules have changed over time)

- Undocumented adults
- 18 years and older
- Income at or below 138% FPL
- Alongside restricted scope (emergency) Medi-Cal
- 4,000 program participant cap < 65; 200 program participant cap 65+

Benefits and Services

- Primary, BH, Women's Health Care
- Preventative and chronic conditions
- Lab, radiology and Rx
- Limited specialty
- EXCLUDES emergency and hospital

Enrollment, Cost & Utilization
(pre-2024)

- ~3,000 enrolled clients per year
- ~$2.5M budgeted per year
- ~$300K to $2M spent per year

Impacts on Sacramento County

State and Federal Statutory Change Timelines

December 31, 2025

Covered California Premium Tax Credits Expire

January 1, 2026

Undocumented Enrollment Freeze

Reinstatement of Asset Test

October 1, 2026

- Non-Citizens (i.e., Refugee/Asylee)

January 1, 2027

- Work Requirements*
- Undocumented Monthly Premiums
- Eligibility Redeterminations
- Retroactive Coverage
- Waiting Period

Fiscal Year 2025–2026

Fiscal Year 2026–2027

See Appendix, slide 24-32 for more details.

Impacted Populations

Change	Impacted Groups	Impacted Group Numbers	Effective
Enhanced Premium Tax Credits Ends	Covered California Enrollees	37,000	December 31, 2025
Undocumented Enrollment Freeze	Medi-Cal Adult Undocumented	Unknown, 36,000	January 1, 2026
Reinstatement of Asset Limit	Older Adults with Higher Incomes	Unknown	January 1, 2026
Non-Citizens	Medi-Cal Refugee/Asylee	24,000	October 1, 2026
Work Requirements	Medi-Cal Adult Expansion	174,000	January 1, 2027
Undocumented Monthly Premiums	Medi-Cal Adult Undocumented	36,000	January 1, 2027
Eligibility Redeterminations	Medi-Cal Adult Expansion	174,000	January 1, 2027
Retroactive Coverage	All Medi-Cal Enrollees	Unknown	January 1, 2027
Waiting Period	Medi-Cal Undocumented and Refugee/Asylee	50,000	January 1, 2027

Framing the Path Forward

Framing the Path Forward: Work in Progress

DHS is evaluating impacts and coverage options for Sacramento's safety net programs by

- Developing a “cost modeler” to estimate # of people impacted and potential options, for various coverage scenarios
- Drafting a comprehensive memo for the Board of Supervisors outlining key decision points, scenario options and county budget impact
- **TODAY: Soliciting SCHA’s input ahead of the December 10th Board of Supervisors meeting**

Framing the Path Forward: Policy Decisions

Your initial perspectives on trade offs, recognizing that program adjustments may be necessary, particularly in response to evolving program needs and policy shifts

Limited funding means we can't provide all services to all people – will have find the right balance of:

- Who qualifies for coverage (e.g., income, assets, etc.), exercising County's discretionary authority?
- What services are offered and for how long?

Policy Decisions: Menti Meter

- While we acknowledge that all participants may have interests related to this matter, we recognize these shared interests transparently and proceed with full awareness of potential conflicts. No abstentions are requested, as broad engagement is essential to informed decision-making
- We’ll be using Mentimeter to gather your input during today’s session.

Memory Refresh: CMISP

- Questions #1 and #2 will be about CMISP
- Purpose: Fulfills statutory requirements

Benefits and Services

- Primary and specialty care
- Emergency and hospital care
- Pharmacy and ancillary services
- Subject to limitations

Eligibility
(rules have changed over time)

- Residents with no other options
- Apply at time of medical service/Rx
- Subject to exclusions
- Up to 12 months
- Cost sharing 138-400% FPL
- No asset test

Enrollment, Cost & Utilization

- Pre-2014: ~50K enrolled, $50M budget*
- Post-2014: Zero enrollment

*Partially paid for by state funding

See Appendix, slide 23 for more details.

Memory Refresh: Federal Poverty Level (FPL)

Household Size	138% FPL	200% FPL	300% FPL	400% FPL
1	$20,783	$30,160	$45,240	$60,320
2	$28,208	$40,300	$60,450	$80,600
3	$35,632	$50,440	$75,660	$100,880
4	$43,056	$60,580	$90,870	$121,160
5	$50,481	$70,720	$106,080	$141,440
6	$57,905	$80,860	$121,290	$161,720

Question #1: CMISP Eligibility

FPL Threshold	Rationale	Considerations
138% FPL and below	Prioritizes the most **economically vulnerable**.	May exclude working poor individuals who fall just above the threshold. Could increase reliance on emergency services.
200% FPL and below	Reflects Sacramento County's **2009** CMISP income **threshold.**	Targeting those with the greatest need.
250–300% FPL and below	Aligns with peer counties such as Contra Costa and Alameda which promotes **regional consistency.**	Supports broader access for low-income residents. May reduce disparities across counties and improve continuity of care for mobile populations.
400% FPL and below	**Current policy.** Maximizes access.	Ensures coverage for moderate-income individuals who may not qualify for other programs.

Question #2: CMISP Asset Limit

Option	Rationale	Considerations
No asset limit (Current policy)	Maximum access. Aligns with Alameda County, which does not impose an asset test.	Simplifies eligibility; supports individuals with episodic income or modest emergency reserves
Retain current policy, revisit next Fiscal Year	Allows time for community input and operational planning.	Provides stability while allowing for future refinement
Institute asset limit based on net income	Aligns with Medi-Cal share-of-cost.	New verification processes; individuals with fluctuating income
Institute asset limit considering personal property	In place in Sacramento prior to 2015 Required spend down. Excluded certain personal property (e.g., primary residence, one vehicle).	Reflects prior CMISP policy
Institute asset limit based on both net income and personal property	Provides a comprehensive view of financial resources. Used in CMSP county models.	May reduce access for working poor residents

Memory Refresh: Healthy Partners Program

- Questions #3 and #4 will be about Healthy Partners
- Purpose: Created by Board to provide primary and preventive health care for low-income, undocumented immigrants at Sac County Health Center

Eligibility
(rules have changed over time)

- Undocumented adults
- 18 years and older
- Income at or below 138% FPL
- Alongside restricted scope (emergency) Medi-Cal
- 4,000 program participant cap < 65; 200 program participant cap 65+

Benefits and Services

- Primary, BH, Women's Health Care
- Preventative and chronic conditions
- Lab, radiology and Rx
- Limited specialty
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Enrollment, Cost & Utilization
(pre-2024)

- ~3,000 enrolled clients per year
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- ~$300K to $2M spent per year

Question #3: Healthy Partners Enrollment CAP

Option	Rationale	Considerations
Retain Current Cap (4,000)	Current enrollment cap that has been in place since 2015.	May result in waitlists or unmet need
Retain Current Cap/Revisit Mid-Fiscal Year	Allows for responsive adjustments based on community need and program trends	Requires mid-year fiscal review and stakeholder engagement
Retain Current Cap/Revisit Next Fiscal Year	Allows for responsive adjustments based on community need and program trends	Aligns with broader planning and evaluation cycles
Adjust Cap based on CMISP Utilization	Connects program growth to broader system capacity and service coordination	May introduce variability in access; requires clear communication and modeling

Question #4: Healthy Partners Services

Options	Rationale / Data	Considerations
Retain current services that focus on preventative care	Currently Healthy Partners emphasizes early intervention and long-term health outcomes. Aligns with public health goals.	May reduce access to specialty or urgent care.
Adjust services to focus on catastrophic care (i.e., urgent care/follow ups after emergency room visit)	Ensures coverage for life-threatening or high-cost events. Provides a safety net for the most severe needs.	Limits access to routine or chronic care management. May increase downstream costs and worsen health disparities.

Question #5: Duration limits, either program

Option	Rationale / Data	Considerations
12 months (retain current policy)	Supports continuity of care. Used by Alameda and Contra Costa counties. Some CMSP counties (e.g., Yolo, Butte, El Dorado) also use 12-months.	Reduces administrative burden and promotes stability for individuals managing chronic or complex conditions. Encourages long-term engagement with care.
12 months, revisit next Fiscal Year	Maintains current access while allowing time for evaluation and stakeholder input.	Offers predictability with ability to make future adjustments based on community needs.
3, 4, or 6 months (align with other counties)	Some counties (e.g., San Diego, Fresno) use shorter enrollment periods to reassess eligibility more frequently.	May increase administrative workload and disrupt care continuity. Could disproportionately affect individuals with unstable housing or employment.

Question #6: Other Considerations

Do you have anything else you would like DHS to consider when determining coverage or services?

Commission Discussion
&
Public Comment

APPENDIX

Statutory Requirements

- **Welfare and Institutions Code (WIC) § 17000:** Sets for the obligation to financially support the indigent through General Assistance (GA) and the obligation to provide health care to medically indigent persons. WIC § 17000 establishes the overarching policy of the state mandating that each county provide aid and relief to its indigent population. Counties have broad discretion to set standards for GA but must ensure that medical care is provided to indigents without imposing unrelated financial eligibility criteria. This obligation neither requires a county to satisfy all unmet needs, nor mandates universal health care. A county's discretion to set eligibility standards can only be exercised within fixed boundaries consistent, not in conflict with WIC § 17000, and reasonably necessary to effectuate its purpose.
- **WIC § 10000**: imposes a minimum standard of care, requiring that subsistence medical services be provided promptly and humanely. Counties retain discretion to determine how to meet this standard, but they may not deny subsistence medical care to residents based upon criteria unrelated to individual residents' financial ability to pay all or part of the actual cost of such care. In the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county. Counties must provide "medically necessary care", and such care must be "sufficient to remedy substantial pain and infection."

State Statute Changes: Undocumented

- **Undocumented Enrollment Freeze (Effective January 1, 2026**) - New enrollments into full-scope Medi-Cal will be frozen for adults aged 19 and older who lack permanent legal status. Approximately 1.6 million current enrollees will retain coverage if they maintain eligibility. Pregnant individuals and those within 12 months postpartum are exempt from the freeze. Individuals who lose coverage may re-enroll within 3 months of disenrollment without losing eligibility.
- **Monthly Premiums for Undocumented Adults (Effective January 1, 2027);** A $30 monthly premium will be required for undocumented adults aged 19–59 with unsatisfactory immigration status. Individuals who do not pay will be disenrolled but may re-enroll within 3 months by repaying the balance.

State Statute Changes: Medi-Cal Eligibility

- **Reinstatement of the Asset Limit (Effective January 1, 2026) -** The asset limit for non-MAGI Medi-Cal programs will be reinstated to 2022 levels: $130,000 for an individual and +$65,000 for each additional household member. In 2022, California raised the asset limit to these higher thresholds. By 2024, the asset test was eliminated entirely to expand access and reduce administrative burden.

Federal Statute Changes: Undocumented /Legal Immigrants

- **Five-Year Waiting Period for Immigrants -** Immigrants with "qualified" status must wait five years after obtaining that status before enrolling in Medicaid. Applies to qualified non-citizens, including:
  - Lawful Permanent Residents (green card holders)
  - Parolees (for more than one year)
  - Battered spouses, children, and parents
  - Victims of trafficking
  - Certain humanitarian categories
  - Exemptions: States may waive the five-year wait for:
    - Children
    - Pregnant individuals
- **Narrowing of Eligible Noncitizen Categories -** Limits Medicaid eligibility to:
  - Lawful Permanent Residents
  - Certain nationals from Cuba, Haiti, Micronesia, Marshall Islands, and Palau
  - Refugees, asylees, and other humanitarian groups currently eligible under federal law would no longer qualify under the new rules.

Federal Statute Changes: Medicaid Eligibility

- **Retroactive Coverage (Effective January 1, 2027) -** Reduces retroactive Medicaid coverage from 3 months to:
  - 1 month for ACA expansion group enrollees
  - 2 months for all other Medicaid enrollees
  - Estimated impact: 86,000 Californians could be affected, according to DHCS.
- **Redetermination Frequency (Effective January 1, 2027) -** Requires semiannual eligibility checks (every 6 months) for adult Medicaid expansion beneficiaries, instead of annual reviews.
  - Estimated impact: 400,000 Californians may lose coverage due to increased administrative churn, per DHCS.
- **Cost Sharing (Effective October 1, 2028) -** Requires states to impose cost sharing up to $35 per service for adults in the expansion group (incomes 100%–138% FPL).
  - Exemptions: Services provided by: Federally Qualified Health Centers (FQHCs), Behavioral Health Clinics and Rural Health Clinics

Federal Statute Changes: ACA Premium Tax Credits

- **Enhanced Premium Tax Credits End (Effective December 31, 2025)** - In 2021, the federal government increased financial help for some people for Covered California Through Enhanced Premium Tax Credits. Premium tax credits help lower insurance costs for eligible individuals and increased healthcare access. Credits are based on income and family size, making healthcare more affordable. The increased help will end on December 31, 2025.

Federal Statute Changes: Work Requirements

- **Monthly Compliance Requirement (Ages 19–64) -** Beneficiaries must demonstrate at least 80 hours/month of one or more of the following:
  - Employment
  - Community service
  - Participation in a work program
  - Enrollment in an educational program (at least half-time)
  - A combination of the above
- **Exemptions -** Certain groups are excluded from the work requirement:
  - Individuals already meeting work requirements under TANF or SNAP
  - Pregnant individuals
  - Parents/caregivers of children under 13 or individuals with disabilities
  - People with disabilities, including those with substance use disorders
  - Incarcerated individuals
  - *States may choose not to require verification of exemptions.*
- **Good Cause Exceptions -** States may temporarily exempt individuals facing:
  - Hospitalization or serious illness
  - Federally declared disasters
  - High local unemployment or other short-term hardships
- **Verification Requirements**
  - Applicants: Must verify compliance for at least 1 month (up to 3) before applying.
  - Current enrollees: Must verify compliance at least once between eligibility checks.
  - Noncompliance: Triggers a notice with 30 days to prove compliance or exemption. Coverage continues during this period. Failure to comply results in disenrollment.
- **Implementation Timeline - Begins January 1, 2027**
  - States may request extensions if they show progress toward implementation.
  - All exemptions and delays expire December 31, 2028.
- **California Impact -** According to the California Department of Health Care Services (DHCS), an estimated 3 million Medi-Cal members could lose coverage due to these work requirements.

Potential Federal Regulatory Changes: FQHCs

- **Redefinition of "Federal Public Benefits" -** The U.S. Department of Health and Human Services (HHS) has issued a proposed rule that revises the interpretation of "Federal public benefit" under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This rescinds the 1998 interpretation and reclassifies programs like community health centers (FQHCs) as federal public benefits.
  - Immigrants with unsatisfactory immigration status may be restricted from accessing services at FQHCs and other programs newly classified as federal public benefits.
  - The rule applies to "qualified non-citizens" and may limit access for undocumented individuals unless they fall under specific exemptions.
  - PRWORA allows narrow exemptions, including:
    - Emergency services
    - Services necessary to protect life or safety regardless of immigration status or ability to pay.

*The PRWORA statute defines "Federal public benefit" as any grant, contract, loan, professional license, or commercial license provided by an agency of the US or by appropriated funds of the US. It also includes any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the US or by appropriated funds of the US.

Existing Programs for Undocumented Immigrants

- **Medi-Cal for Emergency Services/Pregnancy Services:** Medi-Cal covers individuals with restricted scope Medi-Cal aid codes who are eligible only for emergency and pregnancy-related services, including long-term care when needed. Certain groups, such as young adults (ages 21-25), trafficking and crime victims, and individuals under Senate Bill 75, may have additional coverage options.
- **Hospital/Federally Qualified Health Center (FQHC) Coverage:** As set forth in the Emergency Medical Treatment and Active Labor Act (EMTALA) hospitals that participate in Medicare are responsible to provide care to all people, including undocumented immigrants. Undocumented immigrants use of EMTALA-related services is often covered via emergency Medicaid. Additionally, hospitals that received funding under the Hill-Burton Act must provide free or reduced-cost care to eligible patients, regardless of immigration status. Finally, FQHCs receive federal funding to provide primary care services to all individuals, including undocumented immigrants, at reduced costs. HHS issued a notice for public comment in which the interpretation of “federal benefits” would restrict access to certain federal benefits based on immigration status including FQHC coverage.

Agenda Item #6:

Public Comment

Agenda Item #7:

Closing Comments & Adjournment