

CHEAC Annual Meeting · October 2026

Indigent Care in Transition

Early Insights from Evolving County MIA Programs

Funded by the California Health Care Foundation

Findings as of September 2026

TODAY

Six parts

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Where we started

2

What is coming

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**How counties are
changing programs**

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What to watch

PART ONE

Where we started

1

California reached its lowest-ever uninsured rate

Uninsured rate

15% → 8%

2013 to 2024. The lowest ever recorded.

Medi-Cal enrollment

8.4m → 15m

Roughly one in three Californians.

Covered California enrollment

2 million

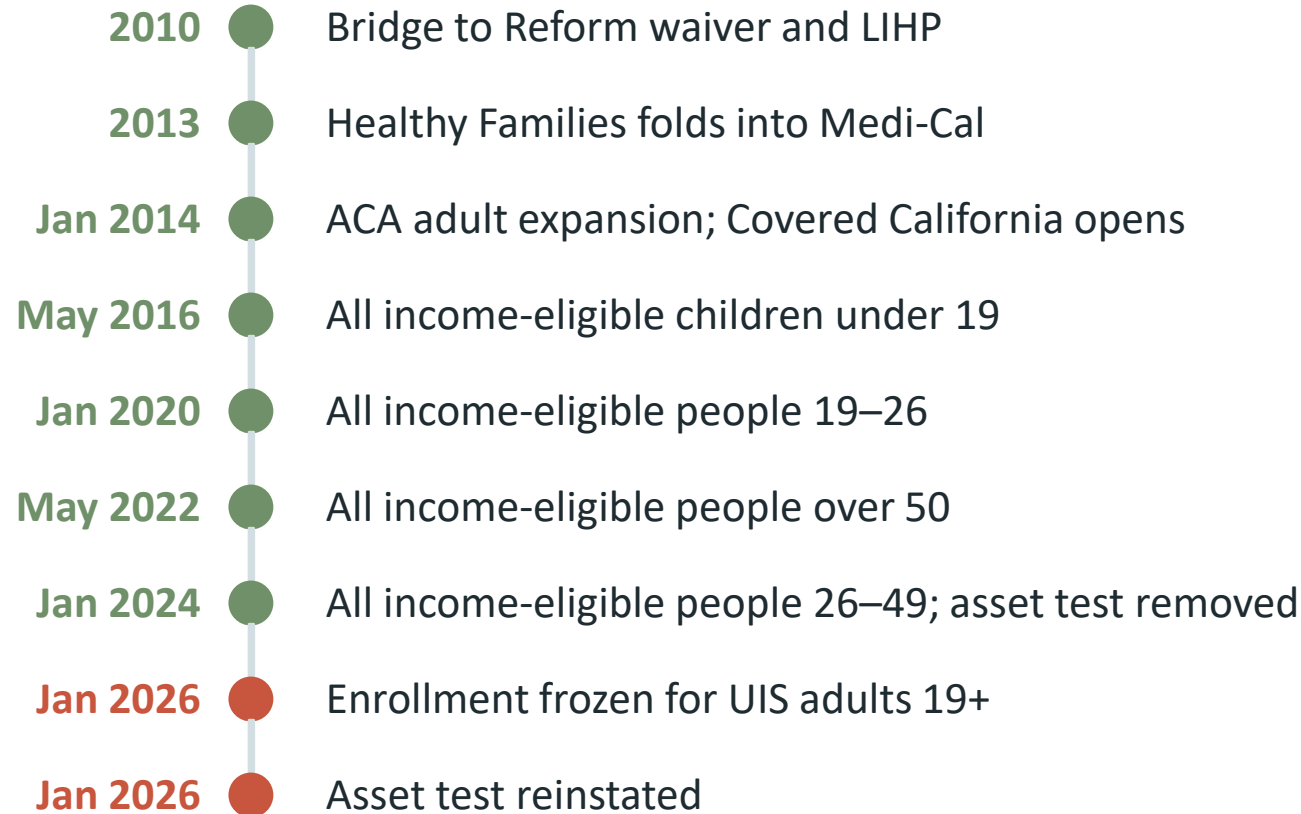
A decade after launch.

- Optional Medicaid expansion for adults without dependents
- A state-based exchange
- Enforced consumer protections
- Expansions to eligible persons regardless of immigration Status

What that coverage bought

- People without insurance are less likely to have a regular doctor
- They delay care over cost, and have more preventable hospitalisations
- Expanding Medicaid reduced deaths among low-income adults by 21%

Fourteen years of expansion — and where it turns



Who the expansions cover

Medi-Cal expansion population, May 2025	Enrollment
ACA expansion adults	5,065,200
Children under 19 with UIS	217,550
Adults with UIS, 19–25	152,912
Adults with UIS, 26–49	849,349
Adults with UIS, 50+	445,707
Total adults with UIS	1,447,968
TOTAL Medi-Cal expansion populations	6,730,718

Source: CHCF, September 2025, Table 1. Total is the sum of the rows above.

Four models of county programs

Provider

County-operated
hospitals and clinics

Payer

Contract with private
hospitals and
providers

Hybrid

County clinics plus
contracted services

CMSP

35 counties under
300,000, shared
network

Also: the Low-Income Health Program, 2010–2014

54 counties, local funds drawing federal match, roughly 650,000 residents at its peak. Closed January 2014. It never covered residents with UIS.

AB 85 redirected realignment funds away from county indigent programs in 2013.

Welfare and Institutions Code §17000 stayed exactly where it was. That is the arrangement counties are now being asked to absorb a new uninsured population inside — and it is the single most common theme in our interviews.

What this project measures against

Appendix C of the CHCF paper profiles all 23 large county programs. Measuring against it is what makes "no change" a finding.

Indigent programs profiled

23 MIA programs in large counties

CMSP covers 35 small and rural counties.

Benefit levels

Limited

Moderate

Extensive

Income eligibility ceilings

<100–650%

FPL. There is no standard.

Limited — selected outpatient services, but no or limited inpatient hospital services

Moderate — numerous outpatient services and inpatient hospital services, but no dental or mental health services

Extensive — wide array of outpatient services, inpatient hospital services, and dental and/or mental health services

Most programs make clear that the coverage is not health insurance.

PART TWO

What is coming, and when

2

Two forces

Federal — H.R.1, July 2025

- ~\$1 trillion in Medicaid cuts over ten years
- Work requirements
- Six-month redeterminations
- Narrower immigrant eligibility
- DSH cuts to public hospitals

State — 2025-26 budget

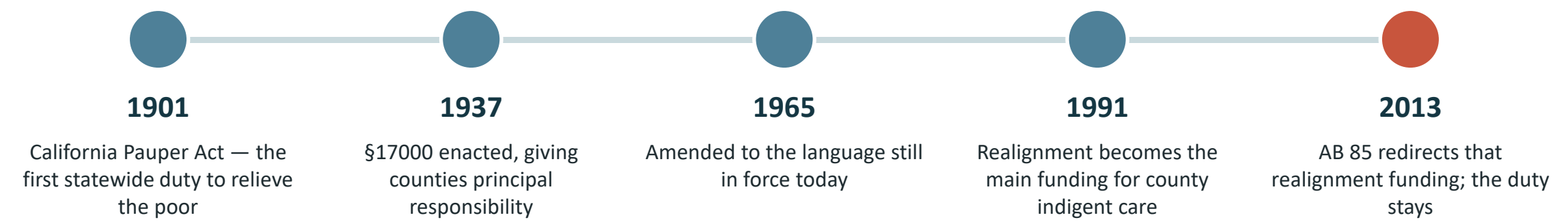
- Enrollment freeze for undocumented adults
- Asset test reinstated
- Premiums for state-only enrollees
- Dental coverage narrowed
- Move out of managed care

What the modelling estimates...

UC Berkeley and UCLA (May 2026): **4.6 million Californians under 65 will be uninsured by 2030** — an increase of 2.2 million, **nearly doubling the uninsured rate to 14.7%**. Among undocumented residents the rate doubles to 50%.

Welfare and Institutions Code §17000 obligates counties to provide care to indigent residents.

“Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.”



The state and counties have passed responsibility for the uninsured back and forth for decades. The duty is not contingent on state funding, and it did not change this year.

Source: County Indigent Programs, briefing for the Senate Budget Subcommittee 3 hearing, March 19, 2026; W&I Code §17000.
https://leginfo.ca.gov/faces/codes_displaySection.xhtml?sectionNum=17000.&lawCode=WIC

2026 and 2027

Effective	Change	What it does
Jan 1, 2026	Enrollment freeze	Undocumented adults 19+ can no longer sign up for full-scope Medi-Cal.
Jan 1, 2026	Asset test reinstated	Seniors, people with disabilities, nursing home residents.
Oct 2026	Federal status reclassification	Refugees, asylees, humanitarian parolees. State backfills to June 2027.
Jan 1, 2027	Work rules	\$580 a month earned, or 80 hours of training, volunteering or school.
Jan 1, 2027	Fee-for-service transition	State-funded members leave managed care. Coverage continues.
Jan 1, 2027	Retroactive coverage cut	One month of prior bills for adults without children; two for others.
Mar 1, 2027	Six-month eligibility checks	Renewal twice a year instead of once.

Mid-2027, and 2028

Effective	Change	What it does
Jul 1, 2027	Dental narrowed	Emergency dental only for some members, by immigration status.
Jul 1, 2027	Monthly premiums	Non-payment drops members to restricted scope.
Jul 1, 2027	Asset limits fall	From \$130,000 for one person to \$21,000.
Oct 1, 2028	Copayments	Adults earning over \$15,560, capped at 5% of household income.

No copayments at community health centers or rural clinics, or for emergency care, check-ups, pregnancy, children, or behavioural health.

Source: DHCS. Medi-Cal Changes. Retrieved September 12, 2026. <https://www.dhcs.ca.gov/medi-cal/updates/medi-cal-changes/>

PART THREE

Approach to Monitoring

3

Four methods in the approach

1

AI agent research

Two agents, same instruction set, run in parallel and reconciled

2

Quantitative signals

Coverage loss and downstream hospital data, standardised per capita

3

Researcher review

Agents produce the record; researchers decide what is reportable

4

Interviews

Program leaders, standardised protocol — this is what search cannot reach

All change is measured against Appendix C of the September 2025 CHCF brief.

METHOD

Eight monitoring data collection passes in 13 weeks



Interviews with counties, providers and experts

Pass 8 (September 24) checked the five decision dates that had passed since the September 12 pass — CMSP, Fresno, Tulare, Sacramento and San Diego — and recorded an outcome, or the reason there was none, for each.

The AI agents, and what each is for

Two AI agents run the same instructions and their outputs are compared, reconciled and merged.

Claude (Anthropic)

Paid Opus-class subscription.
Assigned synthesis, baseline structuring, analytical framing and document production.

ChatGPT (OpenAI)

Paid Pro subscription.
Assigned disciplined coverage, instructions enforcement and disposition logging.

NotebookLM — retired

Retired July 2026. It reasons only over uploaded sources and could not perform live discovery — which is where the highest-value findings have come from.

What these numbers rest on

Sources

- CHCF, "Covering the Uninsured," September 2025
- Board records, budgets, CMSP agenda packets
- DHCS Medi-Cal Certified Eligibles, August 2026
- Covered California Active Member Profiles, March 2026
- HCAI hospital data; DOF population estimates
- Interviews with program leaders

Limitations

- Closed Board sessions are invisible to this method
- "No change" in program can be due to thin documentation
- Enrollment data is preliminary and update by DHCS monthly
- We measure coverage loss, not uptake

PART FOUR

How counties are changing indigent care programs

4

FINDING 1

“Demand” is rising as uninsured increases

Adults losing coverage in
23 large counties

715,070

Working-age adults, Sept 2025
to July 2026.

Counties with a decline

58 of 58

Uniform, not concentrated.

Coverage loss compared
to pre-H.R.1 churn

4× faster

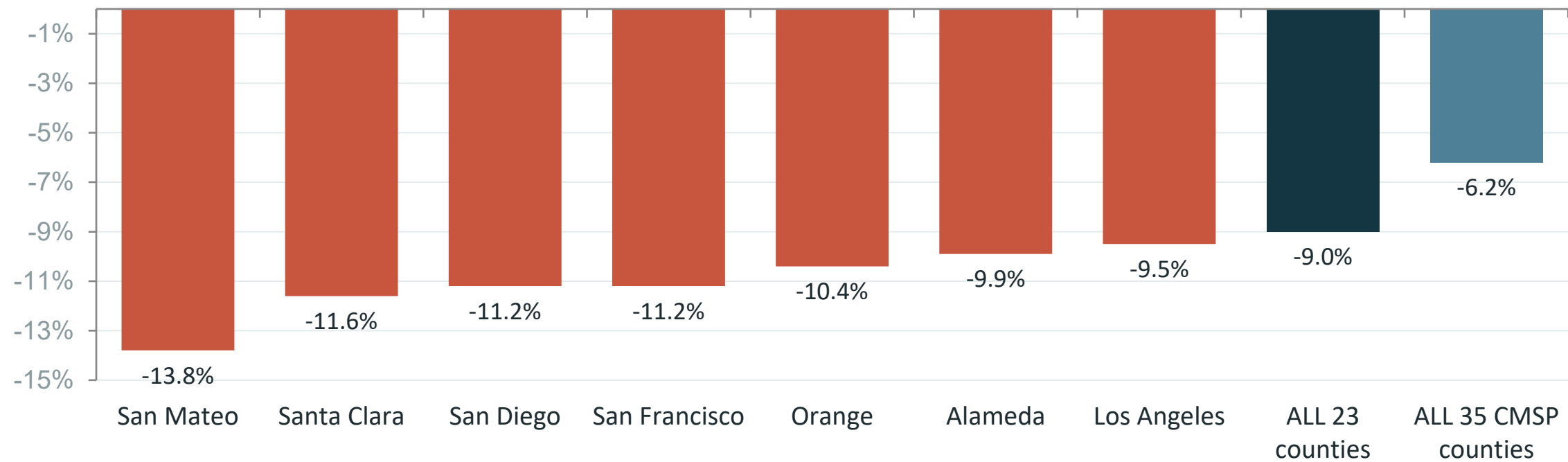
Against the final-to-final rate
of –2.5%.

None of this yet reflects work requirements, six-month checks or premiums.

FINDING 1

Steepest Medi-Cal enrollment declines, by rate

Working-age adults, 3-month average May–Jul 2026 vs Aug–Oct 2025



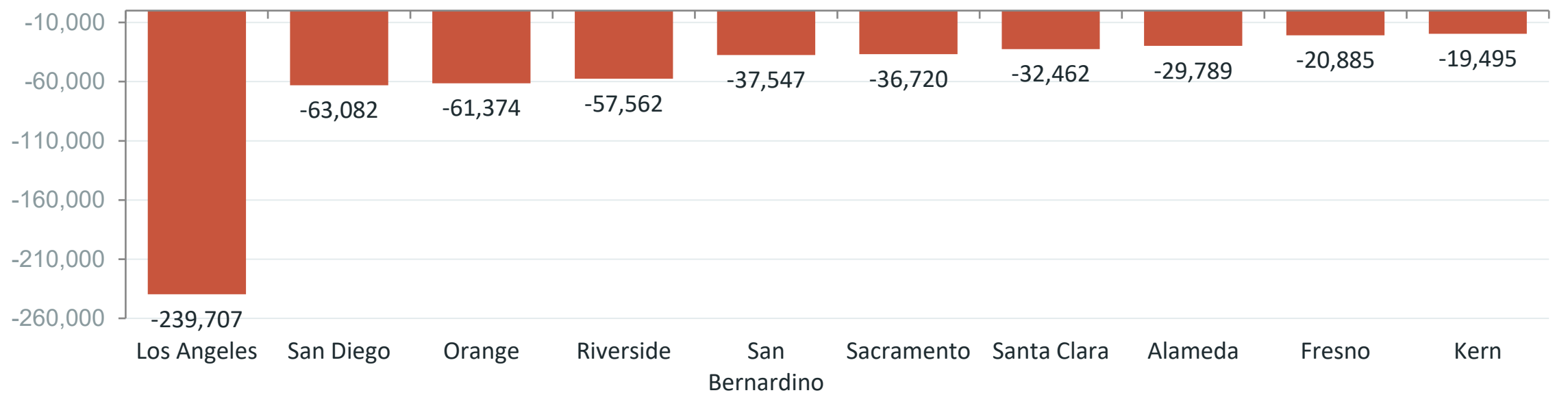
Seven individual counties, then two aggregates — all 23 large MIA counties combined, and all 35 CMSP counties combined.

Source: DHCS. Medi-Cal Enrollment By Medicare Dual Status and Age Group, Certified Eligibles. August 2026. <https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/35261707-8fae-4fe2-97a7-c4e9fc75681a>

FINDING 1

Medi-Cal enrollment lost, by number of people

Working-age adults who left Medi-Cal, September 2025 to July 2026. The ranking changes completely: San Mateo had the steepest rate and does not appear here.



All 23 counties: -715,070 · All 35 CMSP counties: -48,052 · Statewide: -763,122

Source: DHCS. Medi-Cal Enrollment By Medicare Dual Status and Age Group, Certified Eligibles. August 2026. <https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/35261707-8fae-4fe2-97a7-c4e9fc75681a>

FINDING 1

Covered California enrollment says the same thing

September 2025 to March 2026

23 large MIA counties

-8.8%

About 156,500 subsidised members.

35 CMSP (rural) counties

-14.2%

The steepest of any group in the state.

. Marketplace decline does not equal newly uninsured — some is movement to Medi-Cal. Directional.

Source: Covered California. Active Member Profiles. March 2026. <https://www.hbex.ca.gov/data-research/>

CMSP projected 124,000 of its residents would lose Medi-Cal. Roughly 73,000 already have.

And the provisions driving that projection do not take effect until 2027.

FINDING 2

The state did not backstop county indigent care funding

PATH Proposal — excluded

Coalition of counties and providers sought \$125 million in the Legislature's June plan, then it was dropped from the enacted budget. No substitute emerged before adjournment.

AB 2368 — stalled

Would have required county indigent-care plans to report to DHCS by 2028. Passed the Assembly unanimously; held in Senate Appropriations.

The \$761 million and \$2.4 billion asks will carry into the next budget cycle.

FINDING 3

Boards of Supervisors make decisions, with some exceptions

County	Deciding body	Why it matters
San Francisco	Health Commission	Healthy SF never reaches the Board of Supervisors
Kern	Hospital Authority	Separate governing board; some actions reserved to the Board
Alameda / Santa Clara	Standing health committee	Where the work actually happens
San Diego	Ad hoc subcommittee	Publishes no agenda trail
Los Angeles	Full Board, by motion	The HMHS Cluster briefs and gathers feedback — it does not decide
San Mateo	Board sets terms; Health Commission administers	The Commission IS the plan that runs ACE under county contract
San Joaquin	Board, through Health Care Services Agency	Its Health Commission runs an unrelated managed-care plan

What are counties doing: a few rebuilding, most bracing, two tightening

Revival / Restart / New

- Monterey — relaunched
- Santa Barbara — refunded
- Los Angeles — new program

Loosening

- San Diego — 4-1 vote to expand to UIS population
- The only one expanding

Tightening / structural

- CMSP — 35 counties at once
- Sacramento — 400% to 138% FPL
- Merced, Placer joining CMSP; SLO deciding

No change to terms

- Fifteen counties
- Absorbing demand without redesign
- Changes likely ahead

Joining CMSP does not transfer the \$17000 obligation.

FINDING 5

What changed, feature by feature

County	Eligibility	Benefits	Undocumented	Cost sharing
CMSP (35)	Tighten	Tighten	Tighten	Tighten
San Diego	Loosen	Pending	Pending	Loosen
Monterey / Santa Barbara	Restore	Restore	No change	No change
Los Angeles	Restore	Restore	Covered	No copays
Merced / Placer / SLO	Joining CMSP	Joining CMSP	Joining CMSP	Joining CMSP
Sacramento	Tighten	No change	No change	Tiers removed*
Other 15 counties	No change	No change	No change	No change

* Sacramento's CMISP no longer has a share-of-cost tier.

PART FIVE

Three counties up close

5

The largest new program launch — Health Connect LA

Measure ER

~\$1 billion/yr

Half-cent sales tax, passed
June 2026. Runs to 2031.

Revenue dedicated to the program

45%

~\$450 million a year. Budget funds
for DHS cover services there.

Launch target

Jan 2027

Contingent on three contracts
being signed.

Successor to My Health LA, which closed in January 2024 when its 87,000 enrollees became Medi-Cal eligible.

The program at a glance

Who is eligible

≤138% FPL, age 19+, county resident — and either undocumented, or lost Medi-Cal to the work requirement.

How long

Twelve months for undocumented enrollees, renewable. Six months for those who fell off Medi-Cal.

Cost to the member

None. No copayments and no cost sharing of any kind.

Benefits

Mirrors Medi-Cal, less vision and transportation, with a narrower pharmacy benefit.

Providers

55–60 federally qualified health centres and free clinics. Hospitals are not covered.

Provider payment

75% of the PPS rate, plus a quality withhold. "We are not Medi-Cal" — full PPS would exhaust the pool.

Planning for 100,000–200,000 enrollees.

Three open questions

Specialty care

The plan requires it, and the network is still being decided. DHS is at or near capacity across nearly every specialty.

Hospitals

Not covered by the program. Whether any non-DHS hospital is contracted is unanswered.

The enrollment pathway

DHS had proposed a Medi-Cal application first. The confirmed criteria do not mention it.

Financing and policy question - will benefits be revisited if enrollment pressure hits the budget?

CMSP — what changes on January 1, 2027

- Income ceiling cut from 300% to 200% FPL
- Asset limit reinstated, applied to all applicants
- Full share of cost restored — the 75% SOC reduction ends Jan 1, 2027; members pay the full monthly amount
- Enrollees with UIS move to emergency services only
- Benefits narrowed: chiropractic and outpatient SUD treatment cut
- Connect to Care suspended — up to 1,300 enrollees

No record yet from the September 18 hearing; the last statutory hearing is October 5.

CMSP — why it is tightening

CMSP is not cutting because demand fell. It is cutting because the money behind it has already gone, and what remains is a reserve with a countdown on it.

Realignment revenue

None

Suspended since FY2019-20 by trailer bill.

Reserve runway

~18 months

The program is running on reserve alone.

If the uninsured return

**\$300–900
million**

A year, against ~\$50 million that could resume.

And if the reserve runs out...

A 1995 formula in every county participation agreement bills the 35 member counties directly for the overrun. Unused since about 1999.

Santa Cruz — MediCruz stays, no move to CMSP

It considered joining CMSP — and declined

- MediCruz covers residents to 160% FPL, no share of cost, regardless of immigration status
- CMSP priced at \$14.6M against MediCruz's \$10.2M — 42% more
- Eligibility determinations impossible before July 2028
- Ages 19–20 would lose eligibility
- A deferral, not a settled posture — staff return this fall on alternative delivery models

Six weeks later: fiscal distress

- State of fiscal distress declared August 4
- \$23.2M deficit this year, above \$67M by FY2028-29
- Half-cent general tax on the November ballot
- Neither MediCruz nor §17000 appears in the ballot materials

What MediCruz covers:

- Access by medical referral: patients qualify when they seek care, get a set of services, then exit
- No standing enrollment
- Includes 24 specialty services
- Pays providers about 85% of Medicare rates

PART SIX

What to watch

6

The next ten weeks

Who	When	What resolves
San Luis Obispo	Sep 30	Hard deadline to execute the CMSP agreement
Los Angeles	Late Sep	The FQHC solicitation — eligibility, payment, the network
CMSP	Oct 5	The last statutory hearing; the Sep 18 record is not yet posted
Fresno	Oct 6 / Oct 20	MISP eligibility item — not at the Sep 14 budget
San Diego	End of Oct	Board decision on the CMS reform package
Sacramento	Coming months	First Board items on provider contracts and rates since 2013
Santa Cruz	Fall	Alternative indigent-care delivery models

Three ballot measures on November 3

STATEWIDE — Proposition 40

One-time 5% tax on billionaires. Tens of billions, and 90% must go to health care. But the money goes to the STATE — no county allocation, nothing named for indigent care.

San Diego — Measure B

Citizens' initiative half-cent tax, ~\$370–450 million a year. 60% to health, nutrition and children; County Medical Services is named, with no set share.

Santa Cruz — Measure E

Half-cent general tax, ~\$27 million a year from FY2027-28. No MIA program named anywhere in the materials.

ALREADY DECIDED

Santa Clara — passed

Nov 2025 · \$330M a year for hospitals

Los Angeles — passed

June 2026 · Measure ER

Contra Costa — failed

June 2026 · Measure B

San Francisco — failed

June 2026 · Props C and D

Where a statewide solution might come from

- The 2027-28 budget, and the counties' \$2.4 billion ask from this year
 - This retains current county-by-county solution for indigent
- Defaulting people into Emergency Services Medi-Cal — an aid-code change
- Funding indigent care through managed-care contracts with a PMPM add-on
- A joint powers authority to pool risk across counties (e.g. CMSP style program for other counties)
- New Governor's administration and policy and budget priorities

Discussion

- What else should this monitoring project track and report?
- How can this monitoring project be helpful to your county?
- What statewide solutions are the most politically and financially feasible?

Thank you!

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