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Medi-Cal-amity

California's Reckless Expansion of Medicaid Long-Term Care to the Affluent

By Stephen A. Moses

California has opened the floodgates to its most expensive program's highest-cost benefit: Medicaid long-term care (LTC). The Golden State eliminated its asset eligibility test for Medicaid — dubbed Medi-Cal in California — effective January 1, 2024. Historically, Medicaid paid for LTC services for individuals with few liquid financial resources, acting as a safety net for those who could not otherwise afford care. But California massively expanded Medi-Cal's LTC by making it easier for the wealthy to receive taxpayer-funded services. California Advocates for Nursing Home Reform explains: "This means that anyone, regardless of how much they own, may receive Medi-Cal benefits."[1] Moreover, California also repealed its "lookback" penalty for transferring assets, undermining the federal mandate to recover Medi-Cal benefits from deceased recipients' estates. From now on, no level of wealth obstructs access to government-financed LTC in the state.

This paper analyzes California's LTC eligibility overreach and its fiscal fallout and recommends state and federal corrective actions.

KEY TAKEAWAYS

California eliminated its Medicaid asset eligibility test on January 1, 2024, which caused Medi-Cal enrollment and expenditures to explode.

Giving free long-term care to the wealthy creates a moral hazard causing affluent Californians to overwhelm the welfare program's ability to help the poor.

Federal taxpayers bear much of the burden to finance this irresponsible and misdirected policy.

Medi-Calibration

Medi-Cal covers 14.9 million people, nearly double the 7.6 million enrolled in 2012,[2] covering over 38 percent of the state's population compared to 20 percent in 2012.[3] By comparison, Medicaid covers 21 percent of all Americans,[4] 19 percent of Floridians,[5] and 17 percent of Texans.[6]

Federal taxpayers paid for 62 percent of Medi-Cal's $175 billion cost in 2022.[7] About 1.1 million Medi-Cal LTC fee-for-service users (7.3 percent of all Medi-Cal enrollees) consumed $27.3 billion in 2022 (15.6 percent of total Medi-Cal expenditures).[8] While seniors and people with disabilities account for only 17 percent of all Medi-Cal enrollees, they drive 50 percent of the program's costs — $87.5 billion.[9]

Given California's disproportionate contribution to national Medicaid enrollment and expenditures and its residents' heavy utilization of the program's scarce LTC resources, a sobering grasp of the risks — namely, unsustainable budget pressures and diminished care quality for the truly

needy—is imperative. California's decision to scrap the asset test demands significant scrutiny.

Long-Term Care

LTC includes medical and custodial care, which people need if they are unable to manage basic activities of daily living on their own. The need for LTC may arise from injury, illness, cognitive impairment, or old age. LTC can be provided in a variety of settings, including nursing homes ($9,277 per month for a semi-private room), assisted living facilities ($5,900 per month), homemaker services ($6,292 per month), and home health aides ($6,483 per month).[10] Much of LTC is provided by loving family caregivers. Family-provided care greatly relieves the expense for Medicaid but can cause financial and emotional strain.

Given the United States' rapidly aging population, with the population 65 and older projected to grow from 58 million in 2022 to 82 million by 2050 (a 41 percent increase),[11] the rising incidence and exploding cost of LTC for the elderly demands special attention. Historically, the Medicaid program—partially funded and administered by the states but disproportionately financed and overseen by the federal government—has been the largest payer of LTC, and eligibility for Medicaid LTC benefits has been restricted to those with limited financial resources. But California upended that system of funding and providing LTC for needy people based on means-tested eligibility to publicly financed services.

LTC Policy Objectives

The United States' LTC system was designed to ensure access for the poor while encouraging the more prosperous to plan to pay for their own future needs. Eligibility for publicly financed LTC was targeted to low-income people (those with monthly income up to $967 per month in 2025 dollars) and the poor (by requiring that recipients own no more than $2,000 in *countable*[12] assets).[13] Congress imposed penalties to discourage people from transferring assets to artificially reduce their wealth to qualify for taxpayer-financed LTC (by transferring homes and vehicles to their children, for example). Assets transferred for less than fair market value for the purpose of qualifying for Medicaid within a "lookback period," originally 24 months and later 36 and 60 months, were penalized by a delay of eligibility equal in months to the amount of assets thus transferred divided by the average monthly cost of a nursing home in the state.

Congress even required that states recover taxpayer LTC payments from deceased recipients' estates to ensure that resources Medicaid exempted temporarily would eventually be retrieved.[14] For instance, if a Medi-Cal recipient owned a $500,000 home, exempt during the person's lifetime, the state could reclaim funds post-mortem to offset taxpayer costs, ensuring that heirs do not inherit a windfall subsidized by the public. This mechanism, if utilized, would help preserve Medicaid as a safety net program, not an entitlement.

Moreover, a cap on exempt home equity prevented individuals with very high housing net worth from receiving Medicaid LTC benefits. To encourage younger, healthier, and more affluent people to plan early for their future LTC needs and lessen the long-term burden on Medicaid, the government offered tax deductions for private LTC insurance, and "LTC Partnership" programs granted additional inducements to insure privately.

How LTC Policy Evolved

Medicaid policies, originally intended to restrict limited public LTC resources to the neediest, gradually opened up eligibility to middle-class and upper-income households. The government granted eligibility to individuals with higher incomes if they incurred high private medical or LTC expenses, making them "medically needy." Higher income people started using Miller trusts—income diversion trusts to get around their states' income caps. Medicaid's home equity exemption, between $730,000 and $1,097,000 in 2025, barely disqualifies anyone, because it is well above the average senior home equity of $250,000.[15] Medicaid disregards a host of additional financial wealth for eligibility purposes, including Individual Retirement Accounts, one business, a vehicle, prepaid funeral expenses, home furnishings, personal belongings, and others.[16] These exemptions protect most wealth from Medicaid's ostensibly stringent but actually lenient spend-down rules. Higher income people can easily exclude residual countable assets to gain eligibility for Medicaid LTC by using them to purchase any of the exempt assets.

Medicaid law extends eligibility even to the wealthy. Legal specialists in Medicaid planning routinely recommend asset protection trusts,[17] special annuities,[18] and other methods[19] to help clients artificially self-impoverish in order to qualify for Medicaid and preserve wealth. For example, a congressional study cited a Rhode Island resident sheltering $400,000 and a Virginia resident sheltering $900,000 in Medicaid-compliant annuities.[20] There is no limit on how much wealth can be sheltered with a Medicaid compliant annuity.

Medi-Cal Overreach

California took full advantage of this trend toward Medicaid LTC eligibility expansion and pushed its limits for many years. For decades, California refused to implement federally mandated rules to tighten eligibility laws. When Congress required a higher 36-month transfer of assets (TOA) lookback period and removed the cap on the TOA eligibility penalty in 1993,[21] California ignored implementing the rules for 31 years, eliminating them entirely last year. When Congress required states to extend the TOA lookback to 60 months and start it at the date of transfer instead of the application date[22] (thereby vastly increasing the incidence and amount of TOA penalties), Medi-Cal once again refused to comply for 19 years without consequence Likewise, from 2005 until its elimination in 2024, California declined to enforce the "income first" rule, intended to end the costly "transfer assets before income" Medicaid planning technique.[23] But none of this earlier non-compliance[24] compares with Medi-Cal's extreme statutory and regulatory eligibility expansion beginning in 2021.

Medi-Cal's Federal Enablers

While no other state removed the asset test for Medicaid, the Medicare Catastrophic Coverage Act of 1988 (MCCA) gave state Medicaid programs the option to set "income and resource eligibility" limits that "may be less restrictive, and shall be no more restrictive" than the limits imposed on the "aged, blind, or disabled individuals, under the supplemental security income program."[25]

Taking advantage of this authority, California Governor Gavin Newsom signed legislation on July 27, 2021, starting a two-phase process to abolish

the Medi-Cal asset test altogether. Phase I increased the asset limit from $2,000 to $130,000 effective July 1, 2022. Phase II removed the asset test entirely as of January 1, 2024. The Biden administration approved this radical, first-in-the nation change, effectively giving it the federal government's blessing. Also on January 1, 2024, California became the first state to offer Medicaid coverage to all illegal immigrants regardless of age, a policy change estimated to add as many as 700,000 enrollees to the program.[26] These changes are likely to cause substantial fiscal burdens in the decades to come.

This financial pressure will fall heavily on federal taxpayers, because California uses shady tactics to finance Medicaid expansion for illegal immigrants and to offset the state's cost of eliminating the asset test.[27] In essence, California taxes LTC providers and managed care insurers to increase federal Medicaid matching funds. This effectively shifts the cost of extravagant eligibility policies from state taxpayers to the federal government.

Medi-Coup

The lawmakers who enacted the MCCA in 1988 likely never imagined that any state would use that law to open eligibility in the mostly federally funded Medicaid program to nearly all comers, irrespective of their wealth or immigration status. It is also unlikely that they imagined a presidential administration would approve such changes. But that is what the Biden administration approved, and California accomplished.

The consequences of California's Medicaid expansions are already becoming evident. California's Legislative Analyst's Office (LAO) reports, "As of December 2024, the senior caseload in Medi-Cal stands at 1.4 million, about 40 percent higher than at the start of the continuous coverage period that began in 2020 as a response to the COVID-19 pandemic."[28] LAO specifies that 165,000 of the extra enrollees were due to eligibility expansions: "In particular, asset test elimination appears to have been particularly effective at extending Medi-Cal coverage to seniors."[29] LAO estimates that 112,000 of the extra enrollees during this period resulted specifically from the asset test expansion[30] and that "multiplying this figure by average per-enrollee costs for the Medically Needy aid category ($12,533) produces total costs of $1.4 billion for the asset test elimination."[31] As the public becomes more aware of the easier eligibility criteria, these costs are likely to increase substantially.

The illegal immigrants made newly eligible for Medicaid also contributed to the spending surge. On March 17, 2025, California officials informed Governor Newsom that they need $6.2 billion more than projected in the budget to make "critical" payments for Medi-Cal.[32] Given that adults eligible for Medicaid based on age or disability account for one in five enrollees but consume over half of Medicaid spending nationally,[33] California's liberality is reflected in dramatically rising state and federal Medicaid expenditures.

What Is Low Income?

Although California eliminated the asset test for Medi-Cal LTC benefits, it maintains an income test that advocates claim restricts eligibility to low-income people.[34] That claim is specious.

For home and community-based services and non-LTC Medicaid for the aged and disabled, California's monthly income test limit is $1,732 for singles and $2,352 for couples, or 138 percent of

the federal poverty level.[35] However, applicants with higher incomes can still qualify by showing that a certain share of their income is devoted to specific state-defined costs, such as supplemental health insurance or private health care expenses. These include expenditures for medical equipment, prescription drugs, health care, or LTC. Even services Medi-Cal does not cover and treatments denied by Medi-Cal can count toward satisfying that share of cost. Most importantly, qualified expenses—which include high-cost medical care or LTC—offset income amounts. Thus, income can be very high and still not exclude people from qualifying for Medi-Cal.

For nursing home recipients, there is no definable income limit, because they are required to expend all their income (except for a small personal needs allowance) to offset Medi-Cal's cost for their care. So long as their acceptable medical expenditures consume enough of their income, they qualify no matter how high their income. Qualifying expenditures are extensive, including unpaid medical bills,[36] medically necessary supplies, equipment or services that Medi-Cal does not cover,[37] and 27 different products and services identified by an internet search.[38]

Institutionalized Medi-Cal recipients with spouses can get around the requirement to spend their income by means of "spousal impoverishment" protections. These protections, enacted in the same 1988 MCCA legislation that enabled Medi-Cal to abolish the asset test, created a minimum monthly maintenance needs allowance for community spouses. As of 2025, Medi-Cal's allowance is $3,948. If a community spouse's income is below that amount, the institutionalized spouse's income is redirected to bring him or her up to the minimum. This means that the institutionalized spouse's income that would have otherwise offset Medi-Cal's cost for care goes to the community spouse instead.

Intentions vs. Consequences

Easy access to Medicaid LTC, which California has enabled more than any state in the country, causes three main problems. First, eliminating the asset test adds tens of thousands of people to the rolls, but whether these changes increase their quality of life, health, or economic well-being is dubious given widespread reports of poor nursing home quality, long home care waiting lists and many other Medi-Cal access and quality problems. From 2015 to 2024, nursing home staffing in California decreased from 4.54 hours of nurse staff per resident per day to 4.39, and the number of deficiencies per facility rose from 10.5 to 16.7. In the same period, the percentage of California nursing homes receiving a deficiency for actual harm or jeopardy jumped from 14 percent to 27 percent.[39]

As of December 2024, Medi-Cal's Home and Community-Based Alternatives Waiver enrolled 9,259 people and had a waiting list of 5,110.[40] The Assisted Living Waiver enrolled 16,251 people with a waiting list of 7,713.[41] A May 2024 study reported "challenges negotiating care with home health agencies and skilled nursing facilities for Medi-Cal insured patients" and that "the quality and specificity of support services available for patients insured with Medi-Cal raised concerns."[42] Medi-Cal eligibility does not automatically convey access to better care.

Affluent Medi-Cal recipients have one way to ensure higher quality care than the truly needy receive. Medicaid planning specialists advise their clients to hold back enough cash from the artificial spend-down process to pay for private LTC at the start in order to overcome the

discrimination against Medicaid recipients caused by the program's low LTC reimbursement rates. This "key money" gains them access to the best LTC providers that are desperate to attract private payers. But it excludes the genuinely needy enrollees who lack funds to buy their way into these high-quality, relatively less Medicaid-dependent providers.

The second problem is that extending Medicaid eligibility to the wealthy triggers a cascade of negative effects in the LTC industry. It reduces the number of private payers in the LTC market (who pay higher rates to providers than Medi-Cal does) and increases the number of Medi-Cal patients who generate notoriously low reimbursements for LTC providers. Medi-Cal pays only 76 cents for every dollar nursing home care costs to provide.[43] This is the fifth-lowest payment rate for any state Medicaid program in the country and is six cents below the national average.[44] As a result, California's LTC providers rely on charging private payers higher rates to make up for Medi-Cal's insufficient payment rates. The Kaiser Family Foundation reports, "Providers have cited Medi-Cal's low payment rates as a barrier to their participation in the program and sued the state on the basis that the fees violate federal Medicaid payment standards."[45] Across America, and especially in rural areas, nursing home closures due to low Medicaid reimbursements are severely limiting access to much needed post-acute and LTC.[46] Moving the wealthiest Californians onto public assistance not only damages Medi-Cal's ability to fund quality care in the present, but it signals to middle- and upper-income households that they do not need to plan for future LTC financial risk.

Third, disregarding assets and expanding caseloads and expenditures diverts resources from other state priorities, such as education, public works, and law enforcement. Like presumptive eligibility (the practice of accepting applicants' unverified statements regarding their financial eligibility), eliminating the asset test makes more people eligible faster. But unlike presumptive eligibility, which can be reversed, eliminating the asset test removes any restraint on future caseloads and expenditures. Reasonable income and asset limits for LTC eligibility save money and target the public assistance resources to people most in need in the short term. These responsible state actions have important long-term benefits as well—such as encouraging the public to prepare privately for LTC—that California has eschewed.

Ramifications and Recommendations

California's dramatic move to fully socialize LTC effectively informs citizens that the responsibility for their care in old age lies with government, not with themselves or their families. That message obviates the need for individuals and families to consider LTC as part of their retirement planning and shifts that responsibility to the federal government.

This moral hazard leaves everyone vulnerable—but especially the poor who have few private resources to fall back on. Such irresponsible action removes every reason for people to plan early and save, invest, or insure privately for LTC. Americans possess $97 trillion of wealth—held in private financial accounts ($40 trillion),[47] home equity ($35 trillion),[48] and life insurance ($22 trillion)[49] that could potentially fund LTC privately. These private resources are largely off the table to fund LTC, especially in California. There are only four sources of private financing that might offset future Medi-Cal LTC expenditure shortfalls:

(1) increased personal asset spend-down, (2) Medicaid estate recovery, (3) home equity conversion, and (4) private LTC insurance. The current structure of California's Medi-Cal program has extinguished all of these sources.

California lawmakers were able to take such irresponsible policy action because of the ability to access heavily discounted federal dollars. If California prioritizes government welfare programs for wealthy residents, its taxpayers should bear those costs, not taxpayers across the country.

To obtain more responsible and prudent state policymaking, Washington must limit the ability of states to engage in legalized money laundering schemes. CMS should take specific actions to address California's defiance of federal law around Medicaid long-term care eligibility.

- restore a reasonable asset limit for Medi-Cal LTC eligibility, preferably the $2,000 limit, common in other states, that California recently abandoned.
- systematically review all Medi-Cal financial eligibility rules and policies and revise them so that they encourage wealthier individuals to plan for LTC needs and stay off Medi-Cal.
- support private LTC financing and encourage a LTC insurance market to relieve Medi-Cal and Californians from the dysfunctional course of financial and caregiving decline.

Likewise, the federal government should learn from Medi-Cal's failed experiment with socialized LTC and mitigate the perverse incentives in LTC policy that discourage early LTC saving, investment, and insurance. The Paragon Health Institute's papers "Long-Term Care: The Problem,"[50] "Long-Term Care: The Solution,"[51] and "Medicaid's $100+ Billion Leak"[52] explain the problems caused by open-access policies such as California's and propose socially and financially responsible solutions.

These solutions include

- enforcing mandatory estate recovery,
- lowering or eliminating the Medicaid home equity exemption,
- requiring that asset spend-down be for qualified medical or LTC expenses
- lengthening and enforcing the asset transfer lookback period, and
- prohibiting special Medicaid annuities and asset protection trusts

These measures would save trillions of dollars over time, prevent other states from making California's mistakes, and set LTC service delivery and financing on a sustainable path. As long as Medicaid dominates LTC service delivery and financing with easy eligibility access, it will pay rates less than the cost of providing the care, and access to and quality of LTC in the United States will continue to decline.

The fundamental problem with America's LTC service delivery and financing system is that it discourages the use of private finances to fund care. This leaves Americans dependent on an under-financed public welfare system that serves them poorly. California's excursion into free LTC for the wealthy carried this endemic error to unsustainable extremes. In time, economic reality will prevail, preferably through clear thinking and dramatic reform as just described. But, if rational policy does not take hold soon, the country's soaring federal debt will lead to crushing interest burdens and devastatingly high tax rates and

inflation. Thoughtful reform focused on realigning incentives to maximize value from our public expenditures, however difficult, is a far better course of action.

About the Author

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[1] California Advocates for Nursing Home Reform, "Overview of Medi-Cal for Long Term Care," updated September 4, 2024, https://canhr.org/overview-of-medi-cal-for-long-term-care/.
[2] California Department of Health Care Services, *Medi-Cal's Historic Period of Growth: A 24-Month Examination of How the Program has Changed Since December 2012*, August 2015, https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Historic-Growth-Brief.pdf.
[3] California Department of Health Care Services, *Medi-Cal Monthly Eligible Fast Facts, December 2024 (Date Represented: September 2024)*, https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-September2024.pdf.
[4] KFF, "Medicaid in United States," August 2024, https://files.kff.org/attachment/fact-sheet-medicaid-state-US.
[5] Florida Department of Health, "Monthly Medicaid Enrollment," https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0337.
[6] KFF, "Medicaid in United States."
[7] California Health Care Foundation, "Medi-Cal and the Federal Government — Policy at a Glance," January 22, 2025, https://www.chcf.org/publication/medi-cal-federal-government/#related-links-and-downloads.
[8] The amounts cited are fee-for-service only. "Total Medi-Cal spending on long-term care is likely much higher, since long-term care services were carved into Medi-Cal managed care in 27 counties in 2022" (Jennifer Joynt, "Long-Term Care in California 2024 Edition," California Health Care Foundation, December 2024, p. 5, https://www.chcf.org/wp-content/uploads/2024/12/LongTermCareAlmanac2024.pdf.
[9] California Health Care Foundation, *Medi-Cal Facts and Figures: Essential Source of Coverage for Millions*, August 2021, p. 47, https://www.chcf.org/wp-content/uploads/2021/08/MediCalFactsFiguresAlmanac2021.pdf.
[10] CareScout, "Calculate the Cost of Long-Term Care Near You," https://www.carescout.com/cost-of-care.
[11] Mark Mather and Paola Scommegna, "Fact Sheet: Aging in the United States," Population Reference Bureau, January 9, 2024, https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/.
[12] Countable assets include cash, stocks, bonds and, in general, anything easily convertible to cash.
[13] Anyone meeting these income and asset limits for Supplemental Security Income eligibility automatically qualifies for Medicaid, including Medi-Cal.
[14] "It is their children, after all, who stand to inherit whatever property remains after the costs of long-term care are paid and who currently reap the windfall of Medicaid subsidies" (U.S. Department of Health and Human Services, Office of Inspector General, *Medicaid Estate Recoveries: National Program Inspection*, June 1988, p. 47, https://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf.
[15] National Council on Aging, "Get the Facts on Home Equity and Seniors," June 1, 2024, https://www.ncoa.org/article/get-the-facts-on-home-equity-and-seniors/.
[16] Interested readers can search the web for "What assets are exempt from Medicaid?"
[17] "A Medicaid Asset Protection Trust is exactly as it sounds — a trust designed to protect assets from being counted for Medicaid eligibility" (Law Offices of Stephen J. Silverberg, "What Is a Medicaid Asset Protection Trust [MAPT]?," https://www.sjslawpc.com/practice-areas/what-is-a-medicaid-asset-protection-trust-mapt/).
[18] "A Medicaid Compliant Annuity (MCA) is a spend-down tool used in crisis planning. It's a single premium immediate annuity that converts excess funds into an income stream with no cash value. When properly structured, an MCA accelerates Medicaid eligibility, while protecting your client's assets" (Krause Financial Services, "Medicaid Compliant Annuity," https://www.medicaidannuity.com/products/medicaid-compliant-annuity/).
[19] Other self-impoverishment methods include Medicaid divorces, spousal refusal, "half-a-loaf" strategies and many more listed and explained at American Council on Aging, "Medicaid Planning Strategies: Approaches to Qualify for Medicaid Long Term Care," updated December 16, 2024, https://www.medicaidplanningassistance.org/medicaid-planning-techniques/.
[20] On September 14, 2012, four congressional sponsors of the Medicaid Long-Term Care Reform Act (H.R. 6033) queried state governors "on policies to strengthen program integrity and make Medicaid more sustainable for state and federal budgets." The questions they asked and the responses they received, including the MCA examples cited

above, are summarized in Stephen A. Moses, "LTC Bullet: States Decry Medicaid LTC Loopholes," Center for Long-Term Care Reform, January 11, 2013, http://www.centerltc.com/bullets/archives2013/984.htm; and Stephen A. Moses, "LTC Bullet: The Medicaid Long-Term Care Reform Act of 2012," Center for Long-Term Care Reform, October 5, 2012, http://www.centerltc.com/bullets/archives2012/973.htm.

[21] The Omnibus Budget Reconciliation Act of 1993 extended the lookback period for asset transfers to a full three years (36 months) for most improper transfers and to five years for transfers into or out of a trust. The law removed the former 30-month limit on the eligibility penalty and made estate recoveries mandatory for the first time.

[22] The Deficit Reduction Act of 2005 extended the lookback period for TOAs from three years to five years (60 months). It also changed the TOA penalty start date from the date of the transfer to the date of the Medicaid application. This significantly constrained the half-a-loaf strategy of transferring half the assets and spending down or converting the rest to exempt status during the penalty phase, thus reducing or often eliminating the TOA penalty altogether.

[23] The Deficit Reduction Act of 2005 prohibited the Medi-Cal planning technique called "transfer assets before income," whereby institutionalized recipients could transfer large sums of money to community spouses without losing eligibility.

[24] For a full explanation and documentation of Medi-Cal's failure to enforce federal law in these and other cases, see Stephen A. Moses, "Medi-Cal Long-Term Care: Safety Net or Hammock?," Pacific Research Institute and Center for Long-Term Care Financing, January 2011, https://centerltc.com/pubs/Medi-Cal_LTC--Safety_Net_or_Hammock.pdf.

[25] MCCA added Section 1902(r)(2) to the Social Security Act: "The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology—(A) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or(B) in the case of other groups, under the State plan most closely categorically related." Federal regulations at 42 C.F.R. §§ 435.601(d) and 436.601(d) implemented this section.

[26] U.S. House Budget Committee, "ICYMI: Newsom Extends Free Healthcare to 700,000 Illegal Immigrants Despite Record Budget Deficit," January 4, 2024, https://budget.house.gov/press-release/icymi-newsom-extends-free-healthcare-to-700000-illegal-immigrants-despite-record-budget-deficit.

[27] Paul Winfree and Brian Blase, "California's Insurance-Tax Shuffle: How Federal Money Ends Up Paying for Medicaid for Illegal Immigrants," Paragon Health Institute, March 12, 2025, https://paragoninstitute.org/medicaid/californias-insurance-tax-shuffle-how-federal-money-ends-up-paying-for-medicaid-for-illegal-immigrants/.

[28] Gabriel Petek, *The 2025-26 Budget: Understanding Recent Increases in the Medi-Cal Senior Caseload*, LAO, March 2025, p. 1, https://lao.ca.gov/Publications/Report/5010.

[29] Petek, *The 2025-26 Budget*, p. 1.

[30] Petek, *The 2025-26 Budget*, p. 9.

[31] "[S]eniors are a relatively costly category in Medi-Cal, with annual costs per enrollee of around $15,000 (total funds). This compares to the average annual cost per enrollee of about $8,000 (total funds) across all caseload categories" (Petek, *The 2025-26 Budget*, pp. 1-2).

[32] Ana B. Ibarra and Kristen Hwang, "It's Costing California More Than Expected to Provide Immigrant Health Care. Is Coverage at Risk?," *Cal Matters*, March 14, 2025, https://calmatters.org/health/2025/03/medi-cal-budget-shortfall/; Ana B. Ibarra, "California's Medi-Cal Shortfall Hits $6.2 Billion with 'Unprecedented' Cost Increases," *Cal Matters*, March 18, 2025, https://calmatters.org/health/2025/03/medi-cal-shortfall-worsens/.

[33] Alice Burns et al., "10 Things to Know About Medicaid," KFF, February 18, 2025, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/.

[34] "Perhaps the most immediate benefit to consumers is that people with low incomes and some financial assets will no longer be forced to drain their savings to qualify for services like skilled nursing and long-term care" (Robin Buller, "Medi-Cal Now Considers Income, Not Assets, of Enrollees," California Health Care Foundation, April 18, 2024, https://www.chcf.org/blog/medi-cal-considers-income-not-assets-enrollees/.

[35] As the federal poverty level is updated every July 1, the income test limits increase annually.

[36] See California Department of Health Services, Letter No. 93-63, August 27, 1993, https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c93-63.pdf.

[37] See California Department of Health Services, Letter No. 85-59, August 27, 1985, https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c85-59.pdf.

[38] Medi-Cal applicants can claim various products and services as their share of cost when qualifying for benefits. The following is a comprehensive list:

1. Medical appointments and procedures;
2. Hospital bills;
3. Prescription medications;
4. Medical equipment and supplies;
5. Home health care services;
6. Dental services;
7. Vision care and eyeglasses;
8. Hearing aids;
9. Physical therapy;
10. Occupational therapy;
11. Speech therapy;
12. Mental health services;

13. Substance abuse treatment;
14. Durable medical equipment (e.g., wheelchairs, walkers);
15. Prosthetic devices;
16. Orthopedic devices;
17. Ambulance services;
18. Laboratory tests and X-rays;
19. Nursing home care;
20. In-home supportive services;
21. Case management services for returning to the community;
22. Home modifications for safety (e.g., stairway chairlifts, ceiling track Hoyer lifts);
23. Home assessments by occupational therapists;
24. Transportation costs related to medical appointments;
25. Over-the-counter medications prescribed by a doctor;
26. Incontinence supplies; and
27. Nutritional supplements prescribed by a doctor.

These expenses must be medically necessary and consistent with the plan of care ordered by a physician. Applicants should keep all bills and receipts for these expenses and report them to their local county offices to have them applied toward their shares of cost. See Health Consumer Alliance, "Medi-Cal Share of Cost: Meeting Your Share of Cost," https://healthconsumer.org/wp/wp-content/uploads/2018/04/HCA-Medi-Cal-Share-of-Cost_2.pdf; California Department of Health Services, "Ways to Lower or Stop Your Medi-Cal Share of Cost," https://www.smcgov.org/media/148136/download; Disability Rights California, "Using Your Medi-Cal Share of Cost If You Are a Nursing Facility Resident," April 2017, https://www.disabilityrightsca.org/system/files/file-attachments/559701.pdf.

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