



Strengthening Medicaid: **INDIANA** STATE PROFILE



Medicaid is an essential program that provides health services for individuals and families who otherwise would not be able to afford them. In Indiana, 32.6 percent of residents, or 2 million individuals, are enrolled in Medicaid.¹ Medicaid improves health outcomes for recipients, improves their financial stability, saves lives, creates thousands of jobs that bolster our local economies, and helps reduce economic and racial disparities in health insurance and healthcare access.² However, while anyone who is eligible for Medicaid is guaranteed coverage,³ many eligible Indiana residents struggle to enroll in and maintain Medicaid coverage. Even when enrolled, many struggle to get access to the services that they need.

During the COVID-19 public health emergency, Congress passed legislation requiring Medicaid programs to keep people continuously enrolled. During this time, Medicaid enrollees did not face the regular barriers to renewing coverage that leave many temporarily or permanently disenrolled and without access to care. As a result, the number of Medicaid enrollees in Indiana grew from 1.3 million just before the public health emergency was declared to 2.2 million in 2023 and the uninsured rate in the state also declined.⁴ At the end of 2022, Congress passed legislation to terminate the continuous enrollment requirement as of March 31, 2023, and scheduled a phase out of the enhanced federal Medicaid matching funds that were provided to provide that coverage through December 2023. Medicaid enrollees will now need to renew their coverage or risk losing it. To prevent the loss of these important gains in stabilizing Medicaid coverage for millions of residents, Indiana will need to act quickly to remove barriers to enrolling in and maintaining coverage.

The following report provides a brief overview of Indiana's Medicaid system; describes results from a survey conducted by Hoosier Action Resource Center, in partnership with Center for Popular Democracy, Make the Road New York/States, and People's Action Institute, between September 2022 and February

2023; and makes recommendations for how Indiana can avoid losing the critical gains in health care coverage made during the pandemic by addressing barriers to enrollment, renewal, and accessing services. For a description of survey methods and to see the national results of the survey, see the [full report](#). Overall, we find that:

- One in three survey respondents in Indiana were not aware that they will need to renew their coverage when the public health emergency ends, suggesting that many Medicaid recipients are at risk of losing their coverage.
- Most survey respondents (61.7 percent) were either mostly or completely satisfied with the quality of care they receive through Medicaid, and many respondents described how important Medicaid coverage has been for them and their families.
- Close to half of survey respondents in Indiana reported challenges with applying for their Medicaid coverage, such as long waits, experiencing stigma in applying, and difficulties navigating the program website.
- 42.5 percent of survey respondents in Indiana reported experiencing challenges when renewing their coverage, such as no longer meeting very low income eligibility requirements.
- 65.3 percent of survey respondents in Indiana reported challenges with accessing services using their Medicaid coverage, such as difficulty finding a provider that has available appointments and accepts Medicaid. 42.5 percent of survey respondents in Indiana said that they had gone without needed medical care over the previous year.

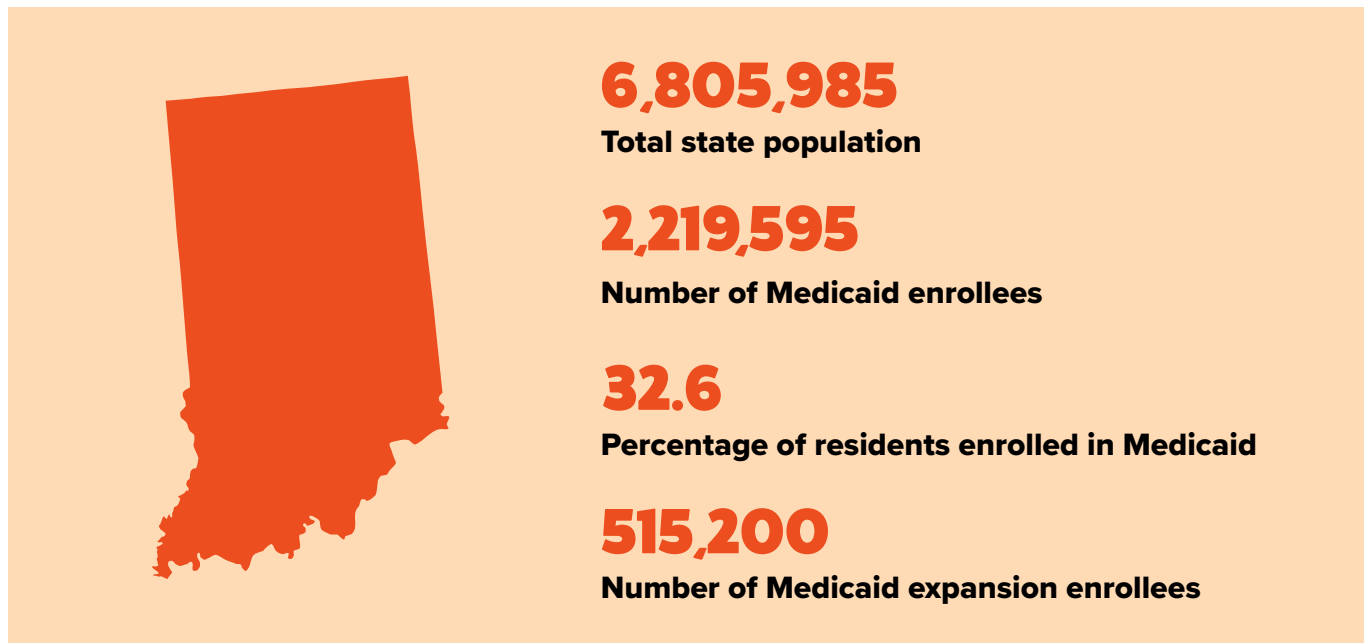
INDIANA'S MEDICAID SYSTEM

In Indiana, adult residents are eligible for one of the Indiana Health Coverage Programs (IHCP) (which includes all of the state's various Medicaid programs) if they have a household income below 138 percent of the Federal Poverty Line (FPL). Children under age 1 are eligible if they live below 208 percent of the FPL, children aged 1 to 18 are eligible if they live below 158 percent of the FPL, and pregnant people are eligible if they are below 208 percent of the FPL.⁵ Indiana opted to participate in the federal Medicaid expansion program starting in 2015, which led an additional 500,000 additional residents to gain health care coverage. The federal government covers 71.9 percent of the costs of Indiana's Medicaid program.⁶ Indiana has also expanded coverage in other ways since then, including extending postpartum coverage from 60 days to 12 months in 2022.⁷

Community organizations in Indiana continue to advocate for improvements to the state's Medicaid system, including pushing for a public health emergency unwinding plan with increased staffing, public notifications, and public data dashboard to prevent widespread disenrollment. Advocates are also working to permanently end Medicaid premiums and address issues with private contractors.

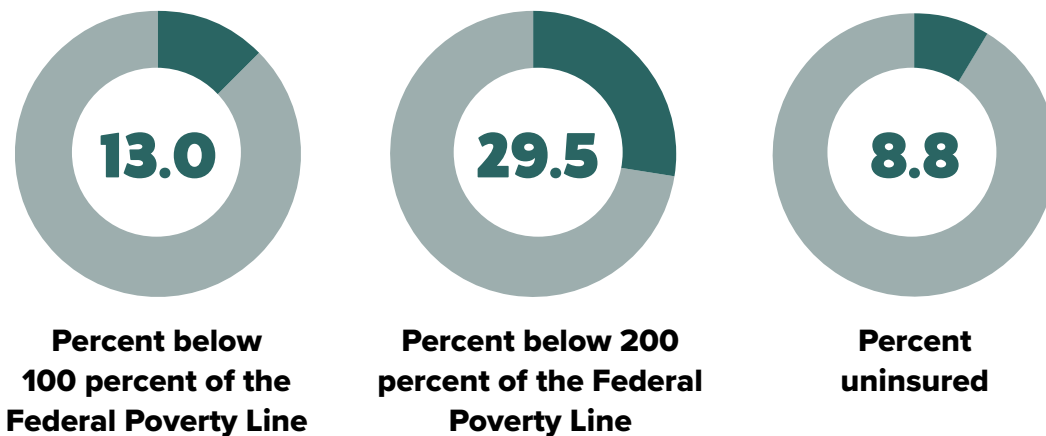
CHARACTERISTICS OF MEDICAID ENROLLEES, UNINSURED, AND ALL RESIDENTS

Compared to all residents in Indiana, Medicaid enrollees live in lower income households, are younger, and more likely to be Black and/or Latinx. Uninsured residents in Indiana live in households with significantly less income than all residents on average and are more likely to be Latinx and/or immigrants.



Source: US Census Bureau American Community Survey 2021 Estimates, Indiana Family and Social Services Administration March 2023, Medicaid Expansion Enrollment September 2021, Kaiser Family Foundation

Percentage of all Indiana residents



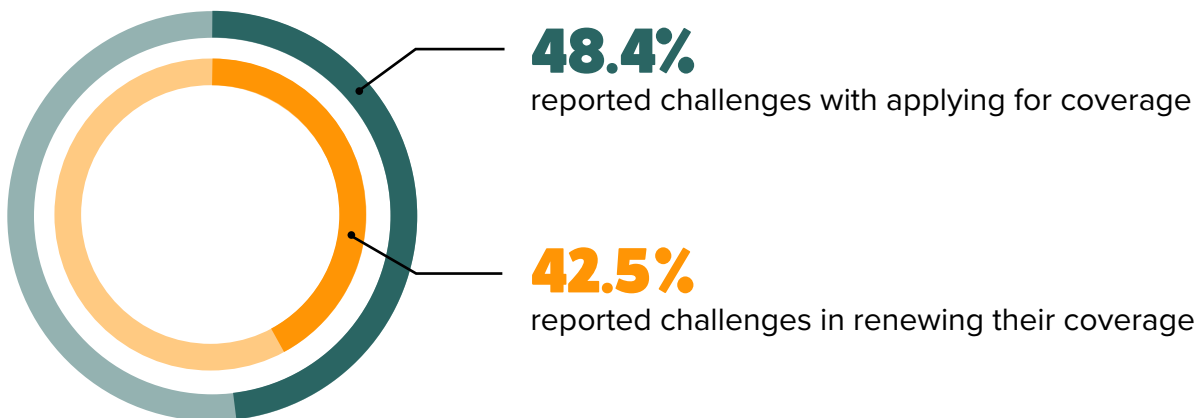
Source: Authors' analysis of IPUMS American Community Survey 2017-2021

	All residents	Medicaid enrollees	Uninsured
Percent Black	9.3	16.7	10.2
Percent Latinx	8.7	12.9	15.2
Percent White Non-Hispanic	74.4	61.4	67.5
Percent Asian	2.6	2.3	2.4
Percent All other races or multiracial	12.2	17.9	17.7
Percent Female	49.8	53.7	44.9
Percent Immigrant	6.7	5.5	14.8
Median age	30.5	18.5	31.5
Median household income	\$68,000	\$37,000	\$51,000

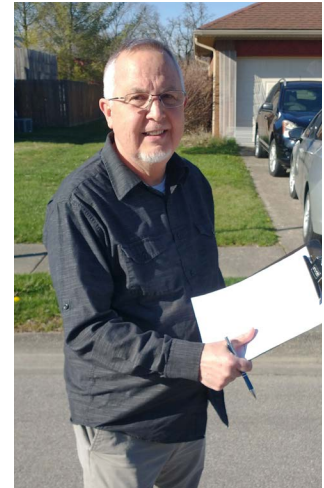
Source: Authors' analysis of IPUMS American Community Survey 2021

SURVEY RESULTS

Close to half of survey respondents in Indiana reported challenges with applying for their Medicaid coverage, and 42.5 percent reported experiencing challenges when renewing their coverage. The most common challenges Indiana residents cited with applying for coverage included long waits, experiencing stigma in applying, and difficulties navigating the program website. The most common challenge Indiana survey respondents cited in renewing their coverage was the income limits. It can be especially challenging for low-income workers to provide documentation showing they meet income requirements as they are more likely to experience fluctuations in income, especially if they do nonstandard work or are employed in an industry with unpredictable schedules, like retail or restaurants.⁸



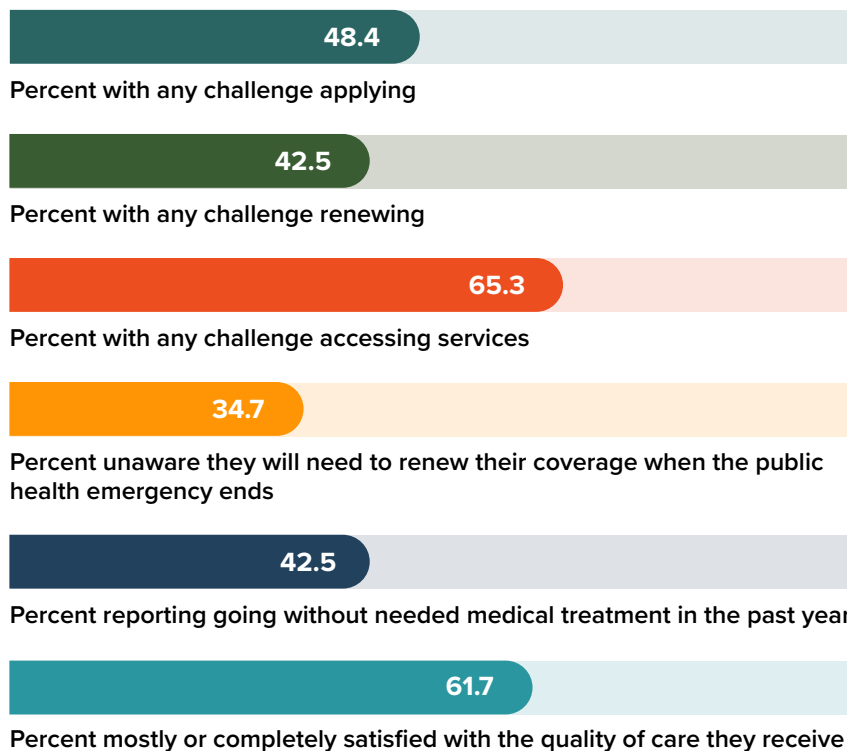
65.3 percent of survey respondents in Indiana reported challenges with accessing services using their Medicaid coverage. The most frequently reported challenge was finding a provider with available appointments, followed by difficulties finding providers who would accept Medicaid. Many survey respondents in Indiana also reported difficulties finding providers close to where they live. Challenges with accessing care can lead individuals to delay or never receive needed care. 42.5 percent of survey respondents in Indiana said that they had gone without needed medical care over the previous year.



Hoosier Action leaders surveyed Medicaid members by knocking on doors, tabling in the community, and reaching out one-on-one to their neighbors.

Despite the challenges, respondents overall expressed satisfaction with the services they receive through Medicaid and described how important they are for their and their families' lives. Most survey respondents (61.7 percent) were either mostly or completely satisfied with the quality of care they receive through Medicaid. Many who were on Medicaid said that if they lost it they would not be able to get care, see doctors, or afford their treatment.

During the COVID-19 public health emergency, the requirement to regularly renew Medicaid coverage was temporarily suspended. Now that the continuous enrollment requirement has been terminated, Medicaid enrollees will need to renew their coverage or risk losing it. One in three survey respondents in Indiana were not aware that they will need to renew their coverage when the public health emergency ends.



For those survey respondents that reported any challenge while applying for Medicaid coverage, what specific challenges did they face?

Top three most common challenges with applying	
I called but experienced long wait times	44.1
I felt stigma in applying	33.9
The website was difficult to navigate	32.2

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 Source: Medicaid Monitoring Survey 2022-2023
 Note: Percentage is of survey respondents who reported at least one challenge

For those survey respondents that reported any challenge while renewing Medicaid coverage, what specific challenges did they face?

Top three most common challenges with renewing	
My income level changed	43.6
I didn't know about or understand the renewal requirements	30.8
I did not have the required forms to renew	17.9

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 Source: Medicaid Monitoring Survey 2022-2023
 Note: Percentage is of survey respondents who reported at least one challenge

For those survey respondents that reported any challenges while accessing care, what specific challenges did they face?

Top three most common challenges with access services	
Healthcare provider not available to see you within a reasonable timeframe	59.5
Unable to find a clinic/provider that will accept Medicaid	50.0
Difficulty accessing care because it was located far away	27.0

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 Source: Medicaid Monitoring Survey 2022-2023
 Note: Percentage is of survey respondents who reported at least one challenge

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I was trying to enroll my son in disability Medicaid and the rest of our family in regular Medicaid. The representative told me that I would have to apply for these things separately which led to duplicate cases. This caused them to cancel one of our open cases and we were then instructed to re-apply for our family. The whole experience was extremely frustrating bc I was told different things by each person I spoke with (i.e. from the local office and the 800 number I called). It also unnecessarily prolonged the process and ultimately prolonged the time interval we were without insurance. Re-submitting the application changed the “date of application” so our retroactive benefits started later than they would have if the original application wasn’t canceled.”

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I am self-employed, so it is always a nightmare to renew. Multiple forms, I have to print out my huge tax returns, take them to the FSSA office, wait for them to stamp them, fax them to the document center. Then the document center takes too long to review them, so it is always denied and then reversed when they finally review the forms. Centralizing the documents hasn’t worked.”

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Unreasonable timelines set in mail communications jeopardized my enrollment multiple times. I was dropped multiple times because of paperwork requirements that in communication delays forced me to restart the process over and over again.”

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It took months to get enrolled. The specificity of income format simply doesn’t work well with the kinds of work I do, and I think that was the biggest hurdle. But the most frustrating part is that I generally had to submit, wait for weeks to hear back, find out something wasn’t presented the way they wanted, and start over. Eventually a staff person was willing to glance through my paperwork and give feedback on the spot, but only after I’d been trying to enroll for months.”

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I didn’t even know if I needed to renew. I had little to no knowledge about my plan and when I would lose eligibility due to age (I recently turned 20, and I have been on a plan for children/youth). I also did not understand the process or what plan I even had.”



I became pregnant with twins and applied for Medicaid to help with all the additional medical cost. We were just \$100 over income and was denied. It definitely put financial strain on our family for the first couple of years. My twins will be 4 in May and I will have not paid off all their medical bills from birth.”



There are a lot of doctors / providers who don't accept [Medicaid], and then the providers that do keep leaving their practices and not taking their patients with them. I've had to change providers multiple times since the pandemic, resulting in 9-month long delays to be seen, and then one of those new appointments being canceled, resulting in a need to make an appointment 60 miles away, or else wait an additional 10 months more.”



I was told by a doctor that I was “less of a priority as a patient” because other insurances paid more.”



I was prescribed 2 medications that neither my Medicare nor Medicaid will cover. My doctor is currently trying to get them to cover it but I'm honestly thinking they won't. I can't afford to pay on my own so I'm just going to have to go without the medication which makes me sad and I have cried over it.”



My child is in need of behavioral health that they can not get because Medicaid covers very little we are forced to see providers that don't really hear our concerns. We're screaming for help with my child & their mental/behavioral health but my child can not get the care they need because the care they actually need isn't covered by Medicaid.”



I have literally had doctors tell me I need a treatment but it doesn't matter because your insurance won't cover it. I also have to fight with them every time I need an antibiotic because I am allergic to all the cheap ones, which always delays my treatment at least a day or two.”



I moved and finding a new doctor who takes my insurance is difficult. I have to drive 1.5 hours away and it's hard to work that around my schedule. My daughter needs mental health care and it's nearly impossible to find a doctor to help with mental health for kids.”

TESTIMONIES FROM INDIANA RESIDENTS ABOUT THEIR EXPERIENCES WITH MEDICAID

ANNA LISA GROSS

(Pastor at Beacon Heights Church & Medicaid Member):

Difficulty getting on Medicaid and getting questions answered: “My current time on Medicaid would have started in 2019 when my husband and I had moved back to the US. We’d been abroad for a year, came back, and it was very easy to qualify for Medicaid by income because our income was clearly low enough. It was still a huge hassle to apply for Medicaid and it feels like it’s an extra hassle for me because of the work that I do...I’m a pastor so my paychecks might look different from pay period to pay period. I also have a housing allowance usually...and whether or not Medicaid counts that as part of my eligibility, no one has been able to answer...It actually took us months to get on Medicaid in 2019. We would get stuff in the mail and it would come late and sometimes we would miss deadlines, but we wouldn’t get the letter that we missed the deadline until after the deadline had passed...It’s been a guess every time.”

Redetermination: “I’m...not exactly sure about what they’ll say about whether or not we’re eligible because it’ll depend on how they interpret the housing allowance part of my income. I’m full-time now but I’m gonna go to part-time in June. If somehow we didn’t get examined until then, there’s a chance that we might qualify but if not, there’s no chance that we would. That’s all frustrating because it means we’ll have to be watching the date on any kinds of appointments or procedures we might have been planning to do and put off doing them since we don’t know what’s going to happen.”

Difficulty of finding providers: “This was a few years ago now, but I just wanted to find someone to do my annual pap...so I went through the CareSource website...and looked at who CareSource said in my area was accepting new patients for OB GYN. And nobody that I called—and I called probably 8 or 10 offices—none of them were actually accepting new patients. So I started asking the person who would answer the phone, can you tell me who is accepting new patients and through that I finally found somebody. But it did not match CareSource. I also was looking for a dentist and called CareSource directly...and what they would tell me on the phone was inaccurate.”

LANE FULTON

Claims denials and conflicting medical bills:

“Over the course of three years, I had six surgeries take place. Three with Anthem, three with Medicaid. In the fall of 2020, I was newly on Medicaid when I received a letter from IU Health, the largest hospital network in Indiana. I was informed that I had nearly \$2,500 in medical debt not covered by Anthem. I had already paid off the bills from this third surgery. I had no idea that I had a latent denial for partial coverage on my account. I was annoyed, though I immediately looked at my options. I applied for financial aid. After another long application process, I submitted all the information IU Health asked of me. A few months later I received a letter stating that all of my medical debt with IU health not covered by Anthem would be canceled. I was happy to the point of tears. I would be able to breathe and focus on important matters. 2020 was starting to look up for me. Shortly after that, I received a letter from Harris and Harris, a debt collection agency. I was informed that I had an outstanding debt of nearly \$5,000 with IU Health from Anthem for these first three surgeries. Double what I had even known.”

KRISTI DECKARD

Cliff effect: “We all know that health care is so complicated and confusing. It was a hard decision for me to pursue a job because we need this income to help our ends meet but also can’t afford to lose the low income services (like free school lunch and SNAP) and Medicaid.”

HEATHER MARITANO

Mental Health Provider

“So much of my time now is spent playing insurance cat and mouse. And so little time spent thinking about the profession that I love and the clients that I love, and the work that I love. And... so many of us are just bitter, angry, exhausted, anxiety-ridden. I know people who are leaving the profession left and right, or going to see if they can make it in the fee-for-service sector and turning their back on the care piece. It drains, so that all of the energy it takes to really hold someone, you’re exhausted by the petty frustrations.”

Low reimbursement rates: “So if you take traditional Medicaid your reimbursement rate is going to be about half to a third of what the going rate is. Now HIP pays a little bit better. But we really have an issue when we’re looking at children. Because doing children’s work is exponentially more work because you have to work with parents and school systems and various other systems. So child based work is always more work anyway. Then Medicaid is always more paperwork, across the board, more paperwork, and the reimbursement rate is the lowest of any. So finding a child provider is really difficult... So the reimbursement rates are lower, the systems are more difficult to navigate, because you’re navigating multiple systems...all the systems are supposed to be consistent, but they’re not consistent. And so it just becomes burdensome” “So you have to hire extra support, or spend more time yourself. You know, I don’t have administrative support.”

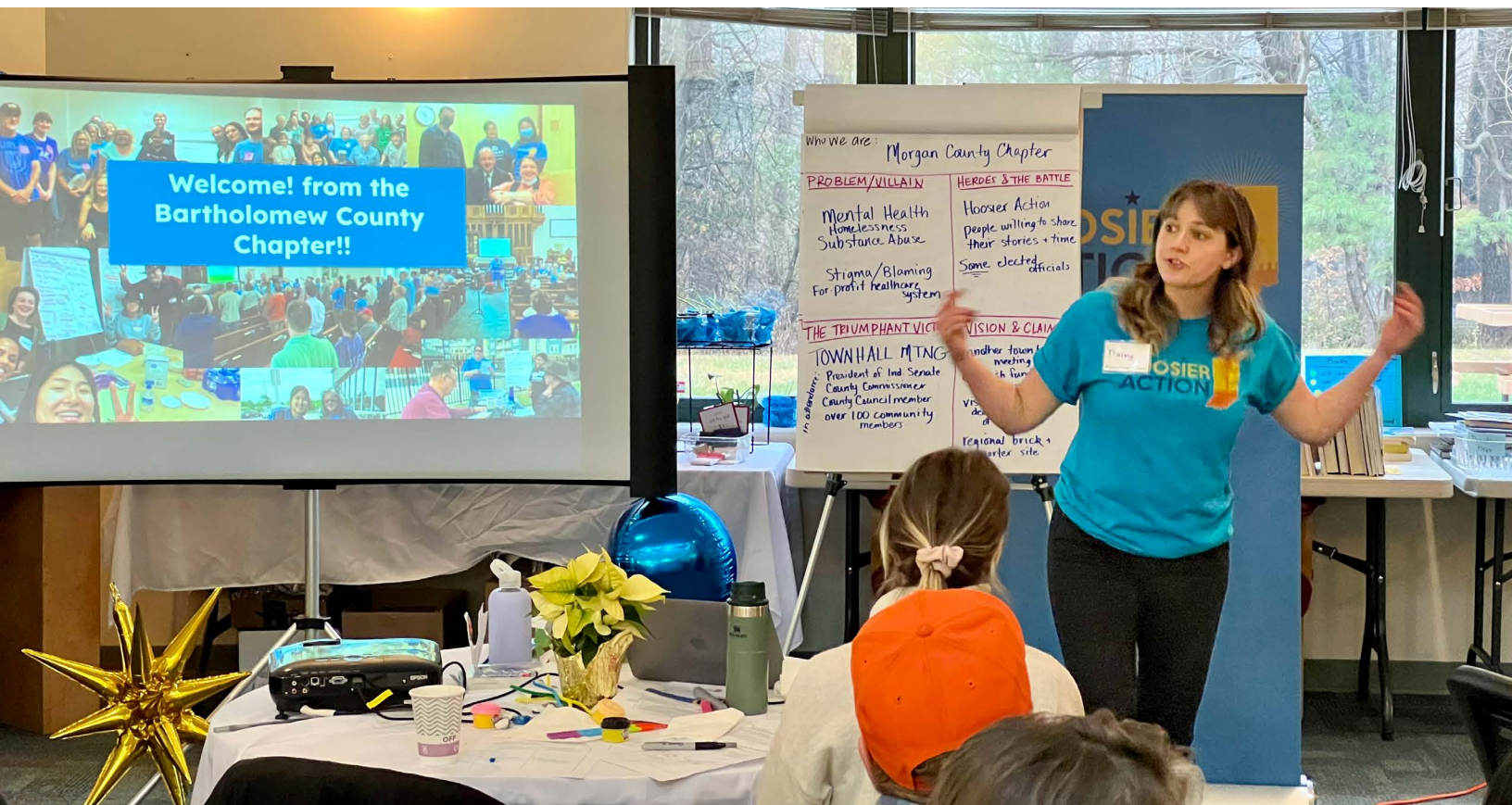
Mental health provider shortage: There are so many people who want to provide therapy services, but they don’t want Anthem to tell them that it was not our covered service. They don’t want Anthem to pay them less. So they take only out of pocket...so then, therapy goes back to being just a privileged thing.”

RECOMMENDATIONS

Hoosier Action Resource Center recommends that Indiana take the follow actions:

- **Reduce churn in the program and increase racial health equity by permanently ending POWER Account Premiums on the Healthy Indiana Plan (HIP), ending HIP Basic and enrolling all HIP members in HIP Plus.**
 - » Since March 2020, Indiana has waived all POWER Account payments with no negative consequences. Data from several years show that premiums have kept thousands of people from accessing HIP coverage, and they've pushed thousands more into inferior coverage.⁹ Independent studies of Medicaid in Indiana conducted by the Lewin group demonstrate that most people on HIP don't understand the POWER Account program, and have no idea that nonpayment will cause them to lose coverage. Since most HIP members do not understand POWER Accounts and that POWER Account payments were often submitted by third parties prior to the pandemic, it is clear that the program does not increase personal responsibility for one's own health. There is, however, ample evidence that POWER accounts hurt Hoosier health and the Hoosier workforce by contributing to loss of coverage.
 - » At the November 30, 2021 Medicaid Advisory Committee meeting, FSSA administrators admitted that the amount of money lost by the state for not collecting premiums was "insignificant," a fact which should come as no surprise given that most POWER account payments are usually on the lower end of \$1-\$20 per month.¹⁰ Despite a massive spike in enrollment during the pandemic, HIP's administrative costs remained stable for the past few years. In June 2022, Indiana's official HIP evaluator (Lewin Group) reported that the program functioned much better and cheaper without the extra burden of running the POWER Accounts.

Hoosier Action Communications and Policy Director, Tracey Hutchings-Goetz, launched the survey project with 50 leaders at Hoosier Action's annual meeting in December of 2022.



- » Although evidence from other states suggests that the cost of administering the POWER Account program might exceed the cost of the program itself, FSSA has not provided a clear accounting for the cost of the program. Furthermore, collecting HIP premiums is associated with increased administrative costs and burdens for the state as the already short-staffed Medicaid agencies would be required to process re-applications for those who are kicked off of and then must reapply to Medicaid.¹¹ Individuals who lose coverage due to POWER Account payment errors—even when it’s not their fault, are often still financially eligible, and thus will reapply for coverage. Each time a person’s case has to be re-opened is an unnecessary step that wastes administrative time.
- **Maximize continuous coverage for all eligible populations by**
 - » Removing Indiana’s retroactive eligibility waiver which limits retroactive eligibility for everyone eligible under the ACA’s Medicaid expansion, except for pregnant women and certain vulnerable groups, limiting coverage to the first month in which the first premium payment was made. Limitations of retroactive eligibility reduce continuity of coverage and are associated with increased medical debt and uncompensated care.
 - » Removing the five year bar on Medicaid for “lawful permanent residing” (LPR) women and children in Indiana
- **Improve Medicaid application and renewal processes by**
 - » Conducting focus groups with members and advocates to create more clearly written and timely communications.
 - » Improve the functionality of Indiana’s Benefits portal so that members and their Authorized Representatives (AR) can see what documents they have submitted, what documents are approved and their annual redetermination date.
 - » Allow ARs to upload materials through portals for their clients.
 - » Allow access to computers and internet in Department of Family Resources (DFR) offices, so members can log on to their portals.
 - » Provide an email address for enrollees to contact DFR.
 - » Extend the verification return deadline beyond 13 days.
- **Remove barriers to accessing health services through Medicaid**
 - » Increase access to care and reduce uncompensated care by granting Medicaid providers the right to appeal Medicaid claim denials and grievances with the state should their claims be denied by the managed care entities or other contractors.
 - » Instituting an Ombudsman to provide oversight of Indiana’s Managed Care Entities and other sub-contractors, similar to California.¹²

42.5 percent of survey respondents in Indiana said that they had gone without needed medical care over the previous year.

ENDNOTES

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- 2 Center for Budget and Policy Priorities, “The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion,” October 21, 2020, <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion>; Manatt Health, “Medicaid’s Impact on Health Care Access, Outcomes and State Economies,” Briefing Series: Ket Medicaid Issues for New State Policymakers (Robert Wood Johnson Foundation, February 1, 2019), <https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html>; The Commonwealth Fund, “The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan,” May 20, 2021, <https://doi.org/10.26099/x6zp-g424>; Center on Budget and Policy Priorities, “Policy Basics: Introduction to Medicaid,” April 14, 2020, <https://www.cbpp.org/research/health/introduction-to-medicaid>; Medicaid and CHIP Payment and Access Commission, “Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography,” April 2021, <https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>; Madeline Guth, Samantha Artiga, and Olivia Pham, “Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care” (Kaiser Family Foundation, September 30, 2020), <https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/>; Owen Thompson, “The Long-Term Health Impacts of Medicaid and CHIP,” *Journal of Health Economics* 51 (January 1, 2017): 26–40, <https://doi.org/10.1016/j.jhealeco.2016.12.003>.
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- 5 Louise Norris, “Medicaid Eligibility and Enrollment in Indiana,” [healthinsurance.org](https://www.healthinsurance.org/medicaid/indiana/), March 10, 2023, <https://www.healthinsurance.org/medicaid/indiana/>.
- 6 “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier,” Kaiser Family Foundation, 2023, <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.
- 7 Kaiser Family Foundation, “Medicaid Postpartum Coverage Extension Tracker,” March 23, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>.
- 8 Kristin F. Butcher and Diane Whitmore Schanzenbach, “Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs | Center on Budget and Policy Priorities” (Center on Budget and Policy Priorities, July 24, 2018), <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>; Katherine Guyot and Richard V. Reeves, “Unpredictable Work Hours and Volatile Incomes Are Long-Term Risks for American Workers” (Brookings, August 18, 2020), <https://www.brookings.edu/blog/up-front/2020/08/18/unpredictable-work-hours-and-volatile-incomes-are-long-term-risks-for-american-workers/>; Joanna Smith-Ramani, David Mitchell, and Katherine Lucas McKay, “Income Volatility: Why It Destabilizes Working Families and How Philanthropy Can Make a Difference” (Asset Funders Network, 2017), https://www.aspeninstitute.org/wp-content/uploads/2017/12/AFN_2017_Income-Volatility_Final.pdf.
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