H.R. 1 Impacts and Medi-Cal

December 4, 2025

Michelle Baass, Director
Department of Health Care Services

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

PURPOSE: PROVIDE EQUITABLE ACCESS TO QUALITY HEALTH CARE LEADING TO A HEALTHY CALIFORNIA FOR ALL

- DHCS is the state agency **responsible for financing and administering Medi-Cal**, the state's Medicaid Program.
- DHCS oversees county-operated community behavioral health and substance use disorder treatment programs.
- DHCS has a **budget of $202.7 billion** ($45.6 billion General Fund) and 4,945 positions for the support of programs and services.

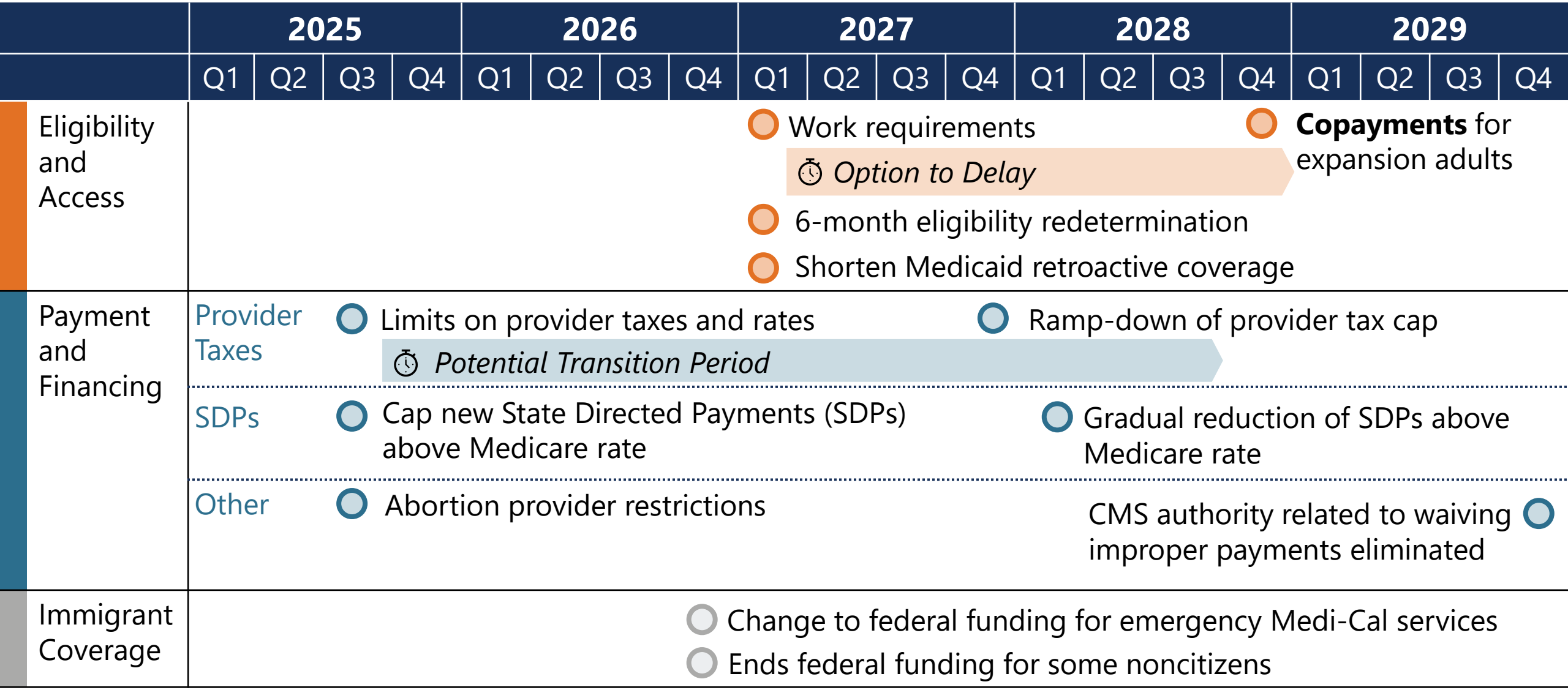
Major Medicaid Provisions of H.R.1

**Bottom Line: Up to 3.4 million Medi-Cal members may lose coverage;
$30+ billion in federal funding is at risk annually;
major disruption in Medi-Cal financing structure for safety nets.**

Eligibility/Access Requirements	State Financing Restrictions	Immigrant Coverage Limitations	Abortion Providers Ban
» Work requirements » 6-month eligibility checks » Retroactive coverage restrictions » Cost sharing	» Managed Care Organization (MCO) and Provider Tax limitations » State Directed Payment (SDP) restrictions » Federal funding repayment penalties for eligibility-related improper payments	» Reduction in FMAP* for emergency UIS** » Restrictions on lawful immigrant eligibility (increases UIS) ** Federal Medical Assistance Percentage* ***Unsatisfactory*	» One-year ban on federal Medicaid funding for "prohibited entities" that provide abortion services

All numbers are estimates and subject to change.

Effective Dates for Key Provisions



Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Implementation Guiding Principles

- **Automate to Protect Coverage**. Maximize the use of data sources to confirm eligibility without burdening members. Reduce paperwork, streamline verifications, and safeguard coverage stability.
- **Communicate with Clarity and Connection**. Implement an outreach and education campaign that is culturally relevant, linguistically accurate, and written in plain language to build trust and help members understand the changes.
- **Simplify the Renewal Experience**. Modernize and streamline the Medi-Cal renewal process with a clearer, member-friendly form and six-month renewal steps that are easier to navigate.
- **Educate and Train Those Who Serve Medi-Cal Members**. Deliver comprehensive training on all H.R. 1 provisions for county eligibility workers. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties and DHCS Coverage Ambassadors can confidently support members.
- **Provide Timely and Transparent Communication to Members**. Share information on H.R. 1 changes early on so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

Outreach and Communication Strategies

- DHCS will implement a phased outreach campaign in all threshold languages, using culturally relevant and plain-language materials.
- The Coverage Ambassador model will continue, leveraging trusted messengers and local partnerships to reach diverse communities.
- Outreach will include FAQs, scripts, templates, and translated materials, distributed through websites, social media, flyers, and direct outreach.
- Communication will focus on equity, language access, and early awareness, with messaging aligned to implementation timelines and member actions.

Eligibility/Access Requirements

Eligibility: Work Requirements

Section 71119: Requires states to condition Medicaid eligibility on compliance with work requirements (called "community engagement requirements") for adults ages 19 through 64. The provision applies to individuals enrolled through Medicaid expansion or a section 1115 demonstration providing minimum essential coverage.

Exemptions must be verified every 6 months

- *Parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 and under or a disabled individual; medically frail individuals; pregnant/receiving Medicaid postpartum coverage; foster/former foster youth under age 26; American Indian and Alaska Native individuals; veterans with a disability rated as total; incarcerated or recently released within 90 days, Medicare Part A/Part B; meet Temporary Assistance for Needy Family or Supplemental Nutrition Assistance Program work requirements; drug addition/alcohol treatment program*

Effective Date: January 1, 2027

Impact:

An estimated **up to 3 million Medi-Cal members may lose coverage**, which will significantly drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: 6-Month Eligibility Checks

Section 71107: Requires states to redetermine eligibility for adults enrolled through Medicaid expansion or an expansion-like section 1115 waiver once every six months.

Effective Date: January 1, 2027

Impact:

An estimated **400,000 Medi-Cal members may lose coverage**, which will drive up the uninsured rate and raise costs for hospitals and clinics treating uninsured patients.

All numbers are estimates and subject to change.

Eligibility: Retroactive Coverage

Section 71112: Shortens Medicaid retroactive coverage from three months to one month for expansion adults and two months for all other Medicaid applicants. This provision also allows states to provide two months of CHIP retroactive coverage. (Currently, CHIP does not have retroactive coverage, and services may only be paid in the month of the application.)

Effective Date: January 1, 2027

Impact:

An estimated **86,000 Medi-Cal members/ year would be affected** by this policy and receive 1 month of retroactive coverage, rather than 3 months.

All numbers are estimates and subject to change.

Eligibility: Cost Sharing

Section 71120: Requires states to impose cost sharing for services provided to Medicaid expansion adults with incomes above 100% of the FPL ($15,560 per year). States would decide the amount, not exceed $35 per service and subject to an aggregate limit of 5% of family income.* Cost sharing must not apply to exemptions under current law or to primary care services, behavioral health services, federally qualified health center services, rural health clinic services, and certified community behavioral health clinic services.

Effective Date: October 1, 2028

*Note: For drugs, cost sharing must be $4 (preferred) and $8 (non-preferred); for non-emergent services received in the hospital emergency department, cost sharing must be no more than $8. (This is as of 2015 and adjusted for inflation over time.)

Impact:

- The cost sharing requirement will limit access (e.g., due to members delaying or forgoing care, confusion about new requirements) among the Medicaid expansion population.
- Providers will likely see an increase in uncompensated care.

All numbers are estimates and subject to change.

State Financing Restrictions

Provider Tax Limitations

Section 71115 and 71117:

- Prohibits any new Medicaid provider tax or increases to existing tax rates (for both local- and state-imposed taxes).
- Prohibits any tax that either (1) imposes a lower tax rate on providers explicitly defined based on their lower Medicaid volumes compared to those providers with higher Medicaid volumes, or (2) taxes Medicaid units of service (e.g., discharges, bed days, revenue, or member months) at a higher rate than non-Medicaid units of service. Also prohibits taxes that have the "same effect" as in (1) or (2) above.
- Modifies the provider tax cap whereby the 6% tax threshold must be reduced by half a percentage point per year until the threshold hits 3.5%.

Effective Date: Moratorium effective immediately; phase-down beginning October 1, 2027.

Impact:

- CA's current MCO tax structure is non-compliant under these new parameters and will need to be modified to align with the new federal standards (though it may be challenging to do so without decreasing the revenue from the tax).
- The new constraints jeopardize other major provider taxes, including the Hospital Quality Assurance Fee, threatening revenue streams.
- Going forward, these limitations may undermine CA longstanding strategy to finance the non-federal share of Medi-Cal.

All numbers are estimates and subject to change.

State Directed Payment Restrictions

Section 71116: Caps any future SDPs at 100% of Medicare payment levels. Requires payments with existing SDPs above Medicare rates to be reduced by 10 percentage points per year until the SDPs are no greater than 100% of Medicare payment levels.

Effective Date: Immediately for new SDPs; reduction in existing SDPs starting January 1, 2028

Impact:

- Limits CA's ability to use SDPs to increase provider payment rates above Medicare levels, which may reduce provider participation and access in Medicaid.
- Constrains CA's ability to raise the non-federal share of Medicaid funding, potentially pressuring other areas of the budget.
- Limits future SDP increases, including for public hospitals and private hospitals, all of which have inpatient and/or outpatient rates exceeding Medicare.

All numbers are estimates and subject to change.

Mitigation: Rural Health Transformation Fund

Section 71401: Establishes $50 billion funding program to mitigate federal funding cuts on rural health providers.

Funding Disbursement: CMS will allocate $10 billion each FY for FY 2026-2030.

Funding Distribution:

- 50% distributed equally across states with approved applications
- 50% distributed to states per CMS discretion, pursuant to specific rural impact factors (e.g. state's % of rural residents; share of rural health facilities in the state compared to nationwide), with at least 25% of states with an approved application included.

Allowable Uses: CMS and states have flexibility to decide (1) allowable uses, and (2) eligible recipients (recipients and benefitting providers are not limited to rural health care facilities used in the funding distribution criteria). States must implement at least three activities specified (e.g., prevention and disease management; training and technical assistance; recruitment; etc.).

Limitations: Cannot be used as non-federal share of Medicaid payments. Admin cap 10%.

Next Steps:

- State to submit application (including a detailed rural health transformation plan) by TBD deadline, no later than December 31, 2025.
- CMS required to approve by December 31, 2025.

All numbers are estimates and subject to change.

Federal Funding Repayment Penalties

Section 71106: Except in limited cases involving the Medicaid "spend down" group and when there is insufficient documentation to confirm eligibility, the law eliminates CMS' ability to waive federal penalties associated with improper payments related to eligibility even when states are making a good faith effort to address them. CMS is also required to issue disallowances upon identifying improper payments under federal audits beyond Payment Error Rate Measurement (PERM), as well as, at the option of the Secretary, state audits.

Effective Date: October 1, 2029

Impact:

CMS may claw back federal funds from CA, even if the state is implementing a corrective action plan to reduce errors, increasing financial risk.

All numbers are estimates and subject to change.

Immigrant Coverage Limitations

Reduction in FMAP for Emergency Medi-Cal

Section 71110: Prohibits states from receiving the 90% enhanced matching rate for emergency services provided to individuals who, but for their immigration status, would have qualified for the ACA optional adult expansion group. Also applies to emergency care provided to refugees, asylees, and other lawfully residing individuals.

Effective Date: October 1, 2026

Impact:

- CA will lose the 90% federal match for emergency Medicaid services, requiring increased General Fund spending and/or a rollback of services covered under the emergency Medicaid benefit.
- May increase financial pressure on safety-net providers, particularly hospitals that deliver high volumes of emergency care to noncitizens.

All numbers are estimates and subject to change.

Restrictions on Lawful Immigrant Eligibility for Medi-Cal

Section 71109: Ends the availability of full-scope federal Medicaid and CHIP funding for most refugees, asylees, victims of human trafficking, certain individuals whose deportation is being withheld or who were granted conditional entry, or individuals who received humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.

Effective Date: October 1, 2026

Impact:

Approximately **200,000 immigrant Medi-Cal members** will shift from satisfactory immigration status (SIS), which is eligible for full Federal Financial Participation (FFP), to unsatisfactory immigration status (UIS), which is only eligible for emergency and pregnancy-related FFP – at the newly reduced rates noted in prior slide.

All numbers are estimates and subject to change.

Abortion Providers Ban

One-year Ban on Federal Funding for "Prohibited Entities" that Provide Abortion Services

Section 71113: Bars Medicaid participation by certain providers of abortion services, including Planned Parenthood, for the one-year period following enactment (through July 2026).

Effective Date: Effective immediately. On September 11th, Preliminary Injunctions were stayed.

Impact:

- In CA, roughly 80% of Planned Parenthood patients rely on Medi-Cal, meaning this proposal would effectively strip $305 million in federal funding from one of the state's largest providers of reproductive health care.
- Loss of federal Medicaid funding may force Planned Parenthood to reduce services, limit appointments, or close centers—particularly in underserved areas.

All numbers are estimates and subject to change.

Thank you!

DHCS