

# Major Impacts to Medi-Cal of Enacted H.R.1 Reconciliation Legislation

*August 2025*

# Major Medicaid Provisions of HR1

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

## Eligibility/Access Requirements

- Work requirements
- 6-month eligibility checks
- Retroactive coverage restrictions
- Cost sharing

## State Financing Restrictions

- MCO and Provider Tax limitations
- State Directed Payment restrictions
- Federal funding repayment penalties for eligibility-related improper payments

## Immigrant Coverage Limitations

- Reduction in FMAP\* for emergency UIS\*\*
- Restrictions on lawful immigrant eligibility (increases UIS)
















*\*Federal matching assistance percentage*

*\*\*Unsatisfactory immigration status*

## Abortion Providers Ban

- One-year ban on federal Medicaid funding for "prohibited entities" that provide abortion services

# Effective Dates for Key Provisions

	2025				2026				2027				2028				2029						
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Eligibility and Access									 Work requirements									 <b>Copayments</b> for expansion adults					
									 <i>Option to Delay</i>														
									 6-month eligibility redetermination														
									 Shorten Medicaid retroactive coverage														
Payment and Financing	Provider Taxes		 Limits on provider taxes and rates																 Ramp-down of provider tax cap				
			 <i>Potential Transition Period</i>																				
	SDPs		 Cap new State Directed Payments (SDPs) above Medicare rate																 Gradual reduction of SDPs above Medicare rate				
	Other		 Abortion provider restrictions																CMS authority related to waiving improper payments eliminated				
			 <i>14-day TRO</i>																				
Immigrant Coverage									 Change to federal funding for emergency Medi-Cal services														
									 Ends federal funding for some noncitizens														

# 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.

# 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.

# 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.

# 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

## 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.

\*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.)



# 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.

# 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.

# 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.

# 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.

# 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.



# **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.

*\*\*Note: At the end of July, two preliminary injunctions were issued that blocks the Trump Administration from implementing this provision nationwide for certain providers.*

## 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.