



# **The New Uninsured:** State Policy Options for Californians Losing Medi-Cal Coverage

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## About the Author

Health Management Associates (HMA) is an independent national research and consulting firm in the health care industry. HMA helps clients stay ahead of the curve in publicly funded health care by providing technical assistance, resources, decision support, and expertise.

## About the Foundation

The [California Health Care Foundation](#) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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# Executive Summary

California has made historic progress in expanding health coverage, reducing its uninsured rate between 2013 and 2024 from 14% to 5.3%.<sup>1</sup> Yet recent federal and state policy changes — including H.R. 1’s Medicaid work requirements, six-month eligibility redeterminations, and immigrant eligibility restrictions — threaten to reverse these gains. The California Department of Health Care Services (DHCS) estimates that 1.8 million Californians could lose Medi-Cal coverage in the coming years.<sup>2</sup>

At the same time, the governor’s FY 2026–27 budget, as introduced in January 2026, anticipates a state budget deficit for 2027–28 of \$22 billion, much of it attributable to the impacts of H.R. 1 but also overall growth in spending on health care.<sup>3</sup> A March 2026 California Legislative Analyst’s Office report found that Medi-Cal spending has more than doubled over the last 10 years, mostly due to per-enrollee spending reflecting changes in benefits, service utilization, and service costs, as well as policy changes expanding eligibility, benefits, and provider rates.<sup>4</sup> These developments and underlying trends destabilize the health care system, increase pressure on safety-net providers, and pose significant health consequences and risks for people unable to access care.

To address these challenges, the California Health Care Foundation worked with Health Management Associates to develop short-term program options to maintain health care access for Californians who will lose health care coverage. This work is intended to support policymakers and stakeholders as they develop an interim solution to ensure continued access to health care services for Californians until a transition back to full-scope Medi-Cal becomes possible.

A stakeholder group and key informant interviews with consumer advocates guided this work,

emphasizing five design goals for the development of any new program:

- ▶ Maintain access to care for all populations statewide losing Medi-Cal coverage
- ▶ Ensure privacy and safety protections for enrollees
- ▶ Consider fiscally prudent strategies in a constrained budget environment
- ▶ Aim for statewide scalability and adaptability to transition back to full-scope Medi-Cal
- ▶ Support fiscal stability and sustainability of the health care safety net, such as Federally Qualified Health Centers, public hospitals, and health systems

A review of California’s historical coverage, program approaches, and current policy realities informed the development of two illustrative program options. These illustrative options allow policymakers and stakeholders to assess impacts and trade-offs in designing a program to maintain continued health care access. Options were developed using a financial modeling tool that provides preliminary estimates depending on choices about benefits, provider rates, and cost sharing for consumers. Depending on choices about these variables, the authors estimate that a program to support continued access to health care services for up to two million Californians would cost the state between \$3.1 and \$4.6 billion annually. More specifically:

- ▶ Option 1 offers benefits more like the essential health benefits (EHBs), with the current provider payment rates in the Medi-Cal program, no cost sharing, and a three-month bridge program for those impacted by work requirements and six-month verification, and would cost approximately \$4.6 billion.

- ▶ Option 2 offers benefits more like the Low-Income Health Program, Medi-Cal fee-for-service payment rates, cost sharing that aligns with the cost sharing required under H.R. 1 for the adult Medi-Cal expansion population and a two-month bridge program for those impacted by work requirements and 6-month verification, and would cost approximately \$3.1 billion.

The core trade-off between the two options is cost versus scope of benefits and access to care. Both program options transition from the current managed care structure to a fee-for-service structure, include pharmacy benefits through Medi-Cal Rx, and assume that specialty behavioral health is provided by county behavioral health programs and that the state continues to receive federal matching funds for limited-scope or Emergency Medi-Cal services.

## Introduction and Purpose

Despite the state's decades of progress to expand health coverage and access, various analyses project that up to 1.8 million Californians are at risk of losing Medi-Cal coverage in the coming years as a result of a broad range of federal and state budget and policy changes.<sup>5</sup> Policymakers now face multiyear budget shortfalls that will require difficult decisions about program cuts, new revenues, and strategies to mitigate coverage losses while preserving the goal of reinstating full-scope Medi-Cal. This paper presents the results of an exercise to design program options to safeguard access to health care services during this unprecedented period of uncertainty.

## Background

California has been a national leader of efforts to expand health coverage, recognizing the importance of full-scope Medi-Cal coverage for all. From 2013

to 2024, the state reduced its uninsured rate from 14% to 5.3%, reflecting a sustained commitment to broadening coverage.<sup>6</sup> This progress has been achieved through California's implementation of the Affordable Care Act (ACA), including the creation of its state-based marketplace, Covered California, and its full Medi-Cal expansion to childless adults, as well as incremental but steady expansion of full-scope Medi-Cal eligibility to all income-eligible residents regardless of immigration status. Despite these gains, however, recent federal and state policy developments and fiscal pressures are projected to result in major coverage reductions in the coming years. Key federal and state policies that will reduce coverage in the coming years include the following:

- ▶ Medicaid work requirements that impose new barriers to eligibility
- ▶ Six-month redeterminations in Medicaid that increase disenrollment due to administrative burden
- ▶ Substantial reductions in federal revenues from changes to California's provider taxes that will increase fiscal pressure on the Medi-Cal program
- ▶ Higher premiums because of reduced federal subsidies for people in Covered California
- ▶ Immigrant-related policies impacting federal funding for coverage of immigrant populations with unsatisfactory immigration status (UIS)
- ▶ Medi-Cal enrollment freeze, program cuts, and premiums impacting adults with UIS
- ▶ Reinstatement of the asset test for seniors and people with disabilities

Federal and state policy changes began in January 2026 and continue through 2028. Appendix A on page 17 provides a further overview of federal and state policy changes that will result in future coverage reductions.

# Program Design Goals

The California Health Care Foundation (CHCF) worked with Health Management Associates (HMA) to develop and explore care program options that would ensure continued access to health care services for Californians projected to lose Medi-Cal eligibility in the next several years. An important component of this exploration is HMA's development of a modeling tool that can estimate the cost of these options so policymakers and stakeholders can weigh the potential trade-offs of various options under consideration. Given California's current fiscal challenges, these options are intended to serve as a short-term strategy to preserve access to health care services for all populations, while the longer-term vision is to reinstate full-scope Medi-Cal for all income-eligible Californians.

A stakeholder group established design goals for potential short-term program options. The group was composed of representatives from local health plans, Federally Qualified Health Centers, public hospitals, county health systems, and policy experts, and was complemented by a series of key informant interviews with consumer advocates and policy experts. The input from the stakeholder group and the key informant interviews emphasized that proposed approaches and programs should reflect several key design goals to meet the needs of the at-risk population:

- ▶ **Access to health care** for all populations statewide who are projected to lose Medi-Cal coverage
- ▶ Protection of **privacy and safety** of Californians
- ▶ **Fiscally prudent strategies** with the recognition that the state budget may not support continuation of Medi-Cal coverage in its current form
- ▶ **Statewide scalability and adaptable design** allowing for efficient implementation and

enabling a smooth transition to full-scope Medi-Cal coverage when fiscal conditions improve

- ▶ **Stability and sustainability** of the safety net to deliver care

## Key Considerations Identified by Key Informants

To inform development of program options for people at risk of losing Medi-Cal, the authors interviewed 15 key informants in October and November 2025. Key informants represented enrollees, health care providers, immigrant communities, and other groups. These conversations focused on what matters most if people lose coverage through Medi-Cal. Across the interviews, several themes stood out:

- ▶ **Access to health care services as a priority.** Full Medi-Cal coverage for all Californians remains the ultimate goal, and there was recognition of the need to develop interim solutions that could provide access to health care services as coverage losses become a reality.
- ▶ **Benefit design.** Interviewees believed that the benefits should emphasize primary and preventive care (vaccinations, chronic disease management). Many favored using essential health benefits as a benchmark rather than using the Low-Income Health Program, which was viewed as a minimum floor and inadequate for specialty care.
- ▶ **Budget trade-offs.** There was general understanding of the need to balance the number of people served with the scope of benefits offered. Most interviewees leaned toward fewer benefits for more people. As one person put it, "We've come too far to not offer something to everyone."
- ▶ **Standardization.** There was strong support for uniform eligibility criteria and benefits across the state.
- ▶ **Cost sharing.** Stakeholders expressed strong opposition to premiums and deductibles.

# California Health Care Programs and Coverage Approaches

California has a long history of offering coverage and programs that provide access to health care services to people who are uninsured. A September 2025 CHCF Issue Brief, *Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses*, outlines historical approaches that California has taken to provide health care coverage and access to health care services at the state and county level.<sup>7</sup> Table 1 summarizes, at a high level, examples from California’s experience providing access to health care and the program features that align with design goals identified by the stakeholder group and key informant interviews, along with the limitations of each program.<sup>8</sup> The goal of this analysis is to determine whether any existing or past care and coverage approaches can serve as a model for future programs and to understand the current landscape of programs available to those who may lose Medi-Cal. See Appendix C on page 20 for a further summary of each program.

Minimal copays were considered acceptable, provided they were waived for preventive care.

- ▶ **Privacy and safety.** Significant concerns were raised about data sharing with federal agencies and the potential deportation risks. At the same time, interviewees recognized that excluding federal funding for limited-scope Medi-Cal would have significant budget implications. Emphasis was placed on the importance of ensuring that people can “opt out” of services when their information could be compromised.
- ▶ **Special populations.** Many felt that children should continue to receive Early and Periodic Screening Diagnostic, and Treatment-level benefits. Others felt that seniors needed to be prioritized. There was broad agreement that undocumented immigrants must be included, given the lack of alternative coverage options.
- ▶ **Provider network.** Interviewees recognized that continuity of care is critical yet understood that only narrow networks may be possible depending on rates for providers; narrow networks were acceptable if directories were correct.

**Table 1. Program Examples from California’s Past Efforts to Provide Coverage and Access to Health Care Services in Relationship to Design Goals and Limitations**

CARE OR COVERAGE APPROACH	ALIGNMENT WITH DESIGN GOALS	KEY LIMITATIONS
<b>STATEWIDE PROGRAMS</b>		
<p><b>Emergency or Limited-Scope Medi-Cal</b></p> <p>This program provides only emergency and pregnancy-related benefits and services to those with unsatisfactory immigration status. The program remains active and is funded through state General Fund and federal matching dollars.</p>	<ul style="list-style-type: none"> <li>▶ Statewide</li> <li>▶ Includes federal funds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Benefit package limited to emergency and pregnancy-related services</li> </ul>
<p><b>Family Planning, Access, Care, and Treatment (Family PACT)</b></p> <p>Family PACT covers the family planning needs of California residents with incomes below 200% of the federal poverty level (FPL). The program remains active and is funded through state General Fund and federal matching dollars.</p>	<ul style="list-style-type: none"> <li>▶ Statewide</li> <li>▶ Includes federal funds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Benefit package limited to family planning and reproductive health services</li> </ul>

*continued on next page*

CARE OR COVERAGE APPROACH	ALIGNMENT WITH DESIGN GOALS	KEY LIMITATIONS
<p><b>Breast and Cervical Cancer Treatment Program (BCCTP)</b></p> <p>BCCTP provides coverage to people with a diagnosis of breast or cervical cancer and income below 200% FPL. The program remains active and is funded through state General Fund and federal matching dollars.</p>	<ul style="list-style-type: none"> <li>▶ Statewide</li> <li>▶ Includes federal funds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Benefit package limited to services related to the treatment of breast and cervical cancer</li> </ul>
<p><b>Major Risk Medical Insurance Program (MRMIP)</b></p> <p>MRMIP operated from 1991 through 2024 and provided health insurance for California residents unable to obtain insurance in the individual health insurance market because of preexisting conditions. The program was fully state funded and included an enrollment cap.</p>	<ul style="list-style-type: none"> <li>▶ Statewide</li> <li>▶ Comprehensive benefits</li> </ul>	<ul style="list-style-type: none"> <li>▶ Based on preexisting condition</li> <li>▶ No longer active</li> </ul>
<b>COUNTY-BASED PROGRAMS</b>		
<p><b>Low-Income Health Program (LIHP)</b></p> <p>Called the “Bridge to Reform,” LIHP was an early expansion of Medi-Cal using existing county-based programs. In exchange for providing the standard benefit package outlined by the state, counties were able to obtain federal matching funds for people who would be eligible for the ACA expansion beginning in 2014. This program was active from 2011 to 2014.</p>	<ul style="list-style-type: none"> <li>▶ Standard benefit package</li> <li>▶ Includes federal funds</li> </ul>	<ul style="list-style-type: none"> <li>▶ Limitations on certain benefits</li> <li>▶ Voluntary by county, not all participated</li> </ul>
<p><b>County Medical Services Program (CMSP)</b></p> <p>CMSP is a collective of 35 mostly small and rural counties that contract with an administrative services organization that provides health coverage for uninsured adults age 21–64 with incomes below 300% FPL who are not otherwise eligible for other publicly funded health care programs. These programs are still active with limited enrollment.</p>	<ul style="list-style-type: none"> <li>▶ Standard benefit package</li> <li>▶ Covers people with UIS</li> </ul>	<ul style="list-style-type: none"> <li>▶ Limited to residents in participating counties</li> <li>▶ Limited benefits</li> </ul>
<p><b>County indigent programs</b></p> <p>California law requires that counties serve as the provider of last resort for county residents who are medically indigent (California Welfare and Institutions Code, Section 17000). Counties are not explicitly required to cover those with UIS and have significant flexibility to interpret requirements. These programs are still active; however, enrollment is limited.</p>		<ul style="list-style-type: none"> <li>▶ Varied benefit packages by county</li> <li>▶ Varied eligibility by county</li> <li>▶ Individual county administration leads to greater variation</li> </ul>
<p><b>Other programs (e.g., hospital charity care)</b></p> <p>State law requires hospitals to provide free or discounted care to patients who cannot afford to pay their medical bills. Under the Hospital Fair Pricing Act and recent updates to state law, hospitals must offer charity care and discounted payment programs to uninsured patients and to insured patients with high medical costs whose household income is at or below 400% FPL. Eligibility is based on income, not immigration or residency status, and hospitals are prohibited from considering a patient’s assets when determining eligibility. These programs are active.</p>	<ul style="list-style-type: none"> <li>▶ Statewide rules about income eligibility</li> </ul>	<ul style="list-style-type: none"> <li>▶ Services limited to provider uncompensated care</li> </ul>

Source: Len Finocchio, *Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses*, California Health Care Foundation, September 2025.

## The Role of Counties

California's experience of providing access to health care services at both the state and county levels before the ACA offers valuable insights for designing a potential coverage alternative to address the anticipated coverage losses.

Counties in California play a critical role in meeting the health care needs of their residents, guided by two key state laws:

- ▶ **Welfare and Institutions Code (WIC) § 17000.** Requires counties to provide coverage for indigent people and grants broad flexibility, subject to certain conditions (often referred to as Section 17000).<sup>9</sup>
- ▶ **WIC § 10000.** Sets a minimum standard of care and gives counties discretion in determining how to meet this standard, subject to certain conditions.<sup>10</sup>

These statutes set minimum standards and allow for significant local flexibility, resulting in notable differences in program eligibility, benefits, and services across counties. The variation is especially apparent between larger counties (with populations over 300,000) and smaller counties (with populations under 300,000). Larger counties have more autonomy to design and manage their programs, while smaller counties operate as a collective through the County Medical Services Program. CMSP counties share a common administrative services organization that administers the program uniformly, maintaining consistent eligibility criteria, benefits, and services. State law does not specify how expansive county programs can be or the limitations they might impose. This ambiguity has allowed some counties to expand services to address the unique needs of their populations, resulting in variation statewide.

While these programs have provided an important safety net, minimizing disparities across counties was a major goal expressed by stakeholders. Because state law was not modified following implementation of the ACA, county programs technically remain active, although enrollment has dropped to minimal or zero levels due to the reduced need. As policy changes loom at the state and federal levels, many counties are seeking guidance on how these changes may affect their obligations under these existing state laws. Counties and safety-net providers will likely face new costs if broad state-level coverage is not maintained.

California's history with the Low-Income Health Program (LIHP) offers additional insights about past efforts to provide statewide uniformity while recognizing the role of counties. Before the ACA, California created the LIHP as part of the 2010 Bridge to Reform 1115 demonstration waiver. The LIHP aimed to create uniformity across county programs by offering additional federal matching funds for a core set of benefits and services to those who would eventually qualify for Medi-Cal under the ACA (income eligible below 138% FPL and satisfactory immigration status). The LIHP was administered by the state, and participation was voluntary for counties, with 54 out of 58 counties opting in. The LIHP marked a step forward toward statewide uniform eligibility and benefits across counties. However, the LIHP's benefits did not match the benefits available under the full-scope Medi-Cal expansion or the essential health benefits (EHBs) eventually available to higher-income people through Covered California marketplace plans. See Table 2 for a comparison of the benefits of each program.

**Table 2. Comparison of Benefits and Services in California’s Medi-Cal Program, the Essential Health Benefits, and the Low-Income Health Program**

BENEFIT	FULL-SCOPE MEDI-CAL	ESSENTIAL HEALTH BENEFITS	LOW-INCOME HEALTH PROGRAM
Ambulatory/outpatient	✓	✓	✓
Emergency services	✓	✓	✓
Hospitalization	✓	✓	✓
Mental health and substance use disorder services and treatment	✓	✓	Minimum mental health services.
Prescription drugs	✓	✓	✓
Rehabilitative services, medical equipment and supplies	✓	✓	With limitations.
Laboratory services	✓	✓	✓
Preventive and wellness services and chronic disease management	✓	✓	
Pregnancy, maternity, and newborn care (before and after birth)	✓	✓	Pregnant and postpartum women were already covered through Medi-Cal at the time, and these benefits were unnecessary.
Pediatric services, including oral and vision care	✓	✓	Children were already covered by Medi-Cal at the time, and these benefits were unnecessary.
Non-emergency medical transportation	✓		With prior authorization.
Long-term services and supports	✓		

Source: Authors’ analysis, 2026.

## Future Program Options to Maintain Access to Health Care for Californians

To support informed discussions among policy-makers and stakeholders about program costs and trade-offs, HMA worked with CHCF to model two program options to support access to health care services for those at risk of losing coverage. This work

draws on California’s past and current coverage and care models, as well as input from the stakeholder group and interviews with consumer advocates.

Designing an alternative program option requires consideration of numerous variables that drive overall program costs, including the scope of benefits and any benefit limits, cost sharing, and provider payment rates. In addition to the program option’s own variables is the duration of any “bridge” coverage for those who lose coverage due to work

requirements and six-month redeterminations, and whether the state offers a program that includes federal funding for limited-scope Emergency Medi-Cal services. HMA developed a financial modeling tool that incorporates these variables to show the potential trade-offs of different choices by allowing users to include or exclude these variables and

to dial them up and down. Given the many possible combinations of these variables, two options consisting of differing variables were designed to demonstrate the range of program possibilities and the estimated costs and enrollment impacts of each. These two options, along with a baseline for comparison, can be seen in Table 3.

**Table 3. Comparison of Baseline Program and Program Options 1 and 2**

PROGRAM FEATURE	BASELINE	OPTION 1	OPTION 2
Benefits	Full-scope Medi-Cal	Essential health benefits plus non-emergency medical transportation	Low-Income Health-like benefits (includes non-emergency medical transportation)
Pharmacy	Yes, via Medi-Cal Rx	Yes, via Medi-Cal Rx	Yes, via Medi-Cal Rx
Long-term services and supports (LTSS)	No	No	No
Administrative structure	Managed care capitation	Fee-for-service	Fee-for-service
Provider rates	Current provider rates	Current provider rates (including enhancements)	Medi-Cal fee-for-service fee schedule
Temporary bridge for disenrollment due to work requirements or 6-month redetermination	Continuous coverage (no disenrollment due to work requirements or 6-month redeterminations)	3 months of temporary coverage for those impacted by work requirements or 6-month verification	2 months of temporary coverage for those impacted by work requirements or 6-month verification
Federal match for Emergency Medi-Cal	Yes	Yes	Yes
<b>Estimated annual program cost</b>	<b>\$6.7 billion</b>	<b>\$4.6 billion</b>	<b>\$3.1 billion</b>
People covered	2 million <ul style="list-style-type: none"> <li>▶ 600,000: full coverage</li> <li>▶ 1.4 million: 3 months of coverage</li> </ul>	2 million <ul style="list-style-type: none"> <li>▶ 600,000: full coverage</li> <li>▶ 1.4 million: 3 months of coverage</li> </ul>	2 million <ul style="list-style-type: none"> <li>▶ 600,000 full coverage</li> <li>▶ 1.4 million: 2 months of coverage</li> </ul>
Total number of member months	10.4 million member months	10.4 million member months	9.0 million member months

Source: Authors' analysis, 2026.

## A Baseline for Comparison

To demonstrate the value and impact of alternative program approaches, the authors estimated the cost of a baseline program. The baseline program assumes maintaining the current scope of Medi-Cal managed care for impacted members, including the benefits and services, provider rates, administrative costs,<sup>11</sup> pharmacy, and some behavioral health.<sup>12</sup> The baseline program also assumes ongoing coverage for people who would be income eligible for Medicaid but with UIS, and three months of coverage for those who do not meet work requirements or fulfill the six-month redetermination process. The estimated state cost of providing **the baseline program is \$6.7 billion annually. The baseline program would serve approximately 2 million people, including 600,000 people receiving continuous coverage and 1.4 million receiving three months of coverage.**

## Option 1: Higher-Cost Program with Broader Access

Option 1 is a higher-cost program that includes benefits aligned with the EHBs, plus non-emergency medical transportation. There are no limits on benefits and no cost sharing for participants; it assumes paying current rates, including targeted rate increases and prospective payment system rates to providers, including hospitals, Federally Qualified Health Centers (FQHCs), and private providers. Finally, it includes a three-month temporary bridge for those who lose coverage due to work requirements or six-month redeterminations. With this set of variables, the model projects that **Option 1 would cost the state \$4.6 billion annually and would serve approximately 2 million members, including 600,000 people receiving continuous coverage and 1.4 million receiving three months of coverage.**

## Option 2: Lower-Cost Program with Reduced Access

Option 2 is a lower-cost program that offers benefits more aligned with the LIHP, plus non-emergency medical transportation. A key difference between Option 1 and Option 2 — to align more with the LIHP — is that there are limits on occupational, physical, and speech therapies and on durable medical equipment. Option 2 includes Medi-Cal fee-for-service rates (unlike the higher-cost option, which maintains current payment rates to providers, including a prospective payment system to hospitals and FQHCs, and targeted rate increases to hospitals and private providers). It also includes a \$35 copayment for all services except primary care, FQHCs, lab, radiology, emergency room, and mental health outpatient services, which would align with the copayment to be applied to the new adult expansion population under H.R. 1. Finally, it includes only a two-month rather than three-month temporary bridge for those who lose coverage due to work requirements or six-month redeterminations. With this set of variables, the model estimates that **Option 2 would cost the state an additional \$3.1 billion annually and would serve approximately 2 million members, including 600,000 people receiving continuous coverage and 1.4 million receiving two months of coverage.**

## Common Features Across Options

In addition to a baseline for comparison, there are some program features that were kept consistent across the options modeled to align with feedback received during the stakeholder process. These components include the following:

### Federal Medicaid Matching Dollars for Emergency Medi-Cal

Due to the US Centers for Medicare & Medicaid Services (CMS) letter released in fall 2025 that mandates that states exclude emergency Medicaid

services eligible for federal matching from capitated arrangements for the UIS population, states are required to separate these services from managed care frameworks. This requirement is a primary factor behind the shift toward a fee-for-service (FFS) structure, as opposed to the existing capitated managed care arrangement, for any alternative coverage options. However, even within an FFS model, if California chooses to continue claiming federal matching funds for emergency services, concerns about privacy and safety persist. Current data sharing agreements between the US departments of Health and Human Services and Homeland Security (DHS), alongside actions taken by Immigration and Customs Enforcement, pose risks that people's private health information could be used to locate them. Stakeholder discussions acknowledged the gravity of these risks associated with continued federal claims for emergency services. Nonetheless, some stakeholders noted that privacy and safety have already been compromised under existing data sharing practices and that securing some federal funding may be worthwhile if it enables broader program coverage. Consequently, stakeholders emphasized the importance of understanding the costs and benefits of potentially enhancing enrollee privacy and safety by forgoing federal funds. As such, both options include drawing federal matching dollars for Emergency Medi-Cal services. **However, if California opted to provide emergency services using state-only funds, the authors estimate the annual cost would be \$800 million.**

### **Program Administration: FFS via State Contract with Existing Managed Care Plans**

Both alternative program options propose state administration of an FFS program utilizing established managed care plan contracts. Both options anticipate a decrease in administrative expenses to 4% as an FFS program rather than a risk-bearing managed care product. The 4% administrative factor reflects a deliberately limited

set of managed care functions; if plans were expected to perform fuller utilization management, care management, and oversight functions, the administrative rate would necessarily be higher. Implementation could also entail additional costs for managed care plans. Moving the program to FFS may also help the state to respond to the CMS letter mandating that states exclude emergency Medicaid services eligible for federal matching from capitated arrangements for the UIS population.

### **Out-of-Network Coverage**

The alternative program options are designed on a narrow network to promote efficiency and optimal coordination and to minimize administrative costs. Consequently, **care provided by out-of-network providers would not be reimbursed under this program.**

### **Specialty Behavioral Health Through Counties**

For the existing Medi-Cal population, specialty behavioral health services are delivered by county behavioral health departments, with services for mild-to-moderate behavioral health needs delivered through Medi-Cal managed care plans. Because of this, Medicaid managed care plans do not have the network to provide specialty behavioral health services for those with more severe needs. Given this reality, to maintain simplicity and minimize administrative costs, both program options maintain providing specialty behavioral health services through counties. **The options do not include these costs due to unavailability of data.**

### **Pharmacy**

The alternative program options assume that pharmacy benefits are delivered by the Medi-Cal Rx program and the costs are included in both options. The authors have estimated that the costs of pharmacy benefits through the Medi-Cal Rx program for both options is approximately \$140 per member per month for each of the program option

estimates. This totals to \$1.45 billion for Option 1 and \$1.25 billion for Option 2.

### **Eligibility and Enrollment (County)**

The options assume that eligibility and enrollment are performed via the county-based system used for Medi-Cal. Counties could require additional resources to support these activities. Because the scope of the program changes are yet to be determined, the costs of implementing program eligibility and enrollment changes are not included in the program option estimates.

## **Considerations for Policymakers**

The intention of modeling higher- and lower-cost alternative program options with different levels of access to care is to illustrate the program design choices to be made, the range of their impacts, and the potential trade-offs of each. As seen in Table 3, the number of people expected to be covered does not change from the baseline program to either option, while the potential state costs vary widely from \$3.1 billion to \$6.7 billion. Key policy choices behind these cost estimates reflect the potential trade-offs for an alternative program regarding program uptake, access to care, and provider participation.

Key policy issues across both options center on whether the design choices meaningfully undermine access to care, resulting in increased use of emergency departments and uncompensated care. Ultimately, the comparison of the options underscores the central trade-off for policymakers: balancing fiscal sustainability with ensuring access to preventive and ongoing care to avoid higher downstream costs and poorer health outcomes.

Option 1 represents a higher-cost, more comprehensive alternative care approach. By offering

EHBs with no benefit limits and no cost sharing, maintaining current provider payment rates, and including a three-month coverage bridge, this scenario is designed to closely approximate existing Medi-Cal coverage. These features are expected to support stronger access to primary care and specialty services by maintaining provider participation and minimizing financial barriers for enrollees. As a result, Option 1 is more likely to promote timely, preventive, and ongoing care, which may help reduce avoidable emergency department use. However, these access advantages come at a substantially higher cost to the state.

Option 2 reflects a lower-cost approach that more closely aligns with the historic LIHP. While it promotes access to primary care, it introduces several constraints that may limit access. Benefit limits on therapies and durable medical equipment, lower provider payment rates, a shorter coverage bridge, and a \$35 copayment for most services could reduce provider participation and discourage access to routine or follow-up care. These factors raise concern that some people may delay care or face challenges accessing primary and specialty services, increasing utilization of emergency department care.

In addition to impacts on access, policymakers must focus on the goal of statewide uniformity while factoring in the role counties may want to play, given existing state law and the historical role many have played in providing access to care for local residents, and seek alignment to the extent possible with their efforts. Also, any statewide program proposed by state policymakers must assure county partners that it will support them in meeting these obligations while preserving flexibility to go further where desired. This may include offering additional benefits or services, expanding coverage or access for people at higher income levels or with UIS, providing financial assistance to residents facing high out-of-pocket costs, or helping providers manage higher levels of uncompensated care.

Lastly, policymakers should anticipate that any ultimate program design details will be informed by several important legal and regulatory constraints. These include federal requirements articulated in the CMS State Medicaid Director letter 25-003, which requires states to exclude emergency Medicaid services eligible for federal matching from capitated arrangements for the UIS population. In addition, new federal restrictions in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) could have implications for providers participating in any program, which will require careful consideration to avoid unintended federal compliance risks. Finally, program design will need to incorporate appropriate patient protections and rate-setting safeguards to ensure limits on what patients are charged and adequate payments to providers.

## Administrative and Financial Considerations

After achieving historically low uninsured rates, California now faces the prospect of up to 1.8 million people losing Medi-Cal coverage, many with no other options. As state leaders and policymakers confront this challenge and weigh policy solutions, financing considerations will be central to the public deliberations. Following are some key questions to be addressed:

### Administrative

- ▶ Which entity should administer the program at the state level to address the needs of the millions of Californians who will lose health care coverage? While managed care plans are positioned to administer the program locally given their presence in all counties, should other entities be considered, such as county indigent care programs or other third party administrators?
- ▶ Given county requirements under state law to provide indigent care, is there value in ensuring some degree of uniformity of approach and coverage statewide? What steps could be taken to ensure consistent approaches statewide?<sup>13</sup>

### Financial

- ▶ How should such services or programs be financed?
- ▶ How should the state ensure revenue stability for these services?
- ▶ What policy and legislative mechanisms could establish a sustainable funding stream?
- ▶ Should the state engage with the private sector to support these services and programs with public financing support?
- ▶ Should the state collaborate with counties or the private sector to pursue joint financing strategies?

## Conclusion

California stands at a critical juncture in its health coverage landscape. After years of progress in reducing the uninsured rate and expanding Medi-Cal eligibility, the state now faces the prospect of millions of residents losing coverage due to federal and state policy changes. The fiscal implications are equally daunting, with billions of dollars in federal funding at risk and significant pressure on the state's General Fund. These challenges underscore the urgency of developing short-term options that preserve access to care while maintaining a vision for reinstating full-scope Medi-Cal in the future.

This report identifies potential options for an alternative program to maintain access to health care services, including a modeling tool for state policymakers and stakeholders to test assumptions, adjust program design features, and evaluate fiscal

impacts under different scenarios. This flexibility is essential in a dynamic environment where federal guidance and state implementation decisions will continue to evolve. By grounding deliberations in data, it offers a practical framework for weighing trade-offs and identifying feasible solutions.

Financing and governance considerations will remain central to the debate. Policymakers must grapple with questions of how to fund these programs, ensure revenue stability, and determine whether responsibility should be shared across state, county, and private-sector partners. Sustainable financing mechanisms will be critical to ensuring health care access and to stabilizing the broader health care system and safety network so providers can continue to deliver care.

## Endnotes

1. [2024 California Health Interview Survey \(CHIS\)](#), UCLA Center for Health Policy Research.
2. [Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1](#) (PDF), California Department of Health Care Services (DHCS), January 29, 2026.
3. [2026–27 Governor’s Budget, Proposed Budget Summary](#) (PDF).
4. Gabriel Petek, [The 2026–27 Budget: Medi-Cal Analysis](#) (PDF), Legislative Analyst’s Office, March 2026.
5. [Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R.1](#) (PDF), DHCS, January 29, 2026; and Gabriel Petek, [Considering Medi-Cal in the Midst of a Changing Fiscal and Policy Landscape](#) (PDF), Legislative Analyst’s Office, October 2025.
6. 2024 CHIS, UCLA Center for Health Policy Research.
7. Len Finocchio, [Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses](#), California Health Care Foundation, September 2025.
8. Appendix C on page 20 provides a more descriptive high-level summary of each of these programs.
9. [Cal. Welf. & Inst. Code § 17000](#).
10. [Cal. Welf. & Inst. Code § 10000](#).
11. HMA estimates administrative costs of the current Medi-Cal managed care program to be approximately 11%.
12. Estimate includes behavioral health benefits managed by managed care plans, but excludes benefits provided by county behavioral health plans due to unavailability of data for this analysis.
13. Scott Graves and Nishi Nair, [“Understanding Realignment: California’s Shifts in State and County Responsibilities,”](#) California Budget & Policy Center, July 2025.

# Appendices

## Appendix A. Shifting California and Federal Medicaid Policies Impacting Medi-Cal

Below is an overview of key federal and state Medicaid policy changes impacting Medi-Cal coverage and financing. The passage of H.R. 1 in July 2025 includes an estimated \$1 trillion in federal Medicaid reductions over the next 10 years, with an anticipated reduction of \$30 billion each year in California.<sup>1</sup> The full effects of many changes will depend on forthcoming federal guidance, as well as state implementation decisions.

### Provider Tax Restrictions

**Limitations on state use of provider taxes.** H.R. 1 restricts state use of Medicaid provider taxes as a source of state Medicaid funds, including reducing the tax revenue limit and restricting disproportionate taxes on Medicaid services. *(To be implemented over the next three years)*

### Increased Marketplace Premiums

**Federal Enhanced Premium Tax Credits ending.** To increase access to marketplace health coverage during the COVID-19 pandemic, Congress expanded the amount of federal subsidies and the populations eligible. These expanded subsidies expired on December 31, 2025, resulting in decreased coverage through the marketplace plans. *(Effective December 31, 2025)*

### Federal Requirements for Adults

**Work requirements.** To maintain eligibility, H.R. 1 establishes requirements for childless adults eligible under the ACA Medicaid expansion population to provide evidence of at least 80 hours per month of work, education, or community service. *(Effective January 1, 2027)*

**Six-month eligibility redeterminations.** H.R. 1 increases the frequency from every 12 months

to every 6 months that states must redetermine Medicaid eligibility for childless adults eligible under the ACA Medicaid expansion population. *(Effective January 1, 2027)*

**Reduced retroactive federal coverage.** H.R. 1 reduces the retroactive coverage period from three months to one month for childless adults eligible through the ACA Medicaid expansion group, and to two months for traditional Medicaid enrollees. *(Effective January 1, 2027)*

**Cost-sharing requirements.** Childless adults with incomes above 100% of the federal poverty level will have new copayments of up to \$35 per service for certain benefits. *(Effective October 1, 2028)*

### Federal Immigrant Eligibility Restrictions

**Expanded UIS categories.** H.R. 1 expanded the definition of UIS categories to include additional groups of lawfully present immigrants such as Temporary Protected Status holders, people protected under Deferred Action for Childhood Arrivals, refugees, and asylum seekers. This means increased immigrant populations will not qualify for federally supported Medicaid coverage (outside of emergency services) increasing reliance on Medi-Cal services funded only by the state. *(Effective October 1, 2026)*

**Reduced federal match for emergency services for those with UIS.** H.R. 1 reduces the federal match rate for emergency services for childless adults with UIS from 90% of the cost of care to the state's regular match rate (50% in California). *(Effective October 2026)* In addition, in September 2025, CMS released a State Medicaid Director Letter communicating that federal funding is available

only for actual services rendered for emergencies, not capitation payments in managed care. This limits how states may administer coverage of emergency services for those with UIS outside of the managed care capitation rates — by using a Medicaid fee-for-service system or through managed care contracts limited to emergency services.

**Privacy concerns.** CMS issued a notice in November 2025 that it will begin sharing Medicaid data it receives from states with Immigration and Customs Enforcement and the Department of Homeland Security (DHS).<sup>2</sup> This would include transfers of confidential Medicaid data, such as phone numbers, addresses, and immigration status. Although California and other states are challenging the transfer of this information, this policy will have a chilling effect on immigrant access and enrollment. *(Effective immediately as of November 2025)*

**Public charge proposed rules.** DHS released a proposed rule in November 2025 that would give immigration officers broader discretion to deny green cards or entry to the US based on a person's use of a wide range of benefits, including Medicaid, as evidence of their likelihood to become a public charge. This rule would have a chilling effect on Medicaid enrollment for immigrant populations. *(Proposed rule, November 2025)*

## California Medi-Cal Program Cuts

**Medi-Cal enrollment freeze for certain adult UIS populations.** In response to state budget challenges and pending impacts of federal Medicaid cuts, California will no longer enroll in full-scope Medi-Cal new adult applicants in certain UIS categories. This means full-scope Medi-Cal coverage for UIS populations will decrease, allowing only limited coverage for emergency and pregnancy-related care. *(Effective January 1, 2026)*

**Reintroduction of Medi-Cal asset test.** The Medi-Cal asset test for seniors and people with disabilities

will be reinstated to the 2022 levels: \$130,000 for an individual and \$65,000 for each additional household member. Given that elimination of this test in 2024 resulted in increased program enrollment, the reinstatement of this test is expected to restrict enrollment. *(Effective January 1, 2026)*

**Reduction of dental benefits.** Medi-Cal dental coverage for adults (age 19+) with unsatisfactory immigration status will be limited to emergency dental. *(Effective July 1, 2026)*

**Reduced safety-net provider payments.** The state will no longer use a prospective payment system to reimburse for services provided by FQHCs and rural health clinics to people with UIS, moving to standard Medi-Cal rates. *(Effective July 1, 2026)*

**Medi-Cal premium requirements for certain adult UIS populations.** In response to state budget challenges, California will begin charging a premium of \$30 per month for certain adults with UIS and who are age 19–59 to remain in full-scope Medi-Cal. This policy is expected to further decrease enrollment in full-scope Medi-Cal, as some enrollees will be unable to pay the premium. *(Effective July 1, 2027)*

## Appendix B. UIS Categories and Upcoming Medi-Cal Eligibility and Benefit Restrictions

IMMIGRANT GROUPS WITH UNSATISFACTORY IMMIGRATION STATUS	FULL-SCOPE MEDI-CAL ELIGIBILITY FREEZE (1/2026)	DENTAL BENEFITS REMOVAL (7/2026)	MONTHLY PREMIUM APPLIES (7/2027)
Adults (19+), not pregnant, without an immigration status or unable to verify their status (for example, undocumented Californians)	Yes	Yes	Yes
Youth (under 19) or pregnant people without an immigration status or unable to verify their status (for example, undocumented Californians)	No	No	No
Asylum applicant with work authorization (age 21 and over)	Yes	Yes	Yes
Battered immigrants (non-VAWA categories) (not exempt from or have not met the five-year waiting period)	No	Yes	Yes
DACA (Deferred Action for Childhood Arrivals) recipients	No	Yes	Yes
Deferred enforced departure (age 21 and over)	Yes	Yes	Yes
Green card holders (not exempt from or have not met the five-year waiting period)	No	Yes	Yes
Paroled into US less than one year	No	Yes	Yes
Pending special immigrant juvenile status (age 21 and over)	Yes	Yes	Yes
Temporary protected status holders (age 21 and over)	Yes	Yes	Yes
U visa applicants	No	Yes	Yes
Visitor/student/work visa holder (age 21 and over)	Yes	Yes	Yes

Source: "[Immigration Status and Medi-Cal Eligibility](#)," California Department of Health Care Services, accessed December 2025.

## Appendix C. Overview of Health Care Coverage Approaches for Uninsured Populations in California

The table below is adapted from the CHCF September 2025 Issue Brief *Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses* to provide an overview of health care coverage approaches for uninsured populations in California.<sup>3</sup>

PROGRAM NAME	SOURCE LINKS	YEARS IN OPERATION	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS
STATEWIDE						
Full-Scope Medi-Cal	<a href="#">Medi-Cal Immigrant Eligibility FAQs<sup>4</sup></a>	2016–present (phased expansion for different populations)	<ul style="list-style-type: none"> <li>▶ Eligible for Medi-Cal regardless of immigrant status</li> <li>▶ Enrollment freeze for adults 26–49</li> </ul>	Medicaid look-alike coverage (dental benefits removed beginning July 2026)	Yes	Enrolled Medi-Cal providers
Emergency Medi-Cal	<a href="#">Social Security Act, Section 1903(v)<sup>5</sup></a>	1965–present	<ul style="list-style-type: none"> <li>▶ Eligible for Medi-Cal, with exception of immigrant status</li> </ul>	Emergency and pregnancy-related services	No	All Medi-Cal providers (FFS only)*
Breast and Cervical Cancer Treatment Program	<a href="#">BCCTP home page<sup>6</sup></a>	2002–present	<ul style="list-style-type: none"> <li>▶ Diagnosis of breast or cervical cancer requiring treatment</li> <li>▶ Income eligibility</li> <li>▶ California resident</li> </ul>	Cancer treatment for breast or cervical cancer	No	Enrolled Medi-Cal providers
Family Planning, Access, Care, and Treatment	<a href="#">Family PACT home page<sup>7</sup></a>	1997–present	<ul style="list-style-type: none"> <li>▶ Able to become pregnant or cause pregnancy</li> <li>▶ Income eligibility</li> <li>▶ California resident</li> </ul>	Family planning services	No	Enrolled Family PACT providers
California Major Risk Medical Insurance Program	<a href="#">Welfare and Institutions Code Section 15870<sup>8</sup></a>	1991–12/31/2024	<ul style="list-style-type: none"> <li>▶ Unable to obtain coverage due to preexisting condition</li> <li>▶ California resident</li> <li>▶ Enrollment cap</li> </ul>	Medical benefits (no dental or vision)	Yes (premium and deductible)	Contracted health plans

*continued on next page*

PROGRAM NAME	SOURCE LINKS	YEARS IN OPERATION	ELIGIBILITY	BENEFITS	COST SHARING	PROVIDERS
<b>COUNTY-BASED</b>						
Low-Income Health Program	<a href="#">Bridge to Reform Section 1115 Medicaid Waiver Resources</a> <sup>9</sup>	2010–14 (transition to Medi-Cal)	<ul style="list-style-type: none"> <li>▶ Adults</li> <li>▶ Income eligibility</li> <li>▶ Proof of citizenship or satisfactory immigration status</li> </ul>	Core set of physical and behavioral health services	No	Varied by county (safety-net providers)
County Medical Services Program	<a href="#">County Medical Services Program Governing Board Regulations</a> <sup>10</sup>	1983–present	<ul style="list-style-type: none"> <li>▶ Adults (not eligible for other programs)</li> <li>▶ Income eligibility</li> <li>▶ California resident</li> </ul>	Core set of physical and behavioral health services	Yes (for certain services)	Contracted community health clinics and hospitals
<b>COUNTY INDIGENT, NON-CMSP</b>						
County medically indigent adult programs	<a href="#">California Welfare and Institutions Code Section 17000</a> <sup>11</sup> <a href="#">See summary of county programs in this CHCF Issue Brief</a> . <sup>12</sup>	Varies by county (many programs have closed)	▶ Varies by county	Varies (most counties provide limited primary care and preventive services)	Varies by county	Varies by county (county providers or contracted providers)
<b>OTHER (HOSPITAL CHARITY CARE)</b>						
Hospital Charity Care	<a href="#">California Hospital Fair Billing Program laws</a> <sup>13</sup>	2006–present	▶ People with income below 400% FPL	Episodic, hospital-based services	Yes	All acute care, psychiatric, and specialty hospitals

\*See Caprice Knapp (acting deputy administrator and director, CMS), to state Medicaid directors, “[Medicaid Managed Care Payments and Emergency Medical Condition Coverage for Aliens Ineligible for Full Medicaid Benefits](#),” State Medicaid Director Letter 25-003, September 30, 2025.

## Appendix D. Data and Model Assumptions and Limitations

### Data Used for Cost Estimates

The data used for modeling the cost of the program options include utilization, unit cost, and per-member per-month data for the Medi-Cal managed care program. Data were provided by Medi-Cal managed care plans (MCPs). These data cover 50 of California's 58 counties. Publicly available membership reports were used to scale the estimates to account for the eight counties not included in the plan-submitted data. These data elements are components of the actuarially sound prospective capitation rates developed by the California Department of Health Care Services (DHCS) and were provided at the county, category of aid, and category of service level of detail. Adjustments were made to these rates to reflect program and policy changes anticipated under this new coverage program, including the populations covered, the provider reimbursement rate, the enrolled population acuity, the covered benefits, and the member cost sharing. All adjustments were applied using research and actuarial judgment. Detailed claim or member-level data were not made available to support cost estimates or adjustments applied to the cost estimate. The data summaries provided were not audited for accuracy and are based on the work product of DHCS and its actuarial consultants. Adjustments to these data are similarly based on the DHCS summary data, including adjustments to remove service categories for the scope of coverage and to revise unit costs for alternative reimbursement strategies.

The above does not apply to estimates for pharmacy and county-based behavioral health, eligibility administration, and program administration. The cost estimates for pharmacy, county-based behavioral health, and eligibility administration were not based on data on expenditures and actuarially sound capitation rates, and instead are based on

discussions with relevant stakeholders and budget expense figures. These figures have been trended and adjusted to match the coverage period and covered populations of this cost estimate. Trend estimates are built on observed national cost and utilization growth observed for the services in question and caseload estimates provided by relevant stakeholders.

**Table D1. Assumptions**

ASSUMPTIONS (ADMINISTRATIVE AND FINANCIAL)	RATIONALE
Program will be administered by managed care plans (MCPs)	<ul style="list-style-type: none"> <li>▶ MCPs could leverage their existing Medi-Cal networks that include critical safety-net providers.</li> <li>▶ MCPs will leverage the strength of their network management, provider payment processes, and call centers to support this program.</li> </ul>
Program eligibility	<ul style="list-style-type: none"> <li>▶ The state will use the current county-based eligibility system for this program and Emergency Medi-Cal enrollment pathways.</li> <li>▶ The state will, thereby, ensure statewide uniformity in administration of this program.</li> </ul>
MCP payments from state	<ul style="list-style-type: none"> <li>▶ The program cost estimate assumes MCP administration at a rate of 4%, which may not fully account for utilization and care management or other managed care responsibilities.</li> </ul>
Provider payments from the MCPs in general	<ul style="list-style-type: none"> <li>▶ The program cost estimate assumes that provider payments are consistent with MCP payments in the Medi-Cal managed care program, inclusive of targeted rate increases and prospective payment system.</li> <li>▶ The program cost estimate does not assume that provider payments include or reflect any additional Medi-Cal payments, such as supplemental payments, quality assurance fee payments, voluntary rate range, or other such payments.</li> </ul>
Payment for pharmacy benefit	<ul style="list-style-type: none"> <li>▶ The program cost estimate assumes that the pharmacy benefit is managed by DHCS.</li> </ul>
Payment for behavioral health (BH) services	<ul style="list-style-type: none"> <li>▶ Medi-Cal BH responsibilities and costs are split between MCPs and county BH agencies.</li> <li>▶ The program costs estimate assumes that MCPs cover "mild-to-moderate" BH services and that the cost for such services is included in MCP component.</li> <li>▶ The program assumes that other BH services (i.e., serious mental illness and substance use disorder) will be managed by county BH agencies, estimated costs for which are yet to be determined.</li> </ul>
Emergency services	<ul style="list-style-type: none"> <li>▶ The program assumes that emergency services will be delivered via the Medi-Cal fee-for-service program, including pregnancy, and will continue to be federally funded.</li> </ul>

Source: Authors' analysis, 2026.

## Appendix Endnotes

1. Monica Saucedo and Hannah Orbach-Mandel, [\*Timeline of Federal and State Funding Cuts to Medi-Cal and CalFresh in California\*](#), *California Budget & Policy Center*, September 2025.
2. [Notice of Medicaid Information Sharing Between CMS and DHS](#), 90 Fed. Reg. 53324 (Nov. 25, 2025).
3. Finocchio, *Covering the Uninsured*.
4. “[Medi-Cal Immigrant Eligibility FAQs](#),” DHCS.
5. [Payment to States](#), 42 U.S.C. § 1396b(v) (2018).
6. “[Welcome to the Breast and Cervical Cancer Treatment Program](#),” DHCS.
7. “[About Us](#),” Family Planning, Access, Care, and Treatment Program, DHCS.
8. [Cal. Welf. & Inst. Code § 15870](#).
9. “[Bridge to Reform Waiver Resources](#),” DHCS.
10. [County Medical Services Program Governing Board Regulations](#) (PDF), County Medical Services Program, last amended October 24, 2013.
11. [California Welf. & Inst. Code § 17000](#).
12. Finocchio, *Covering the Uninsured*.
13. “[Hospital Fair Billing Program Laws & Regulations](#),” California Department of Health Care Access and Information.