CAPH

Navigating Change:

Impacts Of Federal & State Policy on California's Public Hospitals and Health Care Systems

PREPARED FOR: CONTRA COSTA COUNTY BOARD OF SUPERVISORS

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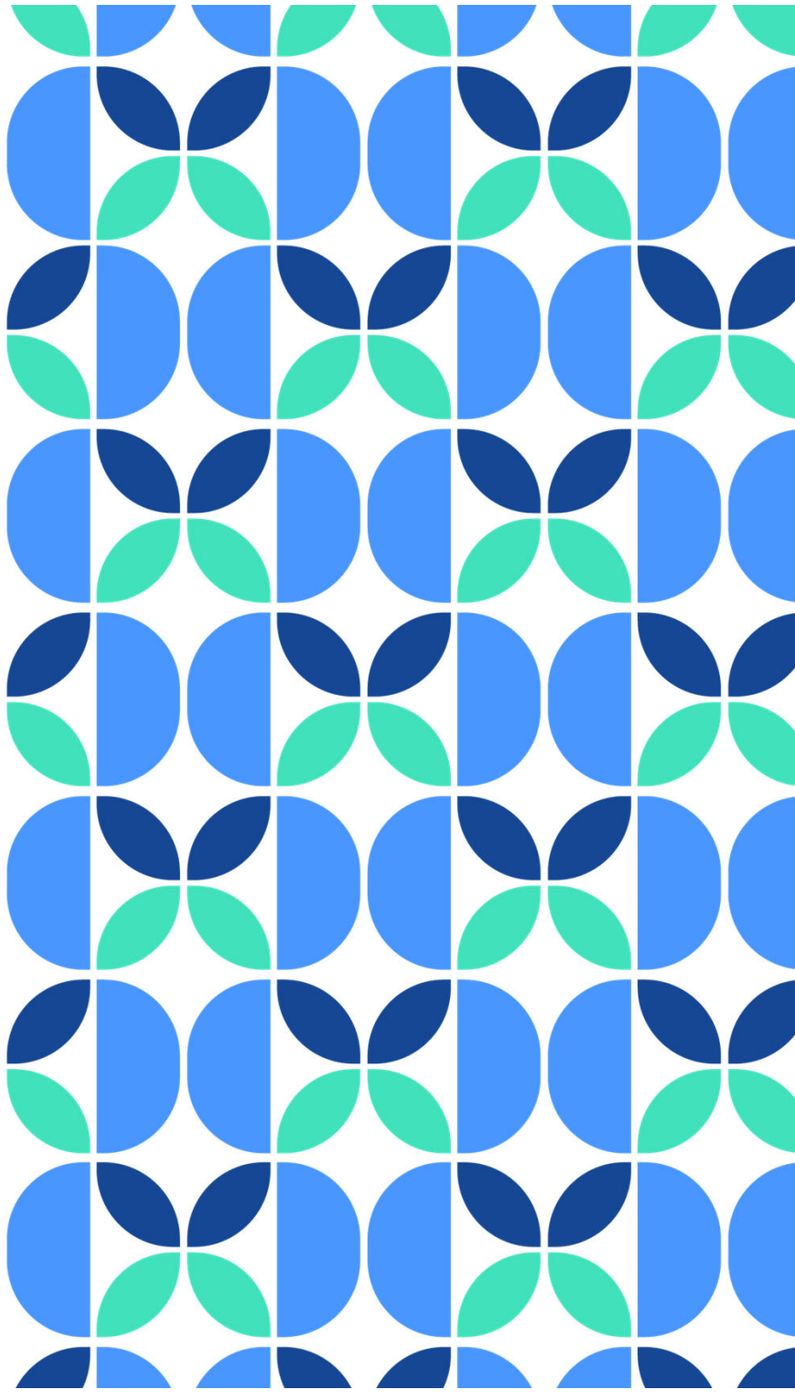
February 3, 2026



Objectives

1. **Provide Landscape of California's Public Health Care Systems (PHS) and Their Fiscal Challenges**
2. **Highlight Federal and State Policy Changes That Impact PHS**
   - HR 1
   - 2025-26 State Budget Decisions
3. **Highlight Potential Future Federal Action** that could worsen PHS financial situation
4. **Answer Questions**

CALIFORNIA'S PUBLIC HEALTH CARE SYSTEMS: 17 Systems, 43 Facilities & 150+ Clinics

Together, these systems care for one in six Californians on Medi-Cal and serve as a crucial access point for uninsured residents.

Alameda Health System
- Alameda Hospital
- Fairmont Rehabilitation and Wellness
- John George Psychiatric Hospital
- Park Ridge Rehabilitation and Wellness
- San Leandro Hospital
- South Shore Rehabilitation and Wellness
- St. Rose Hospital
- Wilma Chan Highland Hospital

Arrowhead Regional Medical Center

Contra Costa Health Services
Contra Costa Regional Medical Center

Kern Medical
- Kern Medical Hospital

LA County Department of Health Services
- Harbor/UCLA Medical Center
- Los Angeles General Medical Center
- Olive View/UCLA Medical Center
- Rancho Los Amigos National Rehabilitation Center

Natividad Medical Center

Riverside University Health System

San Francisco Department of Public Health
- Zuckerberg San Francisco General
- Laguna Honda Hospital and Rehabilitation Center

San Joaquin General Hospital

San Mateo Medical Center

County of Santa Clara Health System
- O'Connor Hospital
- Santa Clara Valley Medical Center
- St. Louise Regional Hospital
- Regional Medical Center

Ventura County Health Care Agency
- Santa Paula Hospital
- Ventura County Medical Center

UC Health
- **UC Davis Health**
  - UC Davis Sacramento Medical Center
- **UC Irvine Health**
  - UC Irvine Health, Fountain Valley
  - UC Irvine Health, Lakewood
  - UC Irvine Health, Los Alamitos
  - UC Irvine Health, Orange
  - UC Irvine Health, Placentia
- **UC San Diego Health**
  - UC San Diego East Campus Medical Center
  - UC San Diego Health, Hillcrest Medical Center
  - UC San Diego Health, Jacobs Medical Center
- **UC San Francisco Health**
  - UCSF Helen Diller Medical Center at Parnassus Heights
  - UCSF Health Saint Francis Hospital
  - USCF Health Saint Mary's Hospital
  - UCS Mission Bay Medical Center
  - UCSF Mount Zion Medical Center
- **UCLA Health**
  - Ronald Reagan UCLA Medical Center
  - UCLA Resnick Neuropsychiatric Hospital
  - UCLA Santa Monica Medical Center
  - UCLA West Valley Medical Center

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What Makes Public Hospitals and Health Care Systems (PHS) Unique?

Serve more than 3.7 million patients each year—about **10%** of California's population—**despite making up only 6% of the state's hospitals**.

Are systems of care providing hospital care, primary care, specialty services, trauma care, rehabilitation, etc.

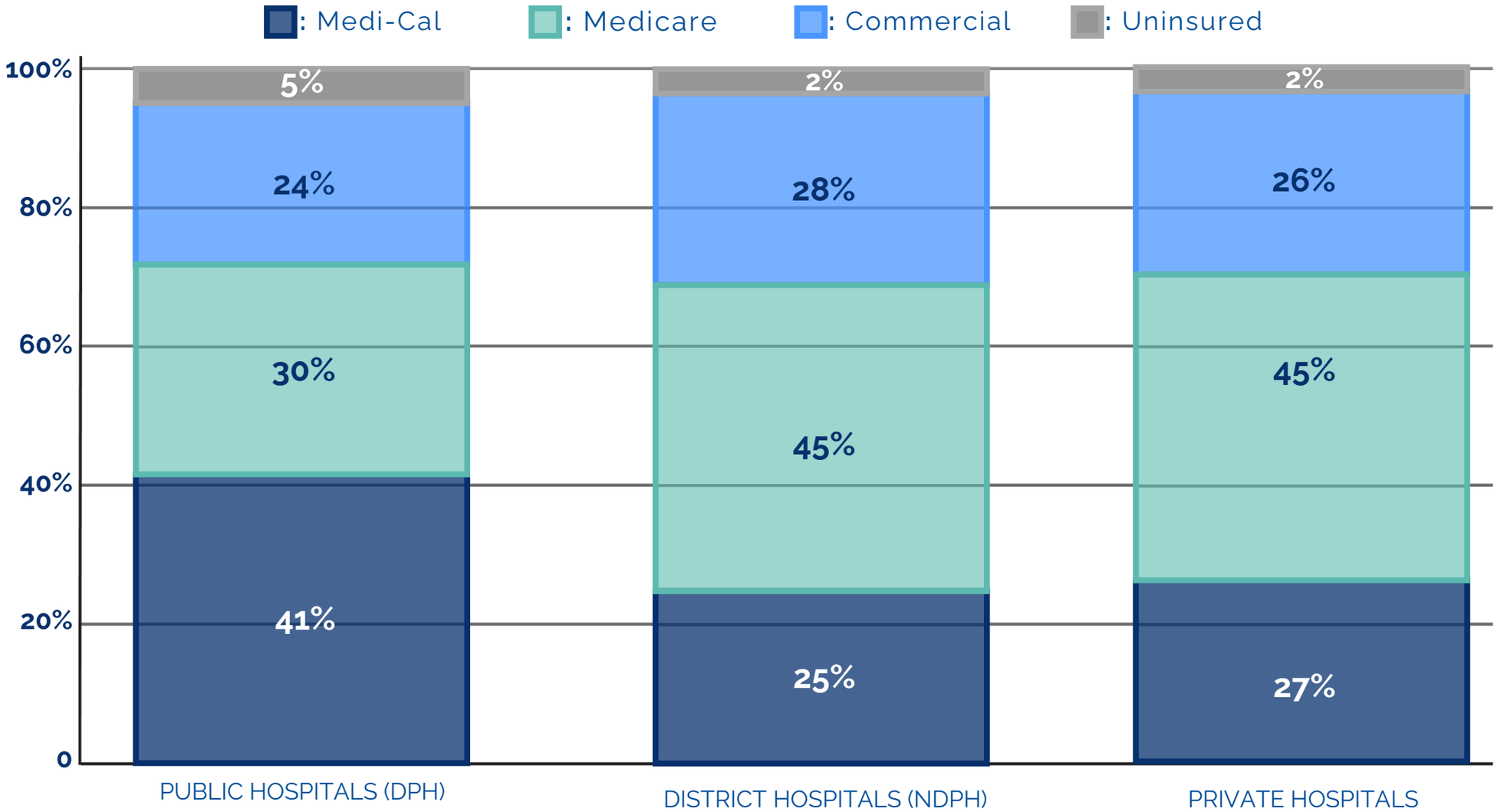
Deliver more than 12 million outpatient hospital visits a year.

Provide 35% of hospital care to state's Medi-Cal beneficiaries.

Provide nearly half of all hospital care for uninsured Californians. In California, counties have a legal obligation to provide care to the uninsured (Section 17000).

Core Providers of Care to Medi-Cal and Uninsured

PAYOR MIX BY COST, FY 22-23



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DPH: 12 county-owned and operated hospitals and 5 University of California medical centers
NDPH: Non-designated public hospitals, often referred to as district hospitals,
Private: All non-DPH, non-NDPH, non-children's comparable general acute hospitals

Source: HCAI FY 2022-23 Hospital Annual Financial Data

Three Reasons Behind Medi-Cal Financing Challenges

1. **The State Under-Invests in the Program**

- The State has pushed its responsibility for the match, or non-federal share (NFS) onto counties, on behalf of their PHS, and the UCs.
- Counties/PHS now put up more than **$4 billion** annually in NFS.

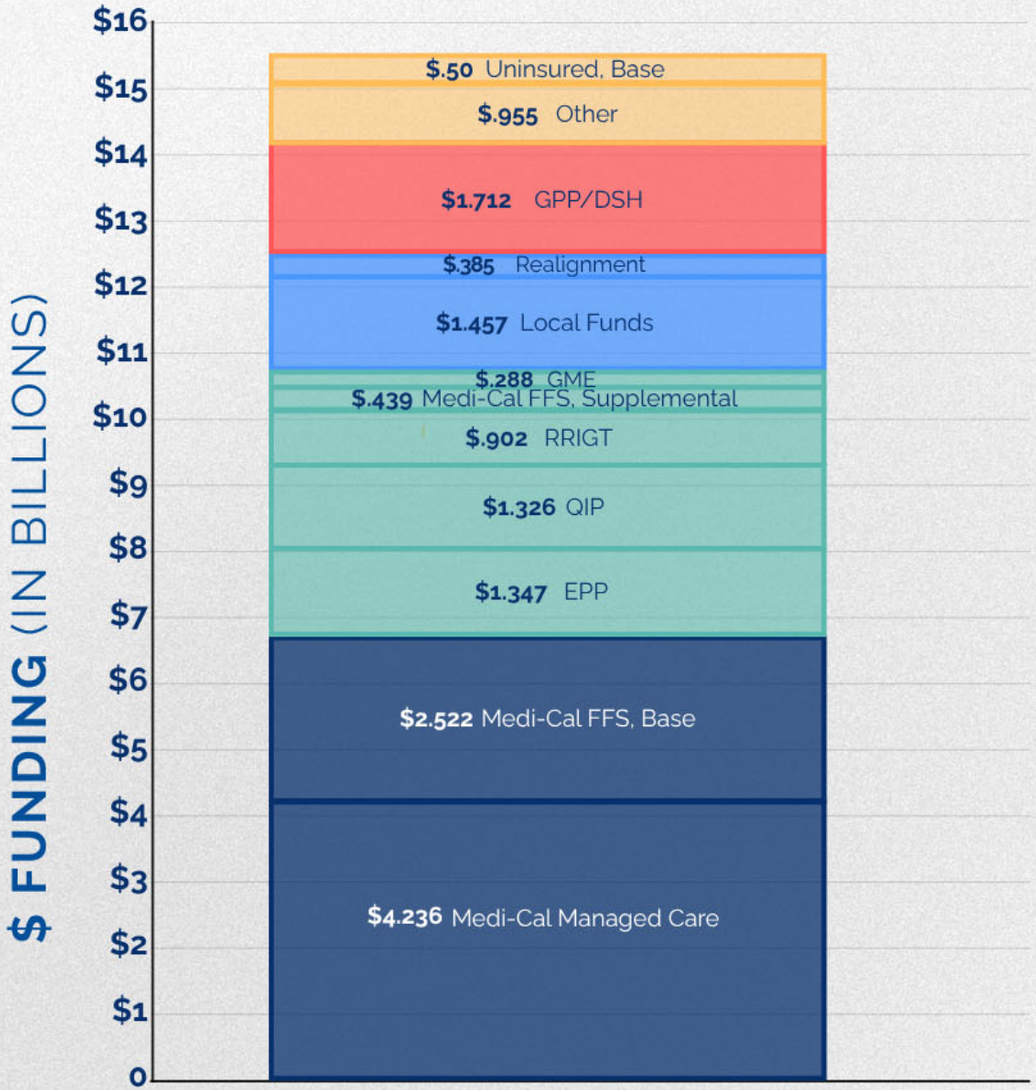
2. **Low Base Rates**

The base payments paid in Medi-Cal come nowhere close to covering the cost of providing the services, sometimes as low as 20% of costs

3. **Federal Assaults**

- PHS have found ways to create (and fund the match) for “supplemental” payments – but these are the payments that H.R. 1 and the Trump Administration are going after.

CAPH PHS FUNDING FOR MEDI-CAL/UNINSURED, FY 20-21



KEY:

- : Other Payments
- : Waiver Payments & DSH
- : Local Funds
- : Supplemental Payments
- : Base Payments

ACRONYM KEY:

- **EPP** = Enhanced Payment Program
- **QIP** = Quality Incentive Program
- **RRIGT** = Rate Range Intergovernmental Transfer
- **GME** = Graduate Medical Education
- **GPP**= Global Payment Program
- **DSH** = Disproportionate Share Hospital

Source: *P14s, AB85 submissions, other data*
**Local funds based on FY 18-19 data*

Rev. 10/8/2025

H.R. 1 IMPLEMENTATION TIMELINE

KEY:

- FUNDING & PAYMENT PROVISIONS DIRECTLY IMPACTING PHS
- ELIGIBILITY & COVERAGE PROVISIONS
- ALL OTHER PROVISIONS

DECEMBER 31, 2025

Rural Relief Fund: States must submit an application, including a detailed rural health transformation plan, by a deadline TBD but no later than December 31, 2025. CMS must approve all applications by that date.

OCTOBER 1, 2025

DSH Cuts Take Effect: $8 billion in annual Disproportionate Share Hospital (DSH) cuts move forward as scheduled.

EARLY 2026

180 days after enactment; around January 1, 2026
HHS must issue guidance on new six-month Medicaid eligibility checks.

JANUARY 1, 2027

1115 Waiver Budget Neutrality: All new 1115 demonstrations must meet federal budget neutrality requirements.

Medicaid Community Engagement (Work) Requirements: States must begin enforcing work requirements for adults ages 19–64. *States showing good faith effort may receive exemptions through December 31, 2028.*

Medicaid Eligibility Redeterminations: States must begin conducting eligibility checks for expansion adults every six months.

Medicaid Retroactive Coverage Limitations: Retroactive coverage reduced to one month for expansion enrollees, two months for traditional enrollees.

2025 — 2026 — 2027 — 2028

JULY 4, 2025

Limits on SDPs: State Directed Payments (SDPs) submitted after this date are capped at 110% of the "total published Medicare rate" for non-expansion states and 100% for expansion states.

Existing SDPs are grandfathered and exempt from these limits until January 1, 2028.

Uniformity Requirements Take Effect: States must restructure provider taxes to apply the same rate to Medicaid and non-Medicaid services or risk losing federal funding. CMS may allow a three year transition period.

Family Planning Provider Ban: One-year ban on federal Medicaid funding to providers mainly offering family planning (aimed at Planned Parenthood).

OCTOBER 1, 2026

Reduction in FMAP for Emergency Services for Undocumented Childless Adults: Federal match for emergency care for undocumented adults drops from 90% to 50%.

Non-Citizen Health Care Funding Restrictions: Ends the availability of federal Medicaid and CHIP funding for refugees, asylees, and certain other non-citizens.

JANUARY 1, 2028

State Directed Payment (SDP) Phase-Down Begins: Grandfathered SDPs begin 10% annual reductions until reaching 100% of Medicare rates

OCTOBER 1, 2028

Provider Tax Reductions Begin: Expansion states must reduce provider taxes from 6% to 3.5% by FY 2032; long-term care excluded. Non-expansion states capped at current rates.

New Copay Requirements: $35 copays required for expansion adults over 100% FPL.

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Rev. 8/8/2025

Key Provisions of H.R. 1 Impacting CA's PHS

- Changes to **State Directed Payments**
  - **$2.3 billion** annual net loss to PHS by 2032.
- Reductions to **Federal Medical Assistance Percentage (FMAP)**
  - Likely result in a loss of **$120 to $331 million** annually for PHS.
- No Delay of **DSH Cuts**
  - A loss of approx. **$856 million** annually, amounting to over **$2.4 billion** over three years.
- New **Medi-Cal Eligibility** Requirements (including community engagement/work requirements, cost sharing, more frequent eligibility checks)
  - DHCS estimates up to **1.8 million** Medi-Cal members may lose coverage due to these eligibility changes resulting in **$800 million** in annual losses for PHS

State Budget Changes: Financial Impact on PHS

Unsatisfactory Immigration Status (UIS) Program Cuts - Estimated Member Impact

- **January 2026:** Enrollment freeze → **5% reduction** in UIS managed care membership
- **July 2026:** PPS payment elimination + dental coverage ends → impacts all state-only members
- **January 2027:** $30 monthly premiums → **25% total reduction** in UIS managed care membership

Impact on PHS

- **CY2026 Total Revenue Reduction:** $76.3 million across all CAPH members
- **CY2027 Total Revenue Reduction:** $231.0 million across all CAPH members

Primary Impact Areas:

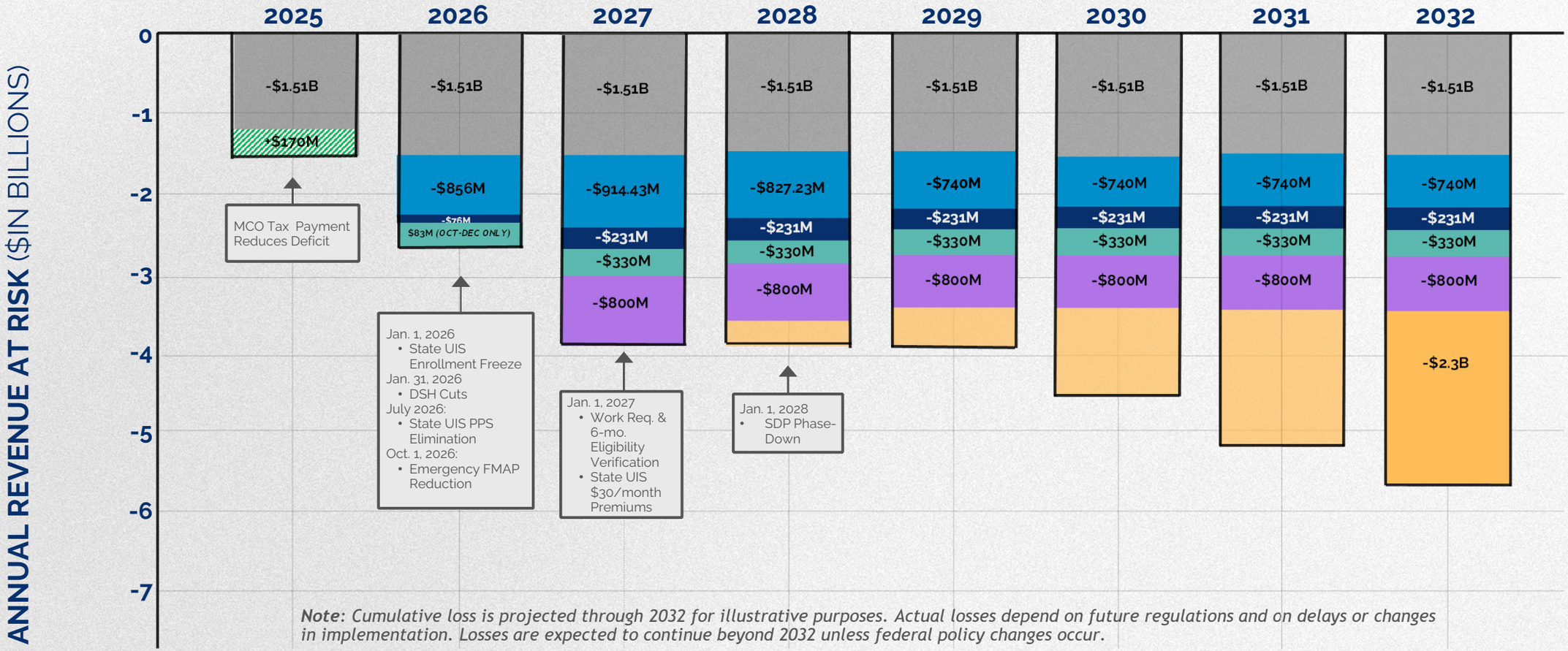
- Lost Medi-Cal base payments (managed care and FFS)
- Increased pharmacy costs for uninsured former members
- FQHC PPS revenue losses starting CY2026

2025-2032 PROJECTED CUMULATIVE IMPACT:

STATE AND FEDERAL POLICY CHANGES AFFECTING CALIFORNIA'S HEALTH CARE SYSTEMS

KEY:

- EXISTING STRUCTURAL DEFICIT
  Does not Include PHS' historical deficit of $1.7B.
- DSH/GLOBAL PAYMENT PROGRAM (GPP) NON-RENEWAL
- STATE UNSATISFACTORY IMMIGRATION STATUS (UIS) CHANGES
- EMERGENCY FMAP REDUCTION
- FEDERAL ELIGIBILITY CHANGES
  Includes Medicaid work requirements and six-month re-verification thereby reducing Medi-Cal enrollment, lowering federal funding, and increasing uncompensated care costs.
- MCO Tax
- STATE DIRECTED PAYMENT (SDP) REDUCTIONS
  SDP impact shown between 2028-2031 assumes gradual reduction through FY 2032, ending with $2.3B annual loss. Actual amounts depend on federal implementation.



***Note**: Cumulative loss is projected through 2032 for illustrative purposes. Actual losses depend on future regulations and on delays or changes in implementation. Losses are expected to continue beyond 2032 unless federal policy changes occur.*

What the future holds…

- **Medicaid DSH Cuts (January 2026)**
- **1115 Waiver Renewal (December 2026)**
- **Federal Regulations**
  - Changes to Payment Structures (“MFAR 2.0”)
  - Revision to Interpretation of Public Benefits and Updates to Public Charge
- **State Budget Cycle**
  - Jan budget included further cuts
  - CAPH seeking:
    - $500M annually in ongoing State General Fund to help stabilize funding & stanch the bleeding
    - Support for county eligibility and county indigent needs

What's Needed

1. **Reinvestment by the State**
2. **Advocacy**
   - Seek to reverse, or at least delay, H.R. 1 provisions
3. **Local Funding Decisions**
   - Sales tax or other revenue generators
4. **Peer Support**
   - Counties coming together through associations to compare notes. No one should be reinventing the wheel