H.R.1 and Medi-Cal Lunch and Learn FAQs

Question	Response
Are there specific Medi-Cal services that we know will be impacted? (i.e. CalAIM ECM, Community Supports, IHSS, etc.)	H.R.1 did not specifically address services offered by state Medicaid programs. But, with the reduction in funding to each state Medicaid program, there will need to be decisions made on how many (and what type) of services each state will continue to offer. To the extent that California has budget deficits in the future, they could always decide to reduce or eliminate optional benefits and services.
How do we effectively serve families with mixed immigration status?	We would recommend that mixed households know their options for continuing with health coverage. To the extent that a UIS member needs full-scope Medi-Cal for serious, ongoing medical care, their most important action will be to pay the monthly premium when that starts in July 2027 (amount to be determined by new Governor). Each family will need to make decisions based on their income level, comfort with data being shared with the federal government, etc. County staff being knowledgeable and sharing this information is critical to mixed households making the right decision for their family.
How families can access higher level care for complex mental health needs of their children. When children are recipients of California Regional Center services under Lanterman Act - how they can access services like wraparound services?	If we are talking about specialty mental health services, families need to contact and be assessed for services by the county behavioral health plan. This includes individuals with developmental or cognitive disabilities.
How should county health and child welfare departments engage with local CBOs in responding to H.R.1 impacts?	Having consistent, factual, reliable information between county departments and CBOs will be critical, given the complexity of the changes and the confusion that will be occurring in the ACA expansion population. Reaching out to any and all trusted partners and points of contact for beneficiaries will be important.
How will these changes impact those at risk of or with a SUD diagnosis?	Individuals with a SUD diagnosis and undergoing treatment will be exempt from work requirements, but not semi-annual redetermination. Also - a diagnosis does not mean an exemption in perpetuity - so ensuring the individual knows that a provider will eventually need to confirm the diagnosis AND confirm the condition renders the individual incapable of meeting the work

	requirements is important. DHCS should be issuing additional guidance in this area by Fall 2026.
How can CBOs can continue to serve current clients despite funding stream changes (and/or expand services to clients as community needs present)?	CBOs will need to evaluate their services and try to bill as many as appropriate as ECM or other Medi-Cal related services (community health worker, dyadic services, etc). The use of grant or charitable dollars should be targeted to supporting services that are NOT Medi-Cal eligible.
What are some potential impacts to core social service programs - IHSS and/or APS - with the continued implementation of H.R.1.?	As California's budget absorbs the impact of H.R.1, it could affect programs such as IHSS or APS because of the reduction in General Fund dollars over the next several fiscal years (which would be true with or without HR 1). However, this is not known at this time because the state will have to go through its annual budget process and make decisions on what to sustain, reduce, augment, etc.
What are the implications of H.R.1 for rural counties? What strategies can counties implement to mitigate any impacts on programs and service delivery?	Counties, just like the state, may see reductions in overall Medicaid funding due to H.R.1, likely from the changes in provider taxes and directed payments. However, this may vary dramatically from county to county. Rural counties may see a drop in Medi-Cal enrollment and an increase in uninsured - which may place greater burden on a county's scarce indigent health program resources.
What is your interpretation around individuals in SUD treatment being exempt from work/community requirements? There is not much clarity around what is meant by treatment, so how will the State determine whether someone qualifies for the exemption?	DHCS will need to issue additional guidance on this very important issue later this year (think Fall 2026). As it stands now, patients will be limited in their ability to self-attest to a qualifying condition and that a provider at some point will need to certify the individual's condition renders them incapable of meeting work/community engagement requirements. We can try and do a follow-up webinar when this guidance comes out to support county staff.
What are the implications for parents who are involved in reunification with their children and have to participate in those services?	The federal guidance is unclear - but from our non-legal reading, parents involved in reunification activities would not be able to use those activities to meet federal work/community engagement requirements. This would be a great question to ask DHCS for guidance/assistance on since they are working with CMS and other state Medicaid programs directly.

Word has been shared that there are 17 counties that will have a waiver for the work requirements. When will those counties be notified if they are one of the 17?	Counties that are exempt from work requirements is due to the unemployment rate in those specific counties. States are allowed to seek a hardship exemption for individuals living in counties where unemployment rates are at or above 8% or at least 1.5 times the national average unemployment rate.
Would verification that an individual is receiving IHSS meet the exemption criteria for being blind or disabled?	I think so because the county would have to make a determination that the individual is so disabled, they cannot perform the ADLs. This will need to be specified and made clear in state implementation activities.
Would cost sharing kick folks off MCP Medi-Cal?	No. It just means the provider takes a loss if the patient cannot pay. It is another way to make services harder for M1 patients to access.
Is the $30-$50-dollar premium for each covered member of a family? Or just for a parent who is signing up themself and teenagers?	The premium for UIS members is per adult, starting no sooner than July 2027. The new Governor will have to decide the level of premium as part of the January 2027 budget (or make some decision to keep/suspend). The premium is only for adults aged 19-59.
Is it possible to define the reunification case plan requirements as "work" within this definition?	This would be better directed at DHCS since they will be issuing clarifying guidance in Fall 2026.