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H.R. 1's Impact on CalAIM:

A 2025-2028 Operational Playbook for California ECM & Community Supports Providers

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Executive Summary

The 2025 federal budget law (H.R. 1; Public Law 119-21) introduces changes that will ripple through Medi-Cal over several years.

The most visible changes are:

1. **Work requirements** for certain low-income adults
2. **Twice-a-year eligibility renewals** for those adults (replacing the previous annual cycle)
3. **Reduced retroactive coverage**
4. **New cost-sharing** for some adults
5. **Tighter rules on how states finance Medicaid** through provider taxes and state-directed payments

What this actually means for CalAIM providers?

More time on **paperwork and verification**, more **member "churn"** even among people who remain eligible, and **slower, more conservative decision-making by MCPs** as they absorb new administrative work and financing constraints.

What does not change?

CalAIM itself is not ending.

ECM remains authorized under **federal Medicaid managed care rules**, and most **Community Supports** operate as "in lieu of services" (ILOS), which can continue beyond the current **Section 1115 waiver cycle**.

This is why you may see the myth that "ECM and Community Supports end in 2026."

Two Community Supports (Recuperative Care and Post-Hospitalization Short-Term Housing) do rely on **waiver authority** and must be renewed, but the rest can continue as ILOS. California's **Medi-Cal Transformation Concept Paper** outlines a path to **renew and evolve CalAIM** rather than wind it down.

What H.R. 1 does, in plain language

Two quick definitions up front:

ACA expansion adults

- People ages **~19-64** who gained Medicaid coverage starting in 2014 because their income is **at or below 138% of the federal poverty level** and they don't qualify through another category.
- In California, this is **a large slice of the Medi-Cal population** – think retail, service, gig, and seasonal workers.

Provider-tax financing (the "MCO tax," hospital fees, etc.)

- California assesses certain providers/health plans, uses those dollars as the **state share to draw federal match,** then returns funds via **higher rates or supplemental payments**.
- It's a **core tool to finance Medi-Cal** without raising broad-based taxes.

Five visible changes introduced by H.R. 1:

Community engagement (work requirements)

By December 31, 2026, adults in the ACA expansion group must show 80 hours per month of qualifying activities (paid work, specified education/training, approved community service). Many are exempt, including pregnant people, individuals considered "medically frail" (serious physical or behavioral conditions, SUD), parents/caretakers of young children, students at least half-time, and certain tribal members.

Practical catch:
If someone is disenrolled for non-compliance, they generally cannot get subsidized ACA Marketplace coverage at the same time – creating a real coverage gap until they re-establish eligibility or an exemption.

Renewals move from once a year to every six months (expansion adults)

States must redetermine eligibility twice a year (every six months) for expansion adults, moved from once annually in California. In practice, that doubles renewal packets and touchpoints and increases the chance that a missed call, mail, text, address, or documentation issue interrupts care.

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3 Retroactive coverage shortened

For expansion adults, retroactive coverage shrinks from 90 days to 30 days. When someone applies today, fewer recent bills may be covered retroactively.

4 Limited cost-sharing for some adults (2028)

Beginning 2028, states must charge small copays (up to $35 per service) for expansion adults above 100% FPL.

Key protections apply: no copays for emergency care, primary care, prenatal and pediatric care, or mental health services; annual family cap of 5% of income.

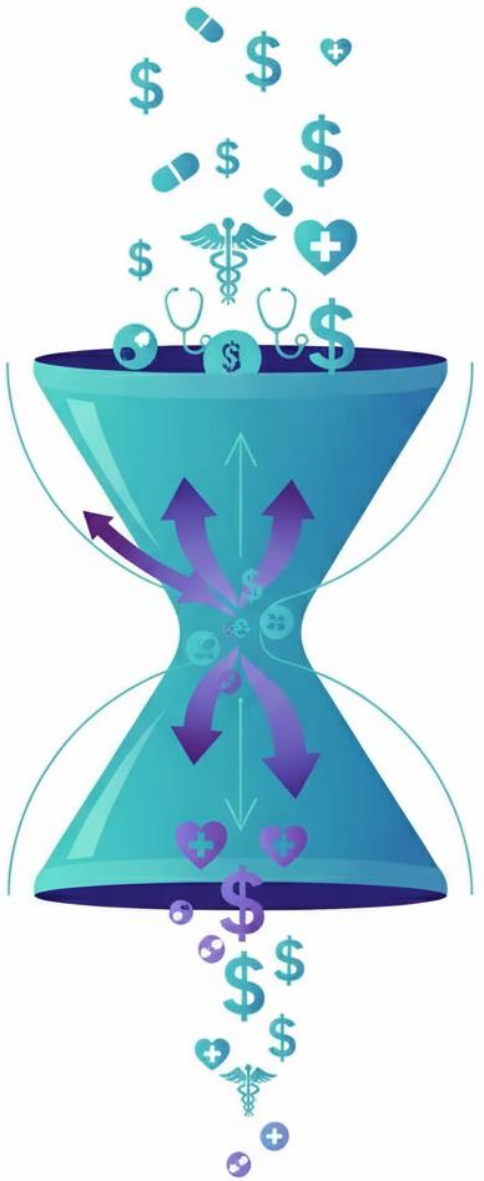
5 Financing rules get tighter

H.R. 1 reduces the provider-tax "safe harbor" from 6% of net patient revenue down to 3.5% by FY 2032, stepping down 0.5 percentage points per year from FY 2028 through FY 2032. It also caps certain state-directed payments relative to Medicare rates.

Translation:

California will have less room to use provider taxes to draw federal funds and will face more guardrails on supplemental payments – putting downward pressure on rates and potentially slowing network growth, especially as plans and the state re-base directed payments and adjust rate-setting to stay within the new limits.

States may continue to fund coverage for undocumented immigrants directly.
Will receive less federal funds for required emergency care coverage.



What does this mean in California?

A Note on Waivers: Why People Think ECM and Community Supports Will End – And Why That's a Myth

Let's be clear: ECM and Community Supports are not ending.

This misconception stems from confusion about federal waiver timelines – but it doesn't reflect how these programs are actually structured or funded.

Today, CalAIM rests on multiple authorities:

- The 1115 demonstration waiver and 1915(b) waiver, which both sunset on 12/31/2026 unless renewed
- Standard Medicaid managed care authority, including the ILOS (In Lieu of Services) authority under 42 C.F.R. 438.3(e)(2)

*PATH funding will expire on December 31, 2026. Any additional implementation funding would require a new, **budget-neutral** 1115 waiver – but DHCS intends to sunset.*

ECM is a managed care benefit, and most **Community Supports qualify as ILOS – neither depends on 1115 authority.**

Only a small subset of Community Supports (e.g., Recuperative Care, Post-Hospitalization Housing) have historically relied on 1115 and are being addressed in waiver renewal planning.

DHCS's 2025 waiver concept paper signals continuation and expansion – not elimination of these services.

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Why MCP operations will feel tight, and what that means day to day?

H.R. 1 arrives as California manages a tight state budget and faces federal limits on provider-tax financing (the “safe harbor” steps down over time) and caps on certain state-directed payments. Plans also have to stand up verification systems for work reporting and six-month renewals.

Expect MCPs to:

Move more cautiously on rate and network decisions

Tighten prior authorization and utilization management where rules allow

Take longer to respond as staffs are retrained, systems adjusted, and capitation bids recalibrated

*In California, **MCP operations will feel tight**. Day to day, that means **slower tempo, more friction in decision-making, and a conservative posture across counties** as plans navigate administrative requirements and tighter financing.*

How Changes in eligibility criteria will impact Californians?

***Directly affected* by work requirements & six-month renewals:**

ACA expansion adults (roughly ages 19-64)

***Not directly affected* by those two changes:**

*Children, pregnant people, SSI-linked disabled adults, most seniors, and **undocumented individuals** covered by state funds.*

However, household churn can still disrupt care plans, transportation, caregiving arrangements, and contact info.

***Overlap* with ECM populations of focus:**

Many ECM members meet "medically frail" criteria or are otherwise exempt.

Still, their families/households may be in the expansion group, so care plans can be disrupted when a spouse, child, or caregiver loses coverage after a missed renewal or documentation issue.

What California providers told us? - August 2025 pulse survey

A short pulse survey of ECM and Community Supports leaders surfaced three consistent signals:

1. **Coverage loss** and **funding pressure** are the top concerns.
2. **Communication from MCPs is inconsistent** – many providers report little or no plan-level guidance so far.
3. **Providers aren't waiting** – leaders report reassessing ROI, meeting with MCPs on sustainability, and seeking additional payers or grants now.

Providers are moving now, not waiting for perfect clarity

Helpful references for operations/coverage rules:

- *DHCS Medi-Cal Transformation Concept Paper (CalAIM renewal/evolution)*
- *DHCS APL 25-011 – H.R. 1 implementation*
- *DHCS All-Plan Letters library*
- *ECM Policy Guide (DHCS)*
- *Community Supports Policy Guide (DHCS)*

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Five moves to make now

1 *Make six-month renewals a routine you can run in your sleep*

Bake renewals into your workflow like an immunization schedule: predictable, trackable, relentless follow-up.

- Add two renewal "ticklers" in your care platform at month 5 and month 11.
- Update cell, email, and mailing address at every encounter.
- Send SMS/call/mail reminders in the member's preferred language with one simple action per message.
- Track and share a monthly renewal save-rate with MCP partners.

Aim: ≥90% renewal completion for actively engaged ECM members.

2 *Stand up a simple work-requirement triage & exemptions process*

Designate a small team to screen for common exemptions (pregnancy, medically frail, caretakers of young children, students, tribal) and assemble consistent documentation packets plans will accept. Track cycle time from first contact to exemption filing.

3 *Stabilize revenue by widening the payer mix*

If >80% of revenue is Medi-Cal, start diversifying. Map ECM-like models to Medicare Advantage/D-SNP and targeted commercial contracts.

Bring a one-page ROI snapshot (recent utilization impacts, member outcomes) to every payer meeting and ask for a PMPM tied to measurable results.

4 *Show your value with simple, defensible outcomes*

Pick 3-5 metrics you can measure cleanly in the next 6-12 months (e.g., ED visits ↓, 30-day readmissions ↓, housing placements, closed care gaps).

Send a quarterly "outcomes postcard" (one page, one chart, three bullets) to all MCP contacts.

5 *Keep Community Supports flowing through smart referral design*

Map the end-to-end path for each Community Support, eliminate duplicate forms, set 2-business-day intake SLAs, and script warm handoffs with a named person/number.

Meet with MCPs if new prior-authorization steps appear.

Quick myth-checks you can share with staff and partners

“ECM & CS end in 2026."

False. ECM is a managed care benefit and most Community Supports are ILOS that can continue beyond the current waiver cycle.

DHCS Medi-Cal Transformation Concept Paper

“Everyone must work full-time to keep Medi-Cal."

No. The requirement is 80 hours per month and applies only to the ACA expansion group, with many exemptions (pregnancy, medically frail status, caretakers of young children, students, tribal members).

KFF tracker | *SHVS*

“Copay starts right away."

No. Limited cost-sharing begins in 2028 for some expansion adults, with protections (no copays for emergency, primary care, prenatal, pediatric, or mental health services) and a 5% family income cap.

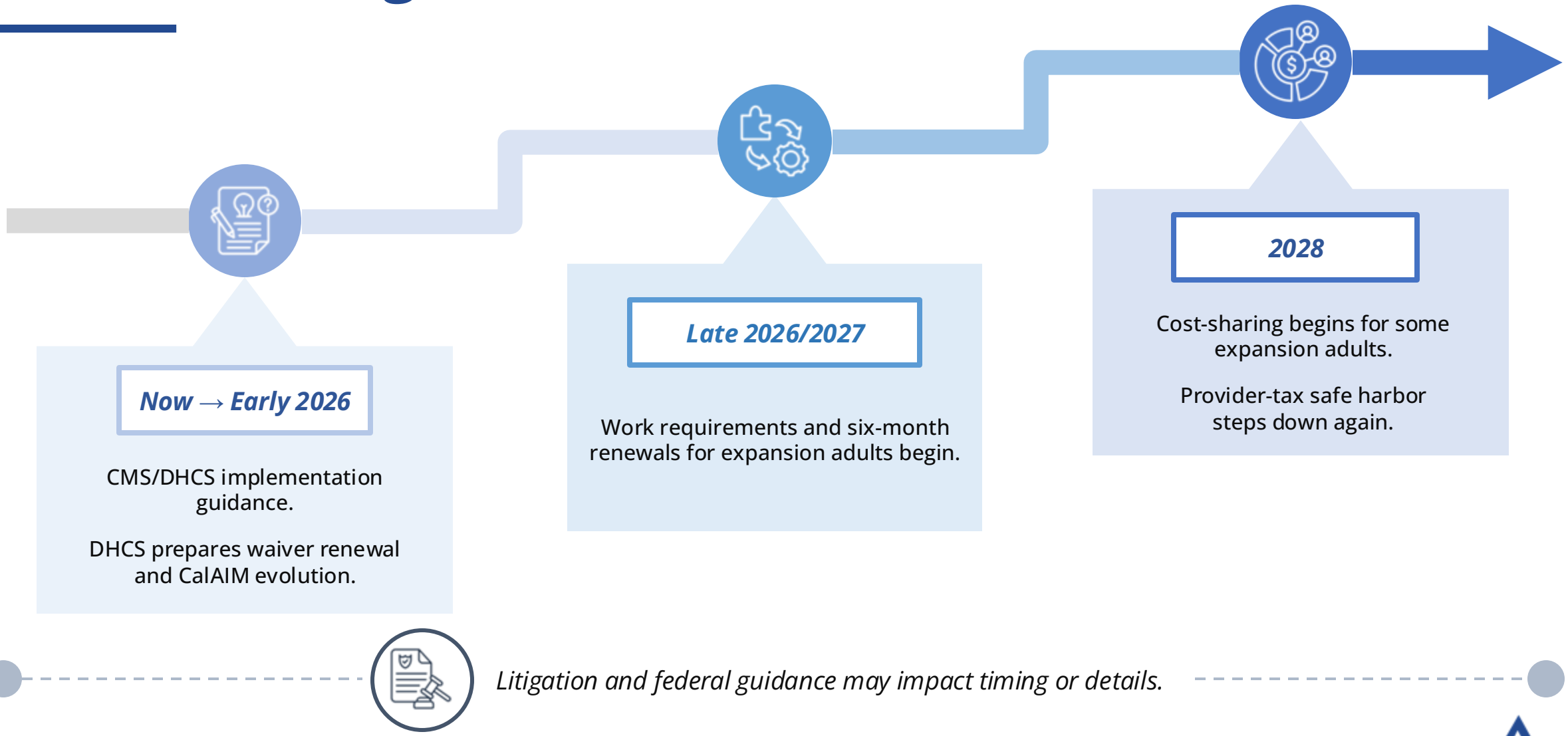
SHVS overview | *KFF summary*

“Provider payments are being slashed overnight."

No. Financing changes phase in and primarily limit how the state raises the non-federal share (for example, the provider-tax safe harbor steps down). Expect gradual pressure rather than an immediate cliff.

KFF provider-tax explainer | *DHCS concept paper*

Timeline at a glance



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Handy links (official sources)

- H.R. 1 bill text: https://www.congress.gov/bill/119th-congress/house-bill/1
- KFF tracker (what's in the law): https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/
- Georgetown CCF explainer (coverage & financing impacts): https://ccf.georgetown.edu/2025/07/22/medicaid-chip-and-affordable-care-act-marketplace-cuts-and-other-health-provisions-in-the-budget-reconciliation-law-explained/
- DHCS Medi-Cal Transformation Concept Paper: https://www.dhcs.ca.gov/CalAIM/Documents/Medi-Cal-Transformation-Concept-Paper.pdf
- DHCS APL 25-011 (H.R. 1): https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL-25-011-HR-1-Act.pdf
- ECM Policy Guide (DHCS): https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf
- Community Supports Policy Guide (DHCS): https://www.dhcs.ca.gov/documents/mcqmd/dhcs-community-supports-policy-guide.pdf
- Provider-tax basics (KFF): https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/

What's next?

How IRG can help

Real implementation, not presentations

LAUNCH YOUR CALAIM PROGRAM

MCP contracts signed, systems built, staff trained - everything you need to go live.

FIX WHAT'S STUCK

Referrals not flowing? Billing rejected? We debug until it works.

SPEED UP WHAT'S SLOW

Cut your implementation time in half with templates, tools, and proven workflows we've built.

★★★★★

" IRG was instrumental in helping us become a CalAIM provider under a tight deadline. Navigating complex requirements, Richard and his team provided strategic guidance, project management, and financial analysis to optimize our approach.

Their expertise, responsiveness, versatility, and collaborative approach have made them invaluable partners."

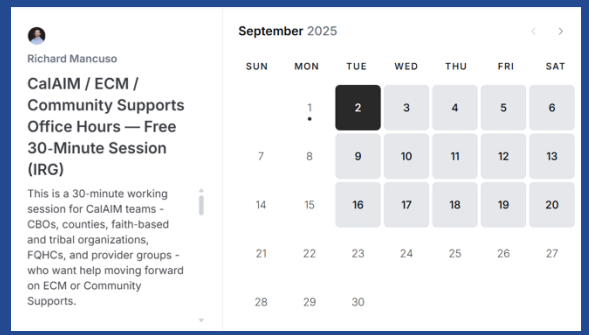
Ayano Ogawa

Chief Program Officer, First 5 Alameda County

Book your complimentary 30-minute strategy session:

- *Clarify CalAIM goals and status*
- *Tackle one key blocker*
- *Outline 2-3 actionable steps*
- *Explore PATH TA fit*

Click here to book now →



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