



May 17, 2026

To: The Honorable Caroline Menjivar
Chair, Senate Budget Subcommittee No. 3

Honorable Members
Senate Budget Subcommittee No. 3

The Honorable Dawn Addis
Chair, Assembly Budget Subcommittee No. 1

Honorable Members
Assembly Budget Subcommittee No. 1

From: Carlos Marquez III, Executive Director, CWDA

RE: PROTECTING MEDI-CAL COVERAGE IN THE FACE OF H.R. 1 & COMMENTS ON
MAY REVISION PROPOSALS

The County Welfare Directors Association (CWDA) is providing our response to proposals included in the May Revision. We note that the May Revision provides county eligibility workers inadequate resources for the significant, ongoing needs of Medi-Cal clients in the face of H.R. 1, while simultaneously increasing penalties and expectations for performance measures, effectively setting up counties to fail during the most disruptive erosion of the social safety net in which they are at the frontlines.

Note: As of the drafting of this memo, the Department of Health Care Services (DHCS) Local Assistance Estimate and various Trailer Bill Language had just been posted. As such, the below reflects our analysis based on the most current understanding of the information available.

May Revision Falls Short of Mitigating Loss of Medi-Cal Coverage as Result of H.R. 1

The May Revision includes a one-time augmentation of \$262 million (\$74 million General Fund) in Fiscal Year (FY) 2026-27 to support county workload associated with Medi-Cal eligibility changes under H.R. 1. Unfortunately, in FY 2026-27, only a portion of that funding—\$229 million (\$57.2 million General Fund)—goes directly to county human services agencies while the remaining \$33 million (\$16.7 million General Fund) goes to fund a state contract intended for

optional surge staffing capacity to support counties upon request with application processing, call center workload, work requirement implementation, and other back-end support. This means that only 30 percent of county staffing needs may be fulfilled in FY 2026-27 by the Administration's proposed modest investment in county administration, but only nominally so as ongoing funding is essential to hire new FTEs. Additionally, as written, the May Revision includes \$33 million (\$16.7 million General Fund) in each of FY 2027-28 and FY 2028-29¹ for the aforementioned optional surge staffing service as opposed to direct funding to counties, which based on initial feedback from counties may have low utilization due to major reservations and concerns related to quality assurance and fidelity to performance metrics, compounding workload due to rework to correct mistakes if they are made, and labor relations. While CWDA appreciates the acknowledgement that the county eligibility workforce will require additional resources to implement these significant new federal requirements, we have concerns that the level of investment is woefully insufficient; and that the one-time nature of the augmentation will not allow counties to adequately staff up. Moreover, the proposed surge staffing capacity is disconnected from operational realities and does not reflect what counties actually need.

The one-time direct county augmentation proposal in FY 2026-27 of \$229 million (\$57.2 million General Fund) is inadequate because it represents only a third of staffing needs identified by counties in Budget Year, and only nominally so, as hiring ongoing FTEs based on one-time funding places counties in an untenable position once they reach a fiscal cliff in FY 2027-28 at the very moment when 6-month redeterminations grow significantly in volume. Importantly, we note that per recent guidance from the Centers for Medicare and Medicaid Services (CMS), the steepest disenrollment projections are now expected to occur between FY 2027-28 and FY 2029-30. The first time work and community engagement requirements will be applied to existing enrollees is March 2027, within Budget Year, and with the first of 6-month redeterminations applying in September 2027 (Budget Year +1). Increased workload associated with new applicants will still be required in FY 2026-27 as work and community engagement will need to be applied to new applicants beginning in January 2027. If resourced with adequate and ongoing funding, counties have the time they need to scale up and hire if state investments are made timely. We should be leveraging the runway we have in FY 2026-27 to invest in adequate and ongoing county staffing levels in FY 2026-27 and holding those investments in place during outyears when enrollees face the greatest risk of disenrollment in FY 2027-28 through FY 2029-30.

¹ In recent discussions with the Administration, CWDA was informed that the \$33 million for surge staffing capacity may only be intended for two FYs. This memo will cite the duration of the funding as described in official budget publications pending updates.

Regrettably, the lack of direct county administrative investments beyond FY 2026-27 fails to recognize the vast majority of initial 6-month redeterminations and work requirement verifications will take place in FY 2027-28 and then on an annualized basis thereafter. While funding is critically necessary in FY 2026-27 to ensure counties can train, prepare, and begin implementation, the distribution and flow of the funding is misaligned with when workload will peak and the ongoing nature of the workload.

Modest One-Time Funding Fails to Recognize Operational Requirements to Prevent Harm

Counties face substantial and ongoing workload increases tied to 6-month renewals, work and community engagement requirements, exemption screening, client outreach, increased call center volume, and more complex case management responsibilities. These are not temporary workload pressures. And these policy requirements bear real and direct impacts on clients. They represent permanent operational changes that require sustained staffing, training, and administrative capacity to mitigate sweeping loss of health care coverage for low-income Californians. The May Revision estimates that nearly 1.3 million Medi-Cal beneficiaries are still at risk of losing their health care by FY 2029-30. If adequately funded, well-trained, and fully staffed, the county eligibility workforce is an upstream approach to mitigate downstream, system-wide impacts of H.R. 1, impacts like increased uncompensated care costs.

CWDA estimates the true resource need for counties to implement H.R. 1 is \$630.3 million total funds (\$157.6 million General Fund) in FY 2026-27, \$1.31 billion total funds (\$328.2 million General Fund) in FY 2027-28, \$789.6 million total funds (\$197.4 million General Fund) in FY 2028-29, and \$497.5 million total funds (\$124.4 million General Fund) in FY 2029-30 and ongoing to support implementation of H.R. 1. While we appreciate the May Revision proposal, the level of funding provided falls significantly below the demonstrated workload need identified by counties.

In addition, the limited-term nature of the proposed augmentation will create operational challenges that will limit counties' ability to effectively utilize the funding. The way in which the resources were structured in the May Revision creates a significant funding cliff for counties after the FY 2026-27 one-time dollars expire. Counties are going to have to ramp down quickly, which will place more Affordable Care Act (ACA) expansion enrollees at risk for potentially losing coverage as counties will not be able to scale up and bring on FTEs to support clients. As a result, limited-term funding that expires within months of implementation of H.R. 1 requirements does not align with the operational realities associated with building and stabilizing the workforce required to administer these permanent federal changes. Given the scale and complexity of these changes, counties require sustained and ongoing investments that allow county welfare departments to build and stabilize the workforce necessary to successfully administer Medi-Cal under H.R. 1.

Staffing Proposal Does Not Meet Counties and Consumers On-the-Ground Needs

CWDA has questions and concerns regarding the May Revision's proposed reliance on contracted "surge staffing" capacity. For example, CWDA has questions regarding the operational and legal implications of the proposal given new rules relating to outsourcing of work (AB 339, 2025). Several counties report they are able to make better use of these funds on retired annuitants, outreach and education, overtime for existing workers, and filling previously frozen vacancies. Additionally, allowing counties to use these funds instead of a state contract is more cost effective, as contracted services are nearly always higher cost than staff. Another concern with the proposal is that a state contract makes it difficult for counties to hold a contractor responsible for performance and accuracy, and may exacerbate labor relations at a time when counties are working hard to preserve morale and staff retention. Some counties also noted that accepting such services may trigger a string of Meet-and-Confers with labor partners and in the end, serve as a far less agile surge strategy than directly providing funding to county administration and to workers who are properly trained and rooted in the community. The stated intent of the proposal is to address and help fill local staffing shortages like those experienced during the Medi-Cal public health emergency (PHE) unwinding period, however, it is important to recognize that many of the hiring challenges counties faced at that time are not analogous to our current implementation environment; the unwinding operating challenges occurred within an unprecedented national labor market environment States and counties were competing against historically high vacancies, wage competition, pandemic related workforce disruptions, and elevated retirement levels. For example, national job openings reached historic highs in 2022.²

While we understand the intent is not to replace eligibility workers, county workers at all levels possess critical knowledge of local communities, county systems, client circumstances, and complex Medi-Cal eligibility processes that cannot easily be replicated through short-term contracted support.

Considerations Around Automated Data Sources for Exemptions

CWDA appreciates the Administration's efforts to leverage automation, data matching, and new data sources to mitigate the impacts of H.R. 1 implementation and protect essential health coverage for Californians, for example, for medically frail individuals. As currently understood, assumptions in the May Revision around exemptions continue to be premised on yet-to-be-

² [Job openings reach record highs in 2022 as the labor market recovery continues: Monthly Labor Review : U.S. Bureau of Labor Statistics](#)

released federal Centers for Medicare & Medicaid Services (CMS) guidance and approval parameters that remain subject to ongoing discussion and interpretation. We continue to seek clarity regarding the extent to which California will be permitted to implement operational flexibilities, such as self-attestation, and data matches that could reduce administrative burden on both beneficiaries and county eligibility systems, ultimately helping protect access to Medi-Cal. Since final guidance is pending, we note that the caseload retention estimates in the May Revision, including the number of individuals who may be exempt for medical frailty, rely on assumptions that could evolve as guidance is finalized. As such, CWDA must assume and account for workload associated with manual activities involving enrollees who may be eligible for a medical frailty exemption, but for whom ex parte may not be available should CMS guidance not allow for certain data matching and self-attestation upon which DHCS ex parte program retention assumptions are premised. The May Revision assumes 717,512 beneficiaries will be determined medically frail, or nearly 15% of ACA optional expansion enrollees.

Further, CWDA would highlight automation alone will not fully solve for the risks that the most vulnerable Medi-Cal clients will face (e.g., those without any data footprint) as a result of H.R. 1. Many impacted individuals will still require manual review, follow-up, documentation collection, exemption screening, and ongoing case management support from county eligibility workers. Automation associated with work requirement verification and renewals does not alleviate significant administrative burdens for both clients and counties alike.

These realities further reinforce the need for sustained county administrative funding, particularly given the scale of the population potentially subject to exemption screening and verification requirements.

CWDA Request: Adopt the true H.R. 1 resource need for counties at \$630.3 million total funds (\$157.6 million General Fund) in FY 2026-27, \$1.31 billion total funds (\$328.2 million General Fund) in FY 2027-28, \$789.6 million total funds (\$197.4 million General Fund) in FY 2028-29, and \$497.5 million total funds (\$124.4 million General Fund) in FY 2029-30 and ongoing. Counties remain committed to minimizing unnecessary coverage loss and implementing H.R. 1 responsibly. However, successful implementation will require stable and sustained operational investments aligned with the permanent nature of the workload.

Medi-Cal CPI Adjustment Freeze Continues to Strain County Operations

CWDA also continues to strongly advocate for reinstatement of the Medi-Cal Consumer Price Index (CPI) adjustment for county administration. Counties are strongly committed to preventing unnecessary loss of coverage. However, existing Medi-Cal county administration funding is inadequate to absorb these new workload demands. Counties fully expended their statewide allocation in FY 2024-25, and the freeze on annual Medi-Cal CPI adjustments in the

2024 Budget Act (WIC Section 14154), which is through FY 2027-28, will strain counties' ability to keep pace with rising salary and operating costs.

The May Revision does not include restoration of the Medi-Cal CPI adjustment, which remains frozen under current law. Counties continue to experience rising salary, benefit, training, and operational costs while simultaneously absorbing significant new workload associated with H.R. 1 implementation. Restoring the CPI adjustment is critical to stabilizing the county eligibility workforce and ensuring counties can maintain adequate staffing levels necessary to administer Medi-Cal effectively. Without restoration of the CPI adjustment, counties will continue to face structural operational pressures that make implementation of new federal requirements substantially more difficult.

CWDA Request: Reinstate the Medi-Cal CPI adjustment beginning in FY 2026-27 at a cost of approximately \$78.47 million total funds (\$39.23 million General Fund) in FY 2026-27 and ongoing (see Attachment I for Trailer Bill Language).

Proposed County Performance Sanctions Trailer Bill Language Sets Up Counties to Fail

CWDA has significant concerns regarding Trailer Bill Language (TBL) related to county Medi-Cal performance sanctions.

Under existing California law, counties are currently subject to sanctions tied to county performance measures only in years when counties receive a Medi-Cal CPI adjustment. This long-standing framework recognizes the importance of aligning county accountability expectations with adequate funding support and therefore staffing levels.

The proposed changes would significantly broaden the circumstances under which counties could be subject to penalties associated with performance measures, including in years where other forms of county administrative funding are provided in lieu of a CPI adjustment. We understand that there is also not a threshold of required county funding to trigger the penalty, such that even a nominal increase (\$1.00) or temporary increase that may not have a bearing on staffing levels could mean outsized exposure. Additionally, these penalties would be assessed much more quickly, and expand the penalty structure. Under the current framework, counties may face up to a two percent base allocation withholding annually, with the possibility of increased penalties in subsequent years if requirements continue to not be met. Under the proposed structure, counties could instead face more near-immediate quarterly withholdings of up to two percent for each individual performance measure. There are three measures and they include:

1. Timely application processing
2. Timely redetermination processing
3. Resolution of error alerts from the department's Medi-Cal Eligibility Data System (MEDS)

This new structure could result in counties facing up to a six percent withholding in a single quarter (versus the status quo of 4 percent in a given year), with continued and compounding exposure for two of the three metrics (applications and redeterminations) in subsequent quarters if performance measures don't improve. While we understand the intent is to increase accountability, this structure risks creating a self-perpetuating cycle in which counties become so resource constrained that meaningful performance improvement becomes increasingly difficult. See below chart as an example, in the case where a county is struggling to meet timeliness requirements due to insufficient resources or temporary turnover, the penalty might *triple* over just the span of four quarters.

				Estimated penalties					
				Year 1				Year 2	Total cumulative penalty
	Max Penalty	Penalty Increases (Compounding)	County Allocation	Q1	Q2	Q3	Q4	Q1	Through Q1 of Year 2
Current*	4%	2% <u>annually</u> for applications and redeterminations (currently combined)	\$ 1,000,000					\$ 40,000	\$ 40,000
Proposed**	6%	2% <u>quarterly</u> per metric for applications and redeterminations (each)	\$ 1,000,000		\$ 15,000	\$ 25,000	\$ 35,000	\$ 45,000	\$ 120,000

*Currently 2% for applications and redeterminations, and 2% separately for MEDS alerts; only applications and redeterminations penalties compound annually.

**Proposed 2% quarterly penalty for applications, 2% quarterly for redeterminations, and 2% for MEDS alerts; only applications and redeterminations are proposed to still compound over time.

For that reason and other reasons explained below, CWDA has significant concerns with this approach and the TBL as we currently understand it. Under the framework developed with DHCS in Fall 2024 and formalized through ACWDL [25-08](#), counties and the department agreed to a two-prong approach to performance standards that combined system data with focused reviews and corrective action plans (CAPs) before penalties would be considered. This structure recognized the limits of system data alone and ensured counties had a clear path to address issues, with sanctions as a last resort. The TBL abandons this approach by removing key elements of the review and CAP framework. This acceleration in penalties and increased amount would be done without an opportunity for counties to vet the data or cite extenuating circumstances, such as CalHEERS, MEDS, and CalSAWS automation errors, that are outside of their control. It limits the ability to identify root causes and make meaningful improvements. Again, counties would be expected to improve performance while simultaneously receiving reduced administrative funding, creating a compounding fiscal and operating challenge.

We would also highlight for the Legislature that the proposal strikes Legislative intent language regarding ensuring counties are sufficiently resourced, which goes well beyond the intent to expand this accountability framework and should be deferred to the Legislature for decision-making. For example, the following is struck-through: “Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases.”

Moreover, counties have not received a Medi-Cal CPI adjustment since FY 2023-24 and continue to face substantial operational pressures associated with rising staffing, training, technology, and administrative costs. At the same time, counties are preparing to implement major new H.R. 1 workload requirements, including six-month renewals, work requirements, exemption screening, and increased client outreach—which the May Revision falls short of providing full funding for. Counties cannot reasonably be expected to absorb increased exposure to penalties while simultaneously implementing unprecedented federal eligibility changes without sustained and adequate funding.

Lastly, CWDA also notes that during previous periods of major policy transition and operational disruption, including implementation of the Affordable Care Act and the COVID-19 Public Health Emergency and unwinding period, counties were appropriately provided relief from certain sanction and penalty exposure in recognition of the extraordinary operational challenges associated with implementing major federal and state policy changes. While CWDA may have additional input as discussions with the Administration continue, CWDA believes similar relief should be afforded during implementation of H.R. 1.

CWDA Request: Reject the proposed TBL related to county performance sanctions.

Additional Medi-Cal May Revision Proposals

CWDA is continuing to evaluate several additional Medi-Cal proposals included in the May Revision and their potential impacts on counties, beneficiaries, and local health and human services systems. Please see below for initial comments.

Community Supports and Enhanced Care Management

The May Revision reflects a General Fund reduction of \$26.9 million in FY 2026-27, \$58.8 million in FY 2027-28, and \$51 million ongoing to refine referral pathways, eligibility criteria, service definitions, and utilization management criteria for select Medi-Cal Community Supports services effective January 1, 2027.

Additionally, the May Revision includes a General Fund reduction of \$41.4 million in FY 2026-27 and \$99.2 million ongoing to refine eligibility criteria, service definitions, utilization management criteria, and payment adjustments for the Medi-Cal Enhanced Care Management (ECM) benefit effective January 1, 2027.

The populations targeted by ECM include older adults and adults with disabilities, groups that are also served through many county-administered programs, including In-Home Supportive Services (IHSS) and Adult Protective Services. ECM provides intensive care coordination and navigation across medical, behavioral health, and social services systems for individuals with complex needs. Community Supports—such as housing services, home modifications, medically tailored meals, and personal care and homemaker services—are also directly relevant to maintaining their health and stability. CWDA has been actively working with counties to improve referrals to both ECM and Community Supports and would like to learn more about the proposed reductions to better understand potential impacts and ensure that they do not result in adverse outcomes for the individuals served by counties.

Medi-Cal Asset Test Limits

The May Revision includes a General Fund reduction of \$278.3 million in FY 2026-27 and \$495.6 million ongoing, inclusive of IHSS impacts, to reinstate the Medi-Cal asset limit for seniors and disabled adults to \$2,000 for an individual and \$3,000 for a couple, effective no sooner than January 1, 2027.

The 2025 Budget Act previously included a partial reinstatement of the Medi-Cal asset limit that became effective January 1, 2026.

Counties remain concerned regarding the significant operational and downstream impacts associated with reinstating more restrictive Medi-Cal asset limits. Changes to eligibility rules and increased verification requirements create additional county workload associated with eligibility determinations, documentation review, client communication, case maintenance, and churn. Additionally, counties are concerned that this change requires automation, and understand that CalSAWS does not believe a January 1, 2027, date is feasible.

Counties are also concerned that increased barriers to coverage for seniors and individuals with disabilities may contribute to additional coverage loss and interruptions in care, resulting in broader downstream impacts to local health systems, safety-net providers, and uncompensated care costs.

Premium Increases for Adults with Unsatisfactory Immigration Status

The May Revision reflects a General Fund reduction of approximately \$427.3 million in FY 2027-28, decreasing to approximately \$314.3 million annually in FY 2029-30, associated with increasing monthly premiums for adults aged 19-59 with unsatisfactory immigration status from \$30 to \$50 effective July 1, 2027.

The 2025 Budget Act previously established monthly premiums of \$30 for this population effective July 1, 2027.

CWDA understands that premium collection functions are administered through the State's vendor structure and therefore may have more limited direct county administrative workload implications relative to other Medi-Cal eligibility changes included in the May Revision.

Transition of Individuals with Unsatisfactory Immigration Status to Fee-for-Service

The May Revision reflects a reduction of \$583.8 million total funds (\$471.6 million General Fund) in FY 2026-27 and \$1.5 billion total funds (\$1.2 billion General Fund) ongoing associated with transitioning Medi-Cal members with unsatisfactory immigration status from managed care to fee-for-service delivery systems effective January 1, 2027.

The Administration indicates this proposal is intended to comply with new federal policy prohibiting states from covering federally eligible emergency Medicaid services for individuals with unsatisfactory immigration status through risk-based managed care delivery systems. CWDA notes this would mean this population would be ineligible for CalAIM supports as well, which could mean seniors, persons with disabilities, and children in the child welfare system could also lose access to upstream Interventions such as ECM and community supports.

Conclusion

CWDA appreciates the Administration's recognition that implementation of H.R. 1 will require substantial county operational support and the inclusion of additional county administrative funding in the May Revision.

At the same time, counties remain concerned that the proposed funding levels and reliance on limited-term funding are insufficient to support the long-term staffing and infrastructure investments necessary to successfully implement these permanent federal requirements. Moreover, the May Revision exacerbates these issues by increasing the risks counties will incur performance sanctions due to being understaffed as a result of inadequate funding.

California's county-administered Medi-Cal system has consistently demonstrated that when counties receive adequate and sustained operational support, counties deliver strong outcomes for beneficiaries and the broader health care system. Counties successfully implemented the Affordable Care Act, maintained continuity of coverage throughout the COVID-19 Public Health Emergency, and helped California achieve among the highest Medicaid retention rates in the nation during the unwinding period.

Counties stand ready to continue partnering with the Administration and Legislature to implement H.R. 1 in a manner that minimizes unnecessary coverage loss, protects continuity of care, and preserves California's longstanding commitment to accessible health coverage.

To achieve those goals, counties will require:

- Adequate and sustained ongoing funding aligned with permanent workload increases;
- Restoration of the Medi-Cal CPI adjustment to stabilize county operations;
- Sufficient staffing and training resources to support implementation;
- Relief from increased exposure to penalties that will be enacted under a more punitive system;
- Continued collaboration regarding caseload assumptions and operational impacts; and,
- Ongoing partnership between the State and counties as implementation planning continues.

CWDA looks forward to continuing to work with the Administration and Legislature on these issues throughout the budget process.

Sincerely,

Carlos Marquez III, Executive Director | CWDA

Cc: Chris Woods, Office of the Senate President Pro Tempore
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