DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: August 7, 2025

Medi-Cal Eligibility Division Information Letter No.: I 25-18

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: MEDI-CAL IMPACTS FROM HOUSE RESOLUTION 1 (H.R. 1)

The purpose of this Medi-Cal Eligibility Division Information letter is to inform counties of changes to Medi-Cal as a result of the codification of House Resolution 1 (H.R. 1), (Public Law 119-21), commonly known as the One Big Beautiful Bill Act. More details, including implementation dates, will be provided in forthcoming All County Welfare Director Letters (ACWDLs).

Background
On July 4, 2025, President Trump signed H.R. 1 into law, which makes significant changes to Medicaid including limitations on enrollment and redefining the definition of Qualified Non-Citizens (QNCs), among others. The implementation date for each provision varies, spanning through October 2029. This document provides an overview of the provisions that impact Medi-Cal eligibility.

Policy Changes Impacting Medi-Cal

Moratorium on Streamlining Eligibility and Enrollment Final Rules
Sections 71101 and 71102 impose a moratorium on the implementation and enforcement of certain sections of two final rules issued by the Centers for Medicare & Medicaid Services (CMS):

- Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment, released September 21, 2023, and
- Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, released April 2, 2024.

This moratorium takes effect immediately and will remain in place until September 30, 2034.

The policy eliminating the requirement to apply for other benefits remains unchanged. For further information on this policy, CEWs can refer to ACWDL 24-19 and ACWDL 25-03.

As a result of this moratorium, the Department of Health Care Services (DHCS) will pause the implementation of applicable provisions from the 2024 CMS final rule, as well as two specific provisions from the 2023 CMS final rule. These provisions include:

- Streamlining Medicare Savings Programs (MSPs) eligibility determinations, including verifications using Low Income Subsidy (LIS) application information ("leads data"), and
- Aligning the family size definition for MSPs with that of LIS through a proposed State Plan Amendment (SPA).

Additionally, due to this federal mandate, the Department will make obsolete ACWDL 25-07, dated April 1, 2025. The Low Income Subsidy Data Exchange Update policy guidance, originally issued in ACWDL 10-04, dated January 13, 2010, and ACWDL 10--04E, dated November 17, 2010, will be reinstated and will remain in effect until further notice.

California, as a Medicare buy-in state, automatically enrolls Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients who are eligible for Medicare into the Qualified Medicare Beneficiary (QMB) program, as detailed in ACWDL 24-20 and MEDIL 25-01. Therefore, this moratorium does not apply to this aspect of the 2023 CMS final rule. Counties are expected to follow those guidelines as previously directed.

Reducing Duplicate Enrollment Under the Medicaid and Children Health Insurance Program (CHIP)

Section 71103 requires states to have a process in place to regularly obtain updated address information for Medi-Cal members using trusted sources:

- Updated address information received from Medi-Cal Managed Care Plans,
- The United States Postal Service's (USPS) National Change of Address (NCOA) database, and
- Mail returned to the county by USPS with an in-state forwarding address.

This requirement was originally included in the 2024 CMS Final Rule; however, Section 71103 of the H.R. 1 codified this into law with an updated federal compliance date of no later than January 1, 2027. While system changes will not be incorporated before that date, counties must continue to follow the guidance in ACWDL 25-06.

Additionally, Section 71103 requires states to submit key identifying information, such as an individual's Social Security Number, to the United States Department of Health and Human Services (HHS) to populate a national system designed to detect and prevent duplicate Medi-Cal enrollment across state lines, ensuring program integrity and reducing risk of improper payments. Implementation for this service is required by October 1, 2029.

Deceased Member Verification

Section 71104 requires that starting January 1, 2027, states must check Social Security Administration's (SSA) Death Master File (DMF) at least quarterly to confirm Medi-Cal members are still alive and to remove those who have died. The State Plan (or waiver of such plan) treats the DMF information as factual information confirming the death of a member.

Six-Month Redeterminations

Section 71107 requires that as of January 1, 2027, states must conduct eligibility redeterminations for adult expansion enrollees under the Affordable Care Act (ACA), also called the "New Adult Group," once every six months instead of once every 12 months per current policy. Tribal members, pregnant members, and children are not subject to this requirement. The six-month redetermination process will largely mirror existing annual renewal processes for automated and manual ex parte efforts, verification requests, and other existing processes.

Amended Definition of the Qualified Non-Citizen

Section 71109 of H.R. 1 amends the current federal definition of Qualified Non-Citizen (QNC), taking effect on October 1, 2026. This new federal QNC definition includes individuals who are:

- Citizens or nationals of the United States.
- Lawful Permanent Residents (LPRs), excluding certain groups, such as temporary visitors, tourists, diplomats, and students who do not intend to settle permanently in the U.S.
- Cuban or Haitian Entrants.
- Migrants legally residing in the United States and its territories under the Compact of Free Association (COFA), such as citizens from the Marshall Islands, Micronesia, or Palau.

The redefined federal QNC definition excludes the following immigration statuses from its current definition:

- Conditional Entrant granted before April 1980
- Paroled into the United States for one year or more
- Battered non-citizen, or parent or child of a battered non-citizen

- Refugees
- Asylees

Additionally, the amended federal definition excludes lawfully present children under the age of 21 and lawfully present pregnant individuals covered under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

Reducing State Medicaid Costs- Retroactive Medi-Cal Reduced Timeframes
Currently Medicaid (Medi-Cal) allows coverage for unpaid medical expenses incurred in the three months prior to the Medi-Cal application date for applicants who were eligible during those months.

Effective January 1, 2027, Sec. 71112 reduces Medi-Cal and Children's Health Insurance Program (CHIP) retroactive coverage from three months before an individual's application date to one month for ACA expansion members and two months for all other Medi-Cal members.

Work/Community Engagement Requirements
Section 71119 establishes new federal community engagement and work requirements for adult expansion enrollees under the Affordable Care Act, also called the "New Adult Group," effective January 1, 2027. Individuals ages 19 through 64, including parents or caregivers of dependent children aged 14 and above, must engage in a minimum of 80 hours per month of qualifying activities such as employment, earning at least $580 per month, community service, education (half-time or more), or participating in an approved work program or a combination there of. Additional implementation details, including system enhancements and exemption criteria will be addressed in future policy guidance.

Cost Sharing for New Adult Group
Effective October 1, 2028, Section 71120 establishes new cost-sharing requirements for adult expansion enrollees under the Affordable Care Act, also called the "New Adult Group," with household income above 100 percent of the Federal Poverty Level (FPL). Under this provision, states will be required to charge cost-sharing amounts, like a copay or deductible, ranging from one to thirty-five dollars per service. Additionally, to protect access to critical types of care, this provision prohibits any cost-sharing for services that include, emergency services, primary care, prenatal, pediatric, and mental-health services.

Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid
Section 71106 implements a federal financial participation (FFP) penalty for erroneous Medicaid payments, effective October 1, 2030. This section removes the good-faith

waiver associated with Payment Error Rate Measurement (PERM) audits for payment reductions related to erroneous excess Medicaid payments for ineligible services in excess of a PERM error rate of three percent.

As noted above, these provisions will require changes to Medi-Cal eligibility and details will be provided in subsequent policy letters. Changes to automation within the California Statewide Automated Welfare System (CalSAWS), BenefitsCal, and the California Healthcare , Eligibility, Enrollment, and Retention System (CalHEERS) will be necessary for implementation.

If you have any questions or need additional guidance regarding the information in this letter, contact mced-policy@dhcs.ca.gov.

Sincerely,

Sarah Crow, Chief
Medi-Cal Eligibility Division