Protect Medi-Cal Funding 2025: Access to Providers

By: Abbi Coursolle

California's Medicaid program (Medi-Cal) provides a critical investment in the health of Californians. Medi-Cal coverage and services are tailored to meet the unique needs of low-income individuals and families, and provides the most affordable coverage. If Medicaid cuts are enacted, states like California will lose billions of dollars in federal Medicaid funding, shifting financial responsibility for Medicaid services to the states and to enrollees. The loss of billions of dollars in federal Medicaid funding will invariably lead to cuts in services and the loss of affordable coverage. This issue brief explains why Medi-Cal is so critical to helping low-income people have access to health care providers, and it explains how low income Californians would be harmed by Medicaid funding caps and cuts.

Why Medi-Cal provider access protections are important:

- **Adequate provider rate protections are designed to ensure access.** Medi-Cal's strength relies on the providers who deliver covered services to those enrolled. Medi-Cal cannot provide meaningful access to care if those providers are paid so little that they do not participate. Medicaid includes specific rules to promote adequate provider payment rates. States must set payment rates high enough to ensure that access to care in Medicaid is equivalent to access for the general population in the geographic area.[1] In addition, payment rates for Medicaid managed care must be "actuarially sound," meaning that the amount of money the state pays the plan should be sufficient to cover the costs incurred by the plan in providing health care services.[2] Recognizing the importance of paying providers adequately, California recently passed a proposition to permanently enact a Tax of certain Managed Care plans, and committing the resulting revenues to certain primary and specialty care providers, community clinics, hospitals, ERs, family planning, and mental health providers beginning this year.[3]

- **Medi-Cal managed care network adequacy requirements protect low-income people.** Nearly one-third of Californians get their health care through Medi-Cal, most through a Medi-Cal managed care plan, including older adults, disabled people, pregnant people, and children and youth in foster care.[4] A robust network of providers is necessary to effectively cover such a diverse and complex population. Thus, federal regulations ensure that each Medi-Cal managed care plan maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area.[5] In California, the state has enacted significant

additional protections to ensure that Medi-Cal managed care enrollees have access to the range of providers they need to see to get care.[6]

- **Medi-Cal ensures that low-income people have access to important safety-net providers**. Low-income individuals, including those enrolled in Medi-Cal, heavily depend on care from safety-net providers.[7] These include Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), which are located throughout the state and treat people regardless of their ability to pay or their immigration status.[8] Federal Law requires Medi-Cal to cover FQHC and RHC clinic services for everyone in Medi-Cal.[9] Federal law guarantees fair minimum payment rates for these providers, including when they are paid by Medi-Cal managed care plans.[10] California ensures that managed care enrollees have access to full range of services provided by FQHCs and RHCs, including chiropractic care and podiatry services.[11]

How funding cuts threaten provider access in Medi-Cal:

- **Funding cuts could lead to provider rate cuts.** In California, Medi-Cal could respond to budget gaps by seeking to cut provider payment rates to save money—something it has done in the past in response to budget pressures.[12] As a result, California's rates are lower than most other state's.[13] Recently, California has made some efforts to address access issues caused by cuts in prior years.[14] A new round of rate cuts would harm providers and health care infrastructure, reduce provider participation in Medi-Cal, and make it more difficult for Medi-Cal enrollees to access care. Rate cuts and related access problems would likely be felt the most in the rural parts of the state where providers are already scarce.[15]

- **Funding cuts could lead to more limited provider networks.** In trying to make up for lost federal funding, California might seek to limit the providers participating in fee-for-service Medi-Cal in an attempt to conserve funds. California might also cut Medi-Cal managed care payment rates to save money, which is likely to lead the Medi-Cal plans narrowing their networks in response. Either way, with fewer providers participating in the program, enrollees in underserved areas, including rural areas, would be seriously harmed.[16] Enrollees with complex medical conditions, such as people with high-risk pregnancies, people with cancer, and individuals with developmental disabilities, could face reduced access to specialists, forcing them to delay or go without needed services. In addition, providers who offer culturally competent care to Black, Indigenous, and Other People of Color (BIPOC) and LGBTQI+ individuals are likely to be disproportionately impacted by cuts, as they already tend to operate on thin margins.[17]

- **Funding cuts would likely lead to reduced access to providers**. Another strategy California could likely use to save costs if federal funding is reduced is to create additional barriers to accessing providers. For example, California could enact greater utilization controls in Medi-Cal such as prior authorization and referral requirements (e.g., requiring people in Medi-Cal to try low-cost interventions before approving higher cost care). California could also seek to impose treatment limits to reduce access to medical or mental

health providers (e.g., limiting physical therapy visits to 4 per year, or prescriptions to 5 per month). California might also try to impose more cost sharing such as premiums and copayments in Medi-Cal, making it difficult for low-income individuals to afford health care services.[18] Policies like these would particularly harm individuals with chronic health conditions or disabilities who need regular medical care to stay healthy.

Conclusion

The Medicaid program is designed to give California wide flexibility in designing and implementing its own Medi-Cal program to meet the particular health needs of its residents. The potential threats to the program on the federal level will not only result into devastating impacts on low-income individuals and families across the state, these threats will also make it necessary for California to impose additional cuts and erect barriers to access life-sustaining care in the future. While it remains unclear what the current 2025 Congress and Trump Administration will do with respect to the Medicaid program, such federal funding cuts or barriers to deter enrollment must be rejected so low-income individuals and families have the access to providers of the quality affordable and comprehensive health care they need.

ENDNOTES

[1] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §§ 447.203-05.
[2] 42 U.S.C. § 1396b(m)(2)(A)(iii).
[3] *See* Cal. Dep't Health Care Servs., Medi-Cal Targeted Provider Rate Increases and Investments, **https://www.dhcs.ca.gov/Pages/Medi-Cal-Targeted-Provider-Rate-Increases.aspx** (last visited Feb. 7, 2025).
[4] Cal. Dep't Health Care Servs., *Medi-Cal Monthly Eligible Fast Facts* (2024), **https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-September2024.pdf**.
[5] 42 C.F.R. § 438.207(b)(2).
[6] *See e.g.,* Cal. Welf. & Inst. Code § 14197 (network adequacy protections for Medi-Cal managed care enrollees); *see also* Abbi Coursolle, Nat'l Health L. Prog., *Network Adequacy in Medi-Cal Managed Care* (2024 ed.), **https://healthlaw.org/wp-content/uploads/2024/05/2024-Updated-NetAd-Paper-FINAL.pdf**.
[7] Shannon McConville & Shalini Mustala, Pub. Pol'y Inst. Cal., *California's Health Care Safety Net* 1 (2025), **https://www.ppic.org/wp-content/uploads/JTF_HealthCareSafetyNetJTF.pdf**; Helen M. DuPlessis & Mary Goddeeris, Cal. Health Care Found., *What Portion of Medi-Cal Primary Care Visits Are Provided by Health Centers?* (2022), **https://www.chcf.org/publication/portion-medi-cal-primary-care-visits-provided-health-centers/**.
[8] *See* McConville & Mustala, *supra* note 8, at 1.
[9] 42 U.S.C. §§ 1396d(a)(2)(A),(B) & (C), 1396u-7(b)(4).
[10] Id. §§ 1396a(bb), 1396b(m)(2)(A)(ix).
[11] Cal. Dep't Health Care Servs., All Plan Letter 19-005 (June 12, 2019), **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-005.pdf**.
[12] *See, e.g., Douglas v. Indep. Living Ctr. of S. California, Inc.*, 565 U.S. 606, 611 (2012) (describing a series of cuts California made during the great recession).
[13] *See, e.g.,* Kaiser Family Found., Medicaid-to-Medicare Fee Index (2021), **https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index** (California ranks 32nd among states in terms of its provider payment rates across services, and 46th for Obstetric care).
[14] *See* Cal. Dep't Health Care Servs., *supra* note 3.
[15] *See, e.g.,* Cal. Hosp. Ass'n, *California's Rural Communities at Risk of Becoming Health Care Deserts* (2024), **https://calhospital.org/wp-content/uploads/2024/04/Preserving-Rural-Health-Care_Issue-Brief_2024_04_Final.pdf**; Nadereh Pourat et al., *Trends in Access to Care Among Rural Patients Served at HRSA-funded Health Centers*, 38 J. RURAL HEALTH 970 (2022).
[16] *See* Cal. Hosp. Ass'n, *supra* note 16.
[17] *See, e.g.,* David C. Radley et al., Commonwealth Fund, *Advancing Racial Equity in U.S. Health Care* 11 (2024), **https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care**; Jesse M. Ehrenfeld, Am.

Med. Ass'n, Address at National Press Club (Oct. 25, 2023), https://www.ama-assn.org/press-center/press-releases/ama-president-sounds-alarm-national-physician-shortage; Ruqaiijah Yearby et al., *Structural Racism In Historical And Modern US Health Care Policy*, 41 HEALTH AFF. 187 (2022); Shabab Ahmed Mirza & Caitlin Rooney, Ctr. Am. Prog., Discrimination Prevents LGBTQ People From Accessing Health Care (2018), https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care.

[18] *See* Abbi Coursolle & Jules Lutaba, Nat'l Health L. Prog., *Protect Medi-Cal Funding 2025: Affordability* (2025), https://healthlaw.org/wp-content/uploads/2025/02/2025.02.05_Protect-Medi-Cal-Series-2025_Affordability-FINAL-1.pdf.