CHAPMAN CONSULTING LLC

Assessing the Financial Impact of Recent and Proposed Policy Changes on California's Community Health Centers

Implications of H.R. 1 and California's State Budget for Federally Qualified Health Centers and Look-Alikes

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Prepared by Chapman Consulting

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Executive Summary

An estimated 2.3 million to 3 million Californians are expected to lose access to full-scope Medi-Cal (California's Medicaid program) in the coming years as a result of H.R. 1 and California's 2025–2026 state budget actions. In addition, the state's current 2026–2027 budget proposes to eliminate the Prospective Payment System (PPS) for state-only services provided to immigrants with unsatisfactory immigration status (UIS). This brief explores the financial impacts of Medi-Cal coverage losses and potential PPS elimination on Federally Qualified Health Centers (FQHCs)[1] and FQHC Look-Alikes (LALs).[2]

Chapman Consulting (Chapman) finds that Medi-Cal enrollment declines could result in community health center (CHC)[3] revenue losses of **$1.1 billion to $1.4 billion**. Chapman further illustrates how the proposed PPS elimination would impact CHCs on a per-patient basis, and at scale. On average, CHC revenue could decline by as much as **89% per patient per year from $1,718 to $191.** If applied across all FQHC/LAL patients with UIS, Chapman estimates **financial losses of $906 million to $1.1 billion**, which aligns with the state's General Fund savings estimate of $1 billion ongoing, beginning in fiscal year (FY) 2026–2027.[4] This amounts to a 14%-cut to California primary care clinic[5] net revenue, which totaled $7 billion in 2023.[6]

These estimates likely understate the full impact. They do not include potential revenue losses associated with lawfully present immigrants, undocumented immigrants, families with mixed immigration status, or U.S. citizens who disenroll from Medi-Cal due to fear or anxiety related to federal immigration actions, often referred to as the chilling effect. As coverage erodes and more Californians become uninsured, CHCs will continue to serve all patients regardless of ability to pay, increasing pressure from uncompensated care.

The downstream effects of coverage losses and reduced reimbursement could result in reduced operating hours, fewer available services, delayed capital improvements, and in some cases, clinic closures. These impacts would extend beyond Medi-Cal enrollees as individuals with private insurance, Medicare, other coverage, or no coverage at all could face longer wait times, reduced access, and other barriers to care.

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[1] FQHCs are public or tax-exempt entities that must meet certain federal requirements to receive grant funding under Section 330 of the Public Health Service Act. These include serving a designated medically underserved population or in a medically underserved area, providing services regardless of ability to pay (i.e., a sliding fee scale), and operating under the governance of a patient-majority board of directors. For more information, visit https://bphc.hrsa.gov/about-health-center-program/what-health-center.

[2] LALs are CHCs that otherwise meet the requirements of the Health Resources and Services Administration (HRSA) Health Center Program but do not receive federal grant funding. For more information, visit https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes.

[3] Community health centers (CHCs) is a broad term that includes FQHCs, LALs, Rural Health Centers (RHCs), free clinics, community clinics, and other health centers. Throughout this report, we use CHCs in a more limited context, referring only to non-profit, non-public FQHCs and LALs.

[4] Although the PPS policy change also affects RHCs, the analysis does not include RHCs because they do not report data to the HRSA *Health Center Program Uniform Data System* (UDS).

[5] As used in this report, California primary care clinics refers to entities that report primary care utilization data to the California Department of Health Care Access and Information (HCAI). For more information, visit https://hcai.ca.gov/data/healthcare-utilization/clinic-utilization/.

[6] Chapman Consulting analysis of HCAI, *Primary Care Clinic (PCC) Annual Utilization Data (2023)*, accessed on March 15, 2026, https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data/resource/97228d49-5f99-4d4b-bf61-92636f4c5f3b.

Introduction

California has made significant strides to expand health care coverage statewide since enactment of the Affordable Care Act (ACA) in 2010. In 2022, prior to the post-pandemic Medicaid unwinding, California achieved its lowest-ever uninsured rate at just 4%, down from a peak of 15% in 2013.[7] As a result, more than nine in 10 Californians reported having a usual source of care in 2023.[8]

California's gains were not only the result of federal coverage expansions under the ACA but also California's broader commitment to health care for all. In 2024, the state became the first in the country to provide full-scope Medi-Cal benefits to all income-eligible residents regardless of immigration status. This expansion was implemented in phases, beginning with children (ages 0–18) in 2016, young adults (ages 19–25) in 2020, older adults (ages 50 and over) in 2022, and, finally, all remaining adults (ages 26–49) in 2024. Due to federal restrictions on matching funds, California finances full-scope Medi-Cal coverage for individuals with UIS using state-only dollars. The cost of providing full-scope Medi-Cal coverage to the undocumented population exceeded original state projections by $2.7 billion in 2024–2025.[9]

As of June 2025, about 14.7 million[10] Californians rely on Medi-Cal for access to comprehensive physical health, behavioral health, prenatal, family planning, dental, and other health care services. CHCs served 4.1 million Medi-Cal patients in 2024, with approximately 28% of all Medi-Cal enrollees receiving care from FQHCs and LALs.[11] For California's primary care clinics, Medi-Cal accounted for two-thirds of their patient population and roughly 70% of net revenue, totaling $4.9 billion in 2023.[12]

Multiple federal and state policies—both recently enacted and under consideration—will eliminate or reduce coverage for millions of Californians. These include reductions in full-scope Medi-Cal enrollment because of federal legislation known as H.R. 1 (enacted in July 2025) and California's 2025–2026 state budget (enacted in June 2025). California's proposed 2026–2027 state budget also has significant financial implications for California's CHCs. This report assesses the potential revenue impacts of these changes on FQHCs and LALs.

In addition to Medi-Cal losses, Covered California has projected that as many as 500,000 individuals could lose access to subsidies and coverage in the exchange by 2030 as a result of H.R. 1 and other recent federal policies.[13] However, Covered California as a payer source makes up less than 0.4% of

[7] California Health Care Foundation (CHCF), "How California Made Almost Everyone Eligible for Health Care Coverage" (September 4, 2024), https://www.chcf.org/resource/how-california-made-almost-everyone-eligible-health-care-coverage/.
[8] KFF, "Usual Source of Care," *Health System Tracker*, accessed March 31, 2026, https://www.healthsystemtracker.org/indicator/access-affordability/usual-source-care/.
[9] California Department of Health Care Services (DHCS), *2025-26 Governor's Budget Department of Health Care Services Highlights* (January 10, 2025), https://www.dhcs.ca.gov/Documents/Budget-Highlights/DHCS-FY-2025-26-Governors-Budget-Highlights.pdf.
[10] DHCS, *H.R. 1 Implementation Plan* (January 29, 2025), https://www.dhcs.ca.gov/federal-impacts/Documents/DHCS-HR1-Implementation-Plan.pdf.
[11] Chapman Consulting analysis of HRSA UDS data (2024). Excludes county-based clinics. See also *2024 UDS Manual* (2024), https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2024-uds-manual.pdf.
[12] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023)*.
[13] California State Assembly Budget Subcommittee No. 1 on Health and Human Services, *Final Agenda: March 9, 2026, Hearing* (March 9, 2026), https://abgt.assembly.ca.gov/system/files/2026-03/final-sub-1-agenda-march-9-hearing.pdf.

California primary care clinics' net revenue.[14] Therefore, this analysis does not assess the financial impact of exchange coverage losses on CHCs.

Projected Medi-Cal Coverage Losses

In July 2025, Congress passed—and President Trump signed—House of Representatives bill 1 (H.R. 1),[15] a federal budget reconciliation package that includes sweeping cuts to Medicaid and the Supplemental Nutrition Assistance Program. Several provisions will reduce overall Medi-Cal enrollment, including:

- **Work requirements (effective January 1, 2027):** Requires individuals in the New Adult Group[16] to work, study, or volunteer at least 80 hours per month, unless exempt.
  - **California implementation note**: DHCS intends to apply the same work-reporting requirements to all New Adult Group enrollees in Medi-Cal, including immigrants with UIS (ages 19–64) who are covered through state-only funds.[17]
- **Six-month renewals (effective January 1, 2027):** Requires states to conduct eligibility renewals for individuals in the New Adult Group every six months. Other populations (such as children, pregnant people, older adults, persons with disabilities, and American Indian and Alaska Natives) will continue to renew on an annual basis.
  - **California implementation note:** DHCS intends to apply the same six-month redetermination requirements to all New Adult Group enrollees in Medi-Cal. including immigrants with UIS (aged 19–64) who are covered through state-only funds.[18]
- **Non-citizen coverage and federal funding (effective October 1, 2026):** Narrows the federal definition of qualified immigrant and restricts federal Medicaid funding for certain lawfully present refugees, asylees, victims of domestic violence and human trafficking, and certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.[19,20]
  - **California implementation note:** While H.R. 1 removes federal funding for this population, states could continue providing full-scope Medicaid coverage using state-only funds. California is proposing to shift this population into restricted-scope (emergency-only) Medi-Cal as part of the proposed Governor's Budget 2026–2027. Lawfully present children under age 21 and lawfully present pregnant or postpartum individuals, if otherwise eligible, will continue to receive federally funded full-scope Medi-Cal.[21]

[14] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023)*.
[15] U.S. House of Representatives. H.R. 1 — *One Big Beautiful Bill Act, 119th Congress* (2025), https://www.congress.gov/bill/119th-congress/house-bill/1.
[16] The New Adult Group encompasses adults ages 19–64 with incomes below 138% of the federal poverty level (FPL).
[17] DHCS, *H.R. 1 Implementation Plan*.
[18] DHCS, "Medi-Cal Changes," last modified August 20, 2025, https://www.dhcs.ca.gov/Medi-Cal/Pages/changes.aspx.
[19] Centers for Medicare & Medicaid Services (CMS), *State Health Officer (SHO) #26-001: Implementation of Section 71109 "Alien Medicaid Eligibility" of the Working Families Tax Cut Legislation (Public Law 119-21)* (April 8, 2026), https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf.
[20] For the full list of lawfully present immigrants who will no longer be eligible for federal Medicaid matching funds, see DHCS, *H.R. 1 Implementation Plan*, page 9.
[21] DHCS, *H.R. 1 Implementation Plan*.

- **Reduced federal match rate for certain emergency-only Medicaid services (effective October 1, 2026):** Reduces the federal matching rate from 90% to 50% for emergency-only Medicaid for immigrants with UIS.[22]
- **Other Medicaid changes (effective January 1, 2027):** Shortens the retroactive Medicaid coverage period from three months to one month, requires states to comply with other administrative changes to verify deceased members and avoid duplicate enrollments, and requires states to implement co-pays for certain services in the New Adult Group population (effective October 1, 2028).[23]

California's 2025–2026 state budget[24] will also cause Medi-Cal enrollment to decline as a result of:

- **Enrollment freeze for undocumented immigrants (effective January 1, 2026):** Allows previously enrolled undocumented adults (ages 19 and over) to maintain coverage in full-scope Medi-Cal as long as they continue to be eligible and timely renew; prohibits new enrollments in full-scope Medi-Cal beginning January 1, 2026.
- **Premiums for certain adult immigrants with UIS (effective July 1, 2027):** Requires undocumented adults and legally present adult immigrants with UIS (ages 19–59) who are enrolled in full-scope Medi-Cal to pay premiums of $30 per month.

The 2025–2026 state budget also eliminates full-scope dental coverage for adults with UIS, shifting them to emergency-only dental benefits. This change is expected to produce a General Fund-savings of $134.6 million in FY 2026–2027 and $336 million annually thereafter[25] across all provider types. FQHCs and LALs that provide preventive and non-emergency dental services to adult patients with UIS will no longer receive Medi-Cal reimbursement, though the precise financial impact is beyond the scope of this report.

The Congressional Budget Office (CBO), California's Legislative Analyst's Office (LAO), and several independent studies suggest most individuals who lose access to full-scope Medi-Cal will become uninsured.[26] While some may be eligible for and enroll in other coverage, such as private insurance or county indigent or other health care programs, many will either be ineligible or decline to enroll. Therefore, Chapman assumes each coverage loss in full-scope Medi-Cal is associated with a corresponding increase in the uninsured/self-pay population.

Complete estimates of the cumulative effect these policies will have on Medi-Cal enrollment over time are limited; however, Table 1 displays projections provided by DHCS, which are subject to change. As of this publication, DHCS has not provided year-by-year or cumulative projections, making it difficult to assess the full impact of all policies combined. However, Chapman assumes nearly 2.3 million Californians will lose access to full-scope Medi-Cal in the coming years as a conservative estimate.

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[22] The Commonwealth Fund, "What Recent Policy Changes Mean for Immigrant Health Coverage" (October 2025), https://www.commonwealthfund.org/publications/explainer/2025/oct/what-recent-policy-changes-mean-immigrant-health-coverage.

[23] DHCS, *H.R. 1 Implementation Plan on Eligibility Webinar* (February 5, 2026), https://www.dhcs.ca.gov/federal-impacts/Documents/HR1-Implementation-Plan-on-Eligibility-Webinar.pdf.

[24] DHCS, *DHCS FY 2025–26 Budget Act Highlights* (July 1, 2025), https://www.dhcs.ca.gov/Budget/Documents/Final-Budget-Act-25-26/DHCS-FY-2025-26-Budget-Act-Highlights.pdf.

[25] California State Senate, Senate Committee on Budget and Fiscal Review, Subcommittee No. 3, *Overview of H.R. 1 and Impact on California's Budget (Departments of Health Care Services and Social Services)*, March 19, 2026, https://sbud.senate.ca.gov/system/files/2026-03/03192026-dhcs-and-cdss-hr-1-calworksfinal.pdf.

[26] California Legislative Analyst's Office (LAO), *Considering Medi-Cal in the Midst of a Changing Fiscal and Policy Landscape* (October 24, 2025), https://lao.ca.gov/Publications/Report/508.

Table 1. DHCS Estimates of Medi-Cal Enrollment Declines[27]

State/Federal Policy	Projected Medi-Cal Losses
H.R. 1: Work requirements	**1,400,000** by June 2028
H.R. 1: Non-citizen coverage changes	**200,000** as of October 1, 2026
H.R. 1: Six-month renewals	**400,000** by 2029–2030
CA 2025–2026 Budget: Full-scope expansion enrollment freeze	**270,000** through FY 2026–27[28]
CA 2025–2026 Budget: $30 premiums for adults with UIS	Not available at this time[29]
Total	**2,270,000** (based on dates provided)

A forthcoming study from the UCLA Center for Health Policy Research and UC Berkeley Labor Center projects **2.98 million** fewer Californians will be enrolled in Medi-Cal by 2028 as a result of H.R. 1, the 2025–2026 enacted state budget, and the state's implementation of H.R. 1 as proposed in the 2026–2027 budget.[30] Chapman therefore provides a side-by-side analysis of potential low and high financial impacts using DHCS-provided figures and estimates provided by UCLA/UC Berkeley.

Financial Impact to FQHCs and LALs

To estimate the financial impact of full-scope Medi-Cal enrollment declines on CHCs, Chapman multiplies the share of those expected to lose Medi-Cal who likely receive care from FHQCs/LALs (28%) by average annual revenue collected per Medi-Cal patient, as described in Table 2 below. Using federally reported data, Chapman finds average FQHC and LAL revenue collected per Medi-Cal patient was $1,718 in 2024.[31] Based on these assumptions, CHCs could face financial losses ranging from $1.1 billion to $1.4 billion as millions of Californians become uninsured or only have access to restricted-scope Medi-Cal.

Table 2. Financial Impact of Medi-Cal Coverage Losses on FQHC and LAL Revenue

Californians projected to lose full-scope Medi-Cal	Share receiving care from FQHCs/LALs (28%)	Average annual revenue collected per Medi-Cal patient[32]	Estimated financial impact
2,270,000 (low)	**635,600**	**$1,718**	**$1,092,000,000** (low)
2,980,000 by 2028 (high)	**834,400**	**$1,718**	**$1,433,500,000** (high)

[27] DHCS, *H.R. 1 Implementation Plan on Eligibility Webinar* (February 5, 2026).
[28] According to the *November 2025 Local Assistance Estimate*, DHCS assumes 15,000 individuals who otherwise would have been enrolled in full-scope coverage each month will not be enrolled, reaching approximately 90,000 by the end of FY 2025-26. For FY 2026-27, the total would be 180,000 individuals for a combined 270,000 in FY 2025-26 and FY 2026-27. Chapman does not project estimates beyond this timeframe.
[29] As of this publication, DHCS has only provided the state savings impacts from this policy. To date, DHCS has not provided specific estimates of the number of individuals expected to lose or drop Medi-Cal rather than pay the monthly premium.
[30] UCLA Center for Health Policy Research and UC Berkeley Labor Center, "Projected Reduction in Medi-Cal Coverage Due to Federal H.R. 1 and 2025–26 State Budget," February 18, 2026, https://laborcenter.berkeley.edu/projected-reduction-in-medi-cal-coverage-due-to-federal-h-r-1-and-2025-26-state-budget-by-county-2028/.
[31] Chapman Consulting analysis of HRSA UDS data (2024). Excludes county-based clinics.
[32] Chapman analysis of HRSA UDS data (2024). Excludes county-based clinics.

Key Finding

Medi-Cal coverage losses could reduce FQHC/LAL revenue by an estimated **$1.1 billion to $1.4 billion** in the coming years.

Data Limitations

This finding has several important limitations. First, while most of the policies that will produce coverage losses apply only to certain *adult* populations (i.e., work requirements, six-month renewals, enrollment freeze, premiums), annual revenue per Medi-Cal patient is an average across all patients. Average patient revenue varies by age, disability status, and other factors; however, this level of granularity is not available in the data sets Chapman reviewed. Revenue also varies by health center, type, location, patient acuity, and other factors. Chapman does not assess impacts at the individual CHC level. The analysis also does not apply inflationary factors to reflect changes in per capita revenue over time.

Second, Chapman assumes Medi-Cal enrollment declines directly correspond to revenue losses. In practice, some individuals may retain partial coverage, transition to restricted-scope Medi-Cal, enroll in other coverage, or receive services through county indigent or other public health programs. To the extent that clinics receive reimbursement from these alternative sources, actual revenue losses could be lower than estimated here. At the same time, the CBO and LAO generally assume most individuals who lose Medi-Cal coverage will *not* be able to obtain other coverage and will become uninsured. Chapman therefore assumes a direct equivalence between loss of coverage and loss of revenue.[33]

Finally, Chapman reiterates that the total number of individuals who lose or disenroll from Medi-Cal could be higher than the low/high estimates used here due to the chilling effect and other factors. Therefore, financial losses to FQHCs and LALs could be higher than projected.

Elimination of PPS for Services Provided to Immigrants with UIS

Federal law generally requires state Medicaid programs to reimburse FQHCs (as well as LALs and RHCs) according to the PPS.[34] For each billable visit, known as an encounter, FQHCs receive their designated PPS rate. These are fixed amounts intended to encompass allowable costs for services provided during a single encounter and are adjusted annually for inflation.[35] The PPS framework is intended to provide financial stability and predictability by ensuring FQHCs receive appropriate reimbursement for the broad range of services they provide and populations they serve.

For CHC patients enrolled in Medi-Cal fee-for-service (FFS), CHCs bill DHCS directly at the full PPS rate for each encounter with that member. For members enrolled in Medi-Cal managed care (accounting for 96% of all Medi-Cal enrollees as of December 2025[36]), Medi-Cal managed care plans (MCPs)—or their

[33] LAO, *Considering Medi-Cal in the Midst of a Changing Fiscal and Policy Landscape*.
[34] States may also adopt an alternative payment methodology that pays the same or more than the federal PPS.
[35] CHCF, *Medi-Cal Explained: How Health Centers Are Paid* (May 2022), https://www.chcf.org/wp-content/uploads/2022/05/MediCalExplainedHealthCentersPaid.pdf.
[36] CHCF, "Medi-Cal Enrollment Tracking Tool," accessed March 15,2026, https://www.chcf.org/resource/medi-cal-enrollment-tracking-tool/.

contracted medical groups and Independent Practice Associations—reimburse CHCs for encounters through either:

- Primary care capitation: these are fixed per-member per-month (PMPM) payments to cover most services provided to assigned Medi-Cal members, accounting for 84% of CHC managed care member-months;[37] or
- Contracted rates (FFS payments), accounting for 16% of CHC managed care member-months.

In both cases, MCPs must pay FQHCs and LALs no less than the amount they would pay other providers for the same service. Because MCP payments are typically lower than cost-based PPS rates, FQHCs and LALs invoice DHCS and receive interim wrap-around payments for the difference between the MCP payment and the PPS rate. During reconciliation, DHCS reviews total payments made to CHCs (from MCPs and DHCS wrap payments). If this amount differs from what the CHC would have received under PPS (i.e., total number of encounters multiplied by the CHC's PPS rate), DHCS issues a payment or recoupment.

The federal requirement to reimburse CHCs using PPS only applies to Medicaid services. For immigrants with UIS, Medi-Cal uses state-only funds to cover this population, and therefore, these services are not considered Medicaid services under federal law. The Governor's proposed 2026–2027 budget seeks to eliminate PPS for this population, beginning no sooner than July 1, 2026.[38] If adopted, CHCs would be paid the DHCS FFS rate for enrollees in Medi-Cal FFS, or the negotiated capitation or FFS rate between the FQHC/RHC and the MCP for enrollees in Medi-Cal managed care.

Under the proposal, the state would no longer make wrap payments to align with PPS rates even though the underlying cost of providing the services would stay the same. The effects of this policy change are likely to vary across FQHCs and LALs depending on factors such as region, operating costs, payer mix, degree of reliance on Medi-Cal, and the share of patients who are immigrants with UIS. The Administration estimates this change would result in $1 billion in annual General Fund savings, beginning in FY 2026–27.

It is worth noting that the elimination of PPS only applies to entities that are paid under PPS. Non-FQHC providers who serve immigrants with UIS do not receive wrap payments, and Chapman assumes these providers would continue to be reimbursed as they are today.

Financial Impact to FQHCs and LALs

To illustrate how the elimination of PPS for state-only populations would impact CHCs at the patient level, Chapman estimates the difference between average annual revenue collected per Medi-Cal patient today and average annual revenue per Medi-Cal patient if PPS were eliminated, as displayed in Table 3. Chapman uses the following assumptions:

- Most affected patients are immigrants with UIS currently enrolled in full-scope Medi-Cal.

[37] Chapman Consulting analysis of HRSA UDS data (2024). Excludes county-based clinics.
[38] DHCS, *Medi-Cal November 2025 Local Assistance Estimate for Fiscal Years 2025-26 and 2026-27* (January 9, 2026), https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_November_Estimate/N25-Medi-Cal-Local-Assistance-Estimate.pdf.

- This population is primarily enrolled in Medi-Cal managed care.[39]
- Most MCPs reimburse CHCs under primary care capitation rather than contracted/FFS rates.
- Using federally reported data, the median capitation rate was $15.91 PMPM in 2024,[40] or $190.92 per member per year (PMPY).
- Capitation is a reasonable proxy for per-patient revenue if PPS is eliminated because FQHCs and LALs would no longer receive supplemental wrap payments to reconcile managed care payments up to the PPS level.

Based on these assumptions, annual revenue per Medi-Cal patient could decline from $1,718 to $191, an 89% decrease.

Table 3. Estimated Per Patient Impact of Eliminating PPS

Current system	If PPS is eliminated	Impact on FQHCs and LALs
$1,718	**$191**	**($1,527)**
Average collection per Medi-Cal patient (MCP rates + DHCS wrap payments)	Median annual MCP capitation payment (no DHCS wrap payments)	89% decrease in annual revenue per Medi-Cal patient

Key Finding

If PPS were eliminated for state-only Medi-Cal populations, average per-patient revenue could decline from **$1,718** to **$191 annually, a reduction of 89%.**

To illustrate this change at scale, Chapman assumes immigrants with UIS receive care from FQHCs and LALs at similar rates as the general Medi-Cal population (28%), though survey data indicates CHCs serve a disproportionately higher share of UIS patients than other providers. In a 2024 survey, for example, 34.5% of non-citizens cited community clinics, government clinics, and community hospitals as their usual source of care.[41] This may be because community-connected health care providers deliver culturally and linguistically competent care, have deep ties to their communities, and have developed trusting relationships with immigrant patients over time.

Chapman therefore applies 28% as a conservative (low) estimate and 34.5% as the high estimate for the share of the UIS population served by FQHCs and LALs. Chapman then multiplies the patient population by average revenue lost per patient if PPS is eliminated, as displayed in Table 4 below. Chapman estimates financial losses ranging from $906 million to $1.1 billion per year, which aligns with the state's General Fund savings estimate of $1 billion annually, beginning in 2026–2027.

[39] DHCS, "Medi-Cal Managed Care FAQs," last modified October 29, 2025, accessed March 15, 2026, https://www.dhcs.ca.gov/individuals/Pages/Medi-Cal-Managed-Care-FAQS.aspx. (Most Medi-Cal beneficiaries must enroll in a managed care plan rather than Medi-Cal FFS.)
[40] Chapman Consulting analysis of HRSA UDS data (2024). Excludes county-based clinics.
[41] UCLA Center for Health Policy Research, "AskCHIS," accessed April 22, 2026, https://healthpolicy.ucla.edu/our-work/askchis.

Table 4. Estimated Statewide Impact of Eliminating PPS

Immigrants with UIS enrolled in Medi-Cal	Share who receives care from an FQHC	Net change in revenue collected per patient	Estimated impact on FQHCs
2,118,287 (July 2024)[42]	28% (low) **593,120**	**($1,527)**	**($905,694,240)** (low)
	34.5% (high) **730,809**		**($1,115,945,343)** (high)

Key Finding

Eliminating PPS for state-only Medi-Cal populations could reduce clinic revenue by an estimated **$906 million** to **$1.1 billion**, broadly consistent with the state's estimate of **$1 billion** in annual savings beginning in 2026–2027.

Data Limitations

As mentioned, capitation is used as a proxy for average revenue per UIS patient in the absence of wrap payments. The analysis does not account for differences in average revenue per UIS patient among CHCs that receive FFS payments from MCPs rather than capitation. Nor does the analysis take into account average annual revenue for UIS patients enrolled in Medi-Cal FFS.

Further, Chapman applies a median PMPY across all CHCs and all UIS patients even though capitation rates vary by MCP, patient age, acuity, and other factors. For example, capitation rates for children are typically much lower than for seniors and persons with disabilities.

As previously stated, Chapman also does not account for changes in Medi-Cal enrollment and associated revenue among immigrants with UIS who transition to restricted-scope rather than full-scope Medi-Cal.

Finally, as noted above, the total number of immigrants with UIS enrolled in Medi-Cal—estimated at more than 2.1 million in July 2024—is expected to drop significantly as multiple policies are implemented on a rolling basis, including the enrollment freeze, work requirements, six-month renewals, monthly premiums, and restricted-scope dental benefits, as well as disenrollments caused by the chilling effect. As enrollment in Medi-Cal among immigrants with UIS declines, revenue losses will be higher than estimated here because CHCs would not only lose out on wrap payments, but they would no longer receive MCP payments either.

Financial impacts will also vary by CHC location and patient mix, with those serving a much higher share of immigrants with UIS losing more revenue than those with fewer UIS patients.

[42] DHCS, *Medi-Cal Certified Eligible Data Tables by Legislative Districts and Aid Category - July 2024 Month of Enrollment (Updated January 2025)* (2025), https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Preliminary-Medi-Cal-Legislative-Districts-July2024.pdf.

Discussion

The financial losses to California's community health centers because of state and federal policies will have far-reaching impacts on all Californians' access to care, including those with and without Medi-Cal. More than one-quarter (28%) of all Medi-Cal enrollees and more than one-third (34.5%) of immigrants with UIS rely on FQHCs and LALs for their care. Likewise, Medi-Cal accounts for two-thirds of California primary care clinic patients and 70% of net revenue, totaling more than $4.9 billion in 2023.[43] For three in 10 clinics, Medi-Cal accounts for 85% or more of net revenue.[44] The loss of $1 billion in PPS payments alone amounts to a 14% reduction in overall net revenue.[45]

These estimates likely understate the full effect of these policy changes. They do not include revenue losses if individuals who continue to be eligible for Medi-Cal coverage—including lawfully present immigrants, certain undocumented immigrants, families with mixed immigration status, and U.S. citizens—disenroll from Medi-Cal or avoid seeking care due to fear or anxiety. For example, a 2023 LA Times/Kaiser Family Foundation survey finds 27% of likely undocumented immigrants and 8% of lawfully present immigrants avoided applying for food, housing, or health care assistance in the past year due to immigration-related fears.[46] Work requirements and six-month renewals will create more frequent interactions with county and state agencies, which could further discourage immigrants from engaging with the health care system.

As coverage erodes and more Californians become uninsured, CHCs will continue to serve all patients regardless of ability to pay, increasing costs for uncompensated care. California's primary care clinics already operate on thin margins, averaging just 1.5% in 2023.[47] The downstream effects of coverage losses and reduced reimbursements could result in reduced operating hours, reduced services, delays in making capital improvements, and, in some cases, clinic closures. These impacts could extend beyond Medi-Cal enrollees, as individuals with private insurance, Medicare, other coverage, or no coverage at all could face longer wait times, reduced access, and other barriers to care.

Reduced access to preventive and primary care services has broader consequences for California's health care system. A 2025 UCLA study found that a pilot program expanding health care access in 35 rural counties before the state fully expanded Medi-Cal to undocumented adults was associated with a 22% reduction in emergency department visits and a 24% reduction in hospital admissions.[48] Moreover, undocumented adults are 36% more likely to visit a CHC for behavioral health (BH) needs.[49] Together, these findings suggest that reduced access to coverage is likely to increase avoidable, higher-cost care,

[43] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023)*.
[44] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023).*
[45] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023).*
[46] KFF, *Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants* (September 17, 2023), accessed March 31, 2026, https://www.kff.org/racial-equity-and-health-policy/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/.
[47] Chapman Consulting analysis of HCAI *PCC Annual Utilization Data (2023).*
[48] County Medical Services Program Governing Board, "Path to Health Program Demonstrates Transformative Impact on Healthcare Access for Undocumented Adults" (February 18, 2025), https://cmspcounties.org/2025/02/18/path-to-health-program-demonstrates-transformative-impact-on-healthcare-access-for-undocumented-adults/.
[49] Public Policy Institute of California, *Health Conditions and Health Care among California's Undocumented Immigrants* (October 2023), https://www.ppic.org/publication/health-conditions-and-health-care-among-californias-undocumented-immigrants/.

add pressure on hospitals and mental health providers, and weaken access to timely primary and BH services.

Policy Options

Although California has limited ability to mitigate the impacts of H.R. 1, there are several policy alternatives the state could explore to protect coverage gains and maintain access to care through California's primary care safety net. These options would require further analysis including assessment of fiscal and operational impacts.

1. **Maintain PPS reimbursement for services provided to immigrants with UIS.** FQHCs and LALs provide the same comprehensive, high-quality, integrated care to all patients regardless of payer. If PPS is eliminated, reimbursement for those services would vary based on the patient's immigration status. As discussed above, CHCs are already projected to face substantial revenue losses if 2.3 million to 3 million Californians lose Medi-Cal. Maintaining PPS reimbursement for state-funded populations would mitigate some of these losses and reduce the risk of service reductions and other access challenges. California could also consider maintaining PPS for specific expansion populations, such as children, young adults (19–25), and/or seniors.

2. **Maintain full-scope Medi-Cal for legally present immigrants.** California could continue providing state-funded full-scope Medi-Cal to lawfully present immigrants who no longer meet the definition of qualified immigrant under federal law. This would allow approximately 200,000 lawfully present immigrants, including asylees, victims of domestic violence and human trafficking, and certain Afghans who aided U.S. operations in Afghanistan, or people fleeing violence in Ukraine, to retain comprehensive coverage rather than transition to restricted-scope Medi-Cal.

Conclusion

Recently enacted state and federal policies, as well as state policies currently under consideration, will have significant consequences for California's coverage gains, health center financing, and access to care statewide. Chapman finds that Medi-Cal coverage losses could result in statewide health center revenue losses of $1.1 billion to $1.4 billion in the coming years. Eliminating PPS services provided to immigrants with UIS would result in additional financial losses of $906 million to $1.1 billion per year.

If the state moves forward with eliminating PPS reimbursement for services provided to immigrants with UIS, it should closely monitor these impacts and their downstream consequences. Additional research will be needed to better understand how coverage losses and clinic financing affect broader health system outcomes, including ED visits, hospital admissions, and delayed, avoided, or uncompensated care. Additional metrics related to health care access, such as clinic closures, appointment wait times, language access, and travel distance to the next available primary care provider should also be monitored.

About the Authors and Acknowledgements

This report was prepared by Chapman Consulting, a boutique health policy firm recognized for advancing innovative solutions to complex health system challenges. The firm provides strategic planning, stakeholder engagement, market research, and regulatory analysis across Medicaid, Medicare, and commercial markets, helping clients navigate evolving policy landscapes and achieve operational goals. Chapman Consulting has authored related publications on FQHC financing, including *Medi-Cal Explained: How Health Centers Are Paid* and *Medi-Cal Explained: What Are Alternative Payment Models*.

Samantha Pellón, MPH, Vice President, served as Project Director and provided overall review and oversight. Sunshine Moore Anger, MA, an independent health care consultant and subcontractor to Chapman Consulting, served as lead writer and data analyst. Ann Choi, Policy Consultant, provided research and analytic support, and Chloe Breaker, Project Manager, provided project management support.

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