CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

Policy Brief

CMS Guidance SMD #25-003: Medicaid Managed Care Payments and Emergency Medicaid for Noncitizens

January 2026

I. Executive Summary

On September 30, 2025, the Centers for Medicare & Medicaid Services (CMS) issued new guidance (State Medicaid Director Letter SMD #25-003) that changes how states can use federal Medicaid funds to pay for emergency medical care for noncitizens who are not eligible for full Medicaid benefits.

This new interpretation limits Federal Financial Participation (FFP) - the federal share of Medicaid costs:

- To only the actual emergency medical services rendered to eligible individuals.
- It prohibits states from claiming federal funds for managed care capitation payments, administrative costs, or any other services not directly tied to an emergency.

The rule will take effect with the first managed care rating period beginning on or after January 1, 2027, giving states time to adjust.

II. Background:

- **Federal Financial Participation (FFP):** FFP is the share of costs the federal government reimburses to states for Medicaid expenditures. Think of it as cost-sharing: the state pays part, and the federal government pays part. Under 45 CFR Part 304, FFP applies only to "necessary and reasonable" program costs.
- **Emergency Medicaid:** Section 1903(v) of the Social Security Act authorizes FFP only for care necessary to treat an emergency medical condition for individuals otherwise ineligible for full Medicaid benefits

- **Previous Practice:** Some states included these individuals in Medicaid managed care contracts, claiming federal reimbursement for capitation and other payments. CMS now says this practice goes beyond what the law allows.

III. What the New Guidance Means

CMS is clarifying that:

- States can only claim federal matching funds (FFP) for actual emergency medical services delivered, such as an emergency room visit or emergency childbirth.

- States **cannot** use managed care capitation rates, state-directed payments, or primary care case management (PCCM) fees to claim FFP for these individuals.

- States may continue to provide emergency Medicaid services through **Fee-for-Service (FFS)** systems or through **non-risk contracts** with a **Prepaid Inpatient Health Plan (PIHP)** or a **Prepaid Ambulatory Health Plan (PAHP)**, but they must claim federal reimbursement only for the direct costs of emergency services that were actually provided.

- States must maintain **separate contracts** and financial reporting for this population to ensure transparency and prevent misuse of federal funds.

A. Populations Affected in California

This policy applies to **"aliens ineligible for full Medicaid benefits"**, which includes:

- **Undocumented individuals** (unlawful immigration status).

- **Certain lawfully present immigrants** who are still barred from full-scope Medicaid such as lawful permanent residents within their five-year waiting period.

- **Individuals with temporary or humanitarian status** do not meet the eligibility criteria for full Medicaid coverage.

These individuals are eligible only for **emergency Medicaid**, which covers life-threatening conditions such as heart attacks, emergency labor and delivery, or injuries requiring immediate care.

B. How It Currently Works vs. How It Will Change

Current Practice (Before Guidance)	After CMS SMD #25-003 (2027 and beyond)
• DHCS includes emergency-only members in managed-care plan capitation rates.	• DHCS must remove these members from managed care and reimburse under FFS or non-risk PIHP/PAHP arrangements.
• FFP can be claimed for capitation payments covering emergency-only members.	• FFP applies only to itemized emergency services actually provided.
• Counties blend state and federal funds under unified MCP contracts.	• DHCS must establish distinct contracts and fiscal reporting for federally matched vs. state-only expenditures.

C. Hypothetical Example:

Current:
An undocumented farmworker in Merced County experiences a cardiac emergency. The local Medi-Cal managed care plan covers the hospital admission under its capitation payment. DHCS claims FFP on the plan's full monthly rate, which also includes administrative costs and care coordination fees.

After 2027:
The same patient will still receive emergency care through Emergency Medi-Cal. However, DHCS must pay the hospital directly on a fee-for-service basis and may claim FFP only for that specific episode of emergency treatment - not for managed care overhead or future services.

D. Impact on California:

From January 2024 through June 2025**,** the California Department of Health Care Services (DHCS) estimated of half a million new applications for *restricted-scope (Emergency) Medi-Cal*. This figure represents individuals primarily undocumented and recently arrived immigrants who sought emergency-only health coverage. The high application volume demonstrates the continuing demand for Emergency Medi-Cal across the state, particularly in regions with large immigrant populations such as Los Angeles County, the Central Valley, and the Bay Area.

In addition to the broader undocumented Medi-Cal population, DHCS data from January 2024 through October 2025 suggest that approximately 200,000 undocumented individuals are currently enrolled in Medi-Cal managed care plans under full-scope coverage. These members represent the group most directly affected by CMS SMD #25-003, as they will need to be carved out of managed care arrangements for purposes of federal reimbursement of emergency services.

With the implementation of CMS SMD #25-003 beginning in 2027, this population will continue to receive emergency care, but the funding and reimbursement model will change significantly. Federal funds (FFP) will only reimburse California for *actual, documented emergency services*, rather than managed care or administrative costs.

California's 1.7 million restricted-scope Medi-Cal recipients along with nearly half a million new applicants in just 18 months illustrate the scale of this policy's reach. To comply, DHCS must transition a substantial portion of these members from managed care systems into fee-for-service or non-risk Prepaid Inpatient Health Plan/ Prepaid Ambulatory Health Plan arrangements. This shift could create administrative challenges for the state and disrupt care coordination for hundreds of thousands of immigrants who rely on Medi-Cal for lifesaving emergency care.

E. Impact by Sector:

A. Managed Care Plans (MCPs)

- Must exclude emergency-only members from capitation contracts before 2027.
- Will lose revenue associated with emergency-only enrollees but gain compliance efficiency.
- Need robust coordination with DHCS to ensure accurate disenrollment tracking and FFP reporting.

B. Hospitals and Providers

- Public and safety-net hospitals will experience greater fee-for-service billing volume.
- Documentation and verification requirements will increase for every emergency case.
- Facilities in Los Angeles, the Central Valley, and the Bay Area will be especially affected by higher administrative demands and potential delays in reimbursement.

C. Patients and Coverage Differences

- **Patients Currently in Managed Care:**
  Will be transitioned out of MCPs and into Emergency Medi-Cal (FFS). They will retain emergency coverage but lose managed-care coordination for follow-up,

prescriptions, and preventive care.

- **Patients Already in Emergency Medi-Cal:**
  Will see minimal change in eligibility, but hospitals will now bill each episode separately under stricter documentation requirements. This could lead to slower provider payments and fewer continuity-of-care supports.

IV. Next Steps

As the Department of Health Care Services (DHCS) moves forward with planning for the implementation of the new CMS SMD #25-003 guidance, a thoughtful and coordinated approach will be essential. DHCS can use this opportunity to strengthen collaboration with managed care plans, hospitals, counties, and community organizations to ensure a smooth transition. The focus should remain on maintaining access to emergency services, supporting providers through clearer processes, and promoting transparency and equity as the state adapts to these new federal requirements.

A. DHCS Transition Framework:

- Develop a comprehensive transition plan by mid-2026 to reclassify restricted-scope enrollees and align managed-care contracts with new CMS requirements.
- Issue updated guidance to MCPs and counties detailing data, billing, and reporting changes.

B. Stakeholder Collaboration:

- Convene MCPs, hospital associations, and community-based organizations to coordinate outreach and minimize coverage disruptions.
- Provide culturally and linguistically appropriate education to impacted enrollees about the upcoming changes.

C. Equity and Monitoring:

- Track utilization trends among immigrant populations to assess service continuity after the 2027 transition.
- Explore state-funded care coordination initiatives to fill the gap left by the removal of managed-care oversight for emergency-only populations.

About the Author

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About California Health Policy Strategies (CalHPS), LLC

- CalHPS is a mission-driven health policy consulting group based in Sacramento. For more information, visit www.calhps.com.