CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

# Policy Brief

# Effect of H.R. 1 on California's Distressed Hospitals

March 2026

## Executive Summary

H.R. 1, enacted in July 2025, is expected to reduce federal spending on Medicaid by $911 billion over the next decade.[1] These reductions are likely to have a significant impact on California hospitals, many of which were identified as fiscally distressed under California's Distressed Hospital Loan Program (DHLP).

In 2023, the state established the DHLP to address lingering financial pressures from the COVID-19 pandemic and healthcare costs. The program authorized short-term loans of nearly $300 million in support of 16 of California's most financially distressed nonprofit and public hospitals.[2]

This brief evaluates the effectiveness of the DHLP program, drawing primarily on stakeholder consultations and the submitted hospital turnaround plans, which were acquired through a California Public Records Act (CPRA) request. It also assesses the potential reversal of gains for these recipients as a result of H.R. 1. Our analysis yields three main findings:

- **Financial Vulnerability:** The primary contributing factors toward the "distressed" state of the awardees include high shares of Medi-Cal and Medicare patients, as well as rising operational costs and geographic isolation. Without a loan, 10 of the 17 initial DHLP recipients (including Beverly Hospital, which ultimately declined its award) projected a collective average of -12 Days Cash on Hand (DCOH), a significant disparity from the nationwide nonprofit hospital average of 218 days.

[1] Mudumala, Anna et al. (2025, Sept 22). The Impact of H.R. 1 on Two Medicaid Eligibility Rules. KFF. https://www.kff.org/medicaid/the-impact-of-h-r-1-on-two-medicaid-eligibility-rules/

[2] 17 hospitals were selected for the DHLP, yet Beverly Hospital declined its award after acquisition by a private entity. Therefore, this brief refers to "16 DHLP recipients" when discussing loan disbursement and program effects, while Days Cash on Hand (DCOH) projections draw on available turnaround plans, including Beverly Hospital.

- **Long-term instability:** The DHLP program signaled short-term effectiveness and averted filings for bankruptcy protection in 15 out of the 16 hospitals. The loans, however, do not represent a solution to deep-seated gaps in structural resiliency that still leave hospitals at risk of instability.

- **Disrupted state financing:** H.R. 1 significantly reduces Medicaid financing for states and is expected to increase the number of uninsured Californians, two changes that disproportionately harm hospitals with high shares of Medi-Cal patients and heavy reliance on state-directed funding. The Rural Health Transformation program (RHTP), although presented as a potential remedy, does not provide guaranteed funding for hospitals or fill a long-term dent in operational revenue.

The brief also considers the impact of H.R. 1 on other fiscally challenged hospitals. As noted by an analysis sponsored by the California Hospital Association, 1 in 5 California hospitals in 2023 faced a risk of closure. The DHLP recipients provide a lens through which we can better understand the fiscal pressures experienced by distressed hospitals and the potential impact of H.R. 1.

## Methodology

This initial DHLP analysis utilizes statements from DHLP recipients, including from the DHLP turnaround plans. As part of the application for the DHLP program, recipients were required to submit a plan that included their financial statements at the time of their application, projected financials with a DHLP loan, and detailed steps for the utilization of the award. Through a CPRA request, the Department of Health Care Access and Information (HCAI) provided the submitted plans for all recipients. Additionally, a stakeholder consultation provided the most recent progress updates from the recipients, including information on the utilization of the loans.

## Background

California hospitals, particularly community and independent facilities, have been facing an unprecedented financial crisis in recent years.[3] Long-lasting structural vulnerabilities coupled with the economic losses of the COVID-19 pandemic have pushed crucial institutions near the brink, risking health care access for several communities. Analysis from Kaufman Hall, a healthcare consulting firm commissioned by the California Hospital

[3] Ibarra, A. B. (2023, Aug 25). California bails out distressed hospitals, offers interest-free loans to 17 troubled providers. CalMatters. https://calmatters.org/health/2023/08/california-hospitals-bailout-loans/.

Association, found that as many as 1 in 5 California hospitals were facing a risk of closure in 2023.[4]

The Distressed Hospital Loan Program was established in 2023 to support nonprofit and publicly operated financially distressed hospitals across the state.[5] HCAI, in collaboration with the California Health Facilities Financing Authority (CHFFA), has disbursed nearly $300 million in interest-free, working capital loans to 16 awardees, most of which were at risk of closure.[6]

The selected hospitals exhibited shared financial vulnerabilities that pushed them near bankruptcy. Out of the 16 recipients, 7 were rural hospitals, 8 were non-designated public hospitals or District Hospitals, and 9 were designated within a medically underserved area or population.[7] Such characteristics may significantly affect levels of financial stability by, for example, influencing the payer mix of the hospital. Specifically, three factors in combination seem to drive financial hardship:

- **Rising operational costs:** The pandemic increased the cost of care for several hospitals, disrupted supply chains, and shifted patient mixes to fill hospitals with sicker individuals, increasing the financial toll.[8] Several DHLP recipients noted their challenge with staffing shortages and payroll as well, highlighting growing labor costs.[9] Three recipients also directly faced a cyber-attack or were affected by outside attacks, affecting their cash flow.

- **Isolation:** Inherent geographic isolation as rural hospitals or the lack of diverse and effective care nearby can result in significant financial burdens. Regardless of low patient volume, hospitals attempt to maintain a range of critical services as an essential provider of care in their communities. [10] Otherwise, several individuals may be forced to travel far to reach adequate care.

[4] California Hospital Association. (2023, April 12). New report shows patients served by one in five California hospitals are at risk of losing their hospital due to closure. https://calhospital.org/new-report-shows-patients-served-by-one-in-five-california-hospitals-are-at-risk-of-losing-their-hospital-due-to-closure/.
[5] California Department of Health Care Access and Information. (n.d.). Distressed Hospital Loan Program. https://hcai.ca.gov/facilities/health-facility-financing/distressed-hospital-loan-program/
[6] Legislative Analyst's Office. (2024, Feb 27). Department of Health Care Access and Information. https://lao.ca.gov/Publications/Report/4860#:~:text=In%20late%20August%2C%20HCAI%20announced,acquired%20by%20another%20private%20entity.
[7] California State Assembly. (2024, March 11). Agenda [PDF]. https://abgt.assembly.ca.gov/system/files/2024-03/sub-1-march-11-agenda-final-fixed.pdf
[8] Hetrick, Christian. (2023, Dec 15). Why some California hospitals are still struggling after COVID-19. USC Price School. https://priceschool.usc.edu/news/california-hospital-bankruptcy-covid/.
[9] Stakeholder consultation (2025, June) and Hospital Turnaround Plans (2023).
[10] Stakeholder consultation (2025, June) and Hospital Turnaround Plans (2023).

- **Government reimbursements**: Many of the recipients are in communities with significant reliance on Medi-Cal and Medicare, leaving hospital revenue dependent on federal and state government reimbursements that are non-negotiable and have not kept pace with the rising cost of care.[11] Multiple hospitals note their struggle with the timing of the disbursement as well. During the 2024 HCAI reporting cycle, 14 of the 16 loan recipients had a combined Medi-Cal and Medicare revenue share exceeding the statewide peer-group average of 58.9% (see Appendix A). Notably, six recipients (El Centro Regional, St. Rose, John C. Fremont, Kaweah Delta, MLKCH, and Pioneers Memorial) exhibited extreme government dependency, with combined revenue shares surpassing 80%.

To address these systemic vulnerabilities, the program targeted hospitals that meet criteria of severe liquidity shortages, high community value, and other factors.[12] Crucially, the loan terms include an 18-month grace period intended to allow for stabilization in the first loan term. However, with loan maturity dates set for late 2029 and early 2030, hospitals will face repayment deadlines just as the full fiscal impact of H.R. 1 is projected to take hold on California's healthcare system.

**Effect of HCAI Loans on Financial Improvement**

Overall, the program seems to have made a significant improvement in the financial status of several of the hospitals, diminishing the risk of bankruptcy and providing short-term stability. The primary use of the loans was meeting immediate cash needs, and the rest of the money was primarily spent on working towards goals listed in the turnaround plans that each hospital submitted.[13] Examples of uses include:

- **New programs and services:** Projects included new capital equipment for current services, reinstating or expanding into new services (e.g., cardiac catheterization laboratories and machines), and overall enhancement of service quality.

- **Staffing:** Funding was directed towards addressing staffing shortages and recruiting.

- **Building improvements:** Almost all hospitals noted concern about their compliance with California's seismic standards for buildings and have directed funds towards meeting those requirements.

[11] Stakeholder consultation (2025, June) and Hospital Turnaround Plans (2023).

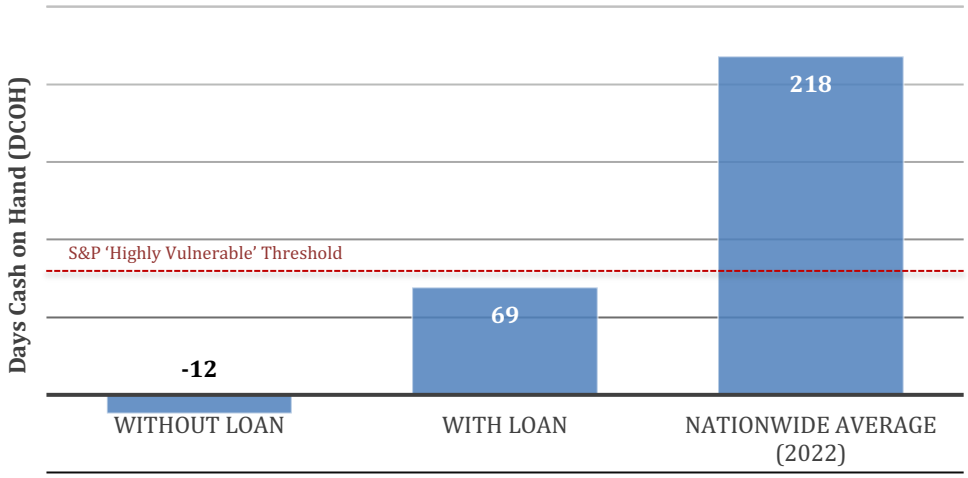
[12] California Department of Health Care Access and Information. (2023, May 23). Distressed Hospital Loan Program Loan Evaluation Criteria Webinar [PDF]. https://hcai.ca.gov/wp-content/uploads/2023/05/DHLP-Powerpoint-Draft-Evaluation-Methodology-Webinar.pdf

[13] Stakeholder consultation (2025, June) and Hospital Turnaround Plans (2023).

A key indicator of financial stability is Days Cash on Hand (DCOH). Based on financial projections for May 2025 from 10 awardees, the average DCOH without an HCAI loan was projected to be around -12 days, as several hospitals predicted they would be in a severe cash deficit by this time (see Appendix B). With a DHLP loan, the projected average DCOH increased to 69 days, highlighting the immense projected value of even a short-term funding boost. The results are visible in Chart 1 below.

Yet, by S&P Global's criteria for evaluating nonprofit acute care health organizations, the recipients remain in the 'highly vulnerable' category for stand-alone hospitals (less than 80 DCOH).[14] In comparison, S&P classifies an 'adequate' DCOH level for stand-alone hospitals in the U.S. as anywhere from 110 to 160 days. Furthermore, in 2022, the average levels of DCOH across 274 nonprofit hospitals and hospital systems, or more than half of all nonprofit hospitals in the U.S., was 218 days.[15] Only 9% of hospitals analyzed had fewer than 100 DCOH (hospital systems) or 110 DCOH (stand-alone hospitals). Actual financial data from May 2025 is unavailable, yet this data provides a useful, quantitative picture for the potential effects of the program prior to H.R. 1.

**Chart 1: Projected DHLP DCOH Averages vs. Nationwide Nonprofit Average**




Additionally, the recipients have reported that several immediate concerns at the time of application have now been addressed due to the loan; as of January 2026, only one of the 16 hospitals has filed for bankruptcy protection.[16] Yet, many of the recipients are still

[14] Keller, Cynthia S. U.S. And Canadian Not-For-Profit Acute Care Health Care Organizations. (2025, July 28). S&P Global. https://www.spglobal.com/ratings/en/regulatory/article/-/view/sourceId/10407192.

[15] Palosky, Craig. (2024, Jan 9). Most Nonprofit Hospitals and Health Systems Had "Strong" Days of Cash on Hand in 2022, Though About One-in-10 Were "Vulnerable." https://www.kff.org/health-costs/most-nonprofit-hospitals-and-health-systems-had-strong-days-of-cash-on-hand-in-2022-though-about-one-in-10-were-vulnerable/

[16] Reyes, J. (2025, Oct 2). Palo Verde Healthcare District Files for Bankruptcy. KESQ. https://kesq.com/news/2025/10/02/palo-verde-healthcare-district-files-for-bankruptcy/

struggling with meeting financial needs. In particular, issues with staffing, seismic compliance, and reimbursement rates remain as key vulnerabilities that are yet to be fully tackled. 15 out of 16 hospitals have also applied for an extension on the first repayment due date as of January 2026.[17] Despite the immediate relief provided by the loan program, deep-seated gaps in structural resiliency suggest that these hospitals remain on the brink of stability.

**Effect of H.R. 1 on Distressed Hospitals**

H.R. 1 threatens to further destabilize distressed hospitals and push them over the edge. H.R. 1 was signed into law on July 4, 2025, almost two years after the initiation of the Distressed Hospital Loan Program.[18] The legislation made significant changes to a wide variety of government programs and policies, including healthcare coverage and financing. Key health changes that may affect Medi-Cal providers include the following:

- **Provider tax rates:** States have limited ability to disproportionately tax Medicaid services, bringing down federal matching funds for Medicaid.[19] The State limit on tax revenue will also be reduced over time.

- **State-directed payments:** States have lower caps on state-directed payments (SDPs), extra payments made from the state to help providers cover the costs of Medi-Cal patients. California must lower their current rate to 100% of the Medicare rate, eroding a critical revenue source for healthcare providers.[20]

- **Uninsured patients:** New eligibility and access requirements for Medi-Cal members, such as work requirements, 6-month eligibility checks, and immigration coverage limitations, may risk up to 3.4 million Medi-Cal members losing coverage, putting further strain on hospitals for treating uninsured patients.[21]

Overall, an analysis led by Harvard researchers named three risk factors that determined the exposure level of a hospital to the Medicaid cuts: serving vulnerable communities, suffering from fragile finances, and having more than a quarter of their patients rely on

[17] California Health Facilities Financing Authority (CHFFA). (2025, Dec 11). List of Loan Awards and Statuses As of December 11, 2025 [PDF]. https://www.treasurer.ca.gov/chffa/meeting/2025/1211/staff/03-02-Hopsital-Loan-Program.pdf
[18] H.R.1 - 119th Congress (2025-2026). An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. (2025, July 4). https://www.congress.gov/bill/119th-congress/house-bill/1.
[19] Legislative Analyst's Office. (2025, Aug 20). Overview of Major Impacts of H.R. 1 – One Big Beautiful Bill Act [PDF]. https://lao.ca.gov/handouts/state_admin/2025/Major-Impacts-of%20HR1-082025.pdf
[20] Ramos-Yamamoto, A. (2025, Sept). How Federal Funding Cuts Threaten the Health of Californians. California Budget & Policy Center. https://calbudgetcenter.org/resources/how-federal-funding-cuts-threaten-the-health-of-californians/
[21] Ramos-Yamamoto. How Federal Funding Cuts Threaten.

Medicaid.[22] With existing government reimbursement rates already standing as insufficient, further cuts are likely to result in greater operational losses for these hospitals.

These risk factors are significantly scaled in distressed hospitals and are already threatening financial outlooks. San Benito County's Hazel Hawkins Hospital, one of the DHLP recipients, noted that due to H.R. 1 budget cuts, the hospital lost a potential outside partner for financial stability.[23] Martin Luther King Jr. Community Hospital, another recipient, expects to see a loss of 15 to 20 percent of their revenue.[24] Emergency hospital funding such as the loan program may become more limited as state revenues decrease as well, further harming distressed hospitals. Without any additional funding sources, distressed hospitals will see massive cuts in revenue and no supplemental income or loans to fill those financial gaps.

*Rural Health Transformation Program (RHTP)*

In response to concerns about the bill's potential impact, H.R. 1 enacted the Rural Health Transformation Program (RHTP) to uplift rural healthcare in particular. The program provides $50 billion over five years to selected states, which then decide how to distribute the money to providers and programs in rural healthcare.[25] The budget is split into two equal portions: baseline funding, which provides an equal amount to each selected state, and workload funding, which is not guaranteed for all applicants and is subject to three categories of criteria: data-driven metrics, initiative-based planning, and adoption of state policies. For FY26, California has received nearly $234 million in funding awards from the RHTP.[26]

The program is structurally ill-suited, however, to offset the damage caused by H.R. 1. While the program offers grant funding for rural hospitals, it cannot replace the reliable, recurring operational revenue lost through Medicaid cuts. Furthermore, the program's rural exclusivity ignores the geography of the crisis. As seen with the loan program, financial distress is not limited to rural zones. In fact, the Harvard analysis cited above indicates that 85% of the hospitals most at risk for Medicaid cuts nationwide reside in

[22] Badger, E. (2025, Nov 18). When the G.O.P. Medicaid Cuts Arrive, These Hospitals Will Be Hit Hardest. The New York Times. https://www.nytimes.com/2025/11/18/upshot/urban-hospitals-medicaid-cuts.html.
[23] Clark, E. (2025, Aug 14). Hazel-Hawkins Hospital: Insight Health withdraws. KSBW. https://www.ksbw.com/article/hazel-hawkins-hospital-insight-health-withdraws/65781889.
[24] Badger. When the G.O.P. Medicaid Cuts Arrive.
[25] Centers for Medicare & Medicaid Services. (n.d.). Rural Health Transformation Program. https://apply07.grants.gov/apply/opportunities/instructions/PKG00291485-instructions.pdf.
[26] Centers for Medicare & Medicaid Services (2025, Dec 29). CMS Announces $50 Billion in Awards to Strengthen Rural Health in All 50 States. https://www.cms.gov/newsroom/press-releases/cms-announces-50-billion-awards-strengthen-rural-health-all-50-states

urban areas.[27] Consequently, H.R. 1 may exhaust the remaining fiscal headroom of some of California's most distressed providers.

## Questions for Further Research

Several questions remain to be answered about the program, distressed hospitals in California, and H.R. 1. Questions for future research include:

- While the loan program provided financial relief for its recipients, many structural challenges remain unaddressed. What long-term policy solutions can the state pursue to support distressed hospitals?

- As H.R. 1 policies come into effect, some financially vulnerable hospitals will likely see a notable reduction in revenue. What alternative funding mechanisms or supplemental programs could help mitigate financial instability during this time?

- Which California hospitals are most at risk under H.R. 1, and what factors best predict that risk? Potential indicators include Medi-Cal revenue share, rates of layoffs, and emergency department utilization. Future research could look to sources like HCAI facility data to develop hospital-level risk profiles.

- What metrics and tools can be utilized to distinguish fundamentally distressed hospitals and providers facing standard operational headwinds? How can the DHLP program be used to guide that thinking?

- H.R. 1 will affect hospitals nationwide, not California alone. What solutions are other states taking in the face of this change, and which of these approaches can be adapted to California's healthcare landscape?

As implementation of H.R. 1 proceeds, metrics such as DCOH also require significant attention for effectively evaluating the impact on California hospitals. Information from DHLP turnaround plans may also be useful for understanding effective ways to distribute funds among and within hospitals. It's crucial that hospitals and the state work together to collect such data and use it to inform future policy decisions in the face of liquidity challenges.

Furthermore, continued attention must be paid to DHLP recipients and the most distressed hospitals in the state. While larger providers may have the resources to absorb H.R. 1's effects, this cohort may lack that capacity. They are leading indicators of systemic stress, and their financial trajectory following H.R. 1 will demonstrate the legislation's impact on California's most vulnerable communities.

[27] Badger. When the G.O.P. Medicaid Cuts Arrive.

## 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.

## Appendix A

The table below presents each loan recipient's Medi-Cal, Medicare, and combined revenue shares relative to statewide comparable averages. This analysis utilizes the HCAI Annual Hospital Financial Dataset for reporting periods ending between January 1, 2024, and December 31, 2024.

**Table A: Payer Revenue Shares (%) vs. Statewide Average**

| Recipient | County | Medi-Cal (%) | Medicare (%) | Combined Share (%) | Gap (%) |
|---|---|---|---|---|---|
| Chinese Hospital | San Francisco | 13.8 | 62.8 | 76.6 | 17.7 |
| Dameron Hospital Association | San Joaquin | 42.0 | 31.0 | 73.0 | 14.1 |
| El Centro Regional Medical Center | Imperial | 34.4 | 49.3 | 83.7 | 24.8 |
| St. Rose Hospital | Alameda | 48.3 | 33.0 | 81.3 | 22.4 |
| John C. Fremont Healthcare District | Mariposa | 49.3 | 44.3 | 93.6 | 34.7 |
| *Kaweah Delta Health Care District | Tulare | 41.8 | 45.6 | 87.4 | 28.5 |
| **Madera Community Hospital | Madera | - | - | - | - |
| MLK Jr. Community Hospital | Los Angeles | 74.9 | 15.5 | 90.4 | 31.5 |
| Palo Verde Hospital | Riverside | 0.1 | 72.0 | 72.1 | 13.2 |
| Pioneers Memorial Healthcare District | Imperial | 42.8 | 46.1 | 88.9 | 30.0 |
| Ridgecrest Regional Hospital | Kern | 16.8 | 35.5 | 52.3 | -6.6 |
| Hazel Hawkins Memorial Hospital | San Benito | 42.9 | 27.3 | 70.2 | 11.3 |
| San Gorgonio Memorial Hospital | Riverside | 47.5 | 27.4 | 74.9 | 16.0 |
| Sonoma Valley Hospital | Sonoma | 25.6 | 32.4 | 58.0 | -0.9 |
| Tri-City Medical Center | San Diego | 17.0 | 47.0 | 64.0 | 5.1 |
| Watsonville Community Hospital | Santa Cruz | 19.9 | 48.4 | 68.3 | 9.4 |

*Source: 2024 Pivot Table - Hospital Annual Selected File (October 2025 Extract)*
** The facility name differs slightly in official HCAI Data (Kaweah Delta Medical Center).*
*** Madera Community Hospital was not operational during this reporting period.*

The revenue shares for Medi-Cal and Medicare were calculated by dividing the Net Patient Revenue (NPR) of each program by the facility's total NPR for the reporting period. The data encompasses both inpatient and outpatient services and includes revenue from

traditional and managed care models. The 'Combined Share (%)' represents the aggregate percentage of total net patient revenue sourced from these two government programs.

To establish a statewide benchmark, the average for the combined revenue share was calculated using a weighted aggregate method. NPR totals for Medi-Cal and Medicare were summed across all qualifying facilities and divided by the total summed NPR of the group. To ensure an accurate comparison, the dataset was filtered to include only 'Comparable' hospital types providing 'General Acute' care. This resulted in a statewide average of 28.8% for Medicare and 30.1% for Medi-Cal. This was combined to create the 58.9% statewide average, which was subtracted from each recipient's combined share to produce the 'Gap (%)' column.

HCAI annual financial data reflects the most recent financial data publicly available for each entity. Data for Beverly Hospital was excluded as it is no longer reported under that name following its 2023 bankruptcy and subsequent acquisition by Adventist Health.

## Appendix B

The data below captures the projected improvement calculated by hospitals at the time of their turnaround plan submission (2023).

**Table A: Days Cash on Hand (DCOH) in May 2025 (Projected)**

| Recipient | County | Without Loan | With Loan |
|---|---|---|---|
| Beverly Hospital | Los Angeles | -125 | 42 |
| Chinese Hospital | San Francisco | 4 | 88 |
| St. Rose Hospital | Alameda | 0 | 1 |
| Hazel Hawkins Hospital | San Benito | 13 | 39 |
| John C. Fremont Health District | Mariposa | -9 | 122 |
| *Kaweah Delta Health Care District | Tulare | 30+ | 80+ |
| **MLK Jr. Community Hospital | Los Angeles | -7 | 68 |
| Palo Verde Hospital | Riverside | -65 | 31 |
| Pioneers Memorial Healthcare District | Imperial | 18 | 97 |
| **San Gorgonio Memorial Healthcare District | Riverside | 19 | 126 |

*Sources: HCAI Turnaround Plan Submissions*
** Exact cash or disbursement values were not reported; only ranges were available based on graphical data, so the lowest value was used for calculations of averages.*
*** Facility-reported DCOH was used here.*

DCOH was calculated by dividing the projected ending cash balance (as of May 2025) by the average daily operating cash disbursements (or expenses) for the same period. The average daily disbursement was determined by dividing total May 2025 operating disbursements by 31 days. Operating cash expenses include payroll, payroll taxes, employee health and pension contributions, insurance premiums, accounts payable, and other cash-based operating disbursements. Non-operating or non-cash items, such as depreciation, capital expenditures, debt service, and employer pension accruals, were excluded. Unrestricted cash was used when reported; otherwise, total ending cash was used. May 2025 was the chosen reference month as it was the last month before H.R. 1 passed. Of the 17 hospitals initially awarded (including Beverly Hospital), complete and standardized financial projections for May 2025 were available for 10 facilities. Facilities with non-comparable data were excluded from the table above, yet other financial data, such as ending cash in FY 2025 and net cash flow, also suggest projected improvement for the 7 excluded facilities as well.