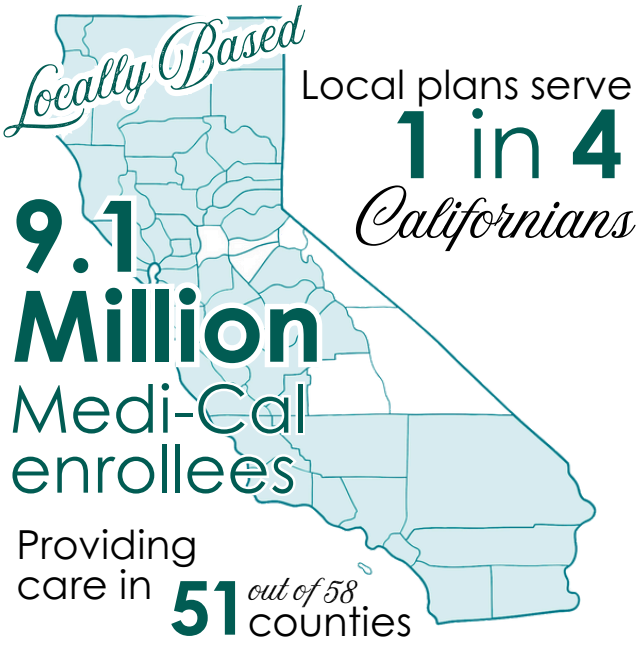
LHPC
Local Health Plans *of* California

ABOUT LOCAL PLANS

Local Health Plans of California (LHPC) is a statewide trade association that represents all 17 of the community-based, not-for-profit health plans that provide access to critical and comprehensive health care services for low-income populations enrolled in California's Medicaid program, Medi-Cal.



All plans are locally based operations with **employees who live in the community**

Created by their counties, local plans are **community-based & locally governed**

As not-for-profit organizations, local plans **reinvest in their communities**

COMMUNITY INVESTMENT

In addition to providing access to high quality health care through robust provider networks, local plans utilize their net income or reserves to improve community health, focusing on:

- Access & Quality
- Food Stability & Nutrition
- Housing
- Workforce Development
- Community Health & Wellbeing

17 MEMBER PLANS

Alameda Alliance for Health
CalOptima Health
CalViva Health
CenCal Health
Central California Alliance for Health
Community Health Group
Health Plan of Imperial Valley
Contra Costa Health Plan
Gold Coast Health Plan
Health Plan of San Mateo
Health Plan of San Joaquin/Mountain Valley Health Plan
Inland Empire Health Plan
Kern Family Health Care
L.A. Care Health Plan
Partnership HealthPlan of California
San Francisco Health Plan
Santa Clara Family Health Plan

Local Plans Sweep 2025 DHCS Medi-Cal Managed Care Quality Awards

3 out of **4**

PEOPLE CHOOSE LOCAL PLANS
when choice is available

THE VALUE OF MEDI-CAL MANAGED CARE

Medicaid managed care, including California's Medi-Cal program, provides coordinated, efficient, quality care to vulnerable populations while ensuring responsible stewardship of public resources. Local health plans strengthen this model as community-based, not-for-profit, publicly governed organizations that operate with transparency and fiscal accountability.

COST CONTROL AND FINANCIAL RISK

Fixed per-member payments transfer financial risk from the state to plans, creating budget predictability

More resources go toward member care by efficiently managing administrative costs

Negotiate fair provider rates that help draw providers into serving Medi-Cal enrollees while falling within established payment limits

Verify that services are appropriate and align with the member's covered benefits

Provide additional support for safety net providers, including advanced payments and workforce grants and scholarships

ACCOUNTABILITY AND PROGRAM INTEGRITY

Plans must meet performance standards, quality metrics and network adequacy requirements or face financial penalties from the state

Prevent fraud, waste, and abuse through:

- Utilization management
- Claims audits
- Eligibility verification

Recover misused funds from providers to ensure public dollars are used as intended

Sustain a strong, reliable network by supporting safety-net providers

ACCESS TO QUALITY CARE

Strong, credentialed provider networks meet the needs of both routine and high-need members, with expanded access through telehealth.

Coordinated care across services reduces fragmentation, decreases the need for emergency room visits, avoids duplicatative care, and helps members navigate the system.

Investing in quality improvement and prevention improves health outcomes and lowers overall healthcare costs.

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