



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**

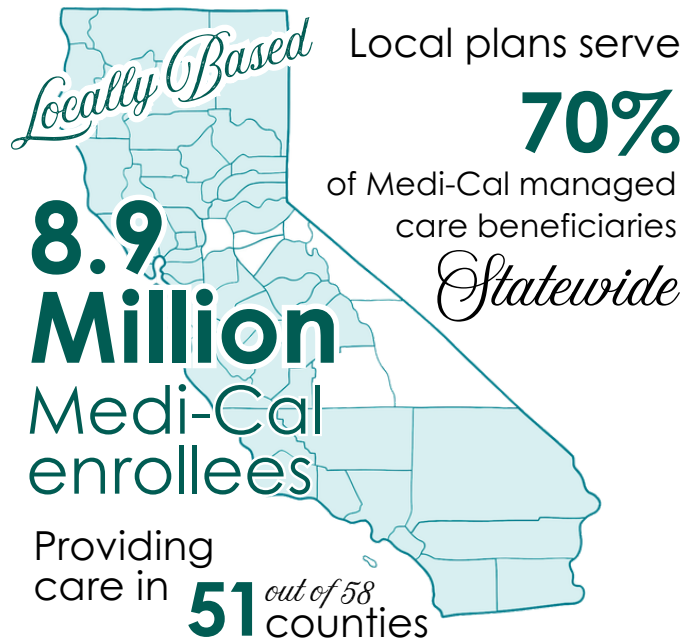
As not-for-profit organizations, local plans **reinvest in their communities**

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



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



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

2 out of **3**



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 duplicative care, and helps members navigate the system.
-  **Investing in quality improvement and prevention** improves health outcomes and lowers overall healthcare costs.