May 22, 2026

Honorable Caroline Menjivar
Chair, Senate Budget Subcommittee 3 on Health
Capitol Office, 1021 O Street, Suite 6630
Sacramento, CA 95814

Honorable Dawn Addis
Chair, Assembly Budget Subcommittee 1 on Health
Capitol Office, 1021 O Street, Suite 4120
Sacramento, CA 95814

RE: Local Health Plans Concerns with Medi-Cal Proposals Included in the 2026-27 May Revision

Dear Chair Menjivar and Chair Addis,

Local Health Plans of California (LHPC) is the statewide trade association representing all 17 of California's public and not-for-profit community-based health plans, which collectively cover 70% of the state's Medi-Cal managed care enrollees, or nearly 9.7 million Californians. We write to express significant concerns with several proposals included in the Governor's 2026-27 May Revision impacting the Medi-Cal program. While LHPC appreciates the Administration's efforts to address the state's fiscal challenges and protect critical health care investments while ensuring compliance with new federal policies, several proposals would undermine access to care for vulnerable Californians, destabilize critical safety net infrastructure, and weaken successful delivery system reforms that have improved health outcomes across the state.

Carve Out of Medi-Cal Members with Unsatisfactory Immigration Status (UIS)
Most notably, LHPC strongly opposes the May Revision proposal to move Medi-Cal members with unsatisfactory immigration status (UIS), inclusive of qualified non-citizens, out of the managed care delivery system and into fee-for-service (FFS) Medi-Cal. While the Administration assumes that providing coverage in the FFS system is comparable to managed care, the reality is that coverage in the FFS delivery system will not provide nearly the same level of access to high-quality, coordinated care delivered through managed care. We understand that the state must comply with the recent Centers for Medicare & Medicaid Services (CMS) guidance within the September 2025 State Medicaid Directors Letter (SMD #25-003). However, the CMS directive addresses an accounting issue related to UIS emergency services and provides a pathway for state-only funded coverage through separate contracts and non-risk based payments. California can address CMS' concerns by ensuring that payments for UIS emergency services are billed directly through the FFS delivery

system and provide the remainder of non-emergency care through a separate state-only funded organized care program that maintains plan continuity with similar benefits and services. This approach would allow UIS members to maintain access to the coordinated, prevention-focused, high-quality care provided through managed care plans.

Importantly, this proposal would not only harm the adult UIS population but would also cause irreparable harm to children who have been served through the managed care delivery system for the past two decades. Disrupting established provider relationships and restricting access to coordinated pediatric care would negatively impact children's access to preventative services, developmental screenings, immunizations, and specialty care coordination.

Further, we have serious questions about the savings assumed by this proposal. The proposal's projected savings rely heavily on the loss of Enhanced Care Management (ECM) ($50.1 million GF) and Community Supports ($39.2 million GF), as well as substantially decreased utilization ($356.1 million GF) due to UIS members facing substantial barriers accessing preventative and chronic care in the FFS delivery system. However, the proposal fails to account for the significant state costs associated with building FFS infrastructure capable of adequately serving nearly two million Medi-Cal members. Moreover, when individuals lose access to coordinated preventative care, they are more likely to seek care through costly emergency departments and inpatient settings. The Administration's proposal accounts for a savings offset of $224.7 million GF cost due to higher utilization of certain services (i.e., increased utilization of emergency care), essentially eliminating almost a third of the savings assumed through the anticipated decrease in utilization.

In addition to the significant access concerns associated with moving the UIS population into fee-for-service Medi-Cal, the proposal also exposes the state to substantially greater financial risk. Under the managed care delivery system, the state benefits from predictable, capitated financing that allows plans to coordinate care, manage utilization, and proactively address members' physical, behavioral, and social health needs before they escalate into more costly interventions. By contrast, the fee-for-service system reimburses based on volume and intensity of services provided, offering the state far fewer tools to manage costs associated with avoidable emergency department utilization, hospitalizations, and unmanaged chronic conditions. Transitioning nearly 2 million vulnerable Californians out of managed care would weaken the state's ability to control long-term cost growth and undermine decades of progress toward a more coordinated, prevention-focused Medi-Cal delivery system.

MCO Tax Proposal

LHPC appreciates efforts to generate revenue to support the Medi-Cal program and mitigate the impacts of potential federal funding reductions. However, we are concerned that the May Revision proposal is inconsistent with the intent of Proposition 35, which requires that MCO tax resources be directed toward specified Medi-Cal provider rate enhancements, rather than used as General Fund backfill. Proposition 35 requires that MCO tax revenues be used to support provider reimbursement rates and other provider supports for those who serve Medi-Cal members and prohibits the tax

revenue from being used to fund unrelated programs or supplanting or replacing existing sources of funding for the Medi-Cal program. LHPC urges the Legislature to engage experts and stakeholders to develop a tax structure that continues to generate meaningful revenue while remaining compliant with both H.R. 1 and Proposition 35.

Quality Withhold and Incentive Program

LHPC opposes the proposal to eliminate the incentive portion of the Quality Withhold and Incentive Program as reflected in the Medi-Cal Efficiencies section of the May Revision. Removing the incentive structure effectively acts as a cut to managed care rates while eliminating plans' ability to earn back funding through demonstrated improvements in quality and reduction of health disparities. These incentive dollars are directly invested into meaningful quality improvement initiatives targeting some of the Medi-Cal program's most vulnerable members. The proposal would reduce resources available to ensure that children receive preventative health visits, developmental screenings, critical immunizations, and timely referrals to specialty care and supportive services. Eliminating these incentives undermines the state's long-standing commitment to advancing health equity and improving outcomes in underserved communities.

Prospective Payment System (PPS) Proposal

LHPC respectfully asks the Legislature to reverse the proposed elimination of PPS reimbursement for state-only Medi-Cal populations or, at minimum, delay implementation until 2028 to allow for appropriate planning and mitigation efforts. Local plans rely heavily on safety net providers, including Federally Qualified Health Centers (FQHCs), to deliver care to Medi-Cal members. Eliminating PPS reimbursement for state-only Medi-Cal populations would have devastating financial consequences for these clinics and threaten their long-term sustainability. The continued stability of health centers is essential to ensuring access to comprehensive clinic-based services, including preventative care, chronic disease management, behavioral health services, and care coordination. Health centers remain indispensable partners in the Medi-Cal delivery system and serve as a critical access point for local plan members throughout California.

Reinstatement of the Asset Limits Test

LHPC opposes the proposed reinstatement of the Medi-Cal asset test, which would create unnecessary barriers to coverage and disproportionately harm seniors and people with disabilities who rely on Medi-Cal to access essential health care and long-term services and supports. Reimposing asset limits would force vulnerable Californians to navigate complex eligibility and verification requirements, increasing the likelihood of coverage disruptions and administrative churn for individuals who often have limited incomes but modest savings. The elimination of the asset test has helped streamline eligibility determinations, reduce administrative burden for counties, and ensure continuity of care for populations with significant health needs. Reinstating the test would reverse this progress, place additional strain on already vulnerable populations, and ultimately increase costs associated with avoidable gaps in care and delayed treatment.

Thank you for your consideration and continued commitment to protecting access to care for Medi-Cal members. We appreciate the opportunity to work collaboratively with the Legislature and Administration on solutions that preserve California's progress toward a more equitable, coordinated, and prevention-focused Medi-Cal program.

Sincerely,

Katie Andrew
Director of Government Affairs, Quality & Behavioral Health
Local Health Plans of California