

Preserving the Safety Net and Critical Access to Care for Immigrant Communities

The Governor’s 2026 – 2027 May Budget Revision includes key changes to the State’s Medi-Cal Program for the provision of services to beneficiaries with Unsatisfactory Immigration Status (UIS) and some Qualified Non-Citizens (QNCs). One prominent change is the Governor’s proposal to transition all services for this population from Medi-Cal managed care to Medi-Cal Fee-for-Service (FFS) delivery system, effective January 1, 2027. This change is primarily attributed to new federal policy that requires the State to provide federally-eligible emergency Medicaid services to the UIS population through a FFS system.

In an effort to remain compliant with this new federal policy, the State has proposed to transition all services provided to UIS individuals to FFS, not just those services that are eligible for federal financial participation. This change would create significant fiscal challenges for safety-net providers and jeopardize the ability of vulnerable immigrant beneficiaries to access critical health care services. Under an FFS system, beneficiaries would no longer have a coordinated infrastructure of care and instead will be limited to a costlier, more fragmented system that will result in fewer provider options.

MOTION

Mitchell _____

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Barger _____

Solis _____

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It is estimated that transitioning these populations to FFS would result in increased inpatient utilization and emergency department visits, reflecting the challenges associated with replacing a coordinated care model for individuals with complex healthcare needs. Managed care provides stable financing, established provider networks, coordinated care and payment arrangements, quality oversight, program integrity safeguards, and investments in provider capacity that support access to care for Medi-Cal beneficiaries. Preserving the managed care delivery system also helps maintain current provider reimbursement levels and supports the financial stability of hospitals, clinics, physicians, and community-based providers. A large-scale shift to FFS financing could increase pressure on the healthcare safety net and adversely affect access to care, workforce stability, and the overall sustainability of the healthcare delivery system.

The Local Health Plans of California (LHPC) have developed an alternative proposal that supports compliance with federal guidance, while generating two-thirds of the State's anticipated savings of \$539 million for fiscal year 2026-27 and \$1.5 billion ongoing, with an FFS transition. These savings will be partially achieved with the Health Plans' contributions of an estimated \$224 million in administrative savings, underwriting concessions, and rate adjustments. LHPC's proposal would enable Medi-Cal members to remain enrolled in State-only contracts with managed care plans, for the provision of non-hospital based outpatient, preventative and specialty care. Meanwhile the State would administer and directly pay providers for federally payable services - including all

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hospital-based inpatient, emergency room, and outpatient services – through a FFS mechanism. LHPC's proposal would preserve federal financial participation for sensitive services through a State-administered FFS payment mechanism, under which Centers for Medicare & Medicaid Services would directly reimburse the State for certain services subject to federal financial participation. This proposal would reduce the State's estimated \$33 million administrative burden related to transitioning this population to FFS, and would further preserve the health care system by reducing the State's projected 16 percent increase in inpatient care and the 12 percent increase in emergency room use, as a result of the FFS transition proposed in the May Revision.

Another significant proposed change that the May Revision does not address is the elimination of Prospective Payment System (PPS) reimbursement for state-only funded Medi-Cal services provided by Federally Qualified Health Centers, which will take effect on July 1, 2026. The elimination of PPS is estimated to generate \$1 billion in annual savings for the State, by eliminating Medi-Cal revenue that would otherwise be paid to health centers for providing Medi-Cal services to patients. According to the Community Clinic Association of Los Angeles County, health centers in Los Angeles County are expected to lose \$300-\$400 million in annual revenue due to the elimination of PPS for these services. PPS is a stable and predictable financing methodology designed to sustain community health centers and their ability to provide critical health care, including coordination, enabling services, and other wrap-around services to some of the County's most vulnerable communities. The elimination of PPS is expected to

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result in up to a 90 percent reduction in per-patient revenue for patients covered by State-only Medi-Cal. Preserving PPS is critical to the financial viability of health centers, which provide care and services to one in three County residents with Medi-Cal, and are a critical source of care for the growing number of uninsured residents in the County.

Public hospitals are also expected to face increased fiscal challenges due to the growing number of uninsured patients. Unfortunately, public hospital inpatient Medi-Cal payments have not received support from the State's General Fund since 2005. Public hospital systems are a safety net lifeline for patients and are at the frontlines of the impending crisis that will result from the federal H.R. 1. Public hospitals are asking the State to include a \$500 million General Fund appropriation for public hospital systems in the final budget.

Preserving access to essential health care services and ensuring the financial stability of the safety net is particularly critical at a time in which federal Medi-Cal changes resulting from H.R. 1 will further decimate the safety net, including County Hospitals and the many community providers that serve Medi-Cal beneficiaries.

I, THEREFORE, MOVE that the Board of Supervisors direct the Chief Executive Office's Legislative Affairs and Intergovernmental Relations branch, in partnership with the Department of Health Services and the Department of Public Social Services, to send a five-signature letter to Governor Newsom with a copy to the Los Angeles County State delegation members, to the Senate Pro Tempore, the Assembly Speaker, and Chairs of the Senate and Assembly Committees on Budget and Health, in support of the

AGN. NO. _____

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Local Health Plans of California's alternative proposal to moving Medi-Cal beneficiaries with Unsatisfactory Immigration Status (UIS) and some Qualified Non-Citizens (QNCs) from managed care into the Fee-for-Service (FFS) system; in support of the Community Clinic Association of Los Angeles County's request to preserve PPS reimbursement for State-funded Medi-Cal services; and in support of the \$500 million General Fund appropriation request for public hospital systems.

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HLS:jgd