2026 Day at the Capitol Agenda

Monday, April 27, 2026 | CPCA Office, Yosemite

12:00 pm – 3:00 pm	**Political Summit*** *At this summit influential players in California Politics will share their best practices with you for: the importance and function of PAC's and Elections, growing political impact, engagement & influence, complying with campaign finance laws, and much more!*

Tuesday, April 28, 2026 | Sheraton Grand Sacramento Hotel, Gardenia Ballroom

7:30 am - 8:00 am	**Event Registration & Continental Breakfast**
8:00 am – 8:40 am	**Welcome** | *Dennis Cuevas-Romero, Esq., VP of Government Affairs, CPCA Advocates* **Opening Speaker** | *Xavier Becerra, Former US HHS Secretary*
9:00 am - 5:00 pm	**Legislative Visits (Swing Space)**
9:15 am – 10:00 am	**Storytelling as Strategy: From Provider Story to Political Priority** *Every policy issue begins as a story—but not every story becomes a priority. Learn how to frame and deploy narratives that command attention in policy spaces, influence decision-makers, and shape policy outcomes.*
10:30 am – 11:30am	**State Budget 101** *Join the California Budget & Policy Center for an overview of the state budget process, and discussion on budget challenges facing California's healthcare delivery system.* ***Speaker |*** *Adriana Ramos-Yamamoto, Senior Policy Fellow, CA Budget & Policy Center*
11:30 am - 1:00 pm	**Lunch Program** *Francisco J. Silva, Esq., President & Chief Executive Officer, CPCA Advocates*
4:00 pm	**Event Concludes**

Tuesday, April 28, 2026 | Smic's Restaurant & Event Venue

4:30 pm – 6:30 pm	**PAC Reception***

***CPCA Advocates PAC Donation required to attend.**

Schedule Subject to Change

CHCs Top Priorities Talking Points

April 2026

Budget

Restore Full-Scope Medi-Cal for Immigrant Californians (PPS for UIS) – Roll back the cuts made in the 2025-26 State Budget Act, including the enrollment freeze, unaffordable monthly premiums, and elimination of dental benefits for undocumented enrollees, to maintain the state's commitment to health equity. Additionally, retain full health center payments (PPS) for services provided to patients with UIS by community health centers and clinics, or at least delay this proposal until Jan 1, 2028 (reduced rate currently planned to go into effect July 1, 2026). PPS restoration would ensure funding for primary care and support stability of the safety net.

NOTE: The Senate FY 2026-27 Budget Plan delays PPS for UIS elimination until January 1, 2028.

- Senate ASK: Thank them for including UIS delays, including PPS for UIS delay in their budget plan.
- Assembly ASK: *Sign onto **Legislative letter supporting PPS for UIS restoration/delay** (or thank them for signing on) **and** ask to align with the Senate's proposal to delay to 1/1/2028 in their budget plan.*

Gender-Affirming Care (GAC) – Support the $26M budget ask to secure state funding to protect gender-affirming care (GAC) services for individuals under the age of 19 and those who have lost access to healthcare coverage due to federal policy changes. Funding will:

1. Create a state-only billing pathway under Medi-Cal for youth GAC services ($1M); and
2. Bolster the capacity of providers to scale up services for patients who have lost access to care due to hospital youth GAC clinic closures ($25M)

Health Enrollment Navigator Funding – Dedicate $8M in one-time state funding to expand a pool of public/private funding to restore funding for the Health Enrollment Navigators Project to support Medi-Cal outreach, enrollment, and renewal efforts given new and significant changes to the Medi-Cal Program.

- DHCS has the authority to collect up to $2M in private/foundation funding ($4M with federal match). Currently $500K has been dedicated by the Centene Foundation ($1M with federal match).
- No state funding is *currently* dedicated to Health Enrollment Navigators in the upcoming fiscal year, despite current and implementing policy changes that will create new barriers to maintaining Medi-Cal enrollment.

Legislation

AB 2386 (Alvarez): California Physician Expansion Act / CO-SPONSOR

- This bill would create a permanent pathway for physicians that have participated in the Mexican Physician Program. It would also create a pathway for internationally trained physicians that meet educational and training requirements and authorized to work in the U.S.
- 21 states have created pathways for international medical graduates to gain full licensure without completing a post-graduate training in the U.S.

Commented [DC1]: @Laura Sheckler - modify these as you see fit. For PPS, the ask I added in the pwpt deck was for Asssemblymembers to sign on to the sign-on letter and for senate to thank them for putting the delay in their budget blueprint.

(916) 440-8050
CPCAadvocates.org
1231 I Street, Suite 400, Sacramento, CA 95814

- This will be another tool for the state to address the physician shortage, particularly addressing cultural and linguistic competency.

➢ ASK: **support the bill when it reaches the Assembly floor**

SD 1179 (Menjivar): Salvadorean Physicians Program/ CO-SPONSOR

- The bill would take the provisions from the Mexican Physicians Program and extend them to physicians from El Salvador that meet educational and training standards to practice at a FQHC under a non-renewable three-year license.
- The bill would allow a community health center with established relationships with universities in El Salvador to help develop, recruit, and coordinate physicians from El Salvador for the program.
- The bill allows up to 60 physicians to participate in the first cohort of the program with the program expanding in future years.

➢ ASK: **support this bill when it makes it to the Senate floor.**

AB 1768 (Bryan): LA County Tax Cap Exemption / SPONSOR

- The bill would authorize LA and Contra Costa Counties to increase its transactions and use tax at a rate of no more than 0.5 percent.
- For LA County, this bill would allow the ballot initiative, if passed in June, to be operationalized. The tax increase would have a five-year sunset.

➢ ASK: **support AB 1768 and act urgently to pass the full Legislature before mid-June.**

Talking PointsProtect the Safety Net:

Preserve PPS for State-Only Medi-Cal Populations

Talking Points for Health Center and Community Partners

Use the sections below to find the messages that resonate most with your audience. You do not need to use every point. The most powerful testimony combines statewide data with your organization's direct experience.

What Is PPS, and Why Does It Matter?

Use these points to explain the policy basics to legislators or community members unfamiliar with PPS.

- The Medi-Cal Prospective Payment System (PPS) is not a special benefit or a discretionary add-on. It is a federally mandated, cost-based reimbursement structure specifically designed to prevent state Medicaid programs from underpaying safety-net providers.
- PPS covers the full cost of comprehensive, team-based care, including primary care, dental, behavioral health, and enabling services such as transportation, food assistance, and housing navigation.
- Eliminating PPS does not eliminate the obligation to provide care. Community health centers are legally and operationally required to serve all patients regardless of immigration status or ability to pay. Cutting PPS simply means they are no longer reimbursed fairly for doing so.
- On average, less than 20% of reimbursement for a UIS patient visit comes from the managed care organization. PPS provides the other 80%. Eliminating PPS means health centers would receive only 20 cents on the dollar for each UIS visit, for patients they are contractually required to see.
- PPS is the financial foundation that allows community health centers to operate on thin margins while serving the highest-need populations. Without it, the math simply does not work.

Who Is at Risk: The Scale of California's CHC Safety Net

Use these points to convey the breadth and importance of the community health center network.

- California's community health centers operate nearly 2,300 clinic sites and serve 6.2 million Californians each year, including nearly one-third of all Medi-Cal patients.
- Nearly half (44%) of all Medi-Cal primary care visits occur at community health centers. These providers are not supplemental to the safety net; they are its core.
- CHCs are frequently the only source of primary, dental, and behavioral health care in rural and underserved communities. When a community health center reduces services or closes a site, there is often no alternative for patients.
- Nearly 40% of CHC patients have limited English proficiency. Health centers provide culturally and linguistically concordant care that other providers often cannot replicate.

The Fiscal Impact: A $1 Billion Cut That Compounds

Use these points in conversations focused on budget, fiscal policy, or system-level cost.

- The elimination of PPS for state-only Medi-Cal populations, including individuals with Unsatisfactory Immigration Status (UIS), represents an estimated $1 billion annual cut to community health center funding beginning July 1, 2026.
- For clinics already operating on narrow margins, this is not a manageable reduction at the margin. For many, it is an existential threat.

- The $1 billion cut does not exist in isolation. When combined with coverage losses under H.R. 1, including Medicaid work requirements and more frequent redeterminations, and other state budget changes, CHCs are projected to lose at least $1.6 billion in FY 2026-27 alone.
- California's own Office of Health Care Affordability has set a benchmark to double primary care's share of total health spending over the next decade. Cutting CHC reimbursement deepens a structural deficit that already exists and moves the state directly in the opposite direction from its own affordability strategy.
- The Department of Health Care Services (DHCS) has not issued any billing guidance for these impending changes, which will likely lead to operational disruptions if implemented July 1, 2026.

A 2024 Congressional Budget Office report found that community health centers generate a net reduction in federal spending of $3.4 billion by reducing long-term Medicare and Medicaid costs. A recent national study found CHCs saved Medicaid $38.6 billion in 2023 by preventing unnecessary hospital and specialty care. Cutting reimbursement to these providers is not a savings strategy; it shifts costs to more expensive healthcare settings and services.

What Happens When PPS Is Cut: Statewide Impact Patterns

Use these points to describe the on-the-ground consequences of this policy. These are the patterns health centers across California are modeling right now.

- **Reduced access:** Reduced clinic hours and site closures.
  - Health centers operating on narrow margins will have no choice but to shorten operating hours, reduce days of service, or close satellite sites, eliminating access points in communities with no other primary care options.
- **Workforce cuts:** Staff reductions across clinical and non-clinical roles.
  - Workforce reductions reduce clinic capacity to serve existing patients and accept new ones, extending wait times and reducing continuity of care.
- **Loss of specialty and enabling services:** Dental, behavioral health, OB/GYN, optometry, pharmacy, nutrition services, and enabling services such as food assistance, transportation, and housing navigation are the first programs at risk because they are the most heavily cross-subsidized.
  - For patients who cannot access these services elsewhere, their loss means going without care entirely.
- **Emergency department cost shifting:** When patients lose access to primary care, they do not disappear from the health care system. They reappear in emergency rooms at far greater cost to the state. Cutting CHC funding shifts costs; it does not eliminate them.
- **The ripple effect on all patients:** Community health centers cannot segment care by immigration status. Reductions in reimbursement for UIS patients ripple across every patient at the same site, affecting hours, staffing, and services for all low-income Californians who depend on these clinics.

Patient Privacy and Immigration Enforcement Risk

Use these points in conversations with legislators or advocates concerned about civil rights, patient trust, or federal-state tensions.

- Implementing differential billing for UIS patients would require health centers to identify and retain patients' unsatisfactory immigration status in their billing systems. This is a significant departure from current practice.
- At a time when the Centers for Medicare and Medicaid Services is actively pursuing Medicaid data sharing with the Department of Homeland Security and Immigration and Customs Enforcement (ICE), retaining this data in billing systems exposes patients to serious and concrete privacy risks.

- This policy could effectively compel California's community health centers to become passive instruments of federal immigration enforcement, in direct conflict with California's values and patient confidentiality protections.
- When patients fear that seeking care could lead to immigration consequences, they delay or avoid care entirely. This drives up costs, worsens health outcomes, and undermines the public health infrastructure California has built.

What We Are Asking the Legislature to Do

Use these points to close your advocacy conversation with a clear, specific request.

- Preferred action: Fully reverse the elimination of PPS reimbursement for state-only Medi-Cal populations, including individuals with Unsatisfactory Immigration Status. Restoring PPS preserves the financial foundation of the safety net and avoids the cascading harms outlined above.
- Minimum action: Delay implementation for one full fiscal year, to July 1, 2027, to allow the Legislature, the Administration, and stakeholders to develop a comprehensive, sustainable alternative.
- Any alternative solution must preserve full and fair reimbursement for safety-net providers, protect patient data privacy, maintain access to a standardized set of essential health benefits, and include a clear pathway back to full-scope Medi-Cal when fiscal conditions allow.
- Without action before July 1, 2026, the financial harm to health centers begins immediately, and the downstream consequences for patients and communities will follow within months.
- ***NOTE:*** *The Senate FY 2026-27 Budget Plan delays PPS for UIS elimination until January 1, 2028.*
- ***Senate:*** *Thank them for including UIS delays, including PPS for UIS delay in their budget plan.*
- ***Assembly:*** *Ask to include the same delay to 1/1/2028 in their budget plan.*

Your Organization's Story: Fill In the Impact

The most powerful advocacy combines statewide data with local, firsthand experience. Use the prompts below to prepare your organization's testimony or constituent outreach.

How many patients with Unsatisfactory Immigration Status does your organization serve? OR how many UIS patients are served by your health center in your Assembly/Senate district(s)? – *See included spreadsheets*

Your answer:

What is your estimated annual revenue loss under PPS elimination? OR what is the revenue loss to CHCs in your Assembly/Senate district(s)? – *See included spreadsheets*

Your answer:

What specific services, sites, or programs are most at risk at your organization?

Your answer:

What steps is your organization already taking to prepare for or respond to PPS elimination? (e.g., hiring freezes, service reductions, financial modeling)

Your answer:

What would your patients experience if your organization had to reduce hours, services, close a site, or reduce care in another way?

Your answer:

For more information, contact: Laura Sheckler, CPCA Advocates | laura@cpcaadvocates.org | (916) 440-8170 ext. 1023

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GOVERNMENTAL ORGANIZATION
HEALTH
MILITARY AND VETERANS AFFAIRS
REVENUE AND TAXATION
TRANSPORTATION

Assembly
California Legislature

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April 2026

The Honorable Jesse Gabriel
Assembly Budget Committee, Chair
1021 O Street
Sacramento, CA 95814

The Honorable Dawn Addis
Assembly Budget Subcommittee 1, Chair
1021 O Street
Sacramento, CA 95814

RE: PPS Elimination for UIS Population in 2026-27 Budget

Dear Chairs Gabriel and Addis:

I, along with the undersigned Members, write to ask for your support in reversing — or at minimum delaying for one full fiscal year — the elimination of Prospective Payment System (PPS) reimbursement for state-only Medi-Cal populations, including individuals with Unsatisfactory Immigration Status (UIS). This provision was enacted in the 2025 Budget Act and is scheduled to take effect July 1, 2026. Absent legislative action, it will impose an estimated $1 billion annual cut on California's community health centers (CHCs), the providers that serve as the last line of primary care for millions of low-income Californians.

What Is PPS, and Why Does It Matter?

The Medi-Cal Prospective Payment System is not a supplemental benefit or discretionary add-on. It is a federally mandated, cost-based reimbursement structure designed to prevent state Medicaid programs from underpaying safety-net providers. PPS sustains the comprehensive, team-based care model that community health centers deliver, including primary care, dental, behavioral health, and enabling services, for populations with the greatest health needs and the fewest alternatives.

California's nearly 2,300 CHC clinic sites serve 6.2 million Californians annually, representing nearly one-third of all Medi-Cal patients, and are often the sole providers of care in rural and underserved communities. CHCs are federally required and mission-driven to serve all patients regardless of immigration status or ability to pay. When the state eliminates PPS for UIS patients, it does not relieve health centers of their obligation to provide care; it simply stops reimbursing them fairly for doing so.

On average, less than 20% of reimbursement for a UIS patient visit comes from the managed care organization, and 80% comes from PPS. Eliminating PPS effectively means health centers would receive only 20 cents on the dollar for each UIS visit, for patients they remain contractually obligated to serve.

The Fiscal and Human Impact: A System Under Strain

The $1 billion annual PPS cut does not exist in isolation. Combined with federal coverage losses under H.R. 1, including Medicaid work requirements and more frequent redeterminations, and other state budget changes, California's CHCs are projected to lose at least $1.6 billion in FY 2026–27 alone, with losses growing exponentially in subsequent years. This is not a manageable reduction at the margins. It is an existential threat to the primary care infrastructure serving our most vulnerable constituents.

Health centers across California are already modeling the consequences of this policy and the picture is consistent: multi-million dollar annual revenue losses, with no viable path to absorb them without reducing care. The responses health centers are contemplating fall into several categories, each with serious consequences for patients and communities:

- **Reduced clinic hours and site closures.** Health centers operating on narrow margins will have no choice but to shorten operating hours, reduce days of service, or close satellite sites entirely, eliminating access points in communities that often have no other primary care options.
- **Workforce reductions.** Across-the-board cuts to clinical and non-clinical staff are among the most commonly projected responses, reducing the capacity of health centers to serve existing patient panels and accept new patients.
- **Elimination of specialty and enabling services.** Dental, OB/GYN, behavioral health, optometry, podiatry, pharmacy, and nutrition services, along with enabling services such as food assistance, transportation, and housing navigation, are the first programs at risk. These are services that low-income patients cannot access elsewhere and that directly address the social determinants of health.
- **Displacement of patients to emergency departments.** When patients lose access to primary care, they do not disappear from the health care system; they reappear in emergency rooms at far greater cost to the state. This is the predictable and inevitable consequence of dismantling the primary care safety net.

It bears emphasis that CHCs cannot segment care delivery by immigration status. Reductions in reimbursement for UIS patients ripple across every patient served at the same site, reducing hours, staffing, and specialty services for all low-income Californians who depend on these clinics.

An Additional Risk: Patient Privacy and Immigration Enforcement

Implementing differential billing for UIS patients would result in health centers identifying and retaining patients' unsatisfactory immigration status in their billing systems. At a time when the Centers for Medicare and Medicaid Services (CMS) is actively pursuing Medicaid data sharing with the Department of Homeland Security and Immigration and Customs Enforcement, this policy would place clinics at the intersection of federal enforcement actions and expose patients to serious data privacy risks. California should not compel its community health centers to become instruments of federal immigration enforcement.

We respectfully ask you to join me in urging the Legislature and the Administration to take one of the following actions:

- **Preferred:** Fully reverse the elimination of PPS reimbursement for state-only Medi-Cal populations, including individuals with Unsatisfactory Immigration Status.
- **Minimum:** Delay implementation for one full fiscal year, to July 1, 2027 to allow the Legislature, Administration, and stakeholders to develop a comprehensive, sustainable alternative.

Any alternative solution must preserve full and fair reimbursement for safety-net providers, protect patient data privacy, maintain access to a standardized set of essential health benefits, and include a pathway to return to full-scope Medi-Cal when fiscal conditions permit.

California's community health centers are the backbone of the primary care safety net. The decisions this Legislature makes in the coming weeks will determine whether that backbone holds. I urge you to stand with me in protecting the clinics, the communities, and the patients who depend on them.

Sincerely,

Assemblymember Juan Carrillo
California State Assembly, 39th District


TRANSFAMILY SUPPORT SERVICES
NAVIGATION FOR THE JOURNEY
ALLIANCE FOR TRANSYOUTH RIGHTS
Planned Parenthood Act. No matter what.
Planned Parenthood Affiliates of California
FOR ALL
EQUALITY CALIFORNIA
LAMBDA LEGAL
ACLU CALIFORNIA ACTION
LOS ANGELES LGBT CENTER
THE TREVOR PROJECT
For Young LGBTQ+ Lives
Public Counsel
CPCA ADVOCATES
EAST BAY COMMUNITY LAW CENTER
RAINBOW FAMILIES ACTION
SIPA
THE LANDING SPOT
NATIONAL HEALTH LAW PROGRAM
BLACK WOMEN FOR WELLNESS ACTION PROJECT
CALIFORNIA CALPRIDE EST. 2024
Advocates For Justice
TransCanWork
LYON MARTIN COMMUNITY HEALTH
HMONG INNOVATING POLITICS
TransLatin@ COALITION
IMPACT FUND
Strategic Litigation for Social Justice
Casita Feliz
LATINE LGBTQ+ CENTER
The Children's Partnership
Nourish California
Okaeri Community
A Program of Little Tokyo Service Center
LYRIC
CENTER FOR LGBTQQ+ YOUTH
CALIFORNIA LGBTQ HEALTH AND HUMAN SERVICES NETWORK
SOLANO PRIDE CENTER
CALIFORNIA LATINAS for REPRODUCTIVE JUSTICE
OCGAPNet
Gender Affirming Professionals
ASIAN AMERICANS ADVANCING JUSTICE SOUTHERN CALIFORNIA
COURAGE CALIFORNIA
Rainbow Labs
CFT
A Union of Educators & Classified Professionals
Gender Alchemy
INDIVISIBLE SF
SOMOS FAMILIA VALLE
THE SAN DIEGO LGBT COMMUNITY CENTER
our family coalition
URGE CA
UNITE FOR REPRODUCTIVE & GENDER EQUITY ★ CALIFORNIA
ROC
SBC SAN BERNARDINO BP
HARVEY MILK LGBTQ DEMOCRATIC CLUB
GENTE ORGANIZADA
JEWISH CENTER FOR JUSTICE
Transgender Health & Wellness Center
SAN FRANCISCO AIDS FOUNDATION
LGBTQ CENTER
PRIDE AT THE PIER
Trans-E-Motion
the SOURCE LGBT+ CENTER
Pomona Valley Pride
CALIFORNIA Work & Family COALITION
LYON MARTIN COMMUNITY HEALTH
T.R.A.N.S.
Viet VOICES
ACCESS REPRODUCTIVE JUSTICE
TRI-COUNTY DIVERSITY YUBA | SUTTER | COLUSA
MIRROR MEMOIRS
GAYLESTA
Aging & HIV INSTITUTE
SANTA CRUZ COMMUNITY HEALTH
Alianza TranslatinX
SAN DIEGO PRIDE
NEVADA COUNTY PRIDE
SACRAMENTO LGBT COMMUNITY CENTER
GENDER JUSTICE LA
Celebrating 40 Years in the Bay Area
PFLAG SAN JOSE / PENINSULA
pflagsanjose.org
PLACER LGBTQ+ CENTER
SFLGBT CENTER
CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Putting Health Care Where Kids Are
LAVENDER PHOENIX
PFLAG OAKLAND/EAST BAY
PFLAG CLAYTON-CONCORD
PFLAG TRI-VALLEY
PFLAG SAN FRANCISCO
PFLAG MANHATTAN BEACH SOUTH BAY
PFLAG FRESNO
PFLAG SACRAMENTO
PFLAG MORAGA / LAMORINDA

February 19, 2026

The Honorable Gavin Newsom
Governor, State of California
1021 O Street, Suite 9000
Sacramento, CA 95814

The Honorable Monique Limón
Senate President pro Tempore
1021 O Street, Suite 8518
Sacramento, CA 95814

The Honorable John Laird
Chair, Senate Budget Committee
1020 N Street, Room 502
Sacramento, CA 95814

The Honorable Robert Rivas
Speaker of the Assembly
1021 O Street, Suite 8330
Sacramento, CA 95814

The Honorable Jesse Gabriel
Chair, Assembly Budget Committee
1021 O Street, Suite 8230
Sacramento, CA 95814

Re: Support for $26 Million One-Time Investment to Protect Access to Transgender Health Care

Dear Governor Newsom, Pro Tem Limón, Speaker Rivas, Chair Laird, and Chair Gabriel:

On behalf of a coalition of LGBTQ+, health, and civil rights organizations representing patients, families, and providers across California, we respectfully urge your support for a $26 million one-time General Fund investment to stabilize and protect access to health care for transgender, gender-diverse, and intersex (TGI) Californians. This one-time, narrowly targeted investment will serve as a critical bridge to stabilize California's gender-affirming care delivery system—preventing irreversible provider withdrawals, protecting patients from dangerous gaps in care, and ensuring continued compliance with California's nondiscrimination and coverage mandates.

California is home to the largest TGI population in the nation, including an estimated 263,700 transgender adults and 84,600 transgender youth. The state has long led the country in recognizing gender-affirming care as medically necessary, evidence-based treatment essential to the health and well-being of TGI people. Under California law, individuals are guaranteed access to medically necessary gender-affirming care without discrimination.

Despite the state's strong legal protections, escalating federal actions are destabilizing California's care infrastructure—particularly for transgender youth. Federal executive actions, investigations, coverage exclusions, and proposed rulemaking have generated widespread uncertainty around the use of federal

funds for gender-affirming care. Most notably, the Centers for Medicare and Medicaid Services (CMS) released two proposed rules that would prohibit the use of federal Medicaid and Children's Health Insurance Program funds for transition-related care for transgender youth and bar hospitals that provide this care from participating in Medicare or Medicaid altogether. If finalized, these rules would effectively force hospitals and many providers to discontinue care for transgender youth, even when medically necessary and required under state law.

The impacts of these federal actions are already being felt across the state. In July 2025, Children's Hospital Los Angeles closed its gender-affirming care clinic, abruptly discontinuing care for approximately 3,000 patients. In January 2026, Rady Children's Hospital and Children's Hospital of Orange County also ended gender-affirming care for youth, further shrinking access to care in Southern California.[1] Other major providers have ended gender-affirming surgical care for patients under 19, with additional providers signaling plans to pause or discontinue services. Because hospitals have historically served as primary providers of youth gender-affirming care, these preemptive actions have been especially disruptive, leaving families scrambling for care and overwhelming community-based providers.

At the same time, changes to federal health programs are compounding these harms. TRICARE now excludes coverage of gender-affirming care for youth. The Department of Veterans Affairs is phasing out coverage for veterans of all ages. The Federal Employees Health Benefits Program and the Postal Service Health Benefits Program eliminated coverage for transgender people of all ages beginning in January 2026. These changes have displaced patients into already overstretched community health centers, increased uncompensated care, and, in some cases, left individuals without access to care entirely. These impacts fall most heavily on low-income families and Medi-Cal beneficiaries, for whom alternative care options are limited or nonexistent.

Taken together, these federal actions have created a chilling effect across California's health care system. Providers face growing fear of audits, enforcement actions, loss of federal funding, and mounting uncompensated care costs, discouraging them from continuing to offer care that remains legal and required under state law. Without targeted state intervention, provider withdrawals will only accelerate, further undermining access to care statewide.

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[1] Although Rady Children's Hospital and Children's Hospital of Orange County announced plans to end gender-affirming care for youth, California Attorney General Rob Bonta filed litigation challenging these actions, and both hospitals must continue providing gender-affirming care while the case proceeds.

To prevent further collapse of California's gender-affirming care delivery system and ensure continued compliance with state nondiscrimination and coverage mandates, we respectfully request a $26 million one-time General Fund appropriation to establish a state-backed continuity and provider stabilization framework for transgender health care. This investment would provide immediate, time-limited support while federal policy changes and litigation unfold, including:

State-only Medi-Cal Coverage and Billing Pathway ($1 million):
Enable the Department of Health Care Services to establish a state-only Medi-Cal billing and reimbursement pathway for gender-affirming care, separate from federal financial participation. This pathway is essential to maintain continuity of care for Medi-Cal beneficiaries and prevent further erosion of the provider network.

Provider Network Stabilization and Uncompensated Care Grants ($25 million):
Provide targeted grants to stabilize, rebuild, and expand the gender-affirming care provider network—particularly for transgender youth—while offsetting growing uncompensated care costs. Allowable uses would include staffing and infrastructure support, operational support for clinics absorbing displaced patients, workforce recruitment and retention, targeted malpractice insurance support for providers opening stand-alone clinics, and reimbursement for uncompensated care delivered to individuals earning up to 400 percent of the federal poverty level who are enrolled in plans with coverage exclusions.

Thank you for your careful consideration of this proposal, which is urgently needed to stabilize California's gender-affirming care delivery system, protect patient access to medically necessary services, and preserve California's leadership in ensuring equitable access to health care for all. If you have any questions, please do not hesitate to contact Equality California's Legislative Director, Craig Pulsipher, at craig@eqca.org or (916) 444-7807, or the California Primary Care Association's Director of Budget Advocacy and Strategic Policy, Laura Sheckler, at lsheckler@cpca.org or (916) 440-8170 ext. 1023.

Sincerely,

Access Reproductive Justice
ACLU California Action
Aging and HIV Institute
AJL Community Health LLC
Alianza Translatinx
Alliance for TransYouth Rights
Asian Americans Advancing Justice Southern California
Black Women for Wellness Action Project

California Latinas for Reproductive Justice
California LGBTQ Health and Human Services Network
California Rural Legal Assistance Foundation
California School-Based Health Alliance
California Work & Family Coalition
CalPride Valle Central
Casita Feliz Latine LGBTQ+ Center
CFT
Courage California
CPCA Advocates
East Bay Community Law Center
Equal Rights Advocates
Equality California
Essential Access Health
Gaylesta
Gender Affirming Professionals
Gender Alchemy
Gender Justice LA
Gente Organizada
Harvey Milk LGBTQ Democratic Club
Hmong Innovating Politics
Impact Fund
Indivisible San Francisco
Jewish Center for Justice
Lambda Legal
Lavender Phoenix
LGBTQ Center OC
Linda K. Reeves Marriage & Family Therapy, Inc.
Los Angeles LGBT Center
Lyon-Martin Community Health Services
LYRIC
Mirror Memoirs
National Health Law Program
Nevada County Pride
Nourish California
Okaeri, a Program of Little Tokyo Service Center
Our Family Coalition
PFLAG Clayton-Concord
PFLAG Fresno
PFLAG Lamorinda
PFLAG Manhattan Beach/South Bay
PFLAG Oakland/East Bay
PFLAG Sacramento
PFLAG San Francisco

PFLAG San Jose / Peninsula
PFLAG Tri-Valley
Placer LGBTQ+ Center
Planned Parenthood Affiliates of California
Pomona Valley Pride
Pride at the Pier
Public Counsel
Rainbow Families Action
Rainbow Labs
Sacramento LGBT Community Center
San Bernardino County Black Pride
San Diego Pride
San Francisco AIDS Foundation
San Francisco LGBT Community Center
Santa Cruz Community Health Centers
Search to Involve Pilipino Americans
Solano Pride Center
Somos Familia Valle
Sound Mind Neurofeedback & Healing Center
The Children's Partnership
The Landing Spot
The San Diego LGBT Community Center
The Source LGBT+ Center
The TransLatin@ Coalition
The Trevor Project
Transcanwork
Trans-E-Motion
TransFamily Support Services
Transgender Health & Wellness Center
Transgender Resource Advocacy & Network Service (T.R.A.N.S.)
Tri-County Diversity
URGE: Unite for Reproductive & Gender Equity
Viet Rainbow of Orange County
Viet Voices
Western Center on Law & Poverty

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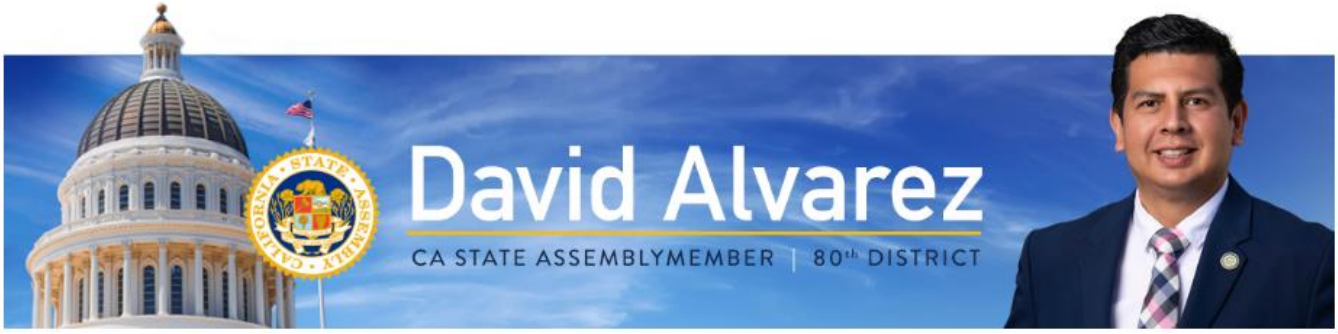

AB 2386: California Physician Expansion Act

Summary:

One quarter of California's population lives in health professional shortage areas, causing many residents to travel a long distance to access care for themselves and their families. To address this critical gap, AB 2386 seeks to expand California's healthcare workforce by creating new pathways for international physicians. By doing so, the bill aims to not only alleviate the physician shortage but also promotes more culturally responsive care for communities across the state.

Background:

California and Mexico share a unique relationship rooted in geographic proximity, economic integration, and strong cultural ties. This interconnectedness extends beyond trade and labor markets to include public health and shared innovation. Recognizing the value of culturally responsive care, the state launched the Mexican Pilot Program in 2002 to increase healthcare access for Latin populations. Through this initiative, 30 licensed physicians from Mexico provided care in underserved community health centers in California. Although the program demonstrated success, its three-year temporary license limit and restrictions on the number and specialty of participating physicians limited its lasting impact, leaving the broader physician shortage unaddressed.

Problem:

Despite these targeted programs, healthcare accessibility remains a pressing issue across the state. Physicians are unevenly distributed, with economic factors, personal preferences, and a lack of training programs in underserved areas deterring doctors from practicing in high-need regions such as the Inland Empire, Northern and Sierra regions, and the San Joaquin Valley. By 2030, California will require an estimated 8,243 additional physicians to meet residents' basic health needs, as nearly 11 million Californians currently lack adequate physician access. Without new solutions, more residents will resort to emergency rooms for treatable conditions like asthma, ear infections, or the flu, simply because primary care clinicians are unavailable. These populations already experience significant delays in care, from traveling long distances for appointments to facing longer wait times and worsening health outcomes. Language barriers further compound these challenges, increasing the risk of miscommunication and limited access to interpreter support.

Solution:

AB 2386 builds on the lessons of the Mexican Pilot Program by establishing a provisional license for international physicians. International physicians will still undergo California's rigorous application process, but with flexible requirements that recognize their training and experience abroad. After a successful provisional period, these physicians will be eligible for permanent licensure. This measure ensures that communities receive the care they need, which will help preserve and strengthen healthcare accessibility for all Californians. By integrating international medical talent into California's workforce, AB 2386 offers a sustainable, culturally responsive solution to the state's evolving healthcare needs.

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Support:
California Primary Care Association (co-sponsor)
Alta Med (co-sponsor)

Senate Bill 1179

Salvadorean Physicians Program

Senator Caroline Menjivar (D – San Fernando Valley)

SUMMARY

SB 1179 seeks to address the bilingual physician workforce shortage in California by mirroring the existing Mexican Physicians program and allowing Physicians from El Salvador to provide care in disenfranchised communities for a limited time.

PROBLEM

The United States stands to experience a physician shortfall of 86,000 by 2036.[1] The numbers are even worse when considering physicians with cultural competency and bilingual expertise. This is compounded by the increased need for physicians amid the growth and aging of the U.S. population,[2] combined with low pay and relative lack of notoriety associated with primary care.[3]

Language competency is tied to key determinants of health, as these linguistic connections are directly linked to better interpersonal communication, improved access to care, mutual trust, and ultimately improved satisfaction in patient-doctor relationships.[4] The report determined that if the state maintains the rates that we are in, it will take approximately 5 centuries to fully address the disparities.[5]

According to the California Healthcare Workforce Commission, approximately 7 million Californians live in a Health Professional Shortage Area, a federal designation for counties that have a shortage of primary care, dental, or mental health care providers. To address this, the federal government has designated Federally Qualified Health Centers (FQHCs), also known as Community Health Centers, as primary care clinics that receive federal funds to provide healthcare services to underserved populations. While there is a strong need to serve these areas, the reality is that these centers are placed in a difficult position. To provide a positive learning experience for trainees, they have to call upon an already overextended primary care workforce to spend time training and teaching the next generation of physicians.[6]

BACKGROUND

Given California's workforce shortage over the years, the state has sought innovative ways to ease the burden. One of those initiatives has been integrating physicians from Mexico through the Licensed Physicians and Dentists from Mexico Pilot program established in AB 1045 (Firebaugh Chapter 1157, Statutes of 2002). While it took many years to stand up the program due to structural issues, the program became permanent in 2024. Recent legislation, AB 2860 (Garcia, Chapter 246, Statutes of 2024), addressed capacity issues and raised the number of doctors from 30 to 125 beginning in 2025.

The University of California, Davis, was tasked with evaluating the Mexico Dentist and Doctor program, and it documented its findings in its final August 2025 Annual report.[7] They found that many patients had positive experiences due to cultural and linguistic alignment, which helped build greater rapport and improve access to services. Additionally, they concluded that health care was more accessible and that discontinuing the program would have devastating consequences for participating FQHCs, severely compromising their ability to deliver timely, high-quality, and accessible care to the patients they serve.

SOLUTION

SB 1179 will replicate the existing proven framework for the Mexico Physicians Program and extend it to doctors from El Salvador to provide care in Federally Qualified Health Centers and any corresponding hospitals serving underserved communities for a maximum period of 3 years.

Specifically,

[1] Adashi EY, O'Mahony DP, Gruppuso PA. The National Physician Shortage: Disconcerting HRSA and AAMC Reports. J Gen Intern Med. 2025 Nov;40(14):3469-3472. doi: 10.1007/s11606-025-09575-7. Epub 2025 May 6. PMID: 40329027; PMCID: PMC12586245.
[2] Adashi EY, O'Mahony DP, Gruppuso PA. The National Physician Shortage: Disconcerting HRSA and AAMC Reports. J Gen Intern Med. 2025 Nov;40(14):3469-3472. doi: 10.1007/s11606-025-09575-7. Epub 2025 May 6. PMID: 40329027; PMCID: PMC12586245.
[3] California's primary care shortage persists despite ambitious moves to close gap - Los Angeles Times
[4] https://latino.ucla.edu/wp-content/uploads/2021/08/LPPI-CPS-Summary.pdf
[5] https://latino.ucla.edu/wp-content/uploads/2021/08/LPPI-CPS-Summary.pdf
[6] https://futurehealthworkforce.org/wp-content/uploads/2025/10/FutureHealthWorkforceCommission_FinalReport.pdf
[7] lpmpp-final-report.pdf

- The physicians must be licensed, certified, or recertified and in good standing in the applicable medical specialty in El Salvador and meet the same requirements that were applied under the Mexico Physicians Program.
- The physicians would be required to undergo the same orientation structure that includes medical protocols, Community Clinic history and operations, Medical Administration, Medical ethics, and California Medical delivery systems.
- The participating locations would be required to work with a California Medical school or residency program to conduct secondary reviews and ensure compliance with the program and Medical Quality Assurance protocols.

STATUS

Introduced- February 18, 2026

SUPPORT

Clínica Monseñor Oscar A. Romero (Co-Sponsor)
California Primary Care Association (Co-Sponsor)

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