Protect 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 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.

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