COMMITTEES
CHAIR, LOCAL GOVERNMENT
GOVERNMENTAL ORGANIZATION
HEALTH
MILITARY AND VETERANS AFFAIRS
REVENUE AND TAXATION
TRANSPORTATION

Assembly
California Legislature

JUAN CARRILLO
CHAIR, LOCAL GOVERNMENT
ASSEMBLYMEMBER, THIRTY-NINTH DISTRICT

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0039
(916) 319-2039
FAX (916) 319-2139

DISTRICT OFFICES
PALMDALE OFFICE
823 EAST AVENUE Q-9, SUITE B
PALMDALE, CA 93550
(661) 266-3908
FAX (661) 266-3931

VICTORVILLE OFFICE
16519 VICTOR STREET, SUITE 301
VICTORVILLE, CA 92395
(760) 530-0139
FAX (760) 530-0140

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