BOARD OF GOVERNORS

Executive Committee Meeting

May 23, 2025 • 1:30 PM

Lobby Conference Room 100

1055 W. 7th Street, Los Angeles, CA 90017

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017.
Public meetings will continue to be held in the Board Room at 1055 W. 7th Street.

DRAFT

AGENDA

Executive Committee Meeting
Board of Governors

Friday, May 23, 2025, 1:30 P.M.
1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m381cc8945e194c69b599daf8994a491d
To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number 2489 042 6192 Password: lacare

Teleconference Site
John Raffoul
2423 Salalmanca, La Verne, CA 91750

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda.
The process for public comment is evolving and may change at future meetings.
All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Ilan Shapiro, MD, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve the April 23, 2025 Meeting Minutes p.5 — *Chair*
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report p.16 — Martha Santana-Chin, *Chief Executive Officer*
   - Government Affairs Update — Cherie Compartore, *Senior Directors, Government Affairs*
     - 2025-2026 May Revise

Committee Issues

6. Approve Consent Agenda Items for June 5, 2025 Board of Governors Meeting — *Chair*
   - May 1, 2025 Board of Governors Meeting Minutes
   - Quarterly Investment Report
   - Regional Community Advisory Committee Membership

- Ratify elected Executive Community Advisory Committee Chairperson, Maritza Lebron, and Vice Chairperson, Estela Lara.

7. Public Comment on Closed Session Items *(Please read instructions above.)* *Chair*

ADJOURN TO CLOSED SESSION (Est. time: 40 mins.) *Chair*

8. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Technology, Business Plan
Estimated date of public disclosure: *May 2027*

9. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates

10. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Initiation of Litigation Pursuant to Paragraph (4) of Subdivision (d) of Section 54956.9 of the Ralph M. Brown Act
One Potential Case

11. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant Exposure (3 cases)
Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act

12. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
- Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

14. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: CEO
Agency Designated Representative: Ilan Shapiro, MD
Unrepresented Employee: Martha Santana-Chin

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Committee meeting is scheduled on Friday, June 27, 2025 at 1:30 p.m.
and may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:

1. At L.A. CARE'S Website: http://www.lacare.org/about-us/public-meetings/board-meetings
2. L.A. Care's Reception Area, Lobby, at 1055 W. 7th Street, Los Angeles, CA 90017, or
3. by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Committee Members regarding any agenda item for an open session after the agenda and meeting materials have been posted will be available for public inspection by email request to BoardServices@lacare.org

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – April 23, 2025
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members
Ilan Shapiro, MD, MBA, FAAP, FACHE, *Chairperson*
John G. Raffoul, V*ice Chairperson**
Stephanie Booth, MD, *Treasurer*
Nina Vaccaro, *Secretary*
Alvaro Ballesteros, MBA*
G. Michael Roybal, MD

Management/Staff
Martha Santana-Chin, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Linda Greenfeld, *Chief Product Officer*
Todd Gower, *Interim Chief Compliance Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Alex Li, MD, *Chief Health Equity Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

**Absent*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ilan Shapiro, MD, *Chairperson,* called to order at 2:05 pm the meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee. The meetings were held simultaneously. He provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The agenda for today's meeting was approved.	**Approved unanimously. 4 AYES (Booth, Roybal, Shapiro, and Vaccaro)**
PUBLIC COMMENT	There was no public comment.	
APPROVE MEETING MINUTES	The minutes of the March 26, 2025 meeting were approved.	**Approved unanimously. 4 AYES**
APPROVE CONSENT AGENDA ITEMS FOR MAY 1, 2025 BOARD OF GOVERNORS MEETING	Approve Consent Agenda Items for May 1, 2025 Board of Governors Meeting • April 3, 2025 Board of Governors Meeting Minutes • Revised 2025 Board and Committee Meeting Schedule • Authorize L.A. Care Management to establish and maintain fund balance reserves pursuant to Governmental Accounting Standards Board (GASB 54), and to delegate	**Approved unanimously. 4 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	authority to the Chief Financial Officer to assign reserve amounts in accordance with the approved policy. • Regional Advisory Community Committees (RCACs) membership • Ratify elected Executive Community Advisory Committee At-Large Members: Deaka McClain and Brynette Cruz	
CHAIRPERSON'S REPORT	Chairperson Shapiro reported that he will appoint members to the ad hoc Legislative Committee to address urgent legislative and regulatory issues that may arise between Board meetings. This will help L.A. Care to be quick and nimble in responding to potential impacts to members and to the health plan. He encouraged all Board Members, and especially members of the Executive Committee, to participate in RCAC meetings throughout the year, to listen to the L.A. Care members and learn about the member experience.	
CHIEF EXECUTIVE OFFICER'S REPORT	Martha Santana-Chin, *Chief Executive Officer*, reported that the senior leadership and a number of other leaders within the organization have been reviewing L.A. Care's strategic plan. A two-day session is planned May 5-6 to finalize a plan. The plan is informed by feedback from a variety of stakeholders and is building on strong foundational work by L.A. Care over the last several years. The strategic plan will take advantage of capital investments and the work done in remediation of the enforcement actions. All those things are included and incorporated in the strategic plan. She requested that the ad hoc legislative committee meet by mid-June to review the strategic plan before it is final. L.A. Care needs to consider measures at the federal and state levels and infuse that into the strategic planning. In the meeting materials are a series of letters, articles, and information that members might find useful in raising awareness around issues that could come to pass if proposed federal cuts are made to programs for L.A. Care members. A key strategy for L.A. Care is to participate in coalitions with a national perspective, to address districts for members of Congress that will have an influence on the proposals. The information included is from organizations such as the California Association of Health Plans, the Partnership for Medicaid, and Medicaid Health Plan Association. There is a letter from twelve Republican members of Congress on the Health Committee, jointly opposing Medicaid cuts. They are the first Republican Congressional members to take this stance.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Roybal referenced the letter sent by the members of Congress to their leadership and noted that it looks like most are in red districts that either went for Biden or are Biden adjacent, and asked if it was a strategy for representatives to align advocacy. Ms. Santana-Chin responded that most of the coalitions that L.A. Care participates with have specifically been educating those members in particular because they are in swing districts and are more moderate members of Congress. In California, L.A. Care has partnered with its sister health plans to arm them with support or information to really make the case. The representatives seem to be at least listening. Board Member Booth thanked her for information because it reads like a list of talking points. Noah Paley, *Chief of Staff*, thanked Chairperson Shapiro for mentioning the RCACs and encouraging Board members to attend the meetings. He and Ms. Santana-Chin attended a RCAC meeting last week. The meetings are amazing forums, and as noted in the CEO Board report this month, the Community Outreach and Engagement (CO&E) Staff has been developing and refining proposals to improve administration of the Community Advisory Committees. A goal is to ensure suitable diversity of inputs, inclusive accountability, and equitable representation. CO&E staff will be reviewing the proposals with senior leadership early next week. The overriding objective is to address member concerns about the diversity of the advisory committees, the accountability of community representatives and leaders, and the barriers that members perceive to being heard and providing meaningful input. To that end, staff is crafting proposed statements of work for engaging experienced consultants to achieve three things: 1. Facilitate listening sessions with RCAC members about diversity concerns and suggestions for improving committee meetings. 2. Enhance the leadership capacity of RCAC Chairs and Vice Chairs. 3. Provide additional training to CO&E staff about inclusive practices for enabling a diversity of member inputs. In addition to vetting and engaging experienced consultants to facilitate these discussions and provide the training and capacity building for advisory committee members, RCAC leaders, and staff, other proposals under consideration will be reviewed early next week which include modifying current advisory committee meeting agendas to provide time for members to discuss topics of their choosing. As presently	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	conceived, the idea would be for members to decide on appropriate discussion topics at a prior meeting and establish their own workable rules for managing the discussion and governing how fellow members can provide input on the previously selected topic. Each RCAC has discretion to decide by majority vote to modify the format of the meeting agendas to establish these proposed topic-specific forums and to decide on the rules of order during the forums. In other words, these modifications would not require a change to the ECAC/RCAC operating rules. Finally, RCAC meeting enhancement options will be shared with the ECAC and RCAC members for their consideration and discussion, facilitated by the consultants engaged for that purpose. Chairperson Shapiro commented that he has heard a lot of governance information and there is history about how things had been done, how they are being done now. He asked about L.A. Care's role, we want to include them, but operation-wise, can L.A. Care guide them or are advisory committees an independent body. Sameer Amin, *Chief Medical Officer*, clarified the question as how forward L.A. Care can be in guiding advisory committees while listening and understanding the concerns. He noted that Chairperson Shapiro has attended and is familiar with RCAC meetings. L.A. Care staff facilitates the discussions. The RCAC members have some self-regulation in the rules the committees have set up. At times there are challenges in following the existing rules and there is a need to create some space within the construct to be able to have an open discussion. L.A. Care attempted to introduce the open conversation format in the restructure about a year ago, and there was some controversy because members felt it would be a separate meeting with different membership, and they were not comfortable with the idea. To facilitate the new structure, that concept was abandoned. This could be a way to bring it back in a way members understand, with a new setting for open discussion. Dr. Amin noted that through some of the L.A. Care Access, Service & System Optimization (LASSO) work around understanding member feedback, there will now be staff from health services and across the organization at the RCAC meetings on a regular basis. Ms. Santana-Chin clarified his question is about the construct under which these committees are formed, what are the requirements for L.A. Care for the existing committee structure, and how much latitude and authority do the members have. She	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	wants to clarify so that, if an answer cannot be given today, staff could provide the information after the meeting. Chairperson Shapiro would like more information on the structure and understand how it works. He is very happy to hear that members are going to be part of the conversation, and the effort that L.A. Care is doing to bring specialists to uplift the voices of everybody. Ms. Santana-Chin responded that staff could send all kinds of important documentation, but staff has pulled together a set of proposed recommendations to make this work better. Augustavia Haydel, *General Counsel,* and the team are looking at ways to refine the structure to make advisory committees work. The proposed structure will be reviewed with the Executive Committee and eventually the Board. It will be organized in a way that is easy to understand. At a very high level, staff is trying to make the Board meeting productive by: • Having an appropriate way to share perspectives, concerns and ideas, etc. • Addressing some of the issues that have been heard, that certain segments of the membership population do not feel heard, do not feel like the diversity is being respected in these conversations. • Addressing the concern that it used to work before, it doesn't work anymore, change it back. Another step to address complaints during public comment is for Board Members and Leadership to attend RCAC meetings. Ms. Santana-Chin's initial observation is that there is variability in how the agendas are set, how they are being facilitated, the meeting dynamics and the agenda topics the RCAC is addressing. There might be a way to streamline that. There is also an opportunity to be strategic with the topics that RCAC members discuss, so the members are empowered to make a difference in the community, and an opportunity for L.A. Care to hear what is important to the members. These are some challenges and opportunities that leadership is considering. L.A. Care has identified consultants to facilitate the meetings taking all the community concerns into account. Staff will provide recommendations at a future meeting. Mr. Paley noted that the restructure had included proposed separate roundtable meetings for topic specific discussions. The roundtable idea involved extra administration and additional stipends. Member feedback indicated they wanted to participate in both RCAC and roundtable meetings or they were feeling disenfranchised.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Staff is proposing to include the roundtable discussion in the RCAC meetings to optimize the value of the RCAC meetings by including an open forum for a pre-selected topic. Going back to the question about authority and the rubric for RCACs, as part of the procurement contract with the Department of Health Care Services (DHCS) and the enabling legislation, L.A. Care is obligated to have consumer advisory committees. The process for approving the changes required by DHCS required a modification to the Consumer Advisory Committee Operating Rules, and the Executive Community Advisory Committee (ECAC) must review and approve changes to those Rules. In turn, ECAC places the revised Rules on the Board agenda for review and approval. The recent proposed update to the Rules would be self-directed with expert guidance from consultants, to be decided by the members. At the RCAC meeting last week, Ms. Santana-Chin responded directly to member concerns about diversity issues, and about access to primary and specialty care services at one clinic. It was a very good discussion, and it was decided that a motion would be submitted to the ECAC for review and approval and then placed on the Board agenda. The process that has been established and the great work done by Dr. Amin and his team on the LASSO project has created an intake mechanism for member concerns and has gone a long way to improving member perceptions about the ability to provide meaningful input through the RCACs. L.A. Care can now follow through and implement the proposals to further support member feedback. Chairperson Shapiro thanked Mr. Paley for the information about the structure, the possibilities and the future. Board Member Booth asked about involvement of consultants. Mr. Paley responded that experts would facilitate the discussions at RCAC meetings. There are six consultants under consideration, five were recommended by Supervisor Holly J. Mitchell. The goal is to retain up to three consultants for purposes described earlier. L.A. Care will ensure engagement with members about diversity concerns, build capacity for RCAC leaders and members to recognize their accountability to one another and to the entire membership of L.A. Care. RCAC members represent the voice of L.A. Care members. The consultants will facilitate additional training to staff to recognize and enable a sufficient diversity of input. He reported at a recent RCAC 5 meeting, the staff accomplished that task, by facilitating a postponement of discussion to allow adequate diverse input from the RCAC members. The discussion was about changing the location of the RCAC meeting, and it was tabled at the suggestion of CO&E staff so more information and input could be gathered. The primary goal is to give members	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	the opportunity to reach appropriate clear consensus and to govern themselves to facilitate meaningful inputs to L.A. Care, with the assistance of discussion facilitators. Board Member Roybal asked about how L.A. Care will work with the Chairs and the Vice Chairs of RCAC, to help them grow into their role and learn to manage a meeting. Mr. Paley responded it is part of the proposal. Board Member Roybal noted it is a good way to help develop members, so that they learn those skills. Modeling meeting management will help future RCAC leaders also gain those skills. He suggested that RCACs have a Chair-designee, so the next chair will have an opportunity to learn.	
• Government Affairs Update	*Ms. Santana-Chin reported on Government Affairs during her CEO Report above.*	
COMMITTEE ISSUES		
L.A. Care Network Community Relief Fund Update	Ms. Santana-Chin commended Shavonda Webber-Christmas, *Director, Community Benefits,* for her work in the community to be sure L.A. Care is using its resources wisely. Ms. Webber Christmas noted that the Board of Governors approved $10 million for a wildfire relief fund, now referred to as the L.A. Care Network and Community Relief Fund (*a copy of her presentation can be obtained by contacting Board Services).* Initially, the purpose was to provide supplemental assistance in several funding rounds. The relief fund planning has evolved from external and internal input, and is guided by a national disaster recovery framework, the 2025 California disaster response overview, and we've been learning through many other collaborative opportunities to meet with and engage multiple partners. Within ten days of the fires, L.A. Care staff was talking and having meetings with concerned organizations. A monthly cross-sector collaborative meeting expanded to include the wildfires, and Cal OES has been instrumental in coordinating response for fire relief. California Community Foundation and United Way are the largest funders and have met with Ms. Webber Christmas and her team to give guidance and provide information about their plans and implementation. Other funders responding, including the Annenberg Foundation, have been collaborative. There are existing collaboratives with other health plans and health systems like Cedars, UniHealth and other foundations as well, communicating on where the needs are.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Core purposes are advancing recovery and rebuilding communities that were impacted, and reinforcing social and health care services systems. The needs of marginalized community members, their voices and concerns are prioritized through strategic support of innovative solutions. A focus for L.A. Care's grant making will be on under resourced and underrepresented community members, based on racial and ethnic identity, marginalized communities, seniors, children and youth, individuals with acute health care risk and mental health conditions and other special health care needs. It will include low wage workers, under insured and uninsured homeowners, renters, and displaced people experiencing homelessness, existing and new, because of the tragedy. L. A. Care will ensure that emergency and relief workers are included. L.A. Care will be funding different types of agencies, closing gaps, rebuilding, and maximizing long-term planning while responding to urgent needs in the community. This will include support for agencies restoring essential community infrastructure, to reduce long term displacement from permanent housing, workplaces, schools, civic culture, health care and other essential services. Support will be provided for mitigating emergency and safety needs of the community members lacking resources such as housing and food, optimizing opportunities for sustained and expanded coordinated health care and social services, and leveraging strategic opportunities to rebuild the economy through local and small business redevelopment, intentional land development and preservation, and through legislative and policy interventions. Staff will solicit recommendations from L.A. Care staff to identify existing sources of support, to learn about organizations already doing the work. L.A. Care will seek to add value to existing distribution and identify gaps in the delivery of response services. There will be a comprehensive vetting process to select aligned and effective agencies. By May 19, L.A. Care will send organizations provisional award notices that request proposals, with grants made in mid-June. Grant recipients will submit semiannual reports. Board Member Booth commented that monitoring the agreements and the reports is important and observed that this sounds like a really good plan. Board Member Vaccaro thanked Ms. Webber Christmas for taking a holistic and comprehensive approach to addressing community needs following this tragedy. She appreciates the vision and the approach that L.A. Care has taken. It is important to have a systemic approach. She has spent a lot of time in her role and personally, talking to people in impacted organizations. Everything she sees here appears to be checking all	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	those boxes for what she would want to see L.A. Care funding used for, even thinking outside of the box. In the work Community Clinics Association of Los Angeles County (CCALAC) is doing to support the community health centers and the federally quality health centers (FQHCs), systemic issues have been raised. AltaMed was deeply impacted by the loss of a facility in Altadena, and patient wait times have drastically increased because people have experienced so much trauma from this fire. It is very difficult. The clinic would like to hold group meetings to alleviate wait times, but there would be no provider reimbursement to the clinic. Board Member Vaccaro offered to speak with Ms. Webber Christmas about the information she has learned about impacts on the health centers and the patients in the fire zones. It is significant and substantial, mental health needs to be at the forefront in addressing trauma that community members have experienced. They will have long term impacts to their health and wellbeing if it is not resolved. Board Member Vaccaro appreciates the leadership at L.A. Care. Ms. Webber Christmas responded that this was a group effort, Ms. Santana-Chin has been guiding her along with Mr. Paley and other senior leadership. They have heard the same concerns around reimbursement, workforce, and that mental health is primary. California Community Foundation and the Los Angeles County Department of Mental Health have a task force with the Department of Public Health to solicit resources for mental health services. L.A. Care is working with Southern California Grantmakers to build resources and will continue to work towards a suitable resolution while pushing for legislation to allow reimbursement.	
Annual Disclosure of Broker Fees (AB 2589)	Terry Brown, *Chief Human Resources Officer,* referred to materials in the meeting packet, reporting information about brokerage commission rates required under AB 2589. L.A. Care is paying an aggregate of about 2.5% of total cost of the benefits in commissions. This represents approximately three quarters of a percent below typical percentage at the medium level of 3.25%. Staff is in a process of a request for proposals for brokers and will see if that cost could go even lower.	
PUBLIC COMMENTS ON CLOSED SESSION ITEMS	There were no public comments.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:56 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:57 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *April 2027* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Initiation of Litigation Pursuant to Paragraph (4) of Subdivision (d) of Section 54956.9 of the Ralph M. Brown Act One Potential Case CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LIT Significant Exposure (3 cases) Pursuant to paragraph 2 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Acacia Reed, *Chief Operating Officer,* Noah Paley, *Chief of Staff,* Terry Brown, *Chief Human Resources Officer* THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Acacia Reed, *Chief Operating Officer,* Noah Paley, *Chief of Staff,* Terry Brown, *Chief Human Resources Officer, and* Augustavia Haydel, *General Counsel*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: CEO Agency Designated Representative: Ilan Shapiro, MD Unrepresented Employee: Martha Santana-Chin	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:51 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:51 pm	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

_____
Ilan Shapiro, MD, MBA, FAAP, FACHE, *Chairperson*
Date: _____

BOARD REPORT EXECUTIVE SUMMARY

The memo contains a summary of the key provisions of the 2025-26 May Revise. The May Revise is an updated version of California's state budget for the state's upcoming fiscal year. Every January, the Governor proposes a budget for the upcoming fiscal year. By May, they review the state's revenue and expenses to see if anything has changed since January. Based on this new information, the budget us adjusted. The May Revise helps make sure the state's plan for spending money is accurate and reflects what is really happening in the economy. It is an important step before the main budget legislation is negotiated and finalized in June.

Report Title: *May Revise 2025-26 Budget Summary*

Date: *May 19, 2026*

Prepared By: *Cherie Compartore, Senior Director, Government Affairs*

---

1. Purpose of the Report

The purpose of this report is to provide an overview of the state budget provisions that impact L.A. Care's strategic planning and operational priorities. It highlights key budget items and their implications for our programs and initiatives, ensuring the L.A. Care Board of Governors is informed.

---

2. Background / Context

- *Each year, the state budget process determines funding for programs critical to L.A. Care's mission, including Medi-Cal and other healthcare services.*
- *The May Revise includes updated funding and policy proposals for fiscal year 2025-2026, reflecting changes in state revenues and economic conditions.*
- *Key provisions in the budget affect areas such as Medi-Cal eligibility, safety net issues, and health equity initiatives, directly influencing L.A. Care's ability to serve our members effectively.*

---

3. Key Considerations / Analysis

- *Proposed adjustments to Medi-Cal funding could impact eligibility, enrollment processes, and the safety net.*
- *Changes in state funding could require L.A. Care to influence operational budgets and strategic and operational considerations.*

---

4. Recommended Action / Decision Requested

This memo is for informational purposes only; no action is required from the Board at this time. Board engagement ensures awareness of budget provisions that may influence L.A. Care's strategic planning and operational decisions.

Board Action Needed:

X For Information Only
☐ For Discussion
☐ For Approval / Decision (specify below)

Proposed Motion (if applicable):

N/A

---

5. Next Steps / Timeline

In the coming weeks, the Assembly and Senate Budget Committees will refine proposals before Legislative Leadership and the Governor negotiate the final budget. The Legislature aims to deliver the main budget bill by the June 15 deadline, with the new fiscal year starting July 1. Budget trailer bills to implement statutory changes, including health-related items, will follow and may extend into late summer or fall. This year's process is particularly complex due to uncertainties in federal funding and state revenue, with supplemental budget packages likely in August to address unresolved issues.

Attachments / Supporting Materials:

May Revise 2025-26 Budget Summary, dated May 19, 2026

May 19, 2025

TO: Executive Committee

FROM: Cherie Compartore, *Senior Director, Government Affairs*

SUBJECT: May Revise 2025-26 Budget Summary

On May 14, Governor Newsom released the May Revise, an updated version of his January budget proposal, reflecting the latest economic forecasts and revenue projections. The revised FY 2025-26 budget is set at $321.9 billion, a $400 million decrease from his January proposal, with $228.9 billion coming from the General Fund. The revised budget anticipates a $12 billion deficit, a significant shift from the $16.5 billion surplus projected in January. This reversal highlights growing economic uncertainty, influenced in part by federal policy changes and proposals.

The May Revise attributes a projected $16 billion revenue decline in 2025-26 to weaker economic conditions, including lower capital gains, reduced corporate profits, lower wages, and decreased personal income tax revenue.

To address the deficit, the revised budget disproportionately impacts healthcare, social services, education, and public safety. Key measures include freezing Medi-Cal enrollment for certain adults, reallocating CAL FIRE funding, and cutting food assistance and foster care programs. Education funding reductions affect transitional kindergarten, community colleges, and higher education. Public safety plans include closing a state prison, while infrastructure proposals continue, such as the Delta Tunnels construction and cap-and-trade extensions to support high-speed rail.

Summary tables with more details and dollar amounts reflecting the magnitude of these cuts, by sector, are displayed at the end of this document.

Medi-Cal Budget Summary

The Medi-Cal budget includes $179 billion ($37.4 billion General Fund) in 2024-25 and $194.5 billion ($44.6 billion General Fund) in 2025-26, an increase of $7.2 billion, compared with the revised 2024-25 expenditures. Medi-Cal is projected to cover approximately 15 million beneficiaries in 2024-25 and decreasing slightly to 14.8 million in 2025-26.

Medi-Cal program costs have grown significantly, outpacing revenue increases. According to the May Revision Summary, a $3.4 billion cash flow loan and a $2.8 billion General Fund (GF) appropriation are allocated to support projected Medi-Cal expenditures of $37.6 billion GF for 2024-2025. The Governor contends the rise in costs is driven by increased enrollment, higher pharmacy expenses, and growing managed care costs due to expansion population coverage.

This following includes highlights from Governor Newsom's proposed budget for 2025-26, specifically the proposals impacting L.A. Care's operational interests.

- Medi-Cal Caseload Estimate
  The caseload is projected to decrease from 14,970,700 in 2024-25 to 14,837,900 in 2025-26, representing approximately a 1% decrease in overall caseload.

- Medi-Cal Enrollment Freeze for Unsatisfactory Immigration Status (UIS) Population
  Establishes a "freeze" on new enrollments for UIS population for individuals aged 19 and older who lack satisfactory immigration status or are unable to verify such status, beginning January 1, 2026. Does not include Qualified Non-Citizens ("Newly Qualified Immigrants") subject to the 5-year ban, individuals classified as Permanently Residing Under Color of Law, and pregnant individuals. It is unclear how long the "freeze" would be in place.

  The 1.6 million immigrants already signed up would not lose their Medi-Cal coverage, and children could still enroll. All UIS Californians would still be covered for emergency medical and pregnancy care — so-called "limited scope" coverage that is paid for with federal dollars. But those adults who don't enroll before January 2026 would be uncovered for other medical expenses, such as prescription drugs and doctor's visits.

  Effective Date: No sooner than January 1, 2026
  Estimated General Fund savings $86.5 million in 2025-26, increasing to $3.3 billion by 2028-29

- Medi-Cal Premiums for UIS Population
  A $100 monthly premium will be required for UIS adults 19 years of age and older. DHCS projects approximately a 25% disenrollment as a result of this policy change.

  Effective date: January 1, 2027
  Estimated General Fund savings are $1.1 billion in 2026-27, increasing to $2.1 billion by 2028-29

- Prospective Payment System (PPS) Rates to Federally Qualified Health Centers (FQHC) for UIS Population
  Discontinue reimbursement at the PPS rate for state-only services provided to Medi-Cal UIS population by FQHCs and RHCs. Since these services do not qualify for federal matching funds or federal requirements mandating PPS rate reimbursement, they will instead be compensated at the applicable Medi-Cal Fee Schedule rate under the fee-for-service delivery system or at the negotiated rate established between a Medi-Cal managed care plan and the FQHC/RHC within the managed care delivery system.

  Effective Date: Assumes implementation no sooner than January 1, 2026
  Estimated General Fund savings are $452.5 million in 2025-26 and $1.1 billion in 2026-27 and ongoing

- Elimination of Long-Term Care Services for Long-Term Care for UIS Population
  Eliminate long-term care benefits for the UIS population.

Effective Date: January 1, 2026
Estimated General Fund savings are $333 million in 2025-26 and $800 million in 2026-27 and ongoing

- Elimination of Medi-Cal Adult Dental Benefit for UIS Population
  Eliminates the adult dental benefit (for those 19 years of age and older) for the UIS Population. Restricted-scope emergency dental coverage will continue to be provided.
  Effective Date: July 1, 2026
  Estimated General Fund savings are $308 million in 2026-27 and $336 million in 2028-29 and ongoing

- Eliminates IHSS benefit for the UIS population
  Eliminates the IHSS benefit for those over 19 years of age.

  Effective Date: Need to verify
  Estimated General Fund reduction of $158.8 million in 2025-26 and ongoing

- Elimination of Medi-Cal Acupuncture Benefit
  Eliminates the Medi-Cal acupuncture benefit for all Medi-Cal recipients.

  Effective Date: No sooner than January 1, 2026
  Estimated General Fund Savings are $5.4 million in 2025-26 and $13.1 million ongoing

- Medi-Cal Asset Test Limits
  Restores the Medi-Cal asset limit to include resources such as property and other assets when assessing eligibility for applicants or members whose determination is not based on modified adjusted gross income (MAGI) financial criteria. The asset limit is set at $2,000 for an individual and $3,000 for a couple.

  Background: The Medi-Cal program's asset limits have historically aligned with those of the federal Supplemental Security Income (SSI) program. However, in 2021, California passed AB 133 to modify these limits through a two-phased approach: Phase I increased the asset limits, and Phase II eliminated them entirely. The budget proposal revises the asset limit test to align with federal program limits.

  Effective Date: No sooner than January 1, 2026
  Estimated General Fund savings are $94 million in 2025-26, $540 million in 2026-27, and $791 million ongoing

- Medi-Cal Minimum Medical Loss Ratio
  Increase the minimum medical loss ratio for managed care plans from 85% to 90%.

  Effective Date: January 1, 2026
  Estimated General Fund savings of $200 million in 2028-29 and ongoing

- Proposition 56 Supplemental Payments
  Eliminate Proposition 56 supplemental payments to dental, family planning, and women's health providers. The May Revise is redirected the funding from Prop 56 to help backfill the General Fund.

  Effective Date: No sooner than July 1, 2025
  Estimated General Fund savings of $504 million in 2025-26 and $550 million ongoing

- Proposition 56 Loan Repayment Program
  Terminates to Prop 56 loan repayment program which recruits and retains health care provider in underserves areas by helping repay student loans for those providers who commit to service Medi-Cal populations.

  Effective Date: July 1, 2025
  Estimated General Fund savings of $26 million in 2025-26

- Proposition 35
  The May Revision reflects $804 million in 2024-25, $2.8 billion in 2025-26, and $2.4 billion in 2026-27 for the MCO Tax and Proposition 35 expenditure plan. However, only $1.3 billion in 2025-26 and $263.7 million in 2026-27 will support provider rate increases, described as for increases to primary care, specialty care, ground emergency medical transportation, and community and hospital outpatient procedures. (Note: Prop 35 language includes approximately $2.5 billion in calendar year 2025 and 2026 for provider rate increases.

  In addition, the May Revise includes several two new Prop 35 investments.
  - Proposition 35 Reproductive Health Investments—$90 million in the Health Care Oversight and Accountability Subfund as part of the Prop 35 expenditure plan for reproductive health investments for emergent needs including midwifery loan repayments and scholarships and education capacity expansion for midwives at the Department of Health Care Access and Information.
  - Proposition 35 Flexible Housing Subsidy Pools—Reflects $200 million Prop 35 funds over two years for Flexible Housing Pool rental assistance and housing supports to help individuals with significant behavioral health conditions who are experiencing, or at risk of, homelessness, enter and maintain stable long-term housing.

  This expenditure will be discussed at the Prop 35 Stakeholder Committee meeting on May 19. DHCS also posted a spending plan https://www.dhcs.ca.gov/Budget/Documents/Prop-35-Spending-Plan-Overview.pdf

  It is important to note the uncertainty surrounding the continued reliance on MCO tax dollars in the May Revise due to ongoing federal proposals and a proposed CMS rule.

- CalAIM
  The budget continues to fund CalAIM enhanced care management and community support services. In addition, the May Revise assumes transitional rent services will be provided.

Additionally, there is $200 million of Prop. 35 funding to support the Flexible Housing Pool rental assistance and housing supports for a two-year period.

- Medi-Cal Prescription Drug Utilization Management
  Implementation of utilization management, step therapy protocols, and prior authorization for prescription drugs. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state – informational only.

  Estimated General Fund savings of $200 million in 2025-26 and $400 million in 2026-27 and ongoing

- Pharmacy Drug Rebates
  Implement a rebate aggregator to obtain state rebates for UIS population. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state - informational only.

  Estimated General Fund savings are $300 million in 2025-26 and $362 million ongoing. Additional General Fund savings of $75 million in 2025- 26 and $150 million ongoing associated with minimum rebate for HIV, AIDS, and cancer drugs.

- Elimination of Over-the-Counter Drug Coverage
  Eliminate pharmacy coverage of certain drug classes including COVID-19 antigen tests, over-the-counter vitamins, and certain antihistamines including dry eye products. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state - informational only.

  Effective Dates: Prior authorizations will be required for all COVID-19 tests effective 01/01/26. COVID-19 test coverage will be eliminated effective October 1, 2027.
  Estimated General Fund savings are $3 million in 2025-26 and $6 million in 2026-27 and ongoing

- Step Therapy Protocols
  Implement a step therapy strategy to promote utilization management and control prescription drug costs. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state -informational only.

  Estimated General Fund savings of $87.5 million in 2025-26 and $175 million ongoing

- Eliminate Glucagon-Like Peptide-1 Coverage (GLP-1) for Weight Loss
  Eliminate coverage for GLP-1 drugs for weight loss. No impact on Medi-Cal managed care as the pharmacy benefit is administered by the state - informational only.

  Effective Date: January 1, 2026
  Estimated General Fund savings are $85 million in 2025-26, increasing to $680 million by 2028-29 and ongoing

- Prior Authorization for Continuation of Drug Therapy
  Eliminates the continuing care status for pharmacy benefits under Medi-Cal Rx. The policy, effective January 1, 2026, requires members to obtain drugs no longer on or removed from the

Medi-Cal Rx contracted drug list (CDL) through the prior authorization process rather than allow continuing care based upon prior drug usage. No impact on Medi-Cal managed care as pharmacy benefit is administered by the state - informational only.

Estimated General Fund savings are $62.5 million in 2025-26 and $125 million in 2026-27 and ongoing

- Pharmacy Benefit Manager Licensure
  Proposed statutory changes to establish licensure and reporting requirements for PBMs to increase transparency, understand cost drivers and develop approaches to improve affordability.

- Hospice
  Implementation of prior authorization requirements for hospice services.
  Estimated General Fund savings of $25 million in 2025-26 and $50 million ongoing

- Skilled Nursing Facilities (SNF)
  Eliminates the SNF Workforce and Quality Incentive Program. Additionally, suspends the requirement for SNFs to maintain a 96-hour backup power system.

  Estimated General Fund savings of $168.2 million in 2025-26 and $140 million annually thereafter

- Behavioral Health Workforce Initiative
  Funding to implement the Behavioral Health Workforce Initiative
  Effective Date: January 1, 2026

- California Food Assistance Program (CFAP)
  Walks back commitment to expanding the California Food Assistance Program (CFAP) to undocumented older adults 55 years of age and older. Adds language that would make the expansion contingent on available funding in 2027.

- Medi-Cal Summer Electronic Benefits Transfer (SUN Bucks)
  Extends the SUN Bucks program, which offers federally funded food benefits (in the form of a debit card) of $120 per child ($40 per month for June, July, and August – but goes out as one $120 debit card per eligible child) to support children who lose access to free and reduced-price meals during summer school closures.

- In Home Supportive Services Overtime and Travel
  Reduces IHSS provider overtime and travel to 50 hours per week.

  Estimated General Fund savings of $705.5 million

- Creation of California Housing and Homelessness Agency (CHHA)
  Creation of the California Housing and Homelessness Agency (CHHA) to streamline efforts addressing housing and homelessness. CHHA will coordinate statewide initiatives, support low-income renters and first-time homebuyers, prevent homelessness, and enforce fair housing

protections. By integrating housing programs and simplifying administration, CHHA will enhance accountability and align state priorities. It will include entities such as the Department of Housing and Community Development and the California Interagency Council on Homelessness. The agency will incorporate the following entities:

- Department of Housing and Community Development
- California Interagency Council on Homelessness
- California Housing Finance Agency
- Civil Rights Department
- Housing Development and Finance Committee

➢ Treatment for Infertility Services (SB 729, 2024) (Covered California)
SB 729, was signed into law in 2024 to mandate coverage for infertility services, starting July 1, 2025. The May Revises proposes a delay to January 1, 2026, to allow the state to update its benchmark plan. This delay would enable the state to align its Essential Health Benefits benchmark plan with SB 729's requirements, which sets a new standard for commercial health insurance coverage. (SB 729 exempts Medi-Cal).

In the coming weeks, the Assembly and Senate Budget Committees will review and revise the various proposals before Legislative Leadership and the Governor negotiate and finalize the provisions. The Legislature is expected to deliver the "main" budget bill to the Governor by the June 15 statutory deadline, with the new fiscal year commencing on July 1. Once signed into law, a series of budget trailer bills will follow to implement the necessary statutory changes, including those addressing health-related items. Unlike the main budget bill, trailer bills have no fixed deadline and may extend through the summer and early fall.

This year's budget process is expected to be particularly intricate due to uncertainties surrounding federal funding and state revenue, leading to prolonged ambiguity regarding final provisions. In recent years, the Legislature has adopted supplemental budget packages in August, a trend likely to continue this year. These packages typically address items that were too complex, contentious, or unprepared for inclusion in the June main budget bill.

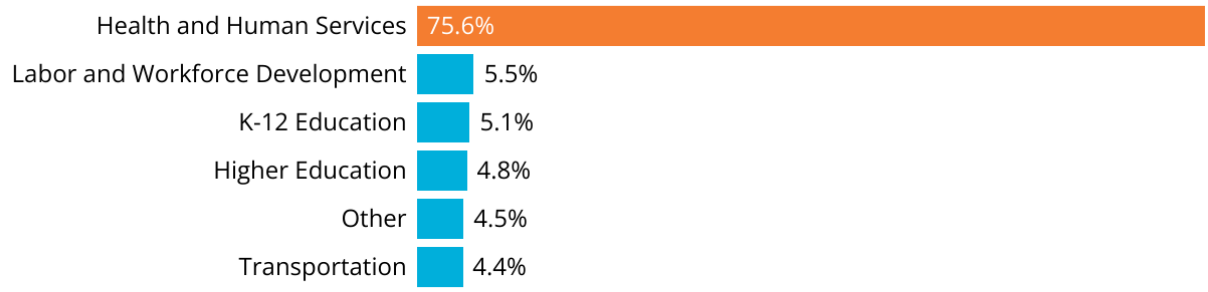
Government Affairs will provide regular updates. For further information, please contact Cherie Compartore, Senior Director of Government Affairs.

References:

- *https://ebudget.ca.gov/FullBudgetSummary.pdf*
- *https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2025-26-May-Revision-Budget-Highlights.pdf*
- *https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf*

75% of Federal Funds Spent Through the State Budget Support Health & Human Services

Federal Funds Estimated to Be Spent Through the State Budget in 2024-25 = $153 Billion



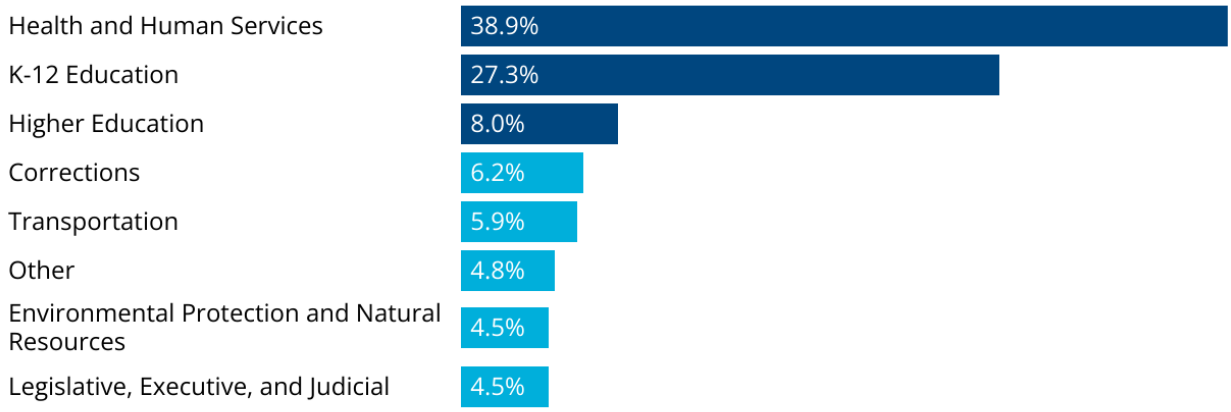
Note: "Other" reflects a number of budget categories, including Environmental Protection, Natural Resources, and Government Operations. Percentages do not sum to 100% due to rounding.

Source: Budget Center analysis of Department of Finance data

California Budget & Policy Center

3 in 4 State Dollars Support Health and Human Services, K-12 Education, or Higher Education

Enacted 2024-25 General Fund and Special Fund Expenditures = $295.5 Billion



Note: "Other" reflects a number of budget categories, including Business, Consumer Services, and Housing; and Labor and Workforce Development. Percentages do not sum to 100% due to rounding.

Source: Budget Center analysis of Department of Finance data

California Budget & Policy Center

BOARD REPORT EXECUTIVE SUMMARY

The memo summarizes key provisions of the Congressional House Budget Reconciliation package, highlighting risks to Medicaid and potential impacts on health insurance Exchanges. The package adjusts federal spending to reflect economic conditions but are threatening Medicaid's role as a critical safety net. Budget reconciliation is a pivotal step in setting funding priorities, addressing deficits, and shaping healthcare policy before final appropriations are negotiated.

Report Title:

Analysis of Congressional House Medicaid and Exchange Proposals

Date:

May 19, 2026

Prepared By:

Cherie Compartore
Senior Director
Government Affairs

---

1. Purpose of the Report

The purpose of this report is to provide an overview of the federal budget provisions that impact L.A. Care's strategic planning and operational priorities. It highlights key budget items and their implications for our programs and initiatives, ensuring the L.A. Care Board of Governors is informed.

---

2. Background / Context

- *Each year, the federal budget process determines funding for programs critical to L.A. Care's mission, including Medi-Cal and other healthcare services.*
- *The federal budget proposal includes updated funding, policy priorities, and the legislative goals of the majority leadership in Congress for the upcoming fiscal year.*

- *Key provisions in the budget affect areas such as Medi-Cal eligibility and coverage and impact on Exchanges, safety net issues, and health equity initiatives, directly influencing L.A. Care's ability to serve our members effectively.*

---

3. Key Considerations / Analysis

- *Proposed adjustments to Medi-Cal funding could impact eligibility, enrollment processes, and the safety net.*

- *Changes in federal funding, combined with the state budget impact could require L.A. Care to influence operational budgets and strategic and operational considerations.*

---

4. Recommended Action / Decision Requested

This memo is for informational purposes only; no action is required from the Board at this time. Board engagement ensures awareness of budget provisions that may influence L.A. Care's strategic planning and operational decisions.

Board Action Needed:

X For Information Only
☐ For Discussion
☐ For Approval / Decision (specify below)

Proposed Motion (if applicable):

N/A

---

5. Next Steps / Timeline

Congressional House Leadership has approved a budget resolution with reconciliation instructions, but the reconciliation bill has not yet been finalized or passed. Committees are currently drafting and reviewing policy and spending details. Once completed, the full House will debate and vote on the bill, likely in late spring or early summer, before it moves to the Senate for further review and amendments through the summer.

Attachments / Supporting Materials:

Analysis of Congressional House Medicaid and Exchange Proposals

May 19, 2025

TO: Executive Committee, Board of Governor

FROM: Cherie Compartore, *Senior Director, Government Affairs*

SUBJECT: Analysis of Congressional House Medicaid and Exchange Proposals

Congressional Republicans are considering a budget reconciliation package that would significantly impact Medicaid and the Affordable Care Act (ACA). Proposals from the Energy and Commerce Committee include imposing work and reporting requirements for certain Medicaid enrollees and codifying changes outlined in a recent Trump Administration proposed rule on ACA Marketplaces. These changes coincide with the upcoming expiration of enhanced premium tax credits for ACA Marketplace coverage at the end of 2025, which currently lower premiums but, if not extended, will lead to higher out-of-pocket costs and substantial coverage losses. Based on draft reconciliation language, the Congressional Budget Office (CBO) released preliminary estimates showing the proposals would reduce federal Medicaid spending by $625 billion. The majority of these savings stem from requiring states to implement work requirements for the Medicaid expansion group, increasing barriers to enrolling in and renewing Medicaid coverage, and limiting states' ability to raise their share of Medicaid revenues through provider taxes.

The Congressional Budget Office (CBO) projects that the proposed policy changes could increase the number of uninsured individuals by at least 13.7 million by 2034, with 10.3 million of this increase coming from a decline in Medicaid enrollment. CBO cautions that these estimates may rise as further analysis continues and additional provisions from the Ways and Means Committee are evaluated and revised. If implemented, these changes would reverse years of progress under the ACA, leading to a 30% increase in the uninsured rate. Additionally, the CBO estimates that Medicaid enrollment decrease indicates that the majority of the projected federal savings result from reduced enrollment rather than cost efficiencies.

In regard to specific impact on California, the Kaiser Family Foundation indicates that estimated Medicaid Enrollment loss would range from 1.6 million to 2.0 million over the 10-year period.

Notably, the package does not currently include block grants, per capita caps, or across-the-board reductions in the Federal Medical Assistance Percentage (FMAP). However, the proposed changes are expected to have significant and detrimental effects on healthcare coverage.

Process & Timing Update

As of now, the House Leadership has agreed on a budget resolution that includes reconciliation instructions, but it has not yet produced or passed the actual reconciliation bill. Budget-related committees are drafting and marking up the specific policy and spending language required by that resolution. Once committee work wraps up, the full House will debate and vote on the reconciliation bill—likely later this spring or early summer—before it moves to the Senate for its own review and amendments which likely will continue throughout the summer.

Key Medicaid Provisions in the House Reconciliation Package

- **Medicaid Work Requirements**
  Mandates that able-bodied adults (19-64 years of age) without dependents (expansion population) engage in at least 80 hours per month of work, educational programs, or community service to maintain Medicaid eligibility. Exemptions apply to individuals under 19, over 64, pregnant women, individuals with disabilities, medically frail, those receiving treatment for substance abuse disorders, incarcerated, former foster youth, and those eligible through the Indian Health Services Program. Allows states to define "medically frail".
  - Effective January 1, 2029
  - Section 44141
  - Preliminary CBO Score: $300.8 billion

- **Medicaid: Unsatisfactory Immigration Status (UIS) Population**
  Reduction in Federal Medicaid Matching Funds (FMAP): States that use state-only funds to provide Medicaid-like coverage to the UIS population would see a 10% reduction in their Medicaid Expansion FMAP – a reduction of the current 90% FMAP to 80% FMAP.
  - Effective October 1, 2027
  - Section 44111
  - Preliminary CBO Score: $11 billion

- **Medicaid: Citizenship/Immigration Status Verification**
  Prohibits FFP for individuals whose citizenship, nationality, or immigration status has not been verified, including during the reasonable opportunity period. Under current law, states can enroll individuals in coverage immediately and allow a 90-day reasonable opportunity period for verifying citizenship, nationality, or immigration status, during which FFP is available. This policy permits states to provide coverage during the 90-day reasonable opportunity period at their own expense, without requesting FFP until the required verification is completed.
  - Effective October 1, 2026
  - Section 44110
  - Preliminary CBO Score: $800 million

- **Medicaid: Mandatory Cost Sharing for Expansion Adults Over 100% FPL**
  Requires states to impose cost sharing on expansion population adults with incomes 100%-138% FPL. This cost-sharing may not exceed $35 per service—rather than the current $100 per

service limit allowed for states to impose. Cost sharing may not exceed 5% of the household's income, which is the current out-of-pocket limit for Medicaid beneficiaries. No cost-sharing on primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room). Limits cost sharing for prescription drugs to nominal amounts. Impacts 5 million Californians.

- Effective October 1, 2028
- Section 44142
- Preliminary CBO Score: $13.0 billion

- **Medicaid: Redeterminations – Expansion Population**

  Requires eligibility redeterminations every 6 months for expansion population adults. Currently, California performs eligibility redeterminations for adults on an annual basis.
  - Effective October 1, 2027
  - Section 44108
  - Preliminary CBO Score: $49.4 billion

- **Medicaid: Restrictions on State Provider Taxes**

  States would face limitations on the use of provider taxes to finance their share of Medicaid, potentially impacting funding mechanisms in states that heavily rely on such taxes. The legislation would freeze state provider taxes at their current rates and prohibit them from establishing any new taxes.

  On a separate track, on May 12, 2025, CMS issued a proposed rule targeting MCO taxes, aiming to restrict taxes that impose higher rates on Medicaid products compared to non-Medicaid products, as seen in California, even if they meet statistical compliance tests. The proposed rule suggests that the effective date may be immediate in some instances, while allowing a one-year transition period in others.
  - Effective Upon Enactment
  - Section 44132
  - Preliminary CBO Score: $86.8 billion

- **Medicaid: Planned Parenthood Funding**

  For 10 years from the enactment date, Medicaid funds are barred from providers that are nonprofits primarily offering family planning or reproductive services, perform abortions outside Hyde Amendment exceptions, and received $1 million or more in Medicaid payments in 2024 (including affiliates) (Target is Planned Parenthood funding).
  - Effective Upon Enactment
  - Section 44126
  - Preliminary CBO Score: $300 million

- **Medicaid: Revising Payment Limits for State Directed Payments (SDPs)**

  Currently, states can use SDPs to require MCOs to pay providers at rates comparable to the Average Commercial Rate (ACR), which is often higher than Medicare rates. This flexibility helps states offer competitive reimbursement rates, encouraging provider participation and supporting care improvements. However, the proposed provision would restrict SDPs to 100% of the published Medicare payment rate, which is typically lower than the ACR. This change could reduce provider reimbursement, potentially discouraging participation and affecting access

to care for Medicaid patients. Existing SDPs that have received prior written approval from CMS could be grandfathered in, including renewals, allowing them to continue operating under their current terms (California has existing SDPs).

- Effective Upon Enactment
- Section 44133
- Preliminary CBO Score:

- **Medicaid: Requiring Budget Neutrality for Medicaid Demonstration Projects**

  The proposal codifies the long-standing practice of requiring Medicaid Section 1115 demonstration projects to be budget-neutral, ensuring they do not increase federal spending beyond what would have been spent without the project. HHS would be responsible for certifying compliance and developing methods to apply project savings toward extensions. While no formal law or regulation currently enforces budget neutrality, it has been standard practice since the 1970s. Under existing rules, states can use savings from these projects to fund non-Medicaid populations or services, such as initiatives addressing social determinants of health. However, the proposal could allow HHS to impose stricter limitations on how states use these savings.

  - Effective Upon Enactment
  - Section 44135
  - Preliminary CBO Score:

- **Medicaid: Gender Affirming Care for Minors**

  Prohibits Medicaid coverage for gender-affirming care for minors.

  - Effective Upon Enactment
  - Section 44125
  - Preliminary CBO Score: $700 million

- **Moratorium on Implementation of Nursing Home Staffing Rule**

  Requires HHS to delay implementation, administration, or enforcement of the Biden-era final mandating increased staffing levels in nursing homes until January 1, 2035.

  - Effective Upon Enactment
  - Section 44121
  - Preliminary CBO Score: $23.1 billion

- **Medicaid: Streamline Enrollment Processes for Out-of-State Providers**

  States would be required to allow "eligible out-of-state providers" to deliver care under the state plan or waiver for individuals under 21. Providers need only submit basic information, such as an NPI, if enrolled in Medicare and deemed low risk for fraud, waste, or abuse. requires states to establish a process for out-of-state providers to enroll as participating providers without further screening requirements if they are providing services to enrollees under age 21. Specifies that enrollment of out-of-state providers is to last 5 years unless the provider is terminated or excluded from participation during that period.

  - Effective 4 Years After Enactment
  - Section 44302
  - Preliminary CBO Score:

- **Medicaid: State Administrative Requirements**
  - *Mandating Address Checks.* Requires regular cross-state address verification. MCOs must transmit address updates to states and HHS is required to establish a system to prevent individuals from being simultaneously enrolled in multiple State Medicaid programs.
    - Effective January 1, 2027: states must implement a process to regularly obtain address information
    - Effective October 1, 2029: states must submit monthly data to HHS.
    - Section 44103
    - Preliminary CBO Score: $17.4 billion

  - *Ensuring Deceased Individuals Are Not Enrolled.* Requires quarterly death record checks to prevent improper payments.
    - Effective January 1, 2028
    - Section 44104
    - Preliminary CBO Score: None available
    - Potential Impact to California: Unknown impact at this time but tighter controls over deceased individuals enrolled in the program are anticipated because of a 2019 OIG Audit which found $74 million in improper payments made on behalf of individuals after their date of death. DHCS committed to a quarterly review of death match sources, including full access to DMF, and other out of state sources by Fall 2019. DMF is currently utilized in CA for provider monitoring.

  - *Intensifying Provider Screening.* Requires states to run checks to confirm that providers have not been terminated (monthly requirement) or are deceased (quarterly requirement).
    - Effective January 1, 2028
    - Sections 44105 & 44106
    - Preliminary CBO Score: None available

  - *Limiting Retroactive Coverage.* Reduces Medicaid retroactive eligibility from 3 months to 1 month, potentially leaving gaps in provider reimbursement and patient access.
    - Effective October 1, 2026
    - Sections 44122
    - Preliminary CBO Score: $6.5 billion
    - Potential Impact to California: There will be an impact, as CA currently reimburses 3 months prior to application if member was eligible during that time.

- **Home Equity Limit for Determining Eligibility for Long-Term Care**

  Establishes a $1 million nationwide cap on home equity when determining Medicaid eligibility, replacing state discretion. In January 2024, California's Medi-Cal program stopped imposing an asset limit for eligibility for long-term care services.
  - Effective January 1, 2028
  - Section 44109
  - Preliminary CBO Score: None available
  - Potential Impact to California: The Legislative Analyst Office (LAO) estimates 112,000 members were enrolled as a result of full elimination of the asset test since January 1, 2024. It is difficult to quantify how many of these enrollees would have assets in excess

of $1 million. In 2002, California's asset limit was $130,000 per individual + $65,000 for each additional household member.

- **Medicaid: Moratorium on Rule Implementation of Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program**

  HHS will delay implementation, administration, or enforcement of the final rule titled "*Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes"* until January 1, 2035. Key Provisions of the Enrollment and Eligibility Rule include:
  - Facilitate enrollment by allowing medically needy individuals to deduct prospective medical expenses
  - Aligning non-MAGI enrollment and renewal requirements with MAGI Policies
  - Acting on Changes in Circumstances Timeframes and Protections
  - Timely Determination and Redetermination of Eligibility
  - Agency Action on Returned Mail
  - Transitions between Medicaid, CHIP and BHP Agencies
  - Remove or limit requirement to apply for other benefits
  - CHIP Proposed Changes (finalized without modification):
    - Allow CHIP beneficiaries to remain enrolled or re-enroll without a lock-out period for failure to pay premiums.
    - Remove the option to allow a waiting period as a substitution of coverage prevention strategy in CHIP.
    - Prohibit annual and/or lifetime limits on benefits in CHIP.
  - Effective Upon Enactment
  - Section 44101 & 44102
  - Preliminary CBO Score: $162.7 billion

- **Medicaid: Good Faith Waiver**

  Effective fiscal year 2030, this section mandates that HHS reduce federal financial participation (FFP) to states for errors identified by the Office of the Inspector General or the Secretary. These reductions apply to erroneous excess payments for medical assistance that are directly tied to payments made to ineligible individuals or for ineligible services.
  - Effective FY 2030
  - Section 44107
  - Preliminary CBO Score: None available

- **Medicaid: Pharmacy Payments**

  Mandates pharmacy participation in the NADAC survey and bans spread pricing by PBMs.
  - Effective 6 months after enactment and 18 months after enactment, respectively
  - Sections 44123 & 44124
  - Preliminary CBO Score: $300 million and $2.6 billion, respectively

- **Medicaid: Delay of Disproportionate Share Hospital (DSH) Payments**

  Delays DSH cuts from 2026-28 to 2029-2031
  - Effective Upon Enactment
  - Sections 44303

Affordable Care Act Provisions in the House Reconciliation Package

The package takes a cautious approach to the Affordable Care Act (ACA), signaling a potential hesitation among Republicans to revisit the widely popular Obama-era law after numerous unsuccessful repeal attempts since its passage in 2010.

One notable omission from the legislation is the extension of enhanced subsidies for ACA marketplace coverage, which have played a key role in increasing enrollment. If these subsidies are allowed to expire at the end of 2025, the Congressional Budget Office (CBO) estimates the federal government would save approximately $340 billion. However, this would also lead to about four million people losing their health insurance coverage.

- **ACA Marketplace-Exchange – Prohibition of Gender Transition Procedures**

  Prohibits coverage of gender transition procedures as an essential health benefit under plans offered by exchanges (Covered California)
  - Effective January 1, 2027
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Coverage for DACA Recipients**

  Makes ineligible Deferred Action for Childhood Arrivals (DACA) recipients for PTC and cost-sharing reductions in exchanges.
  - Effective
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Open Enrollment Period**

  Sets annual enrollment period as November 1-December 15 and prohibits special enrollment periods based on low income; for any other special enrollment period, requires verification of eligibility for 75% of users.
  - Effective
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Income Verification**

  Increases income verification requirements when tax data is unavailable or when income changes exceed 10%. Requires annual filing and reconciliation of Advanced Premium Tax Credits (APTC), eliminating the 90-day extension period for resolving inconsistencies.
  - Effective
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Allowable Variation in Actuarial Value**
  Revises rules on the allowable variation to be between +/- 1% in silver plans or as much as in 2022 (that is, bronze and gold plans could vary more). This could directly increase consumers' costs for many marketplace enrollees by increased deductibles and cost-sharing.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Premium Adjustment Percentage Methodology**
  Reverts the premium adjustment methodology back to 2019 rules (will be based on the on the growth in individual and non-ACA plans as well). Could result in less premium assistance to enrollees.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Elimination of Fixed-Dollar and Gross Percentage Threshold**
  Eliminates the fixed-dollar and gross percentage threshold. Therefore, if enrollees underpay their premiums by a small percentage or by less than $10 in a month, issuers will no longer have the discretion to disregard the shortfall. Instead, this would result in coverage termination.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange – Prohibition of Auto Reenrollment from Bronze to Silver**
  Prohibits automatic reenrollment from bronze to silver.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange: Reduce APTC for Certain Individuals**
  Individuals reenrolled in plans who are eligible for $0 cost sharing will initially be charged $5 premiums until they confirm income information.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

- **ACA Marketplace-Exchange: Guaranteed Issue – Non-Payment of Past Due Premiums**
  If an individual has past-due premiums from a previous year, the issuer may apply their initial premium payment for the subsequent year toward the outstanding balance instead of the new coverage.
  - Effective Date
  - Section 44201
  - Preliminary CBO Score:

If you have any questions, please contact Cherie Compartore.

References:

https://docs.house.gov/meetings/IF/IF00/20250513/118261/BILLS-119CommitteePrintih.pdf

https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

https://www.kff.org/medicaid/issue-brief/state-level-context-for-federal-medicaid-cuts-of-625-billion-and-enrollment-declines-of-10-3-million/

ACAP
Association for Community Affiliated Plans
Mission driven. People focused.

1155 15th Street, N.W., Suite 600 | Washington, DC 20005

202.204.7508 | www.communityplans.net

May 13, 2025

The Honorable Brett Guthrie
Chairman, Energy & Commerce Committee

The Honorable Frank Pallone
Ranking Member, Energy & Commerce Committee

Sent via Email

Dear Chairman Guthrie and Ranking Member Pallone,

The Association for Community Affiliated Plans (ACAP) writes to you on behalf of our 84 not-for-profit Safety Net Health Plan (SNHP) members and the 30 million people they serve through Medicaid, Medicare, the Exchanges, and other publicly-supported coverage programs. We thank you for the opportunity to respond to Title IV, Subtitle D, Parts 1-Medicaid and 2-Affordable Care Act of the reconciliation legislation published May 11 in preparation for the May 13 markup.

ACAP's mission is to strengthen our member plans in their work to equitably improve the health and well-being of people with limited resources or significant health care needs. Many of our health plan members operate exclusively in service to publicly-funded health care programs like Medicaid and the health insurance Marketplaces. To that end, the comments in this letter represent our plans' commitment to ensuring strong and well-functioning coverage programs that work well for people who are enrolled, but also for the states, providers, and health plans that operate them. In this letter, we state our support for policies that will further our mission, and present specific suggestions for amending the legislation based on our plans' input.

Over our 25 years of existence, ACAP and our member plans have consistently supported coverage expansions that not only reduce the numbers of uninsured people in our nation, but that also have the potential to improve the health both of individuals and communities. Medicaid health plans strive to deliver high quality and compassionate coverage to members in partnership with the safety net health care providers in our networks. We also partner with local businesses, schools and universities, and community-based organizations to build and protect a strong web of health care services and supports for the tens of millions of individuals we serve.

After careful review of the reconciliation package, we submit this response. We are happy to support those proposed policies which we believe would streamline and improve Medicaid and the health insurance Marketplaces. In other cases, we are compelled to respectfully oppose the policies in the bill and outline our reasoning for doing so.

Summary
Comments regarding ACAP's top priorities are summarized just below.

Medicaid

- ACAP supports the legislation's provisions to streamline address verification and inclusion of Medicaid managed care organizations as reliable sources of addresses.
- ACAP opposes the proposal to require biannual eligibility checks for Medicaid expansion enrollees and believes it will result in many of those enrollees losing coverage despite still being eligible.
- ACAP opposes the proposal to reduce the expansion FMAP for states covering Medicaid-ineligible state residents.
- ACAP believes that provider taxes and state-directed payments are integral for resourcing Medicaid programs and opposes erosion of these mechanisms.
- ACAP supports making employment support services available to assist individuals in their efforts to attain economic stability, but we oppose a state mandate predicating eligibility on non-health activities such as work.
- ACAP opposes the state mandate to impose minimum cost-sharing requirements for health care services for Medicaid expansion enrollees.

Marketplaces

- While not under this Committee's jurisdiction, ACAP wishes to note that we are concerned about the potential expiration of the enhanced premium tax credits (ePTCs) at the end of 2025. We urge Members to ensure that the tax credits are extended before the bill is set for consideration on the Floor. We wish to flag that if a "current policy baseline" is used to extend the Tax Cuts and Jobs Act, the Enhanced Premium Tax cuts, as established in the Inflation Reduction Act, are also tax credits that can—and should—be extended as such.
- ACAP urges Congress to remove language preventing some consumers from otherwise accessing APTCs for which they would be eligible but for the fact that they applied first to Medicaid and do not meet Medicaid work requirements.
- ACAP urges this Committee to remove provisions stemming from the Marketplace Integrity and Affordability proposed rule. While ACAP supports some of the provisions included therein, we believe they are appropriate for regulation and not statute due to potential unintended consequences or need for future flexibility. We urge the Committee to remove all such policy proposals.

We expand on those comments below. Thank you again for the opportunity to contribute our thoughts, and for your consideration of our positions. We seek a productive and respectful dialogue with you regarding these policies.

MEDICAID

Ensuring Appropriate Address Verification Under the Medicaid and CHIP Programs

ACAP supports policies that help Medicaid and CHIP operate more efficiently for the states that operate them, for the individuals who are served, and for the providers and plans that support the

programs. We recognize the challenges with identifying and disenrolling individuals who are erroneously enrolled in two state Medicaid programs simultaneously. Establishing a system by which such individuals are identified and then disenrolled from the program in the state they no longer reside in is smart policy and a positive step forward. We also appreciate and support inclusion of state-contracted managed care entities in the list of reliable data sources for enrollee addresses and agree that Medicaid health plans frequently hold current and reliable contact information for Medicaid beneficiaries.

ACAP also supports additional provisions in the legislation designed to ensure that Medicaid and CHIP operate efficiently: using the Death Master File to disenroll deceased individuals from the rolls and discontinue medical assistance payments makes rational sense, plus we appreciate that the legislation includes a provision requiring reinstatement of coverage in case of erroneous disenrollment.

Medicaid Eligibility Redeterminations

ACAP believes that enrollment and eligibility processes should be as minimally burdensome and straightforward as possible for Medicaid enrollees, as well as for state and other public agencies that conduct eligibility determinations. These processes should maximize the use of existing data available to states to streamline administration and reduce barriers to coverage. Stable coverage advances the goals of the Medicaid program by promoting consistent access to preventive and primary care and providing essential financial protection for enrollees.

ACAP supported the aims and policies of the 2024 Eligibility and Enrollment rules that simplified and streamlined state enrollment processes, reducing enrollees' burden and ensuring that individuals who qualify for Medicaid and CHIP coverage, as well as financial support for Medicare coverage, can more easily access and maintain it, through the use of data sharing, simplified reporting and leveraging managed care organizations. It is our view that such processes would reduce the potential for waste, and we are disappointed that this legislation includes a moratorium on implementation of the rule.

Because it helps enrollees consistently access care and also provides stability to states as well as Medicaid plans and providers, ACAP has long supported continuous eligibility in Medicaid and CHIP. The legislation's requirement that enrollees in the Medicaid expansion undergo eligibility redeterminations every six months will have implications both for coverage and for state budgets. When Washington State shortened children's eligibility periods from 12 to six months, the state incurred $5 million in additional administrative expenses.[1] We are very concerned that states and other public offices that conduct eligibility reviews will be faced with much higher administrative overhead as a result of this proposal.

[1] Summer L. and Cindy Mann, Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies, The Commonwealth Fund, June 2006.

In addition, the proposal will result in many of those enrollees losing coverage despite still being eligible. This will lead to canceled appointments, surprise medical bills, and added financial stress for the families of these enrollees. According to qualitative interviews with Medicaid enrollees conducted by NORC at the University of Chicago, enrollees threatened with eligibility churn are aware that changes in work hours might affect their eligibility (as well as the eligibility of their children); the stress they experience as a result leads them to frequently avoid accepting additional work hours, and therefore additional pay.[2] In these interviews, enrollees frequently emphasized that having stable health coverage was what allowed them to access necessary, and sometimes lifesaving, care without fear of financial burden.

Research from the George Washington University's Milken Institute School of Public Health underscores the value of continuous eligibility. One study found that the policy, implemented during the COVID-19 PHE, significantly improved access to mental health care for low-income adults.[3] Another study by the same institution demonstrated that 12-month continuous eligibility for children led to improved access to specialty care, increased rates of preventive visits, and fewer gaps in coverage for children in families earning less than 138 percent of the federal poverty line.[4] Eroding consistent coverage by imposing more frequent eligibility redeterminations will also threaten access to these critical services.

Discouraging States From Covering Medicaid-Ineligible State Residents

The Medicaid program has since its inception allowed states to operate with substantial flexibility within a federally-established framework. In addition, states have always had the authority to use state-only dollars to operate Medicaid look-alike health programs without using federal dollars for individuals that are not eligible for federally-supported coverage.

We are disappointed that this legislation mandates a 10 percent cut to a state's Medicaid expansion FMAP – from 90 to 80 percent – for those states that have opted to use their own taxpayer dollars to offer health insurance coverage or other health benefits for certain immigrant families. We are very concerned that such a penalty to states will erode this coverage, further stressing state budgets as well as placing strain on hospital systems and other providers and placing an untenable burden on families with low incomes whose coverage – and whose children's coverage – may be impacted.

Prohibiting Gender Affirming Care for Minors

---

[2] NORC at the University of Chicago, Voices of Medicaid Enrollees: The Importance of Consistent Coverage, https://www.communityplans.net/research/voices-of-medicaid-enrollees-the-importance-of-consistent-coverage/.

[3] George Washington University Milken Institute School of Public Health, Medicaid Continuous Enrollment and Mental Health, October 2024, https://communityplans.wpenginepowered.com/wp-content/uploads/2024/10/Medicaid-Continuous-Enrollment-and-Mental-Health.pdf.

[4] Leighton Ku and Erin Brantley, Continuous Medicaid Eligibility for Children and Their Health, George Washington University Milken Institute School of Public Health, June 2020.

ACAP has long supported laws and regulations that prohibit discrimination, including discrimination against transgender individuals. Specifically, ACAP has supported[5] proposals to protect against discrimination on the basis of sexual orientation and gender identity in Medicaid and Medicaid managed care.[6]

This legislation includes a prohibition on Medicaid funding for states for certain gender affirming services for youth. On the one hand, we assert that the provision is unlikely to produce meaningful savings, as is the purpose of these provisions, given that the population under consideration is very small. Also, ACAP is very concerned that many members of the LGBTQI community already face logistical challenges to securing meaningful coverage, as well as appropriate care and providers they can trust. As such, we have grave concerns that this proposal threatens to aggravate those already substantial barriers to care for transgender youth covered by Medicaid, leading to the denial of medical care considered necessary by patients, patients' families, and their providers. ACAP has a long history of standing against discrimination of any kind in health care.

Moratorium on Provider Taxes and Changes to State Directed Payments

Provider taxes are a key part of how nearly all states support Medicaid programs, including ensuring adequate provider rates. The state-directed payments (SDPs) they often support are essential for improving access to care and quality of services at hospitals, nursing homes, primary care clinics, and substance use treatment providers.[7] These payments help sustain a safety net that already operates on lower reimbursement rates than Medicare or private insurance.

If these funding streams are reduced or eliminated without a clear strategy to replace them, the financial pressure will fall squarely on the states as well as the safety net providers states rely on to provide care under Medicaid. This may lead to cuts to Medicaid coverage or benefits, raising local taxes, or reducing investment in other priorities like education.

If passed, this legislation would prohibit states from enacting new provider taxes or increasing the amount or rate of existing provider taxes. We are concerned that curtailing the use of provider taxes will destabilize state budgets and harm Medicaid provider networks. In practical terms, limiting these taxes could mean lower provider payments, reduced optional benefits, or – in a worst-case scenario – even the closure of vital health care providers. Such a change in policy would also erode state flexibilities that are fundamental the federal/state relationship underpinning the Medicaid program.

---

[5] Margaret A. Murray, "Statement of ACAP CEO Margaret A. Murray on HHS Rollback of Prohibitions on Discrimination in Health Care," *Association for Community Affiliated Plans*, June 15, 2020, https://www.communityplans.net/2020/06/15/statement-of-acap-ceo-margaret-a-murray-on-hhs-rollback-of-prohibitions-on-discrimination-in-health-care/.

[6] Partnership for Medicaid, *Comments on Proposed Rule Regarding Nondiscrimination in Health and Health Education Programs or Activities (Section 1557)*, August 13, 2019, https://communityplans.wpenginepowered.com/wp-content/uploads/2019/08/P4M_Section1557_Submit.pdf.

[7] Medicaid and CHIP Payment and Access Commission (MACPAC), *Directed Payments in Medicaid Managed Care*, October 2024, https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf.

In addition, the legislation would alter a policy that permits waivers specifically for MCO provider taxes of requirements that the taxes be "broad-based" and uniform. It appears that these provisions, if passed into law, will require changes to the existing MCO provider taxes in a number of states, potentially reducing funding for the Medicaid programs in these states. As described above, these reductions are likely to result in lower provider payments or other impacts on providers, as well as reduced benefits for enrollees.

This legislation would also establish an SDP payment ceiling for certain services at the total published Medicare payment rate, instead of the average commercial rate currently allowed and used for many SDPs. It is well known that low Medicaid payment rates have always challenged state Medicaid agencies and Medicaid health plans in recruiting and retaining providers; now, with ongoing provider workforce shortages and a growing behavioral health crisis, especially in rural areas, the challenges are even greater. Our plans inform us that reducing SDPs would seriously threaten the survival of hospitals, nursing homes, and clinics that rely heavily on Medicaid. Maternity and OB/GYN services are especially at risk.

SDPs are complex and often involve drawn-out reconciliation processes that can take more than two years to complete. But despite the administrative burden on both plans and states, these payments are a critical tool for building and maintaining provider networks. Losing them would make it much harder for plans to meet network adequacy standards, which will become more stringent under the new appointment wait time rules in the 2024 managed care final rule.

Medicaid Community Engagement Requirements

Although ACAP supports making employment support services available to assist individuals in their efforts to attain economic stability, we do not believe that access to health care should be predicated on participating in other activities, such as job training or work readiness activities. We believe that Medicaid coverage should contribute to lifting people out of poverty, and that addressing the non-medical drivers of health – including job readiness and education – has great potential to help Medicaid enrollees improve health status and economic stability at the same time. While ACAP does not agree that Medicaid enrollees should be required to engage in certain activities – such as seeking employment – as a *condition* of eligibility, we strongly support providing opportunities for people with low incomes for job training and other critical activities. This critical work – which while increasing front end costs, can result in health system savings – should be recognized and incorporated into any effort to increase Medicaid flexibility. We believe the causality flows in the opposite direction – that good health care coverage supports individuals seek and maintain employment.

ACAP opposes the legislation's imposition of a state mandate for a community engagement requirement for enrollees. Such a mandate for a policy that is not integral to Medicaid and does not fulfill any of the Medicaid program's fundamental objectives of providing coverage and care should not be required of all states.

The legislation provides numerous exemptions from the requirement, including parents or caretakers for a disabled individual or dependent, pregnant or postpartum women, members of a Tribe, individuals who are medically frail such as those who are blind or disabled or have a serious and complex medical condition, and individuals already in compliance with the work requirements under the Temporary Assistance for Needy Families program or Supplemental Nutrition Assistance Program, as well as a state-provided hardship waiver. While we appreciate the consideration of the challenges that meeting a community engagement requirement would pose for these individuals, we have serious concerns that some individuals meeting these qualifications would fall through the cracks or that the act of proving an exemption would be burdensome or faulty, leading to imperfect implementation.

While ACAP is opposed to work requirements and other non-essential activities as a condition of Medicaid eligibility, we do recognize that including certain activities in addition to paid work will help mitigate the impact of the requirements and make it somewhat easier for some people to meet them, should they become law. For example, including community service and participation in work and educational programs may help some people meet the requirement. As referenced above, many of ACAP's member plans operate work readiness and support programs for enrollees; including these activities as voluntary options for enrollees to meet the work requirements will potentially ease the burden on some individuals.

Should community engagement requirements become law, ACAP is deeply concerned about the significant administrative costs and staffing demands that work and community engagement requirements would impose on both states and health plans. Medicaid health plans will have a sincere interest in assisting their members in meeting the community engagement requirements. To avoid unnecessary coverage losses, plans would need to invest heavily in staff and infrastructure to support enrollees in meeting and reporting compliance with these new requirements. Georgia's experience demonstrates that members will require substantial education and hands-on assistance to navigate reporting systems, apply for temporary exceptions, and understand exemption criteria. These complex, time-intensive processes would require hiring additional personnel and forming new partnerships with organizations outside the traditional Medicaid ecosystem, like staffing agencies. In past and existing community engagement requirement programs, managed care organizations have played an important role and have developed staffing strategies to support enrollees. Given this reality, if this requirement is passed into law, ACAP urges Congress to require states to include work requirement activities in plans' actuarially sound capitation rates.

Moreover, verifying employment status electronically will necessitate the development of new state systems and interoperability functions, as well as the use of third-party vendors. Ohio, for example, in its waiver request, details the need to contract with external data vendors to assess compliance through outside data sources and facilitate automated reviews. The state expects to seek federal matching funds to support these investments.[8]

[8] Ohio Department of Medicaid, Waiver Application, p.5

Lastly, past and current work requirement programs have consistently led to negative coverage outcomes—either by causing significant losses, as seen in Arkansas,[9] or by falling short of expected gains, as in Georgia.[10] Health plans depend on stable enrollment to remain viable, and policies that reduce coverage for otherwise eligible individuals raise serious concerns. The Medicaid unwinding illustrated the disruptive impact of sudden enrollee losses. Plans reported that enrollment volatility not only strained operations but also triggered a surge in pent-up demand, as individuals who 'churned' on and off coverage often required high-cost care that had not been factored into capitation rates. These disruptions continue to affect the adequacy of managed care organizations' rate structures and the challenges are expected to persist for another one to two years. This ongoing instability places particular strain on nonprofit Safety Net Health Plans, most of which operate in a single market and all of which primarily serve Medicaid populations. Repeating this level of volatility annually would be operationally unsustainable for many plans.

Minimum Cost-Sharing for Medicaid Expansion Enrollees

If passed, the reconciliation legislation would require states to impose cost-sharing for health care services for Medicaid expansion enrollees with incomes above 100 percent of the FPL. ACAP has several serious concerns with this provision. Past experiments with imposing costs for people with Medicaid covered have resulted in lower coverage and lower utilization of services. Over two decades ago, the Oregon Medicaid program experimented with imposing relatively low-cost premiums for a portion of its Medicaid program, and this led to substantial loss of coverage among the people required to pay.

Our worry is that people will forego needed health care. In addition, while we appreciate that copayments would be capped at a certain amount to mitigate impact, we suspect that ultimately, the $35 per service limit will *not* render services affordable at all. For people with very low incomes – from 100 to 138 percent of the FPL – $35 may not be financially management, and also, we are concerned for individuals who rely on services that reoccur regularly, like behavioral health visits or treatments for chronic conditions or cancer. Weekly payments for such care, for example, costing $35 out of pocket each time, is highly likely to be unaffordable for anyone with Medicaid coverage, even with the cap of 5 percent of family income.

We also raise concerns about the capacity of states to manage this policy. The legislation would exempt individuals with incomes below 100 percent of the FPL, but people low incomes – frequently hourly wage earners – experience frequent income fluctuations, and we question how states, already under-resourced, will track these changes effectively to ensure exempted individuals are not subject to copayments.

---

[9] Leighton Ku and Erin Brantley, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs* 39, no. 11 (November 2020): 1928–36, https://doi.org/10.1377/hlthaff.2020.00538.
[10] Laura Colbert and Leah Chan, *Georgia's Pathways to Coverage Program: The First Year in Review*, Georgia Budget & Policy Institute, April 4, 2024, https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/.

INDIVIDUAL MARKET COVERAGE

ACAP also wishes to weigh in on the Committee's proposals impacting individual market Qualified Health Plan (QHP) coverage available through state and federal Exchanges. First, we wish to note that, while not under this Committee's jurisdiction, we are concerned about the potential expiration of the enhanced premium tax credits (ePTCs) at the end of 2025. We urge Members to ensure that the tax credits are extended before the bill is set for consideration on the Floor. **We wish to flag that if a "current policy baseline" is used to extend the Tax Cuts and Jobs Act, the Enhanced Premium Tax cuts, as established in the Inflation Reduction Act, are also tax credits that can—and should—be extended as such.**

If the tax credits are not extended by the time rate filings are due in late summer and consumer notices are sent, premiums are expected to rise to 4.3 percent in 2026 and 7.7 percent in 2027, it is expected to lead to an estimated 3.7 million consumers becoming uninsured by 2027. When taken in conjunction with the policies proposed in the Committee's reconciliation draft language, we expect an even greater rise in premiums and loss of coverage. We further elaborate on such concerns below.

APTC Interaction with Medicaid Work Requirements

ACAP has long supported ensuring access to affordable coverage, including through a "no wrong door" approach and access to advance premium tax credits (APTCs) for low-income consumers. Unfortunately, language at section 44141(a)(7)(B) of the Committee mark would remove the "no wrong door" approach for consumers applying for coverage via Medicaid, thereby making them ineligible for APTCs if they fail to meet provisions related to Medicaid work requirements—even if they should otherwise be eligible for APTCs based on their income and Marketplace eligibility guidelines. **Some states automatically check Medicaid eligibility before checking APTC eligibility, so this may have the unintended consequence of preventing APTC eligible consumers from accessing coverage.** We also strongly object to unequal treatment of consumers eligible for APTCs based on their income—permitting some consumers to receive APTCs and denying it to others, regardless of whether they have the same projected income. Such a policy could impact consumers who briefly fall ill or are injured and are unable to work for a month, or who are seasonal workers whose incomes fluctuate and are predominantly from one portion of the year. **We urge Congress to remove language preventing some consumers from otherwise accessing affordability assistance for which they would be eligible but for the fact that they applied first to Medicaid and do not meet Medicaid work requirements.**

Changes to Enrollment Periods for Enrolling in Exchanges

The Committee's proposed language at 44201(a) would mandate open a shortened open enrollment period running from November 1 to December 15 of a given year, including for State Based Exchanges (SBEs), which have long been permitted to determine their own open enrollment and special enrollment periods based on their unique state needs. ACAP commented in response to the

proposed Marketplace Integrity and Affordability rule objecting to such a limited open enrollment period, however, we object even more vociferously to doing so in statute. **Extended open enrollment periods have previously been utilized in times of national need, such as during the COVID public health emergency and we urge Congress not to limit in statute the ability to do so in the future.**

As ACAP noted in its previous comments, shortening the open enrollment period will degrade the risk pool, lead to consumer confusion, and lead to significant operational burden for issuers and brokers. Finally, we also are extremely concerned that such a provision would be implemented for this coming open enrollment period, as consumers may need additional time to change plans after January 1st if the enhanced PTCs are not extended and their premiums rise significantly. Given the uncertainty about whether the tax credits will be extended, without such flexibility, consumers may well be liable for significant, unexpected premium increases in order to keep their insurance.

The Committee's proposed language would also prohibit special enrollment periods (SEPs) based on income level. ACAP supported eliminating the blanket SEP for consumers under 150 percent FPL in the Federal Exchange as part of the Marketplace Integrity and Affordability proposed rule, as ACAP plans have firsthand experience of adverse selection from consumers enrolling through SEPs and acknowledge a recent rise in improper enrollments. **We note, however, that such proposals are better suited to regulation than statute and that states should be permitted the flexibility to develop their own SEPs.**

Finally, as noted above, ACAP member plans have seen significant adverse selection and possible abuse of SEPs. **ACAP supports increased enrollment verification requirements, however, we urge the Committee to (1) adjust the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse, and (2) permit SBEs to continue to establish their own pre-enrollment verification standards.** Operationally, a generic threshold may be both difficult to implement and not effective, as it could lead to SEP verification based on volume or ease of verification in order to meet the 75 percent threshold, rather than verification of SEP types that have the most fraud. ACAP recommended to CMS, for example, to direct Exchanges to instead starting with SEP verification requirements for SEP types that tend to have the most instances of fraud or abuse. We also recommend that CMS permit SBEs to retain their own verification rules. SBEs will experience high operational burden and cost to change their SEP verification rules. States also are best positioned to take into account local issues and decisions that may impact the opening of a SEP—such as during a natural or man-made disaster,[11] for which

[11] Massachusetts instituted an SEP in 2018 in response to a natural gas explosion: https://www.mahealthconnector.org/wp-content/uploads/AdminBulletin01-18.pdf; an SEP For TX, LA, FL, GA, and SC in response to Hurricanes Harvey and Irma https://www.cms.gov/newsroom/press-releases/cms-announces-special-enrollment-periods-americans-impacted-recent-hurricanes; an SEP was instituted in North Carolina in response to Hurricane He https://www.hendersonville.com/news/2025/01/people-impacted-by-hurricane-helene-granted-special-enrollment-period-for-aca-health-insurance/; and an SEP was instituted in California in response to the recent wildfires https://www.coveredca.com/apply/emergency/

verification may be difficult if not impossible for consumers, but that if are left unverified would risk making the SBE unable to meet the 75 percent threshold.

Verifying Income for Individuals Enrolling in a Qualified Health Plan Through an Exchange

Changes at 44201(b) would require further eligibility verifications for low-income consumers. **While ACAP understands the importance of increased verifications, we strongly believe that such requirements are better suited to regulation than statute, as they may warrant flexibility in the future**, particularly in the case of income discrepancies for which changes to available data sources may warrant consideration. **ACAP also wishes to note that these provisions are best left until after other provisions, such as elimination of the SEP for consumers under 150 percent FPL are implemented, as doing so may well eliminate the current need for additional verification requirements, which are expected to cost millions to implement due to changes needed to eligibility and enrollment systems.**

Further, the desire to increase enrollment verifications is in response to claims that that millions of applicants are inflating their incomes. We agree that there may be an incentive for consumers to do so, particularly in states that have not expanded Medicaid. However, while we understand that there may be some consumers who overestimate their income, we believe that millions of consumers doing so is an overestimate, based on methodological and data issues addressed in our comments on the Marketplace Integrity and Affordability proposed rule. We also know that it is not uncommon for low-income consumers, particularly those who work in hourly, gig, or seasonal employment to have difficulty predicting their annual income, and may reasonably assume they will be able to work additional hours in the coming year, receive a promotion, or a variety of other things that could increase wages. As long as PTC eligibility is conditioned on the upcoming year's income, there must be ways to account for changes to income that an enrollee may be aware of but are not included in previous year's tax data.

GAO has recommended that a verification process for "when attested income amounts *significantly* exceed income amounts reported by IRS or other third-party sources."[12] As such, in conjunction with the fact that many low-income enrollees' incomes are variable, ACAP urges that Congress instead consider a threshold amount after which point it verifies income, such as a certain percentage or dollar amount above the previous year's income, rather than simply a blanket verification at 100 percent FPL. For example, it would not be unreasonable that someone whose reported income was 99 percent FPL could have an estimated income the following year of 110 percent FPL—which would represent not even a $1,000 difference. ACAP believes it is important to balance verification requirements with ensuring that lower-income consumers who should legitimately receive PTCs are able to do so. **We urge that Congress, in its efforts to ensure that consumers who should not receive tax credits do not inappropriately receive them, not overcorrect to the point where**

[12] U.S. Government Accountability Office (2017, July). Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit; https://www.gao.gov/assets/d17467.pdf

consumers who are eligible are prevented from receiving APTCs, without which they are unlikely to be able to afford health insurance at all. For example, it is unlikely that a consumer earning $15,000 annually could afford a full monthly health insurance premium up front and wait until tax reconciliation for repayment.

Revising Rules on Allowable Variation in Actuarial Value of Health Plans

Section 44201(c) would statutorily loosen the actuarial value (AV) de minimis variation permitted by QHPs. While ACAP was overarchingly supportive of such a change in the Marketplace Integrity and Affordability proposed rule, we strongly object to such a change being made in statute. **Due to the interplay with the Premium Adjustment Percentage and the annual Actuarial Value Calculator, we believe it is vital that CMS be able to adjust AV de minimis variation as needed.**

CMS' proposal to permit greater AV de minimis variation would have provided issuers with needed flexibility in their plan design, however, as we noted in our comments on the rule, permitting a greater downward variation in AV can make it harder to distinguish between metal tiers and reduce the value of the coverage consumers are purchasing. Additionally, we are extremely concerned about the effective date of this provision as 2026 plan design is already underway as QHP applications are due this week in many states.

Updating Premium Adjustment Percentage Methodology

Section 44201(d) would **statutorily legislate a change to the premium adjustment percentage methodology—a methodology not developed by Congress and which may warrant future regulatory change as it is meant to be responsive to premium fluctuations in the market.**

This provision will raise costs for consumers significantly; consumer premiums are expected to increase by approximately 4.4 percent and cost sharing and maximum out of pocket (MOOP) limits would rise by 15 percent. ACAP opposes this proposal to update the PAP methodology both generally and in statute, due to its impact on premiums and cost sharing and the resulting impact on enrollment. Specifically, the proposed PAP methodology will result in a downward pressure in enrollment and upward pressure on claims. That combination runs the risk of leading to a spiral of a worsening risk pool and increased premiums.

As with the provision on de minimis AV ranges, **ACAP is extremely concerned about the effective date for this proposal as issuers have already begun working on actuarial calculations and product design for PY 2026, which are due this week in many states, yet would be impacted by a change to the PAP methodology.** Changes that impact product design parameters, such as cost sharing and MOOP, are extremely difficult to implement last minute.

Eliminating the Fixed-Dollar and Gross Percentage Thresholds Applicable to Exchange Enrollments

Section 44201(e) would remove recent flexibilities that would allow issuers to adopt a 98 percent or greater gross premium percentage or $10 or less fixed dollar premium payment threshold in addition to the 95 percent or greater net premium payment threshold option. CMS in the Marketplace Integrity and Affordability Proposed Rule specifically proposed this provision in order to ensure that consumers do not remain enrolled in coverage for extended periods of time without paying at least some premium as a measure to guard against improper enrollments. Further, **we do not expect this provision to have a budgetary impact or associated score, as it would not change current policy because the fixed-dollar and gross premium percentage thresholds were not set to go into effect until 2026.**

Regardless, ACAP objects to the proposal eliminate the gross percentage and fixed dollar premium payment thresholds. Specifically, **we support greater flexibility for issuers to determine whether and what type of premium payment threshold to institute based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.** This provision has the potential to cause disruptions in coverage and care for consumers over nominal dollar amounts.

Reducing Advance Payments of Premium Tax Credits for Individuals Automatically Reenrolled in $0 Coverage

44201(g) would prevent enrollees from automatically reenrolling in coverage that is fully covered by APTCs without taking action to confirm their eligibility information. Any enrollee whose premium would be $0 after APTCs must submit an application for an updated eligibility determination or they will be charged a $5 per month premium for every month that the enrollee does not update their eligibility determination.

ACAP strongly objects to the Committee's proposal to charge $5 per month to any enrollees receiving $0 coverage who do not return to the Exchanges to confirm their eligibility. First and foremost, this proposal will create significant burden and cost for ACAP's not-for-profit member plans. When asked, one ACAP member noted that it would cost more to change the systems and send the paperwork than the $5 premium. In addition, the $5 is not an extra $5 that the issuer would be receiving—but rather the same $5 that would have come from APTCs and that will, in most cases, go back to the consumer at tax reconciliation, leading to a net loss for issuers and no significant budgetary impact except for consumers who simply drop their coverage rather than pay the $5 premium, which CMS itself asserted in its impact assessment of the Marketplace Affordability and Integrity proposed rule that it believes that the number of enrollees who would have their coverage terminated due to non-payment of the $5 premium is low "given the nominal expense associated with the proposed APTC adjustments."

ACAP further objects to this proposal as any costs associated with system updates, mailing invoices, and collecting the $5 premium will be a loss to the issuer and an increase in issuers' administrative funds, which must already be limited under medical loss ratio (MLR) requirements. Such costs will need to be offset and will therefore necessitate an increase in premiums across the board – both for consumers receiving APTCs and consumers that self-pay the full cost of premiums. Issuers will also

need to account for changes to the risk pool that will result from the consumer confusion associated with receiving a $5 bill for coverage that they know is supposed to be $0 and thus dropping off coverage or entering their grace period and eventually having their coverage terminated. It is safe to expect that healthier consumers are more likely let coverage lapse if they believe their premiums have increased, which will again have a resulting destabilizing impact on the risk pool and require issuers to factor those changes into rates—again increasing premiums across the board and continuing the cycle. Instead, the current reenrollment process helps stabilize the risk pool by retaining lower risk enrollees who are the least likely to actively re-enroll.

Finally**, when taken in conjunction with the proposal at 44201(j) to permit issuers to condition effectuation of new coverage on payment of past due premiums, it could cause significant, long-term harm to a low-income consumer**; it could be devastating to a low-income consumer who knows they are eligible for $0 coverage and therefore assumes the bill is a mistake and disregards it.

Prohibiting Coverage of Gender Transition Procedures as an Essential Health Benefit

44201(h) would prohibit covering the services associated with gender affirming care as an essential health benefit (EHB). As a result, PTCs cannot include the cost of such services, nor would they be subject to annual or lifetime cost sharing limitations. **We question whether this provision would produce any savings, as we expect it will cost more to implement than it would save, potentially causing premiums to increase, rather than leading to a decrease in PTC spending.**

ACAP strongly opposes this provision and urges this Committee to reconsider it based on a number of operational and financial reasons. First and foremost, by definition the procedures listed herein are not essential health benefits themselves but would be required to be excluded as such dependent on *why* they are performed—but would largely be covered as essential health benefits when performed for other reasons. Specifically, the services in question are also performed for many other than gender transition—such as a hysterectomy to treat or prevent cancer, infection, or even endometriosis; or hormone therapy to treat menopause, cancer, any number of endocrine disorders, as part of continued treatment after a hysterectomy, or as treatment for infertility. For these cases, the services would be covered as essential health benefits, requiring issuers to impose additional utilization management and prior authorization requirements for potentially lifesaving care. The operational burden of filtering claims to exclude certain services only in certain cases would be tremendous for ACAP's member SNHPs, particularly when it comes to pharmacy claims. **Implementing such a policy would require significant, expensive systems changes and the ongoing cost would far exceed the cost of providing such services.** This poses a particularly significant financial burden on small, regional and single-state issuers, such as ACAP's member plans. Instead of reducing costs, issuers will be forced to raise premiums, ultimately increasing costs for consumers.

Clarifying Lawful Presence for Purposes of the Exchanges

44201(i) would change the definition of "lawfully present" so that DACA recipients are no longer considered lawfully present for purposes of enrollment in a QHP, eligibility for premium tax credits

and cost sharing reductions. ACAP is concerned that such a policy would have a negative impact on the risk pool and premiums for all consumers are expected to rise as a result. As CMS notes in its Regulatory Impact Analysis of the Marketplace Integrity and Affordability proposed rule, because DACA recipients are young, they generally tend to be healthier, and that excluding them from the Exchanges would have a negative impact on the individual market risk pool. Further, if DACA recipients are unable to enroll in Exchange coverage, they are more likely to go uninsured, which is expected to have the effect of increasing uncompensated care at emergency rooms. Such costs are ultimately absorbed into hospital operating costs and have the effect of raising provider reimbursement costs for all forms of coverage—subsidized or not—and increasing costs to all insured Americans.

Ensuring Appropriate Application of Guaranteed Issue Requirements in Case of Non-Payment of Past Premiums

44201(j) would allow issuers the option to condition new coverage on repayment of outstanding debt from previous years by changing the interpretation of guaranteed availability of coverage. The proposal would allow issuers to attribute past-due premium payments to the initial premium an enrollee must pay to effectuate coverage.

While ACAP's member SNHPs have seen abuses by consumers stopping paying premiums and entering the grace period after an expensive treatment or entering the grace period during the last 90 days of the year in order to avoid paying premiums, we are concerned about a statutory provision as it is currently drafted. ACAP supported a similar optional proposal in 2017, however, that proposal limited the look-back period for past nonpayment to the previous 12 months of coverage. **As we recommended in the Marketplace Integrity and Affordability proposed rule, we strongly believe that this proposal should be regulatory in nature and that any such proposal be limited to premiums due from the past 12 months of coverage.**

While some consumers may game the system by not paying premiums during the final months of the year, we also know that others stop due to legitimate financial hardship. This rule has the potential to disproportionately affect low-income individuals; as studies show that even a small increase in premium costs can lead to a loss in coverage.[13] Additionally, **if consumers do experience a significant financial hardship that leaves them unable to pay significant premiums, ACAP does not believe that should prevent them from being able to purchase coverage into perpetuity, and the provision could be particularly impactful for consumers in states that have a limited number of QHP issuers**, as 4% of consumers in FFE states have just one or two QHPs available to them.[14]

Finally, while the Committee proposes that this provision would become effective for plan year 2026, it will have the effect of changing the rules around their current insurance coverage, as their

[13] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[14] https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf

current policy documents would not inform them of the potential impact of dropping coverage and some consumers may have already let their coverage lapse in 2025.

Conclusion

ACAP thanks the House Energy & Commerce Committee for this opportunity to comment on the reconciliation legislation. Please contact me (mmurray@communityplans.net), Jennifer McGuigan Babcock, our Senior Vice President for Medicaid Policy (jbabcock@communityplans.net), or Heather Foster, Vice President for Marketplace Policy (hfoster@communityplans.net) if you wish to discuss these issues in greater depth.

Sincerely,

Margaret A. Murray
Chief Executive Officer

Cc: Members of the House Energy & Commerce Committee

May 9, 2025

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Re: Protect Critical Medicaid Funding to Preserve Coverage, Access and the Health Care Delivery System

Dear Chairman Guthrie and Ranking Member Pallone:

Today, Medicaid plays a big role in making America a strong and independent nation. By providing essential health coverage through Medicaid to 78.5 million Americans – 15 million of whom live in California – our great country is supporting strong families, protecting American workers, and contributing to the greatest, most advanced health care sector in the world.

The Local Health Plans of California represents 17 public and not-for-profit Medicaid managed care plans in California that collectively serve over 9.5 million Medicaid beneficiaries. Local health plans play a unique role as they are community-based, locally governed and publicly accountable, with a responsibility to ensure the core population we serve, Medicaid beneficiaries, has access to a network of providers that are paid a fair rate to provide care that helps keep enrollees from utilizing unnecessary emergency care. Given our central focus on the safety net, we urge you to protect Medicaid by rejecting major cuts under consideration as a part of the budget reconciliation process. While we welcome Congressional efforts designed to increase program efficiencies and target waste, fraud and abuse, and ensure sufficient resources are available for the most vulnerable, we remain concerned that the cuts under consideration will instead result in coverage loss, increases in uncompensated care, poorer health outcomes for low-income working families, and job loss in local communities.

Specifically, we urge Congress to:

- **Uphold the current financing structure for the Medicaid expansion population that includes working parents, disabled adults, and other vulnerable populations that rely on Medicaid to stay healthy, productive members of their communities.** Changes to underlying Medicaid financing structures, including per capita caps or FMAP reductions for the Medicaid expansion population, will lead to loss of coverage or

reduced benefits for millions of families across the country. *For California alone, the impact of significant changes to Medicaid financing structures such as the federal matching ratio or establishing per capita caps for the expansion population, could mean a loss in federal funding of more than $20 billion annually, depending on the specific proposal.* Even cuts that are much less severe than reducing the federal matching rate to 50% will have a significant and harmful impact on Medicaid beneficiaries and providers.

California, like other states, could not absorb such a significant loss of federal funding and maintain the program at the current coverage or service levels. Significant cuts to funding for the Medicaid expansion population will ultimately lead to difficult decisions about cutting coverage and benefits for millions of Californians, including those who are most vulnerable.

- **Preserve critical Medicaid financing mechanisms that ensure hospitals, long-term care providers, and other health care providers can continue to serve Medicaid populations.** Provider taxes are essential to funding nearly all states' Medicaid programs. Reductions to these taxes would mean that the viability of key safety net providers would be in jeopardy, particularly rural hospitals and hospitals that serve a high proportion of Medicaid beneficiaries. In California, provider taxes mean that hospitals can afford to serve the Medicaid population and provide access to care despite, in many cases, still experiencing losses on Medicaid overall. Even with provider taxes, 60% of California's community safety net hospitals, the hospitals whose patient mix is predominantly Medicaid, are operating at a loss several years post-pandemic. *Without provider taxes, Medicaid reimbursement to hospitals in California would fall from paying 80 cents of every dollar it costs to provide care to 70 cents of every dollar.* Additionally, as a result of Proposition 35 which was supported by 68% of California voters, our state is dedicating critical resources through its MCO tax to improving access to care in Medicaid through workforce funding, and enhanced reimbursement for primary care, specialty care, hospital services, and other Medicaid services.

  Overall, California stands to lose more than $90 billion dollars in federal funding over the 10-year scoring period if provider taxes are eliminated. Even cuts that are a fraction of this amount would be devastating and result in reduced hospital services or even hospital closures, particularly in rural areas where many hospitals are already experiencing financial distress. Without federal funding through California's MCO tax, longstanding workforce shortages and access gaps will remain for those who need care the most.

As the House and Senate contemplate cuts to the Medicaid program, we remind Congress of the strengths of Medicaid:

Medicaid Supports Our Economy

Medicaid is a cornerstone of American economic strength. One in five American workers receives health coverage through Medicaid, enabling them to be productive members of society. These hardworking Americans serve our communities in restaurants, big box stores, and construction sites. With Medicaid's support, they can focus on their jobs without the constant worry of medical bankruptcy or untreated illness.

By keeping our workforce healthy, Medicaid ensures that America's economic engine continues to run smoothly. Workers with reliable healthcare miss fewer days, are more productive, and contribute more fully to our nation's prosperity.

Medicaid Makes American Families Strong

The strength of our nation rests on the strength of our families. Medicaid provides vital coverage to millions of children, seniors, and people with disabilities. Nearly half of all Medicaid enrollees are children – approximately 37 million young Americans receive the preventative care and medical treatment they need to grow into healthy, productive citizens.

When parents have health care coverage, they can maintain employment while caring for their families. Regular preventative care and treatment for chronic conditions keeps Americans of all ages healthy and productive. By supporting multi-generational care, Medicaid upholds our country's commitment to family values and ensuring no American is left behind.

Medicaid Contributes to America's World-Class Medical Infrastructure

America's health care system is the envy of the world, and Medicaid plays a critical role in maintaining this excellence. The program supports hundreds of thousands of health care workers and hospitals across the nation. Rural hospitals, in particular, rely on Medicaid to keep their doors open and continue serving communities that would otherwise lack access to medical care.

By ensuring a steady stream of patients and reliable payment, Medicaid helps maintain the viability of our health care infrastructure from coast to coast. This system enables American health care innovation to continue flourishing, developing life-saving treatments that benefit people worldwide.

Medicaid Has Helped Erase High Rates of Uninsured Americans

Before Medicaid expansion, millions of Americans went without health insurance, leading to high rates of personal bankruptcy from unpaid medical bills and financially struggling hospitals burdened with uncompensated care. Today, Medicaid has dramatically reduced these problems, strengthening both individual financial security and the stability of our health care institutions.

The impact is clear: fewer families face financial ruin from medical emergencies, and hospitals can focus more resources on providing quality care rather than absorbing the costs of treating the uninsured. This achievement represents American pragmatism at its best – solving problems through practical solutions.

Medicaid is Efficient and Effective

As stewards of taxpayer dollars, we must recognize Medicaid's remarkable efficiency. The program delivers health care at costs 83% lower than private coverage, showcasing smart government that works for the American people. This cost-effectiveness demonstrates that Medicaid is not just compassionate policy but fiscally responsible governance.

The American people understand Medicaid's importance to our nation's foundation, with three in four voters expressing support for the program. This bipartisan backing reflects the recognition that Medicaid strengthens America's families, workforce, health care system, and economy.

As you consider upcoming legislation affecting Medicaid, I urge you to protect and strengthen this vital program that underpins so much of what makes America great. Our nation's continued strength and prosperity depend on maintaining this critical support for hardworking Americans and their families.

Sincerely,

Chief Executive Officer
Local Health Plans of California

Cc: Speaker Mike Johnson
Democratic Leader Hakeem Jeffries
CA Delegation Members

May 9, 2025

The Honorable Mike Johnson
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives
Washington, DC 20515

The Honorable Brett Guthrie
Chairman
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

RE: CALIFORNIA HEALTH CARE LEADERS' RESPONSE TO FREEDOM CAUCUS RECOMMENDATIONS TO CUT MEDICAID

Dear Speaker Johnson, Minority Leader Jeffries, Chairman Guthrie, and Ranking Member Pallone,

On behalf of the undersigned health care organizations and the 15 million Californians covered by Medicaid whom we serve, we are writing in response to the Freedom Caucus letter to House Colleagues dated May 1, 2025. The letter urges devastating cuts to the Medicaid program that would hurt every American, threaten the viability of our nation's health care system, and drive up costs for all. The proposed Medicaid cuts threaten care for millions of children, seniors, veterans, people with disabilities, and low-income working adults with chronic conditions. Not to mention the severe harm cuts would inflict on the economic well-being of every rural community.

The letter contains multiple inaccuracies, mischaracterizations, and false assumptions that must be corrected:

- **The letter states that California's managed care organization (MCO) tax allows federal**

funds to be utilized inappropriately. The truth is that California's MCO tax law, under Proposition 35, is explicit in that all MCO tax revenue must be dedicated to Medicaid services, and the state cannot supplant existing state Medicaid funding with federal dollars. California's MCO tax increases rates for providers to improve access to cost-effective primary and specialty care and shore up front-line emergency departments and rural hospitals. It also invests in clinical training to address health care professional shortages in rural areas, so patients have better access to preventative care and services to manage chronic conditions.

- **The letter calls for cuts to Medicaid for people who entered the program through expansion, by claiming federal support should be stripped for "able-bodied, working-age adults."** The truth is that Medicaid expansion enables low-income working adults who do not have access to employer-sponsored insurance to continue to be gainfully employed. The majority of Medicaid expansion adults make less than $21,000 per year and are not able to get coverage through their employers, so Medicaid is the insurer of last resort. In addition, nearly 70% of disabled adults enrolled in Medicaid did so via expansion. Expansion allows these adults to gain access to treatment and medications so they can work.
- **The letter calls on Congress to address "money laundering" by limiting provider and MCO taxes.** The truth is that provider and/or MCO taxes have been used for decades in 49 states, and only with regular approval by the federal government via a rigorous review process that complies with federal law.
- **The letter suggests that MCO taxes are wasteful and unnecessary.** The truth is that these resources have strengthened our nation, helping it through pandemics, economic recessions, natural disasters, and more. California's MCO tax keeps hospitals open, nurses employed, doctors in practice, rural communities whole, and saves people's lives. That is the opposite of wasteful.
- **The letter states that Texans are paying for California Medicaid patients.** The truth is that California taxpayers pay nearly $85 billion more each year in federal taxes than they receive in federal funding. California plays a significant role in financing the nation's Medicaid program and other services.

Beyond these facts, the direct impact of Medicaid cuts would be severe.

Medicaid Cuts Harm Everyone

As people lose coverage and become sick, they delay cost-effective primary and preventive health care services and are forced to eventually seek treatment in hospital emergency departments, the most expensive care setting. As more uninsured people get care in emergency departments, physician and hospital provider viability is threatened and insurance

premiums increase for everyone. Many rural hospitals, clinics, and doctors are already operating on thin or negative margins and will be forced to close, further reducing access to health care for all Americans.

Medicaid Cuts Mean Massive Job Losses

Medicaid cuts will result in hundreds of thousands of jobs being lost, bringing economic instability to communities across the nation. An estimated 477,000 health care jobs and another 411,000 related jobs are at risk due to the current proposals. State economies are estimated to lose $95 billion in GDP in 2026 alone, a blow not only to local communities but the national economy as well. The loss of provider and MCO taxes alone would pull $630 billion from the national health care system.

Medicaid provides care that has helped low-income adults work and care for their families. It has reduced health care costs by helping those with chronic conditions manage their illnesses. It has improved health outcomes and saved lives. We urge Congress to protect and support the hospitals, doctors, clinics, nursing homes, employers, the nation's taxpayers, and most importantly, those for whom Medicaid is a lifeline.

We applaud Congress' goals to strengthen the economy, as doing so will ensure that fewer people need the Medicaid safety net. We also support efforts to curb true waste, fraud, and abuse in the Medicaid program and are happy to discuss ways to help. We stand ready to work with you on these important goals, but we urge you to protect Medicaid.

Protect Our Health Care Coalition

Cc: House Republican Leadership

California Congressional Delegation