



VIA TRUE FILING

October 6, 2026

Honorable Chief Justice Patricia Guerrero
and Associate Justices
Supreme Court of California
350 McAllister Street
San Francisco, California 94102

**Re: Amicus Curiae Letter by a Coalition of Medi-Cal Providers in Support of
Petition for Writ of Mandate**

California Ass'n Health Plans et al. v. California Dep't Health Care Servs. et al.
(case no. S298916)

Dear Chief Justice Guerrero and Associate Justices:

The California Primary Care Association, California Association of Rural Health Clinics, California Dental Association, and California Hospital Association (collectively, “Provider Coalition”) hereby submit this letter in support of the petition for writ of mandate in the above-mentioned case, brought by the California Association of Health Plans, the California Medical Association, Dustin Corcoran, and Charles Bacchi (collectively, “Petitioners”). The petition implicates issues of immense importance to millions of Californians who depend on frontline health care providers, like the members of the associations now before the Court, to deliver health care services to the State’s most underserved communities through the Medi-Cal program. Also at stake are the interests of millions more California voters who overwhelmingly passed state initiative Proposition 35 (“Prop. 35”) to stabilize funding for Medi-Cal and expressly guarantee that the State spends Managed Care Organization (“MCO”) tax revenue only to support the Medi-Cal program. Senate Bill 125 (“SB 125”) betrays the will of the People in directly violating the clear mandates of Prop. 35, with irreparable consequences on the Medi-Cal program and the State’s ability to draw on matching federal support if the Court were to not intervene now.

I. INTERESTS OF AMICI CURIAE

The Provider Coalition consists of statewide trade associations representing the interests of licensed professionals, hospitals, outpatient facilities and clinics, and community centers that form the safety net to deliver health care to millions of Californians through the Medi-Cal program. The California Primary Care Association represents the

interests of more than 2,300 not-for-profit community health centers and regional clinic associations in California that provide comprehensive healthcare services to 6.7 million unique patients each year, particularly to low-income, uninsured, and underserved populations in medically underserved areas. The California Association of Rural Health Clinics is comprised of 158 clinic members helping to expand access to health care in the rural parts of the state. The California Dental Association represents the interests of dental professionals on behalf of its 27,000 members, empowering and supporting the practice of dentistry throughout all sectors and practice settings in California. The California Hospital Association is one of the largest hospital trade associations in the nation, advocating on behalf of nearly 400 hospitals and health care systems in California—comprising over 90 percent of its hospitals—to establish and maintain a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high-quality patient care.

The members of the Provider Coalition deliver nearly the full spectrum of health care services to the State’s Medi-Cal population. Each of the Provider Coalition associations regularly participates as *amicus curiae* in important cases like this one, where their expertise and experience can assist courts decide significant issues of public importance affecting the Medi-Cal program and its enrollees.

II. ARGUMENT

A. The State Has Historically Underpaid Medi-Cal Providers and Worsened Access Gaps in a Safety-Net Program Currently Serving Over One Third of All Californians.

Nearly 14 million individuals are currently eligible or enrolled in Medi-Cal – roughly 35 percent of the state population.¹ Within Los Angeles County, where over one-quarter of the state population resides, close to 40 percent of the county’s population is enrolled in Medi-Cal. The program is predominantly comprised of communities of color. Latinos make up the largest share at 51.4 percent of all enrollees; White residents make up 15.8 percent, Asian/Pacific Islanders represent 9.8 percent, and African Americans make up 6.8%.² Medi-

¹ See E. Ramirez & M. Dietz, “Medi-Cal Enrollment by District and County 2026,” UC Berkeley Labor Center, online at <https://laborcenter.berkeley.edu/medi-cal-enrollment-by-district-and-county-2026/> [visited 10-3-2026]. Enrollment had been near 16 million in 2024. *Id.*

² Dep’t Health Care Servs., “Medi-Cal Monthly Eligible Fast Facts” (July 2026) at 9, online at <https://www.dhcs.ca.gov/wp-content/uploads/2026/07/Fast-Facts.pdf> [visited 10-4-2026].

Cal covers almost 40 percent of all births in California and accounts for more than half of California children up to age 18 (60 percent of children ages 0 to 5).³

Medi-Cal enrollees are historically underserved and sicker than the general population. They have significantly higher rates of complex health needs, chronic illness, and co-occurring conditions, such as asthma, high blood pressure, diabetes, heart disease, and serious mental health issues.⁴ Despite needing more care, Medi-Cal enrollees are more likely to face delays and difficulty accessing dental and primary care services, with even greater problems accessing specialty care or labor and delivery services.⁵ Compared to individuals with private insurance, Medi-Cal enrollees are much more likely to report having no usual site of care other than emergency departments.

Medi-Cal has persistently ranked near the bottom in the nation in provider reimbursement rates, which translates directly to large gaps in access to care for Medi-Cal enrollees. One measure of a state's Medicaid reimbursement level is to compare its rates to what the federal government would pay for the same service under the Medicare program. California's overall Medicaid-to-Medicare fee index sits at 0.67, meaning the state pays just 67 percent of what Medicare pays for the same medical services.⁶ This falls well below the national average index of 0.75. The disparity is more acute when looking at primary care services; California pays 56 percent of what Medicare pays, which is ten points below the national average of 0.66. Medi-Cal rates have historically placed California near the bottom among all 50 states.⁷

To make matters worse, the California Legislature has repeatedly imposed Medi-Cal payment reductions and freezes as a means to shore up general budget shortfalls. In 2008, the Legislature required 10 percent reductions to Medi-Cal fee-for-service payments, including reductions applicable to physicians, nurse practitioners, certified nurse midwives,

³ Dep't Health Care Servs., "Medi-Cal Quick Stats," (Jan. 2016) at 2, online at https://www.dhcs.ca.gov/wp-content/uploads/2025/10/Medi-Cal_Penetration_Brief_Final.pdf [visited 10-4-2026].

⁴ See "Californians with the Top Chronic Conditions," Cal. Health Care Almanac (April 2015), online at <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ChronicConditionsCaliforniansCHIS2015.pdf> [visited 10-4-2026].

⁵ See "Measuring Up? Access to Care in Medi-Cal Compared to Other Types of Health Insurance," Cal. HealthCare Foundation (2018) online at <https://www.chcf.org/wp-content/uploads/2021/08/MeasuringUpAccessMediCalComparedOtherInsurance2018.pdf> [visited 10-4-2026].

⁶ See Medicaid-to-Medicare Fee Index (2024), KFF, online at <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22All%20Services%22,%22sort%22:%22asc%22%7D> [visited 10-3-2026].

⁷ See S. Zuckerman et al., "Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs," Cal. HealthCare Foundation (April 2009) at 17 (ranking California 47th in the nation in physician reimbursement rates).

nurse anesthetists, and organized outpatient clinics, and also capped certain reimbursement rates at prior-year levels. *See, e.g.*, Assembly Bill 5 (Third Extraordinary Sess. 2008); Assembly Bill 1183 (2008) (5 percent reduction). In 2011, California enacted an additional 10 percent reduction for Medi-Cal fee-for-service benefits and an actuarially equivalent reduction for many Medi-Cal managed care plans. *See* Assembly Bill 97 (2011). More recent legislative action has tried to improve rates, but the impact of historically low reimbursement remains.

In addition to rate reductions as a means to reducing program costs, the Legislature has cut certain services altogether from coverage under Medi-Cal. *See* Welf. & Inst. Code § 14131.10 (cataloging services that have been dropped from coverage from 2009 to present).

B. Prop. 35 Established Clear Mandates Designed to Shore Up the Medi-Cal Program, Subject to Applicable Federal Law.

Prop. 35 is designed to directly address the reimbursement and access problems that have hampered the Medi-Cal program. Voters were advised in the official Voter Information Guide that, “Yes on 35 addresses our urgent healthcare crisis by securing dedicated funding—*without raising taxes*—to protect access to primary and specialty care, community clinics, hospitals, ERs, family planning, and mental health providers. Prop. 35 prevents the state from redirecting funds for non-healthcare purposes.”⁸ Such rationale was baked into the text of Prop. 35 itself.

Prop. 35 enacts section 14199.01 of the Welfare and Institutions Code, setting forth detailed findings and policy pronouncements of “the people of the State of California.” The direct connection between the terms of Prop. 35 and the historical problems of Medi-Cal under-reimbursement could not have been made any plainer:

- About 2 out of every 5 Californians, between 12 million and 15 million people, rely on the Medi-Cal program for health care coverage. This includes approximately four million children and two million seniors and people with disabilities.
- However, just being enrolled in the Medi-Cal program does not guarantee access to quality health care. Most Medi-Cal reimbursement rates have not been adjusted in more than a decade, and some providers have not seen a payment increase in over 25 years. As a result, doctors and other health care providers struggle to take on new Medi-Cal patients. Relatedly, Medi-Cal patients, and in some areas entire communities, face a loss of access to critical and emergency

⁸ *See* Official Voter Info. Guide for Prop. 35, online at <https://vigarchive.sos.ca.gov/2024/general/quick-reference-guide/35.htm> [visited 10-4-2026]. No opposition arguments were included in the information guide.

- care as essential hospital services such as labor and delivery are at risk of being reduced or eliminated.
- The problem is exacerbated by a shortage of health care professionals in our state. The current strains on our health care system have left many health care workers physically and mentally exhausted, and thousands have left the profession altogether. This has left our health care system overstretched and made it even harder for the most vulnerable Californians to get access to care, including access to family planning services and other reproductive health care.
 - Medi-Cal patients may wait weeks or months to see doctors who are specialists. The situation is more challenging in rural areas of the state that have fewer primary care providers per person, which results in delays or inability to access basic health care services.
 - Obtaining adequate mental health services can take even longer. California suffers not only from a shortage of mental health care professionals, but also from a shortage of psychiatric beds and treatment for patients with serious mental health conditions. When patients with serious mental health needs cannot obtain adequate care, they frequently wait days in the emergency room or may ultimately be left untreated and become homeless.
 - When Medi-Cal patients are unable to refill a prescription or find a doctor, mental health facility, or other health care provider to treat them, they often end up in emergency rooms. This puts additional, and avoidable, strains on our state's emergency rooms. When Medi-Cal patients are forced to rely on emergency rooms as their primary source of health care, the additional strain makes it harder for all patients to obtain life-saving care.
 - California is one of several states that levy taxes on managed care plans to obtain extra federal dollars to help pay for health care access. **This chapter addresses many of the current flaws in Medi-Cal funding. First, it ensures the existing tax is continued permanently so that California obtains its fair share of federal health care funding. Second, it guarantees that all of the revenue from the continued tax will be spent on investments to improve access to critical health care services and makes it impossible to divert these dollars to unrelated uses.**
 - By ensuring permanent funding for increased Medi-Cal provider payments, generic prescription drug programs, and increasing our health care workforce, bed capacity, and treatment options, and **protecting these dollars from unauthorized uses**, this chapter will improve our overall health care system by providing all patients with greater access to quality health care and affordable drugs.

Welf. & Inst. Code §14199.101 (emphasis added).

To carry out these purposes, Prop. 35 makes the MCO tax established under state law permanent beginning on January 1, 2027, and imposes a cap of \$2.50 per member per month on the non-Medi-Cal tax (with an ultimate limit of \$36 million in total annual revenue). *Id.* at §§ 14199.123(a), 14199.126(a)(1)-(2). Within these parameters, the California Department of Health Care Services (“Department”) must submit annual MCO tax proposals to CMS to “maximize” matching federal participation, **subject to any federal requirements** while staying within the caps imposed under Prop. 35. *Id.* at §§ 14199.124(a)(1)-(4), (b)(1)-(2), (d)(1), 14199.123(d).

Most importantly for Medi-Cal providers, Prop. 35 establishes absolute restrictions on how the State can spend MCO tax revenue. Section 14199.102 sets forth the “Statement of Purpose” in this regard:

In enacting this chapter, the purpose and intent of the people of the State of California is to do all of the following:

(a) Increase access to quality health care by establishing a permanent, dedicated funding stream to be used for increasing reimbursement rates and other supports to health care providers that treat Medi-Cal patients and investments in building an adequate health care workforce, bed capacity, and treatment options.

(b) Increase access to affordable prescription drugs by establishing a permanent, dedicated funding stream to be used to produce and distribute generic prescription drugs through the California Affordable Drug Manufacturing Act of 2020.

(c) **Prevent the revenue stream permanently continued by this chapter from ever being used to fund unauthorized or unrelated programs or from being used to supplant or replace existing sources of moneys that currently fund health care access** and affordable prescription drug programs in this state.

(d) Continue a dedicated funding stream that is fully permitted by federal law, while also ensuring that taxpayers and employers do not bear the financial burden for the implementation of this chapter.

Welf. & Inst. Code § 14199.102 (emphasis added).

Accordingly, Prop. 35 creates the Protect Access to Health Care Fund (the “Prop. 35 Fund”) in the State Treasury, “permanently separate and apart from the General Fund or any other state fund or account.” *Id.* at §§ 14199.103(a)(2)(A), 14199.105(c)(1). All revenue collected under the MCO tax (including all moneys derived therefrom, such as interest and penalties) must be deposited into the Prop. 35 Fund. *Id.* at § 14199.105(c)(1). Such moneys can only be used for specified purposes related to the Medi-Cal program. *See id.* at §

14199.103. Namely, “moneys in the fund shall not be used to replace or supplant state revenue sources” and “shall only be used to expand the health care benefits, health care services, health care workforce, and payment rates above and beyond those already in effect or in existence as of January 1, 2024.” *Id.* at § 14199.107(a)(1). Moreover, “moneys in the fund shall not be borrowed, loaned, or otherwise transferred to the General Fund or any other state or local fund or account.” *Id.* at § 14199.105(b). Leaving no doubt about these restrictions, Prop. 35 declares that the Department “has a nondiscretionary ministerial duty to use all of the moneys in the [Prop. 35] fund, and each sub fund, account, and subaccount within the fund, to accomplish the purposes of this chapter.” *See id.* at §§ 14199.105(c)(2)(A), 14199.106(b)(1), 14199.107(a)(1).

Guarding against attempts by the State to undermine these restrictions, Prop. 35 establishes a high hurdle for amending its provisions. It can only be amended by three-fourths supermajority vote of the Legislature and only if “consistent with, and further[] the purpose of” Prop. 35. *Id.* at § 14199.134(a).

With bipartisan political support (both state Democratic and Republican Parties supported Prop. 35) and an overwhelming margin of victory at the ballot,⁹ Prop. 35 exemplifies “the sovereign people’s initiative power,” which courts must “jealously guard” as “one of the most precious rights of our democratic process.” *Brosnahan v. Brown* (1982) 32 Cal. 3d 236, 241. SB 125 and the State’s efforts to secure an MCO tax thereunder pose direct threats not only to the will of the People but also to the Medi-Cal program.

C. The State’s Actions Under SB 125 Could Irreparably Harm Medi-Cal.

1. SB 125 Squarely Violates Prop. 35’s Provisions Designed to Protect Access to Care.

H.R. 1 has drastically altered California’s ability to use an MCO tax to secure matching federal financial participation, but it does not make the State’s compliance with Prop. 35 impossible. Although Prop. 35 creates caps and limits on an MCO tax that are the subject of H.R. 1, Prop. 35 leaves room for the State to make conforming modifications. Specifically, it provides that the MCO “tax shall comply with federal Medicaid requirements applicable to permissible health care-related taxes, including, but not limited to, [42 C.F.R.] Section 433.68.” Welf. & Inst. Code § 14199.124(a)(3). That federal regulation now requires that the MCO tax must be the same amount for both Medi-Cal and non-Medi-Cal enrollees. *See* 42 C.F.R. § 433.68(e)(3).

⁹ *See* Ballotpedia, California Proposition 35, Managed Care Organization Tax Authorization Initiative (2024), online at [https://ballotpedia.org/California_Proposition_35_Managed_Care_Organization_Tax_Authorization_Initiative_\(2024\)](https://ballotpedia.org/California_Proposition_35_Managed_Care_Organization_Tax_Authorization_Initiative_(2024)) [visited 10-4-2026].

As Petitioners have demonstrated, the Department and the Legislative Analyst's Office readily recognize that California can submit an MCO tax that complies with current federal law and Prop. 35, albeit one that generates less tax revenue and matching federal financial participation than in prior years. *See* Petition for Writ of Mandate at 58. The MCO tax would have to stay within the limits required by Prop. 35 for taxing non-Medi-Cal enrollees while also imposing a companion tax for Medi-Cal enrollees that stays within the restrictions of H.R. 1. That is not logically impossible – the MCO tax would have to assess a tax on non-Medi-Cal enrollees that stays within the \$2.50 per member per month limit and then assess an equivalent tax on Medi-Cal enrollees.

A federally compliant MCO tax also would have to meet Prop. 35's restrictions on how MCO tax revenue can be spent. Nothing in H.R. 1 or any other federal law prohibits Prop. 35's requirements that MCO tax revenue be deposited only in the Prop. 35 Fund and be used only for Medi-Cal. On the contrary, one of the concerns raised by CMS about California's MCO tax was that the State historically had spent MCO tax revenue on non-Medi-Cal purposes. To comply with H.R. 1 and Prop. 35, the State must submit an MCO tax that applies equally to Medi-Cal and non-Medi-Cal enrollees while also limiting the expenditure of such tax revenue only to the permitted uses stated in Prop. 35.

Without going through the proper channels for amending Prop. 35's provisions, SB 125 squarely violates the initiative's requirements by seeking an MCO tax on non-Medi-Cal enrollees that is greater than the \$2.50 per member per month limit (and exceeds the \$36 million total tax revenue cap) while also blatantly ignoring the restrictions on MCO expenditures and permitting the State to use MCO tax revenue "for cashflow loans to the General Fund." *See* SB 125, § 2 (adding Welf. & Inst. Code §§ 14199.92 and 14199.126(a)). The latter violation is especially pernicious because one of the primary purposes of Prop. 35 had been to "guarantee[] that all of the revenue from the continued [MCO] tax will be spent on investments to improve access to critical health care services and **make[] it impossible to divert these dollars to unrelated uses.**" Welf. & Inst. Code § 14199.101 (emphasis added); *see also id.* at § 14199.107(a)(1) ("moneys in the [Prop. 35] fund shall not be used to replace or supplant state revenue sources," and "shall only be used to expand the health care benefits, health care services, health care workforce, and payment rates").

2. Only Direct and Immediate Intervention by this Court Can Avert the Devastating Harms to the Medi-Cal Program and its Enrollees.

Not only is the MCO tax called for by SB 125 incompatible with Prop. 35, it also jeopardizes California's future ability to draw on federal financial participation to support Medi-Cal. H.R. 1 forbids any state from imposing a new or increased MCO tax in 2027. *See* 42 C.F.R. § 433.68(e)(4)(i)(A), (ii)(B). Only grandfathered MCO taxes are permitted, and only if they impose equal levies against non-Medi-Cal and Medi-Cal enrollees.

Under H.R.1, the federal government may approve the MCO tax to be submitted pursuant to SB 125. But it likely would be dead on arrival in California because that MCO tax would violate several provisions of Prop. 35. The window would have closed already if California were then to try to submit a different MCO tax for CMS approval (one that complies with Prop. 35 and H.R. 1) after December 31, 2026.

As Petitioners have explained, SB 125 could unwittingly foreclose California from drawing down federal financial participation in the near future to support the Medi-Cal program. This would be a nightmare scenario in which federal support for Medi-Cal is completely and irredeemably lost.

Slow progress has been made to increase provider reimbursement under Medi-Cal to alleviate the tremendous access problems seen in the recent past. Without federal support, however, it is hard to imagine how California could bolster and maintain reimbursement levels and other program services with nonfederal dollars alone. The many problems that plagued the Medi-Cal program from before would inevitably return – i.e., low reimbursement rates and services, inadequate provider networks and participation rates, and ultimately poor service and large access gaps for the State’s neediest communities.

As a direct result of historically poor and unreliable reimbursement, the Medi-Cal program faced persistent physician shortages. Historical estimates from the California HealthCare Foundation show that only about 50 percent of physicians and 40 percent of private dentists in California accept Medi-Cal patients.¹⁰ These findings are consistent with national research, which has found that low reimbursement rates in Medicaid programs cause a cascade of downstream negative consequences.¹¹ Studies have found that low Medicaid reimbursement pushes providers away from the program or, even if they do participate, providers limit appointment slots and times to Medicaid patients in order to make up for the lower reimbursement. Shortages in provider participation and access gaps

¹⁰ J. Coffman *et al.*, “Physician Participation in Medi-Cal,” Cal. HealthCare Foundation at 4 (Aug. 2014)

¹¹ See Diane Alexander *et al.*, “The Impacts of Physician Payments on Patient Access, Use, and Health,” Nat’l Bureau Econ. Res. (working paper 26095 (July 2019), online at https://www.nber.org/system/files/working_papers/w26095/w26095.pdf [visited 10-5-2026]; Hannah T. Neprash *et al.*, “Physicians’ Participation in Medicaid Increased Only Slightly Following Expansion,” Health Aff (Millwood) (author manuscript; available in PMC 2025 October 10) online at <https://pmc.ncbi.nlm.nih.gov/articles/PMC12512244/pdf/nihms-2084093.pdf> [visited 10-4-2026]; Medicaid and CHIP Payment and Access Commission Issue Brief: “Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services” at 2-3 (Jan. 2025), online at <https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf> [visited 10-5-2026].

were alleviated when the ACA temporarily increased reimbursement in 2013 but reverted immediately when the increases ebbed.

There is a small window to avoid the likely decline in reimbursement rates and their consequences if California were to lose federal financial support, whether permanently or for some period of time. The State must modify the MCO tax to comply with H.R. 1 by the end of this year while also continuing to abide by the requirements of Prop. 35. But the State currently is on a path that could only satisfy federal law, leaving the MCO tax that it intends to implement likely unenforceable under Prop. 35.

A judicial decision next year that forces compliance with Prop. 35 alone would not avert the possible permanent loss of federal support for Medi-Cal. Once the window to submit a MCO tax waiver has closed, funds collected (even retroactively) that would have required a waiver cannot be used for prior quarters to pull down federal matching; in other words, any federal dollars that could have been available during that quarter are lost forever. *See* 42 C.F.R. § 433.72. A permanent loss of such federal support raises the likelihood of the State taking the sort of cost-cutting measures it had earlier taken to meet budget shortfalls at the expense of Medi-Cal enrollees. It would spell the return of a system of persistent failures to deliver adequate care to the neediest communities, one which Prop. 35 was designed to alleviate and ultimately to prevent. Intervention by this Court is thus necessary not only to force compliance with Prop. 35 but also to avert a potentially catastrophic loss of a critical source of support for the Medi-Cal program.

III. CONCLUSION

The California Primary Care Association, California Association of Rural Health Clinics, California Dental Association, and California Hospital Association respectfully ask the Court to grant the relief requested in the petition for writ of mandate.

Respectfully submitted,

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California Primary Care Association, California
Association of Rural Health Clinics, California
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Association

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PROOF OF SERVICE

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Case No. S298916

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the City and County of San Francisco, California. My business address is 5432 Geary Blvd. #200, San Francisco, CA 94121.

On October 6, 2026, I served true copies of the following document(s) described as **AMICUS CURIAE LETTER BY A COALITION OF MEDI-CAL PROVIDERS IN SUPPORT OF PETITION FOR WRIT OF MANDATE** on the following:

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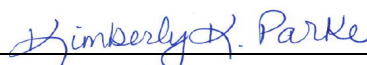
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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on October 6, 2026, at Kimberly, Idaho.



Kimberly Parke, CCLS