



Investing in Community Health: How Local Health Plans Strengthen California's Health Workforce

This explainer provides information on federal health workforce funding in California. This publication is the fourth in a series exploring state, federal, and philanthropic efforts to expand and diversify the health workforce in California. The first report, [How California Is Strengthening Its Health Workforce](#), explores state investments in the health workforce. The second report, [The Role of State and Federal Funding for Graduate Medical Education in California](#), explains the financing of graduate medical education, also known as physician residency training. The third report, [Federal Funds Expand and Support California's Health Workforce](#), provides information on federal health workforce funding in California.

For more than five decades, local health plans have played a critical role in delivering health care to Californians with low incomes through Medi-Cal, the state's Medicaid program. Established and governed by local communities, these non-profit and public plans have evolved in response to significant policy shifts — most notably, California's transition from a fee-for-service system to managed care. Today, local health plans not only serve the majority of Medi-Cal enrollees but also invest deeply in their communities, including through efforts to strengthen the health workforce and reduce health disparities.

This report explores the development, reach, and impact of local health plans; their support for the health workforce; and the potential challenges federal funding cuts pose on future reinvestment efforts.

1 How have local health plans evolved to provide Medi-Cal managed care services in California?

For 50 years, local health plans have been providing health care coverage for Californians with low incomes enrolled in Medi-Cal.¹ These local health plans are independent public and nonprofit organizations created by county leaders to meet the health needs of their communities, particularly underserved residents. Governed by local commissions, local health plans offer publicly funded health benefits, such as Medi-Cal coverage, through a managed care service delivery model.²

The evolution and growth of local health plans stemmed from a shift in the state's Medicaid service delivery system from a fee-for-service model to managed care (see text box).³ This transition to managed care began with small pilot programs in the late 1960s, shortly after Medi-Cal was established, to both control program costs and attempt to privatize public services.⁴ California was the first

state to launch a statewide managed care delivery system in 1971, and, in 1973, Contra Costa Health became the first county-sponsored local health plan in the US to offer Medicaid services.⁵

Delivery Systems

Fee-For-Service: This Medicaid delivery system allows enrollees to receive care from any health care provider that accepts Medicaid. The provider is then reimbursed by the state Medicaid program. The fee-for-service model was the default model when Medicaid was enacted.

Managed Care: Under a managed care delivery system, the state contracts with a commercial or nonprofit managed care organization (MCO) to deliver Medicaid benefits in exchange for a per member per month fee called a “capitated payment.” Managed care plans (MCPs) arrange and coordinate patient care. Today, managed care is the dominant Medicaid service delivery system in the nation.

Source: “[Medicaid Delivery Systems 101](#),” National Conference of State Legislatures, last updated September 2024.

A decade later, federal and state policymakers passed laws that allowed for increased use of managed care delivery systems.⁶ While state leaders were motivated by state budget constraints, and in some cases desires to privatize public services, local leaders took action to expand managed care

in their communities in order to improve health care access and quality for local residents.⁷ In 1983, Santa Barbara County leaders implemented the nation’s first locally-administered County Organized Health System (COHS) — a model of managed care.⁸ Santa Mateo County leaders followed with the establishment of their own COHS in 1987, the Health Plan of San Mateo.⁹

State leaders continued to expand the managed care delivery system in the 1990s as part of the California Managed Care Initiative, including by developing the Local Initiative, another managed care model.¹⁰ In total, 12 new local health plans began offering Medi-Cal services across California during the 1990s, while existing plans also expanded their service area during the same period and into the 2000s.¹¹ Two additional local health plans began offering Medi-Cal members services in 2011, and in 2024, the Community Health Plan of Imperial Valley became the newest local health plan in the state to provide Medi-Cal benefits.¹²

following the launch of the California Managed Care Initiative, 48% of Medi-Cal members were enrolled in MCPs.¹⁴ This share grew to 64% in 2012.¹⁵ Today, 22 Medi-Cal MCPs provide services to 96% of Medi-Cal enrollees across the state, 17 of which are local health plans (see Appendix A).¹⁶

These 17 local health plans operate in 51 of California’s 58 counties, delivering Medi-Cal coverage to nearly 9.7 million people, or 1 in 4 Californians (see Table 1, next page). The number and share of Californians covered by a local health plan varies across the state. Community Health Plan of Imperial Valley, the state’s newest local health plan, provides Medi-Cal coverage to just under 100,000 residents, accounting for more than half of Imperial County’s total population. By comparison, Community Health Group covers approximately 400,000 individuals in San Diego County, representing about 12% of the county’s residents. L.A. Care Health Plan covers roughly 2.4 million people, or one in four residents of California’s most populous county.

2 What role do local health plans play in Medi-Cal?

Local health plans play a large role in the delivery of Medi-Cal, the nation’s largest Medicaid program.¹³ The share of Medi-Cal recipients enrolled in both local and commercial managed care plans (MCPs) has risen steadily over time. In 1998,

3 How do local health plans invest in their community and the health workforce?

Local health plans’ missions typically emphasize-servicing low-income Californians, improving access to health care, and reducing health disparities.¹⁷ Because of their mission-driven approach, local health plans have a long history of reinvesting

Table 1. Local Health Plans and Counties Covered, 2024

LOCAL HEALTH PLAN	COUNTIES COVERED	MEDI-CAL ENROLLEES	SHARE OF TOTAL COUNTY POPULATION ENROLLED IN A LOCAL HEALTH PLAN
Alameda Alliance for Health	Alameda	401,384	24%
CalOptima Health	Orange	906,553	29%
CalViva Health	Fresno, Kings, and Madera	437,150	33%
CenCal Health	San Luis Obispo and Santa Barbara	241,115	33%
Central California Alliance for Health	Mariposa, Merced, Monterey, San Benito, and Santa Cruz	452,274	42%
Community Health Group	San Diego	410,161	12%
Community Health Plan of Imperial Valley	Imperial	97,370	53%
Contra Costa Health Plan	Contra Costa	260,590	23%
Gold Coast Health Plan	Ventura	250,530	30%
Health Plan of San Joaquin/Mountain Valley Health Plan	Alpine, El Dorado, San Joaquin, and Stanislaus	427,153	28%
Health Plan of San Mateo	San Mateo	145,852	20%
Inland Empire Health Plan	Riverside and San Bernardino	1,494,962	32%
Kern Family Health Care	Kern	406,539	45%
L.A. Care Health Plan	Los Angeles	2,363,935	24%
Partnership HealthPlan of California	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba	909,899	29%
San Francisco Health Plan	San Francisco	175,180	21%
Santa Clara Family Health	Santa Clara	293,884	15%

Note: Medi-Cal enrollment reflects data from May 2024 that were last updated in July 2025.

Sources: “[Medi-Cal Managed Care Enrollment Report](#),” California Department of Health Care Services (DHCS), updated July 29, 2025; “[Medi-Cal Managed Care Plans by County \(as of 2023 and 2024\)](#)” (PDF), DHCS, December 2023; and “[P-2A: Total Population Projections, California Counties, 2020-2070 \(Baseline 2023 Population Projections; Vintage 2025 Release\)](#),” California Department of Finance, accessed August 5, 2025.

a share of revenue — which is largely driven by Medi-Cal funding — into projects that improve their communities.¹⁸ These investments are distributed back to the community based on feedback from Medi-Cal members, community-based organizations, providers, and other local leaders.¹⁹

A recent survey of local health plans from the Local Health Plans of California (LHPC) trade association found that over a five-year period from 2019 to 2023, local health plans invested nearly \$800 million into their communities through initiatives focused on improving community health and well-being; supporting stable, supportive, and permanent housing; and growing and diversifying the health care workforce.²⁰ Of these investments, roughly 4 in 10 dollars were categorized as investments in the health workforce.²¹

Local health plan's health workforce investments can be grouped into three categories (see Figure 1).²²

► **Recruitment and retention.** Nearly half (49%) of reported health workforce investments were for worker recruitment and retention. Funded initiatives included salary supplements, hiring and retention bonuses, and loan repayment programs. For example, CenCal Health provided a grant to their provider partner and federally qualified health center, Community

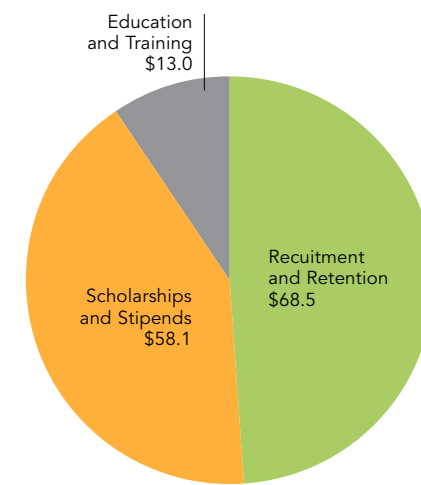
Health Centers of the Central Coast, to both recruit and retain healthcare professionals.

► **Scholarships and stipends.** Roughly 42% of reported health workforce investments were for scholarships and stipends for students seeking degrees and certificates in various health professions. For example, the Inland Empire Health Plan launched a Healthcare Scholarship Fund in 2020 to support students working toward licensure as a physician or psychiatric nurse practitioner.²³

► **Education and training programs.** About 9% of health workforce investments went toward increasing the number of licensed or certificated health professionals through education and training programs. For example, the Central California Alliance for Health provided grants to the Monterey County Workforce Development Board and University of California Merced's Professional and Continual Education Division to support the implementation of community health worker certificate training programs. Other examples include support for career pipeline programs and funding to support nursing and physician education programs.

To learn more about local health plans' community reinvestments, visit LHPC's [Local Plans Invest in the Community](#) resource.

Figure 1. Local Health Plans' Health Workforce Investments by Program Type, 2019–2023 (in Millions)



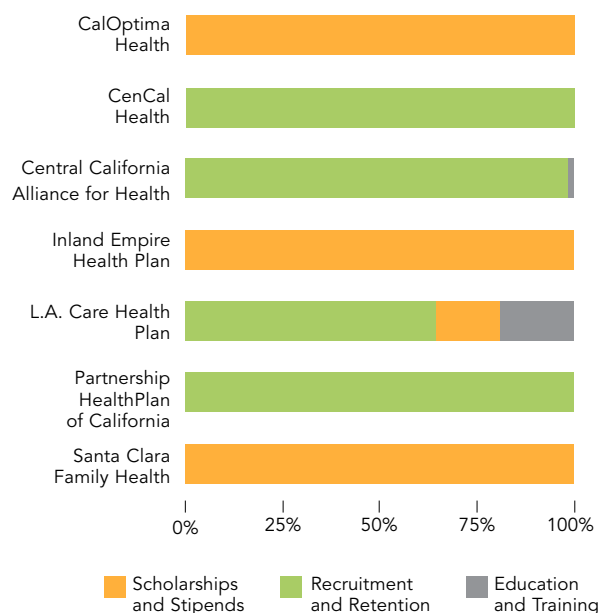
Note: Figure does not reflect local health plan investments where detailed funding data were not available.

Source: Author's analysis of survey data collected by Local Health Plans of California.

Local health plans' workforce investments varied geographically (see Figure 2, next page). Plans such as CalOptima Health, Inland Empire Health Plan, and Santa Clara Family Health, which operate in some of the most populated counties in California, focused their investments on scholarships and stipends for students. To boost the local behavioral health workforce, CalOptima Health invested in a stipend program for students seeking master's degrees in social work, while the Santa Clara Family Health Plan launched a scholarship

program to assist students who qualify for Medi-Cal as they work toward a health care degree.

Figure 2. Share of Local Health Plans' Health Workforce Investments by Program Type, 2019–2023



Note: Figure does not reflect local health plan investments in cases where detailed funding data were not available.

Source: Author's analysis of survey data collected by Local Health Plans of California.

In contrast, local health plans that operate in less populated counties — such as northern and Sierra counties, certain counties in the San Joaquin Valley, and counties along the central coast — largely focused on provider recruitment and retention. For example, Partnership HealthPlan covers 24 largely rural counties in regions of northern California with some of the most acute shortages of health workers in the state.²⁴ The plan implemented its Provider Recruitment Program in 2014 to support the hiring of primary care providers and expanded support of additional specialties including behavioral health professionals in 2021.

Finally, L.A. Care, the largest local health plan in terms of Medi-Cal enrollment, continues to implement its Elevating the Safety Net initiative over a multi-year period to address the shortage of health professionals in Los Angeles County.²⁵ The plan's collective efforts over the last seven years span across all three categories, including supporting recruitment and retention activities, scholarships and stipends for medical students, and local graduate medical education programs.

According to the 2024 LHPC survey, local health plans reported contributing an additional \$29 million in 2024 to initiatives aimed at strengthening the health workforce. This amount represents partial-year funding on top of prior investments. Plans also indicated their commitment to sustaining current efforts and launching new health workforce initiatives in 2025 and beyond.

4 How do state reforms affect local health plans' efforts to sustain the health workforce?

In 2022, the state launched CalAIM (California Advancing and Innovating Medi-Cal) to expand and transform Medi-Cal services to improve access to care for the one in three Californians enrolled in the program.²⁶ In order to implement the wide range of CalAIM programs, the California Department of Health Care Services (DHCS) updated and standardized the Medi-Cal MCP contract in 2024 to reflect new requirements, including provisions relating to reinvestment in local community activities.²⁷ With these conditions, California joins nine other states that also require Medicaid managed care organizations to reinvest locally.²⁸

Under DHCS's new community reinvestment provisions, MCPs — including local plans — must allocate a share of annual net income to one of five categories, with the required share increasing if quality standards are not met.²⁹ The categories include:

- ▶ Healthcare workforce
- ▶ Neighborhoods and built environment
- ▶ Well-being for priority populations
- ▶ Local communities
- ▶ Improved health

The state's MCPs must submit three-year community reinvestment plans for approval to DHCS in 2026. These plans must align with other local planning efforts and community needs assessments, be informed by community advisory committees, and receive approval from local public and behavioral health directors. Initial investments will be based on net income from 2024–2026 and are to be distributed to the community in 2026–2028.³⁰

Since local health plans have been investing in their communities for years, many have established health workforce programs and other projects that could be organized under the new community reinvestment categories. Yet, the state's new administrative rules for plan development and reporting could limit local health plans' flexibility for addressing community needs, particularly in emergency situations such as the COVID-19 pandemic or wildfires.

5 How might recent changes in federal health policy impact community reinvestment?

The recently enacted Republican reconciliation bill (H.R. 1) will reduce federal health care spending by more than \$1 trillion over the next decade, representing the largest cut in health care spending in the nation's history.³¹ As a result of policy changes that will be implemented over the next few years, such as more restrictive eligibility and

work requirements and changes to how states finance their Medicaid programs and determine certain provider payment rates, federal health care dollars in California will drop by an estimated \$150 billion over the next decade.³²

The instability these funding and policy changes will wreak on California's health care system will be particularly harmful for Californians with low incomes, especially those enrolled in Medi-Cal and those who purchase their coverage from Covered California, the state's health insurance marketplace, with the help of federal subsidies. It is estimated that about 1.7 million Californians will become uninsured.³³

H.R. 1 has also created a great deal of uncertainty for local health plans, and many questions still exist around the implementation and impact of its policies. The changes to the Medi-Cal program will likely increase administrative burden, create cost pressures, and reduce plans' revenue. This could ultimately affect plans' abilities to reinvest in their communities. Over time, as more Californians become uninsured as a direct result of H.R. 1, local health plans may shift the focus of their investments from upstream solutions, like investments in the health workforce or in addressing the social determinants of health, to the more immediate health needs of newly uninsured Californians.

Appendix A. 2024 Medi-Cal Managed Care Plans and County Models

MANAGED CARE PLAN	LOCAL HEALTH PLAN	COUNTY PLAN MODEL
Alameda Alliance for Health	Yes	Single Plan
Anthem Blue Cross Partnership Plan	No	Varies
Blue Shield of California Promise Health Plan	No	Geographic Managed Care
CalOptima Health	Yes	County Organized Health System
CalViva Health	Yes	Two Plan
CenCal Health	Yes	County Organized Health System
Central California Alliance for Health	Yes	County Organized Health System
Community Health Group Partnership Plan	Yes	Geographic Managed Care
Community Health Plan of Imperial Valley	Yes	Single Plan
Contra Costa Health Plan	Yes	Single Plan
Gold Coast Health Plan	Yes	County Organized Health System
Health Net Community Solutions	Yes	Two Plan
Health Plan of San Joaquin/Mountain Valley Health Plan	Yes	Two Plan
Health Plan of San Mateo	Yes	County Organized Health System
Inland Empire Health Plan	Yes	Two Plan
Kaiser Permanente	No	Varies
Kern Family Health Care	Yes	Two Plan
L.A. Care Health Plan	Yes	Two Plan

MANAGED CARE PLAN	LOCAL HEALTH PLAN	COUNTY PLAN MODEL
Molina Healthcare of California	No	Varies
Partnership HealthPlan of California	Yes	County Organized Health System
San Francisco Health Plan	Yes	Two Plan
Santa Clara Family Health	Yes	Two Plan

Note: A County Organized Health System is a managed care plan model where the state contracts with a county entity to operate as the sole managed care plan in the county. Geographic Managed Care model is a system of managed care where the state contracts with multiple managed care plans within a defined geographic region, such as a county. A Two-Plan model of managed care occurs when the state contracts with two managed care plans – a county-authorized plan referred to as a Local Initiative and a commercial managed care plan. The Single Plan model is a managed care model where one county-authorized managed care plan serves all Medi-Cal beneficiaries. For more on county managed care plan models, see “[Medi-Cal Managed Care Plan Model Fact Sheet](#),” (PDF) California Department of Health Care Services, accessed June 28, 2025.

Source: “[Medi-Cal Managed Care Plans by County \(as of 2023 and 2024\)](#)” (PDF), California.

About the Authors

[Kristin Schumacher, PhD, MSW](#), is principal owner at Aster Policy Analytics, a public policy research firm that produces data-driven analyses focused on gender, racial, and economic justice. Prior to launching Aster Policy Analytics, Schumacher worked in various mission-driven organizations working to improve the well-being of women, children, and families. Most recently, she led community-driven budget and policy analyses as research director at Kids Forward, the oldest child advocacy organization in the US.

About the Foundation

The [California Health Care Foundation](#) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system. For more information, visit www.chcf.org.

Acknowledgments

The author thanks the CHCF Improving Access team for their guidance and feedback on an early draft of this publication. Appreciation is also extended to local health plan staff who generously provided data and information essential to the publication, as well as Local Health Plans of California Director of Health Plan Financing Beau Bouchard and CEO Linnea Koopmans for sharing survey data and contributing their knowledge and insights during the review of this report.

Endnotes

1. [Medi-Cal Managed Care Program: Baseline Quality Report](#) (PDF), California Department of Health Care Services (DHCS), April 2012.
2. [Local Plans, Local Impact: Partnering to Build Healthier Communities](#) (PDF), Local Health Plans of California (LHPC), 2024.
3. Margaret Tatar, Julia Paradise, and Rachel Garfield, [Medi-Cal Managed Care: An Overview and Key Issues](#), KFF, March 2, 2016.
4. David F. Chavkin and Anne Treseder, ["California's Prepaid Health Plan Program: Can the Patient Be Saved,"](#) *The Hastings Law Journal* 28, no. 3 (Jan. 1977): 685-760; and Ben Zdencanovic et al., [Medi-Cal and the Politics of Healthcare Policy in California](#) (PDF), UCLA Luskin Center for History and Policy, Spring 2024.
5. ["About CCHP Managed Care,"](#) Contra Costa Health, accessed July 9, 2025; and Tatar, Paradise, and Garfield, *Medi-Cal Managed Care*.
6. [California Welfare & Institutions Code § 14087.5–95](#); and [Omnibus Reconciliation Act of 1981](#), Pub. L. No. 97-35, § 1915, 95 Stat. 358 (1981).
7. Zdencanovic et al., *Medi-Cal and the Politics of Healthcare Policy in California*.
8. Caroline Cabias (chief, eligibility branch, DHCS) to all Medi-Cal managed care plans, ["Santa Barbara County Health Initiative"](#) (PDF), All Plan Letter 83-61, DHCS, September 20, 1983.
9. ["History,"](#) Health Plan of San Mateo, accessed July 9, 2025.
10. ["History of California's Local Health Plans,"](#) LHPC, accessed July 10, 2025; and *Baseline Quality Report*, DHCS.
11. "History," LHPC.
12. ["Community Health Plan of IV Now to Cover Medi-Cal Enrollees,"](#) *Calexico Chronicle*, December 28, 2023; [Report on the Medical Audit of Fresno-King-Madera Health Authority DBA CaViva Health](#) (PDF), DHCS, September 2023; and [Report on the Medical Audit of Ventura County Medi-Cal Managed Care Commission DBA: Gold Coast Health Plan](#) (PDF), DHCS, November 2023.
13. [March 2025: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot](#), Centers for Medicare & Medicaid Services, June 27, 2025.
14. Nelda McCall et al., [The Medi-Cal Managed Care Market 1996-1998](#) (PDF), CHCF, September 2000.
15. ["Medi-Cal Enrollment Tracking Tool,"](#) CHCF, last updated August 6, 2024.
16. "Members" reflects "certified eligible" in the original source data. "Medi-Cal Enrollment Tracking Tool," CHCF; and [Medi-Cal Managed Care Plans by County \(as of 2023 and 2024\)](#) (PDF), DHCS, December 2023.
17. ["California's Local Health Plans: A Panoramic View,"](#) webinar, LHPC, September 27, 2018.
18. "A Panoramic View," LHPC.
19. *Local Plans, Local Impact*, LHPC.
20. Total reflects responses from 15 local health plans and does not include funding for "other activities" or emergency relief efforts. *Local Plans, Local Impact*, LHPC.
21. "Health workforce" is broadly defined and includes licensed and unlicensed positions.
22. Some local health plans reported investing in programs across all these categories or in other types of programs, but detailed funding levels were not made available and are not reflected here.
23. ["Local Health Plans Invest in the Community,"](#) LHPC, accessed July 13, 2025.
24. [Health Workforce Research Data Center Annual Report to the Legislature](#) (PDF), California Department of Health Care Access and Information, April 2025.
25. ["Elevating the Safety Net,"](#) L.A. Care Health Plan, accessed July 13, 2025.
26. Kara Carter and Davide Bonazzi, ["CalAIM: Why It's So Much More Important Than Another New Health Program,"](#) *The CHCF Blog*, December 7, 2021.
27. ["Joint Statement on the 2024 Medi-Cal Managed Care Plan Contracts,"](#) DHCS, accessed July 11, 2025; and ["Medi-Cal Managed Care Plan Transition,"](#) DHCS, accessed July 11, 2025.
28. Alison Shippy, Shelli Silver, and Sydney McClendon, [Community Reinvestment: Forging New Partnerships in Medicaid](#), Manatt, September 16, 2024.
29. Michelle Baas (Director, DHCS) to all Medi-Cal managed care plans, ["Community Reinvestment Requirements"](#) (PDF), All Plan Letter 25-004, February 7, 2025.
30. Baas, "Community Reinvestment."
31. [One Big Beautiful Bill Act](#), H.R. 1, 119th Cong., (2025).
32. Rhiannon Euhus et al., [Allocating CBO's Estimates of Federal Medicaid Spending Reduction Across the States: Enacted Reconciliation Package](#), KFF, July 23, 2025.
33. Alice Burns et al., [How Will the 2025 Reconciliation Bill Affect the Uninsured Rate in Each State: Allocating CBO's Estimates of Coverage Loss](#), KFF, June 6, 2025.