Senate Budget and Fiscal Review—Scott Wiener, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Dr. Akilah Weber Pierson, Chair
Senator Shannon Grove
Senator Caroline Menjivar

Thursday, February 27, 2025
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

PUBLIC COMMENT

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FOR VOTE ONLY

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Opioid Settlements Fund Allocations

Local Assistance – Governor's Budget. DHCS requests expenditure authority from the Opioid Settlements Fund of $8.4 million in 2025-26. If approved, these resources would support expansion of the Naloxone Distribution Project.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
3397 – Opioid Settlements Fund	$8,391,000	$-
Total Funding Request:	**$8,391,000**	**$-**

Background. Abuse of opioids has devastated California families and communities over the past several years, with more than 6,800 deaths related to opioid overdoses in 2021, a six-fold increase since 1999. The events and decisions that led to this tragic epidemic are manifold, but one of the biggest contributing factors was opioid manufacturers' and distributors' efforts to promote, market, distribute, and dispense opioid medications to maximize profits, often at the expense of patients who would later develop dependency. These actions led the California Attorney General, in a coalition with attorneys general in 47 other states, to investigate and file suit against manufacturers and distributors of opioids for the damage caused to victims of the opioid epidemic.

Beginning in 2021, the coalition of attorneys general announced several settlement agreements with manufacturers and distributors of opioids:

McKinsey and Company – In February 2021, the Attorney General announced a $573 million nationwide settlement with McKinsey and Company related to the company's role in advising opioid companies, helping those companies promote their drugs, and profiting from the opioid epidemic. In particular, McKinsey advised opioid manufacturers on how to maximize profits from opioid products, including targeting high-volume prescribers, using specific messaging to get physicians to prescribe more opioids to more patients, and circumventing pharmacy restrictions to deliver high-dose prescriptions. According to the Attorney General, California is estimated to receive $59.6 million from this settlement.

Distributors (Cardinal, McKesson, and AmerisourceBergen) and Janssen Pharmaceuticals – In July 2021, the Attorney General announced a $26 billion nationwide settlement with Cardinal, McKesson, and AmerisourceBergen, the three largest pharmaceutical distributors, and Janssen Pharmaceuticals, Inc. (and its parent company Johnson and Johnson) for their role in the opioid epidemic. Under the settlement agreement, the three distributors will collectively pay up to $21 billion over 18 years, while Janssen will pay up to $5 billion over nine years with $3.7 billion to be paid in the first three years. The substantial majority of the money is to be spent on opioid treatment and prevention and each state's share of funding is subject to a formula that considers the impact of the opioid crisis on the state and the population of the state. According to DHCS, California and its cities and counties could receive approximately $2.2 billion for substance use prevention, harm reduction, treatment, and recovery activities pursuant to the settlement.

Purdue Pharma and the Sackler Family – In March 2022, the Attorney General announced a $6 billion nationwide settlement with opioid manufacturer Purdue Pharma, as well as the Sackler family who owns Purdue. The Attorney General estimated California would receive approximately $486 million to fund opioid addiction treatment and prevention.

In addition, the Attorney General announced proposed settlements with Teva and Allergan, as well as pharmacies including Walgreens, Walmart, and CVS. The Attorney General indicates these settlements would provide substantial funds for the abatement of the opioid epidemic in California and require changes in the ways these companies conduct business.

Opioid Settlements Fund. The revenue California receives from these settlement agreements is deposited in the Opioid Settlements Fund (OSF), established in the 2022 Budget Act to receive settlement revenue and allow its use to support state efforts to remediate the impacts of opioid use disorders in California. The 2022 Budget Act included 11 positions and expenditure authority from the Opioid Settlement Fund of $33.9 million in 2022-23 and $2.6 million in 2023-24 and annually thereafter through the terms of California's national opioid settlements, or 18 years. These positions and resources will support oversight of two of the opioid settlements, substance use disorder (SUD) workforce training, establishment of a web-based statewide addiction treatment locator platform, and an outreach and anti-stigma campaign.

In addition, the 2022 Budget Act included expenditure authority from the OSF for the following:

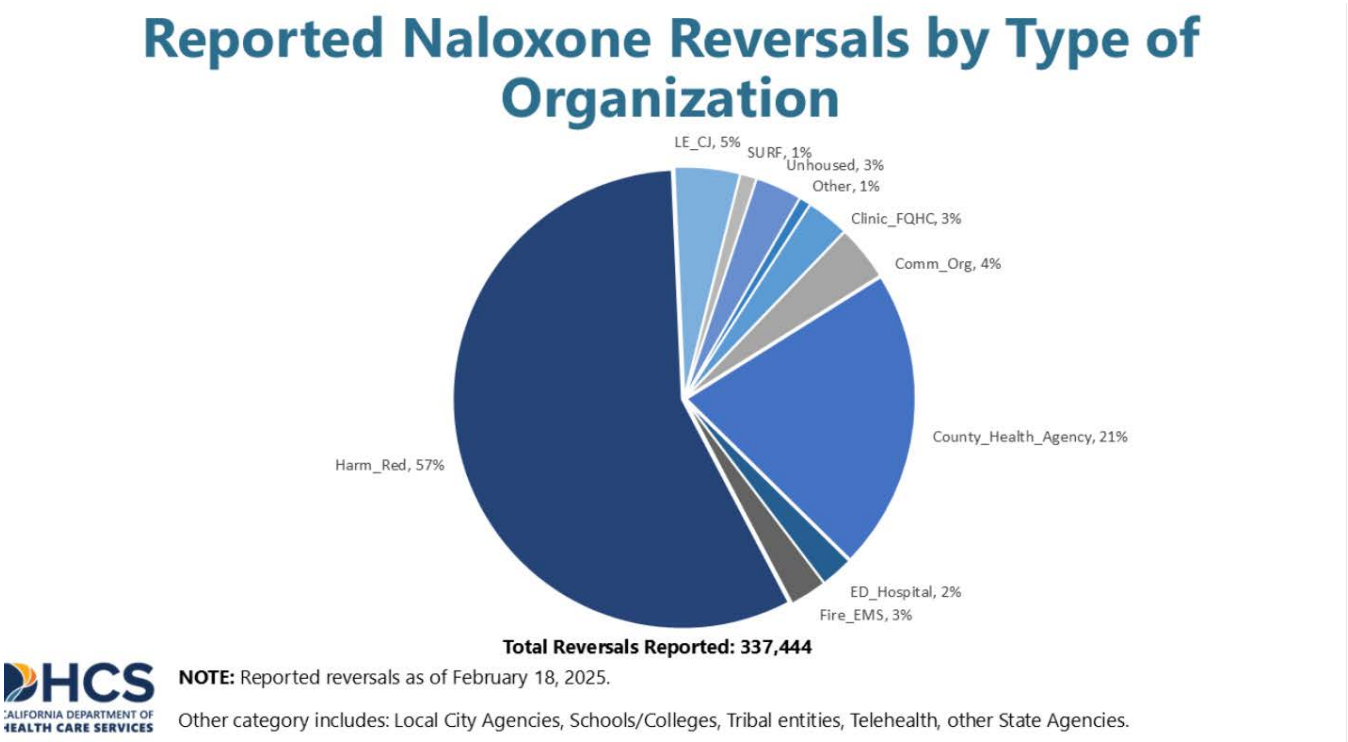
- Naloxone Distribution Project Augmentation - $15 million one-time
- Substance Use Disorder Provider Workforce Training - $51.1 million one-time
- ATLAS Platform Operation and Outreach Campaign - $7.5 million one-time
- Fentanyl Education and Awareness Campaigns - $40.8 million one-time
- Opioid Overdose Data Collection and Analysis - $5 million one-time
- Integrating Employment in Recovery Pilot Project - $4 million one-time

The 2023 Budget Act also included expenditure authority from the OSF of $74.8 million in 2023-24, $35.8 million in 2024-25, $24.8 million in 2025-26, and $24.1 million in 2026-27 for expansion of the Naloxone Distribution Project. The Legislature also approved provisional budget bill language authorizing an increase in expenditure authority from the OSF of up to $15.3 million annually for four years if resources are available in the fund to support additional expansion of the project.

Naloxone Distribution Project. The Naloxone Distribution Project was created in 2018 in response to a sharp increase in overdoses and aims to reduce opioid overdose deaths through the provision of free naloxone in the form of a spray that can be used by laypeople. Eligible entities for the distribution of naloxone include law enforcement, fire departments, first responders, schools and universities, county public health and behavioral health departments, and community based organizations, such as harm reduction organizations or community opioid coalitions.

Resource Request. DHCS requests expenditure authority from the Opioid Settlements Fund of $8.4 million in 2025-26 to support expansion of the Naloxone Distribution Project. These resources are available due to a separate proposal in the California Department of Public Health (CDPH) budget to

reduce expenditure authority for the California Harm Reduction Program by precisely the same amount as the augmentation proposed here. The California Harm Reduction Program, which supports harm reduction sites to prevent overdose by distributing naloxone and training people who use drugs on how to use it to prevent death. According to DHCS, harm reduction sites were responsible for 57 percent of reported naloxone reversals in California, as of February 18, 2025.

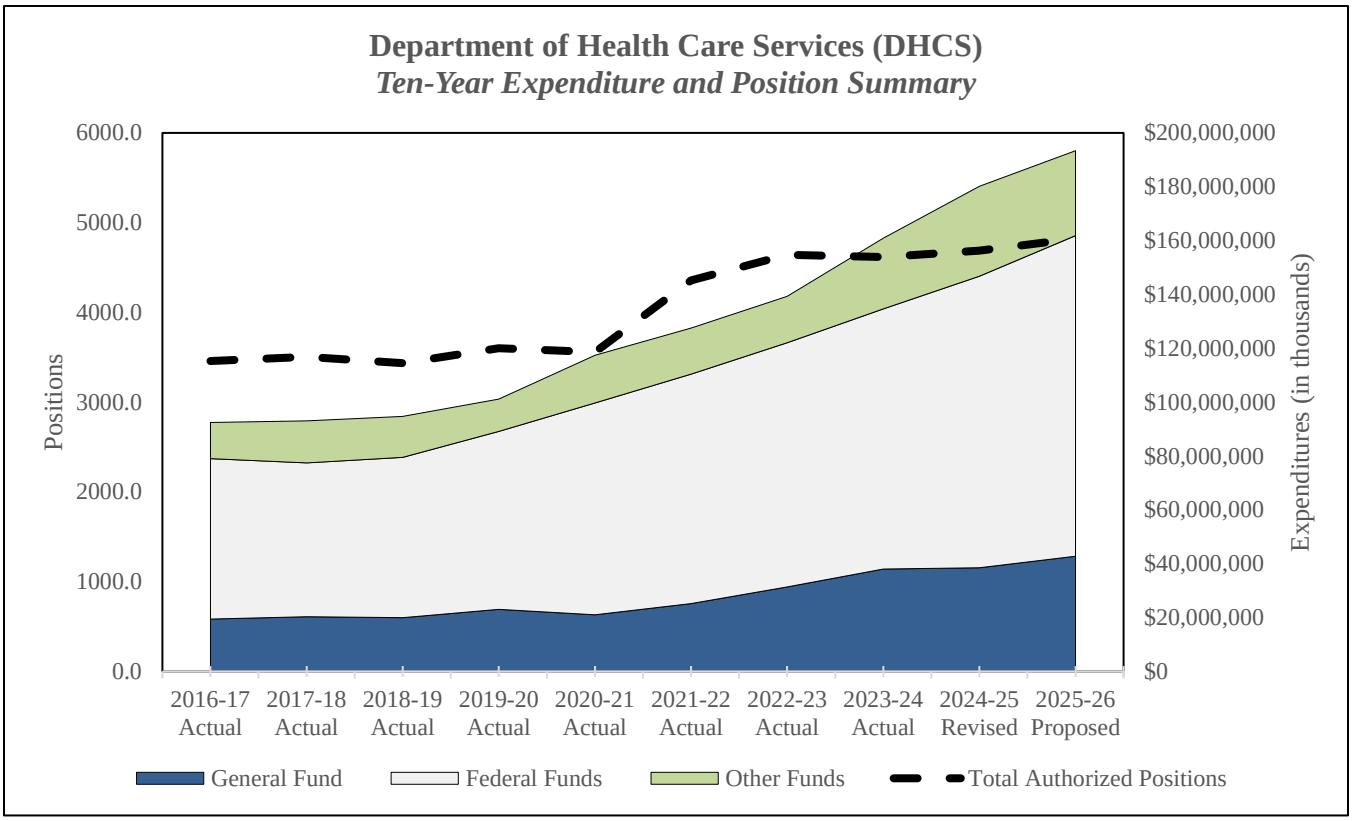


Source: californiaopioidresponse.org/outcomes/naloxone-distribution-project-data (Accessed February 24, 2025).

Subcommittee Staff Comment and Recommendation—Reject. Subcommittee staff recommends rejecting this proposed augmentation. In a separate proposal, CDPH is proposing a reduction in expenditure authority from the Opioid Settlements Fund of precisely this amount that currently supports the California Harm Reduction Initiative. Because harm reduction entities are responsible for 57 percent of reported naloxone reversals in California, this redirection of Opioid Settlements Fund resources is counterproductive to the goal of preventing opioid overdose deaths in the state. Subcommittee staff also recommends taking conforming action during the subcommittee's hearing on CDPH to reject the proposed reduction of Opioid Settlements Fund resources allocated to the California Harm Reduction Initiative.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview



Department of Health Care Services - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2023-24 Actual***	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$38,032,555	$35,730,880	$38,479,359	$42,780,432
Federal Funds	$96,627,962	$99,545,314	$108,342,793	$119,030,777
Other Funds	$26,218,742	$31,027,065	$33,295,386	$31,572,435
Total Department Funding	**$160,879,259**	**$166,303,259**	**$180,117,538**	**$193,383,644**
Total Authorized Positions	**4617.5**	**4688.5**	**4688.5**	**4821.5**
Other Funds Detail:				
Breast Cancer Control Account (0009)	*$8,141*	*$8,065*	*$8,379*	*$8,117*
Childhood Lead Poisoning Prev Fund (0080)	*$0*	*$0*	*$0*	*$0*
DUI Program Licensing Trust Fund (0139)	*$736*	*$1,465*	*$1,458*	*$1,460*

Prop 99 - Hospital Services Acct (0232)	*$70,115*	*$72,949*	*$72,949*	*$61,994*
Prop 99 - Physician Services Acct (0233)	*$19,901*	*$20,826*	*$20,826*	*$17,700*
Prop 99 - Unallocated Acct (0236)	*$41,673*	*$46,683*	*$46,683*	*$41,498*
Narcotic Treatment Program Lic Fund (0243)	*$1,992*	*$2,502*	*$2,489*	*$2,491*
Perinatal Insurance Fund (0309)	*$1,461*	*$399*	*$397*	*$397*
Major Risk Medical Insurand Fund (0313)	*$0*	*$0*	*$0*	*$0*
Audit Repayment Trust Fund (0816)	*$0*	*$41*	*$41*	*$41*
Medi-Cal Inpatient Payment Adj Fund (0834)	*$124,512*	*$119,603*	*$124,630*	*$123,274*
Special Deposit Fund (0942)	*$50,192*	*$83,377*	*$66,925*	*$85,695*
Reimbursements (0995)	*$2,058,488*	*$2,522,623*	*$2,575,125*	*$3,116,399*
County Health Initiative Matching Fund (3055)	*$0*	*$174*	*$174*	*$174*
Children's Medical Services Rebate Fund (3079)	*$651*	*$2,556*	*$3,299*	*$2,056*
Mental Health Services Fund (3085)	*$2,505,973*	*$2,776,782*	*$2,767,343*	*$2,718,932*
Nondesignated Public Hospital Suppl Fund (3096)	*($393)*	*$5,309*	*$0*	*$6,131*
Private Hospital Supplemental Fund (3097)	*$193,530*	*$76,754*	*$70,723*	*$109,732*
Mental Health Facility Licensing Fund (3099)	*$71*	*$373*	*$373*	*$373*
Residential and Outpatient Prog Lic Fund (3113)	*$5,682*	*$10,472*	*$10,395*	*$12,011*
Children's Health and Human Svcs Special Fund (3156)	*$75,853*	*$0*	*$144,464*	*$0*
Hospital Quality Assurance Revenue Fund (3158)	*$4,957,870*	*$4,996,280*	*$5,137,934*	*$5,241,548*
SNF Quality and Accountability Fund (3167)	*$13*	*$501*	*$501*	*$0*
Emergency Medical Air Transportation Fund (3168)	*$1,222*	*$0*	*$0*	*$0*
Public Hosp Investment, Imp, Incentive Fund (3172)	*$0*	*$0*	*$0*	*$0*
Long-Term Care Quality Assurance Fund (3213)	*$562,845*	*$571,142*	*$604,900*	*$580,586*
Health and Human Services Special Fund (3293)	*$0*	*$0*	*$0*	*$0*
Healthcare Treatment Fund (3305)	*$713,550*	*$740,509*	*$630,214*	*$474,023*

Health Care Service Plan Fines/Penalties Fund (3311)	*$6,082*	*$78,864*	*$70,425*	*$495*
Medi-Cal Emergency Med Transport Fund (3323)	*$71,128*	*$47,379*	*$72,056*	*$53,163*
Reversion Acct. Subacct., Mental Health Svcs Fund (3327)	*$3,539*	*$0*	*$0*	*$0*
Medi-Cal Drug Rebate Fund (3331)	*$3,899,940*	*$2,258,631*	*$2,095,877*	*$1,953,944*
Health Care Services Special Fund (3334)	*$0*	*$0*	*$0*	*$0*
YEPEITA - Cannabis Tax Fund (3350)	*$371,737*	*$344,562*	*$323,060*	*$280,923*
PACE Oversight Fund (3362)	*$43*	*$0*	*$748*	*$3,614*
Loan Repayment Acct, Healthcare Treatment Fund (3375)	*$45,924*	*$63,259*	*$62,240*	*$51,227*
Opioid Settlement Fund (3397)	*$80,021*	*$76,123*	*$76,113*	*$34,160*
California Emergency Relief Fund (3398)	*$10,893*	*$0*	*$0*	*$0*
988 State Suicide and BH Crisis Svcs Fund (3414)	*$19,000*	*$13,228*	*$13,228*	*$13,228*
Medi-Cal County BH Fund (3420)	*$479,947*	*$1,567,448*	*$2,336,327*	*$2,105,142*
Managed Care Enrollment Fund (3428)	*$7,627,319*	*$12,373,600*	*$11,592,417*	*$3,942,986*
Medi-Cal Provider Payment Reserve Fund (3431)	*$0*	*$442,000*	*$166,449*	*$0*
Health Care Oversight and Accountability Subfund (3443)	*$0*	*$0*	*$2,175,777*	*$8,761,891*
Behavioral Health Infrastructure Fund (6092)	*$0*	*$340,422*	*$340,422*	*$436,522*
Whole Person Care Pilot Special Fund (8107)	*$6,245*	*$0*	*$0*	*$0*
Global Payment Program Special Fund (8108)	*$1,603,757*	*$1,027,153*	*$989,722*	*$904,016*
DPH GME Special Fund (8113)	*$323,739*	*$281,424*	*$371,195*	*$423,641*
Suicide Prevention Vol Contribution Fund (8124)	*$1,093*	*$0*	*$0*	*$0*
Vision Services CHIP-HSI Special Fund (8140)	*$0*	*$102*	*$1,480*	*$2,851*
LIHP Fund (8502)	*$0*	*$0*	*$0*	*$0*
Coronavirus Fiscal Recovery Fund of 2021 (8506)	*($180,500)*	*$0*	*$180,500*	*$0*
Home- and Comm-Based Svcs ARP Fund (8507)	*$454,757*	*$53,485*	*$137,128*	*$0*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2023-24**	**2024-25 (CY)**	**2025-26 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$421,416,000	$518,351,000	$358,534,000	($159,817,000)
Federal Funds[1]	$548,422,000	$608,300,000	$592,709,000	($15,591,000)
Spec. Funds/Reimb	$371,639,000	$431,007,000	$322,845,000	($108,162,000)
Total Expenditures	**$1,341,477,000**	**$1,557,658,000**	**$1,274,088,000**	**($283,570,000)**
Total Positions	**4617.5**	**4688.5**	**4821.5**	**133.0**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS*)				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$37,611,139,000	$37,961,008,000	$42,421,898,000	$4,460,890,000
Federal Funds[1]	$96,079,540,000	$107,734,493,000	$118,438,068,000	$10,703,575,000
Spec. Funds/Reimb	$25,847,103,000	$32,864,379,000	$31,249,590,000	($1,614,789,000)
Total Expenditures	**$159,537,782,000**	**$178,559,880,000**	**$192,109,556,000**	**$13,549,676,000**
[1]*Federal Funds include Funds 0890, 7502, and 7503.*				

Background. The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering health care services to eligible individuals. DHCS programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.5 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

- ***Children's Medical Services.*** Children's Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 Budget Acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of DHCS programs and budget.

Issue 2: November 2024 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2024 Medi-Cal Local Assistance Estimate includes $174.6 billion ($37.6 billion General Fund, $107.5 billion federal funds, and $29.5 billion special funds and reimbursements) for expenditures in 2024-25, and $188.1 billion ($42.1 billion General Fund, $118.1 billion federal funds, and $28 billion special funds and reimbursements) for expenditures in 2025-26.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2024-25 (CY)**	**2025-26 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$36,184,830,000	$40,611,176,000	$4,426,346,000
Federal Funds	$101,365,419,000	$112,116,006,000	$10,750,587,000
Special Funds/Reimbursements	$29,452,300,000	$27,734,516,000	($1,717,784,000)
Total Expenditures	**$167,002,549,000**	**$180,461,698,000**	**$13,459,149,000**
County and Other Local Assistance Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,452,009,000	$1,477,744,000	$25,735,000
Federal Funds	$6,101,880,000	$5,937,215,000	($164,665,000)
Special Funds and Reimbursements	$55,647,000	$262,506,000	$206,859,000
Total Expenditures	**$7,609,536,000**	**$7,677,465,000**	**$67,929,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$37,636,839,000	$42,088,920,000	$4,452,081,000
Federal Funds	$107,467,299,000	$118,053,221,000	$10,585,922,000
Special Funds and Reimbursements	$29,507,947,000	$27,997,022,000	($1,510,925,000)
Total Expenditures	**$174,612,085,000**	**$188,139,163,000**	**$13,527,078,000**

Caseload. In 2024-25, the budget assumes annual Medi-Cal caseload of 15 million, an increase of 444,200 beneficiaries, or 3.1 percent, compared to assumptions in the 2024 Budget Act. The department estimates 93.3 percent of Medi-Cal beneficiaries, or 14 million, will receive services through the managed care delivery system while 6.7 percent, or 995,217, will receive services through the fee-for-service delivery system.

In 2025-26, the budget assumes annual Medi-Cal caseload of 14.5 million, a decrease of 462,700 beneficiaries, or 3.1 percent, compared to the revised caseload estimate for 2024-25. The department estimates 93.1 percent of Medi-Cal beneficiaries, or 13.5 million, will receive services through the

managed care delivery system while 6.9 percent, or one million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2024 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

Current Year (2024-25) Adjustments – The Estimate includes total expenditures of $174.6 billion ($37.6 billion General Fund, $107.5 billion federal funds, and $29.5 billion special funds and reimbursements) for the Medi-Cal program in 2024-25, a 7.5 percent increase in General Fund expenditures compared to the assumptions included in the 2024 Budget Act. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *Caseload Impacts.* $3.7 billion General Fund costs related to changes in Medi-Cal caseload. Of this amount, $2.7 billion is related to higher than anticipated enrollment and higher pharmacy costs for the Medi-Cal undocumented expansion population, and $1.1 billion is related to smaller than expected savings achieved through post-pandemic Medi-Cal eligibility redeterminations.

- *Pharmacy Expenditures.* $540 million General Fund costs due to growth in Medi-Cal pharmacy expenditures.

These costs are partially offset by the following General Fund savings:

- *Proposition 35 and Managed Care Organization (MCO) Tax Impacts.* $1 billion General Fund savings due to updated estimates of the General Fund impact of Proposition 35 and the MCO tax. Of this amount, DHCS estimates additional General Fund savings of $453.7 million in 2024-25 due to passage of Proposition 35 by the voters, as well as $478.7 million General Fund savings from federal approval of an amendment to MCO tax amounts allowing consideration of Medicare revenue for an additional quarter than originally estimated.

Budget Year (2025-26) Adjustments – The Estimate includes total expenditures of $188.1 billion ($42.1 billion General Fund, $118.1 billion federal funds, and $28 billion special funds and reimbursements) for the Medi-Cal program in 2025-26, an 11.8 percent increase in General Fund expenditures compared to the revised assumptions for 2024-25. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *Proposition 35 and Managed Care Organization (MCO) Tax Impacts.* $3.6 billion General Fund costs due to updated estimates of the General Fund impact of Proposition 35 and the MCO tax. Of this amount, DHCS estimates additional General Fund costs of $2.7 billion in 2025-26 due to passage of Proposition 35 by the voters, as well as a $478.7 million General Fund savings adjustment related to the 2024-25 federal approval of an amendment to MCO tax amounts allowing consideration of Medicare revenue for an additional quarter than originally estimated.

- *Pharmacy Expenditures.* $215.2 million General Fund costs due to growth in Medi-Cal pharmacy expenditures.

- *Baseline Medi-Cal Costs.* $268.5 million General Fund costs due to increases in baseline Medi-Cal costs, particularly the growth in Medi-Cal managed care rates, changes in projected enrollment, growth in Medicare premium costs, and higher projected utilization in the fee-for-service delivery system.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open as updated estimates of caseload and expenditures will be provided at the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2024-25 and 2025-26 fiscal years.

Issue 3: November 2024 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2024 Family Health Local Assistance Estimate includes $247.2 million ($215.3 million General Fund, $5.2 million federal funds, and $26.7 million special funds and reimbursements) for expenditures in 2023-24, and $250.9 million ($218.9 million General Fund, $5.5 million federal funds, and $26.5 million special funds and reimbursements) for expenditures in 2024-25.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2024-25 (CY)**	**2025-26 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$85,680,000	$89,650,000	$3,970,000
Special Funds/Reimbursements	$7,421,000	$6,256,000	($1,165,000)
County Funds [non-add]	[$92,563,000]	[$95,025,000]	[$2,462,000]
Total CCS Expenditures	**$93,101,000**	**$95,906,000**	**$2,805,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$154,337,000	$151,777,000	($2,560,000)
Special Funds and Reimbursements	$368,000	$489,000	$121,000
Total GHPP Expenditures	**$154,823,000**	**$152,306,000**	**($2,517,000)**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	($1,776,000)	$-	($1,776,000)
Federal Funds	$5,518,000	$5,787,000	$269,000
Special Funds and Reimbursements	$17,923,000	$18,180,000	$257,000
Total EWC Expenditures	**$21,665,000**	**$23,967,000**	**$2,302,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$238,241,000	$241,427,000	$3,186,000
Federal Funds	$5,518,000	$5,787,000	$269,000
Special Funds and Reimbursements	$25,830,000	$24,965,000	($865,000)
County Funds [non-add]	[$92,563,000]	[$95,025,000]	[$2,462,000]
Total Family Health Expenditures	**$269,589,000**	**$272,179,000**	**$2,590,000**

Background. The Family Health Estimate forecasts the current and budget year local assistance expenditures for three state-only funded programs that provide services for low-income children and adults with special health care needs who do not qualify for enrollment in the Medi-Cal program.

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.

    - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 173,258 in 2024-25, an increase of 8,246 or five percent, compared to the 2024 Budget Act. The budget estimates Medi-Cal CCS caseload of 173,258 in 2025-26, unchanged compared to the revised 2024-25 estimate.
    - Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 15,052 in 2024-25, a decrease of 1,972 or 11.6 percent, compared to the 2024 Budget Act. The budget estimates state-only CCS caseload of 15,052, in 2025-26, unchanged compared to the revised 2024-25 estimate.

- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate

    - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 713 in 2024-25, a decrease of 121 or 13.6 percent, compared to the 2024 Budget Act. The budget estimates Medi-Cal GHPP caseload of 713 in 2025-26, unchanged compared to the revised 2024-25 estimate.
    - Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 701 in 2024-25, a decrease of 94 or 11.8 percent, compared to the 2024 Budget Act. The budget estimates state-only GHPP caseload of 701 in 2025-26, unchanged compared to the revised 2024-25 estimate.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).

- Caseload Estimate: The budget estimates EWC caseload of 12,668 in 2024-25, a decrease of 3,707 or 22.6 percent, compared to the 2024 Budget Act. The budget estimates EWC caseload of 12,845 in 2025-26, an increase of 177 or 1.4 percent compared to the revised 2024-25 estimate.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2024-25 and 2025-26 fiscal years.

2. What is the reason for the significant decrease in caseload across state-only programs in the Family Health Estimate?

3. Please provide a status update on the implementation of the CCS Compliance, Monitoring, and Oversight Program? Are counties ready to begin implementation on July 1, 2025? What is the funding source for these new county requirements?

Issue 4: Value Strategy for Hospital Payments in Medi-Cal Managed Care

Budget Change Proposal and Trailer Bill Language – Governor's Budget. DHCS requests 29 positions and expenditure authority of $11.3 million ($2 million Hospital Quality Assurance Revenue or HQAF Fund, $3.6 million reimbursements, and $5.6 million federal funds) in 2025-26, $11 million ($2 million HQAF Fund, $3.5 million reimbursements, and $5.5 million federal funds in 2026-27 through 2028-29, and $8 million ($1.5 million HQAF Fund, $2.5 million reimbursements, and $4 million federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to develop, implement, and sustain a comprehensive value strategy for state-directed payments to hospitals in the Medi-Cal managed care delivery system.

DHCS also requests trailer bill language to: 1) authorize the development and implementation of the comprehensive value strategy, in consultation with public and nonpublic hospital stakeholders; and 2) adjust the percentage of hospital quality assurance revenue available for administration of the hospital directed payment program.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0890 – Federal Trust Fund	$5,644,000	$5,489,000
0995 – Reimbursements	$3,632,000	$3,526,000
3158 – Hospital Quality Assurance Revenue Fund	$2,000,000	$2,000,000
Total Funding Request:	**$11,276,000**	**$11,015,000**
Total Requested Positions:	**29.0**	**29.0**

* Additional fiscal year resources requested – 2027-28 through 2028-29: $11,015,000; 2029-30 and ongoing: $8,015,000

Background. California hospitals have reported significant financial distress in recent years, highlighted by the closure of Madera Community Hospital in January 2023. Other hospitals have reduced service delivery to ensure continued operation. These challenges have led to several legislative and administrative efforts to support California hospitals, including the Distressed Hospital Loan Program adopted in May 2023, and proposals in the current budget to expand safety net financing programs that support hospitals through supplemental payments.

Hospital Financing Through Medi-Cal Managed Care. According to DHCS, the Medi-Cal managed care delivery system reimburses hospitals through a combination of base payments negotiated between hospitals and plans, and supplemental payments programs established by the state. Federal Medicaid regulations prohibit states from interfering in payment arrangements between managed care plans and their providers. However, Medicaid regulations allow supplemental payment mechanisms to govern payments to providers in a plan network under certain conditions that generally advance the goals of the Medi-Cal program and its beneficiaries' health. These supplemental payments generally fall into one of two categories:

1) *State-Directed Payments (SDPs)* – Payments approved for one-year terms and that satisfy certain requirements including appropriateness of payment levels, alignment with goals and objectives of Medi-Cal's comprehensive quality strategy, monitoring and evaluation, and documentation and reporting.

2) *Pass-Through Payments (PTPs)* – Payments that are time-limited and subject to federal phasedown and sunset timeframes governed by federal regulations. The federal Centers for Medicare and Medicaid Services (CMS) requires all pass-through payments to be transitioned to state-directed payments on or before January 1, 2027.

According to DHCS, the state currently has six SDP and five PTP programs to provide nearly $14 billion of support to California hospitals. Most of these programs are self-financed, with the non-federal share provided either through a tax on the hospital (the Hospital Quality Assurance Fee or HQAF), or through an intergovernmental transfer (IGT) from designated public hospitals (DPH) or district and municipal hospitals (DMPH).

Supplemental Payment Programs for Hospitals – Medi-Cal			
Type	**Payment Arrangement**	**Non-Federal Share Source**	**CY 2024 Total (millions)**
SDP	DMPH Directed Payment (DHDP)	IGT	$207.3
SDP	DMPH Quality Incentive Pool (DMPH-QIP)	IGT	$172.1
SDP	DPH Enhanced Payment Program (EPP)	IGT	$2,478.2
SDP	DPH Quality Incentive Pool (DPH-QIP)	IGT	$2,037.5
SDP	Major Organ Transplants	State GF	$266.2
SDP	Private Hospital Directed Payment (PHDP)	HQAF	$7,187.3
PTP	Benioff Children's Hospital Oakland PTP	IGT	$22.0
PTP	DMPH PTP	IGT	$97.4
PTP	Martin Luther King Jr. Community Hospital PTP	State GF	$47.4
PTP	Private Hospital PTP	HQAF	$1,200.0
PTP	Public Distinct-Part Nursing Facility PTP	State GF	$130.0

A portion of revenues generated by the HQAF are used to reimburse the state's costs of administering the program. This portion is currently limited to $2 million per year. In addition, DHCS may assess an administrative fee, not to exceed five percent, on IGTs to administer the DHDP, DMPH-QIP, EPP, and DPH-QIP state-directed payment programs.

Expansion of State-Directed Payments to Support California Hospitals. In an effort to improve the financial condition of the state's public and private hospitals, DHCS has engaged extensively with stakeholders to expand state-directed payment programs to provide billions of dollars in additional support. Because these SDPs are self-financed, no additional state General Fund resources are required. Similar to recent state efforts to maximize the federal benefits received from the tax on managed care organizations (MCO tax), these efforts seek to maximize the availability of federal matching funds to support increased reimbursements to the state's hospitals.

While the state is expanding these SDP programs, recently promulgated federal regulations implemented new requirements on state Medicaid programs that utilize SDPs and PTPs for supplemental payments. According to the regulations, SDPs and PTPs must be accounted for in managed care rate certifications and plan contracts, making these supplemental payment programs subject to federal review and approval. As a result, DHCS is seeking to link these programs more closely with beneficiary access to high quality care, appropriate care delivery, and improved health outcomes.

Comprehensive Value Strategy. DHCS is proposing to develop, publish, implement, and sustain a comprehensive value strategy for SDPs that will focus on the following objectives:

- Achieving improved, sustainable levels of Medi-Cal reimbursement for hospital services relative to other payers.
- Advancing appropriate incentives for care delivery, including but not limited to: 1) incentivizing care in appropriate and lower-cost outpatient and community-based settings, 2) evaluating reimbursement levels across all service lines and provider types, and 3) streamlining program design and operational processes, where feasible, to clarify financial incentives, accelerate receipt of payment by hospitals, and minimize avoidable administrative burdens for hospitals, plans, and DHCS.
- Aligning with Medi-Cal's comprehensive quality strategy and leveraging supplemental payments to advance population health, quality of care, and health equity.
- Certifying the continued federal approvability of SDPs.

Staffing and Resource Request. DHCS requests 29 positions and expenditure authority of $11.3 million ($2 million Hospital Quality Assurance Revenue or HQAF Fund, $3.6 million reimbursements, and $5.6 million federal funds) in 2025-26, $11 million ($2 million HQAF Fund, $3.5 million reimbursements, and $5.5 million federal funds in 2026-27 through 2028-29, and $8 million ($1.5 million HQAF Fund, $2.5 million reimbursements, and $4 million federal funds) annually thereafter for DHCS to develop, implement, and sustain a comprehensive value strategy for state-directed payments to hospitals in the Medi-Cal managed care delivery system. Specifically, DHCS is requesting the following positions and resources:

Capitated Rates Development Division – 12 positions

- **One Staff Services Manager (SSM) III** position would have management and supervisory responsibility for the branch overseeing hospital SDPs, including one existing section and one new section with two new units.
- **One SSM II** position would have supervisory responsibility over a new section overseeing implementation of the comprehensive value strategy.
- **Two SSM I** positions would be responsible for the oversight, supervision of staff, and alignment of the new SDP workloads associated with the comprehensive value strategy.
- **Two Research Data Scientists (RDS) II** positions would independently perform complex data analysis, respond to urgent research requests, perform technical quality review of research and data work, develop new standardized research data methodologies and guidelines, and train and mentor research data staff.
- **Two RDS I** positions would develop and maintain tools and methodologies used to analyze and evaluate reimbursement rates, costs, and utilization across counties, regions, hospitals, and plans, to support development and review of hospital reimbursement methodologies. The positions would also design and maintain tools and methodologies to comply with CMS monitoring requirements, and respond to ad-hoc research and data requests.
- **Four Associate Governmental Program Analysts (AGPAs)** would review, analyze, and draft responses to plan and hospital inquiries, develop technical program guidance and documentations, coordinate with other divisions and units the development and implementation of SDPs.

Data Analytics Division – Two positions

- **One Research Scientist Supervisor (RSS) I** position would hire, train, and manage research staff responsible for operationalizing the evaluation of directed payment programs with new federal rules. These responsibilities would include recruitment, retention, training, verifying work standards, evaluating and documenting performance, and communicating with staff and management about technical or scientific issues, program implementation, policy issues, and deadlines.
- **One Research Scientist (RS) I** position would use epidemiologic, biostatistical, and survey techniques and theories to plan, organize, and carry out scientific research and evaluation of health care service utilization, health outcomes, quality of care, and access to effective and appropriate healthcare services for Medi-Cal beneficiaries. This position would also serve as a resource and team lead, as well as a departmental scientific liaison to external requesters or data sharing partners.

Health Care Financing Division – One position

- **One RS V** position would advise executive and senior staff on economic and demographic matters; plan, organize, and direct complex economic and demographic studies to inform reimbursement methodologies; and perform complex statistical and econometric analyses.

Health Information Management Division – Three positions

- **Three Information Technology Specialist (ITS) II** positions would provide data support and consultation related to methodical development and limitations, data collection and improvement, data reporting and querying, and data linkage and integration. These positions would also work with program staff to develop long-term data strategy and support requirements, and design the appropriate exchanges to enable SDP payment data to move across the necessary departmental systems and allow efficient access to SDP data.

Program Data Reporting Division – One position

- **One Research Data Specialist (RDS) III** position would maintain coordination between divisions, acting as lead data steward for translating technical needs to collect the required data, as well as division lead for data analytic support for the division.

Office of Legal Services – Two positions

- **Two Attorney IV** positions would support implementation and maintenance of the SDPs, advise on implementation, and draft and revise documentation needed for federal approvals.

Quality and Health Equity Division – Eight positions

- **Two Medical Consultant (MC) II** positions would oversee programmatic decision-making, program development, and long-term strategy across SDPs. One position would work with private hospitals and one would work with the public hospitals. These positions would interpret measure specifications, perform clinical reviews of hospitals' and plans' data, and provide clinical oversight of teams running each SDP.

- **One Health Program Manager (HPM) II** position would manage all hospital SDPs, supervise staff and provide guidance for program oversight and policy decision-making.
- **One SSM I** position would manage the private hospital SDP, overseeing incentive claims and payments, managing daily program activities, completing policy analysis, convening and engaging with other divisions on payment and program activities, and overseeing other division staff.
- **Four AGPAs** would assist in programmatic support of private hospital SDPs, conduct completeness and comprehensive reviews of reporting, monitor and assess implementation of program policy and protocols, propose recommendations and solutions based on report analyses, perform monitoring and review of performance reports, and provide support and technical assistance to hospitals.

Consultant Contracts - $5.4 million

- **Hospital Comprehensive Value Strategy Design and Implementation -** $3 million ($1 million HQAF, $1 million IGT, and $1.5 million federal funds) would support a contractor for the development and implementation of a comprehensive value strategy for hospital SDPs, including the following activities:

    - Supporting stakeholder engagement on the design of the strategy, including facilitating workgroups, developing materials, and reviewing and analyzing feedback.
    - Designing appropriate population health, quality of care, health equity, and cost accountability metrics, and associated reimbursement mechanisms, to support sustainable hospital reimbursement.
    - Analyzing and leveraging hospital Medi-Cal data on revenue, costs, cost drivers, reimbursement levels relative to other payers, and considerations applicable to specific subsets of hospitals, geographies, lines of service, and other stratifications.
    - Analyzing existing supplemental payment programs to identify opportunities to align with comprehensive value strategy objectives.
    - Support DHCS in obtaining federal approvals and implement operational changes necessary to implement the comprehensive value strategy.

- **Hospital Directed Payment Ongoing Support** - $2.4 million ($400,00 HQAF, $800,000 IGT, and $1.2 million federal funds) annually to support a contractor for ongoing operations of hospital SDPs, including the following activities:

    - Auditing of quality measures submissions for the private and public hospital SDPs.
    - Organizing and facilitating an annual conference to share best practices between hospitals, plans, and other stakeholders to identify strategies to improve patient care quality and continuously leverage lessons learned to improve hospital SDPs.

Trailer Bill Language Proposal. DHCS also requests trailer bill language to: 1) authorize the development and implementation of the comprehensive value strategy, in consultation with public and nonpublic hospital stakeholders; and 2) adjust the percentage of hospital quality assurance revenue available for administration of the hospital directed payment program.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal and the associated trailer bill language.

2. Please describe the efforts to date to improve hospital reimbursement through expansion of existing SDPs.

3. How would the efforts to develop the comprehensive value strategy be linked to the efforts to expand SDPs? Would they happen concurrently and be incorporated into the requests for federal approvals, or would they be developed separately?

Issue 5: Implementation of Chaptered Legislation (SB 1120 and AB 3275)

SB 1120 (Becker)

Legislative Budget Change Proposal (SB 1120) – Governor's Budget. DHCS requests two positions and expenditure authority of $340,000 ($170,000 General Fund and $170,000 federal funds) in 2025-26, and $322,000 ($161,000 General Fund and $161,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of new restrictions on the use of artificial intelligence (AI) for utilization review and utilization management, pursuant to SB 1120 (Becker), Chapter 879, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
0001 – General Fund	$170,000	$161,000
0890 – Federal Trust Fund	$170,000	$161,000
Total Funding Request:	**$340,000**	**$322,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2025-26.

Background. SB 1120 (Becker), Chapter 879, Statutes of 2024, requires health plans and insurers that use artificial intelligence (AI), algorithms, or other software tools for utilization review or utilization management for medical necessity to ensure that the tool complies with the following:

1) Bases determinations on medical or other clinical history, individual clinical circumstances, and other relevant clinical information contained in medical or other clinical records
2) Prohibits basing decisions solely on a group dataset
3) Prohibits supplanting health care provider decision-making
4) Prohibits direct or indirect discrimination against patients in violation of state or federal law
5) Requires fair and equitable application of the tool, in accordance with applicable federal regulations or guidance
6) Requires tools to be open to inspection for auditing or compliance reviews and pursuant to state and federal law
7) Requires disclosures pertaining to the use and oversight of the tool in written policies and procedures
8) Requires tool performance, use, and outcomes to be periodically reviewed and revised to maximize accuracy and reliability
9) Prohibits patient data from being used beyond its intended and stated purpose, consistent with the state Confidentiality of Medical Information Act and the federal Health Insurance Portability and Accountability Act of 1996
10) Prohibits tools from directly or indirectly causing harm to patients
11) Prohibits tools from denying, delaying, or modifying health care services based in whole or in part on medical necessity
12) Requires medical necessity determinations to be made only by a licensed physician or other licensed health care professional competent to evaluate the specific clinical issues involved

According to DHCS, these requirements would apply to Medi-Cal managed care plans and dental managed care plans. As a result, DHCS requests resources to implement these new requirements on its health and dental plans.

Staffing and Resource Request. DHCS requests two positions and expenditure authority of $340,000 ($170,000 General Fund and $170,000 federal funds) in 2025-26, and $322,000 ($161,000 General Fund and $161,000 federal funds) annually thereafter to support implementation of new restrictions on the use of artificial intelligence (AI) for utilization review and utilization management, pursuant to SB 1120 (Becker), Chapter 879, Statutes of 2024. Specifically, DHCS requests **one Health Program Specialist II** position and **one Health Program Specialist I** position to support implementation of SB 1120. As of publication of this subcommittee agenda, DHCS has not provided a narrative for this proposal describing the responsibilities or workload of these positions.

In addition, the Department of Finance, in its analysis of SB 1120 during the prior legislative session, indicated that DHCS would require only one Health Program Specialist II position and $173,000 ($86,500 General Fund and $86,500 federal funds) to implement the bill's requirements. According to DHCS, during analysis of the bill the department did not anticipate application of the bill's requirements to dental managed care plans. The addition of a new Health Program Specialist I position to the request is intended to address the dental managed plan workload.

AB 3275 (Soria)

Legislative Budget Change Proposal (AB 3275) – Governor's Budget. DHCS requests two positions and expenditure authority of $331,000 ($166,000 General Fund and $165,000 federal funds) in 2025-26, and $313,000 ($157,000 General Fund and $156,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of timely claims payment requirements, pursuant to AB 3275 (Soria), Chapter 763, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26***
0001 – General Fund	$166,000	$157,000
0890 – Federal Trust Fund	$165,000	$156,000
Total Funding Request:	**$331,000**	**$313,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2025-26.

Background. AB 3275 (Soria), Chapter 763, Statutes of 2024, requires health plans to reimburse claims no later than 30 calendar days after receipt of a claim and no later than 30 calendar days after receiving information in response to a contested claim. These provisions of the bill apply to Medi-Cal managed care plans.

Staffing and Resource Request. DHCS requests two positions and expenditure authority of $331,000 ($166,000 General Fund and $165,000 federal funds) in 2025-26, and $313,000 ($157,000 General Fund and $156,000 federal funds) annually thereafter to support implementation of timely claims payment requirements, pursuant to AB 3275 (Soria), Chapter 763, Statutes of 2024. Specifically, DHCS requests

one Health Program Specialist II position and **one Associate Governmental Program Analyst** position to support implementation of AB 3275. As of publication of this subcommittee agenda, DHCS has not provided a narrative for this proposal describing the responsibilities or workload of these positions. In addition, the Department of Finance, in its analysis of AB 3275 during the prior legislative session, indicated that DHCS would be able to implement the bill within existing resources.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of these proposals.

2. When can the subcommittee expect narrative descriptions of these and other proposals for department resources to implement chaptered legislation?

3. Please account for the discrepancies between the Department of Finance analyses of the fiscal impacts of these bills during the prior legislative session, and the current staffing and resource requests for implementation of these bills.

Issue 6: Proposition 35 – Managed Care Organization (MCO) Tax and Medi-Cal Investments

Local Assistance – Governor's Budget. The budget reflects total net General Fund savings of $4.4 billion in 2023-24, $7.9 billion in 2024-25, $4.4 billion in 2025-26, and $3.3 billion in 2026-27 as a result of the tax imposed on managed care organizations (MCO tax), approved by the Legislature in 2023, modified in 2024, and adopted by the voters in November 2024 as Proposition 35. The MCO tax provides support for the non-federal share of Medi-Cal expenditures, which results in billions of dollars in net savings to the state's General Fund, and supports targeted investments in the Medi-Cal program to improve access to quality health care for Medi-Cal beneficiaries. According to the Administration, compared to the assumptions in the 2024 Budget Act, the net General Fund savings figures included in the budget represent an increase of $1 billion in General Fund savings in 2024-25, and a decrease of General Fund savings of $2.2 billion in 2025-26 and $1.8 billion in 2026-27.

2025-26 Governor's Budget
Managed Care Organization Provider Tax
(Dollars in Millions)

	CY 2023-24	BY 2024-25	BY+1 2025-26	BY+2 2026-27	All Years Total[2]
AB 119 Pre-2025 Revenue					
Total Revenue	$8,269.3	$6,351.0	$0.0	$0.0	$14,620.3
- Medi-Cal Managed Care Capitation Payments	$3,218.7	$2,250.9	$0.0	$0.0	$5,469.6
= Total State Funding	**$5,050.6**	**$4,100.1**	**$0.0**	**$0.0**	**$9,150.7**
State Administration Costs	$0.0	$2.0	$0.0	$0.0	$2.0
Medi-Cal Provider Payment Increases Effective 1/2024	$0.0	$287.4	$0.0	$0.0	$287.4
Distressed Hospital Loan Program and the Small and Rural Hospital Relief Program for Seismic Assessment and Construction	$0.0	$200.0	$0.0	$0.0	$200.0
Proposition 56 Provider Payments Backfill	$0.0	$145.4	$0.0	$0.0	$145.4
= Total Expenditures[1]	**$0.0**	**$634.8**	**$0.0**	**$0.0**	**$634.8**
Funding to Support Medi-Cal	$4,408.6	$4,107.2	$0.0	$0.0	$8,515.8
Fund Balance[2]	$642.0	-$642.0	$0.0	$0.0	$0.0
AB 119 Post-2025 Revenue (Proposition 35)					
Total Revenue	$0.0	$2,175.8	$8,761.9	$6,703.7	$17,641.4
- Medi-Cal Managed Care Capitation Payments	$0.0	$1,156.3	$3,499.7	$2,374.3	$7,030.3
= Total State Funding	**$0.0**	**$1,019.5**	**$5,262.2**	**$4,329.4**	**$10,611.1**
State Administration Costs	$0.0	$0.0	$4.0	$4.0	$8.0
Medi-Cal Provider Payment Increases Effective 1/2024	$0.0	$124.5	$291.0	$305.0	$720.5
Proposition 35 Expenditures Calendar Years 2025 and 2026	$0.0	$61.6	$2,967.2	$1,562.7	$4,591.5
Proposition 35 Expenditures Calendar Year 2027 and Beyond	$0.0	$0.0	$0.0	$1,188.4	$1,188.4
= Total Expenditures[1]	**$0.0**	**$186.1**	**$3,262.2**	**$3,060.1**	**$6,508.4**
Funding to Support Medi-Cal	$0.0	$833.3	$2,000.0	$1,269.3	$4,102.6
SB 136 and AB 160 Revenue[3]					
Total Revenue	$0.0	$5,232.3	$3,943.0	$2,827.2	$12,002.5
- Medi-Cal Managed Care Capitation Payments	$0.0	$2,231.1	$1,569.5	$839.7	$4,640.3
= Total State Funding	**$0.0**	**$3,001.2**	**$2,373.5**	**$1,987.5**	**$7,362.2**
Funding to Support Medi-Cal	$0.0	$3,001.2	$2,373.5	$1,987.5	$7,362.2
GRAND TOTAL					
Total Revenue	$8,269.3	$13,759.1	$12,704.9	$9,530.9	$44,264.2
- Medi-Cal Managed Care Capitation Payments	$3,218.7	$5,638.3	$5,069.2	$3,214.0	$17,140.2
= Total State Funding	**$5,050.6**	**$8,120.8**	**$7,635.7**	**$6,316.9**	**$27,124.0**
State Administration Costs	$0.0	$2.0	$4.0	$4.0	$10.0
Medi-Cal Provider Payment Increases Effective 1/2024	$0.0	$411.9	$291.0	$305.0	$1,007.9
Proposition 35 Expenditures Calendar Years 2025 and 2026	$0.0	$61.6	$2,967.2	$1,562.7	$4,591.5
Proposition 35 Expenditures Calendar Year 2027 and Beyond	$0.0	$0.0	$0.0	$1,188.4	$1,188.4
Distressed Hospital Loan Program and the Small and Rural Hospital Relief Program for Seismic Assessment and Construction	$0.0	$200.0	$0.0	$0.0	$200.0
Proposition 56 Provider Payments Backfill	$0.0	$145.4	$0.0	$0.0	$145.4
= Total Expenditures[1]	**$0.0**	**$820.9**	**$3,262.2**	**$3,060.1**	**$7,143.2**
Funding to Support Medi-Cal	$4,408.6	$7,941.7	$4,373.5	$3,256.8	$19,980.6
Fund Balance[2]	$642.0	-$642.0	$0.0	$0.0	$0.0

[1/] Only state funds are reflected, expenditures do not include federal funds.
[2/] Positive fund balances reflect funds in the Managed Care Enrollment Fund not utilized within the fiscal year that are available to carry over to the next fiscal year. Negative fund balances reflect the use of fund balances from prior fiscal years.
[3/] Revenues from SB 136 (Chapter 6, Statutes of 2024) and AB 160 (Chapter 39, Statutes of 2024) are not subject to Proposition 35.

Source: DHCS Fiscal Forecasting, February 2025

The budget also reflects expenditure authority of $411.9 million in 2024-25, $291 million in 2025-26, and $305 million in 2026-27 to support Medi-Cal provider rate increases, effective January 1, 2024, for primary care, non-specialty mental health, and obstetrics services, that were adopted in the 2023 Budget Act. Reimbursement rate increases and other investments authorized by voter approval of Proposition 35 will be implemented after consultation with a stakeholder advisory committee, and after federal approval is received. For the Proposition 35 investments authorized for the 2025 and 2026 calendar years, the budget assumes $61.6 million will be spent in 2024-25, $3 billion in 2025-26, and $1.6 billion in 2026-27. For Proposition 35 investments authorized for the 2027 calendar year and beyond, the budget assumes $1.2 billion will be spent in 2026-27. In addition, due to voter approval of Proposition 35, certain targeted reimbursement rate increases and other investments adopted in the 2024 Budget Act will not become operative.

Federal Requirements for Health Care Related Taxes. Section 433.68 of Title 42 of the Code of Federal Regulations (42 CFR 433.68) authorizes state Medicaid programs to receive federal financial participation (FFP) for expenditures using health care-related taxes, as long as certain conditions are met. The MCO Enrollment tax qualifies as a health care-related tax. Taxes must be:

1) Broad-based – For a health care related tax to be considered broad based, it must be imposed on all non-federal (e.g. Medicare) and non-public providers in the state or jurisdiction imposing the tax (e.g. local government).
2) Uniformly imposed – For a health care related tax to be considered uniform, it must be applied at the same rate for all affected providers
3) No hold-harmless provisions – A taxpayer cannot be held harmless for the amount of the tax. A taxpayer is considered to be held harmless if there is a correlation between their Medicaid payments and the tax amount, all or any portion of the Medicaid payment varies based only on the tax amount, or the state or other taxing jurisdiction provides for any direct or indirect payment or other offset for all or any portion of the tax amount.

States may apply for waivers to both the broad-based and uniform requirements. For a waiver of the broad-based requirements, a state must demonstrate that the tax is "generally redistributive" by calculating the proportion of tax revenue applicable to Medicaid under a broad-based tax (P1) and comparing it to the same proportion under the proposed tax (P2). A waiver may be approved if the ratio of P1/P2 is at least 0.95, and the excluded providers are in a list of providers defined in the regulation. For a waiver of the uniform requirements, a state must measure the ratio of the slope of a linear regression equation of a broad-based and uniform tax (B1) compared to the proposed tax (B2). The ratio of B1/B2 must be at least 0.95, and the excluded providers are in a list of providers defined in the regulation. The most recent MCO enrollment tax received a waiver of the uniform requirement, and was designed to comply with the required B1/B2 ratio.

Twenty Years of Provider Taxes on Managed Care Organizations in California. California imposes three provider-related taxes: a fee on certain general acute-care hospitals (Hospital Quality Assurance Fee or HQAF), a fee on free-standing skilled nursing facilities (AB 1629 Quality Assurance Fee), and a tax on enrollment in health care service plans in the state of California (Managed Care Organization or MCO Tax). For over twenty years, California has imposed a fee or tax on managed care organizations, the

proceeds of which have been allocated entirely to offset state General Fund expenditures in Medi-Cal, until the most recent tax imposed in 2023.

Quality Improvement Fee (AB 1762 - 2003)

AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, authorized the state's first provider fee on Medi-Cal managed care organizations. The fee was implemented in July 2005 as a quality improvement fee of 5.5 percent of a plan's revenue. The 2005 Governor's Budget assumed net General Fund savings of $37.7 million as a result of the fee. The fee was allowed to expire in October 2009, as the federal government disallowed the fee because it was not sufficiently broad-based and, therefore, in violation of the relevant Medicaid regulations (see section below on "Federal Medicaid Requirements")

Gross Premiums Tax (AB 1422 - 2009)

AB 1422 (Bass), Chapter 157, Statutes of 2009, replaced the previous quality improvement fee with an extension of the state's existing gross premiums tax of 2.35 percent to Medi-Cal managed care plans. The tax had previously only been levied on insurance products, but taxation of Medi-Cal managed care plans under this existing tax regime was sufficient to comply with federal Medicaid regulations that the tax be broad-based. AB 1422 provided that revenue from the tax would serve as the non-federal share for expenditures in both the Medi-Cal program and the state's program for the federal Children's Health Insurance Program, known as the Healthy Families Program. The 2010 Budget Act assumed the gross premiums tax would provide $99.8 million to Medi-Cal and $82 million to Healthy Families in the 2009-10 fiscal year. The gross premiums tax was extended by Chapter 717, Statutes of 2010 (SB 853), and again by Chapter 11, Statutes of 2011 (ABX1 21), until June 30, 2012.

Managed Care Organization Tax (SB 78 - 2013)

SB 78 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2013 (SB 78), extended the gross premiums tax at its previous rate of 2.35 percent until June 30, 2013. SB 78 then authorized a tax of 3.9375 percent, equal to the state's portion of the sales and use tax, on the operating revenue of Medi-Cal managed care organizations, known as the MCO tax. The tax was authorized for three years, until June 30, 2016. The 2013 Budget Act assumed a General Fund savings of $304.6 million for the Medi-Cal program from the MCO tax. Over subsequent years, additional populations began to enroll in Medi-Cal managed care, particularly related to the Optional Expansion of Medi-Cal pursuant to the federal Affordable Care Act. As a result, General Fund savings from the MCO tax grew significantly because the tax was a percentage of overall expenditures on Medi-Cal managed care. The 2016 Budget Act assumed $971.2 million of annual General Fund savings in the 2015-16 fiscal year, the last year of operation of this version of the MCO tax.

Managed Care Enrollment Tax (SBX2 2 - 2016)

In 2014, the federal government released guidance indicating that the structure of the state's MCO tax did not comply with federal Medicaid regulations. The state was instructed to make any necessary statutory changes to bring the tax into compliance by the end of the next scheduled legislative session, or the end of 2016. SBX2 2 (Hernandez), Chapter 2, Statutes of 2016, 2nd Extraordinary Session, authorized a tax on enrollment of managed care plans statewide, along with certain tax reform provisions. SBX2 2 created a tiered tax on the enrollment of health care service plans based on their enrollment as reported to the Department of Managed Health Care for the 12 month period of October 1, 2014 through September 30, 2015, known as the "base year". There were three sets of tiers: 1) Medi-Cal enrollees, 2) Alternate Health Care Service Plan enrollees (such as Kaiser), and 3) all other enrollees. Each tier, based on the number of

member months, had a different tax rate per enrollee. The 2017 Governor's Budget assumed General Fund savings of $1.07 billion in 2016-17 and $1.63 billion in 2017-18 from the new MCO enrollment tax. SBX2 2 also contained tax reform components that exempted payers of the MCO tax from liability for the state's gross premiums tax and from the corporation tax. The 2017 Governor's Budget assumed a total annual General Fund revenue reduction of $370 million ($280 million gross premiums tax and $90 million corporation tax) for each of the three years of the tax.

Reauthorized MCO Enrollment Tax (AB 112 – 2019)

AB 112 (Committee on Budget), Chapter 348, Statutes of 2019, reauthorized a tax on managed care organizations operating in California, based on enrollment, beginning July 1, 2019, and ending January 1, 2023. The "base year" for enrollment was the cumulative enrollment for each plan between January 1, 2018, and December 31, 2018. The 2019 Budget Act assumed net revenue of $1.7 billion in 2019-20, $1.9 billion in 2020-21, $2.1 billion in 2021-22, and $2.4 billion in 2022-23. The tax authorized by AB 112 was allowed to expire at the end of 2023.

2023 Budget Act MCO Enrollment Tax Renewal. AB 119 (Committee on Budget), Chapter 13, Statutes of 2023, implemented a multi-year tax on managed care organizations (MCO) beginning April 1, 2023, through December 31, 2026, to: 1) support the General Fund shortfall and achieve a balanced budget, 2) support Medi-Cal investments to ensure access, quality and equity over an eight to ten year period. The 2023 Budget Act also authorized expenditure authority of $214.7 million ($89.6 million Medi-Cal Provider Payment Reserve Fund and $125.1 million federal funds) to increase provider rates to 87.5 percent of the rate paid by the Medicare program, beginning January 1, 2024, for the following provider types: 1) primary care services and nonphysician professional services, 2) obstetric care services, and 3) outpatient, non-specialty mental health services. The 2023 Budget Act also included expenditure authority of $150 million for the Distressed Hospital Loan Program (one-time), $75 million for Graduate Medical Education (ongoing), and $50 million for Small and Rural Hospital Relief for Seismic Assessment and Construction (one-time).

The tax established three tiers of enrollment. Tier 1 includes enrollment up to 1,250,000. Tier 2 includes enrollment between 1,250,001 and 4,000,000. Tier 3 includes enrollment over 4,000,001. The tax only applies to enrollment in Tier 2 and was set at $182.50 per enrollee for Medi-Cal managed care plans and $1.75 per enrollee for non-Medi-Cal plans in 2023-24 and 2024-25. In 2025-26, the tax was set to rise to $187.50 per enrollee for Medi-Cal managed care plans and $2.00 per enrollee for non-Medi-Cal plans. In 2026-27, the tax would have risen again to $192.50 per enrollee for Medi-Cal managed care plans and $2.25 per enrollee for non-Medi-Cal plans. This tax structure was approved by CMS in December 2023.

MCO Tax – Enrollment Tiers and Tax Amounts
(as approved in the AB 119 and the 2023 Budget Act)

	Medi-Cal Tier 1	**Medi-Cal Tier 2**	**Medi-Cal Tier 3**	**Other Tier 1**	**Other Tier 2**	**Other Tier 3**
Enrollment:	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*
2023-24	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2024-25	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2025-26	$0.00	$187.50	$0.00	$0.00	$2.00	$0.00

2026-27	$0.00	$192.50	$0.00	$0.00	$2.25	$0.00

2024 Modifications to MCO Tax Amounts to Draw Down Additional Federal Funds. SB 136 (Committee on Budget and Fiscal Review), Chapter 6, Statutes of 2024, approved by the Legislature in March 2024, and AB 160 (Committee on Budget), Chapter 39, Statutes of 2024, approved by the Legislature in June 2024, modified the tiered tax amounts for the MCO tax approved by AB 119 to allow the state to draw down additional federal funds to offset General Fund expenditures in the Medi-Cal program. As the nonfederal share of Medi-Cal expenditures are typically supported by the state's General Fund, these resources are available to help address the state's General Fund shortfall. The new tax amounts by enrollment tier are as follows (changed amounts highlighted):

MCO Tax – Enrollment Tiers and Tax Amounts ***(as modified by AB 160 in June 2024)***						
	Medi-Cal Tier 1	**Medi-Cal Tier 2**	**Medi-Cal Tier 3**	**Other Tier 1**	**Other Tier 2**	**Other Tier 3**
Enrollment:	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*	*Less than 1,250,000*	*1,250,001-4,000,000*	*More than 4,000,001*
2023-24	$0.00	$182.50	$0.00	$0.00	$1.75	$0.00
2024-25	$0.00	$274.00	$0.00	$0.00	$1.75	$0.00
2025-26	$0.00	$274.00	$0.00	$0.00	$2.00	$0.00
2026-27	$0.00	$274.00	$0.00	$0.00	$2.25	$0.00

2024 Budget Act – MCO Tax Provider Rate Increases and Investments. As a result of the expansions of the tax in 2024, the 2024 Budget Act included General Fund savings of $4.5 billion in 2023-24, $7.1 billion in 2024-25, and $6.6 billion in 2026-27. In addition, the 2024 Budget Act included expenditure authority from the Medi-Cal Provider Payment Reserve Fund of $321 million in 2023-24, $426 million in 2024-25, $1 billion in 2025-26, and $1.6 billion in 2026-27, to support provider rate increases and other investments in the Medi-Cal program, including the following:

- **Physician and Professional Services.** $121 million in 2023-24, $291 million in 2024-25, $682 million in 2025-26, and $1.1 billion in 2026-27 to support physician and professional services, beginning January 1, 2024.

- **Emergency Physician Services.** $50 million in 2024-25, $100 million in 2025-26, and $100 million in 2026-27 to support emergency physician services, beginning January 1, 2025.

- **Abortion and Family Planning.** $45 million in 2024-25, $90 million in 2025-26, and $90 million in 2026-27 to support abortion and family planning services, beginning January 1, 2025.

- **Ground Emergency Medical Transportation.** $25 million in 2024-25, $50 million in 2025-26, and $50 million in 2026-27 to support ground emergency medical transportation services, beginning January 1, 2025.

- **Air Ambulances.** $4 million in 2024-25, $8 million in 2025-26, and $8 million in 2026-27 to support air ambulance services, beginning January 1, 2025.

- **Community-Based Adult Services.** $4 million in 2024-25, $8 million in 2025-26, and $8 million in 2026-27 to support community-based adult services, beginning January 1, 2025.

- **Congregate Living Health Facilities.** $4 million in 2024-25, $8 million in 2025-26, and $8 million in 2026-27 to support congregate living health facilities, beginning January 1, 2025.

- **Pediatric Day Health Centers.** $2 million in 2024-25, $3 million in 2025-26, and $3 million in 2026-27 to support pediatric day health centers, beginning January 1, 2025.

- **Private Duty Nursing.** $31 million in 2025-26 and $62 million in 2026-27 to support private duty nursing services, beginning January 1, 2026.

- **Federally Qualified Health Centers and Rural Health Clinics.** $25 million in 2025-26 and $50 million in 2026-27 to support federally qualified health centers and rural health clinics, beginning January 1, 2026.

- **Continuous Medi-Cal Coverage for Children Ages 0 to 5.** $17 million in 2025-26 and $32 million in 2026-27 to support continuous Medi-Cal coverage for children ages 0 to 5, beginning January 1, 2026.

- **Non-Emergency Medical Transportation.** $13 million in 2025-26 and $25 million in 2026-27 to support non-emergency medical transportation, beginning January 1, 2026.

- **Hospital Relief Programs.** $150 million in 2023-24 to support the Distressed Hospital Loan Program and $50 million in 2023-24 to support the Small and Rural Hospital Relief Program for Seismic Assessment and Construction.

- **Medi-Cal Workforce Pool.** $40 million in 2026-27 to support a Medi-Cal Workforce Pool.

- **Administration.** $2 million annually, beginning in 2024-25, to support DHCS administration of these provider rate increases and investments.

The Legislature also approved trailer bill language providing that, if voters approved Proposition 35 in November 2024, the package of Medi-Cal provider rate increases and investments in the budget will become inoperable, as the General Fund condition is insufficient to sustain both these increases and investments and those included in the initiative.

Proposition 35 – Timeline of Medi-Cal Investments. Voter approval of Proposition 35 made inoperative many of the Medi-Cal rate increases and investments made in the 2024 Budget Act, replacing those investments with other investments governed by the initiative. The initiative outlines one set of investments for the 2025 and 2026 calendar years, with specified amounts for certain categories of expenditures, and a slightly different package of investments for 2027 and beyond, with allocations by percentage-based formula to certain accounts that allow specific categories of expenditures. In addition,

Proposition 35 requires consultation with a Stakeholder Advisory Committee prior to implementation or changes to Medi-Cal investments resulting from the MCO tax.

2025 and 2026 Investments. For calendar years 2025 and 2026, after consultation with the Stakeholder Advisory Committee, Medi-Cal provider rate increases and investments will include the following categories and expenditures:

- *General Fund Backfill* – $2 billion
- *Primary Care, Obstetrics, Non-Specialty Mental Health* – $691 million
- *Specialty Care* – $575 million
- *Community and Outpatient Procedures* – $245 million
- *Abortion and Family Planning* – $90 million
- *Services and Supports for Primary Care* – $50 million
- *Emergency Room Facilities and Physicians* – $355 million
- *Designated Public Hospitals* – $150 million
- *Ground Emergency Medical Transportation* – $50 million
- *Behavioral Health Throughput* – $300 million
- *Graduate Medical Education* – $75 million
- *Medi-Cal Workforce Pool* – $75 million

According to DHCS, the effective date of these investments in calendar year 2025 will depend on the timing of the required consultations with the Stakeholder Advisory Committee. These consultations may lead to a delay in the effective date until later in the 2025 calendar year. However, all resources allocated by Proposition 35 are still available for the full calendar year. DHCS indicates it will consult with the committee regarding how to structure the investments given these technical implementation issues.

2027 Investments and Beyond. For calendar year 2027 and beyond, investments in the Medi-Cal program from Proposition 35 are allocated by formula. The first $4.3 billion of funding available for rate increases and other investments is required to be allocated as follows:

- *Primary Care Account (22 percent)* – This account will provide increased reimbursement rates for primary care services. These may be in the form of quality incentive payments or value-based payment models to improve provider participation in Medi-Cal and improve quality.

- *Specialty Care Account (22 percent)* – This account will provide funding to increase Medi-Cal patient access to specialty care services by increasing and retaining the number of Medi-Cal managed care contracting specialists, increasing the number of Medi-Cal patients a specialist serves, providing expanded specialist appointment availability, and supporting specialists in coordinating and overseeing care of patients as part of a multi-disciplinary care team.

- *Emergency Department Physicians Account (2.5 percent)* – This account will provide increased reimbursements for emergency department physicians treating Medi-Cal patients.

- *Outpatient and Clinic Access Account (5.75 percent)* – This account will provide increased net reimbursements for outpatient facilities, including ambulatory surgical centers and clinics, that provide eligible outpatient services and procedures to Medi-Cal patients.

- *Family Planning Account (5.5 percent)* – This account will provide funding support for expanding the scope and availability of family planning services, such as Family PACT, family planning and family planning-related services in Medi-Cal. This funding may also support practice transformation activities, as well as alternative payment methodologies such as bundled payments, directed payments, capitated payments, and value-based payments.

- *Reproductive Health Account (1.25 percent)* – This account will provide funding support for protecting, preserving, and expanding access to abortion and abortion-related services, including increasing payment rates for abortion and abortion-related services.

- *Emergency Medical Transportation Account (3 percent)* – This account will provide increased payments to private ground emergency medical transport providers and emergency air ambulance transport providers. 80 percent of funding will support private ground emergency medical transport, and 20 percent will support emergency air ambulance transport providers.

- *Emergency Department and Hospital Services Account (8.75 percent)* – This account will provide increased reimbursement levels to hospitals for the purpose of protecting access to, and improving the quality of, hospital care, including access to inpatient acute care and emergency departments, for Medi-Cal patients.

- *Designated Public Hospital Account (3.5 percent)* – This account will provide increased net reimbursement or new payments for designated public hospitals and health systems to sustain and promote access to hospital and non-hospital care at designated public hospital systems.

- *Improving Mental Health Account (4.5 percent)* – This account will provide funding support to expand access to mental health programs, including increasing the supply of inpatient psychiatric beds by providing a supplemental payment for psychiatric inpatient days in licensed acute care hospitals and acute psychiatric hospitals.

- *Health Care Workers Account (6.25 percent)* – This account will provide funding support to attract, retain, and expand the pool of health care workers available to treat Medi-Cal patients. 75 percent of funding will support graduate medical education at the University of California to increase the number of physician and surgeon residency slots or residency programs. 25 percent of funding will support a grant program to support and strengthen the development and retention of the Medi-Cal workforce through bona fide labor-management cooperation committees.

- *Clinic Quality Account (3.5 percent)* – This account will provide incentives to clinics that demonstrate improved quality and increased access to care for Medi-Cal patients.

- *Improved Dental Services Account (3.5 percent)* – This account will provide enhanced access to specialty and restorative dental care for Medi-Cal patients.

- *Medi-Cal Access and Support Account (8 percent)* – This account provides the non-federal share of Medi-Cal expenditures, which provides offsetting General Fund savings.

Stakeholder Advisory Committee Membership. In addition to provisions governing Medi-Cal investments, Proposition 35 establishes a Stakeholder Advisory Committee, with which DHCS must consult regarding the development and implementation of many of the provisions of the initiative. The Stakeholder Advisory Committee will be composed of the following ten members:

Appointed by the Governor:
- One member that represents both primary and specialty physicians on a statewide basis
- One member that represents both public and private hospitals, regardless of licensure type, on a statewide basis
- One member that represents a private emergency ambulance provider that performs 500,000 or more emergency medical ground transports per calendar year
- One member that represents family planning and reproductive health providers on a statewide basis
- One member that represents commercial, nongovernmental Medi-Cal managed care plans on a statewide basis
- One member that represents clinics on a statewide basis

Appointed by the Speaker of the Assembly:
- One member that represents public, nonprofit, Medi-Cal managed care plans on a statewide basis
- One member that represents dentists on a statewide basis

Appointed by the Senate President Pro Tempore:
- One member that represents organized labor groups on a statewide basis
- One member that represents a private emergency air ambulance transport provider that bills for more than 2,000 emergency ambulance transports per year.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of the types of reimbursement codes and other investments included in the 2024 provider rate increases and investments package.

2. Please provide a brief overview of the major categories of investments authorized by Proposition 35 for the 2025 and 2026 calendar years.

3. How will DHCS approach consultation with the Stakeholder Advisory Committee for the initial round of investments? Will DHCS offer its own proposal for discussion, or work with the committee to develop a proposal together?

4. One of the goals of Proposition 35 is to increase access to care for Medi-Cal providers. How will the department measure how successful these investments are in achieving the goal of increased access to care? Is there any evidence available regarding the most effective strategies to increase access to care with these resources?

5. How will the department manage the transition from the 2025 and 2026 investments to the investments in 2027 and beyond, given they are structured differently?

6. Please describe how voter approval of Proposition 35 impacted the availability of General Fund savings related to the MCO tax, including how Proposition 35 treats the increased tax rates as a result of the 2024 modifications (SB 136 and AB 160)?

7. Please detail the investments approved as part of the 2024 Budget Act that will no longer be operative as a result of voter approval of Proposition 35.

NOT FOR PRESENTATION

Issue 7: Proposals for Investment

Proposals for Investment. The subcommittee has received the following proposals for investment:

- **Private Duty Nursing Reimbursement Rate Increase.** The California Association for Health Services at Home (CAHSAH) and Aveanna Healthcare request expenditure authority of $62 million ($31 million General Fund and $31 million federal funds) in 2025-26 and $123.9 million ($62 million General Fund and $62 million federal funds) annually thereafter. If approved, these resources would support a 40 percent Medi-Cal reimbursement rate increase for private duty nursing, effective January 1, 2026, to allow children with complex medical conditions to remain in their homes and out of the hospital. According to CAHSAH and Aveanna Healthcare, these nurses serve the most medically fragile individuals in the state, including children with special healthcare needs and children with complex chronic conditions along with adult patients who require similar services. These patients require skilled nursing services performed in the home by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN) under the supervision of an RN typically for 8-12 hours per day every day in order to manage their chronic condition and keep them safe in their homes and communities. The goal is to keep these individuals in their homes, which is the setting that promotes their highest quality of life and allows them the opportunity to be with their families and engage in their communities.

  Improving the Medi-Cal rate for PDN will contain costs and promote better quality of life for California patients and their families. Through reductions in avoidable hospital utilization, home care providers keep people in their homes and communities—where they overwhelmingly prefer to be—and with appropriate skilled care support. This provides cost savings by rebalancing the state's long-term care financing toward home and community-based care rather than more costly facilities or institutional settings.

- **Adjust Daily Rates for Congregate Living Health Facilities.** The Congregate Living Health Facilities Association requests expenditure authority of $15.5 million ($7.7 million General Fund and $7.7 million federal funds) annually. If approved, these resources would support an adjustment of rates for congregate living health facilities for the first time since the inception of the model in 1983. According to the association, Congregate Living Health Facilities (CLHFs) provide care for the most medically fragile persons living in the community. Residents often have nowhere else to live because they require such a high level of acute care that often families cannot provide in their homes. Hospitals and health plans are incentivized to discharge stable patients, but most often do not utilize CLHFs as they are not a carved-in long-term care benefit under CalAIM, and therefore health plans will not be reimbursed by the state for the service. Skilled nursing facilities are not an acceptable placement option as they provide a level of care lower than what CLHF residents require. Additionally, CLHF patients are most often younger than the average nursing home resident and therefore a more homelike long-term care setting with their peers is more appropriate. No other healthcare provider is known to have not received any adjustment to their rates in 40 years. A rate increase would allow providers to increase wages, modernize medically assistive technology, and improve CLHF settings such as kitchen and dining rooms.