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, March 27th, 2025
9:00 am
1021 O Street – Room 1200

Consultants: Elizabeth Schmitt and Scott Ogus

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PUBLIC COMMENT

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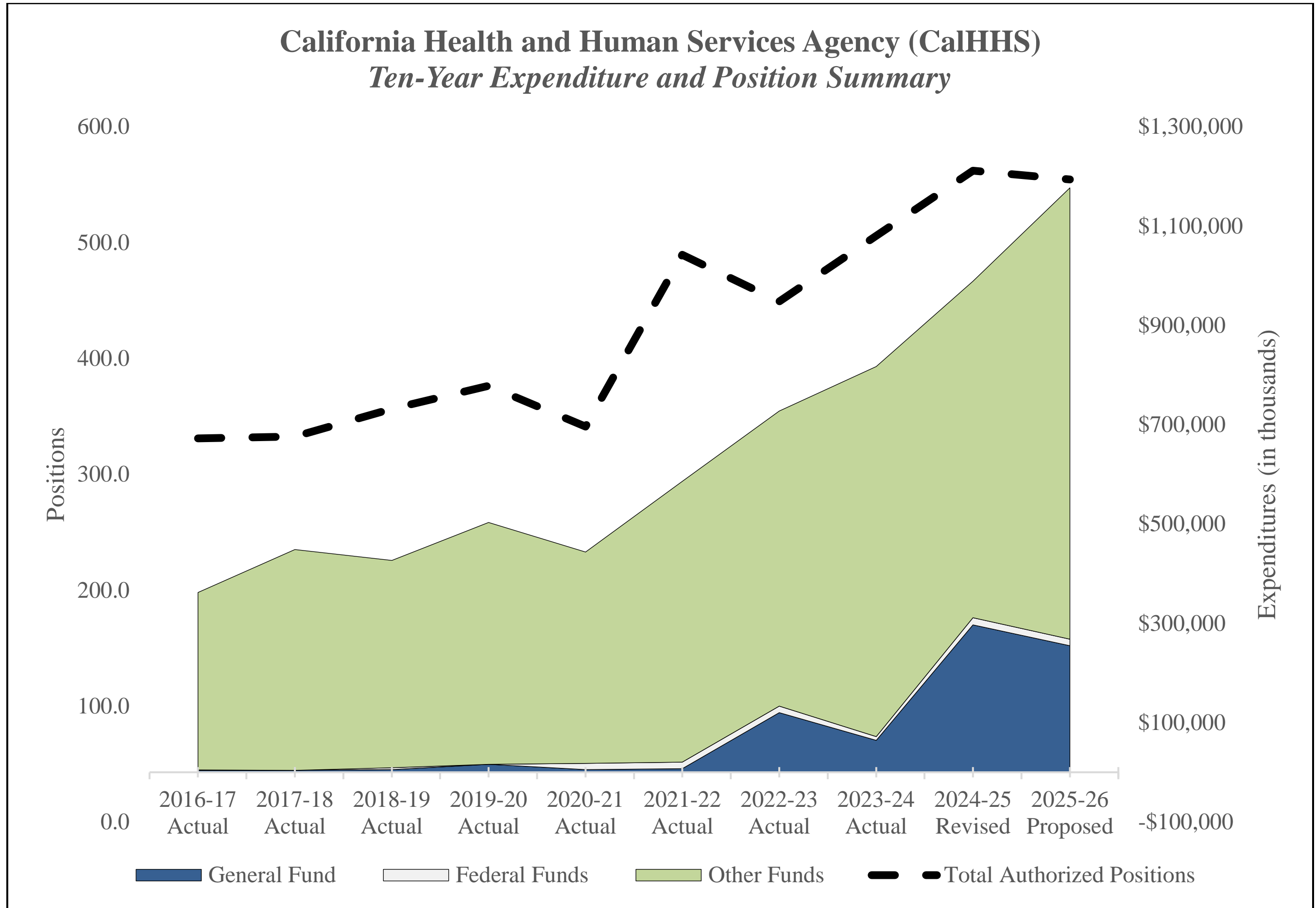
0530 California Health and Human Services Agency

Issue 1: Overview



California Health and Human Services Agency - Department Funding Summary ***(dollars in thousands)***				
Fund Source	**2023-24 Actual**	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$64,583	$295,689	$296,801	$254,955
Federal Funds	$6,931	$14,436	$14,436	$13,018
Other Funds	$745,268	$671,352	$677,383	$908,875
Total Department Funding:	**$816,782**	**$981,477**	**$988,620**	**$1,176,848**
Total Authorized Positions:	**505.8**	**562.0**	**562**	**554.5**
Other Funds Detail:				
Reimbursements (0995)	*$13,680*	*$4,994*	*$11,831*	*$14,991*
Mental Health Services Fund (3085)	*$7,977*	*$0*	*$0*	*$0*

Health Plan Improvement Fund (3209)	*$1,783*	*$2,380*	*$2,358*	*$2,360*
Data Insights and Innovation Fund (3377)	*($12)*	*$0*	*($14)*	*$0*
988 Suicide and BH Crisis Svcs Fund (3414)	*$4,256*	*$0*	*$0*	*$0*
Central Service Cost Recovery Fund (9740)	*$11,407*	*$11,412*	*$11,154*	*$11,164*
California HHS Automation Fund (9745)	*$706,177*	*$652,566*	*$652,054*	*$880,360*

Background. The California Health and Human Services Agency (CalHHS) oversees twelve departments and five offices that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians. CalHHS is administered by a cabinet-level Secretary of Health and Human Services, appointed by the Governor and confirmed by the California State Senate. According to CalHHS, its primary mission is to provide policy leadership and direction to the departments, boards, and programs it oversees, to reduce duplication and fragmentation among departments in policy development and implementation, to improve coordination among departments on common programs, to ensure programmatic integrity, and to advance the Governor's priorities on health and human services issues.

The departments and other entities within CalHHS include:

- Department of Aging (CDA)
- Department of Public Health (CDPH)
- Department of Child Support Services (DCSS)
- Department of Community Services and Development (CSD)
- Department of Developmental Services (DDS)
- Emergency Medical Services Authority (EMSA)
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Department of State Hospitals (DSH)
- Department of Rehabilitation (DOR)
- Department of Social Services (CDSS)
- Department of Health Care Access and Information (HCAI)

Within CalHHS there are several other entities administered by appointed commissions or governing boards, including:

- State Council on Developmental Disabilities
- Commission on Aging
- California Senior Legislature
- California Children and Families Commission
- California Health Benefit Exchange (Covered California)
- State Independent Living Council

CalHHS also oversees the allocation of funds to local governments under 1991 and 2011 State-Local Realignment.

Within the organizational structure of CalHHS are five offices and the Center for Data Insights and Innovation.

Office of the Secretary of Health and Human Services. The Office of the Secretary formulates and coordinates policy among the Agency's departments, and communicates with the Legislature, stakeholders, and the public about issues relating to the state's health and human services programs. The Office of the Secretary is composed of six distinct offices or units, including:

- Office of Legislative Affairs – The Office of Legislative Affairs provides coordination, oversight, and management of proposed legislation and ensures the Administration's legislative priorities are developed and implemented. The office provides policy guidance, instruction, and direction to health and human services departments and entities, and coordinates with the Governor's Office on legislative positions.
- Office of External Affairs – The Office of External Affairs manages ongoing public information and public affairs functions and provides guidance and direction to public information officers in health and human services departments and entities. The office serves as the official Agency spokesperson to respond to media inquiries, and coordinates with the Governor's Office communication staff on significant and sensitive media issues.
- Office of the Agency General Counsel – The Office of the Agency General Counsel provides legal counsel to the Office of the Secretary and senior Agency staff, coordinates with the Governor's Office of Legal Affairs and with the Chief Counsels in health and human services departments and entities.
- Office of Program and Fiscal Affairs – The Office of Program and Fiscal Affairs is responsible for formulating, analyzing, revising, and evaluating the program and fiscal impacts of major health and human services policies of the Administration. This work includes assessment of all policy, legislative, fiscal, and other issues that have implications among health and human services departments and agencies, as well as other state agencies.
- Administration Unit – The Administration Unit manages personnel, human resources, training, and internal budget issues.
- Office of the Agency Information Officer – The Office of the Agency Information Officer supports health and human services departments and entities to successfully deliver data and technology solutions through portfolio support, enterprise architecture, information security, agency governance, and horizontal integration activities.
- Office of Policy and Strategic Planning – The Office of Policy and Strategic Planning is responsible for driving measurable outcomes on CalHHS guiding principles and strategic priorities through system alignment and program integration across the agency's departments and offices. The Office works on a set of initiatives to advance equity, address the social determinants of health, and ensure a whole person approach.

Office of Technology and Solutions Integration (OTSI). The Office of Technology and Solutions Integration (OTSI) procures, manages, and delivers technology systems that support the delivery of health and human services to Californians. OTSI manages a portfolio of large, complex information technology (IT) projects, providing project management, oversight, procurement, and support services for these projects and coordinating communication, collaboration, and decision-making among project stakeholders and program sponsors. After the procurement phase, OTSI oversees the design, development, governance,

and implementation of IT systems that support the administration of health and human services programs in California.

Office of the Surgeon General (OSG). The Office of the Surgeon General (OSG) was established in 2019 to advise the Governor, serve as a leading spokesperson on matters of public health, and drive solutions to the state's most pressing public health challenges. The OSG has established early childhood, health equity, adverse childhood experiences (ACEs), and toxic stress as key priorities. The Surgeon General has set a goal to reduce ACEs and toxic stress by half in one generation.

Office of Law Enforcement Support (OLES). The Office of Law Enforcement Support (OLES) was established in 2014 to provide monitoring and oversight of law enforcement personnel serving in the Office of Protective Services at DSH and DDS. OLES develops training protocols, policies, and procedures for law enforcement officers operating at DSH and DDS, and investigates incidents involving law enforcement personnel at state hospitals or developmental centers.

Office of Youth and Community Restoration (OYCR). The Office of Youth and Community Restoration (OYCR) supports the transition of justice involved youth being served in local communities by promoting a youth continuum of services that are trauma responsive and culturally informed, using public health approaches that support positive youth development, building the capacity of community-based approaches, and reducing the justice involvement of youth. The OYCR also assesses the efficacy of local programs, provides technical assistance and support, reviews local Juvenile Justice Realignment Grants, fulfills statutory obligations of an Ombudsperson, and develops policy recommendations.

Center for Data Insights and Innovation (CDII). The Center for Data Insights and Innovation (CDII) was established in 2021 to advance CalHHS data initiatives and help turn data into insights, knowledge, and action. The Center combines functions from the previous Office of Health Information Integrity (CalOHII), Committee for the Protection of Human Subjects (CPHS), Office of the Patient Advocate (OPA), and Office of Innovation. These functions include ensuring state department compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other related state and federal privacy laws, health plan and medical group report cards evaluating health care quality and the patient experience, and reporting on health care consumer and patient assistance centers by state agencies (Department of Managed Health Care, Medi-Cal, Department of Insurance, and Covered California). CDII also administers the CalHHS Open Data Portal, which provides public access to non-confidential health and human services data.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the CalHHS mission and its oversight of key departments and other entities.

Issue 2: Office of Youth and Community Restoration (OYCR) Overview and Juvenile Justice Realignment Block Grant Formula

Governor's Budget – Office of Youth Community Restoration. The Office of Youth and Community Restoration (OYCR), housed under the California Health and Human Services Agency, is the state's lead agency for assistance, coordination, and oversight of the juvenile justice system. The statutory mission of OYCR is to "promote trauma-responsive, culturally informed services for youth involved in the juvenile justice system that support the youths' successful transition into adulthood and help them become responsible, thriving, and engaged members of their communities." OYCR was established in 2021 concurrent with the permanent closure of the Division of Juvenile Justice (DJJ) and the realignment of remaining juvenile justice responsibilities to the county level.

The 2025-26 Governor's budget for OYCR includes $251.4 million ($228.3 million General Fund) and 37 positions. The majority of OYCR's budget is local assistance to counties via the Juvenile Justice Realignment Block Grant ($208.8 million General Fund). The Governor's budget contains one new proposal for OYCR – a statutorily required revision to the Juvenile Justice Realignment Block Grant (JJRBG) formula – which is covered in detail further below in this section.

PROPOSED OYCR BUDGET (000's)	
	2025-26
Authorized Positions	37.0
General Funds	$19,534
Title II Federal Funds	$790
Reimbursements (DHCS)	$10,000
Total State Ops	**$30,324**
General Fund	$208,800
Title II Federal Funds (funding for 13 grants)	$12,228
Total Local Assistance	**$221,028**
Total Proposed OYCR Budget	**$251,352**

OYCR also administers juvenile justice grants that do not flow directly through OYCR's budget, including the Juvenile Reentry Grant, Juvenile Justice Crime Prevention Act, and Youth Offender Block Grant.

Background: Juvenile Justice Realignment. The 2020 Budget Act included a plan to permanently close DJJ at the California Department of Corrections and Rehabilitation. This realignment marked the culmination of a long-term shift of juvenile justice to county responsibility, following several realignments of certain juvenile justice responsibilities in 1997, 2007, and 2011.

While most youth were already housed or supervised locally prior to 2021, counties could choose to send youths who had committed violent, serious, or sex offenses to state facilities operated by DJJ. There were typically about 650 youth statewide in DJJ facilities, which permanently closed on June 30, 2023. The plans for DJJ closure and realignment are outlined in SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020 and SB 92 (Committee on Budget and Fiscal Review), Chapter 18, Statutes

of 2021**.** Realignment is intended to move juvenile justice in California toward a rehabilitative, trauma-informed, and developmentally appropriate system.

As a result of 2021 realignment, counties are responsible for supervising youth who have committed more serious offenses. The realignment plan outlined a process for counties to establish Secure Youth Treatment Facilities (SYTFs) for high-level juvenile offenders who would have previously been housed at DJJ. To assist counties with their increased responsibility, the state provides block grant funding to counties for each realigned youth via the JJRBG ($208.8 million General Fund in the Governor's proposed 2025-26 budget). The 2022 Budget Act also provided $100 million General Fund one-time for planning and juvenile facility infrastructure needs.

Realignment and Other Juvenile Justice Funding. Funding for 2021 realignment (through the JJRBG) builds upon annual funding to counties for previously realigned responsibilities, including the Youthful Offender Block Grant (which supports responsibilities realigned in 2007) and the Juvenile Reentry Grant (which supports responsibilities realigned in 2011). In 2024-25, the state provided counties with approximately $461 million to support realigned workload (including JJRBG) and $561 million for other juvenile justice-related workload, for a total of over $1 billion in county juvenile justice funding provided through the state each year. More detail is provided in the chart below, provided by the LAO:

Major Sources of County Juvenile Justice Funding Provided Through the State

Program (Millions)	**2024-25 Estimated Funding**		**2025-26 Proposed Funding**	
Funding to Support Realigned Workload	*$*	*461*	*$*	*491*
Youthful Offender Block Grant	$	235	$	256
Juvenile Justice Realignment Block Grant	$	212	$	221
Juvenile Reentry Grant	$	14	$	15
Funding for Other Workload	*$*	*561*	*$*	*577*
Juvenile Probation Activities	$	296	$	304
Juvenile Justice Crime Prevention Act	$	208	$	214
Juvenile Probation Camp Funding	$	57	$	59
Totals	**$**	**1,022**	**$**	**1,068**

Juvenile Justice Population. Juvenile courts place most youth with their families where they are supervised by probation, but some are placed in county juvenile facilities, such as juvenile halls, camps, ranches, and SYTFs. As of December 2024, the average daily population of youth in juvenile justice facilities statewide was 2,787. The average daily population of youth in juvenile justice facilities statewide is on a long-term decline (the average daily population was 5,307 in 2015 and 10,915 in 2005, for example).

OYCR Responsibilities. OYCR was established in 2021 to support counties with realigned responsibilities and to guide a statewide public-health based approach to youth justice. Mandates of the OYCR include:

- Identify policy recommendations for improved outcomes for court-involved youth.

- Identify and disseminate best practices to inform rehabilitative and restorative youth practices.
- Provide technical assistance to develop and expand local youth diversion opportunities.
- Evaluate the efficacy of local programs being utilized for realigned youth and report to the Governor and Legislature by July 1, 2025.
- Develop a report on youth outcomes in the juvenile justice system based on the updated JCPSS (Department of Justice) System.
- Provide an ombudsperson to investigate complaints and resolve where possible and report regularly to the Legislature.
- Assume administration of juvenile grants previously administered by the Board of State and Community Corrections (BSCC) no later than January 1, 2025 (this occurred as part of the 2024 Budget Act).
- Concur with the BSCC on new standards for secure youth treatment facilities.

OYCR Ombudsperson. The OYCR Ombudsperson line opened in August 2022. In 2024, the OYCR Ombudsperson received 296 complaints and closed 156 complaints, mostly from youth in juvenile facilities as well as others including parents, educators, and staff. Of closed cases in 2024: 84 declined to investigate, 25 were unsubstantiated, 21 were substantiated, 18 had no findings, four were inconclusive, and two were referred out. Common subjects of investigations were abuse and punishment (such as excessive force), staffing/conditions of confinement, and lack of family contact and visitation issues. The chart below lists the subjects of complaints across 31 counties; a report to the Legislature summarizing Ombudsperson investigations from 2022-2024 is forthcoming.

Abuse/Punishment	53
Staffing	50
Family Engagement	44
Medical Health	31
Programming/Incentives	30
Education	29
Food/Nutrition	26
Discipline	26
Confidential Communications	24
Retaliation	18
Grievance Processes and Responses	17
Hygiene	15
Healthy Environment	14
Mental Health	12
Court Hearings	7

Exercise/Recreation	6
Property	6
Detention Rights	5
Clothing	5
Discrimination	5
Searches	4
Safety and Security	4
Religion	3
Medication	3
Youth Bill of Rights Materials	2
Bedding	1
Parenting	1
Grand Total	**441**

Juvenile Justice Data Collection and 2024 Budget Act Changes. The 2024 Budget Act included $2 million General Fund for five years and trailer bill language requiring county probation departments to report specified data about youth in SYTFs to OYCR at least twice a year, and requires OYCR to publish an annual report, through January 1, 2030. Counties are required to submit the following data, pursuant to Welfare and Institutions Code (WIC) 2200(g):

- Number of youth and their most serious commitment offense who are committed to a SYTF, including youth committed to SYTFs in another county.

- Number of individual youth in the county who were adjudicated for an offense pursuant to subdivision (b) of Section 707 of WIC or Section 290.008 of the Penal Code.

- Number of youth, including their commitment offense or offenses, transferred from a SYTF to a less restrictive program (LRP) under the terms and provisions of WIC 875(f), disaggregated by program description, as defined by OYCR.

- Number of youth for whom a hearing to transfer jurisdiction to an adult criminal court was held, and the number of youth whose jurisdiction was transferred to adult criminal court.

In addition to requiring the juvenile justice data collection above, the 2024 Budget Act made necessary statutory changes to effectuate the transfer of juvenile justice grant administration from the Board of State and Community Corrections (BSCC) to OYCR, pursuant to the 2021 realignment plan. Lastly, the 2024 Budget Act extended the deadline for the Legislature and Governor to revise the JJRBG formula from 2024 to 2025.

Trailer Bill Language – Governor's Budget: JJRBG Formula. The Governor's proposed 2025-26 budget includes trailer bill language to revise the JJRBG formula. SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020 established a temporary formula for the JJRBG. This temporary formula distributed block grant funding to counties based on three factors: (1) the number of

707(b) and 290.008 adjudications; (2) average daily populations of DJJ wards; and (3) the total youth population in the county from the preceding calendar year. The legislative intent of JJRBG funding is to provide and implement public health approaches to support positive youth development, build the capacity of a continuum of community-based approaches, and reduce crime by youth.

WIC 1991(a)(5) directs the Governor to consult with stakeholders and the Legislature to revise the existing funding formula by January 10, 2025, to improve outcomes for this population. (The original realignment plan required the JJRBG formula to be revised in 2024; the 2024 Budget Act delayed this revision to 2025).

OYCR engaged county probation officers and community stakeholders in several rounds of workgroups to identify priorities for consideration in the revised formula. OYCR proposes the following changes:

- Maintain the existing temporary JJRBG formula in 2025-26 and 2026-27.
- Effective 2027-28 and ongoing, distribute JJRBG funds to counties as follows:

Fiscal Year	Violent and Serious Offenses[i]	Projected Average Daily Population	Youth Population[ii]	Youth not placed in an SYTF/Transferred from SYTF to LRP[iii]
2026-2027 (no change)	50%	30%	20%	N/A
2027-2028	52.5%	--	42.5%	5%
2028-2029	50%	--	40%	10%
2029-2030	47.5%	--	37.5%	15%

[i] Total number of unduplicated wards adjudicated for certain violent and serious felony crime categories per 2018 Juvenile Court and Probation Statistical System data.
[ii] All individuals between 10 and 17 years of age, inclusive, from the preceding calendar year.
[iii] The total of the number of youths adjudicated for a 707(b) that were not committed to an SYTF or the number of youths transferred from an SYTF to an LRP per Welf. & Inst. Code sec. 2200(g)(2) data submission from the counties to OYCR.

Under current law and as proposed in the trailer bill language, counties would receive a minimum allocation of $250,000 in JJRBG funds.

Youth Advocate Concerns. A coalition of juvenile justice organizations including youth advocates, human rights advocates, and public defenders have raised the following concerns with the Governor's proposed revisions to the JJRBG formula:

- **The formula does not distinguish between less restrictive programs (LRPs) in carceral versus community settings.** The coalition notes that the Administration's proposal "does not distinguish LRPs that are in the community from LRPs that are in carceral facilities, like Juvenile Halls, Camps,

or Ranches. Thus, counties that are building the capacity of community-based approaches for LRPs would receive the same funding as counties that are using secure facilities as an LRP."

- **Combining the number of youth eligible for an SYTF, but not committed to an SYTF, with the number of youth who are transferred from an SYTF to an LRP results in the number of youth transferred to LRPs having little impact on the overall funding formula.** The coalition states that **"**the number of youth who are eligible for an SYTF but for whom an alternative, less restrictive disposition is ordered is significantly higher than the number of youth who are committed to an SYTF and later transferred to an LRP. Because of this, the number of youth transferred to an LRP will have a marginal impact on the county allocation of funding and thus will not effectively incentivize the creation and use of LRPs."

- **Data Sources are Outdated.** The coalition recommends using the most updated data source, the data submitted pursuant to the 2024 Budget Act specified in WIC 2200(g), rather than Juvenile Court and Probation Statistical System (JCPSS) data, for accuracy.

To address these concerns, the youth advocates propose the following revisions to the formula:

- *40 percent based on Realignment Target Population,* with additional weighted funding for counties that use alternatives to incarceration.

- *30 percent based on Youth Population*, to ensure stability in year-to-year funding by considering the youth population (ages 12-17) in each county.

- *25 percent based on Youth Transferred to LRP*, to reward counties transferring youth from SYTF to LRPs, with a greater proportion of funds allocated to counties using community-based LRPs or LRPs that are not secure and therefore not subject to Title 15 regulation.

- *5 percent based on Investments in Community*, to reward counties that spend a minimum of 20 percent of their prior year JJRBG funds on community-based support for the Realignment Target Population.

A table summarizing the coalition's recommendations is below:

	Realignment Target Population		**Youth Population**	**Youth Transferred to Less Restrictive Program (LRP)**		**Minimum of 20% of Prior Year JJRBG Funds were Invested in Community**
	Total Target Population	*Target Population not Committed to SYTF*		*Total Youth transferred to LRP*	*Youth transferred to LRP not regulated by Title 15 Regulations*	
FY 2025-26	20%	20%	35%	20%	0%	5%
FY 2026-27	20%	20%	30%	10%	15%	5%
FY 2027-28	20%	20%	30%	5%	20%	5%
FY 2028-29	20%	20%	30%	5%	20%	5%

In addition to these allocations, the coalition suggestions revisiting the funding formula in 2029, to ensure opportunity for evaluation and to align with the sunset of data collection requirements. Lastly the coalition

suggests the formula could disincentivize certain practices that run counter to the Legislature's goals for realignment and youth justice. This includes:

- Reductions in a county's allocation based on increasing transfers to adult court.
- Reductions in a county's allocation for net-widening (an increase in the rates of youth incarceration), unless accompanied by a decrease in adult court transfers.
- Reductions in a county's allocation for racially disparate outcomes for youth of color, particularly in relation to SYTF commitments.

Probation Concerns. The Chief Probation Officers of California (CPOC) has also expressed concerns with the Administration's proposed formula revision. According to CPOC, "CPOC is concerned this proposal will decrease the stability and reliability of resources for probation departments and will not improve outcomes for this populations as intended." CPOC continues to state that "probation departments share the goal of transitioning youth to the least restrictive setting at the earliest appropriate juncture in their rehabilitative plan. With that goal in mind, CPOC stands ready to partner with the state to establish new funding streams to bolster the development or expansion of less restrictive programs in the local juvenile justice continuum. However, conditioning JJRBG on less restrictive programs in an attempt to influence judicial decisions is not appropriate or in the best interest of public safety."

State Audit found JJRBG Funds in Los Angeles County Mostly Unspent. In August 2024, the California State Auditor released the findings of an audit conducted of Los Angeles County's spending of JJRBG funds. The Auditor found that "since fiscal year 2021-22, the state has provided to Los Angeles $88 million in funding for the care and supervision of realigned youth. However, as of late June 2024, the county has spent only $9.7 million of this funding. One reason for the low spending rate is that Los Angeles has yet to begin delivering many of the services that it planned to provide to realigned youth. For example, the county assigned its Probation Department the responsibility to provide 26 programs, services, and goods for which this funding was intended to pay. However, Probation had begun providing only six of these items as of late June 2024. Therefore, we believe that Los Angeles would better ensure the provision of services and programs to realigned youth if it took additional steps to use available funding in a timely manner."

State does not Track JJRBG Expenditures. To be eligible for JJRBG funds, each county is required to convene a subcommittee of the multiagency juvenile justice coordinating council chaired by the chief probation officer and including representatives from the district attorney, public defender, department of social services, department of mental health, the county office of education or school district, and the court, along with at least three community members. The subcommittees develop a plan for juvenile justice realignment within the county. These plans must include information on how counties will provide trauma-informed, culturally responsive, and developmentally appropriate programs and a description of data collection and outcome measures, among other topics detailed in statute (WIC 1995(c)). Counties must update their plan annually. OYCR is required to review these plans, return plans to counties for revision as necessary, and make the plans available on its website.

While OYCR receives county realignment plans, the state does not have a mechanism for tracking JJRBG expenditures. Because the state does not collect JJRBG expenditure data, it is unknown the degree to

which county JJRBG spending aligns with county realignment plans, or the extent to which counties are fully spending their JJRBG allocations each year.

As part of the audit of Los Angeles County JJRBG spending, the State Auditor recommended "the Legislature should amend state law to require counties to include in their annual realignment block grant plans the amount of realignment block grant funds they have spent by fiscal year, as well as their total amount of unused block grant funding. The law should also require OYCR to report this information to the relevant budget subcommittees of the Legislature."

LA Juvenile Hall is Unsuitable for Confinement of Youth. In October 2024, the BSCC issued a notice of facility unsuitability to Los Angeles County. The BSCC determined that Los Angeles County's Los Padrinos Juvenile Hall is not suitable for the confinement of juveniles. The county failed to file an approved corrective action plan, and BSCC ordered the county to stop using Los Padrinos Juvenile Hall for the confinement of juveniles by December 12, 2024. Despite the order from BSCC, Los Angeles County continues to confine over 250 pre-disposition youth in Los Padrinos Juvenile Hall.

Subcommittee Staff Comment and Recommendation – Hold Open. Subcommittee staff notes that stakeholders have raised concerns about the effectiveness of the proposed JJRBG formula to promote a continuum of community-based approaches for realigned youth, including the use of less restrictive programs.

Subcommittee staff additionally notes that the current JJRBG formula lacks accountability, as the state has no mechanism to track actual spending of JJRBG funds. As the Legislature works with the Administration to revise the JJRBG formula in a way that improves outcomes for youth, the Legislature may wish to consider the State Auditor's recommendation.

Questions. The Subcommittee requests the Administration respond to the following:

1. Please provide an overview of OYCR's proposed budget for 2025-26 and OYCR's key activities, including the OYCR Ombudsperson and OYCR's recent assumption of all juvenile justice grant administration.

2. Please describe OYCR's proposal for the JJRBG formula revision. How does this proposal address the mandate to develop the formula in a way that improves outcomes for youth?

3. Please address concerns that have been raised by stakeholders about the Administration's proposed JJRBG formula. Specifically: (A) How will the formula distinguish between LRPs that are based in the community versus LRPs attached to Juvenile Halls, Camps, or Ranches? (B) What is the intention of combining two factors (number of eligible youth not committed to an SYTF and number of youth transferred to an LRP) into one component of the formula?

4. How does the state track county spending of JJRBG funds? Specifically, (1) are counties fully spending their JJRBG allocations and (2) how are counties spending their JJRBG allocations?

Issue 3: IT Enhancement Resource Shift to CalHHS

Budget Change Proposal – Governor's Budget. CalHHS and CDPH request transfer of General Fund expenditure authority of $381,000 annually from CDPH to CalHHS. If approved, these resources would continue support for information technology capital planning, prioritization and enterprise portfolio management workload currently being performed by CalHHS under an interagency agreement. There is no net impact on the General Fund from this proposal.

Multi-Year Funding Request Summary – CalHHS and CDPH		
Fund Source	**2025-26**	**2026-27***
California Health and Human Services Agency (CalHHS)		
0001 – General Fund	$381,000	$381,000
California Department of Public Health (CDPH)		
0001 – General Fund	($381,000)	($381,000)
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The 2022 Budget Act included 33 positions and General Fund expenditure authority of $20.1 million for CDPH to support modernization of public health information technology infrastructure and systems, and to implement recommendations from the department's Future of Public Health Workgroup. The CDPH proposal was titled Information Technology, Data Science, and Informatics Framework for a 21st Century Public Health System. Two of the approved positions, one in the CDPH Enterprise Architecture Services Section (EASS) and one in the Planning and Project Management Branch (PPMB) of the Information Technology Services Division (ITSD), were originally designated to support the CalHHS Office of the Agency Information Officer (OAIO). These positions provide support to the OAIO through an interagency agreement between CDPH and CalHHS, which expires on June 30, 2025.

Funding Shift – CDPH to CalHHS. CalHHS and CDPH request transfer of General Fund expenditure authority of $381,000 annually from CDPH to CalHHS to continue support for information technology capital planning, prioritization and enterprise portfolio management workload currently being performed by CalHHS under an interagency agreement. There is no net impact on the General Fund from this proposal. The specific resources that would be transferred to CalHHS include the following:

- **One Information Technology Specialist II** position and **one Information Technology Specialist I** position support IT capital planning, prioritization and IT enterprise portfolio management for both CDPH and CalHHS.

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 CalHHS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Early Childhood Policy Council and Whole Child Initiative Carryover

Budget Change Proposal – Governor's Budget. The California Health and Human Services Agency (CalHHS) requests a re-appropriation of $752,000 General Fund for the Early Childhood Policy Council.

Early Childhood Policy Council Background. The Early Childhood Policy Council (ECPC) was established under the Child Care and Development Services Act to advise the Governor, Legislature, and the California Department of Social Services (CDSS) on statewide early learning and care policy, including the planning for and the implementation and evaluation of the state's Master Plan for Early Learning and Care (Master Plan) and the 2019 California Assembly Blue Ribbon Commission on Early Childhood Education Final Report. Existing law allows up to $300,000 for CalHHS to staff the council.

Re-appropriation Request. There is approximately $752,000 from prior years that CalHHS requests to re-appropriate in 2025-26 to extend the funding for the ECPC. According to CalHHS, The ECPC is a 27-member body that requires support to conduct public meetings. Funding will be allocated for a contractor who will provide meeting assistance, coordinate travel assistance, process stipends, and develop mid-year and annual reports, and track ECPC and committee members. With the re-appropriation, the ECPC can continue to convene meetings to discuss and provide recommendations on all aspects of the state's early childhood system, including support for the demographic, geographic, and economic diversity of the state's children and families.

According to CalHHS, the ECPC will conduct the following activities each year:

- Convene at least four public meetings. These meetings shall provide access for participants throughout the state.
- Advise the Governor and perform activities required pursuant to Section 9837(b) of Title 42 of the United States Code.
- Prepare a formal public annual report on the work of the council.
- Provide specific recommendations directly to the Governor, the Legislature, and the department on all aspects of the state's early childhood education system.

Subcommittee Staff Comment and Recommendation – Hold Open.

Questions. The Subcommittee requests CalHHS respond to the following:

1. Please provide a brief overview of this proposal.

0977 California Health Facilities Financing Authority

Issue 1: Overview

Background. The California Health Facilities Financing Authority (CHFFA) was established in 1979 in the State Treasurer's Office to provide financial assistance to nonprofit and public health facilities through bonds, loans, and grants. CHFFA achieves these goals by providing cost-effective tax-exempt bond, low-cost loan, and direct grant programs.

The Authority is governed by nine members, including the State Treasurer, the State Controller, the Director of Finance, two members appointed by the Senate Rules Committee, two members appointed by the Speaker of the Assembly, and two members appointed by the Governor subject to confirmation by the Senate. Of the members appointed by the Senate, one member must be a licensed physician or surgeon, and one must be a current or former health facility executive. Of the members appointed by the Assembly, one member must be trained in investment or finance and one member represents the general public. The members appointed by the Governor also represent the general public. Appointed members serve for four years.

California Health Facilities Financing Authority Three-Year Funding Summary			
Fund Source	**2023-24**	**2024-25**	**2025-26**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$3,662,000	($20,631,000)	$20,631,000
0904 – CHFFA Fund	$12,540,000	$9,657,000	$9,737,000
3085 – Behavioral Health Svcs. Fund	$11,777,000	$4,000,000	$4,000,000
3357 – Supp Housing Prog Subacct	$139,459,000	$140,000,000	$140,000,000
3432 – Dist. Hosp. Loan Prog. Fund	$237,570,000	$-	$-
6046 – Children's Hospital Fund	$720,000	$5,362,000	$5,362,000
6079 – Children's Hosp Bond Fund	$18,461,000	$40,497,000	$40,498,000
6090 – Childrens Hosp 2018 Fund	$337,854,000	$200,635,000	$200,636,000
Total Department Funding:	**$762,043,000**	**$379,520,000**	**$420,864,000**
Total Authorized Positions:	**18.4**	**26.5**	**26.5**

CHFFA was created to be the state's vehicle for providing financial assistance to public and non-profit health care providers in California through loans funded by the issuance of tax-exempt bonds. CHFFA has financed a wide range of providers and programs throughout the state and administers the following major programs: 1) Bond Financing Program, 2) Tax-Exempt Equipment Financing Program, 3) the Healthcare Expansion Loan Program (HELP II), 4) Non-Designated Public Hospital Bridge Loan Programs, 5) Distressed Hospital Loan Program, 6) Children's Hospital Programs of 2004, 2008, and 2018, 7) Investment in Mental Health Wellness Grant Program, 8) Investment in Mental Health Wellness Grant Program for Children and Youth, 9) Community Services Infrastructure Grant Program, and 10) Specialty Dental Clinic Grant Program.

Bond Financing Program. The Bond Financing Program provides eligible borrowers access to low interest rate capital markets through the issuance of tax-exempt and taxable conduit revenue bonds. Tax-exempt and taxable bonds may be issued as either a public offering or a private placement. Due to the cost of issuing bonds, this program is primarily utilized by borrowers with capital project financing needs in excess of $5 million. Financing through this program may be used to fund construction or renovation projects, land acquisition for future projects, acquisition of existing health facilities, refinancing of existing debt, working capital for start-up facilities, purchase of equipment, and the costs of issuance. According to CHFFA, as of December 31, 2023, the program has issued bonds worth approximately $47.7 billion to 275 health institutions.

Tax-Exempt Equipment Financing Program. The Tax-Exempt Equipment Financing Program provides health facilities with access to tax-exempt fixed rate financing for equipment purchases. Eligible facilities may use financing to purchase or reimburse all types of qualifying equipment including, but not limited to, medical and diagnostic equipment, computers, telecommunications equipment, and minor equipment installation costs. Financing is providing through notes backed by the full faith and credit of the participating facility, rather than the state. Eligible facilities must be: 1) a public or private, non-profit health facility; 2) have been operating for at least three years; and 3) have revenue or collateral sufficient to cover debt service on the proposed financing.

Healthcare Expansion Loan Program II (HELP II). CHFFA established HELP II in 1995 to assist small and rural health facilities and district hospitals to obtain financing to support expansion and improvement of services to the people of California. Health facilities eligible for financing under HELP II must meet one of the following conditions:

- Receive no more than $30 million in annual gross revenues.
- Located in a rural Medical Service Study Area as defined by the California Workforce Policy Commission.
- A district hospital.

Eligible facilities must be non-profit or publicly operated, have been in existence for at least three years performing the same types of services, and demonstrate evidence of fiscal soundness and ability to meet the terms of the loan. Eligible health facilities may receive loans under the following general terms:

- Two percent fixed interest rate for property acquisition, construction, renovation up to $2 million (maximum 20 year repayment period).
- Two percent fixed interest rate for equipment up to $2 million (maximum five year repayment period).
- Three percent fixed interest for loan refinancing up to $1 million (maximum 15 year repayment period).

According to CHFFA, as of December 31, 2023, HELP II has provided more than $144.9 million in loans to 193 eligible health facilities.

Nondesignated Public Hospital Bridge Loan Programs. The Nondesignated Public Hospital Bridge Loan Program, established in the 2021 Budget Act, authorized CHFFA to issue zero interest rate, two-year term loans to eligible nondesignated public hospitals affected by financial delays associated with the

transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program to the Quality Incentive Program (QIP). The 2021 Budget Act authorized $40 million in loans (NDPH I) and the 2022 Budget Act authorized an additional $40 million (NDPH II). According to CHFFA, there were 15 applications approved totaling $17.8 million in the first round and 12 applications approved totaling $22.2 million in the second round of NDPH I. There were nine applications received and approved totaling $40 million in one funding round, exhausting the total amount appropriated, for NDPH II.

Distressed Hospital Loan Program. The Distressed Hospital Loan Program (DHLP) was established by AB 112 (Committee on Budget), Chapter 6, Statutes of 2023, and authorizes the Department of Health Care Access and Information (HCAI), in collaboration with CHFFA, to make interest-free cashflow loans to financially distressed not-for-profit or public hospitals or governmental entities representing a closed hospital, to prevent hospital closure or facilitate the reopening of these hospitals. AB 112 authorized the transfer of up to $150 million to the newly established Distressed Hospital Loan Program Fund to support the program. AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, authorized an additional transfer of $150 million from the Medi-Cal Provider Payment Reserve Fund, which collects revenue from the state's recently enacted tax on managed care organizations, to the Distressed Hospital Loan Fund to further support the loan program. According to CHFFA, the first application period opened on June 16, 2023, with a submission deadline of July 31, 2023. HCAI awarded loans to 17 hospitals, one hospital forfeited its loan award, and of the 16 remaining hospitals, 12 have been disbursed their full loan amounts with four hospitals in progress. Two of the hospitals are in bankruptcy, which will require unique agreements for their special circumstances. The awards provided to date are as follows:

Borrower Name	Final Loan Award Amount	Status	First Payment Due Date	Maturity Date
Chinese Hospital *San Francisco* *(San Francisco County)*	$10,350,000	Disbursed - Closed on 11/6/2023	6/1/2025	11/1/2029
Dameron Hospital *Stockton* *(San Joaquin County)*	$29,000,000	Disbursed - Closed on 1/2/2024	8/1/2025	1/1/2030
El Centro Regional Med Center *El Centro* *(Imperial County)*	$28,000,000	Disbursed - Closed on 10/5/2023	5/1/2025	10/1/2029
Hayward Sisters/St. Rose Hosp *Hayward* *(Alameda County)*	$17,650,000	Disbursed - Closed on 12/6/2023	7/1/2025	12/1/2029
John C. Fremont Hlthcare Dist *Mariposa* *(Mariposa County)*	$9,350,000	Disbursed - Closed on 1/17/2024	8/1/2025	1/1/2030
Kaweah Delta Health Care Dist *Visalia* *(Tulare County)*	$20,750,000	Disbursed - Closed on 2/20/2024	9/1/2025	2/1/2030

Madera Community Hospital *Madera* *(Madera County)*	$57,000,000	1st disbursement: $15,169,918 Closed on 6/14/2024	1/1/2026	6/1/2030
MLK Jr. Community Hospital *Los Angeles* *(Los Angeles County)*	$14,000,000	Disbursed - Closed on 11/29/2023	6/1/2025	11/1/2029
Palo Verde Hospital *Blythe (Riverside County)*	$8,500,000	Disbursed - Closed on 11/21/2023	6/1/2025	11/1/2029
Pioneers Memorial Hlthcare Dist *Brawley (Imperial County)*	$28,000,000	Disbursed - Closed on 10/30/2023	5/1/2025	10/1/2029
Ridgecrest Regional Hospital *Ridgecrest (Kern County)*	$5,500,000	Disbursed - Closed on 11/29/2023	6/1/2025	11/1/2029
Hazel Hawkins Memorial Hosp *Hollister* *(San Benito County)*	$10,000,000	1st disbursement: $2,700,000 Closed on 7/1/2024	2/1/2026	7/1/2030
San Gorgonio Memorial Healthcare District *Banning* *(Riverside County)*	$9,800,000	Disbursed - Closed on 1/18/2024	8/1/2025	1/1/2030
Sonoma Valley Hospital *Sonoma* *(Sonoma County)*	$3,100,000	Disbursed - Closed on 7/11/2024	2/1/2026	7/1/2030
Tri-City Medical Center *Oceanside* *(San Diego County)*	$33,200,000	Disbursed - Closed on 11/29/2023	6/1/2025	11/1/2029
Watsonville Comm Hospital *Watsonville* *(Santa Cruz County)*	$8,300,000	Disbursed - Closed on 10/30/2023	5/1/2025	10/1/2029
TOTAL	**$292,500,000**			

Children's Hospital Grant Programs of 2004, 2008 and 2018. The Children's Hospital Programs' purpose is to improve the health and welfare of California's critically ill children by providing a stable and ready source of funds for capital improvement projects for children's hospitals. There have been three separate initiatives passed by California voters to support Children's hospitals: 1) Proposition 61 in November 2004, which enabled the State of California to issue $750 million in general obligation bonds to fund the Children's Hospital Program of 2004; 2) Proposition 3 in November 2008, which allowed the State of California to issue an additional $980 million in general obligation bonds to fund the Children's Hospital Program of 2008; and 3) Proposition 4 in November 2018, which permitted the State of California

to issue $1.5 billion in general obligation bonds to fund the Children's Hospital Program of 2018. According to CHFFA, as of December 31, 2023, 46 grants totaling approximately $763 million have been awarded for the Children's Hospital Program of 2004, 40 grants totaling over $1 billion for the Children's Hospital Program of 2008, and 30 grants totaling more than $700 million for the Children's Hospital Program of 2018.

Investment in Mental Health Wellness Grant Program. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designees to develop mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and peer respite. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted six funding rounds for competitive grant awards, approving a total of 79 projects (69 capital and 10 personnel) in 41 counties. Approximately $136.5 million of capital funding and $20 million of funding for mobile crisis support team personnel has been encumbered. As of December 31, 2023, 59 capital projects are complete, consisting of 434 crisis residential treatment beds, 200 crisis stabilization beds, six peer respite care beds, and an equivalent of 110 mobile crisis support teams. An additional 128 crisis residential treatment beds are still pending. The personnel funding supported 57.25 mobile crisis support team positions.

Investment in Mental Health Wellness Grant Program for Children and Youth. SB 833 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2016, expanded the Investment in Mental Health Wellness Grant Program by establishing the Children and Youth (CY) Grant Program with the goal of improving access to mental health crisis services for children and youth ages 21 and under. The 2016 Budget Act included one-time General Fund expenditure authority of $27 million, and allocated any unspent funds under the Investment in Mental Health Wellness Act of 2013 (SB 82) program to support the CY Grant Program, with the goal of adding 200 mobile crisis support teams (MCSTs) and 120 crisis stabilization and crisis residential treatment beds, with funding allowed for capital improvement, expansion and limited start-up costs. According to CHFFA, it has completed five funding rounds, awarding 23 grants totaling $46.6 million. A total of $42.6 million was awarded for capital funding and $4 million for annual MCST personnel funding for up to five years.

Community Services Infrastructure Grant Program (CSI Grant Program). SB 843 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2016, established the CSI Grant Program, a one-time competitive grant program to expand access to jail and prison diversion programs and services for those with mental health illness, substance use disorders, or who have suffered from trauma. CSI Grant Program funding supports capital improvement, expansion and limited start-up costs. The 2017 Budget Act authorized one-time General Fund expenditure authority of $67.5 million to support the program. According to CHFFA, after four funding rounds the program awarded 18 grants to ten counties totaling $65.7 million that will serve an average of approximately 1,339 justice-involved individuals annually.

The counties that received CSI grant awards include: Los Angeles, Merced, Nevada, Riverside, Sacramento, San Joaquin, San Luis Obispo, Santa Clara, Solano, and Sonoma.

Specialty Dental Clinic Grant Program. The 2022 Budget Act authorized General Fund expenditure authority of $25 million in 2022-23 and $25 million in 2023-24 to establish a competitive grant program to support the construction, expansion, modification, or adaptation of specialty dental clinics in California. The Specialty Dental Clinic Grant Program aims to support special health care needs populations by increasing timely access, reducing geographic shortages, increasing equity, and supporting quality of care, while also encouraging prevention services, early intervention, behavior support service and intervention, provider education, and community outreach activities that bring care to community sites. In consultation with stakeholders, CHFFA approved guidelines and the application and opened the first funding round on October 2, 2023, with a deadline to submit applications by April 1, 2024. CHFFA announced on February 27th, 2025, that the program approved $47.2 million in grant funding to 13 new projects in 10 counties that will develop approximately 124 new or newly renovated operatories, surgical suites, or operating rooms. The grant recipients are as follows:

- Alameda Health System (*Alameda County*): $4,350,000
- Amy H. Pham, A Professional Dental Corporation (*Butte County*): $2,618,186
- California Northstate University LLC (*Sacramento County*): $2,241,169
- Community Medical Centers, Inc. (*San Joaquin County*): $5,000,000
- Elmer Hilo II DMD Inc. (*Los Angeles County*): $3,186,889
- ImpowerDent SurgiCenters INC. (*Imperial County*): $5,000,000
- Janice Chen Dental Corporation (*Riverside County*): $4,500,000
- Luciane Queiroz DDS, Inc. (*Kern County*): $2,300,000
- Rajvir S Bhogal DDS Inc. (*Sacramento County*): $2,500,000
- Russell Seheult, D.D.S., A Professional Corporation DBA Redlands Dental Surgery Center (*San Bernardino County*): $2,910,000
- Regents of the University of California/University of California Los Angeles School of Dentistry (*Los Angeles County*): $4,200,000
- University of Southern California, Herman Ostrow School of Dentistry (*Los Angeles County*): $3,403,111
- University of the Pacific, Arthur A. Dugoni School of Dentistry (*San Francisco County*): $5,000,000

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of CHFFA's mission and programs.

Issue 2: CSI Grant Program Reappropriation

Reappropriation – Governor's Budget. CHFFA requests reappropriation of General Fund expenditure authority of $20.6 million, originally approved in the 2021 Budget Act, to be available for encumbrance or expenditure until June 30, 2028. If approved, this reappropriation would allow completion of existing projects awarded under the Community Services Infrastructure (CSI) Grant Program.

Background. SB 843 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2016, established the CSI Grant Program, a one-time competitive grant program to expand access to jail and prison diversion programs and services for those with mental health illness, substance use disorders, or who have suffered from trauma. CSI Grant Program funding supports capital improvement, expansion and limited start-up costs. The 2017 Budget Act authorized one-time General Fund expenditure authority of $67.5 million to support the program. According to CHFFA, after four funding rounds the program awarded 18 grants to ten counties totaling $65.7 million that will serve an average of approximately 1,339 justice-involved individuals annually. The counties that received CSI grant awards include: Los Angeles, Merced, Nevada, Riverside, Sacramento, San Joaquin, San Luis Obispo, Santa Clara, Solano, and Sonoma.

Reappropriation. CHFFA requests reappropriation of General Fund expenditure authority of $20.6 million, originally approved in the 2021 Budget Act, to be available for encumbrance or expenditure until June 30, 2028, to allow completion of existing projects awarded under the Community Services Infrastructure (CSI) Grant Program. According to CHFFA, the expenditure authority for these resources expires on June 30, 2025. This proposed reappropriation would extend the encumbrance and expenditure period for an additional three years, to June 30, 2028.

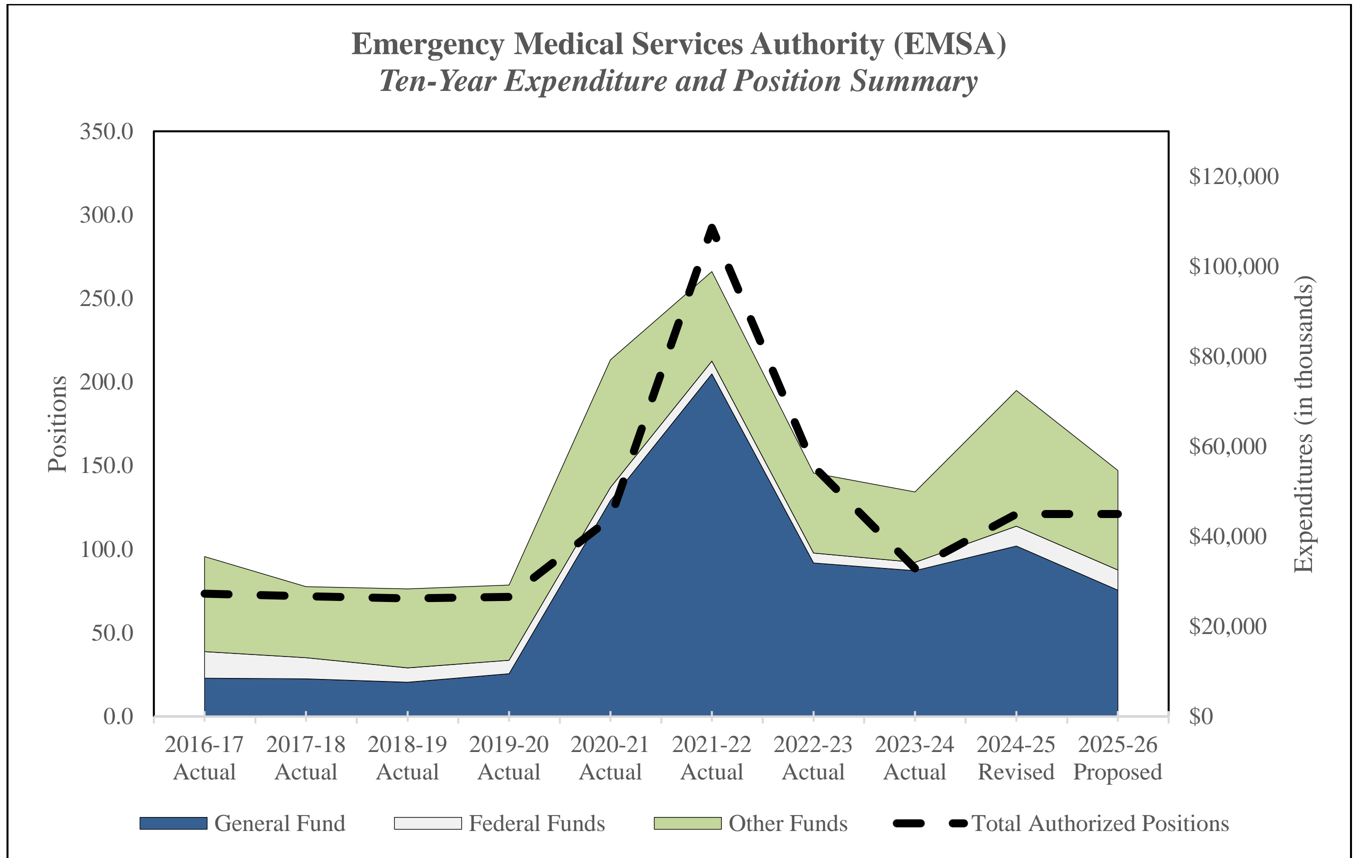
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested CHFFA and the Department of Finance to respond to the following:

1. Please provide a brief overview this proposed reappropriation.

4120 Emergency Medical Services Authority

Issue 1: Overview



Emergency Medical Services Authority - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2023-24 Actual**	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$32,409	$37,968	$37,863	$28,042
Federal Funds	$1,853	$4,412	$4,411	$4,487
Other Funds	$15,585	$21,946	$30,119	$22,127
Total Department Funding:	**$49,847**	**$64,326**	**$72,393**	**$54,656**
Total Authorized Positions:	**88.5**	**121.0**	**121**	**121**
Other Funds Detail:				
EMS Training Prog. Approval Fund (0194)	*$215*	*$253*	*$252*	*$252*
EMS Personnel Fund (0312)	*$3,808*	*$3,621*	*$3,600*	*$3,806*
Reimbursements (0995)	*$10,046*	*$16,306*	*$24,506*	*$16,306*
EMT Certification Fund (3137)	*$1,516*	*$1,766*	*$1,761*	*$1,763*

Background. The Emergency Medical Services Authority (EMSA), authorized by the Emergency Medical Services System and Prehospital Emergency Care Act, administers a statewide system of coordinated emergency medical care, injury prevention, and disaster medical response that integrates public health, public safety, and health care services. Prior to the establishment of EMSA in 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) programs statewide. For example, many jurisdictions maintained their own certification requirements for paramedics, emergency medical technicians (EMTs), and other emergency personnel, requiring individuals certified to provide emergency services in one county to re-test and re-certify to new standards to provide emergency services in a different county. EMSA is organized into three program divisions: the Disaster Medical Services Division, the EMS Personnel Division, and the EMS Systems Division.

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, cardiopulmonary resuscitation (CPR), and preventive health practices for child day care providers and school bus drivers; and develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMS Systems Division. The EMS Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the Authority's mission and programs.

Issue 2: Facility Cost Increase

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $676,000 in 2025-26, $766,000 in 2026-27, and $676,000 annually thereafter. If approved, these resources would support facility cost increases for the EMSA Headquarters building lease, building security, and tenant improvements.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$676,000	$766,000
Total Funding Request:	**$676,000**	**$766,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2027-28 and ongoing: $676,000.

Background. According to EMSA, ongoing maintenance issues with the EMSA Headquarters Building, including leaks, mold, odor, and HVAC failures caused EMSA to relocate its headquarters to a new building in March 2023. The issues with the previous building had led to staff complaints, including medical concerns. In addition, EMSA reports its staff has grown 73 percent over the prior six years and relocating its headquarters to a new building provided necessary space to accommodate personnel and allow for potential future growth.

The relocation to the new EMSA Headquarters Building resulted in a doubling of EMSA's annual lease costs, from approximately $607,000 to $1.2 million. The new building increased the usable space for EMSA from 23,865 square feet to 26,134 square feet, allowing for future growth, and housing the Department Operations Center (DOC) during emergency activations, trainings, and exercises. In addition, EMSA entered into a security contract for the new location in July 2024 to protect staff and property, provide access control and monitoring, minimize disruptions and security incidents, and improve responses to emergencies. EMSA reports it has utilized salary savings to cover the increased facility costs for the new headquarters building prior to this request.

Resource Request. EMSA requests General Fund expenditure authority of $676,000 in 2025-26, $766,000 in 2026-27, and $676,000 annually thereafter to support facility cost increases for the EMSA Headquarters building lease, building security, and tenant improvements.

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 EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Civil Rights Compliance

Budget Change Proposal – Governor's Budget. DHCS requests 12 positions and expenditure authority of $2 million ($987,000 General Fund and $986,000 federal funds) in 2025-26 and $1.9 million ($933,000 General Fund and $932,000 federal funds) annually thereafter. If approved, these positions and resources would support civil rights compliance workload within the department.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$987,000	$933,000
0890 – Federal Trust Fund	$986,000	$932,000
Total Funding Request:	**$1,973,000**	**$1,865,000**
Total Requested Positions:	**12.0**	**12.0**

* Positions and resources ongoing after 2026-27.

Background. DHCS' Office of Civil Rights (OCR) is responsible for three main program areas: Civil Rights Compliance (CRC), Reasonable Accommodation (RA), and Equal Employment Opportunity (EEO), and currently has eight authorized, permanent positions, plus one limited-term funded position for language access. Within CRC, OCR is responsible for facilitating the DHCS external CRC program and overseeing DHCS programs, partners, providers, and vendors receiving federal financial assistance. OCR oversees compliance of these programs with state and federal nondiscrimination laws and requirements. This includes, but is not limited to, external complaints for investigation, external grievance monitoring and review, public contact inquiries, language access program (LAP), Americans with Disability Act (ADA) accommodation services, translation services, and alternative format services, in addition to guidance and training to all DHCS programs on the aforementioned topics as well as responding to routine correspondence from DHCS programs, partners, providers, vendors, and Medi-Cal members.

Equal Employment Opportunity Responsibilities. According to the California Department of Human Resources (CalHR), all state agencies have an affirmative duty to take reasonable steps to prevent and promptly address discrimination and harassment in the workplace. Agencies are responsible for integrating equal employment opportunity into every aspect of human resource management policies and practices in the recruitment, examination, selection, training and advancement of employees. Under the California Fair Employment and Housing Act, equal employment opportunity is afforded to all applicants and employees without regard to age, ancestry, color, disability (mental or physical), engaging in a protected activity, gender, gender identity or expression, genetic information, marital status, medical condition, military veteran status, national origin, political affiliation, pregnancy, race, religion, sex, and sexual orientation. State agencies' EEO programs are responsible for preventing employment harassment and discrimination by monitoring recruitment, examination, hiring, and retention policies, investigating complaints in a timely manner, and overseeing curriculum and learning objectives for employee training regarding their rights and responsibilities to maintain a harassment-free work environment.

Reasonable Accommodations Responsibilities. California state agencies are also required by state and federal laws to provide Reasonable Accommodation (RA) to applicants and employees with disabilities.

An RA may be a modification or adjustment to a job, or to the work environment, that enables an individual with a disability to have the same employment opportunities and benefits as those without a disability. When a request for a disability accommodation is made employers are required to enter an interactive process with the employee to make an individualized assessment of the essential job functions and the specific limitations of the person with a disability. The Fair Employment and Housing Act also prohibits employment discrimination based on religion. This discrimination includes refusing to accommodate an applicant's or employee's sincerely held religious beliefs or practices. Applicants and employees may obtain exceptions to rules or policies in order to fulfill their essential job functions within the constraints of their religious beliefs or practices.

Civil Rights Compliance Responsibilities. Section 1557 of the federal Patient Protection and Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, extending federal nondiscrimination protections to individuals participating in any health program or activity receiving funding from the federal Department of Health and Human Services (HHS), any health program or activity administered by HHS, health insurance marketplaces, and all plans offered by issuers that participate in those marketplaces. These requirements extend to all programs administered by DHCS that receive federal funding including Medi-Cal, community behavioral health programs, family planning programs, and many others. The Office of Civil Rights is responsible for preventing and correcting civil rights violations in the delivery of services administered by DHCS.

***Tran v. DHCS* Settlement Agreement.** According to DHCS, recent litigation against the department has resulted in new workload for the Office of Civil Rights. As a part of the *Tran v. DHCS* settlement, DHCS is required to: develop written policies and procedures for investigating and resolving discrimination complaints within 90 days of receipt; receive and review all Medi-Cal managed care plan and county mental health plan discrimination complaints and grievance determinations, including complaints of discrimination filed with California Department of Social Services (CDSS) State Hearings, which are required to be simultaneously filed with DHCS OCR; and direct all counties to submit all Medi-Cal complaint and grievance determination to DHCS OCR for closure instead of CDSS. DHCS reports these requirements will result in increased workload, as there are 26 Medi-Cal managed care plans, three dental managed care plans, 57 county mental health plans, 33 Drug Medi-Cal Organized Delivery System county plans, and 58 counties serving about 15 million Medi-Cal members. DHCS also reports it has diverted staff temporarily from the EEO program and RA program, resulting in delays completing investigations, providing reasonable accommodations, and policy development in those programs.

Staffing and Resource Request. DHCS requests 12 positions and expenditure authority of $2 million ($987,000 General Fund and $986,000 federal funds) in 2025-26 and $1.9 million ($933,000 General Fund and $932,000 federal funds) annually thereafter to support civil rights compliance workload within the department. Specifically, DHCS is requesting the following positions and resources:

<u>**Office of Civil Rights**</u> – 12 positions

- **One Staff Services Manager (SSM) III** position would manage both the CRC and EEO programs, overseeing policy development, program administration, and quality monitoring and oversight of the LAP.

- **One SSM II** position would supervise the CRC program and LAP and act as a subject matter expert providing additional resources for complex and sensitive workload, develop policies and procedures to improve OCR responsiveness and reduce liability risks, provide guidance to DHCS programs to support civil rights compliance, supervise and manage CRC analysts working on complaints, grievances, and investigations.

- **Ten Associate Governmental Program Analysts (AGPAs)** would support CRC program workload including complaints, grievances, and investigations; manage Americans with Disabilities Act (ADA) coordination, alternative formats, contracts, language access, language taglines, translation services, and member inquiries.

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.

Issue 2: Medi-Cal Administrative Activities for CalAIM Justice Involved Initiative

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $798,000 ($399,000 General Fund and $399,000 federal funds) in 2025-26, and $753,000 ($377,000 General Fund and $376,000 federal funds) annually thereafter. If approved, these positions and resources would support establishment of a Medi-Cal Administrative Activities program for the new Justice-Involved Initiative, which provides eligibility and health care services to individuals 90 days prior to release from a jail, prison, or other correctional facility.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$399,000	$377,000
0890 – Federal Trust Fund	$399,000	$376,000
Total Funding Request:	**$798,000**	**$753,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2026-27.

Background. According to DHCS, the California Advancing and Innovating Medi-Cal (CalAIM) initiative is a long-term commitment to transform and strengthen Medi-Cal into a more equitable, coordinated, and person-centered program to help members maximize their health and life trajectory. One of the components of CalAIM is the Justice-Involved Initiative, which provides certain Medi-Cal services to youth and adults in correctional facilities including state prisons, county jails, and youth correctional facilities, up to 90 days prior to release. These services provide a bridge to services that will be provided by Medi-Cal upon release, including determining eligibility, enrolling in the appropriate Medi-Cal health care delivery systems, and beginning or continuing treatment for health conditions. DHCS received federal approval of a Medicaid 1115 demonstration waiver to enable the department to partner with state agencies, counties, and community-based organizations to establish a coordinated community reentry process to assist people leaving incarceration to connect to the physical and behavioral health services they need upon release.

The Providing Access and Transforming Health (PATH) Justice-Involved Capacity Building grant program supports collaborative planning and information technology investments to support implementation of pre-release and reentry planning. PATH provides one-time funding opportunities to correctional agencies to build up the capacity and infrastructure to participate in the Medi-Cal delivery system. However, due to the one-time nature of this funding, state and county participants will need to transition to ongoing funding streams to support this workload and continue providing services to individuals prior to release. DHCS is proposing to implement a Medi-Cal Administrative Activities (MAA) program for the Justice-Involved Initiative, which would provide ongoing funding for certain administrative activities. MAA programs currently exist in several other contexts in the Medi-Cal program, including the School-Based MAA Program (for local government agencies and local education consortia), the Mental Health MAA Program (for county mental health plans), and the Tribal MAA Program (for tribes, tribal organizations, and tribal subgroups). These MAA programs provide federal reimbursement for the costs of certain activities including Medi-Cal outreach, facilitating Medi-Cal application, non-emergency and non-medical transportation of Medi-Cal eligible individuals to Medi-Cal covered services, contracting for Medi-Cal services, program planning and policy development, MAA

coordination and claims administration, training, and general administration. The new Justice-Involved MAA Program would likely include reimbursement for similar activities, where appropriate.

Staffing and Resource Request. DHCS requests five positions and expenditure authority of $798,000 ($399,000 General Fund and $399,000 federal funds) in 2025-26, and $753,000 ($377,000 General Fund and $376,000 federal funds) annually thereafter to support establishment of a Medi-Cal Administrative Activities program for the new Justice-Involved Initiative, which provides eligibility and health care services to individuals 90 days prior to release from a jail, prison, or other correctional facility. Specifically, DHCS is requesting the following positions and resources:

Local Government Financing Division – Five positions

- **One Staff Services Manager I** position would provide leadership and staff supervision including recruitment, training and evaluation of staff, recommendations and disciplinary action, performance reports and appraisals, training, developing written protocols and procedures; assist in development of interagency agreements and other documents; present program issues and recommendations to senior leadership; and respond to inquiries or requests from stakeholders.

- **One Health Program Specialist I** position would serve as the primary subject matter expert, lead policy development, issue formal guidance, review processes for compliance, obtain and incorporate stakeholder feedback, serve as the primary DHCS liaison to state and local entities and organizations, lead communications, participate in meetings with the federal Centers for Medicare and Medicaid Services (CMS) regarding changes, and provide assistance in development of the Justice Involved Initiatives administrative services and procedures.

- **Three Associate Governmental Program Analysts (AGPAs)** would research, analyze, interpret, and apply applicable statutes, regulations, policies, and procedures, in preparation of interagency agreements or contracts and amendments for claiming federal matching funds, and to pay invoices related to the initiative's administrative activities; conduct review and processing of invoices and claims; analyze documentation provided for qualifying services; facilitate claims for payments of federal funds to verify allowable activity requirements; provide assistance and resolve technical issues or questions during the review process; and provide follow-up on compliance of program guidelines.

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.

Issue 3: Population Health Management Reappropriation

Reappropriation – Governor's Budget. DHCS requests reappropriation of General Fund expenditure authority of up to $19.8 million, originally authorized in the 2021 Budget Act. If approved, this reappropriated funding would continue support for the department's Population Health Management service, known as Medi-Cal Connect.

Background. Under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, Medi-Cal managed care plans must develop and maintain a population health management (PHM) program, defined as a model of care and a plan of action designed to address member health needs at all points along the continuum of care. The PHM program adheres to National Committee for Quality Assurance (NCQA) standards and additional requirements established by the department. The required PHM plan is filed with the state annually and includes assessment and risk stratification of plan members, integration of wellness and prevention services, case management, identification and delivery of in-lieu-of services, and care transition management.

The 2021 Budget Act included expenditure authority of $315 million ($31.5 million General Fund and $283.5 million federal funds) to administer a Population Health Management (PHM) service, to utilize administrative and clinical data and information for DHCS, managed care plans, counties, providers, beneficiaries, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. Of this amount, $15 million ($1.5 million General Fund and $13.5 million federal funds) was available for administration of the service.

According to DHCS, the PHM service, Medi-Cal Connect, supports the plans' PHM responsibilities and planning. Medi-Cal Connect utilizes Medi-Cal administrative and clinical data and information for the department, plans, counties, providers, members, and other partners to use in support of the delivery of care for Medi-Cal beneficiaries. Information is available from the managed care delivery system, the fee-for-service delivery system, specialty mental health, substance use disorder services, dental services, long-term services and supports, developmental disability services, in-home supportive services, 1915c Waivers, CalFresh, the Women, Infants and Children (WIC) program, and other services. Medi-Cal Connect assists the department and others in identifying potential gaps in care, provider and care manager information, information on social determinants of health, population health analytics, health education, and tips for members. Medi-Cal Connect will also provide Medi-Cal beneficiaries with access to their administrative and clinical information.

Reappropriation. DHCS requests reappropriation of General Fund expenditure authority of up to $19.8 million, originally authorized in the 2021 Budget Act to continue support for the department's Population Health Management service. According to DHCS, Medi-Cal Connect will be implemented in five phases. The first two phases are complete, providing user access to all DHCS staff. Phase 3 will provide access to Medi-Cal managed care plans, county behavioral health plans, and state partners and agencies and is expected to launch later this year. Phase 4 will provide access to local county partners, health care delivery partners, tribal partners, and other Medi-Cal delivery partners, as well as support PHM program services and supports. Phase 4 is expected to launch at the end of 2025. Phase 5, expected to launch in late 2026, will provide access for Medi-Cal members.

The expenditure and encumbrance period for the funding provided in the 2021 Budget Act expired on June 30, 2024. This proposal would reappropriate up to $19.8 million of the original $30 million General Fund allocation until June 30, 2026.

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 reappropriation proposal.

Issue 4: California Electronic Visit Verification (CalEVV) Resources

Budget Change Proposal – Governor's Budget. The California Department of Aging, (CDA), DHCS, and the Department of Developmental Services (DDS) request four positions and annual expenditure authority of $1.4 million ($1.1 million General Fund and $341,000 federal funds). If approved, these positions and resources would support compliance with the electronic visit verification requirements of the federal 21st Century Cures Act.

Multi-Year Funding Request Summary - CDA		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$90,000	$90,000
0995 – Reimbursements**	$186,000	$186,000
Total Funding Request:	**$276,000**	**$276,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2026-27.
** Reimbursements reflect transfer of federal matching funds from DHCS (see below).

Multi-Year Funding Request Summary - DHCS		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$832,000	$832,000
0890 – Federal Trust Fund	$186,000	$186,000
Total Funding Request:	**$1,018,000**	**$1,018,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2026-27.

Multi-Year Funding Request Summary - DDS		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$129,000	$129,000
0995 – Reimbursements	$155,000	$155,000
Total Funding Request:	**$284,000**	**$284,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2026-27.

Background. The federal 21st Century CURES Act[1] requires states to implement an electronic visit verification system for all Medicaid-funded Personal Care Services (PCS) by January 1, 2020, and for all Home Health Care Services (HHCS) by January 1, 2023. Federal law defines an electronic visit verification (EVV) system as a system under which PCS or HHCS visits are electronically verified, including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Programs serving Medi-Cal beneficiaries that are required to implement an EVV system include waiver services for individuals with developmental disabilities administered by DDS, In-Home Supportive Services (IHSS) administered by the California Department of Social Services (CDSS), Waiver Personal Care Services and Home Health Care Services administered by DHCS, the Multipurpose Senior Services

[1] 42 United States Code Subsection (*l*), added by 21st Century CURES Act (HR 34, 114th Congress, 2015-16)

Program administered by DHCS and CDA, and AIDS Medi-Cal Waiver services administered by DHCS and the California Department of Public Health (CDPH). These services are offered under one of two models:

- Self-Directed Model – Services provided under a self-directed model are those in which the service recipient is responsible for hiring and managing direct care workers.
- Agency Model – Services provided under an agency model use a provider agency or vendor to recruit, hire, and manage direct care workers.

The Administration has implemented EVV in two phases. Phase I included implementation for the self-directed model components of the IHSS (CDSS) and Waiver Personal Care Services (DHCS) programs, which currently use the Case Management Information and Payrolling Systems (CMIPS II) and Electronic Time Sheet (ETS) System. Phase II included non-IHSS and non-Waiver Personal Care Services self-directed model components, as well as the agency model components of the IHSS and Waiver Personal Care Services programs.

Electronic Visit Verification Phase II Programs

Department	Program	Self-Directed	Agency Model	PCS	HHCS
DDS	1915 (c) DD Waiver	X	X	X	X
DDS	1915 (i) State Plan Services	X	X	X	X
DDS	1915 (c) Waiver Self-Determination Program	X	X	X	X
DHCS	1915 (c) Home- and Community-Based Alternatives Waiver	X	X	X	X
DHCS	Home Health Care Services		X		X
DHCS	Waiver Personal Care Services Agency Model		X	X	X
CDA/DHCS	MSSP 1915 (c) and 1115 Waivers		X	X	
DPH/DHCS	1915 (c) AIDS Medi-Cal Waiver		X	X	X
DSS	IHSS Agency Model		X	X	

After implementation of the two phases of CalEVV, the programs have shifted to maintenance and operations. As a result, the federal financial participation percentage has been reduced from 90 percent to 75 percent. According to the Administration, federal law also requires ongoing quarterly reporting on five key performance indicators (KPIs), including:

1. Ensuring that claims and encounters are not being paid for unverified visits.
2. Ensuring linkage between authorized provider, service, units, and beneficiary for home visits.
3. Reducing incidence of manually entered or edited EVV records.
4. Ensuring that the EVV system has a high availability.
5. Ensuring that the solution, employees, contractors, and downstream subcontractors or entities that create, collect, disclose, access, maintain, store, and use electronic Protected Health Information/Personally Identifiable Information (PHI/PII) comply with the HIPAA privacy, security, and breach notification regulations, and applicable state and federal laws and regulations.

The Administration reports that, while user adoption rates for CalEVV have been satisfactory, there are significant issues with mismatches between provider visit data entry and submitted claims. CDA and DDS have temporarily redirected staff to address these issues, but would need ongoing resources to continue the outreach and training to providers to ensure accurate visit data entry.

Staffing and Resource Request. CDA, DHCS, and DDS request four positions and annual expenditure authority of $1.4 million ($1.1 million General Fund and $341,000 federal funds to support compliance with the electronic visit verification requirements of the federal 21st Century Cures Act. Specifically, these departments request the following staffing and resources:

CDA – Two positions

- **One Health Program Specialist I** position would serve as the EVV technical program consultant for Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP), develop CBAS and MSSP provider surveys to collect information to update data needs, represent the department at stakeholder meetings, provide backup for the EVV monitoring and compliance program, and support and review contracts and other documents.

- **One Associate Governmental Program Analyst (AGPA)** would be responsible for the EVV monitoring and compliance program for CBAS and MSSP, coordinate stakeholder meetings related to EVV policy, assist in developing and maintaining EVV policies and procedures, prepare and develop notices and other communications, respond to inquiries from the public, support and review contracts and other documents, and participate in user acceptance testing.

DDS – Two positions

- **Two AGPAs** would serve as EVV subject matter experts, coordinate stakeholder meetings, develop and maintain policies and procedures related to EVV requirements, prepare and develop guidance and directive documents, respond to inquiries, compile and present reports and other tracking activities, and participate in user acceptance testing.

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.

Issue 5: AB 186 SNF Workload Standards and Accountability Sanctions

Budget Change Proposal – Governor's Budget. DHCS requests 14 positions and expenditure authority of $2.9 million ($1.4 million Long-Term Care Quality Assurance Fund or LTC QAF, and $1.4 million federal funds) in 2025-26 and $2.8 million ($1.4 million LTC QAF and $1.4 million federal funds annually thereafter. If approved, these positions and resources would support implementation and program integrity efforts for the Workforce Standards Program (WSP) and the Accountability Sanctions Program (ASP), two new skilled nursing facility (SNF) financing programs authorized pursuant to AB 186 (Committee on Budget), Chapter 46, Statutes of 2022.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0890 – Federal Trust Fund	$1,448,000	$1,385,000
3213 – Long-Term Care Quality Assurance Fund	$1,449,000	$1,386,000
Total Funding Request:	**$2,897,000**	**$2,771,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and resources ongoing after 2026-27.

Background. Federal Medicaid regulations allow states to impose certain provider-related taxes on health care service providers as long as certain conditions are met. The revenues from these taxes may serve as the non-federal share of expenditures for health care services in a state's Medicaid program, which allows the state to draw down additional federal funding for those services. California imposes several provider-related taxes, including the Hospital Quality Assurance Fee (HQAF), the Managed Care Organization (MCO) Tax, and the Skilled Nursing Facility Quality Assurance Fee (SNF QAF).

AB 1629 (Frommer), Chapter 875, Statutes of 2004, authorized the development of a cost-based, facility-specific reimbursement rate methodology for freestanding skilled nursing facilities serving Medi-Cal beneficiaries and implemented the first SNF QAF, which supports the nonfederal share of reimbursement rate increases to these facilities. The reimbursement rate methodology and SNF QAF have been reauthorized several times since 2004. Though the basic structure of the reimbursement rate methodology and SNF QAF have remained the same, each reauthorization has provided for the rate of reimbursement rate increases each year and imposes certain other requirements on skilled nursing facilities.

The most recent reauthorization of the SNF QAF, AB 186 (Committee on Budget), Chapter 46, Statutes of 2022, establishes a new Medi-Cal reimbursement rate structure for skilled nursing facilities (SNFs), authorized for calendar years 2023 through 2026. AB 186 included the following components:

1. Established reimbursement rates based on an updated annual percentage increase with a separate budgetary growth limit of up to five percent for labor costs and two percent for non-labor costs.

2. Established a new Workforce and Quality Incentive Program (WQIP) under which facilities may earn directed payments.

3. Required, beginning in 2024, half of the annual reimbursement rate increase for non-labor costs to be allocated to base rates and half to increase Workforce and Quality Incentive Program payments.

4. Required DHCS, in consultation with stakeholders, to establish the methodology, parameters, and eligibility criteria for the directed payments, including milestones and metrics that network providers of SNF services must meet in order to receive a directed payment, with at least two of these milestones and metrics tied to workforce measures.

5. Authorized DHCS to sanction SNFs that do not meet the quality standards established by DHCS, in the amount of five dollars per Medi-Cal bed day, with a maximum of $150,000, in a single rating period.

6. Required DHCS to establish workforce standards for 2024 through 2026, and make facilities that meet the workforce standards eligible to receive a base rate augmentation.

7. Authorized the workforce standards to include criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide multi-employer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders.

According to DHCS, in addition to establishment of the WQIP, AB 186 required implementation of two new SNF financing programs: the Workforce Standards Program (WSP) and the Accountability Sanctions Program (ASP). The WSP requires DHCS to establish workforce standards, such as maintaining a collective bargaining agreement or paying prevailing wage. Facilities that meet the workforce standards will receive a facility-specific workforce rate adjustment without applying annual growth limits to the labor cost category. The workforce rate adjustment is intended to supplant the enhanced reimbursement rate provided during the COVID-19 public health emergency that expired at the end of 2023, while ensuring facilities invest these additional funds in workforce. The WSP will provide a rate add-on projected to total $300 million annually to facilities to meet these requirements.

The ASP authorizes DHCS to sanction facilities that do not meet quality standards established by DHCS on a per Medi-Cal bed day basis. AB 186 requires DHCS to determine the criteria for the ASP, communicate potential sanction actions to the impacted SNFs, allow for SNFs to demonstrate any corrective action and financial hardship, and provide a process for appeals. DHCS published program policy and measurement areas for ASP effective in calendar year 2024 and will begin collecting sanctions in early to mid-2025. DHCS estimates that five percent of approximately 1,100 SNFs may be assessed sanctions annually, for a total of 55 facilities, with an anticipated 30 appeals.

Staffing and Resource Request. DHCS requests 14 positions and expenditure authority of $2.9 million ($1.4 million Long-Term Care Quality Assurance Fund or LTC QAF, and $1.4 million federal funds) in 2025-26 and $2.8 million ($1.4 million LTC QAF and $1.4 million federal funds annually thereafter to support implementation and program integrity efforts for the Workforce Standards Program (WSP) and the Accountability Sanctions Program (ASP), two new skilled nursing facility (SNF) financing programs authorized pursuant to AB 186 (Committee on Budget), Chapter 46, Statutes of 2022. Specifically, DHCS is requesting the following positions and resources:

<u>**Audits and Investigations**</u> – Seven positions

- **Six Health Program Auditor (HPA) III** positions would develop the audit manual, perform annual audits for WSP requirements; perform audit functions for appeals, precomputations, and review of findings; participate in mandatory trainings; and engage in peer review of proposed decisions, revisions, and finalized decisions for modification of audit methodologies.

- **One Health Program Audit Manager (HPAM) I** position would develop processes for areas of focus, data to review and capture, and audit scope; design and review audit process for WSP; develop audit schedules, templates, and report formats; conduct oversight of the six HPA III positions in audit process, work papers, issuance, and appeals; perform management functions such as hiring, training, evaluating, and performance monitoring; participate in peer review of proposed decisions, revisions, and finalized decisions for modification of audit methodologies.

Office of Administrative Hearings and Appeals – Three positions

- **One Administrative Law Judge** would review and analyze cases to determine presented legal challenges to departmental action, venue, and jurisdiction; perform status and pre-hearing conferences, rule on motions for continuance and discovery, issue interim orders, set the schedule for pre-hearing briefs, and order the preparation and exchange of exhibits prior to a hearing; review and analyze settlement conference briefs and other documents; preside over settlement conferences; preside over formal hearings; review post-hearing briefs, transcripts or hearing recordings; review submitted exhibits, research contested points of law and fact, and draft a proposed decision; participate in peer review of proposed decision, revisions, and finalized decisions.

- **Two HPAM I** positions would review submitted exhibits, research contested points of fact, coordinate with parties for continuance, preside over informal hearings, review post-hearing documentation and recordings, draft a report of findings for WSP, draft a final decision for ASP, participate in peer review, revisions, and finalization of decisions.

Office of Legal Services – One position

- **One Attorney III** position would support and defend administrative appeals of WSP audits, provide advice and counsel on informal appeals, advise DHCS staff on the imposition of sanctions and informal appeals for WSP and ASP, initiate discovery process to represent DHCS, identify the basis for issues raised in proceedings, evaluate oversight and compliance-related documentation, engage in discovery, prepare or respond to motions, assemble exhibits, conduct legal research and analysis, prepare witnesses for hearing, engage program staff and experts in identifying or exploring potential areas for settlement or resolution, engage with opposing counsel to assess settlement opportunities, prepare settlement conference briefs, participate in formal settlement conference, draft settlement agreements, represent DHCS at evidentiary hearings, present exhibits and witnesses, cross-examine witnesses, make opening and closing arguments, prepare prehearing and post-hearing briefings, and work closely with the Attorney General's Office in the event an administrative decision is challenged in Superior Court.

Quality and Population Health Management Division – Three positions

- **One Staff Services Manager I** position would convene and engage with other DHCS divisions on determination of sanction targets, amounts, and process to recoup money due to sanctions; oversee performance and project completion performed by ASP staff; work with nursing staff in the Medical Monitoring Unit to evaluate each potential sanction case, provide technical assistance to impacted facilities and SNF advocacy groups, and assist internal departmental partners with any inquiries on the corrective action or sanction process; track cases as they move through the administrative hearing and appeals process and coordinate the collection process for sanctions that are not waived or appealed successfully; lead in engagement with external stakeholder meetings regarding the ASP, including tracking suggestions to inform any ASP refinements.

- **Two Associate Governmental Program Analysts (AGPAs)** would perform timely collection of data and reports monitoring SNF performance on clinical measures, equity measures and workforce standards to identify facilities at risk of sanctions; provide administrative support and collect and analyze SNF data from the contractor and managed care plans to develop benchmarks; schedule and provide technical and administrative support for internal DHCS and external stakeholder meetings; certify timely and effective SNF performance monitoring; report when sanction benchmarks have been triggered; coordinate communication with internal stakeholders on the determination of facilities that will be sanctioned; and facilitate communication between DHCS and the sanctioned SNFs, provide technical assistance to get these SNFs back into compliance, and take the lead for DHCS on any Disputes or Appeals resulting from SNF sanctions.

Consultant Contracts - $250,000 annually

- **Quality and Equity Division Accountability Sanction Program Contract -** $250,000 ($125,000 LTC QAF and $125,000 federal funds) annually would support a contract to: lead development of sanction measures and target levels, identify and monitor low-performing providers at risk of sanctions, provide technical assistance to providers, collect sanction measurement data on a quarterly basis, and develop reports to summarize and trend data prior to and throughout the corrective action process.

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.

Issue 6: PACE Growth and Expansion

Budget Change Proposal and Trailer Bill Language – Governor's Budget. DHCS requests 33 positions and expenditure authority of $6.3 million ($2.9 million Program of All Inclusive Care for the Elderly, or PACE, Oversight Fund, and $3.4 million federal funds) in 2025-26, $6 million ($2.7 million PACE Oversight Fund and $3.2 million federal funds) in 2026-27 and 2027-28, and $5.8 million ($2.6 million PACE Oversight Fund and $3.2 million federal funds) annually thereafter. If approved, these positions and resources would support DHCS administration, operation, monitoring, and oversight of Programs for All Inclusive Care for the Elderly (PACE).

DHCS also requests trailer bill language to: 1) authorize establishment of a fee on all PACE organizations for applications, reviews, maintenance and operations, and marketing activities; 2) require the fee be set in an amount sufficient to cover administrative costs; and 3) provide that the maintenance and operations fee not exceed one percent of a PACE organization's capitation payment.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0890 – Federal Trust Fund	$3,403,000	$3,243,000
3362 – PACE Oversight Fund	$2,866,000	$2,729,000
Total Funding Request:	**$6,269,000**	**$5,792,000**
Total Requested Positions:	**33.0**	**33.0**

* Additional fiscal year resources requested – 2027-28: $5,971,000; 2028-29 and ongoing: $5,805,000

Background. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

SB 833 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2016, the PACE Modernization Act, implemented new flexibilities and growth of the PACE program, including removal of the cap on the total number of PACE organizations in the state (previously limited to 15), implementation of an experience-based rate methodology, and allowing for-profit entities to participate. The PACE Modernization Act has resulted in significant growth in the number of PACE programs providing services to Medi-Cal beneficiaries. According to DHCS, in 2022-23 the department received 20 applications and onboarded four PACE organizations, and in 2023-24 the department received 15 applications and onboarded 5 PACE organizations. Future growth is projected in 2024-25, bringing the total number of onboarded PACE organizations to 38.

Staffing and Resource Request. DHCS requests 33 positions and expenditure authority of $6.3 million ($2.9 million Program of All Inclusive Care for the Elderly or PACE Oversight Fund, and $3.4 million federal funds) in 2025-26, $6 million ($2.7 million PACE Oversight Fund and $3.2 million federal funds) in 2026-27 and 2027-28, and $5.8 million ($2.6 million PACE Oversight Fund and $3.2 million federal

funds) annually thereafter to support DHCS administration, operation, monitoring, and oversight of Programs for All Inclusive Care for the Elderly (PACE). Specifically, DHCS is requesting the following positions and resources:

Audits and Investigations – Four positions

- **One Health Program Audit Manager (HPAM) I** position would manage and supervise audit staff, assign and review audit staff work, attend entrance and exit interviews with providers to aid in providing technical support for the audit findings, provide oversight and consultation with audit and other professional staff in the resolution of complex issues, maintain monitoring systems to measure the progress of assigned staff workload, develop and execute time budgets, prepare production reports, forecast personnel requirements, and develop budgeting requests and justifications.

- **One Health Program Auditor IV** position would contact contracted PACE organizations or affiliated locations to coordinate and schedule an audit for contract compliance, send documentation requests to the PACE organizations or affiliated locations and distribute the documentation received to appropriate team members, develop audit scope and request additional data from PACE organizations or affiliated locations, act as a team lead providing support to other team members during the audit, conduct interviews during onsite reviews, review work papers, write final audit reports, conduct exit conferences, and lead risk assessments.

- **Two Health Program Auditor III** positions would perform contract compliance audits of PACE organizations or affiliated locations, analyze documents and data received from the PACE organizations or affiliated locations, develop questions, address issues during onsite reviews, review any additional documentation for the development of findings, submit work papers and draft reports, and participate in entrance and exit conferences.

Capitated Rates Development Division – Four positions

- **One Staff Services Manager (SSM) I** position would provide direct supervision to staff, establish and monitor unit goals and objectives, oversee the quality and consistency of work, review and approve reports and proposed correspondence with PACE organizations, and work closely with other section managers to effectively coordinate workflow, procedures, and review standards.

- **Three Associate Governmental Program Analysts (AGPAs)** would collect, validate, analyze, and interpret PACE organizations' financial statements and other financial supporting documentation to evaluate fiscal soundness of PACE organizations; analysis and recommendation, policy and procedure development, and development and maintenance of reports compiling financial data across PACE organizations for management review; serve as financial liaisons for correspondence between the division and other DHCS divisions; and assist with coordinating policies and procedure regarding financial documents across DHCS divisions.

Health Information Management Division – Four positions

- **Two Information Technology Specialist (ITS) II** positions would act as the project liaison in data management and strategy; provide data support and consultation related to methodical development

and limitations, data collection and improvement, data reporting and querying, and data linkage and integration; develop long-term data strategy to support current and future requirements, work with external project teams; develop and confirm data management solutions align with data management best practices, DHCS data management policies and other DHCS standards; and serve at an expert level to provide consultation in support of data management activities with knowledge and skills in data management principles, services, components, trends, interfaces, protocols, and data architectures.

- **Two Research Data Specialist (RDS) II** positions would address the increasing workload associated with current and future data extraction, compilation, summarization, market analysis, and report generation.

Integrated Systems of Care Division – 14 positions

- **One SSM III** position would serve as the Assistant Division Chief, focus on strategic planning and aligning PACE quality efforts with the larger Medi-Cal program, oversee the development of new processes and procedures aimed at maintaining PACE program integrity while working on process improvements, and utilize project management principles to plan, operate, and effectuate improvements in PACE planning and quality efforts.

- **One SSM II** position would supervise, support, and guide the team of PACE nurses dedicated to level of care evaluations for the PACE beneficiaries and the nurses dedicated to monitoring and oversight; supervise nurses in the day-to-day operations of PACE to plan, develop, implement, and monitor comprehensive quality assurance policies, procedures, strategies, and tools; monitor contractor compliance; establish and maintain priorities; apply and recommend changes in health regulations, policies, and procedures; and establish and maintain cooperative relations with a variety of governmental, educational, and provider entities.

- **Four Nurse Evaluator (NE) II** positions would support workload in the division. Three of the positions would review, validate, and document eligibility of Medi-Cal beneficiaries into PACE; authorize services for Medi-Cal beneficiaries enrolled in PACE; and maintain regular communication with PACE contractors and partners in the Center for Medicare and Medicaid Services. The other position would serve as the clinical subject matter expert in the new PACE Monitoring and Oversight Unit; provide clinical subject matter expertise in PACE related monitoring, oversight, technical assistance, and desk and onsite audits; and lead the development, execution, and follow-up of the clinical portions of corrective action plans, sanctions, and suspensions.

- **Seven AGPAs** would support workload in the division. Three of the positions would support contract management and provide technical assistance to PACE organizations; carry out a wide variety of consultative and analytical staff services on contract management; support assurance of compliance of policies and procedures relating to all aspects of contract management; provide subject matter expertise in contract and amendment development, technical assistance, enforcement of contract and waiver compliance, and the ongoing development of policies and procedures pertaining to contracts; and serve as resources for the division and upper management to verify that all policies and procedures are adhered to. Two positions would be exclusively assigned to the support of the PACE Nurse Evaluator II positions, informing the unit chief of current activities, assignments, projects,

deliverables, achievements, operating problems, vulnerabilities, issues, and concerns. One position would support increased workload due to increases in PACE applications, serve as a subject matter expert and provide administrative duties ranging from technical assistance, licensure exemption review and processing, application processing, desk and onsite review components, policy development and enforcement, and ongoing monitoring and oversight functions; act as team leader or coordinate the efforts of representatives of various governmental agencies on larger projects; represent the state or DHCS as assigned. One position would conduct the administrative portion of PACE audits to verify PACE organizations are meeting all of their state, federal, and contractual obligations; conduct analytical studies of PACE policies, procedures, and contracts to support the unit's mission to verify high quality health care is provided by the program; provide management with recommendations on compliance functions, submit timely audit reports, and analyze audit results; track audit findings and responses to audit findings and provide technical assistance to providers and staff regarding the correction of audit findings; review and approve corrective action plans submitted by PACE organizations in response to findings of noncompliance from state or federal-initiated audits, medical surveys, and other verification studies; and conduct additional desk or field review follow-up related to corrective action plan implementation.

- **One Health Program Specialist (HPS) II** position would advise on PACE contract improvements to strengthen DHCS' program oversight and verify that high quality health care services are delivered; research, report, and make recommendations on highly technical functions that are critical to DHCS' mission; evaluate and research health policy issues; coordinate health program activities; disseminate information to agencies; prepare, monitor and evaluate contracts language for compliance with health regulations; apply and recommend changes in health regulations; policies and procedures; perform or supervise complementary staff support functions; manage or supervise complex major PACE programs and projects; represent the department in dealings with local, state, federal and private jurisdictions; develop, modify, and revise training materials and curriculum and participate as a core team member in statewide formal training seminars and specialty training sessions; assist PACE organizations, including advocate organizations communicating on behalf of PACE organizations, with the most complex issues that have been elevated to DHCS.

Office of Legal Services – One position

- **One Attorney III** position would assist with evaluation of PACE organization applications, audit findings, and corrective action plans; analyze PACE organization structures, licensing, and operation requirements, proposed conditions on PACE expansion and financial stability, and assist with development of sub-regulatory policy letters applicable to PACE organizations; and defend against PACE organization informal and formal legal challenges to DHCS.

Quality and Population Health Management – Six positions

- **Two Health Program Manager (HPM) II** positions would support workload in the division. One position would manage work on PACE quality measure and benchmark development, collect and reporting the measure data from PACE organizations, and provide technical assistance to PACE organizations on measure reporting. The second position would manage technical assistance provided to PACE organizations on quality improvement activities and oversee enforcement actions when PACE organizations are not providing adequate quality of care.

- **One HPS I** position would collect and prepare data reports on quality measures, provide technical assistance to PACE organizations on quality improvement activities, and monitor improvement in response to enforcement actions when PACE organizations are not providing adequate quality of care.

- **One Medical Consultant (MC) II** position would provide clinical expertise in choosing quality measures and benchmarks, lead the efforts around public reporting of quality measures, participate in regular calls and meetings with DHCS divisions and external stakeholders, work with internal and external stakeholders to decide clinical quality measures for the PACE Organizations, and work towards formulating measurable goals to improve quality and health equity.

- **Two AGPAs** would coordinate the collection of measure data from PACE organizations and provide technical assistance to PACE organizations on measure reporting.

Consultant Contracts - $167,000 in 2025-26 through 2026-27, $166,000 2027-28

- **PACE Quality Measures Contract -** $167,000 ($77,000 PACE Oversight Fund and $90,000 federal funds) in 2025-26 through 2026-27, and $166,000 ($76,000 PACE Oversight Fund and $90,000 federal funds) in 2027-28 would support a contractor to assist with proposing and implementing new quality measures for PACE, develop initial criteria for selection and identification of quality metrics, establish and maintain a workgroup, research and develop options for quality measures for monitoring compliance, develop criteria to narrow down measures, evaluate measures based on certain criteria, and select a final set of quality measures to be operationalized through DHCS documents.

Trailer Bill Language Proposal – PACE Fees. DHCS requests trailer bill language to: 1) authorize establishment of a fee on all PACE organizations for applications, reviews, maintenance and operations, and marketing activities; 2) require the fee be set in an amount sufficient to cover administrative costs; and 3) provide that the maintenance and operations fee not exceed one percent of a PACE organization's capitation payment.

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. What is the expected average annual fee that would be imposed on PACE organizations, as a percent of annual capitation payments?

Issue 7: Program Workload

Budget Change Proposal and Budget Bill Language – Governor's Budget. DHCS requests 16 positions and expenditure authority of $7.9 million ($2 million General Fund, $4.4 million federal funds, and $1.5 million LTC-QAF) in 2025-26, $7.8 million ($2 million General Fund, $4.3 million federal funds, and $1.5 million LTC-QAF) in 2026-27, and $3 million ($1.5 million General Fund and $1.5 million federal funds) annually thereafter. If approved, these positions and resources would support ongoing program workload in the department.

DHCS also requests budget bill language to make $1.5 million LTC-QAF available for DHCS to develop a Comprehensive Value Strategy for Skilled Nursing Facility Services, to inform the reauthorization of the Medi-Cal Long-Term Care Reimbursement Act for dates of service on or after January 1, 2027.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$2,005,000	$1,965,000
0890 – Federal Trust Fund	$4,373,000	$4,307,000
3213 – Long-Term Care Quality Assurance Fund	$1,500,000	$1,500,000
Total Funding Request:	**$7,878,000**	**$7,772,000**
Total Requested Positions:	**16.0**	**16.0**

* Additional fiscal year resources requested – 2027-28 and ongoing: $3,000,000.

Background – Administrative Complement. According to DHCS, its practice is to apply an administrative complement to new departmental resources provided through budget change proposals approved by the Legislature in the annual Budget Act. These administrative complement resources include human resources, information technology, and fiscal activities to support the relevant programs. This proposal requests administrative complement staff to support previously approved budget change proposals.

Background – California Community Transitions Demonstration Project. In 2007, California was awarded federal grant funding to implement California's Money Follows the Person (MFP) Rebalancing Demonstration, known as the CCT Demonstration Project. CCT targets Medicaid beneficiaries of all ages who have a skilled nursing facility level of care need, who have continuously resided in an in-patient facility for 60 days or longer, and who want to return home or to a community-based setting. SB 214 (Dodd), Chapter 300, Statutes of 2020, authorized a temporary state-funded, CCT-like program that does not include the 60-day inpatient facility residency requirement to enroll. To be eligible to enroll in the temporary state-funded program, an individual is only required to have been in an inpatient facility for one day paid for by Medi-Cal. SB 214 required DHCS, commencing January 1, 2023, to cease enrollment of beneficiaries and subsequently cease providing services on January 1, 2024. SB 281 (Dodd), Chapter 898, Statutes of 2022, extended the provisions of SB 214, by three years. DHCS is currently required to cease enrollment of beneficiaries commencing January 1, 2026, and cease providing services on January 1, 2027. The 2021 Budget Act authorized resources equivalent to eleven positions for DHCS to support the California Community Transitions (CCT) Demonstration Project. In this proposal, DHCS is requesting continuation of those resources.

Background – Comprehensive Value Strategy for Skilled Nursing Facilities. AB 1629 (Frommer), Chapter 875, Statutes of 2004, authorized the development of a cost-based, facility-specific reimbursement rate methodology for freestanding skilled nursing facilities serving Medi-Cal beneficiaries and implemented the first SNF QAF, which supports the nonfederal share of reimbursement rate increases to these facilities. The reimbursement rate methodology and SNF QAF have been reauthorized several times since 2004. Though the basic structure of the reimbursement rate methodology and SNF QAF have remained the same, each reauthorization has provided for the rate of reimbursement rate increases each year and imposes certain other requirements on skilled nursing facilities.

The most recent reauthorization of the SNF QAF, AB 186 (Committee on Budget), Chapter 46, Statutes of 2022, establishes a new Medi-Cal reimbursement rate structure for skilled nursing facilities (SNFs), authorized for calendar years 2023 through 2026. AB 186 included the following components:

1. Established reimbursement rates based on an updated annual percentage increase with a separate budgetary growth limit of up to five percent for labor costs and two percent for non-labor costs.

2. Established a new Workforce and Quality Incentive Program (WQIP) under which facilities may earn directed payments.

3. Required, beginning in 2024, half of the annual reimbursement rate increase for non-labor costs to be allocated to base rates and half to increase Workforce and Quality Incentive Program payments.

4. Required DHCS, in consultation with stakeholders, to establish the methodology, parameters, and eligibility criteria for the directed payments, including milestones and metrics that network providers of SNF services must meet in order to receive a directed payment, with at least two of these milestones and metrics tied to workforce measures.

5. Authorized DHCS to sanction SNFs that do not meet the quality standards established by DHCS, in the amount of five dollars per Medi-Cal bed day, with a maximum of $150,000, in a single rating period.

6. Required DHCS to establish workforce standards for 2024 through 2026, and make facilities that meet the workforce standards eligible to receive a base rate augmentation.

7. Authorized the workforce standards to include criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide multi-employer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders.

For the next reauthorization of the SNF QAF, DHCS is proposing to establish a consultative workgroup to develop a Comprehensive Value Strategy for Skilled Nursing Facility Services. The strategy would explore: 1) transitioning SNF per diem rates to an actuarially sound acuity-based rate; 2) allow plans and SNFs flexibility to negotiate rates; 3) integrate workforce, quality, and accountability sanctions programs into a streamlined Value-Based Payment program; 4) establish a minimum workforce spending

requirement; 5) develop a sustainable rate growth methodology that considers inflation, state revenues, and the Office of Health Care Affordability's Statewide Health Care Spending Target.

Staffing and Resource Request. DHCS requests 16 positions and expenditure authority of $7.9 million ($2 million General Fund, $4.4 million federal funds, and $1.5 million LTC-QAF) in 2025-26, $7.8 million ($2 million General Fund, $4.3 million federal funds, and $1.5 million LTC-QAF) in 2026-27, and $3 million ($1.5 million General Fund and $1.5 million federal funds) annually thereafter to support ongoing program workload in the department. Specifically, DHCS is requesting the following positions and resources:

<u>Enterprise Technology Services</u> – Three positions

- **One Staff Services Manager (SSM) I** position would develop, manage, lead, and support the ETS training and staff development program; manage program staff and training.

- **Two Associate Governmental Program Analysts (AGPAs)** would act as the IT Personnel Liaison (PL) to manage and provide consultation on personnel matters for ETS staff and managers; evaluate ETS' needs and make recommendations to senior management relative to personnel policies, standards, rules, and procedures; work with all levels of ETS management to establish, fill or refill, redirect or reclassify, over 400 ETS positions, and staff; schedule advertisements through the Exam and Certification Online System; request hard-to-fill position advertisements through the DHCS social media; prepare and send communication on advertisements; and coordinate and maintain a source of record for personnel-related hiring documents.

<u>Fiscal Deputy Director's Office</u> – Two positions

- **One Career Executive Assignment (CEA) B** position and **one SSM II** position would support new contracts, staff, and funds being requested for 2025-26 in two divisions: 1) the Fiscal Forecasting Division, and 2) the Financial Management Division, which estimate, budget, account, and report for the department's nearly $200 billion budget.

<u>Financial Management Division</u> – Eight positions

- **One SSM III** position would function as an Assistant Division Chief.

- **Five Associate Accounting Analysts (AAAs)** would support the following sections of the division: 1) Support Claims and Short Doyle Payables Section, 2) General Ledger & Non-Medi-Cal Grants Section, 3) Service Center and FI$Cal Support Section, 4) Cash Flow & Cash Management Section, 5) Accounts Receivable and Cash Receipts Section.

- **Two AGPAs** would support the Budget Branch.

<u>Human Resources Division</u> – One position

- **One Personnel Specialist** would support workload for hiring, processing applications, retaining the workforce, and performing other human resources functions, including payroll, benefits, and various medical leaves.

Integrated Systems of Care Division – Resources equivalent to nine positions

- **Four AGPAs** would support CCT policy and programmatic guidance for the Lead Organizations (LOs) implementing services; review, organize, and manage the CCT LO application processes, revise and amend program reports and forms, and respond to CCT inquiries; review, analyze, and report program data via semi- and annual reports; and develop policy letters, issue papers, and perform liaison functions with state and federal partners.

- **Two Health Program Specialist (HPS) I** positions would develop and implement policies and strategies associated with the CCT program and serve as leaders or subject matter experts in both internal and external stakeholder workgroups; develop and review CCT deliverables and submit them to the applicable federal and state partners; and serve as a liaison between DHCS and the federal or grant funders.

- **Three Nurse Evaluator (NE) II** positions would conduct CCT enrollment activities which are based on a clinically based level of care assessment; partner with the LO's and Waiver Agencies to review documentation for all CCT transitions, provide TA, and clinically review treatment authorization requests (TAR); and contribute to the transition and sustainability efforts of CCT participants.

Procurement and Contracting Division – One position

- **One AGPA** would support DHCS program areas with procurement with service contracts, purchase of goods, and the processing of all contract encumbrances.

Program Data Reporting Division – Resources equivalent to two positions

- **One Research Data Analyst (RDA) II** position would lead data collection, analysis, and synthesis activities for all federal and state reporting requirements; update databases for all CCT and sustainability statistics, provide technical assistance on policy guidance to staff, and generate cost analyses; complete scheduled and ad hoc data queries for federal and state reports and maintain and update CCT eligibility verification for program or waiver enrollment requirements.

- **One RDA II** position would support the development and review of CCT data; monitor updates to the CCT databases, provide TA on policy guidance to staff, and generate cost analyses; and complete ad hoc data queries for federal and state reports and maintain CCT eligibility verification for program or waiver enrollment requirements.

Program Support Division – One position

- **One AGPA** would perform business services functions commensurate with program staffing increases, including additional support for records management, forms management, asset

management, and space planning to accommodate newly authorized positions and the continuing expansion of the department's telework and hybrid work environment programs.

<u>Consultant Contracts</u> - $3 million in 2025-26 and 2026-27

- **Medi-Cal Long-Term Care Reimbursement Act -** $3 million ($1.5 million LTC-QAF and $1.5 million federal funds) in 2025-26 and 2026-27 would support the establishment of a consultative workgroup to develop a Comprehensive Value Strategy for Skilled Nursing Facilities (SNF) Services, to inform the reauthorization of the Medi-Cal Long-Term Care Reimbursement Act for dates of service on or after January 1, 2027, aligned with the following guiding principles:

    - Coordinating and integrating care through the Medi-Cal managed care system to provide whole-person care to members with institutional level-of-care needs and support the development of comprehensive Managed Long-Term Services and Supports (MLTSS).
    - Incentivizing and holding SNFs accountable for providing quality patient care in alignment and furtherance of DHCS's Comprehensive Quality Strategy.
    - Creating financial incentives for the appropriate delivery of care, including transitions from hospital settings to SNFs and from SNFs to Home-and Community Based Services (HCBS) settings.
    - Emphasizing the critical role of workforce as a key driver of quality patient care, and verifying facilities use Medi-Cal funds to provide fair compensation and benefits to workers.
    - Provisioning services economically and efficiently to support the financial sustainability and affordability of California's health care system.
    - Supporting equitable access to skilled nursing facility care, including in rural areas, and removing perverse incentives in resident admissions, transfers, and discharges.

Budget Bill Language Proposal – Comprehensive Value Strategy for SNF Services. DHCS requests budget bill language to make $1.5 million LTC-QAF available for DHCS to develop a Comprehensive Value Strategy for Skilled Nursing Facility Services, to inform the reauthorization of the Medi-Cal Long-Term Care Reimbursement Act for dates of service on or after January 1, 2027. The language would also provide an exemption from the Public Contract Code for contracts entered into pursuant to this language.

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 budget bill language.

Issue 8: Home- and Community-Based Alternatives Waiver and PACE Sanctions

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to add Home- and Community-Based Alternatives (HCBA) Waiver providers, and Programs for All-Inclusive Care for the Elderly (PACE) to the list of DHCS contractors subject to contract termination or sanctions if the contractor fails to comply with contract requirements, state or federal laws or regulations, the state plan or waivers, or other good cause.

Background – Home and Community-Based Alternatives Waiver. The Home- and Community-Based Alternatives (HCBA) Waiver provides Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility Level of Care (LOC), with the option of returning to or remaining in a home or home-like setting in the community in lieu of institutionalization. DHCS contracts with waiver agencies for the purpose of performing waiver administration functions and directing the comprehensive care management waiver service. The waiver agencies are responsible for functions including: participant enrollment, LOC evaluations, plan of treatment and person-centered care and service plan review and approval, waiver service authorization, utilization management, provider enrollment and network development, quality assurance activities and reporting to DHCS, billing the fiscal intermediary, and provider claims adjudication.

Background – Program for All-Inclusive Care for the Elderly. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

DHCS Sanctions Authority. Current law authorizes the Director of Health Care Services to terminate a contract or impose sanctions on any department contractor providing health care services that fails to comply with contract or other state and federal requirements. This authority currently applies to the following entities providing services in the Medi-Cal program:

- Dental managed care plans
- County health systems
- Medi-Cal managed care plans
- Primary care case management providers
- Prepaid plans
- County mental health plans
- County Drug Medi-Cal Organized Delivery Systems
- Community mental health services
- Opioid Settlements Fund contractors

Trailer Bill Language Proposal. DHCS requests trailer bill language to add Home- and Community-Based Alternatives (HCBA) Waiver providers, and Programs for All-Inclusive Care for the Elderly (PACE) to the list of DHCS contractors subject to contract termination or sanctions if the contractor fails to comply with contract requirements, state or federal laws or regulations, the state plan or waivers, or other good cause. According to DHCS, the federal Centers for Medicare and Medicaid Services (CMS) is encouraging states to establish sanctions authority for enforcement of Medicaid laws and regulations for program contractors. DHCS reports that, because HCBA and PACE contractors are not included in the list of contractors that can be sanctioned under Medicaid authority, contractors violating contracts or state or federal law can only be sanctioned if they also provide services to Medicare. This language would allow these contractors to also be sanctioned for violations under Medicaid.

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 trailer bill language proposal.

Issue 9: Medi-Cal Anti-Fraud Special Deposit Fund

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to establish a permanent Medi-Cal Anti-Fraud Special Deposit Fund to accept Medi-Cal provider payments withheld while investigating a credible allegation of fraud.

Background. The DHCS Audits and Investigations unit is the designated program integrity unit for Medi-Cal. The unit's mission is to protect and enhance the integrity of the health programs administered by DHCS. The unit: 1) performs financial and compliance audits, including post-service post-payment utilization reviews of Medi-Cal providers; 2) performs compliance and medical audits of medical, dental, and behavioral health managed care plans; 3) identifies and investigates Medi-Cal provider and beneficiary waste, fraud, and abuse; 4) identifies overpayments; 5) performs onsite reviews as part of the Medi-Cal provider enrollment process; 6) provides technical assistance for the development and enhancement of DHCS health programs and related policy; and 7) provides technical assistance and audited data to support health care financing initiatives and objectives such as provider rate setting.

According to DHCS, when the Audits and Investigations unit places Medi-Cal providers who have a credible allegation of fraud on a payment suspension, the Controller's Office intercepts the payments to those providers and deposits them in the Controller's Special Deposit Fund (Fund 0942). The subaccounts in the Special Deposit Fund are temporary and can only be used for a limited time unless departments obtain approval to extend their use. Withheld provider payments are held in the Special Deposit Fund until DHCS has concluded its investigation and funds are either released to the provider or maintained by the department if an overpayment is identified.

Trailer Bill Language Proposal – Medi-Cal Anti-Fraud Special Deposit Fund. DHCS requests trailer bill language to establish a permanent Medi-Cal Anti-Fraud Special Deposit Fund to accept Medi-Cal provider payments withheld while investigating a credible allegation of fraud. According to DHCS, use of the Controller's Special Deposit Fund requires the department to periodically request extension of the use of this temporary fund. DHCS reports the use of this fund is set to expire on June 30, 2027. DHCS is proposing to establish a permanent fund to reduce the administrative burden of having to regularly request extensions for use of a temporary fund.

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 trailer bill language proposal.

Issue 10: Implementation of Chaptered Legislation (SB 1131 and SB 1289)

SB 1131 (Gonzalez)

Legislative Budget Change Proposal (SB 1131) – Governor's Budget. DHCS requests one position and expenditure authority of $160,000 ($16,000 General Fund and $144,000 federal funds) in 2025-26 and $151,000 ($14,000 General Fund and $137,000 federal funds) annually thereafter. If approved, this position and resources would support provider enrollment, onboarding, training, and onboarding for non-clinician site certifiers for clinics providing services for the Family Planning, Access, Care and Treatment (Family PACT) program, pursuant to the requirements of SB 1131 (Gonzalez), Chapter 880, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$16,000	$14,000
0890 – Federal Trust Fund	$144,000	$137,000
Total Funding Request:	**$160,000**	**$151,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2026-27.

Background. DHCS administers the Family Planning, Access, Care and Treatment (Family PACT) program, which provides comprehensive family planning and reproductive health services at no cost to eligible, low-income Californians through a network of enrolled providers. Family PACT expands access to publicly-funded family planning services who have no other source of health care coverage for family planning services, increase the use of effective contraceptive methods, promote improved reproductive health, and reduce the rate, overall number, and cost of unintended pregnancies.

SB 1131 (Gonzalez), Chapter 880, Statutes of 2024, allows a clinic corporation under certain circumstances to enroll up to ten service addresses in the Family PACT program under one site certifier. The bill requires a site certifier to be a clinician employed or contracted with the primary care or affiliate clinic who oversees provision of Family PACT services at the clinic.

Staffing and Resource Request. DHCS requests one position and expenditure authority of $160,000 ($16,000 General Fund and $144,000 federal funds) in 2025-26 and $151,000 ($14,000 General Fund and $137,000 federal funds) annually thereafter to support provider enrollment, onboarding, training, and onboarding for site certifiers for clinics providing services for the Family Planning, Access, Care and Treatment (Family PACT) program, pursuant to the requirements of SB 1131. Specifically, DHCS is requesting **one Associate Governmental Program Analyst (AGPA)** to support this workload. As of publication of this subcommittee agenda, DHCS has not provided a narrative for this proposal describing the responsibilities or workload of these positions.

During the prior legislative session, DHCS reported to the Assembly Appropriations Committee that implementation of SB 1131 would require four positions and expenditure authority of $1.2 million ($339,000 General Fund and $854,000 federal funds) in 2025-26, and $748,000 ($131,000 General Fund and $617,000 federal funds) annually thereafter. These estimates differ from the current proposal. According to DHCS, the bill was amended after this fiscal estimate was provided to the committee.

SB 1289 (Roth)

Legislative Budget Change Proposal (AB 3275) – Governor's Budget. DHCS requests six positions and expenditure authority of $1 million ($515,000 General Fund and $514,000 federal funds) in 2025-26 and $975,000 ($488,000 General Fund and $487,000 federal funds) annually thereafter. If approved, these positions and resources would support collection of call center metrics and quarterly reporting, pursuant to the requirements of SB 1289 (Roth), Chapter 792, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$515,000	$488,000
0890 – Federal Trust Fund	$514,000	$487,000
Total Funding Request:	**$1,029,000**	**$975,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2026-27.

Background. SB 1289 (Roth), Chapter 792, Statutes of 2024, requires counties operating call centers for Medi-Cal applicants or beneficiaries to collect and submit their call center metrics to DHCS, and for DHCS to report on those metrics on a quarterly basis on its website. Counties are required to collect and submit total call volume, average call wait times by language, and average call abandonment rate, beginning January 1, 2026 and monthly thereafter. The DHCS report is required to exclude any personally identifiable information and be posted on the department's website no later than 45 days after the conclusion of each quarter.

Staffing and Resource Request. DHCS requests six positions and expenditure authority of $1 million ($515,000 General Fund and $514,000 federal funds) in 2025-26 and $975,000 ($488,000 General Fund and $487,000 federal funds) annually thereafter. If approved, these positions and resources would support collection of call center metrics and quarterly reporting, pursuant to the requirements of SB 1289. Specifically, DHCS is requesting **one Staff Services Manager I** position, **three Associate Governmental Program Analysts, one Research Data Specialist II** position, and **one Research Data Specialist I** position to support this workload. As of publication of this subcommittee agenda, DHCS has not provided a narrative for this proposal describing the responsibilities or workload of these positions.

During the prior legislative session, DHCS reported to the Assembly Appropriations Committee that implementation of SB 1289 would require expenditure authority of $6.3 million ($3.2 million General Fund and $3.2 million federal funds) in 2025-26 and $4.3 million ($2.1 million General Fund and $2.1 million federal funds) annually thereafter. These estimates differ from the current proposal. According to DHCS, the bill was amended after this fiscal estimate was provided to the committee.

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 fiscal analyses provided to legislative fiscal committees in the previous legislative session, and the current staffing and resource requests for implementation of these bills.

NOT FOR PRESENTATION

Issue 11: Proposals for Investment

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

- **Equity Access to 2-1-1 Social Care Resource Connection and Disaster Services.** Inland SoCal United Way 2-1-1+, 2-1-1 California, and United Ways of California request General Fund expenditure authority of $20 million in 2025-26. If approved, these resources would support equitable funding for the 2-1-1 system. According to the advocates, in recent years, Governor Newsom and other public officials have encouraged the public to rely on 2-1-1 on several occasions to access critical information and assistance such as during wildfires, emergency rental assistance, access to vaccine appointments and transportation to vaccinations, home food delivery for seniors, and more. This is what 2-1-1 is designed for. However, when calls to action are shared to all Californians without the necessary resources for associated growth in demand, 2-1-1 call centers experience incredible stress. This is demonstrated not only by longer call wait times and even unanswered calls, which all 2-1-1 providers aim to avoid, but also very real stress on the call specialists that pride themselves on high quality information and experiences for anyone who calls in looking for help.

  Presently, each 2-1-1 operation is responsible for procuring local funding to provide their services. However, local funding is not sufficient and results in counties and cities with smaller revenue bases or even larger counties and cities with budget crises being unable to meaningfully fund 2-1-1 services, resulting in coverage gaps in high-risk regions of the state. Californians need help accessing safety net, preventive, crisis, housing, and other social care resources, and if 2-1-1 is not available to make those connections, millions of Californians will face more barriers to accessing critical help.

  Alternatively, a strong, coordinated statewide 2-1-1 system benefits communities and individuals needing help, counties and cities with serving as a Community Front Door and critical partner during disaster response and recovery, and the State with consistent public information and resource referral service and comprehensive, near real time data on community needs, trends, and service gaps. Funding would be allocated by CalHHS to 2-1-1 California for distribution statewide according to an equitable disbursement method. This distribution would also provide CalHHS and the state access to statewide community needs and service gap data that could be used to inform other state programs.

- **Pediatric Day Health Center Reimbursement Rate Increase.** The Pediatric Day Healthcare Coalition requests expenditure authority of $8 million ($4 million General Fund and $4 million federal funds) in 2025-26 and $16 million ($8 million General Fund and $8 million federal funds) annually thereafter. If approved, these resources would support a 30 percent reimbursement rate increase for pediatric daycare facilities to increase wages for nurses caring for severely disabled and medically fragile children. According to the advocates, pediatric day health centers (PDHCs) provide daycare, social, and enrichment activities for the most medically fragile children in the state, including children with severe developmental disabilities, special healthcare needs and complex chronic conditions. These children require skilled nursing services performed by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN), under the supervision of an RN, while attending daycare and engaging in activities unavailable to them except in a PDHC. Imaginative play, arts and crafts, outdoor play with adaptive equipment, friendships, singing and games should be a part of every childhood yet children

with complex medical needs often do not have access. PDHCs fill this void and allow children to be children while allowing parents to work or attend to other children in their family. Parents share a greatly improved quality of life for their special needs child as well as the entire family.

The lack of PDHC nursing staff is a direct result of the statewide nursing shortage and inadequate Medi-Cal reimbursement rates resulting in wages that are below other segments of the health care delivery system. These other nursing employers have been able to provide higher wages as well as sign-on bonuses to attract nurses. PDHC owners, who are largely individuals and families, report long term nursing staff reluctantly leaving to accept higher wage nursing jobs. The pressure of rising housing costs, inflation, and other economic pressures on their families makes remaining in lower wage PDHC positions an unsustainable option for them.

- **Equitable Compensation for Community Health Workers, Promotores, and Health Representatives (CHW/P/R).** A coalition of community organizations and clinics, including the California Pan-Ethnic Health Network, the Children's Partnership, and the Latino Coalition for a Healthy California, among others, request expenditure authority of $15 million ($10 million General Fund and $5 million federal funds) in 2025-26 and $10 million ($5 million General Fund and $5 million federal funds) annually thereafter. If approved, these resources would support an ongoing rate increase for community health workers, promotores, and health representatives (CHW/P/Rs), as well as one-time funding for streamlining billing and payment. According to the advocates, the 2024-25 state budget included a 22.2 percent increase in reimbursement rates for CHW/P/R services, raising the rate from $26.66 to $32.58 per half-hour visit. This increase was a critical step forward in ensuring fair compensation and supporting the long-term viability of the CHW/P/R workforce. However, the budget included trigger language, which eliminated this planned rate increase, the justification being that the state could no longer pay for the $5 million increase as these funds would be encumbered by Proposition 35. However, the Governor's budget proposes significant MCO tax revenues to support the Medi-Cal program and the general fund, not subject to Proposition 35. Specifically, the budget proposes $7.985 billion in 2024-25, $4.4 billion in 2025-26, and $3.3 billion in 2026-27. As such, the modest investment in CHW/P/R rates should be maintained. To support the sustainability and scalability of critical CHW/P/R services, California must continue with the planned rate increase to complement the forthcoming grant program.

- **Restore Funding for ACEs Aware.** The Children's Partnership and the First 5 Association of California request expenditure authority of $50 million ($25 million Behavioral Health Services Fund and $25 million federal funds) annually. If approved, these resources would support restoration of the ACEs Aware initiative. According to the advocates, the ACEs Aware initiative was funded for three years and was not renewed in full for 2025-26 in the Governor's January budget proposal. Instead, it only afforded a no-cost extension of $5.4 million in remaining funds.

  California was the first state in the nation to implement a strategy to prevent the detrimental impacts of Adverse Childhood Experiences (ACEs) through the program ACEs Aware. At the programmatic level, ACEs Aware is a statewide provider education effort to support Medi-Cal providers with identifying and appropriately treating trauma. At a systemic level, ACEs Aware leverages the opportunity of well-child visits to screen children and their caretakers for a history of adversity, provide education and destigmatize stress responses to the family, and ultimately activate a network of community-based providers to respond to the social and emotional needs uncovered in these visits. This initiative has served as a model for newly established ACES projects across the country and is a

primary example of the state's innovative approach to prevention and early intervention for mental and behavioral health disparities in marginalized communities.

Research shows those who experience ACEs are at greater risk for several serious and chronic health conditions and events, and children from low-income communities of color, such as those who are served by Medi-Cal, experience ACEs at disproportionately higher rates. Recent estimates show unaddressed ACEs cost California $1.5 trillion annually in additional healthcare costs and lost healthy years.

The Medi-Cal provider payment for ACEs screenings is an important state investment in public health surveillance and promotes the health and well-being of children by identifying children who may be at risk for poor outcomes. To date, over 3 million ACE screenings have been facilitated for 1.8 million Medi-Cal members. However, screening is not itself an intervention service, but rather a brief interaction to determine the appropriateness of additional services. The full value of screening children for ACEs is realized when a provider trained on the physiologic effects of trauma and adverse experiences can appropriately educate patients and their families on the results of the screening and a community-based system of care is recruited to support a trauma-informed response to both clinical and social needs uncovered in the screening visit.

California's children and families are under escalating stress. The confusion, prolonged distress, and feelings of instability have been exacerbated by the incoming federal administration's use of anti-immigrant rhetoric, policies, and actions, which have threatened families who are at risk of immigration raids and family separation. Simultaneously, the devastating fires in Los Angeles threaten to deepen the state's homelessness crisis for hundreds of thousands of children and families, many of whom are from historically redlined Black communities in Altadena and Pasadena. We must act swiftly to protect impacted children and families from the toxic stress that, if left unaddressed, will inevitably develop from prolonged housing insecurity and the inherent trauma of witnessing and surviving a climate disaster that consumed their communities.

- **Multi-Year Continuous Medi-Cal Enrollment (MYCE) for Young Children 0-6.** A coalition of advocacy organizations, including The Children's Partnership, the American Academy of Pediatrics California, and Children Now, among others, request expenditure authority of $33 million ($16.5 million General Fund and $16.5 million federal funds) in 2025-26 and $66 million ($33 million General Fund and $33 million federal funds) annually thereafter. If approved, these resources would support implementation of multi-year continuous Medi-Cal enrollment for children ages zero to six. According to the advocates, Medi-Cal's pediatric preventive care rates, including well-child visits and screening rates are dismally low. The pandemic exacerbated these low rates. Well-child preventive care is critically important to early childhood development when 90 percent of brain development occurs. Because Medi-Cal is the primary source of coverage for children of color, Medi-Cal's low preventive care rates disproportionately deprives children of color of essential health services, exacerbating child health inequities.

  DHCS data indicates that about 10 percent of young children experience churn in their Medi-Cal coverage, namely they lose Medi-Cal coverage and then return. From the DHCS data, it appears the average coverage gap is 3 to 4 months. Procedural barriers, such as not providing documentation or not having updated contact information, are the predominant reasons for churn in early childhood. Studies demonstrate that inconsistent coverage leads to a higher likelihood of unmet medical needs

and a lower likelihood of having a usual source of care and access to well-childcare. These gaps in access are particularly consequential for the youngest children as experts recommend 14 well-child checks before age 6.

Parents and guardians report finding out their child has lost coverage when they are seeking care, which adds to the family's stress. For those requiring live-saving medications, even a short gap in coverage can be devastating. Disruptions in coverage result in forgone or delayed developmental screenings and delayed interventions and can often lead to huge out of pocket costs for the family. Between June 2023 and October 2024, 447,463 children lost Medi-Cal coverage and of those, 124,476 were aged 0-6.

To stabilize coverage and continuity of care, the proposal would provide multi-year continuous coverage for Medi-Cal children up to age 6. This is like the 12-month continuous Medi-Cal coverage children currently have, whereby children maintain coverage regardless of changes in eligibility within their first year of life. This proposal would extend that continuous coverage period until the child turns age 6.

- **Medi-Cal Reimbursement for Community Paramedicine, Triage to Alternate Destination, and Mobile Integrated Health Programs.** The California Professional Firefighters request annual General Fund expenditure authority of $5 million. If approved, these resources would support Medi-Cal reimbursement for community paramedicine, triage to alternate destination, and mobile integrated health programs, pursuant to SB 1180 (Ashby), Chapter 884, Statutes of 2024. According to the advocates, SB 1180 provided a structure for health plans, including Medi-Cal, to reimburse for services provided by community paramedicine, triage to alternate destination and mobile integrated health programs as they were not previously a reimbursable service. The provisions that apply to health plans regulated by DMHC and DOI go in to effect on July 1, 2025. The section that requires Medi-Cal to reimburse for these services are contingent upon a state appropriation to implement that section. This request would provide the state appropriation for this purpose.

- **Medi-Cal Benefit for Housing Support Services.** The Western Center on Law and Poverty and the Corporation for Supportive Housing request expenditure authority of $350,000 ($175,000 General Fund and $175,000 federal funds) in 2025-26, $26.6 million ($9.3 million General Fund and $17.3 million federal funds) in 2026-27, and $52.9 million ($18.5 million General Fund and $34.4 million federal funds) annually thereafter. If approved, these resources would support establishment as a Medi-Cal state plan benefit the housing transition navigation services, housing deposits, and housing tenancy sustaining services currently offered as community supports under the California Advancing and Innovating Medi-Cal (CalAIM) program. According to the advocates, Californians experiencing chronic homelessness die 20 to 30 years younger than their housed counterparts with similar conditions. Studies over the last 30 years prove housing support services allow Californians experiencing homelessness to exit homelessness for good, to improve their health conditions, and to decrease hospital admissions, emergency department use, and nursing home referrals. Access to these services reduces spending on acute care, avoiding future costs of over $46,000 per person per year. These services have been historically underfunded and unavailable to the majority of Californians experiencing homelessness.

  Acknowledging decreased costs and improved outcomes of housing support services, the Legislature and the Newsom Administration have committed resources to homelessness through health dollars. In

2016, state policymakers funded the first "Whole Person Care" pilot program that integrated physical and behavioral health, along with social services under Medicaid. The Department of Health Care Services (DHCS) enacted the Health Homes Program as well, to include housing support services.

Replacing the Whole Person Care and Health Homes programs, Medi-Cal managed care plans have had the option to offer Housing Transition and Navigation Services to help people connect to housing, Housing Deposits to pay for one-time move-in costs, and Housing Tenancy Sustaining Services to help people maintain housing stability (the "Housing Trio") as separate Community Supports to people experiencing or at risk of homelessness under California Advancing and Innovating in Medi-Cal (CalAIM) since 2022.

Funding from the Providing Access and Transforming Health, the Housing Homeless Incentive Plan, and the Incentive Payment Program, has led to development of a network of homeless service providers connected to Medi-Cal.

As funded under CalAIM as optional services managed care plans may choose to offer, the Housing Trio services are inconsistent, difficult to administer, underfunded, and often time-limited. The State is not maximizing federal funding for these services, unlike other states that receive a federal match of up to 90 percent (for the expansion population). Finally, providers struggle to offer services in connection to housing resources because of unstable, inconsistent approaches to funding services. Whereas state-funded housing requires commitments to services funding for as long as people need the services, current funding does not allow for this consistent source of services funding. Thousands more people receive Housing Transition Navigation services than receive services after they obtain housing.

The budget request would make the "Housing Trio" services (housing transition navigation services, housing deposits, and housing tenancy sustaining services) a benefit and would add evidence-based employment services as one of the housing tenancy sustaining services available to people once housed. As an entitlement, a benefit would require the state to set standard eligibility criteria applied statewide based on need, serving more people and serving people better. Promising results in other states make this an obvious solution for California. At least nine states, including North Dakota, Minnesota, Washington state, and Washington, D.C., have found this stable federal and state investment in supportive services helps bring people home faster. Further, standardization of a benefit, based on need, has proven extremely effective at achieving improved health.

- **Community Based Adult Services (CBAS) Program Rate Increase.** The California Association of Adult Day Services (CAADS) requests expenditure authority of $149.6 million ($74.8 million General Fund and $74.8 million federal funds) in 2025-26, $251.8 million ($125.9 million General Fund and $125.9 million federal funds) in 2026-27, and $375.6 million ($187.8 million General Fund and $187.8 million federal funds) annually thereafter. If approved, these resources would support reimbursement rate increases for CBAS programs to match program costs, and index the rate to inflation. According to the advocates, the cost of providing CBAS programming has at least tripled over the past 30 years, based on the federal consumer price index (CPI) for adult day services programs. However, the base rate published by DHCS has remained mostly flat, increasing by a net of about 50 percent over that period. The gap between actual costs and the published rate is now so great that about 90 percent of CBAS providers report operating at a deficit most months and are at a medium to high risk of closure.

Program closures are happening with regularity, reducing the state's already low capacity to serve adults with chronic medical conditions, dementia, and developmental disabilities.

This proposal would provide a rate increase, over three fiscal years, to move the published rate to the level of actual costs as calculated based on the federal CPI for the adult day services sector. Indexing the rate to the adult day services CPI going forward so that rates continue to grow with inflation, allowing for a sustainable level of access to the important services provided at CBAS centers.

- **Contingency Fund to Support Continued Reproductive and Transgender Health Care Services.** A coalition of seven LGBTQ and reproductive rights organizations, including Alliance for TransYouth Rights, Equality California, the Los Angeles LGBT Center, and Planned Parenthood Affiliates of California, among others, request General Fund expenditure authority of $100 million in 2025-26. If approved, these resources would support establishment of a contingency fund to preserve immediate access to sexual, reproductive, and gender-affirming health care in the event of federal action that would otherwise disrupt access to these services. According to the advocates, President Trump issued an Executive Order to prevent transgender youth under the age of 19 from accessing basic health care. The Executive Order directs agencies to take a range of actions to target care for transgender and gender-diverse young people, including blocking all federal funding for medical institutions, including hospitals and health centers, that offer care to transgender youth and rewriting regulations related to Medicaid, Medicare, and the Affordable Care Act to prohibit access to care. A loss of federal funding under this structure would make it virtually impossible for hospitals and health centers serving thousands of transgender young people to continue offering this care, and for some it would require closure.

  Similarly, President Trump's Executive Order enforcing the Hyde Amendment directs the Office of Management and Budget to provide guidance to agencies to prohibit the use of any federal funding for abortions. While the Hyde Amendment has been in place for decades, the Trump Administration has signaled their intent to expand the reach of the Hyde Amendment to severely restrict access to reproductive health care, even in access states like California. Any federal actions taken to implement these Executive Orders would necessitate swift action by the state to backfill the loss of federal funding and maintain uninterrupted access to essential, time-sensitive health care services.

- **Sustaining Medi-Cal Health Enrollment Navigation Services.** The California Primary Care Association Advocates, the Community Clinic Association of Los Angeles County, and Maternal and Child Health Access request expenditure authority of $54 million ($27 million General Fund and $27 million federal funds) in 2025-26, available through June 30, 2027. If approved, these resources would support continuation of health enrollment navigators services. According to the advocates, The Medi-Cal Health Enrollment Navigators project was established as part of the 2019 Budget Act. In 2022, SB 154 (Chapter 43, Statutes of 2022) allocated an additional $60 million ($30 million GF), for the project. In Los Angeles County, this project contracted with the Los Angeles County Department of Public Health (LAC DPH) to administer funds to 18 CBOs, including 7 CCALAC health centers, through a program currently known as Community Health Outreach Initiative (CHOI). An additional 24 health center entities across California received Navigation funding through SB 154. SB 154 navigation funding was cut from last year's state budget, which resulted in the loss of a significant portion of Los Angeles' Navigator infrastructure, and navigation service disruptions across the state.

Through the 2023 Budget Act, AB 102 (Chapter 38, Statutes of 2023), appropriated $10 million GF, with a federal match of $10 million, to DHCS to administer the two-year Health Enrollment Navigators Project for Clinics (Clinic Navigator Program) in an effort to increase the reach of longstanding navigation services funded by the state. CPCA administers the Clinic Navigator Program which provides health outreach and enrollment services at 107 health centers across 38 counties, supported by 10 regional associations. Program funding for the Health Enrollment Navigator Program for Clinics is set to end on June 30, 2025.

However, the need and demand for Health Enrollment Navigation services remains urgent, particularly in today's environment. Given the challenges posed by shifting federal policies and misinformation, particularly affecting immigrant and mixed-status families, LGBTQ+ communities, and those seeking reproductive health services, Health Enrollment Navigators will play a critical role in supporting these communities over the coming years.

Since the November election, community health centers (CHCs) and their CHOI community-based organization partners have seen an uptick in patients canceling appointments and expressing fear about staying enrolled in Medi-Cal and other public benefits programs. Health Navigators are the front-line staff that patients and community members go to with these concerns, including when considering whether even to apply for coverage. According to a January 2025 Kaiser Family Foundation report, under the first Trump Administration, uninsured rates among immigrant families and negative health impacts from fear and toxic stress increased based on changes to public charge rules and enforcement activities. For mixed status families, enrollment in public programs such as Medicaid, CHIP and SNAP declined twice as fast as U.S. citizen households between 2016-2019. Similar trends are anticipated over the coming years, particularly if Navigation funding is allowed to expire. Furthermore, current Congressional proposals to cut Medicaid program funding, with block grants, per capita caps, or such as the inclusion of work and work-reporting requirements, would only make Navigation services more critical to guide patients through administratively burdensome program changes.

- **Protect Medi-Cal Coverage Gains Through Permanent Extension of Unwinding Flexibilities.** Western Center on Law and Poverty, the Latino Coalition for a Healthy California, and The Children's Partnership request expenditure authority of $1.5 billion ($533.5 million General Fund and $967.5 million federal funds) annually. If approved, these resources would support permanent extension of Medi-Cal eligibility unwinding flexibilities. According to the advocates, Medi-Cal provides critical healthcare coverage for nearly 15 million low-income Californians, more than one-third of the state. California has made significant advancements in expanding health coverage, more than halving the uninsured rate from 15 percent in 2013 to 6 percent in 2022, due in large part to Medi-Cal coverage expansions. These coverage expansions are now threatened as an estimated 450,000 low-income Californians are at risk of losing their Medi-Cal coverage for paperwork reasons when the state chooses to end flexibilities on June 30, 2025.

  Federal unwinding flexibilities were designed to ensure that eligible people could maintain their healthcare coverage without facing significant administrative challenges as states began processing Medicaid redeterminations for the first time in three years. The flexibilities — which allow auto-verification of certain income and use of other data sources without enrollees needing to submit further documentation — have successfully reduced the number of people whose coverage has been terminated for paperwork reasons. If these critical flexibilities are allowed to expire, ongoing issues with enrollment, renewal, and churn will be exacerbated, threatening health coverage for millions of

low-income Californians who remain Medi-Cal eligible. This disproportionately impacts people who speak Spanish as their primary language, seniors 65 and over, and those with disabilities.

Maintaining the unwinding flexibilities is crucial in preserving access to health care, unnecessary coverage losses, and promoting health equity for Californians in need. We estimate the annual cost of maintaining the unwinding flexibilities is $1.5 billion in total funds ($533.5 million General Fund) the 2025 budget and ongoing based on the latest Medi-Cal estimates published by DHCS.

- **Medi-Cal Share of Cost Reform.** Western Center on Law and Poverty and Justice in Aging request expenditure authority of $6.9 million ($3.5 million General Fund and $3.5 million federal funds) in 2025-26 and $160.3 million ($80.2 million General Fund and $80.2 million federal funds) annually thereafter. If approved, these resources would support implementation of share of cost reform for seniors and persons with disabilities in the Medi-Cal program. According to the advocates, under current law, a disabled person, or person over the age of 65, with monthly countable income of $1,732 is eligible for free Medi-Cal, whereas another person with $1,733 in income must pay a $1,133 "share of cost" before they can receive coverage. The $1 difference in income between these two individuals creates a vast difference in the amount they must spend on healthcare thanks to the "share of cost cliff". One individual receives their health care coverage for free, the other must pay 65 percent of their monthly income on health care before obtaining coverage and live on just $600 a month to meet their basic needs.

  The share of cost cliff forces older Californians and Californians with disabilities to choose between paying their non-medical bills, such as rent, and receiving essential health care. This places older adults and people with disabilities at higher risk for hospitalization and institutionalization. It also harms families and in particular women who must reduce their hours or leave employment entirely to provide care unpaid, risking their own short and long-term economic security.

  Under California's "medically needy" program, persons 65 and older or who are disabled, and low-income families with income over the Medi-Cal limits for free care can obtain Medi-Cal coverage in a given month by paying a "share of cost". Share of cost is similar to a private health insurance deductible but the share of cost occurs monthly. An individual's share of cost is a set amount calculated by subtracting the "maintenance need income level" from their monthly income. For example, an individual who makes $1,900 per month would have a share of cost of $1,300, which is their income minus the $600 maintenance need level. They would need to pay $1,300 out of pocket in medical expenses before they could receive Medi-Cal coverage for that month. The maintenance need income level is defined as an amount of money that a medically needy person should reasonably be expected to need to pay their non-medical living expenses, such as food, housing, and clothing. This $600 amount has not been updated since 1989, despite the fact that the cost of living has increased greatly in the past three decades. Considering that $600 is just 46 percent of federal poverty level for 2025, it is impossible for an individual to meet their basic needs using only $600 a month—especially in California.

  California is one of 34 states that has a medically needy program. Of those states, ten have maintenance need income levels higher than California including Delaware, Illinois, Michigan, Minnesota, Montana, New York, North Dakota, Rhode Island, Utah, and Vermont.

  This proposal requests an increase in California's maintenance need income level to 138 percent of the federal poverty level, the current income cutoff for free Medi-Cal coverage, instead of the current

$600 which has been in effect for decades. This would also ensure that the amount is indexed appropriately along with the other income eligibility limits for Medi-Cal.

Increasing California's maintenance need income level to 138 percent of the federal poverty level, the current income cutoff for free Medi-Cal coverage, would eliminate the cliff people face. For example, an individual who makes $1,900 would have a monthly share of cost of $168 rather than $1300—a more appropriate cost to obtain Medi-Cal coverage for individuals who have incomes just over the limit for free coverage.

- **Los Angeles County Abortion Safe Haven Pilot Program Renewal and Center on Reproductive Health, Law and Policy Funding Renewal.** Planned Parenthood Affiliates of California and Essential Access Health request General Fund expenditure authority of $25 million in 2025-26. If approved, these resources would support funding renewal for the Los Angeles County Safe Haven Pilot Program and the Center on Reproductive Health, Law and Policy. According to the advocates, in 2022, the state made crucial investments in reproductive health care as federal protections for abortion rights were under attack. With the Supreme Court's decision to overturn *Roe v. Wade*, access to abortion has been left to the discretion of individual states, heightening the importance and urgency of state-led initiatives. One of the most significant investments was $20 million to establish the Los Angeles County Safe Haven pilot program, which designated Los Angeles as a "safe haven" for people seeking abortion care, recognizing the important role that LA plays as an access hub in a post-*Roe* landscape. This program has been instrumental in ensuring access to critical reproductive health services for both Californians and people forced to travel to California from states with restrictive laws.

  The LA Safe Haven program has welcomed two cohorts of grantees and awarded $16.47 million to fund 35 two-year projects that support abortion access through clinical care expansions, public awareness and education campaigns, legal support, direct practical support, provider training, research, security, and infrastructure. Demand for this program has far exceeded the funding available. For example, in the 2024 RFP cycle, Essential Access Health, the program administrator, received more than $13.5 million in funding requests but was only able to award about $4.2 million. This proven successful program will be discontinued if additional state funding is not secured.

  Further, in January 2025, Los Angeles County experienced catastrophic wildfires that severely disrupted the region's health care infrastructure. The fires forced the closure of key safety-net health care providers, displacing patients and cutting off essential services. Many health centers serving vulnerable populations were forced to close, some permanently. For example, Planned Parenthood of Pasadena and San Gabriel Valley lost access to its administrative building due to fire damage. Los Angeles County is home to 28 percent of California's population but accounts for over one-third of all abortions performed in the state. This disproportionate need underscores the importance of sustained investment in the LA Safe Haven program, especially in the aftermath of a natural disaster that has made access even more precarious.

  The Center on Reproductive Health, Law, and Policy (CRHLP) is a nationwide think tank and interdisciplinary research center created in 2021 through the budget with a $5 million investment, followed by an additional $2 million in 2023. In the face of the second Trump administration, the CRHLP has and will continue to do vital work to increase access to abortion and contraception, end disparities in maternal health outcomes, support people who decide to build families, and dismantle

gender biases limit reproductive justice. Since inception, CHRLP has greatly expanded its workload, policy areas covered, staffing, and cost. This proposal requests an allocation of $5 million to keep the UCLA CRHLP funded for an additional two years, without which CHRLP will run out of money by the Fall of 2025. The CRHLP is an example of how California's premier public institutions lead the nation by blending long-term strategy, concrete legal advancement and services, and research work to build the legal and policy innovations that this Legislature, as well as health care providers and advocates across the nation, rely on for rapid response and future change.

- **Backfill Loss of Title X Federal Family Planning Funds.** Essential Access Health requests General Fund expenditure authority of $15 million in 2025-26. If approved, these resources would support state backfill of potential loss of federal Title X family planning funds due to Congressional action or actions of the new federal Administration. According to the advocates, the Title X Federal Family Planning Program in California is the largest and most diverse Title X system in the nation. At present, the network includes 350 health centers including City and County Health Departments, federally qualified health centers, Urban Indian Health Centers, university and hospital clinics, Planned Parenthood affiliates, and stand-alone women's health and family planning providers. Data reported to the federal Office of Population Affairs showed that collectively Title X-funded health centers served more than 500,000 patients in 2024. Approximately 85 percent of patients served in California have a household income less than 151 percent of FPL. While state programs such as Medi-Cal and Family PACT reimburse for clinical care provided by some members of the health care team for income-eligible patients, Title X funds are leveraged for non-reimbursable health services provided, community outreach and education, and wraparound services to fill gaps in the family planning safety net.

  In the current federal Administration, swift and severe cuts and changes to the program are expected in the coming months, which would have a devastating impact on patient care. Title X plays an integral role in strengthening the public health safety net by providing funds for health educators, community outreach and education, youth programs, mobile clinics, infrastructure and more. Funding cuts or changes to Title X would exacerbate provider and staffing shortages; increase wait times for patients; eliminate adolescent and teen-friendly clinic hours; reduce frequency of same-day/on-site family planning services; and reduce capacity for drop-in appointments. Some Title X health centers may be forced to leave the network.

  In 2019, harmful Title X regulations took effect which interfered with the provider/patient relationship, denied patients complete and unbiased information about their pregnancy options, placed restrictions on abortion referrals, and enacted extreme rules requiring physical separation of abortion and family planning services. Prior to the implementation of these regulations, California's Title X network served roughly one million patients each year. Once the rules were fully in effect, the number of patients served annually dropped to under 200,000 in 2020, a devastating decrease of more than 80 percent. Simultaneously, some networks of fake clinics (sometimes called crisis pregnancy centers) were awarded Title X funds, while denying funds to legitimate health care providers.

  When new rules were enacted in 2022, many providers and health centers were able to return to the Title X network, and are Title X-funded health centers are serving increasingly more patients with family planning and preventive care year over year. However, because Title X has been flat-funded for a decade, California suffered a 40 percent funding cut in 2022 and every year since. This is the largest cut to Title X funds that California has received in the history of the program.

To help offset these cuts, in 2022, California invested $10 million to help keep California's statewide Title X funding and provider network whole, and maintain the core staff, infrastructure, and training and outreach programs that increase access to sexual and reproductive health care and information throughout California. These funds made a significant difference in supporting the delivery of equitable and high-quality time-sensitive services statewide, and Title X, combined with Medi-Cal and Family PACT, continues to play an essential role in continuing to reduce unintended pregnancy rates and support sexual and reproductive health and well-being statewide.

Given the threats to the Title X program and understanding the vital role that Title X funding plays in our state's public health safety net, this proposal is urgently requesting $15 million in funding to backfill any loss of Title X federal family planning funds.