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, May 1st, 2025
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultants: Nora Brackbill and Scott Ogus

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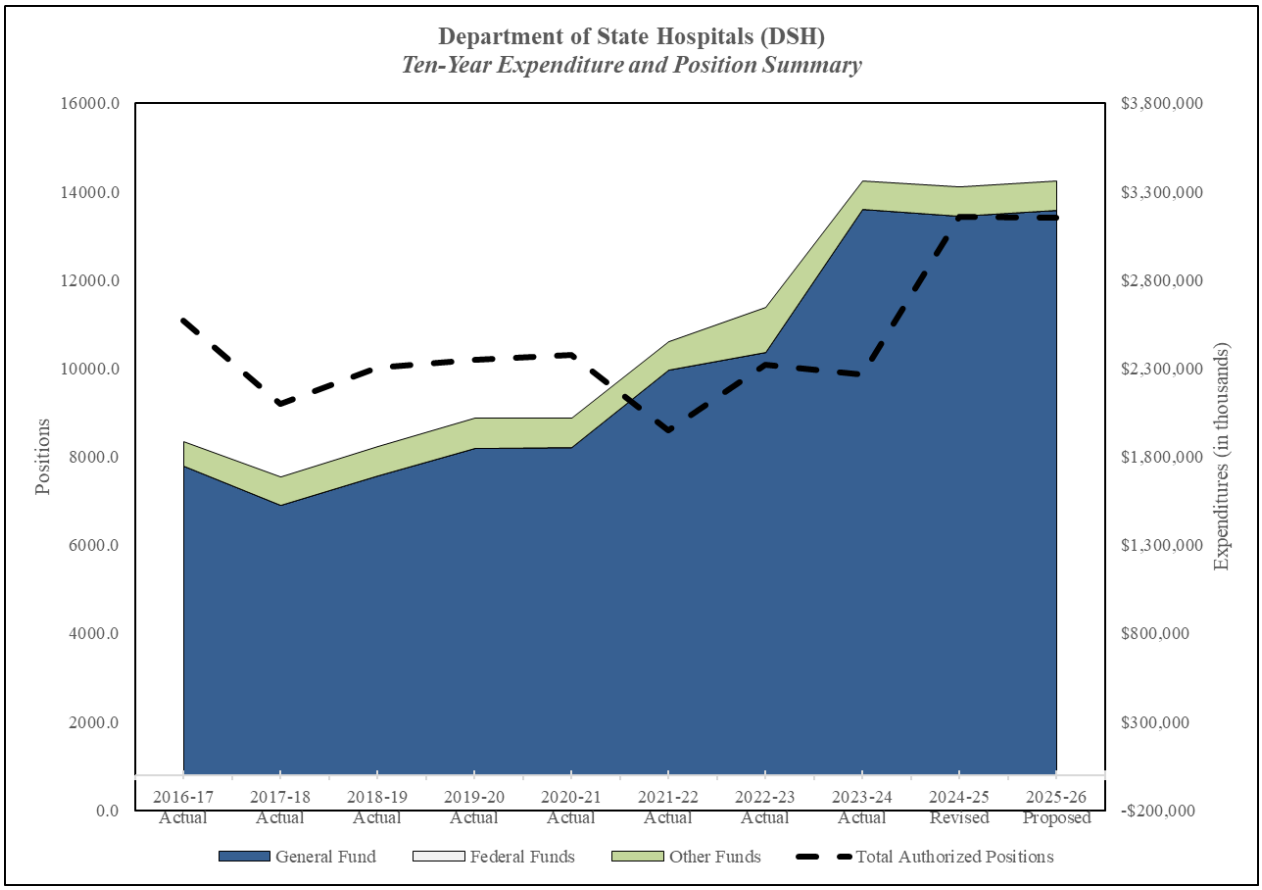
PUBLIC COMMENT

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview



Department of State Hospitals - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2022-23 Actual**	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$2,388,626	$3,138,663	$3,160,309	$3,192,563
Federal Funds	$0	$100	$100	$100
Other Funds	$254,704	$165,346	$165,346	$165,346
Total Department Funding:	**$2,643,330**	**$3,304,109**	**$3,325,755**	**$3,358,009**
Total Authorized Positions:	**10090.8**	**13437.0**	**13437**	**13412**
Other Funds Detail:				
CA State Lottery Education Fund (0814)	*$59*	*$21*	*$21*	*$21*
Reimbursements (0995)	*$192,784*	*$165,325*	*$165,325*	*$165,325*
CA Emergency Relief Fund (3398)	*$61,861*	*$0*	*$0*	*$0*

Background. DSH is responsible for a total patient population of 8,323 individuals, of which 5,762 are housed in five state hospitals, 1,016 are on conditional release, and the remainder are in a variety of contracted programs. The majority of the population is forensic (referred through criminal justice involvement), making it the largest inpatient forensic mental health hospital system in the nation. In addition, DSH admits individuals civilly committed under the Lanterman-Petris-Short (LPS) Act. DSH is funded through the General Fund and reimbursements from counties for the care of LPS patients, as shown in the table above. A table of population by commitment type and hospital is included below.

Commitment Types. The categories of individuals admitted to state hospitals for treatment are:

- *Incompetent to Stand Trial (IST).* IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once they are able to participate in court proceedings.

- *Not Guilty by Reason of Insanity (NGI).* NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- *Offenders with a Mental Health Disorder (OMD).* OMD patients are parolees who meet the following six criteria for OMD classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. OMD commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- *Sexually Violent Predators (SVP).* SVP commitments are civil commitments of individuals released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- *Lanterman-Petris-Short (LPS).* LPS patients are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability, and require physically secure, 24-hour care. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- Coleman *Class Patients (Mentally Ill Prisoners). Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum

benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as an OMD.

- *Conditional Release Program (CONREP).* CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

State Hospitals. The five state hospitals operated by DSH are:

- *DSH-Atascadero*. DSH-Atascadero opened in 1954 on the Central Coast in San Luis Obispo County, and is a forensic mental health hospital with a secure perimeter. It has an all-male population consisting primarily of OMD, *Coleman*, IST, and NGI commitments. The budget includes $387 million and 2,285.9 positions for DSH-Atascadero. As of November 1, 2024, the vacancy rate at DSH-Atascadero was 24.4 percent.

- *DSH-Coalinga.* DSH-Coalinga opened in 2005 in the Central Valley in Fresno County, and is a forensic mental health hospital with a secure perimeter. It has an all-male population primarily consisting of SVPs, OMD, and *Coleman* patients. CDCR provides perimeter security and transportation. The budget includes $423 million and 2,491.5 positions for DSH-Coalinga. As of November 1, 2024, the vacancy rate at DSH-Coalinga was 21.5 percent.

- *DSH-Metropolitan*. DSH-Metropolitan opened in 1916 in Norwalk in Los Angeles County, and has an open-style campus with a secure perimeter. Due to concerns from the community, DSH-Metropolitan does not accept patients charged with murder or a sex crime, or at high risk for escape. DSH-Metropolitan primarily serves the following four patient commitment types: LPS, IST, OMD, and NGI, and recently completed a project to increase its secure bed capacity. The budget includes $268 million and 2,231.3 positions for DSH-Metropolitan. As of November 1, 2024, the vacancy rate at DSH-Metropolitan was 18.2 percent.

- *DSH-Napa*. DSH-Napa is the first state hospital, and opened in 1875. Most of the hospital is a forensic mental health hospital, with an open-style campus with a secure perimeter. DSH-Napa primarily serves LPS, IST, OMD, and NGI patients. The budget includes $418 million and 2,651.2 positions for DSH-Napa. As of November 1, 2024, the vacancy rate at DSH-Napa was 26.1 percent.

- *DSH-Patton*. DSH-Patton opened in 1893 in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an open-style campus with a secure perimeter. Due to concerns from the community, CDCR provides perimeter security and transportation. DSH-Patton primarily serves LPS, IST, OMD, and NGI patients. The budget includes $450 million and 2,551.2 positions for DSH-Patton. As of November 1, 2024, the vacancy rate at DSH-Patton was 10.3 percent.

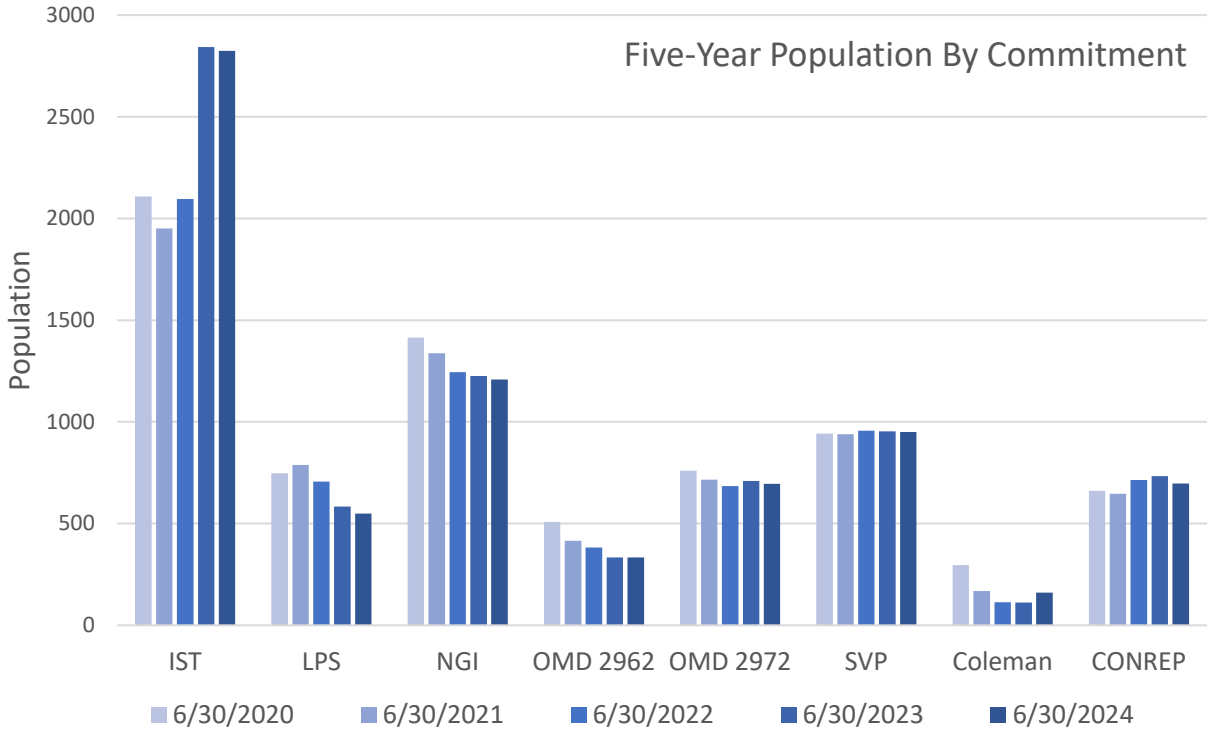
In addition to the five state hospitals, DSH provides services through contracted Jail-Based Competency Treatment, Community-Inpatient Facilities, Conditional Release Program, Community-Based Restoration, and pretrial felony mental health diversion programs.

Population. The population by commitment and placement are outlined in the table below.

	July 1, 2024 Actual Census	June 30, 2025 Projected Census	June 30, 2026 Projected Census
POPULATION BY HOSPITAL			
Atascadero	1,020	1,131	1,131
Coalinga	1,300	1,300	1,300
Metropolitan	847	929	929
Napa	1,069	1,078	1,078
Patton	1,314	1,324	1,324
TOTAL BY HOSPITAL	**5,550**	**5,762**	**5,762**
POPULATION BY COMMITMENT			
Coleman – Penal Code (PC) 2684	159	270	270
IST - PC 1370	1,659	1,741	1741
LPS & PC 2974	547	556	556
NGI - PC 1026	1,208	1,212	1,212
OMD - PC 2962	333	336	336
OMD - PC 2972	694	697	697
SVP - Welfare and Institutions Code 6602/6604	950	950	950
TOTAL BY COMMITMENT	**5,550**	**5,762**	**5762**
CONTRACTED PROGRAMS			
Jail Based Competency Treatment	362	441	488
Community Based Restoration/Diversion	626	910	1033
Community Inpatient Facilities	175	194	228
TOTAL - CONTRACTED PROGRAMS	**1,163**	**1,545**	**1,749**
CONREP PROGRAMS			
CONREP SVP	19	31	31
CONREP Non-SVP	565	692	692
CONREP FACT Program	54	90	90
CONREP STEP Down Facilities	63	203	203
TOTAL - CONREP PROGRAMS	701	1,016	1,016
POPULATION AND CONTRACTED TOTAL	**7,414**	**8,323**	**8,527**
Total IST Population (State Hospitals, JBCT, CBR, and CIF; excludes CONREP)	**2,822**	**3,286**	**3,490**

***Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*[1]

[1] https://www.dsh.ca.gov/About_Us/docs/DSH_2025-26_Governor's_Budget_Estimate_Binder.pdf

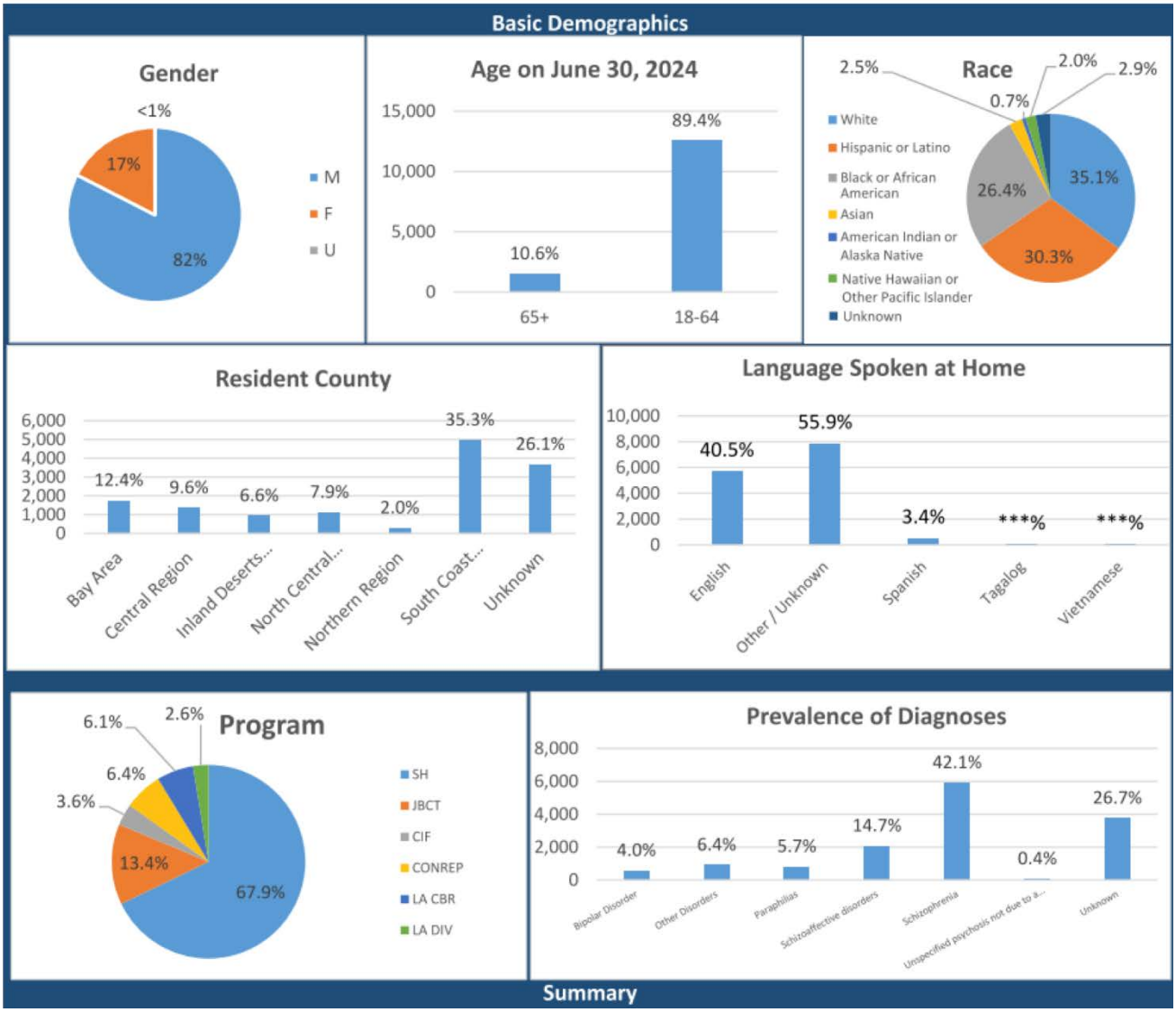


***Data Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*

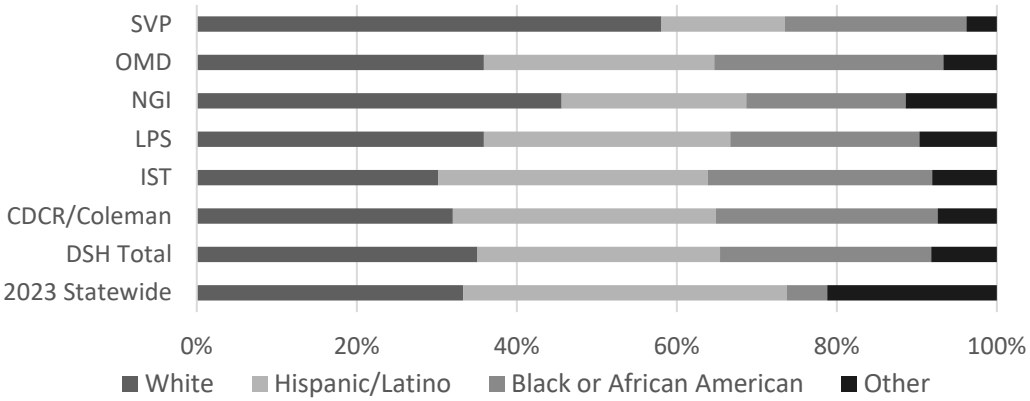
Patient Demographics.

As of June 30, 2024, the DSH population is approximately 82 percent male and 17 percent female, with 89.4 percent of the population between the ages of 18 and 64. The proportion of patients over the age of 65 is increasing, reaching 17 percent in 2023-24 compared to 13 percent in 2019-20. Approximately 35 percent identify as White, 26 percent Black, and 30 percent Hispanic, with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. Schizophrenia, Schizoaffective, and Bipolar-type disorders are the three most common diagnoses for the DSH population, accounting for approximately 83 percent of the population with known diagnoses. The following two charts show a demographic summary for the entire population, and racial demographics by commitment type.

State Hospital Demographic Snapshot: All Commitment Types



Racial Demographics by Commitment Type



***Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*

Operations and Vacancy Reductions. The Budget Act of 2024 included two control sections aimed at improving government efficiencies across state government: Control Section (CS) 4.05, which authorizes the Department of Finance (DOF) to reduce state operations expenditures up to 7.95 percent in fiscal year 2024-25 and ongoing, and CS 4.12, which authorizes DOF to adjust items of appropriation to achieve savings associated with vacant positions in 2024-25 and propose the elimination of vacant positions to achieve ongoing savings beginning in 2025-26.

On January 10, 2025, the DOF provided a letter outlining reductions taken under these control sections. According to this letter, DSH has taken ongoing reductions of $20.4 million General Fund and 171 positions related to CS 4.12, and $8.8 million General Fund related CS 4.05. Many of the positions are associated with closed units at various hospitals, as well as some headquarters positions. DSH is requesting 13,412 positions for 2025-26, and reported an average vacancy rate of 23.0 percent in 2023-24.

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee requests DSH respond to the following:

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

2. Please describe the impact of the state operations and vacancy reductions on DSH's budget and operations.

Issue 2: Program and Caseloads Updates

Program and Caseload Updates – Governor's Budget. DSH requests resources to support the following program and caseload updates in its 2025-26 Governor's Budget Estimate.

Background.

Program Update – Metropolitan Increased Secure Bed Capacity. DSH reports one-time savings of $4.4 million in 2024-25 due to delays in the DSH-Metropolitan Increased Secure Bed Capacity project. This project was initiated in 2016 to address the increase in the IST patient waitlist. Five units have been constructed, but two of them are currently being used to house patients who had to be relocated due to a separate renovation project. DSH anticipates that project will be completed in early 2025, enabling the relocation of those patients, and the activation of those units to serve IST patients. This timeline is delayed by three months compared to the 2024 budget, resulting in current year savings of $4.4 million.

Program Update – Patient-Driven Operating Expenses and Equipment. DSH uses a standardized methodology to provide funding for patient-related operating expenses and equipment (OE&E), adopted in the 2019 budget. OE&E categories include utilities, clothing, food, pharmaceuticals, and other population-driven expenses. The proposed budget includes $21.7 million in 2024-25 and ongoing for increased expenses in Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization. The per-patient cost changes from fiscal year 2022-23 to 2023-24 are outlined in the table below. The amount requested was calculated using the increase in per patient cost from the table below ($3,936.70) and adjusting for the population level.

Budget Categories	2022-23 Avg. Cost Per Patient	2023-24 Avg. Cost Per Patient	Percentage Change
State Hospital Census	*5,689*	*5,550*	*-2%*
Utilities	$4,987	$5,132	3%
Outside Hospitalization	$8,027	$11,009	37%
Foodstuffs	$4,469	$4,705	5%
Pharmaceuticals	$7,620	$8,195	8%
Total	**$25,103**	**$29,040**	16%

***Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*

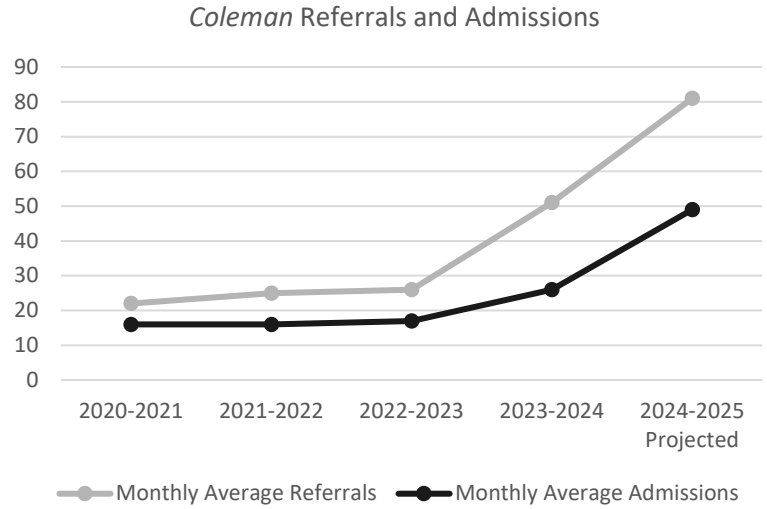
New Item – Increased* Coleman *Referrals. The Governor's budget includes three positions at DSH (authority only) in 2025-26 and ongoing to address increased workload related to referral intake for *Coleman* patients.

Coleman v. Newsom is a class action lawsuit filed in 1990 on behalf of all California state prisoners with serious mental illness. In 1995, the federal court found that prison officials violated the cruel and unusual punishment clause of the Constitution by not providing adequate mental health care. The court issued an injunction requiring major changes in the prison mental health system, and approved CDCR's remedial plan for providing mental health care. The court also appointed a Special Master who, among other things, monitors and reports on CDCR's compliance with the plan. As of January 13, 2025, there are 35,227 incarcerated individuals included in the *Coleman* class.

In some cases, individuals who are part of the *Coleman* class may be transferred from CDCR to DSH for treatment, pursuant to Section 2684 of the Penal Code. DSH has a total of 336 beds at three hospitals designated for *Coleman* patients (DSH-Atascadero – 256 beds; DSH-Coalinga – 50 beds; DSH-Patton – 30 beds, females only). Treatment for *Coleman* patients is focused on psychiatric stabilization, with the expectation that they will return to CDCR.

The criteria for referrals is outlined in CDCR's Mental Health Services Delivery System Program Guide[2], which was developed in agreement with the *Coleman* court. However, transfers have been limited due to DSH's unlocked dorm settings. In recent years, CDCR and DSH have worked with the Special Master to increase utilization of DSH's beds for *Coleman* patients. This resulted in removing the requirement to have a clinical recommendation for an unlocked dorm setting, and performing regular reviews of individuals housed in CDCR's psychiatric inpatient programs, among other changes. This lead to a significant increase in referrals and admissions from 2022-23 to 2023-24, as shown in the graph below.

In addition, DSH and CDCR recently implemented three proposals to increase utilization of DSH's *Coleman* beds: a long-term program for *Coleman* individuals who are not able to reintegrate into CDCR's outpatient programs, an admissions unit to help individuals transition from CDCR's custodial setting to DSH dorms, and expanding DSH reviews to custody classifications that have historically been ineligible for DSH placement (such as life without parole). As shown in the graph below, these changes collectively are expected to result in continued increases in *Coleman* referrals and admissions in 2024-25.



***Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*

Referrals to DSH are processed by the Patient Management Unit, pursuant to Section 7234 of the Welfare and Institutions Code. *Coleman* referrals have a court-mandated timeline (with financial penalties) for processing and admitting patients, and are currently handled by three positions: a senior psychologist, a nurse consultant, and an AGPA. DSH is requesting three positions (two AGPAs and one Chief Psychologist; authority only) in 2025-26 and ongoing to address increased workload related to referral intake for *Coleman* patients.

[2] https://cchcs.ca.gov/wp-content/uploads/sites/60/2021-Program-Guide-2.1.22.pdf

Program Update – Forensic Conditional Release Program (CONREP) General/Non-Sexually Violent Predator (Non-SVP) Program. The Forensic Conditional Release Program (CONREP) was established in 1986 to provide outpatient treatment to NGI, OMD, and IST patients. Courts may order patients to be released under CONREP if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released. Historically, CONREP has been primarily outpatient treatment, but has expanded to include residential placements in Statewide Transitional Residential Programs (STRPs), and Forensic Assertive Community Treatment (FACT) Programs, which are mobile teams that deliver services to clients at their residences.

As of the 2025-26 Governor's budget, DSH anticipates a total contracted caseload of 985 CONREP clients in 2024-25 and 2025-26, with an average census of 743 in 2024-25 and 877 in 2025-26, reflecting activation and phase-in timelines. This contracted caseload includes 692 clients placed in settings without dedicated beds, and the following current and planned dedicated beds to the program:

- STRP – 55 beds
    - 20 beds in Northern CA, closed in December 2024
    - 35 beds in Southern CA

- FACT – 90 beds
    - 30 beds in Northern CA (Sacramento County)
    - 30 beds in Southern CA (San Diego County)
    - 30 beds anticipated to activate in Northern CA (TBD) in Spring 2025

- Institute for Mental Disorder – 168 beds
    - 30 beds in Northern CA
    - 78 beds in Southern CA
    - 60 beds anticipated to activate in Northern CA in Spring 2025

CONREP providers have experienced challenges in hiring and retaining staff, which contributed to the closures of a 30-bed FACT program in Alameda County and the Northern CA STRP, and to reduced admissions at the 30-bed Northern CA IMD facility. Together, these changes resulted in savings of $3.6 million in 2024-25.

Program Update – Contracted Patient Services, Incompetent to Stand Trial (IST) Solutions. The Governor's budget reflects one-time savings of $237.5 million in fiscal year 2024-25, $82.1 million in 2025-26, and $78.9 million in 2026-27, largely due to updated timelines for activating new community-based IST programs. DSH proposes to use $6.0 million in IST savings to fund 23 ongoing positions, including one new position to support data collection related to Felony Mental Health Diversion, and the extension of 22 existing, limited-term positions to support Re-evaluation Services for Felony IST Program, described below.

IST Resources (dollars in thousands)

Description	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28 and Ongoing
Current Service Level Total	**$771,377**	**$933,295**	**$1,061,768**	**$932,295**
Community Inpatient Facilities	$145,526	$145,526	$274,999	$145,526
2025-26 Governor's Budget	($52,104)	$9,738	($39,936)	$59,537
Re-Evaluation	$10,176	$1,000	$1,000	$1,000
2025-26 Governor's Budget	($12,391)	$8,928	$10,800	$10,900
IST Solutions[17,18]	$499,780	$659,774	$658,774	$658,774
2025-26 Governor's Budget	($131,361)	($62,964)	($49,238)	($69,238)
JBCT	$115,895	$126,995	$126,995	$126,995
2025-26 Governor's Budget	($41,661)	($37,935)	($551)	($551)
TOTAL	**$683,343**	**$914,431**	**$982,843**	**$932,943**

Source: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025
IST Solutions includes funding for Early Access and Stabilization Services (EASS), Care Coordination and Waitlist Management (CCWM), Community-Based Restoration (CBR) and Diversion, Alienist Training, Increased Conditional Release Program (CONREP) Placements, and Discharge Planning/County Care Coordination.

DSH reached a high of 1,953 IST patients on the pending placement list as of January 2022, and is now down to 359 as of January 1, 2025. DSH does not anticipate the waitlist to decrease much further, as they received an average of 490 referrals per month in 2023-24 (an increase of 42 percent compared to 2020-21). DSH is court-ordered to provide substantive treatment services within 28 days of a patient being transferred to DSH's responsibility, effective March 1, 2025. As of October 2024, DSH provided services within 28 days for 94.1 percent of IST patients. Of the individuals on the pending placement list, 125 are already receiving substantive treatment services through Early Access and Stabilization Services or other treatment programs, described below.

Both the easing of pandemic-related restrictions and the implementation of various IST solutions, including increasing bed capacity, changes to decrease the average length of stay, and implementing community-based and jail-based programs, among others, contributed to DSH reducing the IST waitlist and achieving the court-ordered timelines. Some of the contracted programs include:

- *Community Inpatient Facility (CIF).* DSH currently contracts with five CIF programs for a total of 197 beds throughout California, and has executed construction contracts to create a 40-bed program in Fresno County and a 198-bed program in San Bernardino County.

- *Early Access to Stabilization Services (EASS).* DSH operates 55 EASS programs statewide, which provides treatment and stabilization to individuals deemed IST on felony charges in jail. EASS programs have served a total of 5,620 patients.

- *Community-Based Restoration (CBR) and Felony IST Diversion.* DSH is in the process of developing CBR and Felony IST Diversion programs. There are currently 29 county pilot diversion programs operating through June 2025, and contracts are in progress to create 26 permanent programs. DSH is requesting one new position to support increased data collection required for the permanent programs.

- *Jail-Based Competency Treatment (JBCT).* DSH contracts with county sheriffs' departments to operate 424 JBCT beds across 24 counties, and plans to expand further. JBCT programs provide

restoration of competency treatment services to lower acuity IST patients while they are in county jail. Delayed activations of JBCT have contributed to the one-time savings in 2024-25, 2025-26, and 2026-27.

The 2022 budget also established a county growth cap on IST referrals. If counties exceed the cap, a penalty is assessed, which the county may use for upstream efforts to reduce future IST referrals. In 2022-23, 11 counties exceeded their 2021-22 baseline, resulting in a total of $22.6 million in growth cap payments. DSH and the counties are in the process of reconciling and correcting 2023-24 IST data, which will be used to calculate the next round of growth cap penalties.

DSH also re-evaluates patients who have been placed on the IST waitlist to identify individuals already returned to competency through treatment in jail and/or identify candidates for diversion, involuntary medication orders (IMOs), or other programs or approaches. As of the 2025-26 Governor's budget, DSH has completed a total of 7,999 evaluations, of which 5,430 (67.9 percent) were found not competent and continued competency restoration treatment, 2,536 (31.7 percent) were found restored to competency, and 33 (less than 1.0 percent) were found unlikely to be restored to competency. In fiscal year 2023-24, approximately 15 percent of participants were identified as needing IMOs, and of those screened for diversion, approximately 82 percent were referred. The Re-Evaluation Program also provides support to forensic evaluation services within the DSH-operated inpatient and outpatient CBR programs. This program was authorized in the Budget Act of 2021 for four years. The proposed budget would redirect savings from IST solutions to support 22.0 positions (authority only) in 2025-26 and ongoing to support the ongoing Re-Evaluation Services for Felony IST Program, which would otherwise end in June 2025.

Potential Updates Expected at May Revision. DSH identified the following areas as potentially needing updates at the May Revision.

- *Program Update – Forensic Conditional Release Program (CONREP) Sexually Violent Predator (SVP) Program.* DSH projects a caseload of 31 persons designated as SVP to be conditionally released into the community as of June 30, 2026. CONREP-SVP is similar to general CONREP with some additional requirements, such as mandated sex offender risk assessments and GPS tracking, among others. The average timeframe from petition to placement has increased to 22 months, largely due to difficulties securing housing due to community opposition and new requirements pursuant to SB 1034 (Atkins), Chapter 880, Statutes of 2022.

- *Program Update – County Bed Billing Reimbursement Authority.* DSH bills counties a daily rate for some patients being held on a county's behalf, including LPS patients and, in some cases, Non-Restorable/Maximum-Term IST defendants who are not returned to the county in a timely manner. As of the 2025-26 Governor's budget, DSH was in negotiations with counties regarding a proposed increase to the daily bed rate, which may lead to a need to adjust the County Bed Billing Reimbursement Authority at May Revision.

- *Staffing.* In 2013, DSH initiated the Clinical Staffing Study, which resulted in a standardized staffing methodology that was adopted in the Budget Acts of 2019 and 2020. DSH is not requesting changes in position or expenditure authority associated with staffing in the current year, but may proposed changes for the budget year as part of May Revision. In particular, DSH notes the DSH Coalinga Intermediate Care Facility project, capacity increases (particularly for IST units) at DSH-

Metropolitan, and changes in the population at DSH-Atascadero as potentially driving changes in future staffing.

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

Questions. The Subcommittee requests DSH respond to the following:

1. Please provide a brief overview of each of the program and caseload updates referenced in this item.

2. What is the current status of IST CBR and diversion programs, including how many temporary and permanent programs are currently in operation?

3. Please describe the reasons for the savings in the IST and CONREP programs.

4. Please describe the strategies taken to increase utilization of the *Coleman* beds.

5. Staffing is a challenge across DSH's entire continuum of care, from contracted programs to the hospitals. Please describe the steps DSH is taking to support workforce development.

Issue 3: Facilities and Planning

Proposal. The proposed budget includes the following resources for facilities and planning at DSH:

- *Napa: Electrical Infrastructure Upgrade*. $2.8 million General Fund for the preliminary plans phase of the DSH-Napa Electrical Infrastructure Upgrade project. This project includes replacing the existing transformer, substation, utility feeder lines, facility transformers, and switch gear, and installing emergency generators.

- *Statewide Project Management*. 12.0 positions (authority only) in 2025-26 and ongoing to convert contract positions to civil staff positions to address workload related to an increase in projects managed by the Facility Planning, Construction & Management (FPCM) section at DSH.

Background. The Administration's proposed five-year infrastructure plan includes $300.2 million ($217.1 million General Fund and $83.1 million Public Buildings Construction Fund) over the next five years for DSH to: (1) address electrical, water, and utility plant deficiencies at Atascadero, Metropolitan, Napa, and Patton State Hospitals, (2) provide a skilled nursing facility at Coalinga to address the aging population, and (3) renovate patient housing at Metropolitan for civilly-committed patients. The funding requested for 2025-26 is described below.

Napa Electrical Infrastructure Upgrade. According to DSH, the electrical power infrastructure at DSH-Napa is roughly 50 years old. Upgrading this system will facilitate ongoing maintenance, help manage peak loads (such as during heatwaves), and provide emergency generator capacity for use during power outages.

Total project costs are estimated at $89.3 million which includes: preliminary plans ($2.8 million), working drawings ($5.5 million), and construction ($80.9 million). The construction amount includes $69.9 million for the construction contract, $4.9 million for contingency, $5.4 million for architectural and engineering services, and $731,000 for other project costs. The current project schedule estimates preliminary plans to commence July 2025 and be completed in October 2026. Working drawings are scheduled to begin in November 2026 and be completed in August 2028. Construction is scheduled to begin in September 2028 and be completed in March 2032.

Statewide Project Management. FPCM coordinates facility, capital outlay, deferred maintenance, and special repair projects statewide for DSH's facilities, which comprise more than 6.6 million square feet of space on 2,600 acres of land. According to DSH, FPCM is currently responsible for 118 active projects which are in various phases of development and construction. These include new types of projects such as information technology infrastructure, energy efficiency upgrades, solar photovoltaic, and electric vehicle charger projects that are recent additions to FPCM's portfolio. This workload has resulted in the use of contracted construction managers, in addition to nine staff currently at FPCM (eight Associate Construction Analysts and one Direct Construction Supervisor II). The department is proposing to redirect the resources used for the contract positions to support 12 civil service positions to cover all DSH projects.

Subcommittee Staff Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

2. Please describe the reasons for the increased project management load.

3. Please describe DSH's long-term infrastructure plans, given the increasing facility needs.

Issue 4: Enhanced Treatment Program Trailer Bill Language and Staffing Update

Trailer Bill Language and Program Update – Governor's Budget. The Governor's budget includes proposed statutory changes to extend the Enhanced Treatment Program (ETP) pilot to January 1, 2030. The proposed budget also reflects savings of $571,000 in 2024-25 due to a delay in activation of the DSH-Patton ETP.

Background. The Enhanced Treatment Program (ETP) pilot was established by AB 1340 (Achadjian), Chapter 718, Statutes of 2014, in response to increases in violent incidents within the state hospitals. ETPs provide additional treatment and enhanced security for patients at high risk of violence, with the goal of eventually returning them to a standard treatment environment. DSH currently operates a 13-bed ETP unit at DSH-Atascadero, which serves male patients, and is nearing the completion of a 10-bed ETP unit at DSH-Patton, which will also serve female patients. DSH anticipates this unit will be completed in April 2025 and activated in June 2025, a nine-month delay from what was reported at the 2024-25 May Revision, resulting in one-time savings of $571,000. The statutory language authorizing the ETP pilot remains in effect for each pilot site until January 1 of the fifth calendar year after the site admits its first patient, pursuant to Section 1265.9 of the Health and Safety Code. For DSH-Atascadero, this would be January 1, 2026. The proposed trailer bill language would extend the authorization for both sites until January 1, 2030.

ETP Activation Timeline			
Units/Hospital	**Scheduled Initiation**	**Scheduled Completion**	**Delay from 2024-25 May Revision**
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	July 2021 (Actual)	N/A
DSH-Patton Unit U-06	December 2023	April 2025	9-month delay

***Source**: 2025-26 Governor's Budget Estimate, Department of State Hospitals, January 2025*

Admission and Evaluation. The criteria and process for both admission to an ETP and return to a standard treatment environment are outlined in Section 4144 of the Welfare and Institutions Code. A state hospital psychiatrist or psychologist may refer a patient to an ETP for temporary placement and risk assessment, upon determining that the patient may be at high risk of most dangerous behavior, and when safe treatment is not possible in a standard treatment environment. Patients receive placement evaluations, and may be certified for 90 days of treatment in an ETP, with an individual treatment plan that is updated every 10 days. When the initial 90 day period is up, the patient is reevaluated and may be certified for ETP placement for up to a year, with reviews at least every 90 days. After one year, patients can be certified for continued ETP placement after an independent medical review is completed by a forensic psychiatrist or psychologist outside of DSH. At any point, the patient may be referred back to a standard treatment environment, if deemed appropriate.

Requirements. Statute specifies that ETP units must meet the following requirements, outlined in Section 1265.9 of the Health and Safety Code:

(1) A staff-to-patient ratio of one to five must be maintained.

(2) Each patient room must be limited to one patient, allow visual access by staff 24 hours per day, and have a toilet and sink in the room.

(3) Each patient room door must be able to be locked externally. The door may be locked when clinically indicated and determined to be the least restrictive treatment environment for the patient's care and treatment.

(4) Emergency egress must be provided for ETP patients.

(5) In the event seclusion or restraints are used in an ETP, all state licensing and regulations shall be followed.

(6) A full-time independent patients' rights advocate who provides patients' rights advocacy services shall be assigned to each ETP.

Monitoring and Reporting Requirements. Statute requires DSH to monitor the pilot ETPs, evaluate outcomes, and report annually on its findings and recommendations to the Legislature. The evaluation must include information regarding characteristics of the patients served, compliance with staffing requirements, lengths of stay, restraint and seclusion use, serious injury to staff and residents, staff turnover, the number of patients' rights complaints, and the type of training provided to staff.

Policies and Procedures. SB 85 (Committee on Budget), Chapter 26, Statutes of 2015 required DSH to submit written draft policies and procedures for the operation of ETP units to the Legislature at least 60 days prior to implementing an ETP. These were provided in October 2017, and updated in June 2019[3]. These cover admittance criteria, staffing levels, services to be provided to patients, a transition planning process, and training requirements.

Pilot Demographics and Insights. The ETP at DSH-Atascadero began admitting patients on September 14, 2021. Since then, the unit has treated 28 patients (all male; the DSH-Patton ETP will serve female patients), according to DSH's annual report[4]. The average age of ETP patients is 39.7 years, which is about 8.5 years below the DSH-wide age average. The ethnic distribution of the total ETP patients served generally aligns with the DSH patient mix in general, except for a slighter larger segment of White patients receiving care in the standard treatment environment compared to the ETP. Compared to the overall DSH population, the ETP serves a significantly higher percentage of LPS patients and a lower percentage of IST and SVP patients.

Since activation of the ETP in September 2021, DSH data shows that following ETP admission, the rates of aggressive incidents towards staff decreased by 71 percent, while aggressive acts towards other patients decreased by 94 percent. Serious injuries to staff decreased by 68 percent, and serious injuries to patients due to aggression by peers were altogether eliminated. DSH also noted that the patients who completed ETP maintained reductions in aggression after returning to the standard treatment environment.

[3] https://www.dsh.ca.gov/Legislation/docs/ETP_Updated_Draft_Policies_Procedures_June_2019.pdf

[4] https://www.dsh.ca.gov/Legislation/docs/ETP_LegislativeReport-January2025.pdf

DSH has also made several significant adjustments since the activation of the ETP unit at DSH-Atascadero. Initially, DSH observed an increase in self-harm behaviors after ETP placement, and ETP placement did not seem to benefit individuals with a significant history of self-harm. As a result, the referral process was adjusted to increase screening for self-harm behavior. In addition, DSH has noticed a significant decrease in the use of non-ambulatory restraints since the first year of ETP operations, which they attribute to improved staff proficiency related to ETP policies, and the increased screening of self-harm behavior. DSH's annual report states that there have been fewer than 11 incidents of seclusion, for a total of 9.13 hours, and all of these incidents occurred prior to September 30, 2022.

Previous Resources. DSH was provided with a total of $23 million over eight years (2014-15 to 2021-22) in capital outlay costs for the two ETPs, and $3.1 million in 2017-18 growing to $15.6 million in 2024-25 in support costs, which are updated at Governor's budget and May Revision.

Subcommittee Staff Recommendation—Hold Open.

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

1. Please provide an overview of the ETP at DSH-Atascadero, and a status update on the project and timelines for the ETP at DSH-Patton.

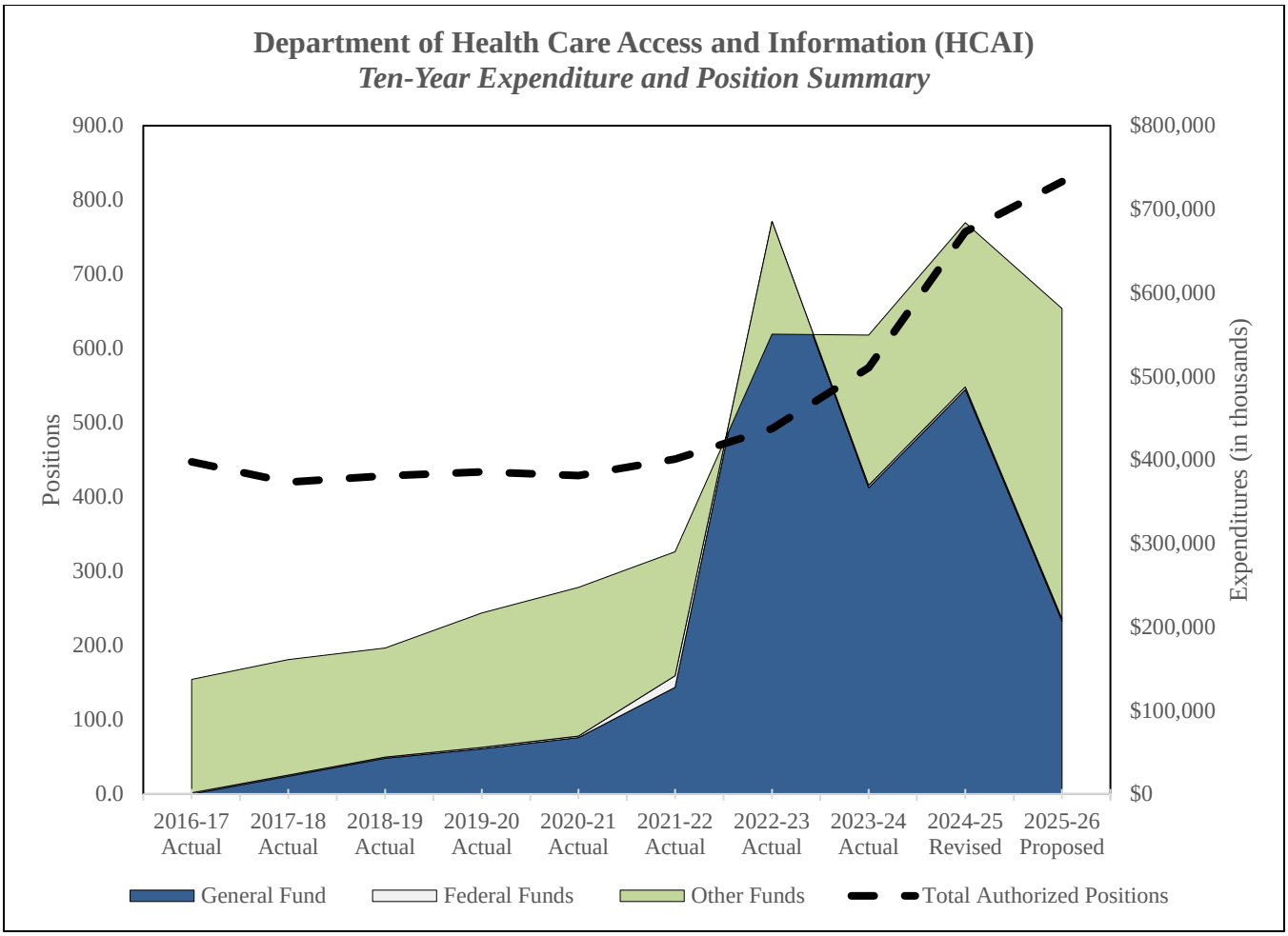
2. What is the level of demand for ETP beds?

3. What has been learned from the implementation of the ETP at DSH-Atascadero?

4. Of the individuals discharged from the ETP, what are their outcomes when they return to a standard treatment environment? How often do they return to ETP?

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 1: Overview



Department of Health Care Access and Information - *Department Funding Summary (dollars in thousands)*				
Fund Source	***2023-24 Actual***	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$366,492	$107,052	$484,075	$206,816
Federal Funds	$3,136	$2,871	$3,233	$2,894
Other Funds	$179,553	$151,153	$196,471	$371,262
Total Department Funding:	**$549,181**	**$261,076**	**$683,779**	**$580,972**
Total Authorized Positions:	**574.1**	**760.2**	**757.2**	**824.7**
Other Funds Detail:				
Hospital Building Fund (0121)	*$64,367*	*$77,893*	*$76,857*	*$79,484*

CA Health Data and Planning Fund (0143)	*$35,920*	*$46,997*	*$53,119*	*$48,769*
Registered Nurse Education Fund (0181)	*$2,081*	*$2,185*	*$2,185*	*$2,185*
Health Facility Const. Loan Ins. Fund (0518)	*$3,361*	*$6,387*	*$6,803*	*$6,849*
Health Professions Education Fund (0829)	*($5,797)*	*$1,095*	*$1,095*	*$1,095*
Medically Underserved Account/Phys (8034)	*$1,945*	*$4,416*	*$4,416*	*$4,416*
Reimbursements (0995)	*$6,521*	*$7,947*	*$17,947*	*$188,804*
Mental Health Practitioner Ed. Fund (3064)	*$695*	*$762*	*$762*	*$762*
Vocational Nurse Education Fund (3068)	*$147*	*$235*	*$235*	*$235*
Behavioral Health Services Fund (3085)	*$8,864*	*$3,236*	*$8,100*	*$31,163*
Small and Rural Hosp Relief Fund (3391)	*$460*	*$0*	*$0*	*$0*
Opioid Settlements Fund (3397)	*$602*	*$0*	*$24,398*	*$0*
Distressed Hosp Loan Prog Fund (3432)	*$3,416*	*$0*	*$0*	*$0*
Health Care Payments Data Fund (3436)	*$0*	*$0*	*$0*	*$7,500*
HCBS American Rescue Plan Fund (8507)	*$56,971*	*$0*	*$554*	*$0*

Background. The Department of Health Care Access and Information (HCAI) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. HCAI also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities, and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Cal-Mortgage Loan Insurance Division. HCAI's Cal-Mortgage Loan Insurance Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of November 30, 2024, Cal-Mortgage insures 59 loans with a total value of approximately $1.3 billion.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act), which required hospitals to meet stringent construction standards to ensure they

are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to HCAI, creating the state's largest building department, the Facilities Development Division.

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all general acute care hospital buildings for seismic resistance according to standards developed by HCAI to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent HCAI regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes.

Health Care Workforce Development Division. HCAI administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. Specifically, HCAI encourages demographically underrepresented groups to pursue healthcare careers, incentivizes primary care and mental health professionals to work in underserved communities, evaluates new and expanded roles for health professionals and new health delivery alternatives, designates health professional shortage areas, and serves as the state's central repository of health education and workforce data.

California Health Workforce Education and Training Council. HCAI's health care workforce development programs are coordinated by the California Health Workforce Education and Training Council. The council is composed of 18 members who represent graduate medical education and training programs, health professionals, and consumer representatives. Six members are appointed by the Governor, three members are appointed by the Speaker of the Assembly, and three members are appointed by the Senate Rules Committee. In addition, the council includes the following individuals or their designees: the Director of the Department of Health Care Services, the Director of the Department of Health Care Access and Information, the Secretary of Labor and Workforce Development, the President of the University of California, the Chancellor of the California State University, and the Chancellor of the California Community Colleges.

HCAI awards scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. HCAI serves as California's Primary Care Office supporting the state's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities.

Loan Repayments, Scholarships, and Grants. HCAI's Workforce Development Division administers a myriad of loan repayment, scholarship, and grant programs to support students, graduates, and institutions providing direct patient care in areas of unmet need. Loan repayment programs include: 1) the Bachelor of Science Nursing Loan Repayment Program, 2) the California State Loan Repayment Program, 3) the County Medical Services Loan Repayment Program, 4) the Licensed Mental Health Services Provider Education Program, 5) the Licensed Vocational Nurse Loan Repayment Program, and 6) the Steven M. Thompson Physician Corps Loan Repayment Program.

Scholarship programs include: 1) the Allied Healthcare Scholarship Program, 2) the Advanced Practice Healthcare Scholarship Program, 3) the Associate Degree Nursing Scholarship Program, 4) the Bachelor of Science Nursing Scholarship Program, 5) the Licensed Vocational Nurse to Associate Degree Nursing Scholarship Program, 6) the Vocational Nurse Scholarship Program, 7) the Train New Trainers Primary Care Psychiatry Fellowship Scholarship Program, 8) the Primary Care Training and Education in Addiction Medicine Fellowship Scholarship Program, 9) the Behavioral Health Scholarship Program, and 10) the Golden State Social Opportunities Program.

Grant programs include: 1) the Song-Brown Healthcare Workforce Training Program, 2) Behavioral Health Programs, 3) the Health Professions Careers Opportunity Program, 4) Rural Health Grant Programs, and 5) Healthcare IT Workforce Programs.

Workforce Development Initiatives. In addition to its loan repayment, scholarship and grant programs, HCAI is a partner in advancing a number of state initiatives with workforce development components, including:

- Children and Youth Behavioral Health Initiative – As part of a $4.4 billion investment over five years to improve behavioral health access and outcomes for children and youth from zero to age 25, HCAI administers several workforce development initiatives including: 1) increasing training capacity for psychiatry and social workers, 2) creating a wellness coach and counselor workforce, 3) developing a substance use disorder workforce, 4) building a behavioral health workforce pipeline, 5) building "earn and learn" apprenticeship models, 6) enhance training to serve justice- and system-involved youth, 7) enhancing behavioral health training for primary care providers, 8) targeting professionals to medically underserved areas and populations, 9) expand peer personnel training and placement programs, and 10) augment HCAI programs to support behavioral health disciplines.

- Community Health Workers/Promotores/Representatives (CHW/P/Rs) – This initiative, in partnership with the Department of Health Care Services, is meant to standardize certification requirements and conditions for participation in Medi-Cal for community health workers, promotores, and representatives (CHW/P/Rs).

- Twenty-First Century Nursing Initiative – The 2022 Budget Act included $220 million to address the largest issues facing our nursing workforce and supporting the development of that workforce in a way that meets California's health care needs. This initiative is subject to delays proposed in the Governor's January budget.

- Reproductive Health Care Access Initiative – The 2022 Budget Act included $120 million to establish and administer five programs designed to support and expand abortion, abortion-related care, and reproductive services across the state including: 1) Clinical Infrastructure scholarship and loan repayment program, 2) Capital Infrastructure program to enhance physical and digital security infrastructure, 3) Uncompensated Care Fund, 4) Abortion Practical Support Fund, and 5) California Reproductive Health Service Corps.

- BH-CONNECT Workforce Initiative – The BH-CONNECT Workforce Initiative will provide $1.9 billion over the BH-CONNECT Demonstration to address shortages in behavioral health practitioners serving Medi-Cal and underserved populations. The components of the Workforce Initiative include: 1) the Medi-Cal Behavioral Health Student Loan Repayment Program, 2) the Medi-Cal Behavioral Health Scholarship Program, 3) the Medi-Cal Behavioral Health Recruitment and Retention Program, 4) the Medi-Cal Behavioral Health Community-Based Provider Training Program, and 5) the Medi-Cal Behavioral Health Residency Training Program.

Health Workforce Pilot Projects Program. HCAI administers the Health Workforce Pilot Projects (HWPP) Program to allow organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals, or new healthcare delivery alternatives before licensing laws are made by the Legislature. Current projects include expansions for community paramedicine and allied dental providers.

Information Services Division. The Information Services Division (ISD) collects and disseminates timely and accurate healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products.

Information Technology Services and Support. The division supports operations, data collection, and reporting functions through maintenance of technical infrastructure and enterprise systems, including IT customer support, project portfolio management, and enterprise architecture.

Data Collection and Management. The division collects and publicly discloses facility level data from more than 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. In addition, approximately 450 hospitals report demographic and utilization data on approximately 16 million inpatient, emergency department, ambulatory surgery patients, and by physician, about heart surgery patients.

Healthcare Data Analytics. The division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality and outcome ratings for heart surgery and other procedures are also published. The division conducts a wide range of special studies on such topics as preventable hospital admissions and readmission, trends in care, and racial or ethnic disparities. The division also provides information to the public on non-profit hospital and community benefits, and hospital prices and discount policies.

Engagement and Technical Assistance. The division provides assistance to the members of the public seeking to use HCAI data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments, and stakeholders.

Office of Health Care Affordability. The 2022 Budget Act established within HCAI the Office of Health Care Affordability (OHCA) to analyze and help constrain the growth of the cost of health care in California. The Office is governed by an eight-member Health Care Affordability Board, with four members appointed by the Governor and confirmed by the Senate, one member each appointed by the Senate Committee on Rules and the Speaker of the Assembly, the Secretary of Health and Human Services, and the Chief Health Director of the California Public Employment Retirement System (CalPERS). OHCA's primary responsibilities are to analyze the health care market for cost trends and

drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, create a state strategy for controlling the cost of health care, ensure affordability for consumers and purchasers, and enforce cost targets. The first cost target will be developed for the 2025 calendar year, for reporting purposes only. The 2026 cost target will be the first in which enforcement action will be taken against providers that fail to meet the target. Enforcement actions will be progressive, beginning with technical assistance or corrective action plans, and could result in financial penalties.

CalRx. CalRx was established by SB 852 (Pan), Chapter 207, Statutes of 2020, the California Affordable Drug Manufacturing Act of 2020. CalRx is authorized to develop, produce, and distribute generic drugs and sell them at low cost. The program will target prescription drugs where the pharmaceutical market has failed to lower drug costs, even when a generic or biosimilar medication is available. The current projects in development by CalRx include:

- Biosimilar Insulin Initiative – CalRx has partnered with CivicaRx, a non-profit pharmaceutical company, to develop the most popular short- and long-acting types of insulin. The 2022 Budget Act included $50 million to support development of the insulin product and $50 million to establish an insulin manufacturing facility based in California. According to CivicaRx, the manufacturer suggested retail price for a 10mL vial of insulin will be no more than $30, and a five-pack of 3mL pens will be no more than $55. Californians and their health insurers commonly pay $300 per vial and $500 for a five-pack of pens in the current marketplace.

- Naloxone Access Initiative – CalRx has partnered with Amneal Pharmaceuticals to manufacture and distribute naloxone nasal spray $24 per twin-pack. The 2023 Budget Act included $30 million from the Opioid Settlements Fund to support this project. In April 2025, CalRx announced its $24 per twin-pack naloxone is now available through a direct to consumer website.

Subcommittee Staff Comment. This is an informational item.

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

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

2) Please provide a status update on implementation of the Office of Health Care Affordability, including statutory and regulatory milestones achieved, evaluation and analysis of cost growth targets, and expected timelines for future actions to restrain the growth of health care costs in California.

3) Please provide a status update on development of biosimilar insulin and improving access to naloxone through CalRx.

Issue 2: AB 112 Implementation – Data Reporting

Budget Change Proposal – Governor's Budget. HCAI requests three positions, supported with previously approved expenditure authority, to support collection and administration of hospital balance sheet data submissions under the Distressed Hospital Loan Program, pursuant to the requirements of AB 112 (Committee on Budget), Chapter 6, Statutes of 2023.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**3.0**	**3.0**

* Positions ongoing after 2026-27.

Background. AB 112 (Committee on Budget), Chapter 6, Statutes of 2023, established the Distressed Hospital Loan Program, to provide interest free cashflow loans to not-for-profit and public hospitals in significant financial distress, or to governmental entities representing a closed hospital. AB 112 was approved in response to the closure of Madera Community Hospital in the Central Valley, as well as concerns about the financial health of other strategically important hospitals, to stabilize the finances of the hospital system and prevent additional closures. The Distressed Hospital Loan Program, administered jointly by HCAI and the California Health Facilities Financing Authority (CHFFA), is supported by a $300 million General Fund allocation authorized under AB 112, and later AB 118 (Committee on Budget), Chapter 42, Statutes of 2023. The program authorizes HCAI and CHFFA to develop a methodology for hospitals to demonstrate eligibility for a loan award, requires a hospital to provide a plan detailing how the hospital proposes to return to financial viability and continue to operate as a hospital, and authorizes HCAI and CHFFA to impose service provision requirements on the hospital. According to CHFFA, 16 loans have been awarded to date, totaling $292.5 million.

In addition to authorizing the loan program, AB 112 expanded hospitals' responsibilities to submit financial and utilization data to HCAI. These expanded responsibilities included: 1) quarterly balance sheet reporting detailing assets, liabilities, and net worth of the hospital; and 2) revenue and utilization attributable to patients with commercial coverage, including total inpatient gross revenues, total outpatient gross revenues, total net patient revenues, total number of inpatient days, total number of outpatient visits, and total number of discharges. According to HCAI, collection of quarterly balance sheet financial data from hospitals enables timely identification and analysis of financial challenges hospitals may face across California communities. However, HCAI reports that AB 112 did not establish permanent position authority to administer these new data reporting requirements.

Staffing Request. HCAI requests three positions, supported with previously approved expenditure authority, to support collection and administration of hospital balance sheet data submissions under the Distressed Hospital Loan Program, pursuant to the requirements of AB 112 (Committee on Budget), Chapter 6, Statutes of 2023. This request would permanently establish three positions, as follows:

- **Two Health Program Auditor III** positions would analyze hospital reports for accounting and reporting errors, communicate with hospital financial personnel to resolve issues and advise them of

compliance requirements, document all items and resolutions, and provide technical support and advise public data users of the technical aspects of the new financial and statistical data usage.

- **One Information Technology Specialist I** position would perform planning, design, engineering, and maintenance of the data infrastructure, as well as serve as a technical subject matter expert for the program.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Enterprise Risk Management – Cybersecurity, Patient Privacy, and Governance

Budget Change Proposal – Governor's Budget. HCAI requests one position and expenditure authority from the California Health Data and Planning Fund of $209,000 annually. If approved, this position and resources would support increased workload demands resulting from new state and federal cybersecurity, patient privacy, and data laws and policies.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0143 – California Health Data and Planning Fund	$209,000	$209,000
Total Funding Request:	**$209,000**	**$209,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and resources ongoing after 2026-27.

Background. According to HCAI, the department collects, manages, and safeguards patient records for over 30 million Californians, which includes demographics, diagnosis, procedures, and addresses of individual residents. HCAI also operates information systems that support California's health care workforce and health care services delivery infrastructure. Each of these systems is governed by state and federal cybersecurity, patient privacy, and data laws and policies.

HCAI reports in June 2023 the department established a department-wide, centralized risk management program, the Enterprise Risk Management Branch (ERMB) to integrate cybersecurity, data privacy, and related governance functions. In its assessment of HCAI's needs in this area, ERMB determined the department lacks resources to develop, deliver, and maintain an enterprise-wide, role-based privacy training program. According to HCAI, organizational privacy awareness and staff training are crucial administrative safeguards against unauthorized disclosure or misuse of sensitive, confidential, and personal information, and privacy training programs are a low-cost and measurably effective mechanism for achieving many of the department's privacy and security goals.

Staffing Request. HCAI requests one position and expenditure authority from the Health Data and Planning Fund of $209,000 annually to support increased workload demands resulting from new state and federal cybersecurity, patient privacy, data laws, and policies. Specifically, HCAI requests the following position:

- **One Information Technology Specialist I** position would serve as a privacy training specialist, developing and delivering role-based data privacy training materials to HCAI programs.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Relocation Rent Adjustment

Budget Change Proposal – Governor's Budget. HCAI requests expenditure authority of $2.4 million ($839,000 General Fund and $1.6 million California Health Data and Planning Fund) in 2025-26, $1.2 million ($399,000 General Fund and $765,000 California Health Data and Planning Fund) in 2026-27, $1.2 million ($416,000 General Fund and $795,000 California Health Data and Planning Fund) in 2027-28, $1.3 million ($432,000 General Fund and $828,000 California Health Data and Planning Fund) in 2028-29, and $1.3 million ($450,000 General Fund and $860,000 California Health Data and Planning Fund) annually thereafter. If approved, these resources would support relocation of HCAI's Sacramento headquarters from its current location to the May Lee State Office Complex. This request is part of a joint proposal from HCAI, the Civil Rights Department, the Department of Housing and Community Development, the Department of Real Estate, and the Commission on Teacher Credentialing.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$839,000	$399,000
0143 – California Health Data and Planning Fund	$1,608,000	$765,000
Total Funding Request:	**$2,447,000**	**$1,164,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2027-28: $1,211,000; 2028-29: $1,260,000; 2029-30 and ongoing: $1,310,000.

Background. HCAI's Sacramento headquarters is currently located in privately leased space at 2020 West El Camino Avenue in Sacramento. In accordance with ten-year planning conducted by the Department of General Services (DGS), HCAI will relocate in July 2025 from its privately leased location to the May Lee State Office Complex (MLSOC). According to HCAI, the MLSOC will bring together eight state entities in a campus setting with amenities such as onsite childcare, gym facilities, secure bike parking, and easy access to public transportation. The building will also provide state of the art office and meeting space and is the largest all-electric, zero-carbon building complex in the United States.

Resource Request. HCAI requests expenditure authority of $2.4 million ($839,000 General Fund and $1.6 million California Health Data and Planning Fund) in 2025-26, $1.2 million ($399,000 General Fund and $765,000 California Health Data and Planning Fund) in 2026-27, $1.2 million ($416,000 General Fund and $795,000 California Health Data and Planning Fund) in 2027-28, $1.3 million ($432,000 General Fund and $828,000 California Health Data and Planning Fund) in 2028-29, and $1.3 million ($450,000 General Fund and $860,000 California Health Data and Planning Fund) annually thereafter to support relocation of HCAI's Sacramento headquarters from its current location to the May Lee State Office Complex. Of the resources requested in 2025-26, $1.3 million is one-time for relocation costs expected in July 2025, while approximately $1.1 million is ongoing.

HCAI notes that its new space in the MLSOC may not be able to accommodate the Governor's return-to-work order requiring personnel to work in-person for four days per week. HCAI indicates it may submit a revised request with release of the May Revision.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: BH-CONNECT Workforce Initiative

Local Assistance – Governor's Budget. HCAI requests expenditure authority of $190.2 million ($66.6 million General Fund, $95.1 million reimbursements, and $28.5 million Behavioral Health Services Fund) in 2025-26. If approved, these resources would support implementation of several behavioral health workforce programs under the Behavioral Health Community-Based Networks of Equitable Care and Treatment (BH-CONNECT) Workforce Initiative. Over the course of the BH-CONNECT demonstration, $1.9 billion total funds is expected to be allocated to these programs.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26**
0001 – General Fund	$-	$66,600,000
0995 – Reimbursements	$-	$95,100,000
3085 – Behavioral Health Services Fund	$-	$28,500,000
Total Funding Request:	**$-**	**$190,200,000**

Background. The BH-CONNECT Workforce Initiative, administered by the Department of Health Care Access and Information (HCAI) will provide $1.9 billion over the BH-CONNECT Demonstration to address shortages in behavioral health practitioners serving Medi-Cal and underserved populations. The components of the Workforce Initiative are as follows:

1) Medi-Cal Behavioral Health Student Loan Repayment Program – This program will provide loan repayment for behavioral health professionals with educational debt, including the following:

   a) *Licensed Prescribing Behavioral Health Practitioners* – Licensed, prescribing behavioral health professionals (e.g. psychiatrists, addiction medicine physicians, psychiatric nurse practitioners) are eligible for up to $240,000 in loan repayment in exchange for a four-year service obligation (regardless of loan repayment amount) in a Medi-Cal safety net setting (e.g. federally qualified health center, community mental health center, rural health clinic, settings with high Medi-Cal or uninsured populations).
   b) *Non-prescribing Licensed or Associate Level Pre-Licensure Practitioners* – Non-prescribing licensed or associate level pre-licensure practitioners (e.g. psychologists, social workers, marriage and family therapists) are eligible for up to $180,000 in loan repayment in exchange for a four-year service obligation (regardless of loan repayment amount) in a Medi-Cal safety net setting.
   c) *Non-licensed, Non-prescribing Practitioners* – Non-licensed, non-prescribing practitioners (e.g. substance use disorder counselors, community health workers, peer support specialists, and wellness coaches) are eligible for up to $120,000 in loan repayment in exchange for a service obligation in a Medi-Cal safety net setting that depends on the loan repayment amount. For loan repayments less than $10,000, the service obligation is two years. For loan repayments of $10,000 to $20,000 the service obligation is three years. For loan repayments of $20,000 or more, the service obligation is four years.

   Applications for this program will open on July 1, 2025, and close on August 15, 2025.

2) Medi-Cal Behavioral Health Scholarship Program – This program will provide scholarships of up to $240,000 for licensed practitioners with prescribing privileges, $180,000 for non-prescribing licensed practitioners, and $120,000 for non-licensed practitioners. Scholarship awards will require recipients to commit to practicing full-time in safety net settings after completing their education, for a defined period of time based on scholarship amounts. HCAI indicates this program will launch in early 2026.

3) Medi-Cal Behavioral Health Recruitment and Retention Program – This program will provide funding to support the following:

   a) Recruitment bonuses of up to $20,000 and retention bonuses of up to $4,000 per practitioner
   b) Recruitment bonuses up to $50,000 specifically for individuals who are completing required field training in advance of their final year of education
   c) Support for training and licensure, with up to $1,500 per practitioner for costs related to licensure or certification and up to $35,000 per organization to support the supervision of license-eligible providers
   d) Backfill of costs for provider training in evidence-based practices to ensure uninterrupted care

4) Medi-Cal Behavioral Health Community-Based Provider Training Program – This program will support education and training for Alcohol or Other Drug (AOD) Counselors, Community Health Workers, and Peer Support Specialists, providing up to $10,000 per participant for tuition, textbooks, and certification costs.

5) Medi-Cal Behavioral Health Residency Training Program – This program will provide up to $250,000 per residency or fellowship slot per demonstration year for new or expanded positions in Psychiatry or Addiction Medicine. Psychiatry residency programs, child and adolescent psychiatry fellowship programs, addiction psychiatry fellowship programs, and addiction medicine fellowship programs will be eligible for this funding. Programs will train residents and fellows in a Medi-Cal safety net setting and participating residents and fellows will be required to commit to a four-year service requirement after graduation. According to HCAI, applications for this program will open in July 2025.

Local Assistance – BH-CONNECT Workforce Initiative. HCAI requests expenditure authority of $190.2 million ($66.6 million General Fund, $95.1 million reimbursements, and $28.5 million Behavioral Health Services Fund) in 2025-26 to support implementation of several behavioral health workforce programs under the Behavioral Health Community-Based Networks of Equitable Care and Treatment (BH-CONNECT) Workforce Initiative. Over the course of the BH-CONNECT demonstration, $1.9 billion total funds is expected to be allocated to these programs.

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 HCAI to respond to the following:

1. Please provide a brief overview of the BH-CONNECT Workforce Initiative Programs, including award types, eligible practitioners, service obligations, and expected implementation dates.

Issue 6: Healthcare Payments Data Program Long-Term Funding

Budget Change Proposal, Reappropriation, and Trailer Bill Language – Governor's Budget. HCAI requests 47 positions and expenditure authority of $22 million ($9 million General Fund, $5.5 million reimbursements, and $7.5 million Health Care Payments Data Fund) in 2025-26 and $22 million ($5.5 million reimbursements and $16.5 million Health Care Payments Data Fund) annually thereafter. If approved, these positions and resources would support operation and implementation of the Healthcare Payments Data Program.

HCAI also requests reappropriation of remaining General Fund expenditure authority originally authorized in the 2018 Budget Act for the Healthcare Payments Data Program.

HCAI also requests trailer bill language to authorize the transfer of funding from the Managed Care Administrative Fines and Penalties Fund to the Health Care Payments Data Fund to support the Healthcare Payments Data Program.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$9,000,000	$-
0995 – Reimbursements	$5,500,000	$5,500,000
3436 – Health Care Payments Data Fund	$7,500,000	$16,500,000
Total Funding Request:	**$22,000,000**	**$22,000,000**
Total Requested Positions:	**47.0**	**47.0**

* Positions and resources ongoing after 2026-27.

Background. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, established the Healthcare Payments Data (HPD) Program, California's all-payer claims database, a large research database made up of healthcare administrative data, such as claims and encounters. The HPD system allows HCAI and others to understand and address healthcare costs and drive improvement in California's healthcare delivery system. According to HCAI, the HPD Program will also play an important role in the new Office of Health Care Affordability to slow the growth in the cost of health care.

HCAI reports that considerable progress has been made in the development of the HPD Program. HCAI substantially completed the database by July 2023 and met the following key milestones:

- Convened the required advisory committee of stakeholders and experts
- Promulgated regulations for data collection
- Completed database technology infrastructure and system functionality, including for data collection, data quality evaluation, data integration, analytic dataset generation, and report creation.
- Received Medi-Cal data files from DHCS and Medicare Fee-for-Service data files from the federal Centers for Medicare and Medicaid Services.
- Collected data files from all mandatory commercial market and Medicare managed care data submitters.
- Convened the required data release committee, which reviews requests for access to non-public HPD data.

- Released analytic reports using HPD data.

HCAI reports it is currently operating the HPD Program using one-time General Fund expenditure authority of $60 million authorized in the 2018 Budget Act. As these resources were one-time, and the HPD Program is ongoing, HCAI is requesting permanent positions and resources to continue the program.

Staffing and Resource Request. HCAI requests 47 positions and expenditure authority of $22 million ($9 million General Fund, $5.5 million reimbursements, and $7.5 million Health Care Payments Data Fund) in 2025-26 and $22 million ($5.5 million reimbursements and $16.5 million Health Care Payments Data Fund) annually thereafter to support operation and implementation of the Healthcare Payments Data Program. Specifically, HCAI requests the following positions and resources:

Data Collection and Quality Management – 13 positions

- **One Staff Services Manager II** position would serve as Program Manager and oversee all data collection and quality management program operations.

- **One Staff Services Manager I** position would serve as Program Supervisor and assist with oversight of data collection and quality management operations.

- **One Research Data Specialist II** position would serve as Senior Data Quality Specialist and serve a lead role overseeing data quality management activities.

- **One Research Data Specialist I** position would serve as a Data Quality Specialist and serve in an associate role performing data quality management activities.

- **One Research Data Analyst II** position would serve as a Senior Data Quality Analyst and serve in an analyst role performing data quality management activities.

- **One Research Data Analyst I** position would serve as a Data Quality Analyst and serve in a support role performing data quality management activities.

- **Two Health Program Specialist II** positions would serve as HPD Program Specialists and serve in a lead role overseeing health data policy and integration with HCAI programs.

- **One Associate Governmental Program Analyst** would serve as a Prescription Drug Cost Transparency Data Analyst and serve in an associate role supporting prescription drug cost transparency data collection and quality management functions, in support of the HPD Program.

- **Two Information Technology Specialist II** positions would serve as Medi-Cal Senior Data Collection Specialists and serve in a lead role overseeing Medi-Cal data transmission and quality management.

- **Two Information Technology Specialist I** positions would serve as Medi-Cal Data Collection Specialists and serve in an associate role performing Medi-Cal data transmission and quality management.

Database Technology Infrastructure and Data Management – Eight positions

- **One Information Technology Specialist II** position would serve as Database Administrator and serve in a lead role performing database administration tasks.

- **One Information Technology Specialist II** position would serve as Senior Data Management Specialist and serve in a lead role performing technical administration of data management and related functions.

- **Four Information Technology Specialist I** positions would serve as Data Management Specialists and serve in an associate role performing technical administration of data management and related functions.

- **Two Information Technology Analysts** would serve as Data Integration Analysts and serve in a support role performing technical administration of data management and related functions.

Analysis, Public Reporting and Data Release – 15 positions

- **One Research Scientist Supervisor I** position would serve as HPD Analytics Supervisor and oversee all HPD data analytic measure development, statistical analysis, visualization, and reporting.

- **One Research Scientist Supervisor I** position would serve as HPD Data Release Supervisor and oversee all HPD data release activities, including managing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **One Research Scientist IV** position would serve as Senior Lead Research Scientist and serve in a senior lead role performing HPD data analytic measure development, statistical analysis, visualization, and reporting.

- **Two Research Scientist III** positions would serve as Senior Research Scientists and serve in a lead role performing HPD data analytic measure development, statistical analysis, visualization, and reporting.

- **One Research Scientist II** position would serve in an associate role performing HPD data analytic measure development, statistical analysis, visualization, and reporting.

- **One Research Scientist I** position would serve as a Junior Research Scientist and serve in a support role performing HPD data analytics measure development, statistical analysis, visualization, and reporting.

- **One Research Data Specialist III** position would serve as Senior Data Access Specialist and serve in a senior role performing specialist-level tasks for processing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **One Research Data Specialist II** position would serve as an Associate Data Access Specialist and serve in an associate role performing specialist-level tasks for processing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **One Research Data Specialist I** position would serve as a Junior Data Access Specialist and serve in a support role performing specialist-level tasks for processing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **Two Research Data Analysts** would serve as Associate Data Access Analysts and serve in an associate role performing analyst-level tasks for processing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **Two Research Data Analyst I** positions would serve as Junior Data Access Analysts and serve in a support role performing analyst-level tasks for processing external applications for non-public data and performing analytical tasks for disseminating data for release.

- **One Research Data Specialist III** position would serve as Senior Medi-Cal Data Research Specialist and serve in a lead role designing and using HPD datasets and data products to support management of the Medi-Cal program.

Program Support Services – 11 positions

Data Governance, Privacy, and Security

- **Two Information Technology Specialist II** positions would serve as Data Governance Specialists and serve in a lead role overseeing data governance and privacy.

- **One Information Technology Analyst** would serve as an Information Security Analyst and serve in an associate role performing security audit, oversight, and policy functions.

Committee Management

- **One Staff Services Manager II** position would serve as Public Meeting Manager and oversee stakeholder relations, policy, and administration of HPD's public committee.

- **One Health Program Specialist II** position would serve as Data Release Committee Lead and serve in a lead role overseeing HPD's Data Release Committee and performing stakeholder relationship management.

- **One Associate Governmental Program Analyst** would serve as Advisory Committee Support and serve in a lead role overseeing HPD's Advisory Committee and performing stakeholder relationship management.

IT Services

- **One Information Technology Specialist I** position would serve as a Security Operations Specialist and serve in a lead role performing security oversight functions.

- **One Information Technology Analyst** would serve as a Software Engineer and serve in an associate role performing general application development to support HPD Program staff.

Acquisition and Management Services

- **One Information Technology Specialist I** position would serve as a Contracts Management Specialist and serve in a lead role overseeing HPD contracts.

- **One Information Technology Analyst** would serve as a Budget and Finance Analyst and serve in an associate role supporting HPD budget and financial activities.

- **One Associate Governmental Program Analyst** would serve as a Personnel Analyst and serve in an associate role supporting HPD personnel activities, including recruitment, hiring, and training.

Information Technology, Consulting and Professional Services - $13.4 million

- $125,000 would support a data acquisition contract for acquisition of necessary third-party data for the HPD system.

- $4 million would support a consulting and professional services contract for healthcare data systems subject matter expertise, data infrastructure development, claims data and analytics subject matter expertise, and analytics and research development.

- $9.3 million would support an information technology software, services, and infrastructure contract for data collection platform infrastructure, data management software, data enclave system infrastructure, online data request form system infrastructure, and general infrastructure costs.

Trailer Bill Language Proposal – Managed Care Administrative Fines and Penalties Fund. HCAI also requests trailer bill language to authorize the transfer of funding from the Managed Care Administrative Fines and Penalties Fund to the Health Care Payments Data Fund to support the Healthcare Payments Data Program. The Managed Care Administrative Fines and Penalties Fund collects revenues from fines and penalties on managed care plans for violations of the Knox-Keene Health Care Service Plan Act. Specifically, the language would:

1) For the 2025-26 fiscal year, transfer any amount in the Managed Care Administrative Fines and Penalties Fund between $1,000,001 and $2,550,000 to the Health Care Payments Data Fund, which supports the Healthcare Payments Data Program at HCAI. Amounts over $2,550,000 would be transferred to the Health Care Services Plan Fines and Penalties Fund, which supports the nonfederal share of health care services in the Medi-Cal program.

2) For the 2026-27 fiscal year and annually thereafter, transfer any amount between $1,000,001 and $7,000,000 to the Health Care Payments Data Fund. Amounts over $7,000,000 would be transferred to the Health Care Services Plan Fines and Penalties 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 HCAI to respond to the following:

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

Issue 7: Diaper Access Initiative

Budget Change Proposal – Governor's Budget. HCAI requests General Fund expenditure authority of $7.4 million in 2025-26 and $12.5 million in 2026-27. If approved, these resources would support establishment of the Diaper Access Initiative, to provide three months of free diapers for every baby born in California, regardless of income.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
0001 – General Fund	$7,400,000	$12,500,000
Total Funding Request:	**$7,400,000**	**$12,500,000**

Background. According to HCAI, almost half a million babies are born in California each year and families spend, on average, around $1,000 per year per baby on diapers. Diaper prices increased by 45 percent during the pandemic and have remained high despite supply chain recovery and decreased cost of materials. Almost half of families in the United States reported difficulty affording diapers and reducing other expenses to afford diapers, with a quarter of families saying they skipped meals to afford more diapers.

The Governor's January budget included resources for HCAI to establish the Diaper Access Initiative, which would provide three months of free diapers for every baby born in California, regardless of income. HCAI would utilize its contracting experience through the CalRx program to procure a source of low-cost diapers that would be provided to Californians through the Diaper Access Initiative. HCAI proposes to implement the initiative in two phases:

1) Phase 1 – Procurement and distribution, via hospitals, of a three-month supply of free diapers to every baby born in California. For phase 1, HCAI plans to identify a partner in the procurement of approximately 168 million diapers per year to offer at no cost to babies born in California. HCAI estimates that 400 diapers constitutes a three-month supply.

2) Phase 2 – Creation of a commercial distribution model where California families could order low-cost diapers. HCAI recently developed a direct-to-consumer distribution outlet for its Naloxone Access Initiative. Presumably the commercial distribution model for diapers would be similar.

In April 2025, HCAI released a Request for Information (RFI) for the Diaper Access Initiative. The RFI seeks to gather preliminary information from diaper manufacturers to evaluate their products, practices, and capabilities to align with California's goals of affordability, environmental sustainability, and quality. Responses to the RFI are due by May 15, 2025.

Resource Request. HCAI requests General Fund expenditure authority of $7.4 million in 2025-26 and $12.5 million in 2026-27 to support establishment of the Diaper Access Initiative, to provide three months of free diapers for every baby born in California, regardless of income.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

2. How would the Diaper Access Initiative make use of existing diaper bank networks to improve access for California families in need of diapers?

3. How would the Diaper Access Initiative distribute diapers to families whose babies are born in an alternative birthing center, or at home, rather than in a hospital?

Issue 8: Wellness Coaches

Trailer Bill Language – Governor's Budget. HCAI requests trailer bill language to make the following changes related to wellness coaches: 1) align statutory references with the current terminology of "Certified Wellness Coach", 2) specify that Pupil Personnel Services – Credentialed employees can supervise Certified Wellness Coaches, and 3) revise the activities that can be carried out by a Certified Wellness Coach.

Background. The 2021 Budget Act established the Children and Youth Behavioral Health Initiative, a multi-billion dollar initiative to improve the behavioral health and wellbeing of children and youth in the state of California. One of the components of the initiative was the design and implementation of a new type of behavioral health profession, the Certified Wellness Coach. According to HCAI, a Certified Wellness Coach is a non-clinical profession that will serve children and youth ages zero to 25; operate as part of a care team; offer six core services including wellness promotion and education, screening, care coordination, individual support, group support, and crisis referral; and operate under the direction of and coordination with a Pupil Personnel Services credentialed or licensed professional.

HCAI reports that the statutory authorization for Certified Wellness Coaches does not align with the current model for coaches, developed in consultation with stakeholders. For example, many school settings are staffed by Pupil Personnel Services-Credentialed employees. The proposed language would clarify these professionals are qualified to supervise Certified Wellness Coaches. In addition, the removal of crisis de-escalation and safety planning activities and addition of crisis referral from the activities that can be carried out by a Certified Wellness Coach is the result of input from the stakeholder engagement process.

Trailer Bill Language – Wellness Coaches. HCAI requests trailer bill language to make the following changes related to wellness coaches: 1) align statutory references with the current terminology of "Certified Wellness Coach", 2) specify that Pupil Personnel Services – Credentialed employees can supervise Certified Wellness Coaches, and 3) revise the activities that can be carried out by a Certified Wellness Coach. Specifically, the language would:

- Change "behavioral health coach" to "Certified Wellness Coach".
- Specify that persons with Pupil Personnel Services Credentials or school nurse services credentials can supervise Certified Wellness Coaches.
- Remove crisis de-escalation and safety planning, and add crisis referral, to the activities able to be performed by a Certified Wellness Coach.
- Make other minor technical changes.

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 HCAI to respond to the following:

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

Issue 9: Implementation of Chaptered Legislation (AB 1577, AB 869, SB 1382, SB 1447)

AB 1577 (Low)

Legislative Budget Change Proposal – Governor's Budget. HCAI requests one position and annual expenditure authority from the Health Data and Planning Fund of $170,000. If approved, this position and resources would support tracking, receipt, and posting of written justifications from health facilities and clinics regarding nursing clinical placement opportunities and other compliance activities, pursuant to the requirements of AB 1577 (Low), Chapter 680, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0143 – California Health Data and Planning Fund	$170,000	$170,000
Total Funding Request:	**$170,000**	**$170,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2026-27.

Background. AB 1577 (Low), Chapter 680, Statutes of 2024, requires hospitals and clinics to meet with a community college or California State University with an approved school of nursing, upon the college's request, and work in good faith to meet the needs of the college's nursing program, including adding additional clinical placement slots to accommodate the nursing program. In addition, the bill requires the hospital or clinic, if unable to provide additional clinical placement slots, to inform HCAI of its lack of capability or capacity using a form developed by the department, subject to a $1,000 fine for failure to provide the information. The bill also requires HCAI to post the submitted information on its website.

Staffing and Resource Request. HCAI requests one position and annual expenditure authority from the Health Data and Planning Fund of $170,000 to support tracking, receipt, and posting of written justifications from health facilities and clinics regarding nursing clinical placement opportunities and other compliance activities, pursuant to the requirements of AB 1577 (Low), Chapter 680, Statutes of 2024. Specifically, HCAI requests the following position:

- **One Associate Governmental Program Analyst** would track, receive and post written justifications from health care facilities and clinics on the HCAI website for five years.

AB 869 (Wood), SB 1382 (Glazer), SB 1447 (Durazo)

Legislative Budget Change Proposal – Governor's Budget. HCAI requests ten positions and expenditure authority from the Hospital Building Fund of $2.6 million in 2025-26 and $2.4 million annually thereafter. If approved, these positions and resources would support program services associated with various seismic safety requirements pursuant to the provisions of AB 869 (Wood), Chapter 801, Statutes of 2024, SB 1382 (Glazer), Chapter 796, Statutes of 2024, and SB 1447 (Durazo), Chapter 896, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0121 – Hospital Building Fund	$2,565,000	$2,420,000
Total Funding Request:	**$2,565,000**	**$2,420,000**
Total Requested Positions:	**10.0**	**10.0**

* Positions and resources ongoing after 2026-27.

Background. During the 2024 legislative session, the Legislature approved and the Governor signed three bills related to seismic safety for various health facilities. These bills were as follows:

1) AB 869 (Wood), Chapter 801, Statutes of 2024, establishes a process for small, rural, critical access, and district hospitals, as well as hospitals that are recipients under the Distressed Hospital Loan Program, to seek a delay of up to three years for the seismic safety compliance deadline of January 1, 2030. Hospitals securing a delay must submit, and receive HCAI approval for, a seismic compliance plan and a Nonstructural Performance Category – 5 evaluation report. HCAI may also extend the delay by an additional two years if certain conditions are met.

2) SB 1382 (Glazer), Chapter 796, Statutes of 2024, makes non-hospital affiliated, licensed primary care clinics subject to the building requirements outlined in federal law for clinics to participate in Medicare and Medicaid. The bill prohibits the construction standards for non-hospital affiliated, licensed primary care clinics from being more restrictive than the construction standards for hospital affiliated clinics.

3) SB 1447 (Durazo), Chapter 896, Statutes of 2024, allows a delay of the deadline for Children's Hospital Los Angeles to comply with seismic safety standards for up to three years beyond the 20230 seismic safety compliance deadline if certain specified criteria are met and HCAI grants approval.

Staffing and Resource Request. HCAI requests ten positions and expenditure authority from the Hospital Building Fund of $2.6 million in 2025-26 and $2.4 million annually thereafter to support program services associated with various seismic safety requirements pursuant to the provisions of AB 869 (Wood), Chapter 801, Statutes of 2024, SB 1382 (Glazer), Chapter 796, Statutes of 2024, and SB 1447 (Durazo), Chapter 896, Statutes of 2024. Specifically, HCAI requests the following positions and resources:

Office of Statewide Hospital Planning and Development – Nine positions

- **Three Senior Structural Engineers** would evaluate and approve seismic compliance plans and retrofit projects for healthcare facilities, ensuring they meet Structural and Nonstructural Performance Category requirements; assist in program administration, including developing and maintaining project software, reviewing applications, tracking project progress, and coordinating the review and issuance of funding requests in collaboration with finance staff.

- **Two Senior Architects** would oversee the implementation and administration of the seismic safety program for healthcare facilities, maintaining project databases, monitoring compliance, and acting as the primary liaison with General Acute Care Hospitals (GACH); conduct plan reviews, provide expert technical guidance on building codes and standards, and assist in developing new building standards, ensuring that facilities meet seismic safety, accessibility, and fire and life safety requirements.

- **One Compliance Officer, Health Facilities Construction** position would assist in administering the seismic safety program for healthcare facilities, maintaining project databases, developing regulatory standards, and coordinating with GACHs to ensure compliance with statutory requirements; conduct field reviews, provide construction oversight, support the development of database software, and participate in stakeholder education and outreach efforts to enforce the building standards.

- **One Associate Governmental Program Analyst** would assist in processing, monitoring, and reporting on seismic compliance applications, coordinating with technical staff to evaluate financial feasibility and project readiness while continuously maintaining and improving data systems; and support the development and adoption of regulation amendments, monitor projects, and ensure compliance with statutory requirements while providing reports to management and technical teams.

- **One Staff Services Analyst** would work with facility technical staff to process and close healthcare facility projects, ensuring compliance with Title 24 and resolving any issues; and provide technical support and guidance, prepare manuals, and assist internal and external stakeholders through various communication channels while researching and implementing improvements to the process.
- **One Office Technician** would assist with retrieving, organizing, and archiving healthcare facility construction project files, maintaining the filing system, and updating databases to ensure project documents are properly stored and accessible; and provide general administrative support, including typing, proofreading, scheduling, answering telephone calls, managing correspondence, and assisting with various tasks to support HCAI managers and staff.

Office of Health Facility Loan Insurance – One position

- **One Health Facility Construction Finance Specialist** would lead the development, implementation, and review of financial metrics and the grant processes for health facility renovation or construction while also managing an online application portal to streamline project submissions; and monitor project progress, respond to inquiries from various stakeholders, and ensure compliance with grant requirements by preparing and processing necessary documents.

Office of Information Services Contract - $250,000

- $250,000 would support an external contract for information technology special programming to modify the existing data capture, storage, and management solutions and infrastructure for the current Small and Rural Hospital Relief Program solution used today. The consultant would be responsible for planning and design, technical integration of new data fields, testing, and modifications to report outputs.

California Building Standards Commission Interagency Agreement - $145,000 one-time

- $145,000 one-time would support an interagency agreement with the California Building Standards Commission for emergency regulations promulgation and building standards updates.

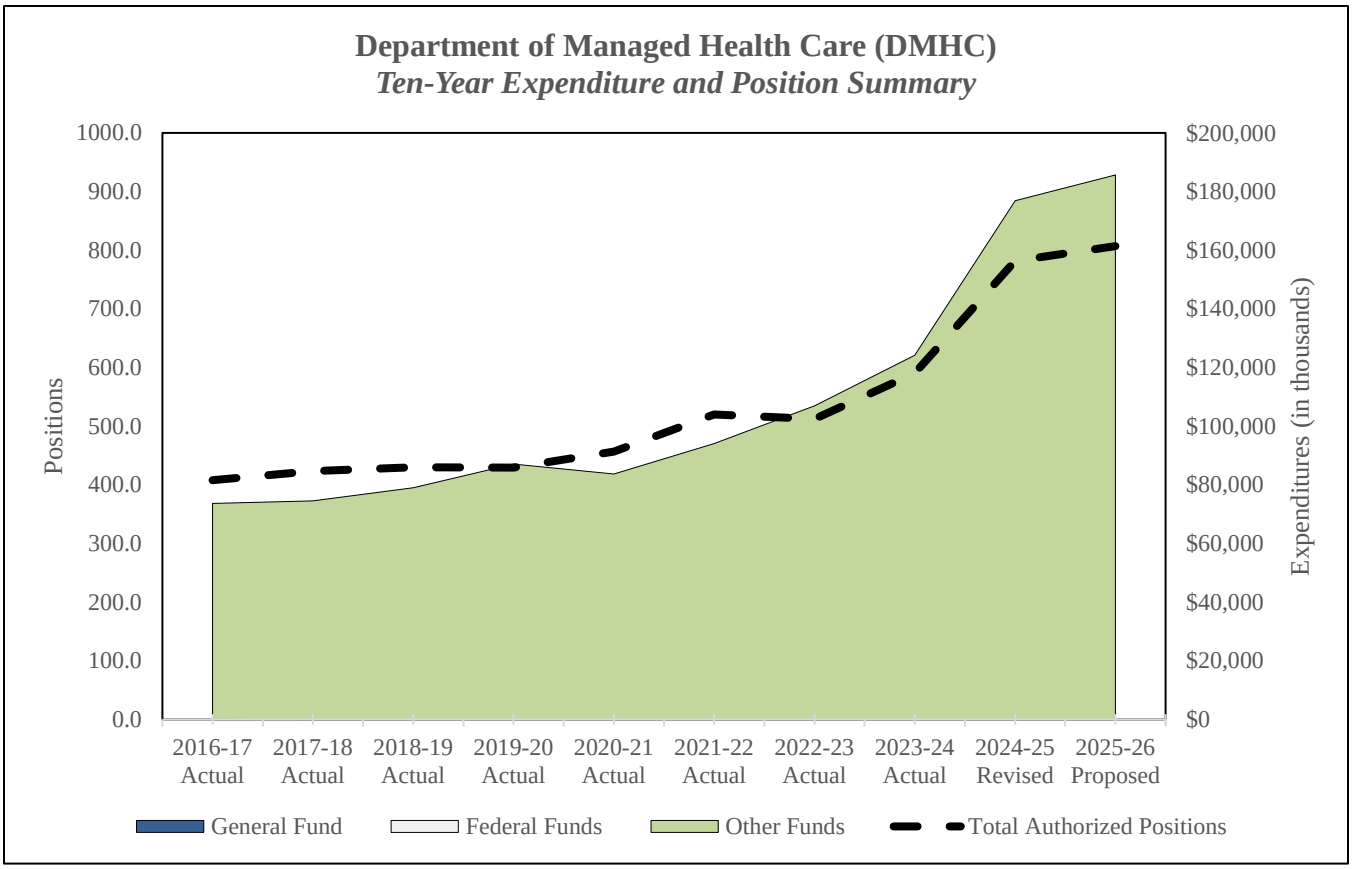
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of these proposals.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview



Department of Managed Health Care - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2023-24 Actual**	***2024-25 Budget Act***	***2024-25 Revised***	***2025-26 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$124,230	$178,435	$176,833	$185,668
Total Department Funding:	**$124,230**	**$178,435**	**$176,833**	**$185,668**
Total Authorized Positions:	**590.5**	**783.0**	**782**	**807**
Other Funds Detail:				
Managed Care Fund (0933)	*$124,230*	*$178,435*	*$176,833*	*$185,668*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 140 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 29.8 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health

Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to regulatory requirements related to consumer protections and plans' financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability: 1) Urgent care without prior authorization: within 48 hours; 2) Urgent care with prior authorization: within 96 hours; 3) Non-urgent primary care appointments: within 10 business days; 4) Non-urgent specialist appointments: within 15 business days; 5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days. The Knox-Keene Act also requires plans to ensure primary care physicians are located within 15 miles or 30 minutes of a beneficiary and there is at least one primary care provider for every 2,000 beneficiaries in a plan's network.

DMHC is composed of the following offices and other units:

Help Center. The Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a service as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints.

The Help Center also manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

Office of Plan Licensing. The Office of Plan Licensing (OPL) reviews all aspects of a health plan's operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, mental health parity and complaint and grievance systems. After a health plan is licensed, OPL monitors the plan and any changes made to plan operations, including changes in service areas, contracts, benefits, or systems. OPL also periodically identifies specific licensing issues for non-routine focused examination or investigation.

Office of Plan Monitoring. The Office of Plan Monitoring (OPM) monitors health plan networks and delivery systems. OPM conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. OPM also monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic standards, provider-to-patient ratios, and timely access to care. Additionally, OPM reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

Office of Financial Review. The Office of Financial Review monitors health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. The Office conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. The Office also administers the department's premium rate review program, which holds health plans accountable through transparency and ensures consumers get value for their premium dollar. When the Office finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

Office of Enforcement. The Office of Enforcement represents the department in actions to enforce managed health care laws. The primary purpose of an enforcement action is to change plan behavior to comply with the law, and may include issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. When necessary, the Office pursues legal action to ensure health plans follow the law.

Office of Legal Services. The Office of Legal Services provides legal, legislative, and policy analysis and advice to the department, and develops necessary and appropriate regulations to administer the Knox-Keene Health Care Service Plan Act of 1975.

Office of Administrative Services. The Office of Administrative Services provides a variety of administrative support services to the department, including accounting, budgets, business management services, and human resources.

Office of Technology and Innovation. The Office of Technology and Innovation provides technology support to the department including hardware, software, and information security services.

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Identity and Access Management – Project Planning

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $187,000 in 2025-26. If approved, these resources would support planning for a project to provide an Identity and Access Management solution that includes Single Sign-On capability, application user role and user account management to enhance application security, simplify user access, and streamline the management of digital identities.

Program Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
0933 – Managed Care Fund	$187,000	$-
Total Funding Request:	**$187,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DMHC, the department is currently maintaining 11,000 external user accounts across six different datasets for public-facing web portals. An individual may have multiple accounts within one portal or across multiple portals depending on the number of organizations the individual represents. The authentication technology used by DMHC applications is outdated and requires custom coding or complex workarounds to integrate with modern cloud platforms. Although DMHC recently integrated multi-factor authentication into its external facing enterprise applications, it did not include implementation of an Identity and Access Management (IDAM) solution, which would allow for management of various external user personas, provide an ability to manage persona data, and would meet CalSecure requirements. IDAM solutions help verify the identity of users ensuring that only legitimate users have access to systems to prevent fraud and impersonation, as well as mitigate the risk of insider threats by ensuring the employees and users have access only to the information necessary for their roles. The IDAM solution would also simplify the process of onboarding, modifying, and offboarding users.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $187,000 in 2025-26 to support planning for a project to provide an Identity and Access Management solution that includes Single Sign-On capability, application user role and user account management to enhance application security, simplify user access, and streamline the management of digital identities. Specifically, these resources would support the following:

Office of Technology and Innovation - $187,000 Consultant and Interagency Costs

- $132,000 would support consultant funding for the planning stage of the IDAM. According to DMHC, this cost is based on an estimated $135 per hour rate for 960 hours of work, and previous experience with similar system modernizations.
- $55,000 would support oversight by the California Department of Technology Project Approval Lifecycle oversight and related fees.

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 DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Customer Relationship Management (CRM) Modernization – Project Planning

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $1.2 million in 2025-26. If approved, these resources would support planning to modernize the consumer and provider complaint Customer Relationship Management System in the department's Help Center.

Program Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
0933 – Managed Care Fund	$1,157,000	$-
Total Funding Request:	**$1,157,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program, provides assistance to health care providers to ensure they receive timely and accurate payments from health plans, and manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

According to DMHC, the Help Center currently operates two separate complaint case management systems to manage and process the consumer and provider complaints. The Provider Complaint System (PCS) was implemented in 2015 as a custom software application developed internally. The Customer Relationship Management (CRM) System was implemented in 2001 and at the time was a leading solution in the industry. In 2018, DMHC implemented a proprietary sustaining technology that provides a more modern web-interface while retaining the old legacy infrastructure. DMHC reports implementing and maintaining functionality in the CRM requires time consuming custom coding, which makes it difficult for DMHC staff to keep up with changing program needs.

DMHC is proposing to begin planning to implement a new CRM system designed to provide timely consumer and provider assistance, address recent increases in complaint volumes and expedited complaints, improve processing times, and comply with data reporting and auditing requirements. Planning would require a multi-year effort. This proposal would cover the initial planning stages of that effort, with the requested resources only for 2025-26.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $1.2 million in 2025-26 to support planning to modernize the consumer and provider complaint Customer Relationship Management System in the department's Help Center. Specifically, these resources would support the following:

Office of Technology and Innovation - $1.2 million Consultant and Interagency Costs

- $912,000 would support consultant funding for the planning stage of the CRM, including project planning and assistance with Project Approval Lifecycle development
- $245,000 would support oversight by the California Department of Technology Project Approval Lifecycle oversight and related fees.

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 DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Web Accessible Service Portal (WASP) Replacement

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $618,000 in 2025-26 and $348,000 in 2026-27. If approved, these resources would support replacement of the existing Web Accessible Service Portal enterprise service management system.

Program Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
0933 – Managed Care Fund	$618,000	$348,000
Total Funding Request:	**$618,000**	**$348,000**
Total Requested Positions:	**0.0**	**0.0**

Background. DMHC's Office of Technology and Innovation (OTI) and Office of Administrative Services (OAS) currently utilizes the Cherwell enterprise service management cloud-based solution to manage information technology (IT) incidents, change requests and asset management as requested by DMHC users and employees. The current Cherwell software system and associated costs were funded by the DMHC with existing budget savings. DMHC reports its current resource funding levels cannot be supported long-term and are not sufficient to initiate replacement of the Cherwell system while maintaining functionality for the current system.

In addition, the existing Cherwell system will be discontinued and reach end-of-life on December 31, 2026, after which the cloud service offering will no longer be available for use. DMHC requires additional funding to migrate its existing Cherwell solution to a new cloud provider to meet mission critical business needs. DMHC is requesting funding to facilitate the procurement of a new platform and fund consulting services required for the successful implementation of the new system.

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Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $618,000 in 2025-26 and $348,000 in 2026-27 to support replacement of the existing Web Accessible Service Portal enterprise service management system. Specifically, these resources would support the following:

Office of Technology and Innovation - $618,000 million Consultant, Interagency and Licensing Costs

- $268,000 in 2025-26 and $137,000 in 2026-27 would support consultant funding to implement a modern enterprise service management solution with a more accessible and intuitive user interface.
- $284,000 in 2025-26 and $142,000 in 2026-27 would support oversight by the California Department of Technology Project Approval Lifecycle oversight and related fees.
- $66,000 in 2025-26 and $69,000 in 2026-27 would support annual licensing costs for acquisition of the new platform.

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 DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: Program Workload Resources

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $2.6 million in 2025-26, $2.3 million in 2026-27, $2.5 million in 2027-28, 2.5 million in 2028-29, and $2.5 million annually thereafter. If approved, these resources would support modernization of information technology infrastructure and ongoing consultant costs to address increased volumes of consumer complaints and mandated caseloads.

Program Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$2,569,000	$2,339,000
Total Funding Request:	**$2,569,000**	**$2,339,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2027-28: $2,451,000; 2028-29: $2,475,000; 2029-30 and ongoing: $2,501,000.

Background - Help Center. DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a service as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints.

The Help Center also manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

Background - Office of Plan Monitoring. The Office of Plan Monitoring (OPM) monitors health plan networks and delivery systems. OPM conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. OPM also monitors health plan provider networks and the accessibility of services to enrollees by

reviewing the geographic standards, provider-to-patient ratios, and timely access to care. Additionally, OPM reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

Background - Office of Enforcement. The Office of Enforcement represents the department in actions to enforce managed health care laws. The primary purpose of an enforcement action is to change plan behavior to comply with the law, and may include issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. When necessary, the Office pursues legal action to ensure health plans follow the law.

Background - Office of Technology and Innovation. The Office of Technology and Innovation provides technology support to the department including hardware, software, and information security services.

Staffing and Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $2.6 million in 2025-26, $2.3 million in 2026-27, $2.5 million in 2027-28, 2.5 million in 2028-29, and $2.5 million annually thereafter to support modernization of information technology infrastructure and ongoing consultant costs to address increased volumes of consumer complaints and mandated caseloads. Specifically, DMHC requests the following resources:

Office of Technology and Innovation – $580,000 in 2025-26, $349,000 in 2026-27, $459,000 in 2027-28 $511,000 in 2028-29, and $537,000 annually thereafter

- $362,000 in 2025-26, $23,000 in 2026-27, $25,000 in 2027-28 $56,000 in 2028-29, and $59,000 annually thereafter would support updates to aging network hardware including device models, switches, and access points.
- $102,000 in 2025-26, $203,000 in 2026-27, $305,000 in 2027-28 $320,000 in 2028-29, and $336,000 annually thereafter would support transition from physical, on-site servers to virtual server infrastructure.
- $20,000 annually would support anticipated increases in fees from the California Department of Technology for internet connectivity, audit and oversight, and email services.
- $96,000 in 2025-26, $102,000 in 2026-27, $107,000 in 2027-28 $112,000 in 2028-29, and $118,000 annually thereafter would support increased licensing costs for virtual private network security for handling confidential document software.

Help Center – $748,000 in 2025-26, $749,000 in 2026-27, $751,000 in 2027-28, and $723,000 annually thereafter

- $601,000 annually would support increased workload volume and consulting rates for Independent Medical Reviews
- $25,000 in 2025-26, $26,000 in 2026-27, and $28,000 in 2027-28 would support limited term funding for annual technical support and maintenance of the department's third party vendor portal for its Independent Dispute Resolution Process.
- $47,000 annually would support increased needs for medical expert reviews.
- $75,000 annually would support additional written translation and desktop publishing services to support consumers with limited English proficiency.

Office of Plan Monitoring – $1.1 million annually

- $64,000 annually would support consultant fees to provide statistical analysis of provider network data and develop formulas.
- $1.1 million annually would support increased rates for clinical consulting services.

Office of Enforcement - $122,000 annually

- $122,000 annually would support filling a funding shortfall for the Office of Enforcement's eDiscovery Solution, which is utilized by DMHC enforcement staff to manage enforcement actions.

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 DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Implementation of Chaptered Legislation (AB 3275, AB 2072, AB 2434, AB 1842, SB 1180, SB 1120, SB 729, AB 3059, AB 2063)

AB 3275 (Soria)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests 17 positions and expenditure authority from the Managed Care Fund of $4.6 million in 2025-26, 24 positions and $5.4 million in 2026-27, $5.4 million in 2027-28, $5.4 million in 2028-29, and $5.5 million annually thereafter. If approved, these positions and resources would support the planning phase to implement an Electronic Filing and Analysis of Claims (eFAC) Settlement data solution, pursuant to the requirements of AB 3275 (Soria), Chapter 763, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$4,568,000	$5,385,000
Total Funding Request:	**$4,568,000**	**$5,385,000**
Total Requested Positions:	**17.0**	**24.0**

* Additional fiscal year resources requested – 2027-28: $5,381,000; 2028-29: $5,425,000; 2029-30 and ongoing: $5,477,000.

Background. AB 3275 (Soria), Chapter 763, Statutes of 2024, requires health plans, beginning January 1, 2026, to reimburse a claim within 30 calendar days after receipt of the claim, or if a claim is contested or denied, notifying the claimant in writing within 30 calendar days. AB 3275 also increases the penalty on health plans that fails to automatically pay interest owed on a claim, raising it from $10 to $15 or 10 percent of the accrued interest on the claim. Additionally, AB 3275 requires that member complaints regarding delayed or denied claim payments be treated as a grievance, making them subject to grievance-related provisions of the Knox-Keene Act. This includes the option to file a complaint directly with the health plan as well as with DMHC.

According to DMHC, AB 3275 would require the department to do the following:

- Promulgate and amend applicable regulations to clarify the requirements of AB 3275.
- Review the health plan policies and procedures submitted by health plans
- Review quarterly and annual financial statements submitted by health plans to analyze increased administrative costs resulting from AB 3275 requirements.
- Address an increased number of health care consumer and provider complaints.
- Address an increased number of significant matter enforcement referrals

Staffing and Resource Request. DMHC requests 17 positions and expenditure authority from the Managed Care Fund of $4.6 million in 2025-26, 24 positions and $5.4 million in 2026-27, $5.4 million in 2027-28, $5.4 million in 2028-29, and $5.5 million annually thereafter. If approved, these positions and resources would support the planning phase to implement an Electronic Filing and Analysis of Claims (eFAC) Settlement data solution, pursuant to the requirements of AB 3275 (Soria), Chapter 763, Statutes of 2024. Specifically, DMHC requests the following positions and resources:

Office of Legal Services – Two positions

- **One Attorney III** position would coordinate complex policy concerns and policy recommendations with other DMHC offices as regulations are developed, draft regulation text, and monitor regulation through formal rule making process.
- **One Research Data Specialist III** position would assist the attorney in researching and gathering information for applicable legal questions presented to the Office of Financial Review, assist in crafting legal positions, and review and analyze Public Record Act and Information Practices Act requests.

Office of Financial Review – Eight positions and $69,000 consultant and licensing costs in 2025-26; 13 positions and $10,000 consultant and licensing costs in 2026-27 and annually thereafter

- **Two Corporation Examiner IV Specialist** positions would review complex claims, coordinate investigation referrals, update examination procedures and collaborate with online claims portal updates.
- **Four Corporation Examiners** in 2025-26 and **four additional Corporation Examiners** in 2026-27 and annually thereafter would review claims, conduct examination of health plans, prepare preliminary and final reports and monitor corrective action plan in compliance with the Knox-Keene Act.
- **One Corporation Examiner IV Supervisor** in 2025-26 and **one additional Corporation Examiner IV Supervisor** in 2026-27 and annually thereafter would provide health plan examination activity oversight and collaborate with management teams and health plans on corrective action plans and other examination result outcomes.
- **One Supervising Corporation Examiner** would provide health plan examination activity oversight and collaborate with management teams and health plans on corrective action plans and other examination result outcomes.
- $8,000 in 2025-26 and $13,000 annually thereafter would support statistical analysis licensing costs to conduct financial reviews of health plans for determining compliance with the Knox-Keene Act.
- $61,000 in 2025-26 and $10,000 annually thereafter to support a consultant contract and anticipated Department of General Services service fees to support ongoing review and maintenance of claim sampling methodology tools.

Help Center – Two positions

- **One Attorney III** position would mediate and analyze complaints and develop a plan response, including composing medical expert analysis requests, independent medical review justifications and act as liaison, provide counsel, respond to inquiries and handle legal referrals and submit to the DMHC's Office of Enforcement.
- **One Associate Governmental Program Analyst (AGPA)** would analyze, process and assist in resolving complaints, including assisting legal staff and clinical staff on subcase reviews and grievances.

Office of Enforcement – Three positions

- **Three Attorneys** would be responsible for providing legal support to investigate referral cases, including the preparation and oversight of the investigation and course of resolution, performing legal

review and analysis of the findings reports, conducting legal research of statutes, and responding to legal questions during the investigations and developing response strategies.

Office of Administrative Services – One position in 2025-26; two positions in 2026-27 and annually thereafter

- **One AGPA** in 2025-26 and **one additional AGPA** in 2026-27 and annually thereafter would perform additional ongoing administrative workload.

Office of Technology and Innovation – One position and $371,000 consultant funding

- **One Information Technology Specialist (ITS) I** position in 2025-26 and **one additional ITS I** position in 2026-27 and annually thereafter would support information technology needs related to program expansion.
- $191,000 in 2025-26 would support project planning and assistance with Project Approval Lifecycle development for the eFAC solution. Of this amount, $61,000 would support interagency costs for the California Department of Technology, and $130,000 would support consultant funding to assist with development.
- $180,000 in 2025-26 would support consultant funding to address maintenance and operations workload of legacy applications.

AB 2072 (Weber) and AB 2434 (Grayson)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $508,000 in 2025-26. If approved, these resources would support an impact analysis of multiple employer welfare arrangements pursuant to the requirements of AB 2072 (Weber), Chapter 374, Statutes of 2024, and AB 2434 (Grayson), Chapter 398, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27**
0933 – Managed Care Fund	$508,000	$-
Total Funding Request:	**$508,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. SB 718 (Bates), Chapter 736, Statutes of 2021, and SB 255 (Portantino), Chapter 725, Statutes of 2021, allowed biomedical multi-employer welfare arrangements (MEWAs) and film and television production MEWAs to offer large group coverage, provided they meet specific requirements. SB 718 and SB 255 created exceptions to the general rule that small employers and individuals cannot purchase large group coverage through an Association Health Plans (AHP) or MEWA.

To qualify as a MEWA that can offer large group coverage, the MEWA must comply with a variety of requirements. For example, the MEWA must be headquartered in California, must have been established prior to March 23, 2010, and must be an organization whose member employers have a commonality of interests beyond simply the provision of health care.

Additionally, to ensure consumer protections, the MEWA must offer employees a level of coverage with an actuarial value equal to or greater than the platinum level of coverage pursuant to the California Health Benefit Exchange. The MEWA may not charge employees or dependents a premium based on their health status, nor may it deny coverage based on a preexisting condition. To qualify, the MEWA must also have filed an application for registration with the DMHC on or before June 1, 2022.

AB 2072 (Weber), Chapter 374, Statutes of 2024, extended the sunset date originally included in SB 718 and SB 255 from January 1, 2026, to January 1, 2030.

AB 2434 (Grayson), Chapter 398, Statutes of 2024, allowed a new category of MEWA to offer large group coverage by authorizing an association with small employer members in the engineering, surveying, or design industry to purchase large group health care coverage through a MEWA if certain conditions are met. The requirements in the bill are like the requirements for biomedical or film and television production MEWAs in existing law. AB 2434 also requires the association and MEWA to file their registration with DMHC on or before June 1, 2025, and provide annual compliance filings. A health plan cannot offer large group coverage to any association or MEWA unless it has registered with DMHC and complies with the requirements set forth by AB 2434. The provisions of AB 2434 are set to expire after January 1, 2030.

According to DMHC, AB 2072 and AB 2434 requires the department to do the following:

- Provide the health policy committees of the legislature with the most recent MEWA filings on or before June 30, 2026.
- Conduct an analysis of the impacts of MEWAs on the small employer market and post a summary of its analysis on the DMHC website by July 1, 2026.
- Conduct an analysis of the impact of health plans and health insurers offering large group contracts and policies to small employers through MEWAs.
- Post a summary of this analysis on the DMHC website by July 1, 2026.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $508,000 in 2025-26 to support an impact analysis of multiple employer welfare arrangements pursuant to the requirements of AB 2072 (Weber), Chapter 374, Statutes of 2024, and AB 2434 (Grayson), Chapter 398, Statutes of 2024. Specifically, DMHC requests the following resources:

Office of Financial Review - $508,000 for consultant funding

- $508,000 would support a consultant to conduct an impact analysis of MEWAs on the small group market.

AB 1842 (Reyes)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $64,000 in 2025-26 and $133,000 annually thereafter. If approved, these resources would support specialized consulting funding to develop survey methodology and provide clinical review during health plan surveys, pursuant to the requirements of AB 1842 (Reyes), Chapter 633, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$64,000	$133,000
Total Funding Request:	**$64,000**	**$133,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2026-27.

Background. AB 1842 (Reyes), Chapter 633, Statutes of 2024, expands on the recent work of the federal government to mainstream addiction treatment by eliminating the unnecessary barriers to treatment. AB 1842 requires group or individual health plans to cover at least one drug in specified OUD treatment categories without prior authorization, step therapy, or utilization review. Health plans would be permitted to select generic drugs and other specified versions to meet the requirements of AB 1842.

According to DMHC, AB 1842 requires the department to:

- Provide statistical consultation to develop methodology for routine surveys that require a focused file review of SUD medication assisted treatment files and review methodology for follow-up surveys conducted.
- Provide clinical review during routine and follow-up survey activity of SUD drug files.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $64,000 in 2025-26 and $133,000 annually thereafter to support specialized consulting funding to develop survey methodology and provide clinical review during health plan surveys, pursuant to the requirements of AB 1842 (Reyes), Chapter 633, Statutes of 2024.Specifically, DMHC requests the following resources:

Office of Plan Monitoring - $64,000 in 2025-26 and $133,000 annually thereafter for consultant costs

- $50,000 in 2025-26 and $112,000 annually thereafter would support clinical consulting services to provide clinical review of substance use disorder drug files.
- $14,000 in 2025-26 and $21,000 annually thereafter would support statistical consulting services to develop methodology for surveys requiring a focused review of substance use disorder and review methodology for follow-up surveys to be conducted.

SB 1180 (Ashby)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests one position and expenditure authority from the Managed Care Fund of $357,000 in 2025-26, $421,000 in 2026-27, $423,000 in 2027-28, $425,000 in 2028-29, and $427,000 annually thereafter. If approved, this position and resources would support clinical and statistical consulting to implement the requirements of SB 1180 (Ashby), Chapter 884, Statutes of 2024.

Multi-Year Funding Request Summary

Fund Source	2025-26	2026-27*
0933 – Managed Care Fund	$357,000	$421,000
Total Funding Request:	**$357,000**	**$421,000**
Total Requested Positions:	**1.0**	**1.0**

* Additional fiscal year resources requested – 2027-28: $423,000; 2028-29: $425,000; 2029-30 and ongoing: $427,000.

Background. SB 1180 (Ashby), Chapter 884, Statutes of 2024, requires health plans to establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program. It also prohibits health plan enrollees from being charged more than the in-network cost-sharing amount, regardless of whether the service provider's network status. Additionally, SB 1180 requires that the reimbursement rates may not exceed the health plan's usual and customary charges for services rendered. This bill applies to health plans issued, amended, or renewed on or after July 1, 2025.

According to DMHC, SB 1180 would require the department to:

- Review health plan data and contracts to ensure compliance.
- Provide clinical review of paramedicine service files during annual health plan surveys.

Staffing and Resource Request. DMHC requests one position and expenditure authority from the Managed Care Fund of $357,000 in 2025-26, $421,000 in 2026-27, $423,000 in 2027-28, $425,000 in 2028-29, and $427,000 annually thereafter to support clinical and statistical consulting to implement the requirements of SB 1180 (Ashby), Chapter 884, Statutes of 2024. Specifically, DMHC requests the following position and resources:

Office of Plan Licensing – One position

- **One Attorney III** position would conduct legal research to determine criteria and requirements for implementation, and annually review evidence of coverages, provider contracts, plan-to-plan contracts and other health plan documents to ensure compliance with SB 1180 requirements.

Office of Plan Monitoring - $64,000 in 2025-26 and $133,000 annually thereafter for consultant costs

- $50,000 in 2025-26 and $112,000 annually thereafter would support clinical consulting service to provide clinical review of paramedicine service files during health plan surveys.
- $14,000 in 2025-26 and $21,000 annually thereafter would support statistical consulting to develop and maintain statistical data review methodologies for health plan surveys.

Office of Technology and Innovation - $36,000 in 2025-26, $38,000 in 2026-27, $40,000 in 2027-28, $42,000 in 2028-29, and $44,000 annually thereafter for software and licensing costs

- $36,000 in 2025-26, $38,000 in 2026-27, $40,000 in 2027-28, $42,000 in 2028-29, and $44,000 annually thereafter for software and licensing costs

SB 1120 (Becker)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests three positions and expenditure authority from the Managed Care Fund of $761,000 in 2025-26 and $740,000 annually thereafter. If approved, these positions and resources would support development of survey methodologies and clinical review to implement the requirements of SB 1120 (Becker), Chapter 879, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$761,000	$740,000
Total Funding Request:	**$761,000**	**$740,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2026-27.

Background. SB 1120 (Becker), Chapter 879, Statutes of 2024, requires a health plan, including a specialized health plan, that uses artificial intelligence (AI), algorithm, or other software tool for the purpose of utilization review or utilization management functions based in whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the tool base its determination on specified information and be fairly and equitably applied

Additionally, SB 1120 prohibits AI, algorithms, or other software tools from making a decision to deny, delay or modify health care services based, in whole or in part, on medical necessity. SB 1120 also requires adverse medical necessity decisions be made only by a competent licensed physician or a licensed health care professional.

According to DMHC, SB 1120 requires the department to:

- Revise survey methodology and develop tools to assess health plan compliance.
- Review health plan processes, including any automated decision-making tools to ensure compliance.
- Review health plan utilization management filings and other health plan documents to ensure compliance.
- Review health plan documents to ensure that only competent licensed physicians or licensed health care professionals make adverse utilization management decisions.

Staffing and Resource Request. DMHC requests three positions and expenditure authority from the Managed Care Fund of $761,000 in 2025-26 and $740,000 annually thereafter to support development of survey methodologies and clinical review to implement the requirements of SB 1120 (Becker), Chapter 879, Statutes of 2024. Specifically, DMHC requests the following positions and resources:

Office of Legal Services – Two positions

- **One Attorney** would promulgate the applicable regulation, conduct legal research, provide legal support for committees and meetings related to legal recommendations, and lead post-implementation actions.

- **One Health Program Specialist I** position would assist attorneys and manage the research and development of regulations, assist in conducting stakeholder meetings and address requests for information related to SB 1120, and lead DMHC's efforts to research state and national trends in health care technology.

Office of Plan Monitoring – One position and $92,000 consultant funding

- **One Attorney III** position would conduct complex utilization management legal review, grievances and appeals and quality assurance documents; provide counsel and respond to SB 1120 compliance inquires, offering legal guidance and consultation to DMHC's Office of Plan Licensing in their review of health plan material modification compliance filings; and coordinate with DMHC's contracted clinical consultants as needed.
- $77,000 would support clinical consulting services to provide clinical review during medical surveys.
- $15,000 would support statistical consultants to develop data review methodologies.

Office of Technology and Innovation - $28,000 software licensing costs

- $28,000 would support software licensing costs for the Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform for the new positions requested in this proposal.

SB 729 (Menjivar)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests three positions and expenditure authority from the Managed Care Fund of $691,000 in 2025-26, seven positions and $2 million in 2026-27, and $2.1 million annually thereafter. If approved, these positions and resources would support implementation of coverage for treatment of infertility and fertility services, pursuant to the requirements of SB 729 (Menjivar), Chapter 930, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$691,000	$2,030,000
Total Funding Request:	**$691,000**	**$2,030,000**
Total Requested Positions:	**3.0**	**7.0**

* Additional fiscal year resources requested – 2027-28 and ongoing: $2,125,000.

Background. SB 729 (Menjivar), Chapter 930, Statutes of 2024, requires a large group health plan contract that is issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services and removes the exclusion of in vitro fertilization (IVF) from coverage. SB 729 also revises the definition of infertility and prohibits a health plan from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, compared to other conditions. SB 729 also requires a small group health care service plan contract to offer such coverage.

Additionally, SB 729 exempts health care benefit plans or contracts entered into with the Board of Administration of the California Public Employees' Retirement System (CalPERS) until July 1, 2027. The bill does not apply to Medi-Cal managed care plan contracts nor to a religious employer.

According to DMHC, SB 729 requires the department to:

- Develop tools and guidance to assess health plan compliance.
- Conduct file reviews during surveys to monitor health plan operations for compliance.
- Provide statistical consultation to develop file selection and review methodology for routine and follow-up surveys.
- Provide clinical review during routine and follow-up survey activity to ensure compliance.
- Conduct enforcement investigation of non-compliance with the requirements of SB 729.

Staffing and Resource Request. DMHC requests three positions and expenditure authority from the Managed Care Fund of $691,000 in 2025-26, seven positions and $2 million in 2026-27, and $2.1 million annually thereafter. If approved, these positions and resources would support implementation of coverage for treatment of infertility and fertility services, pursuant to the requirements of SB 729 (Menjivar), Chapter 930, Statutes of 2024. Specifically, DMHC requests the following positions and resources:

Office of Enforcement – Four positions and $106,000 consultant costs (beginning 2026-27)

- **Two Attorney III** positions would provide legal support to investigate the highly complex referral cases, including the preparation and oversight of the investigation and course of resolution; perform complex legal review and analysis of the findings reports; conduct legal research of statutes; respond to complex legal questions during the investigations; develop strategies to respond to difficult and sensitive matters; and serve as lead counsel throughout all stages of litigation, including pre-trial, trial, hearing and post-trial proceedings.
- **One Attorney** would provide legal support to investigate referral cases, including the preparation and oversight of the investigation and course of resolution; perform legal review and analysis of the findings reports; conduct legal research of statutes; respond to legal questions during the investigations; and develop response strategies.
- **One Senior Legal Analyst** would support the attorneys by planning investigations and discovery for cases, conducting research, analyzing discovery materials, and assisting attorneys in preparing for trials and hearings.
- $46,000 annually would support expert witness consultants for any case that proceeds to trial
- $60,000 annually would support trial-related costs including court reporting, transcription services and other costs.

Office of Plan Monitoring – Three positions and $21,000 in 2025-26, $359,000 in 2026-27 and $464,000 annually thereafter for consultant funding

- **One Attorney IV** position would address highly complex and in-depth legal analysis findings from the survey activity related to SB 729, provide highly complex legal guidance to assist in finalizing corrective action plans and referrals to the Office of Enforcement, and provide ongoing complex legal

guidance and assist staff and consultants to maintain and update compliance tools and program processes and procedures for department review of clinical criteria and guidelines.

- **One Health Program Specialist II** position would provide analytical and managerial support for SB 729 survey activities, including the preparation of reports and supporting documentation; oversee corrective action plan submittals and manage the coordination of documents and data; and collaborate with legal and vendor teams to regularly update compliance tools, ensuring they reflect the latest changes in law and regulations and making necessary revisions.
- **One Health Program Specialist I** position would provide analytical support and coordination for SB 729 survey activities; and assist in the planning, scheduling and developing timelines for each survey, ensuring proper documentation and communication are maintained in the OPM records system.
- $7,000 in 2025-26, $345,000 in 2026-27, and $464,000 annually thereafter would support clinical consulting services to provide clinical review of amendments to health plan utilization management, access, and availability, behavioral health and quality assurance policies to assess compliance with SB 729 during medical surveys.
- $14,000 in 2025-26 and $21,000 annually thereafter would support statistical consulting services to develop a legally defensible methodology for assessing and identifying compliance issues regarding health plan compliance through log analysis and targeted file review.

Office of Technology and Innovation - $25,000 in 2025-26 and $33,000 annually thereafter for software licensing costs

- $25,000 in 2025-26 and $33,000 annually thereafter for software licensing costs for access to the Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform for the new positions requested in this proposal.

AB 3059 (Weber)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $64,000 in 2025-26 and $133,000 annually thereafter. If approved, these resources would support specialized consulting funding for clinical and statistical consultants to implement the requirements of AB 3059 (Weber), Chapter 975, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$64,000	$133,000
Total Funding Request:	**$64,000**	**$133,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2026-27.

Background. AB 3059 provides that the provision of medically necessary pasteurized donor human milk obtained from a licensed tissue bank is within the existing requirement for health plans to cover basic health care services. The bill also adds an exemption to tissue bank licensure requirements for hospitals' storage and distribution of pasteurized human milk obtained from licensed donor milk banks.

According to DMHC, AB 3059 would require the department to:

- Provide statistical consultation to develop methodology for routine surveys that require a focused review of files related to coverage of human milk and human milk derivatives and review methodology for follow-up surveys conducted.
- Provide clinical review of files related to coverage of human milk and human milk derivatives during routine and follow-up survey assessments and draft deficiencies, as needed.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $64,000 in 2025-26 and $133,000 annually thereafter. If approved, these resources would support specialized consulting funding for clinical and statistical consultants to implement the requirements of AB 3059 (Weber), Chapter 975, Statutes of 2024. Specifically, DMHC requests the following resources:

Office of Plan Monitoring - $64,000 in 2025-26 and $133,000 annually thereafter for consultant costs

- $50,000 in 2025-26 and $112,000 annually thereafter would support clinical consulting services to provide clinical review during routine and follow-up survey activity to determine compliance with AB 3059.
- $14,000 in 2025-26 and $21,000 annually thereafter would support statistical consulting services to develop methodologies for surveys requiring a focused review of human milk services, assist other divisions with issues related to AB 3059, and establish selection and review methodologies for follow-up surveys.

AB 2063 (Maienschein)

Legislative Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $178,000 in 2027-28 and 2028-29 for specialized consulting services to implement the requirements of AB 2063 (Maienschein), Chapter 818, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0933 – Managed Care Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2027-28: $178,000; 2028-29: $178,000.

Background. A Voluntary Employees' Beneficiary Association (VEBA) is a tax-advantaged entity for funding certain employee benefits, including health care coverage. Employees can participate in a VEBA based on their common employment-related bond, such as a common employer, coverage under one or more collective bargaining agreements, or membership in a labor union. A VEBA may be associated with an employee welfare benefit plan under the federal Employee Retirement Income Security Act of 1974 (ERISA).

AB 1124 (Maienschein), Chapter 266, Statutes of 2020, authorized two pilot programs, one in Northern California and one in Southern California, under which one VEBA or one trust fund in either region would

be exempt from licensure under the Knox-Keene Act, provided the VEBAs partnered with a risk bearing organization and met certain eligibility criteria. The purpose of the pilot programs was to demonstrate that these arrangements can provide high quality care at a lower cost compared to a fee-for-service reimbursement model.

AB 2063 (Maienschein), Chapter 818, Statutes of 2024, grants a two-year extension for the pilot program in Southern California, allowing it to operate until December 31, 2027. AB 2063 also extends the deadline for DMHC to submit a report on the pilot program effectiveness, moving it from January 1, 2027 to January 1, 2029.

According to DMHC, AB 2063 will require the department to:
- Provide review of clinical patient outcomes reported by pilot participants.
- Report the pilot program findings to the Legislature by January 1, 2029. The report must include the information provided by the VEBA or trust fund (cost savings, clinical patient outcomes and enrollee satisfaction), as well as information on grievances and appeals and independent medical reviews. The DMHC may authorize a public or private third party to prepare the report.

Additionally, AB 2063 requires the pilot program participants to reimburse DMHC for reasonable regulatory costs up to $500,000 for all the following:
- Commissioning the report to the Legislature by January 1, 2029.
- Developing an application process for the pilot program
- Monitoring compliance

Resource Request DMHC requests expenditure authority from the Managed Care Fund of $178,000 in 2027-28 and 2028-29 for specialized consulting services to implement the requirements of AB 2063 (Maienschein), Chapter 818, Statutes of 2024. Specifically, DMHC requests the following resources:

Office of Financial Review - $178,000 in 2027-28 and $178,000 in 2028-29 for consulting costs

- $178,000 in 2027-28 and $178,000 in 2028-29 would support clinical consulting services to provide review of clinical patient outcomes reported by the VEBA pilot participant.

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 DMHC to respond to the following:

1. Please provide a brief overview of these proposals.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Overview and Open Enrollment Update

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013, more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals with incomes between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.

- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94, 87 or 73 percent of medical expenses.

- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.

- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers" https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/*

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum).

Individual Mandate Penalty and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate penalty. The individual mandate penalty was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate penalty, individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures, which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan beneficiaries with incomes under 250 percent of the FPL. These cost-sharing reductions result in

savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until 2017, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes under 250 percent of the FPL. According to Covered California, the loss of these subsidies resulted in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction took effect for coverage in the 2019 calendar year.

State Subsidy Program and State Individual Mandate Penalty. The 2019 Budget Act included General Fund expenditure authority of $428.6 million in 2019-20, $479.8 million in 2020-21, and $547.2 million in 2021-22 to provide state premium subsidies for individuals up to 600 percent of the FPL purchasing health care coverage in Covered California. Approximately 17 percent of the funds supplemented federal APTC subsidies for individuals with incomes between 200 and 400 percent of the FPL (between $51,500 and $103,000 for a family of four) and approximately 83 percent for individuals with incomes between 400 and 600 percent of the FPL (between $103,000 and $154,500 for a family of four). The funding also covered full premium costs for individuals below 138 percent of the FPL ($35,500 for a family of four). In addition, the 2019 Budget Act included trailer bill language to implement a penalty on individuals that fail to maintain minimum essential coverage during a coverage year, to encourage enrollment in the absence of the federal individual mandate penalty. The minimum penalty is $695 for adults in a household and $347.50 for each child. The revenue from the penalty was intended to offset General Fund expenditures for the state subsidy program. According to Covered California, as of June 2020, approximately 598,000 individuals received state subsidies, with 546,000 under 400 percent of the FPL receiving an average of $14 per month and 42,000 between 400 and 500 percent of the FPL receiving an average of $301 per month.

The Federal American Rescue Plan and Inflation Reduction Act Offer More Generous Subsidies. In March 2021, President Biden signed the American Rescue Plan (ARP), which made a significant investment in advance premium tax credits (APTC) to improve affordability for consumers seeking health care coverage in health benefit exchanges, including Covered California. For the 2021 and 2022 plan years, the ARP removes the income eligibility cap on APTC premium subsidies, which previously limited subsidies to individuals at or below 400 percent of the FPL. The ARP provides subsidies so that no individual at any income level will have to pay more than 8.5 percent of their income for a silver plan in an ACA marketplace, such as Covered California. In addition, no individual with income below 150 percent of the FPL, or any individual that receives unemployment insurance payments at any point in 2021, will pay any premiums at all for silver level coverage.

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state

subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state subsidy program resulting from the more generous federal premium subsidies. On August 16, 2022, President Biden signed the Inflation Reduction Act, which extended the ARP subsidies through the 2025 plan year.

Health Care Affordability Reserve Fund. The 2021 Budget Act included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimated the state would receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures. The 2023 Budget Act included trailer bill language to permanently transfer revenues received from the individual mandate penalty into the Health Care Affordability Reserve Fund. Previously, these revenues were transferred directly to the General Fund and used to balance the state budget.

Cost-Sharing Reduction Subsidies. The 2023 Budget Act included expenditure authority from the Health Care Affordability Reserve Fund of $82.5 million in 2023-24 and $165 million annually thereafter to support a program of financial assistance for individuals purchasing coverage in the Covered California health benefit exchange. For the 2024 coverage year, these subsidies will result in elimination of deductibles and reduction in copayments and other health care cost sharing for more than 600,000 Californians. The Legislature also approved trailer bill language to require all revenues collected from the individual mandate penalty to be annually deposited in the Health Care Affordability Reserve Fund to be used by Covered California to improve affordability in the health benefit exchange.

2025 Open Enrollment Update. The 2025 Open Enrollment period began on November 1st, 2024, and closed on January 31st, 2025, for the 2025 coverage year. The 2025 Open Enrollment continued to benefit from implementation of more generous federal subsidies from the American Rescue Plan, extended by the Inflation Reduction Act, as well as implementation of a one-dollar state subsidy program to allow for zero-dollar premiums for income-eligible individuals and the cost-sharing reduction subsidy program established by the 2023 Budget Act.

According to Covered California, as of January 31st, 2025, nearly two million Californians enrolled in coverage through the Covered California health benefits exchange, including more than 1.6 million Californians renewing coverage and more than 345,000 newly enrolled. Covered California reports that the federal subsidies available through the Inflation Reduction Act, coupled with California's new cost-sharing reduction program, helped create the record high enrollment seen in the 2025 Open Enrollment. According to Covered California, the state's uninsured rate has fallen from 17.2 percent in 2014 to 6.4 percent in 2023, the largest percentage point drop for any state in the nation during the Affordable Care Act era. More than 6.3 million Californians, or approximately one in six, have had marketplace coverage since 2014.

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 Covered California to respond to the following:

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

2. Please provide an update on enrollment in Covered California during the most recent open enrollment period.

3. Please provide an update on development of the program design for the 2026 Open Enrollment with the additional resources authorized in the 2023 Budget Act, as well as the likely expiration of the enhanced federal premium tax credits.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Behavioral Health Programs Overview

Funding for Community Mental Health Programs – *Multi-Year Funding Summary*			
Fund Source	**2023-24**	**2024-25**	**2025-26**
1991 Realignment (base and growth):			
Mental Health Subaccount	$444,654,000	$534,981,000	$569,008,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,120,551,000	$1,130,428,000	$1,129,992,000
Behavioral Health Subaccount	$2,221,667,000	$2,224,500,000	$2,323,270,000
Realignment Total	**$3,786,872,000**	**$3,889,909,000**	**$4,022,270,000**
Medi-Cal SMHS Federal Funds	**$2,656,490,000**	**$4,170,882,000**	**$3,223,521,000**
Medi-Cal SMHS General Fund	**$1,066,058,000**	**$2,596,075,000**	**$1,945,693,000**
BHSA Local Expenditures	**$2,481,365,000**	**$2,728,157,000**	**$2,707,916,000**
Total Funds	**$9,990,785,000**	**$13,385,023,000**	**$11,899,400,000**

Community Mental Health - Overview. California's system of community mental health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, and resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Mental Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Mental Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments

including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional mental health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

2. **Managed care plans –** SB 1 X1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy

- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

   - Individual and group mental health evaluation and treatment (psychotherapy)
   - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
   - Outpatient services for the purposes of monitoring drug therapy
   - Outpatient laboratory, drugs, supplies and supplements
   - Psychiatric consultation

Background – The Mental Health Services Act (Proposition 63; 2004). In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. *Community Services and Supports (CSS):* 76 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations. 51 percent of CSS funds, or approximately 37 percent of total MHSA funding, is required to be spent on full service partnerships.

2. *Prevention and Early Intervention (PEI):* Up to 19 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties by the State Controller through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorized the use of up to five percent of annual revenues for state administration and specified that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs. State Administration funds have been used for a variety of state-directed purposes, including behavioral health workforce programs, the Mental Health Student Services Act, triage programs,

The Behavioral Health Services Act – Reforming the MHSA. SB 326 (Eggman), Chapter 790, Statutes of 2023, and AB 531 (Irwin), Chapter 789, Statutes of 2023, made significant changes to the MHSA, with many provisions appearing on the ballot as Proposition 1, approved by voters in March 2024. These changes recast the Mental Health Services Act as the Behavioral Health Services Act (BHSA), revising categories of expenditures for county behavioral health systems with a focus on housing interventions, expanding access to substance use disorder services, increasing transparency in county behavioral health planning, increasing evaluation and reporting on outcomes in the behavioral health system, and realigning oversight responsibilities between state departments and entities. In addition, Proposition 1 authorized $6.4 billion in bonds to construct, acquire, and rehabilitate more than 10,000 new treatment beds and supportive housing units, as well as sites to help serve more than 100,000 people annually.

Drug Medi-Cal - Overview. The Drug Medi-Cal program covers substance use disorder services by certified providers under contract with the counties or with DHCS. Drug Medi-Cal services are offered by counties either through the State Plan or through the Drug Medi-Cal Organized Delivery System (DMC-ODS), an expanded service delivery model offered under an 1115 Waiver authorized by the federal Centers for Medicare and Medicaid Services (CMS). Drug Medi-Cal provides State Plan services under four primary modalities:

- Narcotic Treatment Program – The Narcotic Treatment Program (NTP) provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.
- Outpatient Drug Free – Outpatient Drug Free (ODF) counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group counseling sessions per month. Counseling and rehabilitation services include: 1) admission physical examinations, 2) intake, 3)

medical necessity establishment, 4) medication services, 5) treatment and discharge planning, 6) crisis intervention, 7) collateral services, and 8) individual and group counseling.

- Intensive Outpatient Treatment – Intensive Outpatient Treatment (IOT) services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include: 1) admission physical examinations, 2) intake, 3) medication services, 4) treatment planning, 5) crisis intervention, 6) collateral services, 7) individual and group counseling, and 8) parenting education.
- Residential Treatment Services – Residential Treatment Services (RTS) provides rehabilitation services to perinatal beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in an effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

DMC-ODS counties, in addition to the four primary modalities, are required to offer the following services: 1) non-perinatal RTS, 2) withdrawal management (levels 1.0, 2.0, and 3.2), 3) recovery services, 4) case management, 5) physician consultation, and 6) expanded medication assisted treatment (buprenorphine, naloxone, and disulfiram). DMC-ODS counties may also offer: 1) additional medication assisted treatment (through non-NTP providers), 2) partial hospitalization, and 3) withdrawal management (levels 3.7 and 4.0).

Behavioral Health Continuum Infrastructure Program. The 2021 Budget Act included expenditure authority of $755.7 million ($445.7 million General Fund and $310 million Coronavirus Fiscal Recovery Fund or CFRF) in 2021-22, $1.4 billion ($1.2 billion General Fund and $220 million CFRF) in 2022-23 and $2.1 million General Fund in 2023-24 for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. Of this amount, $150 million was made available to support mobile crisis infrastructure, along with $55 million in federal grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA), for a total investment of $205 million. DHCS announced the BHCIP funding would be released in six rounds, as follows:

- Round 1: Mobile Crisis - $205 million
- Round 2: County and Tribal Planning Grants - $16 million
- Round 3: Launch Ready - $518.5 million
- Round 4: Children and Youth - $480.5 million
- Round 5: Behavioral Health Needs Assessment Phase One - $480 million
- Round 6: Behavioral Health Needs Assessment Phase Two - $480 million

The following facility types may be considered for project funding through BHCIP:

- Community wellness centers
- Hospital-based outpatient treatment (e.g. outpatient detox or withdrawal management)
- Intensive outpatient treatment
- Narcotic Treatment Programs (NTPs)
- NTP medication units
- Office-based outpatient treatment

- Sobering centers
- Acute inpatient hospitals – medical detox or withdrawal management
- Acute psychiatric inpatient facilities
- Adolescent residential treatment facilities for substance use disorders (SUD)
- Adult residential treatment facilities for SUD
- Chemical dependency recovery hospitals
- Children's crisis residential programs (CCRPs)
- Community treatment facilities (CTFs)
- Crisis stabilization units (CSUs)
- General acute care hospitals (GACHs) and acute care hospitals (ACHs)
- Mental health rehabilitation centers (MHRCs)
- Psychiatric health facilities (PHFs)
- Short-term residential therapeutic programs (STRTPs)
- Skilled nursing facilities with special treatment programs (SNFs/STPs)
- Social rehabilitation facilities (SRF)
- Peer respite
- Recovery residence/sober living homes

Funding may also be used for mobile crisis infrastructure.

Proposition 1 – Bond BHCIP. Proposition 1 included a $6.38 billion general obligation bond to develop an array of behavioral health treatment, residential care settings, and supportive housing to help provide appropriate care facilities for individuals experiencing mental health and substance use disorders. $4.4 billion of the bond funding will be used by DHCS for BHCIP competitive grants. According to DHCS, Round 1 of Bond BHCIP will focus on Launch Ready projects and will provide $3.3 billion statewide to eligible counties, cities, tribal entities, nonprofit organizations, and for profit organizations whose projects reflect the state's priorities and serve targeted populations. Award announcements for Round 1 are expected in May 2025. Round 2 of Bond BHCIP will consist of projects that support unmet needs. This funding round is expected to be released in May 2025.

Subcommittee Staff Comment—This is an informational item.

Questions. The subcommittee requests DHCS respond to the following:

1. Please provide a brief overview of the significant program changes related to specialty mental health or Drug Medi-Cal services for the 2024-25 and 2025-26 fiscal years.

Issue 2: Children and Youth Behavioral Health Initiative

Legislative Oversight – Children and Youth Behavioral Health Initiative Fee Schedule. As part of the Children and Youth Behavioral Health Initiative, DHCS in consultation with DMHC was required to implement a school-linked, statewide fee schedule for behavioral health services provided to children and youth in school settings. Though the fee schedule has been implemented since January 1, 2024, Local Educational Agencies (LEAs) have reported difficulty receiving reimbursement for services provided on school campuses, with some reporting they may need to lay off staff if they cannot be reimbursed timely. The subcommittee would like to explore how DHCS and LEAs can work together to find a solution to this problem.

Background. The 2021 Budget Act included expenditure authority of $1.4 billion ($1 billion General Fund, $100 million Coronavirus Fiscal Recovery Fund or CFRF, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.3 billion ($769.2 million General Fund, $429 million CFRF, and $124 million federal funds) in 2022-23, $275.2 million ($175.2 million General Fund and $100 million federal funds) in 2023-24, $262.1 million ($156.1 million General Fund and $106 million federal funds) in 2024-25, and $227.1 million ($121.1 million General Fund and $106 million federal funds) in 2025-26, to support the Children and Youth Behavioral Health Initiative and other interventions to support behavioral health services for students. The total investment over five years is $3.5 billion and includes the following components:

- *Mental Health Student Services Act Augmentation.* $205 million ($100 million CFRF and $105 million Mental Health Services Fund) in 2021-22 for the Mental Health Services Oversight and Accountability Commission (MHSOAC) to support grants to school and county mental health partnerships that support the mental health and emotional needs of children and youth as they return to schools and everyday life.

- *School-Linked Behavioral Health Partnerships.* $100 million CFRF in 2021-22 and $450 million in 2022-23 for the Department of Health Care Services (DHCS) to support school-linked behavioral health partnerships. Of the two year funding, $400 million would support county behavioral health department partnerships with schools and $150 million would support behavioral health services in higher education.

- *Medi-Cal Managed Care Plan Student Behavioral Health Incentive Program.* $400 million ($200 million General Fund and $200 million federal funds) for DHCS to support incentives for Medi-Cal managed care plans to provide mild-to-moderate behavioral health services to students in partnership with schools and county behavioral health departments.

- *Evidence-Based Behavioral Health Programs.* $429 million CFRF in 2022-23 for DHCS to develop and expand evidence-based behavioral health programs addressing early psychosis, disproportionately impacted communities and communities of color, youth drop-in wellness centers, intensive outpatient programs for youth, and prevention and early intervention services for youth. DHCS will coordinate with MHSOAC to implement these programs and allocate 10 percent of the funding for administration by the commission.

- *Behavioral Health Workforce Development.* $600 million General Fund in 2021-22, $125 million General Fund in 2022-23, and $75 million General Fund in 2023-24 for the Office of Statewide Health Planning and Development (OSHPD) to support programs to improve the capacity of the behavioral health workforce, including behavioral health counselors and coaches, substance use disorder counselors, psychiatric nurse practitioners, community health workers, psychosocial rehabilitation specialists, peer support specialists, and social workers.

- *Dyadic Services Benefit in Medi-Cal.* $200 million ($100 million General Fund and $100 million federal funds) annually beginning in 2022-23 for DHCS to add dyadic services as a Medi-Cal benefit.

- *Public Education and Change Campaign.* $5 million General Fund in 2021-22, $50 million General Fund in 2022-23, $40 General Fund in 2024-25, and $5 million General Fund in 2025-26 for the Department of Public Health (DPH) to conduct a comprehensive and linguistically proficient public education and change campaign to raise behavioral health literacy to normalize and support the prevention and early intervention of mental health and substance use challenges.

- *ACEs and Toxic Stress Awareness Campaign.* $25.1 million General Fund in 2021-22 and $100,000 General Fund in 2022-23 through 2025-26 for the Office of the Surgeon General (OSG) to conduct a public education campaign to raise awareness about prevention, signs, and self-care strategies for adverse childhood experiences (ACEs) and toxic stress.

- *Coordination, Subject Matter Expertise, and Evaluation.* $10 million General Fund in 2021-22, $20 million General Fund in 2022-23, $10 million General Fund in 2024-25, and $10 million General Fund in 2025-26 for the California Health and Human Services Agency (CHHSA) for coordination, subject matter expertise, and evaluation of the initiative.

- *Continuation of CalHOPE.* $45 million General Fund in 2021-22 for DHCS to continue CalHOPE, a crisis counseling program that includes a media campaign, web-based resources and services, a 24-hour warm line, and student support for social and emotional learning.

- *Planning for Behavioral Health Services and Supports Platform.* $10 million General Fund in 2021-22 for DHCS to support initial planning for implementation of a behavioral health services and supports platform to expand CalHOPE.

- *State Operations and Administration.* $44 million ($22 million General Fund and $22 million federal funds) in 2021-22, $48 million ($24 million General Fund and $24 million federal funds) in 2022-23, $12 million ($6 million General Fund and $6 million federal funds) in 2024-25, and $12 million ($6 million General Fund and $6 million federal funds) in 2025-26, for DHCS to support state operations and administration of the various components of the initiative.

School-Linked Statewide Fee Schedule. As part of the Children and Youth Behavioral Health Initiative, the Legislature approved trailer bill language to require DHCS to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a school site. A health care service plan, including a Medi-Cal managed care plan, or an insurer is, beginning January 1, 2024, required to reimburse school-based

services provided to one of its members according to the fee schedule, regardless of whether the provider is within the plan's or insurer's contracted provider network.

The 2023 Budget Act included expenditure authority from the Mental Health Services Fund of $10 million in 2023-24 to create statewide infrastructure for provider management and to manage billing for behavioral health services furnished to students under the Children and Youth Behavioral Health Initiative statewide fee schedule. These resources support development and implementation of the infrastructure for provider, billing, and claiming management for the behavioral health services provided to students as part of the Children and Youth Behavioral Health Initiative.

The Legislature also approved trailer bill language to authorize a contract with a third party administrator to administer the school-linked statewide behavioral health provider network and fee schedule authorized by the Children and Youth Behavioral Health Initiative. The language also authorized the imposition of a fee on health care service plans, insurers, and Medi-Cal managed care plans to support the contract with the third party administrator.

Local Educational Agencies, Advocates, and Providers Report Challenges with Fee Schedule. LEAs, advocates, and providers have reached out to legislative staff to report significant challenges related to the implementation of the statewide fee schedule. These challenges include the following:

1) **School Collection of Health Plan Information –** DHCS requires schools to collect health plan information for students, rather than DHCS or the third-party administrator, in order to receive reimbursement. Schools indicate this is difficult as schools are not often in receipt of this information from student families, and this requirement could result in reduced reimbursement for 20 to 40 percent of services provided.

2) **Inability to Receive Reimbursement –** LEAs, advocates and providers have indicated that there have been significant delays in Cohort 1 participants' ability to submit and receive reimbursement for claims. According to DHCS, only $4,720 has been paid in claims of a total of 133 claims that have been submitted.

In addition, several LEAs report that staff hired using one-time CYBHI funding, such as SBHIP or MHSSA, are receiving pink slips for the upcoming academic year because of uncertainty of ongoing funding under the fee schedule.

Panel Discussion. The subcommittee has invited the following panelists to discuss their experience with delivering behavioral health services to children and youth under the school-linked statewide fee schedule:

- **Trina Frazier**, Asst. Superintendent of Student Services, Fresno County Superintendent of Schools
- **Amanda Dickey**, Executive Dir. of Government Relations, Santa Clara County Office of Education
- **Erin Davis, Esq.**, Vice President of Strategic Growth, Hazel Health

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 and panelists to respond to the following:

DHCS

1. Please provide an update on the implementation of the school-linked statewide fee schedule, including LEAs enrolled, the number and dollar amounts of claims submitted, the number and dollar amounts of claims paid, and the average processing time for claims.

2. What type of technical assistance has DHCS or the third-party administrator provided to LEAs to ensure claims are being paid?

3. LEAs are reporting they may need to lay off staff hired with one-time CYBHI funding due to inability to receive timely reimbursement through the fee schedule. Does DHCS have a solution for this problem, such as interim payments, or another cashflow mechanism to support services already provided?

Local Educational Agencies (Santa Clara and Fresno)

4. Please provide an overview of the types of services offered by schools in your LEA.

5. What types of infrastructure has your LEA built or staff hired with one-time funding available under the various components of the CYBHI?

6. What has been your LEA's experience submitting claims to the third-party administrator under the statewide fee schedule?

7. What is the total amounts of claims outstanding under the fee schedule and the total amounts of reimbursement received to date?

8. How has the uncertainty of reimbursement affected planning for future years for delivery of behavioral health services on your LEA's campuses?

Behavioral Health Provider (Hazel)

9. Please describe the types of services you provide on school campuses that are eligible for reimbursement under the statewide fee schedule.

10. Prior to implementation of the fee schedule, how were these services supported?

11. What has been your experience with the claims submission process under the statewide fee schedule?

12. In the LEAs in which you operate, how has the uncertainty regarding reimbursement under the fee schedule affected the services you are able to provide to students on campus? Have any LEAs canceled contracts or reduced service delivery in response to this uncertainty?

Issue 3: Behavioral Health Transformation (Proposition 1) Implementation

Implementation Update – Behavioral Health Transformation (Proposition 1). SB 326 (Eggman), Chapter 790, Statutes of 2023, and Proposition 1, approved by the voters in March 2024, authorized significant reforms to the state's behavioral health programs over the next few years. Known as the Behavioral Health Services Act (BHSA), these reforms will have substantial impacts on the fiscal structure and programmatic operations of behavioral health programs administered by the county behavioral health departments, the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Health Care Access and Information (HCAI), and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Background – The Mental Health Services Act (Proposition 63; 2004). In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. *Community Services and Supports (CSS):* 76 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations. 51 percent of CSS funds, or approximately 37 percent of total MHSA funding, is required to be spent on full service partnerships.

2. *Prevention and Early Intervention (PEI):* Up to 19 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties by the State Controller through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs. State Administration funds have been used for a variety of state-directed purposes, including behavioral health workforce programs, the Mental Health Student Services Act, triage programs,

Local Mental Health Boards and County Three-Year Plans. The Bronzan-McCorquodale Act requires each community mental health service to have a mental health board consisting of 10 to 15 members to serve in an advisory role to the county board of supervisors. The mental health board is required to review and evaluate the local public mental health system and advise the county board of supervisors on the delivery of mental health services in the county.

MHSA requires each county mental health program to prepare and submit to DHCS and MHSOAC a three-year program and expenditure plan, with annual updates, adopted by the county's board of supervisors. The plan must include: 1) a program for prevention and early intervention; 2) a program for services to children; 3) a program for services to adults and seniors; 4) a program for innovations; 5) a program for technological needs and capital facilities; 6) identification of shortages in personnel to provide services and additional assistance needed from education and training programs; 7) establishment and maintenance of a prudent reserve to ensure stability of program funding; 8) certification by the county behavioral health director and county auditor-controller that the county has complied with MHSA requirements and other fiscal accountability requirements. MHSA also requires each three-year program and expenditure plan and update to be developed with local stakeholders, including adults and seniors with severe mental illness; families of children, adults, and seniors with severe mental illness; youths or youth mental health organizations; providers of services; law enforcement agencies; education; social services agencies; veterans; representatives from veterans organizations; providers of alcohol and drug services; health care organizations; and other important interests. The stakeholders must also include individuals representing youth from historically marginalized communities, representatives from organizations specializing in working with underserved racially and ethnically diverse communities, and representatives from LGBTQ+ communities.

Draft three-year plans must be prepared and circulated for review for at least 30 days to stakeholders. In addition, the local mental health board must conduct a public hearing on the plan after the 30 day stakeholder comment period to make recommendations to the local mental health agency on any revisions.

The Behavioral Health Services Act – Reforming the MHSA. SB 326 (Eggman), Chapter 790, Statutes of 2023, and AB 531 (Irwin), Chapter 789, Statutes of 2023, made significant changes to the MHSA, with many provisions appearing on the ballot as Proposition 1, approved by voters in March 2024. These changes recast the Mental Health Services Act as the Behavioral Health Services Act (BHSA), revising

categories of expenditures for county behavioral health systems with a focus on housing interventions, expanding access to substance use disorder services, increasing transparency in county behavioral health planning, increasing evaluation and reporting on outcomes in the behavioral health system, and realigning oversight responsibilities between state departments and entities. In addition, Proposition 1 authorized $6.4 billion in bonds to construct, acquire, and rehabilitate more than 10,000 new treatment beds and supportive housing units, as well as sites to help serve more than 100,000 people annually.

BHSA – Impacts on County Behavioral Health Departments. As the vast majority of California's behavioral health system is realigned to counties, the most significant changes implemented by BHSA are to the operation and funding of county behavioral health departments. Currently, county behavioral health systems support their programs through a combination of funding streams, including 1991 and 2011 state-local realignment funds, state General Fund, federal Medicaid matching funds, federal grant funds for mental health and substance use disorders, and MHSA revenue.

BHSA Revises Previous MHSA Funding Allocations for Counties. The existing county allocations of MHSA revenue allow counties to spend 76 percent on community services and supports, 19 percent on prevention and early intervention, and 5 percent on innovative programs, with special allocations within those categories for capital needs, workforce development, and maintenance of a prudent reserve. Beginning July, 2026, BHSA revises these allocations as follows:

1) 30 percent of funds are required to be allocated for housing interventions. 50 percent of these funds are required to be used for housing interventions for individuals who are chronically homeless with a focus on encampments, with 25 percent to be used for capital development projects.

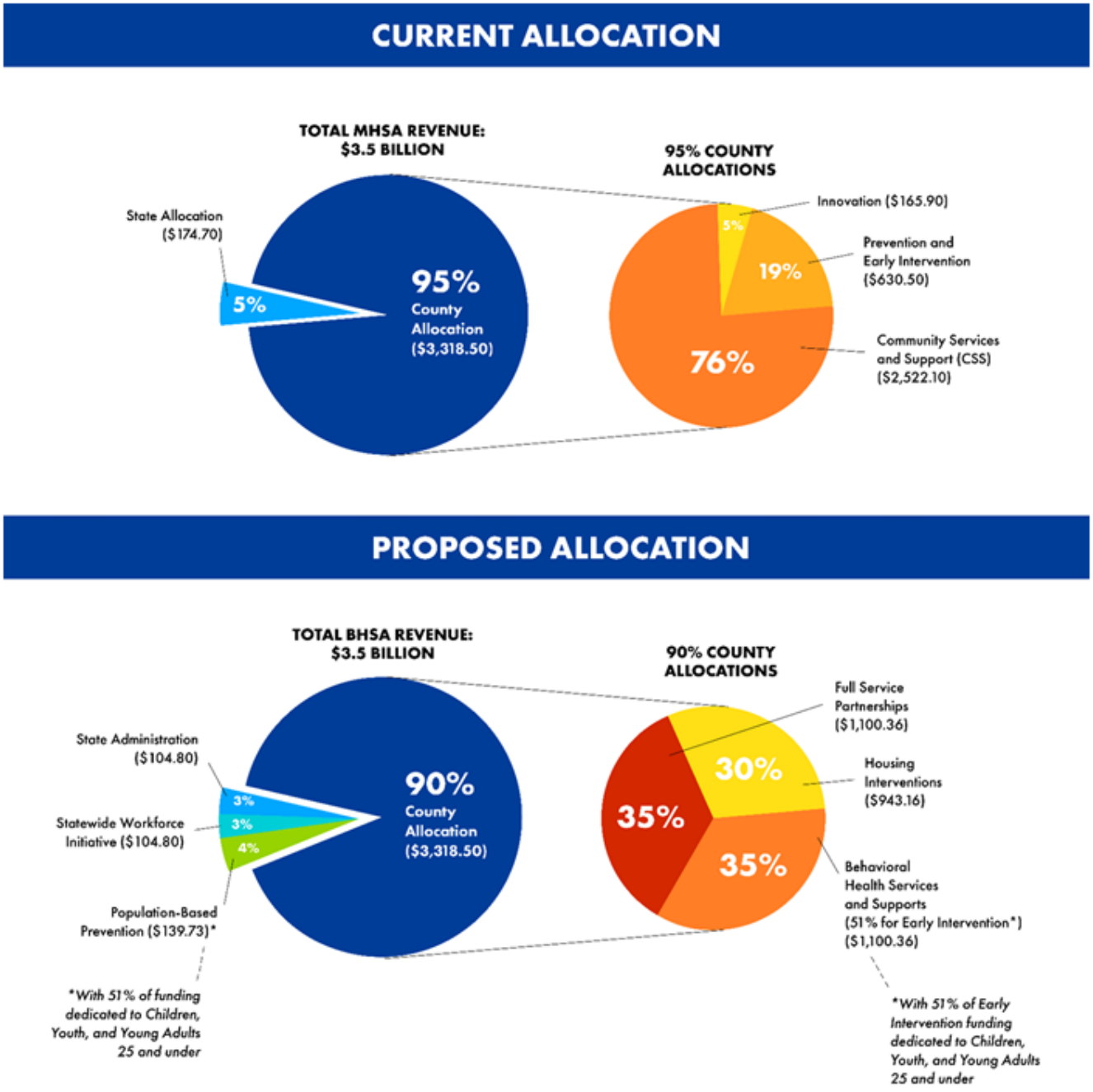
2) 35 percent of funds are required to be used for full-service partnerships, which provide the full spectrum of community services including mental health services (e.g. treatment, peer support, supportive services, etc.), non-mental health services (e.g. food, clothing, housing, health care treatment, etc.), and wrap around services for children. BHSA provides that FSP expenditures for housing would be covered by the housing intervention funding category, rather than the FSP category.

3) 35 percent of funds are required to be used for behavioral health services and supports (BHSS) for children and youth and adults or older adults, early intervention, outreach and engagement, workforce education and training, capital facilities and technological needs, and innovative programs.

Counties may also set aside funding for prudent reserves to ensure programs are able to continue operating despite fluctuations in BHSA revenue allocations. Previously, counties were authorized to set aside prudent reserves of up to 30 percent of the average CSS allocations received in the preceding five years. BHSA, when fully implemented will allow counties to set aside 25 percent of the allocation to its local behavioral health services fund.

Comparison of Existing MHSA Allocations and BHSA Allocations (effective July 1, 2026)
Source: *California Health and Human Services Agency. BHSA Fact Sheet. September 2023.*

(Dollars in Millions)



BHSA provisions allow counties, with the approval of DHCS, to transfer up to 14 percent of the total funds between the housing intervention, FSP, or BHSS allocations, as long as no single allocation is decreased by more than 7 percent. In addition, BHSA allows small counties (less than 200,000 population) to apply for an exemption from the housing intervention requirement beginning in 2026, with other

counties allowed to seek an exemption beginning in 2032. BHSA allows all counties to seek an exemption from the FSP requirement beginning in 2032.

Transitions County Three-Year Plans to Integrated Plan for Behavioral Health Services and Outcomes. Pursuant to the Bronzon-McCorquodale Act, counties currently convene a mental health board consisting of 10 to 15 members to serve in an advisory role to the county board of supervisors, review and evaluate the local public mental health system, and advise the county board of supervisors on the delivery of mental health services in the county. MHSA also requires each county mental health program to prepare and submit to DHCS and MHSOAC a three-year program and expenditure plan, with annual updates, adopted by the county's board of supervisors, and in consultation with local stakeholders. The plan must include: 1) a program for prevention and early intervention; 2) a program for services to children; 3) a program for services to adults and seniors; 4) a program for innovations; 5) a program for technological needs and capital facilities; 6) identification of shortages in personnel to provide services and additional assistance needed from education and training programs; 7) establishment and maintenance of a prudent reserve to ensure stability of program funding; 8) certification by the county behavioral health director and county auditor-controller that the county has complied with MHSA requirements and other fiscal accountability requirements.

BHSA revises the requirements for three-year plans to instead require an Integrated Plan for Behavioral Health Services and Outcomes (Integrated Plan). The Integrated Plan is required to include the following sections:

1) Community mental health services provided
2) Programs and services funded from BHSA revenue
3) Programs and services funded by the Projects for Assistance in Transition from Homelessness (PATH) provided by DHCS
4) Programs and services funded by the federal Community Mental Health Services Block Grant
5) Programs and services funded by the federal Substance Abuse Block Grant
6) Programs and services provided by Medi-Cal managed care plans for mild and moderate conditions
7) Programs and services provided under Drug Medi-Cal or a Drug Medi-Cal Organized Delivery System (DMC-ODS)
8) Programs and services funded by distributions from the Opioid Settlements Fund
9) Services provided through other federal grants or other mental health and substance use disorder programs

The Integrated Plan must also include a budget that includes county planned expenditures and reserves for BHSA distributions, as well as any other funds; a description of how county planned expenditures align with statewide and local behavioral health goals and outcome measures (e.g. reducing homelessness or justice involvement); a description of efforts to reduce identified disparities in behavioral health outcomes; a description of data sources considered to identify disparities and unmet needs for certain populations; and a description of the county's workforce strategy. The Integrated Plan must also be developed with an expanded list of local stakeholders, similar to the previous three-year plan, but with an additional focus on those experienced with substance use disorder treatment services.

In addition to planning around county behavioral health services, BHSA requires a county to participate in the development of its local health jurisdiction's community health improvement plan, required under

the Future of Public Health infrastructure investment adopted in the 2022 Budget Act. BHSA also requires a county to work with each Medi-Cal managed care plan operating in the county to develop the plans' population needs assessment developed under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

County Behavioral Health Outcomes, Accountability, and Transparency Report. BHSA requires counties and Medi-Cal behavioral health delivery systems, including DMC-ODS, to annually submit to DHCS a County Behavioral Health Outcomes, Accountability, and Transparency (BHOAT) Report. The report must include:

1) The county's annual allocation of state and federal behavioral health funds, by category
2) The county's annual expenditure of state and federal behavioral health funds, by category
3) The amounts of annual and cumulative unspent state and federal behavioral health funds, including funds in a reserve account, by category
4) The county's annual expenditure of county general funds and other funds, by category, on mental health or substance use disorder treatment services.
5) The sources and amounts spent annually as the nonfederal share for Medi-Cal specialty mental health services and Medi-Cal substance use disorder treatment services, by category.
6) All administrative costs, by category
7) All contracted services, and the cost of those contracted services, by category
8) Information on behavioral health services provided to persons not covered by Medi-Cal, including those who are uninsured, covered by Medicare, or covered by commercial insurance, by category
9) Other data and information including spending on children and youth, service utilization data, performance outcome measures, data regarding populations with identified disparities in behavioral health outcomes, data to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts, and information on eligible adults and older adults who are incarcerated, experiencing homelessness, and the number of eligible children and youth who access evidence-based early psychosis and mood disorder detection and intervention programs.
10) Data and information on workforce measures and metrics.

Annually, the County BHOAT Report must be approved by the county's board of supervisors and posted on the DHCS website.

Changes to State Administration Allocations. Prior to allocation of funding to county CSS, PEI, and innovation programs, MHSA authorizes 5 percent of total revenue to be allocated for state administrative purposes. State Administration allocations may be used to support the Mental Health Services Oversight and Accountability Commission's operations and programs, as well as other critical statewide priorities, as allocated by the Legislature in the annual Budget Act. MHSA State Administration funding has been used to support behavioral health workforce programs, the Mental Health Student Services Act, Mental Health Wellness programs, and the California Reducing Disparities Project.

Effective July 1, 2026, BHSA revises the allocation for state administration purposes as follows:

1) Increases the total allocation for state administration purposes from five percent to ten percent.
2) The ten percent allocation for state administration is further subdivided into the following allocations:

a. State Directed Purposes – Three percent is allocated for state directed purposes consistent with the BHSA, for CalHHS, DHCS, the California Behavioral Health Planning Council, HCAI, BHSOAC, CDPH and any other state agency. According to the Administration, this allocation is likely to be approximately $105 million annually.

b. HCAI Behavioral Health Workforce Initiative – Three percent is allocated to HCAI to develop and implement a behavioral health workforce initiative. The initiative must be developed in consultation with stakeholders and focus on efforts to build and support the workforce to meet the need to provide holistic and quality services; and support the development and implementation of strategies for training, supporting, and retaining the county behavioral health workforce and non-county contracted behavioral health workforce, including efforts to increase racial, ethnic, and linguistic diversity of behavioral health providers and increase access in geographically underserved areas. A portion of the initiative may focus on providing technical assistance to county and contracted providers to support the stabilization and retention of the behavioral health workforce, as well as maximizing the use of peer support specialists. According to the Administration, this allocation is likely to be approximately $105 million annually.

c. CDPH Population-Based Mental Health and Substance Use Disorder Prevention – Four percent is allocated to CDPH to provide population-based mental health and substance use disorder prevention programs, with at least 51 percent of these funds for serving populations who are 25 years of age or younger. These population based prevention programs are intended to reduce the prevalence of mental health and substance use disorders and resulting conditions, and must incorporate evidence-based promising or community-defined evidence practices to: 1) reduce the risk of individuals developing a mental health or substance use disorder; 2) target populations at elevated risk for a mental health, substance misuse, or substance use disorder; 3) reduce stigma associated with seeking help for mental health challenges and substance use disorders; 4) target populations disproportionately impacted by systemic racism and discrimination; and 4) prevent suicide, self-harm, or overdose. The prevention programs must also be provided in school or off campus settings, and may include school-based health centers, student wellness centers, student well-being centers, group coaching and consultation, stigma reduction, mental health first aid programs to identify and prevent suicide or overdose. According to the Administration, this allocation is likely to be approximately $140 million annually.

MHSOAC Transition to BHSOAC/CBH – Changes to Commission Structure, Funding, and Responsibilities. Effective January 1, 2025, BHSA recast the Mental Health Services Oversight and Accountability Commission (MHSOAC) as the Behavioral Health Services Oversight and Accountability Commission (BHSOAC). The BHSOAC has since rebranded as the Commission on Behavioral Health (CBH). BHSA revises the structure and responsibilities of the commission as follows:

1) Expands the membership of the new CBH from 16 members to 27 members. The members of the CBH will include:

   a. The Attorney General (or designee)
   b. The Superintendent of Public Instruction (or designee)
   c. A Senator selected by the President Pro Tempore of the Senate (or designee)
   d. An Assemblymember selected by the Speaker of the Assembly (or designee)

e. The following 23 members appointed by the Governor:
   i. Two persons who have or have had a mental health disorder
   ii. Two persons who have or have had a substance use disorder*
   iii. A family member of an adult or older adult who has or has had a mental health disorder
   iv. One person who is 25 years of age or younger and has or has had a mental health disorder, substance use disorder, or co-occurring disorder*
   v. A family member of an adult or older adult who has or has had a substance use disorder*
   vi. A family member of a child or youth who has or has had a mental health disorder
   vii. A family member of a child or youth who has or has had a substance use disorder*
   viii. A current or former county behavioral health director*
   ix. A physician specializing in substance use disorder treatment
   x. A mental health professional
   xi. A professional with expertise in housing and homelessness*
   xii. A county sheriff
   xiii. A superintendent of a school district
   xiv. A representative of a labor organization
   xv. A representative of an employer with less than 500 employees
   xvi. A representative of an employer with more than 500 employees
   xvii. A representative of a health care service plan or insurer
   xviii. A representative of an aging or disability organization*
   xix. A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities*
   xx. A representative of a children and youth organization*
   xxi. A veteran or a representative of a veterans organization*

** New positions under BHSA*

2) Transfers responsibility over prevention and early intervention to DHCS, to establish priorities for the use of early intervention program funds.

3) Eliminates responsibility for approving county innovation plans, as this category of county funding is eliminated in BHSA.

4) Requires collaboration with DHCS on establishing early intervention program priorities, establishing a biennial list of evidence-based practices and community-defined evidence practices, establishing FSP standards of care and criteria for step-down, and metrics to measure and evaluate programs and services.

5) Requires collaboration with CDPH to develop population-based prevention programs and develop best practices to overcome stigma and discrimination.

6) Requires CBH to submit a report by January 1, 2030, and every three years thereafter, with recommendations for improving and standardizing promising practices across the state.

7) Authorizes CBH to administer the BHSA Innovation Partnership Fund, to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices, as well as improving BHSA programs and practices for underserved populations, low-income populations, communities impacted by other behavioral health disparities, and other populations determined by the commission. The fund will receive $20 million annually between 2026-27 and 2030-31, with subsequent allocations provided by the Legislature in the annual Budget Act.

8) Requires CBH to submit a report by January 1, 2030, and every three years thereafter, on the key accomplishments of the Innovation Partnership Fund.

DHCS Retains and Expands Role of Oversight and Guidance for BHSA Programs. Under MHSA, DHCS was the primary oversight authority for county expenditures of MHSA funding, the county three-year planning process, reversion of unspent county MHSA funds, and general county compliance with the provisions of the MHSA. Under BHSA, DHCS retains this role and expands its responsibilities to cover oversight and guidance for the early intervention program. In its primary oversight and guidance role, DHCS is also responsible for making determinations regarding how counties will comply with the new categorical funding requirements of the BHSA and fulfill their expanded responsibilities under the new three-year Integrated Plan process. DHCS is also the recipient of new reporting requirements from counties, including the annual County BHOAT Report.

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 and timeline of implementation and milestones for the Behavioral Health Transformation and Proposition 1.

2. Please provide a brief overview of how DHCS envisions counties will utilize their housing funds and how those funds will work in concert with the housing benefits available under CalAIM for Medi-Cal beneficiaries (e.g. housing trio community supports, and transitional rent).

Issue 4: Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Implementation

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $29.6 million ($655,000 General Fund, $20.1 million federal funds, and $8.8 million county behavioral health funds) in 2024-25, and $784.4 million ($31.7 million General Fund, $526 million federal funds, and $226.7 million county behavioral health funds) in 2025-26. If approved, these resources would support DHCS expenditures to implement the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration to expand access and strengthen the continuum of services for Medi-Cal members living with significant behavioral health needs.

Multi-Year Funding Request Summary		
Fund Source	**2024-25**	**2025-26**
0001 – General Fund	$655,000	$31,667,000
0890 – Federal Trust Fund	$20,123,000	$526,006,000
3420 – Medi-Cal County Behavioral Health Fund	$8,815,000	$226,711,000
Total Funding Request:	**$29,593,000**	**$784,384,000**

Background. In December 2024, DHCS received federal approval for a new Section 1115 Waiver Demonstration to expand access and strengthen the continuum of community-based behavioral health services for Medi-Cal members with significant behavioral health needs. The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) includes several key components:

3) *New Evidence-Based Services* – Beginning January 1, 2025, counties may opt-in to cover the following new evidence-based practices for Medi-Cal beneficiaries:

   Adults

   a) Assertive Community Treatment – Assertive Community Treatment (ACT) is a community-based, team-based service to help Medi-Cal beneficiaries cope with the symptoms of their mental health condition and develop or restore skills to function in the community. ACT is provided by a multidisciplinary team that consists of a psychiatrist, nurse, case managers, peers, and other licensed professionals.
   b) Forensic ACT – Forensic ACT (FACT) builds on the ACT model to address the complex needs of members with serious mental illness who are also involved with the criminal justice system. FACT addresses criminogenic risks and needs and has been show to improve functioning and reduce hospitalizations, homelessness, incarceration, and violations of probation and parole among enrolled participants.
   c) Coordinated Specialty Care for First Episode Psychosis – Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) is a community-based service designed for members experiencing first-episode psychosis. CSC-FEP provides timely and integrated support during the critical initial stages of psychosis, reducing the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, criminal justice system involvement, substance use, and homelessness. CSC-FEP is delivered by a multidisciplinary team that consists of a psychiatrist or psychiatric prescriber, a peer support specialist, and other licensed and credentialed practitioners.

d) Individual Placement and Support Supported Employment – Individual Placement and Support (IPS) Supported Employment helps support individuals living with behavioral health needs in obtaining and sustaining competitive employment in the community to support their recovery. Supported Employment is a person-centered intervention that emphasizes s Medi-Cal beneficiary's strengths, goals, and preferences, and promotes self-esteem, independence, a sense of belonging, and overall well-being.
e) Enhanced Community Health Worker Services – Enhanced Community Health Worker (CHW) Services are preventive services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and behavioral health. These services include all the same components as CHW preventive services, but are tailored to Medi-Cal beneficiaries who meet access criteria for specialty mental health or substance use disorder services. Enhanced CHW Services often include more intensive care coordination, deeper community engagement, specialized support, management of chronic conditions, help navigating health care systems, provision of social support, and advocacy for beneficiaries to access necessary resources.
f) Clubhouse Services – The Clubhouse Model is an intentional, voluntary, and organized support system that uses a strengths-based approach to help members build emotional, cognitive, and social skills in an inclusive, community based setting. Clubhouses are physical settings that facilitate opportunities to build skills and relationships supportive of autonomous employment, education, and housing. Clubhouses offer employment programs and provide structured opportunities for socialization and recreation on evenings, weekends, and holidays.

Children

g) Functional Family Therapy – Functional Family Therapy (FFT) is an effective, short-term, family-based, proprietary counseling service which seeks to empower families to solve their own problems through growth and change. FFT is designed for young people ages 10 to 18 who are at risk of, or have been referred for, behavioral or emotional problems.
h) Multi-Systemic Therapy – Multi-Systemic Therapy (MST) is an intensive, evidence-based, family-driven, proprietary treatment model for youth ages 12 to 17 who are involved in the juvenile justice system or who are at risk of out-of-home placement due to a history of delinquent behavior. The service emphasizes cultural responsiveness and the centering of home and community settings, as well as partnership with law enforcement and the juvenile justice system.
i) Parent-Child Interaction Therapy – Parent-Child Interaction Therapy (PCIT) is an evidence-based, short-term treatment designed to foster the well-being of children and families of all cultures by teaching parents strategies that will promote positive behaviors in children and youth ages two to seven who exhibit challenging behaviors such as defiance and aggression.

DHCS also intends to establish Centers of Excellence (COEs) to offer training and fidelity monitoring to specialty behavioral health providers and county behavioral health plans implementing evidence-based practices as part of BH-CONNECT, as well as the Behavioral Health Transformation implemented under Proposition 1, approved by voters in March 2024. According to DHCS, the following organizations have been tentatively selected to serve as COEs:

- University of California Los Angeles (UCLA) Public Mental Health Partnership – To support Assertive Community Treatment (ACT)
- University of California Davis EPI-CAL – To support Coordinated Specialty Care for First Episode Psychosis

- IPS Supported Employment Center – To support Individual Placement and Support model of Supported Employment
- Clubhouse International – To support Clubhouse Services
- MST Services – To support Multisystemic Therapy
- FFT, LLC – To support Functional Family Therapy
- PCIT International – To support Parent-Child Interaction Therapy

4) *Access, Reform, and Outcomes Incentive Program* – Beginning January 1, 2025, this program will provide up to $1.9 billion total funds over the course of the BH-CONNECT Demonstration to behavioral health plans for demonstrating improved performance on key measures related to behavioral health services access, outcomes among Medi-Cal members living with significant behavioral health needs, and targeted behavioral health delivery system reforms. Performance measures will include factors such as increased access to behavioral health services, improved quality of care, implementation of evidence-based practices including Assertive Community Treatment (ACT) and Coordinated Specialty Care for First Episode Psychosis (CSC-FEP), reducing disparities, and achieving measurable positive health outcomes for Medi-Cal members with significant behavioral health needs. Counties can earn incentive payments by meeting specific targets related to these areas.

5) Transitional Rent Assistance – Beginning January 1, 2025, Medi-Cal managed care plans may choose to provide up to six months of transitional rent assistance to qualified individuals. Beginning January 1, 2026, Medi-Cal managed care plans will be required to offer this assistance to all persons with significant behavioral health needs. DHCS indicates the benefit will become mandatory to other populations in later phases.

6) *Community Transition Services* – Behavioral health plans may opt-in to cover Community Transition In-Reach Services as a Medi-Cal benefit to support members' transition from long-term institutional stays. Plans will be required to submit a readiness assessment to assess availability of mental health or substance use disorder services and housing options to ensure that an appropriate behavioral health continuum of care is in place in the county.

7) *Short-Term Inpatient Psychiatric Care* – Behavioral health plans may opt-in to receive federal financial participation (FFP) for care provided during short-term stays in Institutions for Mental Disease (IMDs), which were previously ineligible for FFP. Receipt of FFP requires plans to commit to implementing a full suite of evidence-based practices including ACT, FACT, CSC-FEP, IPS Supported Employment, Enhanced CHW Services, and Peer Support Services, including forensic specialization.

8) *Support for Children and Youth* – Enhances care and resources for youth involved in child welfare who need specialty mental health services, improving outcomes and support systems for families. This component includes the following specific activities, in partnership with the California Department of Social Services (CDSS):

   a) Activity Funds – Beginning July 2025, the Activity Funds Initiative will cover the cost of activities and items that encourage forms of expression beyond words or traditional therapies to support the health and wellbeing of children and youth in the child welfare system. Activity Funds may cover: physical wellness activities and goods that promote a healthy lifestyle (e.g. sports club fees and

equipment), and strengths-developing activities (e.g. music and art lessons, therapeutic summer camps).

b) Initial Joint Child Welfare/Specialty Mental Health Visit – BH-CONNECT will require a specialty mental health provider to accompany a child welfare worker during a home visit within 30 days following substantiation of an allegation of abuse or neglect by an investigating social worker. Through the joint visit, the specialty mental health provider and child welfare worker would partner to: identify necessary social supports, and connect the child and family or families to any needed clinical or community services.

c) Alignment of the Child and Adolescent Needs and Strengths (CANS) Tool – BH-CONNECT will align use of the CANS tool across the child welfare and specialty mental health system to ensure agencies and providers are using the same CANS tool, administered in the same way, to produce robust and comparable outcomes measures that can be tracked over time.

d) Child Welfare Liaison – DHCS requires all managed care plans to include a Child Welfare Liaison to be the point of contact for child welfare departments and to serve as an advocate on behalf of Medi-Cal plan members involved in child welfare.

9) *Workforce Initiative* – The BH-CONNECT Workforce Initiative, administered by the Department of Health Care Access and Information (HCAI) will provide $1.9 billion over the BH-CONNECT Demonstration to address shortages in behavioral health practitioners serving Medi-Cal and underserved populations. The components of the Workforce Initiative are as follows:

a) Medi-Cal Behavioral Health Student Loan Repayment Program – This program will provide loan repayment for behavioral health professionals with educational debt, including the following:

i. *Licensed Prescribing Behavioral Health Practitioners* – Licensed, prescribing behavioral health professionals (e.g. psychiatrists, addiction medicine physicians, psychiatric nurse practitioners) are eligible for up to $240,000 in loan repayment in exchange for a four-year service obligation (regardless of loan repayment amount) in a Medi-Cal safety net setting (e.g. federally qualified health center, community mental health center, rural health clinic, settings with high Medi-Cal or uninsured populations).

ii. *Non-prescribing Licensed or Associate Level Pre-Licensure Practitioners* – Non-prescribing licensed or associate level pre-licensure practitioners (e.g. psychologists, social workers, marriage and family therapists) are eligible for up to $180,000 in loan repayment in exchange for a four-year service obligation (regardless of loan repayment amount) in a Medi-Cal safety net setting.

iii. *Non-licensed, Non-prescribing Practitioners* – Non-licensed, non-prescribing practitioners (e.g. substance use disorder counselors, community health workers, peer support specialists, and wellness coaches) are eligible for up to $120,000 in loan repayment in exchange for a service obligation in a Medi-Cal safety net setting that depends on the loan repayment amount. For loan repayments less than $10,000, the service obligation is two years. For loan repayments of $10,000 to $20,000 the service obligation is three years. For loan repayments of $20,000 or more, the service obligation is four years.

Applications for this program will open on July 1, 2025, and close on August 15, 2025.

b) Medi-Cal Behavioral Health Scholarship Program – This program will provide scholarships of up to $240,000 for licensed practitioners with prescribing privileges, $180,000 for non-prescribing licensed practitioners, and $120,000 for non-licensed practitioners. Scholarship awards will require recipients to commit to practicing full-time in safety net settings after completing their education, for a defined period of time based on scholarship amounts. HCAI indicates this program will launch in early 2026.

c) Medi-Cal Behavioral Health Recruitment and Retention Program – This program will provide funding to support the following:

i. Recruitment bonuses of up to $20,000 and retention bonuses of up to $4,000 per practitioner
ii. Recruitment bonuses up to $50,000 specifically for individuals who are completing required field training in advance of their final year of education
iii. Support for training and licensure, with up to $1,500 per practitioner for costs related to licensure or certification and up to $35,000 per organization to support the supervision of license-eligible providers
iv. Backfill of costs for provider training in evidence-based practices to ensure uninterrupted care

d) Medi-Cal Behavioral Health Community-Based Provider Training Program – This program will support education and training for Alcohol or Other Drug (AOD) Counselors, Community Health Workers, and Peer Support Specialists, providing up to $10,000 per participant for tuition, textbooks, and certification costs.

e) Medi-Cal Behavioral Health Residency Training Program – This program will provide up to $250,000 per residency or fellowship slot per demonstration year for new or expanded positions in Psychiatry or Addiction Medicine. Psychiatry residency programs, child and adolescent psychiatry fellowship programs, addiction psychiatry fellowship programs, and addiction medicine fellowship programs will be eligible for this funding. Programs will train residents and fellows in a Medi-Cal safety net setting and participating residents and fellows will be required to commit to a four-year service requirement after graduation. According to HCAI, applications for this program will open in July 2025.

Local Assistance – BH-CONNECT Demonstration. DHCS requests expenditure authority of $29.6 million ($655,000 General Fund, $20.1 million federal funds, and $8.8 million county behavioral health funds) in 2024-25, and $784.4 million ($31.7 million General Fund, $526 million federal funds, and $226.7 million county behavioral health funds) in 2025-26 to support DHCS expenditures to implement the BH-CONNECT Demonstration to expand access and strengthen the continuum of mental health services for Medi-Cal members living with significant behavioral health needs.

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 each of the major components of the BH-CONNECT Demonstration.

Issue 5: Cognitive Health Assessment Training and Reporting

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to remove the cognitive health assessment training and biannual reporting requirement associated with the department's Dementia Care Aware initiative.

Background. SB 48 (Limon), Chapter 484, Statutes of 2021, expands Medi-Cal benefits to include an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment under the federal Medicare program. Medi-Cal providers may only receive payment for these assessments if the provider completes DHCS-approved cognitive health assessment training and conducts the assessment using DHCS-recommended validated tools. SB 48 also requires DHCS to biennially post information on the cognitive health assessment in Medi-Cal on its website.

In 2022, DHCS launched Dementia Care Aware, in partnership with the University of California San Francisco (UCSF) to establish a statewide standard of care for dementia screening through an equity-focused, culturally appropriate provider training. The program offers education, tools, and support to improve dementia detection and care, with a continued focus on serving underserved and low-income populations. Dementia Care Aware was supported by funding received through the Home- and Community-Based Services (HCBS) Spending Plan, a provision of the federal American Rescue Plan (ARP) Act that provides states with a temporary 10 percentage point increase to federal matching funds for certain home- and community-based services (HCBS), with offsetting state funds able to be used to enhance, expand, or strengthen HCBS under the state's Medicaid program. According to DHCS, funding under the HCBS Spending Plan for Dementia Care Aware expired in January 2025.

Trailer Bill Language Proposal – Cognitive Health Assessment Training and Reporting. DHCS requests trailer bill language to remove the cognitive health assessment training and biannual reporting requirement associated with the department's Dementia Care Aware initiative. DHCS indicates that, because HCBS Spending Plan funding ended in January 2025, it proposes to eliminate the training and biannual reporting requirement currently supported by those funds. The cognitive health assessment benefit would continue to be available, but providers would no longer be required to undergo DHCS-approved training, and DHCS would no longer be required to post its biennial report on the benefit.

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.

2. SB 48 did not have a sunset date for the training and biennial reporting provisions, nor did it make those provisions contingent on available HCBS Spending Plan funding. Why would the expiration of that funding require deletion of those requirements of the bill?

Issue 6: Implementation of Chaptered Legislation (SB 1184, SB 1238)

SB 1184 (Eggman)

Legislative Budget Change Proposal (SB 1184) – Governor's Budget. DHCS requests six positions and expenditure authority of $1.1 million ($543,000 General Fund and $542,000 federal funds) in 2025-26, and $1 million ($516,000 General Fund and $515,000 federal funds) annually thereafter. If approved, these positions and resources would support collection and reporting of data from county behavioral health directors regarding involuntary treatment, pursuant to the requirements of SB 1184 (Eggman), Chapter 643, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$543,000	$516,000
0890 – Federal Trust Fund	$542,000	$515,000
Total Funding Request:	**$1,085,000**	**$1,031,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2026-27.

Background. SB 1184 (Eggman), Chapter 643, Statutes of 2024, establishes certain requirements regarding hearings to determine if a person has capacity to refuse treatment with antipsychotic medication. In addition to these requirements, SB 1184 requires treating facilities to report certain information to county behavioral health directors, who are likewise required to report this information to DHCS. The required information includes:

1) The data and time when a physician or facility originally filed a petition to request a hearing to determine a person's capacity to refuse treatment
2) The date when the applicable detention period was scheduled to expire
3) The data and time when an attestation of exigent circumstances was documented in the person's medical record
4) The reason for the delay of the originally requested capacity hearing, if known
5) The data and time when the capacity hearing was held on an expedited basis.

SB 1184 also requires DHCS to, beginning on May 1, 2026, and every May 1 thereafter, compile the information it receives from county behavioral health directors and include it in its existing annual report on involuntary treatment. According to DHCS, these requirements would increase the data collection and reporting responsibilities of department staff.

Staffing and Resource Request. DHCS requests six positions and expenditure authority of $1.1 million ($543,000 General Fund and $542,000 federal funds) in 2025-26, and $1 million ($516,000 General Fund and $515,000 federal funds) annually thereafter to support collection and reporting of data from county behavioral health directors regarding involuntary treatment, pursuant to the requirements of SB 1184 (Eggman), Chapter 643, Statutes of 2024. Specifically, DHCS is requesting the following:

Licensing and Certification Division – One position

- **One Health Program Specialist I** position would ensure compliance with SB 1184, collect and process data, provide consultation and training to county and facility staff, draft all-county letters, provider bulletins, and policies and procedures for data requirements and consequences of failure to report.

Program Data Reporting Division – Five positions

- **One Research Data Supervisor II** position would supervise the overall data collection and reporting, conduct technical meetings with other division, lead in the development of data analytic methodologies, oversee business processes and work products, and review all data reports for accuracy, completeness, and proper de-identification before release.
- **Two Research Data Specialist II** positions would maintain coordination with other divisions, act as lead data stewards for translating technical needs to collect required data, and lead in data analytic support.
- **Two Research Data Analyst II** positions would provide analytical support, perform monitoring tasks, provide ongoing technical assistance to data submitters, and provide data analytic support.

SB 1238 (Eggman)

Legislative Budget Change Proposal (SB 1238) – Governor's Budget. DHCS requests seven positions and expenditure authority of $1.2 million ($586,000 General Fund and $586,000 federal funds) in 2025-26, and $1.1 million ($555,000 General Fund and $554,000 federal funds) annually thereafter. If approved, these positions and resources would support oversight of additional county facilities for evaluation and treatment of behavioral health conditions, pursuant to SB 1238 (Eggman), Chapter 644, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2025-26**	**2026-27***
0001 – General Fund	$586,000	$555,000
0890 – Federal Trust Fund	$586,000	$554,000
Total Funding Request:	**$1,172,000**	**$1,109,000**
Total Requested Positions:	**7.0**	**7.0**

* Positions and resources ongoing after 2026-27.

Background. SB 1238 (Eggman), Chapter 644, Statutes of 2024, expands the definition of "designated facility" or "facility designated by the county for evaluation and treatment" to include facilities that both 1) have appropriate services, personnel, and security to safely treat individuals being held involuntary; and 2) are licensed or certified as certain types of facilities by DHCS, the California Department of Public Health, or the United States Department of Veterans Affairs. The bill also requires DHCS to: 1) issue guidance regarding Medi-Cal reimbursement for covered Medi-Cal services provided to an individual receiving involuntary treatment, and 2) in consultation with stakeholders to establish updated regulations for the purpose of developing designation requirements for treatment facilities.

Staffing and Resource Request. DHCS requests seven positions and expenditure authority of $1.2 million ($586,000 General Fund and $586,000 federal funds) in 2025-26, and $1.1 million ($555,000 General Fund and $554,000 federal funds) annually thereafter to support oversight of additional county

facilities for evaluation and treatment of behavioral health conditions, pursuant to SB 1238 (Eggman), Chapter 644, Statutes of 2024.. Specifically, DHCS requests the following:

Licensing and Certification Division – Six positions

- **One Health Program Specialist I** position would work with stakeholders to develop statewide county LPS facility designation requirements, coordinate stakeholder communication processes, oversee implementation of state level review and oversight implementation of county LPS facility designation requirements, provide high-level technical expertise, coordination, project management, training, and leadership for the development and implementation of complex policy recommendations and program monitoring activities associated with county LPS designated facilities.
- **Four Associate Governmental Program Analysts** would oversee the approval process for county LPS designated facilities, including on-site surveys and reviews, preparing reports on findings, and following up on compliance actions or plans of correction.
- **One Office Technician** would provide administrative support to the branch chief and clerical support to staff.

Office of Legal Services – One position

- **One Attorney III** position would provide legal support for drafting behavioral health information notices, provider bulletins, policies, and procedures for implementation of SB 1238.

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.

NOT FOR PRESENTATION

Issue 1: Proposals for Investment – Various Departments

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

- **Dedicated Funding for the Peer Personnel Training and Placement Program.** A coalition of nine behavioral health advocacy organizations, including CalVoices, Disability Rights California, and the Mental Health Association of San Francisco, request annual expenditure authority of $14 million ($10 million General Fund and $4 million Behavioral Health Services Fund). If approved, these resources would support continued funding for the Peer Personnel Training and Placement Program. According to the advocates, since 2022, this program has supported the training of about 7,588 individuals, which led to the certification of 4,849 peer support specialists, extending its impact beyond the core mission of facilitating placement. This program is dedicated to assisting participants in securing positions as peer personnel, a vital service that benefits clients, family members, and caregivers alike. With a clear definition of placement encompassing paid employment and volunteer roles, the program emphasizes the importance of collaboration with employers to identify and fund these positions. By ensuring that participants complete the training, the program opens doors to immediate employment opportunities and fosters career progression. This holistic approach demonstrates the program's commitment to enhancing the workforce while delivering essential support to those in need.

  At the county level, the peer workforce has significantly provided essential services for individuals with serious behavioral health conditions. According to HCAI, counties are increasingly using Peer Support Specialists (PSSs) due to a shortage of clinical specialists in the State. PSSs are less expensive to train, have an 86 percent completion rate, and have proven to save lives.

  Currently, the funding for the program has been reduced to $2 million, which will substantially impact the recruiting, training and placing of the peer workforce in California. With a dedicated annual budget of $14 million, California can train thousands of peer specialists each year to help address the behavioral health workforce shortage identified by HCAI. Without this vital support, many qualified and deserving individuals interested in becoming peer service specialists, whether paid or unpaid, would be unable to join and complete the program.

- **Continued Funding for California Peer Run Warm Line.** The Mental Health Association of San Francisco requests expenditure authority of $20 million through June 30, 2028. If approved, these resources would support continued funding for the California Peer Run Warm Line. According to the Mental Health Association of San Francisco, the goal of this proposal is to meet the increase in mental and behavioral health challenges exacerbated in recent years by COVID-19 as reported by the CDC, SAMHSA, and NIMH, and to meet the projected increase in the utilization of the California Peer Run Warm Line services, and additionally build statewide infrastructure that will address the challenges and recommendations identified by our work with the Warm Line Core Group (national collaborative of Warm Lines).

  The California Peer Run Warm Line (aka the Warm Line) provides help to Californians before they experience a crisis. Creating a readily available human connection for people in distress, the Warm Line saves lives and avoids using more expensive crisis and emergency services. The Warm Line's

approach of pre-crisis support benefits individuals and for the State of California. Over 85% of surveyed users across the State of California believe that using the Warm Line helps reduce the likelihood that they will call more costly crisis services such as 911, suicide prevention, or a hospital. In a system that is already stretched to its limits, particularly over the past two years, this deflection is key to ensuring Californians—and the social systems that support them—can thrive. In addition to saving lives and money, the California Peer Run Warm Line provides meaningful paid employment for those who were previously impacted by their mental health issues and are returning or joining the workforce. This budget request will allow for the maintenance and expansion of the California Peer Run Warm Line.

- **Sustain California's Uncompensated Care Grant Program.** Essential Access Health and Planned Parenthood request General Fund expenditure authority of $40 million in 2025-26. If approved, these resources would support continuation of the Uncompensated Care Grant Program, established by AB 2134 (Weber), Chapter 562, Statutes of 2022, within the Department of Health Care Access and Information (HCAI) with an initial investment of $40 million. The program ensures abortion and contraception services are affordable and accessible, and stabilizes our safety net providers offering these services at low or no cost to patients. Providers can apply for the grant to provide abortion and contraception services for individuals below 400 percent of the federal poverty level (FPL) who are uninsured or underinsured and who are not eligible to receive abortion and contraception at no cost through Medi-Cal (income must be at or below 138 percent of FPL) and Family PACT (income must be at or below 200 percent of FPL). The Uncompensated Care program meets an essential need to provide access for Californians and individuals forced to travel due to inhumane bans on abortion in their home state.

  Essential Access Health (Essential Access) serves as the Program Administrator for the Uncompensated Care grant program, which was established in partnership with HCAI. Since January 2023, Essential Access has awarded $27.2 million of the initial $40 million investment to 14 grantee organizations to reimburse health care providers who offer low or no cost abortion and contraceptive care to eligible individuals. To date, grantees have served over 130,000 patients. Demand for this program dramatically exceeds the funding available each grant cycle: in the 2024 RFP cycle, Essential Access received $16.2 million in funding requests and awarded $8.9 million to maximize remaining funding. The final RFP cycle for the remaining funds was launched this spring and the program will be discontinued if additional state funding is not secured.

  New and anticipated federal threats to abortion care, and an evolving national landscape gravely endanger abortion access nationwide, particularly in a post-*Roe* America. Although California is an abortion safe haven state, we are not immune to federal actions that pose direct harm to sexual and reproductive health providers and patients, with a disproportionate impact on people with lower incomes. California's reproductive health care workforce is doing everything they can to meet the needs of patients. The Uncompensated Care program is essential to sustain our provider network and to ensure that no patient is turned away because of an inability to pay. Without it, grantee organizations would receive no compensation for providing this care or would have to charge patients out of pocket, severely hindering access; in some cases, they would not be able to provide care at all. In the current landscape, grantee organizations report an increased demand for uncompensated care.

Additional investments in California's Uncompensated Care program are urgently needed to protect access to abortion and contraception, and uphold California's commitment to being a Reproductive Freedom State.