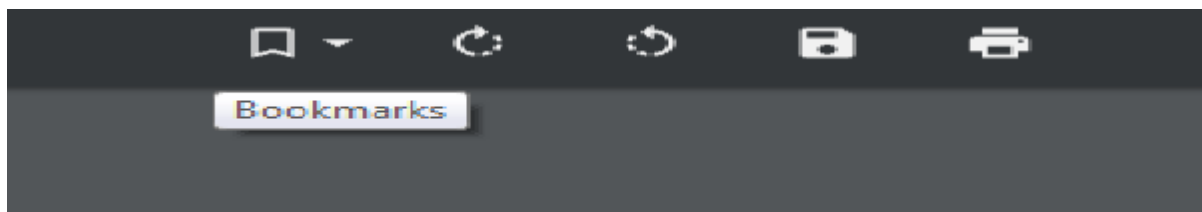


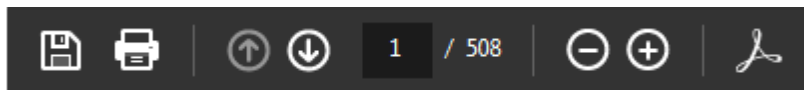
## Senate Budget and Fiscal Review

The 2025 Agendas for Subcommittee No. 1 on Education Finance are archived below. To access an agenda or outcomes by a specific date, please refer to “Bookmarks” icon on the screen. Depending on you web browser the bookmarks menu will look different. Below are instructions to help you find the “Bookmarks” icon on Internet Explorer 11, Mozilla Firefox, or Chrome.

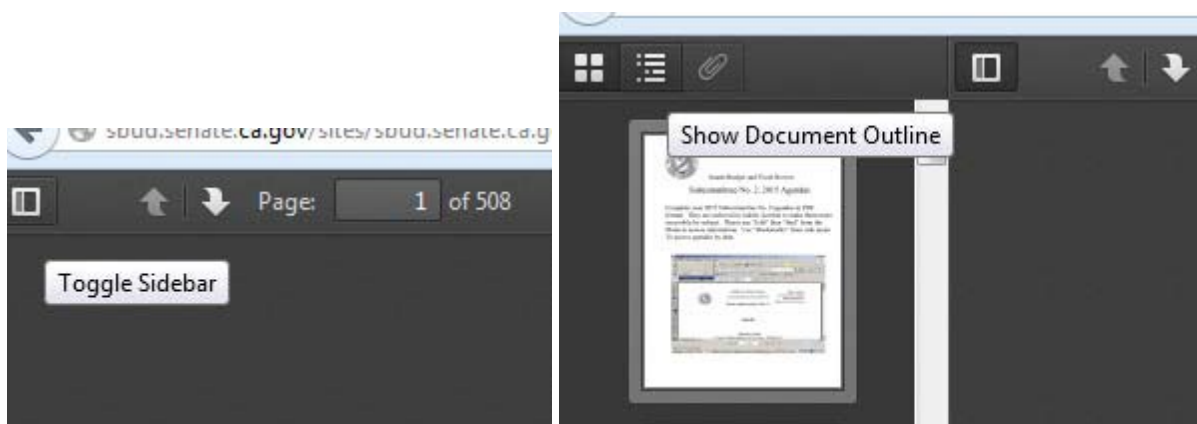
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# SUBCOMMITTEE NO. 3

# Agenda

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



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

Consultant: Scott Ogus

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*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.*

**FOR VOTE ONLY**

**4260 DEPARTMENT OF HEALTH CARE SERVICES**

**Issue 1: Opioid Settlements Fund Allocations**

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

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3397 – Opioid Settlements Fund	\$8,391,000	\$-
<b>Total Funding Request:</b>	<b>\$8,391,000</b>	<b>\$-</b>

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

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

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

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

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

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

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

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

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

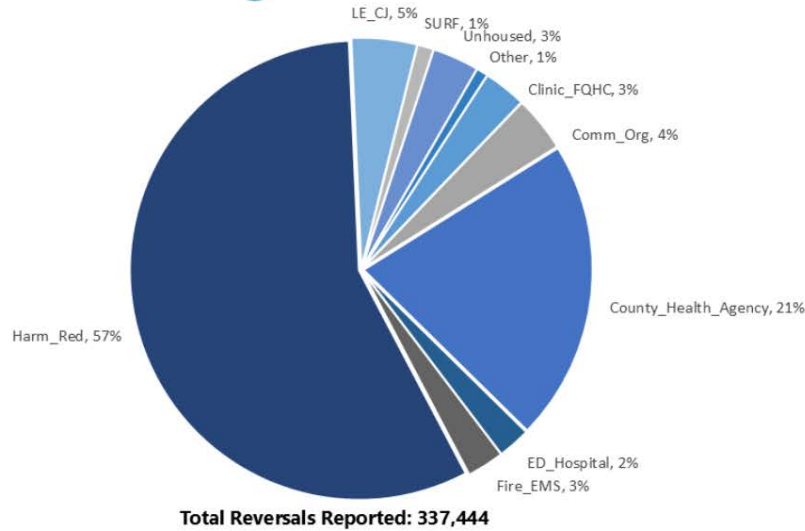
The 2023 Budget Act also included expenditure authority from the OSF of \$74.8 million in 2023-24, \$35.8 million in 2024-25, \$24.8 million in 2025-26, and \$24.1 million in 2026-27 for expansion of the Naloxone Distribution Project. The Legislature also approved provisional budget bill language authorizing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

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

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

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

## Reported Naloxone Reversals by Type of Organization



**NOTE:** Reported reversals as of February 18, 2025.

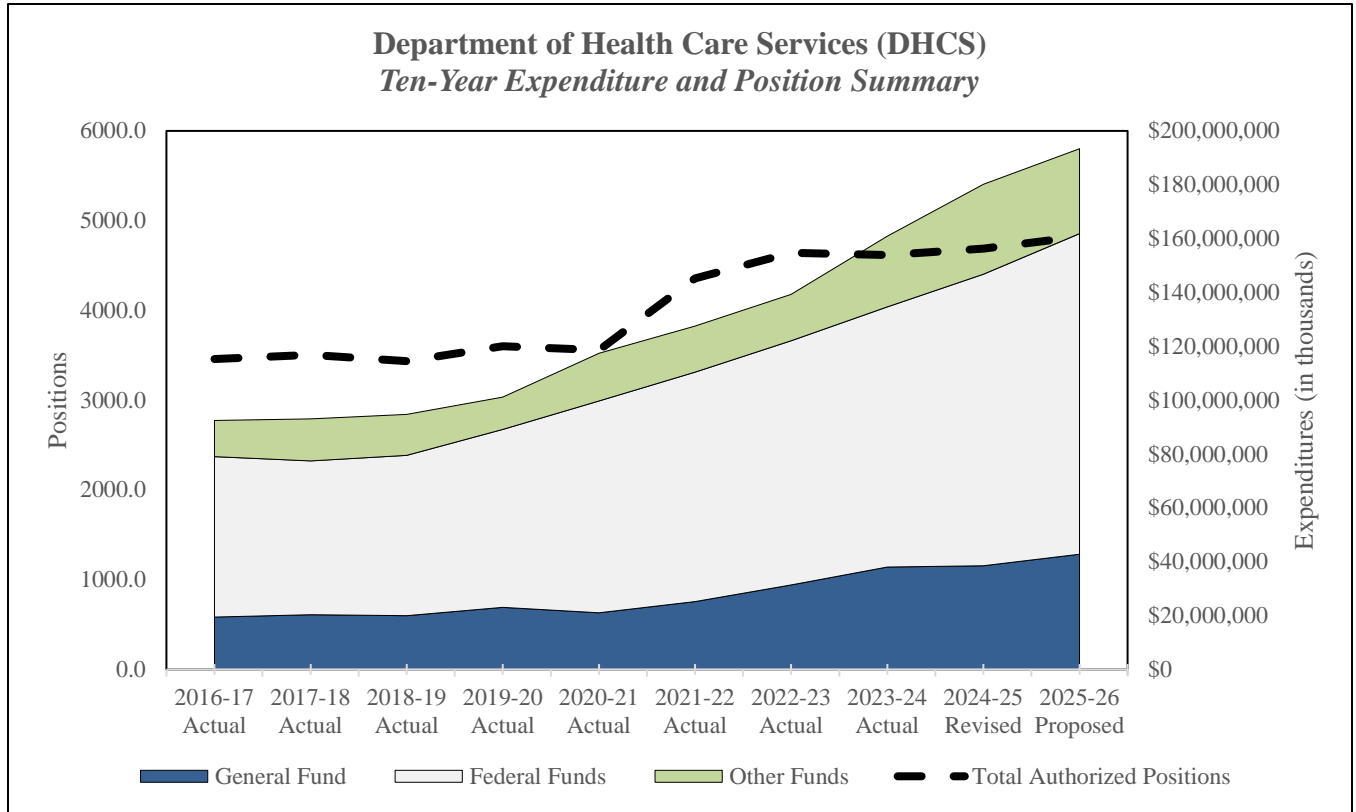
Other category includes: Local City Agencies, Schools/Colleges, Tribal entities, Telehealth, other State Agencies.

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

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

**4260 DEPARTMENT OF HEALTH CARE SERVICES**

**Issue 1: Overview**



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

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

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

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

<sup>1</sup>Federal Funds include Funds 0890, 7502, and 7503.

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

- **Medi-Cal.** DHCS serves as the single state agency for Medi-Cal, California’s Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.5 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.
- **Children’s Medical Services.** Children’s Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children’s Services Program, and Child Health and Disability Prevention Program.
- **Primary and Rural Health.** Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services.*** As adopted in the 2011 through 2013 Budget Acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.
- ***Other Programs.*** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

**Subcommittee Staff Comment.** This is an informational item.

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

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

**Issue 2: November 2024 Medi-Cal Local Assistance Estimate**

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

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

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

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

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

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

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

- *Caseload Impacts.* \$3.7 billion General Fund costs related to changes in Medi-Cal caseload. Of this amount, \$2.7 billion is related to higher than anticipated enrollment and higher pharmacy costs for the Medi-Cal undocumented expansion population, and \$1.1 billion is related to smaller than expected savings achieved through post-pandemic Medi-Cal eligibility redeterminations.
- *Pharmacy Expenditures.* \$540 million General Fund costs due to growth in Medi-Cal pharmacy expenditures.

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

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

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

- *Proposition 35 and Managed Care Organization (MCO) Tax Impacts.* \$3.6 billion General Fund costs due to updated estimates of the General Fund impact of Proposition 35 and the MCO tax. Of this amount, DHCS estimates additional General Fund costs of \$2.7 billion in 2025-26 due to passage of Proposition 35 by the voters, as well as a \$478.7 million General Fund savings adjustment related to the 2024-25 federal approval of an amendment to MCO tax amounts allowing consideration of Medicare revenue for an additional quarter than originally estimated.
- *Pharmacy Expenditures.* \$215.2 million General Fund costs due to growth in Medi-Cal pharmacy expenditures.

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

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

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

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

**Issue 3: November 2024 Family Health Local Assistance Estimate**

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

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

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

The programs included in the Family Health Estimate are:

- **California Children’s Services (CCS):** The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child’s care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 173,258 in 2024-25, an increase of 8,246 or five percent, compared to the 2024 Budget Act. The budget estimates Medi-Cal CCS caseload of 173,258 in 2025-26, unchanged compared to the revised 2024-25 estimate.
  - Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 15,052 in 2024-25, a decrease of 1,972 or 11.6 percent, compared to the 2024 Budget Act. The budget estimates state-only CCS caseload of 15,052, in 2025-26, unchanged compared to the revised 2024-25 estimate.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington’s, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 713 in 2024-25, a decrease of 121 or 13.6 percent, compared to the 2024 Budget Act. The budget estimates Medi-Cal GHPP caseload of 713 in 2025-26, unchanged compared to the revised 2024-25 estimate.
  - Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 701 in 2024-25, a decrease of 94 or 11.8 percent, compared to the 2024 Budget Act. The budget estimates state-only GHPP caseload of 701 in 2025-26, unchanged compared to the revised 2024-25 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).

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

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

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2024-25 and 2025-26 fiscal years.
2. What is the reason for the significant decrease in caseload across state-only programs in the Family Health Estimate?
3. Please provide a status update on the implementation of the CCS Compliance, Monitoring, and Oversight Program? Are counties ready to begin implementation on July 1, 2025? What is the funding source for these new county requirements?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Capitated Rates Development Division** – 12 positions

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

**Data Analytics Division** – Two positions

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

**Health Care Financing Division** – One position

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

**Health Information Management Division** – Three positions

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

**Program Data Reporting Division** – One position

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

**Office of Legal Services** – Two positions

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

**Quality and Health Equity Division** – Eight positions

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

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

### **Consultant Contracts** - \$5.4 million

- **Hospital Comprehensive Value Strategy Design and Implementation** - \$3 million (\$1 million HQAF, \$1 million IGT, and \$1.5 million federal funds) would support a contractor for the development and implementation of a comprehensive value strategy for hospital SDPs, including the following activities:
  - Supporting stakeholder engagement on the design of the strategy, including facilitating workgroups, developing materials, and reviewing and analyzing feedback.
  - Designing appropriate population health, quality of care, health equity, and cost accountability metrics, and associated reimbursement mechanisms, to support sustainable hospital reimbursement.
  - Analyzing and leveraging hospital Medi-Cal data on revenue, costs, cost drivers, reimbursement levels relative to other payers, and considerations applicable to specific subsets of hospitals, geographies, lines of service, and other stratifications.
  - Analyzing existing supplemental payment programs to identify opportunities to align with comprehensive value strategy objectives.
  - Support DHCS in obtaining federal approvals and implement operational changes necessary to implement the comprehensive value strategy.
- **Hospital Directed Payment Ongoing Support** - \$2.4 million (\$400,00 HQAF, \$800,000 IGT, and \$1.2 million federal funds) annually to support a contractor for ongoing operations of hospital SDPs, including the following activities:
  - Auditing of quality measures submissions for the private and public hospital SDPs.
  - Organizing and facilitating an annual conference to share best practices between hospitals, plans, and other stakeholders to identify strategies to improve patient care quality and continuously leverage lessons learned to improve hospital SDPs.

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

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

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

1. Please provide a brief overview of this proposal and the associated trailer bill language.
2. Please describe the efforts to date to improve hospital reimbursement through expansion of existing SDPs.
3. How would the efforts to develop the comprehensive value strategy be linked to the efforts to expand SDPs? Would they happen concurrently and be incorporated into the requests for federal approvals, or would they be developed separately?

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

**SB 1120 (Becker)**

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

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

\* Positions and resources ongoing after 2025-26.

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

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

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

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

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

**AB 3275 (Soria)**

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

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

\* Positions and resources ongoing after 2025-26.

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

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

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

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

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

1. Please provide a brief overview of these proposals.
2. When can the subcommittee expect narrative descriptions of these and other proposals for department resources to implement chaptered legislation?
3. Please account for the discrepancies between the Department of Finance analyses of the fiscal impacts of these bills during the prior legislative session, and the current staffing and resource requests for implementation of these bills.

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

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

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

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

<sup>1</sup> Only state funds are reflected, expenditures do not include federal funds.

<sup>2</sup> Positive fund balances reflect funds in the Managed Care Enrollment Fund not utilized within the fiscal year that are available to carry over to the next fiscal year. Negative fund balances reflect the use of fund balances from prior fiscal years.

<sup>3</sup> Revenues from SB 136 (Chapter 6, Statutes of 2024) and AB 160 (Chapter 39, Statutes of 2024) are not subject to Proposition 35.

*Source: DHCS Fiscal Forecasting, February 2025*

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

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

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

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

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

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

#### Quality Improvement Fee (AB 1762 - 2003)

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

#### Gross Premiums Tax (AB 1422 - 2009)

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

#### Managed Care Organization Tax (SB 78 - 2013)

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

#### Managed Care Enrollment Tax (SBX2 2 - 2016)

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

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

**Reauthorized MCO Enrollment Tax (AB 112 – 2019)**

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

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

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

<b>MCO Tax – Enrollment Tiers and Tax Amounts</b> <i>(as approved in the AB 119 and the 2023 Budget Act)</i>						
	<b>Medi-Cal Tier 1</b>	<b>Medi-Cal Tier 2</b>	<b>Medi-Cal Tier 3</b>	<b>Other Tier 1</b>	<b>Other Tier 2</b>	<b>Other Tier 3</b>
<i>Enrollment:</i>	<i>Less than 1,250,000</i>	<i>1,250,001-4,000,000</i>	<i>More than 4,000,001</i>	<i>Less than 1,250,000</i>	<i>1,250,001-4,000,000</i>	<i>More than 4,000,001</i>
2023-24	\$0.00	\$182.50	\$0.00	\$0.00	\$1.75	\$0.00
2024-25	\$0.00	\$182.50	\$0.00	\$0.00	\$1.75	\$0.00
2025-26	\$0.00	\$187.50	\$0.00	\$0.00	\$2.00	\$0.00

2026-27	\$0.00	\$192.50	\$0.00	\$0.00	\$2.25	\$0.00
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**2024 Modifications to MCO Tax Amounts to Draw Down Additional Federal Funds.** SB 136 (Committee on Budget and Fiscal Review), Chapter 6, Statutes of 2024, approved by the Legislature in March 2024, and AB 160 (Committee on Budget), Chapter 39, Statutes of 2024, approved by the Legislature in June 2024, modified the tiered tax amounts for the MCO tax approved by AB 119 to allow the state to draw down additional federal funds to offset General Fund expenditures in the Medi-Cal program. As the nonfederal share of Medi-Cal expenditures are typically supported by the state’s General Fund, these resources are available to help address the state’s General Fund shortfall. The new tax amounts by enrollment tier are as follows (changed amounts highlighted):

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

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

- **Physician and Professional Services.** \$121 million in 2023-24, \$291 million in 2024-25, \$682 million in 2025-26, and \$1.1 billion in 2026-27 to support physician and professional services, beginning January 1, 2024.
- **Emergency Physician Services.** \$50 million in 2024-25, \$100 million in 2025-26, and \$100 million in 2026-27 to support emergency physician services, beginning January 1, 2025.
- **Abortion and Family Planning.** \$45 million in 2024-25, \$90 million in 2025-26, and \$90 million in 2026-27 to support abortion and family planning services, beginning January 1, 2025.
- **Ground Emergency Medical Transportation.** \$25 million in 2024-25, \$50 million in 2025-26, and \$50 million in 2026-27 to support ground emergency medical transportation services, beginning January 1, 2025.
- **Air Ambulances.** \$4 million in 2024-25, \$8 million in 2025-26, and \$8 million in 2026-27 to support air ambulance services, beginning January 1, 2025.

- **Community-Based Adult Services.** \$4 million in 2024-25, \$8 million in 2025-26, and \$8 million in 2026-27 to support community-based adult services, beginning January 1, 2025.
- **Congregate Living Health Facilities.** \$4 million in 2024-25, \$8 million in 2025-26, and \$8 million in 2026-27 to support congregate living health facilities, beginning January 1, 2025.
- **Pediatric Day Health Centers.** \$2 million in 2024-25, \$3 million in 2025-26, and \$3 million in 2026-27 to support pediatric day health centers, beginning January 1, 2025.
- **Private Duty Nursing.** \$31 million in 2025-26 and \$62 million in 2026-27 to support private duty nursing services, beginning January 1, 2026.
- **Federally Qualified Health Centers and Rural Health Clinics.** \$25 million in 2025-26 and \$50 million in 2026-27 to support federally qualified health centers and rural health clinics, beginning January 1, 2026.
- **Continuous Medi-Cal Coverage for Children Ages 0 to 5.** \$17 million in 2025-26 and \$32 million in 2026-27 to support continuous Medi-Cal coverage for children ages 0 to 5, beginning January 1, 2026.
- **Non-Emergency Medical Transportation.** \$13 million in 2025-26 and \$25 million in 2026-27 to support non-emergency medical transportation, beginning January 1, 2026.
- **Hospital Relief Programs.** \$150 million in 2023-24 to support the Distressed Hospital Loan Program and \$50 million in 2023-24 to support the Small and Rural Hospital Relief Program for Seismic Assessment and Construction.
- **Medi-Cal Workforce Pool.** \$40 million in 2026-27 to support a Medi-Cal Workforce Pool.
- **Administration.** \$2 million annually, beginning in 2024-25, to support DHCS administration of these provider rate increases and investments.

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

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

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

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

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

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

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

- Primary Care Account (22 percent) – This account will provide increased reimbursement rates for primary care services. These may be in the form of quality incentive payments or value-based payment models to improve provider participation in Medi-Cal and improve quality.
- Specialty Care Account (22 percent) – This account will provide funding to increase Medi-Cal patient access to specialty care services by increasing and retaining the number of Medi-Cal managed care contracting specialists, increasing the number of Medi-Cal patients a specialist serves, providing expanded specialist appointment availability, and supporting specialists in coordinating and overseeing care of patients as part of a multi-disciplinary care team.
- Emergency Department Physicians Account (2.5 percent) – This account will provide increased reimbursements for emergency department physicians treating Medi-Cal patients.

- Outpatient and Clinic Access Account (5.75 percent) – This account will provide increased net reimbursements for outpatient facilities, including ambulatory surgical centers and clinics, that provide eligible outpatient services and procedures to Medi-Cal patients.
- Family Planning Account (5.5 percent) – This account will provide funding support for expanding the scope and availability of family planning services, such as Family PACT, family planning and family planning-related services in Medi-Cal. This funding may also support practice transformation activities, as well as alternative payment methodologies such as bundled payments, directed payments, capitated payments, and value-based payments.
- Reproductive Health Account (1.25 percent) – This account will provide funding support for protecting, preserving, and expanding access to abortion and abortion-related services, including increasing payment rates for abortion and abortion-related services.
- Emergency Medical Transportation Account (3 percent) – This account will provide increased payments to private ground emergency medical transport providers and emergency air ambulance transport providers. 80 percent of funding will support private ground emergency medical transport, and 20 percent will support emergency air ambulance transport providers.
- Emergency Department and Hospital Services Account (8.75 percent) – This account will provide increased reimbursement levels to hospitals for the purpose of protecting access to, and improving the quality of, hospital care, including access to inpatient acute care and emergency departments, for Medi-Cal patients.
- Designated Public Hospital Account (3.5 percent) – This account will provide increased net reimbursement or new payments for designated public hospitals and health systems to sustain and promote access to hospital and non-hospital care at designated public hospital systems.
- Improving Mental Health Account (4.5 percent) – This account will provide funding support to expand access to mental health programs, including increasing the supply of inpatient psychiatric beds by providing a supplemental payment for psychiatric inpatient days in licensed acute care hospitals and acute psychiatric hospitals.
- Health Care Workers Account (6.25 percent) – This account will provide funding support to attract, retain, and expand the pool of health care workers available to treat Medi-Cal patients. 75 percent of funding will support graduate medical education at the University of California to increase the number of physician and surgeon residency slots or residency programs. 25 percent of funding will support a grant program to support and strengthen the development and retention of the Medi-Cal workforce through bona fide labor-management cooperation committees.
- Clinic Quality Account (3.5 percent) – This account will provide incentives to clinics that demonstrate improved quality and increased access to care for Medi-Cal patients.

- *Improved Dental Services Account (3.5 percent)* – This account will provide enhanced access to specialty and restorative dental care for Medi-Cal patients.
- *Medi-Cal Access and Support Account (8 percent)* – This account provides the non-federal share of Medi-Cal expenditures, which provides offsetting General Fund savings.

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

*Appointed by the Governor:*

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

*Appointed by the Speaker of the Assembly:*

- One member that represents public, nonprofit, Medi-Cal managed care plans on a statewide basis
- One member that represents dentists on a statewide basis

*Appointed by the Senate President Pro Tempore:*

- One member that represents organized labor groups on a statewide basis
- One member that represents a private emergency air ambulance transport provider that bills for more than 2,000 emergency ambulance transports per year.

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

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

1. Please provide a brief overview of the types of reimbursement codes and other investments included in the 2024 provider rate increases and investments package.
2. Please provide a brief overview of the major categories of investments authorized by Proposition 35 for the 2025 and 2026 calendar years.

3. How will DHCS approach consultation with the Stakeholder Advisory Committee for the initial round of investments? Will DHCS offer its own proposal for discussion, or work with the committee to develop a proposal together?
4. One of the goals of Proposition 35 is to increase access to care for Medi-Cal providers. How will the department measure how successful these investments are in achieving the goal of increased access to care? Is there any evidence available regarding the most effective strategies to increase access to care with these resources?
5. How will the department manage the transition from the 2025 and 2026 investments to the investments in 2027 and beyond, given they are structured differently?
6. Please describe how voter approval of Proposition 35 impacted the availability of General Fund savings related to the MCO tax, including how Proposition 35 treats the increased tax rates as a result of the 2024 modifications (SB 136 and AB 160)?
7. Please detail the investments approved as part of the 2024 Budget Act that will no longer be operative as a result of voter approval of Proposition 35.

**NOT FOR PRESENTATION****Issue 7: Proposals for Investment**

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

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

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

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

# SUBCOMMITTEE NO. 3

# Agenda

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



Thursday, March 13<sup>th</sup>, 2025  
9:30 am, or upon adjournment of session  
1021 O Street – Room 1200

Consultant: Scott Ogus

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**PUBLIC COMMENT**

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*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.*

**FOR VOTE ONLY****4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH****Issue 1: Opioid Settlements Fund Allocations**

**Local Assistance – Governor’s Budget.** CDPH requests reduction in expenditure authority from the Opioid Settlements Fund of \$8.4 million in 2025-26 that currently supports the California Overdose Prevention and Harm Reduction Initiative (COPHRI).

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3397 – Opioid Settlements Fund	(\$8,391,000)	\$-
<b>Total Funding Request:</b>	<b>(\$8,391,000)</b>	<b>\$-</b>

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

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

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

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

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

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

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

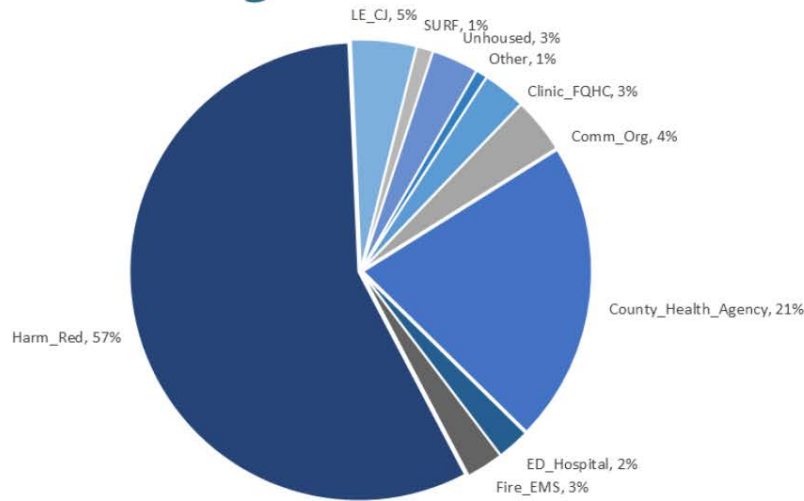
In addition, the 2022 Budget Act included expenditure authority from the OSF for the following:

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

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

**California Overdose Prevention and Harm Reduction Initiative.** The 2023 Budget Act included expenditure authority from the Opioid Settlements Fund of \$15.3 million annually for four years, beginning in 2023-24, to support the California Overdose Prevention and Harm Reduction Initiative (COPHRI). COPHRI supports harm reduction sites to prevent overdose by distributing naloxone and training people who use drugs on how to use it to prevent death. According to DHCS data, harm reduction sites were responsible for 57 percent of reported naloxone reversals in California, as of February 18, 2025.

# Reported Naloxone Reversals by Type of Organization



Total Reversals Reported: 337,444



NOTE: Reported reversals as of February 18, 2025.

Other category includes: Local City Agencies, Schools/Colleges, Tribal entities, Telehealth, other State Agencies.

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

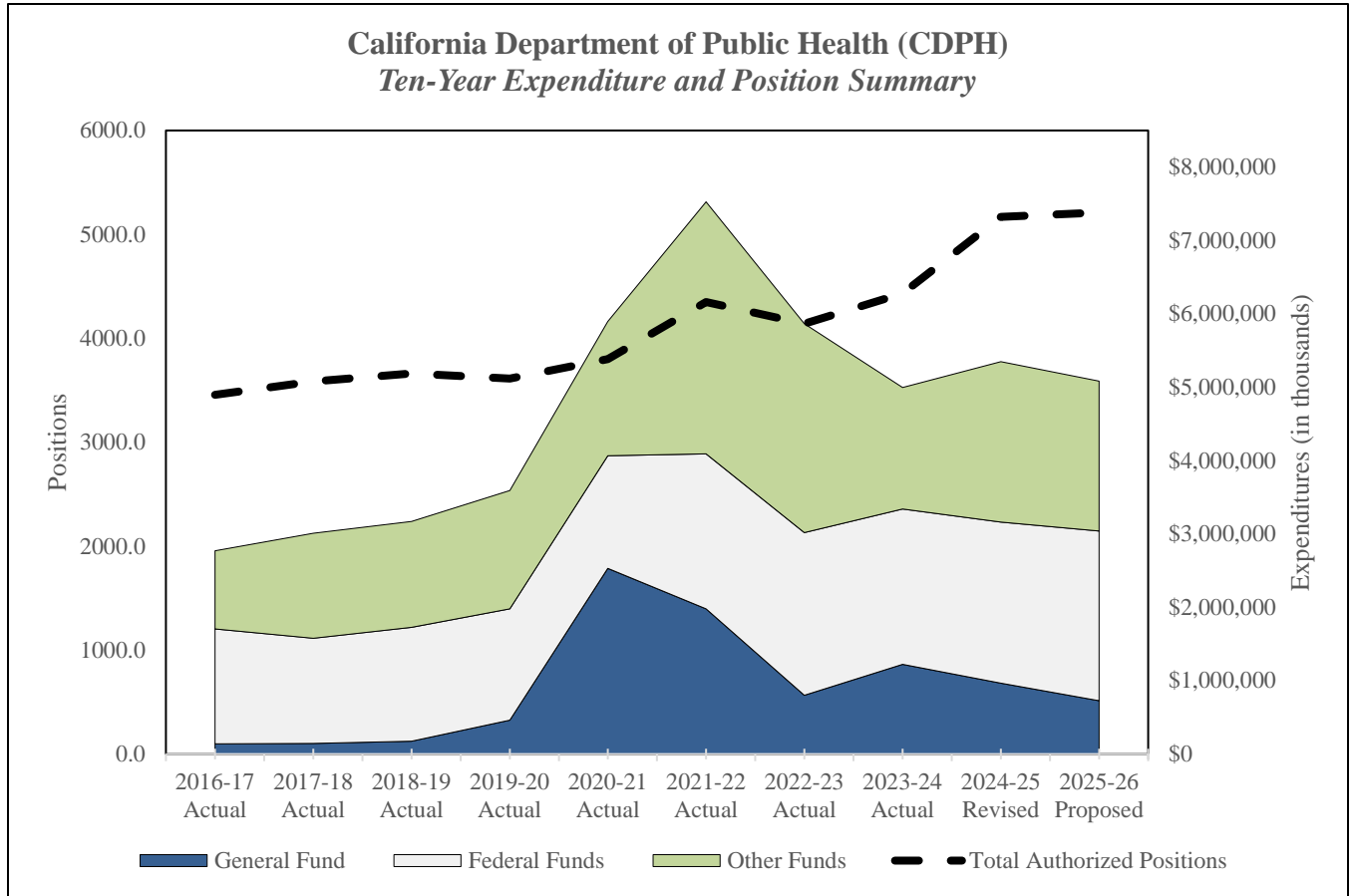
**Naloxone Distribution Project.** The Naloxone Distribution Project was created in 2018 in response to a sharp increase in overdoses and aims to reduce opioid overdose deaths through the provision of free naloxone in the form of a spray that can be used by laypeople. Eligible entities for the distribution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

**Resource Reduction Request.** CDPH requests reduction in expenditure authority from the Opioid Settlements Fund of \$8.4 million in 2025-26 that currently supports the California Overdose Prevention and Harm Reduction Initiative (COPHRI). According to CDPH, this reduction is necessary due to lack of available resources in the Opioid Settlement Fund. However, in a separate request rejected by the subcommittee, DHCS requests expenditure authority from the Opioid Settlements Fund of \$8.4 million in 2025-26 to support expansion of the Naloxone Distribution Project.

**Subcommittee Staff Comment and Recommendation—Reject.** Subcommittee staff recommends rejecting this proposed reduction, consistent with its previous action to reject the related augmentation to the DHCS Naloxone Distribution Project with these redirected funds. Because harm reduction entities are responsible for 57 percent of reported naloxone reversals in California, this redirection of Opioid Settlements Fund resources is counterproductive to the goal of preventing opioid overdose deaths in the state.

**4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH**

**Issue 1: Overview**



Fund Source	2023-24 Actual	2024-25 Budget Act	2024-25 Revised	2025-26 Proposed
<b>General Fund</b>	\$1,222,617	\$787,253	\$967,845	\$727,909
<b>Federal Funds</b>	\$2,117,193	\$2,195,190	\$2,194,362	\$2,311,878
<b>Other Funds</b>	\$1,656,006	\$2,167,473	\$2,186,628	\$2,042,472
<b>Total Department Funding:</b>	<b>\$4,995,816</b>	<b>\$5,149,916</b>	<b>\$5,348,835</b>	<b>\$5,082,259</b>
<b>Total Authorized Positions:</b>	<b>4431.2</b>	<b>5168.4</b>	<b>5168.4</b>	<b>5210.4</b>
<b>Other Funds Detail:</b>				
<i>Breast Cancer Research Account (0007)</i>	\$718	\$620	\$620	\$1,520
<i>Nuclear Planning Assessment Acct (0029)</i>	\$983	\$1,091	\$1,096	\$1,097
<i>Motor Vehicle Acct, Trans. Fund (0044)</i>	\$1,597	\$1,723	\$1,718	\$1,626

<i>Sale of Tobacco to Minors Ctrl Acct (0066)</i>	(\$1,577)	\$1,063	\$1,002	\$1,003
<i>Occup. Lead Poisoning Prev Acct (0070)</i>	\$2,078	\$3,100	\$3,084	\$4,108
<i>Medical Waste Management Fund (0074)</i>	\$2,714	\$3,276	\$3,282	\$3,292
<i>Radiation Control Fund (0075)</i>	\$30,453	\$31,902	\$32,323	\$32,339
<i>Tissue Bank License Fund (0076)</i>	\$435	\$1,675	\$1,682	\$1,659
<i>Child. Lead Poisoning Prev Fund (0080)</i>	\$39,439	\$47,922	\$47,893	\$47,272
<i>Export Document Program Fund (0082)</i>	\$472	\$706	\$546	\$586
<i>Clinical Lab. Improvement Fund (0098)</i>	\$12,361	\$16,607	\$16,735	\$16,408
<i>Health Statistics Special Fund (0099)</i>	\$26,114	\$33,686	\$33,528	\$33,606
<i>Dept. of Pesticide Regulation Fund (0106)</i>	\$307	\$363	\$361	\$320
<i>Air Pollution Control Fund (0115)</i>	\$269	\$320	\$319	\$279
<i>CA Health Data and Planning Fund (0143)</i>	\$240	\$240	\$240	\$240
<i>Food Safety Fund (0177)</i>	\$10,969	\$13,305	\$13,122	\$13,101
<i>Genetic Disease Testing Fund (0203)</i>	\$174,816	\$176,806	\$175,101	\$176,301
<i>Health Education Account, Prop 99 (0231)</i>	\$43,106	\$41,066	\$41,074	\$35,720
<i>Research Account, Prop 99 (0234)</i>	\$3,847	\$4,213	\$4,214	\$3,618
<i>Unallocated Account, Prop 99 (0236)</i>	\$1,591	\$1,819	\$1,812	\$1,619
<i>Inf. Botulism Treatment/Prev Fund (0272)</i>	\$10,385	\$18,278	\$18,273	\$16,584
<i>Child Health and Safety Fund (0279)</i>	\$550	\$551	\$551	\$551
<i>Registered Enviro. Health Spec Fund (0335)</i>	\$509	\$510	\$514	\$515
<i>Indian Gaming Spec Dist Fund (0367)</i>	\$6,123	\$8,519	\$8,511	\$8,515
<i>Vectorborne Disease Account (0478)</i>	\$199	\$195	\$196	\$216
<i>Toxic Substances Control Acct (0557)</i>	\$368	\$586	\$580	\$467
<i>Domestic Violence Training/Ed Fund (0642)</i>	\$463	\$709	\$708	\$708
<i>CA Alzheimers Research Fund (0823)</i>	\$661	\$687	\$687	\$687
<i>Special Deposit Fund (0942)</i>	\$3,225	\$9,868	\$12,733	\$10,597
<i>Reimbursements (0995)</i>	\$347,504	\$756,977	\$764,973	\$617,656
<i>Drug and Device Safety Fund (3018)</i>	\$6,912	\$7,461	\$7,275	\$7,990
<i>WIC Manufacturer Rebate Fund (3023)</i>	\$179,504	\$183,995	\$188,288	\$186,443
<i>Medical Marijuana Program Fund (3074)</i>	\$0	\$0	\$0	\$0
<i>AIDS Drug Assistance Prog. Fund (3080)</i>	\$267,685	\$311,459	\$290,225	\$364,585
<i>Cannery Inspection Fund (3081)</i>	\$4,267	\$4,511	\$4,451	\$4,458
<i>Mental Health Services Fund (3085)</i>	\$3,147	\$2,767	\$4,281	\$3,227
<i>Licensing and Certification Fund (3098)</i>	\$307,790	\$313,858	\$312,910	\$315,652
<i>Gambling Addiction Program Fund (3110)</i>	\$150	\$350	\$350	\$350
<i>Birth Defects Monitoring Prog Fund (3114)</i>	\$2,475	\$2,579	\$2,576	\$2,504
<i>Lead-Related Construction Fund (3155)</i>	\$785	\$1,401	\$1,398	\$6,360
<i>Cost/Impl Acct, Air Poll. Ctrl Fund (3237)</i>	\$150	\$410	\$407	\$409
<i>Cannabis Control Fund (3288)</i>	\$512	\$601	\$601	\$602

<i>State Dental Program Acct., Prop 56 (3307)</i>	\$39,409	\$35,100	\$35,104	\$25,416
<i>DPH Tobacco Law Enforc, Prop 56 (3318)</i>	\$6,472	\$4,071	\$3,712	\$3,729
<i>DPH, Tobacco Prev/Ctrl, Prop 56 (3322)</i>	\$87,205	\$89,850	\$78,079	\$67,964
<i>TGI Wellness and Equity Fund (3385)</i>	\$2,310	\$5,000	\$10,419	\$5,000
<i>Ind. Hemp Enroll/Oversight Fund (3396)</i>	\$0	\$1,327	\$722	\$1,034
<i>Opioid Settlement Fund (3397)</i>	\$26,314	\$18,750	\$52,752	\$6,759
<i>Electronic Cig. Settlements Fund (8141)</i>	\$0	\$5,600	\$5,600	\$7,780

**Background.** The California Department of Public Health (CDPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are primarily state-operated programs, such as those that license health care facilities.

According to CDPH, the goals of these programs include the following:

1. Achieve health equities and eliminate health disparities.
2. Eliminate preventable disease, disability, injury, and premature death.
3. Promote social and physical environments that support good health for all.
4. Prepare for, respond to, and recover from emerging public health threats and emergencies.
5. Improve the quality of the workforce and workplace.

The department is composed of eight major program areas, or “centers”:

- (1) **Center for Healthy Communities (CHC)** – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; reduce the prevalence of obesity; provide training programs for the public health workforce; prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; promote and support safe and healthy environments in all communities and workplaces; and prevent and treat problem gambling. CHC programs include: chronic disease prevention and management, tobacco control, environmental health, occupational health, injury and violence prevention, oral health, and problem gambling.
- (2) **Center for Environmental Health (CEH)** – This center works to protect and improve the health of all California residents by utilizing investigation, inspection, laboratory, technical assistance, regulatory and emergency response activities to improve the safety of food, drugs, and medical devices; conduct underage tobacco enforcement; oversee the use of radiation and radioactive materials; regulate medical waste; and conduct other environmental management programs.
- (3) **Center for Family Health (CFH)** – This center provides improvement to the health and well-being of pregnant people, children and youth as well as reduce disparities in perinatal health outcomes by providing nutritional support and screening newborns and pregnant women for genetic diseases. CFH programs include: Genetic Disease Screening Program (GDSP); Maternal, Child, and Adolescent Health Division; and the Women, Infants, and Children (WIC) Supplemental Nutrition Program.

- (4) **Center for Health Care Quality (CHCQ)** – This center provides regulatory oversight and monitoring for the quality of care in public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators, and certifies nurse assistants, home health aides, and hemodialysis technicians; and oversees the prevention, surveillance, and reporting of healthcare associated infections in California’s health facilities.
- (5) **Center for Infectious Disease (CID)** – This center works to prevent and control infectious diseases such as Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS), tuberculosis, viral hepatitis, influenza and other vaccine preventable illnesses, emerging infections, vector-borne disease, sexually transmitted diseases (STD), infant botulism, and foodborne illnesses.
- (6) **Center for Health Statistics and Informatics (CHSI)** – This center works to improve public health by managing information systems and facilitating the collection, validation, analysis, and dissemination of health statistics and demographic information on California’s population.
- (7) **Center for Preparedness and Response (CPR)** – This center provides overall statewide planning and preparedness for public health disasters and emergencies, distributing and monitoring funding for disaster planning at the local level, operating the Medical Health Coordination Center, developing, and maintaining a standard public health and medical emergency management system for local and state entities.
- (8) **Center for Laboratory Science (CLS)** – This center provides oversight for clinical and public health laboratory operations and clinical and public health laboratory personnel, and is responsible for issuing licenses and certificates.

**Subcommittee Staff Comment.** This is an informational item.

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview of CDPH’s programs and budget.

**Issue 2: State of the State's Public Health**

**State of the State's Public Health.** SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, requires the Director of CDPH to submit a written report every other year, beginning in 2024, to the Governor and the Legislature on the state of public health in California.

**Background.** The 2018 Budget Act included supplemental reporting language requiring CDPH to report to the health and human services budget subcommittees of the Legislature certain information about public health statistics in California. The language was as follows:

**Item 4265-001-0001—Department of Public Health**

1. *State of the State's Public Health.* At its first budget subcommittee hearings of the 2019-20 budget process, the Department of Public Health shall report to the health and human services budget subcommittees of both houses of the Legislature a summary of key public health statistics in California. The briefing and related handout shall include excerpted information from the County Health Status Profiles report on key public health indicators, including available information about these indicators' trends, for issues that the department considers major existing or emerging public health issues. The briefing and related handout may, for example, provide statistics on issues such as opioid overdoses and naloxone treatments, the number of people infected with sexually transmitted diseases (STDs) and the geographic regions in which STD transmissions are highest, rates of diabetes and/or other chronic diseases among various subpopulations, or recent public health outbreaks.

After the initial presentation during the 2019-20 budget process, CDPH staff continued to provide the State of the State's Public Health presentation in subsequent years, through the COVID-19 pandemic years, until codification of the requirement in trailer bill language adopted as part of the 2022 Budget Act.

**Future of Public Health – SB 184.** After the COVID-19 pandemic, the Legislature adopted a package of public health infrastructure initiatives, collectively known as the Future of Public Health, which made significant investments in state and local public health departments, and implemented reforms to improve data sharing between public health officials and state and local elected officials. Among these reforms was codification of the previous State of the State's Public Health presentation, previously reflected in non-binding supplemental reporting language, into the Health and Safety Code. SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, requires the State Public Health Officer to, on or before February 1 of every other year, submit a written report to the Governor and the Legislature on the state of public health in California. SB 184 also requires the State Public Health Officer to present an update annually to the relevant budget subcommittees of the Legislature during legislative budget hearings. The written report must include the following information:

1. Information on key public health indicators that California is experiencing, as determined to be relevant by the State Public Health Officer.
2. Information on health disparities identified as part of the indicators and trends, if any.

3. The leading causes of morbidity and mortality in California and evidence of increasing or decreasing rates of morbidity and mortality over the prior three to five years, inclusive.
4. Data on the incidence and prevalence of communicable and noncommunicable chronic diseases and conditions.
5. Data on the incidence and prevalence of intentional and unintentional injuries, including data specific to suicides and gun violence.
6. Data on the prevalence of morbidity and mortality related to mental illness and substance abuse.

**Subcommittee Staff Comment**—This is an informational item.

**Questions.** The subcommittee has requested CDPH respond to the following:

1. Please present the 2025 State of the State’s Public Health Report update, pursuant to the requirements of SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022.

**Issue 3: AIDS Drug Assistance Program (ADAP) Estimate**

**AIDS Drug Assistance Program (ADAP) Estimate.** The Office of AIDS within CDPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk of acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 600 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

**ADAP Programs.** ADAP provides services to its clients through support for medications, health insurance premiums and out-of-pocket costs. Participating clients generally fall into one of five categories:

1. *Medication-only clients* are people living with HIV who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals, who only receive services associated with medication costs.
2. *Medi-Cal Share of Cost clients* are persons living with HIV enrolled in Medi-Cal who have a share of cost for Medi-Cal services. ADAP covers the share of cost for medications for these clients, who only receive services associated with medication costs.
3. *Private insurance clients* are persons living with HIV who have some form of health insurance, including through Covered California, privately purchased health insurance, or employer-based health insurance and who receive services associated with medication costs, health insurance premiums and medical out-of-pocket costs.
4. *Medicare clients* are persons living with HIV enrolled in a Medicare plan. This group is divided into three client subgroups: Part B, Part C, and Part D. These groups receive medication benefits and may also receive assistance with health insurance premiums and medical out-of-pocket costs.
5. *Pre-exposure prophylaxis (PrEP) Assistance Program (PrEP-AP) clients* are individuals who are at risk for, but not infected with, HIV and have chosen to take pre-exposure prophylaxis (PrEP), or post-exposure prophylaxis (PEP), as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP- and PEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP- and PEP-related medical costs and medication costs for clients who are ineligible for a medication assistance program through a drug manufacturer or other assistance programs.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act, now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

**ADAP Estimate – Governor’s Budget.** The November 2024 ADAP Local Assistance Estimate reflects revised 2024-25 expenditures of \$392.5 million (\$277.3 million ADAP Rebate Fund and \$115.2 million federal funds), a decrease of \$1.8 million or 0.4 percent compared to the 2024 Budget Act. According to CDPH, this decrease is primarily due staggered implementation of program enhancements adopted in the 2024 Budget Act using ADAP Rebate Funds, as well as not including funding for condom distribution in the November 2024 Estimate. Funding has subsequently been allocated for condom distribution and, according to CDPH, will be reflected in the May 2025 Estimate.

For 2025-26, CDPH estimates ADAP expenditures of \$462.3 million (\$352 million ADAP Rebate Fund and \$110.3 million federal funds), an increase of \$69.8 million or 17.8 percent compared to revised expenditures for 2024-25. According to CDPH, the significant increase in expenditures between 2025-26 and 2024-25, compared to the 2024 Budget Act, is due to implementation of program enhancements adopted in the 2024 Budget Act, including expanding eligibility from 500 to 600 percent of the federal poverty level, moving to an open formulary, and providing funding to support harm reduction.

<b>ADAP Local Assistance Funding Summary</b>		
<b>Fund Source</b>	<b>2024-25</b>	<b>2025-26</b>
0890 – Federal Trust Fund	\$115,230,000	\$110,263,000
3080 – AIDS Drug Assistance Program Rebate Fund	\$277,277,000	\$352,013,000
<b>Total ADAP Local Assistance Funding</b>	<b>\$392,507,000</b>	<b>\$462,276,000</b>

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2024-25 and 2025-26 will be as follows:

<u><b>Caseload by Client Group</b></u>	<u><b>2024-25</b></u>	<u><b>2025-26</b></u>
<b>Medication-Only</b>	8,642	7,594
<b>Medi-Cal Share of Cost</b>	50	50
<b>Private Insurance</b>	9,215	9,168
<b>Medicare</b>	6,879	6,648
<b>PrEP Assistance Program</b>	7,720	8,921
<b>TOTAL</b>	<b>32,506</b>	<b>32,380</b>

<u>Expenditures by Client Group</u>	<u>2024-25</u>	<u>2025-26</u>
<b>Medication-Only</b>	\$228,013,305	\$249,523,961
<b>Medi-Cal Share of Cost</b>	\$799,595	\$908,835
<b>Private Insurance</b>	\$107,924,777	\$131,092,117
<b>Medicare</b>	\$20,882,170	\$26,510,933
<b>PrEP Assistance Program</b>	\$20,528,177	\$37,155,125
<b>TOTAL</b>	<b>\$378,148,023</b>	<b>\$445,190,972</b>

Costs for administration of ADAP are estimated to be \$5.5 million in 2024-25 and \$6.1 million in 2025-26. Costs for administration of PrEP-AP are estimated to be \$5.4 million in 2024-25 and \$5.4 million in 2025-26. Enrollment costs are estimated to be \$7.8 million in 2024-25 and \$8.3 million in 2025-26.

In addition, ADAP's pharmacy benefit manager, Magellan Rx Management, contracts with a safety net recovery vendor, Health Management Systems (HMS) to pursue recovery of paid claims when a liable third party is identified post-payment. CDPH estimates recoveries of \$16.4 million in 2024-25 and \$14.7 million in 2025-26.

**ADAP Rebate Fund Loans to the General Fund.** The 2024 Budget Act authorized a \$500 million from the ADAP Rebate Fund to the General Fund to support the General Fund shortfall. The 2023 Budget Act similarly included a \$400 million loan from the fund to the General Fund. According to CDPH, the fund is expected to maintain a reserve of \$189.5 million after program expenditures in 2025-26. The loans are expected to be repaid in 2028-29.

**ADAP Program Enhancements – Early Action Package.** The 2024 Budget Act included expenditure authority from the ADAP Rebate Fund of \$23 million and the Legislature approved budget bill language to implement the following program enhancements to reduce transmission of HIV/AIDS in California:

- *ADAP Program Eligibility Expansion.* Beginning January 1, 2025, or as soon as is technically feasible thereafter, increase financial eligibility standards for ADAP and the Pre-Exposure and Post-Exposure Prophylaxis Assistance Program (PrEP-AP) from 500 percent of the federal poverty level to 600 percent of the federal poverty level.
- *Increase Cap on Premium Payments in Office of AIDS Health Insurance Premium Payment Program.* Beginning January 1, 2025, or as soon as is technically feasible thereafter, increase the cap on premium payments from \$1,938 to \$2,996 per month for the Office of AIDS Health Insurance Premium Payment (OA-HIPP) program, the Employer-Based HIPP program, and the Medicare Premium Payment Program.
- *Open Formulary in ADAP.* Beginning January 1, 2025, or as soon as is technically feasible thereafter, modify the ADAP formulary to an open formulary.

- *TGI Wellness and Equity Fund.* Allocate \$5 million annually for three years, beginning July 1, 2024, to the Transgender, Gender Nonconforming, and Intersex (TGI) Wellness and Equity Fund to fund services related to care and treatment for eligible individuals living with HIV and AIDS.
- *Harm Reduction Supply Clearinghouse.* Allocate \$10 million annually for three years, beginning July 1, 2024, to fund the Harm Reduction Supply Clearinghouse to fund HIV prevention supplies to California syringe access programs.
- *Office of AIDS Programs Needs Assessment and Analysis.* Allocate \$200,000, available until June 30, 2027, to support a needs assessment and analysis to identify needs for client navigation and retention services for clients enrolled in a Ryan White HIV/AIDS Program through the Office of AIDS.
- *PrEP Navigation Services Program Needs Assessment and Analysis.* Allocate \$200,000, available until June 30, 2027, to support a needs assessment and analysis aimed at understanding potential needs for PrEP Navigation Services Program.
- *Condom Distribution.* Allocate \$5 million, available until June 30, 2027, to distribute funding to a community-based organization to make internal and external condoms available to prevent the transmission of HIV and sexually transmitted infections.

The language also requires CDPH to submit, as part of the 2025-26 Governor’s Budget, a plan for modernization and expansion of ADAP and related programs with a focus on addressing the epidemic of HIV/AIDS in California.

According to CDPH, because the language governing the condom distribution component of the program enhancements referenced approval of SB 954 (Menjivar), a policy bill from the 2024 legislative session that was vetoed by the Governor, this component was not included in the November 2024 ADAP Estimate. However, after subsequent discussions with CDPH and the Administration, the condom distribution component will be implemented and the costs included in the May 2025 ADAP Estimate.

**ADAP Rebate Fund Cleanup – Trailer Bill Language Proposal.** CDPH proposes trailer bill language to authorize the use of ADAP Rebate Fund for HIV prevention as part of the TGI Wellness and Equity Fund component of the ADAP program enhancements, as well as clarify that implementation of the condom distribution program is not linked to approval of any policy bill. Specifically, the language would:

1. Add “HIV prevention” to the list of allowable uses of ADAP Rebate Fund.
2. Transfer administration of the TGI Wellness and Equity Fund from the Office of Health Equity, to CDPH broadly.
3. Revise one of the authorized uses of TGI Wellness and Equity Fund resources to refer to “evidence-based therapeutic arts programs”, rather than specifically referencing “dancing, painting, or writing”.
4. Delay implementation date of the transfer from the ADAP Rebate Fund to the TGI Wellness and Equity Fund by one year, until July 1, 2025, to reflect the programmatic delay due to the need for these statutory changes.

5. Remove references to SB 954 from sections regarding the condom distribution program enhancement.

**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 CDPH and Department of Finance to respond to the following:

1. Please provide a brief overview of the major changes to the ADAP Estimate.
2. Please provide an overview of the two loans to the General Fund from the ADAP Rebate Fund, including the terms of repayment, the condition of the fund balance, and the expected repayment date.
3. Please provide a status update on implementation of each of the components of the ADAP Early Action program enhancements including, if applicable, the impacts on ADAP enrollment and expenditures.
4. Please describe the department’s plan to engage stakeholders to develop an expenditure plan for the \$900 million in ADAP Rebate Fund resources that will be repaid by the General Fund beginning in 2028-29.

**Issue 4: Maintenance and Operations Support Public Health Information Technology Systems**

**Budget Change Proposals – Governor’s Budget.** CDPH requests General Fund expenditure authority to support three public health information technology (IT) systems.

*CalCONNECT Maintenance and Operations.* CDPH requests General Fund expenditure authority of \$18 million in 2025-26. If approved, these resources would support maintenance and operations costs for the California Confidential Network for Contact Tracing (CalCONNECT), California’s contact tracing system used to manage case and contact records and notify individuals of possible exposure to people who test positive for infectious diseases.

<b>Multi-Year Funding Request Summary - CalCONNECT</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$18,000,000	\$-
<b>Total Funding Request:</b>	<b>\$18,000,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

*SaPHIRE Maintenance and Operations.* CDPH requests 15 positions and General Fund expenditure authority of \$27 million in 2025-26, \$20.4 million in 2026-27, and \$16.3 million annually thereafter. If approved, these positions and resources would support maintenance and operations of the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system, an integrated data system that provides 24-hour processing of lab results for all reportable infectious diseases.

<b>Multi-Year Funding Request Summary - SaPHIRE</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$27,000,000	\$20,400,000
<b>Total Funding Request:</b>	<b>\$27,000,000</b>	<b>\$20,400,000</b>
<b>Total Requested Positions:</b>	<b>15.0</b>	<b>15.0</b>

\* Additional fiscal year resources requested – 2027-28 and ongoing: \$16,300,000

*CAIR3 Design, Development, and Implementation.* CDPH requests General Fund expenditure authority of up to \$5.1 million in 2025-26. If approved, these resources would support the design, development, and implementation of the California Immunization Registry 3 (CAIR3) Project, which would upgrade California’s statewide immunization information system used to capture, store, track, and consolidate vaccination data.

<b>Multi-Year Funding Request Summary - CalCONNECT</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$5,100,000	\$-
<b>Total Funding Request:</b>	<b>\$5,100,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

### **Cal-CONNECT Maintenance and Operations**

**Background – CalCONNECT.** The California Confidential Network for Contact Tracing (CalCONNECT) is California's system for case and outbreak investigation, contact tracing, symptom monitoring of exposed individuals, and communication with affected persons, including the dissemination of isolation and quarantine guidance to cases and contacts. CalCONNECT was developed during the COVID-19 pandemic and was recently expanded to support Mpox, tuberculosis, and sexually transmitted infections. CalCONNECT has also incorporated a new generic disease condition function that can be utilized for monitoring persons exposed to avian influenza, Ebola, and other infectious diseases. CalCONNECT also supports outbreak investigations by providing workplaces and schools streamlined ways to report exposure events directly to their LHD and CDPH. As a result of CalCONNECT's success related to COVID-19, numerous stakeholder groups, including local health jurisdictions, have requested that CDPH build upon the system and expand its functionality to support additional disease conditions that require case investigation and contact tracing, such as tuberculosis, human immunodeficiency virus (HIV), syphilis, perinatal hepatitis B, and measles.

The 2022 Budget Act included General Fund expenditure authority of \$39.6 million in 2022-23 to provide maintenance and operations for one year to support and operate CalCONNECT. The one-year funding strategy was designed to allow CDPH to obtain ongoing maintenance and operations costs for CalCONNECT through a competitive process and include these costs in a proposal for 2023-24. CDPH engaged in a challenge-based procurement process in March 2022, resulting in a new contract with the existing vendor.

The 2023 Budget Act included General Fund expenditure authority of \$74.4 million in 2023-24 for maintenance and operations for one year. According to CDPH, support for 2024-25 maintenance and operations was supported with federal funds that will not be available in subsequent years.

**Resource Request – CalCONNECT.** CDPH requests General Fund expenditure authority of \$18 million in 2025-26 to support maintenance and operations costs for the California Confidential Network for Contact Tracing (CalCONNECT), California's contact tracing system used to manage case and contact records and notify individuals of possible exposure to people who test positive for infectious diseases. Specifically, CDPH requests these resources to support external technology service contracts, software licenses, and interdepartmental services. These services include system operations, system monitoring, ensuring compliance with the latest security and privacy policies, routine quality assurance, automated regression testing, help desk, and system modifications to remediate security findings. According to CDPH, the one-year funding strategy is designed to allow a transition of some maintenance and operations activities from contract staff to state staff, similar to the proposed transition for SaPHIRE discussed below.

### **SaPHIRE Maintenance and Operations**

**Background - SaPHIRE.** The Surveillance and Public Health Information Reporting and Exchange (SaPHIRE), previously known as the California COVID Reporting System (CCRS), was implemented in October 2020 to address the challenges of managing COVID-19 laboratory data, providing upgraded capabilities for managing all communicable disease laboratory data sent electronically. During the COVID-19 pandemic, CDPH data systems were not able to manage the high volume of data associated

with COVID-19. According to CDPH, there were also substantial quality problems with the data, including: incomplete fields such as race and ethnicity, duplicate reports, incorrect or incomplete information for accurate patient matching, inconsistent use of codes and test labels for laboratory test and result values, system limitations to ingest and handle the rapid surge in lab result submissions, and architecture limitations that prevented adequate system performance monitoring.

In August 2020, during the height of the pandemic, CDPH conducted a challenge-based procurement to develop and implement the CCRS system. For the maintenance and operations phase of this project, CDPH engaged in a new, challenge-based procurement process in March 2022, resulting in a contract with a new vendor. A transition between the old and new vendor was completed by December 31, 2022.

The SaPHIRE system receives laboratory results for COVID-19 and other infectious diseases related to California residents from laboratories across the United States in accordance with state regulations. The great majority of laboratory results are submitted electronically and managed by the system. More than 350 entities are connected directly to this system and submit results on behalf of thousands of other entities, including laboratories that report their own results, and aggregators or hubs that report results for multiple laboratories. Incoming laboratory results are compared against existing laboratory results to identify, match, and remove duplicate records. Processed laboratory results are transferred to CDPH's Enterprise Rhapsody Gateway for routing to downstream public health systems, including CalREDIE, and the Los Angeles and San Diego County disease surveillance systems. Data processed through SaPHIRE is used to monitor infectious disease and testing trends.

The 2022 Budget Act included General Fund expenditure authority of \$26.3 million in 2022-23 to provide maintenance and operations for one year to support and operate CCRS. The one-year funding strategy was designed to allow CDPH to obtain updated maintenance and operations costs through a competitive process and include these costs in a proposal for 2023-24. As part of the transition, CCRS was renamed to SaPHIRE to recognize that the system receives data for all reportable conditions, not just COVID-19.

The 2023 Budget Act included General Fund expenditure authority of \$30.9 million in 2023-24 for maintenance and operations costs for SaPHIRE. These resources were approved to support integration and critical data exchange between SaPHIRE and other core CDPH systems, including the California Reportable Disease Information Exchange (CalREDIE) and the California Confidential Network for Contact Tracing (CalCONNECT).

The 2024 Budget Act included General Fund expenditure authority of \$26.9 million in 2024-25 to support continued maintenance of SaPHIRE. Of this amount, \$26.3 million supported technology service contracts, software licenses, and interdepartmental services, while \$622,000 supported personnel costs to make permanent three redirected staff.

**Staffing and Resource Request - SaPHIRE.** CDPH requests 15 positions and General Fund expenditure authority of \$27 million in 2025-26, \$20.4 million in 2026-27, and \$16.3 million annually thereafter to support maintenance and operations of the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system, an integrated data system that provides 24-hour processing of lab results for all reportable infectious diseases. CDPH reports it plans to migrate the SaPHIRE system from the current vendor's environment to its in-house Azure environment, reducing operating costs and consolidating systems within the department's own infrastructure. In addition, CDPH plans to work with

the current vendor to migrate support services to reduce reliance on the vendor, beginning work in 2025-26, with completion and elimination of vendor costs in 2026-27. Specifically, CDPH requests the following positions and resources:

SaPHIRE Data Quality and Submitter Support Team – Seven positions

- **One Research Data Manager, two Research Data Specialist (RDS) II** positions, and **four RDS I** positions would provide data quality and submitter management support, including ongoing support for public health data submitters, management and resolution of data quality issues, and outreach. This workload is currently being supported by the SaPHIRE system vendor and would be brought in-house.

Information Technology Services Division (ITSD) Data Quality Support Team – Three positions

- **One Information Technology Specialist (ITS) II** position and **two ITS I** positions would provide technical expertise needed to transition the data quality analysis from the current vendor, and to support the SaPHIRE Data Quality and Submitter Support Team.

ITSD Data Warehouse Support Team – Two positions

- **Two ITS II** positions would provide technical expertise to transition data warehouse support from the vendor to CDPH staff including full maintenance and operations support of data transformation and load processes, monitoring of data warehouse processes, troubleshooting of issues, managing accounts, and continuously improving performance.

ITSD Reportable Conditions and Immunization Board Operations – Two positions

- **One ITS II** position and **one ITS I** position would operate, manage, and mature the governance processes for the Reportable Conditions and Immunizations (RCI) Board, including assisting the department and stakeholders to prioritize efforts and efficiently manage IT capacity and services to achieve both business and IT strategic objectives.

Administration Division – One position

- **One Associate Governmental Program Analyst** would support general administrative functions including budget building, human resources, contracting, purchasing, and conducting analytical and administrative support.

Contract Costs - \$24.1 million

- Of the amount requested in this proposal, \$24.1 million in 2025-26 would support technology service contracts, software licenses, and interdepartmental services related to the current vendor, while \$2.9 million supports the personnel costs listed above. In 2026-27, of the \$20.4 million total costs, \$2.9 million continues to support personnel costs, but contract costs decrease to \$17.5 million. In 2027-28 and annually thereafter, personnel costs continue at \$2.9 million, while contract costs decrease to \$13.4 million.

### **CAIR3 Design, Development, and Implementation**

**Background – CAIR3.** AB 1797 (Weber), Chapter 582, Statutes of 2022, requires all administered vaccines in California to be reported to the state immunization registry, as of January 1, 2023. The California Immunization Registry 2 (CAIR2) is the statewide immunization information system used to capture, store, track, and consolidate vaccination data. According to CDPH, the COVID-19 pandemic highlighted significant weaknesses and limitations in the CAIR2 system due to the high volume of vaccination data traffic submitted after approval of the COVID-19 vaccine. The CAIR2 system was unable to sustain this level of traffic, causing system and data reporting delays. Specifically, CAIR2 suffered from the following limitations:

- Inability to support high volumes of incoming electronic data interchange messages.
- Ineffective patient matching leading to large numbers of duplicate patient records, resulting in inaccurate records of patient vaccine doses.
- Limited reporting ability for system users, including counties and health plans.
- Poorly performing dose replacement (historical vs. administered doses) and record update logic.
- Lack of ability to manage and schedule future vaccine doses.

As a result of these limitations, the federal Centers for Disease Control and Prevention (CDC) provided grant funding for the CAIR3 Project, to replace and address the limitations of CAIR2. According to CDPH, the CAIR3 Project is currently in Stage 3 of the California Department of Technology's Project Approval Lifecycle (PAL). According to CDPH, these efforts were supported by federal grant funds which have been exhausted. However, allocation of state funding will enable the department to secure federal matching funds to continue CAIR3 development.

**Resource Request – CAIR3.** CDPH requests General Fund expenditure authority of up to \$5.1 million in 2025-26 to support the design, development, and implementation of the California Immunization Registry 3 (CAIR3) Project, which would upgrade California's statewide immunization information system used to capture, store, track, and consolidate vaccination data. According to CDPH, the Department of Health Care Services indicates federal Medicaid matching funds are available for this project, with a 90 percent federal match rate for the 70 percent of total Medicaid eligible patients covered by the system. This will result in \$8.6 million federal funds and \$5.1 million state funds. These funds would support vendor costs and redirected staff to continue design, development, and implementation of the CAIR3 Project.

### **California Vaccine Management System (myCAvax)**

**Background – myCAvax.** The California Vaccine Management System (myCAvax) connects vaccination providers and local health departments with tools and functionality for managing and administering vaccines. The system supports the Vaccines for Children (VFC) program, Vaccines for Adults (VFA), and the LHD 317 and State General Fund vaccine programs for individuals with limited access to healthcare.

**No Funding Proposed in the Governor’s January Budget for myCAvax.** The Governor’s January budget includes no resources to continue myCAvax. According to advocates, continued operation of the system would cost \$44 million.

**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 CDPH to respond to the following:

1. Please provide a brief overview of the CalCONNECT, SaPHIRE, and CAIR 3 proposals.
2. Why is CDPH proposing no resources for the continuation of the myCAvax system? What would be the cost to continue the system? What would be the consequences of allowing the system to shut down?

**Issue 5: Biomonitoring California Funding Realignment**

**Budget Change Proposal – Governor’s Budget.** CDPH requests to shift two positions and General Fund expenditure authority of \$425,000 to the Department of Toxic Substances Control (DTSC) annually, beginning in 2025-26. If approved, this shift of resources would transition funding directly to DTSC for laboratory services it currently provides under an interagency agreement. There is no net cost to the General Fund.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund – CDPH	(\$425,000)	(\$425,000)
0001 – General Fund – DTSC	\$425,000	\$425,000
<b>Total Funding Request:</b>	<b>\$-</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Resources ongoing after 2026-27.

**Background.** Biomonitoring is the measurement of chemicals or their metabolites in a person’s body fluids or tissues, such as blood or urine. These measurements tell us the amount of the chemical that actually gets into people from all sources including air, soil, water, dust, and food combined. According to CDPH, biomonitoring can provide useful information on how much exposure to toxic chemicals a person has had.

SB 1379 (Perata), Chapter 599, Statutes of 2006, established the California Environmental Contaminant Biomonitoring Program. The program requires CDPH to utilize biological specimens to identify designated chemicals that are present in the bodies of Californians. Participants in the program must reflect the age, economic, racial, and ethnic composition of the state.

AB 164 (Committee on Budget), Chapter 84, Statutes of 2021, allocated nine positions and General Fund expenditure authority of \$2 million to Biomonitoring California. These resources allowed CDPH to enter into an interagency agreement with DTSC to provide laboratory testing services for Biomonitoring California to assess chemical exposures in the state. According to CDPH, the regular renewal of the interagency agreement and processing fund transfers has created administrative delays in DTSC implementation of deliverables and prevents DTSC from hiring permanent positions for this workload.

**Resource Request.** CDPH requests to shift two positions and General Fund expenditure authority of \$425,000 to the Department of Toxic Substances Control (DTSC) annually, beginning in 2025-26 to transition funding directly to DTSC for laboratory services it currently provides under an interagency agreement. There is no net cost to the General Fund.

According to CDPH and DTSC, this shift would support the permanent establishment of **two Research Scientist III** positions, which were previously limited term. These positions would continue to analyze specific toxic chemical contaminants in human and other biological samples from the current statewide biomonitoring program and population-based investigations, allowing timely dissemination of results and science-based decision making.

**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 CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

**Issue 6: Extension of Governor’s Advisory Council on Physical Fitness and Mental Well Being**

**Budget Change Proposal and Budget Bill Language – Governor’s Budget.** CDPH requests reappropriation of General Fund expenditure authority of \$2.5 million, originally approved in the 2022 Budget Act. CDPH also requests provisional budget bill language to extend encumbrance and expenditure authority for these funds through June 30, 2027. If approved, these reappropriated resources would continue to support the Governor’s Advisory Council on Physical Fitness and Mental Well Being.

**Background.** On June 16, 2021, Governor Newsom announced the formation of the Governor’s Advisory Council on Physical Fitness and Mental Well-Being, a new advisory council tasked with exploring health strategies to ensure Californians can thrive. With a special emphasis on child physical and mental health, the council is led and convened by First Partner Jennifer Siebel Newsom and Pro Football Hall of Fame inductee and former San Francisco 49ers cornerback Ronnie Lott. The council includes representatives from health and wellness organizations, youth sports programs, education, the entertainment and fitness industry, and others from around the state. The council’s activities include:

- Advising on the development of physical activity and wellness goals for Californians of all ages
- Advising on methods to increase awareness among all age groups, particularly children and youth, about how physical activity, sport, nutrition, and mental wellness contribute to healthy and productive lives
- Encouraging inter-generational physical fitness activities including the use of physical activity and sport to strengthen families
- Facilitating collaboration among federal, state, and local agencies, education, business, industry, the private sector, and others in the promotion of physical activity and mental wellness.

According to CDPH, councils of this type have been convened under several previous governors, beginning in 1993 with an Executive Order from Governor Pete Wilson. The 1993 council was charged with developing fitness goals for school children and Californians of all ages, creating public awareness campaigns, and encouraging coordination between governments, education, and the private sector in the promotion of physical fitness. In 2005, Governor Arnold Schwarzenegger launched a new council as a non-profit organization that would raise funds and hire its own staff. The goal of the 2005 council was to promote physical activity of all Californians, with an emphasis on children and youth, to reduce the risk of diseases such as type 2 diabetes and obesity and to contribute to academic success.

The 2022 Budget Act included three positions and General Fund expenditure authority of \$10 million, available until June 30, 2025, to support the Council.

**Reappropriation Request and Budget Bill Language Proposal.** CDPH requests reappropriation of General Fund expenditure authority of \$2.5 million, originally approved in the 2022 Budget Act, and provisional budget bill language to extend encumbrance and expenditure authority for these funds through June 30, 2027, to continue support for the Governor’s Advisory Council on Physical Fitness and Mental Well Being.

**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 CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

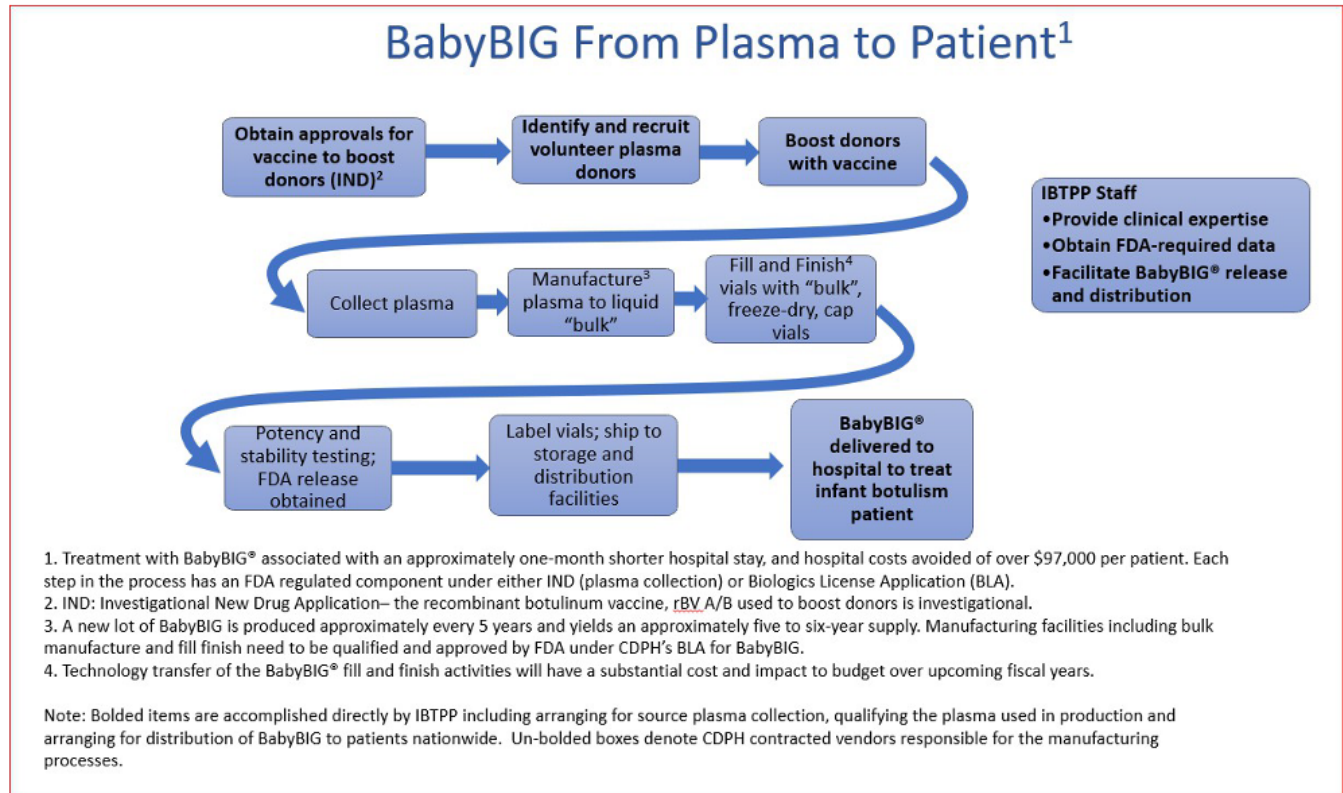
**Issue 7: BabyBIG Infant Botulism Treatment and Prevention Program**

**Budget Change Proposal – Governor’s Budget.** CDPH requests two positions and expenditure authority from the Infant Botulism Treatment and Prevention Fund of \$3 million in 2025-26 and \$2.2 million annually thereafter. If approved, these positions and resources would support the increased manufacturing and regulatory costs associated with producing Lots 8 and 9 of Human Botulism Immune Globulin Intravenous (BabyBIG), used for the treatment of infant botulism.

Multi-Year Funding Request Summary		
Fund Source	2025-26	2026-27*
0272 – Infant Botulism Treatment and Prevention Fund	\$3,000,000	\$2,200,000
<b>Total Funding Request:</b>	<b>\$3,00,000</b>	<b>\$2,200,000</b>
<b>Total Requested Positions:</b>	<b>2.0</b>	<b>2.0</b>

\* Positions and resources ongoing after 2026-27.

**Background.** BabyBIG is an orphan drug that consists of human-derived anti-botulism-toxin antibodies and is approved by the U.S. Food and Drug Administration (FDA) for the treatment of infant botulism types A and B. BabyBIG is the only licensed treatment for infant botulism in the United States, and CDPH is the only source of BabyBIG in the world. BabyBIG is distributed nationwide for a fee to treat patients with infant botulism, as required by the Federal Orphan Drug Act and California law. The U.S. Food and Drug Administration (FDA) licensed BabyBIG to CDPH in October 2003. The license for BabyBIG stipulates using specified processes, facilities, and equipment. There is presently only one facility in the world approved by FDA for production of BabyBIG, Shire Biotechnology in Los Angeles.



**Production of Lots 8 and 9 of BabyBIG.** CDPH reports it plans to undertake a technology transfer of the BabyBIG fill and finish activities, in which the vial is filled with bulk product, it is freeze-dried, and the vial is capped and sealed. This transfer is required due to the acquisition of the existing fill and finish vendor by another company. CDPH reports there will be additional costs associated with updated regulatory filings to update the BabyBIG Biologics License Application. In addition, CDPH plans to implement a fee increase, effective July 1, 2025, from \$57,300 to \$69,300, from hospitals requesting BabyBIG. These fee increases support the increased regulatory and manufacturing costs associated with BabyBIG.

**Staffing and Resource Request.** CDPH requests two positions and expenditure authority from the Infant Botulism Treatment and Prevention Fund of \$3 million in 2025-26 and \$2.2 million annually thereafter to support the increased manufacturing and regulatory costs associated with producing Lots 8 and 9 of Human Botulism Immune Globulin Intravenous (BabyBIG), used for the treatment of infant botulism. Specifically, CDPH requests the following positions and resources:

Infant Botulism Treatment and Prevention Program (IBTPP) – Two positions

- **One Public Health Medical Officer III** position would supervise IBTPP regulatory staff and initiate, lead, direct, supervise, administer, maintain, and improve CDPH production of BabyBIG.
- **One Research Scientist Supervisor II** position would supervise all epidemiological staff and contract vendor staff and collaborate on all epidemiological activities related to infant botulism.

**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 CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

**Issue 8: Laboratory Field Sciences Fees**

**Trailer Bill Language – Governor’s Budget.** CDPH requests trailer bill language to address inconsistencies in licensure fees for clinical laboratories and laboratory personnel, tissue banks, and biologics facilities, including allowing CDPH to increase fees, establish a fee methodology to administer the program, update the phlebotomist certification fee from a biennial to an annual fee, and make other technical corrections.

**Background.** The Laboratory Field Services (LFS) branch at CDPH safeguards the health of Californians by ensuring accurate and reliable clinical and public health laboratory testing, safe and reliable sources of human tissue and blood for transplantation and transfusion, and safe and effective biologics produced from human tissue and blood. LFS is responsible for licensure, inspection, proficiency testing, and oversight of clinical and public health labs, tissue banks, biologics facilities, and blood banks. LFS also has oversight over education, training, examination, and licensure of laboratory personnel.

Applications for issuance or renewal of clinical and public health laboratory licenses under LFS’ jurisdiction are subject to licensing fees. These fees are currently calculated by dividing the current fiscal year appropriation to the Clinical Laboratory Improvement Fund (CLIF), which supports LFS programs, by the General Fund appropriation to LFS in the preceding fiscal year. According to CDPH, utilizing this formula will result in the CLIF being insolvent by 2027-28 due to expenditures outpacing revenues. For 2024-25, LFS revenue will be \$13.7 million with projected expenditures of \$17.5 million.

In addition, application for licensure or renewal for tissue banks require a \$950 fee, adjusted annually in the Budget Act. However, CDPH indicates that the Tissue Bank License Fund, which supports this program, will be insolvent by 2028-29 due to projected expenditures outpacing revenues.

**Trailer Bill Language Proposal.** CDPH requests trailer bill language to address inconsistencies in licensure fees for clinical laboratories and laboratory personnel, tissue banks, and biologics facilities, including allowing CDPH to increase fees, establish a fee methodology to administer the program, update the phlebotomist certification fee from a biennial to an annual fee, and make other technical corrections. Specifically, the language would:

- Replace the existing CLIF licensure and renewal fee calculation with a requirement that the annual adjustment be done by the department to cover the estimated licensing program costs. This is similar to other licensing programs administered by CDPH.
- Replace the existing tissue bank licensure and renewal fee calculation with a requirement that the annual adjustment be done by the department to cover the estimated licensing program costs.
- Charge \$100 for the application and annual renewal fee for a phlebotomist’s certification.
- Make other 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 CDPH to respond to the following:

1. Please provide a brief overview of this trailer bill language proposal.
2. What would be the expected percent change in licensure and/or renewal fees for applicants in each of these programs?

**Issue 9: Women, Infants, and Children (WIC) Program Estimate**

**WIC Program Estimate – Governor’s Budget.** The November 2024 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of \$1.4 billion (\$1.2 billion federal funds and \$188.3 million WIC manufacturer rebate funds) in 2024-25 and \$1.5 billion (\$1.2 billion federal funds and \$186.4 million WIC manufacturer rebate funds) in 2025-26. The federal fund amounts include state operations costs of \$69.5 million in 2024-25 and \$71.1 million in 2025-26.

<b>Women, Infants, and Children (WIC) Funding Summary</b>			
	<b>2024-25</b>	<b>2025-26</b>	<b>BY to CY</b>
<b>Fund Source</b>	<i>Revised</i>	<i>Proposed</i>	<i>Change</i>
0890 – Federal Trust Fund			
State Operations:	\$69,473,000	\$71,105,000	\$1,632,000
Local Assistance:	\$1,183,504,000	\$1,227,125,000	\$43,624,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	\$188,288,000	\$186,443,000	(\$1,845,000)
<b>Total WIC Expenditures</b>	<b>\$1,441,265,000</b>	<b>\$1,484,673,000</b>	<b>\$43,408,000</b>

**Background.** The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding individuals, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and CDPH must report funds and expenditures monthly.

The WIC program’s food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

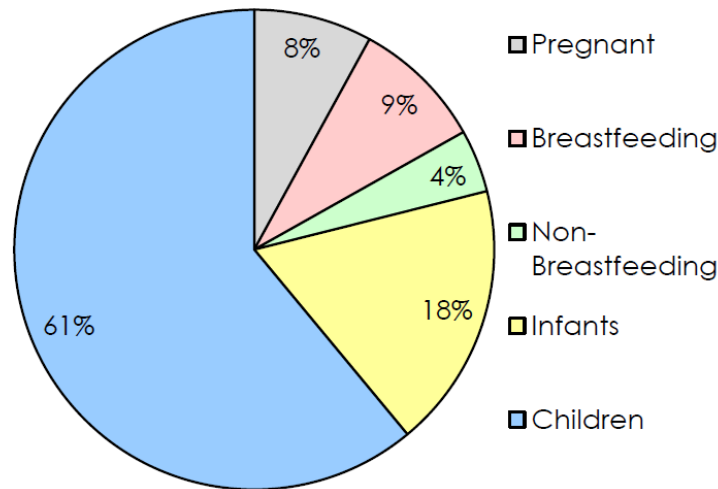
**WIC Participant Caseload.** Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- **Pregnant individuals** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, folate and folic acid, vitamin A, and vitamin C to support optimal fetal development.

- **Breastfeeding individuals** are eligible for benefits up to their infant’s first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.
- **Non-breastfeeding individuals** are eligible for benefits up to six months post-partum, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- **Infants** are eligible from birth until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economic, and emotional benefits to parents and babies. Infants may also receive supplemental foods that are rich in protein, calcium, iron, zinc, vitamin A, and vitamin C during this critical period of development.
- **Children** are eligible from age one up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development.

According to the WIC program Estimate, WIC participation by category, as of 2023-24, was as follows:

**CHART 1:  
Percentage of CA WIC Participation by  
Category: FY 2023-24**



Participant Category	Annual Average Monthly Participation 2023-24
Pregnant	78,828
Breastfeeding	87,727
Non-Breastfeeding	41,844
Infants	176,938
Children	603,088
<b>TOTAL</b>	<b>988,425</b>

**Caseload Estimates.** The budget assumes 1,010,675 average monthly WIC participants in 2024-25, an increase of 36,804 or 3.9 percent compared to the average monthly actual WIC participants in 2023-24. The budget assumes 1,031,891 average monthly WIC participants in 2025-26, an increase of 21,216, or 2.1 percent, compared to the revised estimate for 2024-25.

**Food Expenditures Estimate.** The budget includes \$1 billion (\$841.8 million federal funds and \$188.3 million WIC Manufacturer Rebate Fund) in 2024-25 for WIC program food expenditures, a decrease of \$29.9 million or 2.8 percent, compared to estimates included in the 2024 Budget Act. According to CDPH, the decrease in costs is due to a decrease in estimated participation offset by a slight increase in per participant food costs. Food inflation is estimated to be 2.05 percent compared to 1.99 percent estimated in the 2024 Budget Act. In addition, WIC manufacturer rebate revenue is projected at \$188.3 million, which is an increase of \$4.3 million or 2.3 percent compared to estimates in the 2024 Budget Act. According to CDPH, this increase in rebate revenue is attributable to an increase in projected infant participation compared to estimates in the 2024 Budget Act.

The budget includes \$1.1 billion (\$885.4 million federal funds and \$186.4 million WIC Manufacturer Rebate Fund) in 2025-26 for WIC program food expenditures, an increase of \$41.8 million or 3 percent compared to the revised 2024-25 food expenditures estimate. According to CDPH, this increase in costs is driven by a moderate food inflation rate of 1.92 percent slightly offset by a reduced participation forecast for 2025-26. In addition, WIC manufacturer rebate revenue is projected at \$186.4 million, a decrease of \$1.8 million or 1 percent compared to the revised 2024-25 estimate.

**Nutrition Services and Administration (NSA) Estimate.** The budget includes \$341.7 million for other local assistance expenditures for the NSA budget in 2024-25 and 2025-26, an increase of \$19.7 million or 6.1 percent compared to estimates in the 2024 Budget Act. The budget also includes \$69.5 million for state operations expenditures in 2024-25, a decrease of 0.01 percent from the level assumed in the 2024 Budget Act, and \$71.1 million in 2025-26, an increase of \$1.6 million or 2.3 percent from the revised 2024-25 estimate. According to CDPH, this increase is due to baseline adjustments and additional position and expenditure authority approved in the 2024 Budget Act to support WIC Modernization.

**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 CDPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.
2. Please provide an update on participation in the program as a percentage of eligible individuals in the state.

**Issue 10: Genetic Disease Screening Program (GDSP) Estimate**

**Genetic Disease Screening Program Estimate – Governor’s Budget.** The November 2024 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of \$175.1 million (\$38.6 million state operations and \$136.5 million local assistance) in 2024-25, and \$176.3 million (\$37.4 million state operations and \$138.9 million local assistance) in 2025-26.

<b>Genetic Disease Screening Program (GDSP) Funding Summary</b>			
	<b>2024-25</b>	<b>2025-26</b>	<b>BY to CY</b>
<b>Fund Source</b>	<i>Revised</i>	<i>Proposed</i>	<i>Change</i>
0203 – Genetic Disease Testing Fund			
State Operations:	\$38,625,000	\$37,447,000	(\$1,178,000)
Local Assistance:	\$136,476,000	\$138,854,000	\$2,378,000
<b>Total GDSP Expenditures</b>	<b>\$175,101,000</b>	<b>\$176,301,000</b>	<b>\$1,200,000</b>

**Background.** According to CDPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant individuals for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up, and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening Program and the Prenatal Screening Program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

**Newborn Screening (NBS) Program.** Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and

in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to CDPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,264
Primary Congenital Hypothyroidism	7,857
Galactosemia	1,018
Sickle Cell Disease and other clinically significant Hemoglobinopathies	5,006
Biotinidase Deficiency (BD)	209
Cystic Fibrosis (CF)	636
Congenital Adrenal Hyperplasia (CAH)	376
Metabolic Fatty Acid Oxidation Disorders	741
Metabolic Amino Acid Disorders (other than PKU)	203
Metabolic Organic Acid Disorders	518
Other Metabolic Disorders	62
Severe Combined Immunodeficiencies	75
X-Linked Adrenoleukodystrophy (ALD) and Other Peroxisomal Disorders	50
<b>TOTAL</b>	<b>18,015</b>

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. The current fee for screening in the NBS program is currently \$226.

NBS Caseload Estimate: The budget estimates NBS program caseload of 399,861 in 2024-25, a decrease of 306 or 0.1 percent, compared to 2023-24 actual total caseload of 399,555. The budget estimates NBS program caseload of 395,705 in 2025-26, a decrease of 4,156 or 1 percent, compared to the revised 2024-25 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

**Prenatal Screening (PNS) Program.** The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant individuals in California to detect birth defects during pregnancy. The program offers two types of prenatal screening:

- Cell-free DNA (cfDNA) Screening - Cell-free DNA (cfDNA) is a non-invasive screening test for fetal chromosomal abnormalities that relies on extraction of maternal and fetal cells from a pregnant individual's blood sample. cfDNA can detect chromosomal abnormalities and birth defects including trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), trisomy 13 (Patau syndrome), and sex chromosome aneuploidies. cfDNA can also detect all single and twin pregnancies. Compared to the

metabolic screening methods previously used by PNS, cfDNA screening results in fewer false positives and better accuracy resulting in fewer pregnant individuals being referred for diagnostic follow-up services.

- **Maternal Serum Alpha-Fetoprotein (MSAFP) Screening** – Alpha-fetoprotein (AFP) is a protein mainly produced in the fetal liver and released into the maternal serum (MSAFP) and amniotic fluid. A small amount crosses the placenta and becomes measurable in the maternal serum towards the end of the first trimester. Levels rise steadily through the second trimester. This screening detects neural tube defects, such as open spina bifida or anencephaly, which result in higher than normal MSAFP in maternal serum.

For pregnant individuals with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is \$334. This represents an increase of \$112 from the previous fee level to support cfDNA screening and the addition of prenatal screening for sex chromosome aneuploidy (SCA). Of the total fee, \$324 is deposited into the Genetic Disease Testing Fund (GDTF) and \$10 is deposited in the California Birth Defect Monitoring Fund. There is a separate fee for neural tube defect (NTD) screening of \$85, of which \$75 is deposited in the GDTF and \$10 is deposited in the California Birth Defect Monitoring Fund.

**PNS Caseload Estimate:** The budget estimates PNS program caseload of 202,771 cfDNA specimens in 2024-25, an increase of 331 or 0.2 percent, compared to 2023-24 actual total caseload of 202,440 specimens. The budget estimates PNS program caseload of 205,817 cfDNA specimens in 2025-26, an increase of 3,046 or 1.5 percent, compared to the revised 2024-25 estimate. These estimates are based on state projections of the number of live births in California, with 50.5 percent projected to participate in PNS in 2024-25 and 51.7 percent in 2025-26.

**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 CDPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.
2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

**Issue 11: Genetic Counselor License Fees**

**Trailer Bill Language – Governor’s Budget.** CDPH requests trailer bill language to authorize the establishment of fees for genetic counselor licensure by regulation, rather than fixed in statute.

**Background.** California’s genetic counselors support expecting parents in the nation’s only state supported prenatal screening program and one of the largest newborn screening programs in the world. Genetic counselors are responsible for interpretation of family and medical histories to assess the chance of disease occurrence or recurrence, and education about genetic diseases and related resources and research.

CDPH is responsible for licensure of genetic counselors. Applications for genetic counseling licensure or renewal require a fee established in state law. Currently, the fee for an original or renewal of a genetic counselor license is not to exceed \$200, while the fee for a temporary genetic counselor license is set at \$200. Collected fees are deposited into the Genetic Disease Screening Fund to support the Genetic Disease Screening Program (GDSP).

According to CDPH, while fees collected through the various GDSP programs have increased over time, the state has not increased fees for the genetic counselor license since the inception of the program in 2011. The current fee structure does not support the operational costs of the licensure program or the anticipated increase in systems and services, which will update application technology. The program is experiencing an operational deficit that is currently covered by the Genetic Disease Testing Fund (GDTF) 0203.

**Trailer Bill Language Proposal.** CDPH requests trailer bill language to authorize the establishment of fees for genetic counselor licensure by regulation, rather than fixed in statute. Specifically, the language would:

- 1) Amends genetic counselor licensure fee provisions to require the fee, and any subsequent adjustments, to be established by regulation in order to meet the reasonable costs of the licensure program.
- 2) Amends temporary genetic counselor licensure fee provisions to align with those established by regulation for genetic counselor licensure 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 CDPH to respond to the following:

1. Please provide a brief overview of this proposed trailer bill language.
2. What would be the average fee increase for genetic counselors if this language were to be approved?

**Issue 12: Center for Health Care Quality Estimate**

**Center for Health Care Quality Program Estimate – Governor’s Budget.** The budget includes expenditure authority for the Center for Health Care Quality of \$486.1 million (\$7.5 million General Fund, \$137.3 million federal funds, and \$341.3 million special funds and reimbursements) in 2024-25, an increase of \$11.5 million or 2.4 percent compared to assumptions in the 2024 Budget Act, and \$486.1 million (\$5 million General Fund, \$139.3 million federal funds, and \$341.9 million special funds and reimbursements) in 2025-26, an increase of \$65,000 or 0.01 percent compared to the revised 2024-25 estimate. According to CDPH, the increase in 2024-25 is attributable to baseline adjustments and a projected increase in federal grant expenditures, while the increase in 2025-26 is attributable primarily to an increase in federal expenditure authority, various baseline adjustments, and four budget change proposals: 1) Policy and Legislation Branch Expansion; 2) Internal Department Quality Improvement Account; 3) Health Care Services: Artificial Intelligence (AB 3030); and 4) Long-Term Healthcare Facilities: Payment Source and Resident Census (SB 1354).

<b>CHCQ Funding Summary, November 2024 Estimate</b>		
<b>Fund Source</b>	<b>2024-25</b>	<b>2025-26</b>
0001 – General Fund	\$7,460,000	\$4,963,000
0890 – Federal Trust Fund	\$137,345,000	\$139,266,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	\$1,565,000	\$4,301,000
State Health Facilities Citation Penalty Account	\$2,144,000	\$2,144,000
Federal Health Facilities Citation Penalty Account	\$9,024,000	\$4,152,000
0995 – Reimbursements	\$15,613,000	\$15,648,000
3098 – Licensing and Certification Program Fund	\$312,910,000	\$315,652,000
<b>Total CHCQ Funding</b>	<b>\$486,061,000</b>	<b>\$486,126,000</b>
<b>Total CHCQ Positions</b>	<b>1548.9</b>	<b>1560.2</b>

**Background.** CDPH’s Center for Health Care Quality, Licensing and Certification Program (L&C) is responsible for administering the licensure, regulation, inspection, and certification of health care facilities and certain health care professionals in California. The program is organized into 14 district offices and Los Angeles County, which operates under a contract with the L&C program. L&C staff conduct periodic inspections and investigation of complaints and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. L&C licenses and certifies over 14,000 health care facilities and agencies in California in 30 different licensure and certification categories. In addition to facility oversight, L&C oversees the certification of certified nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

**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 CDPH to respond to the following:

1. Please provide a brief overview of the Center for Health Care Quality, including regulatory responsibilities, organizational structure, funding, and performance.
2. Please provide an update on the L&C Program's vacancy rate, particularly for the HFEN classification, and the results of recent efforts to improve vacancy rates.
3. Please provide an update on the most current timeliness metrics for investigation of complaints and entity-reported incidents.

**Issue 13: Center for Health Care Quality Internal Department Quality Improvement (IDQIA)**

**Budget Change Proposal – Governor’s Budget.** CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account of \$3.1 million in 2025-26. If approved, these resources would support planning and implementation costs for the Centralized Application Branch (CAB) Online Licensing Application Project.

<b>Program Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0942 – Special Deposit Fund	\$3,086,000	\$-
<b>Total Funding Request:</b>	<b>\$3,086,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

**Background.** The Centralized Application Branch (CAB) within the Center for Health Care Quality (CHCQ) processes health care facility licensure and certification applications for CHCQ, including all applications for initial facility licenses, changes to existing licenses, licensure renewals, and conducts activities associated with license expiration and license revocation. CAB processes applications on a first-in, first-out basis and often works with applicants to address incomplete or inaccurate application materials. CAB receives over 15,000 applications annually. Most of the application processing is manual and requires health care facilities to submit various required forms and supporting documentation to CAB via United States Postal Service mail, fax, or email.

AB 2798 (Maienschein), Chapter 922, Statutes of 2018, requires an automated application system to process licensing applications from general acute care hospitals and acute psychiatric hospitals. AB 2798 also authorizes utilization of resources from the Internal Departmental Quality Improvement Account (IDQIA), upon appropriation by the Legislature, to support this project. According to CDPH, the automated license application submission system went live in late 2019, reducing many cumbersome manual processes for hospital applications, eliminating the ability to submit an incomplete application, and reducing back and forth communications around incomplete applications. This system receives 1,000 applications annually with approximately 3,000 end users and an average of 537 technical tickets annually.

For the remaining 33 provider types other than general acute care hospitals and acute psychiatric hospitals licensed and certified by CHCQ, the application submission and review process has remained manual and paper based. As a result, CHCQ is requesting resources to support the CAB Online Licensing Application Project, which proposes to refresh, enhance, and expand the technology of CAB’s original automated license application system to enable all 35 healthcare facility provider types to submit applications electronically, as well as to have the flexibility to add new facility types in the future. The project also seeks to integrate the license application submission system with other CHCQ systems, including the Electronic Licensing Management System (ELMS) and enable facilities to pay licensing fees electronically. According to CDPH, the project is currently in Stage 3 of the California Department of Technology’s Project Approval Lifecycle (PAL) process and the project is expected to begin in June 2027.

**Resource Request.** CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account of \$3.1 million in 2025-26 to support planning and implementation costs for the Centralized Application Branch (CAB) Online Licensing Application Project. Specifically, CDPH

requests these resources to support **one Information Technology Specialist II** position (limited-term) to support the CAB Online Project implementation and maintenance. The position would support the completion of the planning stage and initiate implementation activities, including developing the scopes of work, contract terms with performance measures and outcomes, and requests for offers to solicit bids from contractors.

**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 CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

**Issue 14: Center for Health Care Quality Policy and Legislation Branch Expansion**

**Budget Change Proposal – Governor’s Budget.** CDPH requests seven positions and expenditure authority from the Licensing and Certification Fund of \$1.1 million annually. If approved, these positions and resources would support expansion of the Center for Health Care Quality’s Public Policy and Legislative Branch.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
3098 – Licensing and Certification Fund	\$1,138,000	\$1,138,000
<b>Total Funding Request:</b>	<b>\$1,138,000</b>	<b>\$1,138,000</b>
<b>Total Requested Positions:</b>	<b>7.0</b>	<b>7.0</b>

\* Positions and resources ongoing after 2026-27.

**Background.** The Center for Health Care Quality’s (CHCQ) Public Policy and Legislative Branch researches, analyzes, and communicates CHCQ's policies and legal requirements to internal and external audiences to support safe, effective, and quality health care for all Californians. The branch is also responsible for promulgation of regulations required by enacted state law.

Currently, CHCQ has a total of 33 pending regulations packages that consist of over 75 topics or sub-packages that must be completed. According to CDPH, this number has the potential to increase each year with each passing legislative session. Many CHCQ regulations have not been updated in decades, and some facilities have never had state regulations. Of the existing regulations, many were implemented prior to the use of computers, tablets, smartphones, and modern medical technology; as such, they are severely outdated. CDPH reports that, because many regulations are so outdated, CHCQ frequently uses the program flex process to allow facilities to meet regulatory requirements using alternative methods to implement more current technologies or approaches to care. As part of this process, facilities submit a program flex request to CDPH asking to meet the intent of the specific state regulation using an alternative method. CDPH staff review each request to determine if the facility can still provide services in safe and reliable manner if the request is granted. While facilities operate under federal regulations, there are many instances where state statute is different than federal requirements and thus it is imperative that California has clear regulatory requirements for facilities.

According to CDPH, the CHCQ Regulation Section currently consists of the following staff:

- One Staff Services Manager II to oversee the section
- One Staff Services Manager I to oversee two units
- Five Associate Governmental Program Analysts to write regulations
- One Associate Governmental Program Analyst to serve as fiscal staff.

Based on this level of staffing, CDPH estimates it would take roughly 20 years for this section to complete each of the pending 33 regulation packages. CDPH is requesting additional staff in this branch to support its regulations backlog and ongoing workload.

**Staffing and Resource Request.** CDPH requests seven positions and expenditure authority from the Licensing and Certification Fund of \$1.1 million annually to support expansion of the CHCQ Public Policy and Legislative Branch. Specifically, CDPH requests the following positions and resources:

- **One Staff Services Manager I** position would supervise and manage staff in a second Regulations Writing Unit in the branch, determine unit priorities, create project plans and monitor staff progress, assist in preparation of special projects, prepare annual staff performance and probation reports, and conduct hiring interviews and complete hiring packages and other personnel actions.
- **Five Health Program Specialist I** positions would act as program experts to independently develop regulation packages, perform independent research and analysis of statutory program requirements, coordinate and facilitate pre-notice stakeholder meetings, advise management on strategies to develop and promote regulations of statewide significance.
- **One Associate Governmental Program Analyst** would independently identify economic impacts for regulation packages, independently develop cost estimating methodology and fiscal analyses for regulations, perform independent research and data analysis of statutory program requirements, lead in advising management on strategies to develop and promote regulations of statewide significance.

**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 CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

**Issue 15: Special Deposit Sub-Fund Conversion to Special Funds**

**Budget Change Proposal and Trailer Bill Language – Governor’s Budget.** CDPH requests conversion of four special deposit sub-funds to their own, separate special funds. These special deposit funds include the Internal Departmental Quality Improvement Account (IDQIA), the Skilled Nursing Facility Minimum Staffing Penalty Account, the State Health Facilities Citation Penalties Account, and the Federal Health Facilities Citation Penalties Account.

CDPH also requests trailer bill language to implement these fund shifts.

**Background.** According to CDPH, the Center for Health Care Quality (CHCQ) receives federal grant funds through Title XVIII and Title XIX from the Center for Medicare and Medicaid Services, licensing fees paid by health care facilities, and penalties payments from various health facilities for violations of state or federal laws or regulations. These payments are deposited in sub-funds within the state’s Special Deposit Fund (Fund 0942). These sub-funds include:

- Internal Departmental Quality Improvement Account (IDQIA) – Health and Safety Code Section 1280.15(f) establishes the IDQIA and provides that “moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.” The account is funded by administrative penalties CDPH imposes against health facilities for violations that meet the definition of immediate jeopardy of death or serious harm to a patient or administrative penalties associated with breaches of medical information.
- Skilled Nursing Facility Minimum Staffing Penalty Account – Health and Safety Code Section 1276.66(a)(1) establishes the Skilled Nursing Facility Minimum Staffing Penalty Account, which collects administrative penalties from skilled nursing facilities that violate nursing hours or direct care service hours per patient per day requirements. Resources in the account are continuously appropriated, without regard to fiscal years, to CDPH to support implementation of skilled nursing facility oversight of these requirements.
- State Health Facilities Citation Penalties Account – Health and Safety Code Section 1417.2(a) establishes the State Health Facilities Citation Penalties Account, which receives revenues from civil penalties in violation of state law by health facilities.
- Federal Health Facilities Citation Penalties Account – Health and Safety Code Section 1417.2(a) establishes the Federal Health Facilities Citation Penalties Account, which receives revenues from civil penalties in violation of federal law by health facilities.

**Fund Shifts and Trailer Bill Language Proposal.** CDPH requests conversion of four special deposit sub-funds to their own, separate special funds, including the Internal Departmental Quality Improvement Account (IDQIA), the Skilled Nursing Facility Minimum Staffing Penalty Account, the State Health Facilities Citation Penalties Account, and the Federal Health Facilities Citation Penalties Account. According to CDPH, shifting these special deposit sub-funds to special funds would increase transparency of expenditures from these funds, as there are currently no official fund condition statements provided with annual budget documents. Lack of fund condition statements makes it more difficult to track revenues, expenditures, and the fund balance.

CDPH also requests trailer bill language to implement these shifts. The language would:

- Abolish the IDQIA sub-fund, create a new IDQIA special fund, and transfer the balance from the IDQIA sub-fund to the new IDQIA fund.
- Abolish the Skilled Nursing Facility Minimum Staffing Penalty Account, create a new Skilled Nursing Facility Minimum Staffing Penalty Account Fund, and transfer the balance from the sub-fund to the new special fund.
- Abolish the State Health Facilities Citation Penalties Account, create a new State Health Facilities Citation Penalties Account special fund, and transfer the balance from the sub-fund to the new special fund.
- Abolish the Federal Health Facilities Citation Penalties Account, create a new Federal Health Facilities Citation Penalties Account special fund, and transfer the balance from the sub-fund to the new special 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 CDPH to respond to the following:

1. Please provide a brief overview of these proposed fund shifts.

**Issue 16: Implementation of Chaptered Legislation – AB 1775, AB 1282, AB 3030, SB 1354**

**AB 1775 (Haney)**

**Legislative Budget Change Proposal (AB 1775) – Governor’s Budget.** CDPH requests one position and General Fund expenditure authority of \$183,000 annually. If approved, this position and resources would support implementation of secondhand cannabis smoke guidance pursuant to the requirements of AB 1775 (Haney), Chapter 104, Statutes of 2024.

<b>Multi-Year Funding Request Summary – AB 1775</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$138,000	\$138,000
<b>Total Funding Request:</b>	<b>\$138,000</b>	<b>\$138,000</b>
<b>Total Requested Positions:</b>	<b>1.0</b>	<b>1.0</b>

\* Position and resources ongoing after 2026-27.

**Background.** AB 1775 (Haney), Chapter 1004, Statutes of 2024, creates a new category of food service workers who would be unprotected from secondhand cannabis smoke exposure. The bill authorizes local jurisdictions to permit cannabis retailers to make and sell non-cannabis food and drinks, and sell tickets for live music or other performances on sites where cannabis consumption is permitted. AB 1775 also requires that employees at cannabis consumption sites are provided with written guidance from CDPH on secondhand cannabis smoke. As CDPH does not have existing guidance on secondhand cannabis smoke, additional staff and resources are required to develop this guidance.

**Staffing and Resource Request.** CDPH requests one position and General Fund expenditure authority of \$183,000 annually to support implementation of secondhand cannabis smoke guidance pursuant to the requirements of AB 1775. Specifically, CDPH requests the following position:

- **One Health Program Specialist II** would be responsible for coordinating with subject matter experts and stakeholders to develop and disseminate guidance about secondhand cannabis smoke for workers at cannabis consumption sites.

**AB 1282 (Lowenthal)**

**Legislative Budget Change Proposal (AB 1282) – Governor’s Budget.** CDPH requests expenditure authority from the Behavioral Health Services Fund of \$463,000 in 2025-26 and \$232,000 in 2026-27. If approved, these resources would support development and submission of a report to the Legislature on a statewide strategy to address the mental health risks linked to the use of social media in children and youth, pursuant to the requirements of AB 1282 (Lowenthal), Chapter 807, Statutes of 2024.

<b>Multi-Year Funding Request Summary – AB 1282</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3085 – Behavioral Health Services Fund	\$463,000	\$232,000
<b>Total Funding Request:</b>	<b>\$463,000</b>	<b>\$232,000</b>

<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>
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**Background.** According to CDPH, the number of children and youth using social media and time spent engaging with social media continues to grow, and children and youth are reporting higher levels of negative mental health. Although there are growing concerns about the impacts of social media on children and youth mental health, social media remains mostly unregulated. California has not developed a statewide strategy to address these concerns. The U.S. Surgeon General notes that both the positive and negative impact of social media on youth mental health is related to multiple complex factors and that more research is needed to fully understand those impacts. In 2022, a Pew Research Group survey reported that 32 percent of teens said social media has had a mostly negative effect on people their age, while 32 percent of teens said social media has had a positive effect on themselves. In addition, the survey reported that 80 percent of teens said that they felt more connected to what was happening in their friends' lives and 71 percent reported having a place to show their creative side through using social media.

AB 1282 (Lowenthal), Chapter 807, Statutes of 2024, requires CDPH to report to the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth to at least four identified legislative committees. AB 1282 includes three specific topics the report must include: 1) recommendations to strengthen children and youth resiliency strategies; 2) California's use of mental health services related to social media use; and 3) any barriers to receiving the relevant data.

AB 1282 also specifies five areas CDPH should explore in developing the report:

1. The types of social media.
2. The child and youth populations that use social media, including disproportionate rates and impacts among specific groups.
3. Opportunities to support resilience and mental well-being among children and youth around social media use.
4. Negative behavioral health risks, which includes mental health and substance misuse associated with social media use and misuse among children and youth.
5. The factors that contribute to positive, negative, and neutral impacts among various populations of children and youth.

AB 1282 also requires CDPH to engage with children and youth to prioritize their perspective and to consult with the California mental health community. The report is due by December 31, 2026.

**Resource Request.** CDPH requests expenditure authority from the Behavioral Health Services Fund of \$463,000 in 2025-26 and \$232,000 in 2026-27 to support development and submission of a report to the Legislature on a statewide strategy to address the mental health risks linked to the use of social media in children and youth, pursuant to the requirements of AB 1282 (Lowenthal), Chapter 807, Statutes of 2024. Specifically, CDPH requests the following resources:

- **One Health Program Specialist II** position (limited-term) would review and develop meeting and focus group materials, provide expertise in prevention and health education best practices, oversee the contractor, provide project management support, and lead development of the report to the Legislature.

- **One Research Scientist II** position (limited-term) would review materials relevant to report and meeting topics, analyze current data and information, prepare materials for meetings, summarize and synthesize information, and contribute to the development of the report to the Legislature.
- **Contract Resources** – CDPH also requests expenditure authority of \$100,000 in 2025-26 and \$50,000 in 2026-27 to support contract resources for community engagement. This external contractor would support engagement with children and youth, with a focus on transition-age youth, at-risk populations, in-need populations, and underserved cultural and linguistic populations. The contractor would also support CDPH consultation with the mental health community groups identified in AB 1282, including consumers, providers, and educators.

**AB 3030 (Calderon)**

**Legislative Budget Change Proposal (AB 3030) – Governor’s Budget.** CDPH requests three positions and expenditure authority from the Licensing and Certification Fund of \$672,000 annually. If approved, these positions and resources would support enforcement of requirements that health care service providers that use artificial intelligence to provide patient communications include a disclaimer and instructions describing how a patient may contact a human health care provider or other appropriate person, pursuant to the requirements of AB 3030 (Calderon), Chapter 848, Statutes of 2024.

<b>Multi-Year Funding Request Summary – AB 3030</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
3098 – Licensing and Certification Fund	\$672,000	\$672,000
<b>Total Funding Request:</b>	<b>\$672,000</b>	<b>\$672,000</b>
<b>Total Requested Positions:</b>	<b>3.0</b>	<b>3.0</b>

\* Positions and resources ongoing after 2026-27.

**Background.** According to CDPH, as artificial intelligence becomes increasingly integrated in our health care systems, it is important to maintain the trust between a patient and their provider, while ensuring the accuracy of information being communicated to patients. AB 3030 (Calderon), Chapter 848, Statutes of 2024, requires specified entities that use generative artificial intelligence (GenAI) to generate verbal or written patient communications pertaining to patient clinical information to ensure those communications include both a disclaimer that GenAI generated the communication and clear instructions describing how the patient may contact a human health care provider or other appropriate person. Entities covered by the bill’s requirements include clinics and health facilities, which are under the licensing oversight of CDPH.

**Staffing and Resource Request.** CDPH requests three positions and expenditure authority from the Licensing and Certification Fund of \$672,000 annually to support enforcement of requirements that health care service providers that use artificial intelligence to provide patient communications include a disclaimer and instructions describing how a patient may contact a human health care provider or other appropriate person, pursuant to the requirements of AB 3030. Specifically, CDPH requests the following positions and resources:

- **Three Health Facilities Evaluator Nurse** positions would support enforcement of the requirements of AB 3030 on the 15,000 health facilities and clinics with active licenses regulated by CDPH. This

request assumes 40 percent of facilities use some form of GenAI, resulting in the need to review 6,000 facilities, and two hours of review per facility, resulting in 12,000 hours of workload during each two-year renewal cycle. As each nurse can manage 1,800 hours of work each year, three positions are needed to complete the required reviews.

CDPH also indicates that it plans to absorb workload for the period between the bill’s effective date, January 1, 2025, and the beginning of the new fiscal year on July 1, 2025. These costs are estimated at \$390,000.

**SB 1354 (Wahab)**

**Legislative Budget Change Proposal (SB 1354) – Governor’s Budget.** CDPH requests 1.25 positions and expenditure authority from the Licensing and Certification Fund of \$307,000 annually. If approved, these positions and resources would support oversight of skilled nursing facility requirements to make daily resident census and nurse staffing data available, pursuant to the requirements of SB 1354 (Wahab), Chapter 339, Statutes of 2024.

<b>Multi-Year Funding Request Summary – SB 1354</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3098 – Licensing and Certification Fund	\$307,000	\$307,000
<b>Total Funding Request:</b>	<b>\$307,000</b>	<b>\$307,000</b>
<b>Total Requested Positions:</b>	<b>1.25</b>	<b>1.25</b>

**Background.** According to CDPH, older adults on Medi-Cal have struggled to find skilled nursing facilities (SNFs) willing to accept them because providers want higher reimbursement rates from private pay residents and Medicare beneficiaries. Low-income seniors are often forced to move away from family, friends, and their healthcare support team because they are denied access to a local facility due to the lower Medi-Cal reimbursement rates. Residents, families of residents, and the public have been demanding greater accountability of SNFs for many years now. SNFs receive funds from the Department of Health Care Services (DHCS) to accommodate both Medicare and Medicaid residents for their voluntary participation that requires an agreement certifying under penalty of perjury they will adhere to all state and federal laws, which include a prohibition against Medi-Cal discrimination. Despite these laws, for decades, nursing homes have found numerous ways of discriminating to reduce their Medi-Cal population and free beds up to make way for more lucrative private pay or Medicare residents.

SB 1354 (Wahab), Chapter 339, Statutes of 2024, requires all SNFs to make their current daily resident census and nurse staffing data available to the public by either posting it on the facility’s website or by responding to telephonic requests. The bill also requires that long-term care health facilities certified by Medi-Cal provide the same care, services, and benefits to Medi-Cal beneficiaries as they do the public.

**Staffing and Resource Request.** CDPH requests 1.25 positions and expenditure authority from the Licensing and Certification Fund of \$307,000 annually to support oversight of skilled nursing facility requirements to make daily resident census and nurse staffing data available, pursuant to the requirements of SB 1354. Specifically, CDPH requests the following staff and resources:

- **1.25 Health Facility Evaluator Nurse** would travel to and conduct in-depth surveys of healthcare facilities to determine compliance with state licensing and federal certification requirements including SB 1354 compliance, travel to and conduct investigations of facilities in response to complaints regarding patient care and healthcare delivery in licensed healthcare facilities, attend and present both written and verbal testimony for various enforcement-related proceedings, attend meetings and participate in local programs to improve uniform compliance in healthcare facilities, and advise and assist healthcare facility administrators in matters related to state requirements.

CDPH also indicates that it plans to absorb workload for the period between the bill's effective date, January 1, 2025, and the beginning of the new fiscal year on July 1, 2025. These costs are estimated at \$190,000.

**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 has requested CDPH to respond to the following:

1. Please provide a brief overview of these proposals.

**NOT FOR PRESENTATION****Issue 17: Proposals for Investment**

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

**ADAP Investments to End the Epidemic.** Over the last two fiscal years, the ADAP Rebate Fund has provided loans to the General Fund of \$900 million to address General Fund shortfalls in those fiscal years. The End the Epidemics Coalition, a coalition of 11 organizations, request expenditure authority from the ADAP Rebate Fund, after repayment of the General Fund loans, of \$151 million in 2025-26, \$350 million in 2026-27, and \$250 million in 2027-28, to make the following investments in reducing transmission and ending the epidemic of HIV/AIDS in California:

- *Preventing Service Cuts to Equitable HIV Prevention.* \$15 million, ongoing, to Office of AIDS (OA) to prevent service cuts to equity-informed, CDC-funded HIV-prevention activities, in the likely case that this funding is discontinued after the current funding period ends. CDC already attempted to discontinue the funding immediately, but was unsuccessful due to a court order. Focusing limited HIV-prevention resources on the populations at highest risk of HIV is not only the right thing to do, but the most efficient use of taxpayer dollars. If ADAP Rebate Fund dollars are not allocated to supplant reduced CDC funding, HIV-prevention services prioritizing Black/African-American and Latine populations, as well as the transgender community, across California will come to an end.
- *Youth Health Equity and Safety Act.* \$5 million, ongoing (beginning in 2027-28), to sustain funding for the Youth Health Equity and Safety Act (Senate Bill 954), which helps supply schools with condoms in order to address rising STI rates among young people. Currently allocated funding for SB 954 will end in 2026-27.
- *TGI Wellness and Equity Fund.* \$10 million, beginning in 2027-28 (and reduced to \$6 million, ongoing, beginning in 2029-30), to sustain funding for the Transgender, Nonconforming, and Intersex (TGI) Wellness and Equity Fund, which provides grants for new or existing programs focused on TGI healthcare. Currently allocated funding for the Fund will end in 2026-27.
- *DIS Syndemic Workforce Supplemental Funding Grant.* \$9 million in 2025-26, and \$18 million in 2026-27 and 2027-28, to CDPH to partially replace rescinded funding from the federal DIS Syndemic Workforce Supplemental Funding Grant. This federal funding supported the hiring and training of disease-investigation specialists (DIS), vital public-health professionals who conduct outreach to locate and link to care people diagnosed with HIV and other infectious diseases, like Mpox and bird flu.
- *Routine Opt-Out Testing in Emergency Departments (ROOT-ED).* \$15 million in 2025-26 and \$15 million in 2026-27 to OA to expand a pilot program created by the Legislature to help emergency departments establish routine, opt-out testing for HIV, hepatitis C, and syphilis. This appropriation would allow the pilot to expand from 28 sites to 73 sites.

- *Hepatitis C Testing Equipment.* \$1 million in 2025-26 and \$1 million in 2027-28 to CDPH to support the purchase of rapid hepatitis C virus (HCV) testing equipment by facilities serving highly HCV-impacted populations (e.g., substance use disorder treatment facilities). The recent development of a rapid HCV test offers a high-potential opportunity to test people for HCV and link those who test positive to treatment on the same day. However, the equipment needed to analyze the new rapid test is currently prohibitively expensive for many service-providers.
- *ADAP COBRA Bridge.* \$500,000 in 2025-26, \$500,000 in 2026-27, and \$500,000 in 2027-28 to OA for a program to maintain continuous health-insurance coverage for people living with HIV (PLWH) who experience a short-term loss of income. Currently, PLWH whose incomes have dropped to 138 percent of the federal poverty level or below are required to enroll in Medi-Cal, even if they expect to be eligible for only a brief time. This program would instead allow them to maintain their employer-provided coverage (via COBRA) until their income increases, avoiding both harmful disruptions in their HIV care and costly “churn” in the Medi-Cal program.
- *Medi-Cal Waiver Program.* \$10 million, ongoing, to DHCS to supplement reimbursement rates for certain services provided under the Medi-Cal Waiver Program (MCWP, formerly known as the AIDS Waiver). The MCWP provides case management, nursing, attendant care, and other services for PLWH who need help to live independently and avoid institutionalization. This appropriation will empower MCWP service providers to compete in the healthcare labor market, at a time when the aging population of PLWH means that MCWP services are more needed than ever.
- *Oral Healthcare.* \$10 million, ongoing, to OA for Oral Health Care services in the HIV Care Program. People living with HIV are at higher risk of oral-health issues such as cavities and bone loss around teeth. At the same time, they commonly lack meaningful access to oral healthcare. Directing additional funding to local health departments and community organizations will expand the oral-health resources available to PLWH.
- *Short-Term Rental Assistance.* \$50 million, beginning in 2025-26 (and reduced to \$11 million, ongoing, beginning in 2029-30) to OA to support short-term rental assistance for people living with HIV who are experiencing houselessness (PLWH-EH). A large body of research demonstrates that housing instability is correlated with poor HIV health outcomes—including death. Housing instability is also critical to HIV prevention since studies clearly link instability in housing with increased risk of HIV infection. Unfortunately, at least 5,000 PLWH in California are experiencing houselessness. This appropriation will address this issue—while bringing resources only available for HIV services to bear on our state’s larger houselessness crisis. Short-term rental assistance (up to 24 months) and long-term assistance (more than 24 months) require separate appropriations due to RWHAP regulations.
- *Long-Term Rental Assistance.* \$7.5 million in 2025-26, increased to \$24 million in 2026-27 and 2027-28 (and reduced to \$1 million, ongoing, beginning in 2029-30) to OA to support long-term rental assistance for PLWH-EH.
- *HIV Care Program.* \$28 million in 2025-26, \$161 million in 2026-27, and \$94 million in 2027-28 (then reduced to \$27 million in 2028-29) to OA to allocate to counties that currently receive HIV Care Program funding, fully utilize their funding, but can demonstrate that they still have unmet needs. The HIV Care Program allocates funds from RWHAP to counties for a variety of allowable services for

PLWH, including mental health services, substance abuse outpatient care, and medical case management.

- *Linkage to Care.* \$3 million, ongoing, to OA for grants to organizations providing linkage to care for people who are living with HIV and experiencing homelessness, substance-use disorder (SUD), and/or mental-health issues. Counties across the state continue to see new HIV transmissions and higher viral loads among people experiencing homelessness and people who use drugs. Organizations providing harm-reduction services and linkage to SUD services for those populations are best equipped to identify people living with HIV, build trust, link them to HIV care, and follow up to ensure they are staying in care.
- *Overdose Prevention.* \$2.5 million in 2025-26, increased to \$6 million in 2026-27 and 2027-28 (and reduced to \$3 million, ongoing, beginning in 2029-30) to OA for grants to organizations providing overdose-prevention and other harm-reduction services. Accidental drug overdose has quickly become a leading cause of death for people living with or at highest risk for HIV. This funding will support innovative overdose-prevention services, including drug-checking services co-located with programs reaching people at the highest risk of overdose. Drug checking is an evidence-based strategy that has proven effective at engaging people in services and providing education and information to people at the highest risk of overdose.

**Amyotrophic Lateral Sclerosis (ALS) Wraparound System of Care.** The ALS Network requests General Fund expenditure authority of \$3.5 million annually until 2029-30 to support continued funding for the ALS Wraparound System of Care, initiated in the 2018 Budget Act and extended in the 2021 and 2022 Budget Acts. According to the ALS Network, the ALS Wraparound System of Care enables better health outcomes and improved quality of life in ALS patients by funding a care model that supports at-home care, avoiding unnecessary hospitalizations and ER visits, and avoiding financial catastrophe.

This program is designed to address medical, social, emotional, and financial challenges of living with ALS by providing a continuum of care that emphasizes coordination and collaboration among expert care managers, social workers, and health care providers in clinical, community and home-based settings.

The program funds Regional Care Managers that support patients and families in connecting them to care and treatment options, advocating with insurance companies and government entities, providing consultations and coordinating treatment plans, providing medical and transportation equipment, and more.

**Sexual and Reproductive Health Information.** Essential Access Health, and ACCESS Reproductive Justice request General Fund expenditure authority of \$5 million in 2025-26, available over three years, to support expansion of the state's abortion information website: [abortion.ca.gov](http://abortion.ca.gov). According to these organizations, [Abortion.ca.gov](http://Abortion.ca.gov) was created by SB 1142 (Caballero) in response to *Roe v. Wade* being overturned to share timely and accurate information about abortion access in California, provide linkages to time-sensitive care, and combat disinformation. Subject matter experts were consulted in the initial creation of the website, and ongoing consultation is needed to ensure that the site is meeting the needs of Californians served by the site and those forced to travel to California, reflective of the most up to date

information and responsive to policy changes at the state and federal levels. The site must also continue to counter abortion misinformation and disinformation that has surged in prevalence. Additional investments and updates are needed as emerging and anticipated federal threats are expected to worsen the national abortion access landscape, embolden and empower fake clinics, and result in further proliferation of disinformation that harms public health by delaying access to time-sensitive care.

The current website was created in response to *Roe v. Wade* being overturned and understandably focused on abortion only. Amidst new and emerging threats to sexual and reproductive health care, the website needs to be updated to include broader information regarding comprehensive sexual and reproductive health services and information (e.g. birth control, minors' rights, gender-affirming care, etc.)

Scientific, evidence-based, medically-accurate and inclusive sexual and reproductive health information, including clinical practice guidelines and public health data and research, have been altered and removed from federal websites, and it is clear these federal sites can no longer be trusted for evidence-based, unbiased sexual and reproductive health information. California, as a trusted state action must step in to host sexual and reproductive health information historically relied on and made available on federal websites.

It is imperative to increase public awareness so that members of the public know that this critical resource for time-sensitive, trusted information is available to them.

The requested funding would ensure that the state website, [abortion.ca.gov](http://abortion.ca.gov), is expanded, updated, and maintained by a non-profit organization with content expertise that partners with CDPH. The expansion would include, among other things, a person's legally protected rights to the full range of sexual and reproductive health care services and information, and sexual and reproductive health information historically relied on and made available on federal websites.

The organization that CDPH partners with to update and maintain the website would regularly consult with a Stakeholder and Community Workgroup to determine and update the information and resources posted.

CDPH would ensure public awareness of the website through a broad range of strategies, including but not limited to disseminating governmental newsletters and notifications from relevant departments and public universities, and partnering with one or more community-based organizations with experience administering sexual and reproductive health public awareness campaigns in the state to develop public education and outreach activities to increase public awareness about the website through a broad range of strategies.

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

# SUBCOMMITTEE NO. 3

# Agenda

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



**Thursday, March 20, 2025**  
**9:30 am, or upon adjournment of session**  
**1021 O Street – Room 1200**

Consultant: Elizabeth Schmitt

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*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.*

**5180 DEPARTMENT OF SOCIAL SERVICES****Issue 1: CDSS Housing Programs and Exhaustion of Limited-Term Funding**

**Panel Discussion.** The Subcommittee has requested the following individuals to participate in this discussion:

- Jennifer Troia, Director & Hanna Azemati, Deputy Director, Housing and Homelessness Division, CDSS
- Monica Kirkland, State Policy Director, Alameda Senior Services Coalition
- Megan Van Sant, Senior Program Manager, Mendocino Department of Social Services
- Juwan Trotter, Fiscal & Policy Analyst, Legislative Analyst's Office

**Background: CDSS Housing and Homelessness Programs.** The California Department of Social Services (CDSS) oversees six housing and homelessness programs which are administered locally by counties and Tribes. These programs generally serve specific populations eligible for other social services (such as Adult Protective Services, child welfare, or CalWORKs), and provide housing-related supports for families experiencing homelessness or at risk of homelessness, in order to integrate social services with housing support.

Older adults are the fast growing population experiencing homelessness. According to the California Statewide Study of People Experiencing Homelessness, among single homeless adults, 48 percent were age 50 and older. Among single adults age 50 and older, 41 percent became homeless for the first time at age 50 or older. This study also found that seven percent of homeless adults had children with them, and 26 percent of children living in homeless families were age two or younger. Another 27 percent of homeless adults had children who were not currently living with them. Eighteen percent of adults reported having lost custody of a child to Child Protective Services at some point and 11 percent reported that they did not currently have custody of their minor child due to the child being removed by Child Protective Services.

The department's approach recognizes that housing is foundational to a person maintaining their health and reaching their goals for employment, education, child and family well-being, and long-term stability. The programs utilize evidence-based practices, including Housing First principles, to offer a range of services, including outreach, housing-related case management, housing navigation, as well as housing-related financial assistance including rental subsidies, security deposits, rental arrearages, moving costs, and more. These resources are provided to clients in a flexible and tailored way in order to best meet their needs and ensure sustained housing outcomes. Additionally, programs coordinate with other local government agencies, Tribes, homeless continuums of care, community-based organizations, public housing authorities, and other entities to holistically support individual clients in reaching their housing goals.

The six CDSS Housing and Homelessness programs are described below:

1. **Home Safe Program.** The Home Safe Program supports the safety and housing stability of individuals involved in Adult Protective Services (APS). Home Safe assists APS clients who are experiencing or are at imminent risk of homelessness due to elder or dependent adult abuse,

neglect, self-neglect, or financial exploitation. This may include seniors for whom abrupt changes to life circumstances have left them on the precipice of being homeless for the first time in their lives. The program provides financial assistance and housing-related wrap-around supportive services, including, but not limited to: housing-related intensive case management, housing related financial assistance, deep cleaning to maintain safe housing, eviction prevention, landlord mediation, mobility-related modifications to homes, and connections with local service providers including the homeless Continuum of Care. Home Safe served approximately 7,736 individuals in 2023-24.

2. **Bringing Families Home (BFH) Program.** The BFH Program assists families involved with county or tribal child welfare systems who are experiencing or at risk of homelessness, and for whom housing may be the only barrier to reunification. The program follows the Housing First model and incorporates evidence-based housing interventions, including Rapid Rehousing and Permanent Supportive Housing to reduce the number of families in the child welfare system experiencing homelessness, increase the number of children reunifying with their families, and prevent foster care placement. The BFH program offers financial assistance and housing-related wraparound supportive services including but not limited to, rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, hotel and motel vouchers, legal services, and credit repair. BFH served approximately 4,394 families in 2023-24.
3. **Housing and Disability Advocacy Program (HDAP).** HDAP assists people who are at risk of or experiencing homelessness and are likely eligible for SSI disability benefits. Housing-related financial assistance and wraparound supportive services may include interim housing, rental assistance, housing navigation, security deposits, utility payments, moving costs, legal services (to help secure long-term disability benefits), and credit repair. People experiencing chronic homelessness and those who rely most heavily on state and county-funded services are prioritized. HDAP follows a Housing First model and uses evidence-based housing interventions. HDAP served approximately 16,194 individuals in 2023-24.
4. **CalWORKs Housing Support Program (CalWORKs HSP).** CalWORKs HSP serves families participating in CalWORKs who are at risk of or experiencing homelessness. CalWORKs HSP offers financial assistance and housing-related wraparound supportive services including rental assistance, housing navigation, case management, security deposits, or utility payments. Parents participating in CalWORKs HSP are generally assigned a case manager who helps them find a home, provides financial education, and works with them to retain the home and stable employment. CalWORKs HSP has served over 84,000 families since the program launched in 2014, and approximately 30,616 families in 2023-24.
5. **CalWORKs Homeless Assistance (CalWORKs HA).** CalWORKs HA also serves families who are applicants or recipients of CalWORKs. Temporary CalWORKs HA provides up to 16 days of temporary shelter, and Permanent CalWORKs HA provides payment of a security deposit and last month's rent or rent arrearages to avoid eviction. Unlike the other five housing programs discussed in this section, CalWORKs HA is not a capped program; rather, it is an entitlement to CalWORKs families who are eligible. However, it does not provide the same high level of support and case management as CalWORKs HSP. In 2023-24, over 58,900 families were approved for Temporary CalWORKs HA and 8,800 were approved for Permanent CalWORKs HA.

6. **Community Care Expansion (CCE).** The CCE program funds the acquisition, construction, and rehabilitation of adult and senior care facilities that serve applicants and recipients of Supplemental Security Income (SSI) or Cash Assistance Program for Immigrants (CAPI), including individuals who are at risk of or experiencing homelessness. Funds are also available to preserve residential care settings, including through operating subsidies for existing licensed adult and senior care facilities currently serving SSI or CAPI recipients. CCE is part of a statewide investment in infrastructure funding to address homelessness, support healthcare delivery reform, and strengthen the social safety net, particularly for older or frail adults. The California Health and Human Services Agency has bundled the CCE program with another program, the Behavioral Health Continuum Infrastructure Program. CCE Capital Expansion has created over 3,100 beds in licensed adult and senior facilities, and CCE Preservation has preserved over 2,000 beds in licensed facilities.

**2021 and 2022 budget acts expansion.** The 2021 and 2022 budget acts included a historic expansion of Home Safe, BFH, HDAP, CalWORKs HSP, and CCE, using one-time, multi-year funding. This expansion allowed for local grantees (counties and Tribes) to launch and significantly scale up local capacity to provide housing supports integrated with social services. Programs expanded from 141 to 223 county programs as well as from three to 65 tribal programs (utilizing a \$35 million tribal set-aside). As of 2023, BFH and HSP are serving 67 percent of families receiving homelessness services through their Continuums of Care (CoC), while HDAP and Home Safe are serving nearly 20 percent of individuals who are 55 and older receiving homelessness services through their CoCs. The two charts below detail the prior and ongoing appropriations that made this expansion possible:

PROGRAM	PRIOR APPROPRIATIONS (SINCE 2021)	BUDGET ACT OF 2024
<b>CalWORKs Housing Support Program (HSP)</b>	Budget Act of 2021: \$285 million (\$95 million annual + \$190 million one-time)	<ul style="list-style-type: none"> <li>• \$95 million annual appropriation with reduced one-year encumbrance period</li> </ul>
	Budget Act of 2022: \$285 million (\$95 million annual + \$190 million one-time)	
<b>Bringing Families Home (BFH)</b>	Budget Act of 2021: \$92.5 million one-time	<ul style="list-style-type: none"> <li>• Reappropriate FY 21/22 one-time funds through June 2025</li> <li>• Reappropriate \$80 million of FY 22/23 one-time funds (up to \$40 million through June 2026 and up to \$40 million through June 2027)</li> <li>• No additional or ongoing funding</li> </ul>
	Budget Act of 2022: \$92.5 million one-time	

PROGRAM	PRIOR APPROPRIATIONS (SINCE 2021)	BUDGET ACT OF 2024
Housing and Disability Advocacy Program (HDAP)	Budget Act of 2021: \$175 million (\$25 million annual and \$150 million one-time)	<ul style="list-style-type: none"> <li>\$25 million annual appropriation with local match requirement removed and reduced one-year encumbrance period</li> <li>Reappropriate FY 21/22 one-time funds through June 2025</li> <li>Reduce funding by \$50 million &amp; Reappropriate FY 22/23 one-time funds through June 2026</li> </ul>
	Budget Act of 2022: \$175 million (\$25 million annual and \$150 million one-time)	
Home Safe Program	Budget Act of 2021: \$92.5 million one-time	<ul style="list-style-type: none"> <li>Reappropriate FY 21/22 one-time funds through June 2025</li> <li>Reappropriate FY 22/23 one-time funds through June 2026</li> <li>No additional or ongoing funding</li> </ul>
	Budget Act of 2022: \$92.5 million one-time	
Community Care Expansion (CCE)	Budget Act of 2021: \$805 million one-time	<ul style="list-style-type: none"> <li>No additional or ongoing funding</li> </ul>
	Budget Act of 2022: \$55 million one-time	

Source: CDSS

**Home Safe and Bringing Families Home have no ongoing appropriation.** While some programs (CalWORKs HSP and HDAP) have baseline appropriations that were supplemented with one-time expansion funds in 2021 and 2022, Home Safe and BFH have no ongoing appropriation and will shut down completely when one-time funding expires (largely in the current fiscal year, as discussed below).

Similarly, the operating subsidies provided by the CCE Preservation program are still being expended but when operating subsidies expire, the facilities they are supporting may also be at risk of closure.

**Program outcomes.** CDSS Housing and Homelessness programs are uniquely successful in serving specific vulnerable populations and generally outperform state and national metrics in terms of exits to permanent housing. Below is a summary of outcomes across each program.

**Home Safe outcomes:**

- Over 5,800 clients permanently housed since program launch in 2018.
- 76 percent of participants retained permanent housing six months post program exit; 71 percent retained permanent housing 12 months post program exit.
- In 2022-23, Home Safe served over 40 percent of the Adult Protective Services population with identified housing needs.
- Early findings from the expanded Home Safe program evaluation, launched by UCSF in 2023, indicate Home Safe continues to address a critical gap and no existing alternative program replicates its impact or population served.

**Bringing Families Home (BFH) outcomes:**

- A 2024 evaluation found that family reunifications increased by 20 percent for families who had children in foster care at the time of BFH enrollment as compared to families who did not receive BFH services.
- More than half of BFH families (52 percent) that exited the program by the end of the program’s second year left to a permanent housing arrangement and another 14 percent exited to either community-provided or temporary housing, with only 3 percent reporting exiting to homelessness.

By comparison, across CoCs in California in 2023, just 35 percent of exits in the Homeless Management Information System were to permanent housing.

- BFH reduced the use of shelter and transitional housing by half and doubled the use of rapid re-housing services, which based on evidence is more cost-effective and more likely to lead to stable housing.
- In Mendocino County alone, the BFH program has served 171 households to date who were homeless or at-risk of homelessness. Of the families who have exited the BFH program, only four percent of them were unable to reunite with their children, while 96 percent of households served by BFH were able to obtain or maintain a safe home for themselves and their children.

***HDAP outcomes:***

- Over 8,200 individuals permanently housed since program launch in 2017.
- 77 approval rate for disposed disability applications.
- 92 percent of individuals retained permanent housing six months after disability benefits were approved; 82 percent retained housing 12 months after disability benefits were approved.
- Overall, 50 percent of participants exited to permanent housing in 2023-24.

***CalWORKs HSP outcomes:***

- More than 45,000 families permanently housed since program launch in 2014.
- One of the few programs found to be “likely cost-effective” by the California State Auditor in 2023.
- Auditors found that the average annual cost per family permanently housed by the program was less than the estimated cost to taxpayers for one year of a person experiencing chronic homelessness.

***Community Care Expansion (CCE) outcomes:***

- \$569.7 million awarded in capital expansion funding for the construction of licensed facilities with over 3,100 beds produced or contracted to be produced (61 total projects).
- Seven housing projects providing 499 beds/units have completed construction.
- 13 housing projects providing 725 beds/units have broken ground.
- \$247 million awarded in preservation funding to support operation of licensed homes at risk of closure which have high populations of clients receiving SSI benefits.
- 34 counties participating in CCE Preservation; counties have contracted with 82 facilities and 2,022 beds within those facilities have been preserved.
- 97 percent of the beds preserved by licensed adult and senior care facility operators participating in CCE Preservation were reported occupied by SSI/SSP applicants or recipients.

**2024 Budget Act.** The 2024 Budget Act made the following changes to CDSS housing and homelessness programs:

- **HDAP:** Reduced one-time HDAP funding by \$50 million General Fund in 2025-26, and re-appropriated up to \$100 million General Fund from the 2022 Budget Act to be available through 2025-26. Removed baseline match requirement for HDAP grantees.
- **Bringing Families Home Program.** Delayed \$40 million General Fund for the Bringing Families Home program to 2025-26 and another \$40 million General Fund through 2026-27. Trailer bill

language extends the county or tribe match waiver of one-time funds appropriated for the BFH program through 2027. (While the funds were projected to last through 2026-27 at the 2024 Budget Act, counties are spending down their full allocations in 2024-25 and will likely have no funds available in 2026-27.)

- **Home Safe Program.** Extends the grantee match waiver of one-time funds appropriated for the Home Safe program from June 30, 2025, to June 30, 2026.
- **Data Sharing for Housing Programs.** Trailer bill language permits the Interagency Council on Homelessness to, upon request, share personally identifiable, individual-level data from the Homeless Data Integration System with an agency or department that is a member of the council for purposes of measuring housing instability and examining the effectiveness of, and need for, housing and homelessness programs and other antipoverty programs.

**Programs are ramping down and closing in 2024-25.** The multi-year, one-time funding for the expansions of Home Safe, BFH, HDAP, CalWORKs HSP, and CCE are nearing exhaustion and programs are winding down or closing completely. The 2023-24 fiscal year represents the peak spending and operational period for these programs, with programs projected to serve significantly fewer individuals in 2024-25 and 2025-26.

While the impact of the expiration of this funding will vary by program and county, it is clear that most programs will either shut down completely or significantly scale down between 2024-25 and 2025-26. For programs that have an ongoing appropriation (CalWORKs HSP and HDAP), this means programming will continue, but at significantly lower levels, with fewer resources to spread across to serve people in need of services. For Home Safe and BFH, these programs will close down completely, meaning families and individuals who are involved in Adult Protective Services or child welfare and who are homeless will not have access to housing support. The chart below details county Home Safe and BFH programs which have either already closed or will close soon.

Program	SOON TO CLOSE: Number of counties expected to close by July 2025 based on having spent 70%-99% of funding as of September 30, 2024, and/or notification to CDSS of planning closure -	CLOSED: Number of counties that have exhausted <i>all</i> funds as of September 30, 2024, and/or who have notified CDSS that program is closed.
<b>Home Safe</b>	Amador, Del Norte, Glenn, Humboldt, Inyo, Kern, Kings, Marin, Merced, Mono, Monterey, Napa, Riverside, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Shasta, Sierra, Siskiyou, Trinity, Tulare, Tuolumne, Yolo, Yuba <b>TOTAL: 27</b>	Colusa, Fresno, Madera, Mariposa, Nevada, San Bernardino, Sonoma, Tehama <b>TOTAL: 8</b>
<b>Bringing Families Home</b>	Tuolumne, Siskiyou, Shasta, San Bernardino, Placer, Mendocino, Kings, Inyo, Humboldt, El Dorado, Colusa, Contra Costa, Plumas <b>TOTAL: 13</b>	Kern, Madera, Napa, Solano, Ventura, Yuba <b>TOTAL: 6</b>

Although HSP and HDAP have ongoing funding, some grantees have indicated they will be or already have modified program operations in the following ways:

- Significantly reducing emergency housing/hotel assistance.
- Pausing new enrollments or significantly reducing the number of participants they can serve.
- Offering much more limited range supports, including a shorter timeframe for monthly rental subsidies and a lower rate of financial assistance.

Maintaining existing service levels would cost approximately \$81 million General Fund annually for Bringing Families Home and approximately \$84 million General Fund annually for Home Safe, beginning in 2025-26. The Governor's budget does not contain any proposal to continue funding these programs.

Approximately \$173.8 million General Fund annually would be needed to sustain service levels for CalWORKs HSP and approximately \$133.1 million General Fund annually would be needed to maintain service levels for HDAP.

**Subcommittee Staff Comment and Recommendation – Hold Open.** Subcommittee staff notes that CDSS Housing and Homelessness programs provide housing supports to especially vulnerable populations. Home Safe and BFH by definition provide housing to vulnerable seniors and children who have experienced abuse or neglect (seniors involved in Adult Protective Services and children involved in child welfare), yet these programs are shutting down completely in the current year.

These programs have proven to be uniquely successful, with high rates of exits to permanent housing compared to overall state and national rates, and cost-effective, according to a recent state audit.

In the absence of a Governor's budget proposal, all of these effective programs face a fiscal cliff. Home Safe and BFH will shut down completely. Meanwhile CalWORKs HSP and HDAP will continue at a fraction of current capacity.

The result of this fiscal cliff will be significantly diminished capacity to respond to the needs of vulnerable families, seniors, and children who are homeless or at risk of becoming homeless. Given the critical role these programs play in the state's overall response to homelessness the total loss or diminishment of these programs will likely leave more individuals and families homeless.

For Bringing Families Home, it also means the loss of crucial housing support that has proven to increase the chances of successful family reunification.

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

1. What are the key outcomes of the state's expansion of CDSS housing and homelessness programs that began in 2021 and 2022? How have these programs supported individuals and families who are homeless or at risk of homelessness? What lessons has the Administration learned broadly about how to address homelessness through these programs?
2. Please provide an update on the Community Care Expansion, including operating subsidies for licensed homes serving residents who receive SSI/SSP. Can the expansion of CalAIM provide needed operating subsidies for older or disabled adults who need assisted living care?

3. As a result of the multi-year expansion funding depletion, what will be the impacts of the following: (1) BFH and Home Safe dropping to a baseline of zero, (2) CalWORKs HSP and HDAP returning to baseline appropriations, and (3) CCE operating subsidies expiring? What will be the impact locally to clients currently receiving services or eligible to receive services? What will be the impacts statewide on homelessness?

**Issue 2: Housing and Homelessness Program Complaint Resolution**

**Trailer Bill Language – Governor’s Budget.** Proposed trailer bill language would establish minimum complaint resolution requirements for CDSS housing programs, and declare these requirements sufficient to meet due process for non-entitlement programs.

**Background: CDSS Housing and Homelessness Programs.** CDSS oversees several housing and homelessness programs administered locally by counties and Tribes, including Home Safe, Housing and Disability Advocacy Program (HDAP), Bringing Families Home (BFH), and CalWORKs Housing Support Program (CalWORKs HSP). These programs generally serve specific populations receiving other social services and provide additional housing-related supports for families experiencing homelessness or at risk of homelessness, in order to integrate social services with housing support. CDSS housing and homelessness programs were expanded significantly via limited-term, multi-year funding included in the 2021 and 2022 budget acts. For more background on CDSS Housing and Homelessness programs and the 2021 and 2022 Budget Act expansions, see Issue #1 of this agenda.

**Proposed trailer bill would establish a county-level complaint resolution process.** Currently, there is no formal or statewide process to address complaints from applicants and participants in Home Safe, HDAP, Bringing Families Home, and CalWORKs HSP. The Governor’s proposed trailer bill would do the following for these four programs:

- Express legislative intent that the processes outlined below are sufficient to meet any applicable due process requirements for the provision of notices for the non-entitlement programs referenced.
- Require counties opting in to Home Safe, BFH, HDAP, and CalWORKs HSP to implement and conduct complaint resolution processes according to minimum requirements established by the department.
- Establishes the following five minimum requirements for the complaint resolution process:
  - (1) Informing applicants and recipients of their right to engage in a complaint resolution process;
  - (2) An objective decision-maker;
  - (3) The right to present information in support of the complaint;
  - (4) A written decision describing the outcome of the complaint, and
  - (5) Any other criteria developed by the department.
- Requires CDSS to develop program guidance on a procedure for counties to inform recipients of housing-related services and assistance being provided to the recipient. Requires this guidance to include specified elements, including:
  - (1) A written housing plan describing the assistance being provided, updated at regular intervals;
  - (2) An update to the housing plan if a recipients’ housing-related direct financial assistance is being reduced or discontinued, including a rationale for the change;

- (3) A formal process for discontinuing a recipient from a program;
- (4) Any other criteria developed by the department.
- Makes implementation of the processes described above subject to the availability of funding authorized by the Legislature for the applicable programs.
  - Allows (but does not require) CDSS to develop a department-level written appeal process to allow applicants and recipients to appeal a decision made as part of a county complaint resolution process, subject to appropriation.
  - States that the county-level process described above and the department-level process, if implemented, are the sole administrative remedies available to any applicant or recipient in the programs.
  - Allows CDSS to implement and administer the processes described above through all-county letters or similar written instructions from the department.
  - Requires CDSS to consult with the County Welfare Directors Association, counties, and advocates for program applicants and recipients on the development of the county-level, and potential state-level, processes described above.
  - Requires the use of existing funding appropriated for the four housing programs for administration of the complaint resolution process.

**No formal due process mechanism currently exists for these programs.** Home Safe, BFH, HDAP, and CalWORKs HSP are relatively new programs that have expanded across many new counties and Tribes over the last five years. The programs are optional for counties, and while the program structure is generally consistent throughout the state, counties have discretion to implement in ways that meet local needs. As a result of the discretionary nature of these programs, in some counties and at the state level, there is no formal administrative remedy for people participating in these programs to resolve complaints or program violations.

According to CDSS, “while some county grantees have independently established a local complaint resolution process and provide housing plans...county processes are inconsistent across the state, and CDSS has not issued formal guidance with minimum requirements on these processes. In counties without a local complaint resolution process for these programs, applicants and recipients may not have any options for administrative remedies when complaints regarding county actions or other issues arise.”

CDSS states that the minimum requirements established in the proposed trailer bill will ensure counties are properly communicating with program participants about housing-related assistance they can expect from the program and are notifying them of significant changes to the services provided in their plan. CDSS also states that complaint resolution process will allow counties to act quickly to address concerns while maintaining flexibility to operate programs consistent with the needs of the local community.

**Most social services programs are subject to state hearings.** The CDSS State Hearings Division provides full and timely hearings to recipients and applicants of California public assistance programs.

The primary programs are CalWORKs, CalFresh, In-Home Supportive Services, Foster Care, and Adoption Assistance Program, as well as Medi-Cal, and Covered California, and other programs.

Welfare and Institutions Code (WIC) 10950 establishes the right to a state hearing: “If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services, if his or her application is not acted upon with reasonable promptness, or if any person who desires to apply for public social services is refused the opportunity to submit a signed application therefor, and is dissatisfied with that refusal, he or she shall, in person or through an authorized representative, without the necessity of filing a claim with the board of supervisors, upon filing a request with the State Department of Social Services or the State Department of Health Care Services, whichever department administers the public social service, be accorded an opportunity for a state hearing.”

WIC 10051 defines public social services as: “those activities and functions of state and local government administered or supervised by [CDSS] or the State Department of Health Services and involved in providing aid or services or both, including health care services and medical assistance, to those people of the state who, because of their economic circumstances or social condition, are in need thereof and may benefit thereby.”

The four housing programs are optional for counties to administer, and while they are state-funded, the program budgets are capped, unlike major entitlement programs. (As discussed in Issue #1, HDAP is capped at \$25 million annually, CalWORKs HSP is capped at \$95 million annually, and BFH and Home Safe have no ongoing appropriation).

**Legal aid providers oppose the trailer bill as currently drafted.** In a March 2025 letter, a coalition of nonprofit legal services organizations who represent program participants express concerns with the proposed trailer bill language and recommend amendments to better protect the rights of people in the programs.

The legal services organizations write that the proposed language “would not provide adequate due process protections for housing and homelessness program recipients and could have the effect of reducing the accessibility and efficacy of these programs. The proposed trailer bill language does not guarantee a hearing by an unbiased decision-maker, the right to present and confront evidence, and other necessary components of due process in situations where counties reduce, suspend, or discontinue aid and/or services under these programs.”

The legal services organizations note it is unclear what the intended relationship is between the complaint resolution process and the formal process for program discontinuance, and that there is no requirement for a notice of any adverse action. These organizations also note that the proposed housing plan requirement has the potential to be used to justify the termination or reduction of assistance. These groups recommend the following changes to the trailer bill language:

- Provide for state hearings in situations where CalWORKs HSP, Home Safe, BFH, or HDAP assistance is being reduced, suspended, or terminated.

- Require counties to publish written policies and procedures regarding administration of the housing and homelessness programs.
- Ensure that any housing plans created pursuant to these programs are consistent with Housing First and are not used to deny or discontinue assistance to eligible recipients.

Additionally, these organizations assert that CalWORKs HSP is subject to more specific due process requirements, inclusive of the right to appeal to a state agency, because it is a component of the state's TANF program. The legal services organizations note that premature or inappropriate termination of housing assistance through these programs have led to eviction and family homelessness. They also share that client experiences with the General Assistance/General Relief program, which varies across counties, have resulted in an array of due process issues, such as failure to provide notice of denial, which prevents the applicant from appealing.

**Subcommittee Staff Comment and Recommendation – Hold Open.** Subcommittee staff notes that given the lack of any formal administrative remedy to address client issues related to Home Safe, BFH, CalWORKs HSP, and HDAP, it is appropriate for the state to establish complaint resolution, due process, and appeal requirements for these programs. However, it is not clear that the trailer bill as currently drafted achieves the due process necessary to protect the rights of individuals and families who may be arbitrarily or unfairly denied housing supports through these programs. The Subcommittee may consider modifying the proposed trailer bill to strengthen the level of due process afforded by the trailer bill as currently drafted.

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

1. Please provide a brief overview of the proposed trailer bill. What alternatives did the department consider in developing this proposal? What existing county-level process would this mirror?
2. The trailer bill states that the county-level complaint resolution process and the state-level appeal process are the sole administrative remedies for participants in the four housing programs, but then conditions those processes on the availability of funding, and on a future appropriation, respectively. Given the current state of funding for these programs, how would the Administration define the availability of funding?

**Issue 3: Homelessness Programs Data Budget Change Proposals**

**Governor’s Budget – homelessness program data budget change proposals.** The Governor’s budget contains two budget change proposals related to housing and homelessness program data collection, as follows:

1. **Homelessness programs data collection and sharing (AB 799).** CDSS requests \$421,000 General Fund for two positions to oversee data sharing, coordination, and analysis associated with AB 799 (Luz Rivas, Chapter 263, Statutes of 2024) to support the quarterly sharing of funding opportunities and to assist in the annual publication of a statewide report on homelessness in collaboration with the California Interagency Council on Homelessness.
2. **Limited-term resources for housing and homelessness data reporting solution (HHDRS).** CDSS requests \$219,000 General Fund for one limited-term position to support the Housing and Homelessness Data Reporting Systems Implementation, Maintenance, and Operations.

Both proposals are summarized below.

**Homelessness programs data collection and sharing (AB 799)**

**Background: AB 799.** AB 799 (Luz Rivas, Chapter 263, Statutes of 2024) requires the California Interagency Council on Homelessness (Cal ICH) to publish quarterly updates on funding opportunities available to counties and to compile an annual report on the efficacy of homelessness programs in California, including fiscal and outcome data from every homelessness program administered by the state. CDSS collects and publishes fiscal and outcome data on programs it administers, but is requesting additional resources to coordinate and align reporting and analysis with Cal ICH.

**Staffing and resources request.** CDSS requests two permanent research data supervisor positions to oversee data sharing, coordination and analysis associated with the AB 799 requirements. Specifically, the two permanent positions would be responsible for the following:

- Participate in the development of fiscal and outcome data collection requirements;
- Collection, cleaning, and submission of required data elements;
- Consultation in the aggregation and publication of statewide data;
- Provide the council updated information on new or existing funding opportunities on a quarterly basis;
- Engage with stakeholders, including Legislature, grantees, and advocates, on questions regarding the methodology behind and implications of newly available data.

**Limited-term resources for housing and homelessness data reporting solution (HHDRS).**

**Background: housing and homelessness data reporting solution (HHDRS).** The Housing and Homelessness Data Reporting System (HHDRS) is designed to ensure timely and accurate data reporting across housing and homelessness programs. The project is anticipated to go live in spring 2025. CDSS

requests one limited-term position to oversee the implementation, maintenance, and operation of the system in 2025-26.

**Staffing and resources request.** According to CDSS, the requested IT specialist position is essential to operationalizing the vision of HHDRS, including change management, training, system maintenance, and technical support to all 300+ housing grantees. Effective implementation of HHDRS, in turn, will enable CDSS to leverage data to increase accountability and improve the impact of each program addressing the homelessness crisis. CDSS states that as the HHDRS system enters implementation phase, HHDRS management and operations activities will be a new workload. This workload is essential to ensure accurate reporting and sufficient support for local operators. Without sufficient support, local capacity constraints may lead to inaccuracy or untimely data reported to CDSS.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the two budget change proposals in this issue: (1) Homelessness Programs Data Collection and Sharing (AB 799 implementation) and (2) Limited-term resources for housing and homelessness data reporting solution.

**Issue 4: One California Program and Immigration Legal Services Funding**

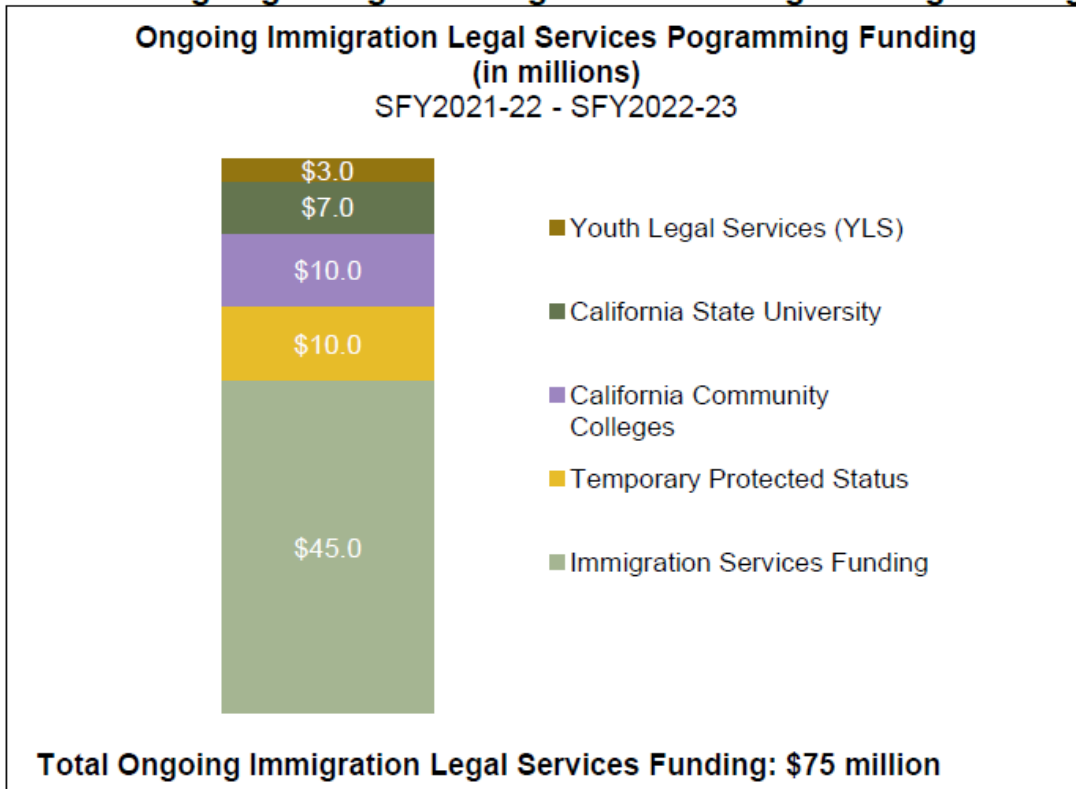
**Panel Discussion.** The Subcommittee has requested the following individuals to participate in this discussion:

- Jennifer Troia, Director & Eliana Kaimowitz, Director, Office of Equity, CDSS
- Shiu-Ming Cheer, Deputy Director of Immigrant &. Racial Justice, California Immigrant Policy Center
- Juwan Trotter, Fiscal & Policy Analyst, Legislative Analyst’s Office

**Governor’s Budget and Special Session – Immigration Legal Services Funding.** The Governor’s 2025-26 budget contains \$75 million to maintain funding for ongoing immigration legal services programs. Since 2015-16, the state has provided some level of funding for pro bono immigration legal services, education, and outreach through qualified nonprofit organizations. CDSS also develops programs and administers funding to provide critical assistance to immigrants during emergency situations. Immigration services funding is administered through the CDSS Office of Equity division.

The primary immigration legal services program is the Immigration Services Funding (ISF) program, commonly known as the “One California,” program, which has a budget of \$45 million General Fund per year. In addition, CDSS administers more specialized legal services programs that serve holders of Temporary Protected Status, students of California Community Colleges and the California State University, and unaccompanied minors (known as Youth Legal Services.)

**Chart 1. Ongoing Immigration Legal Services Programming Funding**



CDSS has also administered immigration-related funding for certain one-time or emergency programs, such as the Rapid Response Program, which generally provides shelter services at the southern border.

As part of the 2025 special session, SBX1-2 (Wiener and Gabriel) Chapter 4, Statutes of 2025, added an additional \$10 million to the One California/Immigration Services Funding program in 2024-25.

**Background: One California Program/ Immigration Services Funding.** Under the One California program, qualified nonprofit organizations provide the following legal services to immigrants with varying immigration status/categories: immigration consultations, application assistance, and full scope direct representation for immigration benefits and remedies including, but not limited to, Naturalization, Deferred Action for Childhood Arrivals (DACA), U Visas, Violence Against Women Act (VAWA) self-petitions, and Asylum, and Removal Defense.

The department’s core services are the Immigration Services Funding (ISF) provider network and Removal Defense (RD) program. CDSS funds 85 ISF organizations to provide free immigration legal services and to conduct education and outreach activities in immigrant communities. These organizations also provide services across an additional 77 extension offices and/or subgrantees. Overall, ISF services are offered at 162 service locations. Currently the ISF providers have a three-year service agreement that began January 1, 2024, and ends on June 30, 2027.

The Removal Defense program provides legal representation to individuals currently in or facing removal proceedings. The Removal Defense program is supported with an average annual allocation of \$10 million from the ongoing ISF and TPS/UUM funding. Currently the Removal Defense providers have a three-year service agreement that began October 1, 2022, and ends on June 30, 2025.

**Capacity building.** CDSS has made investments to various regions including the Central Valley, Central Coast, Northern regions via specific capacity initiatives and within ongoing legal service programs. These regions have historically been underfunded due to a variety of reasons, namely remote geographic location and lack of immigration services providers who meet experience qualifications to provide complex legal services. The department has recognized these barriers and invested in these regions highlighting the efforts to increase legal service capacity and expand the reach of resources to hard-to-reach individuals.

Region	Ongoing Legal Programs	Equity and Capacity Initiatives	Total
Central Coast	\$5,321,687	\$1,540,699	\$6,862,386
Central Valley	\$7,502,831	\$4,103,164	\$11,605,995
Northern	\$1,996,909	\$3,960,613	\$5,957,522

Additionally, the department implemented an Immigration Legal Fellowship (ILFP) aimed to increase the number of removal defense attorneys and the capacity of nonprofit organizations to provide removal defense services in the Central Coast, Central Valley, and Inland Empire regions. These fellowships provide intensive removal defense training and mentoring, as well as practical experience serving rural communities. These efforts help ensure there is quality representation for Californians throughout each region of the State.

In 2022-23, the department allocated \$27 million General Fund one-time to expand immigration legal service capacity across California, known as the Immigration Legal Services Support Project (ILSSP).

The project allowed existing immigration legal services providers to hire and train new attorneys and other individuals who can become accredited representatives with the United States Department of Justice (DOJ) Office of Legal Access Programs (OLAP), thus increasing the capacity of California's network of community-based organizations delivering legal services to immigrants. Applicants requested a total of \$38.6 million in funding for these positions, approximately \$11 million more funding than CDSS allocated for the program, demonstrating a high need for expanding immigration legal service capacity across the state. A total of 101 new Department of Justice candidates and 35 new Immigration attorneys were hired throughout the regions.

**Children's Holistic Immigration Representation Project (CHIRP).** In 2022-23, the Children's Holistic Immigration Representation Project (CHIRP), was created in response to an increase of unaccompanied undocumented minors (UUMs) released to sponsors in California. CHIRP provides holistic legal advocacy for unaccompanied children, with an emphasis on trauma-informed intervention to ensure that unaccompanied minors have both legal services and appropriate care. Each youth is assigned a fully integrated team that includes an attorney and a social services staff member (either a social worker or a case manager) to accompany them throughout the case. CHIRP was funded with \$13.6 million General Fund for a two-year project in 2022-23. To date, awarded organizations have assisted a cumulative total of 582 clients with legal and/or social services. The department was able to continue funding the CHIRP program with existing funds through 2024-25, but funding for CHIRP expires in June 2025.

**Rapid Response Program.** The Rapid Response program is operated through grants or contracts to entities that provide critical assistance to immigrants, primarily for humanitarian response at the southern border and for natural disaster response. This program has been funded with one-time funding in the 2021, 2022, and 2023 Budget Acts. The 2024 Budget Act re-appropriated unspent funding from prior years to sustain critical sheltering services at the border. Over the last three years, nonprofit organizations were also awarded \$158 million in federal Shelter and Services Program, of which only \$3.8 million has been disbursed by the federal government. The re-appropriated funding from the 2024 Budget Act is filling the gaps for nonprofit organizations operating shelters that have limited access to those federal funds.

**Special Session supplement for One California Program.** As part of the 2025 special session, SBX1-2 (Wiener and Gabriel) Chapter 4, Statutes of 2025, added an additional \$10 million to the One California/Immigration Services Funding program for the 2024-25 fiscal year to respond to the increased need for immigration legal services. According to CDSS, the supplemental \$10 million will be used both to augment grants for existing providers and for proposals for competitive grants to respond to emerging needs, such as expanding capacity in underserved areas. The augmentations to existing agreements will take about three months to roll out and the new competitive proposals will take about six months to roll out.

**Federal immigration issues.** Immigration policy is set by the federal government; the state does not control immigration policy. However, federal immigration actions impact Californians and immigration legal services providers and the state are responding to rapidly evolving federal actions. According to CDSS, key areas of concern include the following:

- Through Executive Orders, directives from agencies and public statements, the new federal administration is making changes to migration management measures that were established in previous administrations, eliminating certain humanitarian protections and leaving hundreds of thousands without the ability to apply for relief and putting them at risk of removal. This includes

termination of parole programs for Ukrainian, Cuban, Haitian, Nicaraguan, and Venezuelan parole programs and the revocation of TPS for Venezuelans.

- The federal government is allowing immigration enforcement operations at sensitive locations such as churches, schools, and hospitals. The prior policy only permitted immigration enforcement operations in these areas under exigent circumstances or with prior approval from leadership.
- Executive actions have prohibited work authorization documents for individuals who are unlawfully residing in the US even if they have a pending immigration application.
- There are increased fears across communities, resulting in individuals not accessing government services for which they are eligible. This fear is impacting US citizens and people with legal status, as well as undocumented Californians.
- The potential for immigration enforcement in or near schools has caused fear among immigrant and refugee youth and families. Local education agencies are reporting an increase in absenteeism. If absenteeism becomes chronic due to fear of increased deportations, newcomer students may experience lower academic performance.
- Unaccompanied Undocumented Minors (UUM) already face challenges with navigating the federal immigration system and will experience instability due to further isolation, threatened reductions in federal funding for support, fears of deportation, and separation from sponsors/family members. They are at increased risk of exploitation such as trafficking.
- The federal government allocates and administers funding for refugee resettlement. As a result of recent federal executive orders, the U.S. State Department issued stop work orders to all national Resettlement Agencies (RAs) directing them to immediately cease providing services to refugee and Special Immigrant Visa (SIV) holder newcomers through the Reception & Placement program. The work order required a four-month pause beginning January 27, 2025, in services and supports. The stop-work order led some of the local RAs across the state to reduce or furlough their staff.
- Newly arrived refugees and immigrants holding SIVs rely on reception and placement services that the RAs provide for their essential initial support which includes housing, furniture, clothing, food, English classes, case management, referrals, enrolling children in schools, getting them IDs, SSNs, transportation, job placement, and other key social services designed to integrate refugees in the community and place them on a path to self-sufficiency in the U.S.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief status update on the \$10 million for CDSS immigration legal services funding included in SB 2-X1 as part of the special session package.
2. How does the One California program funding reach areas of the state where legal services are hard to access? What are the current challenges with program reach, and how have recent investments in organizational capacity building supported regional capacity?

3. Please provide an update on the Children’s Holistic Immigration Representation Project. What are the key outcomes of this project and what will happen to children in the program when the project expires at the end of this fiscal year?

**Issue 5: Office of Equity Budget Change Proposals**

**Governor’s Budget – Office of Equity budget change proposals.** The Governor’s budget contains two budget change proposals for the CDSS Office of Equity, as follows:

1. **Office of Equity new staffing resources.** CDSS requests \$188,000 General Fund and \$219,000 federal funds in 2025-26 and \$184,000 General Fund and \$213,000 federal funds ongoing for two permanent positions to ensure continuous oversight and implementation of emerging and expanded programs and workloads in the Office of Equity.
2. **Permanent existing state operations.** CDSS requests \$385,000 General Fund and \$149,000 federal funds in 2025-26 and ongoing to make three limited-term positions permanent.

Both proposals are summarized below.

The Office of Equity within CDSS was established in 2020 and includes the Office of Tribal Affairs, the Civil Rights, Accessibility & Resource Equity Branch, the Immigrant Integration Branch, the Office of Immigrant Youth, the Office of the Foster Care Ombudsperson, and the Equal Employment Opportunity Office.

**Office of Equity new staffing resources**

**Background: Equal Employment Opportunity Office.** California Government Code requires every state agency to have an effective equal employment opportunity (EEO) program. All state agencies and departments have an affirmative duty to take reasonable steps to prevent and promptly address discrimination and harassment in the workplace and the members of the public served. To promptly address discrimination and harassment, the EEO Office must conduct timely investigations and present findings to the hiring authority to take immediate action to eliminate any discriminatory practices identified in investigations. The EEO Office has seen a sharp rise in cases since 2014 (36 cases, compared to 132 in 2024-25) and does not have adequate staff to keep up with the workload. The EEO Office workload increases as the number of department employees increases. Currently, the EEO Office budget is \$1.34 million and the office has eight positions.

**Background: Office of Immigrant Youth.** The Office of Immigrant Youth administers state and federal programs funded by the Legislature and the federal Office of Refugee Resettlement (ORR) serving immigrant and refugee youth. In the last two years, CDSS responded to the extension and expansion of federally funded initiatives by expanding existing programs and supporting the growing network of service providers. As these initiatives increase, additional staffing is needed to ensure appropriate oversight of social support programs for federally eligible youth populations. The Office of Immigrant Youth budget has a budget of \$2.07 million and 17 authorized positions.

**Staffing and resource request.** This request includes two total positions, one new Associate Governmental Analyst position under the EEO Office and one new Staff Services Manager II under the Office of Immigrant Youth. The EEO Office position would be responsible for workload associated with handling increasing discrimination and harassment investigations, including:

- Reduce backlog of investigations.

- Comply with statutory requirement to conduct investigations in a timely manner.
- Comply with Government Code requirements to integrate equal employment opportunity into every aspect of human resource management policies and practices in the recruitment, examination, selection, training, and advancement of employees.
- Promptly address discrimination and harassment allegations to ensure a workplace free of discrimination.
- Conduct timely investigations and present findings to the hiring authority to take immediate action to eliminate any discriminatory practices identified in investigations.

The Office of Immigrant Youth position would be 100 percent federally funded and would support the extension and expansion of federally funded programs serving refugee children and their families and unaccompanied refugee minors. Federal funds support services for newcomers including refugees, Special Immigrant Visa holders, and federally eligible parolees from Afghanistan and Ukraine. Expected outcomes from this position include:

- Increased capacity to oversee expanded local funding allocations.
- Increased capacity to conduct monitoring activities and support the planning and implementation of quality improvement goals.
- Increased capacity to support efforts to ensure parity in foster care and independent living services for Unaccompanied Refugee Minors.
- Increased capacity to support and coordinate the network of service providers.
- Increased support for staff overseeing evaluation of programs for refugee youth and families.

### **Permanent existing state operations**

**Background: Office of Tribal Affairs.** The Office of Tribal Affairs, housed under the CDSS Office of Equity, builds better government-to-government relationships with CDSS and California Indian Tribes (Tribes), Counties, Tribal Governments, and Native American stakeholders. The CDSS OTA is responsible for implementing the Department’s Tribal Consultation Policy, government-to-government Tribal Consultations, Tribal Advisory Committee Meetings, and federal and state laws that impact Tribes, tribal organizations and consortia, and American Indian/Alaska Native children and families. This includes effective implementation of the Indian Child Welfare Act (ICWA). The Office of Tribal Affairs has a budget of \$2.34 million and 13 authorized positions.

**Staffing and resources request.** CDSS requests three existing limited-term positions in the Office of Equity be made permanent, noting that recent program expansions have been achieved using limited-term funds. Of these three positions, two positions are under the Office of Tribal Affairs and one is under the Office of Immigrant Youth (described above). The three positions are: Staff Services Manager II, Associate Governmental Program Analyst, and Executive Secretary.

The two positions under the Office of Tribal Affairs would enable the Office to address workload related with ICWA regulations, which are intended to protect the best interests of Indian Children and promote the stability and security of Indian Tribes and families by establishing minimum federal standards for the removal of Indian children and placement of such children in homes that will reflect the unique values of Indian culture (25 U.S. C. 1902). Expected outcomes of continuing these positions include:

- Provide robust engagement and meaningful consultations with Tribes.

- Gather reliable data to inform policy and program development.
- Ensure transparency and accountability to Tribes and tribal stakeholders.
- Raise staff awareness of tribal impacts in the development of policy, policy guidance, regulations, and program development.
- Deliver efficient policies and procedures to effectively guide CDSS in tribal matters.
- Enable CDSS programs to effectively respond to inquiries coming from counties, Tribes, and stakeholders.
- Maintain staff understanding of ICWA regulations within the purview of their work.
- Review legislation to identify tribal impacts.
- Advise on policy and program development.
- Address historical inequities and inform systems change that address disproportionality and disparity.

The one position under the Office of Immigrant Youth is partially federally funded and is needed to ensure compliance with state and federal policies and regulations under the federal Refugee Resettlement Program and state programs supporting the integration of immigrant and refugee children. According to CDSS, this position will allow California to oversee the implementation of post-release services for Unaccompanied Undocumented Minors, maintain compliance with Title 45 C.F.R. Part 400 et seq., which requires the Refugee Resettlement Program to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible, and Title 45 C.F.R. sections 400.112(a) and 400.116(a), which require the state to provide youth in the Unaccompanied Refugee Minors program with the same range of benefits and services available in traditional child welfare and foster care programs. Expected outcomes of this position include:

- Ensure adequate administration and oversight of grants and contracts to operate social supportive services, placement, and care of vulnerable immigrant and refugee children and youth.
- Maintain the structure built to deliver culturally and linguistically responsive social support services to Unaccompanied Refugee Minors, Unaccompanied Undocumented Minors, and refugee youth and families resettling in California.
- Provide adequate oversight of foster care, referrals and placement, and independent living services to youth in the Unaccompanied Refugee Minors program.
- Facilitate internal coordination and strengthen connections to support youth in foster care and youth experiencing a breakdown in placement.
- Increase service providers' access to case consultations to provide child-specific support to address complex placement and service needs.
- Continue building and improving the capacity of the network of service providers, including non-profit community-based organizations and local education agencies to improve service delivery.

#### **Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide an overview of the following budget change proposals in this issue: (1) Office of Equity new staffing resources, and (2) Permanent existing state operations.

**Issue 6: Adult Programs: In-Home Supportive Services, SSI/SSP, and Adult Protective Services**

**CDSS Adult Programs.** CDSS oversees an array of programs serving adults and individuals with disabilities:

- **In-Home Supportive Services (IHSS)** is a Medi-Cal program administered by CDSS that allows low-income individuals who are blind, over 65, or have disabilities to receive personal care and assistance with daily living in their own home by a provider of their choice, delaying or avoiding more expensive institutional settings. Eligibility is based on Medi-Cal eligibility and assessed need for supportive services.
- **Supplemental Security Income/ State Supplemental Payment (SSI/SSP)** provides a monthly cash benefit for adults who are blind, over 65, or have disabilities to meet basic living expenses. The SSI portion is funded by the federal government and SSP is the state portion funded by the General Fund. Eligibility is based on federal criteria including income and asset limits last updated in 1989 and assessed disability.
- **Adult Protective Services** is a realigned program operated in each county that investigates and provides services to adults age 60 and over or dependent adult who are victims of abuse, neglect, or exploitation.

**Governor’s Budget –In-Home Supportive Services (IHSS).** The revised 2024-25 budget includes \$25.8 billion (\$9.5 billion General Fund) for the IHSS program and administration costs. This reflects an increase of \$654.9 million (\$365.8 million General Fund) from the 2024 Budget Act, reflecting growth in caseload, cost per hour, and hours per case.

The Governor’s proposed 2025-26 budget includes \$28.5 billion (\$10.6 billion General Fund) for IHSS, an increase of \$3.3 billion (\$1.4 billion General Fund) compared to the 2024 Budget Act. This also reflects an increase in projected caseload, cost per hour, and hours per case. Overall, the Governor’s budget projects a 10 percent increase in total funds for IHSS compared to revised 2024-25 estimates.

IHSS costs are shared between federal, state, and local governments. Approximately 98 percent of the IHSS caseload receives federal financial participation, with the majority of the caseload receiving about 50 percent federal financial participation, about four percent receiving 90 percent federal financial participation, and about two percent in the IHSS Residual program receiving only state and county funding.

IHSS caseload in 2024-25 is 717,814 and is projected at 771,650 for 2025-26, a 7.5 percent increase. IHSS recipients generally are eligible to receive up to 283 hours per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. Social workers employed by county welfare departments conduct an in-home assessment of an individual’s needs in order to determine the amount and type of service hours to be provided. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider—oftentimes a family member or relative. The average number of service

hours that will be provided to an estimated 771,650 IHSS recipients is projected to be 123.7 hours per person per month in 2025-26 (which is the same number of hours per case estimated for 2024-25).<sup>1</sup>

The Legislative Analyst's Office notes that based on the most recent actual caseload data, it appears that the IHSS caseload is growing at a faster rate than the Governor's 2025-26 budget proposal – meaning that actual costs may be higher than projected for 2025-26. Many factors contribute to IHSS caseload growth, including: the phase-in of full-scope Medi-Cal regardless of immigration status from 2020-2024, the elimination of the Medi-Cal asset test effective January 2024, and changes to streamline eligibility for minor recipients of IHSS in 2023.

**IHSS Career Pathways Program.** As a part of the 2021 Budget Act, the state was required to submit a package of home- and community-based services (HCBS) enhancements—known as the HCBS Spending Plan—to the federal government as a condition of drawing down additional federal funds resulting from a temporary 10 percentage point increase to the federal Medicaid match rate. California's plan included approximately \$3 billion in HCBS enhancements (which would be matched by an additional \$1.6 billion in standard Medicaid funds, totaling \$4.6 billion), across 26 new initiatives.

The HCBS Spending Plan included \$295 million for the IHSS Career Pathways program, a training program to increase the quality of care, recruitment, and retention of IHSS providers. Providers participating in the IHSS Career Pathways program were paid for the time that they participated in the trainings and were eligible for incentive payments upon completion of certain trainings. In order to be eligible for certain incentive payments, IHSS providers must continue to work for IHSS recipients for a certain amount of time after the completion of the training. To be eligible for the largest incentive payment (\$2,000), a provider must continue to work for a particular recipient for a minimum of 40 hours a month for six months after completing training.

As of January 8, 2025, 59,316 unduplicated providers completed at least one training course and CDSS has approved and paid providers for 1,429,512 claims for time spent in training. CDSS approved and paid providers for the following incentives:

- 83,376 15-Hour Training Incentives (\$500 each)
  - General health and safety: 17,276
  - Adult education: 63,929
  - Cognitive impairments and behavioral health: 1,985
  - Complex physical care needs: 186
- 7,638 One-Month Incentives (\$500 each)
  - Cognitive impairments and behavioral health: 6,719
  - Complex physical care needs: 919
- 4,957 Six-Month Incentives (\$2,000 each)
  - Cognitive impairments and behavioral health: 4,289
  - Complex physical care needs: 668

Over \$55 million in incentives were issued directly to IHSS providers who completed trainings. All HCBS Spending Plan programs had a spending deadline of December 31, 2024. Due to initially slow spending

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<sup>1</sup> Legislative Analyst's Office, "The 2025-26 Budget: In-Home Supportive Services," March 6, 2025.

data within the IHSS Career Pathways Program, the 2024 Budget Act included Supplemental Report Language requiring regular updates on the expenditure of the \$295 million dedicated to the program. However, the IHSS Career Pathways Program ultimately exceeded its HCBS Spending Plan allocation and closed enrollment in September 2024. Approximately \$90 million in excess expenditures was offset by underspending in other HCBS Spending Plan programs. However, a gap of approximately \$24.1 million remains after available HCBS Spending Plan offsets. The Administration has reported to the Joint Legislative Budget Committee that they are evaluating how to address the excess costs.

**Analysis of regional or statewide collective bargaining.** The 2023 Budget Act included \$1.5 million for CDSS to analyze the costs and benefits of transitioning the IHSS program from the current county level collective bargaining model to a statewide or regional collective bargaining model. This analysis was due January 2025; CDSS is in the final stages of compiling this analysis.

The 2024 Budget Act also required CDSS to review the budgetary methodology used to determine annual funding for IHSS county administration costs, beginning in 2025-26.

**Governor's Budget – SSI/SSP.** The Governor's revised 2024-25 budget includes \$11.1 billion (\$3.6 billion General Fund) for SSI/SSP, which reflects a decrease of \$211.9 million (\$55.9 million General Fund). The total fund decrease reflects a lower average grant, partially offset by a slower caseload decline than previously projected in the 2024 Budget Act. The costs for the CAPI program are \$239.7 million General Fund in 2024-25.

The 2025-26 Governor's budget includes \$11.2 billion (\$3.6 billion General Fund) for SSI/SSP, which reflects a decrease of \$83.6 million (\$61.3 million General Fund) compared to the Budget Act of 2024. The total fund decrease reflects a lower average grant, partially offset by a slower caseload decline than previously projected in the 2024 Budget Act as well as the full-year impact of the 2025 COLA of 2.5 percent, and the half-year impact of the anticipated 2026 Federal COLA of 2.3 percent. The costs for the CAPI program are \$254 million General Fund in 2025-26.

SSI/SSP caseload for 2025-26 is projected at 1,078,708 individuals, about a 0.7 percent decrease from the revised 2024-25 estimate (SSI/SSP caseload has been on a steady decline for years due to several factors, including the asset limit of \$2,000 for individuals and \$3,000 for couples.) The maximum SSI/SSP monthly payment effective January 2025 is \$1,206.94 for individuals and \$2,057.83 for couples. Projected 2025-26 maximum grant levels generally equate to about 90 percent of the federal poverty line for individuals and 114 percent of the federal poverty for couples, as shown in the LAO chart below.

## SSI/SSP Monthly Maximum Grant Levels<sup>a</sup>

	2023-24 (Actual)	2024-25 (Actual)	2025-26 (Projected)
<b>Maximum Grant—Individuals</b>			
SSI	\$943.00	\$967.00	\$989.00
SSP	239.94	239.94	239.94
<b>Totals</b>	<b>\$1,182.94</b>	<b>\$1,206.94</b>	<b>\$1,228.94</b>
Percent of federal poverty level <sup>b</sup>	94.26%	92.54%	90.45%
<b>Maximum Grant—Couples</b>			
SSI	\$1,415.00	\$1,450.00	\$1,483.00
SSP	607.83	607.83	607.83
<b>Totals</b>	<b>\$2,022.83</b>	<b>\$2,057.83</b>	<b>\$2,090.83</b>
Percent of federal poverty level <sup>b</sup>	118.76%	116.76%	113.87%

<sup>a</sup>The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective fiscal year.

<sup>b</sup>Compares grant level to federal poverty guidelines from the U.S. Department of Health and Human Services for 2024 and 2025. Estimates of federal poverty guidelines for 2026 are based on the LAO Consumer Price Index for All Urban Consumers projection. The 2026 federal poverty guidelines will not be finalized until fall 2025.

Source: LAO

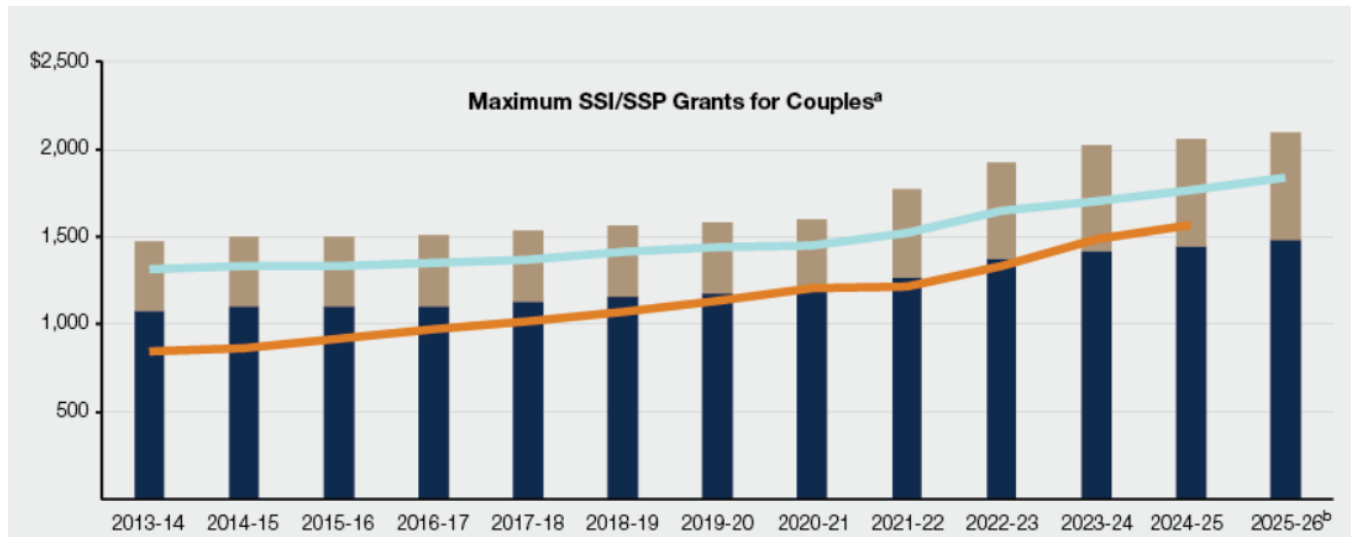
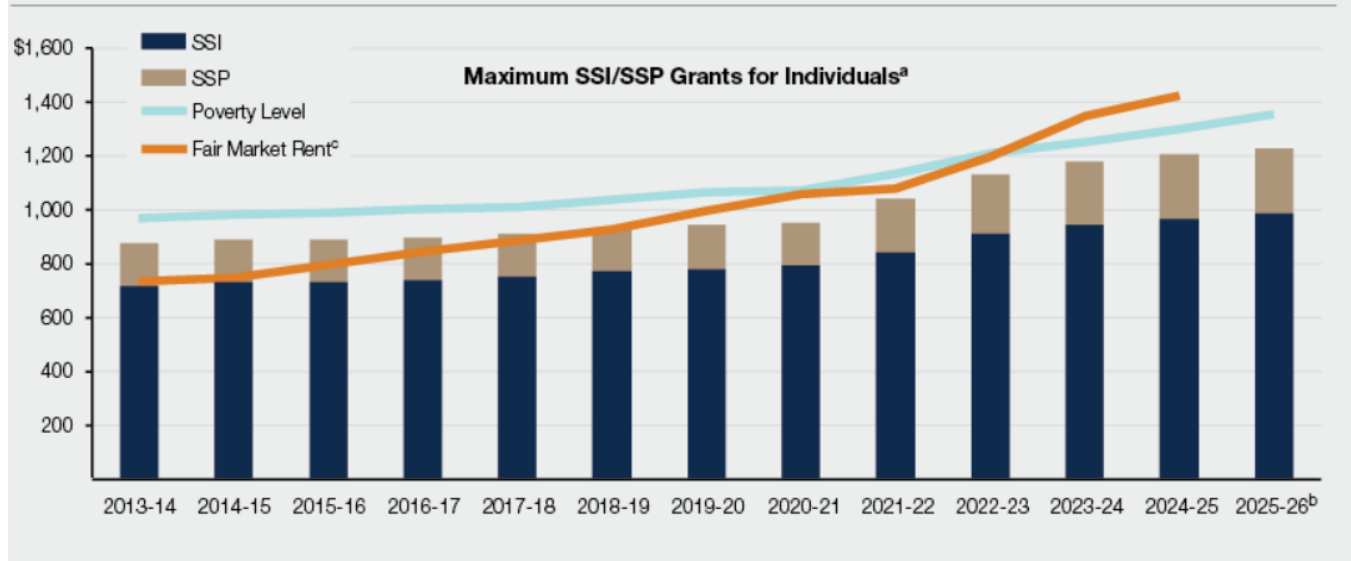
Many individuals who receive SSI/SSP struggle to maintain stable housing and meet basic living expenses. While the maximum SSI/SSP grant is above the federal poverty line for couples, it is below the federal poverty line for individuals, and as shown in the LAO chart above, will fall further below the federal poverty line in 2025-26.

The projected increases to maximum SSI/SSP grant levels in 2025-26 are entirely due to the estimated federal SSI COLA. The Governor’s budget estimates that the federal COLA for the SSI portion of the grant will be 2.5 percent in 2025-26, increasing maximum SSI grants by \$22 for individuals and \$33 for couples in January 1, 2026 (the actual federal SSI COLA will not be known until fall 2025). The Governor’s budget does not propose any change in the maximum SSP grants for 2025-26.

Most SSI/SSP recipients (roughly 60 percent) live in the 14 counties with the highest fair market rents, all of which are located within the Central Coast and San Francisco Bay regions, as well as Los Angeles, Orange, and San Diego Counties. In all of these 14 counties, the maximum SSI/SSP grant for couples is less than the fair market rent for a one-bedroom unit. This includes nine counties (where 22.5 percent of SSI/SSP recipients live) where the maximum SSI/SSP grant for couples is less than the fair market rent

for a studio apartment. The chart below, provided by the LAO, demonstrates maximum SSI/SSP grants for individuals and couples compared to both fair market rent and the federal poverty level.

### Maximum SSI/SSP Grants for Individuals and Couples Compared to Federal Poverty Level & Fair Market Rent



<sup>a</sup> The maximum SSP grant levels for aged and disabled individuals and couples living in their own households, effective January of each fiscal year.  
<sup>b</sup> Federal poverty guidelines as established by the US department of Health and Human Services up to 2024-25. Federal poverty guidelines for 2025-26 are estimates.  
<sup>c</sup> Fair market rents for an efficiency unit are displayed for individuals while fair market rents for a one-bedroom unit are displayed for couples. All fair market rents are from the US Department of Housing and Urban Development website (<https://www.huduser.gov/portal/datasets/fmr.html>).



Source: LAO

**Adult Protective Services.** Each county in California has an Adult Protective Services (APS) agency to support adults 60 and older and dependent adults who are unable to meet their own needs or are victims of abuse, neglect, or exploitation. County APS social workers investigate cases of abuse and arrange for services such as legal support, counseling, money management, and housing stabilization. Most common identified areas of need are self-care, independent living, ambulatory needs, cognitive needs, and financial abuse and neglect. In 2023-24, counties received 277,661 reports of abuse and opened 205,055 cases. Detailed data on APS cases is available on CDSS's APS Data Dashboard.<sup>2</sup>

The APS program was realigned to the counties in 2011; however state General Fund and some federal funds support specific APS programs including a statewide training curriculum, the development of a statewide data warehouse, and most significantly, the expansion of APS services to adults ages 60-65, which is supported by \$70 million General Fund ongoing beginning in 2021-22. The 2021-22 APS expansion also included an enhanced focus on housing and extended case management, in line with the ramp up of the Home Safe program. (See Issue #1 for more information on the Home Safe Program). In total, statewide funding for APS was approximately \$293.3 million in 2023-24.

The 2024 Budget Act included limited-term federal fund authority of \$369,000 in 2024-25 and \$257,000 in 2025-26, including two positions, to begin planning and development efforts toward a data warehouse for the APS program. This project is currently in development.

#### **Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview on the Governor's proposed budget and caseloads for IHSS, SSI/SSP, and Adult Protective Services.
2. Please provide an update on the IHSS Career Pathways Program. What are the key outcomes of this program, both on IHSS caregivers and IHSS recipients?
3. Will the approximately \$24 million in IHSS Career Pathways expenditures that exceed available offsets from other HCBS programs need to be covered by the General Fund in the Governor's May Revision?
4. How will the depletion of Home Safe funding (discussed in Issue #1) affect the state's Adult Protective Services program and caseload?

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<sup>2</sup> [Workbook: STATEWIDE APS SOC 242](#)

**Issue 7: Community Care Licensing Overview**

**Background—Community Care Licensing.** The Community Care Licensing Division (CCLD) under CDSS oversees the licensure or certification of approximately 72,716 licensed facilities that include childcare centers; family child care homes; adult day care facilities; foster family homes; children, adult, and senior residential facilities, and licensed home care organizations. CCLD is responsible for protecting the health and safety of individuals served by those facilities. Licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. CCLD has a total of 1,593 authorized positions. In 2023-24, CCLD completed 39,000 facility inspections, 17,000 case management visits, 18,000 complaint investigations, and 8,300 applications for licensure.

**Governor’s Budget.** The 2024-25 Governor’s budget for CCLD is \$259.3 million total funds. This is comprised of \$130.6 million General Fund, \$95 million federal fund, \$6.5 million reimbursements, and \$27.2 million special funds.

Licensed facilities must pay an application fee and an annual fee, which are set in statute. The revenue from these fees is deposited into the Technical Assistance Fund (TAF) and is expended by the department to fund administrative and other activities in support of the licensing program. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Civil penalties assessed on licensed facilities are also deposited into the TAF, and are required to be used by the department for technical assistance, training, and education of licensees.

CCLD uses an inspection tool known as the CARE Tool to conduct statutorily mandated inspections of licensed facilities. In 2023-24, the compliance rate for facilities inspected was over 98 percent. Despite high compliance, CCLD issued over 25,000 citations and provided technical assistance to licensees over 8,000 times during inspections. In 2023, the most common area of noncompliance included errors in records.

**Updates on Guardian Background Check System.** The 2023 Budget Act included \$4 million General Fund for an increase of staff in the Care Provider Management Bureau for processing background checks, providing technical assistance, and customer services, in order to address a substantial background check backlog. The 2023 Budget Act also included \$900,000 limited-term funding to (1) support ongoing IT maintenance for the Guardian background check system and (2) initiate planning activities to develop a replacement to the Guardian system.

The average caseload backlog has decreased by 21 percent from 1,482 in the last quarter to 1,164 in the third quarter of 2024 (as of September 2024). The department continues to see backlogs trending down due to focused efforts on streamlining processes/procedures, training, and optimizing resource allocations. The average processing time for background checks is 3 days for clearances, 7-14 days for simplified exemptions, and 99 days for standard exemptions and other manual determinations.

**Updates on fire impacts.** CCLD monitors and responds to natural disasters and emergencies affecting facilities and homes licensed by the department. The January 2025 Los Angeles fires had an outsized impact on licensed facilities. CDSS reports the following impacts to licensed facilities as a result of the Los Angeles fires:

- Adult residential facilities: 230 monitored, 116 impacted (i.e. evacuated), 20 destroyed, 2 sustained significant damage.
- Child care facilities: 633 monitored, 435 impacted, 42 destroyed, 9 sustained significant damage.
- Children’s residential facilities and homes: 50 monitored, 39 impacted, 5 destroyed, one sustained significant damage.
- Across all facility types, 67 facilities were destroyed.

In response to the fires, CCLD has been working with licensed facilities on an individual basis to assess their needs. Recent executive orders provide flexibility to facilitate the movement of residents to other facilities, streamline new applications for licensure (for example, if a facility needs to move locations), and waive licensing fees for impacted licensees, among other emergency responses.

**Subcommittee Staff Comment and Recommendation – Informational Item.** No action is needed.

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

1. Please provide an update on the impacts of the Los Angeles fires on licensed facilities. How is the Community Care Licensing Division assisting licensees to retain or regain licensure? What are common barriers that prevent impacted facilities from resuming operations and regaining licensure?
2. Please provide an update on the Guardian replacement system project.

**Issue 8: Licensing Budget Change Proposals**

**Governor’s Budget—licensing budget change proposals.** The Governor’s budget includes four budget change proposals implementing legislation that affect the Community Care Licensing Division (CCLD) under CDSS, as follows:

1. **Administrative support for pool safety (AB 2866).** CDSS requests two permanent positions and one limited-term position to support the new workload under AB 2866 (Pellerin, Chapter 745, Statutes of 2024), which requires child care centers and family child care homes in single-family dwellings with in-ground pools to add specified safety features.
2. **Anaphylactic policy (AB 2317).** CDSS requests five positions to support the new workload created by AB 2317 (Stephanie Nguyen, Chapter 563, Statutes of 2024) to provide guidance and training on anaphylactic prevention and emergency responses in child care facilities.
3. **Children’s camps regulation (AB 262).** CDSS requests \$1.8 million General Fund for a contractor and four positions to conduct the work outlined in AB 262 (Holden, Chapter 341, Statutes of 2024) which requires CDSS to prepare a report, informed by consultation with a wide variety of stakeholders, on children’s camps that includes recommendations for a definition of a children’s camp, minimum health and safety requirements, and responsibilities and requirements for camp oversight to the Legislature.
4. **Resident services and rights support (SB 1406).** CDSS requests \$743,000 General Fund in 2025-26, \$725,000 General Fund in 2026-27, and \$549,000 General Fund in 2027-28 and ongoing for three permanent positions and two-year limited-term funding equivalent to one position, to implement SB 1406 (Allen, Chapter 340, Statutes of 2024), which increases the number of days, from 60 to 90, for which a licensee of a residential care facility for the elderly (RCFE) must provide written notice to residents or their representatives prior to any increases in the rate structures for fees and services.

**Administrative support for pool safety (AB 2866).**

**Background: AB 2866.** AB 2866 (Pellerin, Chapter 745, Statutes of 2024), creates additional requirements for child care centers and family child care homes with pools, and requires the child care licensing program to update pool safety regulations. The bill was introduced due to increased drowning, highlighting the need for stricter pool safety regulations. Specifically, the bill requires child care facilities with pools to add life rings, rescue poles, and fences, covers, and alarms, as specified. CDSS expects a high volume of provider inquiries and intends to provide various communications and technical assistance to the field.

**Staffing and resource request.** CDSS requests \$549,000 General Fund in 2025-26, \$537,000 in 2026-27, and \$414,000 ongoing for one permanent Associate Governmental Program Analyst (AGPA)/Staff Services Analyst (SSA), one two-year limited-term AGPA in the Community Care Licensing Division, and one permanent Senior Legal Analyst in the Legal Division to support the new workload created by AB 2866:

- The AGPA/SSA will be the lead expert on pool safety and will be responsible for: drafting policy and procedure memos, researching inquiries and responding to questions, and providing notifications and instructions to internal staff and affected licensees.
- The Legal Analyst will assist with drafting regulations. They will also develop training and guidance materials and provide ongoing legal assistance to staff.
- The limited-term AGPA will develop Adult and Senior Care regulations or Interim Licensing Standards as well as provide additional communication to the adult and senior care field staff and licensees in the form of Provider Information Notices (PIN).

According to CDSS, these positions will allow the department to update regulations to meet the higher pool safety standards and also update the Department's Compliance and Regulatory Enforcement (CARE) Tools. The CARE tool updates will assist Licensing Program Analysts (LPAs) when conducting inspections in licensed facilities. New fields will need to be added to the CARE Tools so that LPAs can verify compliance with the updated pool safety requirements that are outlined in the new Health and Safety Code and in the regulations that will be drafted.

### **Anaphylactic policy (AB 2317)**

**Background: AB 2317.** AB 2317 (Stephanie Nguyen, Chapter 563, Statutes of 2024), requires CDSS, in consultation with the California Department of Education (CDE), to establish an anaphylactic policy by July 1, 2027. This policy will include guidelines and training recommended for child daycare personnel to prevent anaphylaxis and procedures to be used during a medical emergency resulting from anaphylaxis. The bill also requires CDSS, in consultation with the Emergency Medical Services Authority (EMSA) and CDE, to create informational materials in multiple languages and post them on each of the departments' websites on or before September 1, 2027. The legislation specified certain provisions that must be included in the anaphylactic policy, including staff training, emergency administration of epinephrine auto-injectors, and health care plans for children with allergies, among others.

**Staffing and resource request.** In order to implement AB 2317, CDSS requests \$1.03 million General Fund in 2025-26, \$1 million General Fund in 2026-27, and \$698,000 ongoing for five positions: one permanent staff services manager (SSM) I Specialist, three permanent licensing program analysts (LPAs), and one limited-term attorney:

- The SSM I Specialist will establish an anaphylactic policy that sets forth guidelines and procedures outlined in the legislation and create informational materials detailing the anaphylactic policy. This position will provide technical assistance during the implementation process of the anaphylactic policy and new training requirements. They will also be the lead for outreach efforts and coordinating meetings with CDE and other required collaborating entities outlined in the bill.
- Three LPAs are needed to verify the new training requirements, review the plan for each licensee as required in the legislation, and verify the medication is on-site and not expired. The addition of three LPAs is to help offset the workload increase across the state as these new requirements will increase time spent during the inspection process for each LPA in the field by about 5-10 minutes.

- One limited-term Attorney IV for two years will help to establish the anaphylactic policy, implement regulations, and create training materials for impacted CDSS staff and childcare providers.

### **Children’s camps regulation (AB 262).**

**Background: AB 262.** AB 262 (Holden, Chapter 341, Statutes of 2024) requires CDSS to consult with a variety of stakeholders on children’s camp safety. The department must provide recommendations on the following: (1) the definition of a children’s camp; (2) the government agency or agencies necessary to adopt and enforce standards; and (3) minimum health and safety requirements to protect children attending children’s camps to the Legislature, within 24 months of receiving appropriated funds for this purpose. By approving the state operations and contract funds request, the department would consider the mandate for appropriation met and would commence the work required by AB 262.

**Staffing and resource request.** According to CDSS, the department will need to contract with a vendor to carry out the consultation requirements in AB 262, in addition to four positions, for a total cost of \$1.81 million in 2025-26 and \$787,000 for the next three fiscal years. Based on previous vendor contracts, CDSS estimates \$1 million for a contractor to oversee the process and to coordinate efforts including stakeholder engagement, a statewide survey to capture the number of potential children’s camps, and to identify cost drivers when defining a children’s camp. This contract would be a one-time cost. The CDSS staff is needed to oversee the work of the contractor, conduct research related to children’s camp regulation in other jurisdictions, help coordinate and run the workgroups, and develop recommendations as outlined in AB 262.

The positions include two permanent full-time Staff Services Manager (SSM) II (Specialists) and one permanent full-time Associate Governmental Program Analyst (AGPA) for contract management and workgroup oversight and one Research Data Analyst (RDA) II.

- The two SSM II positions will develop the request for proposal and manage and oversee a contract outlining the AB 262 requirements.
- The AGPA will support the work of the SSM IIs, assist with research, and be responsible for reviewing other states' regulations and oversight of camps, gathering relevant data to support recommendations, participating in the workgroups, and assisting in stakeholder communications.
- The RDA II would support this work by assisting with the cost estimate for implementation of the recommendations included in the report and by supporting the analysis of any survey results received as a part of this process. The RDA II will ensure the data approaches are measurable, achievable, and verifiable.

### **Resident services and rights support (SB 1406).**

**Background: SB 1406.** SB 1406 (Allen, Chapter 340, Statutes of 2024), extends the timeframe (from 60 to 90 days) for RCFE licensees to provide a written notice to residents or the resident’s representatives regarding any increase in the fee rates or rate structures for services and requires a detailed justification for the increase. SB 1406 additionally grants residents in privately operated facilities the personal right to request, refuse, or discontinue a service. CDSS anticipates an increase in the number of complaints,

citations, and regulatory and enforcement queries due to this change in part because there may be disagreements between residents and facilities about whether a service is necessary to help support the resident's safety.

**Staffing and resource request.** CDSS requests \$743,000 General Fund in 2025-26, \$725,000 General Fund in 2026-27, and \$549,000 General Fund ongoing and four positions (three permanent positions and one-limited term) to implement SB 1406. The positions include:

- Three permanent positions: one Staff Services Manager (SSM) I and two Associate Governmental Program Analysts (AGPAs) positions in Community Care Licensing Division's Centralized Complaint and Information Bureau (CCIB) to address the increased complaints and mitigate delays in monitoring licensed facilities and protecting the health and safety of residents.
- One limited-term AGPA position in its Policy Development Bureau (PDB) to implement updates to current policy, provider information notices and guidance letters, regulations, forms, and the CARE licensing inspection tool.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the four proposals in this issue: (1) Administrative support for pool safety, (2) Anaphylactic policy, (3) Children's camps regulations, and (4) Resident services and rights support.

**Issue 9: State Operations Reductions and Vacancies**

**Governor’s Budget – State operations reductions and vacancies.** The 2024 Budget Act included two control sections (Control Section 4.05 and Control Section 4.12) that aimed to implement efficiencies across state agencies in order to produce ongoing General Fund savings without adverse effects on state services. Both control sections established statewide administrative exercises led by the Department of Finance to (1) identify efficiencies in each department and (2) eliminate vacant positions and related funding.<sup>3</sup>

The 2024 Budget Act assumed General Fund savings of \$2.2 billion in 2024-25 and \$2.8 billion ongoing beginning in 2025-26 to reduce General Fund state operations expenditures by up to 7.95 percent. Although the budget assumed this level of savings could be achieved, it did not actually reduce departmental budgets by this amount. Instead, the reduction was made to the overall budget totals and remained “unallocated” to departments.<sup>4</sup> The 2024 Budget Act also assumed savings of \$1.5 billion (\$762.5 million General Fund) resulting from vacant positions across all departments; these savings were also left unallocated. The two control sections also included specific requirements for the Department of Finance to allocate and implement the savings across the Administration and report specified information on the General Fund savings and vacant positions to the Joint Legislative Budget Committee. According to the LAO, the Governor’s 2025-26 budget assumes lower savings than assumed in the 2024 Budget Act.

**CDSS reductions.** CDSS has shared the information below on the department’s solutions to address the requirements of Control Section 4.05:

**Control Section 4.05 State Operations Reductions**

- \$7,000,000 Shift additional personnel costs where allowable to federal funding to maximize federal fund and offsets General Fund costs.
- \$6,281,000 Temporary hiring freeze<sup>1</sup>
- \$3,087,000 Reduce operating expense and equipment spending (travel, training, office supplies, etc.)
- \$2,000,000 Reduce IT procurement spending.
- \$1,000,000 Reduce licensed facility temporary manager funding to meet expected need<sup>2</sup>
- \$19,368,000 TOTAL**

<sup>1</sup>Since the Temporary Hiring Freeze savings is one-time only, CDSS is working to identify ongoing savings of \$6.2 million.

<sup>2</sup>CDSS is funded to place temporary managers in licensed facilities when those facilities are being closed down. The Department will retain \$3.9 million for this purpose after the proposed reduction which the department states should be sufficient to meet needs.

<sup>3</sup> Legislative Analyst’s Office, “The 2025026 State Budget: State Departments’ Operational Efficiencies (Control Sections 4.05 and 4.12), February 19, 2025.

<sup>4</sup> LAO.

According to CDSS, the department was able to identify positions in child welfare programs that are currently supported with General Fund but are eligible to be funded by federal Title IV-E funds. As a result, federal funds can be used to offset General Fund, reducing overall General Fund costs.

**Subcommittee Staff Comment and Recommendation – Hold Open.** The reductions CDSS has identified seem generally in line with the goal of achieving General Fund savings without negatively impacting direct services.

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

1. Please provide a brief overview of how the department is implementing state operations and vacancies reductions pursuant to Control Sections 4.05 and 4.12 of the 2024 Budget Act, and the impacts of these changes.

**NOT FOR PRESENTATION****Issue 10: Proposals for Investment**

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

- **Bolster California’s Immigration Legal Services Programs to Keep California Families Together.** A coalition of organizations including the California Immigrant Policy Center, Immigrant Legal Resource Center, Vera Institute of Justice, Immigrant Legal Defense, Central American Resource Center of Los Angeles, and Immigrant Rights and Education Network, propose \$60 million General Fund one-time to increase access to immigration legal services. According to this coalition, “while current funding for California’s immigration legal services programs support thousands of children and families every year, additional investments are urgently needed to meet the high demand for legal services amid the increase in immigration enforcement and rapid shifts in immigration policy changes by the federal administration. Investments are needed to meet emerging needs, especially in underserved regions such as the Central Valley, Central Coast, and Inland Empire, to provide legal services and community education support, and support for legal orientation and services programs for vulnerable individuals, including children, facing deportation that are cut off from federally funded legal services programs.”

The coalition states “as of December 2024, more than 179,000 people, including children and families, in California are facing deportation in immigration courts without legal representation. Unlike criminal court, people, including children, facing deportation in immigration court are not provided a lawyer if they cannot afford one.” The coalition also notes that “federal stop-work orders have halted critical legal services funded by the federal government, cutting off access to representation for thousands of vulnerable children and families in California... While there has been some temporary relief from these orders, more actions by the federal government are anticipated. This reinforces the necessity for California to prioritize state funding to help bolster and stabilize legal access and representation services that countless Californians rely on to navigate the complexity of the immigration system and relief available to them under existing law.”

- **Transition Collective Bargaining for IHSS Providers from the County to the State Level.** UDW/AFSCME Local 3930 and SEIU request \$1 million General Fund and \$1 million federal fund in 2025-26 and ongoing to cover staffing costs related to implementing current legislation, AB 293 (Haney), to create statewide bargaining for IHSS providers. If approved, the funding would support 10 positions in CDSS or the California Department of Human Resources (CalHR) to establish a state collective bargaining team to oversee changes in provider orientation and potential programming changes to the IHSS case management system. According to these organizations, “California is facing a growing care crisis due to the rapidly increasing population of older adults. Demand for IHSS providers far exceeds supply. IHSS provider wages range from \$16 to \$21.50 per hour, with an average of \$17.60. This is far below the estimated \$28.72 per hour living wage for an adult without children or \$51.15 for a family of four.... From 2017 to 2023, the average annual turnover rate of IHSS providers not related to their clients was 23.76 percent, while the turnover rate for family providers averaged 11.59 percent. High turnover greatly disrupts

quality and continuity of care, leading to negative health outcomes for recipients, especially those without family members able to serve as their providers.”

These organizations state that “to address the crisis, UDW and SEIU California propose shifting IHSS collective bargaining from the county to the state level. Under this mode, wage and benefits disparities across the counties would be reduced and lead to improved provider recruitment, retention, and stability. States like Connecticut, Illinois, Massachusetts, Minnesota, Washington, and Oregon have improved wages, benefits, and retention through statewide bargaining.”

- **End Poverty for SSI/SSP Older Adults and People with Disabilities.** Californians for SSI, a statewide coalition of organizations across the aging, disability rights, housing and homelessness, anti-hunger, and anti-poverty sectors, propose \$468 million General Fund in 2025-26, \$507 million in 2026-27, and \$524 million General Fund in 2027-28 and ongoing to support three changes in the SSI/SSP program:
  1. Provide an ongoing cost-of-living increase (\$78 million General Fund in 2025-26, \$162 million General Fund in 2026-27, and \$167 million General Fund ongoing) to SSP grants.
  2. Revive an emergency grant program for older adults and people with disabilities (\$20 million General Fund in 2025-26 ongoing for five years).
  3. Lift SSI/SSP grants to at least the Federal Poverty Line (\$370 million General Fund in 2025-26, \$325 million General Fund in 2026-27, and \$337 million General Fund in 2027-28 ongoing for five years).

According to Californians for SSI, “current funding levels still fall short of what individuals living on SSI/SSP need to live safely and comfortably in California, due to the ongoing harm caused by recession-era cuts in 2009 and 2011 when California cut the SSP and eliminated the yearly Cost-of-Living Adjustment (COLA) for the state portion (SSP grant). If the COLA had been maintained, grant levels would already have exceeded the Federal Poverty Line. The SSP grant for January 2025 would be at \$430.62 if the COLA had been applied since January 2008, instead of the current \$240. When you take into account the state-portion (SSP) and the federal portion (SSI), the maximum grant for an individual in 2025 is about \$1,206, or 92.5 percent of the federal poverty line.”

“Simultaneously, we must finally close the gap and bring every SSI/SSP older adult and individual with a disability above the poverty level. California’s housing crisis means that SSI recipients remain in dire need, and many continue to be at risk of homelessness and unstable housing. SSI/SSP grants are so low that in 2024, the rent for a studio exceeded one-half of the SSI grant in all 58 counties and was higher than the entire grant in 25 counties. The LAO also noted that currently, 60 percent of SSI/SSP recipients live in 14 counties with the highest Fair Market Rent. Rent, food, and healthcare costs would exceed ALL counties’ SSI/SSP grants... We urge California leadership to appropriate a 5-step increase to lift SSP grants to the Federal Poverty level.”

“It is nearly impossible for older adults and people with disabilities on SSI to save up for emergencies, given the low grant levels, and due to the SSI asset limit test of \$2,000 for individuals and \$3,000 for couples... In the past, California had an emergency grant program for Supplemental Security Income,

In-Home Supportive Services, or Cash Assistance Program for Immigrants, which CA4SSI coalition members found critical to ensuring they could survive in California... Reviving an emergency grant program will support older adults and people with disabilities facing emergencies, by ensuring they can get financial assistance in a one-time lump sum. The funding could be used for a variety of reasons, including but not limited to: moving costs to help prevent homelessness, house repairs to prevent unsafe or unhealthful conditions, maintain heating/cooling systems, and maintain safe and operating stoves and refrigerators.”

- **Equity in Access to 2-1-1 Social Care Resource Connection and Disaster Services.** 2-1-1 California, Inland SoCal United Way 2-1-1, and United Ways of California propose \$20 million General Fund one-time in 2025-26 to support core operations for local 2-1-1 providers, establish 24/7 2-1-1 operations in counties that have limited 2-1-1 service, support 2-1-1 data sharing, and support 2-1-1 disaster response and recovery work.

According to these organizations, “2-1-1 is a critical gateway to accessing social care, preventive, crisis, and disaster resources, and is a trusted source of information for Californians of all backgrounds and languages. To date, counties, local governments, and philanthropic funders have carried funding for local 2-1-1 programs, with no significant core operations funding from the state, despite an increasing reliance on the services 2-1-1 operators provide as trusted messengers during the COVID-19 pandemic and recent disasters. This has resulted in variability and inequity in access to 2-1-1 services across the state, and vulnerability to local government budget constraints and federal funding changes resulting in loss of 2-1-1 coverage and capacity. Counties large and small around the state are struggling with insufficient local funding to meet community demand for 2-1-1 service, resulting in hundreds of thousands of calls unanswered, straining disaster response capacity, and leaving over 722,000 Californians without access to 2-1-1 services and many more at risk of losing service.”

**Subcommittee Staff Comment and Recommendation – Hold Open.**

# SUBCOMMITTEE NO. 3

# Agenda

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



Thursday, March 27<sup>th</sup>, 2025  
9:00 am  
1021 O Street – Room 1200

Consultants: Elizabeth Schmitt and Scott Ogus

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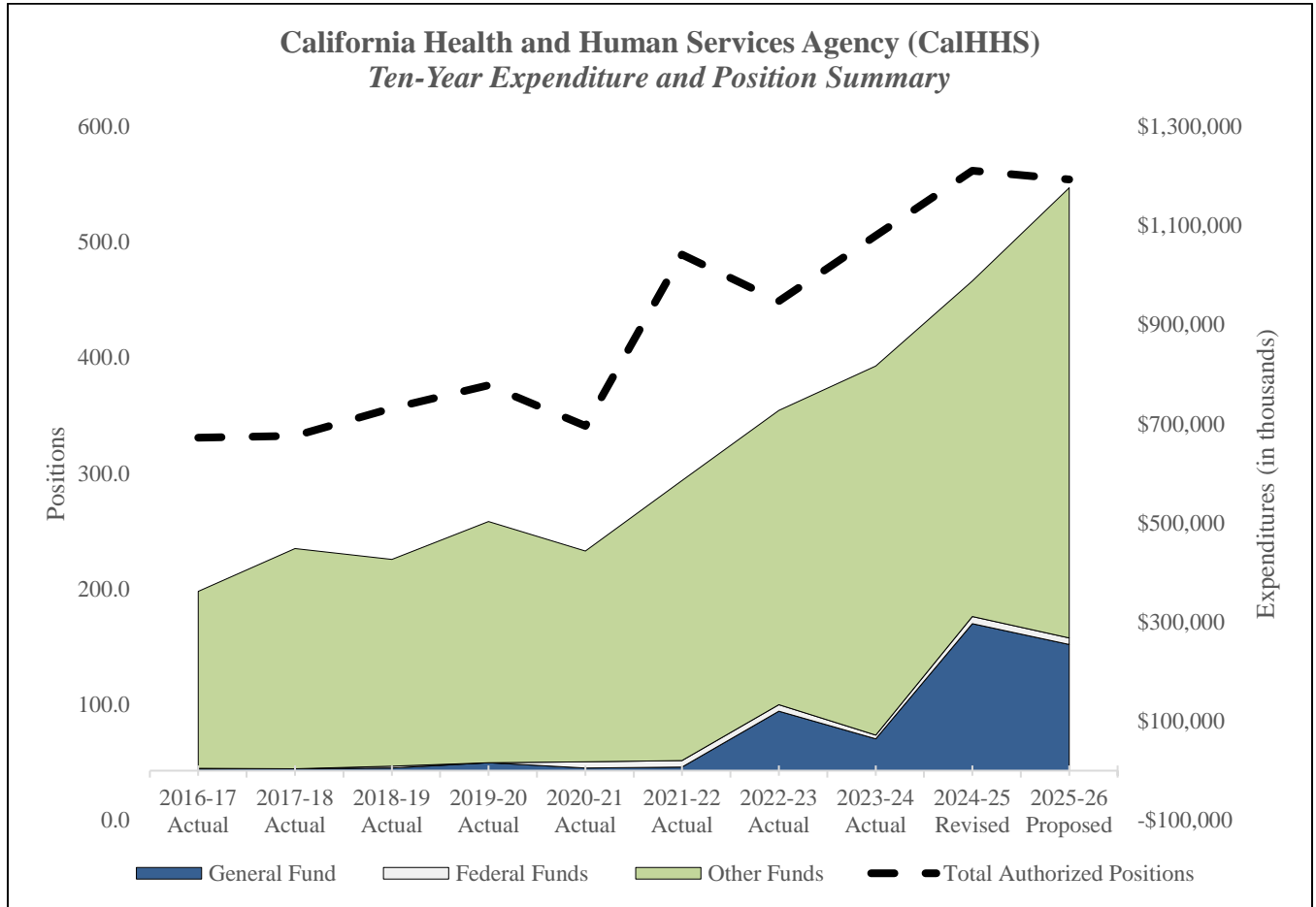
**PUBLIC COMMENT**

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**0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY**

**Issue 1: Overview**



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

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

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

The departments and other entities within CalHHS include:

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

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

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

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

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

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

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

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

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

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

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

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

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

**Subcommittee Staff Comment**—This is an informational item.

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

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

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

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

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

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

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

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

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

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

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

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

<b>Major Sources of County Juvenile Justice Funding Provided Through the State</b>			
	<b>2024-25</b>	<b>2025-26</b>	
<b>Program (Millions)</b>	<b>Estimated Funding</b>	<b>Proposed Funding</b>	
<i>Funding to Support Realigned Workload</i>	\$ 461	\$ 491	
Youthful Offender Block Grant	\$ 235	\$ 256	
Juvenile Justice Realignment Block Grant	\$ 212	\$ 221	
Juvenile Reentry Grant	\$ 14	\$ 15	
<i>Funding for Other Workload</i>	\$ 561	\$ 577	
Juvenile Probation Activities	\$ 296	\$ 304	
Juvenile Justice Crime Prevention Act	\$ 208	\$ 214	
Juvenile Probation Camp Funding	\$ 57	\$ 59	
<b>Totals</b>	<b>\$ 1,022</b>	<b>\$ 1,068</b>	

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

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

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

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

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

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

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

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

- Number of youth and their most serious commitment offense who are committed to a SYTF, including youth committed to SYTFs in another county.
- Number of individual youth in the county who were adjudicated for an offense pursuant to subdivision (b) of Section 707 of WIC or Section 290.008 of the Penal Code.
- Number of youth, including their commitment offense or offenses, transferred from a SYTF to a less restrictive program (LRP) under the terms and provisions of WIC 875(f), disaggregated by program description, as defined by OYCR.
- Number of youth for whom a hearing to transfer jurisdiction to an adult criminal court was held, and the number of youth whose jurisdiction was transferred to adult criminal court.

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

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

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

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

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

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

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

<sup>i</sup> Total number of unduplicated wards adjudicated for certain violent and serious felony crime categories per 2018 Juvenile Court and Probation Statistical System data.

<sup>ii</sup> All individuals between 10 and 17 years of age, inclusive, from the preceding calendar year.

<sup>iii</sup> The total of the number of youths adjudicated for a 707(b) that were not committed to an SYTF or the number of youths transferred from an SYTF to an LRP per Welf. & Inst. Code sec. 2200(g)(2) data submission from the counties to OYCR.

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

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

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

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

- Combining the number of youth eligible for an SYTF, but not committed to an SYTF, with the number of youth who are transferred from an SYTF to an LRP results in the number of youth transferred to LRPs having little impact on the overall funding formula.** The coalition states that “the number of youth who are eligible for an SYTF but for whom an alternative, less restrictive disposition is ordered is significantly higher than the number of youth who are committed to an SYTF and later transferred to an LRP. Because of this, the number of youth transferred to an LRP will have a marginal impact on the county allocation of funding and thus will not effectively incentivize the creation and use of LRPs.”
- Data Sources are Outdated.** The coalition recommends using the most updated data source, the data submitted pursuant to the 2024 Budget Act specified in WIC 2200(g), rather than Juvenile Court and Probation Statistical System (JCPSS) data, for accuracy.

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

- 40 percent based on Realignment Target Population*, with additional weighted funding for counties that use alternatives to incarceration.
- 30 percent based on Youth Population*, to ensure stability in year-to-year funding by considering the youth population (ages 12-17) in each county.
- 25 percent based on Youth Transferred to LRP*, to reward counties transferring youth from SYTF to LRPs, with a greater proportion of funds allocated to counties using community-based LRPs or LRPs that are not secure and therefore not subject to Title 15 regulation.
- 5 percent based on Investments in Community*, to reward counties that spend a minimum of 20 percent of their prior year JJRBG funds on community-based support for the Realignment Target Population.

A table summarizing the coalition’s recommendations is below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide an overview of OYCR’s proposed budget for 2025-26 and OYCR’s key activities, including the OYCR Ombudsperson and OYCR’s recent assumption of all juvenile justice grant administration.
2. Please describe OYCR’s proposal for the JJRBG formula revision. How does this proposal address the mandate to develop the formula in a way that improves outcomes for youth?
3. Please address concerns that have been raised by stakeholders about the Administration’s proposed JJRBG formula. Specifically: (A) How will the formula distinguish between LRPs that are based in the community versus LRPs attached to Juvenile Halls, Camps, or Ranches? (B) What is the intention of combining two factors (number of eligible youth not committed to an SYTF and number of youth transferred to an LRP) into one component of the formula?
4. How does the state track county spending of JJRBG funds? Specifically, (1) are counties fully spending their JJRBG allocations and (2) how are counties spending their JJRBG allocations?

**Issue 3: IT Enhancement Resource Shift to CalHHS**

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests CalHHS respond to the following:

1. Please provide a brief overview of this proposal.

**0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY**

**Issue 1: Overview**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Subcommittee Staff Comment**—This is an informational item.

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

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

**Issue 2: CSI Grant Program Reappropriation**

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

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

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

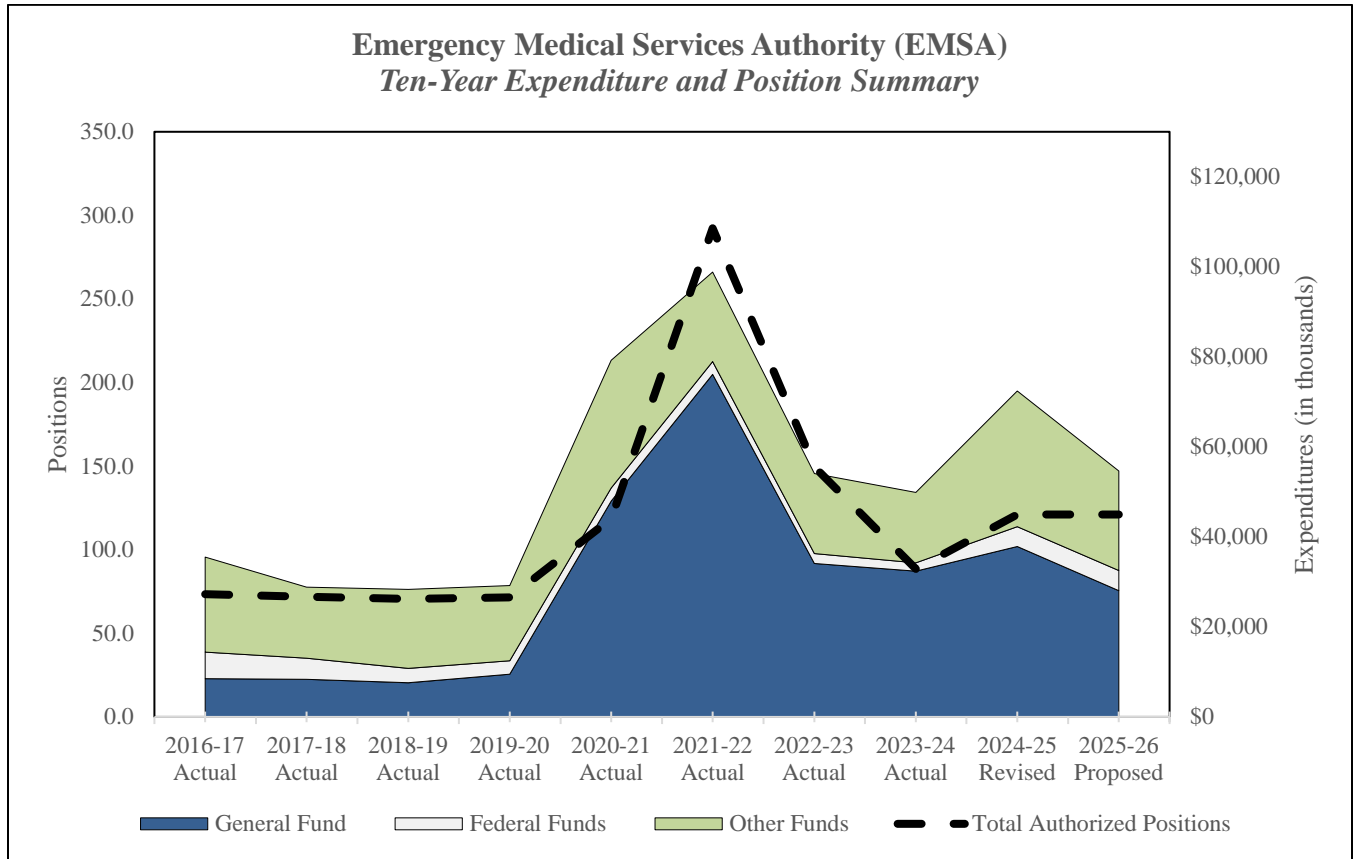
**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview this proposed reappropriation.

**4120 EMERGENCY MEDICAL SERVICES AUTHORITY**

**Issue 1: Overview**



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

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

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

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

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

**Subcommittee Staff Comment**—This is an informational item.

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

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

**Issue 2: Facility Cost Increase**

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

**4260 DEPARTMENT OF HEALTH CARE SERVICES**

**Issue 1: Civil Rights Compliance**

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

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

\* Positions and resources ongoing after 2026-27.

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

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

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

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

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

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

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

**Office of Civil Rights** – 12 positions

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

- **One SSM II** position would supervise the CRC program and LAP and act as a subject matter expert providing additional resources for complex and sensitive workload, develop policies and procedures to improve OCR responsiveness and reduce liability risks, provide guidance to DHCS programs to support civil rights compliance, supervise and manage CRC analysts working on complaints, grievances, and investigations.
- **Ten Associate Governmental Program Analysts (AGPAs)** would support CRC program workload including complaints, grievances, and investigations; manage Americans with Disabilities Act (ADA) coordination, alternative formats, contracts, language access, language taglines, translation services, and member inquiries.

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

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

1. Please provide a brief overview of this proposal.

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

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

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

\* Positions and resources ongoing after 2026-27.

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

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

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

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

**Local Government Financing Division** – Five positions

- **One Staff Services Manager I** position would provide leadership and staff supervision including recruitment, training and evaluation of staff, recommendations and disciplinary action, performance reports and appraisals, training, developing written protocols and procedures; assist in development of interagency agreements and other documents; present program issues and recommendations to senior leadership; and respond to inquiries or requests from stakeholders.
- **One Health Program Specialist I** position would serve as the primary subject matter expert, lead policy development, issue formal guidance, review processes for compliance, obtain and incorporate stakeholder feedback, serve as the primary DHCS liaison to state and local entities and organizations, lead communications, participate in meetings with the federal Centers for Medicare and Medicaid Services (CMS) regarding changes, and provide assistance in development of the Justice Involved Initiatives administrative services and procedures.
- **Three Associate Governmental Program Analysts (AGPAs)** would research, analyze, interpret, and apply applicable statutes, regulations, policies, and procedures, in preparation of interagency agreements or contracts and amendments for claiming federal matching funds, and to pay invoices related to the initiative’s administrative activities; conduct review and processing of invoices and claims; analyze documentation provided for qualifying services; facilitate claims for payments of federal funds to verify allowable activity requirements; provide assistance and resolve technical issues or questions during the review process; and provide follow-up on compliance of program guidelines.

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

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

1. Please provide a brief overview of this proposal.

**Issue 3: Population Health Management Reappropriation**

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this reappropriation proposal.

**Issue 4: California Electronic Visit Verification (CalEVV) Resources**

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

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

\* Positions and resources ongoing after 2026-27.

\*\* Reimbursements reflect transfer of federal matching funds from DHCS (see below).

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

\* Resources ongoing after 2026-27.

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

\* Positions and resources ongoing after 2026-27.

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

<sup>1</sup> 42 United States Code Subsection (f), added by 21<sup>st</sup> Century CURES Act (HR 34, 114<sup>th</sup> Congress, 2015-16)

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

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

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

**Electronic Visit Verification Phase II Programs**

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

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

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

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

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

**CDA** – Two positions

- **One Health Program Specialist I** position would serve as the EVV technical program consultant for Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP), develop CBAS and MSSP provider surveys to collect information to update data needs, represent the department at stakeholder meetings, provide backup for the EVV monitoring and compliance program, and support and review contracts and other documents.
- **One Associate Governmental Program Analyst (AGPA)** would be responsible for the EVV monitoring and compliance program for CBAS and MSSP, coordinate stakeholder meetings related to EVV policy, assist in developing and maintaining EVV policies and procedures, prepare and develop notices and other communications, respond to inquiries from the public, support and review contracts and other documents, and participate in user acceptance testing.

**DDS** – Two positions

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

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

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

1. Please provide a brief overview of this proposal.

**Issue 5: AB 186 SNF Workload Standards and Accountability Sanctions**

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

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

\* Positions and resources ongoing after 2026-27.

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

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

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

1. Established reimbursement rates based on an updated annual percentage increase with a separate budgetary growth limit of up to five percent for labor costs and two percent for non-labor costs.
2. Established a new Workforce and Quality Incentive Program (WQIP) under which facilities may earn directed payments.
3. Required, beginning in 2024, half of the annual reimbursement rate increase for non-labor costs to be allocated to base rates and half to increase Workforce and Quality Incentive Program payments.

4. Required DHCS, in consultation with stakeholders, to establish the methodology, parameters, and eligibility criteria for the directed payments, including milestones and metrics that network providers of SNF services must meet in order to receive a directed payment, with at least two of these milestones and metrics tied to workforce measures.
5. Authorized DHCS to sanction SNFs that do not meet the quality standards established by DHCS, in the amount of five dollars per Medi-Cal bed day, with a maximum of \$150,000, in a single rating period.
6. Required DHCS to establish workforce standards for 2024 through 2026, and make facilities that meet the workforce standards eligible to receive a base rate augmentation.
7. Authorized the workforce standards to include criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide multi-employer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders.

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

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

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

**Audits and Investigations** – Seven positions

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

**Office of Administrative Hearings and Appeals** – Three positions

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

**Office of Legal Services** – One position

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

**Quality and Population Health Management Division** – Three positions

- **One Staff Services Manager I** position would convene and engage with other DHCS divisions on determination of sanction targets, amounts, and process to recoup money due to sanctions; oversee performance and project completion performed by ASP staff; work with nursing staff in the Medical Monitoring Unit to evaluate each potential sanction case, provide technical assistance to impacted facilities and SNF advocacy groups, and assist internal departmental partners with any inquiries on the corrective action or sanction process; track cases as they move through the administrative hearing and appeals process and coordinate the collection process for sanctions that are not waived or appealed successfully; lead in engagement with external stakeholder meetings regarding the ASP, including tracking suggestions to inform any ASP refinements.
- **Two Associate Governmental Program Analysts (AGPAs)** would perform timely collection of data and reports monitoring SNF performance on clinical measures, equity measures and workforce standards to identify facilities at risk of sanctions; provide administrative support and collect and analyze SNF data from the contractor and managed care plans to develop benchmarks; schedule and provide technical and administrative support for internal DHCS and external stakeholder meetings; certify timely and effective SNF performance monitoring; report when sanction benchmarks have been triggered; coordinate communication with internal stakeholders on the determination of facilities that will be sanctioned; and facilitate communication between DHCS and the sanctioned SNFs, provide technical assistance to get these SNFs back into compliance, and take the lead for DHCS on any Disputes or Appeals resulting from SNF sanctions.

**Consultant Contracts** - \$250,000 annually

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

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

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

1. Please provide a brief overview of this proposal.

**Issue 6: PACE Growth and Expansion**

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

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

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

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

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

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

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

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

**Audits and Investigations** – Four positions

- **One Health Program Audit Manager (HPAM) I** position would manage and supervise audit staff, assign and review audit staff work, attend entrance and exit interviews with providers to aid in providing technical support for the audit findings, provide oversight and consultation with audit and other professional staff in the resolution of complex issues, maintain monitoring systems to measure the progress of assigned staff workload, develop and execute time budgets, prepare production reports, forecast personnel requirements, and develop budgeting requests and justifications.
- **One Health Program Auditor IV** position would contact contracted PACE organizations or affiliated locations to coordinate and schedule an audit for contract compliance, send documentation requests to the PACE organizations or affiliated locations and distribute the documentation received to appropriate team members, develop audit scope and request additional data from PACE organizations or affiliated locations, act as a team lead providing support to other team members during the audit, conduct interviews during onsite reviews, review work papers, write final audit reports, conduct exit conferences, and lead risk assessments.
- **Two Health Program Auditor III** positions would perform contract compliance audits of PACE organizations or affiliated locations, analyze documents and data received from the PACE organizations or affiliated locations, develop questions, address issues during onsite reviews, review any additional documentation for the development of findings, submit work papers and draft reports, and participate in entrance and exit conferences.

**Capitated Rates Development Division** – Four positions

- **One Staff Services Manager (SSM) I** position would provide direct supervision to staff, establish and monitor unit goals and objectives, oversee the quality and consistency of work, review and approve reports and proposed correspondence with PACE organizations, and work closely with other section managers to effectively coordinate workflow, procedures, and review standards.
- **Three Associate Governmental Program Analysts (AGPAs)** would collect, validate, analyze, and interpret PACE organizations' financial statements and other financial supporting documentation to evaluate fiscal soundness of PACE organizations; analysis and recommendation, policy and procedure development, and development and maintenance of reports compiling financial data across PACE organizations for management review; serve as financial liaisons for correspondence between the division and other DHCS divisions; and assist with coordinating policies and procedure regarding financial documents across DHCS divisions.

**Health Information Management Division** – Four positions

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

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

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

#### **Integrated Systems of Care Division** – 14 positions

- **One SSM III** position would serve as the Assistant Division Chief, focus on strategic planning and aligning PACE quality efforts with the larger Medi-Cal program, oversee the development of new processes and procedures aimed at maintaining PACE program integrity while working on process improvements, and utilize project management principles to plan, operate, and effectuate improvements in PACE planning and quality efforts.
- **One SSM II** position would supervise, support, and guide the team of PACE nurses dedicated to level of care evaluations for the PACE beneficiaries and the nurses dedicated to monitoring and oversight; supervise nurses in the day-to-day operations of PACE to plan, develop, implement, and monitor comprehensive quality assurance policies, procedures, strategies, and tools; monitor contractor compliance; establish and maintain priorities; apply and recommend changes in health regulations, policies, and procedures; and establish and maintain cooperative relations with a variety of governmental, educational, and provider entities.
- **Four Nurse Evaluator (NE) II** positions would support workload in the division. Three of the positions would review, validate, and document eligibility of Medi-Cal beneficiaries into PACE; authorize services for Medi-Cal beneficiaries enrolled in PACE; and maintain regular communication with PACE contractors and partners in the Center for Medicare and Medicaid Services. The other position would serve as the clinical subject matter expert in the new PACE Monitoring and Oversight Unit; provide clinical subject matter expertise in PACE related monitoring, oversight, technical assistance, and desk and onsite audits; and lead the development, execution, and follow-up of the clinical portions of corrective action plans, sanctions, and suspensions.
- **Seven AGPAs** would support workload in the division. Three of the positions would support contract management and provide technical assistance to PACE organizations; carry out a wide variety of consultative and analytical staff services on contract management; support assurance of compliance of policies and procedures relating to all aspects of contract management; provide subject matter expertise in contract and amendment development, technical assistance, enforcement of contract and waiver compliance, and the ongoing development of policies and procedures pertaining to contracts; and serve as resources for the division and upper management to verify that all policies and procedures are adhered to. Two positions would be exclusively assigned to the support of the PACE Nurse Evaluator II positions, informing the unit chief of current activities, assignments, projects,

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

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

#### **Office of Legal Services** – One position

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

#### **Quality and Population Health Management** – Six positions

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

- **One HPS I** position would collect and prepare data reports on quality measures, provide technical assistance to PACE organizations on quality improvement activities, and monitor improvement in response to enforcement actions when PACE organizations are not providing adequate quality of care.
- **One Medical Consultant (MC) II** position would provide clinical expertise in choosing quality measures and benchmarks, lead the efforts around public reporting of quality measures, participate in regular calls and meetings with DHCS divisions and external stakeholders, work with internal and external stakeholders to decide clinical quality measures for the PACE Organizations, and work towards formulating measurable goals to improve quality and health equity.
- **Two AGPAs** would coordinate the collection of measure data from PACE organizations and provide technical assistance to PACE organizations on measure reporting.

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

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

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

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

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

1. Please provide a brief overview of this proposal and the associated trailer bill language.
2. What is the expected average annual fee that would be imposed on PACE organizations, as a percent of annual capitation payments?

**Issue 7: Program Workload**

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

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

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

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

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

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

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

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

1. Established reimbursement rates based on an updated annual percentage increase with a separate budgetary growth limit of up to five percent for labor costs and two percent for non-labor costs.
2. Established a new Workforce and Quality Incentive Program (WQIP) under which facilities may earn directed payments.
3. Required, beginning in 2024, half of the annual reimbursement rate increase for non-labor costs to be allocated to base rates and half to increase Workforce and Quality Incentive Program payments.
4. Required DHCS, in consultation with stakeholders, to establish the methodology, parameters, and eligibility criteria for the directed payments, including milestones and metrics that network providers of SNF services must meet in order to receive a directed payment, with at least two of these milestones and metrics tied to workforce measures.
5. Authorized DHCS to sanction SNFs that do not meet the quality standards established by DHCS, in the amount of five dollars per Medi-Cal bed day, with a maximum of \$150,000, in a single rating period.
6. Required DHCS to establish workforce standards for 2024 through 2026, and make facilities that meet the workforce standards eligible to receive a base rate augmentation.
7. Authorized the workforce standards to include criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff, payment of a prevailing wage for its direct and indirect care staff, payment of an average salary above minimum wage, participation in a statewide multi-employer joint labor-management committee of skilled nursing facility employers and workers, or other factors, as determined by the department in consultation with the stakeholders.

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

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

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

**Enterprise Technology Services** – Three positions

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

**Fiscal Deputy Director's Office** – Two positions

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

**Financial Management Division** – Eight positions

- **One SSM III** position would function as an Assistant Division Chief.
- **Five Associate Accounting Analysts (AAAs)** would support the following sections of the division: 1) Support Claims and Short Doyle Payables Section, 2) General Ledger & Non-Medi-Cal Grants Section, 3) Service Center and FI\$Cal Support Section, 4) Cash Flow & Cash Management Section, 5) Accounts Receivable and Cash Receipts Section.
- **Two AGPAs** would support the Budget Branch.

**Human Resources Division** – One position

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

**Integrated Systems of Care Division** – Resources equivalent to nine positions

- **Four AGPAs** would support CCT policy and programmatic guidance for the Lead Organizations (LOs) implementing services; review, organize, and manage the CCT LO application processes, revise and amend program reports and forms, and respond to CCT inquiries; review, analyze, and report program data via semi- and annual reports; and develop policy letters, issue papers, and perform liaison functions with state and federal partners.
- **Two Health Program Specialist (HPS) I** positions would develop and implement policies and strategies associated with the CCT program and serve as leaders or subject matter experts in both internal and external stakeholder workgroups; develop and review CCT deliverables and submit them to the applicable federal and state partners; and serve as a liaison between DHCS and the federal or grant funders.
- **Three Nurse Evaluator (NE) II** positions would conduct CCT enrollment activities which are based on a clinically based level of care assessment; partner with the LO's and Waiver Agencies to review documentation for all CCT transitions, provide TA, and clinically review treatment authorization requests (TAR); and contribute to the transition and sustainability efforts of CCT participants.

**Procurement and Contracting Division** – One position

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

**Program Data Reporting Division** – Resources equivalent to two positions

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

**Program Support Division** – One position

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

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

**Consultant Contracts** - \$3 million in 2025-26 and 2026-27

- **Medi-Cal Long-Term Care Reimbursement Act** - \$3 million (\$1.5 million LTC-QAF and \$1.5 million federal funds) in 2025-26 and 2026-27 would support the establishment of a consultative workgroup to develop a Comprehensive Value Strategy for Skilled Nursing Facilities (SNF) Services, to inform the reauthorization of the Medi-Cal Long-Term Care Reimbursement Act for dates of service on or after January 1, 2027, aligned with the following guiding principles:
  - Coordinating and integrating care through the Medi-Cal managed care system to provide whole-person care to members with institutional level-of-care needs and support the development of comprehensive Managed Long-Term Services and Supports (MLTSS).
  - Incentivizing and holding SNFs accountable for providing quality patient care in alignment and furtherance of DHCS's Comprehensive Quality Strategy.
  - Creating financial incentives for the appropriate delivery of care, including transitions from hospital settings to SNFs and from SNFs to Home-and Community Based Services (HCBS) settings.
  - Emphasizing the critical role of workforce as a key driver of quality patient care, and verifying facilities use Medi-Cal funds to provide fair compensation and benefits to workers.
  - Provisioning services economically and efficiently to support the financial sustainability and affordability of California's health care system.
  - Supporting equitable access to skilled nursing facility care, including in rural areas, and removing perverse incentives in resident admissions, transfers, and discharges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**SB 1131 (Gonzalez)**

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

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

\* Position and resources ongoing after 2026-27.

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

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

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

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

**SB 1289 (Roth)**

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

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

\* Positions and resources ongoing after 2026-27.

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

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

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

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

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

1. Please provide a brief overview of these proposals.
2. When can the subcommittee expect narrative descriptions of these and other proposals for department resources to implement chaptered legislation?
3. Please account for the discrepancies between the fiscal analyses provided to legislative fiscal committees in the previous legislative session, and the current staffing and resource requests for implementation of these bills.

**NOT FOR PRESENTATION****Issue 11: Proposals for Investment**

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

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

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

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

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

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

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

- **Equitable Compensation for Community Health Workers, Promotores, and Health Representatives (CHW/P/R).** A coalition of community organizations and clinics, including the California Pan-Ethnic Health Network, the Children’s Partnership, and the Latino Coalition for a Healthy California, among others, request expenditure authority of \$15 million (\$10 million General Fund and \$5 million federal funds) in 2025-26 and \$10 million (\$5 million General Fund and \$5 million federal funds) annually thereafter. If approved, these resources would support an ongoing rate increase for community health workers, promotores, and health representatives (CHW/P/Rs), as well as one-time funding for streamlining billing and payment. According to the advocates, the 2024-25 state budget included a 22.2 percent increase in reimbursement rates for CHW/P/R services, raising the rate from \$26.66 to \$32.58 per half-hour visit. This increase was a critical step forward in ensuring fair compensation and supporting the long-term viability of the CHW/P/R workforce. However, the budget included trigger language, which eliminated this planned rate increase, the justification being that the state could no longer pay for the \$5 million increase as these funds would be encumbered by Proposition 35. However, the Governor’s budget proposes significant MCO tax revenues to support the Medi-Cal program and the general fund, not subject to Proposition 35. Specifically, the budget proposes \$7.985 billion in 2024-25, \$4.4 billion in 2025-26, and \$3.3 billion in 2026-27. As such, the modest investment in CHW/P/R rates should be maintained. To support the sustainability and scalability of critical CHW/P/R services, California must continue with the planned rate increase to complement the forthcoming grant program.
- **Restore Funding for ACEs Aware.** The Children’s Partnership and the First 5 Association of California request expenditure authority of \$50 million (\$25 million Behavioral Health Services Fund and \$25 million federal funds) annually. If approved, these resources would support restoration of the ACEs Aware initiative. According to the advocates, the ACEs Aware initiative was funded for three years and was not renewed in full for 2025-26 in the Governor’s January budget proposal. Instead, it only afforded a no-cost extension of \$5.4 million in remaining funds.

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

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

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

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

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

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

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

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

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

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

- **Medi-Cal Reimbursement for Community Paramedicine, Triage to Alternate Destination, and Mobile Integrated Health Programs.** The California Professional Firefighters request annual General Fund expenditure authority of \$5 million. If approved, these resources would support Medi-Cal reimbursement for community paramedicine, triage to alternate destination, and mobile integrated health programs, pursuant to SB 1180 (Ashby), Chapter 884, Statutes of 2024. According to the advocates, SB 1180 provided a structure for health plans, including Medi-Cal, to reimburse for services provided by community paramedicine, triage to alternate destination and mobile integrated health programs as they were not previously a reimbursable service. The provisions that apply to health plans regulated by DMHC and DOI go in to effect on July 1, 2025. The section that requires Medi-Cal to reimburse for these services are contingent upon a state appropriation to implement that section. This request would provide the state appropriation for this purpose.
- **Medi-Cal Benefit for Housing Support Services.** The Western Center on Law and Poverty and the Corporation for Supportive Housing request expenditure authority of \$350,000 (\$175,000 General Fund and \$175,000 federal funds) in 2025-26, \$26.6 million (\$9.3 million General Fund and \$17.3 million federal funds) in 2026-27, and \$52.9 million (\$18.5 million General Fund and \$34.4 million federal funds) annually thereafter. If approved, these resources would support establishment as a Medi-Cal state plan benefit the housing transition navigation services, housing deposits, and housing tenancy sustaining services currently offered as community supports under the California Advancing and Innovating Medi-Cal (CalAIM) program. According to the advocates, Californians experiencing chronic homelessness die 20 to 30 years younger than their housed counterparts with similar conditions. Studies over the last 30 years prove housing support services allow Californians experiencing homelessness to exit homelessness for good, to improve their health conditions, and to decrease hospital admissions, emergency department use, and nursing home referrals. Access to these services reduces spending on acute care, avoiding future costs of over \$46,000 per person per year. These services have been historically underfunded and unavailable to the majority of Californians experiencing homelessness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APRIL 3, 2025

# Child Care Funding Rates and Transition to an Alternative Methodology

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PRESENTED TO:

Senate Budget and Fiscal Review Subcommittee No. 3  
On Health and Human Services  
Hon. Akilah Weber Pierson, Chair



LEGISLATIVE ANALYST'S OFFICE

# State's Existing Child Care Rates

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## State Has Historically Used Two Different Provider Rates

- **Standard Reimbursement Rate (SRR).** A fixed statewide rate (currently \$54.93 per day for child care programs and \$55.27 for State Preschool) that is annually adjusted based on a statutory cost-of-living adjustment. Historically, the SRR has been used to set rates for licensed child care centers that directly contract with the state. These providers must comply with Title 5 regulations that require stricter staffing ratios and staff qualifications.
- **Regional Market Rate (RMR).** A rate that varies by the county in which the child is served and is based on regional market surveys of a sample of licensed centers and family child care homes. The current rates are based on the 75<sup>th</sup> percentile of the 2018 market survey. RMR levels typically only increase when the state takes action to use a higher percentile of the survey or most recent survey.

## State Shifted Most Providers to the RMR in 2021-22

- The state increased rates for providers funded based on the RMR by shifting from the 75<sup>th</sup> percentile of the 2016 survey to the 75<sup>th</sup> percentile of the 2018 survey.
- The state also shifted direct contract providers to the RMR to the extent the RMR was higher than the SRR.



# State's Existing Child Care Rates

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*(Continued)*

## **2023-24 Budget Included Temporary Cost of Care Plus Payments**

- Chapter 193 of 2023 (SB 140, Committee on Budget and Fiscal Review) codified the collectively bargained agreement between the state and Child Care Providers United (CCPU). To ensure parity across all child care and State Preschool providers, Chapter 193 also extended the collectively bargained provisions to non-represented, center-based child care and State Preschool providers. These provisions generally will expire on June 30, 2025.
- The agreement included monthly per-child payments that range from \$140 to \$211 for licensed providers, depending on provider region. These payments are to be made monthly from January 1, 2024 through June 30, 2025 and are in addition to the current provider rates.



# Alternative Methodology

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## State Began Development of an Alternative Reimbursement Rate Structure in 2021

- Chapter 116 of 2021 (AB 131, Committee on Budget) established two working groups to make recommendations for implementing a single child care reimbursement rate structure.
- The Department of Social Services (DSS), in consultation with the California Department of Education (CDE), convened a workgroup to assess the methodology for establishing a new reimbursement rate and quality standards. The workgroup was to include a range of child care stakeholders and was required to provide recommendations by August 15, 2022.
- The state and CCPU established a Joint Labor Management Committee (JLMC) to make recommendations for a single reimbursement rate structure that addresses quality standards for equity and accessibility while supporting positive learning and developmental outcomes for children. The JLMC was required to provide its recommendations to the Department of Finance by November 15, 2022.

## Alternative Reimbursement Rate Structure to Consider Provider Costs, Not Market Rates

- Intended to include a base rate that incorporates various cost elements, such as mandatory staffing ratios and group sizes, employee salaries, administration, training, and support for dual language learners.
- Also to include an enhanced rate that incorporates the costs of extended evenings and weekends, child transportation, and additional support for children with disabilities.



# Time Lines for New Rate Structure in State Law

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## Specific Milestones for Alternative Reimbursement Rate Structure

- **July 1, 2023.** DSS must begin the process of data collection and analysis for the alternative methodology, consulting with CDE and aligned with the recommendations of the JLMC.
- **February 15, 2024.** DSS, in collaboration with CDE and the JLMC, shall define the elements of the base rate and any enhanced rates. These elements shall be subject to the public engagement state plan process and legislative review.
- **July 1, 2024.** DSS shall submit support for the alternative methodology to the federal government in the state's Child Care and Development Fund state plan. The department shall provide a copy of this plan to the Legislature by July 10, 2024.
- **July 1, 2025.** The state must set new reimbursement rates under the alternative methodology. If rates are not ready to implement, DSS must submit a transition plan to the Legislature. The new reimbursement rates shall not be reduced from the rates previously in effect, including the one-time monthly cost of care plus rates that were part of the most recent collectively bargained and parity agreement.

## State Law Sets Specific Reporting Requirements for DSS

- From October 1, 2024 through January 1, 2026, DSS must provide quarterly updates to the Legislature on the implementation of the new reimbursement rates.
- Within 60 days of federal approval of the single rate structure using the alternative methodology in the state plan, DSS, in collaboration with CDE, must provide the Legislature with a report that outlines the implementation components for the approved single rate structure. The state received federal approval on November 8, 2024. The department issued its report on January 7, 2025.



*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, April 3, 2025**  
**9:30 am, or upon adjournment of session**  
**1021 O Street – Room 1200**

Consultant: Elizabeth Schmitt

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*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.*

**5180 DEPARTMENT OF SOCIAL SERVICES (CDSS)**

**Issue #1: Child Care Overview**

**Governor’s Budget—Child Care and Development.** The Governor’s 2025-26 budget includes \$6.4 billion (\$4.6 billion General Fund) for CDSS child care programs. This represents a net increase of \$287.8 million from the Budget Act of 2024. The following chart, provided by the Legislative Analyst’s Office (LAO), summarizes the total child care budget. Note the LAO chart below includes funding for the Child and Adult Care Food Program (\$683.1 million in 2025-26), which accounts for the difference between the CDSS child care total fund amount (\$6.4 billion) compared to the LAO child care total fund amount in the chart below (\$7.1 billion).

Figure 3

**Child Care Budget**

(Dollars in Millions)

	2023-24 Revised <sup>a</sup>	2024-25 Revised <sup>b</sup>	2025-26 Proposed <sup>b</sup>	Change From 2024-25	
				Amount	Percent
<b>Expenditures</b>					
<b>CalWORKs Child Care</b>					
Stage 1	\$550	\$588	\$602	\$14	2%
Stage 2 <sup>c</sup>	420	546	599	53	10
Stage 3	559	541	524	-17	-3
<b>Subtotals</b>	<b>(\$1,530)</b>	<b>(\$1,675)</b>	<b>(\$1,725)</b>	<b>(\$51)</b>	<b>(3%)</b>
<b>Non-CalWORKs Child Care</b>					
Alternative Payment Program	\$2,028	\$1,990	\$2,052	\$61	3%
General Child Care <sup>d</sup>	1,255	1,495	1,594	99	7
Bridge program for foster children	94	107	94	-14	-13
Migrant Child Care	70	79	80	2	2
Care for Children With Severe Disabilities	2	2	2	—	6
<b>Subtotals</b>	<b>(\$3,449)</b>	<b>(\$3,673)</b>	<b>(\$3,822)</b>	<b>(\$149)</b>	<b>(4%)</b>
<b>Support Programs</b>	<b>\$1,578<sup>e</sup></b>	<b>\$1,929<sup>f</sup></b>	<b>\$1,523<sup>g</sup></b>	<b>-\$407</b>	<b>-21%</b>
<b>Totals</b>	<b>\$6,557</b>	<b>\$7,276</b>	<b>\$7,070</b>	<b>-\$207</b>	<b>-3%</b>
<b>Funding</b>					
Proposition 98 General Fund <sup>h</sup>	\$3	\$2	\$1	-\$1	-37%
Non-Proposition 98 General Fund	3,173	4,189	4,609	420	10
Proposition 64 Special Fund	270	642	202	-440	-69
Federal	3,111	2,443	2,257	-186	-8

<sup>a</sup>Reflects 2024-25 May Revision estimates with LAO adjustments.

<sup>b</sup>Reflects 2025-26 Governor’s budget.

<sup>c</sup>Does not include \$11.2 million provided to community colleges for certain child care services.

<sup>d</sup>Includes funding for family child care home education networks.

<sup>e</sup>Includes cost estimates for quality programs, child care infrastructure, Child and Adult Care Food Program, Child Care Providers United Retirement Benefit Trust, accounts payable, Whole Child Community Equity, court cases, and costs associated with 2023-24 memorandum of understanding (MOU) and parity agreement.

<sup>f</sup>Includes cost estimates for quality programs, Child and Adult Care Food Program, accounts payable, Whole Child Community Equity, and costs associated with 2023-24 MOU and parity agreement.

<sup>g</sup>Includes cost estimates for quality programs, Child and Adult Care Food Program, accounts payable, and Whole Child Community Equity.

<sup>h</sup>Reflects Proposition 98 funds for Child and Adult Care Food Program.

The 2025-26 child care budget reflects increases due to the annualization of 2024-25 General Child Care and Development (CCTR) expansion awards, higher than previously projected caseload in CalWORKs Stages 2 and 3, and an anticipated COLA of 2.43 percent. The total increase is offset by the sun-setting of the current agreement with Child Care Providers United – California (CCPU) and policies outlined in SB 140 (Committee on Budget and Fiscal Review), Chapter 193, Statutes of 2023.

The Governor’s proposed 2025-26 budget includes \$698.5 million General Fund to continue supplemental monthly payments to providers adopted in the 2023 agreement between the state and CCPU, consistent with requirements related to the reimbursement floor established in the 2024 Budget Act. The current Memorandum of Understanding (MOU) with CCPU is set to expire on June 30, 2025, and collective bargaining regarding a successor MOU reconvened in late 2024.

The Governor’s revised 2024-25 budget includes \$6.5 billion (\$4 billion General Fund) for Child Care and Development Programs, which reflects a net increase of \$373.8 million from the Budget Act of 2024. The increase reflects the inclusion of the federal funds needed to support the 2024-25 CCTR expansion awards, higher than previously projected caseload in CalWORKs Stages 2 and 3, and an increase in projected costs associated with SB 140 monthly supplemental payments.

**Background: Child Care and Development Programs.** California provides subsidized child care to some low-income families, including families participating in CalWORKs. For low-income families who do not participate in CalWORKs, the state prioritizes based on income, with lowest income families served first. To qualify for subsidized child care: (1) parents demonstrate need for care (parents working, or participating in an education or training program); (2) family income must be below 85 percent of the most recent state median income (SMI) (\$89,659 annual income for a family of three) and (3) children must be under the age of 13.

The Department of Social Services (CDSS) provides child care and development programs through vouchers and contracts.

- **Vouchers (Also known as California Alternative Payment Program, or CAPP).** The three stages of CalWORKs child care and the Alternative Payment Program are reimbursed through vouchers. Parents are offered vouchers to purchase care from licensed or license-exempt caregivers, such as friends or relatives who provide in-home care. Families can also use these vouchers at any licensed child care provider in the state, and the value of child care vouchers is capped. The state will pay up to the regional market rate (RMR), a different amount in each county based on regional surveys of the cost of child care. Beginning in 2022, the RMR was set to the 75th percentile of the 2018 RMR survey. Alternative Payment agencies (APs), which issue vouchers to eligible families, are paid through the “administrative rate,” which provides them with 17.5 percent of total contract amounts.
- **Contracts (Also known as General Child Care, or CCTR).** Providers of General Child Care, Migrant Child Care, and State Preschool – known as Title 5 programs for their compliance with Title 5 of the California Code of Regulations – must meet additional requirements, such as development assessments for children, rating scales, and staff

development. Title 5 programs contract with, and receive payments directly from, CDSS or the Department of Education (CDE), for the California State Preschool Program (CSPP). All Title 5 programs also operate through family child care home education networks, which serve children in those programs through family child care homes that are members of the network.

Child care and early childhood education programs are generally capped programs, meaning that funding is provided for a fixed amount of vouchers and fixed funding amount for slots, not for every qualifying family or child. The exception is the CalWORKs child care program (Stages 1 and 2), which are entitlement programs in statute.

### Overview of Child Care Programs

Program	Description <sup>a</sup>
<b>CalWORKs Child Care</b>	Provides subsidized child care services to current and former CalWORKs families. Slots are available for all eligible families.
<b>California Alternative Payment Program</b>	Provides subsidized child care vouchers to eligible working families. Slots are limited by budget appropriation.
<b>General Child Care and Development</b>	Directly contracts with center-based and licensed family child care providers to serve working families eligible for subsidized care. Slots are limited by budget appropriation.
<b>Family Child Care</b>	Directly contracts with consortia of licensed family child care providers to serve working families eligible for subsidized care. Slots are limited by budget appropriation.
<b>Migrant Child Care</b>	Provides subsidized child care services to migrant families working in agriculturally related industries. <sup>b</sup> Services are provided throughout the Central Valley. Slots are limited by budget appropriation.
<b>Care for Children With Severe Disabilities</b>	Provides additional access to child care services for children under the age of 21 and with exceptional needs. <sup>c</sup> Program is located in the San Francisco Bay Area. Slots are limited by budget appropriation.
<b>Emergency Child Care Bridge</b>	Provides temporary child care services to children in foster care system and under age 13. Child care services are temporary until family finds longer-term child care solution. <sup>d</sup>

<sup>a</sup>Unless otherwise specified, child must be under age 13 and families must earn at or below 85 percent of the state median income to be eligible for subsidized child care programs. For example, a family of three must earn less than \$89,659 annually in 2024-25 to be eligible for programs.

<sup>b</sup>Family earned at least 50 percent of their total gross income from employment in fishing, agriculture, or agriculturally related work during the 12 months immediately preceding the date of application for services.

<sup>c</sup>Child must have an individualized education program or an individualized family service plan issued through a special education program.

<sup>d</sup>Child care services provided up to 12 months, but may be extended for a compelling reason.

Source: LAO

**Background: Child Care Funding.** The state’s subsidized child care programs are primarily funded with state General Fund (\$4.6 billion in 2025-26), with a substantial portion of costs also covered by federal Child Care and Development Fund (CCDF) (\$2.3 billion in 2025-26). The state uses federal Temporary Assistance for Needy Families/Title XX funds to partially cover CalWORKs child care costs. Additionally, the state draws down federal Title IV-E funds to partially cover Emergency Child Care Bridge program costs—referred to as the Bridge program, for children in foster care. The state also uses some Proposition 64 funding to cover child care programs.

**Background: Collective Bargaining.** In 2019, Governor Newsom signed legislation granting collective bargaining rights to child care providers in California, allowing them to negotiate with the state over matters related to the recruitment, retention, and training of family childcare providers. Child Care Providers United - California (CCPU) represents voucher and direct contract providers that are family child care homes, or license-exempt home providers known as Family, Friend, and Neighbor (FFN) providers. CCPU does not represent center-based child care providers. In 2021, CCPU and the state negotiated their first Master Contract Agreement, which included rate increases, provider stipends, hold harmless policies, and a variety of other supports. In addition, the contracts included a process for continuing conversations through Joint Labor Management Committees on a single reimbursement rate system, and other provider needs such as retirement, and healthcare, among other topics. The 2023 Budget Act included ratification of a second CCPU collective bargaining agreement, with parity provisions for child care centers (described below).

**Slot Expansion Plan.** As part of the 2021 Budget Act, the Governor and the Legislature agreed to increase the number of child care slots by 206,500 across CAPP (142,620 slots), CCTR (62,080 slots), CMAP (1,300 slots), and Emergency Child Care Bridge (500 slots). Initially, these new slots were expected to be fully rolled out by 2025-26. The 2023 Budget Act delayed the slot expansion plan by one year. The 2024 Budget Act contained an additional partial delay, but preserved an approximately 11,000 new CCTR slots for which preliminary award letters had been issued. The 2024 Budget Act also codified the revised slot expansion plan, adjusting for slots that had planned but unawarded or unfilled in prior years. Trailer bill language establishes the slot expansion plan, with future slot increases subject to appropriation.

## State’s Multiyear Child Care Expansion Plan

*Number of New Child Care Slots by Year*

Program	2021-22 Through 2024-25	2025-26	2026-27	2027-28	Totals
General Child Care	33,000	—	12,000	17,000	62,000
Alternative Payment	95,000	—	32,000	16,000	143,000
Migrant Alternative Payment	1,300	—	—	—	1,300
Emergency Child Care Bridge	500	—	—	—	500
<b>Totals</b>	<b>129,800</b>	<b>—</b>	<b>44,000</b>	<b>33,000</b>	<b>206,800</b>

Source: LAO

Prior to the 2021 Budget Act, the state funded approximately 100,000 non-CalWORKs child care slots. Including the expanded slots that have been funded, the state funds a total of 237,374 slots in 2025-26 (390,714 slots when including CalWORKs slots). The total cost of all slots added as part of the slot expansion is \$1.9 billion in 2025-26.

The 2024 Budget Act also included trailer bill language to streamline contracting for existing CCTR providers to take up newly added slots. CDSS implemented this provision in October 2024 to distribute 1,133 unawarded CCTR slots and will continue using the streamlined process moving forward to decrease the administrative burden on CCTR contractors.

**2023 Budget Act Rates Package.** The 2023 Budget Act included over \$2 billion to implement a two-year, collectively bargained agreement between the state and Child Care Providers United (CCPU.) The 2023 two-year package consists primarily of monthly per-child rate supplements (ranging from \$140 to \$210 per child per month), and includes funding for one-time transitional payments, CCPU health, retirement, and training programs, reimbursement based on certified need, and a change in the part-time definition. The package includes parity for center-based child care providers who are not represented by CCPU.

The 2023 Budget Act and CCPU agreement also included an agreement to shift from a market-based approach to a cost-based approach (known as the alternative methodology or single rate structure) for setting child care reimbursement rates. Rate reform is covered in Issue #2 of this agenda.

**Monthly Rate Supplements Established in 2023 Became Rate “Floor” in 2024.** While the two-year, collectively bargained agreement expires on June 30, 2025, the 2024 Budget Act included trailer bill language that set the rates in effect on June 30, 2025 as the floor for future rates. As a result, the Governor’s proposed 2025-26 budget includes \$698 million General Fund to continue the same amount of supplemental funding in 2025-26. This is effectively a placeholder amount as the state is currently bargaining with CCPU on a successor agreement to the two-year 2023 agreement.

**Child Care Unspent Funds.** The 2023 Budget Act included supplemental reporting language requiring CDSS to report to the Legislature with estimates of the amount of child care and development funding appropriated in the prior or current fiscal year that may go unspent by the end of the current fiscal year, including funding not yet allocated or committed in contracts. This was intended to maximize utilization of limited-term federal funding provided during the pandemic. CDSS has reported that \$1.3 billion in 2023-24 child care funds have not been spent, however this includes some multi-year funding that has a longer expenditure window. CDSS reports having accounted for approximately \$1.1 billion in unspent funds as savings in the 2023-24 fiscal year.

**Child Care Cost-of-Living Adjustment.** The Governor’s budget includes a 2.43 percent cost-of-living adjustment (COLA) for child care programs; however, the COLA is applied differently across program types. In 2023-24 and 2024-25, the state suspended the statutory COLA and instead used the funding associated with the COLA to support the two-year collectively bargained rate package.

- *COLA for Direct Contract Providers.* For direct contract (CCTR) child care providers, statute requires an annual COLA for providers whose reimbursement rate is the standard reimbursement rate (SRR), but not for providers whose reimbursement rate is the regional market rate (RMR). However, as part of changes in the 2021 Budget Act, most direct contract providers moved to the RMR, meaning these providers would not receive the Governor’s proposed 2.43 percent COLA. The Governor’s proposed budget includes \$37.9 million for the 2.43 percent COLA to the SRR.

The LAO has noted that the current COLA policy for direct contract providers effectively prioritizes rate increases for lower cost counties. According to the LAO, “prior to 2021-22, when the SRR was the only reimbursement structure for direct contract providers, providing a COLA was a reasonable way to adjust rates to ensure the state was adequately covering provider costs. However, under the state’s current approach—where direct contractors get the higher of SRR or RMR rates—the only providers that receive an annual COLA are those with rates that are higher than the 75th percentile of what private child care providers in their county charge based on the 2018 market survey. For example, in 30 of the 42 counties where direct contractors are currently funded on the SRR and receive an annual COLA, the SRR is higher than the 90th percentile of the regional market rate for four-year olds in full-time care.”<sup>1</sup> The LAO recommends repealing the statutory COLA for providers receiving the SRR and allowing the rates for these providers to be set at the discretion of the Legislature.

- *COLA for Voucher-Based Programs.* For Alternative Payment (AP) agencies, which administer voucher-based programs, the statutory COLA is applied based on the total amount of funding appropriated for voucher-programs from the past year (this includes funding for direct child care payments administered by AP agencies and the AP agency’s support and operational costs). The Governor’s proposed 2025-26 budget includes \$49.6 million General Fund for the 2.43 percent COLA for voucher-based programs.

The LAO notes that this COLA approach for voucher-based programs is similarly worth revisiting. According to the LAO, “providing a statutory COLA to AP agencies’ operational costs is reasonable, as these agencies face inflationary cost pressures in administering voucher-based child care programs. However, there is no clear rationale for applying a COLA to the portion of funding that covers child care provider payments as these payment amounts are typically adjusted through other mechanisms in the state budget. For example, rates are set in statute and, when the Legislature has increased rates in the past, it has provided associated increases in funding to address the higher costs. Also, payments are adjusted when the state provides additional funding for new child care slots as part of the annual budget. As a result, under the current COLA structure—where it is applied to the entire AP agency allocation, rather than only the portion related to operational costs—the amount of COLA funding likely exceeds the amount that is needed to cover inflationary cost increases.”<sup>2</sup>

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<sup>1</sup> Legislative Analyst’s Office, “The 2025-26 Budget: Child Care and State Preschool,” March 28, 2025.

<sup>2</sup> LAO.

**Reimbursement Flexibility.** As noted by the LAO, prior to the COVID-19 pandemic, reimbursement for direct contract providers was based partly on child attendance.<sup>3</sup> For voucher-based programs, reimbursement was also based on child attendance. Since the pandemic, however, the state has provided all child care providers with reimbursement flexibility, also known as “hold harmless” (as providers are not penalized financially for a child’s absence.) This reimbursement flexibility continues through June 30, 2025 as part of the 2023 Budget Act rates package. For voucher-based programs, this means reimbursement is based on a child’s enrollment, similar to the private market. For direct contract programs (CCTR), however, the flexibility allows providers to receive the lesser of their reimbursable program costs or the maximum reimbursable amount under their contract. According to the LAO, for direct contract providers, this reimbursement flexibility disconnects funding from program attendance. As a result, the LAO recommends allowing the reimbursement flexibility to expire, only for direct contract providers.

**New Federal Rule on Reimbursement Policies.** A recent federal rule (45 CFR Part 98.45(m)(2)), effective April 30, 2024, requires states to modify child care reimbursement policies to be based on enrollment rather than attendance. The intention is to recognize the fixed costs of providing child care by delinking provider payments from a child’s occasional absences. Specifically, the federal rule requires states to establish payment practices that reflect generally accepted payment practices of child care providers that serve non-subsidized children, including basing payments on a child’s authorized enrollment.

The Governor’s budget assumes that the current “hold harmless” reimbursement flexibility policies for both direct contract and voucher-based programs will expire on June 30, 2025, in alignment with the 2023 Budget Act and CCPU agreement. This effectively means returning both programs to an attendance-based reimbursement method, which is not consistent with the recent federal rule.

For direct contract providers, because the current reimbursement flexibility is partly based on the maximum contract amount, there would be no additional cost to the state to move to an enrollment-based approach. An enrollment-based approach would be consistent with the federal rule, but avoid some of the pitfalls noted by the LAO about the current reimbursement flexibility. For voucher-based programs, however, there would be a cost (approximately \$88.5 million) to continue the current enrollment-based reimbursement. CDSS states that reimbursement flexibility for voucher-based programs is subject to ongoing collective bargaining with CCPU.

### **Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview on the Governor’s proposed 2025-26 budget for CDSS child care and development programs. Please include an update on the expansion of child care slots, including the new slots added pursuant to the 2024 Budget Act.
2. Please provide an overview of the unspent child care funds from 2023-24 reported to the Legislature. What is the total General Fund savings from unspent child care funds in 2023-24 assumed in the Governor’s proposed budget?

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<sup>3</sup> LAO

3. How does the Administration plan to implement the 2024 federal rule *Improving Child Care Access, Affordability, and Stability in the Child Care and Development Fund*, which requires states to pay child care providers prospectively and based on child enrollment?

**Issue #2: Child Care Rate Reform Update**

**Panel Discussion.** The Subcommittee has invited the following individuals to participate in this discussion:

- Edgar Cabral, Deputy Legislative Analyst, Legislative Analyst’s Office
- Jackie Barocio, Central Operations Branch Chief, Child Care and Development Division, CDSS
- Eric Sonnenfeld, Assistant Administrator, Tulare County Office of Education
- Miren Algorri, Child Care Provider’s Union (CCPU)
- Adriana Pucheta Caixba, Parent Leader, Parent Voices California

**Background: Child Care Rate Reform and Collective Bargaining.** California has taken steps over the last several years to revise the way the state sets reimbursement rates for subsidized child care, moving from a market-based rate model (RMR) to a cost-based model intended to capture the “cost of care.” The 2023 Budget Act, as part of the two-year, collectively bargained rates package, codified the state’s commitment to conducting an alternative methodology for setting child care rates, based on a cost-estimation model. The 2023 Budget Act also established a series of planning and reporting milestones to track the state’s progress toward developing and implementing the cost-based model, including federal approval.

On November 8, 2024, the federal Administration for Children and Families (ACF) approved California’s Child Care State Plan, inclusive of the new cost-based method for setting reimbursement rates, known as the “single rate structure.”

Federal approval initiated several steps for the Administration. First, CDSS is required to regularly report to the Legislature on the department’s plan to set new reimbursement rates by July 1, 2025, and provide details regarding costs, timelines, and other implementation details.

Second, federal approval of the state plan initiated a new round of collective bargaining between the Administration and Child Care Providers United (CCPU), which is ongoing.

CDSS has stated that rate-setting for family child care providers will occur through the collective bargaining process with CCPU, however that does not include the center-based providers not represented by CCPU. CDSS has stated that rate-setting for center-based providers not represented by CCPU will occur in partnership with the Legislature as part of the 2025-26 budget development process, concurrent with collective bargaining.

**2024 Budget Act.** The 2024 Budget Act included trailer bill language to codify federal commitments that CDSS has made to the federal Administration for Children and Families (ACF); primarily, the commitment to set new reimbursement rates for subsidized child care pursuant to the new single rate structure by July 1, 2025. Additionally, the 2024 Budget Act set current rates, including the temporary rate supplements providers are receiving, as the floor for the new single rate structure. This is to ensure that when rate reform is implemented, providers will have certainty that their new rates at a minimum will not drop below what they currently receive. In addition, the 2024 Budget Act outlines a series of reporting requirements to provide the Legislature with an understanding of the costs and timelines associated with the new single rate structure.

**2025-26 Governor’s Budget.** The Governor’s proposed 2025-26 budget meets the requirement from the 2024 Budget Act to continue the temporary rate supplements for an additional year, consistent with the rate floor established in the 2024 Budget Act. However, the Governor’s budget does not include any funding or plan for implementing the new single rate structure in the 2025-26 fiscal year.

**January Implementation Report.** On January 7, 2025, CDSS submitted the first quarterly report to the Budget Committees on single rate structure implementation progress.<sup>4</sup> The report summarizes some decisions regarding the single rate structure that have been made:

**Table 2. Proposed Single Rate Structure Decision Point Summary**

	Decision Points To-Date	Remaining Decision Points
Base and Enhanced Rate Elements	Rate elements identified and defined for all provider/program types.	
Cost Model Selection Points	No recommendation made to date	To be set through the bargaining process for family child care providers. To be set for centers by the Administration in partnership with the Legislature
Design Features of the Single Rate Structure	Informed by costs associated with health and safety standards and other program requirements. Base and enhanced rates will be calculated on a per-child basis. Enhanced rates reimburse services not funded through the base rate, contingent upon eligibility. Rates will vary by geography. Rates will vary by type of care setting. Rates will vary by regulatory requirements. Rates will vary based on time categories. Rates will vary by child age.	Geographical variation categories. Specific time categories. Child age groupings. To be set for centers by the Administration in partnership with the Legislature.
	Decision Points To-Date	Remaining Decision Points
Indirect and Support Services Cost Structure for Contractors	No recommendation made to date	To be established by the Administration in partnership with the Legislature, separate from direct services rate and not subject to the bargaining process.

<sup>4</sup> “Implementation of the Single Rate Structure for Subsidized Child Care and Preschool,” January 7, 2025: [Implementation of the Single Rate Structure for Subsidized Child Care and Preschool - Report to the Legislature](#)

The Implementation Report lays out the base rate and enhanced rate elements that provide the cost-based inputs for the single rate structure, which have been agreed upon with CCPU, as follows:

**Base Rate Elements.**

- *Administration/Office:* Covers costs such as advertising, insurance, legal and professional fees, office supplies, repairs, maintenance, and janitorial.
- *Child Health:* Covers activities related to supporting child health, including costs associated with meeting licensing requirements, such as collecting and keeping records of child immunizations.
- *Child Education and Development:* Covers additional costs above and beyond the basic Education Program costs, including educational materials and curriculum, developmental screening and assessment tools, development specialists, and special activities for children.
- *Discretionary Benefit - Health, Employer Share:* Funds that can be flexibly deployed to cover the employer share of benefit costs such as health insurance expenses, retirement contributions, and other discretionary benefits.
- *Discretionary Benefit - Paid Time Off:* Including sick leave and vacation benefits.
- *Dual Language Learner Supports:* Covers costs associated with serving dual language learners and their families effectively, such as linguistically and culturally appropriate educational materials, translation, lesson plan resources, and books/materials in multiple languages.
- *Education Program:* Covers basic program supplies such as diapering supplies, regular updating of emergency supplies/kits, fire extinguishers, and food.
- *Family Engagement:* Supports required and expected family engagement activities, including but not limited to family conferences or conference equivalents.
- *Inclusion:* Covers expenses within the base rate related to serving a specific share of children with developmental delays, disabilities, and other special needs.
- *Mandatory Expenses Related to Staffing:* Covers non-discretionary employer taxes including FICA payroll tax, Social Security, Medicare, unemployment insurance, and worker's compensation.
- *Occupancy:* Covers facility-related costs such as rent/lease or mortgage, real estate taxes, maintenance, janitorial and repairs.
- *Operating Reserve:* Covers contributions to an annual operating reserve fund.

- *Planning Time*: Covers planning and release time for teachers, assistant teachers, child care providers, and owners.
- *Ratios and Group Size*: maximum number of children for whom care may be provided at any one time.
- *Salary/Wage/Income*: adequate and appropriate compensation (including wage scales that set a living-wage floor that account for job roles, experience and education levels).
- *Staffing Pattern*: Covers the cost to maintain a setting-specific standard staffing pattern.
- *Training*: Covers the cost of hiring a substitute to cover for staff while they attend professional trainings.

**Enhanced Rate Elements:**

- *Inclusion*: Covers expenses related to serving children with developmental delays, disabilities and other special needs, when the share of children served exceeds the share covered through the Base Inclusion rate.
- *Extended Evenings/Weekends*: Covers additional costs associated with providing care during non-traditional hours.
- *Child Transportation*: Covers the cost of year-round transportation services between schools and activities, children's homes and providers' facilities/homes when necessary to support families.

**Legislative Concerns with January Implementation Report.** The January Implementation Report does not contain the level of detail required by statute. To fulfill a statutorily required 30-day review period, the Legislature provided feedback to the Administration via a Joint Legislative Budget Committee (JLBC) letter.<sup>5</sup> The JLBC response to the January Implementation report is summarized below:

1. **Missing estimated costs and timelines for rate reform implementation.** WIC 10227.6(g) requires the Administration provide estimated costs and timelines associated with implementation of the single rate structure. The Implementation Report does not contain any estimated costs associated with the base rate, possible selection points, design features, and enhanced rate elements.

The Legislature has requested the Administration provide a range of estimated costs associated with each element of the single rate structure.

Regarding estimated timelines, the Implementation Report states that a "period of time" will be required before implementation. To meet the requirements of WIC 10227.6(g), the Legislature has requested specific time ranges or dates for when the new single rate

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<sup>5</sup> JLBC Response: Comments on the Child Care Alternative Methodology: [Section Letter](#)

structure can be implemented. (Importantly, even if the Legislature and Governor meet the July 1, 2025 deadline for *rate-setting*, any new rates need to be funded in the budget and then implemented in order to take effect.)

2. **Unclear data and systems requirements.** The Implementation Report states that the implementation timeline is dependent on the systems changes and data collection required by the single rate structure. The Implementation Report also characterizes these systems changes and data collection requirements as unknown factors that could significantly impact the implementation timeline. Given that the elements of the base rate and enhanced rates have been defined, agreed upon by the JLMC, and listed in the Implementation Report, the Administration has had time to develop an estimated range of costs associated with new data and systems requirements. In addition, many data points are captured in current systems utilized by CDSS and CDE.

The Legislature has requested the Administration provide clarity on which specific elements of the single rate structure would require significant modifications to current data collection systems.

3. **Lack of plan for developing the center-based rate in partnership with the Legislature.** The Implementation Report states that rate-setting for center-based providers will occur “in partnership with the Legislature” concurrent with collective bargaining with CCPU for family home-based rates. However, neither the Implementation Report nor the Governor’s proposed 2025-26 budget includes a proposal for center-based rates, a timeline for a proposal, or a clear process for partnership in this policy development.

The Legislature has requested the Administration describe how they intend to partner with the Legislature to determine and implement center-based rates for the 2025-26 fiscal year, including a timeline for this engagement.

4. **Missing a plan to set new reimbursement rates under the single rate structure.** Statute requires that the report to the Legislature includes the department’s plan to set rates by July 1, 2025. Even if the rate model is completed and new reimbursement rates pursuant to the single rate structure are set by this deadline, it is not clear when those rates will actually be implemented for child care providers.
5. **Need for a Transition plan.** WIC 10227.6 states that if the new rates do not take effect on July 1, 2025, CDSS must provide the Legislature with a timeline for transitioning from current rates to the rates set using the single rate structure.

The Legislature has requested the Administration provide a transition plan by the Governor’s 2025 May Revision.

**LAO Comment.** As the LAO notes, “although CDSS is required to set rates based on the alternative methodology by July 1, 2025, the department’s time line for sharing the details with the Legislature is unclear at this time. It is possible that the Legislature will not have any information regarding the overall costs or key details of the alternative reimbursement rates prior to the constitutional deadline to pass a budget by June 15. Furthermore, even if the information is

released around the time of the May Revision or later, the Legislature would have only limited time to review the details of the alternative methodology and consider whether it would like to make changes to the structure for non-represented child care centers.”

**Subcommittee Staff Comment and Recommendation – Hold Open.** Subcommittee staff notes that the Administration provided responses to the JLBC letter on March 21, 2025.<sup>6</sup> However the department’s response continues to leave open fundamental questions about how the department will meet the July 1, 2025 deadline to set new reimbursement rates, when those new rates could feasibly be implemented, and what a temporary transition plan might entail. And while the state is currently collectively bargaining with CCPU on the rate structure for family-based providers, it is unclear how the Administration will partner with the Legislature to set rates for non-represented center-based providers, without the information that has been requested.

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

1. Please provide a range of costs associated with implementation of the single rate structure.
2. What specific steps will the department take between now and July 1, 2025 to meet the deadline for setting child care rates pursuant to the single rate structure? After rates are set, what is the timeline for implementing those rates?
3. WIC 10227.6(i) states that if the new reimbursement rates do not take effect on July 1, 2025, CDSS must provide the Legislature with a timeline for transitioning from the rates that are in effect on July 1, 2025, to the new rates under the single rate structure. The Joint Legislative Budget Committee has requested this transition plan be provided by the Governor’s 2025 May Revision. When does the Administration plan to provide this transition plan?
4. The January 2025 Implementation Report states that rate-setting for non-represented center-based providers will occur in partnership with the Legislature concurrent with collective bargaining with CCPU. Please describe how and when the Administration intends to partner with the Legislature to set and implement center-based rates.

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<sup>6</sup> <https://jtlegbudget.legislature.ca.gov/system/files/2025-03/dss-response-letter-to-jlbc-implementation-of-the-single-rate-structure-for-subsidized-child-care-and-preschool-3-21-2025.pdf>

**Issue #3: Child Care Budget Change Proposals**

**Budget Change Proposals – Governor’s Budget.** The Governor’s proposed 2025-26 budget contains the following two budget change proposals for child care and development under CDSS:

1. **Child Care Development Fund Authority.** CDSS requests a technical change to increase ongoing federal fund authority by \$34.4 million to support the Child Care Development Block Grant (CCDBG) program. There is no General Fund impact.
2. **Child Care Policy, Program, Administrative, and Support Staffing Needs.** CDSS requests 33 federally funded permanent positions and an increase in federal expenditure authority of \$6.4 million in 2025-26 and \$6.2 million ongoing to provide policy, program, and administrative support to child care and development programs.

Both proposals are summarized below.

**Child Care Development Fund Authority**

**Background: Child Care Development Fund (CCDF) Authority.** Prior to 2021-22, CDSS held an interagency agreement with the California Department of Education (CDE), which allowed CDSS to be reimbursed in the amount of \$34.4 million for managing the CCDF award on behalf of CDE. CDSS took over the CCDF grant from CDE in 2021-22 but never established federal fund authority. For the past three fiscal years, CDSS has been submitting budget revisions annually and is now requesting ongoing federal fund authority to alleviate the need for ongoing requests.

**Federal Fund Authority Request.** According to CDSS, this ongoing authorization for CCDF federal fund authority would allow the department to use its federal funds without needing to wait for the reimbursement at the end of each fiscal year. This technical change has no General Fund impact.

**Child Care Policy, Program, Administrative, and Support Staffing Needs**

**Background: CCDF and Child Care Transition.** Over the past three years, the federal CCDF allocation, which is managed by CDSS, has seen substantial growth, with an 18 percent increase in 2022-23, a four percent increase in 2023-24, and a seven percent increase in 2024-25.

CDSS reports that staffing shortages are impeding efforts to support the expansion of the state’s child care and development system and to administer child care programs equitably. Consequently, the department’s child care division needs additional resources to manage the increased workload from new policies and programs generated by this additional federal funding and the expansion of child care programs, as well as accompanying administrative and support needs. CDSS reports needing additional staff to support the following responsibilities:

- **Data and Information Systems.** As a result of the transition of child care programs from CDE to CDSS in 2021, CDSS assumed responsibility for the administration of support services for legacy applications including the Child Development Management

Information System (CDMIS), which is used for federal reporting and compliance. Currently, CDMIS is housed at CDE; however, CDSS is developing a department-specific version of CDMIS. According to CDSS, there will be an increase in workload arising from the expanded scope of responsibilities.

- **Program and Policy Support.** According to CDSS, the department’s child care policy office needs more professional and administrative staff to manage its growing regulatory workload. The child care division also faces resource constraints in centralizing and administering audit response coordination and strategic governance. Lastly, the federal government has identified that the CDSS Community Care Licensing Division (CCLD) must come into compliance with several federal regulations, including consumer education, health and safety standards, and training requirements, including training for Shaken Baby Syndrome prevention, Pediatric First Aid, CPR, and handling hazardous materials. Emergency and disaster preparedness standards also require updates to meet federal requirements.
- **Provider Bargaining Support.** According to CDSS, additional resources are necessary to effectively implement provisions of the collective bargaining agreements with Child Care Providers United (CCPU). CDSS states that the vision of moving to a cost-based, single rate structure requires dedicated specialist support in administering payment processes and procedures as a transitional step, as well as developing and implementing the alternative methodology.
- **Child Care Expansion.** According to CDSS, The Program Quality Improvement Branch (PQIB) has experienced a significant workload increase due to historic investments in child care. California was monitored in January 2024 by the federal Office of Child Care (OCC) and was found to be out of compliance with several health and safety regulations around annual inspections. To support ongoing compliance with the CCDF rules, CDSS needs additional staff within PQIB to develop and implement procedures to monitor and inspect 19,500 license-exempt family child care providers and 723 center-based providers annually, or risk fines or sanctions.

Additionally, CDSS has experienced a 30 percent increase in new child care contractors (111 new contractors) over the last three years due to the historic expansion of child care slots that began in 2021. CDSS states that limited staff resources have hindered the ability to conduct follow-up visits, essential for ensuring compliance and program quality. The PQIB is mandated to review contractors once every three years, or as resources permit; CDSS is experiencing significant challenges to meet this monitoring threshold and may be at risk of being out of compliance with the federal fiscal year 2025-27 State Plan because the number of consultants to support, monitor, and train contractors is currently insufficient. Programs that have several years in between contract monitoring visits have been found to have a higher number of program violations, which impact the quality of services. As the number of contractors increases, the number of reviews also increases.

Lastly, the Child Development Fiscal Services (CDFFS) Section also faces staffing and management shortages. This Section oversees 463 contractors with 753 contracts and

supports nearly 50,000 providers serving over 300,000 children. CDFS staffing and clerical support have not kept pace with the growth in child care contractors, leading to delays in payments and technical assistance. Additionally, outdated payment software from before the transition of programs to CDSS complicates the workload. Additional management and staff are needed to handle the growing demands effectively.

- **Administrative Support.** The CDSS Human Resources Services Branch is responsible for overseeing personnel processes for all departmental staff. According to CDSS, the typical ratio for Personnel Specialist to staff is 180:1; however, existing staffing in the branch is closer to 200:1.

Additionally, the Direct Services Contracts office is staffed with three analyst positions whose primary focus is to process thousands of contracts each year. CDSS states that with the increasing workload due to the expansion of child care slots, it is necessary to increase staffing to keep up with the demand and ensure acceptable turnaround times. The number of contract applications has increased from 397 to 490 (as of 2023-24) since the transition of child care programs to CDSS, and it is estimated to grow to over 600 in 2024-25. For example: in 2021-22, CDSS processed 1,897 contracts and amendments. In 2022-23, CDSS processed 2,451 contracts and amendments (29 percent increase). In 2023-24, CDSS processed 3,628 contracts and amendments (48 percent increase).

**Staffing and Resources Request.** CDSS requests a total of 33 permanent positions, federally funded by the CCDF block grant. The requested positions fall into the following categories:

- *Data Research and Planning Office (two positions).* The Research Data Analyst (RDA) II will manage and support the child care data collection process for CDSS-CDMIS. The Office Technician (OT) position will be responsible for providing organization and clerical support for office activities.
- *Policy Office (two positions).* These positions will help balance the workload of the team that is currently leading the regulation work and provide administrative support to the team responsible for planning, policy direction, and engagement with subsidized child care programs.
- *Operational (three positions).* These positions will create a new Grants Unit to oversee federally funded quality grants. One of the analyst positions is a current limited-term position the department is requesting to make permanent.
- *Audits and Strategic Governance (one position).* The Staff Services Manager I (Specialist) would work with other offices and divisions to collect data and develop administrative data practices, and implement business improvement through technology and software.
- *Equity and Tribal Liaison (one position).* This specialist will act as lead facilitator of the division's Equity Action Plan, lead coordinator on behalf of the child care division with the department's equity and tribal Resources, and lead representative within the division on child care issues that impact Tribes, in partnership with the Office of Tribal Affairs.

- *Child Care Provider Unit (two positions)*. These specialists would act as leads to implement various aspects of the collective bargaining agreements with CCPU. Without these specialist positions, CDSS risks failure to adequately implement negotiated provisions of the collective bargaining agreement. This could result in grievances or unfair practices claims that would require legal resources and potentially impede vital provider policy implementation.
- *Program Quality and Improvement (10 positions)*. These positions would inspect all eligible license-exempt providers and address training needs of newly awarded child care agencies.
- *Child Development Fiscal Services (eight positions)*. These positions will be responsible for training and technical assistance for new contractors, payment timeliness and systems maintenance, monitoring contract funds, and clerical and administrative support to facilitate high quality fiscal services. According to CDSS, these additional staff resources will allow for redirected analysts to return to an appropriately sized caseload to meet the expectations of timely technical assistance, communication, and payments, and also help CDSS comply with state policies regarding staff allocation per supervisor.
- *Administrative Support - Human Resources (two positions)*. A Staff Services Manager I and an additional analyst would provide relief in the processing of the division's recruitment packages, the participation in classification specification revisions currently underway, and the continued development of staff and organizational initiatives.
- *Administrative Support – Child Care Contracts Direct Services (one position)*. To continue to provide contracts and payments to child care providers in a timely manner, the workload needs to be broken down to a manageable level by increasing the number of analysts in order to reduce the risk of error.
- *Child Care Division Support for Community Care Licensing Division (one position)*. The Staff Services Manager I (Specialist) position will lead on legislative and regulatory revisions necessary to come into compliance with federal regulations. Additionally, this position would provide licensing expertise and guidance to division staff as they implement new requirements for license-exempt family, friend, and neighbor child care, including technical assistance to caregivers who need support to come into compliance.

**Table A: Child Care Policy, Program, Administrative, and Support Staffing Needs**

Position Description	Personnel Years
<b>Total Positions Requested</b>	<b>33.0 PY</b>
Office Technician – Data, Research, and Planning Office	1.0 PY
Research and Data Analyst II – Data, Research, and Planning Office	1.0 PY
Office Technician – Policy Office	1.0 PY
Child Development Consultant – Policy Office	1.0 PY
Office Technician – Central Operations Branch	1.0 PY
Associate Governmental Program Analyst – Grants Unit	1.0 PY
Staff Services Manager I – Grants Unit	1.0 PY
Staff Services Manager I (Specialist) – Child Care Administration Bureau (Audits & Strategic Gov.)	1.0 PY
Staff Services Manager I (Specialist) – Equity/Tribal	1.0 PY
Staff Services Manager I (Specialist) – Provider Unit	2.0 PY
Education Administrator I – Program Quality Improvement	1.0 PY
Child Development Consultant – Program Quality Improvement	3.0 PY
Staff Services Manager I (3 Specialists, 1 Supervisor) – Program Quality Improvement	4.0 PY
Associate Governmental Program Analyst – Program Integrity and Improvement	2.0 PY
Office Technician – Child Development Fiscal Services	1.0 PY
Staff Services Manager I – Child Development Fiscal Services	1.0 PY
Staff Services Manager I (Specialist) – Child Development Fiscal Services	1.0 PY
Associate Governmental Program Analyst – Child Development Fiscal Services	3.0 PY
Staff Services Manager II – Child Development Fiscal Services	1.0 PY
Staff Services Manager III – Child Development Fiscal Services	1.0 PY
Staff Services Manager I – Human Resources Support	1.0 PY
Associate Governmental Program Analyst – Human Resources Support	1.0 PY
Associate Governmental Program Analyst – Direct Service Contracts	1.0 PY
Staff Services Manager I (Specialist) – Community Care Licensing	1.0 PY

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the two budget change proposals included in this issue: (1) Child Care Development Fund Authority and (2) Child Care Policy, Program, Administrative, and Support Staffing Needs.

**Issue #4: Child Care Clean-up Language**

**Trailer Bill Language – Governor’s Budget.** The Governor’s budget includes two clean-up trailer bills related to child care:

1. **Child Care Reporting Clean-up.** Trailer bill would delete a requirement for a CDSS to report on the number children receiving part-day preschool and wraparound childcare services.
2. **Child Care Part-time/ Full-time Clean-up.** Trailer bill would reduce the documented need for reimbursements to child care providers based on a daily rate from six hours to five or more, as specified.

**Child Care Reporting Clean-up.**

**Background: Child Care Transition.** The 2020 Budget Act transferred most child care programs from CDE to CDSS. This included a lift of statute from the Education Code to the Welfare and Institutions Code (WIC) and the removal of references to CDE and the California State Preschool Program from the language that was transferred over.

**Clean-up to Remove Reference to Preschool.** According to CDSS, certain references to CDE and the California State Preschool Program (which is administered by CDE) were inadvertently not removed from the language that was lifted and shifted in the codes. Section 10243 of the WIC requires CDSS to report data about children served in child care and development programs administered by CDSS. This section erroneously includes a reference to part-day or wraparound services for preschool age children which are administered by CDE in conjunction with CSPP. These reporting requirements are applicable to CDE and are currently identified in Education Code 8215. The proposed trailer bill would remove these references.

**Child Care Part-time/Full-time Clean-up**

**Background: Part-time/full-time definitions.** SB 140 (Committee on Budget and Fiscal Review), Chapter 193, Statutes of 2023, codified a provision of the 2023 CCPU Memorandum of Understanding that changed the definition of part-time child care from 30 hours per week to 25 hours per week. As a result, hourly, weekly, and monthly definitions are now based on five hours instead of six.

**Clean-up to Align Daily Rate.** According to CDSS, in order to ensure the time-based categories defined in regulations are aligned with statutory changes made to the part-time and full-time definition, clean-up is needed to fix one reference in statute that was inadvertently missed in SB 140. This reference in WIC 10374.5(k)(1) defines full time as six hours or more a day. This needs to be corrected to five hours, to align all time-based rate categories, in order for regulations to be clear.

**Subcommittee Staff Recommendation and Comment – Hold Open.**

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

1. Please provide a brief overview of the two trailer bill proposals included in this issue: (1) Child care reporting Clean-up and (2) Child Care Part-Time/Full-time Clean-up.

**Issue #5: Child Care 12-month Eligibility for New Children**

**Trailer Bill Language—Governor’s Budget.** The Governor proposes trailer bill language to extend a family’s period of eligibility for subsidized child care when a family adds an additional child to the family, ensuring children receive a minimum of 12 months of eligibility.

**Background: Eligibility for Subsidized Child Care.** Federal regulations governing state-subsidized child care require that eligible children receive a minimum of 12 months of eligibility for child care services.

According to CDSS, the department recently received a notice regarding areas of noncompliance from the federal Administration for Children and Families (ACF) based on a monitoring visit in January 2024.

During one of the visits with an external contractor, ACF found inconsistencies regarding how contractors implement eligibility requirements if a family has added a child during their eligibility period. As a result, ACF determined that California does not meet the 12-month eligibility requirement. In its notice, ACF asserted that “the Lead Agency re-determines a child’s eligibility for child care services sooner than 12 or 24 months following the initial determinations or most recent redeterminations, and a child does not always receive services at the same level of the most recent determinations or redetermination under certain circumstances.”

WIC 10271(h) gives contractors the authority to “extend the period of eligibility.” According to CDSS, because of the inconsistencies identified in how the contractors interpret this provision, additional clarification is needed. The proposed changes will clarify each child’s period of continuous eligibility (12 or 24 months, as specified), rectify an area of asserted noncompliance, and avoid potential fiscal penalties imposed by ACF for not meeting the federal requirements.

**Trailer Bill to Clarify 12 Months of Eligibility.** The proposed trailer bill would clarify that if a family already receiving subsidized child care adds another child to the family size, and the family requests services for that child during the current eligibility period, the family’s eligibility period shall be extended, as necessary, to ensure that the additional child receives at least 12 months of eligibility for services before a redetermination of eligibility occurs.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of this proposed trailer bill.

**Issue #6: Child Welfare Overview & Tiered Rate Structure Implementation**

**Governor’s Budget – Child Welfare.** The Governor’s proposed 2025-26 budget includes \$10.8 billion (\$1 billion General Fund) for children and family services programs.

Child welfare is funded mainly through federal funds (\$3.6 billion) and realigned county funds (\$5.9 billion). Approximately \$1 billion General Fund supports child welfare, as shown in the LAO chart below:

Figure 1

**Governor’s Budget Local Assistance Funding for Child Welfare<sup>a</sup>**

(In Millions)

	Total	Federal	State	County	Reimbursement
2025-26 proposed expenditures	\$10,844	\$3,596	\$1,079	\$5,873	\$296
2024-25 revised estimates	9,769	3,423	974	5,119	253
<b>Change From 2024-25 to 2025-26</b>	<b>\$1,075</b>	<b>\$174</b>	<b>\$105</b>	<b>\$754</b>	<b>\$43</b>

<sup>a</sup>Includes Child Welfare Services, Foster Care, Adoptions Assistance Program, Kinship Guardianship Assistance Payment Program, Approved Relative Caregiver Program, and associated automation costs.

Source: LAO

**Child Welfare Caseload.** According to the LAO, California’s child welfare system involves nearly 100,000 children and their families in any given month. The Governor’s proposed 2025-26 budget projects the following child welfare caseloads:

- 29,685 children with emergency response cases, in response to maltreatment allegations.
- 13,429 children with families receiving family maintenance services to help keep children safely at home.
- 12,419 children in foster care whose families are receiving reunification services.
- 26,581 children in foster care for whom the child welfare system is working toward permanent placement.

Other than continued funding for the CWS-CARES project, which is covered in Issue #8 of this agenda, the Governor’s proposed budget does not contain any new child welfare proposals. The LAO chart on the following page details significant adjustments from the 2024 Budget Act.

**Changes in Child Welfare Local Assistance (Net General Fund Increase)**

(In Millions)

Item	Changes From 2024-25 (Revised) to 2025-26 Governor's Budget		Description
	Total Funds	General Fund	
CWS-CARES project increase	\$83	\$42	Revised OTSI spending plan.
Emergency Child Care Bridge	33	35	Restoration of program expansion funding that was previously reduced to help address the budget shortfall.
BH-CONNECT	28	21	Transition from a half-year implementation in 2024-25 to full-year implementation in 2025-26. Includes funding for activity stipends, CFTs for FM cases, and joint home visits.
Tiered Rate Structure: CalSAWS	6	6	Continued automation funding to prepare the state payment system for implementation of the permanent foster care rate structure. Initial funds are provided in 2024-25.
Tiered Rate Structure: CWS-CARES	4	2	Continued automation funding to prepare the new state child welfare case management system for implementation of the permanent foster care rate structure. Initial funds are provided in 2024-25.
Tiered Rate Structure: CANS model fidelity and training support	2	1	New funding to support statewide fidelity in completing CANS assessments, which are an essential component of implementing the permanent foster care rate structure.
CWS-CARES and CalSAWS interface	-12	-12	Revised schedule for implementing the interface solution. As of the 2024-25 budget appropriation, \$25 million total funds (all General Fund) was included in 2024-25 as one-time funding.
Net changes in CCR costs for Home-Based Family Care Rates	14	9	Higher projected costs for foster care, Kin-GAP, ARC, and AAP payments under CCR. This increase is the net change reflecting higher monthly payments to caregivers due to the annual COLA, partially offset by projected caseload trends—which are estimated to be lower for foster care and ARC and roughly flat for AAP and KinGAP.
Other net changes <sup>a</sup>	916	—	Net effect of all other changes across programs, including caseload changes and estimated increases in county and federal expenditures under 2011 realignment.
<b>Totals</b>	<b>\$1,075</b>	<b>\$105</b>	

CWS-CARES = Child Welfare Services-California Automated Response and Engagement System; OTSI = Office of Technology and Solutions Integration; BH-CONNECT = Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment; CFT = Child and Family Team; FM = Family Maintenance; CalSAWS = California Statewide Automated Welfare System; CANS = Child and Adolescent Needs and Strengths; CCR = Continuum of Care Reform; Kin-GAP = Kinship Guardianship Assistance Payment; ARC = Approved Relative Caregiver; AAP = Adoption Assistance Program; and COLA = cost of living adjustment.

<sup>a</sup>We are working with the administration to understand more detail around what is driving the projected increases to the federal and county shares of 2011 realignment costs.

**Background: Child Welfare and Foster Care.** When children experience abuse or neglect, the state responds with a range of interventions. The state provides prevention services—such as substance use disorder treatment and in-home parenting support—to families at risk of child removal to help families remain together, if possible. When children cannot remain safely in their homes, the state provides temporary out-of-home placements through the foster care system, often while providing services to parents with the aim of safely reunifying children with their families. If children are unable to return to their parents, the state provides assistance to establish a permanent placement for children, for example, through adoption or guardianship. California’s counties carry out child welfare activities for the state, with funding from federal funds and state General Funds along with local funds.

Children in foster care are disproportionately from low-income, Black, and Native American families. The proportion of Black and Native American youth in foster care is around four times larger than their proportion of the population in California overall.<sup>7</sup>

Most foster care placements include home-based placements with relatives, or non-relative resource families, who are recruited, trained, and overseen either directly by county child welfare

<sup>7</sup> For more information on disproportionalities in the child welfare system, see the LAO’s 2024 report: [California’s Child Welfare System: Addressing Disproportionalities and Disparities](#).

departments, or through foster family agencies (FFAs), non-profit agencies that contract with county child welfare departments. In certain cases, children or youth may be admitted to a residential program known as a Short-Term Residential Therapeutic Program (STRTP) for short-term, specialized, and intensive therapeutic mental health treatment and supervision. Youth in foster care at age 18 have the option of entering Extended Foster Care through age 21. Older foster youth have additional placement options such as a Transitional Housing Program or a Supervised Independent Living Program (SILP).

Recent state and federal reforms have sought to reduce trauma and increase stability for children in foster care by reducing reliance and duration of congregate care placements, increasing home-based placements, and facilitating placements with relatives whenever possible. This includes funding to support family finding and engagement, child-specific funding, the 24/7 mobile response program known as Family Urgent Response System (FURS), flexible family supports, and most recently, a new rate structure for foster care known as the Tiered Rate Structure.

**2024 Budget Act.** The 2024 Budget Act included the following major actions:

- **Ultimately avoided most cuts to child welfare programs.** The Governor’s proposed 2024 budget included significant cuts to child welfare programs such as eliminating FURS and funding for caregiver approvals, which help caregivers become approved resource families. Ultimately, the final 2024 Budget Act agreement preserved all foster care funding, with the exception of a Los Angeles-only program known as the Public Health Nursing Program (\$8.25 million), and a planned increase to the Supervised Independent Living Program (SILP) Supplement, which was absorbed into the Tiered Rate Structure.
- **Established the Foster Care Tiered Rate Structure.** The 2024 Budget Act established a new permanent rate structure for foster care, effective July 1, 2027, to transition the state away from interim foster care rates. The new permanent rate structure, known as the Tiered Rate Structure, bases foster care payments on the strengths and needs of the child as identified by the Child and Adolescent Needs and Strengths (CANS) assessment, regardless of their placement setting. There are three main components of the Tiered Rate Structure: Care and Supervision Rate, Strengths Building Allocation, and Immediate Needs Allocation, as well as an administrative rate component for foster care providers. The 2024 Budget Act requires CDSS to provide regular pre-implementation and post-implementation updates to the Legislature regarding all components of the Tiered Rate Structure. The 2024 Budget Act included \$20.5 million (\$13.3 million General Fund) for automation costs over two years to implement the Tiered Rate Structure.

**Implementation of Tiered Rate Structure.** The following is a summary of major steps being undertaken in the current year to implement the Tiered Rate Structure, provided by CDSS. CDSS has broken the implementation of the Tiered Rate Structure into five categories:

1. The Child and Adolescent Needs and Strengths (CANS) and Child and Family Teams (CFT) Fidelity
2. Care and Supervision
3. The Strengths Building Program
4. The Immediate Needs Program
5. Automation of the Tiered Rate Structure

The new rates under the Tiered Rate Structure are provided in the CDSS summary below:

### Permanent Foster Care Tiered Rate Structure Framework

Tier 1 (74% of children and youth) (Latent Classes 1 and 2 for the 0-5-year-olds and Latent Classes 1, 2, and 3 for the 6+ year olds)		Tier 2 (19% of children and youth) (Latent Class 3 for the 0 – 5-year-olds and Latent Classes 4 and 5 for the 6+ year olds)	
<b>Care and Supervision*</b> Paid to the caregiver	\$1,788	<b>Care and Supervision*</b> Paid to the caregiver	\$3,490
<b>Strength Building and Maintenance</b> Child and Family work with a Financial Management Coordinator	\$500	<b>Strength Building and Maintenance</b> Child and Family work with a Financial Management Coordinator	\$700
<b>Immediate Needs</b>	NA	<b>Immediate Needs</b> County or contracted provider coordinate services	\$1,000
<b>FFA Admin (for youth placed in an FFA)*</b> <i>Recruitment, retention, approval, training, etc.</i>	\$1,610	<b>FFA Admin (for youth placed in an FFA)*</b> <i>Recruitment, retention, approval, training, etc.</i>	\$2,634
Tier 3 (ages 0-5) (4.5% of children and youth) (Latent Class 4 for 0 – 5-year-olds)		Tier 3+ (ages 6+) (2.5% of children and youth) (Latent Class 6 and 6a for 6+ year olds)	
<b>Care and Supervision*</b> Paid to the caregiver	\$6,296	<b>Care and Supervision*</b> Paid to the caregiver	\$6,296
<b>Strength Building and Maintenance</b> Child and Family work with a Financial Management Coordinator	\$900	<b>Strength Building and Maintenance</b> Child and Family work with a Financial Management Coordinator	\$900
<b>Immediate Needs</b> County or contracted provider coordinate services	\$1,500	<b>Immediate Needs</b> County or contracted provider coordinate services	\$4,100
<b>FFA Admin (for youth placed in an FFA)*</b> <i>Recruitment, retention, approval, training, etc.</i>	\$2,634	<b>FFA/STRTP Admin (for youth placed in an FFA or an STRTP)*</b> <i>Recruitment, retention, approval, training, etc.</i>	\$7,213

\*Components of the rate that will receive a California Necessities Index increase.

Source: CDSS

**Key Components of the Tiered Rate Structure.** The Child and Adolescent Needs and Strengths Tool (CANS) is a validated functional assessment tool which assesses well-being, identifies a range of social and behavioral healthcare needs, supports care coordination and collaborative decision-making, and monitors outcomes of individuals, providers, and systems. It has been implemented statewide since 2018. The Tiered Rate Structure is based on a child’s identified needs and strengths as identified by the CANS assessment, not the child’s placement type. Within each Tier, a child is eligible for the following rate components:

- **Care and Supervision:** funds basic care and supervision of a child (such as clothing, food, transportation).
- **Strengths Building:** a new component of foster care rates that support enrichment activities, promote supportive social connections, and provide opportunities to develop skills. Use of Strengths Building funds will be determined by the child and family but may include activities such as sports, arts, music, and other extracurricular activities.
- **Immediate Needs:** a new component of foster care rates that support a child’s immediate needs, with services provided by qualified providers. This includes the implementation of high-fidelity wraparound services.

The Tiered Rate Structure also includes an administrative rate component for foster care providers.

CDSS has identified three major implementation phases for the Tiered Rate Structure:

1. The Planning Phase: August 2024 – June 2025
2. The Preparation Phase: July 2025 – June 2026
3. The Early Implementation Phase: July 2026 – June 2027

**Planning Phase.** CDSS has taken the following steps as part of the planning phase:

- *The Child and Adolescent Needs and Strengths (CANS) and Child and Family Teams (CFT) Fidelity.* The team has engaged with a wide variety of stakeholders across the child welfare system to inform the CANS Policy and Fidelity implementation guidance. This includes the CFT CANS Statewide Forum, the CFT CANS Steering Committee, CQI & Fidelity Workgroup for CFT & CANS. CDSS also held listening sessions with Child and Family Team (CFT) facilitators, CANS Completers, child welfare social workers, probation officers, contract managers, juvenile court judges and attorneys, training partners, parents, resource parents and caregivers, and youth. In January of 2025, CDSS held a listening session for Tribes and Tribal Communities.

The CANS Policy All County Letter (ACL) was released on February 18, 2025, after stakeholder and tribal feedback. The CANS Fidelity requirements will begin in July 2025, and some fidelity tools will be implemented into practice through a phased approach to allow time for necessary training and staff hiring.

- *Care and Supervision.* The Tiered Rate Structure statute mandates CDSS to establish the specific conditions in which a child who receives adoption and guardianship benefits may receive a rate that exceeds Tier 1 Care and Supervision but does not exceed Tier 2 Care and Supervision. CDSS kicked off a working group to inform those specific conditions in January. Informed by this feedback, the team will work to establish the specific conditions.
- *The Strengths Building Program.* The Strengths Building Program implementation team at CDSS held three listening sessions in November and December 2024 to gather feedback to inform the Request for Information (RFI) for the Spending Plan Manager. Session one focused on ensuring the Spending Plan Manager selected is aware of the expectations of tribal communities and that the Spending Plan Manager will have an understanding of culturally relevant enrichment activities that Tribal youth might be interested in. Session two gathered feedback on the need for more support or mentoring, whether transportation should be offered at the state or regional level, what outreach services should be developed to inform families about available resources, how CDSS can combine both permanent and natural supports, and how to create a program for children aged 0-5. Session three summarized key takeaways from the other sessions and allowed stakeholders to elaborate on past recommendations, including their vision of how this would look. CDSS is preparing to release the RFI for the Spending Plan Manager for the Strengths Building Program.
- *The Immediate Needs Program.* The Tiered Rate Structure statute mandates CDSS to conduct an analysis of the Immediate Needs of children in Tier 2, 3, and 3+ and the types

of services necessary to address those needs, reasonable administration and operational activities necessary for providers to address those needs, and a cost analysis of those services. In the fall of 2024, CDSS held two listening sessions to inform the Scope of Work being developed for the contractor to conduct this analysis. One listening session was held with stakeholders and one listening session was held with Tribes. Informed by these listening sessions, CDSS drafted the scope of work for this analysis. CDSS is working with the Public Consulting Group (PCG) to conduct this analysis.

CDSS kicked off an Immediate Needs Working group in January 2025. This working group is seeking input from stakeholders to inform the development of the Immediate Needs Program. In March, CDSS convened a working group with Tribes on the Immediate Needs Program.

- *High-fidelity Wraparound Services.* Lastly, the Tiered Rate Structure statute requires CDSS to publish guidance on the implementation of high-fidelity wraparound services, which must also address reducing administrative and programmatic burdens and duplication and promote consistent procedures statewide. To obtain feedback on opportunities to reduce administrative and programmatic burdens within the Immediate Needs Program, CDSS is coordinating a listening session to inform the development of this guidance.
- *Automation of the Tiered Rate Structure.* The All County Letter (ACL) for automation of the Tiered Rate Structure within CalSAWS was released on December 23, 2024. The ACL provides a high-level overview of the Tiered Rate Structure (TRS) as a whole and instructions for CalSAWS on which components within the TRS will need to be automated within CalSAWS. CDSS has a monthly working group with the CalSAWS team on the automation of the Tiered Structure within CalSAWS.

**Provider Implementation Questions and Concerns.** According to the California Alliance of Child and Family Services, “currently, there is confusion about which services, supports, and resources should be funded under each component of the rate structure. Clarifying these distinctions is essential to ensuring each component is used appropriately to prevent funding gaps and support services that are critical to youth healing. Additionally, significant clarifications and concrete mechanisms are needed regarding the implementation plan for the Immediate Needs component of the rate structure.” The Alliance recommends a number of implementation components, including: using Immediate Needs funding for services that are not Medi-Cal billable, streamlining certification for presumptive Immediate Needs providers, and establishing a statewide contract for those providers, increasing the administrative component of rates, streamlining a pathway for presumptive Immediate Needs Providers to become high-fidelity wraparound providers, developing a centralized purchasing model for immediate needs providers, and designating certain program types as presumptive immediate needs providers.

**Tiered Rate Structure Costs.** The chart on the following page, provided by the Department of Finance, provides a summary of the multi-year costs associated with the Tiered Rate Structure.

**Tiered Rate Structure Multiyear<sup>1</sup> (000s)**

(000s)

**FY 2024-25**

Funding	Total	Federal	State	County
Automation	\$ 5,062	\$ 2,531	\$ 2,531	\$ -
<b>Total</b>	<b>\$ 5,062</b>	<b>\$ 2,531</b>	<b>\$ 2,531</b>	<b>\$ -</b>

**FY 2025-26**

Funding	Total	Federal	State	County
Automation	\$ 15,514	\$ 4,702	\$ 10,812	\$ -
County Administration	\$ 1,655	\$ 438	\$ 1,217	\$ -
State Operations	\$ 1,784	\$ -	\$ 1,784	\$ -
<b>Total</b>	<b>\$ 18,953</b>	<b>\$ 5,140</b>	<b>\$ 13,813</b>	<b>\$ -</b>

**FY 2026-27**

Funding	Total	Federal	State	County
County Administration	\$ 1,655	\$ 438	\$ 1,217	\$ -
State Operations	\$ 1,734	\$ -	\$ 1,734	\$ -
<b>Total</b>	<b>\$ 3,389</b>	<b>\$ 438</b>	<b>\$ 2,951</b>	<b>\$ -</b>

\*Reflects 0% caseload intake.

**FY 2027-28**

Funding	Total	Federal	State	County
Care and Supervision <sup>2</sup>	\$ 120,632	\$ 56,265	\$ 53,942	\$ 10,425
Strength Building	\$ 171,898	\$ 7,592	\$ 164,306	\$ -
Immediate Needs	\$ 120,950	\$ -	\$ 120,950	\$ -
County Administration	\$ 25,510	\$ 6,760	\$ 18,750	\$ -
State Operations	\$ 1,734	\$ -	\$ 1,734	\$ -
<b>Total</b>	<b>\$ 440,724</b>	<b>\$ 70,617</b>	<b>\$ 359,682</b>	<b>\$ 10,425</b>

\*Reflects 50% caseload intake year 1.

**FY 2028-29**

Funding	Total	Federal	State	County
Care and Supervision	\$ 204,194	\$ 93,295	\$ 94,694	\$ 16,205
Strength Building	\$ 257,847	\$ 11,388	\$ 246,459	\$ -
Immediate Needs	\$ 181,425	\$ -	\$ 181,425	\$ -
County Administration	\$ 37,438	\$ 9,920	\$ 27,517	\$ -
State Operations	\$ 1,734	\$ -	\$ 1,734	\$ -
<b>Total</b>	<b>\$ 682,638</b>	<b>\$ 114,604</b>	<b>\$ 551,829</b>	<b>\$ 16,205</b>

\*Reflects 75% caseload intake year 2.

**FY 2029-30**

Funding	Total	Federal	State	County
Care and Supervision	\$ 295,391	\$ 132,756	\$ 140,301	\$ 22,335
Strength Building	\$ 343,797	\$ 15,184	\$ 328,612	\$ -
Immediate Needs	\$ 241,900	\$ -	\$ 241,900	\$ -
County Administration	\$ 49,365	\$ 13,081	\$ 36,284	\$ -
State Operations	\$ 1,734	\$ -	\$ 1,734	\$ -
<b>Total</b>	<b>\$ 932,187</b>	<b>\$ 161,021</b>	<b>\$ 748,831</b>	<b>\$ 22,335</b>

\*Reflects 100% caseload intake year 3.

<sup>1</sup>The multiyear reflects DSS costs for the Tiered Rate Structure and does not include DHCS limited-term costs of \$400,000 General Fund and \$400,000 federal funds annually from FY 2024-25 through FY 2026-27.

<sup>2</sup>Care and Supervision costs are inclusive of Provider Administration.

**BH CONNECT.** BH-CONNECT is a federal Medicaid waiver demonstration project that allows the state to use Medi-Cal funding for enhanced community-based behavioral health care services, including early intervention to prevent entry into the child welfare system.<sup>8</sup> The Department of Health Care Services (DHCS) is the lead entity for BH-CONNECT; however, CDSS is coordinating with DHCS on provisions that affect eligible children in foster care. This includes “activity funds” for children in foster care with behavioral health conditions, for activities such as sports, music and art, and therapeutic summer camps, if those activities meet specified criteria regarding improving health outcomes. CDSS reports that the two departments (CDSS and DHCS) are working together on a joint Request for Information (RFI) for a third-party vendor for both the BH-CONNECT activity stipends and the Strengths Building Program under the Tiered Rate Structure.

In addition to activity funds, CDSS is implementing additional activities in support of the BH-CONNECT waiver. This includes child and family team (CFT) meetings for family maintenance cases (cases in which there is an allegation of maltreatment but the child welfare agency determines the youth is able to remain safely at home with interventions). Implementation also includes joint home visits, in which child welfare social workers will partner with specialty mental health workers following substantiated maltreatment allegations.<sup>9</sup>

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the Governor’s proposed 2025-26 budget for child welfare programs.
2. Please provide a brief status update on the department’s implementation of the Tiered Rate Structure for foster care, effective July 1, 2027. How will the Tiered Rate Structure improve outcomes and reduce disparities for children in foster care? How is the Administration working with stakeholders to address implementation questions and concerns about the Tiered Rate Structure?
3. Please describe the department’s work to define and implement high-fidelity wraparound in conjunction with the implementation of the Tiered Rate Structure.
4. How is the department working with the Department of Health Care Services to integrate the Strengths Building Program under the Tiered Rate Structure with the activity stipends under the BH-CONNECT waiver?

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<sup>8</sup> LAO: The 2025-26 Budget: Child Welfare, February 13, 2025.

<sup>9</sup> LAO

**Issue #7: Foster Family Agency Closures**

**Panel Discussion.** The Subcommittee has invited the following individuals to participate in this discussion:

- Jennifer Troia, Director, California Department of Social Services (CDSS)
- Brittany Lucas, Chief Financial Officer, Redwood Community Services

**Background: Foster Family Agencies.** Foster Family Agencies (FFAs) recruit, retain, and train foster families to become resource families for children in foster care. While some resource families work directly with county child welfare agencies, many counties contract with FFAs to provide resource families for children in foster care, including nearly 100 percent of Intensive Services Foster Care (ISFC) families, which are families trained to support high-needs children in a home-based setting. FFAs often specialize in serving medically fragile children, LGBTQ+ youth, older youth, and children with high support needs. FFAs not only provide foster care placements, but an array of services for families involved in the child welfare system, such as parenting classes, substance use disorder counseling, mental health services, and other resources.

There are approximately 220 FFAs in California providing homes for approximately 7,400 children in foster care, or about one fifth of the state's total foster care caseload.

**FFA Insurance Crisis.** In August 2024, the Nonprofit Insurance Alliance of California (NIAC), which provided insurance coverage to 90 percent of FFAs, announced its decision to non-renew existing FFA insurance policies. According to the California Alliance for Child and Family Services (CA Alliance), as a result of the NIAC decision, FFAs are now seeking insurance from non-admitted insurers whose premium costs are unregulated by the California Department of Insurance, leading to higher insurance costs for FFAs.

The CA Alliance worked with CDSS to survey FFAs to understand the impacts of the insurance crisis in February 2025. Among the 36 FFAs that responded, 28 reported that their costs of insurance increased by 139 percent, and 30 percent of FFAs reported they would not be able to afford these increased insurance costs by next year and are at risk of closure. FFAs have reported using reserves as a short-term solution to pay for insurance premiums, but have emphasized that the current foster care rates do not support their increased insurance costs.

**Foster Family Agency Closures.** According to CDSS, in the wake of the NIAC decision, eight FFAs have closed their doors, and a ninth FFA will have closed by the end of March 2025.

According to CDSS, 49 resource families home to 61 children have been administratively transferred to either other FFAs or come directly under the county. This means that the children whose FFA closed have been able to remain in their current placement. However, CDSS has acknowledged that transferring FFA homes to other FFAs or directly under county control is not a long-term solution. Counties do not have capacity to absorb all FFA homes or replace the work they do to recruit, retain, and train qualified and specialized foster families.

AB 2496 (Pellerin), Chapter 403, Statutes, of 2024, streamlined the process for transferring homes between FFAs and counties, which has facilitated the ability of the 61 children mentioned above to remain in their current homes. AB 2496 also requires CDSS to work with stakeholders on options for making insurance available to FFAs. CDSS has been meeting routinely with the

Department of Insurance, counties, FFAs, insurance associations, and other stakeholders, consistent with AB 2496.

The CA Alliance has requested two-year funding to address increased costs borne by FFAs to stay open amid the insurance crisis, until the new Tiered Rate Structure takes effect on July 1, 2027. When the Tiered Rate Structure takes effect, FFAs will receive an annual COLA to their administrative costs which will provide greater sustainability than the current interim foster care rates.

**Subcommittee Staff Comment and Recommendation – Hold Open.** The Governor’s proposed 2025-26 budget does not include funding to keep up with FFAs’ increased administrative costs or other solutions to prevent further closures that jeopardize the stability of vulnerable children in foster care.

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

1. As a result of the foster family agency (FAA) insurance crisis, how many foster family agencies have closed? How many total foster homes and individual children in foster care have been administratively transferred to (A) other foster family agencies, or (B) counties? How is the department ensuring that children are receiving the same services they were receiving before the foster family agency supporting their home closed? Have any foster homes providing Intensive Services Foster Care been affected? Can the wave of foster family agency closures continue to be absorbed by counties and other FFAs? What are the impacts to children in foster care if foster family agencies continue to close?
2. Please respond to provider concerns that the current interim foster care rates are insufficient to cover the care and supervision of children receiving foster care through foster family agencies, given their increased costs. What immediate and long-term solutions are being worked on together with the Department of Insurance and other stakeholders?

**Issue #8: Child Welfare Services – California Automated Response and Engagement System**

**Budget Change Proposal – Governor’s Budget.** The Office of Technology and Solutions Integration (OTSI) requests a total of \$256.5 million (\$129.9 million General Fund, \$125.6 million federal funds, and \$940,000 reimbursements) in 2025-26; three new, permanent positions for CDSS; provisional language to increase project expenditure up to an additional \$47.3 million (\$23.6 million General Fund) following contract negotiations, up to an additional \$45.6 million (\$22.8 million General Fund) utilizing prior year savings; and an increase in expenditure authority for OTSI of \$150.1 million for the Health and Human Services Automation Fund, to continue the CWS-CARES project.

According to the LAO, “CWS-CARES remains the costliest and longest running IT project still in the state’s current IT portfolio.”<sup>10</sup> The CWS-CARES project was originally approved in January 2013. Since project inception, the total approved baseline cost for this project is \$1.7 billion (\$850 million General Fund).

Important child welfare reforms rely on successful roll-out of CWS-CARES. The Tiered Rate Structure (covered in Issue #6), needs to be automated in CWS-CARES. Additionally, implementation of the Families First Prevention Services Act (FFPSA), which allows states to claim federal funding for prevention services, also hinges on the successful implementation of CWS-CARES, because this federal law requires tracking of per-child prevention spending (which is not available in the state’s current child welfare IT system.)

According to OTSI, CWS-CARES will launch statewide in October 2026, replacing the current IT system. The second version (V2) will launch April 2028.

**Background on CWS-CARES.** CWS-CARES is a statewide case management and data solution for child welfare services to replace the state’s current child welfare case management system, known as CWS/CMS. The replacement of the current CWS/CMS system is needed to meet federal requirements. According to OTSI, CWS-CARES will:

- Allow key members of the Child and Family Team (CFT) to have direct access to enter information or access shared information to support case plan and service delivery.
- Allow children and their families to be at the center of decision making by providing families with direct access to help them have access to key information and communicate with their worker.
- Provide timelier service delivery and enable social workers to spend less time doing data entry and more time working directly with families.
- Increase process and system efficiency, resiliency, quality, and maintainability across the state.
- Track cost at the individual level (a step towards tracking dollars to outcomes by person and by program).

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<sup>10</sup> LAO, “The 2025-26 Budget: CWS-CARES,” March 5, 2025.

- Support achievement of the Comprehensive Child Welfare Information System (CCWIS) certification requirements to maintain federal financial participation (FFP) funding and avoid large state repayments and federal non-compliance penalties.

According to OTSI, funding to continue the CWS-CARES project is necessary to improve the quality and overall effectiveness of statewide child welfare delivery while also meeting CCWIS regulations that secure retention of federal funding. The existing CWS/CMS system was initially implemented in 1997 and is not compliant with the CCWIS federal and state laws, regulations, or policies.

This project will deliver the core CWS-CARES solution through two versions: CWS-CARES Version 1 (V1) and CWS-CARES Version 2 (V2). The CWS-CARES V2 extends the functionality of the CWS-CARES V1 with data-intensive features supporting CCWIS compliance and continuation of interfaces, and external systems.

The following chart, provided by the LAO, demonstrates how CWS-CARES project plans have changed, costs have grown, and completion dates have changed:

### CWS-CARES IT Project Plans Officially Updated Six Times

Project Plan	Total Cost (In Millions)	Completion Date
FSR	\$392.7	September 2017
SPR 1	449.0	April 2019
SPR 2	420.8	December 2019
SPR 3	420.8 <sup>a</sup>	December 2023
SPR 4	911.4	July 2025
SPR 5	911.4 <sup>a</sup>	July 2025 <sup>a</sup>
SPR 6	1,711.0	October 2026 <sup>c</sup>

<sup>a</sup>No updates to project cost included in SPRs 3 and 5.

<sup>b</sup>No update to project completion date in SPR 5.

<sup>c</sup>Completion date is for CWS-CARES V1. Completion date of CWS-CARES V2 is April 2028.

CWS-CARES = Child Welfare Services-California Automated Response and Engagement System; IT = information technology; FSR = Feasibility Study Report; SPR = Special Project Report; V1 = version 1; and V2 = version 2.

Source: LAO

**Production Pilot Scheduled for 2026-27.** According to the LAO, “prior to completion of CWS-CARES V1 in October 2026, the project plans to conduct a production pilot with at least three counties over four to six weeks. During this production pilot, these counties will use CWS-CARES V1 for child welfare program activities, and report defects or deficiencies to the project team. After

a two-week stabilization period following the production pilot (which assumes there are no severe system defects or deficiencies), the project will launch CWS-CARES V1 statewide.”<sup>11</sup>

**Loss of Federal Financial Participation (FFP).** According to the LAO, “to receive federal funds for CWS-CARES IT project costs, the state must submit project planning documents for approval by the federal ACF. Once ACF approves the state’s planning documents, the project is eligible for FFP of 50 percent for all CCWIS-related planning, development, and implementation costs (that is, a CCWIS claiming status). Over the past year, however, ACF determined that the project is no longer eligible for CCWIS claiming status primarily because of its failure to make progress according to the schedule it submitted to ACF. The project’s current non-CCWIS claiming status now extends back to the beginning of federal fiscal year 2024 (beginning October 1, 2023), and will continue to reduce FFP for CWS-CARES IT project costs from 50 percent to 26.5 percent until ACF returns the project to its CCWIS claiming status and potentially allows retroactive claiming of costs at the higher FFP. Additional General Fund needed to cover the 23.5 percentage point reduction in FFP is expected to total \$49.6 million in 2024-25.”<sup>12</sup>

The federal ACF will conduct a virtual project review in May 2025, after which ACF will re-assess the project’s progress and potentially allow retroactive claiming of costs at the higher FFP. This budget proposal assumes that CCWIS claiming status (and thus the higher FFP) will be restored following the May ACF review; however, the state will likely not know until sometime in July whether ACF has decided to restore FFP.

**Transition to Holistic Design.** To address rework identified in user testing, and mitigate potential project risks, in 2024 OTSI transitioned the project to a new “holistic design” approach. According to the LAO, the holistic design approach “incorporates additional milestone design review focused on understanding how program processes work from start to finish under different scenarios. The additional design review incorporates user feedback, and looks across child welfare service areas to identify milestone interdependencies prior to their development.”<sup>13</sup> The transition to holistic design has not affected the project’s completion date of October 2026; however it has pushed certain project milestones and testing to later in the project’s life, compressing the project time line.

**Project Underspent Appropriations in 2023-24 and 2024-25.** According to the LAO, the CWS-CARES project underspent its 2023-24 appropriation by \$45 million (24 percent) as is projected to underspend its 2024-25 appropriation by \$30.4 million (14 percent.) Across cumulative one-time project costs of \$1.2 billion, \$417.7 was spent as of January 2025. The LAO chart on the following page details actual spending of 2023 and 2024 Budget Act appropriations.

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<sup>11</sup> LAO

<sup>12</sup> LAO

<sup>13</sup> LAO

## CWS-CARES IT Project Continues to Underspend Its Appropriations (In Millions)

Budget Item	Budget	Expenditures			Percent of Budget
		Actual	Projected	Total	
<b>2023-24<sup>a</sup></b>					
Contract Services	\$122.0	\$95.2	\$8.0	\$103.2	85%
OE&E <sup>b</sup>	27.2	19.6	1.2	\$20.8	76
CCP Costs	23.0	5.2	—	\$5.2	23
Personal Services	14.1	12.1	—	\$12.1	86
<b>Totals</b>	<b>\$186.3</b>	<b>\$132.1</b>	<b>\$9.2</b>	<b>\$141.3</b>	<b>76%</b>
<b>2024-25<sup>a</sup></b>					
Contract Services	\$134.7	\$27.1	\$82.3	\$109.4	81%
OE&E <sup>b</sup>	29.5	5.8	20.7	\$26.5	90
CCP Costs	30.8	1.5	29.3	\$30.8	100
Personal Services	15.9	4.4	9.2	\$13.6	86
<b>Totals</b>	<b>\$210.8</b>	<b>\$38.9</b>	<b>\$141.5</b>	<b>\$180.3</b>	<b>86%</b>
<sup>a</sup> The expenditure tables combine DSS local assistance funding and OTSI expenditure authority for comparative purposes. <sup>b</sup> The OE&E budget item includes data center services, enterprise services, hardware and software, training, and travel. CWS-CARES = Child Welfare Services-California Automated Response and Engagement System; IT = information technology; OE&E = operating expenses and equipment; CCP = Core Constituent Participation; DSS = Department of Social Services; and OTSI = Office of Technology and Solutions Integration.					

Source: LAO

**Staffing and Resources Request.** OTSI requests \$256.5 million (\$129.9 million General Fund) in 2025-26 to continue the CWS-CARES project. In addition, OTSI and CDSS propose provisional budget bill language to do the following:

- Allow the Department of Finance (DOF) to augment the project’s appropriation by up to \$47.3 million (\$23.7 million General Fund) after completion of vendor contract negotiations.
- Allow DOF, in consultation with the California Department of Technology, to augment the project’s appropriation by up to \$45.6 million (\$22.8 million General Fund) using prior year project savings. This augmentation requires DOF to consider whether the project is making satisfactory progress towards completion of milestones, incorporation of end user feedback, progress towards user adoption; and provide 30-day written notification of the

Joint Legislative Budget Committee (JLBC) that confirms DOF’s consideration of satisfactory progress before any augmentation is authorized.<sup>14</sup>

The LAO figure provided below includes a high-level of project costs proposed in 2025-26. This includes the \$256.5 million request in addition to most of the \$92.9 million in requested provisional augmentations:

## Proposed 2025-26 CWS-CARES IT Project Costs

(In Millions)

Budget Item	Proposed Cost <sup>a</sup>
Contract Services	\$208.9
OE&E <sup>b</sup>	73.3
CCP Costs	35.5
Chaptered Legislation <sup>c</sup>	15.0
Personal Services	15.3
<b>Total</b>	<b>\$347.9</b>

<sup>a</sup>The proposed costs table combines DSS local assistance funding and OTSI expenditure authority for comparative purposes.

<sup>b</sup>The OE&E budget item includes data center services, enterprise services, hardware and software, training, and travel.

<sup>c</sup>Chapter 46 of 2024 (AB 161, Committee on Budget) and Chapter 780 of 2022 (AB 2309, Friedman).

CWS-CARES = Child Welfare Services-California Automated Response and Engagement System; IT = information technology; OE&E = operating expenses and equipment; CCP = Core Constituent Participation; DSS = Department of Social Services; and OTSI = Office of Technology and Solutions Integration

Source: LAO

**LAO Recommendations.** The LAO has offered the Legislature a series of recommendations to improve oversight and more precisely budget for CWS-CARES project costs. The overall effect of the LAO’s recommendations would be the same total amount of funding, but with more funding

<sup>14</sup> LAO

contingent on project progress. The LAO’s recommendations include the following (included in the chart below and subsequent bullet points):

### Recommended Funding Changes Simplify Appropriations and Make More Funding Based on Project Progress

(In Millions)

Funding	Total Funds	General Fund
<b>2025-26 Governor’s Budget Proposal</b>		
Appropriation	\$256.5	\$129.9
Allowable Augmentations	92.9	46.4
<b>Proposed Grand Total</b>	<b>\$349.3</b>	<b>\$176.4</b>
<b>Appropriation/Reappropriation Recommendations</b>		
2025-26 Governor’s Budget Proposal - Appropriation	\$256.5	\$129.9
<b>Recommended Funding Changes</b>	<b>-\$71.2</b>	<b>-\$35.8</b>
-10 Percent for Historical Underspending <sup>a</sup>	-25.7	-13.0
-2023-24 Prior Year Savings Amount <sup>a</sup>	-45.6	-22.8
<b>Recommended Appropriation Subtotal</b>	<b>(\$185.3)</b>	<b>(\$94.1)</b>
2023-24 Prior Year Savings Reappropriation	\$45.6	\$22.8
<b>Recommended Appropriation + Reappropriation Subtotal</b>	<b>(\$230.9)</b>	<b>(\$116.9)</b>
<b>Allowable Augmentation Recommendations<sup>b</sup></b>		
2025-26 Governor’s Budget Proposal - Allowable Augmentations <sup>c</sup>	\$92.9	\$46.4
<b>Recommended Funding Changes</b>	<b>\$25.7</b>	<b>\$13.0</b>
+10 Percent from Historical Underspending <sup>a</sup>	25.7	13.0
<b>Recommended Allowable Augmentation Subtotal</b>	<b>(\$118.5)</b>	<b>(\$59.4)</b>
<b>Recommended Grand Total</b>	<b>\$349.4</b>	<b>\$176.3</b>

<sup>a</sup>These changes are non-add items that sum up to the recommended funding changes line.

<sup>b</sup>In addition to the recommended funding changes, all allowable augmentations would be based on the determination of satisfactory progress in placeholder provisional budget bill language.

<sup>c</sup>Includes additional funding of same amount as prior-year savings.

- Reduce the requested appropriation and re-appropriate prior year savings in 2025-26. This would make the total appropriation \$185.2 million (\$94.1 million General Fund) with a re-appropriation of \$45.6 million (\$22.8 million General Fund) in 2025-26.
- Subtract \$25.7 million (\$13 million General Fund) (10 percent) to reflect the project’s historical underspending, and make that funding available contingent on demonstration of satisfactory progress.
- Subtract \$45.6 million (\$22.8 million General Fund) from prior year savings, proposed by the Administration as a provisional augmentation, and instead re-appropriate that amount to cover project costs in 2025-26.

- Reject proposed provisional budget bill language to augment the project’s appropriation by up to \$47.3 million (\$23.7 million General Fund) after completion of vendor contract negotiations, and by up to \$45.6 million (\$22.8 million General Fund) using prior year savings. The LAO notes that “prior year savings should instead be used to cover budget year costs in the requested 2025-26 appropriation. Additional vendor funding after contract negotiations should instead be added to placeholder provisional budget bill language on condition of, at a minimum, the determination of satisfactory progress.”
- Instead, adopt placeholder provisional budget bill language with up to \$118.5 million (\$59.4 million General Fund) in additional funds available based on the determination of satisfactory progress. This amount is based on the two provisional components mentioned above, plus an additional share of total project costs to account for historical underspending.
- Adopt placeholder provisional budget bill language to include JLBC notification regarding the ACF determination regarding the project’s CCWIS claiming status and any associated General Fund impacts, and any other potential changes or delays in the project schedule or scope.<sup>15</sup>

**Subcommittee Staff Comment and Recommendation – Hold Open.** The Legislature may wish to consider the LAO’s recommendations in order to improve oversight over this project.

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

1. Please provide an overview of this proposal and summarize the decision to move the CWS-CARES project to a holistic design approach.
2. Please describe the reduction of federal financial participation for this project in 2024. What is the process and timeline for restoring full federal financial participation, both retroactively and prospectively? The proposed appropriation assumes full federal financial participation will be restored over summer 2025. How will the Administration address increased General Fund costs if full federal financial participation does not materialize?
3. What factors led to the projected underspending of \$45 million in 2023-24 and \$30.4 million in 2024-25? How does the 2025-26 proposal avoid overestimating actual project costs, unlike the past two budget proposals?

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<sup>15</sup> LAO

**Issue #9: Child Welfare Budget Change Proposals**

**Governor’s Budget – Child Welfare Budget Change Proposals.** The Governor’s proposed 2025-26 budget contains the following three budget change proposals for child welfare under CDSS:

- 1. First Phase of Foster Care Tiered Rate Structure State Operations.** CDSS requests \$1.8 million General Fund in 2025-26 and \$1.7 million General Fund ongoing for nine permanent positions to support the first phase of implementation of the Tiered Rate Structure.
- 2. Ongoing Funding for Foster Care Placement Services.** CDSS requests \$1.2 million General Fund in 2025-26 and \$1.2 million General Fund ongoing to make six limited-term positions permanent, to continue the workload associated with developing a Congregate Care Continuous Quality Improvement framework.
- 3. California HOPE for Children Trust Account.** CDSS requests \$374,000 General Fund in 2025-26 and \$364,000 General Fund ongoing and two positions to implement SB 242 (Skinner), Chapter 1010, Statutes of 2024, related to the HOPE program for foster youth.

All three proposals are summarized below.

**First Phase of Foster Care Tiered Rate Structure State Operations**

**Background: Tiered Rate Structure.** AB 161 (Committee on Budget), Chapter 46, Statutes of 2024, establishes the Tiered Rate Structure for foster care payments, effective July 1, 2027. The Tiered Rate Structure contains three separate tiers and bases a foster care payments on a child’s assessed level of need, identified via the Child and Adolescent Needs and Strengths (CANS) assessment. The Tiered Rate Structure contains three key components of the rate: Care and Supervision, Strengths Building and Maintenance, and Immediate Needs. More background on the Tiered Rate Structure is included in Issue #6 of this agenda.

A child or youth’s CANS assessment plays a pivotal role within the Tiered Rate Structure. CANS results dictate a child’s tier, and thus fidelity to the CANS assessment is crucial to the implementation of the Tiered Rate Structure. CDSS will need to increase CANS completion rates and to enhance fidelity to the CANS assessment. In addition, AB 161 requires the inclusion of those with lived experience, including Tribal Representatives, in the development of the Tiered Rate Structure.

According to CDSS, current staffing levels are not able to absorb the workload associated with implementing the Tiered Rate Structure and to fully develop and coordinate the engagement of lived experts.

**Staffing and Resources Request.** CDSS requests nine permanent positions to implement the first phase of the Tiered Rate Structure. These positions will be responsible for the following:

*Two Associate Governmental Program Analysts, two health program specialists, two research and data specialists, and one staff services manager.*

- Support with coordination, technical assistance, and preparation of the necessary materials for legislative reporting requirements.
- Use behavioral health expertise and the CANS Fidelity tool to assess whether a county is administering the CANS assessment in a way that adequately informs what a child or youth's tier (and thus rate) would be.
- Extract the necessary data to inform the overall analysis of CANS assessment completion rates, utilization of the fidelity tool within counties, and more.
- Serve as the manager of the unit. This manager will assist in delegating tasks assigned to the unit, triaging competing priorities, and coordinating the workflow.

*Two Staff Services Manager Specialists.*

- Initiate, develop and manage contract agreements with entities and Tribes equipped to support and facilitate partnership with those with lived experience.
- Train and support CDSS staff and stakeholders on appropriate engagement with lived experts, making sure they are full partners and consulted from the outset.

CDSS states that having additional CDSS staff to review statewide and county-level CANS data and to utilize the CANS fidelity tool, which will be developed between August of 2024 and July of 2025, will allow CDSS to measure CANS completion rates, fidelity to the CANS, and more. With this data, CDSS staff will be able to build necessary trainings and technical assistance materials to improve CANS completion rates and enhance fidelity. The inclusion of lived experts makes sure the creation of training, delivery of technical assistance and development of relevant guidance is reflective of the needs of the children and families served. Utilization of continuous quality improvement strategies in collaboration with lived experts will allow for evaluation of outcomes associated with the Tiered Rate Structure, measuring impact and effectiveness. This is key to the successful implementation of the new Tiered Rate structure.

According to CDSS, the department will not be able to absorb the necessary workload to develop and implement the permanent Tiered Rate Structure on July 1, 2027, without these additional positions.

### **Ongoing Funding for Foster Care Placement Services**

**Background: Continuum of Care Reform and AB 2083 System of Care.** According to CDSS, following the enactment of Continuum of Care Reform (CCR), data shows a successful decrease in the number of youths experiencing congregate care and an increase in family placements; however, the length of stay for youth who experience congregate care has remained high, and too many youths experience long stays in congregate care, inconsistent with state and federal policy. Further, data analysis continues to reflect some younger children experiencing lengthy stays in

congregate care and remaining in such settings through adolescence. CDSS states that in the past 13 months, 3,708 distinct youth had 8,952 placements in a congregate care setting. Placement data reports from the Child Welfare Services/Case Management System (CWS/CMS) show that 43 percent of children who were in Short-Term Residential Therapeutic Programs (STRTPs) between March 1, 2023, and March 31, 2024, have been in those settings for one or more years, in total, since the start of their current placement episode, which is contrary to the intent of AB 403 (Stone), Chapter 773, Statutes of 2015 and the federal Families First Prevention Services Act Part IV.

CDSS states that the recent data supports the need for CDSS to conduct continued oversight of the usage of congregate care settings and provide support related to alternatives. Youth who experience stays in congregate care settings often have co-occurring disorders and complex needs. The system of care has faced challenges in responding to the needs of such youth, which can often result in placement instability. When youth with complex needs experience such instability, this may result in extended stays in shelters or in some cases, in unauthorized unlicensed settings. There has been an increase in lawsuits brought against counties due to unlicensed care and overstay in shelter settings. CDSS responsiveness to these lawsuits has required substantial data analysis and technical assistance responses. In addition, county child welfare, probation, residential providers, and local system of care agencies continue to request significant levels of assistance from CDSS regarding serving such youth with complex needs.

AB 2083 (Cooley), Chapter 815, Statutes of 2018, requires a joint interagency resolution team, in consultation with county agencies, service providers, and advocates for children and resource families, to develop and submit recommendations to the Legislature addressing any identified gaps in placement types or availability, needed services to children and resource families, or other identified issues for children and youth in foster care who have experienced severe trauma.

As a part of the joint interagency resolution team, CDSS must have the resources to provide ongoing technical support and assistance to counties as each county is required to implement a Memorandum of Understanding (MOU) pursuant to AB 2083. According to CDSS, siloed practices in planning and services cause gaps and inefficiencies in how systems assess and respond to the needs of children and families, adding to the trauma that children and families experience, and can minimize the positive impacts of each individual system. These silos also lead to ongoing structural gaps in the network/service continuum (including placement settings) that each system provides, and impede the ability of each individual system to adapt and respond to structural gaps in the overall system of care. Thus, providing technical assistance to counties around the implementation and development of their MOUs is critical. CDSS recognizes the need for continued implementation efforts to support the intended level of change and successful outcomes for children. This includes the need for a reduction in the number children entering congregate settings, as well as the increased need to make sure the entire system of care is situated in a way that can respond to the complex needs of these youth.

**Staffing and Resource Request.** CDSS requests permanent position authority and \$1.2 million General Fund in 2025-26, and \$1.2 million General Fund ongoing to convert six limited-term positions set to expire on June 30, 2025 previously approved in the 2022 Budget Act to continue critical work associated with increased data-informed oversight, accountability, and continuous quality improvement for the child welfare continuum. The requested resources will focus on the following:

- Increased oversight of foster care placements in congregate care facilities and unlicensed care.
- Oversight related to disproportionality in the continuum of care.
- Continuing effective implementation of AB 2083, which provides critical accountability for local agencies to develop and collaborate within their continuum of care.

CDSS requests position authority for two Staff Services Managers, one Associate Governmental Program Analyst, and three Health Program Specialists. The requested resources will allow CDSS to continue to provide guidance to counties and other stakeholders regarding STRTP standards, develop and respond to county self-assessments, and develop and implement tools to measure the quality of services provided by counties and congregate care providers.

The positions responsible for this workload also provide highly complex project management of cross-divisional coordination with respect to county-specific engagement and multi-agency deliverables. This supports effective use of state resources, including effectively linking subject matter expertise and actionable interventions that support state efforts to comply with federal and state law.

The ongoing implementation of the Continuous Quality Improvement (CQI) Framework, as well as the ability to provide support to counties, congregate care providers, and system partners related to youth with unmet complex needs will require the continuation of funding of the positions listed in this proposal. The requested resources will:

- Support all wide-scale projects of the division, including project management, development, and implementation of a deliverable driven framework for implementation and ongoing support of broad System of Care efforts.
- Provide independent technical assistance while navigating complex data and highly sensitive matters across the systems of care, including a thorough understanding of specialty mental health services.
- Provide oversight, leadership, and day-to-day support and supervision for the collection, analysis, and use of data around technical assistance, youth with complex needs, and CQI.
- Oversee non-technical tasks, including project oversight of policy and program implementation related to the CQI Framework, organizing, and coordinating requests related to unlicensed care, and creating briefing documents and responses for high level, sensitive assignments.

CDSS states that with ongoing permanent funding and position authority, the department can continue to systematically review and respond to the data while proactively engaging with counties to improve care and support for youth, which also prevents litigation.

### **California HOPE for Children Trust Account**

**Background: SB 242.** SB 242 (Skinner), Chapter 1010, Statutes of 2024, established the HOPE Program and creates trust accounts for children who meet certain eligibility criteria, including children in foster care whose reunification services have been terminated.

According to CDSS, the current Child Welfare System, Child Welfare System/Case Management System (CWS/CMS), does not have the functionality necessary to meet the requirements of SB 242, and requires two additional staff to: (1) routinely flag eligibility for the HOPE program, (2) generate an account number, and (3) transmit information to relevant parties. CWS/CMS is currently scheduled to be decommissioned starting in November 2026 and replaced by Child Welfare Services California Automated Response and Engagement System (CWS-CARES). The subset of the data flow that can be automated will be developed for CWS CARES. However, the tasks of identifying eligible children, assigning HOPE Account numbers, transferring authorized information to the State Treasurer's Office, and creating reports for eligibility communication and outreach will require ongoing manual workarounds.

**Staffing and Resource Request.** CDSS requests permanent ongoing authority and \$374,000 General Fund in 2025-26 and \$364,000 General Fund ongoing for one Research Data Specialist and one Associate Governmental Program Analyst to implement SB 242.

CDSS states that these two positions are needed to provide the State Treasurer's Office with the required information on eligible children in a way that protects confidentiality and minimizes administrative burden in accordance with SB 242. Information that would be reported to the State Treasurer's Office on a regular basis includes, but is not limited to: (1) the numbers of eligible children, (2) dates eligibility began and ended, and (3) a unique HOPE account number assigned to each eligible child. To be eligible, a child must have been subject to a foster care order for at least 18 months and family reunification services have been terminated. Youth who enter foster care after age 16 do not need to meet the 18-month requirement.

According to CDSS, SB 242 requires the setup of a careful flow of information between CDSS and the State Treasurer's Office that protects confidentiality of foster youth. CDSS will create a monthly report of eligible children for the Treasurer's Office that identifies children with a newly created "HOPE Account" number. Using that number, and other non-confidential data points regarding their time in care, the Treasurer's Office will set up the accounts. CDSS will develop a process to assist eligible children in activating their accounts. The requested positions will be responsible for the following activities:

- *The research data specialist* will develop and implement a new methodology to extract the required data from CWS/CMS without violating confidentiality laws until CWS-CARES is operational and has implemented the required automation to assume this workload.
- *The analyst position* will develop and implement policy guidance on this new program. CDSS anticipates there will be an ongoing need for substantial technical assistance and verifications of eligible children.

CDSS states that without these positions, CDSS will not be able to absorb the workload and provide this information within necessary timeframes.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the three budget change proposals included in this issue: (1) First Phase of Foster Care Tiered Rate Structure State Operations, (2) Ongoing Funding for Foster Care Placement Services, and (3) California HOPE for Children Trust Account.

**NOT FOR PRESENTATION****Issue #10: Proposals for Investment**

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

- **Critical Bridge Funding Needed to Prevent Collapse of 220 Foster Family Agencies that Serve 1 in 5 Foster Youth in California.** The California Alliance of Child and Family Services (California Alliance) proposes \$47 million General Fund one-time over two years to stabilize California’s 220 Foster Family Agencies (FFAs) and protect placements for the more than 7,400 foster youth they serve. If approved, \$36.1 million would support FFA administrative costs due to the current FFA insurance crisis, and \$10.6 million would provide a cost-of-living adjustment (COLA) for FFAs. The Alliance proposes that the \$47 million General Fund over two years would include \$39.6 million in 2025-26 (\$36.1 million in administrative costs related to insurance, and \$3.3 million COLA), and \$7.1 million in 2026-27 for a COLA to allow FFAs to continue operating until the Tiered Rate Structure takes effect on July 1, 2027.

According to the California Alliance, “FFAs across the state are facing an insurance crisis that will jeopardize placements and finding permanent homes for youth in their care. In August 2024, The Nonprofit Insurance Alliance of California (NIAC) that provided coverage to 90 percent of FFAs in California, announced that they would have to stop renewing liability coverage policies. Although limited alternate insurance options are emerging for some FFAs to continue operating and retain coverage in the short-term, these options are significantly more expensive and unsustainable in the long run. While the Insurance Commissioner called for admitted insurers to step up and offer FFAs coverage, not a single state-admitted insurer has joined the market to help insure agencies. FFAs cannot operate without liability insurance, as it is essential for mitigating risk, ensuring financial stability, providing safe and reliable care for children and families, and a requirement of county contracts. Many of the non-admitted state insurers who were willing to offer liability coverage to FFAs are significantly more expensive with often lower levels of coverage, making them an unsustainable long-term solution for agencies.”

The California Alliance further states that “Without insurance coverage, FFAs will continue to downsize and close, which would overwhelm the understaffed county child welfare system and jeopardize placements and quality of care. These exorbitant insurance costs add even more financial distress on already underfunded and understaffed FFAs. The insurance crisis is already impacting agencies financially, with one agency reporting that they had to resort to reducing staff salaries to make up for the costs as ‘hours and payment rates have been reduced to social workers to try and offset insurance hikes. Such reduction of hours can directly affect quality foster care services to both resource parents and foster consumers.’”

In addition to support to address the immediate-term impacts of the insurance crisis, the \$47 million requests includes \$10.6 million for a COLA. According to the California

Alliance, “CDSS plans to implement the Tiered Rate Structure in 2027, after its originally scheduled launch in 2025. This structure will introduce, for the first time, an annual COLA to the FFA administrative rate, tied to the California Necessities Index (CNI)... This one-time bridge funding will help bridge the gap between 2025 and 2027 for FFAs to pay their staff a competitive wage until finalized child welfare rates are established in 2027 in accordance with the new tiered rate structure.”

- **California Success, Opportunity, and Academic Resilience (SOAR) Guaranteed Income Program.** A coalition of organizations including Economic Security Project Action, End Poverty in California, United for a Guaranteed Income, Young Invincible, Santa Clara County, What We All Deserve, and United Way California, Capitol Region request \$44 million General Fund one-time in 2025-26 to fund the first year of the CalSOAR Guaranteed Income Program contemplated in pending legislation, SB 33 (Cortese). According to this coalition, “the CalSOAR Guaranteed Income Program would serve high school seniors in California experiencing homelessness. Following the current California Guaranteed Income Pilot Program framework, the program would provide exiting 12th-grade high school students experiencing homelessness with monthly, unconditional cash payments during the critical transition period between high school graduation and postsecondary education or employment. Funding would be passed through the Department of Social Services on a population-based formula to counties that opt-in.” This request is associated with pending legislation, SB 33 (Cortese).
- **One-time Investment in Renovations for Permanent, Year-Round Camp Experience for Foster Youth.** Happy Trails for Kids requests \$2.4 million General Fund one-time to make various renovations to a newly acquired facility. According to Happy Trails for Kids, “this budget request – which would help Happy Trails open the doors at a permanent camp site in time to welcome campers for the 2025 summer season – seeks to provide foster youth with happy and healthy childhood experiences, learn from and connect to mentors (camp counselors) with lived experience, and give campers a sense of belonging. Further, the permanent camp site will permit Happy Trails to greatly expand its annual offerings, meaning that the organization will be able to (1) welcome foster kids from across the state to the overnight camp experience and other extracurricular activities and (2) increase employment and housing opportunities for camp counselors – the majority of whom have lived foster care experience... Happy Trails is entering a new and transformative chapter in its evolution. A long-time renter, the organization recently was deeded by the County of Los Angeles a 135-acre site in Acton, situated in the unincorporated part of the county near the Antelope Valley. While the possibilities now available to Happy Trails are limitless, considerable work must be undertaken to reimagine the venue and make it “camper ready” for the 2026 season.”
- **Child Care Emergency Preparedness.** The California Child Care Resource & Referral Network request \$20.5 million General Fund ongoing to support child care resource and referral agencies to support disaster assistance. According to the California Child Care Resource & Referral Network, “currently, federal law requires the state to have a State Emergency Plan, with the Child Care Disaster Plan serving as an annex to that broader plan. The Child Care Disaster Plan outlines the roles and responsibilities of key state

agencies to support the childcare infrastructure to provide childcare services to children and families affected by disasters. The recent devastating wildfires in Los Angeles are only the latest example of the growing frequency and intensity of catastrophes in the state. They are also the latest example of how Child Care Resource and Referral agencies were called upon to assist the state and respond to local needs. With at least one agency serving each of California's 58 counties, these organizations play a vital role in ensuring child care providers and families receive the necessary support during crises. The state's Child Care Disaster Plan, written in 2016, recognizes the need for these agencies in disaster response and recovery. However, despite their designated and important role, California Childcare Resource and Referral agencies are not currently equipped with the necessary resources to fully implement and coordinate their responsibilities." This request is associated with pending legislation, AB 1471 (Soria).



# Master Plan for Developmental Services

## A Community-Driven Vision

MARCH 2025

# Community Commitments

**What to Expect in the Master Plan for Developmental Services (MPDS).** The MPDS is a community-driven vision. The goal of the MPDS is to improve how California supports people with intellectual and developmental disabilities (I/DD) and their families into the future. The MPDS provides recommendations for California to provide services for people with I/DD that are:

- Equitable
- Consistent
- Accessible

This plan was developed by a diverse group of stakeholders. A stakeholder is someone who is affected by an issue. The stakeholders who developed the MPDS included:

- People with I/DD
- Their family members
- Other members of the community

The California Health and Human Services Agency (CalHHS) provided staff and other support to stakeholders in developing the MPDS. All the recommendations in the plan were developed with and by community stakeholders. The plan was developed to advise CalHHS, the Department of Developmental Services (DDS), and other state departments on how to achieve a shared vision of improved services and supports for all Californians with I/DD.

This report talks about ways to make the developmental services systems work better. It also provides a vision for a future where people with I/DD have the resources they need to thrive. These resources include the flexible and innovative services and supports that people with I/DD need to be full participants in the community of their choice. The MPDS is designed to inform California's ongoing work to create opportunities for, and to serve, people with I/DD.

**Making This Report Accessible to Everyone by Using Plain Language.** This report is written in plain language. We use plain language so that everyone can understand the recommendations in the MPDS. Plain language is a way of writing that makes information easy to understand. It uses clear words and sentence structures to help readers understand what is in the Plan. This approach is especially helpful for people with I/DD. It helps to make sure everyone can access and understand information that affects their lives.

There is a lot of information in this report about how to make the systems work better. Some of these recommendations are complicated and might use words that are not familiar. There is a glossary at the end of this report with definitions for many of the words used in the report.

**Referring to People With I/DD Using the Language They Choose.** People with I/DD have different ways of describing themselves. People might prefer terms like advocate, self-advocate, disabled person, or individual with lived experience. Some people prefer “person-first” language. Person-first language means saying things like “people with disabilities.” Other people prefer “identity-first” language. Identity-first language means saying things like “disabled people.”

This report usually uses terms like “people with intellectual and/or developmental disabilities” (I/DD) or “people served.” This report will also use the term “self-advocate” to refer to people with I/DD who participated in the MPDS process.

**Self-Advocate Input:** This report uses information and ideas shared by self-advocates. Their personal experiences help us understand how to improve the services they use. The stories, experiences, and ideas of self-advocates and family members of people with I/DD helped shape recommendations to provide equitable, consistent, and accessible services and policies.

In this report there are boxes that highlight quotes from self-advocates. These quotes talk about self-advocate experiences with the system. The quotes also talk about the hopes and dreams that self-advocates have for the MPDS. Self-advocates are experts with real experience. Their ideas were a very important part of the Master Plan process. These voices helped lead and guide the development of the Master Plan.

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# Appreciation From the Agency Secretary

Dear Committee, Workgroup Members, and Community,

On behalf of the California Health and Human Services Agency, I extend my gratitude for your contributions to the Master Plan for Developmental Services. Your expertise, dedication and collaboration have been essential in understanding and capturing what people in California's developmental disability services community need and want for the future. The process of creating the Master Plan was ambitious, requiring the input of diverse perspectives. Your commitment to inclusivity, thoughtful and thought-provoking conversation, and innovative ideas have enriched the Master Plan.

Whether you participated as a Committee Member, Workgroup Member, or through public forums, provided feedback, participated in one of the more than 45 sessions with community groups, or worked directly with staff to offer assistance and insights, your contributions are invaluable. The recommendations that you developed will improve the quality of services and life outcomes for individuals with I/DD and their families. This work will also help maintain and expand services and supports remain responsive, equitable, accessible, and sustainable for Californians.

I would like to recognize the work of Victor Duron, Chief Deputy Director at the Department of Rehabilitation (DOR), who led the Master Plan effort while balancing his existing responsibilities and briefly serving as acting Director. In addition, thank you to the team of logistics experts, consultants, facilitators, interpreters and translators, note-takers, writers, and others who made possible the dozens of Committee and workgroup meetings, and community listening sessions. The Master Plan itself could not have come together without your efforts.

Significant and transformative efforts are currently underway across Governor Newsom's Administration. This includes the January 1, 2025, full implementation of rate reform in California's developmental services system, to stabilize and expand the service provider network and its essential workforce. Planning is

underway for a modern and unified case management and fiscal system that provides access for individuals, families, and service providers to information, including their own. Employment First policies and a Master Plan for Career Technical Education and new apprenticeship and internship programs present new opportunities for people to achieve their goals and financial success. Collectively, the goal is to make sure that the systems are fair, support the provision of high-quality care, and help people get the services they need. As we move forward, we recognize that the implementation of recommendations in the Master Plan requires continued partnership and collaboration. We remain deeply committed to working with the community and the Legislature to realize the plan developed by and for the community. Together, we will achieve lasting positive improvements for the people of California.

In partnership,

**Kim Johnson**

Secretary, California Health and Human Services Agency

## Why Do We Need a Master Plan for Developmental Services?

All people have the right to make choices about how they live their lives. People with I/DD often face discrimination and stigma. Discrimination happens when people are treated unfairly because of things like their gender, age, race, or ability level. Stigma happens when people believe negative things about someone and treat that person unfairly or do not include them. People with I/DD from certain groups face more discrimination and stigma than people in other groups. This can be true for:

- People who speak a language other than English
- People who are not citizens
- People who are part of racial or ethnic groups that have historically been discriminated against
- People who have certain disabilities

People with I/DD do not always get the same freedom, support, and opportunities as others. This happens for many reasons:

- Sometimes non-disabled people think they know what is best for people with I/DD and tell them what to do.
- Sometimes non-disabled people do not listen to the opinions of people with I/DD.
- Sometimes the systems that provide services to people with I/DD do not explain what supports and opportunities are available.

**“They seem to assume if you’re a consumer, that means you’re not necessarily intelligent enough to make decisions for yourself or anyone else. It’s like—excuse me?”**

Elena

- Sometimes supports and opportunities that people with I/DD want and need are not available to them when they should be.

- Sometimes vendors don't want to provide services and supports to certain people with I/DD because of the disability they have, or for other reasons.

It is not right or fair that many Californians with I/DD do not get to make choices about their own lives. It is not right or fair that they are not always listened to. It is not right or fair that Californians with I/DD do not always get equal treatment.

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This Master Plan for Developmental Services (MPDS) is a plan to make things better and more fair for people with I/DD. The Plan has recommendations to make sure that people with I/DD get the services and supports they need and choose, when they need them, so they can lead the lives they want.

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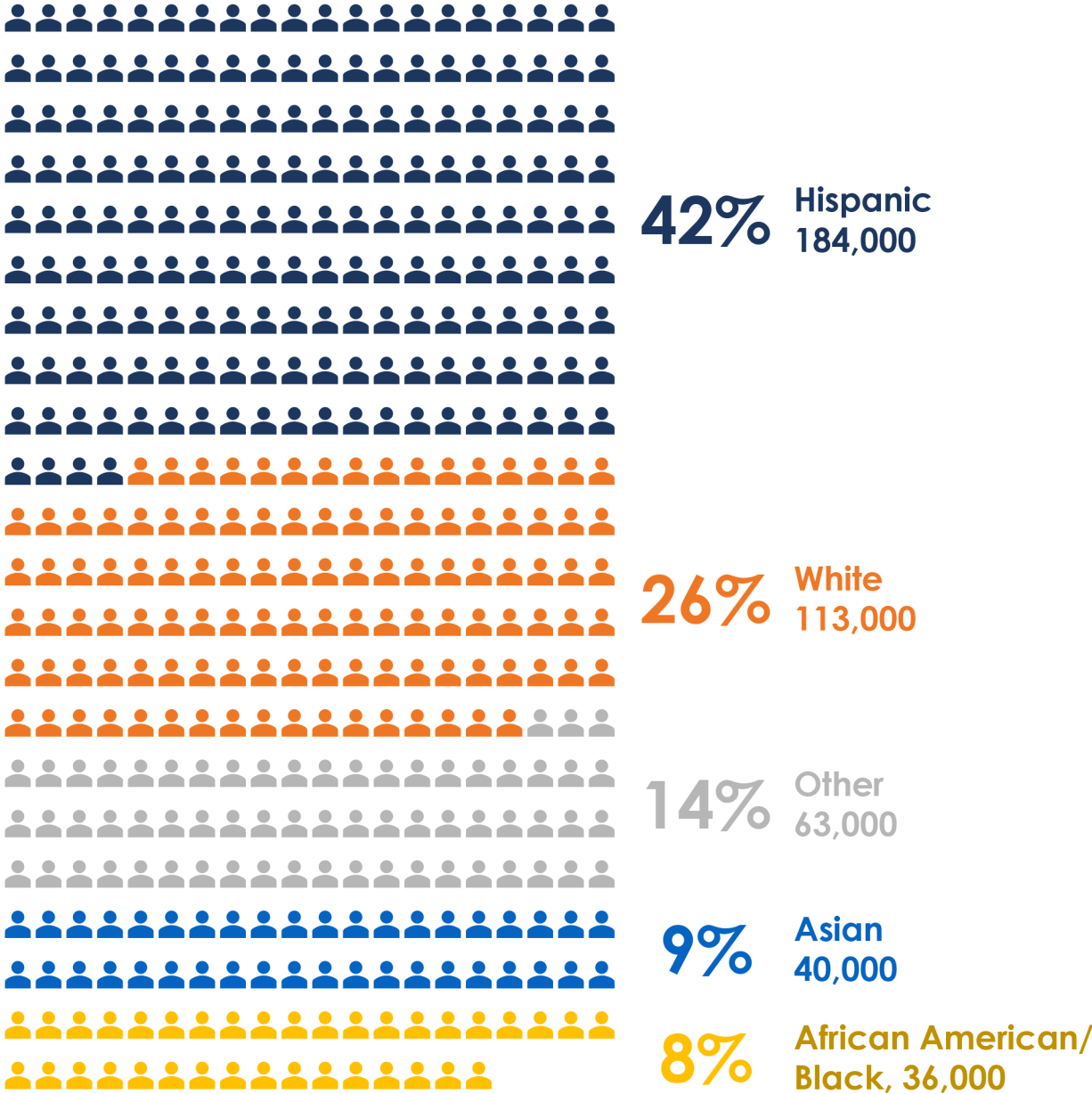
California's law for the developmental services system is called the Lanterman Act.<sup>1</sup> This law was passed in 1969. The Lanterman Act says that people with I/DD and their families have a right to get services and supports they need. This is called an "entitlement." It means that California is responsible for making sure people with I/DD get the services they need to live the lives they want. There are other state and federal laws that support people with I/DD and their families. One of those is the Early Start program. California's Early Start program provides access to developmental services for infants, toddlers, and their families.

In California, the Department of Developmental Services' (DDS) is responsible for making sure people with I/DD receive services and supports. DDS has contracts with regional centers to provide and coordinate services and supports to eligible people with I/DD. There are 21 regional centers in California. Each regional center coordinates services for eligible people with I/DD who live in their area. In 2024, nearly half a million people with I/DD were served by the regional center service system.

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<sup>1</sup> [For more information about the Lanterman Act \(https://www.dds.ca.gov/transparency/laws-regulations/lanterman-act-and-related-laws/\)](https://www.dds.ca.gov/transparency/laws-regulations/lanterman-act-and-related-laws/)

**Population Served by the Regional Center System in 2024**



## What Is “The System”?

People with I/DD and families served by the developmental services system often get services from other systems too. These systems are meant to work together to provide services and supports that people with I/DD and their families need. But the systems don't always work that way. People and families served by the developmental services system may also receive services and supports from other systems like:

- The California Department of Health Care Services (DHCS)
- The California Department of Rehabilitation DOR
- The California Department of Social Services (DDS)
- Schools, colleges, and educational programs

## Equity in the System

Recent reports identified challenges people experience when getting services in the developmental services system. For example, in 2023 a report by the Little Hoover Commission found problems with the ways that people with I/DD and families get developmental services.<sup>2</sup> The report said that people from different racial and ethnic groups did not get services fairly. The report also said that people living in different parts of the state did not get services fairly. The report said that it was important to fix these problems with the system. Fixing problems like these would help to make sure that there is equity in the system.

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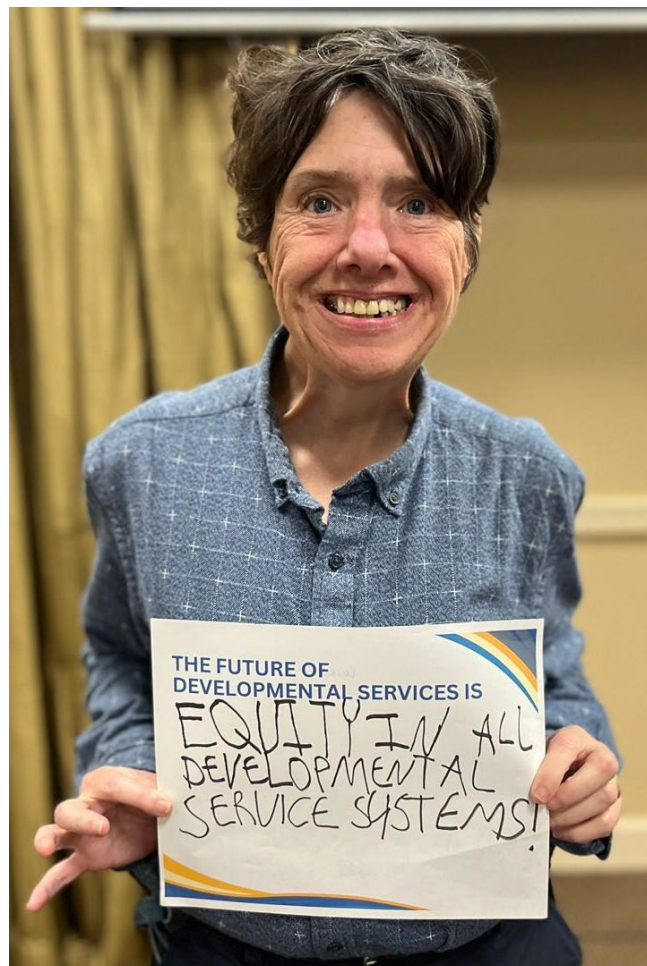
<sup>2</sup> [For more information about the Little Hoover Commission report \(https://lhc.ca.gov/report/system-distress-caring-californians-developmental-disabilities/\)](https://lhc.ca.gov/report/system-distress-caring-californians-developmental-disabilities/)

## What Is Equity?

- Equity means giving each person with I/DD the help they need to lead the lives they want.
- Equity means understanding that people do not start in equal or fair places.
- Equity aims to correct unfairness.

Equity was a guiding principle for the MPDS process because there are people and communities who experience unfair treatment and unequal outcomes in the developmental services system. Early in the MPDS process, the Committee talked about equity to make sure that everyone had a shared understanding of what equity means. Throughout the MPDS process there was outreach to many diverse communities, including communities that are not served by the system and communities that are served by the system. This was to make sure everyone's input would be reflected in the MPDS.

We put equity at the center of the MPDS process to make sure equity was considered in all of the Master Plan recommendations.



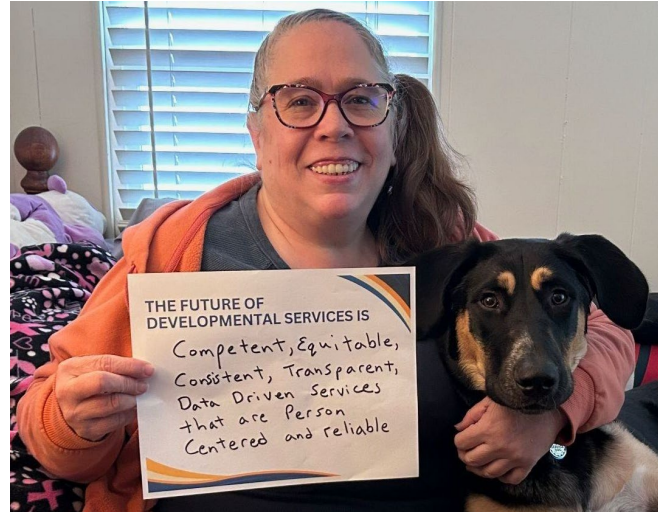
## What Is the Master Plan for Developmental Services?

The MPDS can help inform progress to:

- Better services and supports
- Improved coordination across systems
- People with I/DD getting the life outcomes they want

CalHHS provided staff and other support to stakeholders in developing the Master Plan. But

the plan was ultimately developed with and by the community. This includes people with I/DD who are served by the system and their circles of support. “Circles of support” means the people in our lives that help us be successful. This can include parents, siblings, close friends, and other loved ones. The Master Plan was also developed with support from other community members like service providers, policy experts, and other stakeholders. Together, self-advocates and other stakeholders developed this plan and all of the recommendations in it that talk about how to make California better for all people with I/DD.



The vision for the MPDS is centered in:

- Equity
- The promise of the Lanterman Act's entitlement to services
- The experience and expertise of people with I/DD and their families

The vision applies to all systems that serve people with I/DD and their families. The goals of the Master Plan are:

- People with I/DD and their families experience person-centered service systems they trust. Their basic needs are met so they can live in the community of their choice.

- People with I/DD receive timely, inclusive, and seamless services throughout their life span across all service systems.
- People with I/DD and their families receive services from a high-quality, stable, and person-centered workforce.
- People with I/DD and their families experience consistent, transparent, accountable, and data-driven systems that focus on outcomes.
- People with I/DD receive quality, life-long, person-centered services from systems with adequate resources.

The MPDS talks about how to make these improvements for everyone with I/DD, no matter:

- The type of disability they have
- Their age, gender identity, or sexual orientation
- What language they speak
- Where in California they live
- How much money they have
- What racial or ethnic group they belong to

The MPDS has many recommendations to improve systems. These recommendations would:

- Make sure people with I/DD from all backgrounds feel respected and get person-centered services.
- Make sure people with I/DD live in inclusive communities where they feel they belong and have the resources to thrive.
- Improve accountability in the systems that serve people with I/DD. Being accountable means being responsible for your actions. It is about systems doing what they say they will do and facing the consequences if they do not.

- Make sure people get services they want and choose.
- Make sure there are resources and supports to meet the needs of more people.
- Make sure there are enough highly qualified people working to provide supports and services.
- Improve transparency in the systems. Transparency means making sure people have information to understand how the system works.

Another important part of the MPDS is removing barriers and closing gaps between systems that serve people with I/DD. This means improving coordination between the developmental services system and other systems. This would make sure that systems work together to help people get the services and supports they want and need.

**“We want the systems to work together instead of leaving people to navigate everything themselves.”**

Viri

# How Did We Create the Master Plan for Developmental Services?

## Committee and Workgroups

In early 2024, a MPDS Committee was appointed by the Secretary of CalHHS. The Committee's job was to develop the MPDS. Committee members had diverse backgrounds and lived experiences.<sup>3</sup> The Committee was asked to use their expertise to develop the MPDS together. They got input from diverse communities in California.



The Committee met every month between April 2024 and March 2025. All Committee meetings were open to the public and allowed on-line participation. Committee meetings took place around the state, including:

- Sacramento
- Los Angeles
- San Diego

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<sup>3</sup> For a complete list of MPDS Committee members, see Appendix A.

- Fresno
- Berkeley

In addition to the MPDS Committee, five workgroups were created to focus on different MPDS goal areas. Each workgroup's job was to develop recommendations for their goal areas. Workgroups included some Committee members and members of the public who applied to be on a workgroup. Almost 900 people from all over the state applied. Of those who applied, 57 people were selected to be workgroup members.<sup>4</sup>

To have a broad representation of workgroup members we selected applicants with the following diversity:

- People with I/DD
- People with diverse expertise
- People from all parts of the state, including rural communities
- People with diverse backgrounds and identities including race and ethnicity, sexual orientation and gender identity, and different types of disability

Each workgroup had about 20 members. Each workgroup was led by two co-chairs. In each workgroup, one of the co-chairs was a self-advocate with I/DD, and the other was a family member of someone with I/DD.

**“Each one of us in our own way, represents thousands of other self-advocates who, for whatever reason, didn’t have the ability or the time or the interest to show up for multiple meetings. In our own way we got to be their voice and represent their needs and interests.”**

Lisa

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<sup>4</sup> For a complete list of MPDS workgroup members, see Appendix B.

Workgroups met every month between August 2024 and March 2025. Each workgroup focused on developing recommendations in one focus area. The five workgroup focus areas were:

- People with I/DD and families who experienced person-centered service systems they trust
- People with I/DD who received timely, inclusive, and seamless services across all service systems
- People with I/DD and their families who receive services from a high-quality, stable, and person-centered workforce
- People with I/DD and their families experience consistent, transparent, accountable, and data-driven systems that focus on outcomes
- People with I/DD are entitled to life-long services with adequate resources

Recommendations from the workgroups were discussed during Committee meetings. These discussions focused on how to improve workgroup recommendations. During the last Committee meetings, Committee members talked about the final recommendations that should be included in the MPDS.

Some workgroup recommendations are not in this final Master Plan. This is because Committee members could not agree to include them. These recommendations are available in a separate document ("Recommendations That Were Considered and Not Adopted") on the CalHHS MPDS website (<https://www.chhs.ca.gov/home/master-plan-for-developmental-services/>). Committee members who did not agree with the final decisions about the recommendations could make comments about the final decisions. Those comments are also available on the Master Plan website (Stakeholder Committee Comments About Recommendations). There are other important documents on the Master Plan website. One document provides more details and technical information about some of the recommendations (Recommendation Background and Technical Information).

## Public Engagement



Every Committee meeting and every workgroup meeting were open to the public. Members of the public were invited to contribute their ideas. Committee meetings started and ended with comments from the public. Notes were taken on all public comments. The notes were used to make sure that the Committee considered all ideas and experiences in the Master Plan.

CalHHS also had a public engagement campaign during the MPDS process. This included many opportunities to engage with people with I/DD, their families, and other partners in their communities. The goal of the public engagement campaign was to better understand hopes and dreams for an improved developmental services system.<sup>5</sup> During the MPDS process there were public engagement events with 45 different groups. Thousands of people from diverse communities shared their ideas during these meetings. For example, there were events with:

- Diverse cultural community advocacy groups
- Disability civil rights organizations
- Representatives of service provider systems

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<sup>5</sup> For a complete list of MPDS Community Engagement Opportunities, see Appendix C.

Summaries of public engagement events are available on the CalHHS MPDS website (“Community Engagement Summaries”).

## Topics in the Master Plan

Recommendations in the MPDS were organized by topic area. Topics include recommendations from more than one workgroup. The six topics in the MPDS are:

- Systems Serving People with I/DD Are Centered in Equity
- People with I/DD Making Their Own Life Choices
- People with I/DD Getting Services They Need and Choose
- People with I/DD Being Part of and Being Served by a Strong Workforce
- Accountability and Transparency in All Systems That Serve People with I/DD
- Informing the Future of the Developmental Services System

## The Master Plan Is Centered in Lived Experience

People with I/DD and their families shared their real-life stories to help create the Master Plan. This is called “lived experience.” It means learning from actual life events, not just from studies or reports. By including these personal experiences, the plan better reflects what people truly need and want.

Self-advocates played a key role in developing the Master Plan. They received the time and support to participate effectively and share their own thoughts and opinions.

**“In any kind of big conversation about people, it’s really important to have the people who are being talked about in the room right? And not only just to be there, but to give expertise based on things that we know.”**

Elizabeth

To empower self-advocates to participate, a new role, the Support Facilitator, was created. These facilitators helped self-advocates prepare for meetings, understand complex information, and share their own ideas confidently. Facilitators provided one-to-one help, group discussions, and support for self-advocates to participate on their own. Each self-advocate chose the support that worked best for them.

Before recommendations were finalized, self-advocates had their own information sessions. These sessions allowed them to review recommendations from each workgroup before decisions were made.<sup>6</sup>

**“I may be good at one thing, but it does not make me good at everything else. I need supports and real help in many other areas that a lot of people don’t consider...I love the pre meetings, because it gives us the chance to be with other self-advocates.**

Oscar

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<sup>6</sup> For more detail on how self-advocates were supported during the Master Plan process, see Appendix D.

# What Are the Recommendations in the Master Plan for Developmental Services?

There are six topic areas and 167 recommendations in the Master Plan. This report provides a summary of each recommendation. Recommendations are organized by topic area. Each topic area provides information about what problems the recommendations are trying to solve. Some of the recommendations have more details and background than you will see in this section of the report. This additional information is available in a separate document (“Recommendation Background and Technical Information”) on the CalHHS MPDS website.

## Systems Serving People With I/DD Are Centered in Equity

There are people with I/DD who experience unfair treatment and worse outcomes than others in the system. Some people with I/DD have an even harder time than others getting the services and supports that they need. This is not fair, and it is not equitable.

Recommendations in this topic area are focused on addressing fairness and equity in the systems that serve people with I/DD. These recommendations will help to make sure that the systems which serve people with I/DD are fair and work the way they should for everyone.



- 1. Define Equity.** DDS should work with diverse communities to create a clear, plain language definition of equity. The definition should be updated regularly. This definition should acknowledge that everyone has different needs. This means an equitable system must be person-centered to provide everyone with opportunities to achieve their goals. DDS, regional centers, and stakeholders should use the definition of equity to guide their work and be accountable for achieving equity in the system. To do this, each regional center must work with DDS to create an internal Equity Team, and an equity advisory committee made up of community members. Both the Equity Team and the equity advisory committee should have strong self-advocate representation. Each regional center's Equity Team should participate in an independent statewide community of practice. A "community of practice" is a group of people who are working on a topic. The group meets regularly to discuss the topic and learn together. This community of practice would focus on the topic of equity. Each regional center's Equity Team should report to the DDS equity team regularly. This reporting to DDS would be separate from the Equity Team's relationship with the regional center that they work for.
- 2. Build Support and Oversight for Equity at DDS and Regional Centers.** DDS staff and leadership should have the resources and expertise they need to support and oversee equity at all regional centers. This means that DDS understands and responds to equity issues for people served by the regional center system. This should include training for DDS and regional center staff on how implicit and structural bias impact individuals and their circles of support. "Implicit bias" means prejudices or stereotypes that a person may believe without even realizing that they believe them. "Structural bias" means inequalities that are part of systems, policies, or practices. Training should also focus on how intersecting identities impact people served by the system. This recommendation means recognizing that people can experience unfair treatment because of multiple parts of their identity, like their race as well as their disability. This is called "intersectionality."

**"We want clear rules that are fair but they have to be flexible to meet each person's needs. Equity should include clear actions to make sure everyone is treated fairly."**

Kecia

DDS should also incorporate equity requirements into their contracts with regional centers. This recommendation would make sure that DDS uses the definition of equity to analyze system data and outcomes. This would improve how DDS can enforce accountability. It would also support services, like Ombudsperson and client assistance services, to use an equity lens when addressing the needs of people with I/DD and their families. An “ombudsperson” is an independent third party who investigates and resolves complaints. Using an “equity lens” means keeping equity in mind when thinking about a problem or issue. This recommendation would help DDS address the specific needs of people with I/DD and help identify and resolve the causes of issues that are related to equity.

3. **Implement Language Access Plans at Regional Centers.** Regional Centers should adopt language access plans. A “language access plan” is a plan that clearly describes:

- The ways the regional center will communicate with individuals and families
- The languages they will use
- Any other supports that are needed so that individuals and families can easily understand them

The regional center language access plans should expand on plans which other state agencies have developed to serve the needs of individuals and their communities. The plans should be designed to meet the diverse needs of individuals and their circles of supports. The plans should include commitments to:

- Use plain language
- Use preferred language
- Provide digital access
- Provide Augmentative and Alternative Communication (AAC) and other accommodations. “AAC” means communicating using methods other than or in addition to spoken language. These communication methods can include gestures, pictures, symbols,

electronic devices, and changes to the environment that make it easier for people to communicate.

The plan should also describe how equitable language will be used in all interactions with people with I/DD and their families—for example, during intake, during Individual Program Planning (IPP) meetings, and at fair hearings.

4. **Remove Language Barriers to Services.** DDS should make sure that language is not a barrier when people with I/DD and their families access services. DDS should:

- Make sure that all information about programs and services is available in plain language.
- Translate plain language information into languages spoken by people served by the regional center.
- Create programs and materials in multiple languages. This will make sure that people from diverse cultural communities can get the information they need.
- Develop a process of sharing these language support materials across regional centers.
- Hold regional centers accountable for using these language support materials.
- Make sure all regional center employees meet linguistic competency and cultural humility requirements.
  - “Linguistic competency” means that if employees are expected to use a language other than English, they can speak and understand the language well.
  - “Cultural humility” means that employees understand and respect differences that people from diverse backgrounds might have. It also means they understand there are things they do not know about other cultures, and that they are willing to learn from others.

- Make sure high-quality interpretation services are available at all regional centers. This way people with I/DD and their families will have the support they need during meetings and other interactions.
  - Require companies that provide interpretation services at regional centers to undergo trainings, complete certifications, and adhere to standards. This will help to make sure that the interpretation services they provide are of high quality.
- Establish an office at DDS that receives and responds to complaints about poor quality interpretation or translation supports. This will make sure that issues with interpretation or translation related to IPP meetings, service providers, fair hearings, and other interactions, are fixed.

5. **Make Sure People With I/DD Can Meaningfully Participate in Systems That Serve Them.** DDS and regional centers should provide person-centered supports to people with I/DD, so they can meaningfully participate in the systems that serve them. This includes participating in:

- DDS and regional center advisory boards
- Regional center boards of directors
- Employment opportunities in DDS and regional center leadership positions
- Decision-making in the next steps of the MPDS

Supports should:

- Include support facilitators
- Be provided without reducing or otherwise restricting the other services authorized in a self-advocate's IPP or their Self-Determination Program (SDP) budget

DDS should also provide resources and explain the steps people can take if they believe that they are not being supported to meaningfully participate or

are being tokenized. “Tokenism” is when people with diverse backgrounds are included without their concerns actually being listened to.

6. **Support People With I/DD and Their Intersectional Identities.** DDS and regional centers should develop plans for outreach and meaningful engagement with communities within their service area that experience additional barriers to equity. Some people with I/DD and their circles of support face additional barriers depending on other parts of their identity. This can include their:

- Race
- Sexual orientation and gender identity
- Geographic community
- Immigration status
- Tribal/Native American ancestry
- Disability type. People may experience discrimination within the disability community for their disability. This can be particularly true for people with the highest support needs or for people who have few or no circles of support.

The plans should describe:

- How communities which need better service will be identified
- Partners within communities, like trusted leaders in their community
- How outreach will be provided to those communities. For example, by:
  - Building relationships
  - Inviting the community to provide input
  - Supporting the community in being full partners in decision making within the system

7. **Engage With Tribal Communities to Enhance Services.** The State and the developmental disability system in California acknowledge the unique needs

and governmental status of Tribal communities. In creating the MPDS, the State received invaluable input from individuals receiving and providing developmental disability services in Tribal communities.

- One example of this input was that the State should look at special considerations in the law, such as the Indian Child Welfare Act, and consider if something similar is needed in the developmental disability system.
- Another example was to analyze the ways funding is set aside for Tribal services in other service systems and consider if there should be similar set-aside funding for Tribal communities in the developmental disability system.

After considering this and other Tribal input, the State would then engage in government-to-government Tribal consultation to get input from Tribal leadership and communities. This input would help the State know which changes to the developmental disability system will improve access and outcomes for Native American individuals with I/DD in California.

## People With I/DD Making Their Own Life Choices

People with I/DD often do not feel heard or respected when they share what they want in their own lives. Sometimes people with I/DD are left out of being included in decisions that impact their lives. This can happen when family members or service providers think they know best for a person with I/DD. This can also happen when family members or service providers think they know what a person with I/DD wants without even asking them.

**“We are very knowledgeable in our own lives and how we want to be. We understand each step of our life. So we’re the best experts, and sometimes these agencies don’t give us enough credit where credit needs to be given.”**

Tracey

Sometimes people with I/DD try to make choices and other people do not listen to them. Sometimes people with I/DD lose their right to make choices for themselves. A goal for this topic is that people with I/DD can make their own

choices to live a self-determined life. Another goal for this topic is that people with I/DD get the supports they need to make decisions.

## **Use Supported Decision Making (SDM) More. Have Fewer Conservatorships.**

Sometimes a court decides that someone else will make choices for a person with I/DD. This is called “conservatorship.” This means that the person with I/DD loses their right to make their own choices.

**“In personal life I get advice from people. People advise me. But I’m the ultimate decision maker. Whether that is good or bad, I’m the one making decisions.”**

Sascha

Conservatorship sometimes happens to people with I/DD who just need support making decisions. Supported decision making (SDM) is a tool that allows individuals to choose supporters who have a legal right to be part of the individual’s decision-making process. This means that people with I/DD can pick people that they trust in their circles of support to support them in making decisions.

These recommendations focus on making sure SDM is used more, and conservatorships are used less. These recommendations build upon the work of an expert panel and its March 2023 report: *Expert Panel: Review of California Developmental Services Conservatorship Program Report*.<sup>7</sup>

**“Free will absolutely does exist, and we all have it, and we have the power to make a decision. But sometimes we get stumped on a certain situation, and we need that support.”**

Oscar

1. **Continue to Invest in Statewide Resources for SDM.** DDS should make sure there is ongoing funding for the SDM Technical Assistance Program (SDM-TAP). SDM-TAP is coordinated through the State Council on Developmental

<sup>7</sup> [For more information about the Expert Panel: Review of California Developmental Services Conservatorship Program Report \(https://www.dds.ca.gov/wp-content/uploads/2023/03/ExpertPanelFinalReportMarch2023.pdf\)](https://www.dds.ca.gov/wp-content/uploads/2023/03/ExpertPanelFinalReportMarch2023.pdf)

Disabilities (SCDD). SDM-TAP is a statewide resource and online hub for people seeking information about SDM. SDM-TAP provides education, guidance, assistance, and training to:

- People with I/DD
- Families
- Service providers
- Professionals
- Courts
- Attorneys
- Mediators
- Others in California who wish to use or expand SDM in their professional or personal life

2. **Create System-Wide Values About Alternatives to Conservatorship.** DDS should work with diverse stakeholders, including people with I/DD, to develop system-wide values about alternatives to conservatorship. These values should include:

- Using SDM
- Using conservatorships only as a last resort
- Using conservatorship only for the shortest period of time possible

DDS should create leadership opportunities for people who use SDM to share their experience and best practices. DDS should develop and make mentorship programs available. These mentorship programs would allow experienced users of SDM to provide support to people with I/DD who are new to SDM and families. DDS should develop user-friendly apps and platforms that facilitate SDM processes and communication between people with I/DD and their support networks.

3. **Make Sure People With I/DD and Their Families Can Access Information and Training to Use SDM.** DDS and regional centers should work with diverse stakeholders, including people with I/DD, to develop plain language information and training resources about SDM. These resources should be designed for people with I/DD and their family members. The information and training resources should talk about:

- How people with I/DD can make decisions
- Why conservatorship is not the only option
- Alternatives to conservatorship, including SDM

The information and training resources should:

- Address the needs of diverse communities
- Be available in languages spoken by individuals served by regional centers
- Explain how adults with I/DD can identify a supporter, including a family member, to help them make decisions at IPP meetings

The regional centers should discuss this information during each IPP meeting for transition-aged youth. "Transition-aged youth" means young people who are teenagers through people who are in their mid-twenties. Transitioned-aged youth should be supported in making decisions at each IPP meeting.

4. **Train School Systems and Other Key Stakeholders About SDM and Limiting Conservatorships.** The California Department of Education (CDE) should work with DDS to develop guidance about:

- How people with I/DD can make their own decisions
- Why conservatorship is not the only option
- Alternatives to conservatorship, including SDM

The guidance about SDM should talk about how adults with I/DD can identify a supporter, including a family member, to help them make decisions at Individual Education Program (IEP) meetings. Plain language information

about this guidance should be provided to transition-aged youth with I/DD and their family members at each IEP meeting. Local school districts should support transition-aged youth to make decisions at their IEP meetings.

Training about the guidance should be provided:

- By CDE and local school districts to their staff
- By DDS and regional centers to judges and court staff
- By DDS and regional centers to professionals, including health care professionals
- By DDS and regional centers to their staff
  - Training for regional center staff should also include training about conservatorship court reports which they might be required to complete.

**5. Provide Guidance and Training to Regional Centers to Limit Conservatorships.**

DDS should provide more guidance and training about how regional centers and regional center service coordinators can reduce conservatorships. The guidance, tools, and training should include:

- Clear direction about how to assess a person with I/DD's ability to make their own decisions. This is called "decision making capacity."
- Clear direction about how to report information about decision making capacity to courts.
- Types of services and supports that people with I/DD can use to make decisions. For example:
  - SDM agreements
  - Limited powers of attorneys. This means that someone else can help a person with I/DD make certain decisions.
  - Social security representative payees. This means that someone else can help a person with I/DD to manage their benefit payments.

- Advanced health care directives. This means that a person with I/DD can make a decision about what should happen to them if they have a serious health problem in the future.
- Additional supports to help SDP participants manage their individual budgets and spending plans.
- How to help people with I/DD use these services and supports to make decisions.

These efforts should focus on:

- Transition-aged youth who are often initially conserved between the ages of 18 through 21
- Older adults who sometimes face conservatorship after making their own decisions for many years

The State should also work to change the law so that regional centers are notified about, and required to provide the court with a court report for, all types of conservatorship proceedings for people with I/DD. This includes probate conservatorship and mental health conservatorships.

6. **Make a Plan to Remove all DDS Court-Appointed Conservatorships.** DDS should make a plan to remove all of its court-appointed conservatorships. Right now, DDS is the court-appointed conservator of about 370 people with I/DD. As part of the plan, DDS should:

- Turn down future conservatorship nominations from regional centers and the courts. This may require a change in the law.
- Use the many options available if an adult is in need of SDM. For example:
  - Have the SCDD approve health care decisions on an individual basis
  - Have the regional center physician approve procedures

7. **Measure Progress on Limiting Conservatorships.** DDS should continue to collect data about the numbers of people with I/DD who are conserved. This data should include:

- Demographic data about people with I/DD who are conserved
- The type of conservatorship
- Relevant dates for when conservatorship will be reviewed

A priority should be collecting data on the initial conservatorships of people ages 18 through 21. This is because many people with I/DD are initially conserved at these ages.

DDS should also assess the extent to which SDM reduces the number of conservatorships in California. This data should be used to measure progress and to inform other initiatives to reduce the number of conservatorships.

## **Making Choices in Regional Center Services**

People with I/DD who are served by regional centers can have different experiences. This can happen because regional centers have different ways of doing things. Even at the same regional center, service coordinators can have different ways of doing things. This means that some people served are able to make choices that other people served are not given the opportunity to make. This is not fair. Sometimes IPP does not happen in a person-centered way. This means that the person who the plan is for may not get to choose what is in the plan. Sometimes people do not have access to programs or services which they want and choose. These recommendations focus on making sure that people served

**“I don’t like the fundamental idea of acting in our ‘best interests’... I don’t want that. I want them [the regional center] to act in my interests.”**

Derek

**“When I first entered the Self-Determination Program, I was so used to nobody caring that when they started actually asking me what I wanted, I had to think about it.”**

Tina

by the regional center get to choose what goes into their IPP.

### 1. **Use a Person-Centered Approach to IPP.**

DDS should make sure that the IPP process is person-centered and consistent across regional centers. For this to happen, DDS should:

- Give regional center service coordinators the authority to approve the IPP as part of a collaborative planning process with the person or family served.
  - Make clear rules about what kinds of decisions service coordinators can make and how these decisions are made. This will make sure service coordinators' approval authority is clear and consistent across all regional centers. DDS should get input from diverse stakeholders to develop these clear rules. These rules should:
    - Clarify that service coordinators can approve services that meet a person's needs. This will make sure that services can be approved and authorized more quickly.
    - Clarify that service coordinators should consider input from all members of the IPP team to make service approval decisions.
    - Clarify that services can only be denied after all options and exceptions have been tried. There should be a clear timeline established and transparent process for denial of services. This will help to make sure there are not barriers to people accessing the services they need.
    - Make sure that service coordinators are trained on how to interpret these new rules consistently.
- Make sure that regional centers:
  - Stop having service coordinators serve as “messengers” by sending information to managers, clinical teams, or committee that make decisions. This will make sure that decisions are made with the person served and the service coordinator in the room.

- Update the “exceptions process.” The exceptions process happens when a person’s unique needs do not fit within the usual standards of getting services. The updated exceptions process should be more transparent and should work better for people served.
  - More detail about these rules and expectations can be found in the Recommendation Background and Technical Information Addendum document on the CalHHS MPDS website.
- Make it a practice to hold a meeting with people served and their circles of support to find creative solutions when a service is denied. This should happen before the regional center issues a Notice of Action. If a solution cannot be reached during the meeting, the regional center should continue with service coordination efforts to connect the person served to generic services or some other solution.
- Begin providing people served with access to services in a timely manner once a service approval agreement is reached.
- Provide people served with verbal and written explanations of all service approvals and denials. These explanations should be provided in a timely manner and in plain language, so that people served can understand what is happening and why.

**2. Remove Barriers to the SDP. Make the SDP an Option for Everyone Served by Regional Centers.** DDS should break down barriers to participation in the SDP. DDS should also make the SDP more consistent around the state. For this to happen, DDS should:

- Establish streamlined, consistent processes and procedures for the SDP
- Hold regional centers accountable for:
  - Ensuring the five principles of SDP are being met for participants

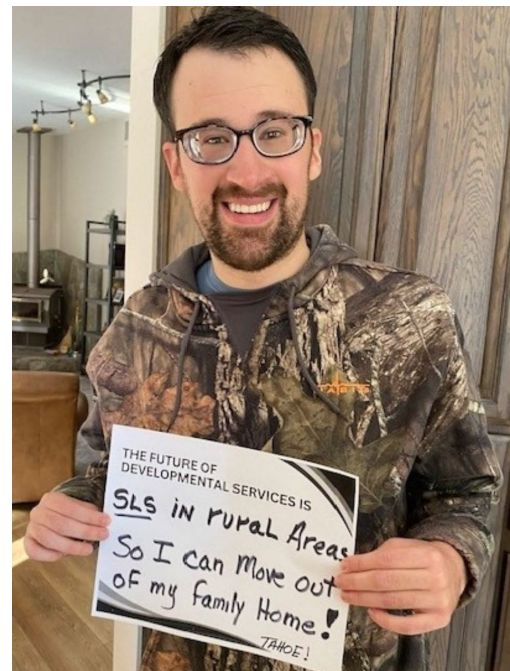
- Making measurable improvements toward achieving equity in enrollment in the SDP (by race, ethnicity, geography, and regional center)
- Make sure that SDP participants have authority over their spending plans by clarifying that:
  - Regional centers only verify federal funding and generic resource requirements
  - Regional centers still have all responsibilities related to:
    - Making sure that people's health and safety are protected
    - Making sure that services in spending plans relate to the goals in IPPs
  - Services used to develop the individual budget are not tied to services listed in the spending plan
  - Purchase of service (POS) standards for traditional regional center service coordination should not be applied to services in the SDP spending plan
- Standardize and simplify spending plans by:
  - Only requiring participants to assign expenses to one of three budget categories
  - Allowing estimation of costs
  - Not requiring names of providers to be listed
- Make sure the Financial Management Service (FMS) is held responsible for any penalties or fines that result from failure to comply with state and federal labor requirements, such as timely pay
- Require budgets and spending plans to roll over until new authorizations have been completed and sent to the FMS. This will make sure that people served can continue to participate in the SDP.

- Reduce delays related to accessing the SDP that are within regional center control by setting explicit timelines for:
  - Sending a consumer their POS twelve-month expenditure report
  - Scheduling budget meetings
  - Reaching out to schedule a renewal budget meeting with a person served
  - Reviewing the spending plan
  - Sending the POS authorization to the FMS
- Make sure every person served by a regional center receives unbiased information at every IPP meeting about the opportunity to participate in the SDP
  - Require regional centers to offer SDP as a standard service model option in every IPP meeting and whenever a person requests it
  - Require regional centers to include information about SDP as a standard option in all collateral and marketing materials
  - Contract with an outside organization to:
    - Develop consistent informational materials about the SDP in plain language. These materials should also be translated into languages spoken by people served by the regional center.
    - Improve the SDP orientation
      - For example, by providing multiple shorter online trainings, available when people need them
    - Train all service coordinators on the SDP
- Have a goal of significantly increasing participation in SDP by:

- Developing a pilot project in multiple regional centers to provide additional supports for enrollment in SDP for communities that are underrepresented. For example:
  - o Latinos
  - o African Americans
  - o Consumers with low or no POSs
- Requiring regional centers to conduct proactive outreach to individuals from these communities and offering comprehensive training on the SDP, intensive supports from independent facilitators and FMSs, and faster onboarding from the regional centers
- Evaluating the pilot project to assess whether more individuals were able to enroll, their satisfaction and outcomes once people enter the SDP, and whether streamlined processes were used

## People With I/DD Living in Inclusive Communities With the Resources They Need to Thrive

People with I/DD face barriers to being included in their communities. This can mean that people with I/DD and their families may experience isolation. "Isolation" means being alone and not being connected to other people. People with I/DD also face stigma and discrimination about what they can do and achieve. It can also be harder for people with I/DD to meet their basic needs like housing, health care, food, and clothing. Challenges like lack of transportation can make it hard for people with I/DD to get where they need to go and to participate in community activities or events. There are more barriers for:



- People who live in rural communities
- People who are immigrants
- People who have a hard time reading, or who cannot read
- People who speak a language other than English

## **Support Relationships as Part of a Full Life in the Community for People With I/DD**

People with I/DD want friendships, romantic relationships, marriage, and children, like anyone else. These kinds of relationships are an important part of living a full life and being part of a community. These relationships are also part of a person's circles of support. Natural supports, like friendships with people with and without disabilities, are important parts of a healthy social network. Healthy social networks can give people with I/DD support that they need to be independent. Many people with I/DD experience barriers to building healthy social connections. People with I/DD are more likely to experience loneliness, bullying, or abuse than people without disabilities.

There can be few opportunities for people with I/DD to meet new people in person or in disability-specific online spaces. Some people with I/DD use dating apps to meet people, even though they don't always feel that this is safe.

People with I/DD have a right to privacy, dignity, and romantic relationships. It can be challenging for some people with I/DD to have romantic or sexual relationships.

- Adults with I/DD may struggle to pursue intimate sexual relationships because they do not have privacy in their homes. This can be true for people with I/DD who live in some types of residential living arrangements or in their family home.
- Some people with I/DD have a hard time getting education about sexuality.
  - Students with I/DD have a right to education about sexuality in school, but many schools do not provide this training for students who are educated in non-inclusive settings.

- Many regional centers have long waiting lists for sexuality training services.

These recommendations focus on making sure that people with I/DD are able to build the kinds of relationships that are an important part of a full life in a community.

1. **Make Sure Students With I/DD Can Access Education About Sexuality.** DDS and the CDE should work with diverse self-advocates to identify best practices and materials for sexuality education for students with I/DD. These materials should:

- Talk about the social rights of people with I/DD
- Talk about safe sexuality. This should include inappropriate touching and abuse protection.
- Be available in plain language
- Be available in the languages spoken by individuals served by regional centers
- Be culturally appropriate for the diverse communities served by regional centers

The CDE should also provide guidance to local school districts about the responsibility to provide sexuality education to people with I/DD covering the same topics as covered in sexual education classes for students without disabilities.

2. **Make Sure People Served by Regional Centers Can Access Education About Sexuality.** Regional centers and community-based partners should also use the best practices and materials for sexuality education which DDS and the CDE develop. They should use these resources to provide information and training about sexuality for people served by the regional centers and their families and/or caregivers.

3. **Make Sure People With I/DD Can Access Social Skills Training.** DDS and regional centers should increase service options for social skills training for adolescents and adults with I/DD. This kind of training would help people with

I/DD to make and keep friendships and romantic relationships. These services should be provided for free to people with I/DD. For example, the services could be purchased by regional centers through their vendored providers or from other community-based services. One example of this kind of skills training would be PEERS.<sup>8</sup>

4. **Support People With I/DD to Grow Their Circles of Support.** Regional centers should make sure that conversations about ways to grow a person's circles of support happen during every IPP meeting. This should include talking to people served about ways that they can:
  - Meet new people
  - Continue to grow their circles of support
  - Continue to grow their social networks

Sexuality training and education services should be offered during IPP meetings for adolescents and adults served.

5. **Make Sure People With I/DD Have Opportunities to Meet New People.** DDS should provide guidance about how regional centers can use the social recreation category of services or other services to fund inclusive social gatherings for people served. This could include events like:
  - "Speed dating"
  - "Speed friendship"

Regional centers should use the guidance from DDS to work with their vendors and community-based partners to make sure there are more opportunities for people with I/DD to attend inclusive social gatherings.

6. **Relationship Film Contests.** DDS and regional centers should host film contests about relationships for people with I/DD. The films in the contest should be filmed in partnership with people with I/DD. The films could be about:
  - Friendship

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<sup>8</sup> [For more information on PEERS training \(https://www.semel.ucla.edu/peers\)](https://www.semel.ucla.edu/peers)

- Dating
- Parenting
- Inclusive neighborhoods

To make these film contests happen, DDS and regional centers could:

- Work with Film schools
- Work with current vendors who have film studios
- Expand Service Access and Equity grants to be used to produce films

## **Make Sure People With I/DD Have Technology That They Need**

Technology is an important tool for many people with I/DD. Many people with I/DD use technology for important parts of their lives. For example, people with I/DD may use technology to:

- Communicate
- Stay safe
- Participate in their communities

People with I/DD are not always able to access the technology that they need. Sometimes it can be hard to get technology services and devices because the process is confusing. Some locations may not support people with I/DD in using the technology that they need. People who live in rural places may have challenges with internet or cell-phone service to support the technology that they need. These recommendations

**“People with speech disabilities are sometimes seen as incapable of speaking for themselves. Nonverbal people can speak, it may be another way. We find some way to communicate in another way.”**

Sascha

**“I grew up in the foothills of Yuba-Sutter, where you get one or two bars on your phone at most, and have to use satellite internet because DSL/wi-fi is not available.”**

Elena

focus on making sure that people with I/DD are able to access and use the technology that they need.

1. **Make Sure People With I/DD Can Access and Use Technology.** DDS and regional centers should make sure that people with I/DD can get the technology that they need. DDS and regional centers should make sure that people served have access to:

- Internet. This should build on existing efforts in California to provide access to internet services, like the “Middle-Mile Broadband Initiative.”<sup>9</sup>
- Cell phone services
- Devices like laptops, tablets, and cellphones
- Support to access AAC services and devices. “AAC” means using methods of communication in addition to or other than the spoken language. These communication methods can include gestures, pictures, symbols, electronic devices, and changes to the environment that make it easier for people to communicate.

2. **Make Sure People With I/DD Can Choose to Access Some Services From Home.** DDS and Regional Centers should also give people with I/DD more access to services virtually and remotely, by using Zoom and other tools. This would mean that people with I/DD could have the option to get some services they want and need from their home, instead of having to be in-person. DDS should make sure that virtual or remote services or the choice of the person served. This will make sure that services are not provided virtually or remotely just because it is easier for the service provider.

Better access to technology would help people get better access to services and opportunities. For example:

- Working from home

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<sup>9</sup> [For more information on the Middle-Mile Broadband Initiative \(https://middle-mile-broadband-initiative.cdt.ca.gov/\)](https://middle-mile-broadband-initiative.cdt.ca.gov/)

- Learning from home
  - Seeing a doctor or therapist from home
  - Being a part of virtual communities, like social media
3. **Make Sure AAC is Supported in Public Spaces.** The State should make sure that forms of AAC, like technology devices, are allowed and supported at all public places and government facilities. For example:
- Airports
  - Immigration offices
  - Jails
  - Hospitals
4. **Make Sure People With I/DD Can Access Assistive Technology.** DDS, regional centers, and the DHCS should work together to make sure people with I/DD are able to access assistive technology that they need. To make this happen, DDS, regional centers, and DHCS should work together to:
- Make it easy for people to quickly get assistive technology they need
    - This includes working together to make it clear how assistive technology should be provided and paid for
  - Provide insurance and accessible customer service support in case assistive technology needs to be fixed
  - Make sure there are enough vendors to provide assistive technology in a timely manner. This should include equipment (like wheelchairs) and environmental accessibility modifications (like ramps, or wider doors).
  - Research and develop pilot programs for independent living with use of technology
    - For example, expand access to innovative technology, such as “smart homes.” Smart homes use technology to control and

monitor devices remotely. This would help people with I/DD be more independent in their own homes.

- Provide supports and learning opportunities to help people with I/DD, their families, and their staff to improve skills to use technology. For example, skills like:
  - How to use and maintain assistive technology
  - How to use technology that can help people in their daily lives. This could include virtual meeting software, like Zoom.
- Provide access to assistive technology to people regardless of where they live

## **Make Sure People With I/DD Can Participate in Community Programs, Services, and Activities**

Often, community activities and spaces are not set up in a way that makes it easy for people with I/DD to be included. Sometimes people in the community do not understand how they can help include people with I/DD. Sometimes people with I/DD and their families do not get information about supports that are available to help them access community resources. These recommendations focus on making sure that people with I/DD and their families are able to participate in their communities. This means making it easier for them to be a part of community programs and activities, and to get services in the community.



1. **Remove Barriers in Communities.** Regional centers should work with community partners, like local governments, to remove barriers that make it hard for people with I/DD to be a part of their community. Regional centers and their community partners should work together to:

- Create more public spaces that use “universal design.” Universal design means creating spaces that as many people as possible can use, no matter their ability level.
- Educate people about the needs of people with I/DD. For example, give information about people with I/DD to local government officials and local businesses to make sure they understand how to support people with I/DD.
- Provide accommodations so that people with I/DD can participate in activities in their communities.

**“Sometimes it feels like you have to fight for the things you need and want. Instead of just having the space made for us to be asked what we want.”**

Tracey

2. **Flexible Ways to Pay for Inclusive Community Services.** DDS and regional centers should make sure there are flexible ways to pay for inclusive community services for people with I/DD and their families. DDS and regional centers should:

- Provide people with I/DD and their families with information about how regional centers can help pay for inclusive community services. This also includes tools to make payment easy.
- Make sure people served can be reimbursed to pay for community services. Reimbursed means that a person with I/DD or their family can get paid back for community services they spent their money on.
- Make sure people served can use Participant Directed Services to access community services. Participant directed services give people served the option to choose how they receive certain services, and who provides those services.

DDS also should provide guidance that says:

- Regional center policies should not limit the number of community services a person can use
- SDP participants can be reimbursed for community services through their FMS

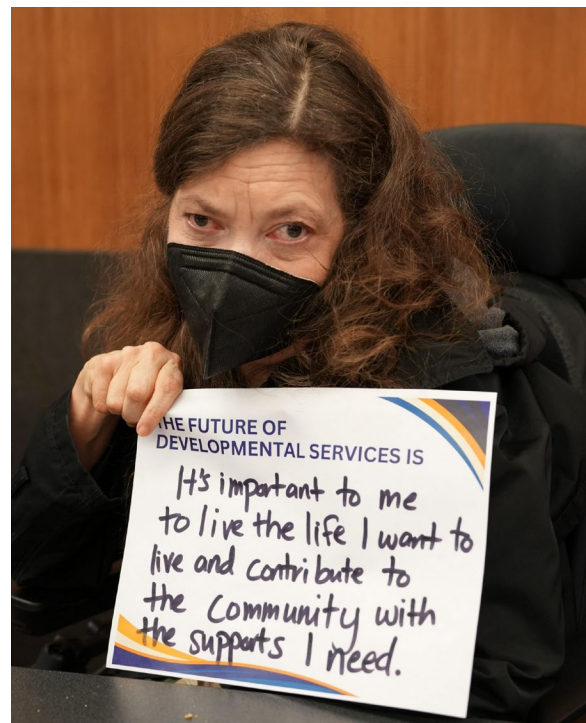
3. **Make Sure People With I/DD Have Support to Participate.** Regional centers should help identify and provide needed supports so that people with I/DD can fully participate in community programs. Regional centers should:

- Help people identify natural supports. For example, a natural support might be a friend who could help a person with I/DD to access or participate in a community activity that they are interested in.
- Work with local government and businesses to provide supports.
- Pay for supports if other options are not available.

### **Make Sure People With I/DD Can Participate in Decision Making About Their Communities**

People with I/DD have opinions about issues in their communities, just like anybody else. Being a part of decision making in communities is called “civic participation.” Civic participation can include things like:

- Voting in elections
- Volunteering to give back to the community
- Serving as a member of a board or commission to give back to the community



Sometimes when people with I/DD try to participate in conversations about their communities, they are left out or not listened to. Sometimes people with I/DD are even told that they should not vote. Sometimes when people with I/DD try to participate in their communities by volunteering, they are not included. These recommendations focus on making sure that people with I/DD understand how to participate in community processes like voting or volunteering for local organizations. The recommendations also focus on making sure that people in the community, like local officials, understand how to include people with I/DD in civic participation.

**“I think that it would be great if people with I/DD could run for elected leadership positions within local, county wide, State of California, and federal government positions.”**

Kecia

- 1. Learn How to Support Civic Participation for People With I/DD.** Regional centers should put together a diverse stakeholder group which includes people with I/DD. This group should work together to:
  - Define civic participation for people with I/DD
  - Identify opportunities for civic participation for people with I/DD
  - Identify training and support that people with I/DD might need for civic participation
- 2. Make Sure People With I/DD Know About Civic Participation.** Regional centers should make sure that civic participation is a topic in all planning meetings. This will make sure that people served get information about civic participation and have opportunities to ask for support with civic participation. This should include meetings about the development of person-centered plans (PCPs), like IPP meetings.
- 3. Make Sure People With I/DD Have Opportunities for Civic Participation.** Regional Centers should work with community partners to make sure people with I/DD have opportunities for civic participation. Regional centers should:
  - Develop ways to support the civic participation of people with I/DD, through natural supports or paid supports.

- Make sure there are local volunteer opportunities for people with I/DD.
- Make sure there are opportunities for people with I/DD to participate on local boards and commissions.
- Make sure there are resources available to support people with I/DD who want to take these civic participation opportunities. For example, training and mentoring resources.
  - One example of a training program would be Partners in Policy Making. This program is designed to support people with I/DD in civic participation.<sup>10</sup>
  - Regional centers could also create mentoring programs led by self-advocates with experience in civic participation.
- Educate local policy makers about how people with I/DD can contribute to civic participation.

**4. Make Sure People With I/DD Have the Supports They Need to Vote.** DDS and regional centers should provide support and education about voting rights for people with I/DD. This would increase the number of voters with I/DD.

- DDS should work with diverse self-advocates to review and update plain language about voting rights. This should also include information about when a conserved individual can vote and about voting accommodations. DDS should make sure this updated information is available on all regional center websites.
- Regional centers and community-based organizations should provide families and other caregivers with information about voting rights for people with I/DD.
- Regional centers should work with community-based organizations that have expertise in voting access to provide information on voting to people with I/DD. This should include information about:

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<sup>10</sup> [For more information about Partners in Policy Making \(https://mn.gov/mnddc/pipm/\)](https://mn.gov/mnddc/pipm/)

- What voting means
- How to vote
- How to understand the issues that are voted on, to be an informed voter
- Regional centers should make sure that voting is a topic at all IPP meetings.
  - It is especially important that these discussions begin at the meeting which occurs closest to the person's 18<sup>th</sup> birthday. This will make sure that people with I/DD have the supports they need when they turn age 18 and are able to vote.

## **Make Sure People With I/DD Can Get an Inclusive and High-Quality Education**

All children and young people with I/DD should get a receive a “free, appropriate public education” (FAPE). They should also receive their education in inclusive classrooms with their peers without disabilities. This is the law. But people with I/DD continue to face many barriers in their education.

Education for children and young people with I/DD should:

- Be inclusive
- Be equitable
- Provide individualized supports and services

This recommendation focuses on making sure that children and young people with I/DD are included in their schools and get the best possible education to meet their needs.

1. **Inclusive and Flexible Education.** The CDE in partnership with Local Education Agencies (LEAs) should make sure that all children and young people with I/DD receive FAPE.

There are many things the State should do to make sure that all children and youth with I/DD receive an inclusive and flexible education to meet their unique needs. For example, the State should:

- Make sure the educational system is based on the principles of “Universal Design for Learning.” This is an approach to education that accommodates the needs and abilities of all students. It provides flexibility in how students learn.
  - This will help make sure that schools and other educational organizations are able to serve everyone, including people with I/DD, in an equitable and inclusive way.
  - The State should make sure that the California CDE and local partners should work with people with I/DD, their families, and other community partners to transition the public education system to the Universal Design for Learning. This process should also develop and implement ways to fix gaps and issues.
- Make sure that schools include and support youth with I/DD to participate in their IEP process. Students should be supported to learn skills to advocate for themselves, make informed choices, and practice self-determination.
- Make sure schools and teachers receive adequate supports, training, and resources to make inclusion a reality.
  - This includes making mental health supports, including counseling, in schools fully accessible to students with I/DD. This also includes bringing interdisciplinary teams together to support students who require supports from different professionals. Schools should also make sure that career and college counseling and Think College options are inclusive if students with I/DD.
- Develop accountability measures for the public education system. This can include tracking information on graduation rates, transitioning into post-school education or jobs, and other outcomes for people with I/DD.

- These accountability measures should build on or refine existing measures to make sure that data about all students with I/DD is collected.
- Make sure that school campuses are accessible for everyone.
- Make sure that schools have equal opportunities for everyone to participate in all school activities and events. This should include graduation activities and ceremonies, school clubs and more.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

## **Make Sure People With I/DD Have Transportation to Get Where They Need to Go**

Access to transportation helps people with I/DD fully participate in their community. Without reliable transportation, many people with I/DD are not able to get where they need to go. There should be many options for transportation. Options are important in rural areas where public transportation is limited. They are also important for people who use mobility devices. These recommendations focus on making sure that people with I/DD are able to access high-quality transportation options.

**“If we need to go to jobs or to other places, we need to know that we are safe in the community out there with transportation services.”**

Sara

1. **Make More Transportation Options Available.** DDS and regional centers should make more transportation options for people with I/DD. This includes identifying efficient ways to pay for these services. To make more transportation options available, DDS and regional centers should:
  - Make sure there are enough transportation options to support independent travel. This would make sure that more people with I/DD can access community services when and where they want. Transportation options to support independent travel should include:

- Ride-share services, like Lyft and Uber
  - Autonomous vehicles, like Waymo
  - Carpools
  - Transportation stipends
- Make sure there are opportunities for people with I/DD to get driver's training that meets their disability-related needs.
  - Provide reimbursement to people with I/DD or their family for vehicle modifications that are needed to provide transportation for people who use mobility devices such as wheelchairs.
  - Support regional center vendors to provide "on-demand" rides by removing barriers like insurance restrictions and liability issues.
  - Encourage transportation vendors to expand service options during evenings and on weekends.
  - Expand transportation reimbursements to increase equitable service access. This includes accounting for long distances in rural community to access services, paying for staff time and mileage when a staff member helps a person access their community, including grocery shopping, picking up prescriptions, or doing errands. Eliminate reductions in the length of services a person receives due to long transportation time.
  - Make sure high-quality mobility training is available to all people with I/DD. There should not be discrimination based on the type of disability. Public transportation mobility training should start while the individual is in school as it increases independence and can change a person's life view. Peer-to-peer mobility training should be among the mobility training options.
2. **Improve Public Transportation Systems.** DDS and Regional Centers should work with partners to develop plans to improve public transit. Partners should include state government, local government, and transit agencies. To

improve public transportation systems, DDS, regional centers, and partners should work together to:

- Identify transportation gaps and solutions.
- Educate transit officials about the transportation needs of people with I/DD.
- Prioritize system improvements for people who experience the most barriers to using public transportation. This includes individuals who use mobility devices and people living in rural areas.

### **Make Sure People With I/DD Have Money to Pay for Their Basic Needs**

People with I/DD often do not have the resources they need to meet basic needs such as housing and food. This can be because they do not have enough money to pay for the things that they need. Some people with I/DD get money every month from the federal government. This is called the Supplemental Security Income (SSI) benefit. California gives people who get SSI additional money. This is called the State Supplemental Payment (SSP). The amount of money that a person gets every month from SSI and SSP is still below the federal poverty level (FPL). This means that even when people get money every month from SSI and SSP, they still do not have enough money to pay for the basic things that they need.

Another problem is that people with I/DD who get married may receive less SSI benefits. Other people with I/DD may lose benefits, like Social Security Disabled Adult Benefits if they get married. This is called “the marriage penalty.”

The federal government increases the amount of money that people get from SSI each year. This is called an annual Cost of Living Adjustment (COLA). A COLA is meant to equal the increased costs of purchasing food or paying for rent. California law does not require the State to provide an annual COLA. This means that the amount of money people get from the SSI benefit may increase every year, but the amount of money people get from the SSP benefit may not increase each year.

These recommendations focus on making sure that people with I/DD have enough money to pay for their basic needs.

1. **Increase the SSP.** The State should increase the amount of money that people get every month from SSP. The increase should be enough to make sure that people who get individual SSI benefits are above the FPL. The State should also increase SSP benefits for all SSI recipients every year to keep up with annual COLA.
2. **Protect Benefits When People With I/DD Get Married.** The State should support changes to federal laws to protect SSI and other social security benefits when people with I/DD want to get married. This includes changing laws to:
  - Make sure that people with I/DD do not receive less money in SSI benefits when they get married.
  - Allow people with I/DD to keep their Disabled Adult Child Social Security benefits when they get married.
  - Increase the limit on the amount of money that people with I/DD who are married can have in their bank account, from \$3,000 to \$4000.
3. **Reduce or End the Marriage Penalty.** California has already taken some steps to reduce the marriage penalty. The CalHHS, working with DDS and the Department of Finance, should analyze the cost and benefits of further reducing the SSI “marriage penalty” or eliminating the SSI marriage penalty. The “marriage penalty could be reduced or ended by further increasing the amount of the SSP. Once the analysis is complete, CalHHS should get input from diverse stakeholders, including self-advocates, about what to do next.
4. **Provide Housing Assistance through the SSP.** The State should give more money through SSP for people with I/DD, including those who live with family members, who pay more than 40% of their income toward housing costs. This would provide assistance to pay for their housing. This would help make sure that people do not become homeless. It would also help to give people a choice on where they want to live.

## Make Sure People With I/DD Have a Home of Their Choice

It can be very hard for people with I/DD to find housing in California. This is because:

- Housing costs are very high in California.
- There are not enough apartments and houses for everyone who lives in California.
- Even though there are housing subsidy programs, which are available for people with I/DD, not everyone who needs support can get it. This is because there are limited opportunities to apply for these programs, and the waiting lists can be years long.

These recommendations focus on making sure that people with I/DD have supports that they need to find stable housing. These recommendations also focus on making sure that people with I/DD have accessible places to live.

1. **Build More Housing.** The State and DDS should create more affordable and accessible housing for people with I/DD across California. To do this, DDS should use existing and new resources and programs. To make sure that more affordable and accessible housing is available for people with I/DD, the State should:

- Make sure there is money in the State budget to build community-based affordable and accessible housing units for adults with I/DD.
  - For example, there is money in the State budget which is specifically used to fund housing for other at-risk groups like veterans, seniors, and people with mental illness. A similar program should be established for people with I/DD.
- Give cities and counties money for making affordable housing available for people with I/DD.

To make sure that more affordable and accessible housing is available for people with I/DD, DDS should:

- Give more funding to existing programs that help build housing in communities. DDS should also explore new ways to use these programs.
- Set up a low-interest loan program and downpayment assistance to help people with I/DD and their families pay to build Accessory Dwelling Units (ADU). ADUs could be used to support long-term housing needs of individuals with I/DD. An ADU is a space where someone can live on a property that is separate from the main house. For example:
  - A basement apartment
  - A garage that has been converted into an apartment

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

2. **Provide Clear Housing Information.** DDS should develop plain language, accessible information about how to help people with I/DD get stable housing. DDS should make sure that this information is available to people with I/DD and their families. The information should be made available in different ways so that it is easy to understand for everyone. For example, in writing and in videos. This information should be about:
  - Housing supports that are available
  - The rights that people have when they rent their home
  - Other housing issues
3. **Help People With I/DD Find Affordable Housing.** DDS should make sure people with I/DD and their families can get quick local help to find housing no matter where they live, or which regional center serves them. These services are called Housing Access Services. DDS should:
  - Make sure that regional centers make Housing Access Services available to people with I/DD their families. Especially families that have children and youth with I/DD.

- Update payment rates to Housing Access Service providers so they can afford to serve everyone and provide high-quality support.

4. **Make Sure People With I/DD Can Access Support for Life Changes and Moves.** DDS should develop a statewide plan to help people transition to new housing or services. The plan should include how people with I/DD will get help with:

- Rent
- Deposits
- Utilities
- Furniture for whatever stage of life they are in
- Supports for smooth transitions to more independent living from different living situations, like:
  - Family homes
  - Group homes
  - Foster care
  - Shelters
  - Being unhoused

5. **Make Sure People With I/DD Can Access Affordable Housing and Rent Help.**

The State and DDS should help people with I/DD and their families to easily use existing affordable and accessible housing resources. For example, housing programs, rent subsidies, and other community resources.

DDS should:

- Set up and fund a Rent Subsidy program that provides funding to close the gap that currently exists with other rent subsidy programs.
  - This can include providing rent subsidies while people wait for HUD vouchers.

- DDS and Regional Centers should partner with local housing authorities and managed care organizations to design one seamless process for people to get rent subsidies.
- Make sure people can get a Housing Needs Assessment and Housing Access Services when they have a crisis, are found to be at-risk, or any time they have a need.
- Work with housing authorities and other development agencies to create special rent programs, reserved housing units, or rent help for people with I/DD.

The State should stop unfair housing practices like:

- Rejecting renters based on where their money comes from
- Rejecting renters based on their lack of credit history

6. **Make Sure People With I/DD can Access Legal Help for Housing Issues.** The State should make sure people with I/DD can get quick, local, legal help if they need it. The State should:

- Increase funding for Legal Aid programs and advocacy organizations to:
  - Provide legal help for housing issues
  - Provide advocacy to people with I/DD
  - Stop local unfair housing practices
- Create a way to count and report how many people need housing—targeted legal help. This will help improve the State's housing rights protection, advocacy, anti-discrimination, fair-housing, and other important laws. This should include information about:
  - What type of help people need
  - Actions needed
  - Agencies or organizations involved

- Services provided
- Final outcomes
- Complete a review to identify the barriers legal practitioners face when trying to serve people with I/DD. Then develop a plan to address these barriers.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

7. **Make Homes Accessible for People With I/DD.** DDS should work with regional centers to create a clear and easy process for people with I/DD to request home modifications related to their disability. People with I/DD should be able to request home modifications no matter what kind of services they receive. DDS should also:

- Make sure people with I/DD can get accessibility updates in their homes whether they rent or own their home.
- Provide funds to remove modifications if a landlord requires it when a person with I/DD moves out of a rental home.
- Collect and use data. This will make sure that DDS can:
  - Understand people's needs
  - Improve the process of requesting home modifications
  - Make sure funding and access for home modifications is fair

8. **Use Incentives to Encourage Renting to People With I/DD.** The State should explore different ways to incentivize companies, people, and organizations to rent housing units to people with I/DD. To "incentivize" means to encourage someone to do something by giving them money when they do it. This could include creating ways for people who rent housing units to people with I/DD to get money, like giving them:

- State tax deductions

- Property tax incentives

The State should also explore ways to provide affordable property insurance to providers who serve and provide housing to individuals with I/DD in residential settings they own or lease. This will help make more housing available to serve people who have high needs.

**9. Make a Plan to Move People With I/DD From Institutions Into the Community.**

DDS should make a plan to support people with I/DD to move from institutional settings into community settings. California has closed large state operated institutions for people with I/DD and supported many individuals to move into the community. Many people still live in private institutional settings like:

- Intermediate Care Facilities
- Nursing homes
- Institutions for Mental Disease (IMDs). An IMD is a setting which is sometimes used for people with significant behavioral health needs.

This plan would help people in institutional settings to move into the community. The plan should:

- Make sure people with I/DD moving into the community get appropriate supports to live self-determined lives
- Use the experience and lessons learned from closing state operated institutions

**10. Make Sure There is Enough Specialized Housing for People With I/DD.**

DDS should make sure that there are enough integrated inclusive housing options available. These are housing options where people with I/DD can live with people who do not have disabilities and have access to, and participation in, the community and get special supports that they need. Integrated inclusive housing options include:

- Medical and behavioral homes
- Foster homes

DDS should make sure:

- Integrated inclusive housing options focus on personal choice, independence, and inclusion
- Housing policies follow fair rules and meet the needs of all individuals
- All residential settings fully comply with the settings requirements of the Home and Community-Based Services (HCBS) final rule
  - More details monitoring and oversight of residential settings to support this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website

**11. Stronger Government and Partner Agency Collaboration on Housing.** The State and DDS should improve how state, federal government, and local agencies work together on housing. This includes how they work together to make sure people with I/DD can access housing and homelessness prevention services.

The State should:

- Establish cross-sector partnerships by requiring formal agreements between DDS, regional centers, and California housing agencies. These partnerships would make sure that there is equitable access to affordable, accessible, and supportive housing resources.

DDS should:

- Create a special housing division to focus on community-based, affordable, and accessible housing issues for people with I/DD. The division should also focus on community involvement of people with I/DD.
- Form a Housing Advisory committee to advise DDS and its partner agencies. This committee should include experts and people with lived experience.

**12. Align With California’s Housing First Laws.** The State should align housing programs and services for people with I/DD with California’s “Housing First” laws. The State should make sure the principals of Housing First are used as system-wide values. “Housing First” means that everyone is ready for housing, no matter how complicated their needs are. The Housing First principals should replace any “housing readiness” model language that requires a person to meet some standard before being allowed to obtain housing of their choice. The State should make sure that all investments and efforts to develop affordable and accessible housing options for individuals with I/DD fully align with HCBS core principles and requirements.

**13. Make Sure Housing Laws and Technology Are Fair.** The State should make sure that housing laws and housing programs are fair for people with I/DD. To do this, the State should:

- Support laws that:
  - Protect fair housing rights for people with I/DD
  - Remove barriers to housing for people with I/DD
  - Prevent discrimination against people with I/DD
  - Protect people with I/DD
- Fix laws that need to be updated or changed to better protect people with I/DD
- Make sure that any new technology used for housing programs does not accidentally:
  - Discriminate against people with I/DD
  - Leave out people with I/DD
  - Create unfair outcomes for people with I/DD trying to live in their community and access housing
- Make sure that people with I/DD who are trying to access housing programs, services, or resources can:

- Get help
- Report problems
- Overcome barriers

## **Make Sure the Justice System Works for People With I/DD**

When people with I/DD commit or are accused of crimes, they interact with the justice system just like anyone else would. The justice system has a lot of problems with equity and fairness, in general. People with I/DD may encounter even more unfairness in the justice system. This can be because justice system services are not designed to accommodate the needs of people with I/DD. These recommendations focus on making sure that the justice system works for people with I/DD.

1. **Provide Diversion Services Consistently.** DDS and regional centers should work together to develop guidance on how people with I/DD get diversion services. Diversion services are an alternative for people who would otherwise be incarcerated for committing a non-violent crime. Being “incarcerated” means going to jail or to prison.

All people with I/DD who meet the legal criteria for diversion services should have that option available to them. Diversion services, like all Lanterman Act services, are based on a person's individualized support needs. They are also based on a judge saying that the diversion plan will not pose an unreasonable risk to public safety.

The guidance that DDS and regional centers develop should talk about:

- Parts of the diversion process
- How to make sure that diversion is available to all eligible people with I/DD
- The regional center's role
  - The regional center's role should not be:
    - To give an opinion about whether diversion is appropriate

- To make recommendations for or against diversion

DDS could also help strengthen diversion programs by streamlining rate increase requests when needed for a person's diversion plan, such as for emergency housing or crisis intervention services.

2. **Transition Planning for Individuals Committed to Porterville Developmental Center (PDC).** DDS and the Regional Centers should work together to develop guidance about comprehensive transition plans for people at PDC. Sometimes people with I/DD do not get diversion services and need to go to trial. If the person does not understand why they are being charged or how to assist in their defense, they can be found "incompetent to stand trial." When this happens, they do not go to jail and are not found guilty. Instead, they may be ordered by a court to go to PDC, a large institution run by DDS. At PDC they are supposed to receive treatment that will help them understand why they were charged with a crime and how trials work. But there are some people that will never be able to understand why they were charged with a crime. Some people in this situation are locked up at PDC for many years, sometimes for longer than the time they would have served in jail if they went to trial and were found guilty. But not everyone at PDC needs to be there.

Transition plans for people at PDC should:

- Identify what kind of services the person needs to live in their community again
- Identify best practices for supporting people while they are at PDC and after their release
- Include a description of the issues or barriers preventing community placement for the person
- Include what actions are being taken to resolve the barriers to placement

3. **Make Sure Regional Center Services Are Provided Even if a Person Is Incarcerated.** DDS and regional centers should make sure that all

incarcerated people who are eligible for regional center services continue to get necessary support while they are incarcerated.

- The person should get supports from the regional centers to prepare them for release.
- The person should get support from the regional center as they come back into the community after release.
- Regional centers should not be allowed to “deactivate” a person's case solely for being incarcerated. Deactivate means to close a person's case and stop supporting them.
- Regional centers should continue to serve and monitor individuals who are incarcerated to prevent bad outcomes, like the person getting sent back to jail.
- DDS and regional centers should work together on how to identify and serve incarcerated people who are eligible for regional center services.
- DDS, regional centers, jails, youth corrections and state prisons should work together to develop a plan to support people with I/DD who are incarcerated. The plan should include requirements and best practices for supporting people during incarceration and after their release.
- DDS should provide guidance clarifying the roles and responsibilities of the regional centers in serving individuals who are incarcerated. This guidance should talk about how to partner with other systems, such as DHCS, to make sure people exiting incarceration have other important services, like health care.

## **Emergency Preparedness**

People with I/DD should have plans and supports to stay safe during emergencies, just like other people in their communities. Emergencies can include:

- An emergency a member of their household might experience. For example, a sudden health problem or a power outage in their home.
- A larger-scale emergency such as a natural disaster. Large-scale emergencies can impact entire communities. An example of this type of emergency would be the wildfires that recently occurred in Southern California.

1. **Make Sure People With I/DD Are Safe During Emergencies.** Regional centers should help people have a plan for what to do during an individual family emergency, as well as a disaster that is impacting entire communities. This emergency plan should be discussed and updated at each individual's IPP meetings. The emergency plan should include information and options on who to call for help and how to evacuate from a dangerous situation. DDS and many regional centers also have dedicated staff who are responsible for emergency preparedness and response. Families and individuals should know who these staff are and how to reach them in an emergency.

Regional centers should also have a plan for how they will respond to a large disaster that impacts:

- Their staff
- Their ability to provide services
- Their ability to keep their offices open

This plan should include:

- Agreements with neighboring regional centers, so they can help impacted individuals, regardless of the service area they live in.
  - This should include neighboring regional centers providing a place that people can call, text, or email to get information and help.
  - This is especially important if the local regional center is impacted by the disaster and cannot provide the help directly.

- A coordination plan with state entities like DDS, the California Office of Emergency Services, and the State Functional Assessment Service Teams.
- A plan for coordinating with first responders, like firefighters and paramedics, so they know where people with I/DD are and what they need.

## **People With I/DD Getting Services They Need and Choose**

It can be hard for many people with I/DD to get the services and supports they need. Services can be harder to get for people in some groups than others.

- People who live in rural areas are often far away from places that provide services. It can be hard for them to travel to get services. It can also be hard for service providers to travel to their homes to provide services.
- It can also be harder for people with different ability levels to get services. People with I/DD who have specific needs, like being blind or using AAC, can have a harder time finding service providers who can meet their needs.
- People with I/DD who do not speak English may have a harder time getting services. Sometimes information about services is not available in different languages the way that it should be. Sometimes it can be hard to find service providers that speak different languages.

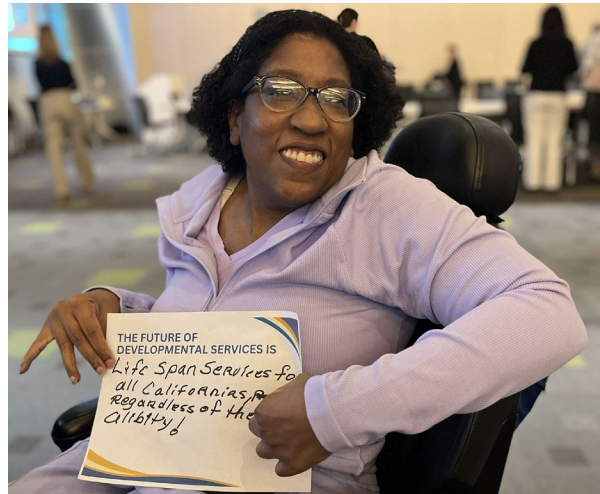
Some people with I/DD who are eligible do not get any services at all. Challenges with accessing services can be difficult because of barriers in the system. Barriers in the system happen when:

- Information about services and supports is not accessible to people with I/DD
- People with I/DD live far away from the places where services and supports are available

- There are not enough providers for everyone to receive a service that they choose
- There is not enough money to pay for everyone to receive a service that they choose

These barriers may be caused by unfair rules, discrimination, or unfair treatment. There can also be barriers because there are not enough resources for everyone to get what they need.

The goal for this topic is that people with I/DD get the services and supports they need and choose, when they need them, so they can lead the lives they want.



## **DDS and Regional Center Services**

The DDS's regional center system provides important services and supports to people with I/DD and their families. There are 21 regional centers in California, and they do not all do things in the same way. People I/DD who receive regional center services can have very different experiences with the system. Sometimes people with I/DD and their families have a hard time getting the information that they need from regional centers. Sometimes people with I/DD and their families cannot get services that they need and choose, even if they are eligible. People with I/DD and families from different groups can have an especially hard time getting what they need from regional centers.

These recommendations are about things that DDS and regional centers should do to make regional center services work better for people with I/DD and their families.

1. **Make Communication Better.** DDS and regional centers should work to improve the way regional centers and providers communicate with individuals and families. To do this:

- DDS should establish customer service standards that guide Regional Centers and providers in how to better support individuals and families. These standards should include:

**“Most of the information relating to the regional center, I had to find out on my own, and Mom was there to help me out...don’t leave the consumer to figure things out on their own if the coordinators are there to help with the services they provide... I keep learning things I could have gotten.”**

Eric

- Requirements that communication should be in plain language and in the language preferred by the person served and their family.
- Requirements to return phone calls or emails in a timely manner.
- Requirements not to use complex “phone trees.” A “phone tree” is an automated telephone system that directs callers according to options selected in response to recorded questions. Phone trees can be confusing and frustrating. People served should be able to get a live person when they call. This person should help them get to the right place to have their questions answered.
- Requirements to have options for people with I/DD and their families to communicate without technology, if that is their preference. Regional Centers and providers should only use technology to communicate when it is helpful.

2. **Conduct Focused Outreach to Under-Represented Communities.** DDS and regional centers should develop outreach plans to under-represented communities. Many people with I/DD and their families live far from a regional center. They would benefit from focused outreach from regional centers. DDS should:

- Require regional centers to develop and implement outreach plans. Outreach plans should focus on geographic areas that are far from regional center offices.
- Require regional centers to send staff to communities where it is more challenging to access and maintain services. For example:
  - Rural communities
  - Tribal communities
  - Communities of migrant workers
  - Communities that do not speak English
- Outreach should include information about Medi-Cal and other available services. This can help make sure that all eligible individuals are aware of and can access the services they need.
- Require regional centers to measure outreach efforts and outcomes.
- Include outreach expectations and accountability in regional center contracts.

3. **Make Sure People With I/DD Can Access Services and Supports.** DDS and regional centers should make sure that every person served has access to any service and support they are eligible for. This should be true no matter where a person with I/DD or their family live. Every regional center should:

- Offer the same core set of services.
- Make sure those services are available in all areas, including those with fewer resources.
- Work with people served to find acceptable solutions in cases where a service is approved but there are no available vendors. The responsibility and lack of services should not be the burden of the individual served.
- Expand the use of high-quality online services for eligible participants statewide.

- Make sure people with I/DD and families can access services within a reasonable driving distance and have reliable and timely transportation options to access those services.
- Create ways for vendors to pay enough to make sure that they are able to send clinicians and other providers to serve people with I/DD who live in remote areas.

4. **Make Sure Definitions of Services Are Clear and Consistent.** DDS should make sure all service definitions are easy to understand for individuals and family members. DDS should get help from an independent organization to develop and update definitions for services. These definitions should be available to:

- People with I/DD and the circle of supports. That organization should include people living with I/DD and people that understand the community, equity, and regional centers. These definitions should:
  - Describe things that must be included in each type of service, who is eligible to receive each service, and how services can be accessed.
  - Be used by all regional centers and providers.
  - Be easy for everyone to understand.
  - Be flexible so that they can accommodate the unique needs of individuals, including those in rural or other communities that might have resource constraints.
  - Regional centers should be required to provide training about these definitions for regional center staff and people who support individuals and families. DDS should collect, analyze, and report data about people's experience receiving services.

5. **Give People With I/DD More Flexibility in Services and Providers.** DDS should modernize the developmental services system to make sure people with I/DD have more flexibility in how they receive services.

6. **Make Sure Day Programs Are Person-Centered.** DDS should work with people with I/DD, their families and other community partners to make sure day-programs are person-centered. This could include developing day programs that are individualized.
7. **Improve Support Services That People With I/DD Receive at Home.** DDS should improve the support services that people with I/DD receive when they live in their own home or their family homes. People need flexible supports that are responsive to their needs. Supports and services should be provided when and where people need them. Services should follow the individual through their life and should not be disrupted by life transitions.

The services that are available do not work well for many people with I/DD. The services are complicated, disjointed, and they limit rather than support access. Some of these services are provided by regional centers. Some of these services are provided by other agencies and programs. These services depend on a person continuously meeting criteria set by the system. These criteria can include where they live or how old they are.

These services include:

- Independent Living Services (ILS)
- Supported Living Services (SLS)
- In-Some Supportive Services (IHSS)
- Personal care services
- Personal attendant services

Short-term improvements to these services should focus on expanding the SLS program and making sure that people with I/DD can access person-centered SLS.

Long-term improvements should redesign the services which are provided to people who live in their own or family home. DDS should work with individuals, families, and other community partners to redesign services for individuals who live in their own or family homes using a flexible unified approach.

More detail to support this recommendation is available in the Recommendation Background and Technical Information document on the CalHHS MPDS website.

**8. Seamless Services Between Child Welfare, Probation, and Regional Centers.**

DDS and regional centers should continue their work with counties to establish statewide best practices for serving children with I/DD in the child welfare or probation systems, including youth served in both systems. The best practices should include:

- Providing child welfare and probation systems with tools to screen for developmental disabilities in children who are not yet being served by regional centers
- Expediting referrals for regional center assessments

Case management systems should include data on disability related needs of the children they serve that can also be shared with regional centers. They should also include a process for seamless transfer of cases between regional centers when a child in the child welfare and probation systems moves to a different regional center catchment area. Regional centers and the child welfare system should collaborate to create a transition plan with families and youth when they transition out of the child welfare or juvenile legal systems. This is particularly important for young adults with I/DD who are going to age out of these systems. The plan should include describing the services that will be needed, and which organization will provide the services, like:

- Housing
- Health care and behavioral health
- Employment services

## **Health Care and Wellness**

Health care and wellness services can include many different types of services. For example:

- Medical services

- Behavioral health services. These are services to support people who have mental health or substance use needs.
- Dental services

Many people with I/DD have complicated health needs. This can mean that they need to get health care services from different systems. People with I/DD should get the health care services that they need to be as healthy as possible, just like anybody else. But people with I/DD sometimes have a hard time getting the health care services that they need. There are many reasons for this barrier.

- In some places, there are not enough health care providers. This can mean that people have to wait a long time to get the services they need.
- Sometimes health care providers, like doctors, do not fully understand that people with I/DD can have health problems that do not have anything to do with their disability. They might believe that people with I/DD should only get disability-specific health care services. For example:
  - If a person with I/DD also has a mental health condition, like depression, their doctor might think that the person with I/DD does not need behavioral health services like counseling. The doctor might think that the person with I/DD only really needs disability services.
- Sometimes health care providers do not have the training to appropriately serve people with I/DD.
- Some providers may not have resources they need to provide disability related accommodations to be able to serve people who need accommodations or additional supports.
- Sometimes the systems that provide health care services to people with I/DD do not work together to coordinate services in the way that they should.

These recommendations focus on making it easier for people with I/DD to get the health care services they need. The recommendations also focus on making sure that the health care services provided to people with I/DD are high quality.

1. **Address All Parts of Health for People With I/DD.** The State should develop equitable medical and behavioral health care where all parts of an individual's health are addressed. This means that their health needs should not be overlooked because they have a disability. This will lead to healthier individuals with disabilities living a better quality of life.
2. **Recognize That People With I/DD Have Health Needs That Are Not Related to Their Disability.** The State should make sure that health care and behavioral health systems recognize that individuals with I/DD can have a full range of human experiences. This means that they can have physical health, mental health and substance use conditions, in addition to their disability. People with I/DD who have health conditions are entitled to receive necessary services and supports to meet all their needs.
3. **Make Sure People With I/DD Do Not Face Discrimination From Health Care and Behavioral Health Systems.** The State and DHCS should make sure that health care systems do not discriminate against people with I/DD. This includes health care and behavioral health services that DHCS funds and oversees. People I/DD are sometimes denied services because they have a disability. This is called discrimination. Many people with I/DD experience discrimination when trying to get health care services and behavioral health services. When people with I/DD cannot get health care and behavioral health services they need, they cannot live the lives they want and fully participate in the community. It can also make it harder and more costly for DDS and Regional Centers to serve people. To prevent discrimination, there are many things that the State and DHCS should do. For example:
  - DHCS should change contracts and agreements with organizations and providers in their system to make it clear that they cannot discriminate against people with I/DD. DHCS should create measures and ways to hold them accountable to those expectations.
  - The State should create a responsible organization where people can report when they experience discrimination and barriers to health care services.
    - When providers deny services to people with I/DD, they should provide an explanation. This organization should review this explanation to make sure it is not discriminatory.

- DHCS should provide outreach and education to health care and behavioral health providers to transition to compliance with antidiscrimination laws. including:
  - Provide outreach and education, including information about providing accommodations, if needed, to individuals with I/DD.
  - Provide technical assistance, training, and outreach to help health care and behavioral health professionals and organizations understand their rights, responsibilities, and mandates to serve individuals with I/DD.
- DHCS should engage self-advocates, family members, DDS, and community partners to develop strategies to make sure antidiscrimination laws and rules are followed.

Background and more details about this recommendation can be found at the CalHHS MPDS website in the “Recommendation Background and Technical Information Addendum.”

4. **Make Sure Health Care Providers Understand How to Support People With I/DD.** CalHHS should work with the University of California and State University Systems to make sure that health care providers learn about disability and about serving people with I/DD. This would give health care providers the knowledge and skills they need to meet the needs of people with I/DD. This would mean providing information to health care professionals. This information should be included in requirements for training programs, like medical school. This information should also be included in continuing education requirements. The State should:
- Incorporate requirements for training on person-centered principles and practices into health care workforce development.
  - Make sure systems and professionals are aware of their legal obligation to serve all individuals regardless of disability status. They should provide necessary accommodations to ensure equitable services for individuals with I/DD.

- Establish awareness building and education efforts about disability for the general community.
- Include self-advocates and family members in development and delivery of trainings.
- Provide financial incentives to providers to complete disability and I/DD specific trainings.
- Collect data on current education/training of physicians, therapists, psychiatrists and other health care and behavioral health professionals on topics related to I/DD populations and needs. Use the data to promote and improve training.
- Training should reflect demographic, cultural, geographic, and other diverse characteristics of California's population.
- Training and awareness building efforts should also cover a variety of other areas that serve or impact people with I/DD including, but not limited to:
  - Law enforcement and correctional systems
  - Child welfare systems
  - Dentists

5. **Make Sure There Are Enough Health Care Providers to Support People With I/DD.** DHCS and DDS should provide resources and funding to make sure there are enough providers for people to choose from across the State. This includes providers in I/DD system, health care system, and behavioral health system.

DDS and DHCS should develop ways to pay I/DD, health care, and behavioral health providers so that people with I/DD can get services they need in a timely way. Providers should be paid enough to provide accommodations and accessibility supports people need.

DDS and DHCS should recognize adverse selection as a form of discrimination. Adverse selection is when providers only agree to serve

people with fewer support needs. DDS and DHCS should develop funding models for I/DD, health care, and behavioral health providers that reflect the level of need of people with I/DD and the cost of services that meet their needs. This will prevent adverse selection.

**6. Make Sure Health Care Service Systems Coordinate to Support People With I/DD.** CalHHS should make sure that all of the systems that provide health care services to people with I/DD work together. Different systems have different rules and ways for people to get needed supports. This can make it very difficult for people with I/DD and their families to know how to get the services and supports they need. It is important that the systems work together to make getting services easier. This will help make sure that people with I/DD and their families can get all of the services that they need from the different systems that serve them. There are many things CalHHS should do to make sure that health care systems work together. CalHHS should:

- Require that DHCS and DDS set up agreements that make it clear how they coordinate all services that people with I/DD and their families need.
- Require that DHCS and DDS create ways to coordinate services and supports across systems using person-centered principles and practices. This includes sharing data and information.
- Require that DHCS and DDS work together to make it clear how people with I/DD and their families will get specific services. This will require making sure that people can get services from DHCS and DDS that might be similar, but which might meet different needs.
  - For example, DHCS ECM and Community Supports services from DHCS.<sup>11</sup>

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

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<sup>11</sup> [For more information about ECM and Community Supports \(https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx\)](https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx)

7. **Make Sure People With I/DD Can Get Telehealth Services.** DDS and DHCS should partner with health care providers to continue to expand telehealth options, to make sure that people with I/DD can access specialized telehealth services. “Telehealth services” mean health care services that a person can receive remotely or virtually, instead of going into a health care office. Health care providers should include managed care organizations and community-based organizations. This will help people with I/DD to get remote and virtual supports from doctors and other professionals that are specialized in supporting people with I/DD. This could allow individuals to connect quickly with a doctor at any hour of the day, 365 days a year, for any medical concern or for disability-specific advice. This also helps people with I/DD and families who live in rural areas. They might not be able to access the same health care resources as people who live in more urban areas. With telehealth, they can access services from experts without having to leave their own homes and communities.

## **Health Care and Wellness: Behavioral Health Services**

Many people with I/DD cannot get the behavioral health care services they need and choose. There are many causes for this. For example:

- There are not enough behavioral health care providers with the skills and knowledge to serve individuals with I/DD. It is also difficult to find providers who speak languages other than English and who can support people in a culturally responsive way.
- There is a lack of coordination between many regional centers, county behavioral health agencies, and managed care plans.
- There are fewer resources in rural areas. In many areas throughout the State, there are long waiting lists to receive behavioral health services.
- People with I/DD and co-occurring significant behavioral health disabilities may be placed in restrictive settings such as Institutions for Mental Disease (IMDs).
  - IMDs are locked residential treatment facilities with at least 16 residents. These placements may be used because there are not

enough supports for people to live in their own home or family home, or enough smaller facilities that meet their needs.

- Sometimes, regional center staff may not be aware of less-restrictive service options for people with significant co-occurring behavioral health disabilities.

These recommendations focus on making sure that people with I/DD can access the behavioral health services that they need. The recommendations also focus on making sure that behavioral health services for people with I/DD are high-quality.

**1. Develop a System of Care for People With I/DD and Behavioral Health Needs.**

As a part of the larger work to coordinate care between health care systems, DHCS should develop a System of Care plan for providing services to people with I/DD. A “System of Care” means that different service systems work together to provide all of the different services that a group of people need. The plan for people with I/DD should be based on the principles of trauma informed care and the fact that individuals with I/DD can also have mental health conditions. The plan must include:

- Memorandums of understanding (MOU) in all 58 counties. An MOU is an agreement in writing. The MOU agreement should include different organizations that provide behavioral health services to people with I/DD, including:
  - Regional centers
  - County behavioral health departments
  - Managed health care plans
  - County offices of education
- The MOU work should be led by a team of leaders from the different organizations.
- The MOU should include information about:

- Processes for screening, assessment, and entry to behavioral health services
- Processes for universal service planning
- Processes for aligning and coordination of services
- Processes for information and data sharing
- Processes for financial management and cost sharing
- Processes for resolving disagreements between organizations

**2. Make Sure There Are Enough Behavioral Health Providers for People**

**With I/DD.** CalHHS and its departments, including DHCS, should build on the workforce efforts undertaken by California's Department of Health Care Access and Information (HCAI). For example, DHCS and HCAI should:

- Expand HCAI's Health Care Work Force Pilot Projects and Workforce Initiatives to include efforts to increase the number of professionals with training to serve individuals with I/DD and co-occurring behavioral health needs
- Build on current workforce initiatives to allow staff with an Associate of Arts (AA), Bachelor of Arts (BA), or Bachelor of Science (BS) degree and unlicensed staff with a master's degree to deliver, with appropriate supervision, "manualized," structured, evidence-based services
- Expand the availability of HCAI internships at regional centers, University Centers for Excellence in I/DD and other programs serving individuals with I/DD and behavioral health needs
  - A focus of these internships could be in rural communities and other underserved communities
- Expand the pre-service training and in-service continuing education for behavioral health providers to include knowledge and skills to meet the needs of individuals with I/DD

- Work with community colleges, state colleges and universities to develop career pathways for individuals to serve individuals with I/DD and behavioral health needs
  - Consider loan repayment, scholarships, or student loan grants

3. **Change Behavioral Health Billing Practices.** DHCS should change billing practices and rules to allow new behavioral health service delivery models to be billed across all funding sources. This will make sure that behavioral health services can be paid for and will be provided.

For example, allow billing for:

- Services provided by providers who would not usually be allowed to provide services, as long as they have appropriate supervision
  - For example, staff who have an associate's degree, a bachelor's degree, or a master's degree, but who do not have a license
- Group therapy services
- Behavioral health intervention services provided on the same day as a health care visit at Federally Qualified Health Centers
  - Current rules do not allow providers to get paid for some services if they are provided on the same day as other services
- Behavioral health services which are provided based on the symptoms a person is experiencing, even if they do not have a mental health diagnosis
- Behavioral health services which are provided to parents or other primary caregivers of people with I/DD
  - For example, allowing the mental health provided who is treating a child with I/DD who has behavioral health needs to also provide and bill for services provided to a primary caregiver parent who is experiencing anxiety or depression related to the child's care. This would allow a similar approach to treating both the newborn and

a mother who experiences post-partum depression by the child's health care provider.

**4. Make Sure People With I/DD and Behavioral Health Needs Get Enhanced Care Management (ECM) and Enhanced Service Coordination.** DDS and DHCS should develop and implement a statewide approach to provide ECM and enhanced service coordination.

- DHCS should make a new population of focus for the ECM Medi-Cal benefit. A “population of focus” for ECM means a group of people who have specific needs which ECM would help with. ECM is a service that provides a Lead Care Manager to coordinate health and health-related care and services. ECM helps connect people with complex needs to care that they need, wherever they are. Making people with I/DD who also have behavioral health needs population of focus for ECM would help make sure that people with these kinds of complex needs can get care coordination support.
- DDS and regional centers should include people with I/DD with complex behavioral health needs in lower regional center caseloads ratios for individuals with complex needs. This should specifically include people who are “at risk” of needing crisis services or for whom the crisis services are not available. DDS and regional centers should also include placement in IMDs as a criterion for complex needs and lower caseload ratios.

**5. Expand Services for People With I/DD With Complicated Needs.** DDS and DHCS should work together to make sure there are enough services for people with I/DD who have complex needs. For example, people who have I/DD and high behavioral health needs. To make this happen, DHCS and DDS should explore different models for providing care to people with I/DD with complex needs. These models should include:

- Supports models in crisis homes. This includes models that provide therapeutic, trauma informed care models for people with I/DD who have substance use issues.

- Trauma-informed care is an approach to providing services which recognizes that people experience trauma, and that trauma impacts their lives and experiences.
  - Models that are different from traditional Applied Behavioral Analysis (ABA).
    - ABA is a service that works to understand a person with I/DD's behavior and help them to change their behavior. ABA does not work for everyone, and some people with I/DD require different approaches.
  - Crisis management techniques rooted in the belief that the use of physical restraints is unnecessary and unproductive. For example, Ukeru.<sup>12</sup>
  - Individualized residential homes for youth.
  - Long-term wraparound services for families and single child residential homes.
    - These are services that provide high-need children and families with many different services and supports to meet their needs, over a long period of time.
  - Short term single person residential homes for people with I/DD with supports to transitions back to family home or community living.
  - Homes for people with I/DD and Alzheimer's, to provide them with needed services and supports.
    - Alzheimer's disease is a common cause of dementia. Dementia causes problems with memory and thinking.
6. **Address Complex Needs for People With I/DD.** DDS and regional centers should use develop an improved approach to meet the complex needs of people with I/DD. This approach should:

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<sup>12</sup> [For more information about Ukeru \(https://www.ukerusystems.com/\)](https://www.ukerusystems.com/)

- Use strategies and assessment tools
- Recognize the higher rates of abuse, neglect, and trauma that people with I/DD may experience
- Include training for regional center and other staff
- Guide assessments for community services
  - This will make sure that people with I/DD who have complex needs can get support in their current living arrangement
  - This will help to make sure people with I/DD and complex needs can stay living in community-based residential settings instead of more restrictive settings
    - More restrictive settings would include IMDs, Canyon Springs Community Facility, and state operated facilities

7. **Support Families and Caregivers to Support People With I/DD and Complex Needs.** DDS should clarify, and expand as needed, the kinds of training, services, and supports that are available to individuals, family members, and other care givers. Regional centers should provide training and services and support to families and caregivers of people with I/DD and complex needs. This will help families and caregivers to better support the needs of at-risk individuals with complex needs. Support should include:

- Individualized, person-centered strategies to de-escalate behavioral challenges
- Environmental modifications
- Timely access to additional supports and services

8. **Make Sure Parents and Caregivers of People With I/DD Can Get Behavioral Health Support.** DHCS, DDS, and regional centers should coordinate to make sure that parents and other family member caregivers of people with I/DD can access behavioral health services. These services should not be limited to peer support services. This will make sure that family caregivers of people

with I/DD can get the services and supports that they need to continue providing care to their loved one.

9. **Develop Person-Centered Crisis Care Plans.** DDS should identify best practice recommendations for person-centered crisis care plans. Regional centers should develop person-centered crisis care plans for people with I/DD and their families and/or caregivers. These crisis care plans should include ways to use specific crisis services which are available through regional centers and system partners during a crisis. This Crisis Care Plan should be included in the person's IPP.
10. **Expand START Teams.** DDS should continue to expand the availability of Systemic, Therapeutic, Assessment, Resources and Treatment (START) teams to all regional centers. START teams provide person-centered, trauma-informed services, and crisis support for people with I/DD over the age of six. START teams provide services 24 hours a day to people with I/DD. Expanding START services to all regional centers will make sure that prevention and early intervention services are available to all people served by regional centers in California.<sup>13</sup>

## Dental Services

People with I/DD may have significant dental needs due to their disability. They may also experience difficulty timely accessing dental care. Some regional centers have Dental Coordinators, who can help address access challenges. These recommendations focus on making sure that people with I/DD can access the dental services that they need. The recommendations also focus on making sure that dental services for people with I/DD are high-quality.

1. **Increasing Access to Dental Care Providers.** DDS and regional centers should identify strategies to increase access to dental coordinators. This could include regional models which coordinate services beyond specific regional center catchment areas.

DDS and other State partners should work with the dental care industry to identify and implement strategies to increase the number of dental care

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<sup>13</sup> [For more information about START \(https://www.dds.ca.gov/services/crisis-safety-net-services/start-program/\)](https://www.dds.ca.gov/services/crisis-safety-net-services/start-program/)

providers for people with I/DD. This should include working with schools of dentistry to prepare dental students to treat people with I/DD. Dental students could also provide basic dental services to people with I/DD as part of their training.

The State should also consider higher or supplemental rates for dental care providers in rural and underserved communities. Untreated dental issues often result in more expensive treatments in the future, so offering higher rates may save the State money and increase availability of providers.

2. **Increasing Options for Dental Care Services.** DDS should work with insurers, DHCS and the Medi-Cal system, and dental care providers to increase access to the types of services that people with I/DD often need. This includes services like:
  - In-home dental care
  - Desensitization services for individuals who are easily overstimulated
  - Anesthesia for individuals with greater behavioral needs or involuntary movements

DDS should begin by providing education and awareness about why these services are medically necessary for many people with I/DD. DDS should also work with insurers and Medi-Cal to identify the barriers to accessing these services and possible solutions. For example:

- Providing exemptions or expedited approval processes to obtain services like anesthesia and in-home services for individuals with I/DD
- Providing incentives to expand providers that accept Medi-Cal Dental

## Transition Supports

These recommendations are about transition supports. These are supports and services that people with I/DD get when they are going through a big change in their life. Life transitions include:

- When a child leaves Early Start services and starts to go to school
- When a young person leaves school and starts planning what they want to do after school
- When a person becomes a parent
- When an older adult wants to make changes in their life and the services they receive



These recommendations focus on making sure that people with I/DD get the supports they need during transitions.

1. **Make Sure People With I/DD Have Transition Supports.** DDS and regional centers should provide transition supports to people with I/DD before any transition begins. This makes sure that all people making a transition will have support that they need. These transition supports should include:

- The option of a PCP by a provider they choose
- Someone to help them, who they can choose. This person is called a “navigator.”
  - Navigators can help by:
    - Attending planning meetings

- Completing service applications
- Identifying service options
- People should have the option to choose a navigator who is a peer with I/DD
- Information about the life transition and what happens next. DDS should work with diverse stakeholders, including self-advocates, to develop information for each major life transition. This information must:
  - Be designed with the “end-users” in mind. The end users are individuals and their families. End-users may also be community-based organizations, navigators, and service coordinators.
  - Include information about individual’s rights.
- The option of a PCP and planning services by a provider they choose as part of each transition. DDS has proposed a waiver amendment to allow for a PCP during life transitions. This recommendation would expand upon that effort as follows:
  - DDS should develop information about PCP with diverse stakeholders, including self-advocates. The information must be in plain language. It must be translated into the languages spoken by individuals and their families.
  - DDS should define a PCP as planning tool based on core PCP principles, such as:
    - The PCP focuses on the whole person.
    - The PCP focuses on life goals and dreams. This means long-term goals, how to achieve them and ways to address barriers.
    - The PCP identifies what the person needs to prosper. This includes the kinds of supports the individual chooses to reach their goals.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

2. **Coordinate Supports for Transitions From Early Start.** CalHHS, DDS, regional centers, the CDE, and local school districts should work together to provide effective transition supports. This collaborative work should include:
  - Developing plain language information about the types of programs available to children. This includes the qualifications of providers. It must be translated into languages spoken by families served by the regional centers and school districts.
  - Developing common processes and planning tools for Early Start transitions. All school districts and regional centers should also be required to use these processes and tools.
  - Requiring regional centers and school districts to develop or update local MOUs about the transition process. This should include information about each agencies' responsibilities and how they will resolve any disputes.
  - Developing strategies to increase inclusive preschool and transitional kindergarten options for 3–5-year-olds served by the regional centers. This should include providing the needed supports and accommodations so children can be successfully included.
3. **Support Transitions From Early Start.** Regional centers should provide families of young children transitioning from Early Start services to school services with the transition supports they need and choose.
  - Transition supports should start at least six months before the referral to school services and continue until the child and their family receive the services they need and choose.
  - Transition supports should be provided to every Early Start family.
  - Transition supports should include:

- Information about the transition, person-centered planning, and navigation supports.
  - Navigators who have received training and are knowledgeable about:
    - The needs and strengths of young children with disabilities and their families.
    - Services available. For example, services from regional centers, school districts, other state programs (such as Medi-Cal and California Children's Services), and local resources.
  - Navigators who know how to support families, before, during, and after planning meetings. They must be able to attend planning meetings with families.
4. **Train Staff on Early Start Transitions.** DDS and regional centers should provide training and support on Early Start transitions. This will make sure that service coordinators and other navigators are knowledgeable about the needs and strengths of young children and available services. Navigators must know how to support families or caregivers before, during and after planning meetings. They must be available to attend planning meetings. DDS and regional centers should provide training and information so service coordinators are better equipped to support families in these meetings.
5. **Improve Transitions From Early Start.** DDS should support successful transitions from Early Start to school services. This includes:
- Monitoring eligibility decisions. This includes identifying and correcting disparities about who is eligible for regional center services.
  - Developing guidance about regional centers paying for services not available through schools and other departments. This guidance will be used by all regional centers.
    - This will include information about the types of services and supports young children served by regional centers can receive. This includes children who are:

- Eligible for school services
  - Ineligible for school services
  - Provisionally eligible
  - On waiting lists for school or HeadStart services
- Developing guidance about Early Start Service Coordinators responsibilities to attend IPP meetings. This includes:
    - Monitoring and analyzing Lanterman Act and provisional eligibility decisions to determine if there are disparities in who is eligible.
    - If there are disparities, DDS will develop a plan to address the disparities.
  - Developing guidance about Early Start service coordinator's responsibility to attend school district planning meetings with families.
    - This should include the regional center's responsibility to provide training and information, so they are equipped to support families in these meetings.
  - Developing guidance to make sure that provisional eligibility decisions are completed before a child is referred for school services.
  - Analyzing data to determine if there are disparities in who is eligible under the provisional eligibility criteria.
    - This includes working with diverse stakeholders to develop strategies to address identified disparities.
6. **Support Transitions From High School.** Regional Centers should provide all high school students with the transition supports they choose. These supports should start at age 14. This will make sure that there is time to plan before the person leaves school. The supports will continue until the person receives the services they have chosen to receive after high school.
7. **Support High School Students to Make Decisions.** DDS, the CDE, and regional centers should work together to help transition-aged students make their own

decisions. This should include staff training about how to help individuals with I/DD make decisions. They should also include developing uniform plain language information about alternatives to conservatorship. This information should be provided to staff, the people served, and their families.

8. **Improve Transitions From High School.** CalHHS, DDS, DOR, and the CDED should work together to improve planning for transitions from high school. They should develop a way for each person with I/DD who is leaving high school to develop a post-secondary pathway plan. A post-secondary pathway is the educational, training, or career path an individual chooses. The collaborative transition planning should include uniform guidance and tools to develop this plan that all departments will use. It should recognize that transition planning is an ongoing process and not a one-time event. These efforts should be coordinated with the California Master Plan for Career Education.
9. **Support Transitions From High School to Work.** DDS and regional centers should support successful post-secondary transitions by increasing ways to get work experience. This should also include planning for competitive integrated employment (CIE). This should include:
  - Piloting reduced service coordinator caseloads for transition-aged youth
  - Expanding the Coordinated Career Pathways program to help more students get CIE
  - Providing information and guidance about how regional centers can provide work experience while individuals are in high school
  - Developing guidance to eliminate waiting lists for post-secondary services
  - Increasing the number of employees with I/DD at all levels of DDS and regional center organizations
10. **Increase Opportunities After High School.** DDS, the CDE, and DOR should work together to support post-secondary transitions. This should include:
  - Removing barriers for employment services supports.

- DDS and DOR should enter into an MOU to make sure that employment services are provided and continue no matter which department the consumer initially contacted.
- DDS and DOR should increase the number of benefits counselors so that each person with I/DD can access this service.
- Working with the State and local college leadership to expand college options.
  - DDS and DOR should work with the Community College Chancellor's office, and State Universities and University of California systems and trade schools to increase the number of students with I/DD who attend college.
  - This may include expanding college options and expanding the supports available for students with I/DD at college.
- The CDE should provide guidance and resources to increase the number of students with I/DD who obtain a high school diploma. This will make sure they have access to the same career education supports as students without disabilities. For example:
  - Career exploration.
  - Volunteer opportunities.
  - Opportunities for paid and unpaid CIE.
- The CDE should provide guidance to local school districts about the rights of students with I/DD to complete needed classes for post-secondary education.
  - This should include best practices for providing accommodations and supports so students with I/DD can complete classes.

11. **Give Young Adults With I/DD the Choice to Leave School at Age 18.** The State should amend the Lanterman Act so that people with I/DD who are age 18 or older can still receive services from their regional centers, even when they choose to leave the school system without formally graduating. These

individuals should not be required to remain in public school transition programs until the age of 22 in order to receive services. Instead, they should have the option to leave the school system with access to developmental services between the ages of 18 and 22. The law used to offer this choice before State budget cuts in 2009.

While many students with I/DD may be happy to stay in their school for a transition program until age 22, this is not true for everyone. Some people find school stressful or disrespectful. Young adults with I/DD should be able to exit school at age 18 just like young adults without disabilities can. If they do, they should still be able to get the services they need from their regional center to lead the kind of life they want.

**12. Make Sure Parents With I/DD Have Supports They Need.** DDS and regional centers should make sure that people with I/DD who are parents or becoming parents get the supports they need and choose. These supports include:

- Plain language information and training available in many formats. Topics should include:
  - Pregnancy complications
  - Pre- and post-natal care
  - Well baby care
  - Developmental milestones
  - Dealing with emergencies
  - Dealing with stress
  - Discipline
  - Hygiene
- Person-centered planning
- Navigation supports

- Help interacting with courts, and the child welfare system
- Help getting housing, government benefits, and other services

**13. Expand Services for Parents With I/DD.** DDS and regional centers should support successful transitions for parents with I/DD by developing additional flexible service options. This should include:

- New kinds of flexible living arrangements such as co-housing.
- Expanding the Coordinated Family Supports (CFS) program and not capping the number of direct service hours that are available.
- Identifying more providers who can support parents with I/DD.
- Purchasing adaptive equipment needed by parents with I/DD. For example, a modified crib that can be used by a parent who uses a mobility device.

**14. Support Parents With I/DD With Information About Services and Supports.**

CalHHS and its departments, including DDS and the DSS should develop plain language information about:

- Services and supports that people with I/DD who are parents can get from different state and local agencies
- Child welfare system processes and court processes
- Domestic violence and victimization and how to get help

The information should be developed in consultation with individuals with I/DD who are parents and other stakeholders.

**15. Support Parents With I/DD to Keep Their Families Together.** CalHHS and its departments, including DDS and DSS, should develop effective best practices and models for supporting parents with I/DD. These practices and models:

- Will support the principle that many people with I/DD are able to care for their own children

- Will include strategies to reduce the removal of children from their parents' home and care

CHHS and its departments will work with regional centers and county child welfare agencies to develop agreements about how they will implement these best practices. These agreements should include:

- Identifying effective best practices and models for providing coordinated services to people with I/DD who receive services from regional centers and child welfare agencies
  - These practices and models should meet the needs of parents from diverse disability, racial and cultural backgrounds
- Requiring child welfare agencies and regional centers to develop MOUs identifying how they will implement the identified effective best practices and models to reduce the removal of children from the parental home
- Developing training modules about the needs of parents with I/DD and best practice strategies and services to meet those needs
  - The training should address the stigma and discrimination that parents with I/DD face about their ability to successfully parent a child
  - The training should address the disproportionate focus on removing the child from the parent's care
  - The training should be available for regional center staff, child welfare staff, health care professionals, and attorneys involved in the child welfare system

**16. Make Sure Older Adults Get Transition Supports.** DDS and regional centers should make sure that older adults get the transition supports they need and choose, when they need them. Regional centers should proactively provide information and discuss transition supports with people served no later than age 55. This should happen sooner if requested or when needed by the person served. For example, for individuals with Down Syndrome who are at risk of developing dementia. These supports include:

- Information
- Person-centered planning
  - This should include the individual's preferred future as an older adult and any additional support needs. It should also discuss end of life planning including health care advanced directions, powers of attorneys, wills, burial instructions. It should consider the family as a whole, additional care-giving resources and access to shared generic services.
- Navigation supports
  - All navigators must receive training and be knowledgeable about:
    - The needs and strengths of older adults
    - The needs of aging parents or caregivers that the older adult lives with
    - Services, including those available from regional centers, community based older adult services, and other state programs (such as Medi-Cal, IHSS, Aging and Disability Resource Centers, and local resources)
- Access to support groups led by peers with I/DD
- Access to support groups for aging caregivers so they can connect with their peers

**17. Improve Supports for Older Adults.** DDS and regional centers should develop new and more flexible ways to support older adults. For people with I/DD who live with an aging parent or other aging family member, the support should address the needs of the family unit. These supports should include:

- Guidance about paying for supports to attend older adult programs in their community.
- Flexible ways for older adults to get services during the day and where they live such as the ability to attend vendored programs on a part-time basis. Expand the definition of supportive living services to include

living in their family homes, so older adults can continue to live in their aging care-giver's home.

- Training on modules for direct support professionals (DPSs), service coordinators and other professionals about the needs of older adults with I/DD and their aging caregivers.
- Considering how smart home technology can be used to support people with I/DD living in their own home.
- Continue and expand the Coordinated Family Supports program to meet the needs of older adults and their aging parents. For example:
  - Expand CFS to help people who live independently who may need help coordinating their services.
  - Remove the cap on direct service hours so people living with an aging caregiver can continue to live in their family home.
- Developing new ways to help older adults maintain benefits such as IHSS, Medi-Cal and SSI when they need help managing their benefits.
- Developing new ways for SDP participants to get additional help to manage their Spending Plan and Budgets so they can stay in the SDP.

#### **18. Help Plan for the Future for People With I/DD Who Live With an Aging**

**Caregiver.** DDS and regional centers should help people with I/DD and their families plan for long-term housing and residential care needs. This means making a plan for where a person with I/DD will live when their parent or other family caregiver is no longer able to live with and care for them. This planning should happen before aging caregivers can no longer provide support. The plan should be included in the person with I/DD's IPP.

More details about planning tools to support this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

#### **19. Improve Transitions for Older Adults.** CalHHS and its departments including DDS, and the Department of Aging should collaborate to support older adult transitions. They should:

- Develop plain language information about the types of programs available to older adults.
  - This should include services available through regional centers and local senior services community-based living options. Particularly services for individuals who may no longer be able to live with an aging parent or caregiver.
  - The information should be developed with diverse stakeholders. It should be translated into the preferred languages of persons served by regional center.
- Increase the number of Alzheimer's Disease Centers. Make sure these centers have knowledge of I/DD and adequate funding to be able to provide assessments. Identify strategies to train Alzheimer's Disease Center staff, regional center staff, and staff at the Aging and Disability Resource Centers and community service providers about the needs of people with I/DD and dementia.

20. **Make Sure End of Life Planning Is Available.** DDS and Regional centers should proactively make sure end of life planning is available for older adults and individuals with I/DD who have serious health conditions. The regional center should make sure they get the supports they need and choose at the end of their lives. This includes:

- Developing uniform plain language end of life information that regional centers proactively share with all adults.
- Developing end of life resources.
  - This should include information and forms for an Advanced Health Care Directive including identification of a substitute decision-maker who can help make decisions when the person cannot do so and Powers of Attorney.
  - It should also include estate planning information such as a simple will. This will help individuals make their own decisions about who can get their property.

- Developing flexible models for increasing the types/amount of support that people can receive.
- Developing training modules for staff and other professionals. This information should include:
  - A road map to help people with I/DD and their families or other caregivers understand the end-of-life process.
  - Information on available services and supports, including hospice, and the decisions they need to make including burial and memorial service preferences.
- Developing best practices for intensive care planning, for people with serious health conditions. Intensive care planning can include hospice and other services. Intensive care planning should involve the individual's circle of support. These best practices should be considered during the development of a PCP.
- Developing flexible models for increasing the types and amount of support that people at the end of their life can receive. This should include:
  - Additional services and supports for individuals who are hospitalized.
  - Support for interacting with health care providers and benefits programs.
  - Increasing support so individuals can continue to live in their own home at the end of their life.
  - Expansion of the CFS program to be available to individuals at the end of their life. This should include an elimination of the cap on direct services hours.

## Access to Other Services

These recommendations are about services that people with I/DD use that are not specific to the developmental services system. These services are called “generic services.” These recommendations are focused on making it easier for people to get generic services that they need and choose from different service systems.

### 1. Clarify the Definition of Generic Services.

DDS should clarify the definition of generic services. This will make sure that people with I/DD and their families understand what services are available to them. This will help them to access services and supports that they need and choose.

The definition should:

- Be easy to understand by people with I/DD and their families.
- Be used by all regional centers.
- Respect the individual's choice about how they use generic services.
- Say what a generic service is and when the service is available.
- Say what is and is not a generic service.
  - For example, cash benefits such as Social Security benefits, SSI, and Cal Fresh are not generic services.
- Say when generic services are available. This will make sure that services are provided on time.
  - Individuals must receive the service within 30 days or sooner if it is an emergency or immediate need putting the individual's health and safety at risk.



- The definition should make it clear that if a person is on a waiting list, the service is not available to them.
- Explain that generic service agencies must use their own eligibility, assessment, or planning processes when making decisions about services.
- Explain that regional centers may provide services that are different from generic services which are provided.
  - This means that IPP teams may decide that other services are still needed, in addition to generic services.
  - For example, a school IEP team may decide to provide a communication device for a person with I/DD to use at school. The regional center can then decide to provide a communication device at home to meet the person's in-home communication needs.
- Explain that the IPP should include:
  - The generic services that a person is referred to.
  - The way the regional center will support the person in accessing these services.
  - The steps the regional center will take to make sure the person gets the service they need and choose, if the generic service is not available.

2. **Make Sure Regional Centers Can Provide Generic Services That Have Waitlists.** CalHHS and DDS should propose changes to the Lanterman Act. These changes would allow regional centers to pay for a generic service when the service cannot be provided by a generic services agency within 30 days (or sooner in an emergency or other immediate need putting the individual's health and safety at risk). This is sometimes called "gap" funding. If the person is on a waiting list, the service is not available to them. CalHHS and DDS should also develop ways for regional centers to be reimbursed for the cost of the generic services they pay for.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

3. **Make it Easier for People to Get Generic Services.** CalHHS and DDS should change the Lanterman Act to remove the requirement that people with I/DD and their families must appeal a generic services denial. They should also create a way to resolve disagreements between systems about which system should pay for a generic service. This will make it easier for people with I/DD and their families to get the generic services that they need.
  - DDS should also make sure that:
    - If a person served wants to appeal a denial, the regional center should help them get an attorney or agency to help.
    - If the attorney does not work for a legal aid program and requires payment, the regional center should pay for the attorney.
  - The regional center cannot use information it learns when helping a person access a service or benefit against the person.
    - For example, if the regional center is helping a person served write a letter to support an SSI appeal and they learn something about the person's disability, they cannot use that information to change the person's regional center eligibility.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

## Help Getting Services

These recommendations focus on ways that people with I/DD and their families can get help with getting services.

1. **Strengthen Community Networks.** DDS and regional centers should work to strengthen community networks that connect people with I/DD to services. DDS should learn from a successful outreach strategy currently used by the DHCS to connect people with services.

- DHCS uses community health workers—who are also called Promotores in Latino communities—to educate and refer people to services in communities that have been historically marginalized and disconnected from the health system
- These individuals speak a variety of languages and serve diverse communities with diverse needs across the State

DDS should use this strategy to connect people with I/DD and families to regional center services. It is critical to partner with organizations who are trusted and trustworthy to connect individuals and families with needed support. This is especially true for immigrant communities who face real and perceived risks of interacting with government-related services, Trusted community organizations and individuals could include:

- Faith-based organizations, like religious leaders at churches, temples, or mosques
- Medical providers, like pediatricians
- School staff, like school administrators and teachers
- Social workers
- Staff at senior centers

When these communities understand disabilities and the services available to, they can serve as essential referral networks to connect people with I/DD to services. DDS should fund and hold regional centers accountable for outreach to trusted communities and leaders. Regional centers should:

- Educate these leaders and organizations. This education will help them to model acceptance, respect, and celebration of neurodiversity. This should include providing education about:
  - Neurodiversity
  - Ableism
  - I/DD issues and services

- Share accurate and consistent information and materials, in multiple languages, with these trusted community members and organizations about regional center services, so they can learn about and connect families and individuals with services, as early in life as possible.

2. **Make Sure Regional Centers Offer Peer Mentoring.** DDS should work with regional centers to make sure every regional center is providing effective peer mentoring opportunities. Peer mentoring is a process where two people of similar lived experiences work together to help each other. Peer mentoring offers a level of acceptance, understanding, and validation not found in many other relationships. Turning to peers for advice and support is an important way for people served by regional centers to:

- Understand the service system
- Learn to advocate for themselves
- Gain leadership, social, and other skills
- Discover opportunities and networks in the broader community
- Connect with others who “get it” and can relate to their specific challenges

There is wide variation across regional centers in the availability of and support for peer mentoring. All regional centers should have thriving peer mentoring communities in which people served feel a sense of belonging and connection, no matter how complex their needs may be. DDS should work to:

- Develop an understanding of what “peer mentoring” looks like at each regional center today
  - Have regional centers submit descriptions and share a statewide inventory of the 21 programs or opportunities on DDS’s website
- Identify regional centers that have strong peer mentoring programs or opportunities and share these best practices across regional centers

- Develop a common framework to guide regional centers in the elements of effective peer mentoring to include in program development
  - Have regional centers collaborate with people served to design a peer mentoring plan that includes elements from the framework and responds to the needs of that people served community
    - For example, people served may want to choose from group and one-on-one mentoring opportunities. They may want to choose from different platforms for communicating with their peer mentor: online, in-person, or through an app.
  - Develop and implement training for individuals who will serve as peer mentors
  - Implement peer mentoring programs at regional centers with ongoing feedback from people served and collaboration to improve peer mentoring programs
  - Post peer mentoring information and resources on every regional center website where it is easy to find and understand; and have DDS's website serve as a central source of this information.
3. **Make Sure Information About Generic Services Is Accessible.** CalHHS should work with its departments and stakeholders to expand or create accessible, user-friendly plain language information, and tools about generic services. This includes how to access these services and how to get help. The tools should help people gather the information they need. The materials should be in languages spoken by people served by the regional center. The information, tools and any forms should be short. They will be accessible on mobile devices. They will be in formats used by people with disabilities, including videos. The user-friendly plain information should:
- Be designed with the end-user in mind. The end-users are individuals and their families.
    - The design should consider people's experiences accessing generic services and data about equitable use of generic services

- The information should address common barriers to accessing services, for example, eligibility criteria
  - The materials should be developed with the California Office of Data and Innovation
  - Be easy to access through state and local agencies, regional centers, and community-based organizations.
    - The information must be located on DDS's website and updated as needed to make sure it is accurate
    - Regional centers, generic service agencies, and community-based organizations' websites should provide links to this information
  - Include links to other user-friendly information such as BenefitsCal.com which helps people apply for cash benefits such as CalFresh, cash aid such as CalWORKs and Medi-Cal. It also provides information about accessing mental health services.
  - Be supported by regional center strategies to proactively outreach to communities that underutilize generic services.
    - Data about who uses generic services should be used to focus outreach to groups that under-utilize generic services
    - Outreach should include other non-traditional means, such as providing information to video relay services
4. **Give People With I/DD and Their Families Tools So They Are Referred to the Right Generic Services and Can Keep the Benefits They Have.** CalHHS should work with its departments and stakeholders to develop tools to help people get the generic services they need. This should include services that are available across agencies, departments, and systems. The initial priority should be developing tools for the most frequently used generic services.

The tools should:

- Include eligibility screening tools for generic services that will be used before making a referral
  - Be based on the rules for generic services developed by DDS and other departments that provide generic services
    - This means the tools should include eligibility requirements and steps to be taken before eligibility can be decided.
    - For example, to receive some generic services, a person needs to be Medi-Cal eligible. If they are not Medi-Cal eligible, they should not be referred to the generic agency unless they get Medi-Cal eligible.
  - Be available to all generic services agencies, navigators, and community-based organizations
  - Be used by all regional centers each year to help people who work keep their benefits
  - Include tools to help people keep their SSI and SSDI benefits
    - For example, the tools should include uniform processes to report job-related income and employer subsidies and special conditions that reduce countable income. This will help make sure that people who work avoid large Social Security benefit terminations and overpayments.
5. **Make a Single On-Line Application for Services.** CalHHS should work with its departments and diverse stakeholders to develop a single on-line application for the health and human services the individual needs and chooses. When developing this system, CalHHS should consider current systems which provide some of the expected functionality and assess whether the functionality of those systems can be expanded. Examples of existing systems include:
- BenefitsCal
  - The San Diego Community Integration Exchange, which is part of its 211 system

The goal of the single on-line application would be to create a unified, accessible platform that allows people with I/DD, families, or caregivers to access all eligible services from any CalHHS department regardless of the department they first contacted. The system should:

- Provide a seamless experience.
- Provide personalized service recommendations.
- Provide automatic enrollments.
- Allow 24/7 access for people to access their information.
- Provide notifications about application status.
- Provide connections to ways to get help.
- Support enrollment by using a network of community-based partners and service centers to provide in-person or phone-based assistance for individuals who need help navigating the system.
- Prioritize users who have an immediate crisis. This includes homelessness, domestic violence, food insecurity, or medical emergency.
- Protect privacy and confidentiality.
- Require cross-system data sharing.
- Provide training for users.
- Ask users to provide feedback.
  - Feedback will be used to evaluate system improvements and for futures planning. This will help ensure the system is taking advantage of new technologies that will make it better.

More details about this recommendation can be found in the Recommendation Background and Technical Information Addendum on the CalHHS MPDS website.

6. **Make Sure Navigators Are Available.** DDS should increase the number of navigators available to help people with I/DD access the generic services they need and choose. People served should have choices about who provides navigation supports. Navigation services should include services provided by people with I/DD. Navigators should be culturally diverse and have cultural humility. When expanding its navigation program, DDS should work with diverse stakeholders, including self-advocates, to develop:

- Common services that navigators provide. For example:
  - Information and training about generic services. This includes eligibility requirements, how to access services, how to get help.
  - Help with generic services applications and annual review forms.
  - Help talking to generic service agencies. This can be about an application, assessment, notices from the agency, or to fix a problem.
  - Collaboration with other navigators and agencies to make sure the person gets the right help at the right time.
- Common skills and knowledge for navigators. For example:
  - Communication skills.
  - Interpersonal and relationship-building skills.
  - Navigation and advocacy skills.
  - Community education and training skills.
  - Outreach skills.
  - Knowledge of the regional center system. Knowledge of the generic service system(s).
  - The needs of the community they will serve.
- Common reporting used by all navigators that is reported to DDS at least once a year. For example:

- Demographic data about each person who was helped.
- The kind of service(s) provided to each person.
- The outcomes. For example, the generic services the person received. Or the skills the person learned.

7. **Increase Funding for Navigators.** CalHHS and DDS should work to increase federal funding for navigation services. Federal funds should be used to increase the number of navigators.

- CalHHS should learn from work done by departments to develop programs like Community Health Worker and Promoters. These are other programs that help people get the services that they need in other services systems. Learnings from the development of these programs should inform the navigator services eligible for federal funds.
- The navigation model proposed for federal funding must be developed in consultation with stakeholders.

8. **Develop Local Resource Guides.** Regional centers and DDS should work with local partners to develop and expand local resource guides. The guides should provide information about resources that are available to people with I/DD.

- The guides should include information about regional center services. This information should include consistent information on who is eligible for regional center services and the services available.
- The guides should be available online. They should also be accessible to people who do not have easy access to the internet. It is important to keep resource materials up to date.
- AI could be used to keep materials up to date. AI could use available information on websites and other sources to update contact information and the services provided by the listed agencies.

Regional centers and DDS should also:

- Work to improve the quality of information provided by 211
- Provide training to front-line staff to use systems like 211

9. **Provide Funding for Resource Centers.** DDS should provide state-wide funding for Resource Centers to help people with I/DD and their families or other caregivers access state and local community resources and services.

- The intention should be to develop a system to better integrate available resources, including peer-support resources.
- These Resource Centers could be an expansion of current models such as Family Resource Centers, Aging and Disability Resource Centers or Independent Living Centers.
- Another model would be to provide funding to other community-based organizations to establish Resource Centers. Resource Center staff must include individuals with I/DD.
- The services must be provided in languages spoken by people and families served by regional centers.

10. **Develop Shared Service Models.** DDS should work with people with I/DD, families, and other community partners to develop innovative service models where people can share resources and services with others. These models:

- Can be called “co-op models”
- Can be more resource effective
- Can include sharing staff or hours of support
- Can make it easier for people to get assistance from providers who are not their parents or relatives
- Can be explored to develop supports for people with I/DD who live with their aging parent or caregiver who also needs services and supports

- Should reflect United States Department of Labor overtime compensation requirements

DDS and Regional Centers should develop policies and oversight to prevent this model to be used to develop unlicensed group homes or similar models that are not based on person's choice. DDS and Regional Centers should also develop ways to measure quality and outcomes of this service.

11. **Life Tracker System.** The State should develop a "Life Tracker System" that supports individuals from birth through end of life. This system should provide people served with access to information about their services across all systems of support. This includes:

- Regional centers
- Health care, including behavioral health
- Schools
- DOR
- Other service systems

In developing the Life Tracker system, the State should keep in mind:

- Individuals should have a choice to participate in Life Tracker system or not.
- Individuals should have a choice on what information about them should be shared in Life Tracker.
- Life Tracker should have a portal so people with I/DD can see important information themselves. This portal can be similar to "MyChart." "MyChart" is a patient portal tool in the electronic health record system. Using the portal people with I/DD should be able to communicate with their RC and providers by sending secure messages.
- Life Tracker should be able to alert systems of support to prevent late responses, lags in supports, and remove barriers to services.

- Each system of support should have access to the Life Tracker system based on their role in a person's life. This will help them track, deliver, monitor services, and to coordinate with other systems, if the person chooses that.
- The Life Tracker system should provide resources to individuals and families and support them in planning for and going through life transitions. This can include information about services and resources, support with paperwork, and more.

## **People With I/DD Being Part of and Being Served by a Strong Workforce**

There are not enough people working to provide services to people with I/DD. These kinds of jobs are called the “disability field.” There are not enough people working in these jobs because the disability field is often viewed as a temporary job with low pay and challenging work situations. People don't get paid enough and don't get enough benefits to want to stay in the field. They are forced to find other jobs, even when they don't want to change careers. There are not enough opportunities for training and promotions. Another reason that there are not enough people working in the disability field is that many people do not know about careers connected to disability. There is not enough information for how to get a career in disability services.

Some jobs in the field can be very different depending on where someone works. For example, service coordinators at regional centers. Service coordinator roles and caseload sizes are very different at different regional centers. Their responsibilities can shift and change over time. This can make it hard for service coordinators to support people with I/DD and their families well.

There are also many people with I/DD who would like to work in the disability field but who have a hard time finding a job. People with I/DD are not encouraged and supported to seek jobs in the disability field.

The goal for this topic is that people who want to work supporting people with I/DD have what they need to stay in their jobs. This includes people with I/DD who want to work in this field. Recommendations in this topic area include:

- Ways to get more people working in the disability field
- Ways to make it easier for people in the disability field to stay in their jobs
- Ways to make it easier for people in the field to do their jobs well

## **People Who Provide Services to People With I/DD**

These recommendations focus on making sure that people with I/DD can be supported by a strong workforce. Some of the recommendations are about making sure that people who already work in the field have what they need to do their jobs well. Some of the recommendations focus on making sure that people who work in the field have what they need to stay in their jobs. Some of the recommendations focus on making sure that more people will work in the field. This will help to make sure there are enough people working in the field to support people with I/DD.

1. **Build Trust With Regional Center Service Coordinators.** DDS should work with regional centers to hold service coordinators accountable to certain expectations about how they do their jobs. These expectations will help people served feel like they can trust their service coordinators. To support trust, DDS should make sure that service coordinators receive training to support people with I/DD and families:

- With cultural humility and awareness.
- In a trauma informed way.
- With an inclusive and person-centered approach.

Service coordinators should also be expected to:

- Try to understand what people served communicate about their needs and goals.
  - This includes asking questions when they do not understand.
- Support people served when they communicate with staff at regional centers and service providers.

- Service coordinators should not make assumptions about what is in the person's "best interest."
- Tell people served about all possible options and service providers related to what they want and need.
- Refer people served to assessments, when necessary, instead of judging their abilities and needs.
- Support people served by asking if they want advice, instead of giving people advice they did not ask for.
- Let people served decide which services might be a good fit. Service coordinators should not make judgments or discourage what people served want.
- Value the perspectives of people served over others' biases. Promote the self-advocacy of people served over social approval.
  - For example, service coordinators should not discourage people served from communicating their triggers and authentic goals, even if the service coordinator judges them to be "too negative."
- Support people served to express their feelings. This includes validating beliefs about flaws in the system.
- Assume that when people served seek information, they are not necessarily implying an action should be taken.
  - This means that service coordinators must obtain explicit consent from a person served before moving forward.
- Keep a log of all actions taken for the person served and share it with them.
- Respect when people served decide to switch coordinators for any reason. This includes not tolerating any form of regional center retaliation in response to these or other decisions.

- Participate in interviews so people served can choose the service coordinator that is right for them. This should happen outside of IPP meetings.
- Fully disclose ahead of time all decisions that will be made about a person served without their consent. This should include decisions to withhold information to prevent a person's anxiety.
- Learn and respect how people served think and communicate.
- Assist and encourage people served in making complaints, even against the service coordinator themselves.

Asking for help is one of the most vulnerable things anyone can do. Asking for help is what people served by the regional center do every time they reach out to a service coordinator. If people served do not trust their service coordinators, they may not feel safe to share information. This trust in the relationship between service coordinators and the people served is vital for service coordinators to do their job.

2. **Support Staff at Regional Centers.** DDS and regional centers should create a support staff position at regional centers. This staff could be assigned to support multiple service coordinators with processing paperwork. The goals for this position would be to:

- Allow service coordinators to focus on building relationships with people and families that they serve
- Allow service coordinators to spend more time providing services
- Provide another opportunity for people interested in disability-related careers

The first step should be to get information about best practices used by regional centers that have similar support staff positions. This could show what is already working well at regional centers. DDS and regional centers should work together to decide which tasks that service coordinators are responsible for could happen in different, more efficient ways. For example, by:

- Using technology to complete certain tasks instead of assigning those tasks to a regional center staff
- Removing tasks that are not actually necessary
- Streamlining tasks that can be made simpler or quicker

This information should then be used to inform the job description for the regional center support staff position.

3. **Give Students Information About Disability Service Careers.** DDS should collaborate with the CDE to launch a curriculum for middle and high school students, including students with disabilities. This curriculum should teach students about:

- Disability history.
- The abilities and contributions of people with disabilities.
- Disability services careers. This should also include information and career guidance for students who are interested in disability-related careers.

4. **Spread Awareness About Disability Related Careers.** The State should sponsor an awareness campaign to increase interest in disability-related careers. It should:

- Feature major employers
- Highlight people with I/DD in successful careers
- Reduce stigma about disability

This campaign should reach culturally diverse and underserved communities and youth in middle and high school.

5. **Help People Start Disability Service Careers.** The State should create a partnership with community colleges, and employers to establish a paid internship program. This program would help people start their careers in disability services. This should be in addition to the Paid Internship Program, known as the PIP. This new internship program should be available to anyone

interested in a career in disability services. This internship program could begin as a pilot through a partnership with a community college and their local regional center.

6. **Help Connect People to Jobs.** DDS and Regional Centers should create regional plans for using existing employment tools. Tools should be used to:
  - Promote disability services careers
  - Match people looking for disability services careers with organizations and individuals that are looking to hire

This should include expanding and enhancing state-sponsored online tools, like the DSPCollaborative and CalJobs. It should also include more partnerships with private industry resources like Indeed and LinkedIn.

7. **Help People Be Successful as Disability Service Providers.** The State should work with the community college system to provide training and Career and Technical Education (CTE) programs for those in disability services careers. The programs should include an apprenticeship and competency-based education to make sure that students in the program get the skills they need to be successful as disability services providers. These programs would provide easy to access low-cost/no cost training opportunities. The State could begin by identifying a lead person at DDS to work with a community college willing to sponsor this effort or expand existing similar programs.
8. **Make Sure People in Disability Service Careers Have Benefits.** The State should create a directory of benefits programs that people in disability-related careers could access if they do not receive benefits through their employer. This would be particularly helpful for people who are self-employed or employed through the SDP. The benefits could include:
  - Health care benefits
  - Retirement programs
  - Other savings and insurance programs

The State could also explore creating new state-sponsored benefit programs where there are any benefits gaps.

- 9. Make Sure People in Disability Service Careers Make Enough Money.** The State should update the way it determines how much to pay vendors and DSPs. This is known as the vendor rate model. The goal of an updated vendor rate model is to have a rate that allows competitive pay for DSPs and covers the costs of administering services.

The State should also conduct a study to understand the wages and the required skills and qualifications for other types of jobs that DSPs sometimes apply for. This study should also examine rates needed to make sure there are enough providers in rural communities, to adequately support group services, and for serving individuals with high-support needs.

The State should include an assessment of how vendors use rate increases, including how much money from increased rates goes to paying DSPs.

DDS should use the results of these studies to make sure that the vendor rate model is paying DSPs a competitive wage and provide more flexible ways for providers to obtain rate exceptions when needed. After this update is complete, the State should make a commitment to periodically update the vendor rate model to make sure that it continues paying competitive wages in the future.

## Opportunities for People With I/DD

These recommendations focus on making sure that people with I/DD who want to work have the opportunity to work. Some of these recommendations focus on making sure that people with I/DD can find a job. Some of these recommendations focus on making sure that people with I/DD who are working have the supports that they need to be successful.

- 1. Make Sure People With I/DD Get High Quality Employment Services.** DOR and regional centers should work together on how they provide employment services. This will make sure that people get excellent service



from both programs. They can do this by having designated DOR liaisons for each regional center who can work together with the service coordinator on helping people achieve their employment goals. They should also work together to help young people who are still in school so they can:

- Learn about employment options
- Start thinking about their future employment goals
- Include employment goals in their IEP

This should include working with parents, teachers, and special education staff on having high expectations and believing in the goals of young people with I/DD.

2. **Support People With I/DD in Leadership Positions.** DDS, DOR, and CalHHS should work together to create an annual State Leadership Academy. This program would support employment for people with I/DD disabilities in well paid leadership positions. These positions should be at:

- Regional centers
- State departments
- The State Legislature

This leadership academy should prepare its participants for how to be leaders in public service. It should include ongoing mentorship and an internship placement with the State, legislature, or a regional center upon completion of the program.

3. **Make Sure People With I/DD Get Benefits.** The State should create guidance for employers on how to offer flexible benefits for employees with I/DD who also get public benefits. This should be provided to regional centers and their vendors. DDS, work incentive planning experts, and individuals with lived experience can inform the best practices to be shared with employers. Best practices should be used to provide people with good compensation benefits without negatively impacting their eligibility for other public benefits. Best practices should include:

- Benefits planning
- Financial planning
- Use of CalABLE and other similar programs. For example, a CalABLE account allows people with I/DD to receive money (like pay from their employer) without that money being counted in a way that might cause their benefits to be lowered.

4. **Support People With I/DD to Start Businesses.** DOR and regional centers should work together to create a program that helps consumers successfully start and run their own business. This program should provide step-by-step training on:

- Requirements to start a business
- Managing money
- Finding customers
- Understanding labor laws
- Doing important things like paying taxes and managing benefits

DDS and Regional Centers should partner with other programs that already provide services for people interested in starting their own business. For example, Job Centers and employment service vendors.

The program should also include finding people a mentor who is experienced at running a business. The mentor would provide frequent check-ins, advice, and help to answer questions.

## Accountability and Transparency in All Systems That Serve People With I/DD

Information should be available to help individuals understand what services and supports are available and what the rules are for getting different services and supports. This is called “transparency.” Transparency means that people can get the information that they need to understand what is happening and why. Many people with I/DD do not get clear information about the system. People with I/DD need clear information to:

- Understand their rights
- Understand how to get help they need to stay safe
- Get the services and supports they choose to lead the lives they want

There also is not enough information available for the system to track how well regional centers and providers are doing to meet the needs of people served. This is because the information collected is more focused on compliance, and not enough on person-centeredness or outcomes. It is also because information technology (IT) systems used by regional centers and DDS are too old to collect all the data needed to track and pay for good, equitable outcomes. It is important that information is available about what is happening across the system and if the system is working well. Having this type of information will help make sure everyone is responsible for doing the things they are supposed to do. This is called “accountability.”



**“There need to be consequences that are for the regional center, not just the clients. There’s plenty of consequences for us, but there’s no accountability for them. You need accountability, or nothing will change.”**

Tina

The goal for this topic is that systems will have more transparency and accountability.

Recommendations in this topic area include:

- Ways to make sure people with I/DD are safe in the systems that serve them
- Ways to create statewide standards that are also flexible to meet individual needs and circumstances in different communities
- Ways to make information easier for people to access, understand and use
- Ways to use information to help everyone navigate the systems while keeping information private and secure
- Ways to make sure everyone is accountable for achieving equitable and person-centered outcomes

## **Keeping People With I/DD Safe**

People with I/DD are more likely to be mistreated, abused, or neglected than people without disabilities. Sometimes people with I/DD experience mistreatment and are not sure what to do. People with I/DD should be safe in the systems that serve them. If a person with I/DD is ever mistreated, they should have a way to report what happened to them and make sure it does not happen again. These recommendations focus on keeping people with I/DD safe.

1. **Keep People With I/DD Safe From Mistreatment, Abuse, and Neglect.** Prevent future instances of mistreatment, abuse, and neglect. Support individuals and families who need help with cases of mistreatment, abuse, and neglect.
  - DDS should review and adopt the California State Auditor report and most of the Massachusetts Disabled Persons Protection Commission recommendations to prevent harm to those served by the system. That means that DDS should:

- Make sure there is accountability and consequences that are enforced for people who abuse, mistreat and neglect individuals.
- Create a statewide abuse reporting hotline.
- Increase transparency in reporting investigations, including creating a registry.
- Create a “before, during, and after” abuse plan during IEP and IPP meetings with school systems and other partners.
- Make sure there are clear processes, technology, and systems for identifying, communicating, and taking care of potential dangers early. Make sure those processes support reporting, investigating, and addressing cases of mistreatment, abuse, and neglect.
- Make sure people have options and independent support to report problems. Make sure they feel comfortable and protected when they do report problems. Make sure people with complex needs including people who use alternative communication devices are supported.
- Make sure self-advocates who lose their cases against suspected abusers are not retaliated against.
- Strengthen the DDS Office of the Ombudsperson to handle problems better. Create a special unit in the office to support abuse complaints and processes. Hire specialized people to deal with these cases.
- Require training on harm prevention, care for people who experience abuse, and reporting. Include people with disabilities and others with specialized skills in these areas in trainings for dealing with these cases.
- Make sure there is training and resources for individuals and families about examples of mistreatment, abuse, and neglect and how to report it.

- Individuals should be able to use surveillance cameras in their own homes so they feel safe. Individuals should make sure people who enter their homes know there are cameras being used. Rules should be made that talk about how surveillance cameras may be used in other settings. Those rules should talk about how privacy is important, and what rights individuals have about the use of cameras.
- Engage and educate the medical community about abuse and how it can be reported.
- Create partnerships between regional centers and rape crisis centers and train people who work in rape crisis centers about people with disabilities and how to best serve them.

**2. Protect Children and Young People With I/DD in the Child Welfare System.**

DDS and the DSS should work together to develop a joint framework for preventing and responding to abuse of children with I/DD. Regional centers and county child welfare agencies should use this framework to strengthen their ability to jointly serve children who may be experiencing abuse or neglect in either system. This framework should include strategies for:

- Rapid responses
- Good communication
- Using technology solutions
- Consideration of the child's disability related needs when addressing possible abuse and neglect
- Education of regional center, child welfare staff and local community partners such as the educational system, on the issues that families in the I/DD community face
  - This includes understanding that poverty does not necessarily mean neglect
  - It also includes understanding the behavioral challenges some children and youth with autism and other disabilities face and the

need for additional services and supports in the family home to address these challenges when deciding if there is an issue of abuse

## Hold Regional Centers Accountable

Regional centers should be accountable for the ways that they support people with I/DD. Sometimes services with the same name can mean different things at different regional centers. Sometimes rules for what services and supports people can get are not the same at every regional center. This is because there are not consistent statewide standards about what services individuals can get and how they can get them. Regional centers should have clear processes for what needs to happen to support people served. These recommendations focus on making sure that regional centers are doing what they are supposed to do. The recommendations also focus on improving how regional centers do things they are supposed to do.

1. **Make Sure Intake and Assessment Processes Are Clear and Equitable.** DDS should create an intake and assessment process that build on SB-138 requirements and is family-centered, supportive, accessible, and equitable. DDS should work with a diverse set of stakeholders to:
  - Improve transparency, equity and accountability throughout the intake and assessment process.
  - Require regional centers to develop intake and assessment processes that are more person-centered. This will make sure that the process is respectful, equitable and sensitive to the culture and background of the individual and family being served.
  - Develop and share clear requirements about each step of the intake and assessment process. Those requirements should talk about how many days each step should take. Confusing terms and legal requirements for intake and assessment processes should be clearer. This will make sure everyone can understand how it works.
  - Make sure regional centers communicate things simply and clearly in a way that is personalized and culturally sensitive.

- Make sure regional centers provide supports throughout the intake and assessment process for individuals and families who want and need them.
- Make sure mental health and other non-eligible conditions are considered during intake and assessment processes. These conditions must not be used as an excuse to deny services and supports.
- Collect and use more data during intake and assessment processes. This will help to improve transparency, equity, accountability, and performance. That data should include how long each step in the process took, how many people are being turned away, and why they are being turned away. It should also include more information about the kinds of people that are being turned away. For example, information about their race, ethnicity, or language they speak, where they live, and other things about them.
- Make sure people are not automatically being turned away because they don't have the "right" documents they need to prove they are eligible. Develop a screening tool to help identify people that should be automatically eligible for assessments.
- Identify ways to expand intake and assessment workforce capacity.

2. **Make Sure IPP Processes are Consistent and Equitable.** DDS tells the department to create one way to make an IPP and provide directions. It also tells all regional centers to use the new IPP by January 1, 2025. DDS should look at and update the new IPP to make sure it is more consistent, transparent, and equitable across all regional centers. This means:

- IPP processes should be updated to make sure they talk about what services people need, and when those services are available during IPP meetings.
  - It should also talk about when services aren't available, how long it might take to get them, and what other options are available.

- Technology and other processes should be used to make IPP meetings more accessible. This should include using technology and tools so that IPP meetings can happen in person or virtually (e.g., using Zoom).
  - Training about the new IPP should be provided to individuals and regional center staff.
  - Regional centers should provide clear and consistent communication that is sensitive to different cultures and including translation services.
  - Regional centers should provide detailed documentation of IPP meetings, including copies of the individual's IPP, meeting recordings and transcripts to all IPP participants.
  - Individuals should have access to advocates to help facilitate IPP processes.
  - Anonymous surveys should be sent to self-advocates, their parents, and other people in their circle of supports about the IPP process.
  - Fair hearings processes should be reformed so they are equitable and transparent. Fair hearings transcripts and recordings should be available to all participants.
  - Self-advocates should have more support during fair hearings. They should have clear and easy to understand information about every step in fair hearings and appeals. This information should talk about what self-advocates should expect when meeting with judges and other people. It should also talk about words that might be used. This is called a "glossary." Self-advocates should have access to independent facilitators with expertise in the appeals process to support them.
  - A technology portal should be developed so individuals can access their IPP documents. The Modernize IT Systems recommendation talks about this.
3. **Make Sure That Rules About Service Approvals Are Clear and Consistent.** DDS should develop and maintain an updated list of clear, fair, and consistent rules for how regional center services are approved. These are also called

“service authorization standards.” These rules should be created by a statewide committee that includes self-advocates, family members and experts. Experts should have knowledge of DDS policy, regulations, and the Lanterman Act. This means that DDS should:

- Make sure all regional centers use consistent service authorization standards for a core set of services they have to provide. These standards should be clear, equitable, transparent, and flexible to meet the unique needs of all individuals. Authorization standards should be consistent, but there may be certain services that are only available in some communities and not available in others.
- Each regional center should have a diverse, multi-cultural advisory council representative of their local community to advise them about these standards.
- Make sure no one loses a service because a standard was changed or they move to another regional center. These rules must not prevent access to any services that an individual should be able to receive.
- Make sure regional centers provide training for staff on service authorizations standards.
- Review all service authorization standards. Some of these rules are not fair and should be fixed. Others can be fixed when there are statewide standards. Rules that should be fixed now might talk about standards that don't give independent living skills for people who live at home. Other rules that should be fixed now are about regional center that don't pay for transportation for children because they say that parents must do this.
- Require regional centers to have clear, consistent, and transparent processes for Notices of Actions (these are also sometimes called “service denials”) and appeals. These should be included in an individual's IPP.

4. **Make Sure People Served Can Get Compensation Support With Appeals and Complaints.** DDS should create a fair, transparent system and processes so people can get compensation and supports for appeals and complaints. This

kind of compensation is sometimes called “compensatory damages.” The system should recognize disparities and make sure outcomes are equitable. The system and processes should also hold regional centers, and vendors are accountable. This means:

- When people file an appeal or complaint and win, they should be able to receive extra services, or funding for extra services, to make up for what they missed. Making up for what they lost will help build trust in the system.
- Any extra services or funding should be based on a person’s individual needs. There should also be some flexibility for how long the individual has to use the extra services.
- People should get more help if they need it so they can appeal bad hearing decisions in court. DDS or the regional center should cover the cost of the individual's attorney if the individual wins their court case.
- People also should be protected from retaliation so they feel safe when making an appeal or complaint.
- DDS should look at other systems that do this well, like special education.
- An equity committee should also support the system. That committee should make sure the system reduces disparities. It should also make sure anyone has a fair chance to try and get compensatory damages.
- Nothing in this recommendation should stop an IPP team from agreeing that a person has not received the services they need. It should also not stop an IPP team from agreeing to voluntarily provide extra services to help them make up for what they lost.

5. **Improve Vendorization Processes.** DDS should improve the vendorization process and access to service providers and vendors to make them more accessible to everyone. Vendorization is the process where regional centers contract with providers and others to deliver services. DDS should improve the vendorization process by:

- Streamlining the vendor application process across all regional centers. Once a vendor is approved by one regional center, all other regional centers must accept that vendor.
  - Accommodating different requirements for different regions, particularly rural areas and for different populations.
  - Reviewing and updating Title 17 vendorization rules.
  - Making vendorization standards and processes more transparent.
  - Speeding up vendorizations and eliminating “denial by delay” practices.
  - Identifying vendor shortages and coming up with plans to reduce them.
  - Making it easier for independent facilitators and non-profit corporations to become vendors. This can be done by removing barriers and having a more flexible process for them for them. A more flexible process to attract vendors must not mean that standards and expectations for vendor quality are lower.
  - Making sure there are background checks for vendors and their staff, and that there are ways to remove people and vendors who commit abuse.
  - Requiring regional centers to train staff in vendorization processes.
  - Requiring regional centers to host information sessions about vendorization processes.
6. **Use Outcome Measures for Accountability.** DDS should create clear performance, quality, accountability and outcomes measures at the individual, regional center, and systemwide level. All measures should:
- Include standards that can help hold vendors, regional centers, and DDS accountable.
  - Include accountability through coordination with other departments and agencies.

- Make sure they don't result in unintended consequences that make things worse for people with I/DD, especially those with more intense needs.
- Include measures that prevent abuse, mistreatment, and discrimination against people served and families.
- Meet federal and state legal requirements and human rights principles. These requirements should be shared with regional centers and vendors.
- Be measured and tracked in any new statewide IT system that DDS develops.
- Link with other important state datasets for research.
  - An example of outcome measures would be the accountability measures for the public education system in the “Inclusive and Flexible Education” recommendation.

7. **Reward Good Outcomes.** DDS should pay developmental service providers and regional centers for good performance that improves outcomes for individuals and systems. These incentive payments must be in addition to base rates that are high enough. This means that DDS should:

- Get information about what is working (or not working) with existing incentive program models. For example, existing DDS initiatives like the Quality Incentive Program.<sup>14</sup>
  - Part of this should include developing better definitions of what good and bad performance and outcomes look like.
  - This information should be used to design how payments for good outcomes will be provided.
- Make sure there is funding for regional centers and providers to pay incentives for good performance that goes above and beyond what

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<sup>14</sup> [For more information about the Quality Incentive Program \(https://www.dds.ca.gov/rc/vendor-provider/quality-incentive-program/\)](https://www.dds.ca.gov/rc/vendor-provider/quality-incentive-program/)

is required by the job. Performance should be rewarded if it is great in all important areas. But it should not be rewarded if it is great in some areas and bad in others.

- Make sure input from diverse individuals, families and other stakeholders is used to decide what the goals should be and what good performance looks like.
  - Make sure that groups of people who have a harder time accessing services are able to provide ongoing input about outcome standards and incentive program goals. DDS should work with each regional center, SCDD, and others to help identify diverse groups. These groups include:
    - People with complex needs
    - People with multiple disabilities
    - People who live in rural areas
    - People from communities that have historically faced discrimination
    - People who speak a language other than English
- This will help make sure the goals and standards for good performance are equitable. This will also help make sure that the goals and standards do not have unintended negative impacts on quality of life or service delivery. Make sure diverse groups also help define bad performance and bad outcomes that will be used to result in consequences and corrective actions, when appropriate.
- Make sure regional centers and service providers know what performance standards they are expected to meet to receive incentives. This should include accountability and outcome measure goals.
  - Make sure that when regional centers and providers go above and beyond the standards and goals, they are rewarded.

- Make sure that if they do not meet the basic performance standards, they will face corrective actions.
  - Make sure that efforts for accountability do not result in bad outcomes for people served. That also means making sure money does not leave the developmental services system. Develop incentives that benefit DPSs to make sure providers take good care of certain populations that may have a harder time accessing services.
  - Create incentives for vendors so that their employees can be directly rewarded.
  - Think about ways to provide non-financial incentives for regional center employees that align with the goals of the individuals served.
  - Investigate providers and regional centers when performance is consistently poor or when there is reported mistreatment taking place. Update regional center contracts to pay for the right high-quality outcomes.
  - Make sure all the data that is needed to identify high-quality outcomes can be collected and used for payment, research, and accountability. An example of using incentives to encourage an outcome would be the “Use Incentives to Encourage Renting to People with I/DD” recommendation.
8. **Use Contracts for Accountability.** DDS should review and update contracts they have with regional centers to make sure they provide high-quality services and outcomes for everyone they serve. This means that:
- The Legislature should review and recommend if there are ways DDS contracts with regional centers can be improved. The recommendations should talk about whether DDS needs more power to make sure regional centers do a good job.
  - Individuals, families, regional centers, and other stakeholders should be able to provide their ideas when DDS updates regional center contracts. DDS should also get stakeholder input when they update regional center performance contracts. Regional center performance

contracts talk about financial incentives and goals regional centers must meet.

- DDS should create a process and standards to make sure regional centers are providing high quality services and outcomes. DDS should pay regional centers for meeting standards and have consequences when they don't.
- DDS should make sure that penalties for regional centers do not lead to fewer services being available. DDS should also make sure there are no unintended consequences for people served by the system.
- DDS should more regularly check to make sure regional centers are doing what they are supposed to do. These are called audits.
- DDS should make sure regional centers have requirements in their vendor contracts that talk about how vendors must deliver high-quality services and outcomes.

9. **Strengthen Consumer Advisory Committees (CAC).** DDS and regional centers should strengthen the role of CAC to make sure people served have a strong role in system oversight. The CAC should play a central role in driving improvements at the regional center level and statewide level of developmental services. The Lanterman Act should be amended to reflect these expectations. DDS should work with regional centers to strengthen the role of CACs in the following ways:

- Every regional center should be required to have a CAC.
  - The Lanterman Act currently states that regional centers “may” have a CAC. This option should be changed to a requirement.
- The regional center CAC should meet monthly.
- All people served should be invited to attend CAC meetings.
- The officers of CAC should be elected by people served at an annual election meeting.
- The role of the CAC should be:

- To share experiences of people served.
- To make recommendations about:
  - Person-centered services and service coordination.
  - How to eliminate systemic discrimination and ableism;
- To present recommendations for improving developmental services and service coordination at each meeting of the regional center board of directors.
- To identify and plan activities that people served by the regional center want. These activities could include trainings and information opportunities.
- The regional center should support the CAC by:
  - Providing an individual to support the CAC in its preparation and presentation of recommendations. The CAC should have options for facilitators to choose from.
  - Providing sufficient resources and expertise to help the CAC grow and maintain its efforts.
  - Providing support for the CAC to share ideas and complaints. The regional center should provide a safe and welcoming space for the CAC to share input.
- A report on the recommendations should be compiled by each regional center and sent to the DDS CAC. The report should also be posted on each regional center's website under "Transparency."
- The DDS CAC should:
  - Be comprised of the chairs of each regional center's CAC, or the chair's designee in their absence.
  - Meet quarterly to advise DDS on addressing systemic changes to:
    - Improve service coordination and delivery.

- Eliminate systemic discrimination and ableism.
- Each member of the DDS CAC should be supported by the individual who supports that individual on the regional center CAC.
- A report of the DDS CAC's recommendations should be compiled by DDS and posted on the DDS website under "Transparency."
- The DDS CAC should make recommendations for updates and changes to the Bill of Rights in the Lanterman Act and/or by departmental policy.

**10. Support Regional Center Governing Boards for Oversight of Regional Center and Executive Director Performance.** DDS should work with regional centers to make sure regional center governing boards are supported. This will allow governing boards to provide effective and independent oversight of regional center and executive director performance. To strengthen governing boards, DDS should improve processes for:

- Recruiting and nominating members of the governing board.
  - The process for board appointments needs to be transparent. This includes nomination and voting processes. These processes should be accessible and easy to understand for anyone who wishes to participate.
  - The process should be clear and easy to find in materials related to the regional centers' boards. For example, on their websites.
    - Information about the process should clearly encourage self-advocates, family members, and community members to participate.
    - Information about the governing board and the application process should be available to every person served by the regional center and/or their family.
  - The board nominating committee should solicit interest and nominations from the broader community through outreach.

- The community should be asked for help in board member nomination, recruitment, and selection.
- The committee should interview board member candidates. Then the committee should make recommendations to the governing board for election.
- The nominating process should also establish rules for an individual to be nominated “from the floor.”
  - This means that a person could be nominated as a candidate for the board during a board meeting. This would require one board member to nominate the individual at the meeting and have a second board member also express support for this nomination.
- The Chair and Vice Chair of the regional CAC should be given the option of sitting on the governing board or selecting someone to sit on the board for them.
  - This should include supports for helping people find someone to sit on the board for them.
- Regional center Executive Directors, staff, and vendors should be prohibited from voting, or influencing the votes, in the election of board members.
- Providing effective board training and support.
  - DDS should provide board member training for all regional center governing boards. DDS should collaborate with the State’s designated “protection and advocacy agency” and the State Council on Developmental Disabilities.
    - The training should be developed with community input, including individuals served and family members.
    - DDS should provide and require consistent board member trainings.

- In addition to the universal board member trainings from DDS, regional centers should have flexibility to provide trainings that are specific to their local needs.
- This should include training for outreach and recruiting diverse representation from their unique community.
- The training should include the importance of engaging and representing the voice of the community.
- Training and information should be provided to members of the community who want to better understand the responsibilities of the board and how a board is managed.
  - This will help encourage community members to seek positions on the board. Board training should be provided annually.
- DDS should ensure appropriate and adequate support for consumer and family board members by surveying members about their ability to meaningfully participate and understand the subjects and votes at board meetings and using the survey feedback to make improvements to the training and to ensure additional supports are provided.
- Improve facilitation for consumers and family members who sit on regional center boards by using independent supporters, making the board members less reliant on staff.
- Protecting board members and their families.
  - DDS should review policies to protect board members from retaliation. DDS should also review grievance procedures for board members who have concerns, complaints, or questions. Based on this review, DDS should make improvements as needed.
  - Governing board members should serve six-year terms and be required to step off the board for five years before being eligible to run for the board again. This would create more opportunities for community members to serve on the board.

- Other supports and protections.
  - DDS should establish guidelines for governing boards on regional center Executive Director compensation.
  - DDS should support boards in their review of large contracts by developing an objective rating system or set of criteria to consider in their decision-making.
  - Make sure regional centers are accountable to their contract with DDS and the State of California and not to outside organizations or trade associations.
  - Require boards to be notified of complaints with sufficient evidence against a service provider before the board takes up a vote to approve, renew, or deny that provider's contract. These complaints would include mistreatment, abuse, or negligent injury or death.

**11. Make Sure Regional Center Governing Board Meetings Are Transparent.** DDS should work with regional centers to make sure that governing board meetings have full transparency. This means that governing board meetings should support robust public comment on decisions they make. To support public comment, DDS and regional centers should make sure that the public:

- Has sufficient access to meeting materials in advance of meetings
- Has sufficient time to give public comment during meetings about items not on the agenda and prior to any votes taken at the meeting
- Is able to attend meetings remotely

The following requirements should be established, by amending the Lanterman Act or through a DDS directive. These requirements should be monitored and enforced by DDS:

- All information that will be presented at a board meeting should be placed on the regional center's website at least seven days before that meeting. DDS should monitor whether this provision is followed and alert the regional center and the public when it is not.

- If information that is being discussed at a meeting is not provided to the public at least seven days in advance of that meeting, any votes surrounding that information should be considered null and void. This means that the votes won't count.
- A minimum of 30 minutes should be allotted for general public comment at each board meeting. This could happen before the meeting begins or at the end of the meeting. This will give the public the opportunity to bring up issues that are not on the agenda. Boards should make a good-faith effort to allow every member of the public who wants to give comment to be able to do so.
- Time limits for each public comment should be decided by the board in a public meeting. People served by the regional center should be allowed more time to provide public comment.
- Public comment periods should be required before every vote by the board. The board should be presented with information and have a discussion. Then before the vote, the public should be given an opportunity to comment on the issue before the board. The board may take the public comment into account when voting on that issue.
- If a public comment is made that requires an action item, a response should be provided by the board at the following board meeting or within a specified timeframe.
- Boards should be encouraged to offer their board meetings virtually or as a hybrid to encourage public participation.
- For board meetings that are held online or as a hybrid meeting, the chat should be open, at a minimum during the public comment period. This will accommodate people who are unable or unwilling to provide their comment verbally.

## **Make Sure the DDS System Is Transparent**

People served by the system need clear information about what to expect. This helps people with I/DD and their families have choice and control in their lives.

This also helps them know when things are not happening how they should, so they can reach out for help. These recommendations focus on making the DDS system, including regional centers, more transparent.

**1. Make Sure Information From Regional Centers Is Transparent and Accessible.**

DDS make sure that information shared by regional centers with people served is accessible and transparent. Regional center staff should be held accountable to meet the communication needs of people served. To make sure that regional centers and staff are providing information in a transparent and accessible way:

- Regional center staff should ask people served about the best way to meet their communication needs.
- Information should be accessible to people served and their families at all times. This information should include, at a minimum:
  - How to access services
  - How services and supports can meet needs
  - Eligibility for services
  - Reasons for denials
  - Changes and updates (before they happen)
  - The rights of people served
  - Roles and responsibilities, for people served and service providers

To be accessible to people served and their families, the information needs to:

- Be more transparent and available.
- Be provided in multiple ways and at multiple times. Accessible ways include a printable version, video, voice recording, one on one, mailed, with graphics/without graphics, and use of accessible fonts.

- Be shared without judgment when a person served asks about the information that has been previously shared.
- Be easier to access, as in find or locate. To request or locate information, there needs to be a search or easy way to obtain information that is needed and figure out where to go to get this information.
- Account for sensory differences, such as sensitivity to color or the number of images.
- Account for how people process information, such as taking things literally.
- Make instructions clear. For example, if a form needs to be completed in a blue or black pen, then the form should say that.
- Include the name and contact information for who the person served can follow up with if they have any questions or want to discuss the information further.

2. **Improve the Information Technology System.** DDS should develop and maintain a single statewide information technology (“IT”) system for California’s developmental disability services.

- DDS and all regional centers should use a single IT system to track service access, delivery, payment, and case management.
- DDS should work with stakeholders to create a plan and a charter (“rules of the road”) to guide development of the system. The plan should talk about the goals of the IT system and how it will be put in place. The Plan should talk about how the IT System will get more data for analysis, reporting and research. Researchers and other people from the community should be involved in the plan and how the IT System is used.
- DDS should regularly present updates about the development of the IT system to the Legislature.

- The system should improve data exchange between regional centers, DDS and other health and social service departments. Regional Centers should be required to sign the CalHHS Data Exchange Framework Data Sharing Agreement.<sup>15</sup> There should be clear data exchange privacy and security rules.
- The system should have a portal that individuals and families can use to access all of their information. The portal should allow people to track requests and communicate with the regional center and providers.
- DDS and regional centers should develop and provide training for regional centers, staff, individuals, families, and other stakeholders about how to use the system. Self-advocates should help create these training programs.
- The system should include a plan for how data will be available for analysis, reporting and research.
- DDS should make sure there is support for individuals and families so they can get internet service and devices. Those supports should be used to help people access and use the new IT system.
- DDS should make sure regional centers who have fewer resources and less reliable high-speed internet have more support to meet these recommendations. DDS should also make sure that these regional centers do not face unintended consequences by using a new IT system.

3. **Make the Service Access and Equity Grant Program More Transparent.** DDS should strengthen the Service Access and Equity Grant Program. This means that DDS should:

- Develop a clear definition of equity. That definition should be used to help decide what types of projects, organizations, and communities should be funded by the grant program. That definition should also be

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<sup>15</sup> [For more information about the CalHHS Data Exchange Framework Data Sharing Agreement \(https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/\)](https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/)

used to create flexibility in grant processes to meet the needs of the community.

- Include more people in the grant review and selection process. It should include people with lived experience from the community, and people with research, program evaluation, and data analysis experience.
- Provide more support to community-based organizations to help them write grants and access funding.
- Hold grantees accountable for using funds the way they are supposed to. Make sure grantees provide reports on how they served the community, what successes they had, and what barriers they faced.
- Be more transparent about the results of each grant and how grant funds are used.
- Give stakeholders a chance to provide feedback on whether the services they got paid for by a grant met their needs. This feedback should include surveys from people who receive services that were paid for by an equity grant.
- Develop equity and other measures to identify successful grant programs that should be prioritized.
- Find out which grants worked well. Make successful grant programs available statewide. Add them to regional center POS policies.
- Evaluate the equity grant program using equity and other measures. Get help from researchers to evaluate the program.

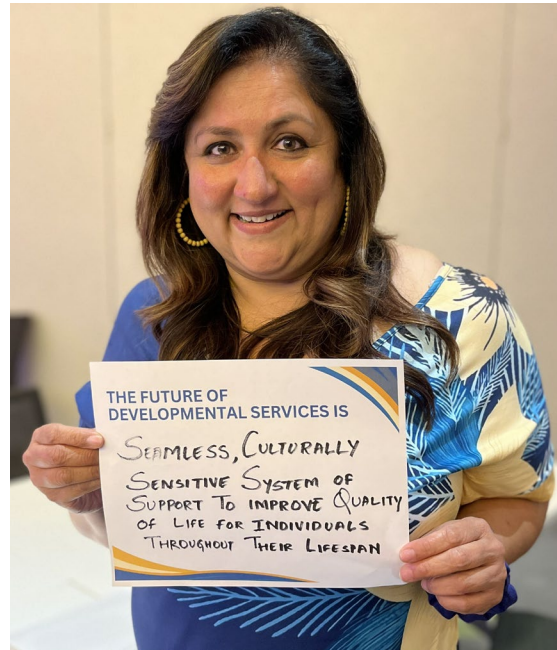
## Inform the Future of the Developmental Services System

The MPDS should inform the future of the developmental services system. This means that the recommendations in the MPDS can keep working to make the system better, even if the future brings unexpected changes. The future could bring new barriers or new opportunities for the system. This topic in the MPDS focuses on how to keep improving the system in the future, no matter what barriers or opportunities might be ahead.

The goal for this topic is that the developmental services system will continue to improve over time. An important part of this is improving the way that data and other information about the system is collected. Recommendations in this topic include ways that the systems that support people with I/DD can improve how data and information are collected. Recommendations in this topic also include ways to improve how data and information is used.

Recommendations in this topic area include:

- Ways to prepare for changes in the future
- Ways to understand why gaps or barriers in the system are happening
- Ways to get better information and data to study what is happening in the system and why
- Ways to improve how data and information are used by the system



## Funding for I/DD Services in California

Medicaid is a partnership program between the federal and state government. Together they pay for health care and behavioral health services, as well as supports for people with I/DD. In California the Medicaid program is called Medi-Cal. It provides health insurance coverage for 14.8 million low-income Californians. This includes children and their parents, pregnant women, seniors, people with disabilities, and non-elderly adults.

Medi-Cal pays for many things including primary care, specialty, hospital, and pharmacy are behavioral health and other services. These services are also referred to as State Plan services. Medi-Cal also provides Home and Community Based Services (HCBS) for people with disabilities, including those with I/DD. These services are also referred to as Waiver services that DDS provides. These services and supports include helping people with daily activities, such as dressing, eating, and shopping for food. They also include supports to get and keep jobs in the community, assistive technology, transportation, making homes more accessible, and more.

Today DDS is funded and provides services under two Medicaid Waivers:

- HCBS Waiver for Californians with Developmental Disabilities, and
- SDP for People with Developmental Disabilities

DDS also has a third Medicaid option called 1915(i) that serves people who are Medicaid eligible but don't qualify for the HCBS or the Self Determination Waivers. This is sometimes called a state plan amendment or option. All three programs provide similar services.

In California, it costs about 15 billion dollars every year for the developmental disabilities system to operate. Federal Medicaid funds are about 5 billion dollars, or one third of all funds for the developmental disabilities system.

In California people eligible under Lanterman Act are entitled to receive services regardless of their Medi-Cal or Waiver eligibility.

These recommendations focus on how people with I/DD can more easily access state plan services. This will bring more federal Medicaid funding to California. These recommendations are also about how to better connect and coordinate

waiver and state plan services. This will help all the systems work together to help people live better lives and reach their goals.

**1. Make It Easier for People With I/DD to Enroll in I/DD Waivers and Medi-Cal.**

DHCS, Counties, DDS, and regional centers should work together to make it as easy as possible for individuals to enroll in I/DD Waivers and Medi-Cal through one simple process with supports.

- DHCS, DDS, regional centers and counties should provide individuals with accessible information in plain language. This will help them make informed choice about Medicaid/Medi-Cal and DDS Waivers eligibility and enrollment.
  - Information sharing can include supports from people with lived experience (peer supports), information hubs, informational toolkits, workshops, process visuals, short plain language documents, and instructional videos.
- DDS and regional centers should provide information to individuals, families, and other community partners so that they can understand why Medicaid is important for long-term sustainability of the I/DD system and services.
- DDS and DHCS should explore options for raising income limits above current levels to allow more people to be Medicaid eligible, including through the “working disabled program.” This program allows people with disabilities to work and make money without losing their access to Medi-Cal.
- DDS and DHCS should work together to make sure that person's experience and outcome of eligibility and enrollment process are equitable. This means that their experiences are not defined by their race, ethnicity, language, gender, age, health condition, or any other identity or background. The State should evaluate data to identify and remedy any disparities.
- DHCS, DDS and regional centers should do a study to see how much funding can be received if the State and regional centers prioritize enrolling eligible individuals into Medi-Cal and DDS Waivers.

2. **Regional Centers Support People With I/DD to Get Medi-Cal.** DDS should make sure that regional centers prioritize supporting individuals and families with Medi-Cal eligibility and enrollment process. To make this happen, DDS should:
  - Provide regional centers with enough resources and staff to support individuals and families in navigating the eligibility and enrollment process.
    - This will help make the process as quick and easy as possible. Some up-front funding may be needed to start the process before more federal funding is brought to the State.
  - Find regional centers that are good at providing a fast and well-supported eligibility process.
    - DDS should share what these regional centers do and how they do it with other regional centers.
    - DDS should establish and support a community of practice to continuously improve processes across regional centers.
  - Develop outcome metrics and ways to hold regional centers accountable for supporting individuals and families with eligibility and enrollment.
  - Make sure that service coordinators and other regional center staff receive quality training on Medi-Cal, and Waiver eligibility and enrollment.
    - This should include training on how to complete necessary forms and paperwork for eligibility.
3. **Improve Words Used to Talk About Eligibility.** CalHHS should work with its departments to change language about Medi-Cal and Lanterman eligibility. The new language should be simple and not intimidating. Language that has negative meaning for some people or might trigger trauma should be revised. For example:

- Words like “institutional deeming,” and “waiver” can be intimidating and can mean different things to different people
- Words like “mild,” “moderate,” and “severe” should be removed from the titles of Lanterman-qualifying diagnoses and the eligibility process

4. **Clarify Rules About Eligibility.** DDS should issue guidance to regional centers to make sure that people served are able to receive services quickly and without interruption. Whether people receive regional center services should not depend on Waiver and Medi-Cal eligibility. This guidance should clarify that:

- Waiver and Medi-Cal eligibility process or the type of Medicaid authority individual enrolls in should not delay or restrict access to regional center services
- People should be able to start receiving regional center services while waiting on Medicaid eligibility process to be completed
- Regional Centers will do pre-screening for services so that people can start receiving some basic supports quickly, even as they are going through eligibility process
- Eligibility and enrollment process should not impact continuity of services at eligibility redeterminations

5. **Use Waivers to Make Seamless Service Systems.** DDS and DHCS should work together to develop a way to use Medicaid waivers and state plan options. The goal would be to create a seamless and easy access to services and supports. DHCS and DDS will work with individuals with I/DD, family members, and community partners to look at Waivers and state plan options and see if the way Medicaid programs exist today makes it harder for people and families get the services they need. DHCS and DDS should check if there are services that people cannot get because of the waiver or state plan option they are enrolled in.

- DDS and DHCS should work together with people with I/DD, family members, and community partners to develop and implement a Medicaid program that helps individuals get all the services they need

throughout their life. This Medicaid program should help people access services without having to choose between various Waivers or having to move from one Waiver to another.

- Regional centers shall improve the way they support individuals and families in understanding available options for HCBS waivers and programs and making best choices for themselves. Regional centers should be the one source of information to know where to enroll and to connect to supports.
- DDS and DHCS should provide regional centers and service coordinators with resources, training, and information they need to support individuals and families well in understanding their choices of Medicaid programs. This includes Service Coordinators working with smaller number of individuals and families so that they can support them better, having low caseloads.

6. **Use Grant Funding for Pilot Projects.** The State of California, including DHCS and DDS, should explore and prioritize the use of grant funding for innovative projects and pilot projects. This will allow the State to try new services or ways to deliver services. The State should develop a resource where community partners, including diverse community organizations and nonprofits, can find information on federal or other funding opportunities or grants to apply for. This can be a web site or a regular newsletter. As part of this work, DDS should partner with researchers, universities, specifically University Centers for Excellence in Developmental Disabilities, to explore innovative service models and opportunities.

## **Changes in Federal Funding**

The MPDS process started in March of 2024. In January 2025, there was a different Federal Administration. This Administration has different priorities than the Administration before. It is hard to know if any changes will impact California's developmental disability systems. For example, there might be changes to Medicaid program funding. There might also be changes to how Medicaid funding can be used. Any changes or cuts made to Medicaid funding will require difficult decisions to be made about how to use available funds. It is important that the State is prepared to make these decisions, to protect the services that people with I/DD rely on.

These recommendations focus on things that California can do to address these kinds of policy changes in the future.

1. **Prepare for Cuts to Medicaid.** If the federal government makes cuts to the Medicaid program and funding, DDS should follow these principles and approaches:

- Preserve all aspects of the Lanterman Act entitlement. Keep eligibility standards where they are. Everyone should continue to have access to necessary supports.
- Keep the commitment to inclusive, person-centered services in the community. Prioritize supports that keep people in their own homes, their communities, and at their jobs.
- Preserve participant-directed and self-directed services.
- Keep access to respite services, including therapeutic respite for people with complex needs.
- Prioritize HCBS compliance across all settings to maximize quality of life and independence of choice, regardless of federal and state climates that impact people's lives.
- Strengthen natural supports, including community-based organizations, family resource centers and “Circle of Friend” systems.
  - “Circle of Friends” is an approach to including young people with disabilities who are having a difficult time in school.
- Make it easier for people to access generic services.
- Give people informed choice on sharing their demographic or legal status information to protect privacy.
- Prioritize Get Out the Vote, People First, and civic engagement efforts that create and increase platforms for self-advocates and families to be heard.
- Create and strengthen advisory committees that prioritize self-advocates and families, to make sure that systems are working as well

as they can with expert feedback from people with lived and living experience. Provide supports for participation.

2. **Protect Early Start.** If funding for the Early Start program is reduced or eliminated, California should prioritize continuing the services and supports provided to children and their families through this program with state funding. California should do this because the State recognizes the value and importance of providing comprehensive services and supports to children from birth up to 3 years of age and their families through the federally funded Early Start program.

## Gap Analyses

When people cannot access services they need, it is sometimes called a “gap” in services. A “gap analysis” is a way to understand the ways the system is and isn’t working, so that it is easier to fix or change it. It is also a way to see if services are accessible, high quality, and if they are delivered equitably in a person-centered way. Understanding these things can help to make sure people can have good service outcomes. It is important that findings from gap analyses are used to make things better.

The Master Plan committee and workgroups have worked with the information they can get, but gap analyses of the system are needed to support the transformation of service systems that impact the lives of people with I/DD. These recommendations focus on different gap analyses that the State should do to understand gaps in services, and to fix those gaps. Following any gap analysis, CalHHS and its departments should develop recommendations to address any gaps.

1. **Gap Analysis on Services for People With I/DD.** The State should conduct a gap analysis of the ways people with developmental disabilities are served in systems across California throughout their lives. As part of the gap analysis, the State should review the Lanterman Act to:
  - List all services that people I/DD should get
  - Find out who pays for each service and which agency is in charge of it

- Make sure people with I/DD can actually get all the services they need and have a right to
- No matter what the gap analysis finds, the State should not move all services people with I/DD into managed care system

2. **Gap Analysis on Behavioral Health Services for People With I/DD.** The State should conduct a gap analysis of behavioral health services that are available to individuals with I/DD. This means identifying gaps in:

- Supports
- Services
- Residential living arrangements

It should include all behavioral health services, including:

- School-based mental health services
- Community based behavioral health services
- Crisis and emergency services
- Residential services

The gap analysis should also look at the adequacy of the behavioral health workforce with a particular focus on the adequacy of workforce trained to provide services to individuals with I/DD.

3. **Gap Analysis on Early Start for Children With I/DD.** The State should conduct a “gap” analysis about the availability of services for children ages 3-5. This should include children who have received Early Start services. The gap analysis should look at:

- The availability of current services. These include services that are available from:
  - Regional centers
  - School districts

- Other state or federally funded pre-school programs
  - Medi-Cal
  - California Children Services (CCS)
  - Waiting lists for services
  - New services that families want
4. **Gap Analysis on School for Children and Youth With I/DD.** The State should conduct a gap analysis of the ways people with developmental disabilities are served by the school system in California. This study will:
- Show where schools are doing well
  - Show where schools are not providing fully inclusive, person-centered learning experience for students with I/DD
  - Look at data related to supports and outcomes for students with I/DD. This should include:
    - Graduation rates
    - Type of diploma achieved
    - Transition rate to jobs or post-secondary education

This study should be done with input from individuals with I/DD and their families from diverse backgrounds.

5. **Gap Analysis on Post-Secondary Services for Young Adults With I/DD.** The State should conduct a gap analysis about the availability of post-secondary services and supports people want. The gap analysis should look at:
- The services that are currently available
  - Waiting lists for those services
  - New services that people with I/DD want to achieve their post-secondary pathway

Following the gap analysis, CalHHS and its departments should develop recommendations to address any gaps.

6. **Gap Analysis on Services for Older Adults With I/DD.** The State should conduct a gap analysis about the availability of services that older adults need and choose. This should include:

- The availability of more flexible service options
- The need for new service models
- Needed living options, including living arrangements for people with Down Syndrome or other I/DD who also have dementia

## Data

There are barriers to accessing services and gaps in the system that are hard to understand. One reason for this is that the data collected is not complete or of high quality. Data can be used to understand patterns in how individuals receive (or don't receive) services. Access to high quality data is important to understand what is happening within a system and what might need to be improved.

1. **Collect Data to Attract People to Disability Services Careers.** The State should conduct a study with specific recommendations for types of financial incentives that could be provided to people in disability-related careers. This could include:

- Tax breaks
- Loan forgiveness
- Work visas
- Housing assistance

The State should use the results of the study to create an action plan. The plan should have specific timelines and goals for improving the financial incentives for people going into disability-related careers.

2. **Collect Data on Hiring and Keeping Regional Center Staff.** The State should conduct a study of the regional center service coordinator role at all regional centers. This should collect data on:
  - Vacancy, meaning open positions
  - Pay (including benefits)
  - Retention rates, meaning how long service coordinators stay in their jobs

This study should include existing data that is already collected to compare wage ranges across the regional centers. The study should look at how wage ranges align with retention and performance outcomes for service coordinators. The results of this study should be shared with regional center Boards and the public. The results should be used to create recommendations and requirements for regional centers to support better recruitment, compensation, and retention of service coordinator.

3. **Collect Data on the Service Coordinator Caseload Sizes.** The State should conduct an independent study of regional center caseload sizes and staffing ratios. This should include ratios for all specialized caseload types. This study should be used to update and modernize requirements for:
  - Caseload sizes
  - Caseload types
  - Staffing ratios for roles like service coordinators and client advocates assigned to regional centers

The results of this study should be used to update:

- Statute on the service coordinator caseload formula
  - Funding formulas for regional centers to support the new caseload and staffing levels
  - Consequences for failing to meet caseload requirements
4. **Collect Data on Homelessness.** DDS should improve data collection to track:

- Prevention of homelessness
- Events that cause risk of homelessness
- Homelessness
- Housing outcomes
- Housing threats
- Who gets housing resources
- Who needs housing services
- Other needs of people with I/DD related to homelessness

DDS should use this data to:

- Make sure policies are fair
  - Improve access to housing programs
  - Target services
5. **Use Data to Better Understand Unmet Need.** DDS should conduct a study to measure the gap between the number of individuals served by regional centers and the number of individuals who are eligible for services. This study should collect statewide data and data by regional center catchment area. This baseline data would be tracked over time to measure regional centers' effectiveness in closing the gap. Currently, no data exists on what percentage of all eligible individuals this number represents. Without a sound estimate of the total number of eligible individuals, the State is unable to know the gap in unmet need or effectively strategize on how to close that gap.
6. **Increase Access to Data.** DDS should increase access to high-quality data for individuals, the public and researchers. This means that DDS should:
- Create a work group with individuals from the community, researchers and other people that have experience with data. The workgroup

should talk about how data must be collected and used to support accountability, oversight, and research.

- Create an action plan that describes these steps:
  - How different types of data should be collected, combined, and used from service providers, regional centers, and health, education, and other systems.
  - How individuals, the public, and researchers should access the data.
  - How data will be protected and can be accessed by different types or organizations where appropriate and necessary.
  - How privacy will be protected. That means there are also ways that the wishes of individual to keep their data private can be respected.
- Develop a guide describing how data will be collected and made available for individuals and families, the public, and for research.
- Collect, manage, and keep data safe for research and analysis.

## **Recommendation Needing Further Consideration**

There are nearly 170 recommendations in the Master Plan. The Committee and co-chairs spent many hours discussing the recommendations. They worked hard to understand different opinions on all the recommendations. They were able to reach a consensus on all the recommendations except for one. A “consensus” means that enough people agree to support something that it can move forward. The Committee’s definition of consensus was that the recommendation was supported by two-thirds of the members. The recommendation that the Committee did not reach a consensus on is about letting people served by the regional center choose to receive service coordination from outside of the regional center.

There was a lot of discussion about this recommendation. There were diverse opinions about how the recommendation should be finalized. There were two final versions of this recommendation. Each of these versions received a close

vote but did not reach consensus. These are the two versions of the recommendation:

- DDS should look at best practices at regional centers that are currently using vendored service coordination. DDS should also look at models in other states that allow choice of service coordination. The study should include input from very diverse perspectives on this issue. Based on this information, DDS should develop a report on the study findings. The report should explain the pros and cons of service coordination provided outside the regional center. The results of this study should be shared with the DDS Master Plan Committee. The Committee could then make recommendations to DDS to create a pilot program. This pilot program could create an option for people served by the regional center to choose a service coordinator outside of the regional center. The Lanterman Act already allows for certain individuals from outside of regional centers to serve in the role of service coordinator, with regional center approval.
- DDS should look at best practices at regional centers that currently use vendored service coordination. Based on this information, DDS should develop a pilot program to create an option for people served by the regional center to choose a service coordinator from outside of the regional center. The Lanterman Act already allows for certain individuals from outside of regional centers to serve in the role of service coordinator, with regional center approval. Based on the results of reviewing current vendored service coordination and this pilot program, DDS should determine next steps.

These draft recommendations should be considered in ongoing work to implement the MPDS but are not being included as a final recommendation.

# What Comes Next for the Master Plan for Developmental Services?

The MPDS is a community-driven vision to improve how California supports people with I/DD and their families into the future. In the spirit of a California for All, the MPDS:

- Is inclusive
- Is forward-looking
- Reflects the diversity of our State
- Reflects the cultures of our communities
- Reminds us of our values, including:
  - Service and support
  - Understanding
  - Compassion

The MPDS weaves together the stories from many members of the community into shared recommendations to improve the programs and resources they need to thrive and achieve their goals.

The MPDS will help inform progress toward:

- Better services and supports
- Improved coordination across systems
- The attainment of desired life outcomes

These improvements require the continued partnership and collaboration of our entire community. The Master Plan will be used to inform existing work, new work, and future work. The Master Plan provides both the community's desired

objectives and recommendations on how to achieve them, on many topics. Here are some examples of the workgroups that the MPDS will inform:

- The Lived Experience Advisory Group (LEAG). This workgroup is an expanded and renamed Consumer Advisory Committee. LEAG will help with:
  - Developing plain language materials.
  - Commenting on policy.
  - Contributing to the Life Outcome Improvement System (LOIS) project.
  - The LOIS project is an IT project. It will modernize the case management and money systems used to deliver regional centers services. LOIS will provide people served and their families with access to their information and communication with regional centers.<sup>16</sup>
  - Centering the experiences of people with I/DD in our collective work.
- The Quality Incentive Program workgroup. This workgroup develops and provides incentives for achieving individual outcomes.
- The Regional Center Performance Measures workgroup. This workgroup develops and provides incentives for regional centers that make improvements on issues which are important to the community.
- The Quality Assurance Advisory Group. This workgroup will inform work to improve the knowledge and experiences of people with I/DD and families receiving services.
- Several advisory groups engaged with the Service, Access, and Equity Division of DDS.

DDS also will reconvene the MPDS Committee two times per year. These meetings will share updates on work related to the MPDS recommendations. Using the information shared in these meetings, DDS will submit an annual report

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<sup>16</sup> [For more information about LOIS \(https://www.dds.ca.gov/newsletter/a-look-ahead-at-2025/\)](https://www.dds.ca.gov/newsletter/a-look-ahead-at-2025/)

to the Legislature. This report will be submitted in March of each year, beginning in 2026, and ending in 2036.

The Administration greatly values the community's contributions to the MPDS. The Administration encourages continued participation in these and other efforts that enhance the lives of people with I/DD and their families. DDS will continue to seek out input from diverse members of the community to include in focused conversations. To learn more and to join these ongoing engagement opportunities, go to the DDS Events website (<https://www.dds.ca.gov/dds-events/>).



# Appendices

## Appendix A: Master Plan for Developmental Services Committee Members

The Master Plan for Developmental Services Committee consisted of a diverse group of individuals appointed by the CalHHS Secretary. Committee members brought different backgrounds and experiences to help build the Master Plan.

Committee Members	
Amy Westling	Kecia Weller
Areva Martin	Kelly Kulzer-Reyes
Barry Jardini	Larry Yin
Beth Burt	Lisa Cooley
Brett Eisenberg	Marie Poulsen
Brian Zotti	Mark Klaus
Cheryl Brown	Mark Melanson
Claudia Center	Marty Omoto
Dora Contreras	Norma Ramos
Edith Arias	Oscar Mercado
Elena Tiffany	Sara Speck
Elizabeth Hassler	Sascha Bittner
Eric Ramirez	Season Goodpasture
Fernando Gomez	Sheila Comin-DuMong

Committee Members	
Gloria Wong	Sylvia Yeh
Joe Perales	Tiffany Whiten
Joyce McNair	Victor Lira
Judy Mark	Will Leiner
Kavita Sreedhar	Yvette Baptiste

For biographies of the workgroup members visit: <https://www.chhs.ca.gov/wp-content/uploads/2024/07/1-Master-Plan-Committee-Member-Bios-7-16.pdf>.

## Appendix B: Master Plan for Developmental Services List of Workgroup Members

Workgroup Members	
Aderonke Adejuyigbe	Jesse Rocha
Alessandra Aldai	Jesse Weller
Alex Mountford	Jonathan Padilla
Alison Morantz	Joyce Cabrera
Ana Seda	Kaitlynn Truong
Angel Montoya	Kathleen Barajas
Angelina Ordonez	Katie Hynes
Araceli Garcia	Kendra Wagner
Carolina Navarro Garcia	Kiara Hedglin
Cheryl Ann Whittle	Lauren Loza
Chloe Carrier	Lety Garcia
Chloe Medina	Lisa Macafee
Christine Couch	Mariana Molina Nava
Christopher Chu	Mirela Bere
Cindy Cox	Mitra Ordibehesht
Derek Hearhtower	Renu Moon
Dominique Mellion	Shannon Cogan
Dustlyne Beavers	Suad Bisogno

<b>Workgroup Members</b>	
Erendida Gonzalez	Susan Stroebel
Gaby Abdel-Salam	Suzy Requarth
Glenis Ulloa	Teresa Anderson
Harold Ashe	Tiffany Swan
Hyun S. Park	Tina Ewing-Wilson
Isabel Torres	Tracey Mensch
Jamie Johnson	Viri Salgado
Jay Kolvoord	

Most members of the Committee also served as members of workgroups.

## Appendix C: Stakeholder and Community Engagement

Throughout this process, we have made it a priority to hear from the community. We did this by gathering public comments and feedback through outreach efforts. Over eight months, we held 47 community meetings, about one per week, to ensure a wide range of experiences were included in the MPDS. These meetings have brought together people from diverse backgrounds, including:

- Individuals from underrepresented communities
- Service providers
- Policy experts
- Self-advocates, and their families

By listening to so many different perspectives, we are shaping the MPDS with a strong focus on fairness and inclusion. The goal of the Master Plan is to build a developmental services system that is fair, consistent, and accessible to all Californians with I/DD. Our commitment to community engagement made sure that the experiences of those most impacted by the system are heard, valued, and included in every step of the process.

For more information and to access these engagements, visit:

<https://www.chhs.ca.gov/home/master-plan-for-developmental-services/#>.

Host	Community	Date
Department of Developmental Services Hispanic/Latino Focus Group	Hispanic/Latino advocates that meet regularly with DDS to provide input	06/07/2024
California Foundation for Independent Living Centers	Directors and senior leaders of California's Independent Living Centers	06/13/2024

Host	Community	Date
Association of Regional Center Agencies	Regional Center Executive Directors	06/20/2024
Department of Developmental Services African American Focus Group	African American advocates that meet regularly with DDS to provide input	06/28/2024
Integrated Community Collaborative	Hispanic/Latino Spanish speaking families and self-advocates	07/11/2024
Service Access & Equity Monthly Meeting	Representatives of DDS -Service Access and Equity grant recipients	07/12/2024
Family Resource Centers Network of California	Directors and senior leaders of California's Family Resource Centers	07/17/2024
Summer Institute on Neuro- Developmental Disabilities	Families, self-advocates, & professionals attending MIND institute conference	07/19/2024
Westside Resource and Empowerment Center Parent Support Group	Ethiopian parents, family members, and people with developmental disabilities	08/16/2024
Disabilities Voices United Communication Access Connect	AAC users and their families	08/20/2024
El Arc de California	Committee members of El Arc representing the Latino community	09/03/2024
State Alliance Team for Aging	Representatives of state and local entities serving older adults and people with disabilities	09/04/2024

Host	Community	Date
Golden Gate Regional Center Advocates	Service providers and advocates serving the San Francisco Bay Area	09/10/2024
Let Your Ideas Be Known	Disability Rights California hosted a webinar for families, self-advocates, and activists	09/12/2024
PRAGNYA Coffee, Chai, and I	Families and self-advocates from the South Asian communities and greater San Jose area	09/21/2024
“Voices for Change” Event	Families and individuals from the Chinese, Japanese, and Vietnamese communities	09/21/2024
State Council on Developmental Disabilities (SCDD)	Membership of the SCDD	09/24/2024
Korean Community Collaboration	Families and Individuals with disabilities in the Korean community	09/27/2024
California Association of Health Facilities (CAHF)	Non-profit trade association representing skilled nursing facilities and intermediate care facilities for people with I/DD	10/02/2024
Cafecito	Hispanic/Latino Spanish speaking families and self-advocates	10/03/2024
Sac6 Area Listening Party	Convening for self-advocates from six counties in the Central Valley	10/04/2024
National Council on Severe Autism (NCSA)	Advocates and professionals who provide recognition, policy and solutions for individuals, families and caregivers affected by autism and related disorders	10/07/2024

Host	Community	Date
Tribal Developmental Disabilities Symposium	Tribal community members in I/DD community and Tribal I/DD service providers	10/10/2024
Valley Mountain Regional Center SDP LVAC	Local Volunteer Advisory Committee to the Regional Center (SDP LVAC) in the self-determination program	10/17/2024
North Los Angeles County Regional Center SDP LVAC	Local Volunteer Advisory Committee to the Regional Center (SDP LVAC) in the self-determination program	10/17/2024
South San Francisco Families Engagement Forum	Parents of individuals with I/DD from South San Francisco and surrounding area	10/24/2024
El Arc de California Coalition Leaders Board	Self-advocates, family members, service providers and community members that focus on civil rights of people with I/DD in the Latino community	10/29/2024
Sac6 Area Listening Party	Convening for self-advocates from six counties in the Central Valley	11/01/2024
Service Coordinators Focus Group	Focus group for SEIU member service coordinators from ten regional centers	11/01/2024
California Foundation for Independent Living Centers CA Community Living Network	Professionals from across the state who had provided independent living services under the original California Supported Living Arrangement (CSLA) pilot program	11/04/2024

Host	Community	Date
Korean Community Listening Session	Forum for Korean families and individuals receiving DD services	11/07/2024
CFILC Quarterly Meeting	Update on the Master Plan to leadership of California's Independent Living Centers	11/07/2024
Autism Society San Francisco Bay Area	Nonprofit organization of parents, family members and professionals of people within the autism community in the Bay Area	11/12/2024
Developmental Disabilities Councils of the of the East Bay Convening	Convening with the Developmental Disabilities Councils of Alameda and Contra Costa Counties	11/13/2024
North Bay Regional Center Board Meeting	North Bay Developmental Disabilities Services Board Directors	11/18/2024
Westside Family Resource and Empowerment Center	African American/Black families support group to ensure people with intellectual and developmental disabilities	11/21/2024
The Lanterman Coalition	Stakeholders who work to preserve the Lanterman Act for people with intellectual and developmental disabilities	11/22/2024
Congreso Familiar	Service providers who serve Spanish speaking families that have children or family members with disabilities	12/02/2024

Host	Community	Date
Associate of Regional Center Agencies - 2024 Partners in Policymaking graduates	Leadership training program for adults with developmental disabilities and families to become community leaders and catalysts for systems change	12/05/2024
University of California, Irvine Center for Autism and Neurological Disorders	UC Irvine Center for Autism Latino support group	12/12/2024
Self-Advocate Listening Party- Inland Regional Center	A convening of self-advocates from Inland Regional Center to discuss and share their experiences	01/21/2025
Hlub Hmong Center	Hmong advocacy organization which focuses on policy and systems change in public-serving institutions to tackle social justice disparities	01/23/2025
National Council on Severe Autism (NCSA)	Advocacy organization focused on addressing unique challenges faced by families and individuals with autism	01/28/2025
University of California, Irvine Center for Autism Health and Neurological Disorders Empowering Women of Color Support Group	Black, African American, and Biracial parents and caregiver support group for those who have children with a neurological disability	01/28/2025

Host	Community	Date
Interagency Coordinating Council on Early Intervention	Members are appointed by the Governor. The council is comprised of parents of children with disabilities, early intervention service providers, health care professionals, state agency representatives, and others interested in early intervention	02/07/2025
University of California, San Francisco (UCSF) Virtual Conference  Developmental Disabilities: An Update for Health Professionals	Healthcare professionals who support the developmental disability population in California	03/06/2025

## Public Comment

We created an accessible public comment process to support community engagement throughout the development of the MPDS. Each of the 12 full committee meetings had public comment periods at the beginning and end. This allowed for meaningful participation. Each of the five workgroups also met monthly, with public comment periods at each meeting to ensure transparency and community involvement. A record of public comments is available here: <https://www.chhs.ca.gov/home/mpds-committee-workgroup/#>.

Additionally, individuals could submit suggestions or recommendations by email at [DSMasterPlan@chhs.ca.gov](mailto:DSMasterPlan@chhs.ca.gov). This approach made sure everyone's input was heard and considered in shaping the MPDS.

## Appendix D: Process for Supporting Self-Advocates

### The Support Facilitator Role

The Support Facilitator role was created to help people with I/DD participate fully in the Master Plan process. This approach effectively supported self-advocates in sharing their knowledge, experiences, and ideas with confidence. Facilitators:

- Simplified complex information
- Prepared self-advocates for meeting
- Increased self-advocate participation in decision-making

### Who Were the Support Facilitators?

For the time-limited Master Plan process, there was an immediate need to provide support to self-advocates. To meet this need, professionals, and students with experience in education, training, and coaching individuals with I/DD were recruited. Their familiarity with the developmental disabilities system, including services and supports, helped them guide self-advocates effectively.

Support Facilitators were not decision-makers in the Master Plan process. They assisted self-advocates without influencing their opinions or contributions. Their role was to simplify materials, explain meeting topics, and help self-advocates determine when and how to share their perspectives. Facilitators provided support before, during, and after meetings to make participation more accessible and inclusive. Over time, some self-advocates required less one-on-one support as they gained confidence and independence.

### How Support Facilitators Helped

#### Before Meetings

- **Monthly Group Pre-Meetings:** Self-advocates and facilitators met before each Master Plan Committee meeting to go over the agenda, learn new skills, and talk about key topics. Facilitators:
  - Explained complex issues in plain language

- Helped self-advocates prepare
- Provided notes with their comments to use during the meeting
- **One-on-One Support:** Some self-advocates met individually with facilitators to review materials, simplify ideas, and ask questions. Facilitators adjusted their support based on each self-advocate's needs.

### During Meetings

- **Helping With Discussions:** Facilitators made sure self-advocates could follow the conversation and understand key points.
- **Encouraging Participation:** They prompted self-advocates to share their thoughts and encouraged them to speak up.
- **Providing Real-Time Support:** Facilitators clarified information to help self-advocates stay engaged.
- **Workgroup Leader Practices:** Workgroup leaders encouraged self-advocates' participation by inviting their feedback first.

### After Meetings

- **Organizing Feedback:** Facilitators helped self-advocates go over key points and prepare for next steps.
- **Building Confidence:** They gave positive feedback and encouragement to help self-advocates grow in their roles.

### Why This Support Was Important

- **Increased Confidence:** Self-advocates became more comfortable speaking in meetings.
- **Better Understanding:** They could fully participate because they understood the topics being discussed.
- **Leadership Growth:** They developed skills to advocate for themselves and others.

- **Stronger Collaboration:** They learned from and worked with fellow self-advocates.

## Looking Ahead

Self-advocates believe this support should continue and be available in other leadership and decision-making spaces, such as:

- Regional center Boards
- Consumer Advisory Committee
- Other civic committees

Many self-advocates shared that they would not have been able to fully participate in the MPDS process without this assistance. Looking ahead, peer support models should be explored. This will make sure that self-advocates can support one another in future policy and planning efforts.

## Appendix E: Glossary

- **Ableism** – A form of prejudice which happens when people with disabilities are treated unfairly because they have a disability. Ableism can also happen when people who do not have disabilities are favored over people who have disabilities. For example, choosing a job candidate without a disability over a job candidate with a disability, even though the candidate with a disability is more qualified.
- **Applied Behavioral Analysis (ABA)** – A therapy that helps to understand behavior and to make positive changes to behavior. ABA can help people with autism and other I/DD develop positive skills like communicating and taking care of themselves. ABA can also help to replace negative behaviors with positive behaviors. ABA is personalized for each individual and their unique needs.
- **Assistive Technology (AT)** – Tools, devices, or other items that help people with disabilities. AT can be as simple as a special pencil grip or as complicated as an artificial leg.<sup>17</sup>
- **Augmentative and Alternative Communication (AAC)** – All of the ways that someone communicates besides talking. Augmentative means to add to someone's speech. Alternative means to be used instead of speech. AAC methods can include gestures, pictures, symbols, electronic devices, and changes to the environment that make it easier for people to communicate. People of all ages can use AAC if they have challenges with speech or language skills. Some people use AAC throughout their life. Others may use AAC only for a short time. An example of when ACC might be used is when someone has surgery on their jaw and cannot talk while they recover.
- **Behavioral Health** – A term that includes mental health, issues with drug or alcohol use, and how stress affects the body. Behavioral health care focuses on preventing, diagnosing, and treating these issues.

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<sup>17</sup> [For more information about AT \(https://www.who.int/news-room/fact-sheets/detail/assistive-technology\)](https://www.who.int/news-room/fact-sheets/detail/assistive-technology)

- **Bias (Implicit and Structural)** – Implicit bias is when someone has prejudices for or against a person or group without realizing it. Structural bias is when systems have been designed to benefit one group over others. These hidden biases can affect how people make decisions and act.
- **CalABLE** – An investment account designed for people with disabilities. CalABLE accounts are made possible by the federal Achieving a Better Life Experience (ABLE) Act. A CalABLE account allows money to be saved for qualified, disability-related expenses. The money in a CalABLE account is not counted towards eligibility for public benefits, so people can save money without losing their benefits. The money in the account grows without being taxed and can be used tax-free for approved disability expenses.<sup>18</sup>
- **Career and Technical Education (CTE)** – An educational program spread out over several years. The program involves a set of classes that combine core academic knowledge with technical and occupational knowledge. The goal of the program is to provide students with a pathway to education after high school and careers.<sup>19</sup>
- **Caregiver** – A person who helps someone with an illness, injury, or disability with their daily needs. Caregivers can provide short-term or long-term support. Caregivers can be family members or people who are paid to provide support.
- **Caseload** – The number of people or cases a worker or organization is responsible for. For example, a regional center service coordinator's caseload is the number of people they are assigned to support at one time.
- **Circle of Support** – Family, friends, and other important people who support a person with a disability. Having support from others can help a person with a disability be more successful and independent. For example, people in a circle of support can provide help with problem

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<sup>18</sup> [For more information about CalABLE \(https://calable.ca.gov/about\)](https://calable.ca.gov/about)

<sup>19</sup> [For more information about Career and Technical Education \(https://www.cde.ca.gov/ci/ct/\)](https://www.cde.ca.gov/ci/ct/)

solving or participating in the community. A circle of support is one type of “natural support.”

- **Consumer** – An individual with I/DD who is eligible for regional center services. The term consumer has replaced the prior term “client.” The term consumer references not only the individual, but the individual’s authorized representative. Authorized representatives include parents, guardians, and conservators.
- **Consumer Advisory Committee (CAC)** – The Director of DDS created the CAC in 1992 to give consumers a voice at DDS. The CAC gives DDS information about important issues that affect Californians with I/DD and provides consumers with information about things DDS is doing. The CAC makes decisions from information they receive from the community about DDS issues and community priorities. The CAC’s Vision is “My Life-My Way.”<sup>20</sup> Each regional center also has its own CAC made up of consumers in its catchment area.
- **Conservatorship** – A legal term for when a judge appoints another person to make decisions for a person who might have a hard time making decisions for themselves. The person the judge appoints is called the conservator. The person who the conservator makes decisions for is the conservatee. A judge can only appoint a conservator if other, less-restrictive options will not work.<sup>21</sup> If they are needed, DDS and regional centers are committed to person-centered conservatorships that respect the rights and choices of conservatees.<sup>22</sup>
- **Contract** – A legal agreement between people or groups that requires them to do (or not do) something.
- **Competitive Integrated Employment (CIE)** – A program that helps people with I/DD find jobs where they work alongside people without disabilities and earn at least minimum wage. DDS, DOR, and CDE work together to make employment in an integrated setting, at a competitive wage, for

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<sup>20</sup> [For more information about Consumer Advisory Committees \(https://www.dds.ca.gov/consumers/consumer-advisory-committee/\)](https://www.dds.ca.gov/consumers/consumer-advisory-committee/)

<sup>21</sup> [For more information about conservatorship \(https://selfhelp.courts.ca.gov/conservatorships/\)](https://selfhelp.courts.ca.gov/conservatorships/)

<sup>22</sup> [For more information about person-centered conservatorships \(https://www.dds.ca.gov/newsletter/a-more-person-centered-conservatorship-program/\)](https://www.dds.ca.gov/newsletter/a-more-person-centered-conservatorship-program/)

people with I/DD a high priority for the state. The goals of the program include helping people with I/DD get the support they need to have more opportunities and to find jobs, especially as they become adults. Another goal is to make it easier for businesses to hire people with I/DD. In this program, schools, rehabilitation districts, and regional centers work together to support people with I/DD effectively.<sup>23</sup>

- **Community of Practice** – A group of people who are working on a topic, like equity. The group meets regularly to discuss the topic and learn together.
- **Community Supports** – Services provided by Medi-Cal that help people with health-related social needs.<sup>24</sup> These services are meant to improve people’s well-being and avoid more costly care. These supports include:
  - Help finding and keeping housing
  - Access to medically tailored meals to support short term recovery
  - A variety of other community-based services
- **Coordinated Family Supports (CFS) Program** – A service option for adults (age 18 and older) who live in their family home and receive regional center services. CFS provides:
  - Support for developing skills at home
  - Help coordinating and getting services, including “generic services”
  - Assistance with community access
  - A service plan to reduce or remove barriers, address challenges, and meet goals

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<sup>23</sup> [For more information about Competitive Integrated Employment \(https://www.chhs.ca.gov/home/cie/\)](https://www.chhs.ca.gov/home/cie/)

<sup>24</sup> [For more information about Community Supports \(https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf\)](https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf)

CFS services are individualized, flexible, and tailored to each person's language, culture, and needs, to help them stay in their family home.<sup>25</sup>

- **Coordinated Career Pathway (CCP)** – A service that helps people transition from work activity programs, below minimum wage jobs, or high school (within the last two years) to CIE. CCP includes two services:
  - Career Pathway Navigator (CPN)
  - Customized Employment Specialist (CES)

CCP services last 18 months, with the option to extend up to 24 months.<sup>26</sup>

- **Crisis** – A crisis is a time of intense difficulty, trouble, or danger. Often “crisis” refers to a high intensity behavioral health challenge which an individual is experiencing. For example, if someone is at risk of harming themselves or someone else.
- **Data** – Data is information which can be used to understand patterns and to make decisions. Data can include measurements or statistics. It is important to have good data to understand what is happening in a system and what might need to be improved.
- **Demographic** – A specific section of a population with a shared characteristic. For example, age, race, and gender are all demographic characteristics.
- **Department of Education (CDE)** – A California state government department that oversees public education and is responsible for the education of millions of children. The CDE oversees:
  - Funding
  - Testing

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<sup>25</sup> [For more information about Coordinated Family Supports \(https://www.dds.ca.gov/services/coordinated-family-support-service/\)](https://www.dds.ca.gov/services/coordinated-family-support-service/)

<sup>26</sup> [For more information about Coordinated Career Pathways \(https://www.dds.ca.gov/services/coordinated-career-pathways-ccp-services/\)](https://www.dds.ca.gov/services/coordinated-career-pathways-ccp-services/)

- Improving and supporting public school programs
- Providing resources to schools, teachers, and parents<sup>27</sup>
- **Department of Health Care Access and Information (HCAI)** – A California state government department that focuses on expanding equitable access to quality, affordable health care for all Californians.<sup>28</sup>
- **Department of Health Care Services (DHCS)** – A California state government department that provides equitable access to quality health care. DHCS is responsible for the state’s Medicaid program, Medi-Cal.<sup>29</sup>
- **Department of Rehabilitation (DOR)** – A California state government department that provides employment support services and advocacy to Californians with disabilities. DOR works with people served and other community partners to support employment, independent living, and equality for people with disabilities.<sup>30</sup>
- **Department of Social Services (DSS)** – A California state government department that provides services to low-income and vulnerable California residents.<sup>31</sup> The CDSS oversees:
  - The CalWORKs cash aid program
  - The CalFresh food electronic benefits program
  - In-Home Supportive Services
  - The child welfare system
- **Disabled Persons Protection Commission (Massachusetts) (DPCC)** – An independent state agency that investigates and responds to abuse of adults with disabilities (ages 18 to 59) in Massachusetts. Created in 1987,

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<sup>27</sup> [For more information about the California Department of Education \(https://www.cde.ca.gov/\)](https://www.cde.ca.gov/)

<sup>28</sup> [For more information about the Department of Health Care Access and Information \(https://hcai.ca.gov/about/mission-statement/\)](https://hcai.ca.gov/about/mission-statement/)

<sup>29</sup> [For more information about DHCS \(https://www.dhcs.ca.gov/Pages/AboutUs.aspx\)](https://www.dhcs.ca.gov/Pages/AboutUs.aspx)

<sup>30</sup> [For more information about DOR \(https://dor.ca.gov/Home/DepartmentOverview\)](https://dor.ca.gov/Home/DepartmentOverview)

<sup>31</sup> [For more information about CDSS \(https://www.cdss.ca.gov/\)](https://www.cdss.ca.gov/)

the DPPC reports to the Governor and Legislature and is led by an Executive Director. The DPPC:<sup>32</sup>

- Runs a 24-hour hotline for reporting abuse, neglect, or deaths
  - Investigates cases and oversees other agency's investigations
  - Provides protective services and training and education
  - Helps people recognize and report abuse and neglect
  - Maintains an Abuser Registry
- **Early Start:** A program that provides services for infants and toddlers with developmental delays or who are at risk for having a developmental disability and their families. Early start services are provided in a coordinated, family-centered system.<sup>33</sup>
  - **Eligibility** – Meeting the necessary requirements to get a service or a program. For example, to get regional center services or Medi-Cal, a person has to meet eligibility criteria.
  - **End of Life Planning** – Making a plan for what will happen when someone dies. This can include making decisions about things like:
    - Medical care at the end of a person's life
    - What will happen to a person's belongings and money at the end of their life
    - What kind of funeral a person or family wishes to have
  - **Enhanced Care Management (ECM)** – A Medi-Cal benefit for eligible people with complex health needs.<sup>34</sup> It provides:

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<sup>32</sup> [For more information about the Massachusetts DPCC \(https://www.mass.gov/info-details/overview-0\)](https://www.mass.gov/info-details/overview-0)

<sup>33</sup> [For more information about Early Start \(https://www.dds.ca.gov/services/early-start/\)](https://www.dds.ca.gov/services/early-start/)

<sup>34</sup> [For more information about ECM \(https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx\)](https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx)

- A Lead Care Manager who coordinates all of the health and health-related care and services that a person gets
- **Family Resource Center (FRC)** – These centers work with local organizations to help parents and families with young children learn about early intervention services and how to use the Early Start system. FRCs are run by parents who have children with special needs. They offer information and support to other parents. Each center is different and meets the needs of its community. They can be located in various places like regional centers, schools, health facilities, hospitals, or homes. Support services are available in many languages and are tailored to each family’s cultural needs.<sup>35</sup>
- **Federal Poverty Level (FPL)** – A threshold set by the federal government to measure an individual’s or household’s degree of poverty. Poverty means not having enough money to pay for very basic needs. The FPL provides a measurement that is used to determine if a person may be eligible for certain programs and benefits.
- **Financial Management Service (FMS)** – Participants in the Self-Determination Program must use a FMS to handle all payments for their services. The FMS:
  - Pays bills
  - Provides monthly spending statements
  - Handles taxes and legal compliance issues for staff

The FMS is independent but must be contracted by a regional center. There are three types of FMS providers:

- Bill Payer
- Sole Employer
- Co-Employer

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<sup>35</sup> [For more information about Family Resource Centers \(https://www.dds.ca.gov/services/early-start/family-resource-center/\)](https://www.dds.ca.gov/services/early-start/family-resource-center/)

- **Home and Community Based Services (HCBS) Final Rule** – The “Home and Community Based Services (HCBS) Final Rule” is a federal rule that protects the freedom of people with disabilities who receive Medicaid services to:
  - Live as independently as possible in the community, and not be segregated in institutions
  - Make their own choices about their care and services
  - Have the same rights as anyone else when accessing support services
  - Have privacy and control in their lives<sup>36</sup>
- **Individual Program Plan (IPP)** – A planning document that is prepared in a standard format according to specific instructions. An IPP is developed by identifying a person’s unique needs. The IPP identifies the goals, services, and supports which the regional center will coordinate for a person served.
- **Incentive Program** – A program that encourages organizations to do something by giving them a reward or other benefit when they do it.
- **Individualized Education Program (IEP)** – A special education plan explaining the educational support which a student with disabilities will receive from their school. The Individuals with Disabilities Education Act (IDEA) is the national special education law. A key part of IDEA is the concept that every child with a disability has a legal right to a free and appropriate public education (FAPE). A student’s IEP explains what their school needs to do for them to receive FAPE. The IDEA requires certain information to be included in an IEP. The IDEA also requires that a student’s parents or guardians are involved in the IEP process.<sup>37</sup>
- **In Home Supportive Services (IHSS)** – A program that provides assistance in a person’s home to eligible people. For example, people with

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<sup>36</sup> [For more information about HCBS \(https://www.dds.ca.gov/initiatives/hcbs/\)](https://www.dds.ca.gov/initiatives/hcbs/)

<sup>37</sup> [For more information about IEPs \(https://www.ed.gov/sites/ed/files/parents/needs/speced/iepguide/iepguide.pdf\)](https://www.ed.gov/sites/ed/files/parents/needs/speced/iepguide/iepguide.pdf)

disabilities. IHSS provides the support that people need to live safely in their own homes instead of moving to a care facility.<sup>38</sup>

- **Intake and Assessment Process** – The process which DDS and regional centers use to determine if a person is eligible for regional center services.
- **Intellectual and/or Developmental Disability (I/DD)** – A lifelong condition that:
  - Begins before age 18
  - Lasts for someone's entire life
  - Affects daily activities, like walking, speaking, taking care of yourself, or working

Examples of I/DD include conditions like:

- Cerebral palsy
  - Autism
  - Down Syndrome
  - Epilepsy
- **Institutional Deeming** – A process that checks a child's eligibility for Medi-Cal as if they lived in an institution and not in their family home. This allows children served by regional centers to qualify for Medi-Cal, even if their family's income is too high for them to meet the eligibility criteria under usual circumstances.<sup>39</sup>
  - **Institutions** – Places where people with I/DD or other conditions live where they are segregated from the community. When people live in institutions, they often have **limited freedom and control** over their lives.

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<sup>38</sup> [For more information about IHSS \(https://www.cdss.ca.gov/in-home-supportive-services\)](https://www.cdss.ca.gov/in-home-supportive-services)

<sup>39</sup> [For more information about institutional deeming \(https://www.dds.ca.gov/wp-content/uploads/2019/02/HCBS\\_WaiverDDEng\\_20190212.pdf\)](https://www.dds.ca.gov/wp-content/uploads/2019/02/HCBS_WaiverDDEng_20190212.pdf)

- **Lanterman Act** – A California law that says that people with I/DD and their families have a right to get services and supports they need. The Lanterman Act was passed in 1969. The law makes sure that people with I/DD receive personalized services based on their needs and choices. The law recognizes that people with I/DD may need supports to live full, independent, and productive lives.<sup>40</sup>
- **Medi-Cal** – California's Medicaid program. This is a public health insurance program which provides needed health care services for people who have low-income. Medi-Cal is financed jointly by the state and federal government.<sup>41</sup>
- **Medicaid Waiver** – Medicaid waivers are programs that provide additional services to specific groups of people. In California these are called Medi-Cal waivers. Examples of waivers include Home and Community Based Services (HCBS), Home and Community-Based Alternatives (HCBA), and other waivers.<sup>42</sup>
- **Navigator** – A person who helps people and families to understand the system and to access the services that they need.
- **Neurodiversity** – The idea that people's brains work in different ways and that these differences should be recognized and respected. The term is often used to describe conditions like autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and learning disabilities.
- **Office of Clients' Rights Advocacy (OCRA)** – A part of Disability Rights California (DRC) that provides free help to people receiving regional center services. Clients' Rights Advocates (CRAs) work at each of the 21 regional centers to protect the rights of people served. OCRA services

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<sup>40</sup> [For more information about the Lanterman Act \(https://www.dds.ca.gov/transparency/laws-regulations/lanterman-act-and-related-laws/\)](https://www.dds.ca.gov/transparency/laws-regulations/lanterman-act-and-related-laws/)

<sup>41</sup> [For more information about Medi-Cal \(https://www.dhcs.ca.gov/services/med-cal/Pages/default.aspx\)](https://www.dhcs.ca.gov/services/med-cal/Pages/default.aspx)

<sup>42</sup> [For more information about Medicaid waivers \(https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx?utm\\_source=Resources&utm\\_medium=SideBar&utm\\_campaign=Waivers\)](https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx?utm_source=Resources&utm_medium=SideBar&utm_campaign=Waivers)

include legal information, advice, and representation. OCRA has been supporting people served at regional centers since 1999.<sup>43</sup>

- **Person-Centered Planning** – A process that supports an individual to set goals for their future and decide what they need to achieve those goals. The process should be driven by the individual and reflect what is important to and for that person. Person-centered planning can include other people, such as family or friends, if the individual chooses to include them in the process. Person-centered planning should be used to inform a person’s IPP with their regional center.
- **Pilot Project** – A small-scale test of a new program or service before it is fully launched. A pilot project can help to identify what works and what needs improvement.
- **Purchase of Service (POS)** – A purchase of service is created when a regional center pays a vendor to provide a service to a person served. POS data can be used to understand which groups of people served are getting services and supports.
- **Regional Center** – A private, non-profit agency that is under contract with DDS to coordinate services and supports for people with I/DD. Regional centers help individuals and families access services that support independence and quality of life. Each regional center serves a specific area in California. Regional center roles and responsibilities are defined in Sections 4620-4696 of the California Welfare and Institutions Code.<sup>44</sup>
- **Service Coordinator** – The person who is responsible for managing and monitoring an individual’s IPP. The service coordinator works for a regional center, or an agency that contracts with a regional center to provide service coordination services.
- **Service Access & Equity Grants** – A program which was created to reduce disparities and increase equity in regional center services. This program awards \$11 million each year to regional centers and

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<sup>43</sup> [For more information about OCRA \(https://www.disabilityrightsca.org/what-we-do/programs/office-of-clients-rights-advocacy-ocra/\)](https://www.disabilityrightsca.org/what-we-do/programs/office-of-clients-rights-advocacy-ocra/)

<sup>44</sup> [For more information about regional centers \(https://www.dds.ca.gov/rc/\)](https://www.dds.ca.gov/rc/)

community-based organizations to implement strategies to reduce disparities and increase equity in regional center services.<sup>45</sup>

- **Self-Determination Program (SDP)** – A regional center program that gives people served and their families more freedom and allows them to choose services and supports that help them to achieve their IPP goals. The SDP was created in 2013 and was initially limited to 2,500 individuals during a three-year trial period. As of July 1, 2021, it is available to all eligible individuals receiving regional center services.<sup>46</sup>
- **Systemic, Therapeutic, Assessment, Resources and Treatment (START)** – A program that provides crisis support to people served by regional centers. START teams provide person-centered, trauma-informed services and crisis support for people with I/DD over the age of six. START teams provide services 24 hours a day to people with I/DD who live in their family home or in an out-of-home setting.
- **Workforce** – All of the people who are available to work in a specific job field. In the Master Plan the workforce being talked about is the people who work in jobs providing support to people with I/DD.

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<sup>45</sup> [For more information about the Service Access & Equity Grant Program \(https://www.dds.ca.gov/rc/disparities/disparity-funds-program/\)](https://www.dds.ca.gov/rc/disparities/disparity-funds-program/)

<sup>46</sup> [For more information about SDP \(https://www.dds.ca.gov/initiatives/sdp/\)](https://www.dds.ca.gov/initiatives/sdp/)

# Acknowledgements

We want to thank everyone who made the MPDS possible. Many different people gave their time and shared their experiences to help create this plan to improve California's system for developmental disabilities. The people who made the Master Plan a reality included:

- Countless leaders with I/DD
- Family members of people with I/DD
- Community members
- Members of the Disability Services workforce
- Researchers and educators
- Other stakeholders

Special thanks go to:

- The Committee and workgroup members who worked tirelessly to develop the recommendations in the plan
- Members of the public who participated and gave comments throughout the Master Plan process
- The community organizations that helped us host over 45 community engagement sessions with diverse communities across the state
- The writers, translators, and interpreters that made sure our work was in plain language and available in many languages
- The Support Facilitators who worked with self-advocates to make sure they had what they needed to participate during the Master Plan process
- The staff and consultants at DDS, DOR, and CalHHS who worked hard behind the scenes to support the Master Plan process



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, April 24, 2025  
9:30 am, or upon adjournment of session  
1021 O Street – Room 1200

Consultant: Elizabeth Schmitt

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## PUBLIC COMMENT

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*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.*

**4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****Issue #1: Department of Developmental Services Budget Overview**

**Department of Developmental Services – Governor’s Budget.** The Governor’s budget includes \$19 billion (\$12.4 billion General Fund) for DDS in 2025-26, a net increase of \$3.2 billion (20 percent) over the updated 2024-25 budget. The majority of the DDS budget, \$18.56 billion (\$12.05 billion General Fund) consists of the Community Services Program, or regional center budget, which includes services paid by regional centers to service providers on behalf of each person with intellectual or developmental disabilities (I/DD), known as purchase of services. The remaining components of the DDS budget include state-operated facilities at \$324.64 million (\$293.22 million General Fund) and DDS headquarters at \$156.6 million (\$101.4 million General Fund). California uses the Home- and Community-Based Services (HCBS) Waiver to receive federal reimbursement for most regional center services (\$6.5 billion federal reimbursements in 2025-26).

**Background: Department of Developmental Services.** DDS is responsible for administering the Lanterman Developmental Disabilities Services Act (Lanterman Act). Under the Lanterman Act, individuals with intellectual and developmental disabilities (I/DD) are entitled to an array of services and supports sufficiently complete to meet their individual needs and choices, regardless of age or degree of disability, and at each stage of life. Additionally, the Early Start Program provides for the delivery of services to infants and toddlers at risk of a developmental disability. Services provided to Californians with I/DD under the Lanterman Act are provided at no cost to individuals with qualifying disabilities regardless of income.

The department carries out its responsibilities through contracts with 21 community-based non-profits known as regional centers, as well as through state-operated homes and facilities. Regional centers are fixed points of contacts for all individuals with I/DD. The regional centers coordinate services for each individual with I/DD through an Individual Program Plan (IPP), and work with local service providers to purchase needed services and supports to carry out the IPP.

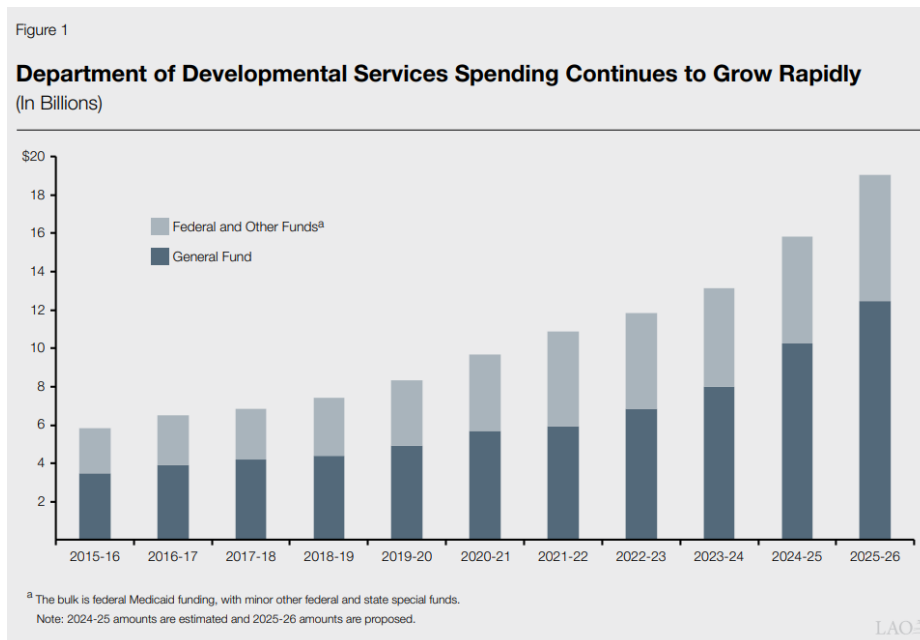
Major DDS programs include the following:

- **Early Start Caseload.** The Early Start program is California’s early intervention program for infants and toddlers ages 0-3 with developmental delays who are at risk of having a developmental disability. The 2025-26 Governor’s Budget projects an Early Start caseload of 66,756. Early Start services are coordinated through regional centers.
- **Lanterman Act Caseload.** Californians with I/DD ages three and over receive services through the general Lanterman Act program. Under the Lanterman Act, services are an entitlement for all Californians with I/DD. Regional centers coordinate services according to an individual’s IPP, and those services are delivered by service providers, known as vendors. Common services and supports include: supported living services, housing/residential services, independent living services, respite, personal assistance, employment services, transportation, adult day programs, and others. Total Lanterman Act caseload at 2025-26 Governor’s budget is 422,526 individuals; plus an additional 15,623

children ages 3-4 who have been determined provisionally eligible for regional center services.

- Self-Determination Program.** The Self-Determination Program is a voluntary program for Californians receiving Lanterman Act services. In the Self-Determination program, the individual with I/DD and their planning team create a spending plan that allows them to purchase services and supports from organizations or individuals of their choosing, instead of receiving services only through vendors contracted with the regional center, under certain conditions. As of January 2025, 6,146 individuals are enrolled in the Self-Determination Program.
- State-Operated Facilities.** In the last decade, the state largely closed down the remaining Developmental Centers, large institutional settings that previously housed thousands of Californians with I/DD. Today, only one Developmental Center is still in operation: Porterville Developmental Center in Tulare County, a secure facility which houses individuals who have been found incompetent to stand trial due to I/DD or are determined by a court to be dangerous to themselves or others and have been civilly committed to the facility. Fairview Developmental Center in Orange County is in warm shutdown pending long-term planning and no longer houses any individuals. DDS also operates a 55-bed Intermediate Care Facility known as Canyon Springs, which largely serves as crisis stabilization for individuals stepping down from other highly restrictive settings like Porterville Developmental Center. DDS also directly operates seven small specialized residential homes across the state for individuals in acute crisis, known as STAR Homes. The 2023 Budget Act approved the development of three new residential homes, similar to STAR homes, on Fairview property.

**Budget Growth.** The primary drivers of the 20 percent total fund increase from 2024-25 to 2025-26 are caseload growth and the full implementation of service provider rate reform.



A summary of DDS’s proposed 2025-26 budget is below.

**Program Highlights**

*(Dollars in Thousands)*

	<b>FY 2024-25</b>	<b>FY 2025-26</b>	<b>Difference</b>
<b>Community Services Program</b>			
Regional Centers	\$15,368,492	\$18,561,632	\$3,193,140
<b>Total, Community Services</b>	<b>\$15,368,492</b>	<b>\$18,561,632</b>	<b>\$3,193,140</b>
General Fund	\$9,882,782	\$12,052,618	\$2,169,836
Program Development Fund	\$434	\$434	\$0
Developmental Disabilities Services Account	\$150	\$150	\$0
Federal Trust Fund	\$55,589	\$55,589	\$0
Reimbursements	\$5,428,797	\$6,452,101	\$1,023,304
Behavioral Health Services Fund	\$740	\$740	\$0
<b>State Operated Services</b>			
Personal Services	\$257,825	\$266,221	\$8,396
Operating Expense & Equipment	\$56,879	\$58,422	\$1,543
<b>Total, State Operated Services</b>	<b>\$314,704</b>	<b>\$324,643</b>	<b>\$9,939</b>
General Fund	\$283,253	\$293,228	\$9,975
Lottery Education Fund	\$77	\$77	\$0
Reimbursements	\$31,374	\$31,338	(\$36)
<b>Headquarters Support</b>			
Personal Services	\$119,964	\$119,515	(\$449)
Operating Expense & Equipment	\$39,055	\$37,116	(\$1,939)
<b>Total, Headquarters Support</b>	<b>\$159,019</b>	<b>\$156,631</b>	<b>(\$2,388)</b>
General Fund	\$101,443	\$101,413	(\$30)
Federal Trust Fund	\$2,968	\$3,026	\$58
Program Development Fund	\$447	\$447	\$0
Reimbursements	\$53,659	\$51,243	(\$2,416)
Behavioral Health Services Fund	\$502	\$502	\$0
<b>Total, All Programs</b>	<b>\$15,842,215</b>	<b>\$19,042,906</b>	<b>\$3,200,691</b>
<b>Total Funding</b>			
General Fund	\$10,267,478	\$12,447,259	\$2,179,781
Federal Trust Fund	\$58,557	\$58,615	\$58
Lottery Education Fund	\$77	\$77	\$0
Program Development Fund	\$881	\$881	\$0
Developmental Disabilities Services Account	\$150	\$150	\$0
Reimbursements	\$5,513,830	\$6,534,682	\$1,020,852
Behavioral Health Services Fund	\$1,242	\$1,242	\$0
<b>Total, All Funds</b>	<b>\$15,842,215</b>	<b>\$19,042,906</b>	<b>\$3,200,691</b>
<b>Caseloads*</b>			
State Operated Services	302	302	0
Regional Centers	465,165	504,905	39,740
<b>Departmental Positions</b>			
State Operated Services	1,909.8	1,900.7	(9.1)
Headquarters	708.0	720.0	12.0

\*Updated FY 2024-25 caseload reflects no change from Enacted Budget for purposes of core staffing funding assumptions.

The 2025-26 proposed budget estimates over 500,000 individuals will be served by the developmental services system in 2025-26 via both the Early Start and Lanterman Act caseloads. DDS anticipates a caseload increase of 39,740 individuals in 2025-26.

**Service Provider Rate Reform Implementation.** In 2016, the Legislature required a rate study to address the sustainability, quality, and transparency of community-based services for individuals with I/DD. The development of a new rate study was a response to concerns that existing DDS rates lacked transparency, were overly complex, were not tied to person-centered outcomes, and varied across providers who provide the same service in the same region. DDS, with the help of a consultant, completed the rate study in 2019, which recommended a series of changes, including rate models within each service category; regional differentials to account for variance in the cost of living and doing business, enhanced rates for services delivered in other languages, wage differentials based on training and demonstrated competency, and the consolidation of certain service codes.

Beginning in the 2021 Budget Act, the Governor and Legislature initiated a multi-year plan to phase in rate reform, with an annual cost of \$1.8 billion (\$1.1 billion General Fund) at full implementation. The 2024 Budget Act moved the final phase (50 percent) of rate reform implementation to January 1, 2025. DDS has been working to consolidate and clarify service codes and categories under the now fully funded rate model.

The 2021 Budget Act required that at full implementation, fully funded models be implemented using two payment components: (1) a base rate equaling 90 percent of the rate model, and (2) a quality incentive payment, equaling up to 10 percent of the rate model, implemented via a new quality incentive program. The quality incentive component of rate reform responds to the prevailing need within the developmental services system of moving from a compliance-based system to an outcomes-based system rooted in meeting individual needs and person-centered planning.

**Provider Directory and Quality Incentives.** To develop the 10 percent quality incentive component of the fully funded rate model, existing law allows measures and benchmarks in the initial years of implementation to focus on building capacity, developing reporting systems, gathering baseline data, and similar activities, while working towards meaningful outcome measures at the individual level for all services. By 2026, the quality incentive component must include measures at the individual level. This ramp-up time recognizes that DDS must first develop the infrastructure to allow for the collection of data and information that reflects individual outcomes.

To ensure every service provider has an opportunity to earn 100 percent of their rate in the first year of full implementation, DDS launched a Provider Directory. For the years 2024-25 and 2025-26, providers are able to earn the 10 percent quality incentive by registering and validating their information in the Provider Directory. While the service provider directory does not meet the ultimate goals of measuring service quality and transforming to an outcomes-based system, it is a step to create the infrastructure to eventually meet these goals.

As of April 10, 2025, the Provider Directory contains over 18,000 vendor records, 64 percent of which have been validated and submitted by service providers to regional centers for approval. DDS reports that over 14,500 vendors have qualified for their 10 percent quality incentive via the provider registry. DDS continues to encourage service providers to review and submit their records for inclusion in the Provider Directory. Providers currently have until May 30, 2025 to complete the required steps in the Provider Directory to earn the final 10 percent of their rates. According to DDS, the Provider Directory will ultimately make it easier for individuals and families to find service options and can be a platform used for future quality measures.

As the LAO notes, “Previously, DDS lacked a centralized mechanism to store statewide provider information (including service location address, phone number, email address, and organization type). The state’s 21 Regional Centers stored this information separately for their own unique service areas. The creation of the Provider Directory will therefore be a first step in providing a more comprehensive view of the state’s network of providers. Once the information in the Provider Directory is linked to Regional Center Service areas, the department could identify potential gaps in service availability throughout the state.”<sup>1</sup>

Separate from the 10 percent quality incentive for vendors who register in the Provider Directory, DDS has been developing standalone quality incentives specific to certain service types. These are one-time payments to providers for meeting quality measures around workforce capacity and service access, employment access, employment capacity, and prevention and wellness. Two employment-related quality measures are currently active, but will not be funded separately past 2024-25, now that the rate models are fully implemented and all providers have the opportunity to earn 100 percent of their rate through the Provider Directory. However, DDS has stated that they plan to continue development of these more specific quality measures to collect baseline data and inform future 10 percent quality incentive components of the rate structure.

**Hold Harmless.** Implementation of rate reform has resulted in rate increases for most service providers; however, approximately 1,693 of the 12,981 (13 percent) of rate study vendors have rates that exceed the rate model for their respective service. Current law stipulates that providers’ rates that exceed the rate model amounts, as well as rates that exceed the base rate of 90 percent of the rate model, are “held harmless” (not reduced) to reflect the updated rate models until June 30, 2026. After June 30, 2026, rates are to be adjusted to the respective rate model. According to DDS, an updated fiscal impact for hold harmless will be conducted post alignment of services to the updated service descriptions.

**PAVE.** In 2020, California Community Living Network (CCLN), through a grant from the California State Council on Developmental Disabilities, began a project to identify service outcomes for individuals with I/DD. PAVE is working with stakeholders to create clear, consistent, and measurable service outcomes that could be used to inform service improvement, training, and value-based purchasing.

The PAVE Project will create a portal for individuals, authorized representatives, service providers, and others in the circle of support to contribute information on a person’s wants, needs, and goals. PAVE, when developed, will consist of three main components: (1) a software platform

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<sup>1</sup> The 2025-26 Budget: Department of Developmental Services, Legislative Analyst’s Office, March 2025

with tools to support planning and monitor outcomes in a person-centered way at the individual level; (2) training for people receiving services, direct support professionals, families, and others involved in the person's circle of support, and (3) a system for evaluating the quality, accuracy, and reliability of the data gathered from the software platform, incorporating the views and lived experiences of the people using the services.

According to DDS, PAVE could help to provide information to inform the individual outcomes for the quality incentive component of the rate model, either as a standalone platform, or incorporated into the Life Outcomes Improvement System (LOIS), which will modernize the current case management and financial systems.

**Life Outcomes Improvement System (LOIS).** DDS is in the process of replacing outdated case management and accounting systems. The new name for this project is Life Outcomes Improvement System (LOIS). Upon completion, LOIS will replace separate IT systems used by Regional Centers for accounting and case management. According to the LAO, "these systems are outdated and rely on technology from the 1980s, making it challenging and time-consuming for Regional Centers to perform their responsibilities."<sup>2</sup> The department's vision for LOIS is a modern, integrated case and financial management system that will be consistent across Regional Centers and allow consumers to view their own records. The LOIS project (previously referred to as the UFS/CERMS project) began with \$6 million in federal funds from the 2021 Home and Community-Based Services Spending Plan. The 2023 Budget Act included \$12.7 million (\$12.2 million General Fund) for continued planning, and also required supplemental report language requiring quarterly updates to the Legislature on project status. The 2024 Budget Act included \$1 million General Fund and up to \$5 million in provisional authority for continued planning, pending federal funding.

In its original Project Approval Lifecycle (PAL) Stage 2 document, DDS estimates total multi-year project costs of \$135 million to \$180 million total funds. DDS is also requesting enhanced federal funding which could yield a 90 percent match in federal funding.

From 2021-22 to 2024-25, the LOIS project has received \$26.6 million total funds (including federal funds). As of the second quarter of 2024-25, DDS reports spending \$22.2 million of that total, including \$4.5 million for staffing, \$17.1 million for contracts, and \$700,000 for operating expenses and equipment.

In 2024, the department canceled a separate project, known as the Reimbursement System Project. According to DDS, the department is evaluating incorporating elements of this canceled project into the LOIS project.

The Governor's proposed 2025-26 budget does not include any new funding for the LOIS project. According to DDS, the department is continuing community engagement in 2025 to identify and incorporate requirements for the case management and fiscal needs, and anticipates an update to the Stage 2 Alternatives Analysis documentation for California Department of Technology (CDT) review around the end of the current fiscal year. As part of updating the Stage 2 documents, DDS will establish a new project schedule and cost estimate that is reflective of the project's increased

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<sup>2</sup> LAO

scope. DDS states that implementation of the solution is dependent upon a variety of factors that are being evaluated as part of updating the Stage 2 documents. DDS anticipates final approval of the Stage 2 documents by June 2025 and expects the LOIS project to take several years to complete.

**Direct Support Professional (DSP) Workforce Initiatives.** In addition to initiating service provider rate reform, the 2021 and 2022 Budget Acts included various programs designed to address challenges in recruiting and retaining regional center service coordinators and direct support professionals (DSPs). Some elements of the 2022 workforce stability package that were in the early implementation stages, including a DSP Internship Program and a Regional Center Tuition Reimbursement Program, were phased out in the 2024 Budget Act to address the deficit.

However, other programs have yet to be fully implemented. This includes the DSP University program, a training and certification program tied to wage differentials, and bilingual pay differentials, both of which were included in the 2021 Budget Act. Both of these programs are tied to wage differentials, with the goals of stabilizing service access and diversifying and professionalizing the DSP workforce. DDS has provided the following status updates on these programs:

- *DSP University:* The three-tiered, competency-based training and certification program is designed to enhance DSP professional training, fostering person-centered, culturally and linguistically responsive services that improve outcomes for individuals with I/DD. The completion of each tier is directly tied to a wage differential for DSPs. The Learning Management System (LMS) is currently under development in collaboration with California State University Sacramento (CSUS). Additionally, the California Community Living Network (CCLN) is developing supplemental material. The curriculum is aligned with and supported by the Department's Workforce Workgroup, which has identified 16 core competencies essential for DSPs. Development of the LMS platform is actively underway, with implementation anticipated in summer 2025.
- *Bilingual Pay Differential:* The test case for the DSP Bilingual Pay Differential launched in December 2023 through Alta California Regional Center and one provider. Subsequently, additional regional centers were added, including Harbor Regional Center, Westside Regional Center and Tri-Counties Regional Center. A statewide implementation date for the DSP Bilingual Pay Differentials Program is being determined.

**SB 138: Legislative Equity and Oversight Measures.** SB 138 (Committee on Budget and Fiscal Review), Chapter 192, Statutes of 2023, included several changes to improve consistency, equity, and oversight in the regional center system. These changes were in response to longstanding issues raised by stakeholders and families regarding inequities in access to services across geographic, ethnic, and language lines. The 2023 Budget Act also included \$7.75 million (\$6.2 million General Fund) for DDS to implement the changes included in SB 138. The key components of SB 138 are summarized below:

- Expresses legislative intent to advance regional center service provision that is person-centered and more uniform, consistent, and equitable. Expresses legislative intent that

DDS, consistent with these equity goals, has the authority to oversee and monitor the manner in which regional centers provide services under the Lanterman Act.

- Requires DDS to develop common data definitions to promote access and equity in all regional center services and programs by June 30, 2024.
- Requires regional centers to start recording the race and ethnicity and preferred language of each individual at the time of initial intake, assessment, and the IPP meeting following the individual's 18<sup>th</sup> birthday, by January 1, 2025. Requires this data to be integrated with the department's new case management system.
- Requires DDS to establish standardized processes, including standardized template, for assessing an individual's need for respite services, by June 30, 2025. Requires regional centers to implement the standardized process by January 1, 2026. Requires this process to include obtaining information about respite needs from family members and other caregivers. Requires regional centers to make modifications to their purchase of services policies in order to implement this requirement.
- Requires DDS to establish a standardized IPP by June 30, 2024. Requires the standard IPP template to be integrated with the department's new case management system. Requires regional centers to implement the standardized IPP template and procedures by January 1, 2025.
- Requires DDS to establish standardized vendorization procedures by January 1, 2025. Requires regional centers to implement these procedures and provide updated vendor lists to the department on a quarterly basis, beginning January 1, 2026.
- Requires DDS to establish a standardized intake process by January 1, 2025. Requires regional centers to report the following information on intake: (1) the number of assessments; and (2) length of time it took to determine eligibility, broken down by various demographic factors including age, race/ethnicity, and preferred language, no later than June 30, 2025.
- Requires DDS to incorporate the following in its new case management system: (1) the number of individuals for whom intake was requested; (2) the outcome of that intake, including whether an assessment was determined to be necessary; (3) the length of time it took to complete the assessment; and (4) the number of notices of action sent regarding the outcome of the initial 15-day intake period.
- Requires DDS to develop all of the standardized processes mentioned above with input from stakeholders including individuals with I/DD and families who reflect the demographic diversity of the state, and requires DDS, in developing the standardized processes, to address barriers that may impact access to services.
- Requires DDS, with input from stakeholders, including individuals with I/DD and their families, relevant state agencies involved in the provision of generic services to report to

the Legislature on the following: (1) a definition of generic services; (2) options to improve the coordination of generic services; (3) a description of regional center efforts to coordinate generic services; and (4) identified barriers to accessing generic services, by July 1, 2025. Requires DDS to explore the feasibility of including the functionality to track utilization of generic services in its new case management system.

- Requires DDS to evaluate the availability of common services and supports throughout the state and recommendations for addressing inconsistencies in service availability. Requires DDS to provide a status updates on these efforts by January 10, 2025.
- Beginning January 1, 2025, requires a regional center, by the end of the 15-day intake period, to determine if the individual is eligible or determine if the regional center will initiate an assessment; inform the individual regarding the action; and, in the case a regional center determines an individual is ineligible, provide them or their family with adequate notice.

**Update on SB 138 Implementation.** DDS has made progress implementing many of the SB 138 requirements, and continues to work towards the various milestones outlined in SB 138:

- *Common Data Definitions:* DDS developed a consistent set of data definitions including race, ethnicity, and language data. As of January 1, 2025, Regional Centers began to record required information at specified milestones.
- *Standard IPP Template:* DDS worked with stakeholders to establish a standardized IPP template and procedures by June 30, 2024, which Regional Centers phased in January 1, 2025. The new IPP template has also been integrated within DDS's current case management system. DDS collects responses from an anonymous survey to evaluate the effectiveness of the standard IPP template, and initial results demonstrate positive feedback.
- *Evaluation of Common Services and Supports:* DDS expects completing the required evaluation of common services and supports by spring 2026.
- *Standard Respite Assessment:* DDS is developing an assessment tool, known as the family support tool, to assess an individual's need for respite, personal assistance, and day care. DDS piloted a draft tool with some service coordinators and will be collecting feedback from the public in an upcoming 30-day public comment period. DDS expects the development of this assessment to be complete in summer 2025.
- *Standard Intake Process:* DDS is behind the January 2025 milestone to establish a standard intake process, given the complexity and variation in existing intake processes across Regional Centers. DDS is meeting regularly with Regional Center intake staff and clinicians to understand current intake processes and plans to solicit stakeholder feedback.
- *Standard Vendorization:* DDS is phasing in a standard vendorization process with new service providers who enroll in the Provider Registry.

- *Intake Data and Reporting:* DDS anticipates sending guidance to Regional Centers soon regarding the requirement to report regularly on timeliness of eligibility assessments. Regional Centers have also begun to take specified actions regarding notification of initial intake decisions.

**2024 Budget Act.** The 2024 Budget Act included various reductions to the DDS in order to address the deficit, and made other various changes, summarized below:

- **Final Phase of DDS Rate Reform.** The 2024 Budget Act delayed the final phase of developmental services rate reform to January 1, 2025.
- **Other DDS Reductions.** The 2024 Budget Act made cuts to various DDS workforce initiatives, specifically: reduced \$20 million from the Direct Support Professional internship Program, reduced \$18.6 million from the Regional Center Tuition Reimbursement Program, and reverted \$10 million unspent from the Direct Support Professional Stipend Program. The budget also delayed a \$10 million Preschool Inclusion Grant Program. The budget included a reduction of \$20 million General Fund in 2024-25 and \$10 million General Fund in 2025-26 to Porterville Developmental Center, holding the budget to the revised 2023-24 spending level.
- **Master Plan for Developmental Services.** As part of the 2024 Budget, the Governor convened a new workgroup, led by the California Health and Human Services Agency (HHS), tasked with developing a Master Plan for Developmental Services to strengthen accessibility, quality, and equity for all Californians with intellectual and developmental disabilities. The workgroup delivered their report and recommendations to the Legislature in March 2025. The Master Plan for Developmental Services is covered in Issue #2 of this agenda.
- **Individual Program Plan Meetings.** Trailer bill language extended the option for an individual or family served by a regional center to choose to have their individual program plan (IPP) or, for infants and toddlers, individualized family service plan (IFSP), held remotely, as specified.
- **Social Recreation.** Trailer bill language requires regional center purchase-of-services policies to promote access to social recreation services, camping services, and nonmedical therapies. The trailer bill prohibits regional centers from enacting restrictive purchase-of-services policies that generally prohibit or disfavor the purchase of social recreation, camping, and nonmedical therapies, as specified.
- **Provisional Eligibility Assessments.** Trailer bill language allows a regional center to concurrently assess an infant or toddler referred for early intervention services for provisional eligibility or full eligibility for regional center services.
- **Repeal of Regional Center Family Fees.** Trailer bill language repealed the Family Cost Participation Program and Annual Family Program Fee.

**DDS State Operations and Vacancies Reductions.** The 2024 Budget Act included two control sections (Control Section 4.05 and Control Section 4.12) that aimed to implement efficiencies across state agencies in order to produce ongoing General Fund savings without adverse effects on state services. Both control sections established statewide administrative exercises led by the Department of Finance to (1) identify efficiencies in each department and (2) eliminate vacant positions and related funding.<sup>3</sup>

DDS has identified 83 currently vacant positions and \$1.1 million in vacant position reductions and \$3.33 million General Fund from state operations reductions in 2025-26. According to DDS, the vacant positions are generally aligned with the reduction to Porterville Developmental Center included in the 2024 Budget Act.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the department’s proposed 2025-26 budget and caseload, including caseload growth. Additionally, please provide a brief overview of how the department is implementing state operations and vacancies reductions pursuant to Control Sections 4.05 and 4.12 of the 2024 Budget Act.
2. Please provide an update on implementation of service provider rate reform, including the establishment of the Provider Directory. How will the quality incentive component of the rate structure evolve over time? How will the department continue advancing an outcome-based system, including through the Quality Incentive Program and the PAVE Project?
3. Please provide an update on the delivery of workforce initiatives funded in previous budget acts, specifically the Direct Support Professional University (DSPU) and bilingual pay differentials. When will these programs reach full implementation, and how will they support the direct support professional workforce?
4. Please provide a brief update on the department’s progress and work ahead to implement equity and consistency changes included in the 2023 Budget Act under SB 138, including a standard Individual Program Plan template, standard respite assessment, standard intake procedures, and clarifying definitions of generic services.

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<sup>3</sup> Legislative Analyst’s Office, “The 2025-26 State Budget: State Departments’ Operational Efficiencies (Control Sections 4.05 and 4.12), February 19, 2025.

**Issue #2: Master Plan for Developmental Services**

**Panel Discussion.** The Subcommittee has invited the following individuals to participate in a panel discussion on this discussion:

- Pete Cervinka, Director, Department of Developmental Services
- Sascha Bittner, Master Plan on Developmental Services Committee, Workforce Workgroup co-chair
- Oscar Mercado, Self-Advocate and Member, Integrated Community Collaborative
- Amy Westling, Executive Director, Association of Regional Center Agencies
- Will Leiner, Managing Attorney, Disability Rights California
- Karina Hendren, Fiscal & Policy Analyst, Legislative Analyst’s Office

**Master Plan for Developmental Services.** The Governor’s 2024-25 budget proposal included the creation of a Master Plan for Developmental Services. On February 14, 2024, former California Health and Human Services (CalHHS) Secretary Dr. Mark Ghaly announced the creation of a stakeholder committee to create the Master Plan for Developmental Services, to strengthen accessibility, quality, and equity for all Californians with I/DD. The Stakeholder Committee was tasked with working with CalHHS to develop a Master Plan for Developmental Services, to serve as California’s collective roadmap for the entire developmental services system to deliver meaningful and concrete results.

**Background: Longstanding Issues around Equity, Accountability, and Access.** Longstanding concerns about systemic disparities and inequities in the regional center system persist. These inequities have surfaced in the form of spending disparities between ethnic groups; disparities in spending on different types of services across regional centers; inconsistent purchases of services policies across regional centers; and the complicated web of “generic services” from multiple agencies that families must exhaust before a regional center will pay for a service or support. Groups such as Disability Rights California,<sup>4</sup> Disability Voices United,<sup>5</sup> and the Little Hoover Commission<sup>6</sup> have analyzed these issues and provided recommendations to improve access to services and oversight of regional centers.

In announcing the creation of a Master Plan for Developmental Services, DDS cited the need to ensure that services are more equitable, consistent, and accessible by addressing inequities and geographic disparities and improving how individuals and their families navigate the developmental services system.

**Master Plan Process.** The stakeholder committee appointed by CalHHS met publicly every month from April 2024 to March 2025. In addition to the primary Master Plan for Developmental Services Stakeholder Committee, five workgroups were created to focus on different Master Plan goal areas. Each workgroup developed recommendations for their goal areas. Workgroups included

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<sup>4</sup> From Navigation to Transformation: Addressing Inequities in California’s Regional Center System Through Community-Led Solutions, Disability Rights California, January 2023.

<sup>5</sup> A Matter of Race and Place: Racial and Geographic Disparities within California’s Regional Centers Serving Adults with Developmental Disabilities, Disability Voices United, October 2022.

<sup>6</sup> A System in Distress: Caring for Californians with Developmental Disabilities, Little Hoover Commission, April 2023.

some committee members and members of the public. Each workgroup was led by two co-chairs, one co-chair who was a self-advocate with I/DD, and one co-chair who was a family member of a person with I/DD. Workgroups met every month between August 2024 and March 2025. Each workgroup focused on developing recommendations in one focus area. The five workgroup focus areas were:

1. People with I/DD and families experience person-centered service systems they trust.
2. People with I/DD receive timely, inclusive, and seamless services across all service systems.
3. People with I/DD and their families receive services from a high-quality, stable, and person-centered workforce.
4. People with I/DD and their families experience consistent, transparent, accountable, and data-driven systems that focus on outcomes.
5. People with I/DD are entitled to life-long services with adequate resources.

Recommendations from each workgroup were brought to the full Stakeholder Committee for discussion and inclusion in the final Master Plan. The Master Plan is centered in lived experience, with self-advocates playing a key role in developing the Master Plan.

**Master Plan Report and Recommendations.** The full Master Plan for Developmental Services is available on the CalHHS website.<sup>7</sup> There are 167 total recommendations in the Master Plan. The recommendations fall under six topic areas:

- Systems Serving People with I/DD Are Centered in Equity
- People with I/DD Making Their Own Life Choices
- People with I/DD Getting Services They Need and Choose
- People with I/DD Being Part of and Being Served by a Strong Workforce
- Accountability and Transparency in All Systems That Serve People with I/DD
- Informing the Future of the Developmental Services System

Below are some examples of Master Plan recommendations across the topics above. This is not an exhaustive list.

- Create system-wide values about alternatives to conservatorship.
- Remove barriers to the Self-Determination Program.
- Make sure people with I/DD can choose to access some services from home.
- Make sure people with I/DD have the supports they need to vote.
- Help people with I/DD find affordable housing.
- Make sure people with I/DD can access support for life changes and moves.
- Make a plan to move people with I/DD from institutions into the community.

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<sup>7</sup> <https://www.chhs.ca.gov/home/master-plan-for-developmental-services/>

- Transition planning for individuals committed to Porterville Developmental Center.
- Make sure Regional Center services are provided even if a person is incarcerated.
- Make sure definitions of services are clear and consistent.
- Give people with I/DD more flexibility in services and providers.
- Improve support services that people with I/DD receive at home.
- Recognize that people with I/DD have health needs that are not related to their disability.
- Coordinate supports for transition from Early Start.
- Give young adults with I/DD the choice to leave school at age 18.
- Help plan for the future for people with I/DD who live with an aging caregiver.
- Clarify the definition of generic services.
- Make sure regional centers can provide generic services that have waitlists.
- Give people with I/DD and their families tools so they are referred to the right generic services and can keep the benefits they have.
- Make sure people in disability service careers have benefits.
- Make sure people with I/DD get high quality employment services.
- Protect children and young people with I/DD in the child welfare system.
- Make sure intake and assessment processes are clear and equitable.
- Make sure IPP processes are consistent and equitable.
- Make sure that rules about services approvals are clear and consistent.
- Use outcome measures for accountability.
- Use contracts for accountability.
- Make sure Regional Center governing board meetings are transparent.
- Use waivers to make seamless service systems.
- Conduct a gap analysis on school for children and youth with I/DD.

**Implementation and Next Steps.** DDS will reconvene the Master Plan Committee two times per year. These meetings will share updates on work related to the Master Plan recommendations. Using the information shared in these meetings, DDS will submit an annual report to the Legislature. This report will be submitted in March of each year, beginning in 2026, and ending in 2036. DDS states that the department will incorporate the recommendations of the Master Plan into activities currently underway at the department, including continued implementation of SB 138, the LOIS project, the Quality Incentive Program workgroup, and other programs. However, the Governor’s budget does not include any funding or specific new proposals related to the Master Plan recommendations.

The Legislative Analyst’s Office suggests that “while these recommendations form a key starting point, the Master Plan cannot be put into action without initiative from the administration. A critical missing piece, therefore, is a roadmap for how to translate the community’s recommendations into a workable set of policy and budget proposals for legislative consideration.”<sup>8</sup>

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**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the Master Plan for Developmental Services. What are the key themes and recommendations of the Master Plan? How did the California Health and Human Services Agency work across departments and agencies in developing the Master Plan?
2. What is the Administration’s vision for the Master Plan for Developmental Services moving forward? How will decisions about implementation be prioritized?

**Issue #3: Public Records Act (AB 1147)**

**Budget Change Proposal – Governor’s Budget.** DDS requests \$11.5 million (\$8.3 million General Fund) in 2025-26 and \$15.4 million (\$11.1 million General Fund) in 2026-27 and ongoing for 10 permanent headquarters positions and 84 Regional Center positions to address the new workload associated with AB 1147 (Addis), Chapter 902, Statutes of 2024.

**Background.** AB 1147 (Addis), Chapter 902, Statutes of 2024, makes Regional Centers Subject to the Public Records Act (PRA), effective January 1, 2026. The PRA provides that specified public records of public entities, including public agencies and state agencies, are subject to inspection at all times, and states that every person has a right to inspect any public record, as specified. DDS and records held by DDS are subject to the PRA. However, prior to AB 1147, Regional Centers and their records were not subject to the PRA, given Regional Centers’ unique status as private, nonprofit entities.

According to DDS, the requirement to disclose certain documents pursuant to the PRA is a significant new responsibility for Regional Centers, and for DDS to monitor Regional Center compliance with the PRA. DDS states that Regional Centers will require significant training to implement and maintain ongoing PRA compliance, including proper de-identification and redaction. DDS and Regional Centers (as “business associates” of DDS) must also comply with the federal Health Insurance Portability and Accountability Act (HIPAA) and state confidentiality laws. DDS states that under AB 1147, Regional Centers will need to be properly trained in order to balance their responsibilities under both HIPAA and the PRA.

**Staffing and Resources Request.** According to DDS, the 10 headquarters positions will establish written guidance on the PRA for Regional Centers. Guidance would include expectations on when certain high-profile PRA requests should be submitted to the department for review before a Regional Center responds to a PRA request and best practices on how to protect the privacy rights of individuals. Guidance will also include handling PRA requests that contain confidential or privileged information.

DDS will provide initial and ongoing training at each Regional Center on a semi-annual basis in the following areas: (1) processing PRA requests; (2) processing PRA requests involving data extraction and statistical de-identification analysis; and (3) safe harbor redaction training. DDS will also provide guidance for complex or sensitive PRA requests and technical assistance on a real-time basis. The Department’s Office of Legal Affairs (OLA) will provide a liaison to assist Regional Center staff on best practices in responding to PRA requests and responding to their PRA questions. For data extraction requests, the department’s Information Technology Division will provide technical assistance to the Regional Centers in conducting statistical de-identification.

DDS anticipates a high volume of high-profile PRA requests based on recent experience. Since 2020, DDS has seen an increase of over 15 percent in PRA requests, and receives approximately 20 PRA requests a month (240 per year). At least half of those PRA requests involve high-profile matters related to media issues, litigation or pre-litigation matters, data extractions, and other matters involving complaints and investigations where consumer information must be redacted prior to disclosure. Lastly, DDS notes there is a possibility that litigation support and/or litigation

monitoring will be needed if there is an allegation that a regional center is out of compliance with the PRA, and the Department is named as a party in such lawsuits.

The requested positions include 10 positions at DDS Headquarters and 84 Regional Center positions (four positions at each Regional Center), as described below:

*DDS Office of Legal Affairs (Four Positions)*

- One Attorney IV to act as subject matter expert in PRA requests; to take the lead in preparing initial and ongoing PRA guidelines and policies in collaboration with DDS staff; prepare and conduct semi-annual training on the PRA process and safe harbor redaction; review, conduct legal analysis, and provide strategies for responding to high-profile PRA requests.
- One Attorney III to provide advice to regional center and/or Department staff on PRA requests; to assist in preparing initial and ongoing PRA guidelines; prepare and conduct semi-annual training on the PRA process and safe harbor redaction; to serve as a resource to the Staff Services Manager I and Legal Analyst in answering regional center questions on the PRA and exemptions; and to review responsive documents of high-profile PRA requests to ensure proper redaction or de-identification.
- One Staff Services Manager (SSM) I to track the status of PRA requests; to analyze PRA data trends; to answer incoming questions from regional center and DDS staff on the PRA, and obtain attorney assistance as needed; to draft responses to PRA requests as determined by Chief Counsel or Assistant Chief Counsels; to provide PRA resource materials to Regional Center and Department staff; and to supervise Legal Analyst, AGPA and Legal Secretary positions.
- One Legal Analyst to serve as the DDS liaison to the Regional Centers in providing PRA support and guidance; to assist DDS in reviewing and conducting safe harbor redaction on responsive documents to PRA requests; to assist attorneys in gathering information responsive to cross-over PRA requests that have come to the Department; and to collaborate with the Information Technology Division staff as needed on PRA requests.

*DDS Information Technology Division (ITD) (Six Positions)*

- Training unit: Two IT Specialist I positions to develop and maintain technical training materials and provide at least two training events per year to staff at each of the 21 Regional Centers.
- Technical Support Unit: Three IT Specialist I positions to provide expert technical support on complex PRA deliverables. Each position will be assigned seven regional centers to support.
- Technical Lead: One IT Specialist II position to provide technical leadership over the training and technical support units and maintain consistency across the team for addressing de-identification issues.

- Ongoing annual contract funding (\$500,000 General Fund) for a cloud-based PRA system software that can support tracking and role-based access from DDS and representatives from each Regional Center.

*Regional Center Local Assistance (84 Positions)*

- \$9.7 million (\$6.8 million General Fund) in 2025-26 and \$12.9 million (\$9 million General Fund) in 2026-27 and ongoing for 84 Regional Center positions and a \$1.5 million training contract. This estimate assumes four state equivalent classifications for each Regional Center: one Staff Services Manager, one Legal Analyst, one Legal Secretary, and one IT Specialist, to coordinate and respond to public records request. The IT position will provide technological support to perform first level data de-identification.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of this budget change proposal.
2. How did DDS determine that four positions will be required at each of the 21 Regional Centers in order to implement AB 1147?

**Issue #4: Rate Reform – Employment Services**

**Trailer Bill Language—Governor’s Budget.** The Governor’s Budget includes trailer bill language that will facilitate implementation of service provider rate reform for employment services.

**Background: Service Provider Rate Reform and Employment Services.** In 2016, the Legislature required a rate study to address the sustainability, quality, and transparency of community-based services for individuals with I/DD. The development of a new rate study was a response to concerns that existing DDS rates lacked transparency, were overly complex, were not tied to person-centered outcomes, and varied across providers who provide the same service in the same region. DDS, with the help of a consultant, completed the rate study in 2019, which recommended a series of changes, including rate models within each service category; regional differentials to account for variance in the cost of living and doing business, enhanced rates for services delivered in other languages, wage differentials based on training and demonstrated competency, and the consolidation of certain service codes.

Beginning in the 2021 Budget Act, the Governor and Legislature initiated a five-year plan to phase in rate reform. The 2024 Budget Act moved the final phase (50 percent) of rate reform implementation to January 1, 2025. DDS has been working to consolidate and clarify service codes and categories under the now fully funded rate model.

According to DDS, current law limits employment services to nonprofit agencies; however for-profit providers of employment services have been approved to provide services under different service codes for many years (many under a “miscellaneous” service code.) As rate reform is designed to consolidate inconsistent service codes, DDS proposes amending current law to allow for-profit providers to offer employment services. This would have the effect of realigning providers to their most appropriate service category, thus making service codes more uniform.

Additionally, current law specifies a specific reimbursement rate for employment services. However, under rate reform, reimbursement rates are not established in statute; rather, DDS establishes a rate for each service based on the rate models that are posted on the department’s website. DDS proposes striking out the current specific rate values in existing law so that the department can update rates more timely.

Lastly, current law limits “group supported employment services” to a ratio of one provider to three individuals served; however, the new rate models assume a ratio of one to two.

**Trailer Bill to Adjust Employment Services Rate.** The proposed trailer bill would do the following:

- Remove the requirement that providers of employment services must be non-profit organizations. This would facilitate the consolidation of service codes, as for-profit providers are generally already providing these types of services under different codes.

- Remove the specific hourly rates for employment services in statute; and instead refer to the rate models set by the DDS and published on the DDS website.
- Reduces the minimum job-coach-to-consumer ratio for group supported employment from 1:3 to 1:2. According to DDS, this will allow more individualized support.

**Provider Concerns.** Providers have raised concerns that the rate models would change the billing practice for employment services by requiring providers to bill based on individuals rather than by the job coach. Providers note this could have a destabilizing effect, as core costs for providers are the same whether two or three individuals are in attendance. This change is built into the rate model itself, and is not proposed for codification in this trailer bill. DDS has allowed providers to continue billing by job coach hour through December 2025 as the department continues to phase in the rate models.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of this trailer bill proposal.

**4100 STATE COUNCIL ON DEVELOPMENTAL DISABILITIES****Issue #1: Budget Overview and Re-appropriation Request**

**Governor’s Budget – State Council on Developmental Disabilities (SCDD).** The Governor’s proposed 2025-26 budget includes \$15.2 million total funds for SCDD. SCDD’s budget for 2025-26 is comprised solely of federal funds (\$8.7 million) and reimbursements (\$6.5 million) and contains no General Fund.

**Background: SCDD.** SCDD is responsible for engaging in advocacy, capacity building, and systems change activities that promote self-determination, independence, productivity, and inclusion in all aspects of community life for Californians with intellectual and developmental disabilities (I/DD) and their families. SCDD has 81 positions across twelve Regional Offices supported by Regional Advisory Committees. The twelve Regional Offices provide support for emergency preparation and response, in addition to other local programming including: advocacy services for individuals who have no legally appointed representative; clients’ rights advocacy services for people with I/DD, quality assessments for individuals living in residential homes, and other projects and grants related to self-determination and supported decision-making. SCDD is responsible for the transition plan to phase out the use of subminimum wage employment pursuant to SB 639 (Durazo), Chapter 339, Statutes of 2021, which ended subminimum wage employment for individuals with I/DD, effective January 1, 2025.

**Supported Decision-Making Technical Assistance Program.** The 2022 Budget Act allocated \$5 million General Fund to SCDD for implementation of the Supported Decision-Making Technical Assistance Program (SDM-TAP). The SDM-TAP provides a statewide resource for people seeking information about supported decision-making (SDM) – the ability for a person with a disability to make their own informed decisions. Often referenced in the context of conservatorship, SDM is a tool that allows people with disabilities to retain their decision-making capacity by choosing supporters to help them make choices. A person using SDM selects trusted advisors, such as friends, family members, or professionals, to serve as supporters. The supporters agree to help the person with a disability understand, consider, and communicate decisions, giving the person with a disability the tools to make their own informed, decisions.

According to SCDD, the SDM-TAP grant program provides support, education, guidance, assistance and training to educational entities, families, service providers, professionals, people with disabilities, courts, attorneys, mediators, and others in California who wish to use or expand SDM in their professional or personal life. Special attention is paid to communities that have been historically underserved, including non-English speakers, as well as immigrant, native, and rural populations. The SCDD has awarded nearly \$3 million to grantees such as community-based non-profits and colleges coordinating training and SDM resources for families, individuals, and professionals. The remaining \$2 million portion of the SDM-TAP allocation supports three limited-term positions and technical and program assistance contracts with UCLA Resource Library and UC Davis.

**SDM-TAP Re-appropriation Request.** SCDD states that The SDM-TAP implementation plan originally included contracting plans for additional supports such as an outreach campaign.

However, public invitations for bid were unsuccessful. Moreover, several successful grantees included plans in their proposals that will provide some of the outreach the SCDD intended to conduct via a contractor.

SCDD anticipates approximately \$507,000 in remaining program funds will be available for re-appropriation into 2025-26. The funding will be used for additional contracts for statewide warm line services, regional center trainings, translation of materials and informational resources into threshold languages (e.g., Spanish, Chinese, and Tagalog), and support of limited-term personnel into 2025 to oversee grant project closeout and manage the review and publishing of the evaluation study. Additionally, the amount of grant funding available for expenditure will support small-scale, supplemental grant project request(s) among current grantees.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests SCDD respond to the following:

1. Please provide an overview of the re-appropriation request for the Supported Decision-Making Technical Assistance Program.
2. What is the status of SCDD’s federal grant funding under the federal Health and Human Services department?

**5160 DEPARTMENT OF REHABILITATION**

**Issue #1: Department of Rehabilitation Budget Overview**

**Department of Rehabilitation – Governor’s Budget.** The Department of Rehabilitation (DOR) provides employment and independent living services for over 150,000 individuals with disabilities. The Governor’s proposed 2025-26 budget includes \$582.6 million (\$86.6 million General Fund) for DOR. The majority of DOR’s budget comes from federal funds (\$480.9 million General Fund), followed by General Fund and some special fund and reimbursements. DOR’s budget summary is included below:

	<b>2024-25</b>	<b>2025-26</b>	<b>Difference</b>
<b>Vocational Rehabilitation Services</b>			
General Fund	\$77,985,000	\$78,918,000	\$933,000
Vending Stand Fund	\$3,361,000	\$3,361,000	\$0
Federal Trust Fund	\$458,590,000	\$464,587,000	\$5,997,000
Reimbursements	\$8,080,000	\$8,080,000	\$0
Opioid Settlements Fund	\$2,993,000	\$0	(\$2,993,000)
<b>Total, Vocational Rehabilitation Services</b>	<b>\$551,009,000</b>	<b>\$554,946,000</b>	<b>\$3,937,000</b>
<b>Independent Living Services</b>			
General Fund	\$12,354,000	\$7,693,000	(\$4,661,000)
DDTP Admin Committee Fund	\$3,657,000	\$3,657,000	\$0
Federal Trust Fund	\$16,195,000	\$16,272,000	\$77,000
HCBS ARP Fund	\$139,000	\$0	(\$139,000)
<b>Total, Independent Living Services</b>	<b>\$32,345,000</b>	<b>\$27,622,000</b>	<b>(\$4,723,000)</b>
<b>Total Funding</b>			
General Fund	\$90,339,000	\$86,611,000	(\$3,728,000)
DDTP Admin Committee Fund	\$3,657,000	\$3,657,000	\$0
Vending Stand Fund	\$3,361,000	\$3,361,000	\$0
Federal Trust Fund	\$474,785,000	\$480,859,000	\$6,074,000
Reimbursements	\$8,080,000	\$8,080,000	\$0
Opioid Settlements Fund	\$2,993,000	\$0	(\$2,993,000)
HCBS ARP Fund	\$139,000	\$0	(\$139,000)
<b>Total, All Funds</b>	<b>\$583,354,000</b>	<b>\$582,568,000</b>	<b>(\$786,000)</b>

**Background: Department of Rehabilitation.** DOR provides services to over 150,000 Californians with disabilities annually to obtain, retain, and advance in employment with competitive wages in integrated settings, and to maximize equality and the ability to live independently in communities of their choice. Major DOR programs include the following:

- **Vocational Rehabilitation (VR) Program.** The Vocational Rehabilitation Program delivers vocational rehabilitation services to individuals with disabilities through

vocational rehabilitation professionals in district and branch offices located throughout the state, so that individuals with disabilities may prepare for and engage in competitive integrated employment and achieve economic self-sufficiency. VR services are funded with 78.7 percent federal dollars and 21.3 percent matching funds, part of which are provided by General Fund and part by public agencies through DOR's cooperative program agreements. The 2023 Budget Act included an increase of \$180 million in federal fund authority over three fiscal years (\$60 million each year beginning in 2023-24 through 2025-26) to expand Vocational Rehabilitation services, allowing DOR to significantly expand caseloads.

- **Blind/Visually Impaired Programs.** DOR, through its Business Enterprises Program, provides comprehensive training and technical assistance to enable individuals who are blind or visually impaired to support themselves in the operation of vending stands, snack bars, and cafeterias. Prevocational, including employment readiness, services are provided by the Orientation Center for the Blind to individuals with vision loss to prepare them for independent living.
- **Independent Living Program.** DOR administers and supports 28 non-profit independent living centers in communities located throughout California. Each Independent Living Center provides services necessary to assist individuals with disabilities to live independently with full inclusion in their communities. Core services consist of information and referral, peer counseling, individual and systems change advocacy, independent living skills, housing assistance, personal assistance referral services, transition and diversion services to community-based living, and transition services to postsecondary life for youth.
- **Traumatic Brain Injury (TBI) Program.** DOR administers and supports the Traumatic Brain Injury (TBI) Program. In coordination with individuals and their families, six service state funded centers throughout California provide a coordinated post-acute care service model for individuals with TBI.
- **Assistive Technology (AT) Program.** DOR administers the California AT Program through federal Assistive Technology Act of 2004 funds and Social Security Reimbursement funds. The AT Program includes device lending and demonstrations, equipment reutilization, and AT information and referral and technical assistance.
- **Voice Options Program.** Through a partnership with the California Public Utilities Commission's Deaf and Disabled Telecommunications Program, DOR's Voice Options program provides eligible Californians who are unable to speak, or who have difficulty speaking, with a free speech-generating device. The goal of this program is to ensure full and equal telephone communications access for all Californians with disabilities.

**Outcomes of Recent Limited-Term DOR Programs.** Several recent DOR programs funded with limited-term funds are winding down in 2024-25. The programs include:

- **TBI Program Expansion.** DOR expanded the capacity of existing TBI sites and stood up six new TBI sites in alignment with American Rescue Plan Act (ARPA) Home and Community-Based Services (HCBS) Spending Plan funding. The HCBS Spending Plan included \$5 million total for the TBI expansion. DOR used the increased funding to expand the capacity of TBI program sites in underserved areas in 33 counties. DOR expended its full \$5 million HCBS allocation and reports that the TBI program sites continue to provide services through DOR’s ongoing TBI grant funds.
- **Community Living Fund.** The 2022 Budget Act included \$10 million General Fund one-time, available over three years to assist eligible older adults and persons with disabilities in transitioning from nursing homes to independent living. In November 2024, seven months prior to the program’s end date, the goal to serve 1,360 consumers was met. As of January 2025, DOR served 1,413 individuals with institutional transition and diversion services through grants with 33 community-based organizations throughout the state. Of those that were served, 1,236 individuals received services to prevent them from going into an institutional setting, and 177 individuals received services to transition from an institution to independent living in the community. DOR receives an average of 108 requests per month and currently has 113 consumers on the waitlist. DOR anticipates to fully expend the fund. While the one-time funding will end in June 2025, DOR’s goal is to ensure that individuals with disabilities can continue to receive the support they need, either through alternative funding or community resources.
- **Employment in Recovery Program.** DOR received \$4 million from the Opioid Settlements Fund to administer the Integrating Employment in Recovery program. This program provides training to the provider workforce on evidence-based practices to serve people with substance use disorders (SUD) related to opioid use. The training focuses on incorporating the full range of vocational rehabilitation services into treatment delivery as part of a whole-person approach to recovery. To date, 2,940 individuals in treatment received vocational programming including workshops on career exploration, resume development, interview techniques, and instruction on self-advocacy; 550 individuals directly applied for the full scope of vocational services to include educational support after treatment; and 660 professionals were trained in the efficacy of including vocational rehabilitation services during treatment. In addition, all DOR direct service staff were trained in serving individuals with substance use disorders. DOR anticipates to fully expend the funding.

**Control Sections 4.05 and 4.12.** The 2024 Budget Act included two control sections (Control Section 4.05 and Control Section 4.12) that aimed to implement efficiencies across state agencies in order to produce ongoing General Fund savings without adverse effects on state services. Both control sections established statewide administrative exercises led by the Department of Finance to (1) identify efficiencies in each department and (2) eliminate vacant positions and related funding.<sup>9</sup>

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<sup>9</sup> Legislative Analyst’s Office, “The 2025-26 State Budget: State Departments’ Operational Efficiencies (Control Sections 4.05 and 4.12), February 19, 2025.

DOR has identified 66.5 currently vacant positions and \$11.37 million in vacant position reductions and \$649,000 General Fund from state operations reductions in 2025-26. Of the \$11.37 million identified in vacant position funds, \$2.39 million is General Fund and \$8.983 million is matching federal funds. According to DOR, the department anticipates minimal impact to core services and is prioritizing consumer-facing services to ensure continuity of support.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of DOR’s budget and caseload proposed in the 2025-26 Governor’s budget. Additionally, please provide a brief overview of how the department is implementing state operations and vacancies reductions pursuant to Control Sections 4.05 and 4.12 of the 2024 Budget Act.
2. Please provide a brief overview of one-time programs that are winding down in the current year, including the Traumatic Brain Injury program expansion, Integrating Employment in Recovery, and the Community Living Fund.

**4170 DEPARTMENT OF AGING**

**Issue #1: California Department of Aging Budget Overview**

**California Department of Aging – Governor’s Budget.** The California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. The 2025-26 Governor’s Budget includes \$404.4 million (\$164.7 million General Fund) for CDA. The majority of CDA’s budget is supported by federal Older Americans Act funding (\$208 million). Approximately 87 percent of CDA’s overall budget is local assistance funding.

**3-YEAR EXPENDITURES AND POSITIONS †**

	Positions			Expenditures		
	2023-24	2024-25	2025-26	2023-24*	2024-25*	2025-26*
3890 Nutrition	41.3	44.9	44.9	\$219,339	\$228,996	\$224,166
3895 Senior Community Employment Service	1.2	3.8	3.8	3,197	20,996	7,800
3900 Supportive Services	80.8	85.3	85.3	312,875	147,949	127,331
3905 Community-Based Programs and Projects	12.1	9.7	9.7	17,477	21,733	19,138
3910 Medi-Cal Programs	63.6	65.9	69.9	64,350	14,260	16,990
3915 Policy & Planning	43.1	55.0	55.0	17,680	13,767	8,962
9900100 Administration	-	-	-	-	-	-
9900200 Administration - Distributed	-	-	-	-	-	-
<b>TOTALS, POSITIONS AND EXPENDITURES (All Programs)</b>	<b>242.1</b>	<b>264.6</b>	<b>268.6</b>	<b>\$634,918</b>	<b>\$447,701</b>	<b>\$404,387</b>
<b>FUNDING</b>				<b>2023-24*</b>	<b>2024-25*</b>	<b>2025-26*</b>
0001 General Fund				\$272,812	\$167,331	\$164,697
0289 State HICAP Fund				4,392	4,582	4,832
0890 Federal Trust Fund				221,579	218,061	208,285
0942 Special Deposit Fund				2,232	3,233	1,234
0995 Reimbursements				22,274	24,737	24,939
3098 State Department of Public Health Licensing and Certification Program Fund				400	4,650	400
8507 Home & Community-Based Services American Rescue Plan Fund				111,229	25,107	-
<b>TOTALS, EXPENDITURES, ALL FUNDS</b>				<b>\$634,918</b>	<b>\$447,701</b>	<b>\$404,387</b>

† Savings resulting from SEC. 4.05 and/or SEC. 4.12 of the 2024 Budget Act are currently being recorded as an unallocated statewide set-aside. As a result, this department’s budgetary displays may reflect overstated expenditures and may also potentially reflect negative fund balances in particular programs and funds.

**Background: California Department of Aging.** As the federally designated State Unit on Aging, CDA administers federal Older Americans Act (OAA) programs, the Health Insurance Counseling and Advocacy Program (HICAP), and two Medi-Cal programs, the Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS). CDA administers most of these programs through contracts with the state’s 33 local Area Agencies on Aging (AAA). At the local level, AAAs contract for and coordinate this array of community-based services to older adults, adults with disabilities, family caregivers, and residents of long-term care facilities.

CDA is the lead department on the state's Master Plan for Aging, a comprehensive framework to prepare the state for the growth of the 60-and-over population to 10.8 million people by 2030. Major CDA programs include:

- **Home and Community Living Programs.** Home and community-based services support older adults, people with disabilities, and family caregivers in the setting of their choice. CDA works with 33 AAAs, 11 Caregiver Resource Centers, 286 Community-Based Adult Services (CBAS) Centers, and 37 Multipurpose Senior Services Program (MSSP) sites through contracting, budget setting, program guidance, monitoring and oversight, technical assistance, and quality assurance. This includes senior nutrition programs, such as Meals on Wheels and congregate meal sites.
- **State Long-Term Care Ombudsman (LTCO).** The LTCO seeks to resolve problems and advocate for the rights of residents of long-term care facilities. The LTCO oversees 35 local ombudsman programs consisting of 249 paid staff and 384 volunteers who advocate on behalf of residents of long-term care facilities.
- **Aging and Disability Resource Connections (ADRCs).** ADRCs are coordinated networks of local providers that serve as community access point for older adults, people with disabilities, and caregivers navigating long-term services and supports. ADRC partnerships provide core service functions (Enhanced Information & Referral, Options Counseling, Short-Term Service Coordination, and Facility-to-Home Transition Services) using person-centered practices that empower individuals to make informed decisions and exercise control over their long-term care needs. There are currently 17 designated ADRCs.
- **Office of the Long-Term Care Patient Representative.** The Office of the Long-Term Care Patient Representative provides trained representatives for long-term care residents who may need medical treatment but lack the capacity to make health care decisions and have no legal surrogate authorized to make decisions on their behalf.

**CA2030 initiative.** In 2022, CDSS initiated the CA2030 initiative, with the goal of reimagining California's aging network based on statewide survey data about what is important to older Californians. CDA and the California Health and Human Services Agency (CalHHS) plan to put forward a set of policies to modernize the network of local AAAs and strengthen the governance system, set performance standards, standardize the delivery of services across the state, and make the system easier to navigate for older Californians and caregivers across the system. Over the course of 2024, CDA met with AAAs to focus on updating AAA designations, updating formulas, and standardizing core services. CDA plans to draft regulations to continue implementing the CA2030 initiative and strengthen the AAA network.

**Home and Community Based Services Spending Plan.** California's federal Home and Community-Based Services (HCBS) Spending Plan included \$365 million in federal HCBS funds for programs and initiatives administered by CDA. HCBS investments included technology for seniors and persons with disabilities (\$50 million), nutrition infrastructure (\$40 million), caregiver workforce training and stipends (\$150 million), and other programs such as expansions of senior

nutrition programs, ADRCs, senior legal services, and fall prevention and home modifications. HCBS funds expired March 31, 2025, and CDA and local partners expended 91 percent across local investments. The funding unable to be spent by the deadline was transferred to CDSS to fill the funding gap created by overspending in the IHSS Career Pathways Program.

The AAAs continue to spend down the final year of American Rescue Plan Act (ARPA) funds. CDA was allocated \$138 million in ARPA funding, and the funding expires September 30, 2025. This ARPA funding is distinct and different from the HCBS Spending Plan.

**Older Californians Act Modernization.** The 2022 Budget Act included \$186 million General Fund over five years to restore supports and services for older adults that were reduced during the last recession, including senior nutrition programs, family caregiver supports, volunteer development programs, and aging in place programs. This funding will support maintaining current service levels for core services, such as congregate and home-delivered meals, as federal HCBS and ARPA funds expire in 2025.

**2024 Budget Act.** The 2024 Budget Act included the following significant changes under CDA:

- **Long-Term Care Ombudsman Funding.** The 2024 Budget Act drew \$4.25 million from the California Department of Public Health Licensing and Certification Program Fund in 2024-25 to supplement the Long-Term Care Ombudsman Program. The budget also increased the amount available for the Long-Term Care Ombudsman Program from the State Health Facilities Citation Penalties Account in 2024-25 and ongoing. CDA reports that with this increase in funding, local ombudsman programs have been able to hire additional staff, increase hours, and purchase needed equipment and vehicles to facilitate ombudsman visits.
- **CDA Reductions.** To address the deficit, the 2024 Budget Act cut \$43.4 million General Fund over three years for the Older Adult Behavioral Health Initiative and \$11.9 million General Fund to cancel a home health pilot program.

**Control Sections 4.05 and 4.12.** The 2024 Budget Act included two control sections (Control Section 4.05 and Control Section 4.12) that aimed to implement efficiencies across state agencies in order to produce ongoing General Fund savings without adverse effects on state services. Both control sections established statewide administrative exercises led by the Department of Finance to (1) identify efficiencies in each department and (2) eliminate vacant positions and related funding.<sup>10</sup>

CDA has identified 3 currently vacant positions and \$361,000 vacant position reductions and \$1.2 million General Fund from state operations reductions in 2025-26.

**Status of Federal Funds.** The federal government has moved to eliminate the Administration for Community Living (ACL), which administers Older American Act funding to states. CDA

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<sup>10</sup> Legislative Analyst's Office, "The 2025-26 State Budget: State Departments' Operational Efficiencies (Control Sections 4.05 and 4.12), February 19, 2025.

currently does not have a regional federal administrator as those staff have been laid off. CDA expects to receive notices of regular federal fund awards in May 2025.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of CDA’s budget and caseload proposed in the 2025-26 Governor’s budget. Additionally, please provide a brief overview of how the department is implementing state operations and vacancies reductions pursuant to Control Sections 4.05 and 4.12 of the 2024 Budget Act.
2. Please provide a status update on the \$4.25 million Licensing and Certification Program funding that was provided to CDA for support of the Long-Term Care Ombudsman Program in the 2024 Budget Act.

**Issue #2: CDA Budget Change Proposals**

**CDA Budget Change Proposals – Governor’s Budget.** The Governor’s proposed 2025-26 budget includes two budget change proposals for CDA:

1. **Health Insurance Counseling and Advocacy Program Administration.** CDA requests \$2.3 million Health Insurance Counseling and Advocacy Program (HICAP) in 2025-26 and 2026-27 to further HICAP modernization efforts, serve more Medicare beneficiaries, and improve service quality and access. This proposal has no impact on the General Fund.
2. **Multipurpose Senior Services Program Case Management Software and Support.** CDA requests \$2.8 million General Fund in 2025-26, \$2.7 million General Fund in 2026-27, and \$1.1 million General Fund in 2027-28 and ongoing to support two positions and to acquire and implement a case management software system for the Multipurpose Senior Services Program (MSSP).

The two proposals are described below.

**Health Insurance Counseling and Advocacy Program (HICAP) Administration**

**Background: HICAP.** HICAP is California’s federal State Health Insurance Assistance Program (SHIP). HICAP offers consumer-oriented Medicare counseling and education services including assistance with enrollment, claims, appeals, coverage issues, and, in some cases, legal assistance with grievances and appeals. Eligibility for HICAP services is limited to Medicare beneficiaries and persons imminent of Medicare eligibility. As of June 2024, over 6.8 million Californians have Medicare coverage. There are currently 26 local HICAP programs in California that provide Medicare counseling and education services. Local HICAP programs largely rely on volunteers, but experienced a sharp decline in volunteers during COVID-19.

In 2021, CDA received limited-term funding to modernize the HICAP program, including funding to increase local staffing to one full-time volunteer coordinator per program, and state operations resources to improve HICAP data management, fiscal oversight, and training and technical assistance. The limited-term positions approved in the 2021 Budget Act were extended in both the 2023 and 2024 Budget Acts. During this time, CDA conducted an analysis evaluating the current HICAP infrastructure and design, and a vision for a more effective HICAP program. CDA is currently working with a contractor on a HICAP Modernization Plan that is expected to be complete in June 2025.

According to CDA, with receipt of the augmentation funding, local HICAPs have begun rebounding their recruitment and training of new volunteer HICAP counselors including 64 new HICAP counselors registered in 2021- 22, 88 in 2022-23 and 84 in 2023-24. However, the number of new HICAP counselors is still below highs observed in years before the COVID-19 pandemic. The augmentation funding has been instrumental in providing stability to local HICAPs and provides necessary resources to recruit, retain, and train volunteer HICAP counselors.

**Staffing and Resources Request.** CDA requests \$2.3 million HICAP Special Fund in 2025-26 and 2026-27 to continue the administrative investments initiated in 2021-22 while CDA continues the HICAP Modernization Plan. According to CDA, continuation of the resources provided in

2021-22 through 2026-27 is crucial to support local HICAP providers with resources to recruit new volunteers and coordinate volunteer activities and for CDA to adequately support and monitor local HICAP programs. The requested positions include the following:

- *Local Assistance Resources.* Local Assistance resources of \$1.8 million will provide stability to local HICAP programs to retain one full-time staff position and/or conduct program activities that support recruiting, training, and coordinating volunteer counselors for the purpose of serving the increasing number of Medicare beneficiaries across the state.
- *State Operations Resources.* CDA requests limited term resources from the HICAP Special Fund for one Research Data Specialist II and two Associate Governmental Program Analysts to continue planning, implementation, and maintenance of CDA's HICAP Modernization Business Plan and Strategic Roadmap:
  - One Research Data Specialist oversees, reviews, updates, and provides recommendations for HICAP data collection and reporting.
  - Two analysts review, monitor, and support local HICAP programs in expending state and federal funds to enhance, develop, and expand the program. These positions are responsible for review of the monthly expenditures, closeouts, and annual budgets to ensure that HICAPs were adequately investing in modernizing and expanding services. One analyst serves as a project lead for the development of new training resources and updating of existing training resources, coordinates in-person and virtual meetings and training events, and provides technical assistance to AAAs and HICAP service providers.

**HICAP Special Fund.** The HICAP Special Fund receives all of its revenue through a \$1.40 fee per person enrolled in a Medicare health care service plan, pursuant to Welfare and Institutions Code 9541.5. The use of this fee revenue deposited into the HICAP Special Fund is limited to the administration of the HICAP program. The 2024 Budget Act included a \$10 million General Fund loan from the HICAP Special Fund.

### **Multipurpose Senior Services Program (MSSP) Case Management Software and Support**

**Background: MSSP.** MSSP is a 1915(c) federal Medicaid Home and Community-Based Services (HCBS) Waiver program that provides services to enable frail older adults to remain in their home or in the community and avoid premature nursing home placement. To be eligible for the program, individuals must be age 65 or older, Medi-Cal eligible, and certified for placement in a nursing facility. MSSP provides social and health care management services to assist individuals to remain in their own homes and communities, including case management, ongoing care coordination, linking participants to community services and resources, and limited purchase of services to prevent or delay institutionalization. At an annual rate of \$5,356 per participant slot per year, MSSP's total annual combined cost of care management and other services is significantly less than the cost of receiving care in a skilled nursing facility.

CDA administers MSSP under an interagency agreement with the Department of Health Care Services (DHCS). CDA's MSSP Bureau is responsible for overseeing all programmatic, fiscal, and service components of local MSSP site operations. As a part of operational and fiscal management, CDA performs regulatory compliance activities including biennial utilization reviews of MSSP sites, deficiency follow-up visits, and providing ongoing training and technical assistance to sites.

CDA currently manually collects and sends review and critical incident data, waitlists, expenditures, and enrollments as part of the fiscal and reporting requirements associated with the administration of the waiver program. Information regarding demographics, services, and fiscal data are critical to the successful administration, quality assurance, and oversight of the program. This data is used to establish and monitor program performance standards, and to provide assurance to the state and federal oversight agencies that the MSSP Waiver is being implemented as approved. Monitoring activities occur through a highly manual process. CDA contracts with 37 local government and private, non-profit agencies as MSSP site providers. MSSP sites use manual Excel spreadsheets to report and track CMS required critical incident reporting and activities, which have resulted in performance measure deficiencies during the annual reporting process to the Centers for Medicare & Medicaid Services (CMS).

Under the CMS final rule, Ensuring Access to Medicaid Services (Final Rule), which goes into effect January 1, 2025, the state is required to operate and maintain an electronic incident management system that identifies, tracks, and trends critical incidents. The new rule will also require secure, HIPAA compliant collection of participant level data cross all contracted providers. This data will need to be then transmitted to DHCS to meet federal reporting requirements. Additionally, CDA must now assume responsibility for the waiver requirement to adjudicate Level of Care (LOC) determinations for all participants. LOC determines program eligibility and enrollment using individual client assessment health/personal information and documentation found in the participants' care management record. California is currently non-compliant with this requirement and must correct this along with the waiver renewal.

According to CDA, in order to provide timely LOC determinations and comply with the Final Rule, CDA staff will need secure, direct access to review participant records and data. As such, CDA requests funding to support acquisition and implementation of statewide case management software to support the CMS waiver requirement, ensuring both participant LOC determinations performed by state-level nursing staff, ensure the ability to come into compliance with the CMS Final Rule, and provide efficiencies and consistency in secure data collection and reporting.

**Staffing and Resources Request.** CDA requests CDA requests \$2.8 million General Fund in 2025-26, \$2.7 million General Fund in 2026-27, and \$1.1 million General Fund in 2027-28 and ongoing to support two positions and to acquire and implement a case management software system for MSSP.

Limited-term project costs of \$5.46 million over 2025-26 and 2026-27 include software, implementation services, organization change management services, project oversight, independent verification and validation services, and staff resources. Annual recurring costs of \$1.14 million include software, professional services, and staff resources. According to CDA, the two requested positions will provide business management and technical assistance, as follows:

- **Technical Architect (IT Specialist II):** This position will be a liaison between the solution vendor IT team and CDA. The IT Specialist II will be the main CDA point of contact for ensuring configuration, application development, interface development, testing, and development activities are managed to plan. Post implementation, the IT Specialist II will continue to support the MSSP program, provide product management and technical support functions, including leading and mentoring junior staff responsible for day-to-day solution support. The IT Specialist II will continue to be the primary point of contact and manage the relationship with the solution vendor and coordinate system changes, upgrades, and resolve support issues.
- **Health Program Specialist (HPS) II:** This position will serve as the Access Rule program lead and liaison between the software vendor, DHCS, and MSSP sites. Their role will include responsibility for system testing to ensure accuracy of documentation and the case management and data collection process. This position will work with the vendor to review outputs during program development and ensure the new federal reporting requirements are met, such as waitlist information (42 CFR §441.311), the average amount of time from when services were approved to when they actually started being delivered, and an electronic grievance system (42 CFR §431.301(c)(7)). This resource is responsible for ensuring that any future case management database updates meet state and federal technical requirements through the implementation phase.

CDA states that it is critical for the department to initiate this project now due to the time it will take to plan, procure, pilot, test, and fully implement the software, which will be in effect by 2027-28 at all 37 MSSP sites. CDA plans to initiate the project in September 2025 and for the project to take approximately 18 months, with a February 2027 project finish. The project will transition to operations beginning March 2027.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the two budget change proposals included in this issue: (A) HICAP Administration funding and (B) MSSP Case Management Software and Support.

**4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT****Issue #1: Department of Community Services Budget Overview and Budget Change Proposals**

**Department of Community Services and Development -- Governor's Budget.** The Governor's budget proposes \$350.6 million (\$1 million General Fund) for the Department of Community Services and Development (CSD). CSD is a federally funded department, with the vast majority of CSD's budget supported by federal funds (\$343.9 million) and federal reimbursements (\$5.6 million).

**Background: Department of Community Services and Development (CSD).** CSD is responsible for administration of federal energy assistance programs for low-income households. The Low Income Home Energy Assistance Program (LIHEAP) provides financial assistance to eligible low-income households to offset the costs of heating and/or cooling residential dwellings, assistance for weather-related or energy-related emergencies, and weatherization services to improve the energy efficiency of low-income residential dwellings. The Low-Income Weatherization Program (LIWP) provides energy efficiency and renewable energy services in low-income single-family farmworker and multi-family dwellings to reduce greenhouse gas emissions and lower energy costs. LIWP projects include energy efficient weatherization and solar photovoltaic system installations.

CSD also is the administrative entity for the federal Community Services Block Grant, which enables local government and nonprofit community organizations to support low-income families achieve and maintain economic security through activities such as education, employment services, emergency services, housing, income support and management, and health and nutritional services, among others.

**Budget Change Proposals – Governor's Budget.** The Governor's proposed 2025-26 budget includes two budget change proposals for CSD:

- 1. Proposition 4: LIWP Farmworker Housing Component.** CSD proposes \$200,000 Proposition 4 Funds in 2026-27, and \$10 million ongoing Proposition 4 Funds, to support the LIWP Farmworker Housing Component. This component represents CSD's portion of the \$10 billion Proposition 4 spending plan.
- 2. LGBTQ Disparities Reduction Act (AB 1163) Augmentation.** CSD requests an augmentation of \$1.06 million General Fund to implement statewide data collection system changes to comply with AB 1163 (Luz Rivas, Chapter 832, Statutes of 2023.)

The two budget change proposals are described below.

**Proposition 4: LIWP Farmworker Housing Component.**

**Background: Proposition 4.** The Safe Drinking Water, Wildfire Prevention, Drought Preparedness, and Clean Air Bond Act of 2024 (Proposition 4 or the Climate Bond), approved by voters in November 2024, authorizes \$10 billion to protect communities and nature from the impacts of climate change, such as drought, flooding, wildfire, extreme heat, and sea level rise; to

reduce or remove carbon pollution where possible; and in some cases address existing environmental challenges exacerbated by climate change. The Administration proposes \$2.7 billion in Climate Bond funds in 2025-26. This item only pertains to the \$10 million in Proposition 4 funds proposed under CSD. The full Proposition 4 spending proposal is covered by Subcommittee #2 on Resources, Environmental Protection, and Energy.

**LIWP Farmworker Housing Component.** CSD's Low-Income Weatherization Program (LIWP) provides low-income households with solar photovoltaic systems and energy efficiency upgrades at no cost to residents. The program reduces greenhouse gas emissions and household energy costs by saving energy and generating clean renewable power. The energy efficiency improvements, funded by LIWP, reduce energy costs and provide a long-term solution for low-income households that might struggle to afford heating and cooling their home. There are currently two LIWP program components in operation, the LIWP Multifamily Component and the LIWP Farmworker Housing Component.

The LIWP Farmworker Housing Component has been in operation since 2017 and targets vulnerable farmworker households across 18 counties with high farmworker populations. Low-income farmworkers pay a large share of their income on energy expenses and often cut back on other critical needs to pay their energy bills. The energy efficiency upgrades and solar systems funded by the Farmworker Housing Component reduce energy bills, provide access to cost-saving, clean renewable energy, and improve the health and safety of residences owned or rented by farmworkers. The energy efficiency upgrades can include central heating and cooling, appliances (refrigerators, freezer, washers, and dryers), window replacements, insulation, water heaters, lighting, and rooftop solar systems, among other measures.

Proposition 4, the Safe Drinking Water, Wildfire Prevention, Drought Preparedness, and Clean Air Bond Act of 2024, provides \$10 million to support the LIWP Farmworker Housing Component.

### **LGBTQ Disparities Reduction Act (AB 1163) Augmentation.**

**Background: AB 1163.** AB 1163 (Luz Rivas), Chapter 832, Statutes of 2023, requires CSD to collect voluntary self-identification information pertaining to sexual orientation, gender identity, and intersexuality while collecting demographic data from applicants applying for services funded by the federal Community Services Block Grant (CSBG).

According to CSD, in order to collect these new data elements, CSD must make modifications to its third-party data collection system and the intake systems of the 60 local CSBG sub-grantees.

**Staffing and Resources Request.** The 2024 Budget Act appropriated \$943,000 General Fund one-time for local CSBG agencies to comply with AB 1163. Based on further analysis of surveys completed by CSBG agencies, CSD has determined that the total cost of compliance with AB 1163 is \$2 million. As such, CSD requests an additional \$1.057 million General Fund one-time to complete necessary system modifications.

According to CSD, with the requested funding, CSD will be able to update its current data systems and the data systems of CSBG sub-grantees to facilitate the collection of self-identification information pertaining to sexual orientation, gender identity, and intersexuality demographic data pursuant to AB 1163.

**Status of CSD Federal Funds.** As of April 15, 2025, California has received \$215,756,159 in LIHEAP funding for Federal Fiscal Year 2025. This funding was appropriated by Congress in September 2024 under a partial year continuing resolution. The amount appropriated for LIHEAP under the continuing resolution was equal to about 90 percent of what was appropriated to LIHEAP in Federal Fiscal Year 2024. Congress passed a continuing resolution on March 14, 2025 that funds the federal government for the 2025 Federal Fiscal Year at 2024 levels. CSD is awaiting details of additional LIHEAP grant awards for 2025.

For the Community Services Block Grant (CSBG), California has received \$33,847,608 in CSBG funding as of April 15, 2025 for federal fiscal year 2025. This funding was appropriated by Congress in two partial year continuing resolutions passed in September and December 2024. The amount appropriated for CSBG under these two continuing resolutions was equal to about 50 percent of what was appropriated for CSBG in federal fiscal year 2024.

Congress passed a continuing resolution on March 14, 2025 that funds the federal government for the 2025 federal fiscal year at 2024 levels. CSD is awaiting details of additional CSBG grant awards for 2025. When Congress passes a continuing resolution, 90 percent of LIHEAP funds are typically allocated to grantees based on the prior year appropriation amount, with the remaining 10 percent of funding allocated once a final budget is passed. The Office of Community Services (OCS), Administration for Children and Families, U.S. Department of Health and Human Services determines the amount of funds to be allocated to LIHEAP grant recipients and makes funds available.

The federal government recently laid off the entire LIHEAP division under the federal Office of Community Services (OCS) under the Administration for Children and Families (ACF).

According to CSD, There are two LIHEAP items that will require submission in 2025 that are typically reviewed and approved by OCS. The first item is the 2025 LIHEAP Weatherization Waiver Request. CSD is required under state law to request a waiver to use up to 25 percent of LIHEAP funds for residential weatherization services. The waiver gives LIHEAP grantees the ability to increase the maximum funding allowance for weatherization from 15 percent to 25 percent of the total grant award. CSD is scheduled to submit its 2025 Weatherization Waiver Request after the conclusion of the public comment period on the waiver, which is April 17, 2025.

The second item that will require federal submission is the 2026 LIHEAP State Plan. LIHEAP grantees must submit an annual application for funding, the LIHEAP State Plan, by early September, covering a grant period of October 1 through September 30. Federal approval of the state plan is a condition for receiving LIHEAP funds.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide a brief overview of the two budget change proposals included in this issue (A) Proposition 4 LIWP Farmworker Housing Component, and (B) LGBTQ Disparities Reduction Act (AB 1163) Augmentation.
2. Please describe the status of CSD's federal funds given the move to eliminate the LIHEAP division and Office of Community Services under the federal administration.

**5175 DEPARTMENT OF CHILD SUPPORT SERVICES**

**Issue #1: Department of Child Support Services Budget Overview**

**Department of Child Support Services – Governor’s Budget.** The Governor’s proposed 2025-26 budget includes \$1.2 billion (\$373.7 million General Fund) for the Department of Child Support Services (DCSS). DCSS is funded mainly by federal funds (\$735 million), and Child Support Collections Recovery Fund (\$81.3 million).

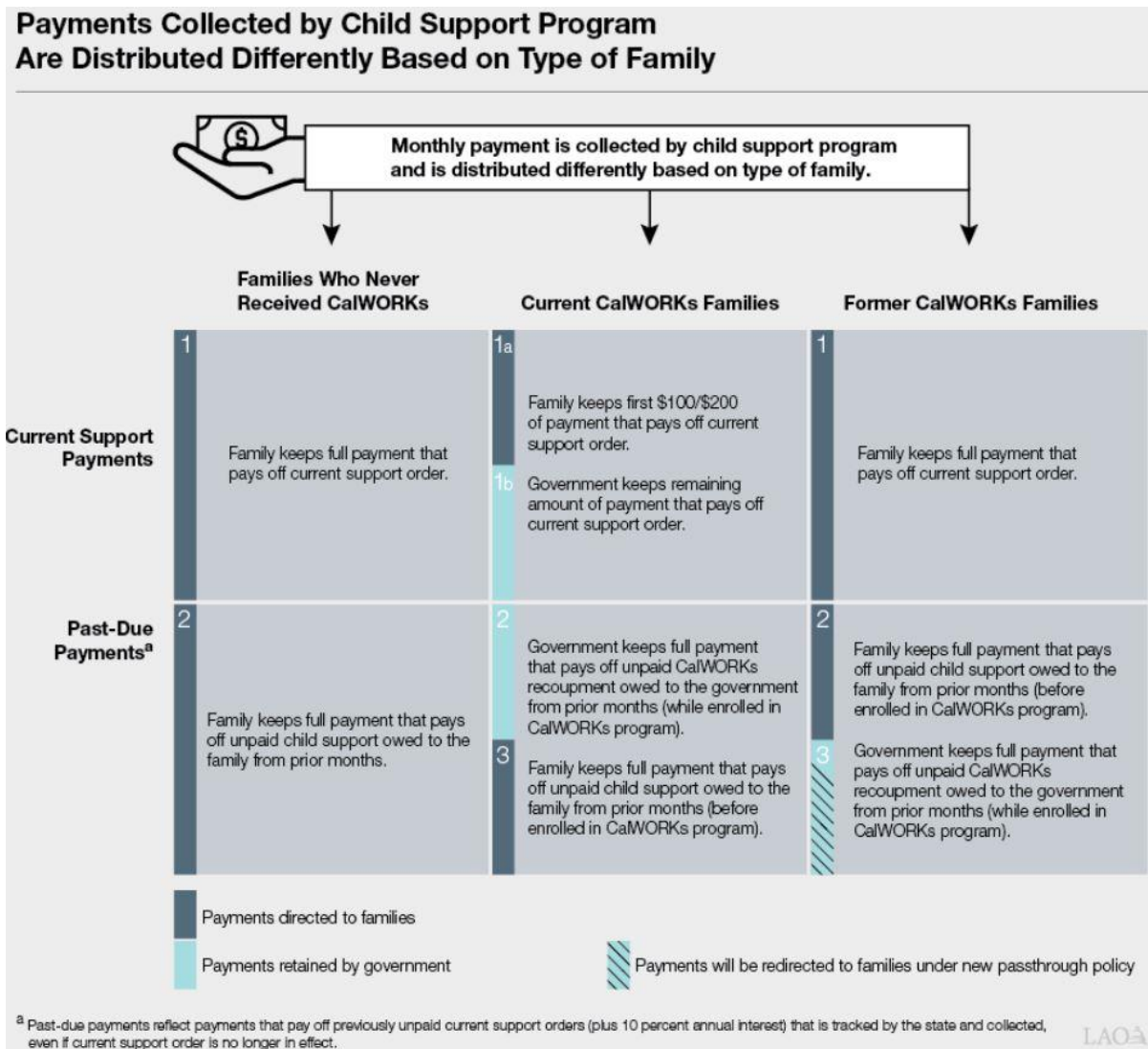
**Child Support Program Highlights**  
(Dollars in Thousands)

	2024-25 Enacted Budget	2025-26 Governor's Budget	Difference
Child Support Program Total	\$ 1,183,362	\$ 1,190,147	\$ 6,785
State Operations	\$ 215,790	\$ 218,058	\$ 2,268
General Fund	\$ 67,192	\$ 67,041	\$ (151)
Federal Fund	\$ 148,475	\$ 150,894	\$ 2,419
Reimbursements	\$ 123	\$ 123	\$ -
Local Assistance Administration	\$ 894,535	\$ 899,052	\$ 4,517
General Fund	\$ 281,896	\$ 281,837	\$ (59)
Federal Fund	\$ 550,202	\$ 534,754	\$ (15,448)
Child Support Collections Recovery Fund	\$ 62,437	\$ 81,284	\$ 18,847
Section 1115 (Federal Grants)	\$ -	\$ 1,177	\$ 1,177
Local Assistance Automation	\$ 73,037	\$ 73,037	\$ -
General Fund	\$ 24,832	\$ 24,832	\$ -
Federal Fund	\$ 48,205	\$ 48,205	\$ -
Program caseload	1,058,447	1,020,026	(38,421)
State Positions	699.2	699.2	-
LCSA Positions	5,481.9	5,390.1	(91.7)

**Background: Department of Child Support Services.** The child support program is a federal-state program that establishes, collects, and distributes child support payments to participating parents with children. These tasks include: locating parents; certifying paternity; establishing, enforcing, and modifying child support orders; and collecting and distributing payments. In California, the child support program is administered by 47 county and regional local child support agencies (LCSAs), in partnership with local courts. Local program operations are overseen by DCSS.

Approximately 75 percent of child support cases are comprised of families who receive or formerly received cash aid from the CalWORKs program. Under federal law, when a parent applies for CalWORKs cash aid (and is not living with the other parent), they generally are required to open

a child support case and sign over a portion of their child support payments to the state. The state retains this portion as reimbursement toward the total government costs for the cash aid the family received under the CalWORKs program. This process of retaining child support payments to offset CalWORKs costs is referred to as CalWORKs recoupment. The CalWORKs recoupment payments are generally split between the state (roughly 50 percent), counties (roughly five percent), and federal government (roughly 45 percent). The state’s share of CalWORKs recoupment is accounted for as General Fund revenue. The following figure, provided by the Legislative Analyst’s Office (LAO), illustrates how current support and past-due payments are directed to the family or government, depending on whether the family is currently receiving, or has ever received, CalWORKs cash aid.



Source: Legislative Analyst’s Office

The Legislature has moved in recent years to end the practice of intercepting child support payments from low-income families receiving CalWORKs. Current practices differ whether a family formerly received CalWORKs (formerly assisted families), or is currently receiving CalWORKs (currently assisted families).

- **Formerly assisted families:** As part of the 2022 Budget Act, the state ended the practice of intercepting child support payments from families who were formerly enrolled in CalWORKs. This change took effect May 2024.
- **Currently assisted families:** In addition to ending the interception of child support payments for formerly assisted CalWORKs families, the 2022 Budget Act included trigger language to implement a full pass-through of child support payments to families currently receiving CalWORKs assistance. This was subject to an evaluation of General Fund availability by the Department of Finance (DOF) in spring 2024 (May Revision). Due to the deficit, the trigger was not activated in 2024, which means the state continues to intercept child support payments from families currently receiving CalWORKs.

**2024 Budget Act.** The 2024 Budget Act included the following changes related to DCSS:

- **Local Child Support Agency (LCSA) Reductions.** The 2024 Budget Act reduced funding for local child support agencies by \$6 million General Fund in 2023-34, 2024-25, and 2025-26 to align with recent expenditures.
- **Child Support Full Pass-through.** Supplemental report language requires DCSS to report to the Legislature on the infrastructure and other implementation components necessary to effectuate the full pass-through of child support to families currently receiving CalWORKs.

**Implementation of Pass-Through for Formerly Assisted Families.** Based on updated estimates, DCSS estimates formerly assisted arrears pass-through to be \$118 million total funds in 2024-25, and \$118.4 million total funds in 2025-26. In comparison with the enacted budget, the formerly assisted arrears pass-through estimate was reduced by \$47.5 million total funds, or 29 percent. Since implementation, between May 2024 and March 2025, \$88.7 million in former assistance collections has passed through to the families of nearly 75,000 cases.

**LCSA Spending.** The 2023-24 allocation for LCSAs was \$876.2 million, of which \$834.3 million, or 95.2 percent, was spent or obligated. Expenditures will be finalized in the spring 2025. The \$41.8 million in total savings does not account for the mandated early reversions of \$17.6 million (\$6 million General Fund) pursuant to the 2024 Budget Act. Additionally, \$5.01 million was reallocated across LCSAs, \$3.1 million reallocated to technology refresh, and \$3.4 million was reallocated for LCSA special depreciation of capital asset purchases.

In 2024-25, the LCSA allocation is \$858.5 million. LCSAs have expended \$539.9 million as of February 2025. DCSS has reallocated \$6.8 million of these savings to other LCSAs, \$6.3 million to technology refresh needs, and \$2.2 million for special depreciation. DCSS expects LCSAs to generate savings in 2024-25 as the budget reductions were scheduled for two years, while LCSA staffing costs are expected to increase in 2025-26. As such, LCSAs must generate savings in order to absorb cost increases.

**Uncollectible Debt.** The 2021 Budget Act included trailer bill language to cease enforcement of state-owed child support arrearages determined to be uncollectible. DCSS has already

implemented some sections of the statute regarding case participants that solely receive CAPI/SSI/SSP/SSDI/Veteran Disability Compensation. DCSS has contracted with UC San Diego to conduct a collectability study comprised of child support data of current case participants. The collectability study was expected to be completed and shared by DCSS by March 2024. DCSS received the report from UC San Diego, and it is currently under administrative review. Additionally, DCSS is engaging with an LCSA workgroup to gather input from local subject matter experts.

**DCSS State Operations and Vacancies Reductions.** The 2024 Budget Act included two control sections (Control Section 4.05 and Control Section 4.12) that aimed to implement efficiencies across state agencies in order to produce ongoing General Fund savings without adverse effects on state services. Both control sections established statewide administrative exercises led by the Department of Finance to (1) identify efficiencies in each department and (2) eliminate vacant positions and related funding.<sup>11</sup>

DCSS has identified 40 currently vacant positions and \$3.46 million in vacant position reductions (\$1.18 million General Fund and \$2.3 million in matching federal funds) and \$1.14 million General Fund from state operations reductions in 2025-26. According to DCSS, to achieve the state operations reduction, DCSS eliminated discretionary costs such as training, travel, supplies, software, and various discretionary contracts.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests DCSS respond to the following:

1. Please provide a brief overview of DCSS’s proposed budget for 2025-26. How is the department implementing state operations and vacancies reductions pursuant to Control Sections 4.05 and 4.12 of the 2024 Budget Act?
2. Please provide a brief update on the first full year of implementation of the child support pass-through for formerly assisted families.
3. What amount of additional savings from LCSA administrative funding does DCSS expect to materialize in 2024-25?

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<sup>11</sup> Legislative Analyst’s Office, “The 2025026 State Budget: State Departments’ Operational Efficiencies (Control Sections 4.05 and 4.12), February 19, 2025.

**ISSUES FOR NON-PRESENTATION****Issue #1: Proposals for Investment**

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

- **Special Olympics.** The Special Olympics of Northern and Southern California together propose \$68 million General Fund (\$13.6 million General Fund each year for five years) to continue their current statewide program delivery and expand their operations to reach a growing population of individuals with I/DD. If approved, this funding would support the Special Olympics' Unified Champion Schools Program, Healthy Athletes Program, Community Sports Program, and general operating expenses. According to the Special Olympics of California, "services by Special Olympics CA can reduce health care costs and combat health disparities among the I/DD Population with an emphasis on preventative care, create new programming for Adult Day Centers and Regional Centers, supporting inclusion programs in California's public schools to reduce bullying and absenteeism, and bringing opportunities for people with intellectual disabilities to develop and demonstrate their abilities in leadership roles and in the workforce. Special Olympics CA is year-round and no cost to participants and their families." Special Olympics CA received \$30 million General Fund through the California Department of Education (CDE) in the 2022 Budget Act over three years to support these programs. That funding expires June 30, 2025.
- **Supported Decision-Making Technical Assistance Program (SDM-TAP).** Disability Voices United proposes \$3 million General Fund one-time for the State Council on Developmental Disabilities (SCDD) Supported Decision-Making Technical Assistance Program (SDM-TAP). If approved, this funding would continue grants administered by SCDD under the 2022 Budget Act to promote supported decision-making (SDM) as alternatives to conservatorships. Grant activities include developing free trainings for professionals in the medical, legal, educational, and I/DD fields about SDM and individual coaching to educate people with I/DD and their families about Supported Decision-Making, craft agreements, and overcome obstacles. According to Disability Voices United, "Demonstrating the need for Supported Decision-Making education and the interest in this topic, [SCDD] received grant requests totaling \$8.5 million, however only \$3 million was available. Some examples of grant programs that weren't funded include support for individuals in group homes; standardized training development for IDD professionals such as regional center service coordinators; training for parents of children just entering the education system; and targeted outreach to rural, BIPOC and other underserved communities. The overwhelming interest in grant funding demonstrates the ongoing need to invest in Supported Decision Making education and promotion and shows the critical need for additional State investment to continue the program. Increasing awareness of Supported Decision Making and breaking down barriers for mainstream knowledge and acceptance will be a long-term driver of reduced costs to the State. By choosing options that keep families out of the court system, the courts can benefit from reduced workload and refined ability to focus resources where they are most needed."

- **Utilizing Special Fund Reserves for Long-Term Care Ombudsman Program Mandates.** The California Long-Term Care Ombudsman Association (CLTCOA) proposes \$15.9 million Special Funds (State Citations Account and Licensing and Certification Program Fund) ongoing to support the Long-Term Care Ombudsman Program. If approved, this funding would increase baseline funding for reach local ombudsman program from \$100,000 to \$200,000 – enabling local long-term care ombudsman programs to hire up to 100 additional staff and recruit, train, and supervise up to 500 additional volunteers to conduct ombudsman activities. Activities include unannounced facility visits, abuse and neglect investigations, and other essential ombudsman activities. According to CLTCOA, “Currently, Ombudsmen are unable to respond timely to many complaints or visit all facilities quarterly as required by federal and state law. Twenty eight percent of skilled nursing and fifty one percent of assisted living facilities are not receiving quarterly unannounced visits due to an ongoing lack of staff and volunteers. Despite losing 53 percent of the program’s certified volunteers since 2014, in no small part due to the COVID-19 pandemic, staffing for the program has not increased past 2019 staffing levels (175 full-time staff). Today, the average paid Ombudsman is responsible for 1,830 long-term care beds while the average volunteer Ombudsman, who only works 8-9 hours per month, is responsible for 885 beds. There are simply not enough staff or volunteer Ombudsmen in California to meet the existing demand for their services.” This proposed investment would build upon the 2024 Budget Act, which drew \$4.25 million one-time from the California Department of Public Health Licensing and Certification Program Fund and increased the amount available for the Long-Term Care Ombudsman Program from the State Health Facilities Citation Penalties Account in 2024-25 and ongoing, to supplement the Long-Term Care Ombudsman Program.
- **Phased Expansion and Sustainability of Aging and Disability Resource Connections (ADRCs) to Support Master Plan on Aging Implementation.** The California Association of Area Agencies on Aging (C4A) and the California Foundation for Independent Living Centers (CFILC) propose \$15 million General Fund ongoing to support emerging ADRCs and expand existing ones. If approved, these funds would support equitable access to long-term services and supports, enable infrastructure growth to ensure all Californians have access to an ADRC, and prevent a zero-sum funding environment to encourage new partnerships. According to C4A and CFILC, “California’s current ADRC network is significantly underfunded, with only \$10 million annually supporting 24 designated and two emerging ADRCs. This amount is insufficient to expand and meet growing demands, especially for regions and populations still unserved or underserved...A phased funding increase beginning with \$15 million in 2025-26 would support emerging ADRCs and expand existing ones, with the goal of building toward full \$62 million statewide funding for a statewide ‘No Wrong Door’ system.”

# SUBCOMMITTEE NO. 3

# Agenda

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



Thursday, May 8, 2025  
9:30 am, or upon adjournment of session  
1021 O Street – Room 1200

Consultant: Elizabeth Schmitt

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**5180 DEPARTMENT OF SOCIAL SERVICES****Issue 1: CalFresh, SUN Bucks, & Food Programs Overview**

The Subcommittee has invited the following individuals to participate in this discussion:

- Jennifer Troia, Director, and Alexis Fernández Garcia, Deputy Director, Family Engagement and Empowerment Division, CDSS
- Sonia Schragger Russo, Fiscal & Policy Analyst, Legislative Analyst’s Office
- Becky Silva, Government Relations Director, California Association of Food Banks

**Governor’s Budget – CalFresh and Food Programs.** The Governor’s proposed budget for 2025-26 includes \$3 billion (\$1 billion General Fund) for CalFresh and food programs administration, across CalFresh, California Food Assistance Program, SUN Bucks, and other food programs. This is in addition to \$12.7 billion in food benefits provided from the federal government directly to individuals outside of the state’s budget. There are no significant changes or new proposals included in the Governor’s proposed 2025-26 budget for CalFresh and food programs.

**Hunger in California.** Data from the US Census Household Pulse Survey shows that as of September 2024, 22 percent of California households are food insecure and 27 percent of California households with children are food secure. Rates of food insecurity are higher than the statewide average for Black and Hispanic/Latino households, including Black households with children (43 percent) and Hispanic/Latino households with children (33 percent).<sup>1</sup>

**Background: food assistance programs.** CalFresh is the state’s main anti-hunger program, alongside several other food assistance programs (including school meals, which are part of the K-12 education budget). Food benefits in California are primarily federally funded and state administered. The state’s main food assistance programs administered by CDSS are described below.

**CalFresh.** CalFresh is California’s version of the federal Supplemental Nutrition Assistance Program (SNAP), an entitlement program that provides eligible households with monthly benefits to purchase food. To be eligible, households must generally earn less than 200 percent of the federal poverty level. CDSS oversees the CalFresh program and each county is responsible for local administration. CalFresh food benefits are 100 percent federally funded and issued through an EBT card. CalFresh administration costs are funded with 50 percent federal funds, 35 percent General Fund, and 15 percent county funds. Monthly benefits per household vary based on household size, income, and deductible living expenses—with larger households generally receiving more benefits than smaller households and relatively higher-income households generally receiving fewer benefits than lower-income households.

**California Food Assistance Program (CFAP).** CDSS also administers the California Food Assistance Program (CFAP), which provides state-funded food benefits to certain eligible noncitizens who do not have eligibility for CalFresh benefits due to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (generally, lawful permanent residents and some other immigration categories,

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<sup>1</sup> California Association of Food Banks, “Food Insecurity in California,” September 2024.

but not undocumented individuals.) To be eligible for CFAP, noncitizens must meet all CalFresh eligibility criteria except for their immigration status. The expansion of CFAP to include all adults age 55 and over regardless of immigration status is slated to implement in 2027, pursuant to a delay agreed upon in the 2024 Budget Act.

**SUN Bucks.** In 2023, Congress created a new permanent entitlement program known as Summer EBT (SUN Bucks in California), which provides a \$120 benefit for low-income children for food during the summer months when children are out of school. Eligibility is tied to free-and-reduced price meal eligibility, and children may be automatically eligible through participation in CalFresh or Medi-Cal. SUN Bucks benefits, like CalFresh, are fully funded by the federal government; with administrative costs split 50 percent federal funds and 50 percent General Fund. California implemented the first year of SUN Bucks in Summer 2024, with 5.6 million children receiving \$672 million in federal SUN Bucks benefits.

**CalFood.** CalFood provides funding directly to food banks to purchase food directly from California farmers and food producers. The baseline budget for CalFood is \$8 million General Fund; however one-time pandemic investments have increased CalFood funding to \$62.7 million annually over the last three years, through 2024-25. More information on the CalFood budget is below.

**Child and Adult Care Food Program.** The Child and Adult Care Food program provides federal reimbursement for meals served in child care and senior care facilities.

**Governor’s Budget – CalFresh and Food Programs.** The Governor’s revised 2024-25 budget for CalFresh and food programs administration includes \$3 billion (\$1.1 billion General Fund) and represents an increase of \$46.3 million (\$3.8 million General Fund) from the Budget Act of 2024, due to faster CalFresh caseload growth than previously projected, partially offset by lower CalFresh Shared Eligibility costs. The Governor’s proposed 2025-26 budget for CalFresh and food program administration includes \$3 billion (\$1 billion General Fund), a net increase of \$17.8 million (decrease of \$11.6 million General Fund) from the Budget Act of 2024. The total fund increase reflects an increase in the CalFresh caseload and updated federal grants for Nutrition Education and CalFresh Outreach; the General Fund decrease reflects lower costs for CalFresh Shared Eligibility and SUN Bucks transactions, as well as the anticipated effects of Electronic Benefit Transfer (EBT) card technology improvements for food benefit theft administration. In addition, \$12.6 billion federal funds in 2024-25 and \$12.7 billion federal funds in 2025-26 will be provided directly to individuals outside of the state’s budget.

**CALFRESH AND NUTRITION PROGRAMS**

Funding (millions)	FY 2024-25 Appropriation	FY 2024-25 Revised Budget	FY 2025-26 Governor’s Budget	FY 2024-25 Change from FY 2024-25 Appropriation	FY 2025-26 Change from FY 2024-25 Appropriation
Total*	\$17,185.1	\$17,482.3	\$17,364.7	\$297.3	\$179.7
Federal	15,504.4	15,801.9	15,693.8	297.5	189.4
State	1,284.4	1,278.5	1,266.3	-5.9	-18.1

\*In addition to federal funds and GF for administration and state funded benefits, the total includes county funds and federal Supplemental Nutrition Assistance Program (SNAP) benefits which are not reflected in the budget. The state funds include CACFP Proposition 98 funding.

Source: CDSS

**Child and Adult Care Food Program (CACFP) Budget.** The Governor’s revised 2024-25 budget for CACFP includes \$667.3 million (\$10.9 million General Fund) and reflects an increase of \$47 million (\$0.3 million in General Fund) from the Budget Act of 2024, reflecting higher participation by children’s and adult day care centers. The Governor’s proposed 2025-26 budget for CACFP includes \$683.1 million (\$10.4 million General Fund) and reflects a net increase of \$62.8 million (decrease of \$0.2 million General Fund) from the Budget Act of 2024, reflecting higher participation by children’s and adult day care centers as well as the anticipated impact of the federal and state Cost-of-Living Adjustment (COLA). The General Fund decrease reflects a projected decline in meals provided under School Food Authorities.

A summary of the Governor’s proposed budget for CalFresh and CFAP is included below:

### CalFresh and CFAP Budget Summary

(Dollars in Millions)

	2024-25	2025-26 Proposed	Change From 2024-25 to 2025-26 Proposed	
			Amount	Percent
<b>CalFresh Households</b>	3,194,500	3,228,200	33,700	1%
<b>CFAP Households</b>	28,900	29,800	900	3
<b>Benefits</b>				
CalFresh Benefits <sup>a</sup>	\$12,602	\$12,746	\$144	1%
CFAP Benefits <sup>b</sup>	130	133	4	3
<b>Subtotals</b>	<b>(\$12,732)</b>	<b>(\$12,880)</b>	<b>(\$148)</b>	<b>(1%)</b>
<b>Administration</b>				
Federal Share	\$1,228	\$1,238	\$10	1%
State Share	902	905	3	—
County Share	348	350	3	1
<b>Subtotals</b>	<b>(\$2,478)</b>	<b>(\$2,493)</b>	<b>(\$15)</b>	<b>(1%)</b>
<b>Totals</b>	<b>\$15,210</b>	<b>\$15,373</b>	<b>\$163</b>	<b>1%</b>

<sup>a</sup>CalFresh benefits are 100 percent federally funded. The Governor’s budget estimates an average monthly benefit of \$328 per household. CalFresh benefits also include replacement benefits. SUN Bucks benefits are excluded from this figure and are included in Figure 3.

<sup>b</sup>CFAP benefits are 100 percent General Fund. The Governor’s Budget estimates an average monthly benefit of \$372 per household. CFAP benefits also include replacement benefits.

CFAP = California Food Assistance Program.

Source: LAO

**CalFresh caseload and benefits.** The Governor’s budget projects CalFresh caseload in 2025-26 will be 3.2 million households, about a one percent increase from 2024-25. CFAP caseload is projected to be 64,538 households, about a 3.7 percent increase from 2024-25. As the LAO has noted, CalFresh and CFAP caseloads have increased by 60 percent since 2019-20, attributed largely due to the expansion of CalFresh

to SSI households, benefit increases and supplements during the pandemic years, and multi-year efforts to increase CalFresh enrollment.<sup>2</sup>

The administration projects that in 2025-26, the average CalFresh benefit is \$328.85 per household (\$190.78 per person). The average CFAP benefit is \$373.59 per household (\$173.55 per person).

**Federal Government has cut about \$100 million in food bank funding in 2025.** The federal government has rescinded funding states use to support food banks and small farmers, reducing California’s resources for fighting hunger. Federal cuts have primarily impacted three programs to date:

- **Local Food Purchase Assistance Program.** The Local Food Purchase Assistance Program (LFPA) is a federal program designed to maintain and improve food and agricultural supply chain resiliency through the procurement of local, domestic, and unprocessed or minimally processed agricultural commodities. Since 2022, this funding has been used to buy locally and regionally produced food for distribution to children and families through schools, food banks, and other community organizations, while enhancing the food supply network. In 2024, California distributed over \$22.3 million to provide over 18.6 million meals to food-insecure Californians.

On March 7, the U.S. Department of Agriculture (USDA) abruptly terminated LFPA funding for federal fiscal year 2025. This termination effectively withholds \$47.28 million in congressionally approved funding committed to California. CDSS has appealed the USDA’s termination of LFPA funds. In its appeal letter to USDA, CDSS notes the termination of LFPA funding will weaken the state’s food supply system and restrict access to fresh produce for millions of low-income Californians.<sup>3</sup> The appeal letter states, “the termination of the LFPA25 Program is not only damaging to California’s farmers, thousands of food insecure families and children and economy; it also appears to be unlawful and must be reversed.”

- **The Emergency Food Assistance Program.** The Emergency Food Assistance Program (TEFAP) is a USDA program that directly distributes food to low-income households through a network of food banks. One component of the TEFAP program, known as TEFAP Commodity Credit Corporation (TEFAP CCC), enables USDA to directly purchase food, make food selections available to states, and then deliver truckloads to food banks who place food orders through their state. TEFAP CCC has been cancelled by the USDA for the 2025 federal fiscal year. Because TEFAP CCC provides direct truckloads of food to states (rather than dollars), the first phase of cancelled TEFAP CCC resulted in the loss of 410 truckloads of food (including high value items such as meat, dairy, eggs, fruit, and vegetables), designated for California food banks. Across the three expected phases of TEFAP CCC, food banks estimate that California has lost approximately \$60 million in food that would have been delivered to Californians in 2025.
- **Emergency Food and Shelter Program.** The Emergency Food and Shelter Program (EFSP) is FEMA-funded program authorized by the McKinney-Vento Homeless Assistance Act of 1987. The program supplements and expands local nonprofits and governments that provide food to

<sup>2</sup> LAO, “The 2025-26 Budget: Food Assistance Programs,” February 19, 2025.

<sup>3</sup> Appeal of the Termination of Local Food Purchase Assistance 2025 Cooperative Agreement: [California-Department-of-Social-Services-LFPA25-Appeal-04042025.pdf](https://www.cdss.ca.gov/Programs/OPDC/Informational/Pages/Social-Services-LFPA25-Appeal-04042025.pdf)

individuals and families experiencing, or at risk of, homelessness. Organizations across California (such as local United Ways and food banks) received approximately \$19 million in 2024. FEMA has put a hold on federal EFSP funds and local organizations are not able to access EFSP funds.<sup>4</sup>

**CalFood funding cliff.** The CalFood program allocates funding to California’s network of food banks to purchase food primarily sourced from California. This funding is vital for food banks to secure food and reduce supply chain issues as demand for food continues at pandemic highs. According to the California Association of Food Banks, each dollar of CalFood funding enables California food banks to provide approximately five meals. Food banks use funds to purchase items that are rarely donated, such as eggs, fresh produce, and proteins. The 2022 Budget Act included \$112 million General Fund total for the CalFood program in 2022-23 and the 2023 Budget Act approved an additional \$52 million General Fund in 2023-24 above the program’s baseline budget (\$8 million).

In 2025-26, the CalFood budget reduces to the baseline of \$8 million (compared to an average of \$62.7 million from 2022-23 through 2024-25). California’s network of food banks is experiencing sustained and heightened levels of demand, serving over six million Californians every month. If the CalFood budget returns to an \$8 million baseline, as proposed in the Governor’s budget, food banks will limit or reduce the amount of food offered per household, and one fifth of food banks would have to close existing food distribution sites, according to the California Association of Food Banks. See Issue #9 for a budget request to increase the CalFood baseline.

**SUN Bucks summer 2024 update.** Summer 2024 marked the first year of the SUN Bucks program in California. The total number of children enrolled in SUN Bucks for summer 2024 was 5.6 million, with approximately 3.75 million children automatically enrolled by CDSS via participation in CalFresh, CalWORKs, or Medi-Cal. As of March 2025, about 77 percent of cards have been activated (meaning a PIN has been selected), and of the \$672 million in total benefits issued, \$515 million have been loaded onto activated cards and \$498 million benefits have been used (representing 97 percent of benefits loaded onto activated cards).

**Governor’s Budget – SUN Bucks administrative hearings.** Federal regulations require the use of a third party to conduct fair hearings for programs administered directly by CDSS. The 2025-26 Governor’s Budget includes \$2.3 million (\$1.1 million General Fund) for a contract with the Office of Administrative Hearings to provide applicants and recipients with access to an impartial hearing for SUN Bucks and the Commodity Supplemental Food Program.

**Governor’s Budget – National Accuracy Clearinghouse.** The federal Food and Nutrition Services is requiring all states to utilize the National Accuracy Clearinghouse, an interstate data matching system, to enhance CalFresh Program integrity. The system helps prevent households from receiving SNAP benefits in more than one state simultaneously. The 2025-26 Governor’s Budget includes \$7.6 million (\$2.7 million General Fund) for automation associated with anticipated use of the National Accuracy Clearinghouse beginning in November 2026.

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<sup>4</sup> CBS News, “[FEMA's emergency food and shelter program paused, impacting Northern California organizations - CBS Sacramento](#),” March 11, 2025.

**CFAP Expansion.** The expansion of CFAP to include previously ineligible immigrants age 55 and older is planned to implement October 2027, due to a delay agreed upon as part of the 2024 Budget Act. The 2023 Budget Act included \$38 million General Fund for automation and outreach associated with the expansion. The 2024 Budget Act shifted some of these funds to 2024-25, and those funds expire on June 30, 2025. In order to align with the 2027 implementation timeline, the remaining unspent funds of the \$38 million for automation and outreach would need to be re-appropriated to 2025-26. See Issue #9 for a budget request to expand CFAP.

**CalFresh Minimum Nutrition Benefit pilot.** The 2023 Budget Act included \$15 million one-time and trailer bill language establishing the California Minimum Nutrition Benefit pilot program, which will provide some CalFresh households with a state supplement to raise the current minimum benefit from \$23 to \$60. CDSS has released policy guidance and anticipates the 12-month pilot to launch January 1, 2026. The focus population is Elderly and Simplified Application Project households, meaning households of two or more older adults or people with disabilities with no earned income. CDSS anticipates the pilot will reach approximately 36,000 individuals statewide who meet this criteria and currently receive less than \$60 in CalFresh benefits per month.

**CalFresh Fruits and Vegetables EBT pilot.** The California Fruit and Vegetable EBT Pilot Project allows CalFresh recipients to double the purchasing power of their CalFresh benefits when they purchase fruits and vegetables at participating retailers. The 2023 Budget Act included \$9.9 million General Fund one-time for this project. The 2024 Budget Act included \$10 million General Fund one-time to continue the project. Due to popularity and demand, the \$10 million from the 2024 Budget Act lasted from November 2024 through the end of January 2025 and the program is now inactive. See Issue #9 for a budget request to increase funding for this program.

**Able-Bodied Adults without Dependents (ABAWD) Federal Rule.** Since 1996 federal welfare reform, someone receiving SNAP (CalFresh in California) who is determined to be an “Able-Bodied Adult Without Dependents,” or ABAWD, is only allowed three months of CalFresh within a 36-month period unless they meet an exemption. Federal changes in the Fiscal Responsibility Act of 2023 increased the ABAWD population to newly include those ages 50-54 and included a variety of additional exemptions to the rule. Due to economic conditions in the state, California currently has a statewide ABAWD waiver in place, which is set to expire on January 31, 2027.

**Governor’s executive order on healthy food.** On January 3, 2025, the Governor issued an executive order directing state agencies, including CDSS, to recommend potential actions to limit the harms associated with “ultra-processed foods” and food ingredients that pose a health risk to individuals.

**Food assistance and disaster relief.** In the aftermath of the January 2025 Los Angeles fires, CDSS moved quickly to activate a variety of food and other assistance programs and measures to support people affected by the disasters, including the following:

- **Disaster CalFresh:** On January 27, 2025, USDA approved Disaster CalFresh (D-CalFresh) operations in Los Angeles County. This approval expands eligibility to people who lived or worked in one of 58 ZIP codes in Los Angeles County. For ongoing CalFresh households, automatic disaster supplements were approved for nine ZIP codes and were issued to impacted households on February 8, 2025.

- **Emergency Food Bank Reserve:** The 2024 Budget Act established the Emergency Food Bank Reserve to provide emergency food during natural or human-made disasters. This allowed CDSS to distribute about a dozen truckloads of emergency food boxes to the LA Regional Food Bank and the Westside Food Bank during the LA fires.
- **Other CalFresh modifications:** CDSS also worked with USDA to automatically replace food benefits in 13 counties, replacing benefits for lost food for over 127,000 households valued at approximately \$17 million. CDSS additionally secured a hot foods waiver for affected households to purchase hot foods.

CDSS also administers the following disaster relief programs, which are not directly related to CalFresh or food:

- **State Supplemental Grant Program (SSGP):** The SSGP is able to provide survivors that have received a Federal Emergency Management Agency (FEMA) maximum grant of \$43,600 with the possibility of an additional up to \$10,000. As of February 2, 2025, 144 households are eligible for a SSGP grant award of \$10,000 for a total of \$1.44 million. At that time, there were 22,984 pending applications with FEMA and 12, 2121 registrants awaiting insurance adjusters.
- **Disaster Case Management Program (DCMP):** The DCMP is a time-limited, scope-limited intervention that provides disaster survivors with a single point of contact to access a broad range of programs, services, and resources to address disaster-caused unmet needs.
- **Immediate Services Program (ISP):** The ISP funds short-term disaster relief and crisis counseling services to help communities in the immediate aftermath of disaster and is available for anyone impacted by the recent Los Angeles wildfires. Contracted counselors began meeting with survivors to provide crisis counseling at the disaster recovery centers and shelters beginning February 1, 2025.

**Subcommittee Staff Comment and Recommendation – Hold Open.** The Governor’s proposed 2025-26 does not contain any major changes to CalFresh and other food programs. Subcommittee staff notes that the return to baseline for CalFood comes at a time when the federal USDA has abruptly cancelled approximately \$100 million in direct food assistance for California – further straining the ability of food banks to meet the needs of food insecure families.

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of the Governor’s proposed 2025-26 budget for CalFresh, CFAP, SUN Bucks, and other food programs.
2. Please provide an overview of the first year of SUN Bucks implementation.
3. Please provide a brief update on Disaster CalFresh, the Emergency Food Bank Reserve, and other food-related supports in response to the fires in Los Angeles.

4. Please describe how the USDA's decision to withdraw funding for food programs is affecting the state, particularly the loss of LFPA and TEFAP CCC funding for 2025. What impacts does the department anticipate these cuts will have on low-income Californians, farmers, and the state's network of food banks?

**Issue 2: SUN Bucks Automation and Cost-Per-Case-Month**

**Budget Change Proposal—Governor’s Budget.** California Health and Human Services Agency (CalHHS) Office of Technology and Solutions Integration (OTSI) requests an increase in expenditure authority of \$86.4 million CalHHS Automation Fund for the operation and administrative costs associated with the federal SUN Bucks Program. This request is for expenditure authority only; funding for SUN Bucks transactions are included in the CDSS budget.

**Background: SUN Bucks.** In 2023, Congress created a new permanent entitlement program known as Summer EBT (SUN Bucks in California), which provides a \$120 food benefit for low-income children during the summer months when children are out of school. Eligibility is tied to free-and-reduced price meal eligibility, and children may be automatically eligible through participation in CalFresh or Medi-Cal. SUN Bucks benefits, like CalFresh, are fully funded by the federal government; with administrative costs split 50 percent federal funds and 50 percent General Fund. Summer 2024 marked the first year of California’s SUN Bucks program, in which 5.6 million children received \$672 million in federal SUN Bucks benefits.

**Expenditure Authority Request.** OTSI requests an increase in expenditure authority of \$86.4 million for administrative and operating expenses to support the SUN Bucks program. Funding for the administrative and operating expenses for SUN Bucks has already been included as part of the CDSS budget. This request only seeks the establishment of the corresponding expenditure authority for OTSI which manages the EBT project on behalf of CDSS. The \$86.4 million represents the external vendor cost to process SUN Bucks transactions on EBT cards. Because SUN Bucks administration costs are shared between the state and federal government, the General Fund cost is \$43.2 million and the federal share is also \$43.2 million.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests OTSI respond to the following:

1. Please provide an overview of this proposal.

**Issue 3: CalFresh Budget Change Proposals**

**Budget Change Proposals—Governor’s Budget.** The Governor’s Budget contains two budget change proposals related to the CalFresh program, as follows:

- 1. New CalFresh Outreach Section.** CDSS requests an increase in federal expenditure authority of \$780,000 in 2025-26 and \$760,000 ongoing for four federally funded positions to bolster the CalFresh Outreach program and reach people eligible for CalFresh.
- 2. CalFresh Confirm Inter-Agency Agreements.** CDSS requests to increase reimbursement authority by \$269,000 ongoing to continue receivable Inter-Agency Agreements with fellow state-level entities seeking to use the CalFresh Confirm tool. The positions are funded by the Federal Employment and Training (E&T) funds at 50 percent and from revenue generated from agreements at 50 percent.

Both proposals, which are described below, have no General Fund impact.

**Background: CalFresh Outreach Unit.** CDSS has a CalFresh Outreach Unit dedicated to increasing CalFresh participation, through seven prime contractors and 167 subcontracting agencies. The CalFresh Outreach Unit is responsible for federally required reporting, oversight, and program activities associated with this outreach, in addition to the development of CalFresh outreach materials, CalFresh language access, and, increasingly, assistance with outreach for Disaster CalFresh during major declared disasters.

In federal fiscal year 2023, the CalFresh Outreach Unit achieved several milestones, including the submission of over one million CalFresh applications with help from CalFresh Outreach contractors, resulting in 596,049 new households approved for CalFresh. Over 242,536 households additionally received assistance with recertification to retain CalFresh benefits. This investment yielded an estimated \$2.9 billion in additional CalFresh food benefits to the state by new and retained households.

CalFresh program reach (the measurement of how many eligible people participate in the program) has increased by approximately 20 percentage points in the last decade (from 57 percent in 2011 to 77 percent in 2021). According to CDSS, much of the increase in program access can be directly attributed to outreach work, providing an easy online application process, and implementing targeted media campaigns. While this increase represents major progress, CDSS estimates that there are still hundreds of thousands of people in California who are not receiving CalFresh benefits, even though they may be eligible. CDSS also anticipates that the CalFresh Outreach Unit’s efforts to close the participation gap will become increasingly more difficult as the Unit focuses on populations that are the hardest to reach.

In addition, the CalFresh and Nutrition Branch has responded to substantially more disaster and emergency situations in California with the legislatively mandated operation of a Disaster CalFresh benefit program during declared disasters. Lacking dedicated resources to respond to Disaster CalFresh operations, the existing Outreach team is forced to pause or redirect workload to be able to absorb the urgent and unpredictable work associated with supporting Disaster CalFresh operations.

**CalFresh Outreach Section Expenditure Authority Request.** The additional CalFresh Outreach unit will collaborate on county-specific outreach strategies. According to CDSS, additional programmatic

support in the Outreach section will also facilitate better management of the Disaster CalFresh workload and allow for more on-site and fiscal reviews of contracted CalFresh Outreach partners.

The additional CalFresh Outreach Unit resources requested in this proposal will fund one Staff Services Manager II (SSMII), one Staff Services Manager I (SSMI), and two Associate Governmental Program Analyst (AGPA) positions. There is one existing CalFresh Outreach Unit at CDSS; these positions would create a second outreach unit. These positions are 100 percent federally funded.

The proposed CalFresh Outreach Section Chief will lead the development of the vision for the CalFresh Outreach program, securing contracts for activities, and organizing the pieces necessary to secure federal plan approval, such as staffing, budgets, and data. The SSM II will assist with consulting and advising leadership teams on necessary programmatic and system changes while also directing program projects in alignment with the Branch goals. The SSM I will direct statewide outreach campaigns targeted at underserved populations and deepen partnerships needed to develop meaningful outreach strategies. Further, the SSM I will work directly with analysts to develop contracts as needed, manage special projects, lead stakeholder engagement to collect feedback, and share regular program updates with the unit and Branch as necessary. The two AGPAs will be responsible for the day-to-day maintenance of the program to ensure compliance with state and federal guidelines, monitor performance of contracted partners, and document areas of improvement during site visits and fiscal desk reviews.

**Background: CalFresh Confirm.** CalFresh Employment and Training (CalFresh E&T) provides CalFresh recipients with opportunities to gain skills, training, and experience to support employment. California's E&T program operates in 35 counties with an annual budget of over \$144 million. Services are offered by counties and over 65 third-party providers and overseen by CDSS. CDSS also provides support to two state-contracted third-party partners, the Foundation for California Community Colleges, which operates the Fresh Success Program, and the Center for Employment Opportunities Works.

As part of CDSS' efforts to support counties and third-party providers in expanding access to E&T services, CDSS developed and launched the "CalFresh Confirm" tool in September 2021. CalFresh Confirm is an online tool which was partially funded by the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) through a federal technology improvement grant. CalFresh Confirm allows authorized users to confirm CalFresh eligibility for the purpose of seeking CalFresh E&T reimbursement for employment and training services provided to CalFresh recipients. While CalFresh Confirm was built primarily for CalFresh E&T providers, other partners who enter into agreements with CDSS are also able to access the tool to confirm CalFresh eligibility and support access to other essential services, such as reduced court fines, utility and phone services, transportation passes, and others. CalFresh Confirm requires ongoing management and maintenance to ensure appropriate agreements are established with authorized users, only authorized users are accessing the system, and that authorized users are receiving adequate support and technical assistance.

CDSS currently has executed interagency agreements with the California Public Utility Commission and Judicial Council of California. CDSS is also working on a new interagency agreement with the California Department of Technology (CDT). The IAAs are receivable contracts, and the CDSS uses the funds generated from the IAAs to maintain staff levels that support the maintenance and operation of CalFresh Confirm.

**CalFresh Confirm Expenditure Authority Request.** Currently, the CalFresh Confirm tool is managed by two positions at CDSS. The CalFresh Confirm SSM I Specialist and ITS II participate in ongoing project-related activities, including providing technical assistance to users, adding, editing, monitoring, suspending, and/or revoking user accounts; communicating directly with users, oversight agencies, and CDSS staff if the system is malfunctioning to correct the error in a timely fashion; acting immediately should suspected fraud occur; developing interagency agreements, contracts, and memorandum of understanding; and tracking program budgets and preparing invoices.

Without increased reimbursement authority, CDSS cannot execute interagency agreements to fund necessary staffing levels that manage the maintenance and operation of CalFresh Confirm. The increased reimbursement authority will allow CDSS to support existing staffing levels, which are critical to maintaining the CalFresh Confirm tool.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of the two budget change proposals included in this issue. For the CalFresh Outreach Section proposal, please include an update on the CalFresh participation rate.

**Issue 4: Disaster CalFresh**

**Trailer Bill Language – Governor’s Budget.** CDSS proposes trailer bill language to codify a provision that provides for administrative funding to operate the Disaster CalFresh program.

**Background: Disaster CalFresh.** Disaster CalFresh, known federally as Disaster SNAP, provides temporary food benefits to disaster survivors who are not participating in the regular CalFresh program at the time of the disaster. Each instance of Disaster CalFresh must be federally approved and is only available for a presidential disaster declaration that includes individual assistance. Since 2017, there have been six Disaster CalFresh operations, most recently in response to the January 2025 LA fires.

AB 607 (Gloria, Chapter 501, Statutes of 2017) provides CDSS with up to \$300,000 per in administrative funding per disaster to implement Disaster CalFresh. However, the provision allowing for administrative funding was uncodified.

**Trailer Bill Language to Codify Administrative Funding.** CDSS proposes trailer bill language to codify that administrative funding of up to \$300,000 General Fund for CDSS and counties to operate Disaster CalFresh in the event of a major disaster declared by the Governor or President. According to CDSS, codifying this provision will ensure that funding to implement Disaster CalFresh is available to CDSS and counties.

This proposed trailer bill has no fiscal impact, as funding for Disaster CalFresh administration is already included in the Governor’s Budget.

**Subcommittee Staff Comment and Recommendation – Hold Open.** Subcommittee staff notes there is no new funding associated with this proposal.

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of this proposal, including an overview of the Disaster CalFresh program.

**Issue 5: CalWORKs Budget Overview**

**CalWORKs.** California Work Opportunities and Responsibilities to Kids (CalWORKs), the state’s version of the federal Temporary Assistance for Needy Families (TANF) program, is the state’s primary anti-poverty program for families with children. CalWORKs provides cash assistance and job services, known as welfare-to-work, to eligible low-income families with children. CalWORKs is funded through a combination of the federal TANF block grant (\$3.7 billion annually), the state General Fund, realignment funds, and other county funds. The program is administered locally by counties and overseen by CDSS. CalWORKs was created in 1997 in response to the 1996 federal welfare reform legislation that created the TANF program.

To qualify for CalWORKs, a family generally must earn less than about 80 percent of the federal poverty level (about \$1,700 per month for a family of three in 2024) and have limited assets. The foundational elements of the CalWORKs program are cash aid and employment services. Participation in “welfare-to-work” activities (such as employment, job training, and education) are a condition of receiving aid, and parents who do not meet work requirements (generally 20-35 hours per week) may be “sanctioned” – meaning their monthly cash aid is reduced. State law provides for a cumulative 60-month lifetime limit on cash aid for adults. California provides a safety net program for children of adults who exhaust the 60-month time limit. The children may continue to receive cash aid, if otherwise eligible, up to the age of 18.

CalWORKs offers an array of supportive services. These include: child care, family stabilization, subsidized employment, home visiting, mental health and substance use disorder programs, and two housing programs, Homeless Assistance and the Housing Support Program, which offer temporary and permanent housing assistance.

Eighty-four percent of CalWORKs families are single-parent families; about half of the caseload has children under six years old; and approximately 18 percent have experienced domestic abuse.<sup>5</sup> The majority of adults entering the program lack a high school diploma, and 11.5 percent of the caseload has needed to access homeless assistance.

**Governor’s Budget – CalWORKs.** The Governor’s revised 2024-25 budget includes \$6.4 billion (\$375.6 million General Fund) for CalWORKs, a net increase of \$44.3 million (decrease of \$49.5 million General Fund) from the Budget Act of 2024. The net increase reflects higher CalWORKs assistance expenditures due to a faster caseload growth than previously projected. The decrease in General Fund is due to available federal TANF carry forward funds. (The state can carry forward unspent TANF funds from prior years to future years to offset General Fund costs.)

The Governor’s proposed 2025-26 budget includes \$6.4 billion (\$961.4 million General Fund), a net increase of \$50.2 million (\$536.3 million General Fund) from the Budget Act of 2024. The net increase primarily reflects higher CalWORKs assistance expenditures due to an increase in caseload, full funding restoration for expanded subsidized employment and partial funding restoration for mental health and substance use disorder services, and decreases in the shared eligibility and Medi-Cal common costs shifts,

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<sup>5</sup> Sara Kimberlin, “Harmful Obstacles: CalWORKs Work Participation Rate Penalty,” California Budget and Policy Center, February 2023.

offset by slower growth in the employment services caseload. The General Fund increase is primarily due to a lower amount of federal TANF carry forward funds available in 2025-26.

## CalWORKs Budget Summary

All Funds (Dollars in Millions)

	2024-25	2025-26 Proposed	Change From 2024-25 to 2025-26 Proposed	
			Amount	Percent
<b>Number of CalWORKs Cases</b>	<b>359,786</b>	<b>361,834</b>	<b>2,048</b>	<b>1%</b>
<b>Cash Grants</b>	<b>\$4,348</b>	<b>\$4,375</b>	<b>\$27</b>	<b>1%</b>
<b>Single Allocation</b>				
Employment services	\$1,207	\$1,162	-\$45	-4%
Cal-Learn case management	11	11	—	1
Eligibility determination and administration	444	444	—	—
<b>Subtotals</b>	<b>(\$1,662)</b>	<b>(\$1,617)</b>	<b>(\$44)</b>	<b>(-3%)</b>
<b>Stage 1 Child Care</b>	<b>\$588</b>	<b>\$602</b>	<b>\$14</b>	<b>2%</b>
<b>Other Allocations</b>				
Home Visiting Program	\$80	\$65	-\$16	-19%
Housing Support Program	95	95	—	—
Expanded Subsidized Employment	97	134	37	38
Family Stabilization	71	63	-9	-12
Mental Health and Substance Abuse Services	93	104	12	12
<b>Subtotals</b>	<b>(\$436)</b>	<b>(\$461)</b>	<b>(\$24)</b>	<b>(6%)</b>
<b>Other<sup>a</sup></b>	<b>\$25</b>	<b>\$24</b>	<b>-\$1</b>	<b>-3%</b>
<b>Totals</b>	<b>\$7,059</b>	<b>\$7,079</b>	<b>\$20</b>	<b>Less Than 1 %</b>

<sup>a</sup>Primarily includes various state-level contracts.

Source: Legislative Analyst’s Office (LAO)

**TANF carry forward.** The primary funding source for CalWORKs is the federal TANF block grant of \$3.7 billion per year. Most TANF block grant funds directly support CalWORKs, with some block grant funds diverted to student aid for low-income college students and other human services programs.

In order to receive the annual TANF block grant, states must meet a Maintenance of Effort (MOE) requirement, meaning states must maintain a certain level of state and local funding for CalWORKs eligible families. California’s MOE requirement is \$2.9 billion annually, which can be spent directly on CalWORKs or other programs that meet federal requirements.

States are permitted to carry over unspent funds from the TANF block grant into future years, known as TANF carry forward. The LAO notes that from 2020-2023, spending plans significantly overestimated CalWORKs caseload and caseload-related costs (largely due to challenges predicting caseload during the COVID-19 pandemic). This resulted in hundreds of millions of unspent TANF funds in those years, which were available to carry forward and offset General Fund in recent years. The LAO notes that most TANF carry forward funds were used to offset General Fund in 2022-23 (about \$767 million), meaning federal funds made up a larger portion of CalWORKs total funds in 2022-23 than in years prior. The Governor’s proposed budget includes \$671 million in TANF carry forward in 2024-25 and \$110 million TANF carry forward in 2025-26, likely reflecting the expenditure of remaining TANF carry forward funds from pandemic years.<sup>6</sup>

As seen in the LAO chart below, the Governor’s proposed budget shows an increase of about \$590 million General Fund for CalWORKs from 2024-25 to 2025-26. This increase in General Fund is largely a reflection of the lower level of TANF carry forward available compared to recent years, and not major changes in CalWORKs policy.

### CalWORKs Funding Sources

(Dollars in Millions)

	2024-25	2025-26 Proposed	Change From 2024-25 to 2025-26 Proposed	
			Amount	Percent
Federal TANF block grant funds	\$3,289	\$2,748	-\$541	-16%
• TANF carry forward <sup>a</sup>	671	110	-562	-84
General Fund	660	1,250	590	89
Realignment funds from local indigent health savings	715	677	-38	-5
Realignment funds dedicated to grant increases	1,177	1,185	8	1
Other county/realignment funds	1,218	1,219	\$1	—
<b>Totals</b>	<b>\$7,059</b>	<b>\$7,079</b>	<b>\$20</b>	<b>Less Than 1 %</b>

<sup>a</sup>TANF carry forward is a non-add line item for display purposes only. This amount is included in Federal TANF block grant funds.

TANF = Temporary Assistance for Needy Families.

Source: LAO

**CalWORKs caseload.** The Governor’s proposed budget estimates the CalWORKs caseload to be 361,834 families in 2025-26, compared to 359,786 families in the revised 2024-25 budget.

Of the families receiving CalWORKs assistance, 84 percent are one-parent households with average monthly earnings of \$1,496, while 16 percent are two-parent households with average monthly earnings

<sup>6</sup> Legislative Analyst’s Office, “The 2025-26 Budget: CalWORKs,” February 19, 2025.

of \$1,618. The average CalWORKs family contains two children. According to CDSS, 90 percent of program participants are women, approximately 60 percent identify as Hispanic, 18 percent identify as White, and 17 percent identify as Black. Approximately 59 percent of parents entering CalWORKs have no high school diploma. Program data shows an alarmingly high rate of homelessness among CalWORKs families (11.5 percent of total CalWORKs families were approved for homelessness assistance in 2023-24).

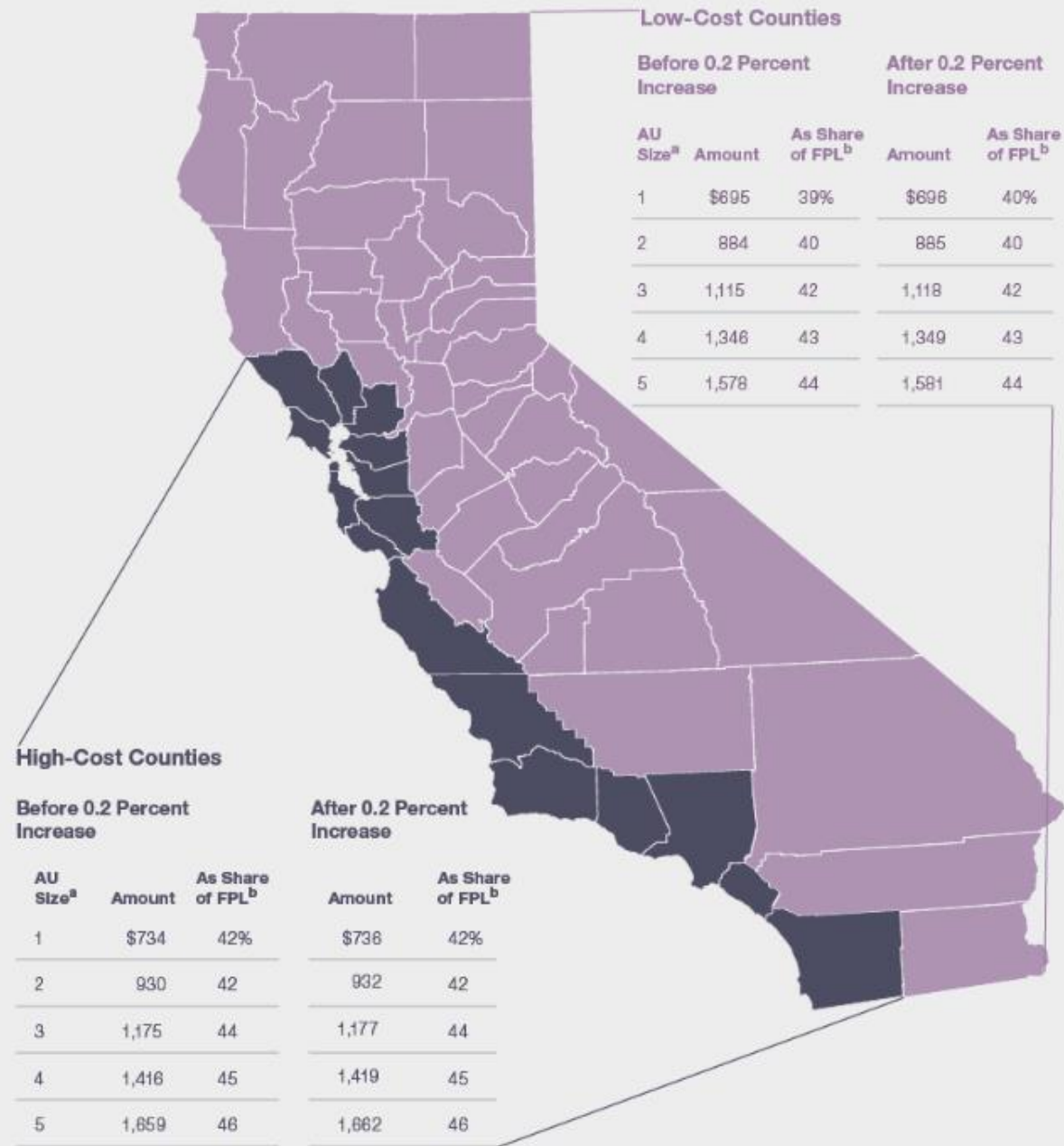
**Minor CalWORKs grant increase.** CalWORKs grants vary based on region, number of eligible family members, and income. Generally grants increase as family size increases and decrease as family income increases.

As part of 1991 realignment, some local revenue growth accrues to the Child Poverty and Family Supplemental Support Subaccount, which automatically triggers CalWORKs grant increases when the Subaccount experiences sufficient growth. Modest growth in this account in 2025-26 supports a projected 0.2 percent CalWORKs grant increase, a \$2 increase in the monthly maximum family grant from \$1,175 to \$1,177 in a high-cost county. This equates to 55 percent of the federal poverty level. The Governor's budget projects an average monthly grant (across all regions and household sizes) of \$1,002 in 2025-26.

**Majority of CalWORKs families live in deep poverty.** A 2023 analysis found that only about 40 percent of the CalWORKs caseload includes the full family size in the "assistance unit" (AU), the number of CalWORKs-eligible people in the household. Family members may be excluded from the AU for several reasons, most commonly, because they exceeded the 60 month lifetime limit on aid for adults; are sanctioned for not meeting program requirements; receive federal disability benefits (SSI/SSP), or due to their immigration status. When family members are excluded from the AU, this means the grant the family receives is for a family one person smaller than their actual family size.

Because about 60 percent of the CalWORKs caseload does not include the full family size in the AU, the Legislature set a goal in the 2018 Budget Act to increase CalWORKs grants to 50 percent of the federal poverty level for a family that is one person larger than the AU size (to account for CalWORKs households in which the actual family size is larger than the CalWORKs AU). Fifty percent of the federal poverty level is used as a measure of deep poverty. Despite significant grant increases in recent years, including a 10 percent grant increase which was made permanent in the 2023 Budget Act, current grant levels (including the projected 0.2 percent grant increase) still leave most CalWORKs families living in deep poverty, as shown in the LAO figure below. This chart measures CalWORKs grants against the poverty level for a family that is one person larger than the AU size. Across regions and family size, grants range from 40 to 46 percent of the federal poverty level.

### Governor's Budget Estimates 0.2 Percent Grant Increase



<sup>a</sup> Assistance unit size is the number of family members who are eligible for CalWORKs.

<sup>b</sup> Share of 2025 federal poverty guideline for a family size that is one person larger than the AU size.  
 AU = assistance unit and FPL = federal poverty level.

Note: Grant amounts are for non-exempt households. Non-exempt households are generally those that do not include adult(s) receiving Supplemental Security income, In-Home Supportive Services, or other disability benefits.

LAOA

Source: LAO

**CalWORKs county administration.** Funding for county administration of the CalWORKs program is provided via the CalWORKs single allocation, which is a combination of federal TANF funds and state General Fund. The single allocation combines funding for eligibility administration, employment services, and Cal-Learn county functions into one allocation that may be used interchangeably. Cal-Learn provides case management to pregnant and parenting teens participating in CalWORKs. The majority of single allocation funding is dedicated for eligibility administration (processing applications and other program administration functions) and employment services, with Cal-Learn making up a small portion. Funding for all three components of the single allocation are interchangeable, meaning counties can shift funds across components. In 2023-24, counties significantly overspent the eligibility administration component by nearly double the allocation and underspent the employment services component by nearly a third.

Total single allocation funding for 2024-25 is held to the Budget Act of 2024 level of \$1.66 billion total funds. This funding level does not account for the slower caseload growth in employment services than previously projected. The Governor’s proposed 2025-26 budget includes \$1.62 billion total funds for the single allocation, about a three percent decrease (\$44.5 million) from total 2024-25 single allocation funding, primarily due to a lower projected employment services caseload, and partially offset by a projected increase in the Cal-Learn caseload.

**CDSS reassessed county administration funding in 2024.** Single allocation funding is determined by a formula that increases or decreases in set increments based on caseload changes. CDSS is required to reassess the methodology for the eligibility administration component of the single allocation every three years. The 2024 reassessment made several findings, including that updating the eligibility worker rate to align with local costs, as reported by counties, would result in a 21.4 percent increase (\$160.3 million) for the eligibility administration component; and that updating the formula to account for changes in the number of CalWORKs applications submitted would result in a 6.7 percent increase (\$48.8 million).<sup>7</sup> The Governor’s proposed 2025-26 budget does not incorporate these findings, which would add approximately \$215 million total funds above the proposed single allocation level.

The LAO notes that from 2021-22 to 2023-24, “over \$300 million in unspent single allocation funds naturally reverted to the General Fund each year (over 15 percent of total single allocation funds annually). Given counties consistently underspent total single allocation funds in recent years, along with the fungibility of single allocation funds between the components, counties may be able to fully fund current activities in 2025-26 under the Governor’s proposal.”<sup>8</sup> According to the County Welfare Director’s Association, “funding for the eligibility component of the Single Allocation has fallen behind, with counties forced to overspend the statewide eligibility allocation and redirect employment services funding to backfill eligibility.” (See Issue #9 for a budget request to increase county single allocation funding.)

**TANF Work Participation Rate.** Since federal welfare reform in 1996, the federal government has used a singular outcome to measure states’ performance in TANF: the Work Participation Rate (WPR). TANF work requirements require families to participate in specified “welfare-to-work” (WTW) activities as a condition of receiving cash aid. For one parent households, the adult must participate in eligible WTW activities for an average of 30 hours per week (or 20 hours per week if they have a child under age six). Two parent households must participate in WTW activities for a combined average of 35 hours per week.

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<sup>7</sup> LAO.

<sup>8</sup> LAO.

Adults who fail or refuse to comply with these WTW program requirements without good cause may be sanctioned, resulting in a reduction to their cash aid.

The WPR is the statewide percentage of adults who meet federally defined WTW requirements. To meet federal requirements, at least 50 percent of all families and 90 percent of two-parent families receiving TANF must meet the weekly hours requirements described above. Federal law outlines specific WTW activities that count toward the WPR requirements.<sup>9</sup>

If states do not meet WPR requirements, they face financial penalties, starting at five percent of the state's annual TANF grant and increasing to a maximum of 21 percent of a state's block grant. State law includes a county "pass-through" provision for any potential federal WPR penalties, meaning counties that did not meet the WPR requirements locally incur a portion of the federal penalty.

While California has struggled to meet federal WPR requirements over time, the state has submitted appeals for all potential penalties and to date, has never had to pay a WPR fiscal penalty in the history of the CalWORKs program.

Because states have some flexibility in defining allowable WTW activities, California laws provide more flexibility than the current federal rules on the types of activities that can be counted towards WTW participation. Federal rules stipulate that only "core activities" – mainly employment, community services, and job search activities – can count towards WPR participation, but not activities such as education. California rules allow CalWORKs adults to participate in a more expansive set of WTW activities, including education and addressing barriers to employment (such as mental health). The result of these differences is that while many CalWORKs families are participating and meeting state requirements, their participation is not counted towards the state's WPR.<sup>10</sup>

A recent report by the California Budget and Policy Center found that the CalWORKs WPR penalty undercuts state reforms focused on supporting families.<sup>11</sup> According to this report, "state CalWORKs policy continues to threaten counties with financial penalties tied to the federally defined WPR, incentivizing counties and caseworkers to direct CalWORKs participants away from supportive activities to address barriers that do not fully count toward meeting the federal WPR."

**CalWORKs Sanctions.** When parents receiving CalWORKs do not meet WTW requirements without good cause, they are subject to a sanction (a reduction of their monthly cash grant). A typical sanction could reduce a single parent's cash aid by approximately \$120, or up to \$235 for a single parent family with two children.<sup>12</sup>

The latest data available through the state's Cal-OAR dashboard show that as of August 2024, over 13 percent of all CalWORKs families were sanctioned. Sanction rates vary widely; Los Angeles County's sanction rate is close to the statewide average at 14 percent and many counties are far below 10 percent.

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<sup>9</sup> LAO

<sup>10</sup> LAO

<sup>11</sup> Sara Kimberlin.

<sup>12</sup> Sara Kimberlin and Monica Saucedo, "Reforming CalWORKs Sanctions Can Better Support Children and Families," California Budget and Policy Center, April 2023.

However some counties have disproportionately high sanction rates; for example, Orange County’s sanction rate is over 20 percent and Imperial County’s sanction rate is over 36 percent.

A 2023 report by the California Budget and Policy Center found that sanctions, which penalize CalWORKs parents who are not meeting program requirements by reducing their monthly grants, have the effect of pushing about 60,000 children per month deeper into poverty.<sup>13</sup>

California’s sanction policies exceed the minimum required by federal law, which requires sanctions for the “duration” of a parent’s “refusal” to comply with work requirements. The disparity in sanction rates across counties is likely an indicator of additional county-level discretion to impose sanctions on CalWORKs parents.

**California Outcomes and Accountability Review (Cal-OAR).** Initiated in 2017 and implemented in 2021, Cal-OAR is California’s framework for measuring outcomes in the CalWORKs, beyond the WPR.

Cal-OAR consists of three core components: 26 performance measures, a county CalWORKs self-assessment, and a county CalWORKs system improvement plan, which takes place over a five-year period. The Cal-OAR performance measures follow the clients’ experiences during their time in CalWORKs through one year post-aid, assessing a variety of outcomes, including client access to supportive services, educational completion, and engagement in activities like employment, education, and other activities that support the client’s goals. Presently, 12 of the 26 performance measures are hosted publicly on the Cal-OAR Data Dashboard for each of the 58 counties and statewide, and the remaining performance measures are still in development and will be available in mid-2026.

Cal-OAR is informed by a county-led initiative known as “CalWORKs 2.0” which encourages counties to develop and utilize a goal-achievement service delivery that shifts from compliance-oriented to a more participant-led focus, based on research that shows the benefits of prioritizing family stability and individualized success.

The 26 Cal-OAR metrics are listed below.

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<sup>13</sup> Sara Kimberlin and Monica Saucedo.

## CalWORKs Outcomes and Accountability Review Performance Measures

<b>Economic Measures</b>	<b>Participation Measures</b>
Current and former participant employment rates	WTW engagement rate
Subsidized to unsubsidized employment rate	Sanction rate
Wage progression (6 and 12 months after exit)	Sanction resolution rate
Rate of exits with earnings	Orientation attendance rate
Rate of program re-entries (including after exit with earnings)	Appraisal completion rate
Rate of re-entry after exit with earnings	Time from appraisal to first WTW activity
Intergenerational enrollment rate	First WTW activity attendance rate
<b>Education Measures</b>	<b>Access to Supplemental Services</b>
Education and skills development rate	Homeless Assistance and Housing Support Program access rates
Education and skills development activity utilization rate	Ancillary services access rate
Child care access rate	Transportation provision rate
Improved literacy, basic skills, and English language acquisition rate	Home Visiting to WTW transition rate
Community college progress rate	Family Stabilization to WTW transition rate
Educational completion rate	
WTW = Welfare-to-Work.	

Source: LAO

**WPR workgroup findings.** The 2022 Budget Act required CDSS to consult with a stakeholder workgroup on recommendations to address the state’s emphasis on the federal WPR and penalty pass-on structure, while optimizing implementation of the first cycle of the Cal-OAR process. Key takeaways from the workgroup included:

- A strong desire from the workgroup for a full repeal of the WPR penalty pass-on to counties.
- Accountability in the form of Cal-OAR performance measures or other metrics to be further explored and established.
- Reducing the harm caused by sanctions, with workgroup members noting that any repeal of the penalty pass-on structure or changes in county accountability should be equitably paired with a revision of the sanction policy in recognition that reducing a family’s income does not support its economic stability.
- Reducing the financial impact and duration of sanctions for families.

**Federal Fiscal Responsibility Act of 2023 made changes to state TANF programs.** The federal Fiscal Responsibility Act of 2023 (FRA) allowed up to five states to participate in a pilot to promote accountability and test alternative benchmarks for work and family outcomes in lieu of the Temporary Assistance for Needy Families (TANF) Work Participation Rate (WPR), the sole performance measure in the federal TANF program. The pilot intended to hold states accountable for their performance on employment and earnings outcomes and measures of family stability and well-being. California was selected with five other states in November 2024; however, the federal government rescinded California and all other states’ pilot status in March 2025.

The FRA made other changes to TANF at the federal level that re-base the WPR methodology in a manner that rewards states for TANF caseload declines by reducing WPR requirements.<sup>14</sup> Because of this “caseload reduction credit,” California’s WPR burden will be significantly reduced in future years. California will continue to meet both the all-families and the two-parent families WPR targets, making the possibility of a WPR fiscal penalty even more remote.

**2024 Budget Act required CDSS to report policy options to improve CalWORKs.** The 2024 Budget Act included trailer bill language in AB 161 (Committee on Budget) Chapter 46, Statutes of 2024 that established the Legislature’s intent to continue to reimagine CalWORKs into a trauma-informed, family-centered program that maximizes family and child well-being while building meaningful pathways out of poverty. AB 161 suggested the department consider the following reforms:

- Modify the existing welfare-to-work process to be family centered.
- Align sanctions to the minimum federal requirements.
- Repeal the federal WPR penalty pass-through.

AB 161 additionally encouraged CDSS to consider the reforms above as part of the state’s FRA pilot application, and required CDSS to provide a report to the Legislature on necessary statutory changes to align state policy to the goals of the federal pilot program, including comprehensive cost estimates, by January 10, 2025. While California was selected and then removed from the federal pilot program, the policy options provided are generally not contingent on federal pilot status.

A summary of the policy options presented in the AB 161 report are summarized in the LAO chart on the following page. Some of the policy options outlined in the AB 161 report, such as eliminating sanctions during the first 90 days in CalWORKs, would incur some General Fund/ TANF costs because the families currently sanctioned within 90 days of beginning the program would be able to retain their full grant. This would also incur some General Fund/TANF savings because, according to CDSS, “each family will generate one hour of potential county efficiencies for no longer having to be sanctioned.”

Other policy options present straightforward changes to reduce administrative complexity, such as simplifying the income reporting threshold to align with CalFresh. And some options, such as streamlining the appraisal process and making job club optional, would incur cost savings from potential county efficiencies.

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<sup>14</sup> Fiscal Responsibility Act of 2023, Section 301, 42 USC 607(b)(3)

## CDSS Pilot Policy Options and Estimated Costs

General Fund (In Millions<sup>a</sup>)

Policy Options and Estimated Costs	CDSS Estimated Cost	
	Initial Year <sup>b</sup>	Ongoing
<b>Centering Family Engagement</b>		
Eliminate non-compliance sanctions and penalties during first 90 days in CalWORKs	\$1.9	\$1.7
Expand allowable WTW activities	—	—
Replace fixed hourly work requirements with individualized engagement requirements	93.5	93.5
Make job club optional as an initial WTW activity	—	—
<b>Reducing Administrative Burden</b>		
Eliminate the WPR penalty passthrough to counties	—	—
Replace Online CalWORKs Appraisal Tool with new alternate, streamlined appraisal tool	\$3.9	—
Eliminate applicant resource limit	16.7	\$30.1
Eliminate penalty for teens 16 through 18 who fail to attend school regularly <sup>c</sup>	0.2	0.2
Eliminate consideration of in-kind income in eligibility determinations	32.9	35.3
Simplify income reporting requirements	112.4	112.1
Suspend some current WTW data reporting requirements	—	—
<b>Support Local Implementation</b>		
Train and provide technical assistance to counties on pilot-related policy and programmatic changes	\$4.0	\$4.0
Provide grants to counties to implement program changes	2.0	2.0
Provide funding to counties for increased engagement with CalWORKs families	97.5	97.5
<b>Total Cost of Options<sup>d</sup></b>	<b>\$365.0</b>	<b>\$376.4</b>
<b>County Savings</b>		
Possible county-level administrative efficiency savings	-\$90.4	-\$90.4
<p><sup>a</sup>California's annual \$3.7 billion federal TANF block grant can be used flexibly for the policy options. The TANF block grant is fully allocated within the existing and proposed state budgets. As such, new costs for the CalWORKs program are considered General Fund cost impacts. State General Fund costs may be mitigated to the extent TANF funding is not fully expended in any particular year, or if one of the CalWORKs subaccounts has sufficient revenue available to support CalWORKs assistance costs. No additional federal funds were provided for the pilots.</p> <p><sup>b</sup>The initial year of the pilot aligns with the federal fiscal year (October 2025 to September 2026). As such, if the options above were adopted, some initial year costs may fall in state fiscal year 2024-25 while others may fall in state fiscal year 2025-26.</p> <p><sup>c</sup>One-time automation cost is pending and not included in cost estimate.</p> <p><sup>d</sup>Total cost of policy options, including those supporting local implementation, before any county-level administrative efficiency savings.</p> <p>CDSS = California Department of Social Services; TANF = Temporary Assistance for Needy Families; WTW = Welfare-to-Work; and WPR = work participation rate.</p>		

While CDSS has presented the policy options listed above to the Legislature, the options in the AB 161 report are not included in the Governor’s proposed 2025-26 budget.

**2024 Budget Act Reductions.** The 2024 Budget Act made several reductions to CalWORKs programs to address a 2024-25 budget problem. The cuts, described below, were intended to temporarily align funding to recent actual expenditures and to avoid adverse impacts to families in the programs.

- **CalWORKs Home Visiting.** Reduction of up to \$30 million General Fund in 2023-24, \$25 million General Fund in 2024-25, and \$25 million General Fund in 2025-26, to align funds to recent actual expenditures. Program funding returns to the baseline level of approximately \$97.6 million in 2026-27.
- **CalWORKs Subsidized Employment.** Reduction of up to \$30 million General Fund in 2023-24 and \$37 million General Fund in 2024-25, to align funds to approximate 2022-23 spending. Program funding returns to the baseline level of approximately \$134 million in 2025-26. Additionally, trailer bill language established outcome reporting requirements for the CalWORKs Subsidized Employment Program regarding utilization of funds, employment placements and industry sector data, and average earnings of CalWORKs participants, beginning April 1, 2025.
- **CalWORKs Mental Health and Substance Use Disorder Services.** Reduction of \$30 million General Fund in 2023-24, \$37 million General Fund in 2024-25, and \$26 million General Fund in 2025-26, to align funds to recent actual expenditures. Program funding returns to the baseline level of approximately \$127 million in 2026-27.
- **CalWORKs Single Allocation Reversion.** Early reversion of approximately \$295 million in unspent General Fund from the 2022-23 CalWORKs Single Allocation.
- **CalWORKs Employment Services Intensive Case Management.** Cancelled a planned increase of budgeted hours for employment services intensive case management by \$47 million General Fund ongoing.
- **Safety Net Reserve.** Fully depleted the \$900 million Safety Net Reserve, which was designed to cover the costs of Medi-Cal and CalWORKs caseload increases in the event of an economic downturn.

**Impacts of 2024 Budget Act CalWORKs Reductions.** The intent of the reductions described above was to preserve existing service levels, by reducing only in areas where there was projected underspending. However, counties have reported to CDSS that they have reduced services in the Subsidized Employment and Home Visiting programs as a result of lower funding available. In the Home Visiting Program in particular, counties have reported staff reductions, increased waitlists in at least two counties, reduced number of families served, decreased referrals and outreach activities, and a decrease in health and safety materials (such as car seats and cribs).

### **Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of the Governor’s proposed 2025-26 budget for CalWORKs, including caseload, grants, and the single allocation.

2. What challenges do CalWORKs families face in achieving family stability? What elements of the CalWORKs program are most effective in achieving positive family and employment outcomes and what program elements have proven to be barriers to family engagement and stability?
3. Please provide an overview of the AB 161 Report on policy options to center family engagement and reduce administrative burden in the CalWORKs program, including the associated costs and savings.

**Issue 6: CalWORKs: Permanent Housing Assistance – SB 1415 Implementation**

**Budget Change Proposal—Governor’s Budget.** CDSS requests \$180,000 General Fund in 2025-26 and \$176,000 in 2026-27 for one limited-term position to implement SB 1415 (Glazer, Chapter 798, Statutes of 2024) including development of guidance, regulations, automation, and technical assistance to counties for the CalWORKs Homeless Assistance program.

**Background: CalWORKs Homelessness Assistance Program.** Families participating in CalWORKs who are homeless or at risk of homelessness are entitled to receive CalWORKs Homelessness Assistance (CalWORKs HA.) There are two components to CalWORKs HA: temporary HA, which provides 16 days of hotel vouchers, and permanent HA, which is used to secure or maintain permanent housing, in the form of security deposits or up to two months of rent arrearages.

In 2023-24, counties received 78,268 applications for CalWORKs HA, of which 67,789 were approved for approximately 63,000 unduplicated families, or approximately 11.5 percent of the total CalWORKs caseload. Expenditures for the CalWORKs HA program in 2023-24 totaled \$100.5 million. CalWORKs families who are homeless or at risk of homelessness are also eligible for a more robust array of services as part of the CalWORKs Housing Support Program (CalWORKs HSP), however CalWORKs HSP is supported with limited funding, and may not be available to any CalWORKs family, whereas CalWORKs HA is a nonrecurring special needs benefit available to any family that meets the criteria outlined in statute. Historically, a much smaller portion of CalWORKs families have accessed permanent CalWORKs HA compared to temporary CalWORKs HA.

In order to qualify for permanent CalWORKs HA (a security deposit or up to two months of rent), the family must secure housing in which monthly rent is no more than 80 percent of their total monthly income, excluding certain income sources like CalFresh. In 2021-2022, 20 percent of families who applied were denied permanent CalWORKs HA, most often because the rents for housing they secured were over 80 percent of the family’s monthly income.

**SB 1415 (Glazer, Chapter 798, Statutes of 2024).** SB 1415 modified the 80 percent threshold for permanent CalWORKs HA by allowing a more expansive definition of income, including any regularly received government, non-profit, or private support, to be part of the income calculation. This broader definition of income would potentially allow for more families’ rent to fall under the 80 percent income threshold and therefore allow the county to use permanent CalWORKs HA to pay for those families’ security deposits or rent arrearages.

**Staffing and Resource Request.** CDSS requests one limited-term position for two years to update CalWORKs HA regulations, develop guidance, and advise counties of changes to program requirements, forms, regulations, provide technical assistance to counties, and lead one-time automation changes.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of this proposal.

**Issue 7: CDSS Automation & EBT Issues**

**Update on EBT card security.** Since October 2021, California has seen a severe increase in criminal EBT theft, which is a nationwide problem. CDSS has implemented a variety of theft mitigation strategies and is actively collaborating with federal, state, and local law enforcement on the investigation of criminal activity related to EBT theft. The key cause of this theft is that EBT cards have outdated technology and are not chip-enabled, making CalFresh, CalWORKs, and CAPI recipients particularly vulnerable to skimming theft relative to other cardholders. The 2023 and 2024 budget acts provided funding to improve EBT card technology by deploying chip/tap enabled cards (which better protect against skimming and fraud), bringing EBT card up to the same technology standard as other credit and debit cards. From November to December 2024, over \$16 million per month in EBT benefits were stolen. The federal government reimbursed the state for replacement CalFresh benefits for a limited period of time between December 2023 and December 2024; CDSS has requested just under \$61 million in reimbursement from USDA for that time period.

CDSS and OTSI have been working with a complex array of stakeholders including the USDA, grocers and retailers, EBT vendors, payment processors, and others to prepare for the deployment of chip/tap cards, including retailer testing and fallback testing to determine readiness of retailers and financial institutions to successfully process chip/tap cards. CDSS and OTSI in February 2025 began mass replacement of Californians’ EBT cards, beginning with households enrolled in both CalWORKs and CalFresh.

**Governor’s Budget—California Statewide Automated Welfare System (CalSAWS).** CalSAWS is the single automated case management and eligibility system supporting CDSS programs and other public benefits programs, including CalWORKs, CalFresh, Medi-Cal, Foster Care, and other social services. BenefitsCal is the public-facing portal and CalSAWS is the county eligibility and benefit calculation system. CalSAWS is governed by a Joint Powers Authority (JPA) representing the 58 counties. As of October 2023, all 58 counties have migrated to the single CalSAWS system, the culmination of a multi-year project that began in 2018.

Funding for CalSAWS consists of state, federal, and county funds based on the sharing ratios of the various benefit programs. The total CalSAWS Project budget for 2025-26 is \$376.9 million (\$108.3 million General Fund). This is exclusive of automation projects to fund specified state or federal policy changes outside of the base CalSAWS budget. The budget for CalSAWS is summarized below:

**California Statewide Automated Welfare System  
(CalSAWS)**

**EXPENDITURES:**  
(in 000s)

			<u>FY 2024-25</u>		
<b>Item 141 – Automation</b>	<b>Total</b>	<b>Federal</b>	<b>State</b>	<b>County</b>	<b>Reimb.</b>
CalSAWS	\$369,395	\$55,567	\$105,876	\$15,559	\$192,393
			<u>FY 2025-26</u>		
<b>Item 141 – Automation</b>	<b>Total</b>	<b>Federal</b>	<b>State</b>	<b>County</b>	<b>Reimb.</b>
CalSAWS	\$376,944	\$56,190	\$108,319	\$16,050	\$196,385

The following breakdown of the CalSAWS budget is provided by the California Health and Human Services Agency Office of Technology and Solutions Integration (OTSI):

The CalSAWS budget for 2025-26 includes \$342 million (91 percent) for general maintenance and operations. Operations for CalSAWS includes hardware, software, cloud services; technical infrastructure services such as wide area network, local area network, help desk, system performance monitoring, batch operations, and project management; personnel and legal services; print services; quality assurance services; and facilities. The remaining \$34 million (nine percent of the total) accommodates system changes.

<b>September 2024 CAP</b>	<b>SFY 25/26</b>	<b>%</b>
<b>Operations</b>		
Hardware	\$36,442,000	9.7%
Software	\$53,732,000	14.3%
Cloud Services	\$53,229,000	14.1%
Technical Infrastructure	\$111,543,000	29.6%
Personnel & Legal Services	\$49,155,000	13.0%
Print Services	\$28,138,000	7.5%
Quality Assurance & IV&V Services	\$6,411,000	1.7%
Facilities	\$3,490,000	0.9%
<b>Subtotal</b>	<b>\$342,140,000</b>	<b>90.8%</b>
<b>System Changes</b>		
BenefitsCal	\$3,897,000	1.0%
CalSAWS Interface with CARES	\$1,520,000	0.4%
CalHEERS Interface	\$2,388,000	0.6%
Intake Appointments, Worker/Customer Appointments, Worker Availability	\$2,118,000	0.6%
Additional System Changes ( <b>Details Below</b> )	\$24,881,000	6.6%
<b>Subtotal</b>	<b>\$34,804,000</b>	<b>9.2%</b>
<b>Combined Total</b>	<b>\$376,944,000</b>	<b>100.0%</b>

The breakdown of the costs for additional system changes according to historical categories is provided below.

<b>Additional System Changes by Category</b>	<b>Annual Cost</b>	<b>% of Total</b>
Legislative & Recurring Policy Maintenance	\$15,276,900	61.4%
Online Help/Training, Texting & Notifications	\$2,371,500	9.5%
CalSAWS/BenefitsCal Integration	\$1,693,900	6.8%
Software and Security Upgrades	\$1,439,800	5.8%
Change Management and Communications	\$1,439,800	5.8%
Worker-Facing System Usability	\$762,300	3.1%
Ancillaries (Interactive Voice Response/Contact Center/Lobby Management, Imaging)	\$1,034,500	4.2%
Reports & State Requests	\$608,200	2.4%
Bank Changes, Office Schedules, Warrant Print Updates	\$254,100	1.0%
<b>Total</b>	<b>\$24,881,000</b>	<b>100%</b>

**Migration to single CalSAWS system is complete.** The migration of all 58 counties to a single, unified CalSAWS system was completed in October 2023, marking the end of the design, development, and implementation phase of the project and the transition to maintenance and operation. This includes new vendor contracts for infrastructure services and maintenance and enhancements, which were recently executed.

**2023 Budget Act – State Oversight of CalSAWS Project and Interface with Child Welfare System.**

The 2023 Budget Act included funding for five permanent positions across OTSI, CDSS, and Department of Health Care Services to support the CalSAWS consolidation and to direct, govern, and oversee the planning and implementation of CalSAWS. The 2023 Budget Act also included \$25 million for a bi-directional interface between CalSAWS and Child Welfare Services-California Automated Response and Engagement System (CWS-CARES) systems.

**CalSAWS Stakeholder Engagement.** Welfare and Institutions Code 10823.1 requires CDSS, DHCS, OTSI, and CalSAWS to engage with stakeholders to discuss current and planned functionality changes, system demonstrations of public portals and mobile applications, and advocates’ identification of areas of concern, especially with the design of public-facing elements and other areas that directly impact clients.

The 2023 Budget Act included Supplemental Report Language requiring the Administration and CalSAWS to report on efforts to improve engagement with stakeholders to solicit and integrate their feedback into prioritization of enhancements to public-facing elements of CalSAWS. This was in response to stakeholder concerns that client and community-based organization feedback into the design of public-facing elements of CalSAWS, such as BenefitsCal, were not being considered meaningfully, leading to design issues that could have been avoided. The 2024 Budget Act included additional Supplemental Report Language requiring the Administration and CalSAWS to respond to ongoing stakeholder concerns that were not fully addressed in the 2023 report.

**Subcommittee Staff Comment and Recommendation – Hold Open.** Subcommittee staff notes that 2023 marked the end of the design, development, and implementation phase of the CalSAWS project and the transition to maintenance and enhancements. Despite the completion of this major project, the Governor’s proposed CalSAWS project budget has modestly increased relative to 2024-25. At the same time, the Legislature continues to experience long delays in the implementation of legislation affecting public benefits, which is consistently modified to be contingent on the completion of CalSAWS automation.

On EBT security, subcommittee staff notes that California will be the first state to provide chip/tap enabled EBT cards, providing EBT cardholders with the same level of theft protection as non-EBT cardholders. This is a major milestone. The Legislature should continue to monitor EBT theft levels, as well as the mass replacement of EBT cards, to ensure enrollees maintain access to benefits during the transition period.

**Questions.** The Subcommittee requests CDSS/OTSI respond to the following:

1. Please provide an update on EBT card security and mass card replacement.
2. Please provide a brief overview of the total budget for CalSAWS in 2025-26. How and when might the overall CalSAWS budget change as a result of contract changes?
3. How will the CalSAWS budget change, now that the migration of all the counties onto a single system is complete? How will the speed at which CalSAWS is able to automate new policies change, now that the migration is complete?

**Issue 8: Information Systems Division Growth and Sustainability**

**Budget Change Proposal—Governor’s Budget.** CDSS requests an increase in General Fund expenditure authority of \$1.56 million in 2025-26 and \$1.53 million ongoing for seven permanent positions and \$1.46 million for contract funding over two years to ensure the Information Systems Division (ISD) has adequate capacity to support the growing department IT needs.

**Background.** As CDSS has been tasked with administering new and expanded programs in recent years, department staffing has increased to over 6,000 employees in 2023-24. According to CDSS, the department’s IT support staffing has not kept pace with this growth and is not properly resourced to keep up with increased program demands.

According to CDSS, the department has experienced a significant increase in the day-to-day IT support needed for the growing number of department staff. This includes managing IT assets; deploying equipment; properly ensuring software updates; monitoring electronic traffic; securing network infrastructure; and other activities to make sure that CDSS staff are able to effectively use technology and to keep CDSS information and the client data the department holds secure. CDSS states that the ISD customer support and maintenance support staff only grew by three percent from 2017-2018 through 2023-24, while the department grew by over 45 percent over this same time period. The Service Desk experienced a 40 percent increase in ticket volume when comparing 2021 and 2022 data. CDSS notes that the department’s current ratio of IT support to staff ratio is one agent per 119 customers, which is almost double the industry standard of one staff to every 70 customers.

**Staffing and Resource Request.** According to CDSS, the ISD requires a business adaptive IT operating model and upfront capacity and staffing resources to meet increasing IT needs. CDSS requests ongoing funding for seven permanent positions and \$1.5 million over two years for contracting to ensure the ISD has adequate capacity to support the growing department's IT needs. The request includes \$1.56 million in 2025-26 and \$1.52 million ongoing for the seven positions, and an additional \$1.46 million for contract funding for consulting services for functions where specialized IT skillsets are required and it is hard to hire qualified staff. The requested seven positions include the following:

- *One Information Technology Manager I (ITM I):* This position manages all activities relating to Regional Office Support. The ITM I will provide leadership and support for both state and federal teams across California and make critical decisions on infrastructure related solutions.
- *One Information Technology Specialist III (ITS III):* This position will support and provide expertise on the ever-growing cloud infrastructure to the Network Operations Bureau. The ITS III allows OPS to keep up with security requirements, including timely and complete patching, and ensure CDSS IT assets are secured.
- *One Information Technology Specialist II (ITS II):* This position acts as the technical leads to ensure interoperability and support infrastructure needs such as cloud solutions, server maintenance, and network expansion and monitoring.

- *One Information Technology Specialist I (ITS I)*: This position will be on-site as network, infrastructure, general support function for the regional offices and act as the technical lead over various positions. They will perform asset management duties and identify and develop best practices and procedures in alignment with Program liaisons. They will also perform the more complex duties related to asset management, support procurement strategies, and disposition planning.
- *Three Information Technology Associates (ITA)*: These positions will directly assist the customer and provide on-site Service Desk support for regional offices. The regional offices have grown to more than 400 people and these ITAs will provide the necessary IT and telecommunications support for regional staff in various programs. They will be responsible for the tagging, distribution, collection, distribution, and data management for organizational IT assets. Additionally, these positions will support end-user equipment, ensuring efficient service delivery to address technical issues that arise.

In addition to the seven permanent positions, the \$1.46 million in contract funding will fill gaps where specialized IT skillsets are required, specifically to address operations and maintenance of certain software platforms where there is a growing backlog of maintenance and enhancements.

According to CDSS, this request will help improve the support staff-to-customer ratio from 1 to 119 to 1 to 109, put the ISD in a better position to successfully provide timely and effective customer service.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

**Questions.** The Subcommittee requests CDSS respond to the following:

1. Please provide an overview of this proposal.

**NOT FOR PRESENTATION****Issue 9: Proposals for Investment**

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

- **CalWORKs right size county administrative funding.** The County Welfare Directors Association (CWDA), SEIU California, and the California State Association of Counties request \$245 million TANF/General Fund in 2025-26 and \$210 million TANF/General Fund ongoing for county human services agencies for administration of the CalWORKs program. If approved, these resources would support a one-time increase to the CalWORKs single allocation of \$245 million in 2025-26 and an ongoing increase of \$210 million to reflect a revised budget methodology for the CalWORKs single allocation. According to CWDA, “funding for the eligibility component of the Single Allocation has fallen behind, with counties forced to overspend the statewide eligibility allocation and redirect employment services funding to backfill eligibility. In 2023-24, for instance, counties overspent eligibility funding by \$245 million, resulting in 20 percent of employment services being redirected to fund eligibility activities.”

CWDA states that “counties are required by state and federal mandates to perform eligibility activities within a specified amount of time, but these same time constraints do not apply to employment services. Consequently, given the underlying methodology shortcomings, counties have had to redirect funding from employment services to backfill eligibility overspending. Counties’ ability to provide essential support—the linkages to services and the follow through to ensure that families’ needs are being met—is significantly undermined. Such services and supports include, but are not limited to, credit recovery services, which play a pivotal role in facilitating access to housing and employment; legal services which remove barriers to education, employment, and career advancement; and other tangible supports that assist with educational and employment attainment such as books, uniforms, and transportation.”

- **Building on the Administration’s Work to Advance an Anti-Racist CalWORKs Program that is streamlined, prevents child poverty, and Improves Work and Education Outcomes for Families.** A coalition of organizations (CA Partnership to End Domestic Violence, Coalition of California Welfare Rights Organizations, CWDA, End Poverty in California, GRACE/End Child Poverty, Parent Voices CA, SEIU CA, Student Parents are Reimagining CalWORKs, and Western Center on Law and Poverty) request up to \$278.9 million ongoing to implement policies from the department’s AB 161 Report and other reforms not included in the AB 161 Report. If approved, these resources would support a package of changes to the CalWORKs program, including the following changes listed in the AB 161 report: focus on upfront engagement by eliminating welfare-to-work sanctions during first 90 days (\$1.7 million ongoing); eliminate the WPR penalty pass-through; simplify the income reporting threshold (\$112.1 million ongoing); reassess mandatory activities and expand allowable activities; streamline appraisal process (\$3.9 million one-time and \$7 million in ongoing savings) and deliver robust and ongoing training, technical assistance, and coaching to counties (\$4 million one-time). The request additionally includes changes not included in the AB 161 report: align the welfare-to-work sanction to federal law; improve access to supportive services; ensure a family-centered welfare-to-work flow; and reduce administrative burden.

The coalition notes that there are several high impact reforms included in this package that have no cost, and that several options could be combined to create low costs and ongoing savings as a result of program streamlining.

According to this coalition, “CalWORKs families face deep discrimination and disenfranchisement from economic prosperity. As a result, 45 percent of CalWORKs parents do not have a high school diploma or GED. We must ensure CalWORKs provides dignity and durable opportunities by ridding the program of failed policies based in racist and sexist ideas that poor people must be punished to work.” The coalition states that “CDSS’s report to the Legislature provides policy options and fiscal estimates that are a powerful foundation toward a CalWORKs program that follows the evidence to be anti-racist, trauma-informed, and deliver real pathways out of poverty.”

- **\$60 million new annual baseline for CalFood.** The California Association of Food Banks (CAFB) requests \$52 million General Fund ongoing to bring the CalFood baseline appropriation up from \$8 million to \$60 million. If approved, these resources would enable food banks to purchase California-grown and produced foods to fight hunger and support the critical food economy. According to CAFB, “in line with alarming poverty rates, the latest data from the Census Household Pulse Survey shows that nearly one in four households in California are facing food insecurity, while nearly one in three households with children are food insecure. While grocery prices continue to rise and strain household budgets, food banks remain a lifeline in helping families to put food on the table. Currently an estimated 10 percent of Californians are reporting getting free groceries from a food bank, food pantry, or other place that provides free food in the previous seven days, representing over 2.6M Californians (this is compared to seven percent for the U.S. overall).”

“In a survey of food banks conducted in February 2025, CAFB found that: CalFood represented 37 percent of the network’s food purchasing budget in 2024. Among the 24 small and medium food banks, 60 percent of their purchasing budget comes from CalFood. For 18 food banks, CalFood accounts for over half of their purchasing budget. CalFood was used to purchase over 80 million pounds of food in 2024. Over one-third of CalFood was used to purchase fresh fruits and vegetables. Another 28 percent was used to buy fresh dairy, eggs, meat, and poultry, and 11 percent went toward shelf-stable proteins, such as tuna, peanut butter, and canned and dry beans... CalFood helps food banks to purchase a wide variety of fresh and shelf stable groceries. Two-thirds of food banks use CalFood to purchase culturally appropriate or significant foods. Examples include tortillas, rice, beans, corn, tomato products, Halal foods, non-dairy items, and specialized produce. Most food banks (75 percent) also use CalFood to purchase specialized items for specific populations including older adults and children, unhoused people and people with chronic health conditions or dietary restrictions, and people with disabilities. These include nutrient-dense items such as fresh produce, milk, and eggs, and diet-specific items such as low-sodium canned goods, non-dairy milk, and gluten-free soups. It also includes ready-to-eat and no-cook items such rice or oatmeal bowls, canned tuna, and beef jerky. A cut to CalFood will mean less food to less people. Most food banks would have to limit or reduce the amount of food offered per household, and reduce nutritious and culturally relevant foods. Most would also have to reduce purchases of California-grown and produced food, including fresh fruits and vegetables, eggs, milk, chicken, holiday turkeys and hams, whole wheat bread, tortillas, peanut butter, and beans. A third of food

banks (32 percent) would have to reduce their paid workforce, most often by 1-2 staff members. One fifth of food banks (21 percent) would have to close existing food distribution sites.”

- **CalFresh fruit and vegetable supplemental benefits program.** Fullwell and Nourish California request \$63 million General Fund one-time for the CalFresh Fruit and Vegetable pilot program. If approved, this funding would allow the program to operate continuously for 12 months and expand its reach. According to Fullwell and Nourish California, “in 2023, CDSS launched the CalFresh Fruit and Vegetable EBT Pilot Project, which provided CalFresh households with up to \$60/month in additional food assistance when purchasing fresh fruits and vegetables using their CalFresh benefits. The program’s pilot phase ran from February 2023 – April 2024, followed by a second phase from October 2024 – January 2025. In that second phase, the program operated at 92 grocery stores and one farmer's market statewide. In its final month (January 2025), 67,000 CalFresh households earned \$3.3 million in rebates for fruits and vegetables -- an average of \$49.41 per household per month -- many of which are grown by California farmers.”

“With approximately one in five Californians reporting food insecurity in a September 2024 U.S. Census survey, this program alleviates hardship and increases access to healthy food for low-income Californians. Without additional funding in the 2025-26 budget, the program cannot be restarted, leaving tens of thousands of Californians with fewer resources to put food on their tables. And, with sufficient funding for at least 12 months of continuous operation, the program would be able to avoid another start-and-stop cycle and the difficulties that entails for CalFresh families, partner retailers, and CDSS.”

- **Food for All.** Nourish California and the California Immigrant Policy Center request \$30 million in 2026-27 and \$398.7 million General Fund in 2027-28 and ongoing to expand CFAP to all Californians regardless of age or immigration status. If approved, these resources would expand CFAP eligibility to income-eligible Californians regardless of age or immigration status in October 2027. This is in contrast to the current plan to expand CFAP to those age 55 and older, regardless of immigration status, in October 2027. According to Fullwell and the California Immigrant Policy Center, “research shows that access to food assistance like CalFresh improves overall health outcomes for individuals with low income and lowers health care costs over the long term... Currently, 45 percent of undocumented Californians and two in three undocumented children are affected by food insecurity according to a CHIS survey with the UCLA Center for Health Policy Research.”

“The 2023-2024 State Budget confirmed an expansion of eligibility for CFAP to include all Californians, age 55 years or older, who are income-eligible, regardless of their immigration status starting October 1, 2025. The 2024-2025 State Budget pushed the implementation date for this expansion to October 1, 2027. With this expansion, roughly 110,000 of California’s older immigrants will gain access to CalFresh food benefits. However, without an expansion of eligibility to include all ages, regardless of immigration status, between 380,000 to 550,000 Californians will continue to be excluded, including 92 percent of California’s undocumented farmworkers.”

- **Diaper Bank Funding.** The California Association of Diaper Banks requests \$16.5 million General Fund ongoing to support the California diaper bank network. If approved, these resources would keep free diapers available in 39 counties representing 83 percent of residents in California.

According to the California Association of Diaper Banks, “state funding for free diapers, again, expires June 30 of this fiscal year, and the Governor’s Budget does not propose funding for 2025-26. Without continued funding, California Diaper Bank Network will cease operations at the start of the 2025-26 fiscal year.”

“The state began providing limited-term funding for diaper banks six years ago and the 2021-22 State Budget included \$30 million one-time over three years for eight Diaper Banks, which expired June 30, 2024. Each site was originally receiving \$1.25 million annually for diapers. The 2024-25 state budget ultimately extended operations by one year by providing a reduced amount of \$9 million one-time—the minimum funding needed to distribute free diapers and wipes to low-income families through 11 Diaper Banks across California... Prior to the 2024-25 allocation, state funding had allowed Diaper Banks to distribute 160 million diapers to over 1 million families with 1.6 million infants...the cost of diapers is upwards of \$100 per month per child, and 57 percent of parents and caregivers reported missing an average of four days of school or work per month because they did not have enough diapers to drop their child off at child care.”

- **Prevent funding cliff for promise neighborhoods.** The California Cradle to Career Coalition, GRACE/End Child Poverty California, and Hayward Promise Neighborhood request \$17.5 million General Fund one-time to continue state support for Promise Neighborhoods in the counties of San Francisco, Alameda, San Diego, and Tehama and support proven regional anti-poverty partnerships in Salinas and the Central Valley. If approved, this funding would continue state funding for four existing Promise Neighborhoods (\$12 million General Fund over three years), and support regional shovel-ready projects in Salinas and the Central Valley (\$3 million over three years.)

According to this coalition, “a funding cliff threatens the four Promise Neighborhoods, undermining the achievements gained in the first two years of the funding awarded in 2022-23 budget. California’s existing investment expires in July and poses severe consequences for the children and families served by the Promise Neighborhoods. Additionally, regional partnerships working in some of the most underserved areas such as the Salinas and Central Valleys have shovel-ready projects with acute need for modest state investment...early data highlights the breadth of impact, including the advancement of several state goals. Statewide: 73,320 children 0-18, and 57,054 adults were reached with comprehensive services at schools, preschools and in the community. Mission Promise Neighborhood (San Francisco): 23 families moved into permanent, affordable housing, 236 families enrolled in public benefits. Hayward Promise Neighborhood (Alameda County): 184 percent increase in families accessing food and nutrition resources, 19 percent decrease in food insecurity. Chula Vista Promise Neighborhood (San Diego County): 15 percent decrease in chronic absenteeism, 4.4 percent increase in high school graduation. Corning Promise Neighborhood (Tehama County): \$3.5 million procured to develop high-wage, high-growth areas in rural high schools through the Career Technical Education Pathway ReDesign, 1,960 mental health therapeutic sessions with K-12 students.

# SUBCOMMITTEE NO. 3

# Agenda

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



Monday, May 19, 2025  
3:00 pm, or upon adjournment of session  
1021 O Street – Room 1200

Consultant: Elizabeth Schmitt, Nora Brackbill, Scott Ogus

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**PUBLIC COMMENT**

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**5180 DEPARTMENT OF SOCIAL SERVICES**

**Issue 1: Child Care May Revision Overview**

**Governor’s May Revision – Child Care.** The May Revision includes the following solutions and adjustments to child care and development programs under the Department of Social Services (CDSS).

**Significant May Revision Solutions: Child Care**

- **Child Care Cost of Living Adjustment (COLA) Suspension.** Reduction of \$60.65 million General Fund in 2025-26 and ongoing to suspend the statutory cost of living adjustment for child care and development programs in 2025-26. This solution includes corresponding trailer bill language.
- **Emergency Child Care Bridge.** Reduction of \$42.7 million General Fund in 2025-26 and ongoing to the Emergency Child Care Bridge program, which funds child care slots for children in foster care on an emergency basis. According to the Department of Finance (DOF), this reduction aligns funding with current expenditures. Approximately \$51 million General Fund remains to support the program for state operations and local assistance. The chart below, provided by DOF, displays spending on Emergency Child Care Bridge over the last three years.

**EMERGENCY CHILD CARE BRIDGE (ECCB)**

FISCAL YEAR	ALLOCATION ASSISTANCE (GF)	EXPENDITURES ASSISTANCE (GF)	ALLOCATION ADMIN (GF)	EXPENDITURES ADMIN (GF)
FY 2022-23	\$63,832,000	\$27,700,512	\$25,075,000	\$9,110,729
FY 2023-24	\$57,830,000	\$27,230,138	\$24,825,000	\$11,883,512
FY 2024-25*	\$66,329,081	\$16,462,769	\$28,245,820	\$6,077,815

\* FY 2024-25 includes July 2024 - December 2024 expenditure data.

**Significant May Revision Augmentations: Child Care**

- **Pay Providers Prospectively.** Increase of \$52 million General Fund to support the implementation of paying Child Care and Development providers prospectively and align with a Final Rule issued by The Administration for Children and Families (ACF). The Final Rule requires states to pay child care providers prospectively prior to the delivery of services. The ACF has approved a waiver until August 1, 2026, to provide California with two years of additional time to begin implementing prospective payments. Of the \$52 million, \$43.8 million is to support local administration ongoing, and \$8.2 million is to support system automation costs. The budgeted costs support implementation for Child Care & Development contractors, as well as administrative support to county administered programs.

This funding does not address a related new federal rule which requires providers to be paid based on enrollment. Absent any further changes, the state would default back to an attendance-based enrollment system on July 1, 2025.

- **Administrative Support for Alternative Payment Programs.** Increase of \$70 million General Fund in 2025-26 to provide resources to Alternative Payment Program agencies (child care contractors) for administration and support costs associated with implementing ongoing provisions of the Memorandum of Understanding with Child Care Providers United.
- **Rate Reform Support Costs.** Increase of \$21.8 million one-time federal funds to support start-up automation activities for CDSS to implement a single rate structure for child care based on the alternative methodology. The Department is working towards the goal of automating the new single rate structure as early as July 1, 2027.
- **Administrative Costs to Distribute Cost of Care plus Payments.** Increase of \$44.8 million for child care contractors to continue distributing the “cost of care plus” monthly rate supplements for child care providers, pursuant to the 2023 and 2024 Budget Acts.

#### **Other May Revision Budget Adjustments: Child Care**

- **Preschool Development Grant Award Authority Adjustment.** Increase reimbursements by \$280,000 one-time federal funds for the Preschool Development Grant.
- **Child Care Direct Deposit Staffing and Re-appropriation.** Increase of \$944,000 and 5 positions in 2025-26, and \$922,000 and 5 positions in 2026-27 and ongoing to provide administrative support to process child care and development contract payments. Re-appropriation of up to \$1.1 million from the 2022 Budget Act to extend the existing direct deposit contract funds.
- **Prospective Pay Implementation.** Increase of \$582,000 and 6 positions in 2025-26 and \$1,111,000 and 6 positions in 2026-27 and ongoing to support implementation of prospective pay for child care providers to comply with federal requirements.

**Subcommittee Staff Comment and Recommendation – Hold Open.** On the Emergency Child Care Bridge Program, DOF states that the \$42.7 million reduction is designed to right-size the program budget with recent spending. Subcommittee staff is aware of at least one county (Santa Barbara), which has fully exhausted its Emergency Bridge Program funds for 2024-25, and has requested access to unspent program funds from other counties in order to cover its shortfall. This casts doubt on the Administration’s assertion that the program could sustain current services for children in foster care with a \$42.7 million reduction.

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

1. Please provide an overview of the May Revision proposals for CDSS child care programs.
2. Please explain the Administration’s rationale for suspending the child care COLA.
3. What assumptions is the Administration making about Emergency Child Care Bridge program trends to determine that a permanent reduction of \$42.7 million will not affect program access for children in foster care? Will Emergency Child Care Bridge program funds be reallocated across counties to maximize available funding?

4. Please describe the May Revision proposal to use \$21.8 million in one-time federal funds for automation and start-up costs for the single rate structure. How will these federal funds be used, and over what time period will they be spent? What components of the single rate structure are being automated?
5. Existing law requires that if the new single rate structure does not take effect July 1, 2025, CDSS shall provide the Legislature with a timeline for transitioning from the rates that are in effect on July 1, 2025, to the new rates. What is the timeline for transitioning to a single rate structure?

**Issue 2: May Revision Child Care Trailer Bills**

**Governor’s May Revision – Child Care Trailer Bills.** The Governor’s May Revision includes the following trailer bills for CDSS child care programs:

- **Cost of Care Plus Payments.** CDSS proposes trailer bill language to extend the current “cost of care plus” supplemental rate payments to child care providers for an additional year. These payments are monthly per-child supplemental payments required under the 2023 CCPU collective bargaining agreement and the 2023 Budget Act. The 2024 Budget Act required that future child care rates be no lower than the rates in effect June 30, 2024, inclusive of the cost of care plus payments.
- **Child Care Cost of Living Adjustment (COLA).** The May Revision includes trailer bill to suspend the statutorily required COLA for child care programs in 2025-26, to align with the proposed \$60.65 million reduction. This trailer bill is not available as of this writing.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the Administration’s proposed child care trailer bills.

**Issue 3: CDSS May Revision Overview (Non-IHSS Items)**

**Governor’s May Revision – CDSS.** The May Revision includes the following solutions and adjustments programs under CDSS. This item includes all CDSS May Revision proposals except for child care, which is included in Issue #1 of this agenda, and In-Home Supportive Services (IHSS), which is on the Subcommittee’s agenda for May 20, 2025.

**Significant May Revision Solutions: CDSS (Non-IHSS Items)**

- **Family Urgent Response System (FURS).** Decrease of \$13 million General Fund in 2025-26 and ongoing. FURS provides 24/7 in-person mobile response to support children in foster care and their caregivers. According to DOF, this reduction aligns budgeted funds with current expenditures (see chart below for recent annual spending). Approximately \$18 million (\$17 million General Fund) remains to support the system.

**FAMILY URGENT RESPONSE SYSTEM (FURS)**

FISCAL YEAR	ALLOCATION (GENERAL FUND)	EXPENDITURES (GENERAL FUND)
FY 2022-23	\$26,277,215	\$10,876,868
FY 2023-24	\$26,407,215	\$12,639,944
FY 2024-25*	\$26,597,000	\$5,338,233

\* FY 2024-25 includes July 2024 - December 2024 expenditure data.

- **Foster Care Tiered Rate Structure.** Makes implementation of the Foster Care Tiered Rate Structure subject to a “trigger,” based on DOF’s assessment of the availability of General Fund in spring 2027. Implementation of the Foster Care Tiered Rate Structure is under way with rates scheduled to take effect on July 1, 2027.
- **California Food Assistance Program (CFAP) Expansion.** Makes implementation of the expansion of CFAP to all adults ages 55 and over subject to a “trigger,” based on DOF’s assessment of General Fund availability in spring 2027.
- **Elimination of the CalWORKs RADEP and E2Lite.** Increase of \$1.5 million total funds in one-time automation costs and decrease of \$18.2 million total fund in ongoing savings to streamline the CalWORKs program experience by implementing a set of policy changes that are consistent with more holistic interventions and family-centered approaches to CalWORKs. The \$18.2 million in savings results from replacing county welfare to work data reporting activities with data elements using administrative data extracts from CalSAWS, instead of the Research and Development Enterprise Project (RADEP) and E2Lite. The proposal to streamline the CalWORKs program experience includes trailer bill.

**Significant May Revision Augmentations: CDSS (Non-IHSS Items)**

- **Facility Management System.** CDSS requests additional one-time funding of \$14.78 million General Fund in 2025-26 to support the development, implementation, and maintenance of the Facility Management System (FMS). This includes resources equivalent to 16 positions to facilitate the successful completion and maintenance of the FMS project. This funding will allow CDSS to procure and deploy the first iteration of FMS in 2025-26. Additionally, this request includes provisional language to make expenditure of these funds contingent upon project approval by the Department of Technology and in alignment with approved project documents.

**Other May Revision Budget Adjustments: CDSS (Non-IHSS Items)**

- **SUN Bucks Administration.** Increase of \$267,000 General Fund in 2025-26, \$262,000 General Fund in 2026-27 and ongoing, and 4 positions to support administration of the SUN Bucks program pursuant to the approval of the 2025 plan by the United States Department of Agriculture Food and Nutrition Service. Increase of \$267,000 federal funds in 2025-26, and \$262,000 federal funds in 2026-27 and ongoing. Includes provisional language for contract exemption language related to administration of the program.
- **Immigration Services Bureau Workload.** Increase of \$582,000 in 2025-26 and ongoing, and 3 positions to maintain ongoing immigration services.
- **Oversight of Manual Restraints and Seclusions in Short-Term Residential Therapeutic Programs, SB 1043 (Grove), Chapter 628, Statutes of 2024.** Increase of \$1,135,000 and 6 positions in 2025-26 and \$1,109,000 and 6 positions ongoing beginning in 2026-27 to implement SB 1043.
- **First Phase of Foster Care Tiered Rate Structure State Operations.** Increase of \$788,000 General Fund and 6.3 positions in 2025-26, \$771,000 General Fund and 6.3 positions in 2026-27 and 2027-28, and \$538,000 General Fund and 4.2 positions in 2028-29 and ongoing to provide additional resources to support the implementation of the Tiered Rate Structure. Increase of \$1,103,000 federal funds and 2.7 positions in 2025-26, \$1,074,000 and 2.7 positions in 2026-27 and 2027-28, and \$974,000 and 1.8 positions in 2028-29 and ongoing for the same purpose. These resources are incremental increases to the state operations proposal included in the Governor's Budget for the Tiered Rate Structure and include adjustments to the Governor's Budget proposal to reflect eligible federal funds that can be leveraged.
- **Information Systems Division Growth and Sustainability.** Decrease of \$1,171,000 General Fund in 2025-26 and 2026-27, and \$150,000 in 2027-28 and ongoing to reflect a technical change to align resources with the proposal included in the Governor's Budget.
- **Technical Cleanup of Program Funds for Foster Family Home and Small Family Home Insurance Fund.** Elimination of federal fund transfer authority to correct that Foster Family Home and Small Family Home Insurance Fund claims are not eligible for Title IV-E federal funding because the claims are not tied to service delivery.

- **Provisional Language Only: Foster Family Home and Small Family Home Insurance Fund.** Increase of the General Fund transfer amount to the Foster Family Home and Small Family Home Insurance Fund and to increase the expenditure authority in the special fund by a corresponding amount, for approved claims exceeding the current \$600,000 appropriation.
- **New Aid Code for TANF Timed-Out Two-Parent Families.** Increase of \$455,000 federal funds in 2025-26 to automate a new aid code into the Medi-Cal Eligibility System and California Statewide Automated Welfare System (CalSAWS) for the two parent Temporary Assistance for Needy Families (TANF) timed-out cases to ensure compliance with federal rules and reporting requirements.
- **Work Participation Rate Penalty Impact.** Increase of \$21,096,000 in 2025-26 to supplement the reduction to the federal TANF block grant due to the Work Participation Rate penalty imposed on the state for failure to meet the requirements from federal fiscal year 2012 through 2014.
- **CalFresh Enhancement to Populate Income Page.** Increase of \$270,000 federal funds in 2025-26 to auto-populate the income page with data from the Payment Verification System to reduce manual data entry and improve accuracy.
- **CalFresh Standard Utility Allowance Standardization.** Increase of \$700,000 General Fund in 2025-26 and \$1 million federal funds to support updates to client-facing forms and notices as well as automation updates to CalSAWS necessary to implement the Final Rule released by United States Department of Agriculture Food and Nutrition Service in 2024, in time for federal fiscal year 2026.
- **Refugee Cash Assistance Eligibility Change.** Increase of \$30,000 General Fund and \$266,000 federal funds in 2025-26 for automation changes to effectuate the federal changes to the Refugee Cash Assistance (RCA) program.
- **Child and Adolescent Needs and Strengths Fidelity and Training.** Increase of \$928,000 in 2025-26 and ongoing to provide additional resources for child and adolescent needs and strengths fidelity and training activities related to the foster care Tiered Rate Structure. Increase of \$335,000 federal funds in 2025-26 and ongoing for corresponding federal funds. These adjustments are in addition to the proposal included in the Governor's Budget.
- **Case Management Information and Payrolling System Automation for Ensuring Access to Medicaid Services Final Rule.** Increase of \$162,000 one-time General Fund in 2025-26 and reimbursement increase of \$1,294,000 one-time in 2025-26 to implement automation changes to the Case Management Information and Payrolling System related to the Ensuring Access to Medicaid Services Final Rule. Includes provisional language to authorize DOF to decrease this item and related reimbursement up to these amounts if the rule is rescinded or repealed.
- **CalFresh Employment and Training Fund.** Allows for the transferring of federal funds to the newly established CalFresh Employment and Training Fund.

- **Ongoing Temporary Protected Status Deadline Extension.** Extends the availability of ongoing funding for the Temporary Protected Status (TPS) Program. This would extend the deadline from one to three years for encumbrance and five years to liquidate.
- **Child Welfare Services - California Automated Response and Engagement System.** Provides flexibility for DOF to increase augmentation amounts available from prior years.
- **Various Re-appropriations for Support and Local Assistance through June 30, 2026.** Proposes to re-appropriate funding from the following items through June 30, 2026:
  - Up to \$80 million from the Budget Act of 2024, for the State Supplemental Grant Program.
  - Up to \$25 million from the Budget Act of 2023, for the California Statewide Automated Welfare System interface with the Child Welfare Services - California Automated Response and Engagement System.
  - Up to \$1,820,000 from the Budget Act of 2024, for automation in the California Statewide Automated Welfare System to support implementation of the foster care Tiered Rate Structure.
  - Up to \$2,531,000 from the Budget Act of 2024, for automation in the Child Welfare Services - California Automated Response and Engagement System to support implementation of the foster care Tiered Rate Structure.
  - Up to \$40 million from the Budget Act of 2022, to increase the use of home-based family care and the provision of services and supports to children in foster care and their foster caregivers.
  - Up to \$301,000 from the Budget Act of 2024, for the County Welfare Department Offices Physical Accessibility Review.
  - Up to \$1.1 million from the Budget Act of 2022, to extend the existing direct deposit contract funds.
  - Up to \$1,850,000 from the Budget Act of 2024, to allow CDSS to conduct a contracted zero trust assessment to comply with statewide cybersecurity standards.
- **Various Re-appropriations through June 30, 2027.** Proposes to re-appropriate funding from the following items through June 30, 2027:
  - Up to \$4 million from the Budget Act of 2021, for complex care services.
  - Up to \$521,000 from the Budget Act of 2021, for the California Fruit and Vegetable EBT Pilot Project.
  - Up to \$10,434,000 from the Budget Act of 2021, for administration of various housing programs.

- **Rapid Response Re-appropriation.** Re-appropriates all remaining Rapid Response Funds from the Budget Acts of 2021, 2022, and 2023, to continue services for the Rapid Response Program.
- **California Food Assistance Program Expansion Re-appropriation.** Re-appropriates up to \$38,000,000 General Fund to be available through June 30, 2029, for the automation of the California Food Assistance Program expansion.

**CDSS May Revision Caseload Adjustments.** The May Revision proposes a net increase of \$1,779,811,000 total funds in 2025-26 that is primarily driven by updated caseload estimates since the 2025-26 Governor’s Budget. The net increase in total funds in 2025-26 is comprised of an \$864,932,000 General Fund increase, \$4,473,000 federal funds increase, \$750,000 special funds decrease, and \$911,156,000 reimbursements increase. Caseload and workload changes since the 2025-26 Governor’s Budget are displayed in the following table:

Item	Program	Change from Governor's Budget
5180-101-0001	California Work Opportunity and Responsibility to Kids (CalWORKs)	\$76,870,000
5180-101-0001	Other Assistance Payments	\$106,157,000
5180-101-0001	Child Care	\$(73,467,000)
5180-101-0890	CalWORKs Federal Funds	\$(117,559,000)
5180-101-0890	Other Assistance Payments	\$50,579,000
5180-101-0890	Child Care	\$40,478,000
5180-101-8004	Other Assistance Payments	\$(750,000)
5180-104-0001	Child Care	\$(1,000)
5180-111-0001	In-Home Supportive Services (IHSS)	\$720,946,000
5180-111-0001	IHSS - Reimbursements	\$926,247,000
5180-111-0001	Supplemental Security Income/State Supplementary Payment (SSI/SSP)	\$(50,328,000)
5180-141-0001	County Automation and Administration Projects	\$70,322,000
5180-141-0001	County Administration & Automation Projects - Reimbursements	\$(74,829,000)
5180-141-0890	County Automation and Administration Projects	\$69,191,000
5180-151-0001	Special Programs	\$(11,000)
5180-151-0001	Children & Adult Services and Licensing	\$7,544,000
5180-151-0001	Children & Adult Services and Licensing - Reimbursements	\$53,514,000
5180-151-0890	Children & Adult Services and Licensing	\$(38,216,000)
5180-161-0001	Special Programs	\$6,900,000

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision proposals for the CDSS non-IHSS programs included in this item.
2. Please explain the Administration’s rationale for imposing a “trigger” on the Foster Care Tiered Rate Structure and the CFAP expansion. Please describe (A) how this would affect ongoing implementation activities for these programs, and (B) how the Administration would move forward in 2027 should DOF decide not to “trigger on” implementation in spring 2027?
3. Please explain the Administration’s rationale for reducing FURS by \$13 million permanently. Stakeholders have noted that FURS utilization has grown steadily since FURS launched in 2021, and that the Administration’s proposal to fully eliminate FURS in 2024 had a chilling effect on implementation. How would the Administration ensure that FURS is able to continue providing its essential services with a reduction of this magnitude, especially if utilization increases?

**Issue 4: CDSS May Revision Trailer Bills (Non-IHSS Items)**

**Governor’s May Revision -- CDSS Trailer Bills.** The Governor’s May Revision includes the following trailer bills for CDSS (not including IHSS trailer bills, which will be on the May 20, 2025 Subcommittee agenda):

- **Streamlining CalWORKs.** According to CDSS, this proposal makes various changes to streamline the CalWORKs program:
  - **Reassessing mandatory activity by making Job Club optional**—This would make Job Club an optional program component and simplify its rules and exceptions. Job Club would instead be offered to, but not required of, all participants.
  - **Expanding allowable welfare to work activities**—This would expand the list of eligible welfare-to-work (WTW) program activities available to participants. Currently, the required development of a WTW Plan consists of participants and their caseworker making selections from a prescribed list of allowable WTW activities. The expanded list of activities includes but is not limited to case plan development, WTW Plan revision, and coaching with a case manager.
  - **Simplifying the sanction curing process**—This would simplify the WTW sanction curing process by allowing an individual to indicate to the county verbally or in writing that they want to cure their sanction and begin participating in activities. In addition, it would clarify that, pursuant to WIC section 11322.81, individuals known to be meeting federal work participation requirements shall have their sanctions automatically cured without the need for the individual to express the desire to cure.
- **Pre-populated Semiannual Report 7.** Clarifies that the requirement to provide recipients of CalFresh and California Work Opportunity and Responsibility to Kids (CalWORKs) benefits with a pre-populated (i.e. pre-filled) Semi Annual Report (SAR) 7 may be completed via mail or electronically, at the election of the recipient.
- **Child and Family Team Meetings for Family Maintenance Cases.** Requires all county child welfare agencies to conduct Child and Family Team (CFT) meetings for youth receiving both voluntary and court ordered Family Maintenance (FM) services. According to CDSS, this helps make sure youth in FM cases receive CFT meetings to help prevent additional children from going into out-of-home placements by providing families with appropriate case plans.
- **Adoption Assistance Program – Wraparound Services and Out-of-Home Placement.** According to CDSS, clarifies the allowable use of Adoption Assistance Program (AAP) payments for wraparound services and out-of-home placement. The proposed changes include:
  - Authorizing AAP payments for wraparound services.
  - Defining and clarifying eligibility criteria for wraparound services and out-of-home placement including standards and requirements that must be met.

- Updating the AAP payments for out-of-home placement to align with the new Tiered Rate Structure.
  - Authorizing the utilization of AAP payments for wraparound services for 12 months, and for an additional 12 months if there is a continued need to resolve a child’s specific condition(s).
  - Clarifying eligibility for wraparound services upon discharge of out-of-home/out-of-state placement.
  - Clarifying the out-of-home/out-of-state placement maximum for 12 months with 60 days additional for transitional planning.
  - Authorization for All-County Letter/written instruction.
- **California Food Assistance Program (CFAP) Expansion Trigger.** At the time of this writing, this trailer bill was not available.
  - **Foster Care Tiered Rate Structure Trigger.** At the time of this writing, this trailer bill was not available.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the proposed trailer bills included in this item.

**0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY**

**Issue 1: Budget Change Proposals and Other Adjustments**

**Budget Change Proposals – May Revision.** CalHHS requests special fund expenditure authority to support the following two budget change proposals.

*Behavioral Health Transformation – Behavioral Health Services Act Continued Implementation.* CalHHS requests expenditure authority from the Behavioral Health Services Fund of \$280,000 in 2025-26 to support coordination and implementation of behavioral health initiatives, including SB 326 (Eggman), Chapter 790, Statutes of 2024, the Behavioral Health Services Act, approved by voters in March 2024 as Proposition 1.

<b>Multi-Year Funding Request Summary – Behavioral Health Transformation</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3085 – Behavioral Health Services Fund	\$280,000	\$-
<b>Total Funding Request:</b>	<b>\$280,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

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.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Child Welfare Services – California Automated Response and Engagement System.* CalHHS requests expenditure authority from the CalHHS Automation Fund of \$15 million in 2025-26 to support project flexibility in accessing unspent appropriations and unused augmentations from prior years.

<b>Multi-Year Funding Request Summary – CWS-CARES</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
9745 – CalHHS Automation Fund	\$15,015,000	\$-
<b>Total Funding Request:</b>	<b>\$15,015,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

OTSI requests an increase of \$15,015,000 one-time to align funding already approved in the Department of Social Services' budget from prior Budget Acts. These funds are separate from the CWS-CARES project costs requested in the 2025-26 Governor's Budget proposal.

**Preschool Development Grant Award Federal Funds Adjustment – May Revision.** CalHHS requests federal fund expenditure authority of \$280,000 in 2025-26 to align federal funding authority with receipt of the federal Preschool Development Grant.

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

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

1. Please provide a brief overview of these proposals and adjustments.

**4100 STATE COUNCIL ON DEVELOPMENTAL DISABILITIES****Issue 1: May Revision Overview**

**Governor's May Revision – State Council on Developmental Disabilities (SCDD).** The May Revision includes the following adjustment to SCDD:

- **Increased Reimbursement Authority – Quality Assessment Project.** Increases reimbursements by \$198,000 in 2025-26 and \$299,000 in 2026-27 and ongoing to support updates to an existing interagency agreement with the Department of Developmental Services related to the Quality Assessment project.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision adjustment included in this item.

**4120 EMERGENCY MEDICAL SERVICES AUTHORITY**

**Issue 1: Budget Change Proposals and Other Adjustments**

**Budget Change Proposals – May Revision.** EMSA requests General Fund and reimbursement expenditure authority to support the following two budget change proposals.

*California Poison Control Systems Funding Augmentation.* EMSA requests expenditure authority of \$2.7 million (\$1.1 million General Fund and \$1.6 million reimbursements) in 2025-26, \$3.5 million (\$1.4 million General Fund and \$2.2 million reimbursements) in 2026-27, and \$4.4 million (\$1.7 million General Fund and \$2.7 million reimbursements) annually thereafter. If approved, these resources would support increased salaries and benefit expenses resulting from negotiated union bargaining agreements for staff operating the California Poison Control System.

<b>Multi-Year Funding Request Summary – California Poison Control Systems</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$1,072,000	\$1,359,000
0995 - Reimbursements	\$1,626,000	\$2,159,000
<b>Total Funding Request:</b>	<b>\$2,698,000</b>	<b>\$3,518,000</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Additional fiscal year resources requested – 2027-28 and ongoing: \$4,386,000.

The California Poison Control System (CPCS) is a statewide network of health care professionals that provide free, immediate, confidential expert information, treatment advice, and referral through a public toll-free hotline accessible 24 hours a day, seven days a week. CPCS also maintains separate 24 hour free hotline numbers for medical professionals and 911 police and emergency medical services. CPCS is composed of four Poison Control Centers (PCCs): 1) Fresno/Madera Division located at Valley Children’s Hospital, 2) Sacramento Division located at UC Davis Medical Center, 3) San Diego Division located at UC San Diego Medical Center, and 4) San Francisco Division located at Zuckerberg San Francisco General Hospital and Trauma Center.

CPCS staff are represented under a collective bargaining agreement with the UC Office of the President. Increased salaries and benefit costs negotiated under these agreements have led to increased costs for the program. CPCS has addressed these costs using carryover Health Resources and Services Administration (HRSA) grant funds and federal Medicaid matching funds. However, according to EMSA, no HRSA or federal matching funds are available for 2025-26, 2026-27, or 2027-28. As a result, EMSA requests General Fund resources to fill these funding gaps and avoid operational and programmatic reductions in the CPCS.

*Enterprise Services and Data Management (ESDM) Solution - Reappropriation.* EMSA requests reappropriation of General Fund expenditure authority of \$3.6 million, originally authorized in the 2021 Budget Act and reappropriated in the 2024 Budget Act. If approved, these reappropriated resources would support continued implementation of the Enterprise Services and Data Management Solution that will support the Electronic Physician Orders for Life Sustaining Treatment (ePOLST) system, the Central

Registry replacement system, and the California EMS Information System (CEMSIS) replacement system.

According to EMSA, it has re-evaluated its approach to implement three information technology (IT) solutions approved in previous fiscal years:

- ePOLST Project – The Electronic Physician Orders for Life Sustaining Treatment (ePOLST) system will digitize the POLST form, allowing emergency responders to have access to real-time, electronic patient care data, including patient care instructions on POLST forms regarding life-sustaining treatment for those who are seriously ill. This project was authorized by the Legislature in the 2021 Budget Act.
- CEMSIS – The California EMS Information System (CEMSIS) collects data related to the provision of emergency medical services in California and provides participating local EMS agencies (LEMSAs) access to aggregate statewide data. CEMSIS is a tool for local EMS system quality improvement, improved EMS system management, and a limited benchmarking against and compliance with national EMS standards. The 2021 Budget Act had allocated resources to support replacement of CEMSIS with another system. However, EMSA has re-evaluated its business needs and instead will reprocure to continue operation of the existing CEMSIS system.
- Central Registry – The Central Registry tracks EMS personnel certification and licensure, accreditation, and enforcement history. The 2023 Budget Act included resources to begin planning to replace the legacy Central Registry with a new system that addresses deficiencies of the legacy system.

EMSA proposes to implement an integrated enterprise data management solution rather than these three separate IT systems to provide faster implementation and cost effectiveness. EMSA is requesting to reappropriate resources originally authorized in the 2021 Budget Act to support the streamlining of the EMSA data enterprise solution.

**Technical Correction to Baseline Budget – May Revision.** EMSA requests annual General Fund expenditure authority of \$5.5 million to correct an error in the 2024 Budget Act that inadvertently duplicated a reduction in ongoing resources.

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

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

1. Please provide a brief overview of these proposals and adjustments.

**4150 DEPARTMENT OF MANAGED HEALTH CARE**

**Issue 1: Budget Change Proposals and Other Adjustments**

**Budget Change Proposals and Trailer Bill Language – May Revision.** DMHC requests special fund expenditure authority to support the following four budget change proposals and associated trailer bill language.

*Behavioral Health Transformation – Behavioral Health Services Act Continued Implementation.* DMHC requests one position and expenditure authority from the Managed Care Fund of \$194,000 in 2025-26, \$188,000 in 2026-27 through 2029-30. If approved, this position and resources would support investigation of county complaints about managed care health plans’ compliance with SB 326 (Eggman), Chapter 790, Statutes of 2024.

<b>Multi-Year Funding Request Summary – Behavioral Health Transformation</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0933 – Managed Care Fund	\$194,000	\$188,000
<b>Total Funding Request:</b>	<b>\$194,000</b>	<b>\$188,000</b>
<b>Total Requested Positions:</b>	<b>1.0</b>	<b>1.0</b>

\* Position and resources ongoing after 2026-27 until 2029-30.

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.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Pharmacy Benefit Manager Licensure and Data Reporting Requirements.* DMHC requests six positions and expenditure authority from the Pharmacy Benefit Manager Fund of \$2.3 million in 2025-26. If approved, these positions and resources would support implementation of licensure and data reporting requirements for Pharmacy Benefit Managers.

DMHC also requests trailer bill language to implement the licensure and data reporting requirements for Pharmacy Benefit Managers.

<b>Multi-Year Funding Request Summary – PBM Licensure and Data Reporting</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3447 – Pharmacy Benefit Manager Fund	\$2,279,000	\$-
<b>Total Funding Request:</b>	<b>\$2,279,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>6.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal or associated trailer bill language from the Department of Finance.

*Web Accessible Service Portal Replacement Adjustment.* DMHC requests reduction of expenditure authority from the Managed Care Fund of \$274,000 in 2025-26 and \$136,000 in 2026-27 to reduce project resources for the Web Accessible Service Portal Replacement proposed in the January budget, to reflect project authority being delegated back to DMHC.

<b>Multi-Year Funding Request Summary – Web Accessible Service Portal Replacement</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0933 – Managed Care Fund	(\$274,000)	(\$136,000)
<b>Total Funding Request:</b>	<b>(\$274,000)</b>	<b>(\$136,000)</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Health Care Service Plans Discipline – Civil Penalties (SB 858).* DMHC requests reappropriation of expenditure authority from the Managed Care Fund of up to \$2.8 million, originally authorized in the 2024 Budget Act. If approved, these reappropriated resources would align with information technology delays in receiving final approval in the project approval lifecycle process, to support implementation of SB 858 (Wiener), Chapter 985, Statutes of 2022.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

**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.

**4170 CALIFORNIA DEPARTMENT OF AGING****Issue 1: May Revision Overview**

**Governor’s May Revision – California Department of Aging (CDA).** The May Revision includes the following adjustments to CDA:

- **Technical Baseline Adjustment.** Technical adjustment of net-zero shifts of existing funds for various programs within each respective state operations item.
- **Federal Trust Fund Authority Technical Adjustment.** Increase of federal fund reimbursement authority by \$23.2 million in 2025-26 and ongoing and \$3,870,000 in 2025-26 to align federal fund reimbursement authority with receipt of federal funds.
- **Multipurpose Senior Services Program.** Allows the Department of Finance to decrease funding if the Centers for Medicare and Medicaid Services’ Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality Final Rule is rescinded or repealed. Any adjustment of this item shall be reported in writing to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee within 10 days of the date the adjustment is approved.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision adjustments included in this item.

**4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****Issue 1: May Revision Overview**

**Governor's May Revision – Department of Developmental Services.** The May Revision includes the following solutions and adjustments to programs under the Department of Developmental Services (DDS).

**Significant May Revision Solutions: DDS**

- **Quality Incentives Program Eligibility Provider Mandate.** Reduction of \$221.7 million General Fund in 2026-27 and ongoing. This includes corresponding trailer bill.
- **Service Provider Rate Reform Hold Harmless Provision.** Reduction of \$75 million General Fund in 2025-26 to end service provider rate reform hold harmless policy as of February 28, 2026 instead of June 30, 2026. This includes corresponding trailer bill.
- **Self-Determination Program Updates.** Reduction of \$22.5 million General Fund in 2025-26, and \$45.5 million General Fund ongoing. This includes corresponding trailer bill.
- **Regional Centers Direct Service Professional Workforce Training and Development.** Reduction of \$17.6 million General Fund in 2025-26 and 2026-27 and \$36.8 million General Fund in 2027-28 and ongoing.
- **Porterville Developmental Center Ongoing Savings.** Reduction of \$10 million General Fund in 2026-27 and ongoing reflecting historical savings.
- **Implicit Bias Training.** Reduction of \$5.6 million General Fund in 2025-26 and ongoing. This includes corresponding trailer bill.
- **Health and Safety Wavier Assistance.** Reduction of \$3.0 million General Fund in 2025-26 and ongoing. This includes corresponding trailer bill.

**May Revision Augmentations: DDS**

- **Life Outcomes Improvement System (LOIS)** (\$13.3 million total funds, \$5.1 million General Fund). Includes one-year limited-term resources equivalent to seventeen (17.0) positions at the Department, and resources for regional centers to continue the planning phase of the Project Approval Lifecycle (PAL) process.
- **Federal Access Rule** (\$1.9 million total funds, \$1.6 million General Fund). Includes one-year limited term resources equivalent to nine (9.0) positions to support the increased workload related to compliance with the new federal Home and Community-Based Access Rule requirements.

- **Staffing for Health and Safety Investigations and Due Process Caseload** (\$1.4 million total funds, \$1.2 million General Fund). Includes nine permanent positions and \$2.0 million total funds (\$1.7 million General Fund) in 2026-27 and ongoing to support increased workload related to health and safety concerns, such as rising appeals and complaints workloads.
- **Clinical Monitoring Team Support for Specialized Community Homes.** (\$680,000 total funds, \$544,000 General Fund). Includes four permanent positions to support development and monitoring of specialized community homes and services.
- **Increased Reimbursement and Cost Recovery** (\$1.3 million total funds, \$1.1 million General Fund). Includes five permanent positions and contracted consultant support to explore options and obtain payment from public and private health insurers for services purchased by regional centers on behalf of eligible individuals.
- **Porterville Developmental Center Capital Outlay.** Request to appropriate \$2.2 million one-time General Fund for the construction phase of the Fire Sprinkler System project at Porterville Development Center and to revert \$1.1 million General Fund of existing authority for the construction phase, resulting in a net increase of \$1.0 million.

#### **Other May Revision Adjustments: DDS**

- **Regional Centers – Caseload and Utilization May Revision.** Decrease of \$168,013,000 and \$57,795,000 reimbursements ongoing. These adjustments reflect updated expenditure estimates in operations and purchase of services driven by caseload and utilization.
- **Loan Authority.** Change General Fund loan authority from \$1,290,420,000 to \$1,269,819,000 to reflect revised federal reimbursement estimates.
- **Public Records Act – Regional Center Requirements (AB 1147) – Adjustments** (-\$819,000 total funds, -\$655,000 General Fund). Reduction of six (6.0) positions compared to the original proposal submitted at Governor’s Budget, reflecting a reevaluation of the compliance approach.
- **Control Section 4.05 – Government Efficiencies Reduction** (-\$3.3 million total funds/General Fund).
- **Control Section 4.12 – Vacancy Savings and Position Elimination** (-\$1.0 million total funds/General Fund).

#### **Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision budget solutions and other adjustments under DDS, including a description of the anticipated impacts of the proposed solutions.

**Issue 2: DDS May Revision Trailer Bills**

**Governor’s May Revision – DDS Trailer Bill Language.** The Governor’s May Revision includes the following DDS trailer bills:

- **Fiscal Allocation Letter Authority.** Proposes statutory changes to streamline administrative processes for issuing fiscal allocations to regional centers, consistent with appropriations in the annual state budget. These changes would add Welfare and Institutions Code (WIC) section 4621.6 to statute and amend Public Contract Code (PCC) section 10295. According to DDS, “Regional centers, as nonprofit community organizations, rely on state and federal funds to perform core operations and provide services. The proposed statutory changes will align the Department’s processes with other health and human services government programs and allow the Department to utilize fiscal letters for allocations and funding adjustments, eliminating the need for formal contract amendments for every adjustment. The current bureaucratic process does not add value to the allocation process but does require multiple months for DGS and regional center board reviews and approvals. This proposal would improve efficiencies and timeliness of making funding accessible to regional centers for operations and the delivery of critical services.”
- **Repeal of Parental Fee Program.** Repeals the Parental Fee Program (PFP) and redirect positions to support increased reimbursement and cost recovery efforts.
- **Implicit Bias Training.** Makes regional center implicit bias training initiative subject to appropriation.
- **Health and Safety Waiver Assistance.** Makes allocations for health and safety waiver application assistance subject to appropriation.
- **Require Provider Mandates for Quality Incentive Program Eligibility.** Stipulates that to qualify for the Quality Incentive Program (QIP), providers must comply with Electronic Visit Verification (EVV), Home and Community-Based Services (HCBS) rules, and independent audit and fiscal review requirements. The proposal assumes that approximately one-third of providers may not meet compliance targets such as EVV, independent audit and fiscal reviews, and HCBS requirements. This trailer bill is associated with a May Revision solution to generate \$221.7 million in General Fund savings in 2025-26 and ongoing.
- **Service Provider Rate Reform Hold Harmless.** Welfare and Institutions Code section 4519.10(d)(1)(2), until June 30, 2026, requires a hold harmless policy for providers whose rates exceed rate model recommendations. The hold harmless policy also applies to providers whose rates, as of January 1, 2023, exceeded 90 percent of the rate model. This policy allows providers time to revise their business practices to align with the new rate models. Once the hold harmless period ends, rates will be adjusted to align with the rate models for other providers within the same service category and region. All providers subject to rate models will be funded using the two-payment component model, the base rate equaling 90 percent of the rate model, and a quality incentive payment, equaling up to 10 percent of the rate model. Rates are required to be fully aligned to rate reform rate models as of December 31, 2025. The proposed trailer bill would move

forward the end of the hold harmless by four months, from June 30, 2026, to February 28, 2026. This is associated with a May Revision solution to generate one-time savings of \$75 million.

- **Self-Determination Program.** Implements guardrails in the Self-Determination Program (SDP) to comply with federal law and protect the program’s long-term sustainability. According to DDS, approximately 7,000 consumers are enrolled in the SDP; however, concerns have emerged that must be addressed to safeguard the program’s future. DDS proposes the following changes:
  - Budget Methodology: Modify the budget calculation to be based on authorized services from the prior year, with adjustments allowed for changes in needs and circumstances.
  - Spending Plan Certification: Require regional centers to certify that spending plans meet federal requirements and align with the needs and goals identified in the Individual Program Plan process.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the proposed DDS May Revision trailer bills.

**4440 DEPARTMENT OF STATE HOSPITALS****Issue 1: May Revision Overview**

**Summary of Expenditures at May Revision.** The May Revision includes \$3.2 billion for the Department of State Hospitals (DSH) in 2025-26, a decrease of 6 percent, or \$192 million, as compared to Governor's budget. Major budget adjustments are outlined below.

**Incompetent to Stand Trial (IST).** DSH reports a waitlist of 278 IST individuals as of the 2025-26 May Revision, a reduction of nearly 23 percent as compared to Governor's budget. Of these, 121 are already receiving substantive treatment services. DSH has also reported consistently meeting the court-ordered timelines for treatment of IST patients. Due to DSH's current ability to meet the court-ordered timelines, DSH is proposing to various budget solutions related to rightsizing its IST programs. These include:

- Reduction of \$232.5 million one-time General Fund included in the 2022 Budget Act for grants to counties to increase residential treatment housing capacity for individuals designated IST. This funding was unspent due to a lack of demand, and all applications received were funded.
- Savings of \$4.5 million in 2024-25, \$161.1 million in 2025- 26, \$238.8 million in 2026-27 and \$157.3 million in 2027-28 and ongoing from right-sizing IST programs including Early Access and Stabilization Services (EASS), Community Based Restoration and Diversion, and County Collaborative Workgroup Grant funding. This sets a new, reduced baseline funding level for IST programs that will support current service levels and program contracts in active negotiation.
- Savings of \$12.3 million in 2025-26 and ongoing related to the LA County Community-Based Restoration and Diversion contract to reflect current enrollment rates.
- Reversion of \$4.6 million from 2023-24 and \$4.5 million from 2024-25 in unused funding originally appropriated for the Judicial Council to develop training for court-appointed evaluators.
- Caseload adjustment resulting in savings of \$10.9 million in 2024-25, \$37.8 million in 2025-26, and \$39.0 million in 2026-27 related to EASS and Jail-Based Competency Treatment.

**County Bed Billing Reimbursement Authority.** The May Revision includes \$13.4 million in 2025-26 and \$21 million in 2026-27 and ongoing in reimbursement authority to collect county bed payments. This increased reimbursement authority is due to (1) a projected increase in the Lanterman-Petris-Short (LPS) patient census and (2) negotiated daily bed rate increases of 4 percent in 2025-26 and 3.5 percent in 2026-27. The increase in LPS census is due to the conversion of 25 existing beds, and the decision to use one of the new secure 44-bed units at DSH-Metropolitan for LPS patients instead of IST patients, due to higher demand for LPS beds.

**DSH-Coalinga Telepsychology Pilot.** The May Revision includes \$474,000 in 2025-26 and \$342,000 in 2026-27 and 2027-28 for a three-year telepsychology pilot at DSH-Coalinga. The proposal would also utilize four vacant psychologist positions. The additional resources requested are for two limited-term

coordinators to provide administrative and technical support onsite at the hospital to the telepsychologists, and for equipment.

**Capital Outlay.** The 2025-26 May Revision reflects a net increase of \$55.9 million in General Fund to continue two existing DSH capital outlay projects, including:

- *Patton: Fire Alarm System Upgrade.* DSH proposes a reappropriation of \$21.6 million General Fund in 2025-26 for the construction phase of the Patton Fire Alarm System Upgrade project.
- *Coalinga: Hydronic Loop.* DSH proposes a reversion of \$26.2 million General Fund from 2024-25 and a new appropriation of \$34.4 million General Fund in 2025-26 for the construction phase of the DSH-Coalinga Hydronic Loop Replacement project. According to DSH, the project design phase experienced delays that, combined with inflation and the remote project location, caused the final bid tabulations to be approximately 36 percent above the state's estimate.

**Solutions.** The May Revision includes DSH budget solutions resulting in combined savings of \$232.5 million in 2022-23, \$4.6 million in 2023-24, \$4.5 million in 2024-25, \$202.1 million in 2025-26, \$281.1 million in 2026-27, and \$196.5 million ongoing beginning in 2027-28. These savings include those described above related to IST Solutions, as well as the following:

- Savings of \$4.8 million in 2025-26, \$5.9 million in 2026-27, and \$2.3 million in 2027-28 and ongoing related to various operational efficiencies.
- Savings of \$250,000 in 2025-26, \$500,000 in 2026-27, and \$1 million in 2027-28 and ongoing related to the implementation of a prior authorization and utilization management software for certain specialty care services.
- Savings of \$22.1 million in 2025-26 and ongoing related to the reduction of 124.1 isolation unit related positions, to align with current isolation practices and utilization.
- Statutory changes and a reduction of 3 positions and \$1.5 million in 2025-26 and ongoing to modify requirements for reporting to the court from semi-annually to annually for the Not Guilty by Reason of Insanity (NGI) population, which aligns with the annual reporting requirements for other long-term patient populations.

**Various Other Adjustments.** The May Revision includes the following other adjustments for DSH:

- Reappropriation of \$7.5 million from 2024-25 to 2025-26 related to DSH's Employee Health Record project, and budget bill language allowing a mid-year augmentation.
- One-time savings in 2024-25 of \$10.3 million due to additional delays in the DSH-Metropolitan Increased Secure Bed Capacity project.
- Reduction of \$1.5 million in 2024-25 and increase of \$290,000 in 2025-26 and ongoing for adjustments to patient-driven operating expenses and equipment.

- Savings of \$3.3 million in 2024-25 in the Conditional Release Program Non-Sexually Violent Predators, due to unfilled beds and a program closure related to staffing issues experienced by providers.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested DSH respond to the following:

1. Please provide a brief overview of the major adjustments to the DSH budget included in the May Revision.

**4560 COMMISSION ON BEHAVIORAL HEALTH**

**Issue 1: Elimination of Mental Health Wellness Act Funding and Other Technical Adjustments**

**Elimination of Mental Health Wellness Act Funding – May Revision.** The Administration requests ongoing reduction of expenditure authority from the Behavioral Health Services Fund of \$20 million. If approved, this reduction would eliminate funding for peer respite, maternal behavioral health, and full-services partnership performance contracting programs. These resources were originally approved ongoing through the Investment in Mental Health Wellness Act, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, and SB 833 (Committee on Budget and Fiscal Review), Chapter 704, Statutes of 2016.

<b>Multi-Year Funding Request Summary – Investment in Mental Health Wellness Elimination</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
3085 – Behavioral Health Services Fund	(\$20,000,000)	(\$20,000,000)
<b>Total Funding Request:</b>	<b>(\$20,000,000)</b>	<b>(\$20,000,000)</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Elimination of resources ongoing after 2026-27.

SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Behavioral Health Services Fund (BHSF, then known as the Mental Health Services Fund) of \$32 million annually for CBH to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to \$20 million annually. Previous expenditures under this program included school-behavioral health partnerships that became the basis for the Mental Health Student Services Act and, subsequently, the Children and Youth Behavioral Health Initiative. Currently, these resources support peer respite, maternal behavioral health, and full-service partnership contracting programs. The Administration proposes to eliminate these ongoing resources.

**Technical Adjustments to Extend Liquidation Periods – May Revision.** CBH requests the following technical adjustments to extend the liquidation periods of previously authorized resources:

- *Emergency, Psychiatric Assessment, Treatment, and Healing (EmPATH).* CBH requests extension of the liquidation deadline of expenditure authority from the Behavioral Health Services Fund of up to \$7.8 million, originally approved in the 2021 Budget Act, until June 30, 2027. These resources support grants for EmPATH units delivering psychiatric care to individuals with behavioral health conditions.
- *Early Psychosis Intervention (EPI) Plus Program.* CBH requests extension of the liquidation deadline of expenditure authority from the Behavioral Health Services Fund of up to \$430,000, originally approved in the 2019 Budget Act, until June 30, 2026. These resources support evidence-based early psychosis and mood disorder detection through the EPI Plus Program, pursuant to the requirements of AB 1315 (Mullin), Chapter 414, Statutes of 2017.

**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 CBH to respond to the following:

1. Please provide a brief overview of these proposals.

**4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT****Issue 1: May Revision Overview**

**Governor’s May Revision – Department of Community Services and Development (CSD).** The May Revision includes the following adjustments to CSD:

- **Climate Bond (Proposition 4): Low-Income Weatherization Program Farmworker Housing Component.** Increase of \$230,000 one-time to support the allocation of Proposition 4 resources to the Low-Income Weatherization Program Farmworker Housing Component. This request accelerates the expenditure timeline proposed at Governor’s Budget by one year, allocating \$9,459,000 for local assistance in fiscal year 2026-27 and continuing support funding through 2027-28.
- **Low-Income Weatherization Program Farmworker Housing Component Re-appropriation.** Extends the liquidation period for one-time 2021-22 General Fund resources supporting the Low-Income Weatherization Program Farmworker Housing Component.
- **Low-Income Weatherization Program Multifamily Housing Component Re-appropriation.** Re-appropriates the remaining balance of unexpended one-time 2022-23 General Fund resources extends the liquidation period for one-time 2022-23 General Fund resources supporting the Low-Income Weatherization Program Multifamily Housing Component.
- **General Fund Cash Flow Loan.** Authorizes a General Fund loan or loans, not to exceed a cumulative total of \$40 million, to assist in cash flow program needs related to unanticipated delays in the receipt of federal funds.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision proposals included in this item.

**5175 DEPARTMENT OF CHILD SUPPORT SERVICES****Issue 1: May Revision Overview**

**Governor’s May Revision – Department of Child Support Services (DCSS).** The May Revision includes the following adjustment to DCSS:

- **Local Assistance.** Decrease of \$1,490,000 federal funds ongoing to update federal fund local assistance expenditures based on additional child support collections data becoming available. DCSS also requests an increase in the Child Support Collections Recovery Fund by \$1,490,000 ongoing to reflect an estimated increase in collections received for the federal government’s share of child support recoupment based on updated child support collections information.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision proposal included in this item.

# SUBCOMMITTEE NO. 3

# Agenda

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



Tuesday, May 20<sup>th</sup>, 2025  
9:00 am  
1021 O Street – Room 1200

Consultant: Elizabeth Schmitt, Nora Brackbill, and Scott Ogus

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**PUBLIC COMMENT**

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**VARIOUS DEPARTMENTS****Issue 1: Suitability for the Confinement of Juveniles Trailer Bill**

**Governor's May Revision – Trailer Bill Language.** The May Revision includes trailer bill language addressing suitability of facilities for the confinement of juveniles. This issue impacts various departments and programs under the jurisdiction of this Subcommittee and Subcommittee #5 on Corrections, Public Safety, Judiciary, Labor and Transportation.

The proposed trailer bill includes the following changes to Welfare and Institutions Code 209, which governs inspections regarding the suitability of juvenile halls, camps, ranches, and secure youth treatment facilities:

- Clarifies the requirement for biennial inspections of facilities used for the confinement of juveniles by the Board of State and Community Corrections (BSCC) is at a minimum a biennial inspection.
- Allows BSCC to delegate the authority to approve or disprove a corrective action plan to administrative staff on the board.
- When determining whether a facility is suitable for the confinement of juveniles, allows BSCC or the judge of the juvenile court to consider the following:
  - Whether the conditions at the facility pose a serious risk to the health, safety, or welfare of juveniles confined in the facility.
  - A facility's failure to submit a corrective action plan.
  - A facility's failure to implement its corrective action plan.
  - Whether the facility is in substantial compliance with BSCC's regulations.
  - Whether there is clear and convincing evidence that the facility will be in compliance with the board's regulations within a reasonable timeframe.
- Authorizes BSCC to bring a civil action in the superior court in the county in which any facility has been noticed of facility unsuitability, in order to enforce compliance.
- Allows BSCC to request the Attorney General bring or assist in any civil action authorized by this section, as specified. If the Attorney General declines to bring or assist BSCC in any civil action, allows BSCC to pursue a civil action independently, as specified.
- Allows BSCC to seek appropriate relief, including injunctive relief, orders compelling compliance, sanctions, and any equitable relief the court deems necessary to protect the health, safety, and welfare of juveniles in custody within the applicable county. Allows BSCC to seek attorneys' fees to the extent authorized by existing law.
- If BSCC brings an action, as specified, allows the requirement that the facility may not be used for confinement of juveniles to be stayed pending order of the court if the affected county brings a noticed motion to stay and meets its burden under applicable law.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of this proposed trailer bill. What is the intent of this trailer bill, and what change would it achieve?

**4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION****Issue 1: May Revision Budget Change Proposals**

**Budget Change Proposals – May Revision.** HCAI requests resources for the following five budget change proposals at May Revision:

*Behavioral Health Workforce Initiative.* HCAI requests a technical adjustment to its January budget change proposal implementing workforce initiatives under the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). The technical adjustments are as follows:

- \$14.2 million in 2025-26 and \$32.1 million in 2026-27 through 2029-30 transferred from item 4140-001-0001 to 4140-002-0001. 57 positions would also be added to this item.
- Reimbursements of \$14.2 million in 2025-26 and \$32.1 million in 2026-27 through 2029-30 transferred from item 4140-001-0001 to 4140-002-0001.
- \$52.4 million in 2025-26 and \$153.2 million in 2026-27 through 2028-29 transferred from item 4140-101-0001 to 4140-102-0001.
- Reimbursements of \$52.4 million in 2025-26 and \$153.2 million in 2026-27 through 2028-29 transferred from item 4140-101-0001 to 4140-102-0001.
- \$28.5 million transferred between programs in item 4140-101-3085.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Health Care Payments Data Program Funding Adjustment.* HCAI requests reduction in expenditure authority of \$7 million (\$3 million General Fund, \$700,000 Health Care Payments Data Fund, and \$3.3 million reimbursements) in 2025-26 and \$16.5 million Health Care Payments Data Fund in 2026-27 that was allocated to support the operations of the Health Care Payments Database in 2025-26. HCAI also requests provisional budget bill language to authorize a one-time revenue transfer to the Health Care Payments Data Fund from the Managed Care Administrative Fines and Penalties Fund.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Long-Term Care Staffing and Transparency Data Reporting.* HCAI requests three positions and expenditure authority from the California Health Data and Planning Fund of 597,000 in 2025-26. If approved, these positions and resources would support implementation of new healthcare data reporting requirements related to the following federal rules: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0143 – California Health Data and Planning Fund	\$597,000	\$-
<b>Total Funding Request:</b>	<b>\$597,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>3.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Pharmacy Benefit Manager Licensure and Data Requirements.* HCAI requests six positions and expenditure authority from the Pharmacy Benefit Manager Fund of \$6.2 million in 2025-26 to implement statutory changes to Pharmacy Benefit Manager licensure and data reporting requirements. This request accompanies trailer bill language proposed under the Department of Managed Health Care. In addition, HCAI requests provisional budget bill language authorizing expenditure of funds after approval of the Post-Implementation Evaluation Report by the California Department of Technology for the Health Care Payments Database Project.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3447 – Pharmacy Benefit Managers Fund	\$6,209,000	\$-
<b>Total Funding Request:</b>	<b>\$6,209,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>6.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Withdrawal of Relocation Rent Adjustment.* HCAI requests reduction in expenditure authority of \$2.4 million (\$839,000 General Fund and \$1.6 million California Health Data and Planning Fund or Data Fund) in 2025-26, \$1.2 million (\$399,000 General Fund and \$765,000 Data Fund) in 2026-27, \$1.2 million (\$416,000 General Fund and \$795,000 Data Fund) in 2027-28, \$1.3 million (\$430,000 General Fund and \$828,000 Data Fund) in 2028-29, and \$1.3 million (\$450,000 General Fund and \$860,000 Data Fund) in 2029-30, to reflect the withdrawal of the January proposal for resources to move HCAI to the May Lee State Office Complex. In previous subcommittee hearings, HCAI indicated the Governor’s executive order mandating staff return to the office has caused HCAI to reevaluate its office space needs.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these proposals.

**Issue 2: Proposition 35 Allocations – Medi-Cal Workforce and Reproductive Health**

**Local Assistance – May Revision.** HCAI reflects local assistance funding provided by Proposition 35, approved by voters in November 2024, for the following initiatives:

- Reproductive Health Services – Proposition 35 allocates \$90 million in calendar years 2025 and 2026 to support abortion and family planning services. HCAI proposes to utilize these funds to support reproductive health investments for emergent needs including loan repayments, scholarships, and education capacity expansion for midwifery.
- Medi-Cal Workforce Development – Proposition 35 allocates \$75 million in calendar years 2025 and 2026 to support Medi-Cal workforce development programs. In addition, HCAI will receive \$75 million in federal matching funds through the Department of Health Care Services, as this program will support Medi-Cal beneficiaries. HCAI has not provided information on how these resources will be allocated.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these Proposition 35 allocations.

**Issue 3: General Fund Solution and Technical Adjustments**

**General Fund Solution and Technical Adjustments – May Revision.** HCAI reflects the following General Fund solution and technical adjustments:

*CalRx Biosimilar Insulin Manufacturing Facility Reduction.* HCAI requests reduction in General Fund expenditure authority of \$45 million that previously was allocated to support building or acquisition of a manufacturing facility for the state’s partnership to develop biosimilar insulin. According to HCAI, \$5 million of the original \$50 million General Fund allocation would be utilized for another program related to albuterol.

As of publication of this agenda, the subcommittee has not received additional information about this proposal from the Department of Finance.

*Technical Adjustment to Chaptered Legislation.* HCAI requests reduction in expenditure authority from the Hospital Building Fund of \$268,000 in 2026-27, \$470,000 in 2027-28, \$161,000 in 2028-29, and increased by \$89,000 in 2029-30. These resources would align with estimated costs of implementing the following legislation related to seismic safety: 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. These adjustments are to a budget change proposal from the January budget. The requirements of these bills are 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.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these proposals.

**Issue 4: Trailer Bill Language Proposals – CalRx and Community Health Workers**

**Trailer Bill Language Proposals – May Revision.** HCAI proposes trailer bill language on the following topics:

*CalRx Partnerships for Emerging Issues in Health Care.* According to the Department of Finance’s website, HCAI will propose trailer bill language related to CalRx, allowing the program to contract for brand name drugs in addition to generic drugs. This change would allow CalRx to address potential shortages of certain drugs, such as those for medication of abortion, related to federal or court actions.

As of the publication of this agenda, the subcommittee has not received this trailer bill language or any fact sheets from the Department of Finance.

*Community Health Workers Certification.* According to the Department of Finance’s website, HCAI will propose trailer bill language related to community health care workers certification.

As of the publication of this agenda, the subcommittee has not received this trailer bill language or any fact sheets from the Department of Finance.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these trailer bill language proposals.

**4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH**

**Issue 1: AIDS Drug Assistance Program (ADAP) Estimate**

**ADAP Estimate – May Revision.** The May 2025 ADAP Local Assistance Estimate reflects revised 2024-25 expenditures of \$356.3 million (\$241.1 million ADAP Rebate Fund and \$115.2 million federal funds), a decrease of \$36.2 million or 9.2 percent compared to estimates in the January budget. According to CDPH, this decrease is primarily due to lower medication and insurance premium expenditures.

For 2025-26, CDPH estimates ADAP expenditures of \$411.7 million (\$301.4 million ADAP Rebate Fund and \$110.3 million federal funds), a decrease of \$50.6 million or 10.9 percent compared to estimates in the January budget. According to CDPH, the decrease is also primarily due to lower medication and insurance premium expenditures.

<b>ADAP Local Assistance Funding Summary</b>		
<b>Fund Source</b>	<b>2024-25</b>	<b>2025-26</b>
0890 – Federal Trust Fund	\$115,230,000	\$110,263,000
3080 – AIDS Drug Assistance Program Rebate Fund	\$241,072,000	\$301,430,000
<b>Total ADAP Local Assistance Funding</b>	<b>\$356,302,000</b>	<b>\$411,693,000</b>

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2024-25 and 2025-26 will be as follows:

<b><u>Caseload by Client Group</u></b>	<b><u>2024-25</u></b>	<b><u>2025-26</u></b>
<b>Medication-Only</b>	8,493	7,763
<b>Medi-Cal Share of Cost</b>	103	138
<b>Private Insurance</b>	9,826	10,451
<b>Medicare</b>	6,715	6,646
<b>PrEP Assistance Program</b>	6,385	11,746
<b>TOTAL</b>	<b>31,522</b>	<b>36,744</b>

<b><u>Expenditures by Client Group</u></b>	<b><u>2024-25</u></b>	<b><u>2025-26</u></b>
<b>Medication-Only</b>	\$199,527,999	\$218,969,711
<b>Medi-Cal Share of Cost</b>	\$1,185,940	\$1,637,978
<b>Private Insurance</b>	\$108,589,944	\$133,976,598
<b>Medicare</b>	\$17,924,609	\$17,335,700
<b>PrEP Assistance Program</b>	\$15,494,563	\$23,539,968
<b>TOTAL</b>	<b>\$342,723,055</b>	<b>\$395,459,955</b>

Costs for administration of ADAP are estimated to be \$4.8 million in 2024-25 and \$5.3 million in 2025-26. Costs for administration of PrEP-AP are estimated to be \$5.4 million in 2024-25 and \$5.4 million in 2025-26. Enrollment costs are estimated to be \$7.8 million in 2024-25 and \$8.3 million in 2025-26.

In addition, ADAP's pharmacy benefit manager, Magellan Rx Management, contracts with a safety net recovery vendor, Health Management Systems (HMS) to pursue recovery of paid claims when a liable third party is identified post-payment. CDPH estimates recoveries of \$16.4 million in 2024-25 and \$14.7 million in 2025-26.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview of the changes to the ADAP Estimate at May Revision.

**Issue 2: Genetic Disease Screening Program (GDSP) Estimate**

**Genetic Disease Screening Program Estimate – May Revision.** The May 2025 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of \$173.5 million (\$37.6 million state operations and \$136 million local assistance) in 2024-25, and \$174.5 million (\$36.4 million state operations and \$138.1 million local assistance) in 2025-26.

<b>Genetic Disease Screening Program (GDSP) Funding Summary</b>			
	<b>2024-25</b>	<b>2025-26</b>	<b>BY to CY</b>
<b>Fund Source</b>	<i>Revised</i>	<i>Proposed</i>	<i>Change</i>
0203 – Genetic Disease Testing Fund			
State Operations:	\$37,574,000	\$36,396,000	(\$1,178,000)
Local Assistance:	\$135,954,000	\$138,119,000	\$2,165,000
<b>Total GDSP Expenditures</b>	<b>\$173,528,000</b>	<b>\$174,515,000</b>	<b>\$987,000</b>

Newborn Screening (NBS) Caseload Estimate: The budget estimates NBS program caseload of 404,023 in 2024-25, an increase of 4,468 or 1.1 percent, compared to 2023-24 actual total caseload of 399,555. The budget estimates NBS program caseload of 402,104 in 2025-26, a decrease of 1,919 or 0.5 percent, compared to the revised 2024-25 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

Prenatal Screening (PNS) Caseload Estimate: The budget estimates PNS program caseload of 201,875 cfDNA specimens in 2024-25, a decrease of 598 or 0.3 percent, compared to 2023-24 actual total caseload of 202,473 specimens. The budget estimates PNS program caseload of 200,911 cfDNA specimens in 2025-26, a decrease of 964 or 0.5 percent, compared to the revised 2024-25 estimate. These estimates are based on state projections of the number of live births in California, with 50 percent projected to participate in PNS in 2024-25 and 50 percent in 2025-26.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.
2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

**Issue 3: Women, Infants, and Children (WIC) Program Estimate**

**WIC Program Estimate – Governor’s Budget.** The May 2025 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of \$1.4 billion (\$1.2 billion federal funds and \$192.7 million WIC manufacturer rebate funds) in 2024-25 and \$1.5 billion (\$1.3 billion federal funds and \$186.3 million WIC manufacturer rebate funds) in 2025-26. The federal fund amounts include state operations costs of \$69.5 million in 2024-25 and \$71.1 million in 2025-26.

<b>Women, Infants, and Children (WIC) Funding Summary</b>			
	<b>2024-25</b>	<b>2025-26</b>	<b>BY to CY</b>
<b>Fund Source</b>	<i>Revised</i>	<i>Proposed</i>	<i>Change</i>
0890 – Federal Trust Fund			
State Operations:	\$69,473,000	\$71,105,000	\$1,632,000
Local Assistance:	\$1,173,581,000	\$1,206,925,000	\$33,344,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	\$192,652,000	\$186,267,000	(\$6,385,000)
<b>Total WIC Expenditures</b>	<b>\$1,435,706,000</b>	<b>\$1,464,297,000</b>	<b>\$28,591,000</b>

**Caseload Estimates.** The budget assumes 1,004,181 average monthly WIC participants in 2024-25, a decrease of 6,494 or 0.6 percent compared to estimates in the January budget. The budget assumes 1,013,240 average monthly WIC participants in 2025-26, a decrease of 18,651, or 1.8 percent, compared to the estimates in the January budget.

**Food Expenditures Estimate.** The budget includes \$1 billion (\$831.9 million federal funds and \$192.7 million WIC Manufacturer Rebate Fund) in 2024-25 for WIC program food expenditures, a decrease of \$5.6 million or 0.5 percent, compared to estimates included in the January budget. According to CDPH, the decrease in costs is due to a decrease in estimated participation.

The budget includes \$1.1 billion (\$865.2 million federal funds and \$186.3 million WIC Manufacturer Rebate Fund) in 2025-26 for WIC program food expenditures, a decrease of \$20.4 million or 1.9 percent compared to estimates included in the January budget. According to CDPH, the decrease in costs is due to a decrease in estimated participation and a lower food inflation rate.

**Nutrition Services and Administration (NSA) Estimate.** The budget includes \$341.7 million for other local assistance expenditures for the NSA budget in 2024-25 and 2025-26, unchanged from the January budget. The budget also includes \$69.5 million for state operations expenditures in 2024-25 and \$71.1 million in 2025-26, unchanged from the January budget.

**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 CDPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

**Issue 4: Budget Change Proposals – May Revision**

**Budget Change Proposals – May Revision.** CDPH requests expenditure authority to support the following budget change proposals at May Revision:

**Workload Budget Change Proposals**

*Behavioral Health Transformation – Behavioral Health Services Act Continued Implementation.* CDPH requests expenditure authority from the Behavioral Health Services Fund of \$7.4 million in 2025-26. If approved, these resources would support implementation of population-level prevention and behavioral health initiatives, pursuant to the Behavioral Health Services Act, SB 326 (Eggman), Chapter 790, Statutes of 2024, and Proposition 1, approved by voters in March 2024.

<b>Multi-Year Funding Request Summary – Behavioral Health Transformation</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3085 – Behavioral Health Services Fund	\$7,355,000	\$-
<b>Total Funding Request:</b>	<b>\$7,355,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*California Syndromic Surveillance Reappropriation.* CDPH requests reappropriation of expenditure authority from the Opioid Settlements Fund of up to \$2.5 million, originally authorized in the 2022 Budget Act. If approved, this reappropriation of resources would support implementation of the California Syndromic Surveillance Program (CalSyS), respond to the state’s overdose epidemic by tracking early symptoms data on opioid overdoses statewide, and enable hospitals to meet statewide requirements in SB 159 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2024.

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Center for Health Care Quality (CHCQ) Acute Psychiatric Hospital Investigation Support.* CDPH requests five positions and expenditure authority from the Licensing and Certification Fund of \$1 million annually. If approved, these positions and resources would support investigations of complaints at acute psychiatric hospitals. CDPH also requests trailer bill language to authorize the promulgation of emergency regulations for oversight of acute psychiatric hospitals.

<b>Multi-Year Funding Request Summary – Acute Psychiatric Hospital Investigations</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
3098 – Licensing and Certification Fund	\$1,029,000	\$1,029,000
<b>Total Funding Request:</b>	<b>\$1,029,000</b>	<b>\$1,029,000</b>
<b>Total Requested Positions:</b>	<b>5.0</b>	<b>5.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal or associated trailer bill language from the Department of Finance.

*CHCQ Operations Support.* CDPH requests eight positions and expenditure authority of from the Licensing and Certification Fund of \$1.5 million annually. If approved, these positions and resources would support operations within the Center for Health Care Quality.

<b>Multi-Year Funding Request Summary – CHCQ Operations Support</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
3098 – Licensing and Certification Fund	\$1,499,000	\$1,499,000
<b>Total Funding Request:</b>	<b>\$1,499,000</b>	<b>\$1,499,000</b>
<b>Total Requested Positions:</b>	<b>8.0</b>	<b>8.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*CHCQ Generative Artificial Intelligence (GenAI) Contract.* CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account to support a minimum viable product contract for generative artificial intelligence (GenAI) to improve investigations within the Center for Health Care Quality.

<b>Multi-Year Funding Request Summary – CHCQ GenAI Contract</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0942 – Internal Departmental Quality Improvement Acct	\$8,000,000	\$-
<b>Total Funding Request:</b>	<b>\$8,000,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Industrial Hemp Compliance Enforcement.* CDPH requests General Fund expenditure authority of \$758,000 in 2025-26. If approved, these resources would support compliance enforcement of the manufacturing and distribution of industrial hemp products, as required by AB 45 (Aguiar-Curry), Chapter 576, Statutes of 2021, and associated emergency regulations.

<b>Multi-Year Funding Request Summary – Industrial Hemp Compliance</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$758,000	\$-
<b>Total Funding Request:</b>	<b>\$758,000</b>	<b>\$-</b>

<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>
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AB 45 (Aguiar-Curry), Chapter 576, Statutes of 2021, authorized the Industrial Hemp Enrollment and Oversight Fund for the collection of fees to establish and maintain a robust industrial hemp inspections and enforcement program to protect California residents. CDPH funding received in 2021 was predicated on the expectation that licensing fees would become self-sustaining after three years. According to CDPH, revenue has been far less than projected and new enforcement and investigative work requires more resources than the fund can support. As a result, CDPH is requesting General Fund resources, as the Industrial Hemp Enrollment and Oversight Fund has insufficient revenue to cover program activities in 2025-26. This funding would support the following existing positions:

- **Two Investigators** conduct investigations of industrial hemp processors, manufacturers, warehouses, and distributors; conduct complaint investigations; prepare investigational supports; and make appropriate disposition of cases based on adequacy of evidence or procedures.
- **0.3 Food and Drug Unit Chief** provides initial oversight of the industrial hemp enforcement activities.
- **0.8 Food and Drug Program Specialist** provides enforcement coordination with allied state and local law enforcement agencies.

*Maintenance and Operations for California Vaccine Management System.* CDPH requests General Fund expenditure authority of \$31.5 million in 2025-26. If approved, these resources would support maintenance and operations of the California Vaccine Management System (myCAvax).

<b>Multi-Year Funding Request Summary – Maintenance and Operations for myCAvax</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$31,451,000	\$-
<b>Total Funding Request:</b>	<b>\$31,451,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

The California Vaccine Management System (myCAvax) connects vaccination providers and local health departments with tools and functionality for managing and administering vaccines. The system supports the Vaccines for Children (VFC) program, Vaccines for Adults (VFA), and the LHD 317 and State General Fund vaccine programs for individuals with limited access to healthcare. The Governor’s January budget included no resources to continue myCAvax. According to advocates, continued operation of the system would cost \$44 million. CDPH request at May Revision is for \$31.5 million for myCAvax.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Sustaining Wastewater Surveillance for Infectious Diseases.* CDPH requests General Fund expenditure authority of \$3.2 million in 2025-26. If approved, these resources would support a wastewater surveillance program in all regions of California.

<b>Multi-Year Funding Request Summary – Wastewater Surveillance</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$3,249,000	\$-
<b>Total Funding Request:</b>	<b>\$3,249,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Transgender Wellness and Equity Reappropriation.* CDPH requests reappropriation of expenditure authority from the Transgender Wellness and Equity Fund of \$7.2 million. If approved, this reappropriation of resources would support continuation of existing gender health equity programs within the Office of Health Equity Gender Health Equity Section.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Vital Records Staffing Resources.* CDPH requests expenditure authority from the Health Statistics Special Fund of \$2.4 million in 2025-26 through 2027-28, and \$1.7 million annually thereafter. If approved, these resources would support efforts to eliminate backlogs in requests for vital records and reduce wait times by one to three months.

<b>Multi-Year Funding Request Summary – Vital Records Staffing</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0099 – Health Statistics Special Fund	\$2,408,00	\$2,408,000
<b>Total Funding Request:</b>	<b>\$2,408,000</b>	<b>\$2,408,000</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Additional fiscal year resources requested – 2027-28: \$2,408,000; 2028-29 and ongoing: \$1,740,000.

CDPH’s Center for Health Statistics and Informatics (CHSI) is responsible for registering and issuing certified copies of birth, marriage, death, and fetal death records, and creating and distributing vital statistics data products to researchers and government. CHSI directly processes 5.3 percent of requests and oversees local county offices that process the remaining 95 percent. According to CDPH, CHSI has not added staff in over 11 years, while workload has increased. As a result, processing time for vital records requests has increased from an expected two weeks, to seven to nine weeks currently. CDPH plans to administratively establish the following positions supported with the requested funding:

Vital Records Issuance Branch – 12 positions

- **Two Program Technician III** positions and **ten Program Technician II** positions would handle incoming mail; search CDPH databases, film reels, and physical certificates for original records; contact local county recorder offices to locate records not found in the database; scan and print birth, death, or marriage certificates; and perform quality control before mailing out requests.

Research and Analytics Branch – One position

- **One Research Data Specialist I** position would serve as subject matter expert to improve disaster-related mortality reporting by training coroners and local health jurisdictions to correctly identify disaster-related deaths in concurrence with national guidance.

Operations Branch – One position

- **One Associate Governmental Program Analyst (AGPA)** would implement revenue processing, tracking, and monitoring; receive and log all checks and cash remitted to the state; ensure fees are remitted to the State Registrar’s Office; resolve fee discrepancies; track, monitor, and maintain revenue tracking tools; analyze data maintained in these trackers for allocating fees to individual funds; projecting workload; projecting revenues; and identifying counties that are not remitting the mandated fees.

Vital Records Registration Branch – Four positions

- **Two Program Technician II** positions in the Customer Service Unit would field calls in the customer service unit.
- **Two Program Technician II** positions in the Birth and Marriage Registration Unit would assist with birth registration; provide helpdesk assistance to external stakeholders with birth and marriage registration related inquiries; process incoming mail; filing marriage records; and processing previous years of marriage records that have not been scanned and indexed.

Death Registration Unit – One position

- **One Program Technician II** position would assist with the review and registration of death and fetal records, death and fetal death certificate amendment processing, and death help desk calls and emails.

**Legislative Budget Change Proposals**

*Anti-Fraud Death Data Files (SB 1511).* CDPH requests expenditure authority from the Health Statistics Special Fund of \$492,000 annually. If approved, these resources would support implementation of new requirements related to death registration, pursuant to the requirements of SB 1511 (Committee on Budget and Fiscal Review), Chapter 492, Statutes of 2024.

<b>Multi-Year Funding Request Summary – Anti-Fraud Death Data Files (SB 1511)</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>

0099 – Health Statistics Special Fund	\$492,000	\$492,000
<b>Total Funding Request:</b>	<b>\$492,000</b>	<b>\$492,000</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Coroners Duties (AB 1859).* CDPH requests one position and General Fund expenditure authority of \$288,000 annually. If approved, these resources would support analysis and posting of xylazine overdose data gathered by coroners to the California Overdose Surveillance Dashboard, pursuant to the requirements of AB 1859 (Alanis), Chapter 684, Statutes of 2024.

<b>Multi-Year Funding Request Summary – Coroners Duties (AB 1859)</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0099 – Health Statistics Special Fund	\$288,000	\$288,000
<b>Total Funding Request:</b>	<b>\$288,000</b>	<b>\$288,000</b>
<b>Total Requested Positions:</b>	<b>1.0</b>	<b>1.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Data Collection – Sexual Orientation, Gender Identity, and Intersex Status (SB 957).* CDPH requests three positions and General Fund expenditure authority of \$538,000 annually. If approved, these resources would support implementation of changes and preparation of reports to comply with the requirements of SB 957 (Wiener), Chapter 868, Statutes of 2024.

<b>Multi-Year Funding Request Summary – SOGI and Intersex Data Collection (SB 957)</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0099 – Health Statistics Special Fund	\$538,000	\$538,000
<b>Total Funding Request:</b>	<b>\$538,000</b>	<b>\$538,000</b>
<b>Total Requested Positions:</b>	<b>3.0</b>	<b>3.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Online Accreditation and Certification Application System Development (SB 1076).* CDPH requests net decrease of expenditure authority of \$2.8 million in 2025-26. The net expenditures consist of a decrease of \$5 million of Lead Related Construction Fund and a \$2.2 million increase in General Fund. If approved, these resources would support the development of an online accreditation and application system for firms

and individuals who perform lead renovation, repair, and painting work, pursuant to SB 1076 (Archuleta), Chapter 507, Statutes of 2022.

<b>Multi-Year Funding Request Summary – Online System for Lead Contractors (SB 1076)</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$2,196,000	\$-
3155 – Lead Related Construction Fund	(\$4,989,000)	\$-
<b>Total Funding Request:</b>	<b>(\$2,793,000)</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Health Facility Patient Safety and Anti-discrimination (SB 3161).* CDPH requests expenditure authority from the Licensing and Certification Fund of \$1.1 million in 2025-26. If approved these resources would support oversight of hospital patient safety plans to include demographic data on injured patients to address racism and discrimination in health care, pursuant to the requirements of AB 3161 (Bonta), Chapter 757, Statutes of 2024.

<b>Multi-Year Funding Request Summary – Patient Safety and Anti-Discrimination (AB 3161)</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0001 – General Fund	\$1,112,000	\$-
<b>Total Funding Request:</b>	<b>\$1,112,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview each of these budget change proposals for May Revision.

**Issue 5: General Fund Solutions – May Revision**

**General Fund Solutions – May Revision.** CDPH proposes the following General Fund solutions to address the General Fund shortfall at May Revision:

*Reversion of Unspent Public Health Funds Adjustments.* CDPH requests reversion of General Fund expenditure authority of \$31 million. If approved, these reversions would eliminate unspent funding for the following public health programs:

- Sexually Transmitted Disease Prevention - \$1 million, from \$1 million originally authorized in the 2023 Budget Act.
- Public Health Workforce Development and Engagement - \$1.4 million, from \$3.2 million originally authorized in the 2023 Budget Act.
- Public Health Pathways Training Corps - \$840,000, from \$8 million originally authorized in the 2023 Budget Act.
- Microbiologist Training - \$1.3 million, from \$2.8 million originally authorized in the 2023 Budget Act.
- Lab Aspire Program - \$1.7 million, from \$5.4 million originally authorized in the 2023 and 2022 Budget Acts
- California Epidemiological Investigation Service (CalEIS) Fellowship - \$1.7 million, of \$3.2 million originally authorized in the 2023 Budget Act.
- Hepatitis C Prevention - \$1 million, from \$1 million originally authorized in the 2023 Budget Act.
- Increased Capacity, Training, and Care for LGBTQ+ Foster Youth - \$4 million, from \$5 million originally authorized in the 2022 Budget Act.
- Hospice Fraud Task Force - \$1 million, from \$1 million originally authorized in the 2022 Budget Act.
- Extreme Heat Action Plan - \$900,000, from \$3 million originally authorized in the 2022 Budget Act.
- California Reducing Disparities Project - \$15.8 million, from \$58.1 million originally authorized in the 2021 Budget Act.
- Hepatitis C Testing Kits - \$328,000, from \$1 million originally authorized in the 2021 Budget Act.

*Lesbian, Bisexual, Queer (LBQ) Women’s Health Equity Funding Expiration.* CDPH requests to allow General Fund expenditure authority of \$15.5 million, originally authorized in the 2019 Budget Act, to expire. This funding was intended to support a local comprehensive grant program to address Lesbian, Bisexual, and Queer (LBQ) women’s health disparities and to fund research targeting LBQ women’s health needs and an inventory of existing programs. According to CDPH, it has been unable to spend this allocation to implement the program prior to expiration of the funding authority. The Administration declined to reappropriate this funding to allow continued operation of the program, but instead has chosen to realize the expired funding as General Fund savings to address the General Fund shortfall.

*Elimination of Public Health Workforce Development and Engagement Program.* CDPH requests a reversion of General Fund expenditure authority of \$3.2 million that supports the Public Health Workforce Development and Engagement Program, which supports public health workforce upskilling.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview of these General Fund solutions.

**Issue 6: Technical Adjustments – May Revision**

**Technical Adjustments – May Revision.** CDPH requests the following technical adjustments at May Revision:

*Maintain Food Safety and Epidemiology Contract Services.* CDPH requests shift of expenditure authority from the Food Safety Fund of \$45,000 from local assistance to state operations. If approved, this shift would allow CDPH to maintain existing contract services with the University of California, Davis to support the California Epidemiologic Investigation Service Fellowship Program.

*Mental Health and Impacts of Social Media Adjustment (AB 1282).* CDPH requests shift of expenditure authority from the Behavioral Health Services Fund of \$100,000 in 2025-26 and \$50,000 in 2026-27 from local assistance to state operations, to reflect changes since the January budget to the proposed resources to implement AB 1282 (Lowenthal), Chapter 807, Statutes of 2024.

*Public Contract Code Exemption for Emergencies and Threats.* CDPH requests budget bill language to exempt from the Public Contract Code requirements for department operations supporting preparedness and response during emergencies and imminent threats with the potential for significant public health impacts.

*Proposition 99 Expenditure Adjustments.* CDPH requests the following adjustments to Proposition 99 tobacco tax expenditure accounts to reflect updated tax revenue:

- Research Account - \$723,000 reduction
- Unallocated Account - \$286,000 reduction
- Health Education Account - \$6.3 million reduction

*Adjustment to Reflect Available Resources in the Breast Cancer Fund.* CDPH requests a reduction in expenditure authority of \$10,000 in the Breast Cancer Research Account of the Breast Cancer Fund to reflect updated tobacco tax revenue estimates.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested CDPH to respond to the following:

1. Please provide a brief overview of these adjustments.

**4260 DEPARTMENT OF HEALTH CARE SERVICES**

**Issue 1: May 2025 Medi-Cal Local Assistance Estimate**

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

<b>Medi-Cal Local Assistance Funding Summary</b>			
<b>Fiscal Year:</b>	<b>2024-25 (CY)</b>	<b>2025-26 (BY)</b>	<b>CY to BY</b>
<b><u>Benefits</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$36,026,962,000	\$43,300,822,000	\$7,273,860,000
Federal Funds	\$102,454,007,000	\$112,751,300,000	\$10,297,293,000
Special Funds/Reimbursements	\$32,890,909,000	\$31,008,696,000	(\$1,882,213,000)
<b>Total Expenditures</b>	<b>\$171,371,878,000</b>	<b>\$187,060,818,000</b>	<b>\$15,688,940,000</b>
<b><u>County and Other Local Assistance Administration</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$1,408,976,000	\$1,308,903,000	(\$100,073,000)
Federal Funds	\$6,180,313,000	\$6,022,645,000	(\$157,668,000)
Special Funds and Reimbursements	\$44,174,000	\$125,055,000	\$80,881,000
<b>Total Expenditures</b>	<b>\$7,633,463,000</b>	<b>\$7,456,603,000</b>	<b>(\$176,860,000)</b>
<b><u>TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$37,435,938,000	\$44,609,725,000	\$7,173,787,000
Federal Funds	\$108,634,320,000	\$118,773,945,000	\$10,139,625,000
Special Funds and Reimbursements	\$32,935,083,000	\$31,133,751,000	(\$1,801,332,000)
<b>Total Expenditures</b>	<b>\$179,005,341,000</b>	<b>\$194,517,421,000</b>	<b>\$15,512,080,000</b>

**Caseload.** In 2024-25, the budget assumes annual Medi-Cal caseload of 15 million, a decrease of 18,300 beneficiaries, or 0.1 percent, compared to assumptions in the January budget. The department estimates 93.6 percent of Medi-Cal beneficiaries, or 14 million, will receive services through the managed care delivery system while 6.4 percent, or 962,006, will receive services through the fee-for-service delivery system.

In 2025-26, the budget assumes annual Medi-Cal caseload of 14.8 million, an increase of 348,200 beneficiaries, or 2.4 percent, compared to assumptions in the January budget. The department estimates 93.6 percent of Medi-Cal beneficiaries, or 13.9 million, will receive services through the managed care delivery system while 6.4 percent, or 951,797, will receive services through the fee-for-service delivery system.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

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

**Issue 2: May 2025 Family Health Local Assistance Estimate**

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

<b>Family Health Local Assistance Funding Summary</b>			
<b>Fiscal Year:</b>	<b>2024-25 (CY)</b>	<b>2025-26 (BY)</b>	<b>CY to BY</b>
<b><u>California Children’s Services (CCS)</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$76,215,000	\$85,155,000	\$8,940,000
Special Funds/Reimbursements	\$7,454,000	\$6,292,000	(\$1,162,000)
County Funds [non-add]	[\$83,669,000]	[\$90,716,000]	[\$7,149,000]
<b>Total CCS Expenditures</b>	<b>\$83,669,000</b>	<b>\$91,447,000</b>	<b>\$7,778,000</b>
<b><u>Genetically Handicapped Persons Program (GHPP)</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$194,547,000	\$163,174,000	(\$31,373,000)
Special Funds and Reimbursements	\$535,000	\$459,000	(\$76,000)
<b>Total GHPP Expenditures</b>	<b>\$195,082,000</b>	<b>\$163,633,000</b>	<b>(\$31,449,000)</b>
<b><u>Every Woman Counts Program (EWC)</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$-	\$-	\$-
Federal Funds	\$5,518,000	\$5,787,000	\$269,000
Special Funds and Reimbursements	\$10,602,000	\$13,758,000	\$444,000
<b>Total EWC Expenditures</b>	<b>\$18,832,000</b>	<b>\$19,545,000</b>	<b>\$713,000</b>
<b><u>TOTAL FAMILY HEALTH EXPENDITURES</u></b>			
<b>Fund Source</b>	<b>Revised</b>	<b>Proposed</b>	<b>Change</b>
General Fund	\$270,762,000	\$248,329,000	(\$22,433,000)
Federal Funds	\$5,518,000	\$5,787,000	\$269,000
Special Funds and Reimbursements	\$21,303,000	\$20,509,000	(\$794,000)
County Funds [non-add]	[\$83,567,000]	[\$90,716,000]	[\$7,149,000]
<b>Total Family Health Expenditures</b>	<b>\$297,583,000</b>	<b>\$274,625,000</b>	<b>(\$22,958,000)</b>

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

The programs included in the Family Health Estimate are:

- **California Children’s Services (CCS):** The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child’s care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 174,837 in 2024-25, an increase of 1,579 or 0.9 percent, compared to estimates in the January budget. The budget estimates Medi-Cal CCS caseload of 174,064 in 2025-26, an increase of 806 or 0.5 percent, compared to estimates in the January budget.
  - Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 13,965 in 2024-25, a decrease of 1,087 or 7.2 percent, compared to estimates in the January budget. The budget estimates state-only CCS caseload of 14,284 in 2025-26, a decrease of 768 or 5.1 percent, compared to estimates in the January budget.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington’s, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  - Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 641 in 2024-25, a decrease of 114 or 15.1 percent, compared to estimates in the January budget. The budget estimates Medi-Cal GHPP caseload of 612 in 2025-26, a decrease of 143 or 18.9 percent, compared to estimates in the January budget.
  - Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 624 in 2024-25, a decrease of 77 or 11 percent, compared to estimates in the January budget. The budget estimates state-only GHPP caseload of 599 in 2025-26, a decrease of 102 or 14.6 percent, compared to estimates in the January budget.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  - Caseload Estimate: The budget estimates EWC caseload of 8,786 in 2024-25, a decrease of 3,902 or 30.8 percent, compared to estimates in the January budget. The budget estimates EWC caseload

of 9,255 in 2025-26, a decrease of 3,590 or 27.9 percent compared to estimates in the January budget.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

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

**Issue 3: Budget Change Proposals – May Revision**

**Budget Change Proposals and Trailer Bill Language – May Revision.** DHCS is requesting expenditure authority and trailer bill language for the following budget change proposals:

*988 Suicide and Crisis Lifeline Allocation Increase.* DHCS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of \$17.5 million in 2025-26. If approved, these resources would support managing an increase in 988 contact volume, including growth in 988 calls, chats, and texts.

<b>Multi-Year Funding Request Summary – 988 Suicide and Crisis Lifeline</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
3414 – 988 State Suicide and BH Crisis Services Fund	\$17,500,000	\$-
<b>Total Funding Request:</b>	<b>\$17,500,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Behavioral Health Infrastructure Bond Act.* DHCS requests 22 positions and expenditure authority from the Behavioral Health Infrastructure Fund of \$13.5 million annually. If approved, these positions and resources would support implementation of the Behavioral Health Continuum Infrastructure Program expanded through AB 531 (Irwin), Chapter 789, Statutes of 2023, and Proposition 1, the Behavioral Health Bond Act.

<b>Multi-Year Funding Request Summary – Behavioral Health Infrastructure Bond Act</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
6092 – Behavioral Health Infrastructure Fund	\$13,522,000	\$13,522,000
<b>Total Funding Request:</b>	<b>\$13,522,000</b>	<b>\$13,522,000</b>
<b>Total Requested Positions:</b>	<b>22.0</b>	<b>22.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Centers for Medicare and Medicaid Services (CMS) Interoperability.* DHCS requests eight positions and expenditure authority of \$1.1 million (\$194,000 General Fund and \$909,000 federal funds) in 2025-26 and \$1.1 million (\$270,000 General Fund and \$811,000 federal funds) annually thereafter. If approved, these

<b>Multi-Year Funding Request Summary – CMS Interoperability</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$194,000	\$270,000

0890 – Federal Trust Fund	\$909,000	\$811,000
<b>Total Funding Request:</b>	<b>\$1,103,000</b>	<b>\$1,081,000</b>
<b>Total Requested Positions:</b>	<b>8.0</b>	<b>8.0</b>

\* Positions and resources ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal or associated trailer bill language from the Department of Finance.

*Federally Qualified Health Center (FQHC) Policy Guide.* DHCS requests expenditure authority of \$700,000 (\$350,000 federal funds and \$350,000 reimbursements) in 2025-26. If approved, these resources would support engagement with stakeholders to develop a consolidated policy manual or similar resource to comprehensively document the FQHC prospective payment system. These resources are supported by a grant from the California Health Care Foundation.

<b>Multi-Year Funding Request Summary – CHCQ GenAI Contract</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27</b>
0890 – Federal Trust Fund	\$350,000	
0995 – Reimbursements	\$350,000	\$-
<b>Total Funding Request:</b>	<b>\$700,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Human Resources Plus Modernization (HR+ Mod).* DHCS requests three positions and expenditure authority of \$3.7 million (\$1.8 million General Fund and \$1.8 million federal funds) in 2025-26 and \$2.8 million (\$1.4 million General Fund and \$1.4 million federal funds) annually thereafter. If approved, these positions and resources would support planning, procurement, and project costs to modernize human resources and related fiscal systems business technology.

<b>Multi-Year Funding Request Summary – HR+ Modernization</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$1,831,000	\$1,382,000
0890 – Federal Trust Fund	\$1,829,000	\$1,381,000
<b>Total Funding Request:</b>	<b>\$3,660,000</b>	<b>\$2,763,000</b>
<b>Total Requested Positions:</b>	<b>3.0</b>	<b>3.0</b>

\* Positions and resources ongoing after 2026-27.

According to DHCS, currently a mix of manually intensive processes and aging legacy systems are used to support the department’s workforce needs. Processes and systems are ineffective, inefficient, and not compliant with current security requirements. The department is pursuing a modern human capital management system to improve operations and resource management, and is currently awaiting approval

of its Stage 2 Alternatives Analysis as part of the Project Approval Lifecycle at the Department of Technology.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Medicaid Managed Care, Access, and Eligibility Final Rules.* DHCS requests 47 positions and expenditure authority of \$7.8 million (\$3.9 million General Fund and \$3.9 million federal funds) in 2025-26. If approved, these resources would support implementation and planning, as well as increased workload, due to recently released federal regulations related to access to care, transparency, and quality. DHCS also requests trailer bill language related to this proposal.

<b>Multi-Year Funding Request Summary – Medicaid Managed Care, Access, and Eligibility</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0001 – General Fund	\$3,908,000	\$-
0890 – Federal Trust Fund	\$3,908,000	\$-
<b>Total Funding Request:</b>	<b>\$7,816,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>47.0</b>	<b>47.0</b>

\* Positions ongoing after 2026-27.

As of the publication of this agenda, the subcommittee has not received this budget change proposal or associated trailer bill language from the Department of Finance.

*Transforming Maternal Health (TMaH) Model.* DHCS requests two positions and federal fund expenditure authority of \$1.1 million in 2025-26, \$1.8 million in 2026-27, \$1.3 million in 2027-28, \$3.5 million in 2028-29, and \$2.3 million annually thereafter. If approved, these positions and resources would support implementation of the Transforming Maternal Health (TMaH) Model, pursuant to a federal grant.

<b>Multi-Year Funding Request Summary – Transforming Maternal Health Model</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0890 – Federal Trust Fund	\$1,100,000	\$1,782,000
<b>Total Funding Request:</b>	<b>\$1,100,000</b>	<b>\$1,782,000</b>
<b>Total Requested Positions:</b>	<b>2.0</b>	<b>2.0</b>

\* Additional fiscal year resources requested – 2027-28: \$1,282,000; 2028-29: \$3,482,000; 2029-30 and ongoing: \$2,282,000.

According to DHCS, California was one of 15 states selected by the federal Centers for Medicare and Medicaid Services to implement a ten-year Medicaid and Children’s Health Insurance Program delivery and payment model designed to improve maternal health outcomes, reduce costs, and address serious gaps in health care. These resources would be used to implement the model in five Central Valley counties including Fresno, Kern, Kings, Madera, and Tulare.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Behavioral Health Transformation – Behavioral Health Services Act Continued Implementation.* DHCS requests 104 positions and expenditure authority of \$131 million (\$52 million federal funds and \$79 million Behavioral Health Services Fund) in 2025-26, \$80.1 million (\$26.1 million federal funds and \$54 million Behavioral Health Services Fund) in 2026-27, and \$18.1 million (\$9.1 million federal funds and \$9 million Behavioral Health Services Fund) annually thereafter. If approved, these positions and resources would support efforts to modernize the Mental Health Services Act and improve statewide accountability and access to behavioral health services, pursuant to the Behavioral Health Services Act, SB 326 (Eggman), Chapter 790, Statutes of 2024, and Proposition 1, approved by voters in March 2024.

<b>Multi-Year Funding Request Summary – Behavioral Health Transformation</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0890 – Federal Trust Fund	\$52,045,000	\$26,109,000
3085 – Behavioral Health Services Fund	\$79,000,000	\$54,000,000
<b>Total Funding Request:</b>	<b>\$131,045,000</b>	<b>\$80,109,000</b>
<b>Total Requested Positions:</b>	<b>104.0</b>	<b>104.0</b>

\* Additional fiscal year resources requested – 2027-28 and ongoing: \$18,109,000.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

*Long-Term Care Staffing and Payment Transparency Final Rule.* DHCS requests eight positions and expenditure authority of \$2.6 million (\$1.4 million federal funds and \$1.2 million Long-Term Care Quality Assurance Fund) in 2025-26. If approved, these positions and resources would support implementation of new federal rules and program support workload related to new federal final rules.

<b>Multi-Year Funding Request Summary – LTC Staffing and Payment Transparency Final Rule</b>		
<b>Fund Source</b>	<b>2025-26</b>	<b>2026-27*</b>
0890 – Federal Trust Fund	\$1,369,000	\$-
3213 – Long-Term Care Quality Assurance Fund	\$1,247,000	\$-
<b>Total Funding Request:</b>	<b>\$2,616,000</b>	<b>\$-</b>
<b>Total Requested Positions:</b>	<b>8.0</b>	<b>8.0</b>

\* Positions ongoing after 2026-27.

According to DHCS, the federal Centers for Medicare and Medicaid Services (CMS) have implemented two new federal rules driving new workload in the Medi-Cal program. The Minimum Staffing Standards for Long-Term Care Facilities establishes federal minimum hours per resident staffing requirements for long-term care facilities, establishes a hardship exemption process, and increases facility staffing assessment requirements. The Medicaid Institutional Payment Transparency Reporting rule requires state Medicaid agencies to calculate, report, and publish the percentage of Medicaid payments for services in skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities that

are spent on compensation for direct care workers and support staff in both the fee-for-service and managed care delivery systems.

As of the publication of this agenda, the subcommittee has not received this budget change proposal from the Department of Finance.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these budget change proposals and associated trailer bill language.

**Issue 4: General Fund Solutions – May Revision**

**General Fund Solutions – May Revision.** DHCS proposes the following General Fund solutions at the May Revision, along with implementing trailer bill language:

*Medi-Cal Coverage for Undocumented Californians – Freeze Enrollment.* DHCS proposes to freeze enrollment in full-scope Medi-Cal coverage for undocumented Californians age 19 and over, beginning January 1, 2026. DHCS estimates General Fund savings for this proposal of \$86.5 million in 2025-26, increasing to \$3.3 billion by 2028-29. These savings are achieved primarily from expected reductions in enrollment in Medi-Cal coverage for undocumented Californians over time.

*Medi-Cal Coverage for Undocumented Californians – Premiums.* DHCS proposes to impose a \$100 monthly premium for undocumented Californians age 19 and older enrolled in full-scope Medi-Cal coverage, effective January 1, 2027. DHCS estimates no General Fund savings for this proposal in 2025-26, with \$1.1 billion of General Fund savings beginning in 2026-27, increasing to \$2.1 billion by 2028-29. These savings are achieved primarily from expected reductions in enrollment in Medi-Cal coverage for undocumented Californians who cannot afford the \$100 monthly premium.

*Medi-Cal Coverage for Undocumented Californians – Clinic Access.* DHCS proposes to eliminate per visit payments to federally qualified health centers and rural health clinics for services provided to undocumented Californians. These services would instead be reimbursed at the applicable fee-for-service payment rate. DHCS estimates General Fund savings for this proposal of \$452.5 million in 2025-26 and \$1.1 billion annually thereafter.

*Medi-Cal Coverage for Undocumented Californians – Benefit Reductions.* DHCS proposes to eliminate the following benefits for undocumented Californians enrolled in full-scope Medi-Cal coverage: long term care, dental services, and in-home supportive services (IHSS). Long-term care coverage would be eliminated for all undocumented Californians, beginning January 1, 2026. Dental services coverage would be eliminated for undocumented Californians age 19 and older, beginning July 1, 2026. IHSS coverage would be eliminated for undocumented Californians age 19 and older. DHCS estimates the following General Fund savings for each of these benefit reductions:

- Long-Term Care Benefit Reduction – \$333 million in 2025-26 and \$800 million annually thereafter
- Dental Benefits Reduction – No savings in 2025-26, \$308 million in 2026-27, and \$336 million annually thereafter.
- In-Home Supportive Services Benefit Reduction\* – \$158.8 million annually, beginning in 2025-26  
\* General Fund savings reflected in the Department of Social Services budget

*Medi-Cal Coverage for Undocumented Californians – Pharmacy Rebates.* DHCS proposes to implement a rebate aggregator to secure state rebates for prescription drugs provided to undocumented Californians in Medi-Cal. DHCS estimates General Fund savings for this proposal of \$300 million in 2025-26, and \$362 million annually thereafter. In addition, DHCS proposes to increase the minimum rebate for HIV/AIDS and cancer drugs. DHCS estimates General Fund savings for this proposal of \$75 million in 2025-26 and \$150 million annually thereafter.

*Managed Care Organization (MCO) Tax General Fund Offset.* DHCS estimates additional General Fund savings of \$1.1 billion in 2024-25, and decreased General Fund savings of \$200 million in 2025-26 and \$400 million in 2026-27 from the managed care organization tax approved by the Legislature and approved by voters in November 2024 as Proposition 35. DHCS estimates that \$804 million in 2024-25, \$2.8 billion in 2025-26, and \$2.4 billion in 2026-27 will be available for provider rate increases for primary care, specialty care, ground emergency medical transportation, and hospital outpatient procedures.

*Medi-Cal Eligibility for Seniors and Persons with Disabilities - Restoration of the Asset Limit.* DHCS proposes to restore the asset limit of \$2,000 for an individual, and \$3,000 for a couple for seniors and persons with disabilities to qualify for Medi-Cal. The Legislature increased the asset limit to \$130,000 in January 2022, and eliminated the limit entirely in January 2024. DHCS estimates General Fund savings for this proposal of \$94 million in 2025-26, \$540 million in 2026-27, and \$791 million annually thereafter. These savings are achieved by significantly reducing Medi-Cal coverage for seniors and persons with disabilities.

*Medi-Cal Rx – Glucagon-Like Peptide-1 (GLP-1) Agonist Drugs for Weight Loss.* DHCS proposes to eliminate Medi-Cal coverage for Glucagon-Like Peptide-1 (GLP-1) agonist drugs, such as Ozempic or Wegovy, for weight loss, beginning January 1, 2026. GLP-1 agonist drugs would continue to be covered for diabetes and obesity. DHCS estimates General Fund savings for this proposal of \$85 million in 2025-26 and increasing to \$680 million annually by 2028-29.

*Medi-Cal Rx – Pharmacy Utilization Management.* DHCS proposes to implement utilization management restrictions on certain drugs, including step therapy and prior authorization. DHCS estimates General Fund savings for this proposal of \$200 million in 2025-26 and \$400 million annually thereafter.

*Proposition 56 Tobacco Tax – Eliminate Supplemental Provider Payments.* DHCS proposes to eliminate supplemental Medi-Cal provider payments for dental services, family planning services, and women’s health services supported by Proposition 56 tobacco tax revenue. DHCS estimates General Fund savings for this proposal of \$504 million in 2025-26 and \$550 million annually thereafter. These savings are achieved by utilizing Proposition 56 tobacco tax revenue to support the non-federal share of expenditures in the Medi-Cal program, rather than supplemental provider payments.

*Proposition 56 Tobacco Tax – Suspend Loan Repayment Program.* DHCS proposes to suspend the final cohort of the physician and dentist loan repayment program supported by Proposition 56 tobacco and e-cigarette tax revenue. DHCS estimates General Fund savings for this proposal of \$26 million in 2025-26. These savings are achieved by redirecting funding to support the non-federal share of expenditures in the Medi-Cal program, rather than the loan repayment program.

*Medical Providers Interim Payment Fund Loan.* In March 2025, the Administration notified the Joint Legislative Budget Committee that it would make use of its statutory General Fund loan authority to make a mid-year loan to support the Medi-Cal program of \$3.4 billion to address unexpected costs. DHCS proposes to utilize \$2.1 billion of the loan in 2024-25 and \$1.3 billion in 2025-26, and to begin repayment of the loan in 2027-28.

*Medi-Cal Managed Care Plans – Increase Medical-Loss Ratio.* DHCS proposes to increase the medical-loss ratio on Medi-Cal managed care plans, beginning January 1, 2026. DHCS estimates General Fund savings for this proposal of \$200 million annually, beginning in 2028-29.

*Skilled Nursing Facilities – Elimination of Quality Incentives.* DHCS proposes to eliminate the Skilled Nursing Facility Workforce and Quality Incentive Program, as well as the requirement to maintain a backup power system pursuant to the requirements of AB 2511 (Irwin), Chapter 788, Statutes of 2022. DHCS estimates General Fund savings from these proposals of \$168.2 million in 2025-26 and \$140 million annually thereafter.

*Elimination of Acupuncture Benefit in Medi-Cal.* DHCS proposes to eliminate acupuncture as a benefit in the Medi-Cal program. DHCS estimates General Fund savings from this proposal of \$5.4 million in 2025-26 and \$13.1 million annually thereafter.

*Program for All-Inclusive Care for the Elderly (PACE) Organization Payments.* DHCS proposes to limit payments to programs for all-inclusive care for the elderly (PACE) to the midpoint of actuarial ranges, except for newly enrolled providers receiving enhanced rates for two years. DHCS estimates General Fund savings for this proposal of \$13 million in 2025-26 and \$30 million annually thereafter.

*Hospice Services – Utilization Management Efficiencies.* DHCS proposes to implement prior authorization requirements for hospice services. DHCS estimates General Fund savings for this proposal of \$25 million in 2025-26 and \$50 million annually thereafter.

*Behavioral Health Services Fund – General Fund Offsets.* DHCS proposes to offset General Fund expenditures for the Behavioral Health Bridge Housing Program and Behavioral Health Transformation County Funding with Behavioral Health Services Fund. DHCS estimates General Fund savings for this proposal of \$40 million in 2024-25 and \$100 million in 2025-26.

*Health Care Service Plan Fines and Penalties Fund Transfer.* DHCS requests expenditure authority from the Health Care Service Plan Fines and Penalties Fund of \$24.9 million in 2025-26 and \$3.5 million in 2026-27 to support the non-federal share of expenditures in the Medi-Cal program. These resources would offset General Fund resources that currently support those expenditures.

### **Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of each of these proposed General Fund solutions.

**Issue 5: Technical Adjustments and Trailer Bill Language – May Revision**

**Technical Adjustments – May Revision.** DHCS requests the following technical adjustments at the May Revision:

*Adjust State Operations for the Breast Cancer Fund.* DHCS requests a reduction in expenditure authority from the Breast Cancer Fund of \$1.7 million annually to reflect updated revenue projections in the fund.

*Behavioral Health Federal Funds Adjustment.* DHCS requests federal fund expenditure authority changes to reflect receipt of federal funding for community mental health and substance use disorder treatment and prevention services, including the following:

- Item 4260-001-0890 – Increase expenditure authority by \$13 million in 2025-26.
- Item 4260-115-0890 – Increase expenditure authority by \$54.1 million in 2025-26.
- Item 4260-116-0890 – Increase expenditure authority by \$5.8 million in 2025-26.

*Behavioral Health Services Schoolsite Fee Schedule Administration Fund.* DHCS requests expenditure authority from the Behavioral Health Schoolsite Fee Schedule Administration Fund of \$69.3 million in 2025-26, reflected in the Medi-Cal Estimate, to support costs related to launching statewide infrastructure for provider management and to manage billing and claiming services for behavioral health services provided to students on school campus under the Children and Youth Behavioral Health Initiative.

*Eliminate Mental Health Block Grant Reappropriation Item.* DHCS requests to eliminate a reappropriation item proposed in the January budget related to the federal mental health block grant because it was already included in early action budget bills adopted by the Legislature earlier this year.

**Trailer Bill Language on Streamlining Legislative Reporting Requirements – May Revision.** DHCS proposes trailer bill language related to streamlining legislative reporting requirements. The previous Administration, under Governor Jerry Brown, had a similar proposal to eliminate obsolete reports and other documents produced for the Legislature and the public. At that time, the Legislature indicated that any effort to eliminate legislative reporting would a collaborative discussion with budget staff, policy committee staff, and stakeholders.

As of the publication of this agenda, the subcommittee has not received this trailer bill language proposal from the Department of Finance.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of the proposed technical adjustments at the May Revision.
2. Please provide a brief overview of the proposed trailer bill language regarding legislative reporting requirements.

**5180 DEPARTMENT OF SOCIAL SERVICES****Issue 1: In-Home Supportive Services May Revision Overview**

**Summary of Expenditures at May Revision.** The May Revision includes \$28.3 billion (\$10.3 billion General Fund) for the In-Home Supportive Services (IHSS) program in 2025-26, a decrease of \$205.1 million (\$251.6 million General Fund), as compared to Governor’s budget. The May Revision estimates IHSS caseload to be 734,917 individuals in 2024-25 and 793,316 individuals in 2025-26 (a 7.8 percent increase). The May Revision budget solutions under IHSS are outlined below.

**May Revision Includes Roughly \$1 Billion in Reductions to IHSS.** The May Revision proposes approximately \$1 billion in reductions to the IHSS program:

- **Eliminates IHSS for Undocumented Adults.** Eliminates the IHSS benefit for undocumented adults age 19 and over, effective July 1, 2025. According to the Administration, this generates General Fund savings of \$158.8 million in 2025-26, \$172.1 million 2026-27, \$185.8 million in 2027-28, and \$200.5 million in 2028-29.

This proposal is part of a larger reduction in Medi-Cal to freeze enrollment in Medi-Cal for all undocumented adults aged 19 and over and eliminate several benefits for this population, including long-term care. The IHSS benefit elimination is not a freeze, as current recipients would be removed from the program.

This proposal to eliminate the IHSS benefit is estimated to impact approximately 5,400 adults in 2025-26 who would otherwise receive IHSS. The LAO notes that a majority of the IHSS caseload for this population is within the 50 and over age group.

- **Caps provider work hours at 50 per week.** Caps IHSS provider overtime and travel hours at 10 hours per week (meaning providers can work no more than 50 total hours per week, of which 10 would be overtime/travel). According to the Administration, this generates savings of \$707.5 million General Fund in 2025-26, \$766.8 million General Fund in 2026-27, and \$893.4 million General Fund in 2028-29 and ongoing.

According to the LAO, IHSS work hours are capped, with some exceptions, at 70.75 hours per week (for providers with one recipient) and 66 hours per week (for providers with multiple recipients.) The Administration has stated that the intent of this reduction is to not make any reductions to a recipient’s authorized hours, and the budget assumes that authorized hours will continue to be paid at their historical utilization rate (approximately 90 percent). According to the LAO, this means that “under the administration’s assumptions, recipients should continue to receive the same number of service hours overall but fewer of those hours will be worked as overtime.”

Under this proposal, IHSS recipients who are authorized for more than 50 hours of services per week and only have one provider (for example, a family member) would need to find a different provider to cover their remaining authorized hours in the week. If they cannot find a new provider, they may go without care (or turn to more costly care alternatives, including supported living

services from their regional center for any person with intellectual or developmental disabilities, as the LAO has noted).

According to CDSS, about 31 percent of IHSS providers currently work over 50 hours. These providers work an average of 55 hours per week. Approximately 70 percent of IHSS recipients have a family member as their IHSS provider.

The Administration has stated that \$19 million of the total \$707.5 million General Fund savings associated with provider travel time was added to this solution in error. It is unclear whether this proposal intends to limit travel time.

- **Reinstates Medi-Cal Asset Limit for Older and Disabled Adults, affecting IHSS Access.** The May Revision proposes to reinstate the Medi-Cal asset limit of \$2,000 for individuals and \$3,000 for couples in order to be eligible for Medi-Cal. This means some older and disabled adults would no longer be eligible for Medi-Cal, and consequentially, lose their IHSS benefit. The Administration estimates savings of \$25.5 million General Fund in 2025-26 and ongoing.
- **Terminates IHSS Automatically for Recipients who are terminated from Medi-Cal.** The May Revision proposes to conform the IHSS Residual program with the timing of Medi-Cal coverage. This results in savings of \$110.6 million General Fund in 2026-27, \$119.4 million General Fund in 2027-28, and \$128.9 million General Fund in 2028-29.

The IHSS Residual program captures IHSS recipients who lose Medi-Cal (for example, because they did not complete their annual Medi-Cal redetermination), and allows them to continue receiving IHSS despite the disruption in Medi-Cal enrollment. Costs for the IHSS Residual program are not eligible for Federal Financial Participation (FFP), meaning the state pays all costs for the IHSS Residual program caseload. The IHSS Residual program caseload also includes recipients who are not eligible for FFP, including undocumented individuals. This proposal would make it so all IHSS recipients who become ineligible for Medi-Cal are automatically terminated from the IHSS program.

- **Assesses Community First Choice Option (CFCO) Late Penalties on Counties.** The May Revision passes IHSS Community First Choice Option reassessment late penalties to counties. This results in General Fund savings of \$81 million General Fund in 2025-26, \$87.4 million in 2026-27, \$94.4 million in 2027-28, and \$101.8 million in 2028-29.

According to the LAO, “IHSS cases eligible for the CFCO program receive a base Federal Medical Assistance Percentage (FMAP) of 50 percent, plus an additional enhanced FMAP of 6 percent (for a total FMAP of 56 percent)... When CFCO recipients are not reassessed on time, those IHSS cases are no longer eligible to receive the additional 6 percent FMAP. The cost of this lost 6 percent FMAP (also referred to as a 6 percent late penalty) has been covered with state General Fund since 2017. Under this proposal, the cost of this 6 percent penalty will no longer be paid for with General Fund and instead, it is our understanding that the penalty will be charged to each county proportionally to how many CFCO cases they have in non-compliance.”

- **Unspecified Cost Savings Proposal.** The May Revision includes a solution under Department of Health Care Services (DHCS) and the Department of Social Services (CDSS) for “various operational improvements.” The savings associated with this solution are \$75 million General Fund in 2025-26 and 2026-27, growing to over \$1 billion in 2027-28 and 2028-29. The Administration has indicated that this solution involves the IHSS program, but has not provided any details.

**Governor’s May Revision – IHSS Trailer Bill.** The May Revision includes the following trailer bills for IHSS, both of which relate to proposed General Fund solutions:

- **IHSS for full-scope Medi-Cal Expansion Adults 19 and Over.** At the time of this writing, this trailer bill was not available.
- **IHSS Provider Overtime and Travel Hours.** At the time of this writing, this trailer bill was not available.

**Subcommittee Staff Comment and Recommendation – Hold Open.**

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

1. Please provide an overview of the May Revision solutions proposed for the IHSS program. How does the Administration expect these proposals will impact individuals who currently receive and provide care through the IHSS program?
2. On the elimination of the IHSS benefit for the undocumented expansion population: how would this elimination be implemented? What types of care options would undocumented Californians be able to access, given the elimination of IHSS and long-term care under Medi-Cal?
3. On the cap of provider hours: please describe the portion of the IHSS caseload that would be affected by the cap on provider overtime. What is the distribution of current annual overtime hours? How many new providers would be needed to ensure recipients continue to receive services? Does this proposal intend to keep in place any existing exemptions to the weekly hours cap in place under current law?
4. On the reinstatement of the Medi-Cal asset limit: how many individuals are expected to lose IHSS coverage as a result of the Medi-Cal asset limit being reinstated? How would this proposal be implemented?
5. On the IHSS Residual program: does this proposal fully eliminate the IHSS residual program? What is the average number of monthly Residual participants that are estimated to move out of the Residual program as a result of this policy, and what are their average hours per case? How many people does the administration believe will remain in the IHSS-Residual program? What are the circumstances that would qualify someone for the Residual program going forward?

6. On the CFCO late penalties: How much state General Fund has supported payment of this penalty since 2017? Have counties been provided adequate administrative resources to perform the timely reassessment of CFCO cases? How could these penalties be avoided altogether?
7. What is the Administration's unspecified solution to achieve various operational improvements in IHSS, generating \$75 million in General Fund savings in 2025-26 (and growing to over \$1 billion in 2027-28)?

**NOT FOR PRESENTATION****Issue 1: Proposals for Investment**

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

- **California Alzheimer’s Disease Centers Annual Budget Augmentation.** The Alzheimer’s Association requests annual General Fund expenditure authority of \$5 million. If approved, these resources would support operations of the California Alzheimer’s Disease Centers. According to the advocates, this budget request is designed to ease the need for CADCs to search for supplemental funding to continue operating. One of the centers - Rancho Los Amigos – is considering ceasing operations at the end of this fiscal year due to narrowing options for supplemental funding and the high expense of operating a medical center. There are additional closures expected in the near future. These closures would displace patients, families and caregivers, increasing the time and distance associated with appointments. Further, if these centers close, we will lose the institutional knowledge that has built a body of research on Alzheimer's disease as California’s diverse population is aging in a critical mass. CADCs operate with a multidisciplinary clinical team which may include neurologists, psychiatrists, physician assistants, psychologists, nurse specialists, neuropsychologists and social workers. These staffing levels cannot be supported on the current annual allocation of \$250,000 per site. The operational cost of running a center can vary due to circumstances but generally costs \$500,000 or more per year. These figures were developed through conversations with the department and the directors of CADCs.

This augmentation would more closely reflect the actual operating cost of a center. This will reduce the number of dramatic changes to staffing levels, which are currently based on the availability of supplemental funding.

- **Accountable Communities for Health.** The California Accountable Communities for Health Initiative (CACHI) requests General Fund expenditure authority of \$17.5 million, available over three years, to sustain and expand Accountable Communities for Health. According to the advocates, this budget request addresses longstanding health inequities and poor community health outcomes that have been exacerbated by historical disinvestment and fragmented service systems. These challenges include the lack of coordinated infrastructure to locally implement major state initiatives (such as CalAIM and ACEs Aware) effectively, and insufficient mechanisms to integrate health, behavioral health, education, and social services at the community level. In short, there is a need for sustainable, cross-sector partnerships that can rapidly respond to crises, reduce disparities, and drive long-term improvements in community health and equity.

This request asks for a one-time allocation of \$17.5 million over three years to:

- Sustain the current network of 36 Accountable Communities for Health (ACHs) and expand to across California.
- Strengthen local infrastructure by supporting cross-sector collaboration among public health, healthcare, behavioral health, education, social services, and community-based organizations.

- Enhance the delivery of state initiatives by acting as a local integrator for programs such as CalAIM, ACEs Aware, and other related priorities.
- Provide the necessary time and resources for ACHs to develop sustainable funding mechanisms beyond state support.
- **Transgender, Gender Expansive, Intersex, and 2 Spirit Wellness and Equity Fund.** The TransLatin@ Coalition requests General Fund expenditure authority of \$7.5 million in 2025-26 and \$7.5 million in 2026-27. If approved, these resources would continue to support and expand the scope of the TGI Wellness and Equity Fund, originally approved in the 2022 Budget Act. According to the advocates, to date, in California, there are 150,100, or 0.04 percent of California's population who are TGI-identifying. Within the TGI community, there are disproportionately high levels of hate crimes, suicide, housing, and mental health. In 2014, the proportion of suicide attempts among trans men were 46 percent and trans women were 42 percent.

Among transgender individuals, 28.2 percent and 31.2 percent reported hazardous drinking and problematic drug use, respectively; 44.4 percent reported recent suicidal ideation, 6.9 percent reported a recent suicide attempt, and 21.4 percent reported recent non-suicidal self-injury. In their lifetime, 81.3 percent of transgender respondents had suicidal ideation, 42 percent had attempted suicide, and 56 percent reported non-suicidal self-injury. Most had utilized formal mental health care and 25.5 percent had sought informal mental health support.

According to the national Center for Transgender Equality, 1 in 3 transgender people has experienced homelessness in their lives. In California, fifty percent (1,252) of all transgender people experiencing homelessness were found in California.

The TGI Wellness and Equity Fund received a one-time appropriation of \$13 million in the 2022-2023 State Budget, rolled over from the previous fiscal year. This funding has been crucial in supporting the expansion of health services for TGI individuals, yet the ongoing needs of our community continue to grow. As a result, this additional request is necessary to ensure that essential services can continue and expand to meet the unique challenges faced by TGI Californians.

# SUBCOMMITTEE NO. 3

# Agenda

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



Thursday, March 13<sup>th</sup>, 2025  
9:30 am, or upon adjournment of session  
1021 O Street – Room 1200

### OUTCOMES

Consultant: Scott Ogus

<u>Item</u>	<u>Department</u>	<u>Page</u>
FOR VOTE ONLY.....		Error! Bookmark not defined.
4265	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH.....	Error! Bookmark not defined.
	Issue 1: Opioid Settlements Fund Allocations.....	Error! Bookmark not defined.
<b>VOTE: 2-0 (Grove NV)</b>		

# SUBCOMMITTEE NO. 3

# Agenda

Senator Dr. Akilah Weber Pierson, Chair  
Senator Shannon Grove  
Senator Scott Wiener



**Tuesday, June 10, 2025**  
**2:30pm, or upon adjournment of Transportation Committee**  
**1021 O Street – Room 1200**

Consultants: Scott Ogus, Elizabeth Schmitt, & Nora Brackbill

- ALL DEPARTMENTS.....
- 1. PUBLIC COMMENT .....
- 2. VOTE ONLY ITEMS (SEE TABLE DISPLAY).....

*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.*

**0530 California Health and Human Services Agency (CalHHS)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
1	0530	CalHHS	Child Welfare Services - California Automated Response and Engagement System	April 3rd, 2025, May 19th, 2025	The CalHHS Office of Technology and Solutions Integration (OTSI) requests a total of \$256.5 million (\$129.9 million General Fund, \$125.6 million federal funds, and \$940,000 reimbursements) for fiscal year 2025-26; three new, permanent positions for CDSS; provisional language to increase project expenditure up to an additional \$47.3 million (\$23.6 million General Fund) following contract negotiations, and up to an additional \$45.6 million (\$22.8 million General Fund) utilizing prior year savings; and an increase in expenditure authority for OTSI of	Modify. Approve Budget Bill Language to (1) withhold 10 percent of the funding based on the project's historical underspending, (2) require reporting on the federal government's decision on project status, and (3) require written notification of any implementation of human services program changes delays.

					<p>\$150.1 million for the Health and Human Services Automation Fund. The May Revision updates this proposal to provide flexibility for Department of Finance to increase augmentation amounts available from prior year unspent appropriations and augmentation amounts. Additionally, OTSI requests expenditure authority from the CalHHS Automation Fund of \$15 million in 2025-26 to support project flexibility in accessing unspent appropriations and unused augmentations from prior years. The May Revision provides flexibility for the Department of Finance to increase augmentation amounts available from prior years.</p>	
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2	0530	CalHHS	Electronic Benefit Transfer Project - SUN Bucks Automation and Cost-Per-Case-Month	May 8th, 2025	CalHHS OTSI requests an increase in expenditure authority of \$86,380,000 California Health and Human Services Automation Fund for the operation and administrative costs associated with the federal SUN Bucks Program.	Approve as budgeted.
3	0530	CalHHS	IT Enhancement Resource Shift to CalHHS	March 27th, 2025	CalHHS and CDPH request transfer of General Fund expenditure authority of \$381,000 annually from CDPH to CalHHS. If approved, these resources would continue support for information technology capital planning, prioritization and enterprise portfolio management workload currently being performed by CalHHS under an interagency agreement. There is no net impact on the	Approve as budgeted.

					General Fund from this proposal.	
4	0530	CalHHS	Behavioral Health Transformation - BHSA Continued Implementation	May 19th, 2025	CalHHS requests expenditure authority from the Behavioral Health Services Fund of \$154,000 in 2025-26. If approved, these resources would support coordination and implementation of behavioral health initiatives, including SB 326 (Eggman), Chapter 790, Statutes of 2024, the Behavioral Health Services Act, approved by voters in March 2024 as Proposition 1.	Approve as budgeted.
5	0530	CalHHS	Preschool Development Grant Award Authority Adjustment	May 19th, 2025	CalHHS requests federal fund expenditure authority of \$280,000 for the Preschool Development Grant. CDSS requests a	Approve as budgeted.

					conforming increase in reimbursements.	
6	0530	CalHHS	Early Childhood Policy Council and Whole Child Initiative Carryover	March 27th, 2025	CalHHS requests re-appropriation of \$752,000 General Fund for the Early Childhood Policy Council.	Approve as budgeted.

7	0530	CalHHS	Trailer Bill: Juvenile Justice Realignment Block Grant Formula Revision	March 27th, 2025	CalHHS Office of Youth and Community Restoration (OYCR) proposes various revisions to the Juvenile Justice Realignment Block Grant Formula.	Modify. Adopt placeholder trailer bill language with the following modifications: (1) require the new formula to begin in 2025-26; (2) Adjust proportions of the formula based on realignment target population (with a formula element for realignment target population not committed to a Secure Youth Treatment facility), total county youth population, and youth transferred to less restrictive programs (with a formula element for less restrictive programs that are not attached to juvenile halls); (3) Prohibit the use of JIRBG funds for any facility that has been determined unsuitable and continues to confine youth against the law in that facility; (5) require counties to report on how JIRBG funds are spent; (6) requires counties to return unspent JIRBG funds after three years; (7) requires the balance of unspent funds to
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						be available to OYCR for grants to improve outcomes for justice-involved youth.
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**0977 California Health Facilities Financing Authority (CHFFA)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
8	0977	CHFFA	Reappropriation for Community Services Infrastructure Grant Program	March 27th, 2025	CHFFA requests reappropriation of General Fund expenditure authority of \$20.6 million, originally approved in the 2021 Budget Act, to be available for encumbrance or expenditure until June 30, 2028. If approved, this reappropriation would allow completion of existing projects awarded under the Community Services Infrastructure (CSI) Grant Program	Approve as budgeted

**4100 State Council on Developmental Disabilities (SCDD)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
9	4100	SCDD	Supported Decision-Making Technical Assistance Program	April 24th, 2025	SCDD requests to re-appropriate \$507,000 General Fund to support the Supported Decision-Making Technical Assistance Program.	Approve as budgeted.
10	4100	SCDD	Increased Reimbursement Authority - Quality Assessment Project	May 19th, 2025	Increases reimbursements by \$198,000 in 2025-26 and \$299,000 in 2026-27 and ongoing to support updates to an existing interagency agreement with the Department of Developmental Services related to the Quality Assessment project. No General Fund impact.	Approve as budgeted.

**4120 Emergency Medical Services Authority (EMSA)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
11	4120	EMSA	California Poison Control System Funding	May 19th, 2025	EMSA requests expenditure authority of \$2.7 million (\$1.1 million General Fund and \$1.6 million reimbursements) in 2025-26, \$3.5 million (\$1.4 million General Fund and \$2.2 million reimbursements) in 2026-27, and \$4.4 million (\$1.7 million General Fund and \$2.7 million reimbursements) annually thereafter. If approved these resources would support increased salaries and benefit expenses resulting from negotiated bargaining agreements for staff operating the California Poison Control System.	Approve as budgeted
12	4120	EMSA	Enterprise Services and Data Management (ESDM) Solution - Reappropriation	May 19th, 2025	EMSA requests reappropriation of General Fund expenditure authority of \$3.6 million, originally authorized in the 2021 Budget Act and reappropriated in the 2024 Budget Act. If approved, these reappropriated resources would support continued implementation of the Enterprise Services and Data Management Solution that will support the Electronic Physician	Approve as budgeted

					Orders for Life Sustaining Treatment (ePOLST) system, the Central Registry replacement system, and the California EMS Information System (CEMSIS) replacement system.	
13	4120	EMSA	Facility Cost Increase	March 27th, 2025	EMSA requests General Fund expenditure authority of \$676,000 in 2025-26, \$766,000 in 2026-27, and \$676,000 annually thereafter. If approved, these resources would support facility cost increases for the EMSA Headquarters building lease, building security, and tenant improvements.	Approve as budgeted
14	4120	EMSA	Technical Correction to Baseline Budget	May 19th, 2025	EMSA requests annual General Fund expenditure authority of \$5.5 million to correct an error in the 2024 Budget Act that inadvertently duplicated a reduction in ongoing resources.	Approve as budgeted

**4140 Department of Health Care Access and Information (HCAI)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
15	4140	HCAI	Medi-Cal Workforce Investments - Proposition 35	May 20th, 2025	Proposition 35 allocates \$75 million in calendar years 2025 and 2026 to support Medi-Cal workforce development programs. In addition, HCAI will receive \$75 million in federal matching funds through the Department of Health Care Services, as this program will support Medi-Cal beneficiaries.	Approve as budgeted
16	4140	HCAI	Reproductive Health Investments - Proposition 35	May 20th, 2025	Proposition 35 allocates \$90 million in calendar years 2025 and 2026 to support abortion and family planning services. HCAI proposes to utilize these funds to support reproductive health investments for emergent needs including loan repayments,	Reject, and adopt modified placeholder trailer bill language to reallocate and require DHCS to support reimbursement rate increases for abortion and family planning services in the Medi-Cal program.

					scholarships, and education capacity expansion for midwifery.	
17	4140	HCAI	Behavioral Health Workforce Initiative	May 1st and 20th, 2025	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 program 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	Approve and adopt placeholder supplemental reporting language to require reporting of expenditures and other programmatic details for workforce development programs. Reject provisional budget bill language for the BH-CONNECT Contractor.

					<p>billion total funds is expected to be allocated to these programs.</p> <p>In the May Revision, HCAI requested technical adjustments to these requested resources and 57 positions, as well as provisional budget bill language to authorized a contract for specified components of the BH-CONNECT Workforce Initiative through the term of the waiver.</p>	
18	4140	HCAI	Wellness Coaches Trailer Bill Language	May 1st, 2025	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	Adopt modified placeholder trailer bill language to make minor adjustments to supervision provisions.

					Wellness Coaches, and 3) revise the activities that can be carried out by a Certified Wellness Coach.	
19	4140	HCAI	Community Health Workers	May 20th, 2025	HCAI requests trailer bill language and provisional budget bill language to make changes to community health worker certification.	Defer without prejudice, as this language was provided late to the subcommittee.
20	4140	HCAI	Health Care Payments Data Program Funding	May 1st and 20th, 2025	After adjustments at May Revision, HCAI requests 47 positions and expenditure authority of \$15 million (\$6 million General Fund, \$2.2 million reimbursements, and \$6.8 million Health Care Payments Data Fund) in 2025-26 and \$5.5 million reimbursements annually thereafter. If approved, these positions and resources would	Approve and adopt placeholder trailer bill language, consistent with the Administration's proposal.

					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.	
21	4140	HCAI	Enterprise Risk Management - Cybersecurity, Patient Privacy, and Governance	May 1st, 2025	HCAI requests one position and expenditure authority from the California Health Data and Planning Fund of \$209,000 annually. If approved, this position	Approve as budgeted

					and resources would support increased workloa demands resulting from new state and federal cybersecurity, patient privacy, and data laws and policies.	
22	4140	HCAI	AB 112 Implementation - Data Reporting	May 1st, 2025	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.	Approve as budgeted
23	4140	HCAI	CalRx Biosimilar Insulin Manufacturing Facility Reduction	May 20th, 2025	<b><u>General Fund Solution</u></b> - HCAI requests reduction in General Fund expenditure authority of \$45 million that previously was allocated to support building or	Approve as budgeted

					<p>acquisition of a manufacturing facility for the state's partnership to develop biosimilar insulin. According to HCAI, \$5 million of the original \$50 million General Fund allocation would be utilized for another program related to albuterol.</p>	
24	4140	HCAI	CalRx Partnerships Trailer Bill Language	May 20th, 2025	<p>HCAI proposes trailer bill language related to CalRx, allowing the program to contract for brand name drugs in addition to generic drugs. This change would allow CalRx to address potential shortages of certain drugs, such as those for medication abortion, related to federal or court actions.</p>	<p>Adopt modified placeholder trailer bill language to incorporate the Administration's proposed changes into the underlying CalRx statute and to expand the CalRx contracting authority to also include gender affirming care drugs, vaccines, medical supplies, and medical devices.</p>

25	4140	HCAI	Diaper Access Initiative	May 1st, 2025	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 to every baby born in California, regardless of income.	Modify, as follows: 1) allocate \$7.4 million in 2025-26 to support diaper bank operations, 2) allocate \$12.5 million in 2026-27 to support HCAI contracts to procure lower-cost diapers, 3) distribute HCAI purchase of diapers through the existing diaper bank network, and 4) develop direct-to-consumer options for Californians to access lower-cost diapers through HCAI.
26	4140	HCAI	Clinical Capacity and Capital Infrastructure for Reproductive Health Services	Not heard	HCAI requests reappropriation of General Fund expenditure authority of \$5.6 million, originally authorized in the 2022 Budget Act, that supports clinical capacity and capital infrastructure for reproductive health services. If approved, these reappropriated resources would support emergent needs in reproductive health care.	Approve as budgeted

27	4140	HCAI	Pharmacy Benefit Manager Licensure and Data Requirements	May 20th, 2025	<p>HCAI requests six positions and expenditure authority from the Pharmacy Benefit Manager Fund of \$6.2 million in 2025-26 to implement statutory changes to Pharmacy Benefit Manager licensure and data reporting requirements. This request accompanies trailer bill language proposed under the Department of Managed Health Care. In addition, HCAI requests provisional budget bill language authorizing expenditure of funds after approval of the Post-Implementation Evaluation Report by the California Department of Technology for the Health Care Payments Database Project.</p>	<p>Approve and adopt placeholder budget bill language, consistent with the Administration's proposal.</p>
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28	4140	HCAI	Long Term Care Staffing and Transparency Reporting	May 20th, 2025	HCAI requests three positions and expenditure authority from the California Health Data and Planning Fund of \$597,000 in 2025-26. If approved, these positions and resources would support implementation of new healthcare data reporting requirements related to the following federal rules: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule.	Approve and adopt modified placeholder budget bill language to make resources contingent on operability of the relevant federal rules.
29	4140	HCAI	Relocation Rent Adjustment - Withdrawn	May 1st and 20th, 2025	In the January budget, HCAI requested expenditure authority to support relocation of its headquarters to the May Lee State Office Complex. In the subcommittee's May	Approve withdrawal of January proposal.

				<p>1st hearing, HCAI indicated the Governor's executive order mandating staff return to the office caused HCAI to reevaluate its office space needs.</p> <p>In the May Revision, HCAI requests to withdraw this proposal.</p>	
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30	4140	HCAI	Implementation of Chaptered Legislation (AB 1577, AB 869, SB 1382, SB 1447)	May 1st and 20th, 2025	<p>1) <u>AB 1577 (Low)</u>: 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 clinical nursing placement opportunities and other compliance activities, pursuant to the requirements of AB 1577 (Low), Chapter 680, Statutes of 2024.2) <u>AB 869 (Wood)</u>, <u>SB 1382 (Glazer)</u>, <u>SB 1447 (Durazo)</u>: HCAI requests ten positions and expenditure authority from the Hospital Building Fund of \$2.6 million in 2025-26 and \$2.4 million</p>	Approve as budgeted
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				<p>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. In the May Revision, HCAI requests reduction in expenditure authority from the Hospital Building Fund of \$268,000 in 2026-27, \$470,000 in 2027-28, \$161,000 in 2028-29, and increased by \$89,000 in 2029-30. These resources would align with updated estimated costs to implement the legislation.</p>	
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**4150 Department of Managed Health Care (DMHC)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
31	4150	DMHC	Behavioral Health Transformation - BHSA Continued Implementation	May 19th, 2025	DMHC requests one position and expenditure authority from the Managed Care Fund of \$194,000 in 2025-26, \$188,000 in 2026-27, and \$188,000 in 2027-28 through 2029-30. If approved, this position and resources would support investigation of county complaints about managed care health plans' compliance with SB 326 (Eggman), Chapter 790, Statutes of 2024.	Approve as budgeted
32	4150	DMHC	Pharmacy Benefit Manager Licensure and Data Reporting Requirements	May 19th, 2025	DMHC requests six positions and expenditure authority from the Managed Care Fund of \$2.3 million in 2025-26. If approved, these positions and resources would support implementation of licensure and data reporting requirements for Pharmacy Benefit Managers.  DMHC also requests trailer bill	Approve and adopt modified placeholder trailer bill language, consistent with the Administration's proposal and legislative adjustments.

					language to implement the licensure and data reporting requirements for Pharmacy Benefit Managers.	
33	4150	DMHC	Customer Relationship Management (CRM) Modernization - Project Planning	May 1st, 2025	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.	Approve as budgeted
34	4150	DMHC	Identity and Access Management - Project Planning	May 1st, 2025	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	Approve as budgeted

					user access, and streamline the management of digital identities.	
35	4150	DMHC	Web Accessible Service Portal (WASP) Replacement	May 1st and 19th, 2025	After May Revision adjustments, DMHC requests expenditure authority from the Managed Care Fund of \$344,000 in 2025-26, and \$212,000 in 2026-27. If approved, these resources would support replacement of the existing Web Accessible Service Portal (WASP) enterprise service management system.	Approve as budgeted
36	4150	DMHC	Program Workload Resources	May 1st, 2025	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	Approve as budgeted

					address increased volumes of consumer complaints and mandated caseloads.	
37	4150	DMHC	Implementation of Chaptered Legislation (AB 3275)	May 1st, 2025	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 3175 (Soria), Chapter 763, Statutes of 2024.	Approve as budgeted
38	4150	DMHC	Implementation of Chaptered Legislation (AB 2072 and AB 2434)	May 1st, 2025	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	Approve as budgeted

					arrangements pursuant to the requirements of AB 2072 (Weber), Chapter 374, Statutes of 2024, and AB 2434 (Grayson), Chapter 398, Statutes of 2024.	
39	4150	DMHC	Implementation of Chaptered Legislation (AB 1842)	May 1st, 2025	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.	Approve as budgeted
40	4150	DMHC	Implementation of Chaptered Legislation (SB 1180)	May 1st, 2025	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	Approve as budgeted

					(Ashby), Chapter 884, Statutes of 2024.	
41	4150	DMHC	Implementation of Chaptered Legislation (SB 1120)	May 1st, 2025	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.	Approve as budgeted

42	4150	DMHC	Implementation of Chaptered Legislation (SB 729)	May 1st, 2025	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 fertility and infertility services, pursuant to the requirements of SB 729 (Menjivar), Chapter 930, Statutes of 2024. DMHC also requests trailer bill language to delay implementation of SB 729 requirements from July 1, 2025, until January 1, 2026, as well as to authorize DMHC and the Department of Insurance (CDI), until January 1, 2027, to issue guidance related to the bill's requirements that would not be subject to the Administrative Procedures Act.	Approve and adopt placeholder trailer bill language, consistent with the Administration's proposal.
43	4150	DMHC	Implementation of Chaptered Legislation (AB 3059)	May 1st, 2025	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	Approve as budgeted

					specialized consulting funding for clinical and statistical consultants to implement the requirements of AB 3059 (Weber), Chapter 975, Statutes of 2024.	
44	4150	DMHC	Implementation of Chaptered Legislation (AB 2063)	May 1st, 2025	DMHC requests expenditure authority from the Managed Care Fund of \$178,000 in 2027-28 and 2028-29. If approved, these resources would support specialized consulting services to implement the requirements of AB 2063 (Maienschein), Chapter 818, Statutes of 2024.	Approve as budgeted
45	4150	DMHC	Implementation of Chaptered Legislation (SB 858)	May 19th, 2025	DMHC requests reappropriation of expenditure authority from the Managed Care Fund of up to \$2.8 million, originally authorized in the 2024 Budget Act. If approved, these reappropriated resources would align with information technology delays in receiving final approval in the project approval lifecycle process, to support implementation of SB 858 (Wiener), Chapter 985, Statutes of 2022.	Approve as budgeted

**4170 California Department of Aging (CDA)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
46	4170	CDA	Health Insurance Counseling and Advocacy Program	April 24th, 2025	CDA requests \$2.3 million Health Insurance Counseling and Advocacy Program (HICAP) in 2025-26 and 2026-27 to further the HICAP modernization efforts, serve more Medicare beneficiaries, and improve service quality and access.	Approve as budgeted.
47	4170	CDA	Multipurpose Senior Services Program Case Management Software and Support	April 24th, May 19th, 2025	CDA requests \$2.8 million General Fund in 2025-26, \$2.7 million General Fund in 2026-27, and \$1.1 million General Fund in 2027-28 and ongoing to support 2 positions and to acquire and implement a case management software system for the Multipurpose Senior Services Program (MSSP). The May Revision proposes provisional language that allows the Department of Finance to decrease funding if the Centers for Medicare and Medicaid Services' Medicaid and Children's Health Insurance	Approve as budgeted. Modify budget bill language to clarify that the amount in this item that can be decreased based on federal changes is up to \$2.77 million related to the budget change proposal.

					Program Managed Care Access, Finance, and Quality Final Rule is rescinded or repealed, and requires any adjustment of this item to be reported to the Joint Legislative Budget Committee, as specified.	
48	4170	CDA	Technical Baseline Adjustment	May 19th, 2025	Technical adjustment of net-zero shifts of existing funds for various programs within each respective state operations item.	Approve as budgeted.
49	4170	CDA	Federal Trust Fund Authority Technical Adjustment	May 19th, 2025	Increase of federal fund reimbursement authority by \$23.2 million in 2025-26 and ongoing and \$3,870,000 in 2025-26 to align federal fund reimbursement authority with receipt of federal funds.	Approve as budgeted.

50	4170	CDA	Long-Term Care Ombudsman	April 24th, 2025	<p>Legislative proposal to Transfer \$11.9 million from 3098 Licensing and Certification Program Fund to CDA for the long-term care ombudsman program, and increase the allowable transfer from 0942 Health Facilities Citation Penalty Account to CDA for the long-term care ombudsman program to \$4 million, in 2025-26, 2026-27, and 2027-28, for a total of up to \$15.9 million to support the long-term care ombudsman program each year for three years, including placeholder trailer bill language. This proposal has no General Fund impact.</p>	<p>Approve legislative proposal, and adopt placeholder trailer bill language.</p>
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**4260 Department of Health Care Services (DHCS)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
51	4260	DHCS	Medi-Cal Local Assistance Estimate	Feb 27th and May 20th, 2025	The May 2025 Medi-Cal Local Assistance Estimate includes \$174.6 billion (\$37.6 billion General Fund, \$107.5 billion federal funds, and \$29.5 billion special funds and reimbursements) for expenditures in 2024-25, and \$188.1 billion (\$42.1 billion General Fund, \$118.1 billion federal funds, and \$28 billion special funds and reimbursements) for expenditures in 2025-26.	Approve the balance of the technical adjustments to the Medi-Cal Local Assistance Estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.
52	4260	DHCS	Family Health Estimate	February 27th and May 20th, 2025	The May 2025 Family Health Local Assistance Estimate includes \$247.2 million (\$215.3 million General Fund, \$5.2 million federal funds, and \$26.7 million special funds and reimbursements) for expenditures in 2023-24, and \$250.9 million (\$218.9 million General Fund, \$5.5	Approve the balance of the technical adjustments to the Family Health Estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.

					million federal funds, and \$26.5 million special funds and reimbursements) for expenditures in 2024-25.	
53	4260	DHCS	Delay Repayment of the Medical Providers Interim Payment Loan	May 20th, 2025	<b>General Fund Solution</b> - In March 2025, the Administration notified the Joint Legislative Budget Committee that it would make use of its statutory General Fund loan authority to make a mid-year loan to support the Medi-Cal program of \$3.4 billion to address unexpected costs. DHCS proposes to utilize \$2.1 billion of the loan in 2024-25 and \$1.3 billion in 2025-26, and to begin repayment of the loan in 2027-28.	Approve and augment loan by \$1 billion with the same repayment terms.
54	4260	DHCS	Enrollment Freeze for Full Scope Medi-Cal Coverage for Undocumented Californians	May 20th, 2025	<b>General Fund Solution</b> - DHCS proposes to freeze enrollment in full-scope Medi-Cal coverage for undocumented Californians age 19 and over, beginning January 1, 2026. DHCS estimates General Fund	Modify - Freeze Enrollment for UIS, 19 years of age and older, with no age-out, and a six month re-enrollment grace period, beginning January 1, 2026. Adopt modified placeholder trailer bill

					savings for this proposal of \$86.5 million in 2025-26, increasing to \$3.3 billion by 2028-29. These savings are achieved primarily from expected reductions in enrollment in Medi-Cal coverage for undocumented Californians over time.	language to reflect these actions.
55	4260	DHCS	Establish \$100 Monthly Premium for UIS Adults 19 and Older	May 20th, 2025	<b>General Fund Solution</b> - DHCS proposes to impose a \$100 monthly premium for undocumented Californians age 19 and older enrolled in full-scope Medi-Cal coverage, effective January 1, 2027. DHCS estimates no General Fund savings for this proposal in 2025-26, with \$1.1 billion of General Fund savings beginning in 2026-27, increasing to \$2.1 billion by 2028-29. These savings are achieved primarily from expected reductions in enrollment in Medi-Cal coverage for undocumented Californians who cannot afford the \$100 monthly premium.	Modify - Implement \$30 per month premiums on UIS, ages 19 to 59, effective July 1, 2027. Adopt modified placeholder trailer bill language to reflect these actions.

56	4260	DHCS	Long-Term Care, Dental, and IHSS Benefit Reductions for UIS	May 20th, 2025	<p><b><u>General Fund Solution -</u></b>  DHCS proposes to eliminate the following benefits for undocumented Californians enrolled in full-scope Medi-Cal coverage: long term care, dental services, and in-home supportive services (IHSS). Long-term care coverage would be eliminated for all undocumented Californians, beginning January 1, 2026. Dental services coverage would be eliminated for undocumented Californians age 19 and older, beginning July 1, 2026. IHSS coverage would be eliminated for undocumented Californians age 19 and older. DHCS estimates the following General Fund savings for each of these benefit reductions:1) Long-Term Care Benefit Reduction – \$333 million in 2025-26 and \$800 million annually thereafter2) Dental Benefits Reduction – No savings in 2025-26, \$308</p>	<p>Modify - Reject elimination of long-term care and IHSS. Approve elimination of dental benefits effective July 1, 2027. Adopt modified placeholder trailer bill language to reflect these actions.</p>
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					million in 2026-27, and \$336 million annually thereafter.3) In-Home Supportive Services Benefit Reduction* – \$158.8 million annually, beginning in 2025-26* General Fund savings reflected in the Department of Social Services budget	
57	4260	DHCS	Eliminate Prospective Payment System Payments to Clinics for UIS	May 20th, 2025	<b><u>General Fund Solution</u></b> - DHCS proposes to eliminate per visit payments to federally qualified health centers and rural health clinics for services provided to undocumented Californians. These	Modify - Approve elimination of Prospective Payment System Payments to Clinics for UIS, effective July 1, 2027. Adopt modified placeholder trailer bill language to reflect these actions.

					services would instead be reimbursed at the applicable fee-for-service payment rate. DHCS estimates General Fund savings for this proposal of \$452.5 million in 2025-26 and \$1.1 billion annually thereafter.	
58	4260	DHCS	Medi-Cal Rx Pharmacy Rebates	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to implement a rebate aggregator to secure state rebates for prescription drugs provided to undocumented Californians in Medi-Cal. DHCS estimates General Fund savings for this proposal of \$300 million in 2025-26, and \$362 million annually thereafter. In addition, DHCS proposes to increase the minimum rebate for HIV/AIDS and cancer drugs. DHCS estimates General Fund savings for this proposal of \$75 million in 2025-26 and \$150 million annually thereafter.</p>	Approve and adopt placeholder trailer bill language consistent with the Administration's proposal.

59	4260	DHCS	Pharmacy Utilization Management	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to implement utilization management restrictions on certain drugs, including step therapy and prior authorization. DHCS estimates General Fund savings for this proposal of \$200 million in 2025-26 and \$400 million annually thereafter.</p>	Approve and adopt modified placeholder trailer bill language regarding notice requirements when drugs are removed from the contract drug list.
60	4260	DHCS	Eliminate Glucagon-Like Peptide-1 (GLP-1) Coverage for Weight Loss	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to eliminate Medi-Cal coverage for Glucagon-Like Peptide-1 (GLP-1) agonist drugs, such as Ozempic or Wegovy, for weight loss, beginning January 1, 2026. GLP-1 agonist drugs would continue to be covered for diabetes and obesity. DHCS estimates General Fund savings for this proposal of \$85 million in 2025-26 and increasing to \$680 million annually by 2028-29.</p>	Approve as budgeted

61	4260	DHCS	Reinstate Medi-Cal Asset Limit	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to restore the asset limit of \$2,000 for an individual, and \$3,000 for a couple for seniors and persons with disabilities to qualify for Medi-Cal. The Legislature increased the asset limit to \$130,000 in January 2022, and eliminated the limit entirely in January 2024. DHCS estimates General Fund savings for this proposal of \$94 million in 2025-26, \$540 million in 2026-27, and \$791 million annually thereafter. These savings are achieved by significantly reducing Medi-Cal coverage for seniors and persons with disabilities.</p>	<p>Modify - Reinstate Medi-Cal Asset Limit at \$130,000 and adopt modified placeholder trailer bill language to reflect this action.</p>
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62	4260	DHCS	Proposition 35 Support for Medi-Cal Capitation Rates	May 20th, 2025	<p><b>General Fund Solution -</b> DHCS estimates additional General Fund savings of \$1.3 billion in 2024-25, and decreased General Fund savings of \$200 million in 2025-26 and \$400 million in 2026-27 from the managed care organization tax approved by the Legislature and approved by voters in November 2024 as Proposition 35. DHCS estimates that \$804 million in 2024-25, \$2.8 billion in 2025-26, and \$2.4 billion in 2026-27 will be available for provider rate increases for primary care, specialty care, ground emergency medical transportation, and hospital outpatient procedures.</p>	Approve as budgeted
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63	4260	DHCS	Eliminate Proposition 56 Supplemental Provider Payments for Dental, Family Planning, and Women's Health	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to eliminate supplemental Medi-Cal provider payments for dental services, family planning services, and women's health services supported by Proposition 56 tobacco tax revenue. DHCS estimates General Fund savings for this proposal of \$504 million in 2025-26 and \$550 million annually thereafter. These savings are achieved by utilizing Proposition 56 tobacco tax revenue to support the non-federal share of expenditures in the Medi-Cal program, rather than supplemental provider payments.</p>	Modify - Reject elimination of supplemental payments for family planning and women's health. Approve elimination of supplemental payments for dental services, effective July 1, 2027.
64	4260	DHCS	Proposition 56 Loan Repayment Program for 2025-26	May 20th, 2025	<p><b><u>General Fund Solution</u></b> - DHCS proposes to suspend the final cohort of the physician and dentist loan repayment program supported by Proposition 56 tobacco and e-cigarette tax revenue. DHCS estimates General Fund</p>	Approve as budgeted

					savings for this proposal for \$26 million in 2025-26. These savings are achieved by redirecting funding to support the non-federal share of expenditures in the Medi-Cal program, rather than the loan repayment program.	
65	4260	DHCS	Medi-Cal Managed Care Plans - Increase Medical Loss Ratio	May 20th, 2025	<b>General Fund Solution</b> - DHCS proposes to increase the medical-loss ratio on Medi-Cal managed care plans, beginning January 1, 2026. DHCS estimates General Fund savings for this proposal of \$200 million annually, beginning in 2028-29	Reject
66	4260	DHCS	Prior Authorization for Medi-Cal Hospice Services	May 20th, 2025	<b>General Fund Solution</b> - DHCS proposes to implement prior authorization requirements for hospice services. DHCS estimates General Fund savings for this proposal of \$25 million in 2025-26 and \$50 million annually thereafter.	Modify - Implement prior authorization requirements for hospice services, beginning July 1, 2026. Adopt modified placeholder trailer bill language to reflect these actions.

67	4260	DHCS	Health Care Services Plan Fines and Penalties Fund Transfer	May 20th, 2025	<p><b>General Fund Solution -</b> DHCS requests expenditure authority from the Health Care Service Plan Fines and Penalties Fund of \$24.9 million in 2025-26 and \$3.5 million in 2026-27 to support the non-federal share of expenditures in the Medi-Cal program. These resources would offset General Fund resources that currently support those expenditures.</p>	Approve as budgeted
68	4260	DHCS	Eliminate Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program and Backup Power Requirements	May 20th, 2025	<p><b>General Fund Solution -</b> DHCS proposes to eliminate the Skilled Nursing Facility Workforce and Quality Incentive Program, as well as the requirement to maintain a backup power system pursuant to the requirements of AB 2511 (Irwin), Chapter 788, Statutes of 2022. DHCS estimates General Fund savings from these proposals of \$168.2 million in 2025-26 and \$140 million annually thereafter.</p>	Approve as budgeted

69	4260	DHCS	Eliminate Acupuncture Benefit in Medi-Cal	May 20th, 2025	<b>General Fund Solution -</b> DHCS proposes to eliminate acupuncture as a benefit in the Medi-Cal program. DHCS estimates General Fund savings from this proposal of \$5.4 million in 2025-26 and \$13.1 million annually thereafter.	Reject
70	4260	DHCS	Cap Program of All-Inclusive Care for the Elderly (PACE) Organization Capitation Payments	May 20th, 2025	<b>General Fund Solution -</b> DHCS proposes to limit payments to programs for all-inclusive care for the elderly (PACE) to the midpoint of actuarial ranges, except for newly enrolled providers receiving enhanced rates for two years. DHCS estimates General Fund savings for this proposal of \$13 million in 2025-26 and \$30 million annually thereafter.	Modify - Approve cap, but delay until July 1, 2027.

71	4260	DHCS	Behavioral Health Services Fund General Fund Offset	May 20th, 2025	<p><b>General Fund Solution -</b> DHCS proposes to offset General Fund expenditures for the Behavioral Health Bridge Housing Program and Behavioral Health Transformation County Funding with Behavioral Health Services Fund. DHCS estimates General Fund savings for this proposal of \$85 million.</p>	Reject proposal, eliminate Behavioral Health Bridge Housing and redirect Behavioral Health Services Fund for the following: 1) \$10m additional for MH Wellness at CBH, of which \$5m will support SUD Youth programs; 2) \$15m augmentation for the CalHOPE Warm Line; 3) \$5m for the Warm Line Orange County; 4) \$3m for the Parents Anonymous Warm Line; 5) \$20m for the ACEsAware initiative, and 6) \$30m for other legislative priorities.
72	4260	DHCS	Reduce Funding for Children and Youth Behavioral Health Initiative - Behavioral Health Services and Supports Platform	Not heard	<p><b>General Fund Solution -</b> The Legislature proposes to reduce General Fund expenditure authority of \$130 million ongoing for the behavioral health services and supports platform, part of the Children and Youth Behavioral Health Initiative, that supports the Soluna and BrightLife Kids smartphone applications.</p>	Approve Legislative Proposal

73	4260	DHCS	Ongoing Resources for CalHOPE Warm Line	Not heard	DHCS requests expenditure authority from the Behavioral Health Services Fund of \$5 million annually. If approved, these resources would support the continuation of the CalHOPE Warm Line in 2025-26 and beyond.	Modify - Augment by \$15m Behavioral Health Services Fund, consistent with action taken under Behavioral Health Services Fund General Fund Offset
74	4260	DHCS	Title X Restoration	Not heard	The Legislature proposes General Fund expenditure authority of \$15 million in 2025-26 to backfill lost federal reproductive health funding for Title X programs.	Approve Legislative Proposal
75	4260	DHCS	Additional Support for Adverse Childhood Experiences Provider Trainings	Not heard	DHCS requests expenditure authority of \$2.9 million (\$1.5 million Behavioral Health Services Fund and \$1.5 million federal funds) in 2025-26. If approved, these resources would support additional provider trainings for adverse childhood experiences (ACEs).	Approve as budgeted

76	4260	DHCS	988 Suicide and Crisis Lifeline Allocation Increase	May 20th, 2025	DHCS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of \$17.5 million in 2025-26. If approved, these resources would support managing an increase in 988 contact volume, including growth in 988 calls, chats, and texts.	Approve as budgeted
77	4260	DHCS	AB 186 SNF Workload Standards and Accountability Sanctions	March 27th, 2025	DHCS requests 14 positions and expenditure authority of \$2.9 million (\$1.4 million Long-Term Care Quality Assurance Fund or LTC QAF, and \$1.4 million federal funds) in 2025-26 and \$2.8 million (\$1.4 million LTC QAF and \$1.4 million federal funds) annually thereafter. If approved, these positions and resources would support implementation and program integrity efforts for the Workforce Standards Program (WSP) and the Accountability Sanctions Program (ASP), two new skilled nursing	Approve as budgeted

					facility (SNF) financing programs authorized pursuant to AB 186 (Committee on Budget), Chapter 46, Statutes of 2022.	
78	4260	DHCS	Behavioral Health Infrastructure Bond Act	May 20th, 2025	DHCS requests 22 positions and expenditure authority from the Behavioral Health Infrastructure Fund of \$13.5 million annually. If approved, these positions and resources would support implementation of the Behavioral Health Continuum Infrastructure Program expanded through AB 531 (Irwin), Chapter 789, Statutes of 2023, and Proposition 1, the Behavioral Health Bond Act.	Approve as budgeted

79	4260	DHCS	Behavioral Health Transformation - BHSA Continued Implementation	May 20th, 2025	<p>DHCS requests 104 positions and expenditure authority of \$131 million (\$52 million federal funds and \$79 million Behavioral Health Services Fund) in 2025-26, \$80.1 million (\$26.1 million federal funds and \$54 million Behavioral Health Services Fund) in 2026-27, and \$18.1 million (\$9.1 million federal funds and \$9 million Behavioral Health Services Fund) annually thereafter. If approved, these positions and resources would support efforts to modernize the Mental Health Services Act and improve statewide accountability and access to behavioral health services, pursuant to the Behavioral Health Services Act, SB 326 (Eggman), Chapter 790, Statutes of 2024, and Proposition 1, approved by voters in March 2024.</p>	<p>Modify as follows: 1) Redirect \$20 million Opioid Settlements Fund from the Naloxone Distribution Project to support this proposal, 2) Redirect \$20 million Behavioral Health Services Fund ongoing from this proposal to support the Mental Health Wellness program at the Commission on Behavioral Health.</p>
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80	4260	DHCS	Centers for Medicare and Medicaid Services (CMS) Interoperability	May 20th, 2025	DHCS requests eight positions and expenditure authority of \$1.1 million (\$194,000 General Fund and \$909,000 federal funds) in 2025-26 and \$1.1 million (\$270,000 General Fund and \$811,000 federal funds) annually thereafter. If approved, these positions and resources would support planning and implementation of the federal Centers for Medicare and Medicaid Services (CMS) Interoperability and Patient Access final rule and the new CMS Advancing Interoperability and Improving Prior Authorization Processes final rule.	Approve as budgeted
81	4260	DHCS	Civil Rights Compliance	March 27th, 2025	DHCS requests 12 positions and expenditure authority of \$2 million (\$987,000 General Fund and \$986,000 federal funds) in 2025-26 and \$1.9 million (\$933,000 General Fund and \$932,000 federal funds) annually thereafter. If approved,	Approve as budgeted

					these positions and resources would support civil rights compliance workload within the department.	
82	4260	DHCS	Federally Qualified Health Center (FQHC) Policy Guide	May 20th, 2025	DHCS requests expenditure authority of \$700,000 (\$350,000 federal funds and \$350,000 reimbursements) in 2025-26. If approved, these resources would support engagement with stakeholders to develop a consolidated policy manual or similar resource to comprehensively document the FQHC prospective payment system. These resources are supported by a grant from the California Health Care Foundation.	Approve as budgeted
83	4260	DHCS	Human Resources Plus Modernization	May 20th, 2025	DHCS requests three positions and expenditure authority of \$3.7 million (\$1.8 million General Fund and \$1.8 million federal funds) in 2025-26 and \$2.8 million (\$1.4 million	Reject

					General Fund and \$1.4 million federal funds) annually thereafter. If approved, these positions and resources would support planning, procurement, and project costs to modernize human resources and related fiscal systems business technology.	
84	4260	DHCS	Long-Term Care Staffing and Payment Transparency Final Rule	May 20th, 2025	DHCS requests eight positions and expenditure authority of \$2.6 million (\$1.4 million federal funds and \$1.2 million Long-Term Care Quality Assurance Fund) in 2025-26. If approved, these positions and resources would support implementation of new federal rules and program support workload related to new federal final rules.	Approve and adopt modified placeholder budget bill language to make resources contingent on operability of the relevant federal rules.

85	4260	DHCS	Medicaid Managed Care, Access, and Eligibility Final Rules	May 20th, 2025	DHCS requests 47 positions and expenditure authority of \$7.8 million (\$3.9 million General Fund and \$3.9 million federal funds) in 2025-26. If approved, these resources would support implementation and planning, as well as increased workload, due to recently released federal regulations related to access to care, transparency, and quality. DHCS also requests trailer bill language related to this proposal.	Approve and adopt placeholder trailer bill language consistent with the Administration's proposal.
86	4260	DHCS	Medi-Cal Administrative Activities for CalAIM Justice Involved Initiative	March 27th, 2025	DHCS requests five positions and expenditure authority of \$798,000 (\$399,000 General Fund and \$399,000 federal funds) in 2025-26, and \$753,000 (\$377,000 General Fund and \$376,000 federal funds) annually thereafter. If approved, these positions and resources would support establishment of a Medi-Cal Administrative Activities program for the	Approve as budgeted

					new Justice-Involved Initiative, which provides eligibility and health care services to individuals 90 days prior to release from a jail, prison, or other correctional facility.	
87	4260	DHCS	PACE Growth and Expansion	March 27th, 2025	DHCS requests 33 positions and expenditure authority of \$6.3 million (\$2.9 million Program of All Inclusive Care for the Elderly, or PACE, Oversight Fund, and \$3.4 million federal funds) in 2025-26, \$6 million (\$2.7 million PACE Oversight Fund and \$3.2 million federal funds) in 2026-27 and 2027-28, and \$5.8 million (\$2.6 million PACE Oversight Fund and \$3.2 million federal funds) annually thereafter. If approved, these positions and resources would support DHCS administration, operation, monitoring, and oversight of Programs for All	Modify - Approve positions and resources for 2025-26 only, and adopt modified placeholder trailer bill language to: 1) authorize maintenance and operations fee of no more than 0.25 percent for one year, 2) require, consistent with actuarial soundness, the fee to be built into capitation rates, 3) exempt PACE organizations that cannot have the fee built into their capitation rates from payment of the fee, and 4) require the department to conduct a stakeholder process to propose an updated maintenance and operations fee structure.

					<p>Inclusive Care for the Elderly (PACE).</p> <p>DHCS also requests trailer bill language to: 1) authorize establishment of a fee on all PACE organizations for applications, reviews, maintenance and operations, and marketing activities; 2) require the fee be set in an amount sufficient to cover administrative costs; and 3) provide that the maintenance and operations fee not exceed one percent of a PACE organization's capitation payment.</p>	
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88	4260	DHCS	Program Workload	March 27th, 2025	<p>DHCS requests 16 positions and expenditure authority of \$7.9 million (\$2 million General Fund, \$4.4 million federal funds, and \$1.5 million LTC-QAF) in 2025-26, \$7.8 million (\$2 million General Fund, \$4.3 million federal funds, and \$1.5 million LTC-QAF) in 2026-27, and \$3 million (\$1.5 million General Fund and \$1.5 million federal funds) annually thereafter. If approved, these positions and resources would support ongoing program workload in the department. DHCS also requests budget bill language to make \$1.5 million LTC-QAF available for DHCS to develop a Comprehensive Value Strategy for Skilled Nursing Facility Services, to inform the reauthorization of the Medi-Cal Long-Term Care Reimbursement Act for dates of service on or after January 1, 2027.</p>	<p>Approve and adopt modified placeholder budget bill language, consistent with the Administration's proposal.</p>
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89	4260	DHCS	Transforming Maternal Health (TMaH) Model	May 20th, 2025	DHCS requests two positions and federal fund expenditure authority of \$1.1 million in 2025-26, \$1.8 million in 2026-27, \$1.3 million in 2027-28, \$3.5 million in 2028-29, and \$2.3 million annually thereafter. If approved, these positions and resources would support implementation of the Transforming Maternal Health (TMaH) Model, pursuant to a federal grant.	Approve as budgeted
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90	4260	DHCS	Value Strategy for Hospital Payments in Medi-Cal Managed Care	February 27th, 2025	<p>DHCS requests 29 positions and expenditure authority of \$11.3 million (\$2 million Hospital Quality Assurance Revenue or HQAF Fund, \$3.6 million reimbursements, and \$5.6 million federal funds) in 2025-26, \$11 million (\$2 million HQAF Fund, \$3.5 million reimbursements, and \$5.5 million federal funds in 2026-27 through 2028-29, and \$8 million (\$1.5 million HQAF Fund, \$2.5 million reimbursements, and \$4 million federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to develop, implement, and sustain a comprehensive value strategy for state-directed payments to hospitals in the Medi-Cal managed care delivery system.</p> <p>DHCS also requests trailer bill language to: 1) authorize the development</p>	<p>Modify - Approve positions and resources, but shift funding from the HQAF Fund to the California Health Planning and Data Fund. Adopt modified placeholder trailer bill language consistent with the Administration's proposal, and these legislative changes.</p>
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					and implementation of the comprehensive value strategy, in consultation with public and nonpublic hospital stakeholders; and 2) adjust the percentage of hospital quality assurance revenue available for administration of the hospital directed payment program.	
91	4260	DHCS	Home- and Community-Based Alternatives Waiver and PACE Sanctions	March 27th, 2025	DHCS requests trailer bill language to add Home- and Community-Based Alternatives (HCBA) Waiver providers, and Programs for All-Inclusive Care for the Elderly (PACE) to the list of DHCS contractors subject to contract termination or sanctions if the contractor fails to comply with contract	Approve as budgeted

					requirements, state or federal laws or regulations, the state plan or waivers, or other good cause.	
92	4260	DHCS	Cognitive Health Assessment Training and Reporting	May 1st, 2025	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.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
93	4260	DHCS	Behavioral Health Services Schoolsite Fee Schedule Administration Fund	May 20th, 2025	DHCS requests expenditure authority from the Behavioral Health Schoolsite Fee Schedule Administration Fund of \$69.3 million in 2025-26, reflected in the Medi-Cal Estimate, to support costs related to launching statewide infrastructure for provider management and to manage billing and claiming services for behavioral health services provided to students on school campuses under the	Modify - Authorize payments to support the third party administrator that do not exceed fifteen percent of claims paid in a given year. Adopt modified placeholder trailer bill language to ensure more efficient, timely, and accountable operation of the third party administrator.

					Children and Youth Behavioral Health Initiative.	
94	4260	DHCS	Implementation of Chaptered Legislation (SB 1120 and AB 3275)	February 27th, 2025	<p>DHCS requests positions and resources to support implementation of the following chaptered legislation:</p> <p>1) <u>SB 1120 (Becker)</u> - DHCS requests two positions and expenditure authority of \$340,000 (\$170,000 General Fund and \$170,000 federal funds) in 2025-26, and \$322,000 (\$161,000 General Fund and \$161,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of new restrictions on the use of artificial intelligence (AI) for utilization review and utilization management,</p>	Approve as budgeted

					<p>pursuant to SB 1120 (Becker), Chapter 879, Statutes of 2024.</p> <p>2) <u>AB 3275 (Soria)</u> - DHCS requests two positions and expenditure authority of \$331,000 (\$166,000 General Fund and \$165,000 federal funds) in 2025-26, and \$313,000 (\$157,000 General Fund and \$156,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of timely claims payment requirements, pursuant to AB 3275 (Soria), Chapter 763, Statutes of 2024.</p>	
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95	4260	DHCS	Implementation of Chaptered Legislation (SB 1131 and SB 1289)	March 27th, 2025	<p>DHCS requests positions and resources to support implementation of the following chaptered legislation:1) SB 1131 (Gonzalez) - DHCS requests one position and expenditure authority of \$160,000 (\$16,000 General Fund and \$144,000 federal funds) in 2025-26 and \$151,000 (\$14,000 General Fund and \$137,000 federal funds) annually thereafter. If approved, this position and resources would support provider enrollment, onboarding, training, and onboarding for non-clinician site certifiers for clinics providing services for the Family Planning, Access, Care and Treatment (Family PACT) program, pursuant to the requirements of SB 1131 (Gonzalez), Chapter 880, Statutes of 2024.2) SB 1289 (Roth) - DHCS requests six positions and expenditure authority of \$1 million</p>	Approve as budgeted
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					<p>(\$515,000 General Fund and \$514,000 federal funds) in 2025-26 and \$975,000 (\$488,000 General Fund and \$487,000 federal funds) annually thereafter. If approved, these positions and resources would support collection of call center metrics and quarterly reporting, pursuant to the requirements of SB 1289 (Roth), Chapter 792, Statutes of 2024.</p>	
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96	4260	DHCS	Implementation of Chaptered Legislation (SB 1184 and SB 1238)	May 1st, 2025	<p>DHCS requests positions and resources to support implementation of the following chaptered legislation:</p> <p>1) SB 1884 (Eggman) - 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.</p> <p>2) SB 1238 (Eggman) - DHCS requests seven positions and expenditure authority of \$1.2 million (\$586,000 General Fund</p>	Approve as budgeted
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					<p>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.</p>	
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97	4260	DHCS	Behavioral Health Federal Funds Adjustment	May 20th, 2025	DHCS requests federal fund expenditure authority changes to reflect receipt of federal funding for community mental health and substance use disorder treatment and prevention services, including the following:1) Item 4260-001-0890 – Increase expenditure authority by \$13 million in 2025-26.2) Item 4260-115-0890 – Increase expenditure authority by \$54.1 million in 2025-26.3) Item 4260-116-0890 – Increase expenditure authority by \$5.8 million in 2025-26.	Approve as budgeted
98	4260	DHCS	Withdraw Mental Health Block Grant Reappropriation	May 20th, 2025	DHCS requests to eliminate a reappropriation item proposed in the January budget related to the federal mental health block grant because it was already included in early action budget bills adopted by the Legislature earlier this year.	Approve withdrawal of January proposal

99	4260	DHCS	Population Health Management Reappropriation	March 27th, 2025	DHCS requests reappropriation of General Fund expenditure authority of up to \$19.8 million, originally authorized in the 2021 Budget Act. If approved, this reappropriated funding would continue support for the department's Population Health Management service, known as Medi-Cal Connect.	Approve as budgeted
100	4260	DHCS	Medi-Cal Anti-Fraud Special Deposit Fund	March 27th, 2025	DHCS requests trailer bill language to establish a permanent Medi-Cal Anti-Fraud Special Deposit Fund to accept Medi-Cal provider payments withheld while investigating a credible allegation of fraud.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
101	4260	DHCS	Streamlining Legislative Reporting Requirements	May 20th, 2025	DHCS proposes trailer bill language related to streamlining legislative reporting requirements. The previous Administration, under Governor Jerry Brown, had a similar proposal to eliminate obsolete reports	Defer without prejudice to allow for the necessary and appropriate discussions to occur before the end of the legislative session.

					and other documents produced for the Legislature and the public. At that time, the Legislature indicated any effort to eliminate legislative reporting would require a collaborative discussion with budget staff, policy committee staff, and stakeholders.	
102	4260	DHCS	Nondesignated Public Hospital Supplemental Fund and Intergovernmental Transfer Programs	Not heard	DHCS proposes trailer bill language to: 1) beginning 2026-27, align the amount of intergovernmental transfers for non-designated public hospital programs retained by the department with projected administrative costs; 2) effective December 31, 2028, abolishes the Nondesignated Public Hospital Supplemental Fund; 3) beginning 2025-26, adjusts supplemental payment methodologies for nondesignated public hospitals	Adopt placeholder trailer bill language consistent with the Administration's proposal.

103	4260	DHCS	Adjust State Operations for the Breast Cancer Fund	May 20th, 2025	DHCS requests a reduction in expenditure authority from the Breast Cancer Fund of \$1.7 million annually to reflect updated revenue projections in the fund.	Approve as budgeted
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4265 California Department of Public Health (CDPH)

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
104	4265	CDPH	AIDS Drug Assistance Program Estimate	March 13th and May 20th, 2025	<p>The May 2025 ADAP Local Assistance Estimate reflects revised 2024-25 expenditures of \$356.3 million (\$241.1 million ADAP Rebate Fund and \$115.2 million federal funds), a decrease of \$36.2 million or 9.2 percent compared to estimates in the January budget. According to CDPH, this decrease is primarily due to lower medication and insurance premium expenditures.</p> <p>For 2025-26, CDPH estimates ADAP expenditures of \$411.7 million (\$301.4 million ADAP Rebate Fund and \$110.3 million federal funds), a decrease of \$50.6 million or 10.9 percent compared to estimates in the January</p>	<p>Approve May Revision Estimate and adopt modified placeholder trailer bill language, consistent with the Administration's proposal, and to allocate \$75 million ADAP Rebate Fund to support programs experiencing loss of federal funding.</p>

					<p>budget. According to CDPH, the decrease is also primarily due to lower medication and insurance premium expenditures.</p> <p>In addition, CDPH proposes trailer bill language to authorize the use of ADAP Rebate Fund for HIV prevention as part of the TGI Wellness and Equity Fund component of the ADAP program enhancements, as well as clarify that implementation of the condom distribution program is not linked to approval of any policy bill.</p>	
105	4265	CDPH	Genetic Disease Screening Program Estimate	March 13th and May 20th, 2025	The May 2025 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of \$173.5 million (\$37.6 million state operations and \$136 million local assistance)	Approve May Revision Estimate

					in 2024-25, and \$174.5 million (\$36.4 million state operations and \$138.1 million local assistance) in 2025-26.	
106	4265	CDPH	Women, Infants, and Children (WIC) Program Estimate	March 13th and May 20th, 2025	The May 2025 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of \$1.4 billion (\$1.2 billion federal funds and \$192.7 million WIC manufacturer rebate funds) in 2024-25 and \$1.5 billion (\$1.3 billion federal funds and \$186.3 million WIC manufacturer rebate funds) in 2025-26. The federal fund amounts include state operations costs of \$69.5 million in 2024-25 and \$71.1 million in 2025-26.	Approve May Revision Estimate

107	4265	CDPH	Reversion of Unspent Public Health Funds	May 20th, 2025	<p><b>General Fund Solution -</b>          CDPH requests reversion of General Fund expenditure authority of \$31 million. If approved, these reversions would eliminate unspent funding for the following public health programs:1) Sexually Transmitted Disease Prevention - \$1 million2) Public Health Workforce Development and Engagement - \$1.4 million3) Public Health Pathways Training Corps - \$840,0004) Microbiologist Training - \$1.3 million5) Lab Aspire Program - \$1.7 million6) California Epidemiological Investigation Service (CalEIS) Fellowship - \$1.7 million7) Hepatitis C Prevention - \$1 million8) Increased Capacity, Training, and Care for LGBTQ+ Foster Youth - \$4 million9) Hospice Fraud Task Force - \$1 million10) Extreme Heat Action Plan</p>	Reject
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					- \$900,00011) California Reducing Disparities Project - \$15.8 million12) Hepatitis C Testing Kits - \$328,000	
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108	4265	CDPH	Lesbian, Bisexual, Transgender, Queer (LBTQ) Women's Health Equity Funding Expiration	May 20th, 2025	<p><b>General Fund Solution -</b>  CDPH requests to allow General Fund expenditure authority of \$15.5 million, originally authorized in the 2019 Budget Act, to expire. This funding was intended to support a local comprehensive grant program to address Lesbian, Bisexual, and Queer (LBQ) women's health disparities and to fund research targeting LBQ women's health needs and an inventory of existing programs. According to CDPH, it has been unable to spend this allocation to implement the program prior to expiration of the funding authority. The Administration declined to reappropriate this funding to allow continued operation of the program, but instead has chosen to realize the expired funding as General Fund savings to</p>	Approve reappropriation of funding for expiring programs in the Office of Health Equity.
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					address the General Fund shortfall.	
109	4265	CDPH	Reproductive Health Education Funding Expiration	May 20th, 2025	<p><b>General Fund Solution</b> - CDPH requests to allow General Fund expenditure authority of \$13.3 million, originally authorized in the 2022 Budget Act, to expire. This funding was intended to support reproductive health and sexual health education.</p>	Approve reappropriation of funding for expiring programs in the Office of Health Equity.
110	4265	CDPH	Elimination of Public Health Workforce Development and Engagement Program	May 20th, 2025	<p><b>General Fund Solution</b> - CDPH requests a reversion of General Fund expenditure authority of \$3.2 million that supports the Public Health Workforce Development and</p>	Modify - Retain \$370,000 to support previously made commitments to training cohorts.

					Engagement Program, which supports public health workforce upskilling.	
111	4265	CDPH	California Immunization Registry 3 (CAIR3) Design, Development, and Implementation	March 13th, 2025	CDPH requests General Fund expenditure authority of up to \$5.1 million in 2025-26. If approved, these resources would support the design, development, and implementation of the California Immunization Registry 3 (CAIR3) Project, which would upgrade California's statewide immunization information system used to capture, store, track, and consolidate vaccination data.	Approve as budgeted
112	4265	CDPH	CalCONNECT Maintenance and Operations	March 13th, 2025	CDPH requests General Fund expenditure authority of \$18 million in 2025-26. If approved, these resources would support maintenance and operations costs for the California Confidential Network for Contact	Approve as budgeted

					Tracing (CalCONNECT), California's contact tracing system used to manage case and contact records and notify individuals of possible exposure to people who test positive for infectious diseases.	
113	4265	CDPH	SaPHIRE Maintenance and Operations	March 13th, 2025	CDPH requests 15 positions and General Fund expenditure authority of \$27 million in 2025-26, \$20.4 million in 2026-27, and \$16.3 million annually thereafter. If approved, these positions and resources would support maintenance and operations of the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system, an integrated data system that provides 24-hour processing of lab results for all reportable infectious diseases.	Approve as budgeted

114	4265	CDPH	California Vaccine Management System Maintenance and Operations	May 20th, 2025	CDPH requests General Fund expenditure authority of \$31.5 million in 2025-26. If approved, these resources would support maintenance and operations of the California Vaccine Management System (myCAvax).	Approve as budgeted
115	4265	CDPH	California Syndromic Surveillance Reappropriation	May 20th, 2025	CDPH requests reappropriation of expenditure authority from the Opioid Settlements Fund of up to \$2.5 million, originally authorized in the 2022 Budget Act. If approved, this reappropriation of resources would support implementation of the California Syndromic Surveillance Program (CalSyS), respond to the state's overdose epidemic by tracking early symptoms data on opioid overdoses statewide, and enable hospitals to meet statewide requirements in SB 159 (Committee on	Approve as budgeted

					Budget and Fiscal Review), Chapter 40, Statutes of 2024.	
116	4265	CDPH	Sustaining Wastewater Surveillance for Infectious Diseases	May 20th, 2025	CDPH requests General Fund expenditure authority of \$3.2 million in 2025-26. If approved, these resources would support a wastewater surveillance program in all regions of California.	Approve as budgeted
117	4265	CDPH	Augmentation to the BabyBIG Infant Botulism Treatment and Prevention Program	March 13th, 2025	CDPH requests two positions and expenditure authority from the Infant Botulism Treatment and Prevention Fund of \$3 million in 2025-26 and \$2.2 million annually thereafter. If approved, these positions and resources would support the increased manufacturing and regulatory costs	Approve as budgeted

					associated with producing Lots 8 and 9 of Human Botulism Immune Globulin Intravenous (BabyBIG), used for the treatment of infant botulism.	
118	4265	CDPH	Behavioral Health Transformation - BHSA Continued Implementation	May 20th, 2025	CDPH requests expenditure authority from the Behavioral Health Services Fund of \$7.4 million in 2025-26. If approved, these resources would support implementation of population-level prevention and behavioral health initiatives, pursuant to the Behavioral Health Services Act, SB 326 (Eggman), Chapter 790, Statutes of 2024, and Proposition 1, approved by voters in March 2024.	Approve as budgeted
119	4265	CDPH	Biomonitoring California Funding Realignment	March 13th, 2025	CDPH requests to shift two positions and General Fund expenditure authority of \$425,000 to the Department of Toxic	Approve as budgeted

					Substances Control (DTSC) annually, beginning in 2025-26. If approved, this shift of resources would transition funding directly to DTSC for laboratory services it currently provides under an interagency agreement. There is no net cost to the General Fund.	
120	4265	CDPH	Governor's Advisory Council on Physical Fitness and Mental Well-Being	March 13th, 2025	CDPH requests reappropriation of General Fund expenditure authority of \$2.5 million, originally approved in the 2022 Budget Act. CDPH also requests provisional budget bill language to extend encumbrance and expenditure authority for these funds through June 30, 2027. If approved, these reappropriated resources would continue to support the Governor's Advisory Council on Physical	Reject reappropriation, and redirect \$2.5 million General Fund resources to the Transgender, Gender Nonconforming, and Intersex (TGI) Wellness and Equity Fund.

					Fitness and Mental Well Being.	
121	4265	CDPH	Industrial Hemp Compliance Enforcement	May 20th, 2025	CDPH requests General Fund expenditure authority of \$758,000 in 2025-26. If approved, these resources would support compliance enforcement of the manufacturing and distribution of industrial hemp products, as required by AB 45 (Aguiar-Curry), Chapter 576, Statutes of 2021, and associated emergency regulations.	Approve as budgeted
122	4265	CDPH	Maintain Food Safety and Epidemiology Contract Services	May 20th, 2025	CDPH requests shift of expenditure authority from the Food Safety Fund of \$45,000 from local assistance to state operations. If approved, this shift would allow CDPH to maintain existing contract services	Approve as budgeted

					with the University of California, Davis to support the California Epidemiologic Investigation Service Fellowship Program.	
123	4265	CDPH	TGI Wellness and Equity Reappropriation	May 20th, 2025	CDPH requests reappropriation of expenditure authority from the Transgender Wellness and Equity Fund of \$7.2 million. If approved, this reappropriation of resources would support continuation of existing gender health equity programs within the Office of Health Equity Gender Health Equity Section.	Approve as budgeted, and augment with General Fund expenditure authority of \$12.5 million in 2025-26.
124	4265	CDPH	Vital Records Staffing Resources	May 20th, 2025	CDPH requests expenditure authority from the Health Statistics Special Fund of \$2.4 million in 2025-26 through 2027-28, and \$1.7 million annually thereafter. If approved, these resources would support efforts to eliminate backlogs in	Approve as budgeted

					requests for vital records and reduce wait times by one to three months.	
125	4265	CDPH	Parkinson's Registry Reappropriation	Not heard	CDPH requests reappropriation of General Fund expenditure authority of \$3 million, available through June 30, 2027, to support the Parkinson's Disease Registry.	Approve as budgeted
126	4265	CDPH	Laboratory Field Science Fees	March 13th, 2025	CDPH requests trailer bill language to address inconsistencies in licensure fees for clinical laboratories and laboratory personnel, tissue banks, and biologics facilities, including allowing CDPH to increase fees, establish a fee methodology to administer the program, update the phlebotomist certification fee from a biennial to an annual fee, and make other technical corrections.	Adopt modified placeholder trailer bill language to set fee levels in statute

127	4265	CDPH	Genetic Counselor License Fees	March 13th, 2025	CDPH requests trailer bill language to authorize the establishment of fees for genetic counselor licensure by regulation, rather than fixed in statute.	Adopt modified placeholder trailer bill language to set fee levels in statute
128	4265	CDPH	CHCQ Acute Psychiatric Hospitals Support	May 20th, 2025	CDPH requests five positions and expenditure authority from the Licensing and Certification Fund of \$1 million annually. If approved, these positions and resources would support investigations of complaints at acute psychiatric hospitals. CDPH also requests trailer bill language to authorize the promulgation of emergency regulations for oversight of acute psychiatric hospitals.	Approve and adopt modified placeholder trailer bill language that includes a deadline for the promulgation of final regulations.
129	4265	CDPH	CHCQ Internal Departmental Quality Improvement Account (IDQIA)	March 13th, 2025	CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account of \$3.1 million in 2025-26.	Approve as budgeted

					If approved, these resources would support planning and implementation costs for the Centralized Application Branch (CAB) Online Licensing Application Project.	
130	4265	CDPH	CHCQ Operations Support	May 20th, 2025	CDPH requests eight positions and expenditure authority of from the Licensing and Certification Fund of \$1.5 million annually. If approved, these positions and resources would support operations within the Center for Health Care Quality.	Approve as budgeted
131	4265	CDPH	CHCQ Policy and Legislation Branch Expansion	March 13th, 2025	CDPH requests seven positions and expenditure authority from the Licensing and Certification Fund of \$1.1 million annually. If approved, these positions and resources would support expansion of the Center for Health Care Quality's Public	Approve as budgeted

					Policy and Legislative Branch.	
132	4265	CDPH	Generative Artificial Intelligence Contract	May 20th, 2025	CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account to support a minimum viable product contract for generative artificial intelligence (GenAI) to improve investigations within the Center for Health Care Quality.	Reject
133	4265	CDPH	Implementation of Chaptered Legislation (AB 1775)	March 13th, 2025	CDPH requests one position and General Fund expenditure authority of \$183,000 annually. If approved, this position and resources would support implementation of secondhand cannabis smoke guidance pursuant to the requirements of AB 1775 (Haney), Chapter 104, Statutes of 2024.	Approve as budgeted

134	4265	CDPH	Implementation of Chaptered Legislation (AB 1282)	March 13th, 2025	CDPH requests expenditure authority from the Behavioral Health Services Fund of \$463,000 in 2025-26 and \$232,000 in 2026-27. If approved, these resources would support development and submission of a report to the Legislature on a statewide strategy to address the mental health risks linked to the use of social media in children and youth, pursuant to the requirements of AB 1282 (Lowenthal), Chapter 807, Statutes of 2024.	Approve as budgeted
135	4265	CDPH	Implementation of Chaptered Legislation (AB 3030)	March 13th, 2025	CDPH requests three positions and expenditure authority from the Licensing and Certification Fund of \$672,000 annually. If approved, these positions and resources would support enforcement of requirements that health care service providers	Approve as budgeted

					that use artificial intelligence to provide patient communications include a disclaimer and instructions describing how a patient may contact a human health care provider or other appropriate person, pursuant to the requirements of AB 3030 (Calderon), Chapter 848, Statutes of 2024.	
136	4265	CDPH	Implementation of Chaptered Legislation (SB 1354)	March 13th, 2025	CDPH requests 1.25 positions and expenditure authority from the Licensing and Certification Fund of \$307,000 annually. If approved, these positions and resources would support oversight of skilled nursing facility requirements to make daily resident census and nurse staffing data available, pursuant to the requirements of SB 1354 (Wahab), Chapter 339, Statutes of 2024.	Approve as budgeted

137	4265	CDPH	Implementation of Chaptered Legislation (SB 1511)	May 20th, 2025	CDPH requests expenditure authority from the Health Statistics Special Fund of \$492,000 annually. If approved, these resources would support implementation of new requirements related to death registration, pursuant to the requirements of SB 1511 (Committee on Budget and Fiscal Review), Chapter 492, Statutes of 2024.	Approve as budgeted
138	4265	CDPH	Implementation of Chaptered Legislation (AB 1859)	May 20th, 2025	CDPH requests one position and General Fund expenditure authority of \$288,000 annually. If approved, these resources would support analysis and posting of xylazine overdose data gathered by coroners to the California Overdose Surveillance Dashboard, pursuant to the requirements of AB 1859 (Alanis), Chapter 684, Statutes of 2024.	Approve as budgeted

139	4265	CDPH	Implementation of Chaptered Legislation (SB 957)	May 20th, 2025	CDPH requests three positions and General Fund expenditure authority of \$538,000 annually. If approved, these resources would support implementation of changes and preparation of reports to comply with the requirements of SB 957 (Wiener), Chapter 868, Statutes of 2024.	Approve as budgeted
140	4265	CDPH	Implementation of Chaptered Legislation (SB 1076)	May 20th, 2025	CDPH requests net decrease of expenditure authority of \$2.8 million in 2025-26. The net expenditures consist of a decrease of \$5 million of Lead Related Construction Fund and a \$2.2 million increase in General Fund. If approved, these resources would support the development of an online accreditation and application system for firms and individuals who perform lead renovation, repair, and painting work, pursuant to SB	Approve as budgeted

					1076 (Archuleta), Chapter 507, Statutes of 2022	
141	4265	CDPH	Implementation of Chaptered Legislation (SB 3161)	May 20th, 2025	CDPH requests expenditure authority from the Licensing and Certification Fund of \$1.1 million in 2025-26. If approved these resources would support oversight of hospital patient safety plans to include demographic data on injured patients to address racism and discrimination in health care, pursuant to the requirements of AB 3161 (Bonta), Chapter 757, Statutes of 2024.	Approve as budgeted
142	4265	CDPH	Public Contract Code Exemption for Emergencies and Threats	May 20th, 2025	CDPH requests budget bill language to exempt from the Public Contract Code requirements for department operations supporting preparedness	Adopt placeholder budget bill language, consistent with the Administration's proposal.

					and response during emergencies and imminent threats with the potential for significant public health impacts.	
143	4265	CDPH	Special Deposit Sub-Fund Conversion to Special Funds	March 13th, 2025	CDPH requests conversion of four special deposit sub-funds to their own, separate special funds. These special deposit funds include the Internal Departmental Quality Improvement Account (IDQIA), the Skilled Nursing Facility Minimum Staffing Penalty Account, the State Facilities Citation Penalties Account, and the Federal Health Facilities Citation Penalties Account.	Approve and adopt placeholder trailer bill language consistent with the Administration's proposal.
144	4265	CDPH	Proposition 99 Expenditure Adjustments	May 20th, 2025	CDPH requests the following adjustments to Proposition 99 tobacco tax expenditure accounts to reflect updated tax revenue: <ul style="list-style-type: none"> <li>• Research Account - \$723,000 reduction</li> </ul>	Approve as budgeted

					<ul style="list-style-type: none"> <li>• Unallocated Account - \$286,000 reduction</li> <li>• Health Education Account - \$6.3 million reduction</li> </ul>	
145	4265	CDPH	Adjustment to Reflect Available Resources in the Breast Cancer Fund	May 20th, 2025	DPH requests a reduction in expenditure authority of \$10,000 in the Breast Cancer Research Account of the Breast Cancer Fund to reflect updated tobacco tax revenue estimates.	Approve as budgeted

**4300 Department of Developmental Services (DDS)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
146	4300	DDS	Public Records Act (AB 1147)	April 24th, May 19th, 2025	DDS requests \$11.5 million (\$8.3 million General Fund) in 2025-26 and \$15.4 million (\$11.1 million General Fund) in 2026-27 and ongoing for 10 permanent headquarters positions and regional center (RC) resources to address the new workload associated with AB 1147 (Addis, Chapter 902, Statutes of 2024). The May Revision reduces this proposal by six DDS positions (decrease of \$819,000 total funds and \$655,000 General Fund).	Approve as budgeted.
147	4300	DDS	Trailer Bill: Rate Reform - Employment Services	April 24th, 2025	Changes job coach to consumer ratio from 1:3 to 1:2 for group services, removed "accredited community nonprofit agencies" for habilitation services, removes hourly rate for employment services and group services, and work activity	Adopt placeholder trailer bill language consistent with the Administration's proposal.

					programs, and other technical changes.	
148	4300	DDS	Quality Incentive Program Eligibility Provider Mandate	May 19th, 2025	Reduction of \$221.7 million General Fund in 2026-27 and ongoing. Stipulates that to qualify for the Quality Incentive Program (QIP), providers must comply with Electronic Visit Verification (EVV), Home and Community-Based Services (HCBS) rules, and independent audit and fiscal review requirements. This includes corresponding trailer bill.	Approve as budgeted. Adopt placeholder trailer bill language consistent with the Administration's proposal.
149	4300	DDS	Service Provider Rate Reform Hold Harmless	May 19th, 2025	Reduction of \$75 million General Fund in 2025-26 to end service provider rate reform hold harmless policy as of February 28, 2026 instead of June 30, 2026. This includes corresponding trailer bill.	Approve as budgeted. Adopt placeholder trailer bill language consistent with the Administration's proposal.
150	4300	DDS	Direct Support Professional Workforce Training and Development	May 19th, 2025	Reduction of \$17.6 million General Fund in 2025-26 and 2026-27 and \$36.8 million General Fund in	Reject.

					2027-28 and ongoing to eliminate funding for wage differentials tied to completion of service provider training program.	
151	4300	DDS	Porterville Developmental Center Ongoing Savings	May 19th, 2025	Reduction of \$10 million General Fund in 2026-27 and ongoing reflecting historical savings at Porterville Developmental Center.	Modify. Increase the reduction by \$15 million in 2025-26 and \$6 million in 2026-27 and ongoing to align budget to recent expenditure trends and vacant positions. This reduction is not expected to have any adverse impact on services at Porterville Developmental Center.
152	4300	DDS	Implicit Bias Training	May 19th, 2025	Reduction of \$5.6 million General Fund in 2025-26 and ongoing. This includes corresponding trailer bill.	Approve as budgeted. Adopt placeholder trailer bill language consistent with the Administration's proposal.
153	4300	DDS	Health and Safety Waiver Assistance	May 19th, 2025	Reduction of \$3.0 million General Fund in 2025-26 and ongoing. This includes corresponding trailer bill.	Approve as budgeted. Adopt placeholder trailer bill language consistent with the Administration's proposal.
154	4300	DDS	Life Outcomes Improvement System (LOIS)	May 19th, 2025	Increase of \$13.3 million total funds, (\$5.1 million General Fund) for one-year limited-term resources equivalent to seventeen (17.0) positions at the Department, and resources for regional centers to	Approve as budgeted. Additionally, approve placeholder Supplemental Report Language for updates to the Legislature and stakeholders on the timely development of the LOIS project.

					continue the planning phase of the Project Approval Lifecycle (PAL) process.	
155	4300	DDS	Federal Access Rule	May 19th, 2025	Increase of \$1.9 million total funds (\$1.6 million General Fund) for one-year limited term resources equivalent to nine (9.0) positions to support the increased workload related to compliance with the new federal Home and Community-Based Access Rule requirements.	Approve as budgeted.
156	4300	DDS	Staffing for Health and Safety Investigations and Due Process Caseload	May 19th, 2025	Increase of \$1.4 million total funds, (\$1.2 million General Fund) for nine permanent positions and \$2.0 million total funds (\$1.7 million General Fund) in 2026-27 and ongoing to support increased workload related to health and safety concerns, such as rising appeals and complaints workloads.	Approve as budgeted.
157	4300	DDS	Clinical Monitoring Team for Specialized Community Homes	May 19th, 2025	Increase of \$680,000 total funds (\$544,000 General Fund) for four permanent	Approve as budgeted.

					positions to support development and monitoring of specialized community homes and services.	
158	4300	DDS	Increased Reimbursement and Cost Recovery	May 19th, 2025	Increase of \$1.3 million total funds (\$1.1 million General Fund) for five permanent positions and contracted consultant support to explore options and obtain payment from public and private health insurers for services purchased by regional centers on behalf of eligible individuals.	Approve as budgeted.
159	4300	DDS	Porterville Developmental Center Capital Outlay	May 19th, 2025	Increase of \$2.2 million one-time General Fund for the construction phase of the Fire Sprinkler System project at Porterville Development Center and reversion of \$1.1 million General Fund of existing authority for the construction phase, resulting in a net increase of \$1.0 million.	Approve as budgeted.

160	4300	DDS	Regional Centers Caseload and Utilization May Revision Update	May 19th, 2025	Decrease of \$168,013,000 and \$57,795,000 reimbursements ongoing. These adjustments reflect updated expenditure estimates in operations and purchase of services driven by caseload and utilization.	Approve as budgeted.
161	4300	DDS	Loan Authority	May 19th, 2025	Changes General Fund loan authority from \$1,290,420,000 to \$1,269,819,000 to reflect revised federal reimbursement estimates.	Approve as budgeted.
162	4300	DDS	Trailer Bill: Fiscal Allocation Letter Authority	May 19th, 2025	Proposes statutory changes to streamline administrative processes for issuing fiscal allocations to regional centers, consistent with appropriations in the annual state budget.	Reject.
163	4300	DDS	Trailer Bill: Repeal of Parental Fee Program	May 19th, 2025	Repeals the Parental Fee Program (PFP) and redirect positions to support increased reimbursement and cost recovery efforts.	Adopt placeholder trailer bill language consistent with the Administration's proposal.

164	4300	DDS	Self Determination Program	May 19th, 2025	Reduction of \$22.5 million General Fund in 2025-26, and \$45.5 million General Fund ongoing. This includes corresponding trailer bill. Trailer bill modifies the budget calculation based on authorized services and requires regional centers to certify that spending plans meet federal requirements.	Approve as budgeted. Adopt placeholder trailer bill language with modifications based on stakeholder feedback.
165	4300	DDS	Master Plan for Developmental Services	April 24th, 2025	Legislative proposal to specify continued stakeholder involvement and promote transparency in achieving the goals and recommendations of the Master Plan.	Adopt placeholder trailer bill language.
166	4300	DDS	Employment Outcomes Reporting	April 24th, 2025	Legislative proposal for supplemental report language requiring DDS, along with the Department of Rehabilitation (DOR) to provide information on transitions to employment, status of employment, and barriers to employment.	Adopt placeholder supplemental report language.

**4440 Department of State Hospitals (DSH)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
167	4440	DSH	Contracted Patient Services, Incompetent to Stand Trial (IST) Solutions	May 1st	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 the Felony IST Program.	Approve as budgeted.
168	4440	DSH	Enhanced Treatment Program – Trailer Bill Language and Program Update	May 1st	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.	Approve as budget and adopt placeholder trailer bill language consistent with the Administration's proposal.
169	4440	DSH	Increased Coleman Referrals	May 1st	The Governor’s budget includes three positions at DSH (authority only) in 2025-26 and ongoing to address increased workload related	Approve as budgeted.

					to referral intake for Coleman patients.	
170	4440	DSH	Napa:  Electrical Infrastructure Upgrade	May 1st	DSH requests \$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.	Approve as budgeted.
171	4440	DSH	Statewide Project Management	May 1st	DSH requests 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 section.	Approve as budgeted.
172	4440	DSH	CONREP Non-SVP Caseload Adjustment	May 1st and May 19th	DSH estimates savings of \$6.9 million in 2024-25 due to reduced census in the Conditional Release Program (CONREP) Non-Sexually Violent Predators (Non-SVP) program.	Approve as budgeted.
173	4440	DSH	Metropolitan Increased Secure Bed Capacity	May 1st and May 19th	DSH reports one-time savings of \$10.3 million in 2024-25 due to delays in the DSH-Metropolitan Increased Secure Bed Capacity project.	Approve as budgeted.

174	4440	DSH	Patient Driven Operating Expenses and Equipment Adjustment	May 1st and May 19th	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 Governor's budget includes \$21.7 million in 2024-25 and ongoing for increased expenses in Utilities, Pharmaceuticals, Foodstuffs, and Outside Hospitalization. The May Revision included a reduction of \$1.5 million in 2024-25 and increase of \$290,000 in 2025-26 and ongoing for adjustments to patient-driven operating expenses and equipment.	Approve as budgeted.
175	4440	DSH	Coalinga: Hydronic Loop Replacement	May 19th	DSH proposes a reversion of \$26.2 million General Fund from 2024-25 and a new appropriation of \$34.4 million General Fund in 2025-26 for the construction phase of the DSH-Coalinga Hydronic Loop Replacement project.	Approve as budgeted.
176	4440	DSH	Community-Based Restoration and Felony Diversion Program Adjustment	May 19th	The May Revision reflects savings of \$12.3 million in 2025-26 and ongoing related to the LA County Community-Based Restoration and Diversion contract to reflect current enrollment rates.	Approve as budgeted.

177	4440	DSH	Continuum Electronic Health Records Phase 1 Implementation	May 19th	The May Revision includes a reappropriation of \$7.5 million from 2024-25 to 2025-26 related to DSH's Employee Health Record project, and budget bill language allowing a mid-year augmentation.	Approve as budgeted.
178	4440	DSH	County Bed Reimbursement Authority	May 19th	The May Revision includes \$13.4 million in 2025-26 and \$21 million in 2026-27 and ongoing in reimbursement authority to collect county bed payments. This increased reimbursement authority is due to (1) a projected increase in the Lanterman-Petris-Short (LPS) patient census and (2) negotiated daily bed rate increases of 4 percent in 2025-26 and 3.5 percent in 2026-27. The increase in LPS census is due to the conversion of 25 existing beds, and the decision to use one of the new secure 44-bed units at DSH-Metropolitan for LPS patients instead of IST patients, due to higher demand for LPS beds.	Approve as budgeted.
179	4440	DSH	Court-Appointed Evaluator Training Reversion	May 19th	The May Revision includes a reversion of \$4.6 million from 2023-24 and \$4.5 million from 2024-25 in unused funding originally appropriated for the Judicial Council to develop training for court-appointed evaluators.	Approve as budgeted.

180	4440	DSH	Decrease Court Reporting Requirements for a Limited Patient Population – Savings and Trailer Bill Language	May 19th	The May Revision includes statutory changes and a reduction of 3 positions and \$1.5 million in 2025-26 and ongoing to modify requirements for reporting to the court from semi-annually to annually for the Not Guilty by Reason of Insanity population, which aligns with the annual reporting requirements for other long-term patient populations.	Approve as budget and adopt placeholder trailer bill language consistent with the Administration's proposal.
181	4440	DSH	DSH-Coalinga Telepsychology Pilot	May 19th	The May Revision includes \$474,000 in 2025-26 and \$342,000 in 2026-27 and 2027-28 for a three-year telepsychology pilot at DSH-Coalinga.	Approve as budgeted.
182	4440	DSH	Educational Institution Partnership Contracts – Provisional Language	May 19th	The May Revision includes provisional language to allow DSH to enter into agreements with educational institutions and hospitals to provide clinical training and education.	Approve provisional language.
183	4440	DSH	Isolation Unit Staffing	May 19th	The May Revision reflects savings of \$22.1 million in 2025-26 and ongoing related to the reduction of 124.1 isolation unit related positions, to align with current isolation practices and utilization.	Approve as budgeted.
184	4440	DSH	IST Infrastructure Grant Program Reversion	May 19th	The May Revision includes a reversion of unspent \$232.5 million one-time General Fund included in the 2022 Budget Act for grants to counties to increase residential	Approve as budgeted.

					treatment housing capacity for individuals designated IST.	
185	4440	DSH	IST Program Caseload Adjustment	May 19th	The May Revision includes a caseload update resulting in savings of \$10.9 million in 2024-25, \$37.8 million in 2025-26, and \$39.0 million in 2026-27 related to Early Access and Stabilization Services and Jail-Based Competency Treatment.	Approve as budgeted.
186	4440	DSH	IST Program Rightsizing	May 19th	The May Revision reflects savings of \$4.5 million in 2024-25, \$161.1 million in 2025-26, \$238.8 million in 2026-27 and \$157.3 million in 2027-28 and ongoing from right-sizing IST programs including Early Access and Stabilization Services, Community Based Restoration and Diversion, and County Collaborative Workgroup Grant funding.	Approve as budgeted.
187	4440	DSH	Patton: Fire Alarm System Upgrade – Reappropriation	May 19th	DSH proposes a reappropriation of \$21.6 million General Fund in 2025-26 for the construction phase of the Patton Fire Alarm System Upgrade project.	Approve as budgeted.
188	4440	DSH	Prior Authorization Software	May 19th	The May Revision reflects savings of \$250,000 in 2025-26, \$500,000 in 2026-27, and \$1 million in 2027-28 and ongoing related to the implementation of a prior	Approve as budgeted.

					authorization and utilization management software for certain specialty care services.	
189	4440	DSH	Various Operational Efficiencies	May 19th	The May Revision reflects savings of \$4.8 million in 2025-26, \$5.9 million in 2026-27, and \$2.3 million in 2027-28 and ongoing related to various operational efficiencies.	Approve as budgeted.

**4560 Commission on Behavioral Health (CBH)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
190	4560	CBH	Elimination of Mental Health Wellness Act Funding	May 19th, 2025	<b>General Fund Solution</b> - The Administration requests ongoing reduction of expenditure authority from the Behavioral Health Services Fund of \$20 million. If approved, this reduction would eliminate funding for peer respite, maternal behavioral health, and full-services partnership performance contracting programs. These resources were originally approved ongoing through the Investment in Mental Health Wellness Act, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, and SB 833 (Committee on Budget and Fiscal Review), Chapter 704, Statutes of 2016.	Reject
191	4560	CBH	Emergency, Psychiatric Assessment, Treatment, and Healing (EmPATH)	May 19th, 2025	CBH requests extension of the liquidation deadline of expenditure authority from the Behavioral Health Services Fund of up to \$7.8 million, originally approved in the 2021 Budget Act, until June 30, 2027. These resources support grants for EmPATH units delivering psychiatric care to individuals with behavioral health conditions.	Approve as budgeted

192	4560	CBH	Early Psychosis Intervention (EPI) Plus Program	May 19th, 2025	CBH requests extension of the liquidation deadline of expenditure authority from the Behavioral Health Services Fund of up to \$430,000, originally approved in the 2019 Budget Act, until June 30, 2026. These resources support evidence-based early psychosis and mood disorder detection through the EPI Plus Program, pursuant to the requirements of AB 1315 (Mullin), Chapter 414, Statutes of 2017.	Approve as budgeted
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**4700 Community Services and Development (CSD)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
193	4700	CSD	Proposition 4: Low-Income Weatherization Program Farmworker Housing Component	April 24th 2025, May 19th 2025	CSD requests \$200,000 Proposition 4 Funds in 2026-27, and \$10 million ongoing Proposition 4 Funds, to support the LIWP Farmworker Housing Component. This component represents CSD's portion of the \$10 billion Proposition 4 spending plan. The May Revision requests to accelerate the expenditure timeline by one year, allocating \$230,000 Proposition 4 Funds in 2025-26, \$9.5 million in 2026-27, and continuing support funding through 2027-28.	Conform to Budget Subcommittee #2 action on Proposition 4 Spending Plan.
194	4700	CSD	LGBT Disparities Reduction Act (AB 1163) Augmentation	April 24th, 2025	CSD requests an augmentation of \$1.06 million General Fund to implement statewide data collection system changes to comply with AB 1163 (Luz Rivas), Chapter 832, Statutes of 2023.	Reject, and additionally revert \$943,000 General Fund from the 2024 Budget Act, for total savings of \$2 million General Fund one-time. The Department of Finance has requested to withdraw this proposal.

195	4700	CSD	Low-Income Weatherization Program Re-appropriations	May 19th, 2025	CSD requests to extend the liquidation period for one-time 2021-22 General Fund resources supporting the Low-Income Weatherization Program Farmworker Housing Component. CSD requests to re-appropriate the remaining balance of unexpended one-time 2022-23 General Fund resources extends the liquidation period for one-time 2022-23 General Fund resources supporting the Low-Income Weatherization Program Multifamily Housing Component.	Approve as budgeted.
196	4700	CSD	General Fund Cash Flow Loan	May 19th, 2025	CSD requests authorization for a General Fund loan or loans, not to exceed a cumulative total of \$40 million, to assist in cash flow program needs related to unanticipated delays in the receipt of federal funds.	Approve as budgeted.

4800 California Health Benefits Exchange (Covered CA)						
Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
197	4800	CovCA	Health Care Affordability Reserve Fund - Increase Available Resources to Offset Expiring Federal Premium Subsidies	Legislative Proposal	The Legislature proposes to augment the expenditure authority from the Health Care Affordability Reserve Fund from \$165 million to \$215 million to support premium subsidies in the Covered California Health Benefits Exchange that will help defray expiring federal premium subsidies provided by the Inflation Reduction Act.	Approve Legislative Proposal

**5175 Department of Child Support Services (DCSS)**

Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
198	5175	DCSS	Local Assistance	May 19th, 2025	DCSS projects a decrease of \$1,490,000 federal funds ongoing to update federal fund local assistance expenditures based on additional child support collections data becoming available. DCSS also requests an increase in the Child Support Collections Recovery Fund by \$1,490,000 ongoing to reflect an estimated increase in collections received for the federal government's share of child support recoupment based on updated child support collections information.	Approve as budgeted.

5180 Department of Social Services (CDSS)						
Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
199	5180	CDSS	Administrative Support for Pool Safety (AB 2866)	March 20th, 2025	CDSS requests two permanent positions and one limited term position to support the new workload under AB 2866 (Pellerin), Chapter 745, Statutes of 2024, which requires child care centers and family child care homes in single-family dwellings with in-ground pools to add specified safety features.	Approve as budgeted.
200	5180	CDSS	Anaphylactic Policy Implementation (AB 2317)	March 20th, 2025	CDSS requests five positions to support the new workload created by AB 2317 (Stephanie Nguyen), Chapter 563, Statutes of 2024 to provide guidance and training on anaphylactic prevention and emergency responses in child care facilities.	Approve as budgeted.
201	5180	CDSS	Children's Camps Regulation (AB 262)	March 20th, 2025	CDSS requests \$1.8 million General Fund for a contractor and four positions to conduct the work outlined in AB 262, which requires CDSS to prepare a report, informed by consultation with a wide variety of stakeholders on children's camps	Approve as budgeted.

					that include recommendations for a definition of a children’s camp, minimum health and safety requirements, and responsibilities and requirements for camp oversight to the Legislature.	
202	5180	CDSS	Homelessness Programs Data Collection (AB 799)	March 20th, 2025	CDSS requests two positions to oversee data sharing, coordination, and analysis associated with AB 799 (Luz Rivas), Chapter 263, Statutes of 2024 to support the quarterly sharing of funding opportunities and to assist in the annual publication of a statewide report on homelessness in collaboration with the California Interagency Council on Homelessness.	Approve as budgeted.
203	5180	CDSS	Limited-Term Resources for Housing and Homelessness Data Reporting	March 20th, 2025	CDSS requests limited-term resources to support the Housing and Homelessness Data Reporting Systems Implementation, Maintenance, and Operations.	Approve as budgeted.
204	5180	CDSS	Office of Equity New Staffing Resources	March 20th, 2025	CDSS requests \$188,000 General Fund and \$219,000 Federal Fund in Fiscal Year 2025-26 and \$184,000 General Fund and \$213,000 Federal Fund ongoing for two permanent authorized	Approve as budgeted.

					positions to ensure continuous oversight and implementation of emerging and expanded programs and workloads in the Office of Equity.	
205	5180	CDSS	Permanent Existing State Operations	March 20th, 2025	CDSS requests \$385,000 General Fund and \$149,000 federal funds in 2025-26 and ongoing for three permanent authorized positions to continue operating its essential equity and related population specific programs.	Approve as budgeted.
206	5180	CDSS	Resident Services and Rights Support (SB 1406)	March 20th, 2025	CDSS requests \$743,000 General Fund in 2025-26, \$725,000 General Fund in 2026-27, and \$549,000 General Fund in 2027-28 and ongoing for three permanent positions and two-year limited-term funding equivalent to one position, to implement SB 1406 (Allen, Chapter 340, Statutes of 2024), which increases the number of days, from 60 to 90, for which a licensee of a residential care facility for the elderly (RCFE) must provide written notice to residents or their representatives prior to any increases in the rate structures for fees and services.	Approve as budgeted.

207	5180	CDSS	California HOPE for Children Trust Account	April 3rd, 2025	CDSS requests \$374,000 General Fund in 2025-26 and \$364,000 General Fund ongoing and two positions to implement SB 242 (Skinner, Chapter 1010, Statutes of 2024) related to the HOPE program for foster youth.	Approve as budgeted.
208	5180	CDSS	Child Care Development Fund Facility Savings to Authorized Positions	April 3rd, 2025	CDSS requests a technical change to increase ongoing federal funding authority by \$34,400,000 to support the Child Care Development Block Grant (CCDBG) program. There is no General Fund impact.	Approve as budgeted.
209	5180	CDSS	Child Care Policy, Program, Administrative, and Support Staffing Needs	April 3rd, 2025	CDSS requests 33 federally funded permanent positions and an increase in federal expenditure authority of \$6.4 million in 2025-26 and \$6.2 million ongoing to provide policy, program, and administrative support to child care and development programs.	Approve as budgeted.

210	5180	CDSS	First Phase of Foster Care Tiered Rate Structure State Operations	April 3rd, May 19th 2025	CDSS requests \$1.8 million General Fund in 2025-26 and \$1.7 million General Fund ongoing for nine permanent positions to support the first phase of implementation of the Permanent Foster Care Rate Structure. The May Revision increases this proposal by \$788,000 General Fund and 6.3 positions in 2025-26, \$771,000 General Fund and 6.3 positions in 2026-27 and 2027-28, and \$538,000 General Fund and 4.2 positions in 2028-29 and ongoing to provide additional resources to support the implementation of the Tiered Rate Structure. Increase of \$1,103,000 federal funds and 2.7 positions in 2025-26, \$1,074,000 and 2.7 positions in 2026-27 and 2027-28, and \$974,000 and 1.8 positions in 2028-29 and ongoing for the same purpose.	Approve as budgeted.
211	5180	CDSS	Ongoing Funding for Foster Care Placement Services	April 3rd, 2025	CDSS requests \$1.2 million General Fund in 2025-26 and \$1.2 million General Fund ongoing for six permanent positions to support the workload associated with developing a Congregate	Approve as budgeted.

					Care Continuous Quality Improvement framework.	
212	5180	CDSS	CalWORKs Permanent Housing Assistance (SB 1415)	May 8th, 2025	CDSS requests one limited-term position and \$180,000 General Fund in 2025-26 and \$176,000 in 2026-27 to implement SB 1415 (Glazer, Chapter 798, Statutes of 2024) including development of guidance, regulations, automation, and technical assistance and oversight to counties for the Homeless Assistance Program.	Approve as budgeted.
213	5180	CDSS	Increase Reimbursement Authority for Receivable CalFresh Confirm Inter-Agency Agreements	May 8th, 2025	CDSS requests to increase reimbursement authority by \$269,000 to continue receivable Inter-Agency Agreements with fellow state-level entities seeking to use the CalFresh Confirm tool. The positions are funded by the Federal Employment and Training (E&T) funds at 50 percent and from revenue generated from agreements at 50 percent. No General Fund impact.	Approve as budgeted.

214	5180	CDSS	Information Systems Division Growth and Sustainability	May 8th, 2025	CDSS requests an increase in General Fund expenditure authority of \$1,563,000 in 2025-26 and \$1,527,000 ongoing for seven permanent positions and \$1,458,000 for contract funding over two years to ensure the Information Systems Division (ISD) has adequate capacity to support the growing department IT needs. The May Revision includes a decrease of \$1,171,000 General Fund in 2025-26 and 2026-27, and \$150,000 in 2027-28 and ongoing to reflect a technical change to align resources with the proposal included in the Governor's Budget.	Approve as budgeted.
215	5180	CDSS	New CalFresh Outreach Section	May 8th, 2025	CDSS requests an increase in federal expenditure authority of \$780,000 in 2025-26 and \$760,000 ongoing to bolster the CalFresh Outreach program and engage in more strategies to reach people eligible for CalFresh in California.	Approve as budgeted.
216	5180	CDSS	Trailer Bill: Housing and Homelessness Programs Complaint Resolution	March 20th, 2025	Establishes minimum requirements for CalWORKs HSP, Home Safe, Bringing Families Home, and HDAP and declares these requirements are sufficient	Reject.

					to meet due process for non-entitlement programs.	
217	5180	CDSS	Trailer Bill: Child Care Reporting Clean-up	April 3rd, 2025	Removes "part-day preschool and wraparound child care services" from CDSS reporting requirements as those programs are administered by the Department of Education.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
218	5180	CDSS	Trailer Bill: Child Care Part-time Clean-up	April 3rd, 2025	Reduces the documented need for reimbursements to providers based on a "daily rate" from 6 hours to 5.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
219	5180	CDSS	Trailer Bill: Child Care 12-month eligibility for new children	April 3rd, 2025	Allows a family currently eligible for child care to retain eligibility for an additional 12-months if another child is born.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
220	5180	CDSS	Trailer Bill: Disaster CalFresh	May 8th, 2025	Codifies existing law regarding administrative funding for Disaster CalFresh.	Adopt placeholder trailer bill language consistent with the Administration's proposal.
221	5180	CDSS	Child Care COLA Suspension	May 19th, 2025	Reduction of \$60.65 million General Fund in 2025-26 and ongoing to suspend the statutory cost of living adjustment for child care and development programs in 2025-26. This solution includes corresponding trailer bill language.	Approve as budgeted. Adopt placeholder trailer bill language to restructure the statutory cost-of-living adjustment to be applied to all programs based on the single rate structure.

222	5180	CDSS	Emergency Child Care Bridge	May 19th, 2025	Reduction of \$42.7 million General Fund in 2025-26 and ongoing to the Emergency Child Care Bridge program, which funds child care slots for children in foster care on an emergency basis	Modify. Revert up to \$30 million General Fund estimated to be unspent in 2024-25. Reduce by \$30 million General Fund in 2025-26 and ongoing. This decreases the amount of the Governor's proposed reduction by \$12.7 million.
223	5180	CDSS	Child Care Prospective Pay Policy	May 19th, 2025	Increase of \$52 million General Fund to support the implementation of paying Child Care and Development providers prospectively and align with a Final Rule issued by The Administration for Children and Families (ACF). The Final Rule requires states to pay child care providers prospectively prior to the delivery of services. The ACF has approved a waiver until August 1, 2026, to provide California with two years of additional time to begin implementing prospective payments. Of the \$52 million, \$43.8 million is to support local administration ongoing, and \$8.2 million is to support system automation costs. The budgeted costs support implementation for Child Care & Development contractors, as well as	Modify. Approve \$8.2 million for system automation costs. Reduce local administration by \$21.9 million in 2025-26, reflecting a half-year implementation. Approve full-year of local administration costs of \$43.8 million in 2026-27. Reject ongoing appropriation in 2027-28 and ongoing. Partial approval of this request is contingent on the adoption of trailer bill language to reimburse child care providers based on enrollment by January 1, 2026.

					administrative support to county administered programs.	
224	5180	CDSS	Administrative Support for Alternative Payment Programs	May 19th, 2025	Increase of \$70 million General Fund in 2025-26 to provide resources to Alternative Payment Program agencies (child care contractors) for administration and support costs associated with implementing ongoing provisions of the Memorandum of Understanding with Child Care Providers United.	Approve as budgeted.

225	5180	CDSS	Rate Reform Support Costs Federal Funds	May 19th, 2025	Increase of \$21.8 million one-time federal funds to support start-up automation activities for CDSS to implement a single rate structure for child care based on the alternative methodology.	Modify budget bill language to require written notification to, and approval by, the Joint Legislative Budget Committee. This written notification shall include, at a minimum, the following: a spending plan describing the specific goals and activities the department will conduct with these funds; how these activities will achieve the implementation of a single rate structure for child care reimbursement; how rates set pursuant to the single rate structure will differ from the rates in effect on June 30, 2025, by program; and how the department proposes to increase child care reimbursement rates pursuant to the single rate structure in future fiscal years. Prohibits allocation of these funds prior to approval from the Joint Legislative Budget Committee.
226	5180	CDSS	Administrative Costs to Distribute Cost of Care plus Payments	May 19th, 2025	Increase of \$44.8 million for child care contractors to continue distributing the “cost of care plus” monthly rate supplements for child care providers, pursuant to the 2023 and 2024 Budget Acts.	Approve as budgeted.

227	5180	CDSS	Preschool Development Grant Award Authority Adjustment	May 19th, 2025	Increase reimbursements by \$280,000 one-time federal funds for the Preschool Development Grant.	Approve as budgeted.
228	5180	CDSS	Child Care Direct Deposit Staffing and Re-appropriation	May 19th, 2025	Increase of \$944,000 and 5 positions in 2025-26, and \$922,000 and 5 positions in 2026-27 and ongoing to provide administrative support to process child care and development contract payments. Re-appropriation of up to \$1.1 million from the 2022 Budget Act to extend the existing direct deposit contract funds.	Approve as budgeted.
229	5180	CDSS	Child Care Prospective Pay Implementation State Operations	May 19th, 2025	Increase of \$582,000 and 6 positions in 2025-26 and \$1,111,000 and 6 positions in 2026-27 and ongoing to support implementation of prospective pay for child care providers to comply with federal requirements.	Approve, contingent on adoption of trailer bill language to reimburse child care providers based on enrollment by January 1, 2026. Adopt placeholder trailer bill language requiring CDSS to report on the specific goals and activities these funds the department will conduct using these funds.
230	5180	CDSS	Trailer Bill: Cost of Care Plus Payments	May 19th, 2025	CDSS proposes trailer bill language to extend the current "cost of care plus" supplemental rate payments to child care providers for an additional year. These payments are monthly per-child supplemental payments required under the 2023 CCPU	Adopt placeholder trailer bill language consistent with the Administration's proposal.

					collective bargaining agreement and the 2023 Budget Act. The 2024 Budget Act required that future child care rates be no lower than the rates in effect June 30, 2024, inclusive of the cost of care plus payments.	
231	5180	CDSS	Family Urgent Response System (FURS) Reduction	May 19th 2025	Decrease of \$13 million General Fund in 2025-26 and ongoing. FURS provides 24/7 in-person mobile response to support children in foster care and their caregivers.	Modify. Revert up to \$9 million General Fund estimated to be unspent in 2023-24 and 2024-25. Reduce by \$9 million General Fund in 2025-26 and ongoing.
232	5180	CDSS	Foster Care Tiered Rate Structure Trigger	May 19th, 2025	Makes implementation of the Foster Care Tiered Rate Structure subject to a “trigger,” based on DOF’s assessment of the availability of General Fund in spring 2027. Includes trailer bill language.	Reject.
233	5180	CDSS	California Food Assistance Program Expansion Trigger	May 19th, 2025	Makes implementation of the expansion of CFAP to all adults ages 55 and over subject to a “trigger,” based on DOF’s assessment of General Fund availability in spring 2027. Includes trailer bill language.	Reject. Maintain the planned implementation date of October 1, 2027. Reduce the automation/outreach funding by \$26 million General Fund in 2025-26 and move this amount to 2026-27. This allows automation to continue with \$12 million in 2025-26.

234	5180	CDSS	CalWORKs: Elimination of the CalWORKs RADEP and E2LITE	May 19th, 2025	Increase of \$1.5 million total funds in one-time automation costs and decrease of \$18.2 million total fund in ongoing savings to streamline the CalWORKs program experience by implementing a set of policy changes that are consistent with more holistic interventions and family-centered approaches to CalWORKs. The \$18.2 million in savings results from replacing county welfare to work data reporting activities with data elements using administrative data extracts from CalSAWS, instead of the Research and Development Enterprise Project (RADEP) and E2Lite. The proposal to streamline the CalWORKs program experience includes trailer bill.	Approve as budgeted.
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235	5180	CDSS	Trailer Bill: Streamlining the CalWORKs Program Experience	May 19th, 2025	Makes various changes to streamline the CalWORKs program, including (1) reassessing mandatory activities by making job club optional, expanding allowable welfare-to-work activities, and simplifying the sanction curing process.	Approve, and augment the trailer bill to additionally include (1) first 90-day sanction deferral, promoting early engagement and family stabilization, (2) family-centered program flow changes to appointment structure and plan development, (3) improve access to existing child care and transportation supportive services, and (4) Work Participation Rate county penalty pass-through repeal on a prospective basis. These modifications together result in net General Fund estimated savings of \$10.2 million in 2025-26 and \$14.2 million in 2026-27 and ongoing, with all savings remaining in the CalWORKs Single Allocation.
236	5180	CDSS	Facility Management System	May 19th, 2025	CDSS requests additional one-time funding of \$14.78 million General Fund in 2025-26 to support the development, implementation, and maintenance of the Facility Management System (FMS). This includes resources equivalent to 16 positions to facilitate the successful completion and maintenance of the FMS project. This funding will allow CDSS to procure and deploy the first	Approve as budgeted.

					iteration of FMS in 2025-26. Additionally, this request includes provisional language to make expenditure of these funds contingent upon project approval by the Department of Technology and in alignment with approved project documents.	
237	5180	CDSS	SUN Bucks Administration	May 19th, 2025	Increase of \$267,000 General Fund in 2025-26, \$262,000 General Fund in 2026-27 and ongoing, and 4 positions to support administration of the SUN Bucks program pursuant to the approval of the 2025 plan by the United States Department of Agriculture Food and Nutrition Service. Increase of \$267,000 federal funds in 2025-26, and \$262,000 federal funds in 2026-27 and ongoing. Includes provisional language for contract exemption language related to administration of the program.	Approve as budgeted.
238	5180	CDSS	Immigration Services Bureau Workload	May 19th, 2025	Increase of \$582,000 in 2025-26 and ongoing, and 3 positions to maintain ongoing immigration services.	Approve as budgeted.

239	5180	CDSS	Oversight of Manual Restraints and Seclusions (SB 1043)	May 19th, 2025	Increase of \$1,135,000 and 6 positions in 2025-26 and \$1,109,000 and 6 positions ongoing beginning in 2026-27 to implement SB 1043 (Grove), Chapter 628, Statutes of 2024.	Approve as budgeted.
240	5180	CDSS	Technical Clean-up of Program Funds for Foster Family Home and Small Family Home Insurance Fund	May 19th, 2025	Elimination of federal fund transfer authority to correct that Foster Family Home and Small Family Home Insurance Fund claims are not eligible for Title IV-E federal funding because the claims are not tied to service delivery.	Approve as budgeted.
241	5180	CDSS	Provisional Language: Foster Family Home and Small Family Home Insurance Fund.	May 19th, 2025	Increase of the General Fund transfer amount to the Foster Family Home and Small Family Home Insurance Fund and to increase the expenditure authority in the special fund by a corresponding amount, for approved claims exceeding the current \$600,000 appropriation.	Modify budget bill language to establish an upper limit on claims exceeding the current appropriation at \$4.2 million, and require reporting to the Joint Legislative Budget Committee regarding approved claims.
242	5180	CDSS	New Aid Code for TANF Time-Out Two-Parent Families	May 19th, 2025	Increase of \$455,000 federal funds in 2025-26 to automate a new aid code into the Medi-Cal Eligibility System and California Statewide Automated Welfare System (CalSAWS) for the two parent Temporary Assistance for Needy Families (TANF) timed-out cases to ensure compliance with	Approve as budgeted.

					federal rules and reporting requirements.	
243	5180	CDSS	Work Participation Rate Penalty Impact	May 19th, 2025	Increase of \$21,096,000 in 2025-26 to supplement the reduction to the federal TANF block grant due to the Work Participation Rate penalty imposed on the state for failure to meet the requirements from federal fiscal year 2012 through 2014.	Approve as budgeted.
244	5180	CDSS	CalFresh Enhancement to Populate Income Page	May 19th, 2025	Increase of \$270,000 federal funds in 2025-26 to auto-populate the income page with data from the Payment Verification System to reduce manual data entry and improve accuracy.	Approve as budgeted.
245	5180	CDSS	CalFresh Standard Utility Allowance Standardization	May 19th, 2025	Increase of \$700,000 General Fund in 2025-26 and \$1 million federal funds to support updates to client-facing forms and notices as well as automation updates to CalSAWS necessary to implement the Final Rule released by United States Department of Agriculture Food and Nutrition Service in	Approve as budgeted.

					2024, in time for federal fiscal year 2026.	
246	5180	CDSS	Refugee Cash Assistance Eligibility Change	May 19th, 2025	Increase of \$30,000 General Fund and \$266,000 federal funds in 2025-26 for automation changes to effectuate the federal changes to the Refugee Cash Assistance (RCA) program.	Approve as budgeted.
247	5180	CDSS	Child and Adolescent Needs and Strengths Fidelity and Training	May 19th, 2025	Increase of \$928,000 in 2025-26 and ongoing to provide additional resources for child and adolescent needs and strengths fidelity and training activities related to the foster care Tiered Rate Structure. Increase of \$335,000 federal funds in 2025-26 and ongoing for corresponding federal funds. These adjustments are in addition to the proposal included in the Governor's Budget.	Approve as budgeted.

248	5180	CDSS	Case Management Information and Payrolling System Automation	May 19th, 2025	Increase of \$162,000 one-time General Fund in 2025-26 and reimbursement increase of \$1,294,000 one-time in 2025-26 to implement automation changes to the Case Management Information and Payrolling System related to the Ensuring Access to Medicaid Services Final Rule. Includes provisional language to authorize DOF to decrease this item and related reimbursement up to these amounts if the rule is rescinded or repealed.	Approve as budgeted.
249	5180	CDSS	CalFresh Employment and Training Fund	May 19th, 2025	Allows for the transferring of federal funds to the newly established CalFresh Employment and Training Fund.	Approve as budgeted.
250	5180	CDSS	Ongoing Temporary Protected Status Deadline Extension	May 19th, 2025	Extends the availability of ongoing funding for the Temporary Protected Status (TPS) Program. This would extend the deadline from one to three years for encumbrance and five years to liquidate.	Approve as budgeted.

251	5180	CDSS	Various Re-appropriations for support and local assistance through June 30, 2026	May 19th, 2025	Includes the following re-appropriations through June 30, 2026: up to \$80 million from the State Supplemental Grant Program, up to \$25 million for the CWS-CARES SAWS interface, up to \$1.8 million for Tiered Rate Structure automation in SAWS, up to \$2.5 million for Tiered Rate Structure automation in CARES, up to \$40 million for flexible family supports, up to \$301,000 for county welfare department offices physical accessibility review, up to \$1.1 million for child care direct deposit, and \$1.85 million for zero trust assessment.	Approve as budgeted.
252	5180	CDSS	Various Re-appropriations for support and local assistance through June 30, 2027	May 19th, 2025	Includes the following re-appropriations through June 30, 2027: \$4 million for complex care services, \$521,000 for the California Fruit and Vegetable EBT Pilot Project, up to \$10.4 million for administration of housing programs.	Approve as budgeted.
253	5180	CDSS	Rapid Response Re-appropriation	May 19th, 2025	Re-appropriates all remaining Rapid Response Funds from the Budget Acts of 2021, 2022, and 2023, to continue services for the Rapid Response Program.	Approve as budgeted.

254	5180	CDSS	California Food Assistance Program Expansion Re-appropriation	May 19th, 2025	Re-appropriates up to \$38,000,000 General Fund to be available through June 30, 2029, for the automation of the California Food Assistance Program expansion.	Modify. Revert \$26 million General Fund in 2025-26 and move to 2026-27. This allows automation to continue with \$12 million General Fund in 2025-26.
255	5180	CDSS	CDSS May Revision Caseload Adjustments	May 19th, 2025	The May Revision proposes a net increase of \$1,779,811,000 total funds in 2025-26 that is primarily driven by updated caseload estimates since the 2025-26 Governor's Budget. The net increase in total funds in 2025-26 is comprised of an \$864,932,000 General Fund increase, \$4,473,000 federal funds increase, \$750,000 special funds decrease, and \$911,156,000 reimbursements increase. This item includes all May Revision caseload estimates for all CDSS programs.	Approve as budgeted.
256	5180	CDSS	Trailer Bill: Pre-populated Semiannual Report 7	May 19th, 2025	Clarifies that the requirement to provide recipients of CalFresh and California Work Opportunity and Responsibility to Kids (CalWORKs) benefits with a pre-populated (i.e. pre-filled) Semi Annual Report (SAR) 7 may be completed via mail or electronically, at the election of the recipient.	Adopt placeholder trailer bill language.

257	5180	CDSS	Trailer Bill: Child and Family Team Meetings for Family Maintenance Cases	May 19th, 2025	Requires all county child welfare agencies to conduct Child and Family Team (CFT) meetings for youth receiving both voluntary and court ordered Family Maintenance (FM) services. According to CDSS, this helps make sure youth in FM cases receive CFT meetings to help prevent additional children from going into out-of-home placements by providing families with appropriate case plans.	Adopt placeholder trailer bill language.
258	5180	CDSS	Trailer Bill: Adoption Assistance Program Wraparound Services and Out-of-Home Placement	May 19th, 2025	Makes various changes to clarify the allowable use of Adoption Assistance Program (AAP) payments for wraparound services and out-of-home placement, including: authorizing AAP payments for wraparound services, defining and clarifying eligibility criteria and standards that must be met, updating the AAP payments to align with the new Tiered Rate Structure, authorizing the utilization of AAP payments for wraparound services for 12 months, as specified, among other changes.	Adopt placeholder trailer bill language, to continue review of the proposal for needed and urgent clarifications to child welfare policy, with modifications based on stakeholder feedback.

259	5180	CDSS	IHSS Elimination for Undocumented Adults	May 20th, 2025	Eliminates the IHSS benefit for undocumented adults age 19 and over, effective July 1, 2025. According to the Administration, this generates General Fund savings of \$158.8 million in 2025-26, \$172.1 million 2026-27, \$185.8 million in 2027-28, and \$200.5 million in 2028-29. The Administration later revised these estimates to \$79.4 million General Fund in 2025-26. This includes corresponding trailer bill language.	Reject.
260	5180	CDSS	IHSS Cap on Provider Overtime	May 20th, 2025	Caps IHSS provider overtime at 10 hours per week, meaning total IHSS provider hours would be capped at 50 hours per week. The May Revision reflected savings of \$707.5 million General Fund in 2025-26, \$766.8 million General Fund in 2026-27, and \$893.4 million General Fund in 2028-29 and ongoing. The Administration later revised these estimates to \$211 million General Fund in 2025-26. This includes corresponding trailer bill language.	Reject.

261	5180	CDSS	IHSS Reinstatement of the Medi-Cal Asset Limit	May 20th, 2025	The May Revision proposes to reinstate the Medi-Cal asset limit of \$2,000 for individuals and \$3,000 for couples in order to be eligible for Medi-Cal. This means some older and disabled adults would no longer be eligible for Medi-Cal, and consequentially, lose their IHSS benefit. The Administration estimates savings of \$25.5 million General Fund in 2025-26 and ongoing. The Administration later revised this estimate to \$12.8 million in 2025-26.	Modify. Reinstate asset test limit change to prior interim step on asset test (\$130,000 for individuals and \$195,000 for couples that was in effect from July 1, 2022 to December 31, 2023), starting January 1, 2026, conforming to action in Medi-Cal under the Department of Health Care Services. This results in savings for IHSS of \$15.96 million in 2025-26, \$220.3 million in 2026-27, and \$317.2 million in 2027-28 and ongoing, based on estimates that have been further revised by the Administration.
262	5180	CDSS	IHSS Residual Program	May 20th, 2025	The May Revision proposes to conform the IHSS Residual program with the timing of Medi-Cal coverage. This results in savings of \$110.6 million General Fund in 2026-27, \$119.4 million General Fund in 2027-28, and \$128.9 million General Fund in 2028-29. The Administration later revised this estimate to include \$106.6 million in additional savings in 2025-26.	Reject. Approve modified proposal to establish a six-month grace period in the IHSS Residual Program for those losing Medi-Cal due to redetermination, starting July 1, 2026. This results in savings of \$55.3 million in 2026-27, \$59.7 million in 2027-28, and \$64.5 million in 2028-29.

263	5180	CDSS	Assess Community First Choice Option (CFCO) Late Penalties on Counties	May 20th, 2025	The May Revision passes IHSS Community First Choice Option reassessment late penalties to counties. This results in General Fund savings of \$81 million General Fund in 2025-26, \$87.4 million in 2026-27, \$94.4 million in 2027-28, and \$101.8 million in 2028-29.	Modify. Require counties to share 50 percent of penalty costs in 2025-26, resulting in lower net savings of \$40.5 million General Fund in 2025-26. In 2026-27, approve proposal to pass 100 percent of any reassessment late penalties on to counties.
264	5180	CDSS	Trailer Bill: Foster Care Tiered Rate Structure Clean-up	May 20th, 2025	The May Revision include various technical clean-up to the Foster Care Rate Structure. This also includes the Administration's proposed "trigger" language.	Adopt placeholder trailer bill language on the various technical clean-up. Reject "trigger" language.
265	5180	CDSS	Trailer Bill: Child Care Rate Reform Implementation	April 3rd, 2025	Legislative proposal to adopt placeholder trailer bill language to extend and expand existing reporting requirements regarding the implementation of child care rate reform; add reporting requirements on implementation of prospective pay based on enrollment; require CDSS to base child care rates on a single rate structure based on the cost of care (rather than the regional market rate and standard reimbursement rate); and require all future cost-of-living adjustments to be based on the single rate structure.	Adopt placeholder trailer bill language.

266	5180	CDSS	In-Home Supportive Services Overtime Fiscal Adjustment	May 20th, 2025	The Administration's revised estimates for In-Home Supportive Services, post May Revision, result in \$140 million General Fund net savings to fully fund all IHSS overtime hours.	Approve legislative proposal.
267	5180	CDSS	CalFood	May 8th, 2025	Legislative proposal to restore the CalFood baseline appropriation to \$60 million in 2025-26. This is a General Fund increase of \$52 million in 2025-26.	Approve legislative proposal.
268	5180	CDSS	CalFresh Fruit & Vegetable Pilot Program	May 8th, 2025	Legislative proposal to restore funding for the CalFresh Fruit and Vegetable Pilot Program by \$36 million General Fund in 2025-26.	Approve legislative proposal.
269	5180	CDSS	Bringing Families Home	March 20th, 2025	Legislative proposal to restore funding for the Bringing Families Home Program by \$81 million in 2025-26.	Approve legislative proposal.
270	5180	CDSS	Home Safe	March 20th, 2025	Legislative proposal to restore funding for the Home Safe program by \$83.8 million in 2025-26.	Approve legislative proposal.
271	5180	CDSS	Foster Family Agencies Bridge Funding	April 3rd, 2025	Legislative proposal to provide \$31.5 million (\$23 million General Fund) in 2025-26, over two years, for foster family agencies at risk of closure.	Approve legislative proposal.

272	5180	CDSS	Children's Holistic Immigration Representation Project	March 20th, 2025	Legislative proposal to provide \$10 million General Fund in 2025-26 to continue the Children's Holistic Immigration Representation Project (CHIRP), which provides integrated social and legal services to unaccompanied minors.	Approve legislative proposal.
273	5180	CDSS	Mandated Reporting Training	-	Legislative proposal to appropriate \$600,000 in 2025-26, \$300,000 in 2026-27, \$5.6 million in 2027-28, and \$1 million in 2028-29 (all General Fund) for the development and use of a standardized curriculum for mandated reporters, with placeholder budget bill language and placeholder trailer bill language.	Approve legislative proposal and adopt placeholder trailer bill language.
274	5180	CDSS	CalFresh Strategic Plan	-	Legislative proposal to appropriate \$200,000 General Fund in 2025-26 and on-going for the development of a strategic plan to maximize benefits to those eligible for CalFresh benefits, with placeholder trailer bill language.	Approve legislative proposal and adopt placeholder trailer bill language.
275	5180	CDSS	Holocaust Survivors Assistance Program	-	Legislative proposal to appropriate \$14.5 million General Fund in 2025-26 to support the Holocaust Survivors Assistance Program.	Approve legislative proposal.

276	5180	CDSS	Child Care Slots	April 3rd, 2025	Legislative proposal to increase funding by \$150 million General Fund to add approximately 6,770 new voucher slots and 2,500 general child care center slots, effective July 1, 2026.	Approve legislative proposal.
277	5180	CDSS	Diaper Access Initiative	May 1st, 2025	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 to every baby born in California, regardless of income.	Conform to action under 4140 HCAI for this item. In 2025-26 only, shift \$7.4 million General Fund from HCAI to CDSS to support diaper and wipe distribution to low-income families with infants and toddlers.
278	5180	CDSS	Housing and Disability Advocacy Program	March 20 <sup>th</sup> , 2025	Legislative proposal to restore funding for the Housing and Disability Advocacy Program (HDAP) by \$45 million General Fund.	Approve legislative proposal.

VARIOUS DEPARTMENTS						
Issue	Org Code	Department	Proposal	Hearing Date	Summary	Staff Recommendation
279	Various	BSCC	Trailer Bill: Suitability for the Confinement of Juveniles	May 20th, 2025	The May Revision includes trailer bill language addressing suitability of facilities for the confinement of juveniles. Trailer bill clarifies criteria for suitability and allows the Board of State and Community Corrections (BSCC) to bring a civil action in order to enforce compliance. This issue impacts various departments and programs under the jurisdiction of this Subcommittee and Subcommittee #5 on Corrections, Public Safety, Judiciary, Labor and Transportation.	Adopt placeholder trailer bill language.
280	Various	CDA, DHCS, DDS	California Electronic Visit Verification (CalEVV) Resources	March 27th, 2025	The California Department of Aging, (CDA), DHCS, and the Department of Developmental Services (DDS) request four positions and annual expenditure authority of \$1.4 million (\$1.1 million General Fund and \$341,000 federal funds). If approved, these positions and resources would support compliance with the electronic visit verification requirements of the federal 21st Century Cures Act.	Approve as budgeted