

# SUBCOMMITTEE NO. 3

# Agenda

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



Thursday, March 26<sup>th</sup>, 2026  
9:30 am, or upon adjournment of session  
1021 O Street – Room 1200

Consultant: Scott Ogus

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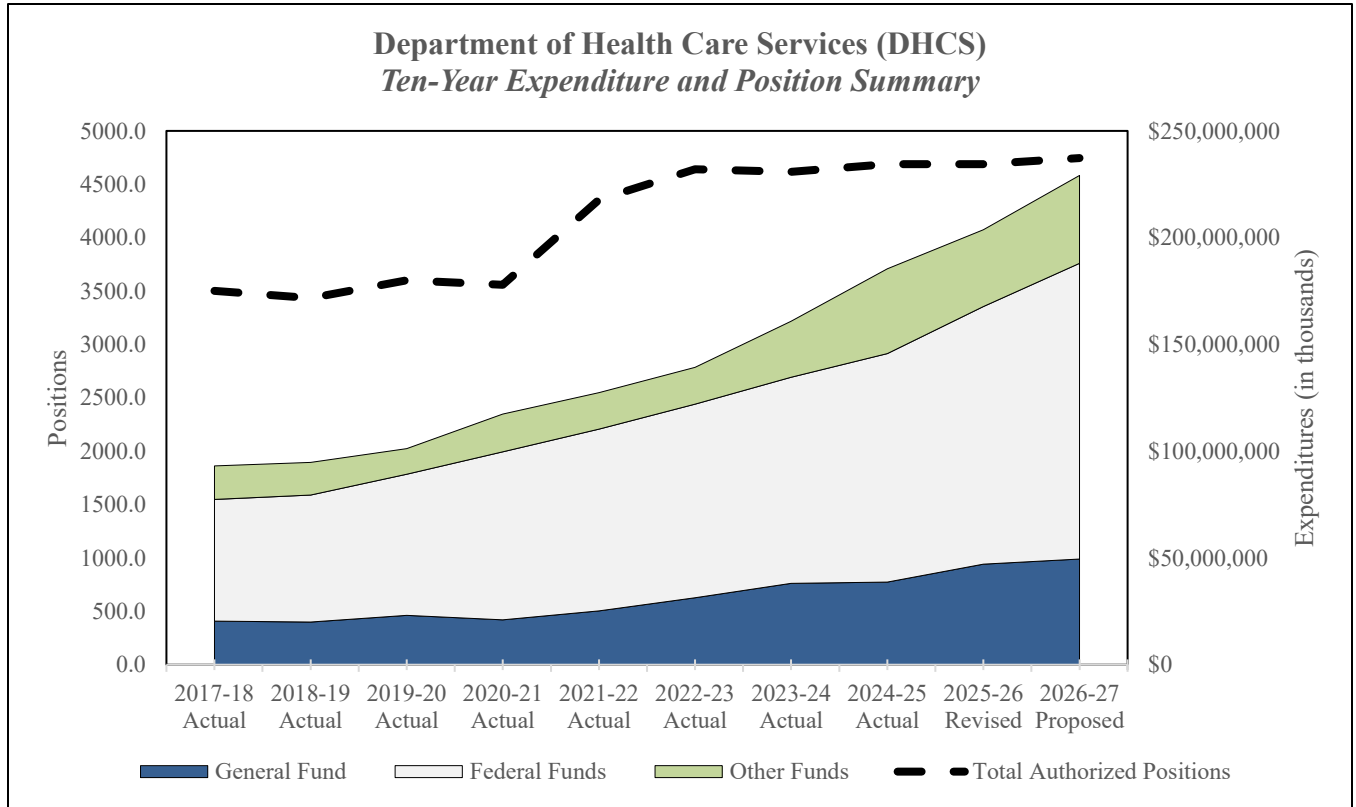
## PUBLIC COMMENT

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**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>2024-25 Actual</b>	<b>2025-26 Budget Act</b>	<b>2025-26 Revised</b>	<b>2026-27 Proposed</b>
<b>General Fund</b>	\$38,665,225	\$45,603,677	\$47,110,472	\$49,525,882
<b>Federal Funds</b>	\$106,988,205	\$120,718,549	\$120,603,394	\$138,466,912
<b>Other Funds</b>	\$39,778,736	\$36,423,994	\$35,954,512	\$41,147,286
<b>Total Department Funding</b>	\$185,432,166	\$202,746,220	\$203,668,378	\$229,140,080
<b>Total Authorized Positions</b>	<b>4688.5</b>	<b>4978.5</b>	<b>4687.5</b>	<b>4745.5</b>
<b>Other Funds Detail:</b>				
<i>Breast Cancer Control Account (0009)</i>	\$6,069	\$6,223	\$6,421	\$6,327
<i>DUI Program Licensing Trust Fund (0139)</i>	\$659	\$1,460	\$1,461	\$1,460
<i>California Health Data and Planning Fund (0143)</i>	\$0	\$0	\$2,000	\$0

<i>Medical Providers Interim Payment Fund (0201)</i>	\$2,149,885	\$2,291,260	\$2,541,324	\$0
<i>Prop 99 - Hospital Services Acct (0232)</i>	\$61,098	\$48,640	\$48,640	\$52,916
<i>Prop 99 - Physician Services Acct (0233)</i>	\$17,434	\$13,894	\$13,894	\$15,122
<i>Prop 99 - Unallocated Acct (0236)</i>	\$39,915	\$34,386	\$34,382	\$31,796
<i>Narcotic Treatment Program Lic Fund (0243)</i>	\$2,113	\$2,491	\$2,237	\$2,243
<i>Perinatal Insurance Fund (0309)</i>	\$1,148	\$397	\$400	\$399
<i>Audit Repayment Trust Fund (0816)</i>	\$41	\$41	\$41	\$41
<i>Medi-Cal Inpatient Payment Adj Fund (0834)</i>	\$203,137	\$168,622	\$276,853	\$214,169
<i>Special Deposit Fund (0942)</i>	\$66,925	\$85,695	\$62,967	\$84,748
<i>Reimbursements (0995)</i>	\$2,569,493	\$3,087,381	\$3,302,167	\$6,541,898
<i>County Health Initiative Matching Fund (3055)</i>	\$0	\$174	\$174	\$174
<i>Children's Medical Services Rebate Fund (3079)</i>	\$1,128	\$2,104	\$4,105	\$2,108
<i>Beh Health Services Fund (3085)</i>	\$5,134,425	\$3,575,608	\$4,306,969	\$4,181,404
<i>Nondesignated Public Hospital Suppl Fund (3096)</i>	(\$305)	\$6,982	\$7,056	\$0
<i>Private Hospital Supplemental Fund (3097)</i>	\$2,729	\$118,863	\$125,629	\$79,608
<i>Mental Health Facility Licensing Fund (3099)</i>	\$166	\$373	\$371	\$375
<i>Residential and Outpatient Prog Lic Fund (3113)</i>	\$8,500	\$12,149	\$11,470	\$11,896
<i>Children's Health and Human Svcs Special Fund (3156)</i>	\$0	\$0	\$0	\$149,702
<i>Hospital Quality Assurance Revenue Fund (3158)</i>	\$4,931,063	\$5,121,189	\$5,020,321	\$10,937,504
<i>SNF Quality and Accountability Fund (3167)</i>	\$629	\$756	\$0	\$0
<i>Long-Term Care Quality Assurance Fund (3213)</i>	\$624,015	\$629,124	\$661,490	\$622,867
<i>Healthcare Treatment Fund (3305)</i>	\$231,222	\$767,099	\$471,272	\$463,387
<i>Health Care Service Plan Fines/Penalties Fund (3311)</i>	\$70,165	\$20,895	\$20,884	\$485
<i>Medi-Cal Emergency Med Transport Fund (3323)</i>	\$70,812	\$51,629	\$50,374	\$51,358
<i>Reversion Acct. Subacct., Beh Health Svcs Fund (3327)</i>	\$2,422	\$0	\$0	\$0
<i>Medi-Cal Drug Rebate Fund (3331)</i>	\$4,240,554	\$2,202,503	\$2,334,506	\$2,350,812

<i>YEPEITA - Cannabis Tax Fund (3350)</i>	\$348,731	\$272,555	\$276,778	\$242,293
<i>PACE Oversight Fund (3362)</i>	\$18	\$3,614	\$750	\$750
<i>Loan Repayment Acct, Healthcare Treatment Fund (3375)</i>	\$57,284	\$22,885	\$52,389	\$48,351
<i>Opioid Settlement Fund (3397)</i>	\$67,350	\$45,769	\$25,639	\$24,053
<i>988 State Suicide and BH Crisis Svcs Fund (3414)</i>	\$12,500	\$30,728	\$30,728	\$67,342
<i>Medi-Cal County BH Fund (3420)</i>	\$2,438,158	\$2,804,853	\$2,806,400	\$3,145,495
<i>Managed Care Enrollment Fund (3428)</i>	\$11,535,834	\$3,942,986	\$3,942,986	\$2,827,155
<i>Medi-Cal Provider Payment Reserve Fund (3431)</i>	\$344,032	\$0	\$0	\$0
<i>Health Care Oversight and Accountability Subfund (3443)</i>	\$2,175,778	\$8,521,891	\$6,906,017	\$6,328,627
<i>Behavioral Health Schoolsite Fee Sch Admin Fund (3451)</i>	\$0	\$69,300	\$69,300	\$69,300
<i>Behavioral Health Infrastructure Fund (6092)</i>	\$340,422	\$450,044	\$450,082	\$450,074
<i>Whole Person Care Pilot Special Fund (8107)</i>	\$30,157	\$13,023	\$17,637	\$0
<i>Global Payment Program Special Fund (8108)</i>	\$1,488,262	\$1,486,190	\$1,495,914	\$1,511,049
<i>DPH GME Special Fund (8113)</i>	\$405,508	\$507,695	\$569,961	\$627,475
<i>Vision Services CHIP-HSI Special Fund (8140)</i>	\$506	\$2,523	\$2,523	\$2,523
<i>Home- and Comm-Based Svcs ARP Fund (8507)</i>	\$98,754	\$0	\$0	\$0

<b>Department of Health Care Services – Changes to State Operations and Local Assistance</b> <i>(dollars in thousands)</i>				
<b>Fiscal Year:</b>	<b>2024-25 Actual</b>	<b>2025-26 (CY) Revised</b>	<b>2026-27 (BY) Proposed</b>	<b>CY to BY Change</b>
<b>STATE OPERATIONS</b>				
<b>General Fund</b>	\$409,626	\$386,937	\$348,394	<b>(\$38,543)</b>
<b>Federal Funds<sup>1</sup></b>	\$534,464	\$667,275	\$644,227	<b>(\$23,048)</b>
<b>Spec. Funds/Reimb</b>	\$388,369	\$402,784	\$355,779	<b>(\$47,005)</b>
<b>Total Expenditures</b>	<b>\$1,332,459</b>	<b>\$1,456,996</b>	<b>\$1,348,400</b>	<b>(\$108,596)</b>
<b>Total Positions</b>	<b>4688.5</b>	<b>4687.5</b>	<b>4745.5</b>	<b>58.0</b>
<b>LOCAL ASSISTANCE (MEDI-CAL AND OTHER PROGRAMS)</b>				
<b>General Fund</b>	\$38,255,599	\$46,723,535	\$49,177,488	\$2,453,953

<b>Federal Funds<sup>1</sup></b>	\$106,453,741	\$119,936,119	\$137,822,685	\$17,886,566
<b>Spec. Funds/Reimb</b>	\$39,390,367	\$35,551,728	\$40,791,507	\$5,239,779
<b>Total Expenditures</b>	<b>\$184,099,707</b>	<b>\$202,211,382</b>	<b>\$227,791,680</b>	<b>\$25,580,298</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 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 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 California Children’s Services (CCS) Program, the Genetically Handicapped Persons Program (GHPP), the Health Care Program for Children in Foster Care (HCPCFC), the Hearing Conservation Program (HCP), the High Risk Infant Follow Up (HRIF) Program, the Newborn Hearing Screening Program (NHSP), the Neonatal Quality Improvement Initiative (NQI), and the Pediatric Palliative Care (PPC) Waiver Program.
- **Primary, Rural, and Indian Health.** Primary, Rural, and Indian Health primarily oversees the Office of Tribal Affairs (OTA), which serves as the department’s principal liaison with Tribes and Indian Health Program representatives, and urban Indian organizations. OTA is also responsible for coordinating and directing the delivery of health care through the following programs: Indian Health Program, American Indian Maternal Support Services, and Tribal Emergency Preparedness Program.
- **Behavioral Health Services.** DHCS oversees the delivery of community mental health and substance use disorder services, including specialty mental health services (SMHS), Drug Medi-Cal (DMC), and the Drug Medi-Cal Organized Delivery System (DMC-ODS). DHCS is also responsible for monitoring expenditures and programs under the Behavioral Health Services Act (BHSA), administering and overseeing the federal Mental Health Block Grant (MHBG) and Substance Use Block Grant (SUBG), the 988 system, the mobile crisis services benefit, the Community Assistance, Recovery, and Empowerment (CARE) Act, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, Recovery Incentives Program, Family First Prevention Services Act, and Complex Care cases. In addition, DHCS is responsible for licensing, certification, monitoring, and complaint investigation for Driving-Under-the Influence Programs, Narcotic Treatment Programs, outpatient and residential providers, Alcohol and Other Drug counselors, Mental Health Rehabilitation Centers, Psychiatric Health Facilities, and 5150

facilities under the Lanterman-Petris-Short Act and the Children’s Civil Commitment and Mental Health Treatment Act.

- **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 2025 Medi-Cal Local Assistance Estimate**

**Local Assistance Estimate – Governor’s Budget.** The November 2025 Medi-Cal Local Assistance Estimate includes \$196.7 billion (\$46.4 billion General Fund, \$119.4 billion federal funds, and \$30.9 billion special funds and reimbursements) for expenditures in 2025-26, and \$222.4 billion (\$48.8 billion General Fund, \$137.5 billion federal funds, and \$36.2 billion special funds and reimbursements) for expenditures in 2026-27.

<b>Medi-Cal Local Assistance Funding Summary</b> <i>(dollars in thousands)</i>			
<b>Fiscal Year:</b>	<b>2025-26 (CY)</b>	<b>2026-27 (BY)</b>	<b>CY to BY</b>
<b><u>Benefits</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$44,056,718	\$46,981,325	\$2,924,607
Federal Funds	\$113,895,044	\$131,674,297	\$17,779,253
Special Funds/Reimbursements	\$30,731,831	\$36,083,861	\$5,352,030
<b>Total Expenditures</b>	<b>\$188,683,593</b>	<b>\$214,739,483</b>	<b>\$26,055,890</b>
<b><u>Administration</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$2,318,556	\$1,812,166	<b>(\$506,390)</b>
Federal Funds	\$5,552,599	\$5,802,792	\$250,193
Special Funds and Reimbursements	\$137,387	\$82,783	<b>(\$54,604)</b>
<b>Total Expenditures</b>	<b>\$8,008,542</b>	<b>\$7,697,741</b>	<b>(\$310,801)</b>
<b><u>TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$46,375,274	\$48,793,491	\$2,418,217
Federal Funds	\$119,447,643	\$137,477,089	\$18,029,446
Special Funds and Reimbursements	\$30,869,218	\$36,166,644	\$5,297,426
<b>Total Expenditures</b>	<b>\$196,692,135</b>	<b>\$222,437,224</b>	<b>\$25,745,089</b>

**Caseload.** For 2024-25, the budget assumes annual Medi-Cal caseload was 14.9 million beneficiaries, a decrease of 82,600, or 0.6 percent, compared to assumptions in the 2025 Budget Act. The department estimates in 2024-25 about 14 million beneficiaries, or 93.7 percent, received services through the managed care delivery system while 931,448 beneficiaries, or 6.3 percent, received services through the fee-for-service delivery system.

For 2025-26, the budget assumes annual Medi-Cal caseload of 14.5 million, a decrease of 307,600 beneficiaries, or 2.1 percent, compared to assumptions in the 2025 Budget Act, and a decrease of 357,800, or 2.4 percent, compared to the January budget’s revised caseload estimate for 2024-25. The department estimates in 2025-26 about 13.8 million beneficiaries, or 94.9 percent, will receive services through the

managed care delivery system while 747,321 beneficiaries, or 6.7 percent, will receive services through the fee-for-service delivery system.

For 2026-27, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 508,400, or 3.5 percent, compared to the January budget's revised caseload estimate for 2025-26. The department estimates in 2026-27 about 13.3 million beneficiaries, or 94.7 percent, will receive services through the managed care delivery system while 741,809 beneficiaries, or 5.3 percent, will receive services through the fee-for-service delivery system.

**Significant General Fund Adjustments.** The November 2025 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

Current Year (2025-26) Adjustments – The Estimate includes total expenditures of \$196.7 billion (\$46.4 billion General Fund, \$119.4 billion federal funds, and \$30.9 billion special funds and reimbursements) for the Medi-Cal program in 2025-26, an increase in General Fund expenditures of \$2 billion, or 4.9 percent, compared to the assumptions included in the 2025 Budget Act. According to DHCS, the primary drivers of increased General Fund expenditures in 2025-26 are as follows:

- *State-Only Claiming Adjustment.* General Fund costs of \$819.3 million due to revised estimates for pharmacy and administrative claims for state-only programs.
- *Medicare Population Growth.* General Fund costs of \$638.7 million due to increases in Medicare costs due to ongoing growth in the Medicare population.
- *Centers for Medicare and Medicaid Services (CMS) Deferrals.* General Fund costs of \$617.6 million due to increased deferrals of federal funding from CMS.
- *Delayed Impact of 2025 Budget Act General Fund Solutions.* Net General Fund costs of \$195.1 million due to the following changes in timing or other technical adjustments of solutions adopted in the 2025 Budget Act:
  - \$321.7 million increased costs due to delayed pharmacy rebates
  - \$86.2 million increased costs from shifting elimination of the Skilled Nursing Facility Workforce and Quality Incentive Program to 2026-27
  - \$44.7 million increased costs due to lower savings from pharmacy budget solutions due to changes to federal matching percentages
  - \$250 million savings related to the 2024-25 Medical Provider Interim Payment Loan funds available in 2025-26 due to end of year adjustments.
  - \$7.4 million savings due to other minor technical adjustments.

- *Managed Care Organization (MCO) Tax Reduced Savings.* Adjustment to estimated savings from the tax on managed care organizations implemented by the Legislature and by the voters in Proposition 35, resulting in a net General Fund cost of \$159.3 million

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

- *Fee-for-Service Base Expenditures – Reduced Utilization.* General Fund savings of \$547.2 million due to lower fee-for-service pharmacy and inpatient utilization.
- *Managed Care Base Expenditures – Reduced Caseload.* General Fund savings of \$43.1 million due to lower enrollment
- *Managed Care Base Expenditures – Updated Expenditures.* Net General Fund savings of \$88.2 million due to the impact of updated estimated expenditures for managed care due to policy and other changes.

Budget Year (2026-27) Adjustments – The Estimate includes total expenditures of \$222.4 billion (\$48.8 billion General Fund, \$137.5 billion federal funds, and \$36.2 billion special funds and reimbursements) for the Medi-Cal program in 2026-27, an increase in General Fund expenditures of \$2.4 billion, or 5.2 percent, compared to the revised assumptions for 2025-26. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *Managed Care Base Projections.* General Fund costs of \$2.7 billion due to adjustments to Medi-Cal managed care base projections, primarily from base rate increases and enrollment growth.
- *Fee-for-Service Pharmacy Costs.* General Fund costs of \$897.8 million due to growth in fee-for-service pharmacy rates.
- *Medicare Population Growth.* General Fund costs of \$648.3 million due to projected growth in the Medicare population and increases in buy-in premiums and Part D costs.

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

- *Caseload Reductions – End of COVID-19 Flexibilities and Improved Residency Verification.* General Fund savings of \$897.2 million due to caseload reductions related to the end of unwinding flexibilities provided after the end of the COVID-19 public health emergency, as well as from implementation of improvements for residency verification.
- *Net Savings Related to 2025 Budget Act General Fund Solutions.* Net General Fund savings of \$648.9 million due to the following General Fund solutions implemented in the 2025 Budget Act:
  - \$1 billion General Fund savings for the elimination of prospective payment system payments to clinics for state-only populations
  - \$901.2 million General Fund savings from pharmacy and pharmacy rebate solutions

- \$659.2 million General Fund savings from the freeze on Medi-Cal enrollment for undocumented Californians
- \$302.1 million General Fund savings for reinstatement of the asset limit for Medi-Cal eligibility determination
- \$134.6 million General Fund savings for elimination of adult dental benefits for Medi-Cal beneficiaries with unsatisfactory immigration status.
- \$132.4 million General Fund savings from the elimination of the SNF WQIP in 2026-27
- \$50 million General Fund savings for utilization management for hospice benefits
- \$2.5 billion General Fund costs due to the expiration of the Medical Provider Interim Payment Loan approved in the 2025 Budget Act.
- *CMS Deferrals.* General Fund savings of \$515.5 million due to lower projected CMS deferrals of funding.
- *State-Only Claiming Adjustment.* General Fund savings of \$395.8 million due to completion in 2025-26 of retroactive payments for state-only claiming adjustments.
- *House Resolution 1 (H.R. 1) Medi-Cal Impacts.* General Fund savings of \$314.1 million due to the impacts of implementation of House Resolution 1 (H.R. 1) requirements related to work and community engagement requirements, changes in federal match for emergency services, loss of full-scope Medi-Cal coverage for certain qualified immigrants, more frequent eligibility redeterminations, and reduced retroactive coverage timeframes.
- *Hospital Quality Assurance Fee (HQAF).* General Fund savings of \$142.1 million due to shifting savings for the hospital quality assurance fee to 2026-27.

**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 2025-26 and 2026-27 fiscal years.

**Issue 3: November 2025 Family Health Local Assistance Estimate**

**Local Assistance Estimate – Governor’s Budget.** The November 2025 Family Health Local Assistance Estimate includes \$292.8 million (\$264.8 million General Fund, \$5.5 million federal funds, and \$22.6 million special funds and reimbursements) for expenditures in 2025-26, and \$307 million (\$280.9 million General Fund, \$5.7 million federal funds, and \$20.3 million special funds and reimbursements) for expenditures in 2026-27.

<b>Family Health Local Assistance Funding Summary</b> <i>(dollars in thousands)</i>			
<b>Fiscal Year:</b>	<b>2025-26 (CY)</b>	<b>2026-27 (BY)</b>	<b>CY to BY</b>
<b><u>California Children’s Services (CCS)</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$83,376	\$87,706	\$4,330
Special Funds/Reimbursements	\$8,289	\$6,292	(\$1,997)
County Funds [non-add]	[\$91,118]	[\$93,446]	[\$2,328]
<b>Total CCS Expenditures</b>	<b>\$91,665</b>	<b>\$93,998</b>	<b>\$2,333</b>
<b><u>Genetically Handicapped Persons Program (GHPP)</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$181,385	\$193,124	\$11,739
Special Funds and Reimbursements	\$539	\$539	\$0
<b>Total GHPP Expenditures</b>	<b>\$181,924</b>	<b>\$193,663</b>	<b>\$11,739</b>
<b><u>Every Woman Counts Program (EWC)</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$0	\$117	\$117
Federal Funds	\$5,468	\$5,737	\$269
Special Funds and Reimbursements	\$13,754	\$13,476	(\$278)
<b>Total EWC Expenditures</b>	<b>\$19,222</b>	<b>\$19,330</b>	<b>\$108</b>
<b><u>TOTAL FAMILY HEALTH EXPENDITURES</u></b>			
<b>Fund Source</b>	<b><i>Revised</i></b>	<b><i>Proposed</i></b>	<b><i>Change</i></b>
General Fund	\$264,761	\$280,947	\$16,186
Federal Funds	\$5,468	\$5,737	\$269
Special Funds and Reimbursements	\$22,582	\$20,307	(\$2,275)
County Funds [non-add]	[\$91,118]	[\$93,446]	[\$2,328]
<b>Total Family Health Expenditures</b>	<b>\$292,811</b>	<b>\$306,991</b>	<b>\$14,180</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): For 2024-25, the budget estimates Medi-Cal CCS caseload was 174,382, a decrease of 455, or 0.3 percent, compared to assumptions in the 2025 Budget Act.

For 2025-26, the budget estimates Medi-Cal CCS caseload of 173,347, a decrease of 717, or 0.4 percent, compared to assumptions in the 2025 Budget Act, and a decrease of 1,035, or 0.6 percent, compared to the revised caseload estimate for 2024-25.

For 2026-27, the budget estimates Medi-Cal CCS caseload of 173,347, unchanged compared to the revised 2025-26 estimate.

- Caseload Estimate (State-Only): For 2024-25, the budget estimates State-Only CCS caseload was 13,231, a decrease of 734, or 5.3 percent, compared to assumptions in the 2025 Budget Act.

For 2025-26, the budget estimates State-Only CCS caseload of 12,718, a decrease of 1,566, or 11 percent, compared to assumptions in the 2025 Budget Act, and a decrease of 513, or 3.9 percent, compared to the revised caseload estimate for 2024-25.

For 2026-27, the budget estimates State-Only CCS caseload of 12,718, unchanged compared to the revised 2025-26 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): For 2024-25, the budget estimates Medi-Cal GHPP caseload was 598, a decrease of 43, or 6.7 percent, compared to assumptions in the 2025 Budget Act.

For 2025-26, the budget estimates Medi-Cal GHPP caseload of 525, a decrease of 87, or 14.2 percent, compared to assumptions in the 2025 Budget Act, and a decrease of 73, or 12.2 percent, compared to the revised caseload estimate for 2024-25.

For 2026-27, the budget estimates Medi-Cal GHPP caseload of 525, unchanged compared to the revised 2025-26 estimate.

- Caseload Estimate (State-Only): For 2024-25, the budget estimates State-Only GHPP caseload was 589, a decrease of 35, or 5.6 percent, compared to assumptions in the 2025 Budget Act.

For 2025-26, the budget estimates State-Only GHPP caseload of 517, a decrease of 82, or 13.7 percent, compared to assumptions in the 2025 Budget Act, and a decrease of 72, or 12.2 percent, compared to the revised caseload estimate for 2024-25.

For 2026-27, the budget estimates State-Only GHPP caseload of 518, an increase of 1, or 0.2 percent, compared to the revised 2025-26 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: For 2024-25, the budget estimates Every Woman Counts caseload was 8,237, a decrease of 519, or 5.9 percent, compared to assumptions in the 2025 Budget Act.

For 2025-26, the budget estimates Every Woman Counts caseload of 8,663, a decrease of 592, or 6.4 percent, compared to assumptions in the 2025 Budget Act, and an increase of 426, or 5.2 percent, compared to the revised caseload estimate for 2024-25.

For 2026-27, the budget estimates Every Woman Counts caseload of 8,862, an increase of 199, or 2.3 percent, compared to the revised 2025-26 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 2025-26 and 2026-27 fiscal years.

**Issue 4: Medi-Cal Provider Taxes – H.R. 1 Impacts on MCO Tax, Hospital QAF, and Others**

**Local Assistance – Governor’s Budget.** The Governor’s January budget reflects significant support for the non-federal share of Medi-Cal expenditures, as well as additional investments, from the implementation of health care related taxes on Medi-Cal providers. These taxes include the enrollment tax on managed care organizations (MCO tax), the hospital quality assurance fee (HQAF), the skilled nursing facility quality assurance fee (SNF QAF), the ground emergency medical transport quality assurance fee (GEMT QAF) and the intermediate care facility-developmental disabilities quality assurance fee (ICF-DD QAF).

For the MCO tax, the Medi-Cal Local Assistance Estimate assumes General Fund savings of \$4.4 billion in 2025-26 and \$2.5 billion in 2026-27. In addition, MCO tax revenue of \$1.2 billion in 2025-26 and \$339 million in 2026-27 is estimated to offset the non-federal share of managed care base rate increases in the Medi-Cal program, providing additional General Fund savings. These figures assumed the federal Centers for Medicare and Medicaid Services (CMS) would allow the tax to continue until it expires on December 31, 2026. Since the release of the Governor’s January budget, CMS has confirmed the tax will be allowable until that date. In addition to the General Fund savings achieved from the MCO tax, the estimate assumes MCO tax revenue of \$440.8 million in 2025-26 and \$2.6 billion in 2026-27 would support provider rate increases in the Medi-Cal program.

For the HQAF, the estimate assumes General Fund savings of \$1.3 billion in 2025-26 and \$1.4 billion in 2026-27 from support of the non-federal share of health care coverage of children in Medi-Cal. The estimate also assumes HQAF will provide support for hospitals in the fee-for-service delivery system of \$2.7 billion (\$1.1 billion HQAF, \$1.6 billion federal funds) in 2025-26 and \$2.6 billion (\$1.2 billion HQAF, \$1.4 billion federal funds) in 2026-27. The estimate assumes HQAF will provide support for hospitals in the managed care delivery system of \$1.2 billion (\$378.7 million HQAF, \$821.3 million federal funds) in 2025-26 and \$893 million (\$287.6 million HQAF, \$605.4 million federal funds) in 2026-27. These figures assume approval of the most recent submission to CMS for the HQAF, known as HQAF Program IX. However, DHCS reports that CMS has required resubmission of HQAF Program IX to more closely match previously approved levels, consistent with interpretations of House Resolution 1 (H.R. 1) restrictions on new provider taxes.

For the SNF QAF, the estimate assumes total fee revenue of \$657.3 million in 2025-26 and \$618.8 million in 2026-27 to support a partial offset of reimbursement rate increases for skilled nursing facilities. These figures assume approval of the Administration’s proposal to extend the existing SNF QAF for one additional year, from December 31, 2026, to December 31, 2027.

For the GEMT QAF, the estimate assumes General Fund savings of \$6.4 million in 2025-26 and \$6.4 million in 2026-27, as well as increased payments to GEMT providers of \$166.1 million (\$49.2 million Medi-Cal Emergency Medical Transportation Fund or MEMTF and \$116.9 million federal funds) in 2025-26 and \$167.1 million (\$51.1 million MEMTF and \$115.9 million federal funds) in 2026-27.

For the ICF-DD QAF, the DHCS assumes approximately \$52 million annually from the fee supports ICF-DD, ICF-DD-Habilitative, and ICF-DD-Nursing providers in the Medi-Cal program.

**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.

**2023 and 2024 Budget Acts MCO Enrollment Tax.** 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.

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 Medi-Cal Tier 2 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.

**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 physician and professional services, emergency physician services, abortion and family planning, ground emergency medical transportation, air ambulances, community-based adult services, congregate living health facilities, pediatric day health centers, private duty nursing, federally qualified health centers and rural health clinics, continuous Medi-Cal coverage for children ages 0 to 5, non-emergency medical transportation, hospital relief programs, Medi-Cal workforce, and administration.

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 would become inoperable, as the General Fund condition would be 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 outlined 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 were required to 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

**2027 Investments and Beyond.** For calendar year 2027 and beyond, investments in the Medi-Cal program from Proposition 35 were allocated by formula. To the extent that funding is available, 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
- Specialty Care Account – 22 percent
- Emergency Department Physicians Account – 2.5 percent
- Outpatient and Clinic Access Account – 5.75 percent
- Family Planning Account – 5.5 percent
- Reproductive Health Account – 1.25 percent
- Emergency Medical Transportation Account – 3 percent
- Emergency Department and Hospital Services Account – 8.75 percent
- Designated Public Hospital Account – 3.5 percent
- Improving Mental Health Account – 4.5 percent
- Health Care Workers Account – 6.25 percent
- Clinic Quality Account – 3.5 percent
- Improved Dental Services Account – 3.5 percent
- Medi-Cal Access and Support Account (General Fund offset) – 8 percent

**Hospital Quality Assurance Fee.** The first hospital quality assurance fee (HQAF) was implemented by AB 1383 (Jones), Chapter 627, Statutes of 2009, and AB 188 (Jones), Chapter 645, Statutes of 2009. The HQAF is a fee imposed on certain general acute care hospitals that is used to provide funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. Proposition 52, passed by voters in 2026, extended the HQAF program permanently. In addition, a portion of the HQAF is used by the state to support the non-federal share of Medi-Cal coverage for children, resulting in a General Fund offset.

**Other Provider Related Taxes in Medi-Cal.** California also imposes three additional provider related taxes to support providers in the Medi-Cal program. The skilled nursing facility quality assurance fee (SNF QAF) provides funding to partially offset reimbursement rate increases for skilled nursing facilities in the Medi-Cal program. The ground emergency medical transportation quality assurance fee (GEMT QAF) provides support for increased reimbursement for GEMT providers in the Medi-Cal program. The ICF-DD quality assurance fee provides support for increased reimbursement for ICF-DD, ICF-DD-Habilitative, and ICF-DD-Nursing programs in the Medi-Cal program.

**H.R. 1 – Impacts on Provider Related Taxes in Medi-Cal.** On July 4, 2025, President Donald Trump signed House Resolution 1 (H.R. 1), also known as the “One Big, Beautiful Bill Act”. H.R. 1, a budget reconciliation bill that allowed passage by a majority vote in both houses of Congress, was primarily a tax bill, making permanent the lower tax rates enacted in 2017 during the president’s first term, as well as other new tax reductions and changes. In addition, H.R. 1 provided hundreds of billions of dollars for border security, for Immigration and Customs Enforcement (ICE), and for defense, among other expenditures. The Joint Committee on Taxation estimates that over ten years, H.R. 1 will lead to net federal tax reductions of nearly \$4.5 trillion<sup>1</sup>. According to an analysis by the Center for American Progress, more than half of these tax reductions, or \$2.3 trillion, will benefit the top 10 percent of the income distribution, with \$1 trillion benefiting the top 1 percent alone<sup>2</sup>.

To offset a portion of these significant tax reductions, H.R. 1 includes \$1.2 trillion in reduced expenditures for public benefit programs for health care and nutrition. These reductions include nearly \$1 trillion in reductions to Medicaid<sup>3</sup>, which are achieved primarily through the following program changes: 1) Implementation of “community engagement” or work requirements for Affordable Care Act (ACA) expansion individuals to qualify for Medicaid coverage, effective December 31, 2026; 2) Increases in the frequency of eligibility redeterminations from annually to every six months, beginning January 1, 2026; 3) Changes to the definition of “qualified alien” for Medicaid eligibility to exclude refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, and trafficking victims, beginning October 1, 2026; 4) Limits on the use of provider taxes, such as the managed care organization tax (MCO tax), to finance the non-federal share of Medicaid programs; 5) Limiting state-directed provider payments to 100 percent of the Medicare rate; 6) Reduction in the federal matching rate for emergency and pregnancy coverage; 7) Enactment of a one-year prohibition on Planned Parenthood clinics providing Medicaid services; 8) Requiring states to impose cost sharing of up to \$35 per service on ACA expansion individuals for certain Medicaid services, beginning October 1, 2028; and 9) Reducing the retroactive coverage period from three months to one month for ACA expansion individuals and two months for all other beneficiaries, beginning January 1, 2027. In addition, H.R. 1 authorized \$50 billion for a new Rural Health Transformation Program, to address impacts of H.R. 1 Medicaid provisions on rural areas.

While many of the impacts of H.R. 1 on the Medi-Cal program center around eligibility changes that will likely lead to coverage losses, the limitations on the use of provider taxes will have a significant impact on the state’s financing of the overall Medi-Cal program and specific programs supporting provider reimbursements. H.R. 1 includes the following restrictions on provider taxes:

- 1) Prohibits new or increased provider taxes after enactment of the bill (July 4, 2025)
- 2) Phases down the indirect hold-harmless threshold, which serves as a de facto maximum level for the tax to comply with hold-harmless provisions of federal Medicaid regulations, from six percent of total revenues to 3.5 percent.

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<sup>1</sup> Joint Committee on Taxation. *Estimated Revenue Effects Relative to the Present Law Baseline of the Tax Provisions in “Title VII – Finance” of the Substitute Legislation as Passed by the Senate to Provide for Reconciliation of the Fiscal Year 2025 Budget.* July 1, 2025.

<sup>2</sup> Husak, Corey. *7 Ways the Big Beautiful Bill Cuts Taxes for the Rich.* Center for American Progress. November 20, 2025.

<sup>3</sup> Tomsic, Trinity. *One Big Beautiful Bill Act: Medicaid Provisions.* Federal Funds Information for States, Budget Brief 25-12. July 17, 2025.

- 3) Revises criteria for “generally redistributive” taxes to exclude taxes that impose a higher rate on Medi-Cal providers or plans than on other providers or plans, similar to the structure of the current MCO tax.
- 4) Provides the federal Health and Human Services Secretary with discretion to provide a transition period for noncompliant taxes of up to three years.

*MCO Tax.* The current MCO tax implemented under Proposition 35 would violate two provisions of H.R. 1: 1) the size of the tax as a percentage of total revenue would exceed the indirect hold harmless threshold when it phases down beginning October 1, 2027; and 2) the tax would not be “generally redistributive” because it taxes Medi-Cal managed care plans at a higher rate than other plans. According to DHCS, the current MCO tax has received approval to remain in effect until the expiration of its original federal approval period, on December 31, 2026.

Provisions of Proposition 35 further complicate the future of the MCO tax under H.R. 1. The initiative requires the imposition of a substantially similar MCO tax on and after January 1, 2027, when the original tax is scheduled to expire. The initiative also caps the annual tax liability of non-Medi-Cal plans at \$36 million. Because H.R. 1 requires a uniform level of tax between Medi-Cal and non-Medi-Cal plans, the tax liability cap of Proposition 35 limits the overall size of any future MCO tax because the size of the tax levied on Medi-Cal plans would be similarly limited.

*HQAF.* The most recent submitted HQAF Program IX would violate two provisions of H.R. 1: 1) the fee is considered “new or increased” because it was not “enacted and imposed” as of July 4, 2025; 2) the fee is not “generally redistributive” under the new rules of H.R. 1 because it is not uniform and not broad-based. According to DHCS, the HQAF may remain non-compliant through June 30, 2028, under the transition period provided by the final rule. The HQAF Program IX submission to CMS is being revised to match the level of a previously approved HQAF to comply with H.R. 1 provisions that the tax not be “new or increased”. The reduction to the previous level will result in a significant decrease in the estimates of revenues available to support hospital payments in the Medi-Cal program.

*SNF-QAF.* The SNF-QAF is not uniform or broad-based, but is allowable under a federal waiver approved by CMS. According to DHCS, the provisions of H.R. 1 will have a limited impact on the SNF-QAF. The department is assessing whether the current tax structure, in which assessments are tiered based on bed day count and certain facilities are exempted, will continue to be allowable under H.R. 1.

*GEMT-QAF.* The GEMT QAF is currently broad-based and uniform and does not require a federal waiver. However, DHCS reports the phase down of the indirect hold-harmless threshold over time will result in a lower rate and reduced revenues for GEMT providers. DHCS estimates this reduction in revenues could occur as soon as 2027-28, but is likely to be later as the threshold phases down.

*ICF-DD QAF.* The ICF-DD QAF is currently broad-based and uniform and does not require a federal waiver. According to DHCS, there is no impact on the ICF-DD QAF from H.R. 1.

**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 current provider rate increases supported by the MCO tax implemented under Proposition 35.
2. Please describe how the provisions of H.R. 1 affect future General Fund support and provider rate increases under Proposition 35.
3. How has the Hospital Quality Assurance Fee been impacted by the provisions of H.R. 1? What is the difference in the level of support for hospitals between the previously submitted fee and the fee that is likely approvable under H.R. 1?
4. What is the current and future status of other provider-related taxes in the Medi-Cal program under H.R. 1?

**Issue 5: Managed Care Final Rule – Implementation and Operations**

**Budget Change Proposal – Governor’s Budget.** DHCS requests expenditure authority of \$12.3 million (\$6 million General Fund and \$6.3 million federal funds) in 2026-27 and \$10.5 million (\$5.2 million General Fund and \$5.2 million federal funds) in 2027-28 through 2029-30. These resources include support for six one-year, limited term positions and 33 four-year, limited term positions, as well as 25 four-year, limited-term positions that were included in the 2025 Budget Act for Medicaid Managed Care, Access, and Eligibility Final Rules. If approved, these resources would support implementation and operations of federal requirements pursuant to the Managed Care Final Rule.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0001 – General Fund	\$6,023,000	\$5,228,000
0890 – Federal Trust Fund	\$6,287,000	\$5,228,000
<b>Total Funding Request:</b>	<b>\$12,310,000</b>	<b>\$10,456,000</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Additional fiscal year resources requested – 2028-29 through 2029-30: \$10,456,000.

**Background.** According to DHCS, the federal Managed Care Access, Finance, and Quality Final Rule, issued by the Centers for Medicare and Medicaid Services (CMS) in April 2024, reshapes the federal regulatory landscape for managed care programs in the areas of ensuring access to care, transparency, quality measurement, and oversight of provider payment rates. According to CMS, the final rule includes the following provisions:

*Access*

- 1) Establishes maximum appointment wait time standards of 15 business days for routine primary care and obstetrics/gynecological services; 10 business days for outpatient behavioral health services
- 2) Requires states to use an independent entity to conduct an annual secret shopper survey to validate plan compliance with wait times and accuracy of provider directories
- 3) Requires states to conduct an annual enrollee experience survey for each plan
- 4) Requires states to submit an annual payment analysis that compares certain plan payment rates to the rates in the Medicare rate
- 5) Requires states to implement a remedy plan for any plan that needs improvement
- 6) Requires states to maintain a single web page that is readily identifiable to the public, easy to use, and contains required information for public transparency

*State Directed Payments*

- 1) Removes regulatory barriers to improve the use of state directed payments for value-based purchasing and include non-network providers
- 2) Requires payment levels for state directed payments for hospital, nursing facility, and professional services at an academic medical center to not exceed the average commercial rate
- 3) Requires states to condition fee schedule based state directed payments on the delivery of services and allows value-based purchasing to tie payment to performance up to one year prior
- 4) Prohibits use of post-payment reconciliation for fee schedule based payments
- 5) Prohibits the use of separate payment terms and requires payments be included in actuarially sound capitation rates

- 6) Establishes submission timeframes for state directed payment preprints, in rate certifications and managed care contracts.
- 7) Requires provider level reporting on actual expenditures
- 8) Requires states to submit evaluation reports to CMS every three years of state directed payment costs exceed 1.5 percent of the capitation rate
- 9) Establishes a process to appeal state directed payment disapprovals
- 10) Requires states to ensure providers do not participate in an arrangement that holds taxpayers harmless for the cost of a tax

#### *Medical Loss Ratio*

- 1) Requires plans to submit actual expenditures and revenues for state directed payments as part of their medical loss ratio reports
- 2) Specifies that states must provide medical loss ratios for each plan
- 3) Requires plans to report identified or recovered overpayments to states within 30 days
- 4) Specifies contractual requirements for provider incentive payments

#### *In Lieu of Service and Setting (ILOS; referred to in CalAIM as “Community Supports”)*

- 1) Specifies that ILOS can be used as immediate or longer-term substitutes for a covered service or setting under the state plan, or when the ILOS can be expected to reduce or prevent future need for such service or setting to better support health related social needs
- 2) Requires an ILOS be considered approvable as a service or setting through the state plan
- 3) Requires documentation for each ILOS in plan contracts, as well as additional documentation if the ILOS cost exceeds 1.5 percent of the capitation rate
- 4) Imposes a limit of five percent on total ILOS costs as a percentage of total capitation rates
- 5) Requires ongoing monitoring of each ILOS and an evaluation after five years if costs exceed 1.5 percent of the capitation rate
- 6) Requires states to develop a transition plan to arrange for state plan services and settings to be provided timely if an ILOS will be terminated

#### *Quality Strategy and External Quality Review (EQR)*

- 1) Increases public engagement around states’ managed care quality strategies
- 2) Eliminates EQR requirements from primary care case management entities
- 3) Makes it easier for states to use accreditation reviews for EQR
- 4) Establishes consistent 12-month review periods for the annual EQR activities
- 5) Requires more meaningful data and information to be included in the annual EQR

#### *Medicaid and CHIP Quality Rating System (MAC QRS)*

- 1) Establishes the MAC QRS website as a state’s “one-stop-shop” where beneficiaries could access information about Medicaid and CHIP eligibility and managed care, compare plans based on quality and other factors, and select a plan
- 2) Establishes the CMS framework and state requirements for the MAC QRS website and process for updates in the future
- 3) Establishes a methodology for calculating quality ratings displayed on the website
- 4) Broadens flexibility for states to implement an alternative QRS

#### *Children’s Health Insurance Program*

- 1) Requires separate CHIP programs to align with Medicaid on most proposed provisions related to access, ILOS, MLR, and quality (*note: California no longer has a separate CHIP program*)

DHCS reports that it is currently in compliance with many of these provisions, such as the appointment wait times, but there are new or more stringent requirements that necessitate additional resources for planning and implementation of the final rule.

**Staffing and Resource Request.** DHCS requests expenditure authority of \$12.3 million (\$6 million General Fund and \$6.3 million federal funds) in 2026-27 and \$10.5 million (\$5.2 million General Fund and \$5.2 million federal funds) in 2027-28 through 2029-30 to support implementation and operations of federal requirements pursuant to the Managed Care Final Rule. Specifically, DHCS is requesting the following positions and resources:

**Behavioral Health Oversight and Monitoring Division** – One position (four-year limited-term)

- **One Analyst II** position would participate in planning and developing the processes for exceptions to network standards and coordinating with stakeholders on the standards.

**Business Operations Technology Services Division** – One position (one-year limited-term)

- **One Information Technology Specialist II** position would collaborate with support teams to define and document a detailed project schedule for changes to information technology systems related to CMS-required changes.

**Capitated Rates Development Division** – Three positions (four-year, limited-term)

- **Three Analyst II** positions would conduct continuous and comprehensive monitoring of expanded requirements within the final rule to certify compliance by managed care plans, dental managed care plans, subcontractors, and downstream subcontractors.

**Data Analytics Division** – One position (four-year, limited-term)

- **One Research Scientist III** position would provide scientific support for EQR reporting and the QRS measure set, provide scientific consultation and technical assistance in developing a data-driven approach to monitoring clinical quality and health equity outcomes related to the measure set, and act as a team lead for data extraction, linkage, research, and statistical analysis.

**Health Information Management Division** – One position (four-year, limited-term)

- **One Research Data Specialist (RDS) I** position would lead data quality efforts to review plan data to confirm the data is adequate to determine if plans are meeting required network adequacy thresholds.

**Information Technology Strategy Services Division** – Two positions (one-year, limited-term) and limited-term contract resources of \$731,000 in 2026-27

- **Two Information Technology Specialist II** positions would help provide oversight into the new standards for access to care through the managed care delivery system, establish maximum appointment wait time standards, conduct annual secret shopper surveys to validate plan compliance, and conduct an annual enrollee experience survey for each plan.
- Contract resources of \$600,000 in 2026-27 would support project management support services
- Contract resources of \$131,000 in 2026-27 would support California Department of Technology (CDT) Project Oversight Services (POS)

**Local Governmental Financing Division** – One position (four-year, limited-term)

- **One Research Data Specialist I** position would provide analytical support and analysis of behavioral health services rates related to network adequacy and report findings to the division for further oversight and monitoring.

**Managed Care Quality and Monitoring Division** – Five position (four-year, limited-term)

- **One Supervisor I** position would meet expanded CMS reporting requirements as part of the final rule and support enhanced monitoring and stakeholder engagement of community support services.
- **One Research Data Specialist III** position would work with stakeholders to support development of reporting templates and provide consultation related to data sources and coding for enhanced exceptions monitoring.
- **Three Analyst II** positions would assist in planning and developing the exception processes to CMS network and access standards, coordinating on development of network and access standard exceptions, developing program requirements to comply with legal and contract guidelines, coordinating with internal data teams to develop enhanced monitoring processes, developing and maintaining compliance tools, conducting review of plans and subcontractors' compliance results and exceptions, and facilitating follow up and technical assistance with plans.

**Medi-Cal Dental Services Division** – One position (four-year, limited-term)

- **One Supervisor II** position would plan, implement and monitor the appointment wait time standards and exceptions process, including the dental managed care plan process for overseeing their contractors.

**Medi-Cal Enterprise Systems Modernization Division** – Three positions (one-year, limited-term)

- **One Information Technology Manager I** position would serve as lead product manager and provide product strategy leadership and guidance to multiple final rules product managers, product owners, and technical leads.
- **Two Information Technology Specialist II** positions would serve as project manager/product owner to manage internal and external stakeholders' satisfaction with the digital services solution's objectives.

**Office of Communications** – One position (four-year, limited-term)

- **One Analyst II** position would assist program staff in maintaining compliance with CMS website transparency requirements by coordinating with web contributors and program teams.

**Program Data Reporting Division** – Ten positions (four-year, limited-term)

- **One Research Data Specialist II** position and **two Research Data Specialist I** positions would continue current steward levels to a new dedicated unit for monitoring and stakeholder engagement of community supports services within Medi-Cal managed care plans.
- **One Research Data Specialist II** position would evaluate and monitor the accuracy of managed care plan-submitted payment files.
- **Two Research Data Specialist II** positions and **two Research Scientist II** positions would verify the integrity and usability of appointment wait time data for internal and external reporting.
- **One Research Scientist II** position and **one Research Data Specialist II** position would design and maintain dashboards, creating proof-of-concept visualizations, and implementing data quality validation protocols that enhance both the accuracy and usability of reported results.

**Quality and Health Equity Division** – Nine positions (four-year, limited-term)

- **One Manager II** position and **one Health Program Specialist I** position would update and align data reporting requirements with the final rule, across delivery systems as related to annual EQR activities.
- **One Health Program Manager II** position, **one Medical Consultant I** position, **one Health Program Specialist II** position, **one Health Program Specialist I** position, and **one Analyst II** position would assess current data collection capacity, strategies, and responsibilities within DHCS and attain subject matter expertise in QRS requirements and rules on alternative QRS.
- **One Medical Consultant Supervisor II** position and **one Health Program Manager I** position would create a system for developing an annual quality improvement plan for each Medi-Cal managed care plan, dental managed care plan, and behavioral health plan based on the findings from enrollee experience surveys for continuous quality improvement.

**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: Managed Care Operations**

**Budget Change Proposal – Governor’s Budget.** DHCS requests the conversion of four limited-term resources to permanent positions and expenditure authority of \$607,000 (\$236,000 General Fund and \$371,000 federal funds) annually. If approved, these positions and resources would support implementation, monitoring, and enforcement of federal and state requirements for Medi-Cal managed care plans, including network adequacy and access.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0001 – General Fund	\$236,000	\$236,000
0890 – Federal Trust Fund	\$371,000	\$371,000
<b>Total Funding Request:</b>	<b>\$607,000</b>	<b>\$607,000</b>
<b>Total Requested Positions:</b>	<b>4.0</b>	<b>4.0</b>

\* Positions and resources ongoing after 2027-28.

**Background.** Since 2021, DHCS has received limited-term resources equivalent to four positions in the areas of behavioral health, compliance with federal interoperability rules, and for the implementation of the statewide procurement of Medi-Cal managed care plans that began in 2024. Specifically, these positions: 1) establishment of the Student Behavioral Health Incentive Program (SBHIP) as part of the Children and Youth Behavioral Health Initiative (CYBHI); 2) enforcing interoperability reporting requirements under federal rules; and 3) assessing managed care plan readiness for the 2024 procurement process.

According to DHCS, maintaining access to these services and the progress achieved during these efforts required the transition of these resources to meet ongoing network adequacy and access monitoring activities to comply with federal reporting requirements.

**Staffing and Resource Request.** DHCS requests the conversion of four limited-term resources to permanent positions and expenditure authority of \$607,000 (\$236,000 General Fund and \$371,000 federal funds) annually to support implementation, monitoring, and enforcement of federal and state requirements for Medi-Cal managed care plans, including network adequacy and access. Specifically, DHCS is requesting the following positions and resources:

**Managed Care Quality and Monitoring Division** – Three positions

- **One Health Program Specialist I** position would provide subject matter expertise supporting the long-term care carve-in as part of the statewide procurement and the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- **Two Analyst II** positions would verify network adequacy and access compliance monitoring of the new components of the 2024 contracts, including for behavioral health services and delegated entity oversight. One Analyst II in the Network Adequacy Unit would monitor utilization and compliance with network adequacy standards. One Analyst II in the Access to Care Unit would lead managed care policy development and issue formal guidance, obtain, analyze, and incorporate stakeholder feedback.

**Health Care Delivery Systems Division** – One position

- **One Health Program Specialist II** position would support managed care program data and other system improvements, sustain essential coordination and project management functions across entities and stakeholders, serve as an expert program advisor for development and implementation of policy recommendations and program monitoring activities related to interoperability and prior authorizations, and lead, organize, and facilitate internal workgroups and trainings.

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

**Budget Change Proposal and Trailer Bill Language – Governor’s Budget.** DHCS requests 23 positions and expenditure authority of \$10.7 million (\$5.3 million reimbursements and \$5.3 million federal funds) in 2026-27, \$9.8 million (\$4.9 million reimbursements and \$4.9 million federal funds) in 2027-28 and 2028-29, and \$6.8 million (\$3.4 million reimbursements and \$3.4 million federal funds) annually thereafter. Included in these resources are the equivalent of three one-year, limited-term positions. If approved, these positions and resources would support development, implementation, and maintenance of a comprehensive value strategy for payments for hospital services in the Medi-Cal managed care delivery system.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0995 – Reimbursements	\$5,332,000	\$4,905,000
0890 – Federal Trust Fund	\$5,332,000	\$4,905,000
<b>Total Funding Request:</b>	<b>\$10,664,000</b>	<b>\$9,809,000</b>
<b>Total Requested Positions:</b>	<b>23.0</b>	<b>23.0</b>

\* Additional fiscal year resources requested – 2028-28: \$9,809,000; 2029-30 and ongoing: \$6,809,000.

**Background.** California hospitals have reported significant financial distress in recent years, closing or reducing 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 previous proposals 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 seven SDP and four 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 2025 Total (millions)
SDP	Private Hospital Directed Payment (PHDP)	HQAF	\$13,187.30
SDP	DPH Enhanced Payment Program (EPP)	IGT	\$3,865.00
SDP	DPH Quality Incentive Pool (DPH-QIP)	IGT	\$3,463.70
PTP	Private Hospital PTP	HQAF	\$1,200.00
SDP	DMPH Directed Payment (DHDP)	IGT	\$842.40
SDP	Children’s Hospital Supplemental Payment	State GF	\$230.00
SDP	DMPH Quality Incentive Pool (DMPH-QIP)	IGT	\$178.50
SDP	Major Organ Transplants	State GF	\$152.10
PTP	Public Distinct-Part Nursing Facility PTP	State GF	\$110.90
PTP	Martin Luther King Jr. Community Hospital PTP	State GF	\$46.90
PTP	Benioff Children’s Hospital Oakland PTP	IGT	\$25.80

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. In addition, House Resolution 1 (H.R. 1) implemented significant changes to many of these programs with some, like the hospital quality assurance fee (HQAF) needing to be revised significantly.

**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.

**2025 Budget Act Approved One-Time Resources For the Comprehensive Value Strategy.** The 2025 Budget Act included expenditure authority of \$11.3 million (\$2 million California Health Data and Planning Fund, \$5.6 million federal funds, and \$3.6 million reimbursements) to support the development by DHCS of the comprehensive hospital value strategy. This request continues these positions and resources, while utilizing reimbursements instead of the California Health Data and Planning Fund for the non-federal share.

**Staffing and Resource Request.** DHCS requests 23 positions and expenditure authority of \$10.7 million (\$5.3 million reimbursements and \$5.3 million federal funds) in 2026-27, \$9.8 million (\$4.9 million reimbursements and \$4.9 million federal funds) in 2027-28 and 2028-29, and \$6.8 million (\$3.4 million reimbursements and \$3.4 million federal funds) annually thereafter to support development, implementation, and maintenance of a comprehensive value strategy for payments for hospital services in the Medi-Cal managed care delivery system. Specifically, DHCS is requesting the following positions and resources:

**Capitated Rates Development Division** – 12 positions

- **One Manager II** 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 Supervisor II** position would have supervisory responsibility over a new section overseeing implementation of the comprehensive value strategy.
- **Two Supervisor 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 Analyst II** positions would review, analyze, and draft responses to plan and hospital inquiries, develop technical program guidance and documentation, coordinate with other divisions and units the development and implementation of SDPs.

**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 Supervisor 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 Analyst II** positions 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.

**Health Information Management Division** – Three positions (one-year, limited-term)

- **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.

**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.

**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.

**Consultant Contracts** - \$5.4 million

- **Hospital Comprehensive Value Strategy Design and Implementation** - \$3 million (\$1.5 million reimbursements, and \$1.5 million federal funds) in 2026-27 through 2028-29 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 (\$1.2 million reimbursements, 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.

**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, including the source of the reimbursements supporting the non-federal share of funding.
2. Please describe the efforts to date to improve hospital reimbursement through expansion of existing SDPs and how those efforts have been affected by H.R. 1 and other federal actions.
3. How would the implementation of the comprehensive value strategy be affected by implementation of H.R. 1 provisions?

**Issue 8: Skilled Nursing Facility Financing Extension**

**Trailer Bill Language – Governor’s Budget.** DHCS proposes trailer bill language to extend for one year the current quality assurance fee and reimbursement provisions for skilled nursing facilities in the Medi-Cal program.

**Background.** 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 imposed a skilled nursing facility quality assurance fee (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 annual reimbursement rate increases and imposes certain other requirements on skilled nursing facilities, including quality measures and labor standards.

AB 186 (Committee on Budget), Chapter 46, Statutes of 2022, was the most recent reauthorization of the skilled nursing facility quality assurance fee, extending the sunset date of the fee and implementing various reimbursement and other provisions until December 31, 2026, including the following:

1. Established a new Medi-Cal reimbursement rate structure for skilled nursing facilities (SNFs), authorized for calendar years 2023 through 2026.
2. Extended the existing quality assurance fee on SNFs until December 31, 2026.
3. Based rates 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.
4. Established a new Workforce and Quality Incentive Program under which facilities are able to earn directed payments, and assumes \$280 million in these payments in 2023.
5. Required DHCS to make a one-time increase to the performance-based directed payment target amount, no sooner than December 31, 2023.
6. Required, beginning in 2024, half of the annual increase for non-labor costs to be allocated to base rates and half to increase Workforce and Quality Incentive Program payments.
7. 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.
8. Exempted freestanding pediatric subacute care facilities and special program services for the mentally disordered from the directed payments.

9. 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.
10. Required that if there is a merger, acquisition, or change of ownership involving a SNF that has an outstanding sanction, the successor SNF shall be responsible for paying the sanction.
11. Established an appeal process for SNFs to contest these sanctions.
12. Authorized DHCS to contract with California's Medicare Quality Improvement Organization, or other qualified entities, to assist with development, collection, analysis, and reporting of the performance data.
13. Specified that for 2023 only, SNFs receive a "bridge rate add-on" equivalent to the COVID-19 Public Health Emergency rate add-on. Restricted the funds to allowable COVID-related costs and subject to audit. Required 85 percent of the funds from the add-on be used for labor costs.
14. Required that any funds from the add-on found to be spent out of compliance with these requirements be recouped and redistributed to the Workforce and Quality Program.
15. Required DHCS to establish workforce standards for 2024 through 2026, and made facilities that meet the workforce standards eligible to receive a base rate augmentation. Specified that a facility could receive the base rate augmentation for the first time in 2024, 2025, or 2026, depending on when the facility meets the workforce standards.
16. Required that subsequent annual rate increases for a facility that meets and continues to meet the workforce standards to be calculated off of the augmented base rate, subject to the annual growth limits.
17. Required that annual rate increases for a facility which has not met, or fails to continue to meet, the workforce standards to be calculated from the un-augmented base rate, subject to the annual growth limits.
18. Required that if a facility that met the workforce standards in a particular year, and received the base rate augmentation, were determined in a subsequent year to no longer meet the workforce standard, the rate for the facility would revert to the rate that would have been received if the facility had not met the workforce standards
19. Authorized the workforce standards to include, but need not be limited to, 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.
20. Required the base rate augmentation to be determined as follows, on a facility-specific basis:

- a. Step One: Calculate what the Calendar Year (CY) 2023 base rate would have been if an annual growth limit had not been applied to labor costs.
  - b. Step Two: Take the difference between the amount calculated in Step One and the un-augmented CY 2023 base rate.
  - c. Grow the amount calculated in Step Two by five percent to determine the potential base rate augmentation for facilities that meet the workload standard for CY 2024.
  - d. For facilities that meet the workload standard for the first time for CY 2025 or CY 2026, grow the base rate augmentation by an additional five percent for each year.
21. Continued the Skilled Nursing Facility Minimum Staffing Penalty Account, which is continuously appropriated to the California Department of Public Health (CDPH).
  22. Required CDPH to use the direct care staffing level data it collects to determine whether a SNF has met the nursing hours or direct care service hours per patient per day statutory requirements.
  23. Required CDPH to assess a SNF an administrative penalty if it determines that the SNF fails to meet the required staffing hours as follows: 1) \$25,000 if the SNF fails to meet the requirements for between 5 and 49 percent of the audited days; and \$50,000 if the SNF fails to meet the requirements for over 49 percent of the audited days.
  24. Authorized CDPH to request that DHCS offset any moneys owed to the SNF by the Medi-Cal program to recoup the penalty.
  25. Established an appeal process for SNFs that are assessed a penalty.

**2025 Budget Act Eliminated WQIP.** Due to a significant General Fund shortfall, the 2025 Budget Act eliminated funding for the Workforce and Quality Incentive Program (WQIP). The WQIP provided the opportunity for facilities to earn directed payments based on compliance with certain standards. The elimination of WQIP is estimated to achieve General Fund savings of \$149.1 million in 2026-27.

**Trailer Bill Language Proposal.** DHCS proposes trailer bill language to extend for one year the current quality assurance fee and reimbursement provisions for skilled nursing facilities in the Medi-Cal program. This extension would also include continuation of the General Fund solution eliminating the WQIP that was adopted in the 2025 Budget Act.

**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 trailer bill language proposal.
2. How would the continued elimination of the WQIP impact facility financing? Is the department considering any measures to adjust rates to compensate for the loss of revenue?

3. What new components could be included in a 2027-28 SNF Financing proposal that includes the SNF value strategy that are not in the current framework?

**Issue 9: Long-Term Care Payment Transparency Final Rule Extension**

**Budget Change Proposal – Governor’s Budget.** DHCS requests eight positions and expenditure authority of \$2.5 million (\$1.2 million Long-Term Care Quality Assurance Fund or LTC-QAF, and \$1.3 million federal funds) in 2026-27 and \$1.3 million (\$604,000 LTC-QAF and \$726,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of the Medicaid Institutional Payment Transparency Reporting provisions of the federal Long-Term Care Final Rule. HCAI is also requesting three positions and expenditure authority of \$597,000 annually from the California Health Data and Planning Fund to implement the new healthcare data reporting requirements related to the final rule. *(Note: the subcommittee will hear the HCAI components of this proposal during a later hearing).*

<b>Multi-Year Funding Request Summary - DHCS</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0890 – Federal Trust Fund	\$1,329,000	\$726,000
3213 – Long-Term Care Quality Assurance Fund	\$1,208,000	\$604,000
<b>Total Funding Request:</b>	<b>\$2,537,000</b>	<b>\$1,330,000</b>
<b>Total Requested Positions** :</b>	<b>8.0</b>	<b>8.0</b>

\* Resources ongoing after 2027-28.

\*\* These eight positions were previously approved in the 2025 Budget Act.

**Background.** According to DHCS, in 2024 the federal Centers for Medicare and Medicaid Services (CMS) have implemented two new federal rules driving new workload in the Medi-Cal program.

- 1) 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.
- 2) 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.

The 2025 Budget Act included 8 positions and expenditure authority of \$2.6 million (\$1.2 million LTC-QAF and \$1.4 million federal funds) in 2025-26 to support implementation of the two long-term care facility federal rules. The positions were permanently established, but the resources were one-time in 2025-26.

In April 2025, the United States District Court for Northern Texas overturned the minimum staffing standards provisions of the final rule. In July 2025, House Resolution 1 (H.R. 1) prohibited implementing, administering, or enforcing the minimum staffing standards until October 1, 2034. However, both the court action and H.R.1 left intact the Medicaid Institutional Transparency Reporting rule.

**Staffing and Resource Request.** DHCS requests expenditure authority of \$2.5 million (\$1.2 million Long-Term Care Quality Assurance Fund or LTC-QAF, and \$1.3 million federal funds) in 2026-27 and \$1.3 million (\$604,000 LTC-QAF and \$726,000 federal funds) annually thereafter to support implementation of the Medicaid Institutional Payment Transparency Reporting provisions of the federal Long-Term Care Final Rule. Specifically, DHCS is requesting the following resources:

**Fee-for-Service Rates Development Division** – 3 positions and contract resources of \$1 million

- **One Research Data Supervisor II** position would have supervisory responsibility of a new LTC Workforce Section and manage development and operations of cost report information flow and financial calculations necessary for payment transparency requirements.
- **One Research Data Specialist II** position would perform complex financial calculations, develop new data methodologies and guidelines, and respond to ad-hoc research requests.
- **One Research Scientist III** position would plan, organize, and direct analysis of labor and workforce data to certify accurate reporting under the payment transparency rule.
- Contract resources of \$1 million (\$500,000 LTC-QAF and \$500,000 federal funds) in 2026-27 would support operational updates to existing long-term care facility cost reporting processes, develop and update technical documentations for providers, and support stakeholder engagement on the implementation of the new requirements.

**Financial Review Inpatient Division** – Two positions

- **Two Health Program Auditor IV** positions would provide consultation based on cost report audit experience of skilled nursing facilities and intermediate care facility-developmental disabilities provider population.

**Health Information Management Division** – One position

- **One Information Technology Specialist (ITS) II** position would collect and document all requirements necessary for the public reporting dashboard, oversee technology solutions for business process re-engineering, prepare and maintain data, prepare data visualizations, and perform quality assurance for data input into the visualizations.

**Program Data Reporting Division** – One position

- **One Research Data Specialist (RDS) III** position would lead identification of populations and data in the DHCS data warehouse, create first line data checks, and create proof of concepts for modeling purposes.

**Quality and Health Equity Division** – One position

- **One Nurse Consultant III Specialist** position would provide clinical expertise, consultation, review, and technical assistance related to workforce requirements established by the final rule, serve as the liaison between the California Department of Public Health staffing audits and DHCS quality initiatives related to long-term care.

**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.
2. If the staffing ratio components of the federal rule are unenforceable until 2034, why does the department require the same level of staff included in the 2025 Budget Act?

**Issue 10: Implementation of Chaptered Legislation (SB 660, SB 246, and AB 543)**

**SB 660 (Menjivar)**

**Legislative Budget Change Proposal (SB 660) – Governor’s Budget.** DHCS requests one position and expenditure authority of \$178,000 (\$89,000 General Fund and \$89,000 federal funds) in 2026-27 and \$169,000 (\$85,000 General Fund and \$84,000 federal funds) annually thereafter. If approved, this position and resources would support monitoring of Medi-Cal managed care compliance with requirements related to the Data Exchange Framework, pursuant to SB 660 (Menjivar), Chapter 325, Statutes of 2025.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0001 – General Fund	\$89,000	\$85,000
0890 – Federal Trust Fund	\$89,000	\$84,000
<b>Total Funding Request:</b>	<b>\$178,000</b>	<b>\$169,000</b>
<b>Total Requested Positions:</b>	<b>1.0</b>	<b>1.0</b>

\* Position and resources ongoing after 2027-28.

**Background.** SB 660 (Menjivar), Chapter 325, Statutes of 2025, transfers responsibility for the California Health and Human Services Data Exchange Framework from CalHHS to HCAI. Among its other provisions, SB 660 requires entities continuing, amending, or entering into a new or existing contract for the provision of health care services with DHCS, the California Public Employees’ Retirement System (CalPERS), and Covered California to execute a data sharing agreement with the Data Exchange Framework. According to DHCS, SB 660 would introduce operational responsibilities for DHCS, including: 1) revising contracts and developing and implementing policy guidance; 2) monitoring compliance to ensure DHCS and plans meet the new requirements; and 3) report on the status of DHCS and plan compliance to HCAI.

**Staffing and Resource Request.** DHCS requests one position and expenditure authority of \$178,000 (\$89,000 General Fund and \$89,000 federal funds) in 2026-27 and \$169,000 (\$85,000 General Fund and \$84,000 federal funds) annually thereafter to support monitoring of Medi-Cal managed care compliance with requirements related to the Data Exchange Framework, pursuant to SB 660 (Menjivar), Chapter 325, Statutes of 2025. Specifically, DHCS requests **one Health Program Specialist II** position to provide ongoing monitoring of deliverables required to oversee plan compliance with the Data Exchange Framework, including program analysis and coordination with subject matter experts.

**SB 246 (Grove)**

**Legislative Budget Change Proposal (SB 246) – Governor’s Budget.** DHCS requests one position and expenditure authority of \$165,000 (\$83,000 reimbursements and \$82,000 federal funds) in 2026-27 and \$156,000 (\$78,000 reimbursements and \$78,000 federal funds) annually thereafter. If approved, this position and resources would support implementation of a program to allow district and municipal hospitals to draw down federal funding for graduate medical education, pursuant to the requirements of SB 246 (Grove), Chapter 308, Statutes of 2025.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</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>1.0</b>	<b>1.0</b>

\* Position and resources ongoing after 2027-28.

**Background.** SB 246 (Grove), Chapter 308, Statutes of 2025, requires DHCS to implement a program to allow district and municipal hospitals to draw down federal Medicaid funding for graduate medical education (GME) costs. According to DHCS, annual GME payments for district and municipal hospitals would be approximately \$18.4 million for the current five hospitals with existing GME programs. DHCS reports it would require a full-time position to implement and maintain the new program, including calculating payment methodologies and preparing federal approval documents.

**Staffing and Resource Request.** DHCS requests one position and expenditure authority of \$165,000 (\$83,000 reimbursements and \$82,000 federal funds) in 2026-27 and \$156,000 (\$78,000 reimbursements and \$78,000 federal funds) annually thereafter to support implementation of a program to allow district and municipal hospitals to draw down federal funding for graduate medical education, pursuant to the requirements of SB 246 (Grove), Chapter 308, Statutes of 2025. Specifically, DHCS requests **one Health Program Specialist I** position to be responsible for interpreting existing GME methodologies as a basis to develop the per resident amount calculation for the state plan amendment to implement the new GME program.

**AB 543 (Gonzalez)**

**Legislative Budget Change Proposal (AB 543) – Governor’s Budget.** DHCS requests four positions and expenditure authority of \$698,000 (\$349,000 General Fund and \$349,000 federal funds) in 2026-27 and \$662,000 (\$331,000 General Fund and \$331,000 federal funds) annually thereafter. If approved, these positions and resources would support implementation of new provisions governing the delivery of health care services to individuals experiencing homelessness, pursuant to the requirements of AB 543 (Gonzalez), Chapter 374, Statutes of 2025.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0001 – General Fund	\$349,000	\$331,000
0890 – Federal Trust Fund	\$349,000	\$331,000
<b>Total Funding Request:</b>	<b>\$698,000</b>	<b>\$662,000</b>
<b>Total Requested Positions:</b>	<b>4.0</b>	<b>4.0</b>

\* Positions and resources ongoing after 2027-28.

**Background.** AB 543 (Gonzalez), Chapter 374, Statutes of 2025, requires Medi-Cal managed care plans who elect to contract with field medicine providers to allow Medi-Cal beneficiaries to receive services from a contracted, in network field medicine provider regardless of network assignment, and allow field medicine providers to make direct referrals for Medi-Cal covered services such as diagnostic services, medications, or durable medical equipment within the managed care network. According to DHCS, while

the delivery of field medicine is currently allowable under DHCS policy, plans that elect to offer services through field medicine providers would be required to provide additional flexibilities to those providers, potentially leading to higher utilization and higher costs, which could be offset by lower utilization of emergency department and other high-cost services. While DHCS does not expect a significant change in utilization to justify an adjustment to managed care plan rates in 2026, there may be additional General Fund costs in the long-run of \$3 million to \$11 million annually, assuming no offsetting reductions in other service categories, such as emergency department services. DHCS expects implementation of AB 543 would require additional staffing to implement the bill's provisions and continue monitoring plan compliance.

**Staffing and Resource Request.** DHCS requests four positions and expenditure authority of \$698,000 (\$349,000 General Fund and \$349,000 federal funds) in 2026-27 and \$662,000 (\$331,000 General Fund and \$331,000 federal funds) annually thereafter to support implementation of new provisions governing the delivery of health care services to individuals experiencing homelessness, pursuant to the requirements of AB 543 (Gonzalez), Chapter 374, Statutes of 2025. Specifically, DHCS requests the following positions and resources:

- **Three Health Program Auditors** would audit program compliance with the provisions of AB 543, perform pre-audit procedures, develop and write audit scopes of work, complete financial audit reports and be responsible for the review of managed care provider systems to determine compliance with regulations and contractual requirements.
- **One Health Program Specialist I** position would resolve issues and problems that arise between field medicine providers and plans, implement compliance and monitoring activities related to utilization management, prior authorization delays, denials, barriers to care, provide technical assistance to plans and track and review grievance and appeal data to identify systemic issues affecting access to care under the field medicine 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 these proposals.
2. 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 11: Advancing Interoperability and Improving Prior Authorization Processes Final Rule**

**Budget Change Proposal – Governor’s Budget.** DHCS requests expenditure authority of \$3.5 million (\$523,000 General Fund and \$3 million federal funds) in 2026-27 and \$2.9 million (\$456,000 General Fund and \$2.5 million federal funds) in 2027-28 and 2028-29. These resources are equivalent to 18 three-year, limited-term positions. If approved, these positions and resources would support planning and implementation of federal rules on Advancing Interoperability and Improving Prior Authorization Processes.

<b>Multi-Year Funding Request Summary</b>		
<b>Fund Source</b>	<b>2026-27</b>	<b>2027-28*</b>
0001 – General Fund	\$523,000	\$456,000
0890 – Federal Trust Fund	\$2,956,000	\$2,490,000
<b>Total Funding Request:</b>	<b>\$3,479,000</b>	<b>\$2,946,000</b>
<b>Total Requested Positions:</b>	<b>0.0</b>	<b>0.0</b>

\* Additional fiscal year resources requested – 2028-29: \$2,946,000.

**Background.** In February 2024, the federal Centers for Medicare and Medicaid Services (CMS) published the Advancing Interoperability and Improving Prior Authorization Processes final rule. The rule requires implementation of standardized data exchange between payers and providers using secure, standard-based application programming interfaces (API). The rule also requires enhancements to prior authorization processes through API data exchange, standardized prior authorization decision time frames, improved notifications, and public reporting on key prior authorization metrics. These efforts are eligible for enhanced federal matching of 90 percent for planning and implementation and 75 percent for maintenance and operations.

DHCS has received resources for interoperability efforts since the 2021 Budget Act. The most recent allocation was in the 2025 Budget Act, which included one-year limited-term resources equivalent to six positions and expenditure authority of \$1.1 million (\$194,000 General Fund and \$909,000 federal funds) in 2025-26, the conversion of six limited-term positions to permanent and expenditure authority of \$1.1 million (\$270,000 General Fund and \$811,000 federal funds) annually thereafter. According to DHCS, it requires the equivalent of nine positions and one contract services team to support technical planning and operational enhancements required by the final rule, as well as the equivalent of an additional nine positions to provide managed care oversight and monitoring of managed care plans, dental plans, and behavioral health plans.

**Staffing and Resource Request.** DHCS requests expenditure authority of \$3.5 million (\$523,000 General Fund and \$3 million federal funds) in 2026-27 and \$2.9 million (\$456,000 General Fund and \$2.5 million federal funds) in 2027-28 and 2028-29 to support planning and implementation of federal rules on Advancing Interoperability and Improving Prior Authorization Processes. Specifically, DHCS is requesting the following positions and resources:

**Behavioral Health Oversight and Monitoring Division** – Three positions (three-year, limited-term)

- **One Health Program Specialist II** position would provide high-level, technical expertise, coordination, training, and leadership for the development and implementation of policy recommendations and program monitoring activities related to interoperability requirements.
- **Two Analyst II** positions would research and analyze laws, rules, policies, and other information necessary to assist behavioral health programs with understanding and implementing interoperability requirements, and would draft Behavioral Health Information Notices (BHINs) announcing new interoperability requirements.

**Integrated Systems of Care Division** – Eight positions (three-year, limited-term)

- **Two Health Program Specialist I** positions would serve as subject matter experts for the development and implementation of policy recommendations and program monitoring activities related to interoperability, working with the California Community Transitions (CCT) Program, the Home and Community-Based Alternative (HCBA) Waiver, and the California Children’s Services (CCS) program.
- **One Nurse Evaluator III** position would serve as the manager to the nurse evaluators under the CCS program, be responsible for the daily monitoring and oversight of the Service Authorization Request (SAR) adjudication process and serve as the subject matter expert, working with the Medical Director and division leadership to achieve compliance.
- **Three Nurse Evaluator II** positions would serve as the primary adjudicators for the CCS Program to review approximately 2,000 or more SARs per month.
- **Two Nurse Evaluator II** positions would be dedicated to the CCT and HCBA programs and would be responsible for adjudicating more than 800 or more treatment authorization requests (TAR) per month.

**Managed Care Quality and Monitoring Division** – Five positions (three-year, limited-term)

- **One Supervisor I** position would lead the unit responsible for the administration, implementation, and oversight of the interoperability and prior authorization programs, including resource planning, attending workgroup meetings, oversight and monitoring, and reporting.
- **One Health Program Specialist II** position would work with external stakeholders to develop and publish managed care plan guidance on the implementation of prior authorization decisions and interoperability, including change requirements.
- **One Health Program Specialist I** position would serve as an expert program advisor and consultant for the development and implementation of policy recommendations and program monitoring activities related to interoperability and prior authorization activities.
- **Two Analyst II** positions would serve as program liaisons, evaluating and monitoring managed care plan compliance with federal interoperability requirements.

**Medi-Cal Dental Services Division** – Two positions (three-year, limited-term)

- **One Health Program Specialist I** position would serve as the subject matter expert for the development and implementation of policy recommendations and program monitoring activities related to interoperability.

- **One Analyst II** position would be the primary contact between the division and its fee-for-service and dental managed care contractors, evaluating and monitoring compliance with interoperability requirements relating to the final rule.

**Information Technology Strategy Services Division** – Contract resources of \$371,000

- **Business Analyst and Project Manager Contract** - \$371,000 (\$43,000 General Fund and \$328,000 federal funds) in 2026-27 would support contractors responsible for managing all project activities, monitoring progress, submitting status reports, and ensuring timely accomplishment of milestones.

**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.

**4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)****Issue 1: Overview and Open Enrollment Update**

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

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

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

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

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

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

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.
- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94, 87 or 73 percent of medical expenses.
- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.
- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.



**Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange**

**Source:** Covered California website: "Coverage Levels/Metal Tiers"

<https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/>

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

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

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

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

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

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

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution

levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of \$405.6 million in 2021-22 to reflect savings in the state subsidy program resulting from the more generous federal premium subsidies. On August 16, 2022, President Biden signed the Inflation Reduction Act, which extended the ARP subsidies through the 2025 plan year.

**Health Care Affordability Reserve Fund.** The 2021 Budget Act included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of \$333.4 million, which is the revenue the Administration estimated the state would receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures. In 2023, the Legislature also approved trailer bill language to require all revenues collected from the individual mandate penalty to be annually deposited in the Health Care Affordability Reserve Fund to be used by Covered California to improve affordability in the health benefit exchange.. Previously, these revenues were transferred directly to the General Fund and used to balance the state budget.

**Congress Failed to Reauthorize Inflation Reduction Act Enhanced Subsidies.** The more generous subsidies provided to Covered California consumers through the federal American Rescue Plan and, later, the Inflation Reduction Act, were allowed to expire as scheduled at the end of 2025 by the United States Congress and the President. As a result, Covered California consumers have lost \$2.1 billion of federal subsidy support, causing out-of-pocket premium costs for certain Covered California consumers to soar, and making high-quality exchange coverage less affordable with more expensive cost-sharing. According to Covered California, weighted average rates prior to premium subsidies for the 2026 coverage year increased by 10.3 percent, partially due to the expected loss of coverage due to higher out-of-pocket costs, leading to a more unstable risk pool for health plans offering coverage in the exchange. For the consumer, the loss of the enhanced premium tax credits could lead as many as 1.7 million Covered California enrollees to see an additional average net premium increase of 66 percent.

**State Health Care Affordability Subsidies.** The 2023 Budget Act included expenditure authority from the Health Care Affordability Reserve Fund of \$82.5 million in 2023-24 and \$165 million annually thereafter to support a program of financial assistance for individuals purchasing coverage in the Covered California health benefit exchange. For the 2024 coverage year, these subsidies resulted in elimination of deductibles and reduction in copayments and other health care cost sharing for more than 600,000 Californians. These cost-sharing reductions were possible because of the enhanced premium tax credits provided under the Inflation Reduction Act. However, due to the lack of enhanced federal subsidies for the 2026 coverage year, these state subsidies will be used to provide premium support to low-income consumers in the exchange. The 2025 Budget Act increased these state subsidies to \$190 million annually to attempt to ameliorate the impact of the lost federal subsidies. According to Covered California, these subsidies will be used to ensure that individuals up to 150 percent of the federal poverty level (about \$48,000 annually for a family of four) maintain monthly premium levels comparable to those under the federal enhanced premium subsidies. However, these resources are only a fraction of the \$2.1 billion lost due to congressional failure to reauthorize the enhanced premium tax credits.

**2026 Open Enrollment Update.** The 2026 Open Enrollment period began on November 1<sup>st</sup>, 2025, and closed on January 31<sup>st</sup>, 2026, for the 2026 coverage year. The 2026 Open Enrollment was expected to be impacted by the failure of Congress to reauthorize the federal subsidies from the American Rescue Plan,

extended by the Inflation Reduction Act, resulting in significantly higher out-of-pocket costs for consumers.

However, according to Covered California, as of January 31<sup>st</sup>, 2026, over 1.9 million Californians enrolled in coverage through the Covered California health benefits exchange, including a record nearly 1.7 million Californians renewing coverage and more than 235,000 newly enrolled. Renewals are up compared to last year by approximately 3.6 percent, while new enrollment is down 32 percent. In addition, Covered California reports that for those consumers over 400 percent of the FPL who lost all enhanced premium tax credits, the cancellation rate among renewing enrollees doubled from 11 percent to 22 percent this year. Latino communities were most affected, with enrollment down 39 percent. Black or African American Californians also saw a 34 percent drop in new signups. There was also a significantly higher uptake in Bronze-level plans, with more than a third choosing Bronze-level plans in 2026 compared to less than one quarter in 2025.

**Gender Affirming Care Coverage Mandate.** In June 2025, the federal Centers for Medicare and Medicaid Services issued a final rule prohibiting the inclusion of “specified sex-trait modification procedures” as an essential health benefit for Affordable Care Act health benefit exchanges, including Covered California. The definitions included in the new rule would essentially remove gender affirming care from the essential health benefits included in Covered California plans beginning in the 2026 coverage year. However, because California law requires gender affirming care services be provided by health plans, for those plans offering gender affirming care coverage in the exchange pursuant to state law the state would be required to defray the costs of federal subsidies for that coverage.

The 2025 Budget Act included expenditure authority from the Health Care Affordability Reserve Fund of \$15 million annually to support continuation of gender affirming care services, consistent with California law, in the Covered California health benefit exchange. AB 144 (Committee on Budget), Chapter 105, Statutes of 2025, requires a qualified health plan in the exchange to provide coverage for state-mandated gender affirming care benefits and authorizes the Health Care Affordability Reserve Fund to support payments by Covered California to health plans to defray the cost of offering state-mandated gender-affirming care benefits in the exchange.

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

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

1. Please provide a brief overview of Covered California’s mission and programs.
2. Please provide an update on enrollment in Covered California during the most recent open enrollment period, including the impact of Congressional failure to reauthorize the enhanced premium subsidies included in the Inflation Reduction Act.
3. Please provide an update on the implementation of the Gender Affirming Care program, pursuant to AB 144.

4. Please provide the expected timeline of repayment of the loans from the Health Care Affordability Reserve Fund to the General Fund implemented during recent budget shortfalls.
5. Please provide an update on the status of federal consideration and approval of California's Essential Health Benefits benchmark plan, submitted pursuant to AB 224 (Bonta), Chapter 680, Statutes of 2025, and SB 62 (Menjivar), Chapter 739, Statutes of 2025.

**4260 DEPARTMENT OF HEALTH CARE SERVICES**  
**4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)**

**Issue 1: Employer-Based Health Coverage in California**

**Panel Discussion.** The subcommittee has requested the following panelists to discuss employer-based health coverage in California:

- **Miranda Dietz**  
Health Care Program Director  
UC Berkeley Labor Center
  
- **Jesús Barrios Fierro**  
Maintenance Cooperation Trust Fund
  
- **Diana Douglas**  
Director of Policy  
Health Access California

**Background.** Access to health care coverage is essential to the health and well-being of individuals and the society in which they live. Individuals without access to health care coverage are much less likely to report being in excellent or very good health, more likely to forgo needed care, receive fewer preventive services and are less likely to have regular care for chronic conditions such as hypertension and diabetes.<sup>4</sup> According to an analysis of 2023 National Health Interview Survey data by KFF, in the prior twelve months uninsured individuals were about three times less likely to have seen a doctor or other health professional, about four times more likely to have no usual source of care, between three and four times more likely to postpone care or go without needed care due to cost, and much more likely to delay filling or go without filling a needed prescription due to cost.<sup>5</sup>

**Barriers to Health Care Among Adults Ages 18-64 by Insurance Status, 2023**

	Uninsured	Medicaid/Other Public	Employer/Other Private
Did Not See Doctor/Health Care Professional	46.6%	14.2%	15.6%
No Usual Source of Care	42.8%	11.4%	11.2%
Postponed Seeking Care Due to Cost	24.7%	8.0%	6.2%
Went Without Needed Care Due to Cost	22.6%	7.7%	5.1%
Delayed Filling or Did Not Get Needed Prescription Due to Cost	14.0%	10.2%	5.9%

<sup>4</sup> Institute of Medicine Committee on the Consequences of Uninsurance. “Coverage Matters – Insurance and Health Care”. National Academy of Science. 2001.

<sup>5</sup> Tolbert, Jennifer, Bell, Clea, Cervantes, Sammy, Singh, Rakesh. “The Uninsured Population and Health Coverage”. KFF. October 8<sup>th</sup>, 2025.

Uninsurance has additional economic impacts, as well. Uninsured workers, particularly low-wage workers, experience more frequent missed work days leading to lower overall productivity in the workplace, and for the economy as a whole. Uninsured people often face unaffordable medical bills when they do seek care, with 62 percent of uninsured adults reporting having health care debt compared to 44 percent of insured adults.<sup>6</sup>

**Health Care in California – A Culture of Coverage.** Over the past two decades, California has demonstrated a commitment to ensuring access to quality, affordable health care coverage for all of its residents. In 2013, on the eve of implementation of the federal Patient Protection and Affordable Care Act (ACA), California had a non-elderly uninsured rate of 15.5 percent. In 2014, California implemented the two main coverage expansion options available under the ACA: 1) the expansion of Medi-Cal coverage to childless adults up to 138 percent of the federal poverty level; and 2) establishment of the Covered California health benefits exchange to provide high-quality, low-cost, subsidized coverage to Californians up to 400 percent of the federal poverty level. DHCS estimates that more than 4.6 million Californians will be covered by Medi-Cal due to the ACA expansion in 2026-27 and Covered California estimates nearly 2 million Californians have enrolled in coverage in the health benefit exchange.

Over the next several years, California began expanding Medi-Cal coverage to the population comprising the vast majority of the remaining uninsured: undocumented Californians. In 2016, California expanded Medi-Cal coverage to income-eligible children up to age 18 regardless of immigration status. Subsequently, the state expanded coverage for young adults up to age 26, seniors over age 50, and in January 2024, completed the expansion to cover all income-eligible Californians in Medi-Cal regardless of immigration status. Although there are additional new barriers to accessing care for undocumented Californians imposed by General Fund solutions implemented in the 2025 Budget Act and impacts of House Resolution 1 (H.R. 1), there are about 1.7 million undocumented Californians enrolled in the Medi-Cal program<sup>7</sup>. As a result of these expansions, California’s uninsured rate dropped to 5.9 percent in 2024, a historic low.<sup>8</sup> It is also important to note that California’s historically low uninsured rate is largely attributable to previously uninsured Californians receiving coverage through public benefit programs like Medi-Cal and Covered California.

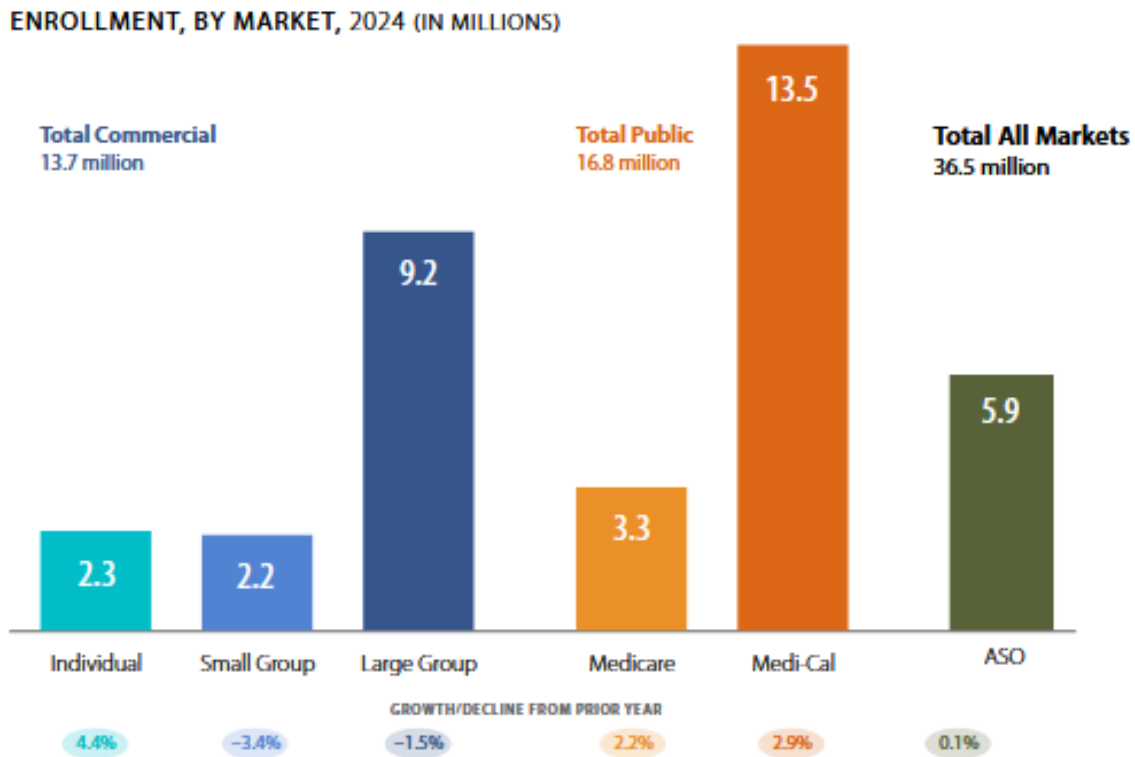
**Sources of Health Care Coverage for Californians.** Californians receive health care coverage in a variety of different ways that often depend on their employment status, income, employer, and region of the state. According to the California Health Care Foundation’s California Health Care Almanac, 13.7 million Californians receive healthcare coverage through the commercial market, with 2.3 million of those receiving coverage through the individual market, 2.2 million through small group coverage, and 9.2 million through large group coverage. 16.8 million Californians receive healthcare coverage through a public program, with 3.3 million receiving coverage through Medicare, and 13.5 million receiving coverage through Medi-Cal. An additional 5.9 million Californians receive coverage through an Administrative Services Only (ASO) coverage arrangement, which are employer self-funded plans for employees.

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<sup>6</sup> Tolbert, Jennifer, Cervantes, Sammy, Bell, Clea. “Key Facts about the Uninsured Population”. KFF. Dec 18, 2024.

<sup>7</sup> Hendren, Karina, Owens, Will, Constantouros, Jason. “Considering Medi-Cal in the Midst of a Changing Fiscal and Policy Landscape”. Legislative Analyst’s Office. October 24, 2025.

<sup>8</sup> Orbach-Mendel, Hannah and Ramos-Yamamoto, Adriana. “The State of Health Coverage in California: Progress, Disparities, and Policy Threats”. California Budget and Policy Center. October 2025.



**Responsibilities of Employers – The ACA Employer Mandate.** In addition to its coverage expansion provisions, the federal ACA implemented new responsibilities for certain employers for health care coverage for their employees. The ACA employer shared responsibility provisions, or employer mandate, requires that employers with over 50 full-time employees must either offer minimum essential coverage that is affordable and provides minimum value to their employees and dependents, or pay a penalty to the Internal Revenue Service (IRS). The penalty is equal to nearly \$3,000 per each full-time employee if the employer does not offer coverage to at least 95 percent of its full-time employees and dependents, or nearly \$4,500 per employee if the employee receives premium tax credits for purchasing coverage in a health benefit exchange like Covered California. According to the IRS, a full-time employee is an employee who works 30 hours per week or 130 hours per month.<sup>9</sup>

These features of the employer mandate allow employers to avoid offering health coverage to their employees, or paying the penalty, by remaining under 50 employees, or ensuring employees work less than 30 hours per week or 130 hours per month. Indeed, despite the implementation of the ACA employer mandate, the percentage of employers offering health benefits declined in California, dropping from 69 percent in 2000 to 64 percent in 2022. Firm size plays a role in the percentage of firms offering health benefits with nearly all firms with 200 or more employees offering health benefits to at least some of their workers.<sup>10</sup>

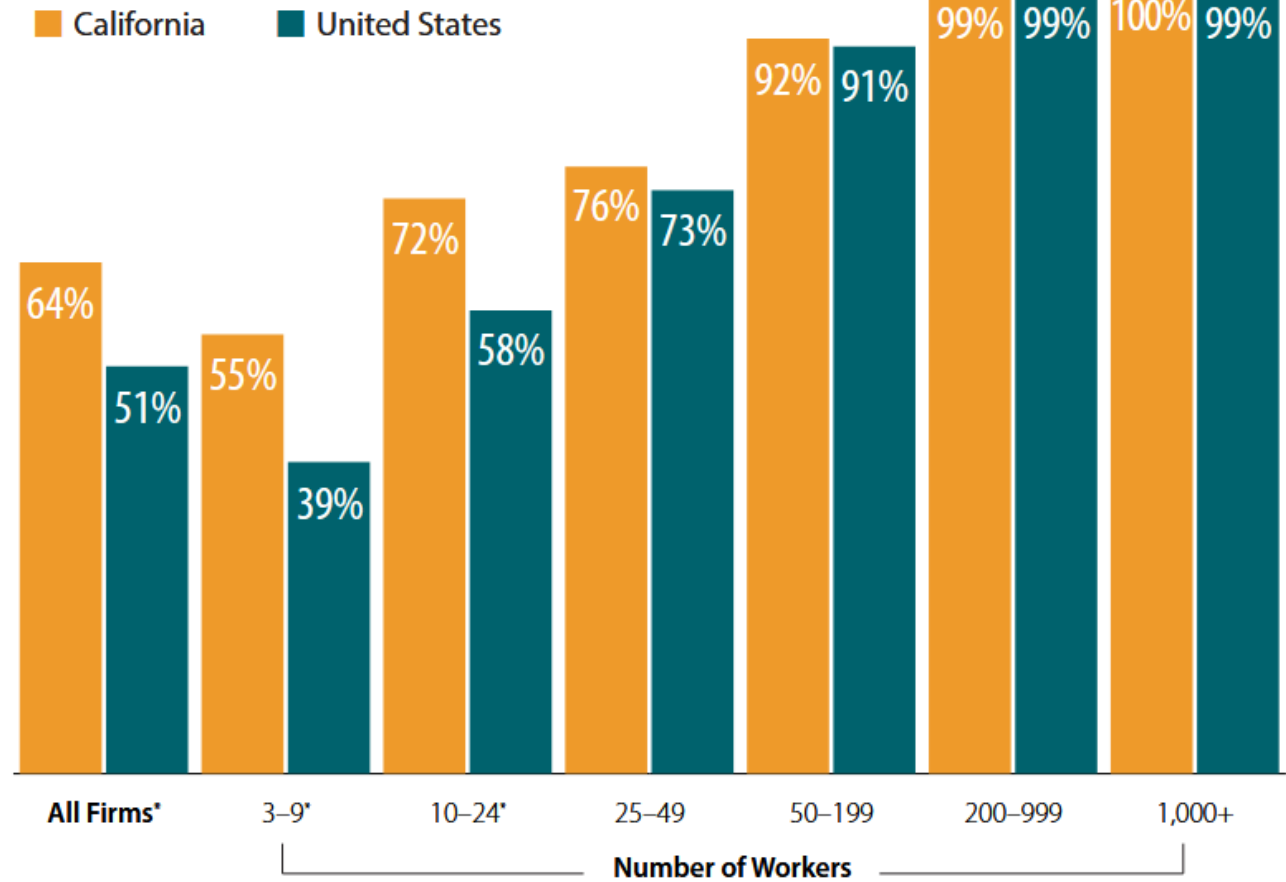
<sup>9</sup> Internal Revenue Service. “Employer shared responsibility provisions”. [www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions](http://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions). Accessed March 24, 2026.

<sup>10</sup> California Health Care Foundation. “California Employer Health Benefits Almanac 2023”. April 2023.

# Employers Offering Health Benefits, by Firm Size

## California vs. United States, 2022

PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS



Source: California Health Care Foundation. “California Employer Health Benefits Almanac 2023”

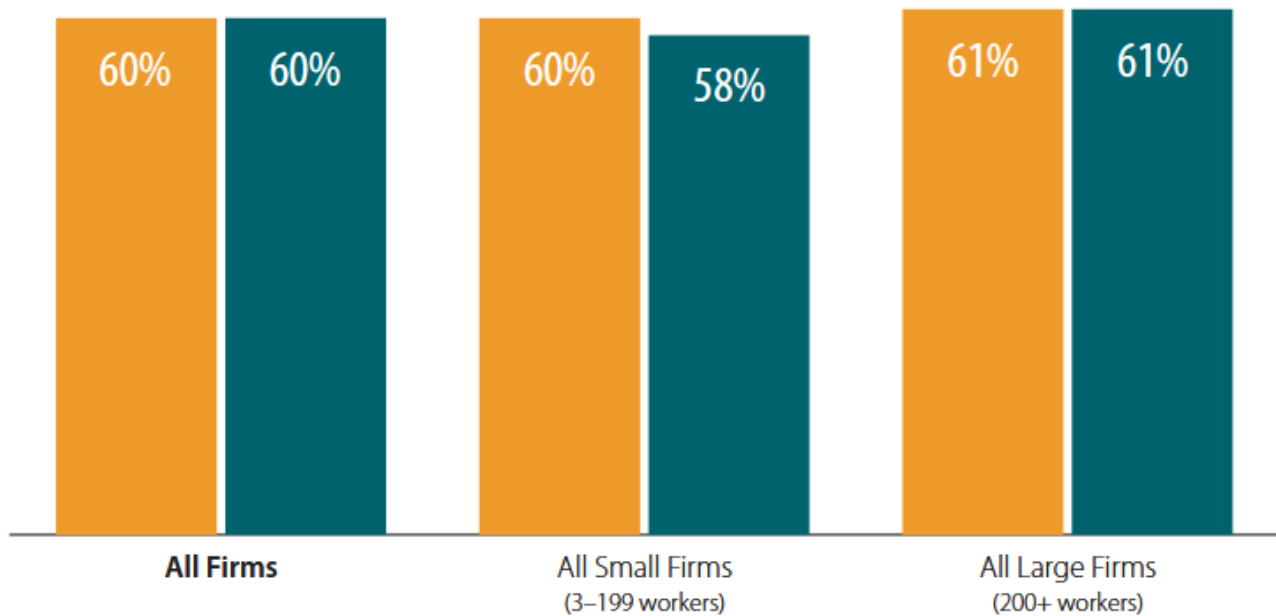
However, despite the large number of large firms offering health care coverage to some of their employees, only about 60 percent of workers were covered by their firm’s benefits. The remaining 40 percent that are not covered may either be ineligible, decline coverage, or are covered on another plan, such as a spouse’s plan or a public benefit program like Medi-Cal or Covered California.

# Worker Coverage Rates, by Firm Size

## California vs. United States, 2022

PERCENTAGE OF WORKERS COVERED AT FIRMS OFFERING HEALTH BENEFITS

■ California    ■ United States



Source: California Health Care Foundation. “California Employer Health Benefits Almanac 2023”

**Growth in Medi-Cal Caseload and Expenditures Over Time.** While employer coverage in California has declined, caseloads and expenditures in the Medi-Cal program have grown significantly. In 2012-13, on the eve of the expansion of Medi-Cal under the ACA, the Medi-Cal program estimated total expenditures (in 2026 dollars) of approximately \$71 billion (\$21.7 billion General Fund) with a caseload of about 7.7 million Californians. In the most recent Medi-Cal Local Assistance Estimate for 2026-27, DHCS estimates total expenditures of approximately \$222.4 billion (\$48.8 billion General Fund) with a caseload of 14 million. In the course of 14 years, Medi-Cal caseload has nearly doubled and total expenditures have more than tripled in real terms, with General Fund expenditures more than doubling. These increases in expenditures are largely due to the expansions of coverage under the ACA and to undocumented Californians, expansion of new benefits addressing issues such as behavioral health and social determinants of health, and increases in provider reimbursement rates through various tax mechanisms.

**H.R. 1 Work Requirements – Revisiting the Role of Employers in Health Care Coverage.** On July 4, 2025, President Donald Trump signed House Resolution 1 (H.R. 1), also known as the “One Big, Beautiful Bill Act”. H.R. 1, a budget reconciliation bill that allowed passage by a majority vote in both houses of Congress, was primarily a tax bill, making permanent the lower tax rates enacted in 2017 during the president’s first term, as well as other new tax reductions and changes, and providing hundreds of billions of dollars for border security, for Immigration and Customs Enforcement (ICE), and for defense, among other expenditures. To offset a portion of these significant tax reductions, H.R. 1 includes \$1.2 trillion in reduced expenditures for public benefit programs for health care and nutrition, including nearly \$1 trillion in reductions to Medicaid.<sup>11</sup> One of the significant changes in Medicaid included in H.R. 1 is the implementation of “community engagement” or work requirements for Affordable Care Act (ACA) expansion individuals to qualify for Medicaid coverage, effective December 31, 2026. According to DHCS, once fully implemented, more than 1.4 million of the 4.6 million Californians receiving Medi-Cal through the ACA expansion will lose coverage. Those losing coverage will either not be eligible due to non-compliance with the work requirements, or because they were unable to verify compliance due to documentation burdens. Indeed, the vast majority of adult Californians on Medi-Cal work, with 42 percent working full-time and 20 percent working part-time. About 38 percent are not working, but among that group 14 percent are caregivers, 9 percent are ill or disabled, and 6 percent are students.

The significant loss of coverage due to work requirements, in a population that is largely comprised of workers, raises new questions about what the proper linkage should be between employment and health insurance. As California’s public benefit programs like Medi-Cal and Covered California have grown to provide health care coverage to more than a third of Californians, the proportion of Californians receiving employer-based coverage has declined over time. Although California has made significant strides in reducing its uninsured rate, those coverage gains have come almost entirely from growth in caseload and expenditures in public programs, rather than in expansion of the number of workers receiving employer-based health care coverage.

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

Berkeley Labor Center:

1. Please provide a brief overview and recap of the employment status of Medi-Cal beneficiaries, including how many already work enough hours to meet H.R.1 requirements.
2. Please provide an overview of the landscape of employer-based coverage for low-wage workers in California, including employer size and types of industries.
3. What are the demographic groups in California most likely to be low-wage workers without an offer of employer-based coverage?
4. How are those low-wage workers without employer-based coverage distributed between small and large employers, either in California or nationally?

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<sup>11</sup> Tomsic, Trinity. *One Big Beautiful Bill Act: Medicaid Provisions*. Federal Funds Information for States, Budget Brief 25-12. July 17, 2025.

5. Is there overlap between the Californians most likely to not have an offer of employer-based coverage and eligibility for public programs like Medi-Cal and Covered California?

Impacted Worker:

1. Please describe your experience with employer-based health coverage.
2. How would a lack of employer-based health coverage impact your health status, and what alternative options would you have for health coverage?
3. In your experience, do employers typically provide any additional compensation to employees when they terminate their health coverage?
4. How does having health coverage contribute to your overall health status and ability to effectively do your job?
5. Do you believe employers have a responsibility to provide for their employees' health care needs?

Health Access California:

1. Please describe your perspective on the landscape of employer-based coverage in California.
2. How has the employer mandate imposed under the Affordable Care Act fallen short in its goal to ensure employers provide adequate health care coverage for their employees?
3. What are the ways that employers are able to avoid their responsibilities to provide health care coverage for their employees? In your view, how does this failure to provide coverage harm both employees' health status and employers' bottom line?
4. What policy reforms might the state consider to ensure the private sector is not shifting responsibility for the health care of its employees onto public benefit programs and, ultimately, California taxpayers?

**0000 PROPOSALS FOR INVESTMENT****Issue 1: Proposals for Investment**

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

- **Level of Care Nursing Staff for Programs for All-Inclusive Care for the Elderly.** CalPACE requests expenditure authority of \$700,000 (\$350,000 General Fund and \$350,000 federal funds) annually to support four additional level of care nursing staff at DHCS. According to the advocates, there are significant processing backlogs of level of care determinations and delays in enrollment for Programs for All-Inclusive Care for the Elderly (PACE) programs. Adding 4 additional nursing staff positions will help alleviate backlogs and delays in processing Level of Care determinations for PACE participant applicants, and support continued, responsible growth of PACE in California.
- **Community Paramedicine, Triage to Alternate Destination, and Mobile Integrated Health Programs Reimbursement in Medi-Cal.** The California Professional Firefighters request General Fund expenditure authority of \$1 million in 2026-27 to support state administration costs related to submitting a state plan amendment to add community paramedicine, triage to alternate destination, and mobile integrated health programs as reimbursable services in the Medi-Cal program. According to the advocates, SB 1180 (Ashby) 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 private health plans regulated by DMHC and DOI went into effect on July 1, 2025. The section that requires Medi-Cal to reimburse for these services is contingent upon a state appropriation to implement that section. This budget request will provide resources to DHCS to seek federal approval as required.
- **Delay Cuts to Prospective Payment System for UIS Population.** CPCA Advocates request General Fund expenditure authority of \$1 billion in 2026-27 to delay the cuts to the prospective payment system (PPS) for Medi-Cal beneficiaries with unsatisfactory immigration status (UIS). According to the advocates, PPS is not a supplemental benefit — it is a federally mandated, cost-based financing system designed to prevent state Medicaid programs from underpaying safety-net providers and to ensure the financial and operational sustainability of community health centers. By design, PPS protects access by aligning reimbursement with the true cost of delivering comprehensive primary care. Eliminating PPS for any population undermines this federal framework by shifting financial risk onto providers that are legally and operationally required to serve all patients.

Recent state budget actions would eliminate PPS reimbursement for state-only Medi-Cal populations, including individuals with Unsatisfactory Immigration Status (UIS). This would result in an estimated \$1 billion annual cut to community health center funding beginning July 2026 — a roughly 13% direct cut to FQHC/RHC Medi-Cal revenue. This policy threatens both patient access and the financial viability of clinics.

- **Increase Medi-Cal Rates for Emergency Physicians.** The California Chapter of the American College of Emergency Physicians (CalACEP) requests General Fund expenditure authority of \$100 million annually to support an increase in Medi-Cal reimbursement rates for emergency physicians.

According to CalACEP, the Legislature and Governor have prioritized increased Medi-Cal reimbursement for emergency physicians in the previous three adopted budgets given the unique and extraordinary challenges facing the safety net and the critical importance for all Californians. While approval for supplemental payments for 2025 are pending before CMS, and DHCS has given public notice for supplemental payments for Jan 1-June 30, 2026, the Governor's proposed budget does not include funding for 2026-27. This is precisely the time when federal cuts are expected to hit; access to emergency care will be dramatically impacted for all Californians without increased funding. The demand on EDs is already high and will continue to increase as a result of state and federal cuts and as millions of vulnerable Californians lose access to health insurance due to H.R.1. This is the last line of defense for all Californians with critical conditions and limited access to care. California must adopt a rate increase for emergency physicians so that they can adequately staff Eds. The funding listed in this proposal continues the funding that has been allocated for Emergency Medicine payments as a part of the MCO tax.

- **Increase Optometry Reimbursement Rates in Medi-Cal.** The California Optometric Association requests expenditure authority of \$30 million (\$15 million General Fund and \$15 million federal funds) annually to increase optometry reimbursement rates in the Medi-Cal program. According to the advocates, reimbursement rates are very low and have not been increased in more than 25 years. Reimbursement for a new patient eye exam is just 25 percent of what Medicare pays. It is very difficult in some counties to find a provider with rates this low. Recently, a new study shows that kids are not getting the care they need, and other studies have shown that increased reimbursements have been shown to increase access to care.
- **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 2026-27 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, 2027, to allow children with complex medical conditions to remain in their homes and out of the hospital. According to CAHSAH, 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.

According to an analysis by David Maxwell Jolly of California Health Policy Strategies, due to lagging Medi-Cal reimbursement rates, there are not enough nurses to care for the medically fragile children who are able to leave the hospital. Lack of in-home nursing drives up costs through:

- Discharge delays,
- Longer overall hospital stays while waiting for adequate in-home nursing coverage,
- Increased chances of readmission within 90 days, and
- Overall increased chances of hospital admissions for children who are being cared for at home but not receiving enough treatment due to lack of adequate nursing coverage.

Maxwell Jolly concludes that current inadequate spending levels for PDN care resulted in 25% fewer hours of in-home health care and a 5-fold (460 percent) increase in delayed hospital discharges and hospital readmissions. If Medi-Cal reimbursement rates were increased to levels that prevailed in 2020 (as reflected in the 40 percent request), the increased PDN cost would be \$314 million but would save at least \$490 million in unnecessary hospital costs, resulting in a net savings of \$175 million to the state.

- **Reinvestment in California's Public Hospital System.** The California Association of Public Hospitals and Health Systems (CAPH) requests General Fund expenditure authority of \$500 million annually to replace the non-federal share of Medi-Cal fee-for-service (FFS) payments for inpatient services currently financed by designated public hospitals. According to CAPH, public hospital systems are the only hospitals in California that are required to pay the full non-federal share for Medi-Cal FFS inpatient care. As core Medi-Cal providers, low base rates limit the ability of public hospital systems to meet the costs of care provided to patients. Low base rates require public hospital systems to turn to supplemental payment mechanisms, like state directed payments, to draw down additional federal funding and offset costs. As financial pressures mount, public hospital systems will require investments to alleviate cascading challenges caused by policy changes in both H.R. 1 and recent state policy changes.

California's public hospital systems estimate \$3.4 billion in annual losses due to H.R. 1. The Trump Administration continues seeking ways to cut Medicaid and supplemental payment mechanisms, such as state directed payments, disproportionately impacting the sustainability of public hospitals and health systems - who predominately serve the State's Medi-Cal population.

There is historical precedent for this request. As part of the 2021-22 Budget Act, the Legislature and Administration included a one-time General Fund appropriation of \$300 million to offset financial strain experienced by public hospital systems during the COVID-19 pandemic when the number of people hospitals greatly increased.

Public hospital systems are navigating significant cuts, which will impact access to services. State investment will reduce the damage of the cuts from H.R. 1, which would help preserve some access to services.