Senate Budget and Fiscal Review—John Laird, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 9th, 2026
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

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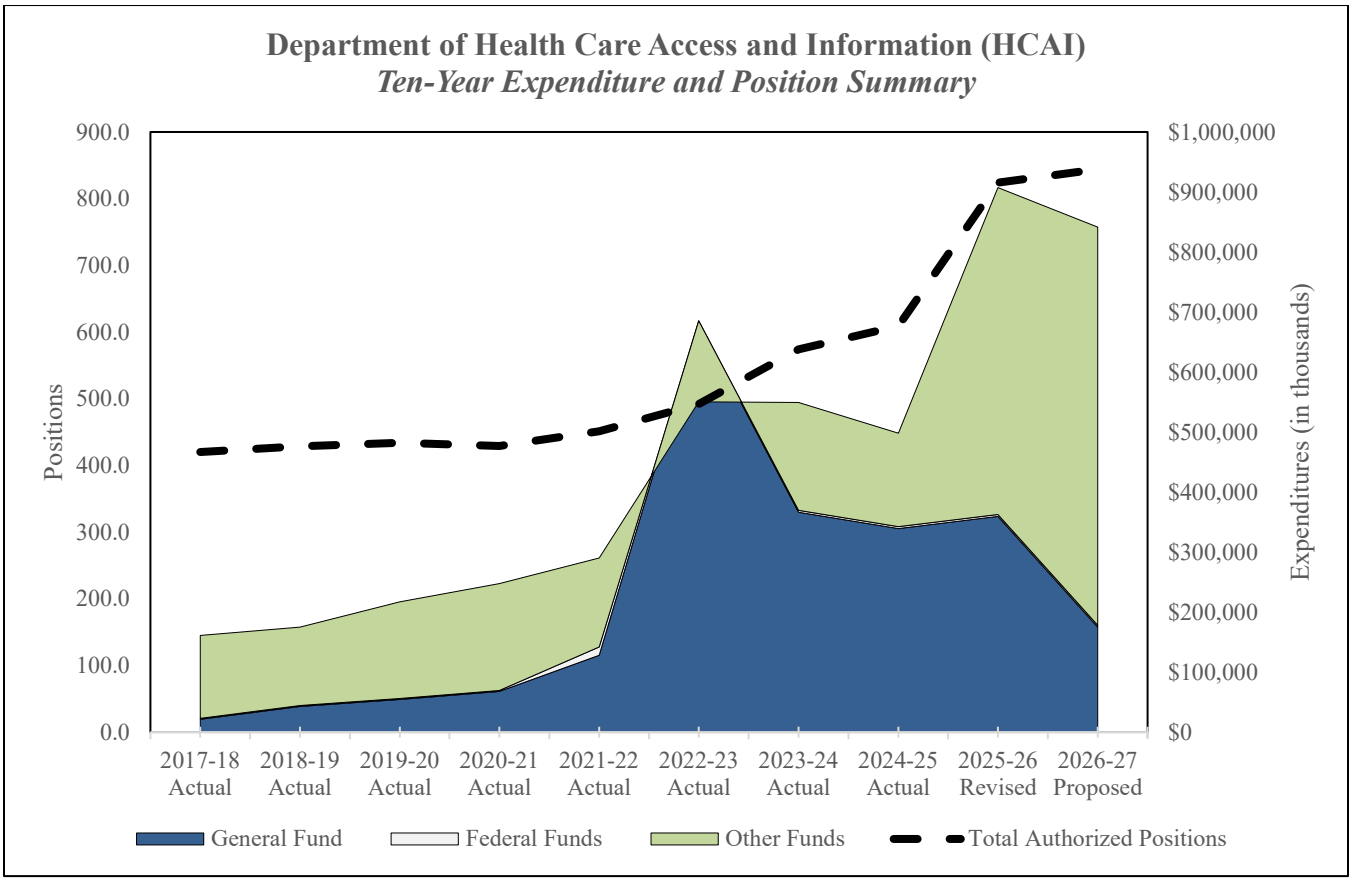
PUBLIC COMMENT

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

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 1: Overview



Department of Health Care Access and Information - *Department Funding Summary (dollars in thousands)*				
Fund Source	***2024-25 Actual***	***2025-26 Budget Act***	***2025-26 Revised***	***2026-27 Proposed***
General Fund	$338,960	$164,431	$359,572	$174,946
Federal Funds	$3,208	$2,894	$2,968	$3,272
Other Funds	$156,008	$455,392	$544,771	$663,039
Total Department Funding:	**$498,176**	**$622,717**	**$907,311**	**$841,257**
Total Authorized Positions:	**609.0**	**890.7**	**824.0**	**844.0**
Other Funds Detail:				
Hospital Building Fund (0121)	*$64,275*	*$79,484*	*$68,194*	*$67,935*
CA Health Data and Planning Fund (0143)	*$34,471*	*$47,758*	*$49,065*	*$43,937*
Registered Nurse Education Fund (0181)	*$2,030*	*$2,185*	*$2,165*	*$2,282*
Health Facility Const. Loan Ins. Fund (0518)	*$16,946*	*$0*	*($380)*	*($380)*
Health Professions Education Fund (0829)	*$9,171*	*$0*	*$0*	*$0*

Medically Underserved Account/Phys (8034)	*$1,879*	*$1,020*	*$1,015*	*$1,015*
Reimbursements (0995)	*$9,703*	*$111,776*	*$130,971*	*$228,226*
Mental Health Practitioner Ed. Fund (3064)	*$735*	*$762*	*$758*	*$996*
Vocational Nurse Education Fund (3068)	*$217*	*$235*	*$228*	*$233*
Behavioral Health Services Fund (3085)	*$7,351*	*$31,163*	*$31,635*	*$141,261*
Health Plan Improvement Trust Fund (3209)	*$0*	*$0*	*$0*	*$2,360*
Small and Rural Hosp Relief Fund (3391)	*$6,783*	*$0*	*$0*	*$0*
E-Cig Excise Tax Fund HPCOP (3394)	*$508*	*$0*	*$0*	*$0*
Opioid Settlements Fund (3397)	*$447*	*$0*	*$23,951*	*$0*
Distressed Hosp Loan Prog Fund (3432)	*$738*	*$0*	*$0*	*$0*
Health Care Payments Data Fund (3436)	*$0*	*$16,009*	*$16,162*	*$174*
Hlth Care Oversight/Accountability Fund (3443)	*$0*	*$165,000*	*$165,000*	*$165,000*
Abortion Access Fund (8143)	*$0*	*$0*	*$56,007*	*$10,000*
HCBS American Rescue Plan Fund (8507)	*$754*	*$0*	*$0*	*$0*

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

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

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act), which required hospitals to meet stringent construction standards to ensure they are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended

to transfer all hospital construction plan review responsibility from local governments to HCAI, creating the state's largest building department, the Facilities Development Division.

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

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

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

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

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

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

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

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

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

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

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

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

- BH-CONNECT Workforce Initiative – The BH-CONNECT Workforce Initiative will provide $1.9 billion over the BH-CONNECT Demonstration to address shortages in behavioral health practitioners

serving Medi-Cal and underserved populations. The components of the Workforce Initiative include: 1) the Medi-Cal Behavioral Health Student Loan Repayment Program, 2) the Medi-Cal Behavioral Health Scholarship Program, 3) the Medi-Cal Behavioral Health Recruitment and Retention Program, 4) the Medi-Cal Behavioral Health Community-Based Provider Training Program, and 5) the Medi-Cal Behavioral Health Residency Training Program.

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

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

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

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

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

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

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

and purchasers, and enforce cost targets. The first cost target will be developed for the 2025 calendar year, for reporting purposes only. The 2026 cost target will be the first in which enforcement action will be taken against providers that fail to meet the target. Enforcement actions will be progressive, beginning with technical assistance or corrective action plans, and could result in financial penalties.

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

- Biosimilar Insulin Initiative – CalRx has partnered with CivicaRx, a non-profit pharmaceutical company, to develop the most popular short- and long-acting types of insulin. The 2022 Budget Act included $50 million to support development of the insulin product and $50 million to establish an insulin manufacturing facility based in California. According to CivicaRx, the manufacturer suggested retail price for a 10mL vial of insulin will be no more than $30, and a five-pack of 3mL pens will be no more than $55. Californians and their health insurers commonly pay $300 per vial and $500 for a five-pack of pens in the current marketplace. On January 1, 2026, CalRx announced the availability of CalRx-branded insulin glargine pens, for $55 per five-pack of 3mL pens.

- Naloxone Access Initiative – CalRx has partnered with Amneal Pharmaceuticals to manufacture and distribute naloxone nasal spray $19 per twin-pack. The 2023 Budget Act included $30 million from the Opioid Settlements Fund to support this project. In April 2025, CalRx announced its naloxone is now available through a direct-to-consumer website.

- School Albuterol Access Initiative – In partnership with the CDPH Office of School Health, CalRx plans to launch a centralized ordering system to supply California schools with albuterol in halers and single-use disposable spacers at no cost over a three-year period beginning in Summer 2026.

In addition to these initiatives, the 2025 Budget Act reappropriated General Fund expenditure authority of up to $5.6 million to support CalRx partnerships for the manufacturing, procurement, and distribution of generic or brand name drugs to address emerging health concerns, including for reproductive health care. The Legislature also approved trailer bill language to authorize CalRx to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs, gender affirming care drugs, vaccines, medical supplies, and medical devices.

Subcommittee Staff Comment. This is an informational item.

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

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

2) Please provide an update on CalRx programs, including the Biosimilar Insulin Program, the Naloxone Access Initiative, the School Albuterol Access Initiative, and any other planned initiatives to improve access to health care for Californians.

3) Please provide an update on the Reproductive Health Care Grant Program and the Abortion Access Fund Grant Program, including number and amounts of grants awarded and remaining funding.

4) Please provide a brief update on the implementation and key milestones of the Office of Health Care Affordability, including how the office is considering ways to address the impacts of House Resolution 1 coverage losses on how the cost growth targets are implemented and enforced.

5) Please provide an update on hospital compliance with the Alquist Act to date and expected challenges as the state and its hospitals approach compliance deadlines.

Issue 2: Health Care Workforce Programs

Budget Change Proposal – Governor's Budget. HCAI requests annual federal fund expenditure authority of $353,000, and annual expenditure authority from the Mental Health Practitioner Fund of $931,000, from the Registered Nurse Education Fund of $1.6 million, and from the Vocational Nursing Education Fund of $142,000. If approved, these resources would continue to support the mental health practitioner and nursing workforce programs associated with these funds.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0890 – Federal Trust Fund	$353,000	$353,000
0181 – Registered Nurse Education Fund	$115,000	$115,000
3064 – Mental Health Practitioner Education Fund	$238,000	$238,000
3068 – Vocational Nurse Education Fund	$5,000	$5,000
Total Funding Request:	**$711,000**	**$711,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2027-28.

Background. HCAI administers a wide array of health care workforce programs that support the training and education of health professionals to ensure and improve the delivery of health care services in underserved areas of California with a culturally and linguistically diverse health workforce. These programs may offer scholarships or loan repayments to students or recent graduates, support expansion of degree programs at colleges and universities, provide stipends to professionals, or support residency or other post-professional health care workforce training programs. Participants in these programs often are required to commit to serving Californians in underserved areas, or to fill a particular workforce need in California. While a few of these programs receive direct support from the state's General Fund, most are supported by special funds, often the proceeds of professional licensing fee assessments that support workforce programs in those professional areas.

Licensed Mental Health Services Provider Education Program. AB 938 (Yee), Chapter 437, Statutes of 2003, established the Licensed Mental Health Service Provider Education Program at HCAI. The program, supported by a $10 surcharge on mental health professionals' licensing fees, supports loan repayment for licensed mental health service providers who provide direct patient care in a publicly funded facility or a mental health professional shortage area. Surcharge revenue is deposited into the Mental Health Practitioner Education Fund to support program costs.

Registered Nurse Education Program. SB 1267 (Maddy), Chapter 252, Statutes of 1988, established the Registered Nurse Education Program at HCAI. The program, supported by a $10 assessment collected at the time of biennial registered nurse licensure renewal, offers scholarships or loan repayments for licensed registered nurses or registered nursing students who commit to serving in county or state facilities with high nursing vacancy rates, health workforce shortage areas, or a California nursing school. Assessment revenue is deposited into the Registered Nurse Education Fund to support program costs.

Vocational Nurse Education Program. SB 358 (Figueroa), Chapter 640, Statutes of 2003, established the Vocational Nurse Education Program at HCAI. The program, supported by a $5 assessment on vocational

nurse license renewals, offers scholarships or loan repayments for vocational nursing students who commit to serving in county or state facilities with high nursing vacancy rates or health workforce shortage areas. Assessment revenue is deposited into the Vocational Nurse Education Fund to support program costs.

According to HCAI, each of these programs is supported by annual Budget Act appropriations from the funds that receive surcharge or assessment revenue associated with licensure renewals. HCAI reports that the revenue received by these funds typically exceeds the annual Budget Act appropriations, which restricts the available funding to support health care workforce awards in these programs. Over the prior three fiscal years, more than $1 million has been unspent annually across these three funds. This excess revenue is due to higher revenue collections than in prior years. HCAI requests additional budget authority to expend the available revenue on additional support for these workforce programs.

California Primary Care Office and Medicare Rural Hospital Flexibility Program. The California Primary Care Office (PCO) within HCAI is supported by the federal Health Resources and Services Administration (HRSA) and the Bureau of Health Workforce (BHW) to improve primary care service delivery and workforce availability to meet and improve the needs of underserved populations by supporting coordination of local, state, and federal resources. The PCO provides technical assistance to clinics and other primary care providers seeking recognition as a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area/Medically Underserved Population (MUA/MUP).

The Medicare Rural Hospital Flexibility Program (FLEX) is administered by the California State Office of Rural Health in partnership with HRSA to stabilize small and vulnerable rural hospitals, as well as improve hospital-based healthcare access for rural communities. The FLEX program grants support rural hospitals with technical assistance, quality assurance studies, network development, and statewide emergency network support systems. The FLEX program also assists rural hospitals to obtain designation as a Critical Access Hospital, which allows those hospitals to receive increased Medicare reimbursement and be certified under a different set of Medicare eligibility rules.

Both the PCO and FLEX program receive federal grants whose grant years are not aligned with the state's fiscal year. HRSA grants received by the PCO run from April 1 through March 31, while those received by the FLEX program run from September 1 through August 31. The annual awards often have additional one-time increases included, which exceeds the annual Budget Act appropriation and leads to deficits of more than $200,000 across both programs. HCAI is annually required to submit budget revisions to the Department of Finance under Section 28.00 of the annual Budget Act, who in turn notifies the Joint Legislative Budget Committee of the request for an increase in federal authority. HCAI is requesting additional federal funds authority for these programs in the 2026 Budget Act to attempt to avoid the need for submitting a budget revision request.

Resource Request. HCAI requests annual federal fund expenditure authority of $353,000, and annual expenditure authority from the Mental Health Practitioner Fund of $931,000, from the Registered Nurse Education Fund of $1.6 million, and from the Vocational Nursing Education Fund of $142,000 to continue support of the mental health practitioner and nursing workforce programs associated with these funds, and ensure federal expenditure authority to support the Primary Care Office and Medicare Rural Hospital Flexibility Program. Increasing Budget Act appropriations for these programs would allow full expenditure of available funds to support their respective missions.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Data Exchange Framework and Office of Patient Advocate Transfer

Budget Change Proposal – Governor's Budget. HCAI requests transfer of expenditure authority of $11.2 million ($8.8 million General Fund and $2.4 million Health Plan Improvement Trust Fund) annually. If approved, these transferred resources would support the transfer of administration of the Data Exchange Framework and the Office of Patient Advocate from CalHHS to HCAI.

HCAI also reports that it will propose trailer bill language in the May Revision to make statutory changes to eliminate duplicative mandates for the Office of Patient Advocate.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$8,800,000	$8,800,000
3209 – Health Plan Improvement Trust Fund	$2,360,000	$2,360,000
Total Funding Request:	**$11,160,000**	**$11,160,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2027-28.

Background – Data Exchange Framework. AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, established a process for CalHHS to develop a Data Exchange Framework (DxF) to integrate and exchange health and human services information to better address the needs of the whole person and address the social determinants of health. AB 133 required CalHHS to establish a stakeholder advisory group to advise on implementation and establish the framework including a single data use sharing agreement and common set of policies and procedures to govern exchange of health information. AB 133 also required most health care organizations to execute a DxF data sharing agreement by January 31, 2024, with all other providers to execute the agreement by January 31, 2026.

SB 660 (Menjivar), Chapter 325, Statutes of 2025, transferred from CalHHS to HCAI the responsibility for the establishment, implementation, and all of the functions related to the DxF, including the data sharing agreement, policies and procedures, and the stakeholder advisory group. SB 660 also added new requirements on providers for participation in the DxF, including using participation as a condition of contracting with Medi-Cal, Covered California, or the California Public Employees' Retirement System. The bill also requires HCAI to develop, in collaboration with the stakeholder advisory group, a report to the Legislature by July 1, 2027, including: 1) a list of entities deemed to be required signatories to the DxF and those entities' status; 2) the compliance pathways utilized to meet contractual requirements under the data use agreement; 3) an evaluation of the need for an independent governing board; 4) an evaluation of the need for technical assistance for providers; 5) an evaluation of other categories of entities for DxF participation; 6) an evaluation of the need for enforcement, investigation, and resolution of disputes between DxF participants; and 7) an assessment of consumer experiences with health and human services information exchange. As of November 30, 2025, there were 4,765 participants in the DxF, with ambulatory care settings representing the largest group at 2,079 or 43 percent.

Background – Office of Patient Advocate. The Office of Patient Advocate (OPA) within CDII rates health plans and medical groups using health performance measures based on quality of medical care and patient experience. OPA also provides information to help consumers compare health plans and medical

groups, track consumer complaints, and identify patient rights and health care resources. Specifically, OPA produces the following reports annually: 1) Health Care Quality Report Cards with clinical performance and patient experience data for the state's largest health plans and over 200 medical groups; 2) Complaint Data Reports and Baseline Review of State Consumer Assistance Call Centers with data findings based on health care consumer complaint data and call center information submitted to OPA from the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California; and 3) Model Protocols for State Consumer Assistance Call Centers with recommendations for responding to and referring calls outside of a call center's jurisdiction.

OPA was originally established as part of the Department of Managed Health Care (DMHC) to represent the interests of enrollees served by health care service plans regulated by the department. AB 922 (Monning), Chapter 522, Statutes of 2011, transferred the office to the California Health and Human Services Agency (CalHHS), and established the Office of Patient Advocate Trust Fund to provide ongoing funding for the office's activities. The fund receives, upon appropriation by the Legislature, transfers from the Insurance Fund and Managed Care Fund proportionate to the number of covered lives regulated by the California Department of Insurance (CDI) and DMHC, respectively. AB 922 also required OPA to operate a toll-free telephone line to act as a single point of entry for consumer assistance with their health benefits.

The 2014 Budget Act revised the role of OPA to remove its direct consumer assistance responsibilities and clarify its directive to track, analyze, and produce reports about problems, complaints, and questions received by other state departments from health care consumers. The Administration's rationale for elimination of OPA as a single point of entry was that existing consumer assistance programs were sufficient for consumers' needs. The OPA was instead tasked with creating a series of reports on complaint data received by four reporting entities: 1) DMHC, 2) CDI, 3) DHCS, and 4) Covered California. The goal of these reports is to collect and analyze data to identify trends and make recommendations to improve the consumer assistance protocols for these four reporting agencies.

In addition to its complaint reporting role, OPA produces Health Care Quality Report Cards. Each year, a random sample of members each health maintenance organization (HMO) and each preferred provider organization (PPO) is selected and their records are reviewed to determine if their medical care meets national standards for care and treatments proven to be effective. Information from health plans' records are collected and scored based on standards for quality of care set by the Healthcare Effectiveness Data and Information Set (HEDIS) performance measurement system to make sure that health plans are offering quality care and service to their members. OPA sorts 45 HEDIS quality care measures into nine health topics, like 'Heart Care' and 'Prenatal Care', which are used to rate health plans on how well the plan and its doctors make sure that members get the right care for each health condition or topic and that they do not receive unnecessary care or services. OPA also produces report cards for medical groups that serve the commercial market, as well as publicly funded programs such as Medicare.

The 2021 Budget Act included positions and resources to establish the Center for Data Insights and Innovation (CDII), and the Legislature approved trailer bill to consolidate several existing offices at CalHHS within CDII, including the Office of Patient Advocate.

Staffing and Resource Transfer. HCAI requests transfer of expenditure authority of $11.2 million ($8.8 million General Fund and $2.4 million Health Plan Improvement Trust Fund) annually to support the transfer of administration of the Data Exchange Framework and the Office of Patient Advocate from CalHHS to HCAI. According to HCAI, this transfer of resources implements the transfer of the DxF to HCAI required by SB 660 and transfers the Office of Patient Advocate as its functions more closely align with HCAI's mission to improve health care access, affordability, equity and quality. This proposal represents a budget neutral transfer of positions and resources from CalHHS to HCAI and includes the following:

Data Exchange Framework - $8.8 million (General Fund) and 12 positions

- **Two Career Executive Appointment B** positions are responsible for leading overall policy development, operations, and programmatic oversight at DxF.
- **One Attorney III** position serves as Assistant Chief Counsel for the DxF program, providing expert legal guidance on data sharing, privacy, statutory compliance, and regulatory issues.
- **One Staff Services Manager I** position supervises the DxF team and is responsible for workload management, staff performance, and timely implementation of legislative analysis, program activities, and administrative functions.
- **Two Staff Services Manager I Specialist** positions serve as program managers, serving as high-level leads and coordinating across offices to support integration of policy and operational goals.
- **Five Analyst II** positions provide analytical and programmatic support including legislative analysis, communications, stakeholder, engagement, program evaluations, and internal coordination.
- **One Office Technician** provides clerical support for the DxF leadership team.

Office of Patient Advocate - $2.4 million (Health Plan Improvement Trust Fund) and four positions

- **Two Staff Services Manager I Specialist** positions manage the office's public reporting initiative and coordinate program activities across multiple functional areas.
- **One Research Data Specialist II** position serves as the technical lead for the office's Health Care Quality Report Cards, responsible for planning, development, and implementation of methodological design work related to public reporting on health care quality, patient experience, and health equity.
- **One Analyst II** position provides analytical and programmatic support including internal coordination and administrative support.

Trailer Bill Language Proposal Pending. HCAI also reports that it will propose trailer bill language in the May Revision to make statutory changes to eliminate duplicative mandates for the Office of Patient Advocate. HCAI indicates the language would make some changes to current reporting responsibilities by the office, but a draft of language will not be released until after the May Revision.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Long-Term Care Rule Extension

Budget Change Proposal – Governor's Budget. HCAI requests three positions and expenditure authority from the California Health Data and Planning Fund of $597,000 annually. If approved, these positions and resources would support implementation of a new healthcare data reporting requirement related to the federal Long-Term Care Final Rule. This proposal is a joint proposal with DHCS to implement the Final Rule.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0143 – California Health Data and Planning Fund	$597,000	$597,000
Total Funding Request:	**$597,000**	**$597,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2027-28.

Background. In 2024 the federal Centers for Medicare and Medicaid Services (CMS) 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.

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.

HCAI is the single state agency designated to collect health facility data for use by all state agencies. HCAI collects cost data for skilled nursing facilities through its Long-Term Care Financial Reporting System. While the current data collection includes labor cost information, HCAI reports it does not contain most of the detail required to meet the new Medicaid Institutional Transparency Reporting requirements. These additional requirements will require an update of current data collection systems and align state regulations and guidance with new technical definitions and requirements under the Final Rule.

Staffing and Resource Request. HCAI requests three positions and expenditure authority from the California Health Data and Planning Fund to support implementation of a new healthcare data reporting requirement related to the federal Long-Term Care Final Rule. Specifically, HCAI requests the following positions:

- **One Health Program Audit Manager I** position would oversee the necessary work to implement and maintain the accounting, auditing, and public liaison functions for the additional data requirements.

- **One Health Program Auditor IV** position would work closely with DHCS to identify changes to data reporting to collect the necessary information, make modifications to accounting systems through promulgation of regulations, and develop desk audit procedures to verify completeness, correctness, reasonableness, and compliance with requirements.

- **One Health Program Auditor III** position would perform ongoing workload of desk auditing the additional required data to verify it is complete and complies with regulatory requirements, and would provide technical support to skilled nursing facilities on how to properly account for and report the additional required information.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Employee Healthcare Coverage Reporting (AB 1418)

Budget Change Proposal – Governor's Budget. HCAI requests one position and expenditure authority from the California Health Data and Planning Fund of $178,000 annually. If approved, this position and resources would support implementation of new reporting requirements for health care workers' coverage waiting periods, pursuant to the requirements of AB 1418 (Schiavo), Chapter 398, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0143 – California Health Data and Planning Fund	$178,000	$178,000
Total Funding Request:	**$178,000**	**$178,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2027-28.

Background. AB 1418 (Schiavo), Chapter 398, Statutes of 2025, requires HCAI to annually collect and publicly report on detailed data on employer-sponsored health care coverage waiting periods from health facilities including clinics, hospitals, long-term care facilities, and home health agencies and hospices. HCAI is the primary state repository for healthcare data in California, collecting and publishing data from over 10,000 licensed health care facilities. HCAI reports that, although it is permitted by AB 1418 to integrate its new reporting requirements into existing reporting, the department currently lacks the resources necessary to implement the programmatic and technological reporting requirements of the bill.

Staffing and Resource Request. HCAI requests one position and expenditure authority from the California Health Data and Planning Fund of $178,000 annually to support implementation of new reporting requirements for health care workers' coverage waiting periods, pursuant to the requirements of AB 1418 (Schiavo), Chapter 398, Statutes of 2025. Specifically, HCAI requests the following position:

- **One Health Program Audit Manager I** position would oversee the necessary work to implement and maintain the accounting, auditing, and public liaison functions for the additional data requirements.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Behavioral Health Services Act Workforce Allocation and General Fund Offset

Local Assistance – Governor's Budget. Proposition 1 (2024), the Behavioral Health Services Act, allocates approximately $100 million annually to HCAI to support a behavioral health workforce initiative beginning July 1, 2026. The Governor's January budget estimates $110.1 million is available for this purpose. The Governor's January budget also includes a $100 million offset to the General Fund as a placeholder for utilizing the Proposition 1 allocation for the behavioral health workforce initiative to support existing workforce programs. The Administration has not released details of this proposed offset.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0001 – General Fund	($100,000,000)	$-
3085 – Behavioral Health Services Fund	$110,136,000	$110,136,000
Total Funding Request:	**$10,136,000**	**$110,136,000**

Background. SB 326 (Eggman), Chapter 790, Statutes of 2023, and Proposition 1, approved by the voters in March 2024, authorized significant reforms to the state's behavioral health programs over the next few years. Known as the Behavioral Health Services Act (BHSA), these reforms will have substantial impacts on the fiscal structure and programmatic operations of behavioral health programs administered by the county behavioral health departments, the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Health Care Access and Information (HCAI),and the Commission on Behavioral Health (CBH). The BHSA sets aside 10 percent of total revenue for the programs administered by state departments, including three percent, or approximately $100 million annually, for HCAI to implement a behavioral health workforce initiative. The initiative must be developed in consultation with stakeholders and focus on: 1) efforts to build and support the workforce to meet the need to provide holistic and quality services; 2) support the development and implementation of strategies for training, supporting, and retaining the county and non-county behavioral health workforce; 3) increase the racial, ethnic, and linguistic diversity of behavioral health providers; and 4) increase access to behavioral health providers in geographically underserved areas. Additionally, the initiative must offer technical assistance to county providers to strengthen their infrastructure to recruit and retain the workforce, and to support utilization of peer support specialists within the behavioral health system.

According to HCAI, the department will use its five-year workforce education and training (WET) planning process as a vehicle to implement the behavioral health workforce initiative under the BHSA. While the planning process is underway, HCAI expects the 2026-2030 Five-Year WET Plan to be published in Spring 2026. Components of the BHSA workforce initiative may include expansions or changes to curricula in behavioral health training programs, maximizing the use of non-licensed professionals, and providing technical assistance for maximizing utilization of non-licensees. In addition, the initiative would support a gap analysis to determine shortage areas in need of intervention by state workforce programs.

$150 Million General Fund Offset Included in January Budget. The Governor's January budget included a placeholder for a one-time $150 million General Fund offset using BHSA funds to support programs currently supported by General Fund resources. $100 million is expected to offset programs at HCAI under the behavioral health workforce initiative, while $50 million is expected to offset programs

at the Department of Public Health (CDPH) under the BHSA-funded population-based behavioral health initiative. Neither the January budget nor the Administration has provided any additional detail on the programs that would be supported by BHSA funds rather than the General Fund.

HCAI reports that the planning underway for the BHSA workforce initiative is subject to resolution of the proposed $100 million General Fund offset in the Governor's January budget. If the offset is approved as budgeted, HCAI would have to re-evaluate the availability of resources in 2026-27 for the initiative. However, absent an additional offset proposed in the Governor's January budget in 2027, the full level of resources would be available for the planned initiative components beginning in 2027-28.

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

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

1. Please provide a brief overview of planning for the BHSA behavioral health workforce initiative at HCAI.

2. How would the approval of the $100 million General Fund offset of BHSA funds impact the implementation of the behavioral health workforce initiative?

3. What existing programs at HCAI supported by General Fund are eligible uses of BHSA funds for purposes of the offset?

Issue 7: Rural Health Transformation Program

Local Assistance – Governor's Budget. House Resolution 1 included $50 billion over five years for states to support access to care, workforce development, and innovation in care and technology for rural and frontier communities. California was awarded $233.6 million in the first year of the program cycle. HCAI, which will administer the program and funding, will implement three main initiatives: 1) The Rural Health Transformative Care Model Initiative, 2) the Rural Health Workforce Development Initiative, and 3) the Rural Health Technology and Tools Initiative.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0890 – Federal Trust Fund	$233,639,308	$-
Total Funding Request:	**$223,639,308**	**$-**

* Future funds subject to federal approval.

Background. House Resolution 1 (HR 1), in an attempt to mitigate the significant adverse impacts of the major Medicaid coverage losses expected from the imposition of work requirements and other provisions, implemented a $50 billion Rural Health Transformation Project (RHTP) to support access to care, workforce development, and innovation in care and technology for rural and frontier communities. In December 2025, the federal Centers for Medicare and Medicaid Services announced California had been awarded $233.6 million for the first year of the project. California's approved application for the RHTP three primary initiatives: 1) Transformative Care Model; 2) Workforce Development; and 3) Technology and Tools. HCAI's allocation of funding to each of these initiatives, as well as to administration, is as follows:

1) Transformative Care Model - $112.2 million
2) Workforce Development - $62.4 million
3) Technology and Tools - $35.7 million
4) Administrative Costs - $23.4 million

Transformative Care Model. The Transformative Care Model initiative aims to create regional hub and spoke networks anchored by hospital hubs and spokes that include critical access hospitals, clinics, birthing centers, and other providers. The initiative would include targeted transformation payments to support rural hospitals' capacity to transform their systems to support regional delivery of care, complete a telehealth gap assessment for each hub and spoke, and use accelerator partners to incubate workforce, technology and payment solutions. This initiative includes the following components:

Transformative Payments to Support Strategically Located Hospitals. $35 million will be made available through grants for approximately 16 hospitals with financial and operational challenges that are strategically important to retain in effective operations for targeted rural regional access. In the first year, hospitals will conduct root-cause analyses of financial instability. In years two through five, hospitals will implement targeted reforms including modernizing billing, adopting sustainable staffing models, participating in hub and spoke models to reduce rural bypass, and strengthening community partnerships. Thes funds may not replace payment for billable services or supplant existing adequate sources of hospital funding.

Establish Regional Hub and Spoke Networks. $39 million will be made available through annual grant funding for participating hospitals, clinics, and affiliated rural providers to directly implement the Transformative Care Model within their regional hub and spoke networks. Each facility will operationalize evidence-based care delivery, workforce, and technology changes identified through regional planning and gap assessments. Hubs and spokes will focus on redesigning internal care flows, integrating telehealth and interoperable electronic health records (EHR) systems, establishing transfer and referral pathways, and expanding service lines such as maternity, chronic disease, and specialty care. Grant funds will also support workforce expansion and training essential to sustaining new care models in rural settings. In the first year, the program will launch select "Accelerator Partners", which are hospitals or other organizations in rural regions that demonstrate readiness and commitment to implement the Transformative Care Model through a hub and spoke network. These partners will serve as testing sites for new innovations and models. Accelerator regions will receive $6 to $8 million annually to support hospitals, clinics, Tribal health programs, and affiliated providers in implementing evidence-based care models, building workforce capacity, expanding telehealth, and advancing interoperability. Lessons learned from these partners will inform future statewide scaling of the initiative.

Expand Rural Health Train-the-Trainer. $2 million will be used to launch "train-the-trainer" programs for physicians, nurse practitioners, nurses, and allied staff to build competencies in maternal health, chronic disease management, behavioral health, and telehealth delivery.

Expand and Support Rural Workforce Capacity. $11.5 million will support clinician upskilling programs, family medicine obstetric fellowships, and Project ECHO and OB Nest programs for specialty and prenatal care. This component would include offering obstetric training fellowship opportunities to family medicine physicians and advanced practitioners to train in obstetric care and leverage entry-level and allied roles to build skills aligning with system priorities like telehealth and remote monitoring.

Hub and Spoke Implementation and Change Management Support. $12.5 million will support a contractor who will provide specialized consulting and technical assistance services to help rural hospitals and healthcare providers successfully design, implement, and sustain regional hub and spoke networks.

Rural Health Workforce Development Initiative. The Rural Health Workforce Development Initiative will build a statewide workforce mapping and planning tool to identify regional, county, and sub-county workforce needs; strengthen education pathways from high school to community colleges and four year universities with wrap around supports; expand regional upskilling through Train-the-Trainer programs in maternal health, chronic disease, behavioral health, and telehealth; and grow non-physician roles such as community health workers, nurses, doulas, and midwives. The program will also fund pipeline and pathway programs, the expansion of clinical placement and supervision sites, and include retention and relocation incentive payments. This initiative includes the following components:

Career Pathways Grants. $7 million will provide funding to rural region high schools, community colleges, and California State University campuses to connect local students to health professions through career education and counseling, mentorships, internships, and fellowships. In the first year, $5 million will support up to 20 participating schools.

Rural Clinical Placement Support and Training Pathway. $6.4 million will support development of a clinical placement network to connect health profession students with rural facilities, including tribal

clinics. These funds will also support expansion of regional training capacity in rural areas including clinical rotations and practicum opportunities for health professionals.

Expand Rural Provider Retention and Relocation. $54.2 million will support regional collaborations of rural facilities to ensure coordination of services across the community and sharing of funds between organizations. Funding will support retention and relocation bonuses for provider who commit to a five year service obligation. HCAI reports it will likely expand existing programs with these funds, but target them specifically to rural regions to help ensure pipelines of new, qualified resources are prepared to complement the Transformative Care Model. In addition to relocation and retention bonuses, these programs will also include funding for onboarding, precepting, temporary housing, and supervision of students.

Workforce Mapping Tool Expansion. $6 million will support development of a dynamic data platform to map existing rural and frontier workforce supply, identify demand trends, and pinpoint regional capacity gaps across licensed professionals, support staff, and allied health roles.

Rural Health Technology and Tools Initiative. The Rural Health Technology and Tools Initiative will modernize infrastructure and connectivity, including EHR enhancements, health information exchange, and cybersecurity; operate a technical assistance center that provides implementation support, training and certification, and capabilities assessment; expand collaboration through shared purchases and services; and deploy patient centered tools, such as remote patient monitoring, that integrate person generated data into clinical workflows. This initiative includes the following components:

EHR Modernization Grants. $11.7 million will provide funding to upgrade, enhance, and extend needed infrastructure technology, including EHR systems, with a focus on rural, frontier, and tribal health facilities that are currently unable to effectively exchange patient data with other providers.

Rural Technical Assistance Center Contractor. $23.6 million will support development of a Rural Technical Assistance Center (RTAC), that will provide expert advice and hand-on, on-site support to grantees. The RTAC will support improved access to technology and tools, including connectivity and health information exchange, telehealth, remote patient monitoring, and e-consult and cybersecurity fortification.

Administrative Contractor Costs. The RHTP will also allocate $6.9 million to support a third party administrator for grants related to rural health technology and tools improvement, and hub and spoke implementations.

According to HCAI, the program will release a Request for Application (RFA) to provide an online portal for hospitals, clinics, tribal entities, and other providers to apply for grant funding. HCAI expects to release the RFA in spring 2026.

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

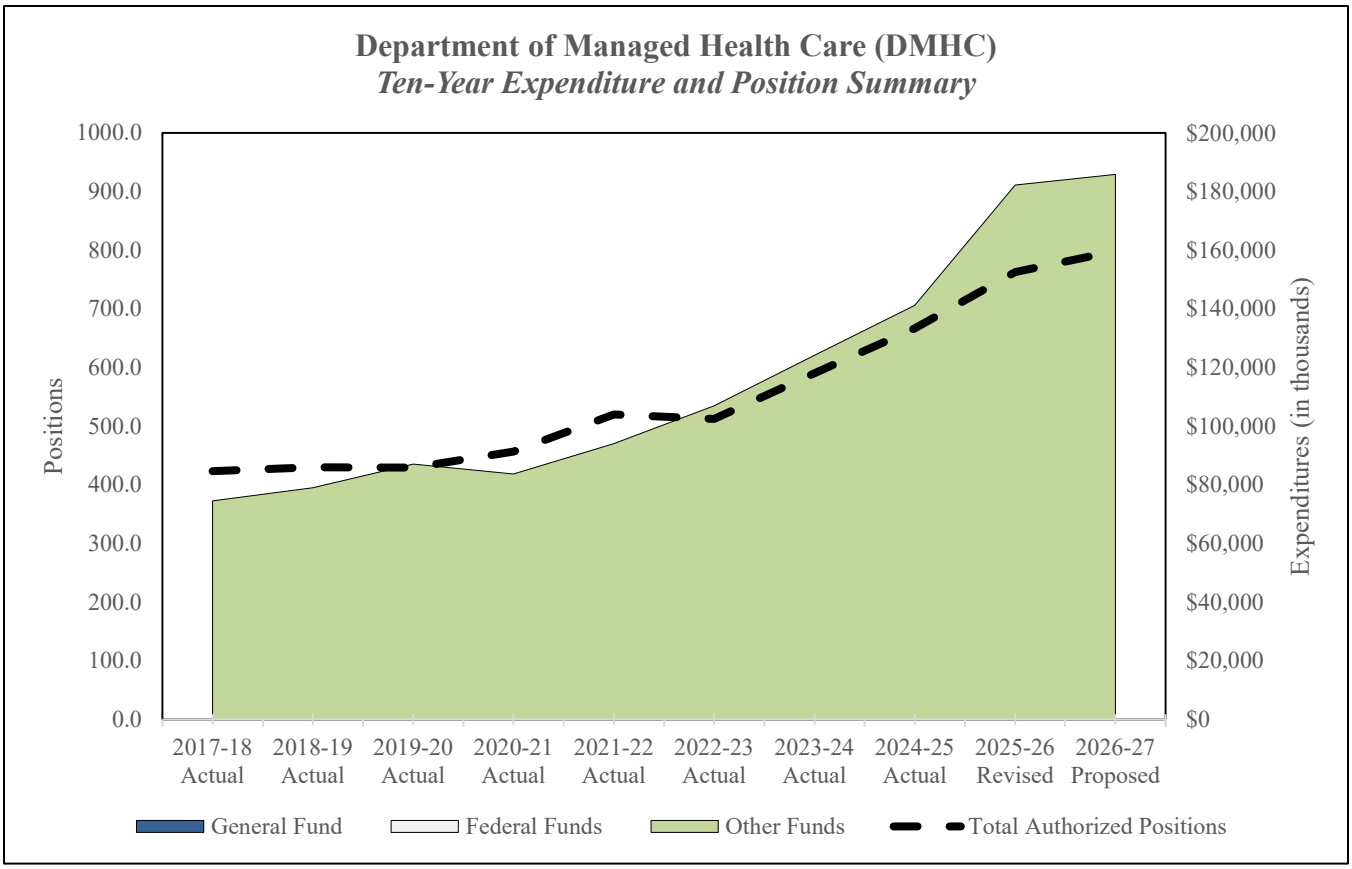
Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of the current, revised plan for implementation of the Rural Health Transformation Project, including changes required by the federal government, and HCAI's response.

2. What is the timeline for application to the various grant programs approved as part of the project, and what entities are eligible to apply for funding?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 8: Overview



Department of Managed Health Care - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2024-25 Actual**	***2025-26 Budget Act***	***2025-26 Revised***	***2026-27 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$141,161	$180,261	$182,259	$185,859
Total Department Funding:	**$141,161**	**$180,261**	**$182,259**	**$185,859**
Total Authorized Positions:	**667.0**	**814.0**	**763.0**	**798.5**
Other Funds Detail:				
Managed Care Fund (0933)	$141,161	$177,982	$179,967	$184,102
Pharmacy Benefit Manager Fund (3447)	$0	$2,279	$2,292	$1,757

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 140 health care service plans, which provide health, mental health, dental, vision, and pharmacy services

to more than 30.2 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

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

DMHC is composed of the following offices and other units:

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 9: Implementation of Chaptered Legislation (SB 41, SB 306, AB 1041)

SB 41 (Wiener) – Pharmacy Benefit Managers

Legislative Budget Change Proposal – Governor's Budget. DMHC requests seven positions and expenditure authority from the Pharmacy Benefit Manager Fund of $1.7 million in 2026-27, nine positions and expenditure authority of $2.2 million in 2027-28, and $2.2 million annually thereafter. If approved, these positions and resources would support implementation of additional requirements on pharmacy benefit managers established pursuant to SB 41 (Wiener), Chapter 605, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3447 – Pharmacy Benefit Manager Fund	$1,721,000	$2,169,000
Total Funding Request:	**$1,721,000**	**$2,169,000**
Total Requested Positions:	**7.0**	**9.0**

* Additional fiscal year resources requested – 2028-29 and ongoing: $2,160,000.

Background. AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, requires pharmacy benefit managers (PBMs) to be licensed and regulated by DMHC, beginning January 1, 2027. The bill required any health plan contracting with a PBM to ensure it is licensed by DMHC and complies with regulatory requirements and established an enforcement process for DMHC to ensure compliance. The bill also authorized the establishment of an annual fee, deposited in the newly created Pharmacy Benefit Manager Fund, to support the department's regulatory activities for PBMs.

SB 41 (Wiener), Chapter 605, Statutes of 2025, builds on the PBM licensure program established by AB 116 by implementing the following requirements:

- Prohibits a PBM from deriving any income for its services to a payer except a PBM management fee.
- Requires PBMs to use a "passthrough pricing model", which requires the PBM to direct 100 percent of manufacturer rebates to the contracted payer.
- Allows performance bonuses to be paid to the PBM based on savings that result in lower premiums
- Prohibits certain "claw back income that PBMs receive from pharmacies
- Prohibits the use of spread pricing.
- Prohibits exclusivity contracts between PBMs and manufacturers, unless the PBM can demonstrate the extent to which the exclusivity results in the lowest cost to the plan and lowest cost sharing to the enrollee
- Allows DMHC to inspect PBM compensation arrangements.

According to DMHC, SB 41 requires the department to:

- Issue guidance regarding the implementation of, and compliance with, the requirements of SB 41. This guidance is not subject to the Administrative Procedures Act (APA) until January 1, 2030.
- Consult with stakeholders in developing guidance.
- Conduct detailed legal research of health plan and PBM documents to verify compliance with SB 41.
- Design and draft All Plan Letters (APL) and filing review checklists.

- Address an increased number of provider complaints against PBMs following the passage of SB 41.
- Revise the reporting template to allow the additional rate data.
- Compile and analyze new PBM data.
- Prepare an annual report
- Update survey methodologies and tools for use in routine triennial survey and non-routine survey processes to assess compliance with the requirements of SB 41.

Staffing and Resource Request. DMHC requests seven positions and expenditure authority from the Pharmacy Benefit Manager Fund of $1.7 million in 2026-27, nine positions and expenditure authority of $2.2 million in 2027-28, and $2.2 million annually thereafter to support implementation of additional requirements on pharmacy benefit managers established pursuant to SB 41 (Wiener), Chapter 605, Statutes of 2025. Specifically, DMHC requests the following positions and resources:

Help Center – One position

- **One Associate Governmental Program Analyst (AGPA)** would conduct the initial review of the provider complaints related to PBMs and review application documents.

Office of Plan Licensing – Three positions

- **One Attorney IV** position would conduct highly complex and in-depth legal analysis of health plan and PBM filings, including review of evidence of coverage, disclosure forms, provider and enrollee notices, plan to plan agreements, policies and procedures, and provider contracts for compliance with SB 41.

- **One Staff Services Manger I** would oversee and direct the administrative team and lead enhancements to databases to support the new PBM requirements.

- **One AGPA** would support the development and implementation of compliance measures and provide ongoing analytical review of PBM filings, contracts, policies and procedures, evidence of coverage, and disclosure forms.

Office of Financial Review – Consultant costs of $57,000 in 2026-27, $24,000 annually thereafter

- Consultant costs of $57,000 in 2026-27 and $24,000 annually thereafter would support the revisions to the reporting template used to capture additional rate data and in the annual data compilation and report preparation.

Office of Plan Monitoring – One position in 2026-27, three positions annually thereafter; consultant costs of $44,000 in 2026-27, $51,000 in 2027-28, and $46,000 annually thereafter

- **Two Attorney III** positions (one in 2026-27 and two annually thereafter) would support implementation activities, work groups, and other forums involved in the development of implementation regulations throughout 2026-27 and 2027-27.

- **One Health Program Specialist II** position (beginning 2027-28) would provide analysis and administrative support for survey activities, including preparation of reports and supporting documentation.

- Consultant funding of $30,000 in 2026-27 and $21,000 annually thereafter would support statistical consultation and assistance with health plan survey methodologies and tools.

- Consultant funding of $14,000 in 2026-27, $30,000 in 2027-28, and $46,000 annually thereafter would support clinical and pharmaceutical consultants to support health plan compliance and PBM oversight by revising survey tools, assisting with data and file selection and conducting clinical file reviews.

Office of Enforcement – Two positions

- **One Attorney III** position would provide legal support to investigate referral cases, including the preparation of investigative discoveries, evaluating response, and providing oversight of the investigation and course of resolution.

- **One Attorney** would provide legal support to investigate referral cases, including the preparation and oversight of the investigation and course of resolution.

- Legal software licensing costs of $4,000 annually would support the enforcement positions. According to DMHC, these expenditures would be absorbed within the department's existing budget.

Office of Technology and Innovation – Software licensing costs of $42,000 in 2026-27, $48,000 annually thereafter

- Software licensing costs of $42,000 in 2026-27 and $48,000 annually thereafter would support annual software licensing costs for the new employees included in this proposal.

Office of Administrative Services – Legal education costs of $8,000 in 2026-27, $10,000 annually thereafter

- Legal education costs of $8,000 in 2026-27 and $10,000 annually thereafter would support annual legal education software licensing for the new legal positions included in this proposal.

SB 306 (Becker) – Prior authorizations

Legislative Budget Change Proposal – Governor's Budget. DMHC requests four positions and expenditure authority from the Managed Care Fund of $1.4 million in 2026-27, eight positions and expenditure authority of $1.6 million in 2027-28, and $1.8 million annually thereafter. If approved, these positions and resources would support implementation of new data collection efforts regarding health plan prior authorizations, pursuant to the requirements of SB 306 (Becker), Chapter 408, Statutes of 2025.

Multi-Year Funding Request Summary

Fund Source	2026-27	2027-28*
0933 – Managed Care Fund	$1,449,000	$1,562,000
Total Funding Request:	**$1,449,000**	**$1,562,000**
Total Requested Positions:	**4.0**	**8.0**

* Additional fiscal year resources requested – 2028-29 and ongoing: $1,809,000.

Background. SB 306 (Becker), Chapter 408, Statutes of 2025, requires health plans and health insurers to submit data to DMHC and the California Department of Insurance (CDI) on prior authorization practices, including the types of health care services subject to prior authorization requirements, approval and modification rates, and related prior authorization information. The bill requires DMHC and CDI to develop and publish a list of health care services that will be exempt from prior authorization requirements by July 1, 2027, which health plans must subsequently implement. The bill also requires a report on the impact of these exemptions after four years.

According to DMHC, implementation of SB 306 would require the department to do the following:

- Promulgate and amend applicable regulations to clarify the requirements of SB 306.
- Review health plan contracts, policies and procedures, evidence of coverage and disclosure forms for compliance with the requirements set forth in SB 306.
- Address consumer complaints related to prior authorization.
- Collect, review and analyze prior authorization data for compliance and reporting purposes.
- Publish a list of health care services exempt from prior authorization requirements.
- Issue a public report on the impact of the prior authorization exemptions.

Staffing and Resource Request. DMHC requests four positions and expenditure authority from the Managed Care Fund of $1.4 million in 2026-27, eight positions and expenditure authority of $1.6 million in 2027-28, and $1.8 million annually thereafter to support implementation of new data collection efforts regarding health plan prior authorizations, pursuant to the requirements of SB 306 (Becker), Chapter 408, Statutes of 2025. Specifically, DMHC requests the following resources:

Office of Legal Services – One position

- **One Attorney IV** position would lead regulation promulgation and formal rulemaking while providing in-depth legal analysis of health plans requests to verify compliance with SB 306.

Office of Plan Licensing – Three positions in 2026-27, four positions annually thereafter; consultant costs of $500,000 in 2026-27

- **Two Attorney IV** positions (one in 2026-27, a second annually thereafter) would review evidence of coverage, disclosure forms, provider and enrollee notices, plan to plan agreements, policies and procedures, and provider contracts for compliance with the requirements of SB 306.

- **Two AGPAs** would support development and implementation of compliance measures and provide ongoing analytical review of health plan contracts, policies and procedures, evidence of coverage, and disclosure forms.

- Consultant costs of $500,000 in 2026-27 to assist with clinical consulting services, including developing guidance to assist health plans in reporting all covered health care services, items and supplies subject to prior authorization, including approval percentage and other related data, evaluate reports submitted by health plans, develop and publish a list of services, items, and supplies for which health plans must cease requiring prior authorization and draft a report on the impacts of ending the prior authorization.

Help Center – Three positions, beginning January 1, 2028

- **One Attorney III** position, beginning January 1, 2028, would review, analyze, and respond to consumer complaints, including evaluating health plan responses and medical group denial letters and supporting documentation from providers and health plans.

- **Two AGPAs** would assist and provide analytical support and conduct analysis to address the increased volume of consumer and provider complaints related to SB 306.

Office of Technology and Innovation – Software licensing costs of $20,000 in 2026-27, $57,000 in 2027-28, $45,000 annually thereafter

- Software licensing costs of $20,000 in 2026-27, $57,000 in 2027-28, and $45,000 annually thereafter would support annual software licensing costs for the new employees included in this proposal.

Office of Administrative Services – Legal education costs of $4,000 in 2026-27, $8,000 annually thereafter

- Legal education costs of $4,000 in 2026-27 and $8,000 annually thereafter would support annual legal education software licensing for the new legal positions included in this proposal.

AB 1041 (Bennett) – Health care provider credentials

Legislative Budget Change Proposal – Governor's Budget. DMHC requests four positions and expenditure authority from the Managed Care Fund of $1.2 million in 2026-27, $1.2 million in 2027-28, five positions and expenditure authority of $1.4 million in 2028-29, and $1.4 million annually thereafter. If approved, these positions and resources would support implementation of new health plan requirements for provider credentialing, pursuant to the provisions of AB 1041 (Bennett), Chapter 630, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0933 – Managed Care Fund	$1,196,000	$1,166,000
Total Funding Request:	**$1,196,000**	**$1,166,000**
Total Requested Positions:	**4.0**	**4.0**

* Additional fiscal year resources requested – 2028-29: $1,434,000; 2029-30 and ongoing: $1,426,000.

Background. AB 1041 (Bennett), Chapter 630, Statutes of 2025, makes changes to the process by which health plans may credential providers to verify qualifications before adding them their plan networks. Previously, health plans were allowed under state law to use their own credentialing programs, which often required providers to submit separate credentialing applications to each health plan. Under AB 1041, health plans or their delegated entities must utilize the credentialing form developed by the Council for Affordable Quality Healthcare (CAQH), a non-profit organization formed by health plans focused on simplifying administrative processes within the healthcare industry. This requirement would being on January 1, 2028.

According to DMHC, AB 1041 will require the department to:

- On or before July 1, 2027, review the National Committee for Quality Assurance (NCQA), Medicare, and Medicaid credentialing requirements and adopt regulations to:
  - Establish minimum standards or policies and processes designed to streamline the provider credentialing process, reduce redundancy and administrative burden and reduce delay in physician credentialing.
  - Develop a standardized credentialing form for use by health plans and insurers.
  - Update the standardized credentialing form at least every three years, or as necessary to reflect changes in laws, regulations or credentialing guidelines.
- Promulgate regulations to implement the requirements of AB 1041.
- Make the standardized credentialing form available electronically to facilitate ease of access and submission.
- Conduct reviews of health plans and medical surveys to confirm compliance with AB 1041.
- Enforce compliance through appropriate oversight for health plans or delegates that fail to meet the requirements of AB 1041.

Staffing and Resource Request. DMHC requests four positions and expenditure authority from the Managed Care Fund of $1.2 million in 2026-27, $1.2 million in 2027-28, five positions and expenditure authority of $1.4 million in 2028-29, and $1.4 million annually thereafter to support implementation of new health plan requirements for provider credentialing, pursuant to the provisions of AB 1041 (Bennett), Chapter 630, Statutes of 2025. Specifically, DMHC requests the following positions and resources:

Office of Plan Licensing – One position

- **One Attorney IV** position would perform legal reviews of provider contracts, plan to plan agreements, and other health plan documents to verify compliance with AB 1041; and would support the development and implementation of regulations, draft guidance, and create standardized formats, procedures, and sample exhibits for credentialing.

Office of Plan Monitoring – Three positions; consultant funding of $131,000 in 2026-27, $133,000 in 2027-28, $118,000 annually thereafter

- **Two Attorney III** positions would lead development and revision of credentialing and survey monitoring tools, write legal memoranda and other program materials, provide legal review, guidance, and consultation in identifying compliance monitoring activities, and work with clinical consultants to revise, validate, and maintain the quality assurance, behavioral health, and delegation oversight

electronic filing checklists, including creating new log requests for credentialing and recredentialing files for health plans and delegates.

- **One Health Program Specialist I** position would provide analysis and administrative support for AB 1041 survey activities, including the preparation of reports and supporting documentation.

- Consultant funding of $43,000 in 2026-27, $30,000 in 2027-28, and $39,000 annually thereafter would support statistical consultation and development of methodology and assessment tools for surveys and enforcement actions to assess compliance with AB 1041 and conduct ongoing statistical review during health plan surveys.

- Consultant funding of $88,000 in 2026-27, $103,000 in 2027-28, and $79,000 annually thereafter would support clinical consulting services to assist in developing new credentialing compliance review tools and updating them on an ongoing basis, and provide ongoing clinical reviews and assessments of health plans and health plan delegates during health plan surveys.

Office of Enforcement – One position, beginning 2028-29; legal software costs of $2,000, beginning in 2028-29

- **One Attorney III** position, beginning in 2028-29, would provide legal support to investigate referral cases, including the preparation, coordination, and oversight of the investigation and the resolution process.

- Legal software costs of $2,000, beginning in 2028-29, for legal software licensing to support the Attorney III position in the Office of Enforcement.

Office of Technology and Innovation – Software licensing costs of $22,000 in 2026-27, $28,000 annually thereafter

- Software licensing costs of $22,000 in 2026-27 and $28,000 annually thereafter would support annual software licensing costs for the new employees included in this proposal.

Office of Administrative Services – Legal education costs of $6,000 in 2026-27 and 2027-28, and $8,000 annually thereafter

- Legal education costs of $6,000 in 2026-27 and 2027-28, and $8,000 annually thereafter would support annual legal education software licensing for the new legal positions included in this proposal.

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

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

1. Please provide a brief overview of these proposals.

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 10: Menopause Services

Budget Change Proposal and Trailer Bill Language – Governor's Budget. DMHC requests two positions and expenditure authority from the Managed Care Fund of $407,000 in 2026-27 and $391,000 annually thereafter. If approved, these positions and resources would support implementation of proposed statutory requirements regarding health care coverage, provider education, and patient information programs for perimenopause, menopause, and postmenopausal care.

DMHC and DHCS also propose trailer bill language to implement the coverage requirements for perimenopause, menopause, and postmenopausal care for commercial health plans and the Medi-Cal program.

CalHHS is also requesting provisional budget bill language authorizing up to $3 million of General Fund expenditure authority in 2026-27 to support a statewide public awareness campaign to support greater understanding of perimenopause and menopause, including evaluation and treatment options.

Program Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0933 – Managed Care Fund	$407,000	$391,000
Total Funding Request:	**$407,000**	**$391,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2027-28.

Background. AB 432 (Bauer-Kahan), vetoed by the Governor in 2025, would have made several changes to physician training, health care, and insurance coverage, to support the delivery of medically necessary treatment for perimenopause and menopause. Among its significant provisions, AB 432 would have:

1) Required health care service plans and health insurers to include coverage for evaluation and treatment options for symptoms of perimenopause and menopause, if deemed medically necessary by a contracted provider.

2) Required coverage to be provided without discrimination on the basis of gender expression or identity

3) Required health care service plans and health insurers to annually provide current clinical care recommendations for hormone therapy form the Menopause Society or other nationally recognized professional associations to all contracted primary care providers who treat enrollees or insureds with perimenopause and menopause.

4) Authorized a California-licensed physician certified as a general internist, family physician, obstetrician and gynecologist, cardiologist, endocrinologist, neurologist, or psychiatrist and whose patient population is composed of 25 percent or more of adult women under 65 years of age, who completes continuing medical education (CME) coursework in perimenopause, menopause, and

postmenopausal, to receive two hours of credit for each hour of the coursework, not to exceed eight hours.

After a well-publicized outcry from advocates of the bill, the Governor's January budget included positions and resources and proposed trailer bill language to implement menopause coverage requirements similar, though not identical, to those contained in AB 432.

Staffing and Resource Request. DMHC requests two positions and expenditure authority from the Managed Care Fund of $407,000 in 2026-27 and $391,000 annually thereafter to support implementation of proposed statutory requirements regarding health care coverage, provider education, and patient information programs for perimenopause, menopause, and postmenopausal care. Specifically, DMHC requests the following resources:

Office of Plan Monitoring – Two positions

- **Two Health Program Specialist II** positions would provide analytical and administrative support for health plan compliance monitoring and survey activities, including the development of reports and supporting documentation.

Office of Technology and Innovation – Software licensing costs of $8,000 annually

- Software licensing costs of $8,000 annually would support annual software licensing costs for the new employees included in this proposal.

Trailer Bill Language Proposal. DMHC and DHCS also propose trailer bill language to implement the coverage requirements for perimenopause, menopause, and postmenopausal care for commercial health plans and the Medi-Cal program. The provisions of the trailer bill language proposal implement similar, though not identical, provisions to AB 432. According to DMHC, the most significant difference from AB 432 in the commercial coverage market is that the coverage of certain menopause services in the Administration's proposal continues to allow utilization management of services by plans and insurers. AB 432 would have covered many services without prior authorization. DMHC reports that, as there are more than 70 symptoms of menopause, this policy could remove a large proportion of care delivery from being eligible for utilization management by health plans and insurers. The other significant difference from AB 432 is that the Administration's proposed trailer bill language clarifies that these services are benefits under the Medi-Cal 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 DMHC and DHCS to respond to the following:

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

2. Please describe the changes in the proposed trailer bill language compared to AB 432, including the rationale for why the Administration is making these changes.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 11: CalAIM Enhanced Care Management and Community Supports

Legislative Oversight – CalAIM Enhanced Care Management and Community Supports. In recent years, this subcommittee has convened many hearings to explore the implementation of the California Advancing and Innovating Medical (CalAIM) Enhanced Care Management (ECM) benefit and community supports services. The subcommittee has explored contracting processes, the status of provider networks, and the process for converting community supports services to statewide State Plan benefits.

CalAIM – A Whole Person-Centered Transformation of the Medi-Cal Program. The California Advancing and Innovating Medi-Cal (CalAIM) initiative is an ambitious effort to incorporate evidence-based and evidence-informed investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's previous 1115 Waiver, Medi-Cal 2020, and CalAIM incorporates many of these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

CalAIM represents a significant transformation of the health care delivery systems that provide physical health, behavioral health, and oral health care services to Medi-Cal beneficiaries. However, CalAIM also represents an opportunity to build into the foundations of the Medi-Cal program an incentive structure that achieves a healthier Medi-Cal population with a comprehensive, whole-person approach that addresses the social determinants of health and avoids cross-cutting impacts and cost shifts to other state or local social service and public safety agencies. While CalAIM contains the broad outlines of building such a foundation, the Legislature continues to work with the Administration to carefully evaluate the implementation of each component of CalAIM to ensure these program changes are consistent with the values of a publicly-supported health care program.

CalAIM Implemented Through New Federal Waiver Authority. CalAIM transitions many of Medi-Cal's existing programs into managed care benefits under a new 1915(b) Waiver, maintains some programs under the previous 1115 Waiver authority, and makes other changes through amendments to the Medicaid State Plan. The federal Centers for Medicare and Medicaid Services (CMS) approved California's 1115 Waiver and 1915(b) Waiver applications implementing CalAIM reforms on December 29, 2021. Both Waivers are approved until December 31, 2026. While the managed care authorities provided by the two Waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the Waiver than they would have been without the Waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and

efficiency (actual expenditures cannot exceed projected expenditures)[1]. This distinction allows for the provision of certain non-traditional community supports services that would previously have been required to undergo a more difficult accounting of savings to the state and federal governments.

Enhanced Care Management. The Governor's January budget includes expenditure authority of $1.2 billion ($528.1 million General Fund and $692.5 million federal funds) in 2025-26 and $1.4 billion ($582.2 million General Fund and $798.8 million federal funds) in 2026-27 to support the enhanced care management benefit. Under its previous 1115 Waiver authority, Medi-Cal 2020, DHCS implemented Whole Person Care pilot programs to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. The 25 approved WPC pilots targeted services to individuals with chronic conditions, with behavioral health needs, experiencing or at-risk of homelessness, or who are justice-involved. The pilots provided eight categories of service to these individuals, including: 1) outreach, 2) care coordination, 3) housing support, 4) peer support, 5) benefit support, 6) employment assistance, 7) sobering centers, and 8) medical respite.

Beginning January 1, 2022, CalAIM expanded the Whole Person Care delivery concept statewide through implementation of a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Medi-Cal beneficiaries are eligible for ECM if they are included in one of the following populations of focus:

- *Individuals and Families Experiencing Homelessness.* (1) Adult individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services; or (2) children, youth, and families with members under 21 years of age who are experiencing homelessness, sharing the housing of other persons, or living in other short-term housing or a hospital without a safe place to be discharged.
- *Individuals at Risk for Avoidable Hospitalization or Emergency Department Utilization.* (1) Adults with five or more avoidable emergency department visits, or three or more unplanned hospital or short-term skilled nursing facility stays in a six month period; or (2) children and youth with three or more avoidable emergency department visits, or two or more unplanned hospital or short-term skilled nursing facility stays in a 12 month period.
- *Individuals with Serious Mental Illness or Substance Use Disorder Needs.* (1) Adults with serious mental illness (SMI) or substance use disorders (SUD) eligible for specialty mental health services or the Drug Medi-Cal program, with at least one complex social factor influencing their health (e.g. food, housing, or economic insecurity; history of Adverse Childhood Experiences, former foster youth, justice-involvement), and are at high risk for institutionalization, overdose and/or suicide; use crisis services, emergency departments, urgent care, or inpatient stays as the primary source of care;

[1] MACPAC. "Features of federal Medicaid managed care authorities". January 2016.

experienced two or more emergency department or hospital visits due to SMI or SUD in the past 12 months; or are pregnant or post-partum; or (2) any children and youth eligible for specialty mental health services or the Drug Medi-Cal program.

- *Individuals Transitioning From Incarceration.* (1) Adults transitioning or transitioned from a correctional facility within the past 12 months with at least one of the following conditions: mental illness, SUD, chronic or significant clinical condition, intellectual or developmental disability, traumatic brain injury, human immunodeficiency virus (HIV), pregnant or postpartum; or (2) children and youth transitioning or transitioned from a youth correctional facility within the past 12 months.
- *Individuals at Risk for Long-Term Care Institutionalization.* Adults living in the community who meet skilled nursing facility level of care criteria or require lower-acuity skilled nursing; are actively experiencing at least one complex social or environmental factor influencing their health; and are able to reside continuously in the community with wraparound supports.
- *Nursing Facility Residents Seeking Community Transition.* Adults residing in nursing facilities who desire to transition back to the community, are likely to make a successful transition, and able to reside continuously in the community.

ECM requires Medi-Cal managed care plans and their contracted ECM providers to deliver the following core services:

- *Outreach and Engagement.* Medi-Cal managed care plans are required to develop comprehensive outreach policies and procedures that can include, but are not limited to:
  - Attempting to locate, contact, and engage Medi-Cal beneficiaries who have been identified as good candidates to receive ECM services, promptly after assignment to the plan.
  - Using multiple strategies for engagement including in-person meetings, mail, email, texts, telephone, community and street-level outreach, follow-up if presenting to another partner in the ECM network, or using claims data to contact other providers the beneficiary is known to use.
  - Using an active and progressive approach to outreach and engagement until the beneficiary is engaged.
  - Documenting outreach and engagement attempts and modalities.
  - Utilizing educational materials and scripts developed for outreach and engagement.
  - Sharing information between the managed care plan and ECM providers to assess beneficiaries for other programs if they cannot be reached or decline ECM.
  - Providing culturally and linguistically appropriate communications and information to engage members.
- *Comprehensive Assessment and Care Management Plan.* Medi-Cal managed care plans must conduct a comprehensive assessment and develop a comprehensive, individualized, person-centered care plan with beneficiaries, family members, other support persons, and clinical input. The plan must incorporate identified needs and strategies to address those needs, such as physical and developmental health care, mental health care, dementia care, SUD services, long-term services and supports (LTSS), oral health services, palliative care, necessary community-based and social services, and housing.
- *Enhanced Coordination of Care.* Enhanced coordination of care includes coordination of the services necessary to implement the care plan. This coordination could include:
  - Organizing patient care activities in the care management plan
  - Sharing information with the care team and family members or support persons.
  - Maintaining regular contact with providers, including case conferences

  - Ensuring continuous and integrated care, with follow-up with primary care, physical and developmental health care, mental health care, SUD treatment, LTSS, oral health care, palliative care, necessary community-based and social services, and housing.
- *Health Promotion.* Medi-Cal managed care plans must provide services to encourage and support lifestyle choices based on healthy behavior, such as: identifying and building on successes and support networks, coaching, strengthening skills to enable identification and access to resources to assist in managing or preventing chronic conditions, smoking cessation or other self-help recovery resources, and other evidence-based practices to help beneficiaries with management of care.
- *Comprehensive Transitional Care.* Medi-Cal managed care plans must provide services to facilitate transitions from and among treatment facilities, including developing strategies to avoid admissions and readmissions, planning timely scheduling of follow-up appointments, arranging transportation for transitional care, and addressing understanding of rehabilitation and self-management activities and medication management.
- *Member and Family Supports.* Medi-Cal managed care plans must ensure the beneficiary and family or support persons are knowledgeable about the beneficiary's conditions, including documentation and authorization for communications, providing a primary point of contact for the beneficiary and family or support persons, providing for appropriate education of the beneficiary and family or support persons, and ensuring the beneficiary has a copy of the care plan and how to request updates.
- *Coordination of and Referral to Community and Social Support Services.* Medi-Cal managed care plans must ensure any present or emerging social factors can be identified and properly addressed, including determining appropriate services to meet needs such as housing or other community supports services, and coordinating and referring beneficiaries to available community resources and following up to ensure services were provided.

The ECM phase-in schedule was based on which counties implemented Home Health Programs and Whole Person Care pilots under the 1115 Waiver, and for certain populations of focus. As of July 1, 2023, all counties must provide ECM services to all populations of focus.

Community Supports. The Governor's January budget includes expenditure authority of $1.1 billion ($439.1 million General Fund and $622.3 million federal funds) in 2025-26 and $1.1 billion ($468.8 million General Fund and $674.3 million federal funds) in 2026-27 to support community supports services. Community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months. The community supports plans may provide include the following:

- Housing Transition Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for

occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.

- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.
- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.
- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.
- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing.
- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures

and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing.

- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.
- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.
- Medically-Supportive Food/Meals/Medically Tailored Meals – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition.
- Sobering Centers – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.
- Asthma Remediation – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide an overview of utilization of each of the enhanced care management benefit and each of the community supports services, including estimates, if any, of the scope of cost savings to the Medi-Cal program from avoiding utilization of higher acuity, more costly services.

2. Please provide a status update on the adequacy of provider networks for each of the community supports services and what steps would be required to transition these services into State Plan benefits. What planning has the department done to move towards transitioning to State Plan benefits?

3. Please provide an overview of how DHCS ensures Medi-Cal managed care plans are maximizing the benefits of local vendors who know their communities for the delivery of community supports services to Medi-Cal beneficiaries.

Issue 12: California Community Transitions (CCT) Federally Funded Limited-Term Position

Budget Change Proposal – Governor's Budget. DHCS requests limited-term resources equivalent to one position and federal fund expenditure authority of $165,000 in 2026-27 and $90,000 in 2027-28. If approved, these resources would support operations of the California Community Transitions Program.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0890 – Federal Trust Fund	$165,000	$90,000
Total Funding Request:	**$165,000**	**$90,000**
Total Requested Positions:	**0.0**	**0.0**

Background – California Community Transitions (CCT) Demonstration Project. In 2007, California was awarded federal grant funding to implement California's Money Follows the Person (MFP) Rebalancing Demonstration, known as the CCT Demonstration Project. CCT targets Medicaid beneficiaries of all ages who have a skilled nursing facility level of care need, who have continuously resided in an in-patient facility for 60 days or longer, and who want to return home or to a community-based setting. Members are enrolled in the demonstration for a maximum of 365 days post-transition, but also receive transition coordination services prior to leaving the inpatient facility. The CCT program also supports efforts to streamline access to long-term services and supports by updating systems and operational infrastructure. The "No Wrong Door System" (NWDS) was designed to simplify access and is a key component to system reforms.

Resource Request. DHCS requests limited-term resources equivalent to one position and federal fund expenditure authority of $165,000 in 2026-27 and $90,000 in 2027-28 to support operations of the California Community Transitions Program. According to DHCS, the one position would support compliance with federal requirements regarding the NWDS Medicaid Administrative Claiming (MAC) Guidance. **One Health Program Specialist I** position would work with the California Department of Aging, and the Aging and Disability Resource Connection to review their MAC Operational Plan for the state's Aging and Disability "No Wrong Door".

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 13: Ensuring Access to Medicaid Services

Budget Change Proposal – Governor's Budget. DHCS requests one-year limited-term resources equivalent to seven positions, four-year limited-term resources equivalent to 15 positions, and expenditure authority of $7.3 million ($1.8 million General Fund and $5.5 million federal funds) in 2026-27, and $5.3 million ($1.5 million General Fund and $3.8 million federal funds) in 2027-28 through 2029-30. In addition, DHCS requests four-year limited-term funding for 15 positions approved in the 2025 Budget Act. If approved, these resources would support compliance with federal and state requirements related to the Ensuring Access to Medicaid Services Final Rule.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$1,788,000	$1,497,000
0890 – Federal Trust Fund	$5,487,000	$3,839,000
Total Funding Request:	**$7,275,000**	**$5,336,000**
Total Requested Positions:	**22.0**	**22.0**

* Additional fiscal year resources requested – 2028-29 through 2029-30: $5,336,000.

Background. According to DHCS, the Ensuring Access to Medicaid Services Final Rule, known as the Access Rule, takes a comprehensive approach to improving access to care, quality, and health outcomes, and addressing health equity. The Access Rule includes the following components:

1) *Medicaid Advisory Committee and Beneficiary Advisory Council.* The rule requires DHCS to include Medi-Cal members in designing and running its programs by establishing and operating a Medicaid Advisory Committee and a Beneficiary Advisory Council to advise the program on the beneficiary experience.

2) *Grievance Procedures.* The rule requires states to establish a grievance process for fee-for-service home- and community-based services beneficiaries to submit complaints. DHCS reports it would work collaboratively with other state departments to implement electronic systems to capture and track grievances for all home- and community-based services waiver programs, none of which are in compliance with these requirements.

3) *Critical Incident Management.* The rule establishes a minimum definition of "critical incident" and establishes minimum state performance and reporting requirements for investigation and action related to critical incidents. The rule also requires states to operate and maintain an electronic incident management system.

4) *Person-Centered Planning.* The rule requires states to demonstrate that Person-Centered Service Plans for every individual are reviewed and revised as appropriate, based upon the reassessment of functional need every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

5) *Home- and Community-Based Services (HCBS) Quality Measure Set (QMS).* The rule requires states to report every other year on the HCBS QMS and establishes a process for updating the measure set. The HCBS QMS is a set of nationally standardized quality measures for HCBS in Medicaid programs.

6) *Quality Assurance and Improvement Plan Quality Improvement (QI).* The rule requires states to incorporate a continuous QI process that includes monitoring, remediation, and QI, including recognizing and reporting critical incidents.

7) *Reporting Requirements.* The rule requires states to report on a wide range of new requirements, including compliance reporting, access reporting, and quality reporting.

8) *Money Follows the Person (MFP) Requirements.* The rule requires certain aspects of the rule to be implemented on an accelerated basis for MFP grant recipients.

Resource Request. DHCS requests one-year limited-term resources equivalent to seven positions, four-year limited-term resources equivalent to 15 positions, and expenditure authority of $7.3 million ($1.8 million General Fund and $5.5 million federal funds) in 2026-27, and $5.3 million ($1.5 million General Fund and $3.8 million federal funds) in 2027-28 through 2029-30. In addition, DHCS requests four-year limited-term funding for 15 positions approved in the 2025 Budget Act. If approved, these resources would support compliance with federal and state requirements related to the Ensuring Access to Medicaid Services Final Rule. Specifically, DHCS is requesting the following resources:

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

- **One Research Scientist IV** position would provide direction for the development and maintenance of the data science components of a scientific research agenda focused on access to care, quality of care, and improving health outcomes for Medi-Cal beneficiaries across delivery systems.

Fee-for-Service Rates Development Division – Three positions (four-year limited-term)

- **Three Research Data Specialist II** positions would perform financial calculations, develop new standardized data methodologies and guidelines, and perform technical quality review of research data work.

Information Technology Strategy Services Division – Four positions (one-year limited-term) and contract resources of $631,000 in 2026-27

- **Four Information Technology Specialist II** positions would serve as project managers, a business analyst, and an enterprise architect. One project manager would be responsible for project governance, inter- and intra-departmental conversations, project reporting and communication across various departments for the Critical Incident Management System and the Grievance System. The other project manager would focus on coordination of system-related changes, guiding the technical aspects of the rule implementation and improving documentation and reporting quality through technical writing, editing, review, and diagram development. The business analyst would provide guidance, analysis, and documentation required by the California Department of Technology and CalHHS for oversight reporting and support functions related to the implementation of the Critical Incident Management System and the Grievance System, additional reporting requirements, and quality metrics. The enterprise architect would assess and support the Critical Incident Management and Grievance Systems to verify compliance with the rule.

- Contract costs of $500,000 ($75,000 General Fund and $425,000 federal funds) in 2026-27 would support project management support services (PMSS) to provide project oversight, project advisory, and project management support necessary to execute monitor, and support the electronic statewide Critical Incident Management System, statewide Grievance System, additional reporting requirements, and quality metrics required by the Access Rule.

- Contract costs of $131,000 ($20,000 General Fund and $111,000 federal funds) in 2026-27 would support California Department of Technology (CDT) oversight of the Project Approval Lifecycle (PAL) process.

Integrated Systems of Care Division – Seven positions (four-year limited-term)

- **One Supervisor II** position would oversee a new section to manage staff providing monitoring and oversight activities for the Access Rule's Person-Centered Planning Program requirements.

- **One Supervisor I** position would hire, train, and manage all program staff responsible for operationalizing necessary components to comply with the new federal rule.

- **Two Health Program Specialist I** positions would provide policy support to develop the Critical Incident Management System, particularly for In-Home Supportive Services and Waiver Personal Care Services

- **Three Analyst II** positions would support policy and programmatic guidance of the operational requirements of the new federal rulemaking.

Medi-Cal Enterprise System 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 product managers, product owners, and technical leads supporting implementation of the Critical Incident Management system, the Grievance System, additional reporting requirements, and quality metrics.

- **Two Information Technology Specialist II** positions would provide technical delivery of requirements for the Critical Incident Management System, the Grievance System, additional reporting requirements and quality metrics.

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

- **One Supervisor I** position would oversee implementation and operation of the new stakeholder group and continued support for the beneficiary advisory group to meet the requirements of the Access Rule.

Office of Legal Services – One position (four-year limited-term)

- **One Attorney III** position would support implementation, operation, monitoring, and oversight of new federal regulations established by the Access Rule.

Program Data Reporting Division – Two positions (four-year limited-term)

- **One Research Data Specialist III** position would lead advanced analytic efforts and develop and oversee data methodologies used to report on HCBS quality, access, and compliance measures.

- **One Research Data Specialist II** position would support the collection, validation, and reporting of federally mandated quality and performance measures.

DHCS is also requesting four-year limited-term funding for 15 permanent positions established 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 this proposal.

Issue 14: Human Resources Plus Modernization

Budget Change Proposal – Governor's Budget. DHCS requests three positions and expenditure authority of $4.5 million ($2.3 million General Fund and $2.3 million federal funds) in 2026-27, $2 million ($1 million General Fund and $1 million federal funds) in 2027-28, $312,000 ($156,000 General Fund and $156,000 federal funds) in 2028-29, and a reduction of expenditure authority of $1.7 million ($839,000 General Fund and $838,000 federal funds) annually thereafter. DHCS is also requesting ongoing funding authority for three positions approved in the 2025 Budget Act. If approved, these positions and resources would support planning, procurement, and project implementation costs to modernize the department's human resources and related fiscal systems business technology.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$2,268,000	$1,011,000
0890 – Federal Trust Fund	$2,267,000	$1,011,000
Total Funding Request:	**$4,535,000**	**$2,022,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested – 2028-29: $312,000; 2029-30 and ongoing: ($1,677,000).

Background. According to DHCS, the department is a complex enterprise of 4,749 positions utilizing 159 job classifications in 19 locations supporting Medi-Cal, behavioral health, and other programs with a budget of more than $200 billion annually. To support these staff, DHCS relies on legacy human resources systems and processes that are inefficient, not integrated, and lack necessary functionality. To address these challenges, DHCS requested resources in the 2025 Budget Act to implement its Human Resources Plus Modernization effort, to develop solutions to the following issues:

1) *Staff Updates, Onboarding, and Offboarding.* When staff are onboarded or offboarded, or need to make changes to their records, they are required to learn new processes and procedures and access multiple systems to complete their tasks. There is no self-help option and existing staff use emails or navigate multiple systems to get and provide the required information.

2) *Timekeeping Management.* Currently, all time worked report information is manually keyed into the legacy Human Resources Information System by the attendance coordinators. DHCS reports this process consumes a substantial number of resources and risks federal disallowances for inappropriately claimed administrative costs resulting from manual input of data.

3) *Position Control and Reporting.* DHCS reports it is difficult to manage positions and get accurate reporting because multiple departmental systems store varying levels of distinct data and updates are performed manually.

4) *Information Exchange and Reporting.* Staff manually download files from one system and upload them to another to achieve consistent data. A modern system would seamlessly perform this task in real-time.

5) *Hiring.* To complete the hiring process, the Human Resources Division manually downloads, screens, and redacts applications received from the California Department of Human Resources. The lack of

a modern user interface, inability to modify the system, and absence of workload management can contribute to delays and unacceptable timeframes.

6) *Legacy Systems.* DHCS' current portfolio of human resources systems is comprised of legacy systems that are outdated, require manual steps to synchronize information and can create a challenge to business continuity.

7) *Lack of Interoperability.* These technologically disparate systems are unable to mutually communicate or interoperate, causing users to navigate multiple systems to gather the information they require to complete their tasks.

DHCS reports it likely will utilize a software as a service provider to achieve its goals for human resources modernization.

Staffing and Resource Request. DHCS requests three positions and expenditure authority of $4.5 million ($2.3 million General Fund and $2.3 million federal funds) in 2026-27, $2 million ($1 million General Fund and $1 million federal funds) in 2027-28, $312,000 ($156,000 General Fund and $156,000 federal funds) in 2028-29, and a reduction of expenditure authority of $1.7 million ($839,000 General Fund and $838,000 federal funds) annually thereafter. DHCS is also requesting ongoing funding authority for three positions approved in the 2025 Budget Act. If approved, these positions and resources would support planning, procurement, and project implementation costs to modernize the department's human resources and related fiscal systems business technology. Specifically, DHCS is requesting the following positions and resources:

Business Operations Technology Services Division – Funding for one existing position

- **One Information Technology Specialist II** position, approved in the 2025 Budget Act, serves as the Product Owner of technology services procured for the project and is responsible for developing, managing, and communicating acceptance criteria, scope, and requirements with technical teams according to DHCS integration, architecture, and interoperability standards.

Data Analytics Division – One position

- **One Research Data Specialist II** position would plan, develop, and implement analytic methodologies for data collected and created through the various human resources processes.

Financial Management Division – One position

- **One Associate Administrative Analyst** would address the financial management elements of the project.

Information Technology Strategy Services Division – Funding for two existing positions

- **Two Information Technology Specialist II** positions, approved in the 2025 Budget Act, provide project management and business analyst services for the project.

Strategic Planning and Workforce Development Division – One position

- **One Supervisor I** position would serve as the department's chief resource to lead change management and training activities in support of the new system.

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. Please describe the cost savings achieved in the out-years for implementation of the system changes.

Issue 15: Breast Cancer Research Account Technical Cleanup

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to correctly name the California Department of Public Health (CDPH) instead of DHCS as the designated state department for the Breast Cancer Fund's Breast Cancer Research Account.

Background. In 2012, the Breast and Cervical Cancer Treatment Program and the Every Woman Counts program were transferred from CDPH to DHCS. In 2025, AB 144 (Committee on Budget), Chapter 105, Statutes of 2025, streamlined various reporting requirements for these programs and also updated department references to special fund accounts that receive tobacco tax revenues that support these programs. AB 144 inadvertently changed a reference to DHCS that should have remained with CDPH.

Trailer Bill Language Proposal. DHCS requests trailer bill language to correctly name the California Department of Public Health instead of DHCS as the designated state department for the Breast Cancer Fund's Breast Cancer Research Account. AB 144 inadvertently changed this reference to DHCS, but the program remains under CDPH. This proposal would correct that error.

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

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

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

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 16: Genetic Disease Screening Program (GDSP) Estimate

Genetic Disease Screening Program Estimate – Governor's Budget. The November 2025 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $169.6 million ($37.2 million state operations and $132.3 million local assistance) in 2025-26, and $175 million ($36.7 million state operations and $138.3 million local assistance) in 2026-27.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2025-26	**2026-27**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$37,227,000	$36,747,000	($480,000)
Local Assistance:	$132,331,000	$138,288,000	$5,957,000
Total GDSP Expenditures	**$169,558,000**	**$175,035,000**	**$5,477,000**

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

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

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

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

screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

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

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

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

NBS Caseload Estimate: The budget estimates NBS program caseload of 393,151 in 2025-26, a decrease of 3,842 or one percent, compared to 2024-25 actual total caseload of 396,993. The budget estimates NBS program caseload of 390,727 in 2026-27, a decrease of 2,424 or 0.6 percent, compared to the revised 2025-26 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

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

- Cell-free DNA (cfDNA) Screening - Cell-free DNA (cfDNA) is a non-invasive screening test for fetal chromosomal abnormalities that relies on extraction of maternal and fetal cells from a pregnant individual's blood sample. cfDNA can detect chromosomal abnormalities and birth defects including

trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), trisomy 13 (Patau syndrome), and sex chromosome aneuploidies. cfDNA can also detect all single and twin pregnancies. Compared to the metabolic screening methods previously used by PNS, cfDNA screening results in fewer false positives and better accuracy resulting in fewer pregnant individuals being referred for diagnostic follow-up services.

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

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

PNS Caseload Estimate: The budget estimates PNS program caseload of 184,822 cfDNA specimens in 2025-26, a decrease of 2,863 or one percent, compared to 2024-25 actual total caseload of 187,685 specimens. The budget estimates PNS program caseload of 183,923 cfDNA specimens in 2026-27, a decrease of 899 or 0.5 percent, compared to the revised 2025-26 estimate. These estimates are based on state projections of the number of live births in California.

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

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

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

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

Issue 17: Women, Infants, and Children (WIC) Program Estimate

WIC Program Estimate – Governor's Budget. The November 2025 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.5 billion ($1.3 billion federal funds and $146.2 million WIC manufacturer rebate funds) in 2025-26 and $1.5 billion ($1.4 billion federal funds and $134.4 million WIC manufacturer rebate funds) in 2026-27. The federal fund amounts include state operations costs of $71.1 million in 2025-26 and 2026-27.

Women, Infants, and Children (WIC) Funding Summary			
	2025-26	**2026-27**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$71,105,000	$71,105,000	$-
Local Assistance:	$1,290,360,000	$1,334,117,000	$43,757,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$146,221,000	$134,373,000	($11,848,000)
Total WIC Expenditures	**$1,507,686,000**	**$1,539,595,000**	**$31,909,000**

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

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

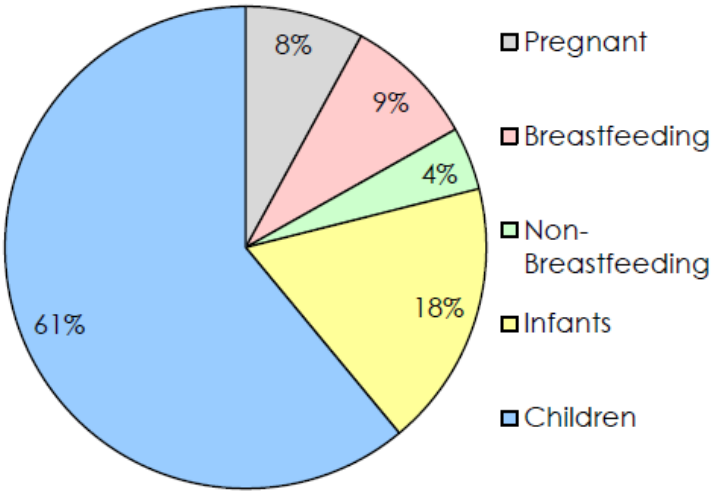
WIC Participant Caseload. Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

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

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

According to the WIC program Estimate, WIC participation by category, as of 2024-25, was as follows:

Chart 1:
Percentage of CA WIC Participation by Category: FY 2024-25



Participant Category	Annual Average Monthly Participation 2024-25
Pregnant	79,436
Breastfeeding	92,852
Non-Breastfeeding	40,093
Infants	177,202
Children	613,509
TOTAL	**1,003,092**

Caseload Estimates. The budget assumes 1,013,250 average monthly WIC participants in 2025-26, a decrease of 7,624 or 0.8 percent compared to assumptions in the 2025 Budget Act. The budget assumes 1,006,704 average monthly WIC participants in 2026-27, a decrease of 6,536, or 0.7 percent, compared to the revised estimate for 2025-26.

Food Expenditures Estimate. The budget includes $1.1 billion ($940.7 million federal funds and $146.2 million WIC Manufacturer Rebate Fund) in 2025-26 for WIC program food expenditures, an increase of $35.5 million or 3.4 percent, compared to estimates included in the 2025 Budget Act. According to CDPH, the increase in costs is due to a substantially higher food inflation rate of 3.42 percent compared to 1.71 percent assumed in the 2025 Budget Act. This increase is slightly moderated due to a downward adjustment in WIC participation. In addition, WIC manufacturer rebate revenue is projected at $146.2 million, which is a decrease of $40 million or 21.5 percent compared to estimates in the 2025 Budget Act. According to CDPH, this decrease in rebate revenue is attributable to a reduction in the projected rebate per can to be received with the start of new infant formula rebate contracts as well as a slight decline in infant participation compared to the 2025 Budget Act.

The budget includes $1.1 billion ($984.5 million federal funds and $134.4 million WIC Manufacturer Rebate Fund) in 2026-27 for WIC program food expenditures, an increase of $32 million or 3 percent compared to the revised 2025-26 food expenditures estimate. According to CDPH, this increase in costs is driven by a moderately higher food inflation rate of 2.8 percent slightly offset by a reduced participation forecast for 2026-27. In addition, WIC manufacturer rebate revenue is projected at $134.4 million, a decrease of $11.8 million or 8 percent compared to the revised 2025-26 estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $349.6 million for other local assistance expenditures for the NSA budget in 2025-26 and 2026-27, an increase of $7.9 million or 2.3 percent compared to estimates in the 2025 Budget Act. The budget also includes $71.5 million for state operations expenditures in 2025-26, unchanged since the 2025 Budget Act, and $71.1 million in 2026-27, unchanged compared to the revised 2024-25 estimate.

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

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please provide an update on participation in the program as a percentage of eligible individuals in the state.

3. Please provide an update on implementation of WIC Online Ordering and its impact on availability of food benefits in the WIC program, as well as any related programs such as CalFresh.

4. Has the department conducted any analysis to determine how the availability of online ordering in WIC has impacted the availability of brick-and-mortar options for fresh and nutritious food in low-income communities?

Issue 18: Behavioral Health Services Act Population Health Funding

Legislative Oversight – Governor's Budget. Proposition 1 (2024), the Behavioral Health Services Act, allocates a minimum of four percent of funding to CDPH for population-based prevention, requiring at least 51 percent to be used for populations 25 years old or younger. The Governor's January budget includes an allocation of $184.8 million for this purpose. The Governor's January budget also includes a $50 million offset to the General Fund as a placeholder for utilizing the Proposition 1 allocation for existing population-based prevention efforts currently supported by the General Fund. The Administration has not released details of this proposed offset.

Background. According to CDPH, the BHSA allocates funding to the department dedicated to addressing behavioral health prevention including, but not limited to:

- Population-based mental health and substance use disorder prevention programs
- Population -based behavioral health prevention strategies, with the majority of funds directed at individuals 25 years of age or younger
- Public awareness efforts to educate Californians about mental health and substance use disorders and opportunities for treatment
- Enhancement of school-based and school-linked health services and supports for students and staff designed to identify and prevent suicide and substance misuse, and reduce the stigma associated with seeking help for mental health and substance use disorder challenges
- Statewide suicide prevention efforts and resources

In addition, the BHSA prioritizes the following populations:

Children and Youth
- Who are chronically homeless or experiencing homelessness or at risk of homelessness
- Who are in, or at risk of being in, the juvenile justice system
- Who are reentering the community from a youth correctional facility
- Who are in the child welfare system
- Who are at risk of institutionalization

Adults and Older Adults
- Who are chronically homeless or experiencing homelessness or at risk of homelessness
- Who are in, or at risk of being in, the justice system
- Who are reentering the community from a state prison or county jail
- Who are at risk of conservatorship
- Who are at risk of institutionalization

According to the CDPH BHSA Population Based Prevention Final Plan, the department has developed a focused set of strategies that advance statewide population behavioral health goals and incorporate recommendations from existing initiatives and the expertise of subject matter experts in fields of suicide and self-harm prevention substance use disorders, and overdose prevention. The prevention strategies identified by CDPH are as follows: 1) lethal means safety and harm reduction; 2) cultural and social connections; 3) social-emotional learning and emotional regulation, resilience, and stronger school-based

relationships; 4) behavioral health awareness, identification, and engagement trainings; 5) stigma and discrimination reduction; 6) policy, systems and environmental change; 7) promotion of protective factors and Positive Childhood Experiences (PCEs); and 8) early childhood and parenting programs. CDPH reports these strategies may be amended based on research and results of statewide policy initiatives as part of the continuous evaluation of CDPH and local implementation of strategies, as data and emerging issues dictate.

CDPH has indicated that the following funding opportunities are available to support local reach of statewide strategies and policy:

Funding Opportunity	Eligible Entities
Community Defined Evidence Based Practices and Evidence Based Practices Program	• Community-based organizations • Tribes
Trusted Messenger Grant Program	• Community-based organizations • Tribes • 988 Crisis Centers
Regional Policy Research and Development	• Community-based organizations • Tribes • Other entities to be determined
Regional Implementation of Focused Strategies	• Community-based organizations • Tribes
Tribal Program	• Tribes
Training and Technical Assistance Funding	• Community-based organizations • Tribes • Educational Institutions • Other technical assistance experts
Local Health Jurisdiction Program	• Local Health Jurisdictions
988 Suicide and Crisis Line Outreach Campaign Program	• Community-based organizations • Tribes

CDPH reports that funding announcements for each of these program will specify all eligibility requirements and should be available beginning in spring 2026.

$150 Million General Fund Offset Included in January Budget. The Governor's January budget included a placeholder for a one-time $150 million General Fund offset using BHSA funds to support programs currently supported by General Fund resources. $100 million is expected to offset programs at HCAI under the behavioral health workforce initiative, while $50 million is expected to offset programs at the Department of Public Health (CDPH) under the BHSA-funded population-based behavioral health initiative. Neither the January budget nor the Administration has provided any additional detail on the programs that would be supported by BHSA funds rather than the General Fund.

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

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

1. Please provide a brief overview of the current status of the BHSA Population Based Prevention Plan.

2. How is the funding structured between statewide entities and initiatives, and funding for local assistance for community-based organizations and other local entities?

3. Please describe how the first year of the plan would be impacted if the Legislature were to approve the Governor's proposed allocation of $50 million from the BHSA Population Based Prevention Plan to other, General Fund supported purposes.

Issue 19: Center for Health Care Quality Field Operations Strike Team

Budget Change Proposal – Governor's Budget. CDPH requests six positions and expenditure authority from the Licensing and Certification Fund of $1.2 million annually. If approved, these positions and resources would support a dedicated strike team to address priority survey and investigation workload.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3098 – Licensing and Certification Fund	$1,162,000	$1,162,000
Total Funding Request:	**$1,162,000**	**$1,162,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2027-28.

Background. CDPH's Center for Health Care Quality (CHCQ) is responsible for regulatory oversight of licensed health care facilities and health care professionals. CHCQ's licensure and oversight workload is completed by survey teams stationed in 17 District Offices across the state, in addition to workload completed by the Los Angeles County Department of Public Health under contract with CHCQ. According to CDPH, the volume of complaint investigation workload has increased due to an increase in the number, complexity, and severity of complaints. CDPH reports that survey and support staff resources have not kept pace with this growth, leading to missed regulatory timelines, reduced oversight of non-compliant facilities, potential risks to patient safety, decreased access to care in affected communities, and lower staff morale due to unplanned travel and shifting workloads.

Staffing and Resource Request. CDPH requests six positions and expenditure authority from the Licensing and Certification Fund of $1.2 million annually to support a dedicated strike team to address priority survey and investigation workload. Specifically, CDPH requests the following positions and resources:

- **One Health Facilities Evaluator Supervisor, three Health Facilities Evaluator Nurses,** and **two Health Facilities Compliance Surveyors** would establish a specialized, statewide strike team that would focus on emergent, high priority survey and investigation workload. The team would be located in Sacramento, where it is easier for CDPH to fill positions, and would allow rapid deployment to high need areas throughout the state, allowing for timely response to facilities impacted by internal, local, or regional emergencies, emergent public safety threats, and facilities requiring additional oversight due to critical or ongoing serious noncompliance with regulatory requirements for the provision of safe patient care. The strike team would also assist District Offices by providing support to complete their priority workload and eliminate backlogs.

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

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

1. Please provide a brief overview of this proposal.

Issue 20: Hospital Bed Capacity System

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority of $2.4 million ($1.2 million Licensing and Certification Fund and $1.2 million Internal Departmental Quality Improvement Account or IDQIA) in 2026-27 and 2027-28, and $2.5 million ($1.2 million Licensing and Certification Fund and $1.2 million IDQIA) annually thereafter. If approved, these resources would support the Hospital Bed Capacity System to allow near real-time monitoring of hospital bed capacity.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3098 – Licensing and Certification Fund	$1,211,000	$1,225,000
3477 – Internal Departmental Quality Improvement Acct	$1,211,000	$1,224,000
Total Funding Request:	**$2,422,000**	**$2,449,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2028-29: $2,474,000; 2029-30 and ongoing: $2,471,000.

Background. AB 177 (Committee on Budget), Chapter 999, Statutes of 2024, authorized CDPH and DHCS to contract or develop and administer a capacity data solution to collect, aggregate, and display real-time information about the availability of hospital beds. California does not have a statewide hospital bed capacity system, with counties conducting manual polling of hospitals to gain insight into bed capacity for patient movement and patient load leveling. According to CDPH, in 2024 the department participated in the Hospital Bed and Emergency Medical Services Data System (HBEDS) pilot project. The project provided a statewide hospital bed capacity system and was funded by the federal government. HBEDS is a software subscription services that displays real-time staffed bed availability by bed type for participating hospitals on a private dashboard that is accessible to participants, as well as local and state government officials. HBEDS is automated and pulls staffed hospital bed data from hospital records systems as opposed to the multitude of disparate existing bed-polling systems in the state. Federal funding for the pilot program expires in 2025-26.

Resource Request. CDPH requests expenditure authority of $2.4 million ($1.2 million Licensing and Certification Fund and $1.2 million Internal Departmental Quality Improvement Account or IDQIA) in 2026-27 and 2027-28, and $2.5 million ($1.2 million Licensing and Certification Fund and $1.2 million IDQIA) annually thereafter to support the Hospital Bed Capacity System to allow near real-time monitoring of hospital bed capacity. Specifically, CDPH requests these resources to support the onboarding of up to 329 general acute care hospitals (GACHs) and the annual software subscription fee for the system.

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

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

1. Please provide a brief overview of this proposal.

Issue 21: Centralized Application Branch License Renewal Certification Branch Expansion

Budget Change Proposal – Governor's Budget. CDPH requests seven positions and expenditure authority of $986,000 ($493,000 reimbursements and $493,000 Licensing and Certification Fund) annually. If approved, these positions and resources would support expansion of the Center for Health Care Quality's License Renewal Certification Branch, including a Provider Certification Section and a second Provider Certification Unit.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2026-27***
0995 – Reimbursements	$493,000	$493,000
3098 – Licensing and Certification Fund	$493,000	$493,000
Total Funding Request:	**$986,000**	**$986,000**
Total Requested Positions:	**7.0**	**7.0**

* Positions and resources ongoing after 2027-28.

Background. The Centralized Applications Branch (CAB) within CHCQ's Licensing and Certification Division consists of four sections: the CAB Administration (CABA) Section, the Long Term Care (LTC) Section, the Non-Long-Term Care (NLTC) Section, and the Home Health Agency (HHA)/Hospice Section. Within each section there are three to four units, comprising 14 units in total. The CAB processes health care facility licensure and certification applications for CHCQ. CAB processes all applications for initial health care facility licenses and certification, changes to existing licenses and certification, licensure renewals, and conducts activities associated with license expiration, license revocation, certification termination, and certification adverse actions. According to CDPH, CAB processes applications on a first-in, first-out basis and often works with applicants to address incomplete or inaccurate application materials. The LTC Section, NLTC Section, and HHA/Hospice Section workload funnels through the CABA Section.

CDPH reports that in the CABA Section, the Provider Certification Unit (PCU) needs additional resources to timely process the increasing workload and mitigate delays to the providers seeking certification. The PCU processes initial certification kits for enrollment into the Medi-Cal Program, processes certification kits for changes to current enrollment in the Medi-Cal Program and performs certification activities associated with adverse actions. According to CDPH, the challenges the CABA Section faces includes the volume of incoming workload and the limited resources to process the workload in a timely manner. The delays in processing applications in a timely manner results in expenses incurred by providers seeking licensure and certification.

Providers incur overhead expenses such as property, staffing, equipment, and other business expenses before they can generate revenue while waiting for licensure approval to operate a health care facility. Additionally, providers cannot bill Medicare and Medi-Cal to receive reimbursement for services provided until they are approved to enroll in the Medicare or Medi-Cal Programs. The number of licensed and certified facilities increases each year, which increases the number of incoming applications licensure and certification activities. Without additional resources, these delays will likely persist.

Staffing and Resource Request. CDPH requests seven positions and expenditure authority of $986,000 ($493,000 reimbursements and $493,000 Licensing and Certification Fund) annually to support expansion of the Center for Health Care Quality's License Renewal Certification Branch, including a Provider Certification Section and a second Provider Certification Unit. Specifically, CDPH requests the following positions and resources to support a new PCU B unit and a new supervisor for both the PCU A and B units:

Provider Certification Section – One position

- **One Staff Services Manager II** position would supervise, manage, and direct workload priorities for the Provider Certification Section, overseeing the PCU A Unit and the proposed new PCU B Unit.

PCU B Unit – Six positions

- **One Staff Services Manager I** position would supervise and direct staff in the development and implementation of public and program policy, procedures, interpretation of statute and regulation, special projects, correspondence, and other activities.

- **Two Associate Governmental Program Analysts** would be responsible for intake, review, analysis, and coordination of all incoming certification related transactions involving health facilities certified by CDPH.

- **Three Staff Services Analysts** would be responsible for intake, review, analysis, and coordination of all incoming certification related transactions involving health facilities certified by CDPH.

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

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

1. Please provide a brief overview of this proposal.

Issue 22: Facilitating Projects to Benefit Nursing Home Residents

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Federal Health Facilities Citation Penalties Account of $5 million in 2026-27, 2027-28, and 2028-29. If approved, these resources would support projects to benefit nursing home residents.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
8510 – Fed Health Facilities Citation Penalties Account	$5,000,000	$5,000,000
Total Funding Request:	**$5,000,000**	**$5,000,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2028-29: $5,000,000.

Background. Federal regulations allow the federal Centers for Medicare and Medicaid Services (CMS) to impose monetary penalties against skilled nursing facilities (SNFs), nursing facilities (NFs), and dually certified facilities that are not in substantial compliance with one or more Medicare or Medicaid participation requirements. A portion of these penalties are returned to the states in which the penalties are imposed and states may reinvest these funds to support CMS-approved activities that improve the quality of life of nursing home residents. In California, federal penalties are deposited in the Federal Health Facilities Citation Penalties Account, which CDPH uses to support various CMS-approved projects.

CDPH's Center for Health Care Quality (CHCQ) has approved and implemented the following projects using funding from the Federal Health Facilities Citation Penalties Account:

2013-14
- A three-year contract with the California Culture Change Coalition to reduce antipsychotic medication in SNFs in California

2015-16
- A three-year contract with the California Association of Health Facilities for the Music and Memory program for improving dementia care.

2017-18
- A four-year contract with the California Association of Health Facilities for a project to improve dietary services in California nursing homes.

2018-19
- A three-year contract with the California Association of Health Facilities for a Volunteer Engagement project.
- A two-year contract with the Quality Care Health Foundation for the Certified Nursing Assistant (CNA) Training Kickstarter Project.

2019-20

- *Using AI-Enabled Cameras to Reduce Falls for Residents with Dementia*. A pilot project using the SafelyYou service which applies breakthroughs in artificial intelligence to automatically detect falls from off-the-shelf, wall-mounted cameras for residents with dementia.
- *Nurse Leadership*. Leadership training for registered nurses currently in leadership positions in California Long Term Care (LTC) Nursing Facilities as well as follow-up with personal mentoring for successful graduates.
- *California Wound Care Excellence Program for SNFs.* Provides scholarships for eligible nurses to complete an online wound care certification curriculum.
- *iNSPIRE*. Implementation of the It's Never Too Late (iN2L) program to participating skilled nursing communities to engage residents with cognitive decline (dementia), social isolation, and/or depression through technology-delivered activities.
- *A Person-Centered Approach to Reducing Transfer, Discharge, and Eviction.* Development and delivery of training focused on a person-centered approach and engaging residents and families in collaborative strategies to reduce discharge and eviction complaints.

2020-21

- *University of California Irvine Infection Prevention.* Provides participating nursing homes with onsite trainings and assistance to adopt evidence-based guidelines on infection control.
- *SNF Clinic.* Provides participating skilled nursing facilities an electronic learning management system of comprehensive, accurate, and cost-effective tools to ensure that facilities are providing high quality care to their residents.
- *LifeBio*. Interviews nursing home residents and compile each resident's details into life Story Books, Snapshots, and Action Plans to introduce nursing homes to person-centered care values to build stronger personal connections between residents and direct care staff.
- *Pilgrim Place-Make it Home.* Trains facility staff on creating and implementing a person-centered care model to build relationships with residents and promote quality end-of-life care.
- *Memory Care Buddies.* Development and pilot of a visitor's program in which volunteers receive ongoing support and training and visit regularly with nursing home residents diagnosed with dementia and impaired memory loss.
- *In-Person Visitation Grants*
- *Communicative Technology Grants*

2021-22

- *LeadingAge CA's The Java Project.* Implements a suite of social and emotional support programs aiming to decrease social isolation and loneliness in nursing and skilled nursing homes caused by COVID-19.
- *LITA Memory Care Buddies.* Development and pilot of a visitor's program in which volunteers receive ongoing support and training and visit regularly with nursing home residents diagnosed with dementia and impaired memory loss.
- *LifeBridge*. A full interdisciplinary program utilizing concepts of person-centered care based on individualized care and centered around coping mechanisms to better approach residents with behavioral outbursts and other challenging behaviors.

2022-23

- *Enlightenment/ Obie.* Work with EyeClick to work with SNF communities to install and implement an Obie mobile cart and software. Mobile carts will be located in an activity room, rehabilitation room, or common space within each SNF.
- *Creativity Never Gets Old*. Develop processes and communication plan to implement Creative Spark's 6-week training in five (5) SNFs. Promote Creative Spark's 6-week training and deliver training to activity and wellness staff at all participating SNFs.
- *Improving Resident Engagement through use of Linked Senior Install Linked Senior software onto Barton facility iPads*. Develop, document, and provide Barton activity staff training on how to use the software. Meet with each current Barton resident and their care partners to best structure their Life Story pages. Barton activity staff will develop Life Story pages for each resident.
- *GARDEN Project (Garden Access Responds to Diagnosis & Environmental Needs).* Provide and install gardens to SNFs and provide program training to SNFs.
- *SPARKing Creativity, Joy, and Arts Engagement*. Build and ship 15,609 SPARK Boxes to residents in 151 Civil Money Penalty grant participant communities. Provide 96 online arts workshops to 151 Civil Money Penalty grant program participating communities. Workshops will occur twice per week throughout the objective's timeline.

In 2023-24, 2024-25, and 2025-26 CHCQ did not develop or execute any projects or contracts.

Resource Request. CDPH requests expenditure authority from the Federal Health Facilities Citation Penalties Account of $5 million in 2026-27, 2027-28, and 2028-29. If approved, these resources would support projects to benefit nursing home residents. Specifically, CDPH requests the resources to support the following expected projects:

Organization	Project Title	2025-26	2026-27	2027-28
International Alliance of Wound Care Scholarship Fund (IAWCSF)	IAWCSF Long-Term Care Wound, Education, and Scholarship Project	$19,750	$39,500	$19,750
LeadingAge California Foundation	The Java Project II: Addressing Loneliness and Social Isolation COMBINED	$287,500	$575,000	$575,000
Mildred DeCastro, Inc DBA Synergy Healthcare Resources & Solutions Group	Synergy SYNQAIC Initiative	$499,736	$999,517	$499,758
Wound MD, PC.	Wound Education and Training Academy Wound Care Certification Project	$32,200	$64,400	$64,400
California Association of Health Facilities (CAHF)	CAHF CARES Project	$241,555	$483,628	$483,628
Fremont Health Care Center	Improving Dementia Capability with CARES Dementia 5-Step Method	$2,499	$4,998	$4,998
Generations Healthcare	The Java Project: Addressing Loneliness and Social Isolation	$60,000	$120,000	$120,000
Golden Heights Healthcare	Improving Dementia Capability with CARES Dementia 5-Step Method	$2,499	$4,998	$4,998
HealthCare Interactive, Inc.	Improving Dementia Capability with CARES Dementia 5-Step Method	$349,860	$699,720	$699,720
Huntington Valley Healthcare Center	Robin the Robot	$28,800	$28,800	-

Mariner Healthcare	Improving Dementia Capability with CARES Dementia 5-Step Method	$14,994	$29,988	$29,988
Santa Monica Rehabilitation Center	The Java Project: Addressing Loneliness and Social Isolation	$2,500	$5,000	$5,000
Silver Kite Community Arts Consulting, LLC (DBA SilverKite Community Arts)	SilverKite MOREArts ArtKits	$277,430	$277,430	-
Spring Hill Manor Convalescent Rehabilitation Hospital	Improving Dementia Capability with CARES Dementia 5-Step Method	$2,499	$4,998	$4,998
Stockton Nursing Center	Improving Dementia Capability with CARES Dementia 5-Step Method	$2,494	$4,987	$4,987
Tarzana Health and Rehabilitation Center	Keeping Nursing Home Residents and Safe from Accidents and Hazards	$27,500	$27,500	-
Vale Healthcare Center	Improving Dementia Capability with CARES Dementia 5-Step Method	$2,499	$4,998	$4,998
Yucaipa Hills Post Acute	Activities to Improve Quality of Life	$2,464	$2,464	-
Joshua Tree Post Acute	Activities to Improve Quality of Life	$1,852	$1,852	-
University Post Acute	Activities to Improve Quality of Life	$1,852	$1,852	-
Indian Canyon Post Acute Care Center	Activities to Improve Quality of Life	$1,400	$1,400	-
Long-Term Care Consultants, LLC	SNFClinic (Extension)	$592,620	$592,620	$592,620
Silver Kite Community Arts Consulting, LLC DBA SilverKite Community Arts	SPARKing Conversation, Connection, and Fun! During COVID-19 and Beyond (Extension)	$117,715	-	-
California Association of Health Facilities	Disaster Preparedness Program Support	-	$260,000	$260,000
Anticipated additional applications to be received		$427,784	$764,352	$1,625,157
TOTAL		**$3,000,000**	**$5,000,000**	**$5,000,000**

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

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

1. Please provide a brief overview of this proposal.

Issue 23: Center for Health Care Quality Internal Department Quality Improvement

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account of $5.9 million in 2026-27. If approved, these resources would support planning and implementation costs for the Centralized Application Branch (CAB) Online Licensing Application Project.

Program Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
3477 – Internal Departmental Quality Improvement Acct	$5,941,000	$-
Total Funding Request:	**$5,941,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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

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

For the remaining 33 provider types other than general acute care hospitals and acute psychiatric hospitals licensed and certified by CHCQ, the application submission and review process has remained manual and paper based. As a result, CHCQ is requesting resources to support the CAB Online Licensing Application Project, which proposes to refresh, enhance, and expand the technology of CAB's original automated license application system to enable all 35 healthcare facility provider types to submit applications electronically, as well as to have the flexibility to add new facility types in the future. The project also seeks to integrate the license application submission system with other CHCQ systems, including the Electronic Licensing Management System (ELMS) and enable facilities to pay licensing fees electronically. According to CDPH, the project has completed Stage 3 of the California Department of Technology's Project Approval Lifecycle (PAL) process and is currently in Stage 4 and pending vendor selection, with implementation phase scheduled to begin in August 2026.

Resource Request. CDPH requests expenditure authority from the Internal Departmental Quality Improvement Account of $5.9 million in 2026-27 to support planning and implementation costs for the

Centralized Application Branch (CAB) Online Licensing Application Project. Specifically, CDPH requests these resources to support **two Information Technology Specialist II** positions (limited-term) to support the CAB Online Project implementation and maintenance. One of these positions would serve as a software engineer and the other as a business analyst.

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

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

1. Please provide a brief overview of this proposal.

Issue 24: Radiologic Health Program

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Radiation Control Fund of $4.6 million annually. If approved, these resources would support increased program operation costs.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0075 – Radiation Control Fund	$4,592,000	$4,592,000
Total Funding Request:	**$4,592,000**	**$4,592,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and resources ongoing after 2027-28.

Background. According to CDPH, the Radiologic Health Branch (RHB) licenses and inspects radioactive materials (RAM) users, registers and inspects facilities where X-ray machines are used, and certifies X-ray machines as well as the medical professionals who use X-ray machines or RAM for medical diagnosis and treatment. Additionally, RHB approves physicists who provide services to mammography and radiation therapy facilities, as well as schools that offer training courses for these professionals.

Radiation licensees pay fees, which are deposited in the Radiation Control Fund (RCF), which finances the California Radiation Protection Program that is designed to safeguard workers, the public, and the environment from the harmful effects of RAM and machine-produced radiation. Inflation and numerous new activity costs have resulted in RHB incurring increasing operational costs. As a result, RHB is no longer able to absorb these increased costs within its current expenditure authority. To manage the increasing costs, RHB has limited backfilling vacant positions, resulting in an understaffed program.

Resource Request. CDPH requests expenditure authority from the Radiation Control Fund of $4.6 million annually to support increased program operation costs. According to CDPH, the proposed increase in expenditure authority is necessary to safeguard public and worker health, maintain compliance with state and federal requirements, promptly certify medical radiation professionals so that they can perform diagnostic and therapeutic services, and reduce regulatory burdens on businesses.

However, this increase will create a structural fund deficit in the fund, as authorized expenditures will exceed revenues under the current fee structure. A fee increase of 20.3 percent would be required to stabilize the RCF to create sustainability. The last fee increase was assessed in 2017 to establish fund solvency and encountered minimal opposition.

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

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

1. Please provide a brief overview of this proposal.

2. What is the current licensing fee structure in this program and what would the fee structure look like after the proposed increase?

Issue 25: Chaptered Legislation (SB 20, AB 1264, SB 313, SB 646, AB 660, AB 460, SB 669)

SB 20 (Menjivar) – Silicosis Surveillance

Legislative Budget Change Proposal – Governor's Budget. CDPH requests four positions and General Fund expenditure authority of $912,000 annually. If approved, these positions and resources would support occupational safety activities related to silicosis required by SB 20 (Menjivar), Chapter 734, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$912,000	$912,000
Total Funding Request:	**$912,000**	**$912,000**
Total Requested Positions:	**4.0**	**4.0**

* Position and resources ongoing after 2027-28.

Background. Silicosis is an irreversible but preventable occupational lung disease caused by the inhalation of silica dust. Silicosis can lead to lung transplant or death. Silica is a common mineral found in quartz, sand, and other rock types. Countertop fabrication workers who cut, grind, polish, and drill engineered stone are at elevated risk due to exposure to high concentrations of silica within engineered stone. As of September 11, 2025, CDPH had identified 385 cases of silicosis among engineered stone fabrication workers in California, including at least 45 workers who have undergone lung transplants and at least 22 workers who have died. Moreover, silicosis disproportionately affects immigrant workers in California. Based on data collected to date, 98 percent of silicosis cases in California are among young Latino men, which represents a significant overrepresentation relative to the proportion of Latino individuals in California. Given the relatively recent popularity of engineered stone as a countertop material, it is expected that many more California workers have been exposed to silica dust and will be identified with silicosis in the near future.

SB 20 (Menjivar), Chapter 734, Statutes of 2025, aims to address silicosis among stone fabrication workers by prohibiting dry fabrication methods, requiring reporting and tracking of silicosis cases, requiring outreach and education about silicosis prevention and diagnosis, and enhancing enforcement by deeming silicosis a "serious injury or illness" that requires an investigation by the Department of Industrial Relations (DIR). SB 20 requires CDPH to track cases of silicosis, identify fabrication shops, provide outreach and education about silicosis prevention and diagnosis to workers, employers, and healthcare providers, and provide technical assistance to local health jurisdictions.

Staffing and Resource Request. CDPH requests four positions and General Fund expenditure authority of $912,000 annually to support occupational safety activities related to silicosis required by SB 20 (Menjivar), Chapter 734, Statutes of 2025. Specifically, CDPH requests the following position:

- **One Public Health Medical Officer III** would review medical records to confirm cases of engineered stone silicosis and conduct outreach and provide technical support and education to clinicians and local health jurisdictions.

- **One Research Scientist III** would oversee silicosis surveillance and database management related to silicosis cases reported to CDPH through electronic case reporting, hospital discharge and emergency department data, direct reporting to CDPH, or reporting to the California Reportable Disease Information Exchange (CalREDIE).

- **One Health Program Specialist I** would process surveillance data and conduct and review case interviews to gather information related to exposures and health outcomes, and would consult with the Department of Industrial Relations to obtain regularly updated information related to silicosis cases

- **One Health Program Specialist II** would identify businesses who conduct fabrication activities, generate educational materials, and provide outreach and education about silicosis prevention and diagnosis to workers, employers, and healthcare providers.

AB 1264 (Gabriel) – Real Food, Healthy Kids Act

Legislative Budget Change Proposal – Governor's Budget. CDPH requests General Fund expenditure authority of $3.6 million in 2026-27 and $2.6 million in 2027-28 and 2028-29. If approved, these resources would support adoption of regulations to address ultraprocessed foods in schools, pursuant to the requirements of AB 1264 (Gabriel), Chapter 467, Statutes of 2025. CDPH also requests provisional budget bill language allowing augmentation of this amount of $1 million in 2026-27 for implementation and consulting contract costs available upon approval of Stage 4 of the Project Approval Lifecycle at the Department of Technology.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$3,634,000	$2,604,000
Total Funding Request:	**$3,634,000**	**$2,604,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2028-29: $2,604,000.

Background. AB 1264 (Gabriel), Chapter 467, Statutes of 2025 establishes the Real Food, Healthy Kids Act, which regulates and monitors ultraprocessed foods and other foods of concern served within California schools. The bill defines these foods as having industrial additives and ingredients and those high in saturated fat, salt, and added sugar. CDPH would be required to adopt regulations to define and update definitions for ultraprocessed foods of concern and restricted school foods. Schools would be required to begin phasing out these foods by July 1, 2029, and prohibits their sale beginning July 1, 2035. CDPH is also required to provide training and technical assistance to school food professionals and vendors to support compliance with requirements, receive data from food vendors disclosing information about their products sold to schools, and submit annual reports on progress of the bills' provisions.

Resource Request. CDPH requests General Fund expenditure authority of $3.6 million in 2026-27 and $2.6 million in 2027-28 and 2028-29. If approved, these resources would support adoption of regulations to address ultraprocessed foods in schools, pursuant to the requirements of AB 1264 (Gabriel), Chapter 467, Statutes of 2025. CDPH also requests provisional budget bill language allowing augmentation of this amount of $1 million in 2026-27 for implementation and consulting contract costs available upon

approval of Stage 4 of the Project Approval Lifecycle (PAL) at the California Department of Technology (CDT). Specifically, CDPH is requesting:

- *PAL Process.* $232,000 in 2026-27 would support fulfilling the requirements of the PAL process at CDT. The department anticipates a six month timeline for completion of the process.

- *Promulgation of Regulations.* $149,000 annually for three years would support developing regulations to create and update definitions.

- *Research and Reporting Contract.* $200,000 annually for three years would support a contract for subject matter expertise in ultraprocessed food to support evidence review to inform definitions, definition updates, and writing elements of the legislative report.

- *Outreach Contract.* $500,000 annually for three years would support educational and outreach efforts to schools, their food services staff, and vendors to promote compliance, including vendor reporting requirements.

- *IT Costs Implementation and Consultation.* $1 million in 2026-27 would support project management assistance, Independent Verification and Validation, and Design, Development and Implementation consulting.

SB 313 (Cervantes) – Birth Certificates

Legislative Budget Change Proposal – Governor's Budget. CDPH requests one position and expenditure authority from the Health Statistics Special Fund of $258,000 in 2026-27 and $163,000 annually thereafter. If approved, this position and resources would support listing of parents' birthplace fields in the confidential section of birth certificates, pursuant to the requirements of SB 313 (Cervantes), Chapter 669, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0099 – Health Statistics Special Fund	$258,000	$163,000
Total Funding Request:	**$258,000**	**$163,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2027-28.

Background. According to CDPH, there are two types of birth and death certificates available: an authorized copy and an informational copy. The authorized copy is only available to an authorized person, such as the registrant or their family member, law enforcement, the registrant's attorney, or a person empowered by the court. Any person who is not an authorized person can obtain an informational copy. The main differences between authorized and informational copies of death certificates are that an informational copy will have Social Security numbers and signatures redacted along with a legend across the document that states, "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY." The confidential section of a birth record is restricted and contains confidential medical and social information, which is often used for health or research purposes. Only the registrant, the parent who

signed the certificate, or a person who has petitioned to adopt the person named on the certificate can receive the confidential section of the birth certificate.

SB 313 (Cervantes), Chapter 669, Statutes of 2025, removes parents' birthplace details from the public section of birth certificates and lists such information in the confidential section of the certificate, beginning January 1, 2027. The provisions of SB 313 will require CDPH to update current registration systems, reference materials, and will require the department to work with stakeholders regarding the updated Certificate of Live Birth and Certificate of Fetal Death. This work will include updating forms and systems in the California Integrated Vital Records System, printing and distributing updated paper certificates, and make updates to handbooks, user guides, trainings, and other materials. Prior to the implementation date, CDPH staff will manually redact the parents' birthplace information on affected records before issuance.

Staffing and Resource Request. CDPH requests one position and expenditure authority from the Health Statistics Special Fund of $258,000 in 2026-27 and $163,000 annually thereafter to support listing of parents' birthplace fields in the confidential section of birth certificates, pursuant to the requirements of SB 313 (Cervantes), Chapter 669, Statutes of 2025. Specifically, CDPH requests the following position and resources:

- **One Associate Governmental Program Analyst** would assist with updating the birth and fetal death certificate forms to move the location of the parent birthplace, and provide system testing on an ongoing basis to improve stability of updated certificates within the vital records systems.

SB 646 (Weber Pierson) – Prenatal Multivitamins

Legislative Budget Change Proposal – Governor's Budget. CDPH requests one position and General Fund expenditure authority of $173,000 annually. If approved, this position and resources would support inspection work, compliance, and enforcement activities, and engage with stakeholders and industry regarding technical questions, related to prenatal multivitamins, pursuant to the requirements of SB 646 (Weber Pierson), Chapter 602, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	$173,000	$173,000
Total Funding Request:	**$173,000**	**$173,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2027-28.

Background. SB 646 (Weber Pierson), Chapter 602, Statutes of 2025, requires manufacturers and brand owners of prenatal vitamins to test their products for heavy metals including arsenic, cadmium, lead, and mercury. Manufacturers must make testing results publicly available on the brand owner's website and provide a hyperlink to the U.S. Food and Drug Administration's (FDA) latest information related to heavy metals. Prenatal multivitamins are vital for the health of pregnant individuals. However, recent studies have found that some prenatal multivitamins had elevated levels of arsenic, cadmium, lead, and mercury which can pose serious health risks such as hypertension, kidney dysfunction, and anemia. Currently, there

are no federal regulations requiring manufacturers to test for or disclose the presence of these heavy metals in prenatal multivitamins. This lack of oversight leaves consumers without the information needed to make safe and informed choices. SB 646 addresses these issues by requiring manufacturers to test for and publicly disclosure the heavy metal content in their products. SB 646 protects consumers from exposure to heavy metals in both imported and California manufactured prenatal multivitamins.

Staffing and Resource Request. CDPH requests one position and General Fund expenditure authority of $173,000 annually to support inspection work, compliance, and enforcement activities, and engage with stakeholders and industry regarding technical questions, related to prenatal multivitamins, pursuant to the requirements of SB 646 (Weber Pierson), Chapter 602, Statutes of 2025. Specifically, CDPH requests the following staff and resources:

- **One Environmental Scientist** would perform new license and renewal inspections, re-inspections, field audits or checks, compliance activities, records reviews, label reviews, and field visits to California firms holding prenatal multivitamins manufactured in California, out-of-state, or from other countries.

In addition, CDPH reports a leased vehicle would be required to enable this position to conduct field inspections.

AB 660 (Irwin) – Food and beverage products

Legislative Budget Change Proposal – Governor's Budget. CDPH requests two positions and expenditure authority from the Food Safety Fund of $369,000 annually. If approved, these positions and resources would support food labeling regarding quality and safety, pursuant to the requirements of AB 660 (Irwin), Chapter 911, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0177 – Food Safety Fund	$369,000	$369,000
Total Funding Request:	**$369,000**	**$369,000**
Total Requested Positions:	**2.0**	**2.0**

* Position and resources ongoing after 2027-28.

Background. AB 660 (Irwin), Chapter 911, Statutes of 2024, introduced new food labeling requirements for manufacturers, processors, and retailers, effective July 1, 2026, that require food labels to use "best if used by" to indicate quality and "use by" to indicate safety. AB 660 requires CDPH to enforce these provisions, given its regulatory authority over food products, manufacturing, and retail under the California Retail Food Code. According to CDPH, AB 660 requires CDPH to create educational materials to help industry comply with the bill, inspect firms for adherence to food safety laws and new labeling standards, verify corrective actions, and provide support to resolve compliance issues and address complaints.

Staffing and Resource Request. CDPH requests two positions and expenditure authority from the Food Safety Fund of $369,000 annually to support food labeling regarding quality and safety, pursuant to the

requirements of AB 660 (Irwin), Chapter 911, Statutes of 2024. Specifically, CDPH requests the following staff and resources:

- **One Senior Environmental Scientist** would respond to industry questions, create educational materials, and assist field staff with technical issues.

- **One Environmental Scientist** would conduct inspections, verify compliance, and provide information to help the industry meet new requirements and resolve complaints.

AB 460 (Chen) – Radiologic technologists and venipuncture supervision

Legislative Budget Change Proposal – Governor's Budget. CDPH requests one position and expenditure authority from the Radiation Control Fund of $296,000 in 2026-27 and $201,000 annually thereafter. If approved, this position and resources would implement remote supervision of radiologic technologists, pursuant to AB 460 (Chen), Chapter 435, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0075 – Radiation Control Fund	$296,000	$201,000
Total Funding Request:	**$296,000**	**$201,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2027-28.

Background. According to CDPH, state law permits a certified radiologic technologist (CRT) to perform venipuncture, a medical procedure involving the insertion of a needle into a vein of the patient's upper extremity for the purpose of injecting contrast media to enhance X-ray imaging, provided that a supervising physician is physically present at the facility. AB 460 (Chen), Chapter 435, Statutes of 2025, authorizes remote supervision of the CRT by the physician if the physician is immediately available to communicate with supervised personnel via audio and video technology and has access to the patient's medical imaging records.

Staffing and Resource Request. CDPH requests one position and expenditure authority from the Radiation Control Fund of $296,000 in 2026-27 and $201,000 annually thereafter to implement remote supervision of radiologic technologists, pursuant to AB 460 (Chen), Chapter 435, Statutes of 2025.. Specifically, CDPH requests the following staff and resources:

- **One Associate Health Physicist** would verify that each facility has video and communication technology that enables the supervising physician to communicate with the technologist and onsite personnel, established safety protocols, qualified onsite personnel with appropriate licensure to respond as directed to the supervising physician, and remote access for the supervising physician to view patients' medical imaging records.

In addition, CDPH requests one-time operating expenses for a vehicle and radiation test equipment to complete inspections.

SB 669 (McGuire) – Standby Perinatal Services

Legislative Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Licensing and Certification Fund of $515,000 in 2026-27. If approved, these resources would establish a 10 year pilot project to allow up to five critical access hospitals to provide standby perinatal services to patients transferred from an alternative birth center or who present with an urgent or emergent obstetric issue, pursuant to the requirements of SB 669 (McGuire), Chapter 603, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
3098 – Licensing and Certification Fund	$515,000	$-
Total Funding Request:	**$515,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to CDPH, one of the most significant health care challenges in rural areas of California is the lack of access to labor and delivery care. Data collected by CalMatters shows that 56 hospitals in the state have stopped delivering babies since 2012, equal to 16 percent of all general acute care hospitals in California. At the same time, there is an unmet demand for alternative birth centers for those with low-risk pregnancies.

SB 669 (McGuire), Chapter 603, Statutes of 2025, requires CDPH to establish a 10 year pilot project to allow up to five critical access hospitals that meet eligibility requirements to provide standby perinatal services, including obstetric and neonatal medical care, to patients who are transferred from an alternative birth center, or who present with an urgent or emergent obstetric issue. The bill requires physician, midwifery, and nursing services be available onsite within 30 minutes. The bill also requires that, if qualified, the first two hospitals selected be nonprofit and be in Humboldt County and Plumas County. Eligibility requirements to participate in the pilot include compliance with the standards for specified levels of care within the Guidelines for Perinatal Care developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) and requirements for general service provision, staffing, space, equipment, and supplies. Finally, the bill requires CDPH to consult with specified stakeholders to develop a template to collect and evaluate data, submit a report to the Legislature within two years of the pilot's completion, and make the report publicly available.

Staffing and Resource Request. CDPH requests expenditure authority from the Licensing and Certification Fund of $515,000 in 2026-27 to establish a 10 year pilot project to allow up to five critical access hospitals to provide standby perinatal services to patients transferred from an alternative birth center or who present with an urgent or emergent obstetric issue, pursuant to the requirements of SB 669 (McGuire), Chapter 603, Statutes of 2025. Specifically, CDPH requests the following:

- **0.5 Medical Consultant I** (limited-term) would review the evidence that participating hospitals must submit to prove compliance with service requirements, determine participant eligibility, assist with defining data reporting elements and initial monitoring and evaluation of pilot outcome data, and provide consultation on the potential establishment of additional pilot requirements.

- **0.5 Research Data Specialist I** (limited-term) would assist with developing the pilot data reporting template and establish procedures for compiling and processing pilot data.

- **0.5 Associate Governmental Program Analyst** (limited-term) would process applications for prospective participants, assist with drafting compliance criteria and participant hospital eligibility, respond to participant and stakeholder inquiries, and perform other administrative functions.

- **0.5 Attorney IV** (limited-term) would assist with determining applicant eligibility and compliance with service requirements, advise on oversight and monitoring and the legality of potential enforcement actions, assist with developing and reviewing forms, and provide general legal support.

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

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

1. Please provide a brief overview of these proposals.

0000 PROPOSALS FOR INVESTMENT

Issue 26: Proposals for Investment

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

Let California Kids Hear. Let California Kids Hear and Children Now request trailer bill language to shift pediatric hearing aid coverage to the large group insurance market, avoiding exchange defrayal costs for kids in the exchange, and reducing General Fund exposure from the Hearing Aid Coverage for Children Program (HACCP) at DHCS. California is currently relying on a high-cost state-administered workaround to address a market failure in pediatric hearing aid coverage, while more than 20,000 children still lack access to medically necessary care. This proposal establishes coverage in the large-group commercial market, where employer-sponsored insurance should function as the primary payer. This proposal shifts children under 600 percent of the federal poverty level with employer-sponsored coverage from the HACCP to their large-group commercial insurance, reducing General Fund exposure for pediatric hearing aids and ensuring the state is not acting as the payer of first resort. HACCP will remain in place for children in the individual and exchange market without coverage of hearing aids and services.

Cost Relief Trailer Bill Language to Prevent Community-Based Adult Services (CBAS) Closures. The California Association for Adult Day Services (CAADS) requests trailer bill language to assist CBAS providers in identifying and implementing cost relief measures to help reduce fiscal pressure in lieu of a rate increase in the short term during the current fiscal uncertainty. California currently has 318 CBAS centers serving almost 45,000 Medi-Cal beneficiaries, with a fifth of them having dementia. The purpose of CBAS is to reduce General Fund cost pressures by offering a cost-effective alternative to nursing homes – while also providing health care, social services, and independence to low-income, high-needs Californians. Roughly four in five participants do not speak English at home, highlighting the critical role CBAS centers play in protecting immigrant communities. CBAS also provides high-stakes relief to caregivers in working families, thus supporting workforce participation and career advancement.

CBAS is facing a statewide closure crisis. 29 centers have shut down since 2020, impacting 47 state legislative districts. The root cause is a fast-growing gap between CBAS reimbursements and operating costs. The State-set reimbursement level for 2026 is only five cents higher than it was in 2006, while the cost of gas, food, personnel, insurance, and other core operating costs have steadily risen, year after year. The result is a destabilizing financial pressure on all CBAS providers. 90% operate with regular losses and more than half report facing medium or high closure risks.

The closure crisis is preventing California from rebuilding state capacity for older and disabled adults. There were 366 centers in 2004, before Great Recession-fueled pressures and other factors reduced state capacity to 240 centers in 2016. The Department of Health Care Services (DHCS) and the California Department of Aging (CDA) are the two main agencies overseeing CBAS. Both have helped rebuild the program and get California back to our current level. However, the growing gap between reimbursements and operating costs undermined the State's progress. Three centers have closed for every five that have opened over the last fifteen years, making it difficult to support our rapidly aging population.

CAADS has begun developing new options for making progress on mitigating the closure crisis by identifying potential areas for cost relief, administrative efficiencies, and eligibility and claims

improvements. To refine, expand, and implement these possibilities, state partnerships with DHCS and CDA will be critical. The proposed trailer bill language is designed to facilitate collaborative efforts between key state agencies and stakeholders in order to stabilize CBAS operations and prevent closures.

Nurse-Midwifery Education Programs Funding. The California Nurse-Midwives Association requests General Fund expenditure authority of $2 million in 2026-27 to support new masters degree nurse-midwifery education program in the California State University of University of California systems, prioritizing programs that serve an area of demonstrated maternity or midwifery workforce need. There is currently only one nurse-midwifery master's degree program offered in California, at CSU Fullerton. The lack of educational pathways places limitations on the workforce potential and ultimately on access to high-quality reproductive healthcare in California. To meet current demand, California needs as many clinically prepared midwives as quickly and cost-effectively as possible. With an effective pipeline, midwives can be rapidly, efficiently, and professionally prepared to provide high quality health care to both mother and child.

The funding would cover start-up costs associated with establishing institutional partners, curricular development, recruiting and hiring faculty, purchasing simulation/training equipment, educational software and texts, identifying clinical precepting sites, accreditation costs, marketing and student recruitment, and other related costs.

Utilizing Community Health Workers/Prometoras-es/Representatives (CHW/P/R) to Keep Californians Covered. The California Pan-Ethnic Health Network (CPEHN) requests General Fund expenditure authority of $4 million in 2026-27 to augment and expand HCAI's existing Immigrant Community Health and Resilience Fund by strengthening CHW/P/R and community-based organization capacity to provide culturally and linguistically responsive health navigation services. CHW/P/Rs are trusted messengers embedded in the communities most affected by Medi-Cal changes and immigration-related fear. By expanding CHW/P/R-led health navigation capacity, this proposal directly addresses the primary drivers of preventable coverage loss: lack of trusted information, language barriers, administrative complexity, and fear-based disengagement. Strengthening CHW/P/R and CBO capacity enables timely, community-based intervention before coverage disruptions occur—supporting members to complete renewals, respond to notices, and remain connected to care even as eligibility requirements evolve. Leveraging existing HCAI grant infrastructure allows these services to be deployed quickly and at scale, ensuring that support reaches communities during a critical transition period. In addition, many CHW/P/R organizations and community-based partners already work closely with counties and Medi-Cal eligibility offices through DHCS-administered programs. Expanding CHW/P/R navigation capacity will complement county-led eligibility and renewal efforts by helping beneficiaries understand notices, gather documentation, and resolve issues before cases are discontinued. This coordinated approach can reduce administrative churn and lessen strain on county eligibility workers during a period of significant policy change.

Amyotrophic Lateral Sclerosis (ALS) Wraparound System of Care. The ALS Network and the ALS Association request General Fund expenditure authority of $10.5 million, available over three years, to support continued funding for the ALS Wraparound System of Care originally approved in the 2018 Budget Act. According to the ALS Network and ALS Association, this funding would continue to improve access to an evidence-based model of care and keep pace with the growth in the number of people diagnosed with Lou Gehrig's Disease. The ability to keep pace with the increasing number of patients

will enable those afflicted with the disease, because of the ALS Wraparound System of Care, to live longer, with improved quality of life, at home and avoid unnecessary hospitalizations and emergency room visits, and avoid financial catastrophe.

Ensuring Young Children Retain Access to Preventative Mental Healthcare. The First 5 Association of California requests expenditure authority from the Behavioral Health Services Fund of $20 million in 2026-27, and associated trailer bill language, to continue support for children's preventative mental healthcare through county First 5 programs. The Behavioral Health Services Act (BHSA) separated the prevention and early intervention services that were combined under the Mental Health Services Act (MHSA). Under BHSA, early intervention services remain county-administered and prevention services will be funded through a new state-level population-based prevention fund administered by the California Department of Public Health (CDPH). The transition from MHSA to BHSA threatens to eliminate millions of dollars in prevention and early intervention funding that currently supports infant and early childhood mental health services across California counties. Early intervention funding for children ages 0-5 will likely decrease due to changes in BHSA priority population definitions, making access to prevention funding even more critical for this age group.

This proposal would seek to do two things:
(1) One-time $20 million allocation to the Population-Based Prevention Fund specifically for children ages 0-5, to offset the loss of infant and early childhood prevention funding at the county level.
(2) Clarify statutory eligibility to ensure that county First 5s are explicitly eligible applicants for CDPH BHSA Population-Based Prevention Funds; and establish within the fund an ongoing, dedicated funding stream for children ages 0-5 within the Population-Based Prevention Fund.

Mental Health and Care Coordinated Services for Persons Diagnosed with Sickle Cell Disease. Cayenne Wellness Center requests General Fund expenditure authority of $5 million annually for three years to continue funding and expand life-saving Sickle Cell Disease Care-Coordinated Services to individuals and families living with Sickle Cell Disease throughout California. The programmatic expansion supported by this budget request directly addresses documented gaps in health care access, social services, and mental health support experienced by individuals and families living with sickle cell disease in California. By scaling proven existing services rather than introducing untested programs, Cayenne Wellness Center ensures immediate, measurable progress in reducing disparities in care.

Expanding access to mental health services helps address the high prevalence of depression, anxiety, trauma, and chronic stress among individuals and families living with sickle cell disease—conditions that are often overlooked or untreated. Improved mental health support strengthens patients' ability to manage their condition, adhere to treatment plans, and engage effectively with health care providers, thereby reducing crisis-driven care and avoidable hospitalizations.

Permanent Long-Term Forgiveness of the Distressed Hospital Loan Program. El Centro Regional Medical Center requests General Fund expenditure authority to permanently forgive loans provided under the Distressed Hospital Loan Program. Many of the hospitals who participated in this program are rural or critical access hospitals. Without long-term forgiveness, hospitals face uncertainty, and loan repayment presents added challenges in a time that hospitals are facing enormous pressures from federal cuts. Providing permanent long-term forgiveness through this program will allow the state to support hospitals that are at most danger of closing.

Pioneers and ECRMC are merging under the Imperial Valley Healthcare District. They are currently undergoing this process and bond debtors are assessing the added liability of the merger. Long-term forgiveness would provide reduce the risk profile and would improve the district's ability to deliver healthcare services once the merger occurs.

Distressed Hospital Loan Program Refresh. The California Hospital Association requests General Fund expenditure authority of $300 million in 2026-27 to support an additional round of funding for the Distressed Hospital Loan Program. The Distressed Hospital Loan Program (DHLP) was created in 2023 to prevent hospital closures and reopen a recently closed hospital. The $300 million program has been a resounding success, saving 15 hospitals from closing or severely curtailing services, and helping another hospital reopen its doors. The program, administered jointly by the California Health Facilities Financing Authority and the Department of Health Care Access and Information, succeeded in swiftly providing stabilization funds while also promoting accountability and sustainability for participating hospitals.

Funding from the current $300 million program has been fully depleted to participating hospitals (not-for-profit and public hospitals). This is a result of a myriad of drivers, including unprecedented cost growth pressures, low reimbursement from Medicare and Medi-Cal, patients visiting with greater unmet needs than ever before, and impacts from the One Big Beautiful Bill Act (OBBBA), which enacted the largest cuts to Medi-Cal coverage and reimbursement in history.

LGBTQ Community Center Fund. A coalition of local LGBTQ Centers across California request General Fund expenditure authority of $35 million, available over three years, to strengthen California's LGBTQ community centers, which are essential safety nets that provide affirming health, housing, legal, and social services while fostering advocacy, community building, and resilience. LGBTQ Californians face ongoing disparities in housing, mental health, HIV care, and safety, exacerbated by national rollbacks of LGBTQ protections and funding threats led by the Trump Administration. Federal actions, such as attempts to limit gender-affirming care, erase LGBTQ data, and undermine nondiscrimination protections, heighten the urgency of this proposal. The proposed LGBTQ Community Center Fund will:

- Protect core services against federal funding threats to non-profits and Community-Based Organizations (CBO's).
- Enhance safety, security, and infrastructure for LGBTQ-serving spaces throughout California, including rural areas where services are limited.
- Ensure minimum and maintain current levels of access to culturally competent care for mental health, housing, immigration, and health services, among many others.
- Funding LGBTQ community center capacity to address emerging needs through coordinated service implementation, especially as funding cuts and policy restrictions from the federal administration continue.

Across California, approximately 60 LGBTQ community centers serve an estimated 480,000 to 800,000 individuals each year, yet these centers are being placed under severe strain by federal funding cuts and policy rollbacks under the Trump Administration. The elimination of many millions of dollars in federally funded specialized LGBTQ programs has already created service interruptions and forced LGBTQ Californians out of care. These federal actions have reduced access to mental health support, crisis intervention, and culturally competent care, increasing risk and instability for LGBTQ people across the state. A $35 million California LGBTQ Community Center Fund would not replace all lost federal

funding, but it would significantly mitigate harm by stabilizing service delivery, preserving access to affirming care, and preventing further service collapse. The investment translates to roughly $44 to $73 dollars per person served each year, a modest cost when weighed against the essential role these centers play in reducing emergency system use, preventing homelessness, supporting employment, and protecting the health and safety of LGBTQ Californians.

Funding for Public Health Information Technology Systems. The County Health Executives Association of California (CHEAC), Health Officers Association of California (HOAC), and Service Employees International Union (SEIU) California requests General Fund expenditure authority of $97.6 million in 2026-27 to continue funding for critical public health information technology (IT) systems. These systems include:

- *California Vaccine Management System (myCAvax)* is the statewide platform used by CDPH, local health departments, and providers to order, manage, and distribute vaccines across all state vaccine programs, including programs serving uninsured and underinsured populations. The Governor's budget does not include funding beyond June 30, 2026

- *California Confidential Network for Contact Tracing (CalCONNECT)* supports case investigation and contact tracing for reportable infectious diseases, enabling state and local health departments to quickly identify exposures and limit disease spread. The Governor's January Budget does not propose funding for this system beyond June 30, 2026.

- *Future Disease Surveillance System (FDSS)* is the planned cloud-based replacement to California's primary disease reporting and surveillance system, the California Reportable Diseases Information Exchange (CalREDIE). The Governor's budget does not include funding for the FDSS system.

- *California Immunization Registry (CAIR)* is the statewide immunization information system used to capture and share vaccination records for Californians. Despite the transition to a more robust CAIR platform following pandemic-related challenges, the Governor's budget does not propose funding to sustain or improve the system in 2026-27.

Restoration of Proposition 56 Dental Provider Rates. The California Dental Association and Western Dental request expenditure authority of $829 million ($311.4 million General Fund and $517.6 million federal funds) in 2026-27, and $927.2 million ($358.2 million General Fund and $579 million federal funds) annually thereafter to restore Proposition 56 supplemental Medi-Cal dental provider payments that were cut in the 2025 Budget Act and are scheduled to take effect July 1, 2026. Without restoration, dental provider reimbursement will fall sharply, undermining recent gains in dental provider participation in Medi-Cal and patient access, and increasing the risk that Medi-Cal dental coverage becomes a benefit in name only for many enrollees. This request would preserve the current Medi-Cal dental provider payment framework and avoid destabilizing and undermining the existing Medi-Cal dental delivery system which expanded considerably over the past decade due in large part to improved rates from supplemental payments. Restoring the cut would help maintain adequate rates and provider participation in Medi-Cal Dental, reducing the likelihood that providers leave the program or substantially limit the number of Medi-Cal patients they serve, impacting access to care.

Protect Access to Transgender Health Care. A coalition of LGBTQ+, health, and civil rights organizations requests General Fund expenditure authority of $26 million, available until June 30, 2029, to establish a state-backed continuity and provider stabilization framework for transgender health care. This funding would enable DHCS to implement a state-only Medi-Cal coverage and reimbursement pathway and provide targeted grants to stabilize and rebuild the provider network.

California has long been a national leader in protecting access to health care for transgender, gender-diverse, and intersex (TGI) people. However, recent federal actions are destabilizing this care infrastructure—particularly for transgender youth—despite care remaining legal and protected under California law. As a result, transgender patients are losing access to medically necessary care, and providers are facing growing uncompensated costs and heightened operational risk.

California is home to the largest TGI population in the nation, with an estimated 263,700 transgender adults and 84,600 transgender youth. Health care for transgender people, often referred to as gender-affirming or transition-related care, enables individuals to live openly and authentically as their true selves. Decades of research show that this care is safe, effective, and beneficial. It is also supported by every major U.S. medical and mental health association. Under California law, this care is medically necessary and legally protected.

Despite California's strong legal protections, escalating federal actions have created immediate and destabilizing threats to care, particularly for transgender youth. Federal executive actions, investigations, coverage exclusions, and proposed rulemaking have generated widespread uncertainty around the use of federal funds for gender-affirming care. Most notably, the Centers for Medicare and Medicaid Services (CMS) released two proposed rules that would prohibit the use of federal Medicaid and Children's Health Insurance Program (CHIP) funds for transition-related care for transgender youth and bar hospitals that provide this care from participating in Medicare or Medicaid. If finalized, these rules would effectively force hospitals and many providers to discontinue care for transgender youth, even when medically necessary and required under state law.

To prevent further collapse of California's gender-affirming care delivery system and ensure compliance with state law, the coalition requests a $26 million one-time General Fund appropriation to establish a state-backed continuity and provider stabilization framework. This investment would provide immediate, time-limited support to maintain access to care while federal uncertainty persists:

State-Only Medi-Cal Coverage and Billing Pathway — $1 Million
Enable DHCS to establish a state-only Medi-Cal coverage and reimbursement pathway for gender-affirming care separate from federal financial participation. This would include claims submission processes, audit protections, and administrative guidance to ensure providers can continue delivering medically necessary, legally protected care to Medi-Cal beneficiaries without fear of federal enforcement. This pathway is essential to maintain continuity of care for Medi-Cal beneficiaries and prevent further erosion of the provider network.

Provider Network Stabilization and Uncompensated Care Grants — $25 Million
Provide targeted grants to stabilize, rebuild, and expand California's gender-affirming care provider network, particularly for transgender youth, while offsetting the growing burden of uncompensated care caused by recent federal actions. Funding would be distributed using geographic equity considerations to

ensure resources reach providers serving both rural and urban communities and address regional gaps in care. Allowable uses of funds would include:

- Staffing, infrastructure, and capacity support to sustain and scale care delivery.
- Operational support for clinics and community health centers absorbing displaced patients.
- Targeted malpractice insurance support for providers who opt to open stand-alone clinics, addressing a major financial barrier to entry and expanding access to care outside of hospitals.
- Workforce recruitment and retention in a high-risk care environment; and
- Reimbursement for uncompensated care delivered to individuals earning up to 400 percent of the federal poverty level who are enrolled in health plans with coverage exclusions.

Sustain California's Uncompensated Care Abortion Access Grant Program. Essential Access Health and Planned Parenthood Affiliates of California request General Fund expenditure authority of $10 million annually for three years to support the Uncompensated Care Abortion Access Grant Program at HCAI. The grant program expands access to abortion and contraception services and supports and stabilizes safety net providers offering these services at low or no cost to patients statewide in-person and through telehealth.

Providers can apply for the grant to provide abortion and contraception services for individuals below 400 percent of the federal poverty level (FPL) who are uninsured or underinsured and who are not eligible to receive abortion and contraception at no cost through Medi-Cal (income must be at or below 138 percent of FPL) or Family PACT (income must be at or below 200 percent of FPL). The grant program meets an essential need to provide access for Californians and individuals forced to travel due to inhumane abortion bans and restrictions in their home state.

Dementia Care Aware Training Program. The Alzheimer's Association requests General Fund expenditure authority of $1.8 million annually for three years to support the Dementia Care Aware Training Program. Dementia Care Aware (DCA) is the only statewide training program dedicated to training health care professionals on screening for dementia. The program stopped receiving state funding in September of 2024. It received a private grant but may cease operations after that funding source is exhausted. California risks losing courses that were developed and perfected by DCA's team of experienced professionals, who have reached more than 7,450 individuals in nearly every California county, at a time when the state's population of older adults is rapidly growing.

Unfortunately, Alzheimer's disease and dementia are significantly underdiagnosed, meaning that individuals living with these conditions go without the care and support that they need for far too long. This is largely because the symptoms and behaviors can be attributed to normal aging rather than a health condition causing cognitive decline. A secondary issue many individuals report is that they are left without the necessary resources to navigate care and create a plan for next steps after receiving a diagnosis.

Dementia Care Aware provides in-person and remote training opportunities in exchange for free CMEs/CEUs to address this critical gap in knowledge. This incentivizes those working on primary care teams to improve their readiness. DCA also developed the screening, called the Cognitive Health Assessment, with experts across the state, and helps with the clinical implementation of the Cognitive Health Assessments. This is a critical tool for the detection of dementia, and increasingly relevant as it helps the state meet a requirement to track the number of assessments among older adults who are in Dual Eligible Special Needs Plans (D-SNPs).

Today, we have FDA-approved treatments that slow cognitive decline in the early stage of Alzheimer's disease and new data around the efficacy of lifestyle interventions staving off cognitive decline for years. These developments, along with the advent of biomarker testing, have changed perspectives around early detection and diagnosis because they provide proactive measures to slow cognitive decline. It is important that primary care teams are ready to address this advancement in clinical care and improve the lives of people with dementia.

California has long been a leader in the movement to end Alzheimer's disease and other kinds of dementia. Through the California Department of Aging and California Department of Public Health, the state executes on the important work to raise awareness, educate the public and support individuals and their caregivers as we collectively work towards risk reduction.

This budget request would enable Dementia Care Aware to continue operations, building out their training program to rapidly improve dementia capability in our healthcare workforce. It would also enable them to continue collaborating on projects with the CDPH. Thus far, they have also developed Dementia Care California providing a provider-specific resource for care navigation and case management that highlights best practices in dementia care.

Continue Scholarship Funding for Train New Trainers in Primary Care Psychiatry. The Psychiatric Physicians Alliance of California requests General Fund expenditure authority of $5.5 million in 2026-27 to support continued scholarship funding for the Train New Trainers in Primary Care Psychiatry (TNT-PCP) Fellowship. Primary care and emergency providers are on the front line of delivering mental health and substance use disorder care. Yet most receive only limited formal training in psychiatry. The rapid uptake of these scholarships by primary care providers in the last decade demonstrates that front-line clinicians practicing in underserved areas recognize the importance of strengthening their behavioral health skills.

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