Senate Budget and Fiscal Review—John Laird, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Wednesday, May 20, 2026
1:30 pm
1021 O Street – Room 1200

PART A

Consultant: Scott Ogus

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0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Workload Adjustments - Reappropriation

Reappropriation – May Revision. CalHHS requests reappropriation of General Fund expenditure authority of up to $294,000, previously authorized in the 2025 Budget Act. If approved, these reappropriated resources would support increases in legal workload associated with House Resolution (HR) 1.

Background. The 2025 Budget Act included General Fund expenditure authority of $294,000 in 2025-26 to support staff resources coordinating the California Health and Human Services Agency's response to House Resolution (HR) 1. CalHHS had planned to hire one Attorney III position to address CalHHS entities' involvement with HR 1 and other federal issues. However, according to CalHHS, they were unable to hire the position due to operational and leadership capacity constraints as a result in vacancies in the General Counsel and Deputy Secretary for Administration positions.

Reappropriation Request. CalHHS requests reappropriation of General Fund expenditure authority of up to $294,000, previously authorized in the 2025 Budget Act to support increases in legal workload associated with House Resolution (HR) 1. Reappropriation of these resources would allow CalHHS to hire and onboard the legal staff necessary to support CalHHS entities' coordinated response to HR 1.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 2: Statewide Verification Hub Project

Budget Change Proposal – Governor's May Revision. CalHHS requests $831,000 in California Health and Human Services Automation Fund (Automation Fund) and four state positions to be transferred from the California Department of Social Services (CDSS) to the California Health and Human Services (CalHHS) Office of Technology and Solutions Integration (OTSI) for the Statewide Verification Hub (SVH) initiative.

Background. The Statewide Verification Hub (SVH) project under OTSI will leverage modern data and integration capabilities to provide Californians and the programs/team members that support them with a more effective and efficient experience.

Current methods for collecting verifications, particularly for CalFresh, CalWORKs, and Child Care, are time-consuming and rely on data from multiple sources, some of which are outdated or difficult for the recipient and county to either access or obtain. Verifications may be obtained from disparate sources—including state and county data systems, federal data systems, the client themselves, and various third-party vendors. A single form of verification, such as periodic earned income, might be provided in a

variety of potential formats— including a regular file, a paper pay document, or a scan or photo uploaded from a mobile device. This creates challenges both from a data management and storage perspective, as well as from the perspective of logistics for both obtaining and validating the information.

OTSI, along with CDSS and DHCS, recognize the challenges with both the electronic and non-electronic (paper) processes currently used to complete the required verifications for CalFresh, CalWORKs, Child Care, and Medi-Cal. In 2018, an analysis performed by Social Interest Solutions, under a contract with CDSS, found that the current environment that supports the verification processes for CalFresh and CalWORKs is a combination of data sources, systems, and access points that has significant variability throughout the state.

The creation of a centralized infrastructure provides a solution that can be leveraged by multiple CalHHS programs. The overarching vision of the SVH is as an agency-wide IT data infrastructure platform that will improve California families' access to services by streamlining and modernizing the process related to data verifications, providing near real-time information on application progress, safeguarding State resources, and improving program administration outcomes, all while preserving Californians' privacy and security.

Request to transfer positions from CDSS to OTSI. CalHHS, in partnership with all affected departments, has decided to move the SVH Initiative under OTSI to conduct and manage the continued planning and solution delivery work. This work has Agency-level importance and is a key component of its core mission and related service coordination and integration strategy, as defined within the CalHHS IT and Data Strategic Plan. OTSI's IT solution delivery expertise, coupled with its Enterprise Architecture, Strategic Portfolio Management, and Data Insights and Innovation functions, position it to best work within and across departments to understand and support the data verification needs. To support management of the SVH Initiative, OTSI is requesting to transfer 4 of the 13.5 positions under CDSS to OTSI. The other 9.5 positions will remain at CDSS to work in partnership with OTSI on planning and solution delivery, providing program focused support for the initiative, consistent with other efforts managed by OTSI on behalf of sponsor departments.

As part of the SVH staffing transition from CDSS to OTSI, four positions approved as part of the 2021 Budget Act will be transferred from CDSS to OTSI. The four existing positions to be transferred from CDSS to OTSI include the SVH roles of Project Manager, Data Engineer, Solution Architect, and Program Subject Matter Expert. Two of these positions are currently vacant and will remain unfilled within CDSS. The remaining two positions are currently filled; the incumbents will transition into other existing permanent, authorized vacancies within the unit. These staff will continue supporting existing non-SVH work currently assigned to them.

This proposal has no net General Fund impact.

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal.

Issue 3: Child Welfare Services – California Automated Response and Engagement System

Budget Change Proposal – Governor's May Revision. The CalHHS Office of Technology and Solutions Integration (OTSI) requests a total of $357.3 million ($179.77 million General Fund, $176,794,000 federal funds, and $748,000 reimbursements) for 2026-27 to carry out the next phase of the Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) project. This request includes provisional language regarding legislative reporting requirements and authorization for the Department of Finance (DOF) to augment the project budget by unused amounts, in both the current and prior years.

Background: CWS-CARES. CWS-CARES is a statewide case management and data solution for child welfare services to replace the state's current child welfare case management system, known as CWS/CMS. The replacement of the current CWS/CMS system is needed to meet federal requirements. According to the CalHHS Office of Technology and Systems Integration (OTSI), CWS-CARES will:

- Allow key members of the Child and Family Team (CFT) to have direct access to enter information or access shared information to support case plan and service delivery.
- Allow children and their families to be at the center of decision making by providing access to key information and communication with their social workers.
- Provide timelier service delivery and enable social workers to spend less time doing data entry and more time working directly with families.
- Increase process and system efficiency, resiliency, quality, and maintainability across the state.
- Track cost at the individual level (a step towards tracking dollars to outcomes by person and by program).
- Support achievement of the Comprehensive Child Welfare Information System (CCWIS) certification requirements to maintain federal financial participation funding and avoid large state repayments and federal non-compliance penalties.

The existing CWS/CMS system was initially implemented in 1997 and is not compliant with the CCWIS federal and state laws, regulations, or policies. According to OTSI, CWS-CARES will launch statewide in October 2026, replacing the current IT system. The second version (V2) will launch in April 2028.

Important child welfare reforms rely on successful roll-out of CWS-CARES. The Foster Care Tiered Rate Structure needs to be automated in CWS-CARES. Additionally, implementation of the Families First Prevention Services Act (FFPSA), which allows states to claim federal funding for prevention services, also hinges on the successful implementation of CWS-CARES, because this federal law requires tracking of per-child prevention spending (which is not available in the state's current child welfare IT system.)

Resource History
(Dollars in thousands)

Program Budget	2021-22	2022-23	2023-24	2024-25	2025-26
Authorized Expenditures	91,000	109,273*	130,178**	173,410***	230,916****
Actual Expenditures	80,081	131,171	147,174	162,725	102,319
Revenues	-	-	-	-	-
Authorized Positions	72	76	91	96	99
Filled Positions	58	71	78	85	94
Vacancies	14	5	13	11	5

Note: Table includes CARES-Live expenditures. Actuals for 2025-26 reflect expenditures as of November 2025.
*The total budget requested for 2022-23 was $144,035,000. Of the requested amount, $34,762,000 was held in provisional language.
** The total budget requested for 2023-24 was $200,279,000. Of the requested amount, $70,100,000 was held in provisional language.
***The total budget requested for 2024-25 was $225,480,000. Of the requested amount, $52,070,000 was held in provisional language.
****The total budget requested for 2025-26 was $364,361,000. Of this requested amount, $73,282,000 is held in provisional language.

Resource Request. This request is for funding for state, county, and vendor resources; hardware/software; and core constituent participation to continue the Design, Development & Implementation (DD&I) of the CWS-CARES project to replace the existing legacy system. In 2026-27, the focus for the project will be:

- Training approximately 25,000 users for the October 2026 CWS-CARES Version 1 (V1) implementation to all 58 counties, CDSS and tribes with California Title IV-E Agreements.

- Stabilizing the CWS-CARES system.

- Initiating the Version 2 procurements.

Project Team Staffing. The project currently has 99 permanent project staff positions (86 OTSI and 13 CDSS) performing critical work for the successful development and implementation of the CWS-CARES.

- *OTSI Staffing – $17.4 million (86 existing positions).* The result of a prior staffing needs analysis identified the right resources in the required roles by functional areas throughout the project proposal requests continued funding for these 86 permanent positions.

- *CDSS Staffing – $2.4 million (13 existing positions and 5 position equivalents).* This proposal requests continued funding for the existing 13 permanent positions, along with funding to continue supporting the equivalent of 5 five-year limited-term positions approved in 2021-22. These 5 positions include regulation support, fiscal monitoring and external stakeholder coordination, executive project support for CDSS, office technician, and governance support.

CWS-CARES Project Team Staffing	FY 26/27 CARES Costs	FY 26/27 CARES-Live Costs
CARES/CARES-Live Positions (86)	**$15,674,579**	**$1,732,421**
OTSI Positions	$15,674,579	$1,732,421
CARES/CARES-Live Positions/Position Equivalents (18)	**$2,410,000**	**0**
CDSS Positions	$2,410,000	0

Contract Services. This proposal includes costs associated with the following contract services:

- *Contract Support Services - $228.73 million.* The project requests continued funding for contract services associated with the CWS-CARES project's design, development, and implementation efforts and ongoing support of the CARES-Live activities.

- *County Consultant Services - $9.56 million*. County consultants are essential contributors as subject matter experts to the CWS-CARES service areas and will take part in every aspect of the Service Delivery Life Cycle to make sure the CWS-CARES solution meets the child welfare services stakeholder needs and business practice model.

- Detail on contract support services and county consultant services is included on the following page.

CWS-CARES Contract Services	FY 26/27 CARES Costs	FY 26/27 CARES-Live Costs
Contract Support Services	$226,253,204	$2,477,162
CARES Data Infrastructure (CDI)	$30,254,441	
Implementation Services	$46,903,936	
PaaS Systems Integrator (SI)	$100,033,913	
Product Value Services (PVS)	$15,800,038	
Service Desk Services	$5,920,140	
Project Management/Technical Support	$2,762,518	$32,720
IV&V Services	$1,171,000	
Other Contract Services	$16,246,781	$2,444,442
Contract Services - Software Customization	$7,160,437	-
Consulting Services	$9,295,076	$260,094
CWDA - CC2, 19, 24, 29 & M&O02	$1,723,930	$135,590
CWDA - CC05 & M01 &O01	$676,213	$28,788
Kern County - (CC12)	$229,812	
Los Angeles County - (CC15)	$223,109	$6,703
Los Angeles County - (CC16)	$248,667	
Los Angeles County - (CC17)	$227,200	
Los Angeles County - (CC18)	$229,811	
Los Angeles County - (CC33)	$194,034	$59,054
Madera County - (CC03)	$463,756	
Monterey County - (CC09)	$173,346	
Placer County Consultant (CC25)	$290,551	
Riverside County - (CC08)	$259,284	
Riverside County - (CC20)	$223,108	$6,703
Sacramento County - (CC04)	$128,640	
Sacramento County - (CC11)	$97,248	
San Bernardino County - (CC14)	$159,060	$15,252
San Francisco County - (CC07)	$266,432	$8,004
Stanislaus County - (CC01)	$229,811	
Stanislaus County - (CC10)	$263,445	
Yolo County - (CC13)	$261,221	
County Consultant Services (CC06)	$227,200	
County Consultant Services (CC21)	$227,200	
County Consultant Services (CC22)	$227,200	
County Consultant Services (CC23)	$227,200	
County Consultant Services (CC26)	$227,200	
County Consultant Services (CC27)	$227,200	
County Consultant Services (CC28)	$227,200	
County Consultant Services (CC30)	$227,200	
County Consultant Services (CC31)	$227,200	
County Consultant Services (CC32)	$227,200	
County Consultant Services (CC34)	$227,200	
County Consultant Services (CC35)	$227,200	
Total	**$235,548,281**	**$2,737,256**

- *Hardware/software - $39.78 million.* Salesforce subscription services are required for the design and development activities of the CWS-CARES. The state expects to increase license use incrementally beginning in April 2026 through 2027-28. The Hardware/Software line item has increased as the state has assumed responsibility for the procurement of software previously purchased under a vendor contract:

CWS-CARES Hardware and Software	FY 26/27 CARES Costs	FY 26/27 CARES-Live Costs
Hardware	**$550,000**	
Laptop Refresh	$550,000	
Miscellaneous Hardware Items		
Software	**$38,589,813**	**$643,942**
Adobe AEM & Load Balancers	$599,863	
Adobe Sign	$384,360	
Atlassian eazyBI Reports	$209,458	$22,238
Checkmarx	$212,634	
Copado Robotics	$235,280	
ImageTrust	$108,239	
Checkmarx	$212,634	
Copado Robotics	$235,280	
ImageTrust	$108,239	
ServiceNow	$162,959	
Splunk Cloud	$87,285	
SalesForce	$34,820,172	
Additional Software Under $100k	$1,213,411	$621,704
Total	**$39,139,813**	**$643,942**

- *Operating Expenses and Equipment (OE&E) – $22.39 million.* The project requests funding for services provided by the California Department of Technology (CDT) for processing IT contracts and executing purchase orders and services provided by the State Data Center. The requested funding also includes costs associated with enterprise services, the Department of General Services, and other OE&E costs for OTSI and CDSS in 2026-27.

- *Core Constituent Participation (CCP) - $36.25 million.* This participation is part of the project's user-centered design model to secure county and tribal engagement throughout the transition process from the CWS/CMS to the CWS-CARES. This effort is a critical component to the success of the project. The CCP cost estimate is consistent with the amount included in SPR 6.

- *Independent Project Oversight Consultant Contract Services - $800,000.* CDT conducts independent project oversight on medium and high-criticality reportable IT projects for departments and constitutional offices. These staff embedded in the project review and monitor project health; create project oversight reports; escalate project risks and issues; and assist project staff in developing appropriate risk and issue mitigation strategies.

Overall Project Detail. The chart below provides the project budget detail for this proposal.

Budget Category	2026-27 Proposed CWS-CARES Costs	2026-27 Proposed CARES-Live Costs	2026-27 Total Proposed Costs
CWS-CARES Project			
OSI Personal Services	15,674,835	1,732,421	17,407,256
Hardware/Software	39,139,813	643,942	39,783,755
Contract Services	235,548,281	2,737,256	238,285,538
CARES Development Services	200,145,654	-	200,145,654
Project Support Contracts	16,253,893	2,444,442	18,698,335
Project Management Services	3,933,518	32,720	3,966,238
Operations	5,920,140	-	5,920,140
County Consultant Services	9,295,077	260,094	9,555,170
OE&E	17,278,421	4,321,425	21,599,846
OSI Other OE&E (Gen Exp., Travel, & Facilities)	2,713,240	299,874	3,013,114
DGS Fees	1,987,718	219,687	2,207,405
Enterprise Services	7,124,578	787,426	7,912,004
Data Center Services	5,452,885	3,014,437	8,467,323
Total OTSI Spending Authority	307,641,350	9,435,044	317,076,394
CWS-CARES Project			-
CDSS Personal Services	2,410,000	-	2,410,000
CDSS Other OE&E (Gen Exp., Travel, & Facilities)	779,000	-	779,000
Core Constituent Participation	36,250,596	-	36,250,596
IPOC Contract Services	800,000	-	800,000
Total CDSS Local Assistance	40,239,596	-	40,239,596

Subcommittee Staff Comment and Recommendation – Hold Open.

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

1. Please provide an overview of this proposal, including a description of the major cost components proposed for 2026-27 and how these resources will deliver a successful launch of CWS-CARES in October 2026.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 4: 988 and the Behavioral Health Crisis Continuum Implementation

Budget Change Proposal – May Revision. CalHHS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $445,000 in 2026-27, and $439,000 in 2027-28 and 2028-29. If approved, these resources would support CalHHS responsibilities to convene the 988 Crisis Policy Advisory Group and produce an annual progress report.

EMSA requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $203,000 in 2026-27. If approved, these resources would support statewide guidance on behavioral health crisis response for local Emergency Medical Services Agencies (LEMSAs).

Multi-Year Funding Request Summary - CalHHS		
Fund Source	**2026-27**	**2027-28***
3414 – 988 State Suicide and BH Crisis Svcs Fund	$445,000	$439,000
Total Funding Request:	**$445,000**	**$439,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested: 2028-29: $439,000.

Multi-Year Funding Request Summary - EMSA		
Fund Source	**2026-27**	**2027-28**
3414 – 988 State Suicide and BH Crisis Svcs Fund	$203,000	$-
Total Funding Request:	**$203,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The Miles Hall Lifeline and Suicide Prevention Act, AB 988 (Bauer-Kahan), Chapter 747, Statutes of 2022, implemented the 988 system in California, establishing 988 as the three-digit number for the National Suicide Prevention Hotline, which is now known as the 988 Suicide and Crisis Lifeline. Among other provisions, AB 988 requires the following:

- Requires CalHHS to participate in the State 988 Technical Advisory Board convened by CalOES no less than quarterly until December 31, 2028.
- Requires CalHHS to convene a state 988 policy advisory group to advise on a set of recommendations for the implementation and administration of the five-year implementation plan for the 988 System;
- States the intent of the Legislature that, by June 30, 2024, CalHHS and CalOES develop a plan for the statewide coordination of 988, 911, and behavioral health crisis services.
- Specifies the plan will be based on a five-year implementation plan that includes a landscape analysis of existing services and describes how to expand, improve, and link services with the goal of fully implementing the 988 system by January 1, 2030.

The 2025 Budget Act included $575,000 for CalHHS to coordinate with CalOES, DHCS, and California's 988 Crisis Centers on developing the AB 988 Five-Year Plan. According to CalHHS, changes in federal policy have accelerated the need for state leadership in the 988 system, including the federal elimination

of specialized services for LGBTQ+ young people as of July 2025. CalHHS has entered a contract with the Trevor Project to provide California 988 crisis counselors with enhanced competencies, and to strengthen statewide capacity to identify risk factors and support best practices for effective crisis intervention to populations at significantly higher risk for suicide or behavioral health crises.

EMSA is responsible for the coordination, administration, and integration of California's statewide emergency medical services (EMS) system. Part of EMSA's responsibilities include coordinating with, and providing guidance to, local Emergency Medical Services Agencies (LEMSAs) regarding policies and procedures related to 988. In addition, EMSA reports it plans to provide guidance to LEMSAs to support coordination between the 911 and 988 systems.

Companion Budget Change Proposal and Trailer Bill Language in January Budget for DHCS. The January budget included a request from DHCS for eight positions and expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $25.9 million in 2026-27, $25.8 million in 2027-28 through 2029-30, and $4.4 million annually thereafter to support increased workload related to 988 and to support 988 Crisis Centers. The January budget also proposed trailer bill to establish a process and standard criteria for entities to apply for approval as designated 988 centers, quality standards designated 988 centers must meet to maintain designation, and comprehensive monitoring and oversight of designated 988 centers. These proposals were held open by the subcommittee during its April 30th hearing.

CalHHS and EMSA Resource Request. CalHHS requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $445,000 in 2026-27, and $439,000 in 2027-28 and 2028-29 to support CalHHS responsibilities to convene the 988 Crisis Policy Advisory Group and produce an annual progress report. Specifically, CalHHS requests the following:

- Resources equivalent to **one Public Health Medical Administrator I** would lead implementation of the AB 988 five year plan, support impacted departments to achieve their specific responsibilities and goals under the plan, serve as subject matter expert on behavioral health policy and clinical practice related to 988 and the crisis care continuum, support external and internal workgroups and trainings, lead inter- and cross-departmental coordination on cross-system issues, and coordinate additional clinical and subject matter expertise on quality metrics and outcomes.

EMSA requests expenditure authority from the 988 State Suicide and Behavioral Health Crisis Services Fund of $203,000 in 2026-27. If approved, these resources would support statewide guidance on behavioral health crisis response for local Emergency Medical Services Agencies (LEMSAs). Specifically, EMSA requests the following:

- Resources equivalent to **one EMS Behavioral Health Policy Specialist** would provide vision and strategic guidance for aligning EMS services with state behavioral health related initiatives including 988, develop and oversee policies and procedures to integrate EMS with county behavioral health crisis services, coordinate with LEMSAs and other partners to facilitate integration and resource alignment, partner with national entities to standardize communications and awareness strategies, and represent EMSA in state level behavioral health related workgroups including 988 and 988 implementation.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How is CalHHS partnering with the Trevor Project to address the federal loss of LGBTQ+ support options through the 988 system? Would these resources, or the 988 Five-Year Implementation Plan address this issue?

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 5: Enterprise Services Data Management Solution

Budget Change Proposal – May Revision. EMSA requests General Fund expenditure authority of $4.3 million in 2026-27 and $4.4 million in 2027-28. If approved, these resources would support operationalization of the Enterprise Services Data Management (ESDM) System.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0001 – General Fund	$4,264,000	$4,414,000
Total Funding Request:	**$4,264,000**	**$4,414,000**
Total Requested Positions:	**0.0**	**0.0**

Background. EMSA's Enterprise Services Data Management (ESDM) System provides a single integrated solution to support three major functionalities:

1) *California Emergency Medical Services Information System (CEMSIS).* CEMSIS provides participating LEMSAs access to aggregate statewide data submitted to the CEMSIS data system and is a tool for local EMS system quality improvement, improved EMS system management, and a limited benchmarking against and compliance with existing EMS national standards. CEMSIS allows system evaluation of EMS encounters using local and regional data. According to EMSA, encounter evaluation requires interoperability and electronic interfaces with various entities that oversee and work with EMS, including the National EMS Information System, LEMSAs, EMS providers, emergency response dispatch, hospitals, health care centers, and other state departments.

2) *Central Registry.* AB 2917 (Torrico), Chapter 274, Statutes of 2008, required EMSA to establish a Central Registry for the tracking of EMS certification, recertification, licensure, accreditation, and enforcement history. According to EMSA, the current Central Registry is composed of two independent systems: 1) My License Office, a commercial off-the-shelf solution that provides licensing, certification, and personnel-related functionality; and 2) a custom-built training database that provides publicly viewable lists of approved EMS training programs and continuing education courses. According to EMSA, maintenance of the Central Registry requires interfacing with several entities and consolidating disparate data, including from all LEMSAs, certified or licensed EMS personnel, applicants, and the California Department of Justice.

3) *Physician Orders for Life Sustaining Treatment (POLST) eRegistry.* The Electronic Physician Orders for Life Sustaining Treatment (ePOLST) system will digitize the POLST form, allowing emergency responders to have access to real-time, electronic patient care data, including patient care instructions on POLST forms regarding life-sustaining treatment for those who are seriously ill. This project was authorized by the Legislature in the 2021 Budget Act.

The 2025 Budget Act included reappropriation of General Fund expenditure authority of $3.6 million, originally authorized in the 2021 Budget Act, and reappropriated in the 2024 Budget Act, to support implementation of the EDSM to integrate CEMSIS, the Central Registry, and the POLST eRegistry.

Resource Request. EMSA requests General Fund expenditure authority of $4.3 million in 2026-27 and $4.4 million in 2027-28 to support operationalization of the Enterprise Services Data Management (ESDM) System. Specifically, these resources would support securing of software licenses and information technology consulting services in 2026-27 and 2027-28 to operationalized the ESDM System.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 6: Hospital Pricing (AB 1312)

Budget Change Proposal and Trailer Bill Language – April Finance Letter. HCAI requests eight positions and expenditure authority from the California Health Planning and Data Fund of $1.6 million in 2026-27, 2027-28, and 2028-29. If approved, these positions and resources would support review of hospital charity care and discount payment policies, pursuant to the requirements of AB 1312 (Schiavo), Chapter 450, Statutes of 2025.

HCAI also requests trailer bill language to establish the Hospital Fair Pricing Penalties Fund to collect administrative penalty revenue collected pursuant to AB 1312, and authorize its use to implement the provisions of the bill and related regulations.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0143 – California Health Data and Planning Fund	$1,611,000	$1,611,000
Total Funding Request:	**$1,611,000**	**$1,611,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested – 2028-29: $1,611,000.

Background. According to HCAI, AB 1312 expands existing hospital fair pricing statutes by better connecting eligible patients with hospital financial assistance before they receive a bill. Under AB 1312, hospitals are required to:

- Prescreen patients to determine presumptive eligibility for the charity care or discount payment policy if the patient is experiencing homelessness or enrolled in certain government programs.
- Prescreen patients for presumptive eligibility for the charity care or discount payment policy if the patient is uninsured, enrolled in Medi-Cal with cost sharing, eligible for Medi-Cal under the Hospital Presumptive Eligibility (HPE) program, or enrolled in Covered California. If the hospital determines the patient is financially qualified, the hospital must determine if the patient is eligible without requiring the patient to complete a separate application.
- Inform patients of the hospital's intent to screen for presumptive eligibility for discount payment or charity care, that financial information provided will not be used for any other purpose, and that the patient may opt out of the screening.
- Provide a written notice of the eligibility determination to all patients that are presumptively determined to be eligible for discount payment or charity care in English and the language spoken by the patient.

HCAI reports it would need to perform the following to implement the provisions of AB 1312:

- Review hospital charity care and discount payment policies for compliance with the new requirements, including new presumptive eligibility provisions.
- Determine, during the patient complaint investigation process, if the patient met qualifying parameters to trigger the hospital's presumptive eligibility review.
- Request and review hospital presumptive eligibility notices for compliance with AB 1312

- Investigate whether presumptive eligibility processes are followed, eligibility notices comply with AB 1312, and were sent to the patient within required timeframes.
- Impose administrative penalties against hospitals for violations
- Respond to any appeals submitted by hospitals in response to assessment of penalties.

Staffing and Resource Request. HCAI requests eight positions and expenditure authority from the California Health Planning and Data Fund of $1.6 million in 2026-27, 2027-28, and 2028-29 to support review of hospital charity care and discount payment policies, pursuant to the requirements of AB 1312 (Schiavo), Chapter 450, Statutes of 2025. Specifically, HCAI requests the following positions and resources:

- **One Associate Governmental Program Analyst** position would provide administrative assistance, including tracking and logging of patient complaints, closing patient complaints, and sending administrative penalty notices.
- **One Associate Health Program Advisor** would review policy submissions and patient complaints to identify violations of AB 1312, draft correspondence letters to hospitals requesting documents required by AB 1312, draft closing letters, and assist with administrative penalty notices.
- **Two Health Program Specialist I** positions would serve as secondary reviewer to confirm violations and penalty assessments, assist with preparing witness lists and evidentiary documents for the appeal process, and serve as liaison between hospitals and HCAI program staff to facilitate seamless policy and complaint review.
- **One Attorney IV** position would review and confirm AB 1312 violations identified by staff attorneys and analysts during the policy review and patient complaint processes and take lead on responding to appeals filed by hospitals.
- **One Staff Services Manager I** would manage critical human resources operational functions to support the staff meeting the requirements of AB 1312, including managing audits, leave management escalations, and internal control tracking.
- **One Senior Accounting Officer** would process penalty assessment invoices, track payment progress, and notify hospitals of delinquent penalties.
- **One Attorney IV** position would act as hearing officer, including holding hearings and issuing written determinations.

Trailer Bill Language Request – Hospital Fair Pricing Act. HCAI also requests trailer bill language to establish the Hospital Fair Pricing Penalties Fund to collect administrative penalty revenue collected pursuant to AB 1312, and authorize its use to implement the provisions of the bill and related regulations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 7: Data Exchange Framework (SB 660)

Budget Change Proposal – April Finance Letter. HCAI requests expenditure authority from the California Health Data and Planning Fund of $1.5 million in 2026-27 and 2027-28. If approved, these resources would support administration of the Data Exchange Framework Program by HCAI, pursuant to the provisions of SB 660 (Menjivar), Chapter 325, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0001 – General Fund	$4,264,000	$-
0890 – Federal Trust Fund	$4,264,000	$-
Total Funding Request:	**$4,264,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. 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.

January Budget Proposal Transfers DxF Resources from CalHHS to HCAI. In the January budget, CalHHS and HCAI requested the 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 DxF and the Office of Patient Advocate from CalHHS to HCAI. No additional resources were included in this transfer to support the additional HCAI responsibilities included in SB 660.

Resource Request. HCAI requests expenditure authority from the California Health Data and Planning Fund of $1.5 million in 2026-27 and 2027-28 to support administration of the Data Exchange Framework Program by HCAI, pursuant to the provisions of SB 660 (Menjivar), Chapter 325, Statutes of 2025. Specifically, HCAI requests the following position equivalents:

- Resources equivalent to **one Assistant Chief Counsel** would oversee a team of attorneys supporting oversight, regulatory review, contracting and compliance reporting requirements, managing litigation, serving in a lead role over health data privacy, and supporting compliance with federal and state health privacy laws and regulations, as well as the Bagley-Keene Public Meeting Act and the Administrative Procedures Act.
- Resources equivalent to **one Attorney IV** position would serve as lead legal counsel for the DxF program.
- Resources equivalent to **one Manager II** position would provide senior management of program areas and supervisors to perform oversight of all new programmatic activities.
- Resources equivalent to **two Supervisor II** positions would provide higher level management of new program areas, including the new Qualified Health Information Organization (QHIO) program and oversight over complex program activity.
- Resources equivalent to **one Supervisor I** position would provide program-level management, planning and implementation support, and oversight of accountability activities.
- Resources equivalent to **one Health Program Specialist II** position would assess the regulatory landscape, develop rulemaking to support the QHIO program and enforcement actions, enact amendments to the data sharing agreement policies and procedures, and other guidance materials, coordinate contract provision, and make state licensing agency referrals.
- Resources equivalent to **one Research Data Specialist I** position would perform analysis to support Stakeholder Advisory Committee discussions, develop legislative reports, and support strategic direction setting for the program.
- Resources equivalent to **four Analyst II** positions would manage program activities, stakeholder outreach and engagement, development of rulemaking packages, budgets and contracts administration.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 8: Healthcare Payments Data Program

Budget Change Proposal and Trailer Bill Language – April Finance Letter. HCAI requests expenditure authority of $22.5 million ($17.5 million Health Care Payments Data Fund and $5 million reimbursements) in 2026-27 and $23.6 million ($18.6 million Health Care Payments Data Fund and $5 million reimbursements) annually thereafter. Expenditure authority from the Health Care Payments Data Fund is derived from transfers from various special funds and user fees. If approved, these resources would support the operation of the Healthcare Payments Data (HPD) Program.

HCAI is also requesting transfer to DHCS of four positions and expenditure authority of $829,000 ($207,000 California Health Data and Planning Fund and $622,000 federal funds) in 2026-27, and $793,000 ($198,000 California Health Data and Planning Fund and $595,000 federal funds) annually thereafter to manage and transmit Medi-Cal data to HCAI and utilize HPD to support management of the Medi-Cal program. This portion of the request will be heard by the subcommittee when it considers May Revision proposals for DHCS.

In addition, HCAI is requesting trailer bill language to authorize transfer of funds from various special fund and revenue sources to the Health Care Payments Data Fund to support the HPD Program.

Multi-Year Funding Request Summary – HCAI HPD Request		
Fund Source	**2026-27**	**2027-28***
0995 – Reimbursements	$5,000,000	$5,000,000
3436 – Health Care Payments Data Fund	$17,500,000	$18.600,000
Total Funding Request:	**$22,500,000**	**$22,500,000**
Total Requested Positions:	**-4.0**	**-4.0**

* Resources ongoing after 2027-28.

Background. AB 1810 (Committee on Budget), Chapter 35, Statutes of 2018, established the Healthcare Payments Data (HPD) system, California's all-payer claims database, which collects healthcare administrative data such as claims and encounters. According to HCAI, the information from the HPD System is intended to support greater health care cost transparency and is used to inform policy decisions regarding the provision of quality health care, to reduce health care costs and disparities, and to develop innovative approaches, services, and programs to deliver health care that is both cost effective and responsive to the needs of all Californians. The HPD System also supports the calculation of total healthcare expenditures for HCAI's Office of Health Care Affordability, assists DHCS in federal Medi-Cal reporting, supplements CDPH communicable disease surveillance activities, informs analysis of proposed healthcare legislation at the California Health Benefits Review Program, and allows researchers and analysts access to data to support research on the healthcare system.

The 2025 Budget Act included 47 positions and one-time expenditure authority of $15 million ($6 million General Fund, $2.2 million reimbursements, and $6.8 million Health Care Payments Data Fund) in 2025-26 and $5.5 million reimbursements annually thereafter, as well as reappropriation of remaining General Fund expenditure authority originally approved in the 2018 Budget Act, to support operation and implementation of the HPD System. The Legislature also approved trailer bill language to authorize transfer of funding to support the HPD System from the Managed Care Administrative Fines and Penalties Fund. These positions and resources supported operations of the HPD System including data collection and quality management for submissions from health plans and insurers, DHCS, and the federal Centers for Medicare and Medicaid Services. In addition, these positions and resources supported database technology infrastructure, data management, analysis, public reporting, and release of data; program support services including data governance, privacy, security, committee management, information technology (IT) services, and acquisition and management services; and IT consulting and professionals services.

Resource Request. HCAI requests expenditure authority of $22.5 million ($17.5 million Health Care Payments Data Fund and $5 million reimbursements) in 2026-27 and $23.6 million ($18.6 million Health Care Payments Data Fund and $5 million reimbursements) annually thereafter. Expenditure authority from the Health Care Payments Data Fund is derived from transfers from various special funds and user fees. These resources would support the operation of the Healthcare Payments Data (HPD) Program. Specifically, HCAI requests the following transfers from special funds to the Health Care Payments Data Fund:

- California Health Data and Planning Fund - $6,250,000 in 2026-27 and 2027-28
- Health Plan Improvement Trust Fund - $6,250,000 in 2026-27 and 2027-28
- Pharmacy Benefit Manager Fund - $4,500,000 in 2026-27 and $5,600,000 in 2027-28
- Medi-Cal Federal Funds - $5,000,000 in 2026-27 and 2027-28
- Collected User Fees - $500,000 in 2026-27 and 2027-28

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How would the transfer of funding from the various special funds to the Health Care Payments Data Fund impact the programs supported by those funds, as well as those funds' fiscal sustainability?

Issue 9: CalRx Biosimilar Insulin Program Reappropriation

Reappropriation – May Revision. HCAI requests reappropriation of up General Fund expenditure authority of up to $18.4 million, originally authorized in the 2022 Budget Act. Of these amounts, $18.3 million is for local assistance and $105,000 is for state operations and would be available for encumbrance or expenditure until June 30, 2029. If approved, these reappropriated resources would support continued development of low-cost interchangeable biosimilar insulins.

Background. SB 852 (Pan), Chapter 207, Statutes of 2020, the California Affordable Drug Manufacturing Act of 2020, requires the California Health and Human Services Agency (CalHHS) to enter into partnerships or contracts resulting in the production or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers, suppliers, and pharmacies. SB 852 targets failures in the market for generic drugs resulting from supplier concentration and other anti-competitive practices that lead to higher prices for consumers and health care service providers. CalHHS is required to prioritize production and distribution of drugs that would have the greatest impact on lowering patient drug costs, increasing competition, addressing shortages, and improving public health. In making these determinations, CalHHS must consider the drug expenditure reporting from the Department of Managed Health Care and the Department of Insurance pursuant to SB 17 (Hernandez), Chapter 603, Statutes of 2017, as well as prioritize the production of at least one form of insulin, drugs for chronic and high-cost conditions, and those that can be delivered through mail order.

The 2022 Budget Act included one-time General Fund expenditure authority of $100 million to establish the Biosimilar Insulin Initiative, consistent with the mandate included in SB 852 to prioritize the production of insulin. Of this amount, $50 million was allocated to enter into a partnership with a contract manufacturer to develop and bring to market interchangeable biosimilar insulin products in both vial and pen form. 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.

Reappropriation Request. HCAI requests reappropriation of up General Fund expenditure authority of up to $18.4 million, of which $18.3 million is for local assistance and $105,000 is for state operations, available for encumbrance or expenditure until June 30, 2029. If approved, these reappropriated resources would support continued development of low-cost interchangeable biosimilar insulins. HCAI reports the timeline for developing three separate biosimilar insulin products (aspart, glargine, and lispro) will take longer than originally expected due to regulatory and technical delays in biosimilar drug development from the state's partner, CivicaRx.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Has CivicaRx provided a timeline for development or distribution of the additional insulin products?

Issue 10: Diaper Access Initiative

Budget Bill Language Proposal – May Revision. HCAI requests budget bill language to exempt the Diaper Access Initiative from provisions of the Public Contract Code.

Background. The 2025 Budget Act included General Fund expenditure authority of $7.4 million in 2025-26 and $12.5 million in 2026-27 to support establishment of the Diaper Access Initiative, to provide 400 free diapers to every baby born in California, regardless of income. In May 2026, the Governor announced the state would be partnering with Baby2Baby to launch Golden State Start, which will provide free diapers to all new babies born in California. For the first year of the program, HCAI and Baby2Baby will prioritize hospitals that serve large numbers of Medi-Cal patients.

Budget Bill Language – Public Contract Code Exemption for the Diaper Access Initiative. HCAI requests budget bill language to exempt the Diaper Access Initiative from provisions of the Public Contract Code.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Would this exemption cover the announced contract with Baby2Baby? What other contracts does HCAI anticipate needing to implement the Diaper Access Initiative/Golden State Start?

Issue 11: Distressed Hospital Augmentation

Local Assistance and Budget Bill Language – May Revision. HCAI requests budget bill language to authorize an augmentation of General Fund expenditure authority of $50 million in 2026-27. If approved and augmented, these resources would support grants to hospitals in immediate and significant financial distress to help prevent closure of those hospitals.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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

Volatility in Hospital Profitability Based on State and Federal Policy Changes. According to a recent analysis by the Legislative Analyst's Office (LAO), hospital profitability fell significantly in early 2022, likely due to lingering impacts on hospital volume from the COVID-19 pandemic, as well as increases in inflation and slower investment returns. The typical hospital's margin fell to nearly zero percent. After implementation of the Distressed Hospital Loan Program, hospital margins overall have rebounded to near pre-pandemic levels, but some hospitals are still in distress. Identifying these hospitals could be difficult due to point-in-time limitations on data reported to HCAI.

Early Action to Support Hospitals in Immediate and Significant Financial Distress. Earlier this year, the Legislature approved and the Governor signed AB 108 (Gabriel), Chapter 8, Statutes of 2026 to provide General Fund expenditure authority of $25 million to HCAI to support hospitals in immediate and significant financial distress and at risk of imminent closure. Hospitals eligible for grant funds must meet the following criteria:

- The hospital must have less than 10 days cash on hand
- The hospital must have demonstrated best efforts to exhaust other financial options
- More than 50 percent of the hospital's payer mix is composed of government payers and uninsured patients
- The hospital must be a not-for-profit or public hospital
- Any other criteria determined by HCAI, in consultation with the Department of Finance

The language also exempted HCAI from the Public Contract Code, allowed implementation through information notices or similar actions, and required any unobligated funds be returned to the General Fund as of June 30, 2026.

On May 12, 2026, HCAI launched the Distressed Hospital Small Grant Program authorized by AB 108. Applications were due to HCAI by May 18th, 2026, with releases of grant award determinations expected by May 26, 2026.

Local Assistance and Budget Bill Language – Distressed Hospitals. HCAI requests budget bill language to authorize an augmentation of General Fund expenditure authority of $50 million in 2026-27. If approved and augmented, these resources would support grants to hospitals in immediate and significant financial distress to help prevent closure of those hospitals. The requested funding and provisions are identical to those included in AB 108 and would support not-for-profit or public hospitals under the same eligibility criteria, including 10 days or less cash on hand, 50 percent payer mix of public programs or uninsured, exhaustion of other financial options, and other criteria established by HCAI in consultation with the Department of Finance.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Is HCAI monitoring the financial health of hospitals with enough regularity to be able to determine if a hospital is at risk of having 10 days or less cash on hand?

3. What data limitations exist and what additional reporting could help mitigate those limitations?

Issue 12: Opioid Settlements Fund Reversion

Reversion – May Revision. HCAI requests reversion of expenditure authority from the Opioid Settlements Fund of $19.6 million, originally authorized in the 2023 Budget Act. If approved, these

resources would be redirected to DHCS to support the non-federal share of Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) costs in the Medi-Cal program.

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

Beginning in 2021, the coalition of attorneys general announced several settlement agreements with manufacturers and distributors of opioids to mitigate the costs to state public benefit and other programs due to the opioid epidemic. The revenue California receives from these settlement agreements is deposited in the Opioid Settlements Fund (OSF), established in the 2022 Budget Act to receive settlement revenue and allow its use to support state efforts to remediate the impacts of opioid use disorders in California. Recent investments from the OSF have included support for the Naloxone Distribution Project, the California Opioid Prevention and Harm Reduction Initiative, ATLAS Platform Operation and Outreach Campaign, Fentanyl Education and Awareness Campaigns, Opioid Overdose Data Collection and Analysis, and Integrating Employment in Recovery Pilot Project. At HCAI, the 2023 Budget Act included expenditure authority from the OSF of $30 million to support the CalRx Naloxone Initiative, to develop, manufacture, or procure low-cost naloxone. The CalRx Naloxone Initiative has resulted in a partnership with Amneal Pharmaceuticals to manufacture and distribute naloxone nasal spray at $19 per twin-pack. CalRx naloxone is available through a CalRx direct-to-consumer website.

Reversion Request. HCAI requests reversion of expenditure authority from the Opioid Settlements Fund of $19.6 million, originally authorized in the 2023 Budget Act, to be redirected to DHCS to support the non-federal share of Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) costs in the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How would continuation of the CalRx Naloxone Initiative be supported with the reversion of these funds?

Issue 13: Rural Health Transformation Program Implementation

Budget Change Proposal – May Revision. HCAI requests federal fund expenditure authority of $126.4 million in 2026-27. Of this amount, $11.4 million would be state operations, and $115 million would be

local assistance. If approved, these resources would support the Rural Health Transformation Program, developed under provisions of House Resolution (HR) 1.

HCAI also requests budget bill language to exempt the program from certain provisions of the Public Contract Code and to use a third-party administrator to operate the program.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0890 – Federal Trust Fund (State Operations)	$11,396,000	$-
0890 – Federal Trust Fund (Local Assistance)	$114,968,000	$-
Total Funding Request:	**$126,364,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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.

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.

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.

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.

Third-Party Administrator. According to HCAI, the scope and complexity of administering grants under the RHTP in such a short timeline requires assistance of a third-party administrator (TPA). The TPA would allow for scalability and specialized experience to administer and monitor these programs and allow HCAI to focus on strategic oversight, financial management and oversight, and policy development.

Resource Request. HCAI requests federal fund expenditure authority of $126.4 million in 2026-27 ($11.4 million state operations and $115 million local assistance) to support the Rural Health Transformation Program, developed under provisions of House Resolution (HR) 1. Specifically, HCAI requests the following:

- Personnel costs of $3.2 million
- Costs for consultants, contractors, and subrecipients of grants of $118.5 million.
- Indirect costs of $4.6 million.

These costs include contract resources of $3.5 million in 2026-27 would support the following:

- *Program Management* – HCAI plans to engage program management consultants to provide specialized, time-limited support for successful implementation of the RHTP during the fixed federal funding period. Consultants would assist with strategic planning, program design, and governance development, including establishing a Rural Health Policy Council. The consultants would also provide subject matter expertise in rural health systems, financing, and information technology (IT) infrastructure; develop evaluation frameworks to measure program impact; support research and data analysis to inform evidence-based decisions; and lead community outreach and communications to engage rural and Tribal communities.
- *TPA for Grant Administration* – HCAI plans to engage a contractor to serve as the TPA for grants related to rural health technology and tools improvement, and hub-and-spoke implementation. The contractor would assist HCAI with subaward payments by creating grant management plans, award and monitoring protocols, and oversight processes. The contractor would also provide technical assistance to grantees related to documentation required to issue payments, monitor grantees' service obligations, close grant agreements, and design a data dashboard to track subrecipient outcomes and performance.

Budget Bill Language – Contract Code Exemptions and Third-Party Administrator. HCAI also requests budget bill language to exempt the program from certain provisions of the Public Contract Code and to use a third-party administrator to operate the program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Previously HCAI announced its RHTP award was $233.6 million in the first year. Why is this request for approximately $100 million less than that amount?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 14: Pharmacy Benefit Manager Licensure and Data Requirements

Budget Change Proposal – April Finance Letter. DMHC requests eight positions and expenditure authority from the Pharmacy Benefit Manager Fund of $5.6 million in 2026-27, nine positions and expenditure authority of $4.3 million in 2027-28, and ten positions and $4.4 million annually thereafter. If approved, these positions and resources would support implementation of new licensing requirements on pharmacy benefit managers established pursuant to SB 116 (Committee on Budget and Fiscal Review), Chapter 21, Statutes of 2025.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3447 – Pharmacy Benefit Manager Fund	$5,641,000	$4,333,000
Total Funding Request:	**$5,641,000**	**$4,333,000**
Total Requested Positions:	**8.0**	**9.0**

* Additional fiscal year resources requested – 2028-29: $4,426,000; 2029-30 and ongoing: $4,418,000.

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.

Accompanying these new requirements, the 2025 Budget Act included six positions and expenditure authority from the Pharmacy Benefit Manager Fund of $6.2 million in 2025-26 to implement the licensure and data reporting requirements for PBMs included in AB 116.

Staffing and Resource Request. DMHC requests eight positions and expenditure authority from the Pharmacy Benefit Manager Fund of $5.6 million in 2026-27, nine positions and expenditure authority of $4.3 million in 2027-28, and ten positions and $4.4 million annually thereafter. If approved, these positions and resources would support implementation of new licensing requirements on pharmacy benefit managers established pursuant to SB 116 (Committee on Budget and Fiscal Review), Chapter 21, Statutes of 2025. These resources would maintain ongoing funding for the six positions authorized in the 2025 Budget Act and provide additional ongoing resources to implement information technology systems for PBM licensure activities and provide administrative oversight. Specifically, DMHC requests the following positions and resources:

Office of Plan Licensing – $2.1 million annually for three new positions, four positions approved in 2025, and consultant funding of $508,000

- **One Supervisor I** position would lead and oversee the analytical team, provide guidance on the filing review guidelines and All Plan Letters, and facilitate and oversee meetings with stakeholders.

- **Two Analyst II** positions would assist with development of compliance implementation and the ongoing analytical review and responsive comments for PGM filings, including review of formularies and policies and procedures to verify compliance.

- Consultant funding of $508,000 annually would support pharmacy consultants to assist in reviewing complex pharmaceutical relationships, payment reimbursements and methodologies.

Office of Financial Review – Four positions and $1.6 million in 2026-27, five positions and $1.5 million in 2027-28, and six positions and $1.6 million annually thereafter; including support for one position approved in 2025, and contract and licensing resources of $418,000 in 2026-27, $217,000 in 2027-28 and $119,000 annually thereafter

- **One Supervising Corporation Examiner** would oversee PBM examination activities, work closely with management teams and health plans to develop and implement corrective action plans, conduct final reviews of financial statements and other submissions to verify accuracy and compliance, and collaborate with stakeholders.

- **One Corporation Examiner IV Supervisor** would oversee PBM examination activities and collaborate with management teams and PBMs to develop and implement corrective action plans, address examination outcomes, support the development and enhancement of examination tools, procedures and protocols, provide direct supervision and training for corporation examiners, review work products, serve as first point of escalation for complex issues, propose and implement process improvements.

- **Two Corporation Examiners** in 2026-27, increasing to **three Corporation Examiners** in 2027-28 and **four Corporation Examiners** annually thereafter would coordinate with the Office of Plan Licensing on implementation of activities and development of reporting templates.

- Consultant costs of $406,000 in 2026-27, $203,000 in 2027-28, and $102,000 annually thereafter would support the update of PBM reporting templates, develop audit procedures, and assist on financial review of quarterly and annual reports.

- Analytics client software licensing costs of $12,000 in 2026-27, $14,000 in 2027-28, and $17,000 annually thereafter would support statistical analysis licensing costs required to assist staff in conducting financial reviews and assist in determining compliance with the Knox-Keene Act.

Office of Enforcement – $290,000 in 2026-27 and $282,000 annually thereafter for one position and software licensing costs

- **One Attorney IV** position would provide legal support for investigating PBM referral cases, including case evaluation, drafting discovery materials and recommending appropriate courses of action.

- Software licensing costs of $2,000 annually for legal software licensing to support the enforcement position.

Office of Legal Services - $288,000 in 2026-27 and $280,000 annually thereafter to maintain one position approved in 2025.

Office of Administrative Services – $10,000 annually for continuing legal training licenses for legal administrative positions

Office of Technology and Innovation – $1.4 million in 2026-27, $158,000 in 2027-28 and $162,000 annually thereafter for consultant services and California Department of Technology and Department of General Services fees.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 15: California Managed Care Complaint System Resources and Project Implementation

Budget Change Proposal – May Revision. DMHC requests expenditure authority from the Managed Care Fund of $3.3 million in 2026-27. If approved, these resources would support health plan member and provider complaints through the California Managed Care Complaint System in the DMHC Help Center.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0933 – Managed Care Fund	$3,336,000	$-
Total Funding Request:	**$1,721,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The DMHC Help Center educates health plan members about their health care rights, resolves health plan member complaints, helps health plan members navigate and understand their coverage and assists health plan members in getting timely access to appropriate health care services. Through a team of health care analysts, nurses and attorneys, the Help Center uses a variety of mechanisms to assist health plan members. Common complaints include cancellation of coverage, billing issues, quality of service, denied health care services, coverage disputes and access complaints.

According to DMHC, the Help Center currently operates two separate complaint case management systems to manage and process health plan member and provider complaints. The Provider Complaint System (PCS) was implemented in 2015 as a custom software application developed by DMHC. This custom framework has led to increased challenges when trying to implement major upgrades and cannot handle the long-term needs for processing all provider complaints due to outdated underlying technology.

The Customer Relationship Management System (CRM) was implemented in 2001, and was updated with a proprietary sustaining technology in October 2018. The system also includes outdated underlying

technology, which makes it difficult for DMHC's information technology (IT) staff to keep up with changing program needs.

The 2025 Budget Act included expenditure authority from the Managed Care Fund of $1.2 million in 2025-26 to support planning to modernize the CRM in the Help Center. These planning activities have led to the current proposal, to implement a new California Managed Care Complaint System (CalMaCCS), to provide timely health plan member and provider assistance, address increases in complaint volume and expedited complaints, improve processing times and comply with data reporting and auditing requirements.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $3.3 million in 2026-27 to support health plan member and provider complaints through the California Managed Care Complaint System in the DMHC Help Center. Specifically, DMHC requests the following resources:

- Consultant funding of $2.9 million in 2026-27 would support the following IT project consultants to assist with initial implementation and development of the new CalMaCCS system and maintenance and operations activities during the project:
  - Senior Technical Lead
  - Senior Project Manager
  - Business Solutions Analyst
  - Two Senior Programmers
  - Two Senior Quality Assurance Analysts
  - Maintenance and Operations

- Annual licensing costs of $107,000 in 2026-27 for annual platform licensing. DMHC plans to redirect $290,000 from existing CRM platform licensing expenditures to partially offset the new CalMaCCS platform licensing costs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 16: Electronic Filing/Analysis of Claims Settlement Data Project Implementation (AB 3275)

Budget Change Proposal – May Revision. DMHC requests expenditure authority from the Managed Care Fund of $2.4 million in 2026-27 and $2 million in 2027-28. If approved, these resources would support implementation of an Electronic Filing and Analysis of Claims (eFACS) data solution to meet the requirements of AB 3275 (Soria), Chapter 763, Statutes of 2024.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
0933 – Managed Care Fund	$	$2,169,000

Total Funding Request:	**$2,420,000**	**$2,026,000**
Total Requested Positions:	**0.0**	**0.0**

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

The 2025 Budget Act included 17 positions and expenditure authority from the Managed Care Fund of $4.6 million in 2025-26, 24 positions and $5.4 million in 2026-27, $5.4 million in 2027-28, $5.4 million in 2028-29, and $5.5 million annually thereafter to support the planning phase to implement an Electronic Filing and Analysis of Claims (eFAC) Settlement data solution. These additional resources are to support the implementation phase of the project.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $2.4 million in 2026-27 and $2 million in 2027-28 to implement an Electronic Filing and Analysis of Claims (eFACS) data solution to meet the requirements of AB 3275 (Soria), Chapter 763, Statutes of 2024. Specifically, DMHC requests the following positions and resources:

- Consultant costs of $2.1 million in 2026-27 and $1.8 million in 2027-28 to support the following project implementation consultants:
    - Senior Technical Lead Architect
    - Senior Project Manager
    - Business Solutions Analyst
    - Senior Programmer
    - Senior Data Engineer
    - Senior Report Developer
    - Senior Quality Assurance Analyst
- California Department of Technology project oversight costs of $52,000 in 2026-27 and 2027-28.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4560 COMMISSION FOR BEHAVIORAL HEALTH

Issue 17: Reduction of Resources for Behavioral Health Services Act Innovation Partnership

Budget Solution – May Revision. The Administration requests reduction of expenditure authority from the Behavioral Health Services Fund of $10 million. If approved, this reduction would cut in half the available resources made available to the Innovation Partnership Fund administered by CBH pursuant to Proposition 1, approved by voters in 2024.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28**
3085 – Behavioral Health Services Fund	($10,000,000)	$-
Total Funding Request:	**($10,000,000)**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The Behavioral Health Services Act allocates up to $20 million annually from the Behavioral Health Services Fund to support the Innovation Partnership Fund. BHSA requires the commission to use the fund to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorders and practices. The funded innovative programs and practices are required to improve BHSA programs and practices for underserved populations, low-income populations, communities impacted by behavioral health disparities, and other populations determined by the commission.

Round 1 Request for Application Released in March. On March 20, 2026, CBH released a request for application (RFA) for Round 1 of funding for the Innovation Partnership Fund. The RFA identified two grant categories available for funding:

1) *Small Grants* – The program will award a minimum of eight grants of less than $500,000 each to community-based organizations, non-profit entities, or tribal organizations.

2) *Large Grants* – The program will award a minimum of three grants of between $500,000 and $5 million to organizations of any size or type.

Grantees will enter into a contract with CBH that will require a workplan within the first 90 days, a semi-annual implementation and outcomes survey for staff and clients, a semi-annual data submission, a semi-annual quality improvement plan, an annual report detailing information about the project, and an annual expenditure summary.

Applications were due to CBH by May 8, 2026, with award announcements anticipated on June 15, 2026. Contracts would begin in July 2026.

Reduction of Funding Request. The Administration requests reduction of expenditure authority from the Behavioral Health Services Fund of $10 million, which would cut in half the available resources made available to the Innovation Partnership Fund administered by CBH pursuant to Proposition 1, approved by voters in 2024. The Administration proposes to deposit $10 million of the $20 million available under

Proposition 1 into the Behavioral Health Services Act Innovation Partnership Fund to support the grant program for which CBH was scheduled to announce awards on June 15, 2026. It is unclear how the commission would manage adjustments to awards if this proposal were approved and the amount of available funding were reduced by half. The reductions to CBH funding from the Behavioral Health Services Fund are part of the Administration's overall expenditure plan that utilizes these funds from CBH, HCAI, and CDPH to offset General Fund expenditures elsewhere in the budget and address General Fund shortfalls in 2027-28.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested CBH and DOF respond to the following:

1. DOF: Please provide a brief overview of this proposal.

2. DOF: What is the rationale for proposing a withdrawal of half of this funding just before the expected announcement of awards?

3. CBH: What types of programs applied for funding under the Innovation Partnership Fund?

4. CBH: How would the commission manage an abrupt termination of half of the funding for this program immediately before award announcements?

Issue 18: Reduction of Resources for Behavioral Health Advocacy Contracts

Budget Solution – May Revision. The Administration requests reduction of expenditure authority from the Behavioral Health Services Fund of $6.7 million. If approved, this reduction would eliminate resources made available since the adoption of the Mental Health Services Act in 2004 for advocacy contracts that ensure consumers, families, and historically underserved communities can meaningfully participate in planning, oversight, and continuous improvement of California's behavioral health system.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3085 – Behavioral Health Services Fund	($6,700,000)	($6,700,000)
Total Funding Request:	**($6,700,000)**	**($6,700,000)**
Total Requested Positions:	**0.0**	**0.0**

***** Reduction of resources ongoing after 2027-27.

Background. Since the approval of the Mental Health Services Act by voters in 2004, CBH has awarded contracts to local and state-level organizations to provide advocacy, training and education, outreach and engagement on behalf of specific groups of people. These organizations advocate for a state and local system that is client and family-driven, culturally competent, and collaborative in design. The advocacy contracts provide opportunities for engagement and are a direct expression of one of the fundamental commitments of the Mental Health Services Act and reconfirmed by the Behavioral Health Services Act: "Nothing about us without us". The nine populations and 16 contracts that are part of the program are as follows:

Advocacy Population	*Advocacy Contractor(s)*
LGBTQIA+ Community	Mental Health of America
Diverse Racial/Ethnic Minorities	CA Pan-Ethnic Health Network
Veterans	CA Association of Veteran Service Agencies
K-12	Youth Leadership Institute
Clients/Consumers	CalVoices
Family Members	National Alliance on Mental Illness
Parents	United Parents
Transition Age Youth	ProYouth
Immigrants and Refugees (Statewide)	CA Pan-Ethnic Health Network
Immigrants and Refugees (Local)	Asian Americans for Community Involvement
Immigrants and Refugees (Local)	Center for Empowering Refugees and Immigrants
Immigrants and Refugees (Local)	Health Education Council
Immigrants and Refugees (Local)	Refugees Enrichment and Development Assoc
Immigrants and Refugees (Local)	BPSOS Center for Community Advancement
Immigrants and Refugees (Local)	El Sol Neighborhood Educational Center
Immigrants and Refugees (Local)	International Rescue Committee

Reduction of Funding Request. The Administration requests reduction of expenditure authority from the Behavioral Health Services Fund of $6.7 million, which would eliminate resources made available since the adoption of the Mental Health Services Act in 2004 for advocacy contracts that ensure consumers, families, and historically underserved communities can meaningfully participate in planning, oversight, and continuous improvement of California's behavioral health system.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested CBH and DOF respond to the following:

1. DOF: Please provide a brief overview of this proposal.

2. DOF: Does the Administration believe the populations currently supported by advocacy contracts are no longer in need of support for engagement in the behavioral health system?

3. CBH: How do these contractors help support the populations of focus in engaging in the behavioral health system?

4. CBH: Without these contractors, are there any other resources are available to specifically assist these sensitive populations with high behavioral health care needs in engaging and interacting with the behavioral health system on which many rely for essential care?

4800 COVERED CALIFORNIA

Issue 19: State Premium Subsidy Augmentation

Program Augmentation – May Revision. The Administration requests total, ongoing expenditure authority from the Health Care Affordability Reserve Fund of $300 million annually. If approved, these resources would support additional state health care affordability subsidies for consumers in the Covered California health benefit exchange.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
3381 – Health Care Affordability Reserve Fund	$300,000,000	$300,000,000
Total Funding Request:	**$300,000,000**	**$300,000,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2027-28.

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

Program Augmentation – State Health Care Affordability Subsidies. The Administration requests total, ongoing expenditure authority from the Health Care Affordability Reserve Fund of $300 million annually to support additional state health care affordability subsidies for consumers in the Covered California health benefit exchange. According to the Administration, this level of premium subsidy would allow expansion of the state premium subsidy program to enrollees up to 200 percent of the federal poverty level.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal, including the expected level of premium support at various income levels available with this additional funding.

Issue 20: Health Care Affordability Reserve Fund – Gender Affirming Care and Abortion Services

Expenditure Adjustment and Fund Shift – May Revision. The Administration requests expenditure authority from the Health Care Affordability Reserve Fund of $26.8 million in 2026-27 and $13.4 million in 2027-28 to augment the Gender Affirming Care program, beginning in the 2026 coverage year, to align program funding with projected per-member per-month costs.

The Administration also requests expenditure authority from the Health Care Affordability Reserve Fund of $20.4 million annually, and a reduction in equivalent General Fund expenditure authority, to shift funding for support of the One-Dollar Premium Subsidy Program that provides payments to qualified health plan issuers for abortion services.

Multi-Year Funding Request Summary		
Fund Source	**2026-27**	**2027-28***
0001 – General Fund	($20,350,000)	($20,350,000)
3381 – Health Care Affordability Reserve Fund	$47,198,000	$33,774,000
Total Funding Request:	**$26,848,000**	**$13,424,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2027-28.

Background – One Dollar Premium Subsidy Program. Section 1303 of the federal Patient Protection and Affordable Care Act (ACA) prohibits the use of certain federal funds to pay for coverage of abortions by Qualified Health Plans offering coverage in health benefit exchanges, including state-based exchanges such as Covered California. Section 1303 requires plans to charge and collect at least one dollar per enrollee per month for coverage of such abortion services. As a result, Covered California enrollees that would receive federal or state subsidies that would combine to reduce premium costs to zero, instead have to arrange to pay one dollar per month.

The 2021 Budget Act included General Fund expenditure authority of $20 million annually, later augmented to $20.4 million, to subsidize the one dollar per month premium required for the cost of providing abortion services. The subsidy program was implemented in the 2022 coverage year.

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

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

payments by Covered California to health plans to defray the cost of offering state-mandated gender-affirming care benefits in the exchange.

Expenditure Adjustment for Gender Affirming Care and Cost Shift for Abortion Services. The Administration requests expenditure authority from the Health Care Affordability Reserve Fund of $26.8 million in 2026-27 and $13.4 million in 2027-28 to augment the Gender Affirming Care program, beginning in the 2026 coverage year, to align program funding with projected per-member per-month costs.

The Administration also requests expenditure authority from the Health Care Affordability Reserve Fund of $20.4 million annually, and a reduction in equivalent General Fund expenditure authority, to shift funding for support of the One-Dollar Premium Subsidy Program that provides payments to qualified health plan issuers for abortion services.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this adjustment and fund shift.