

SUBCOMMITTEE NO. 3

Agenda

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



Thursday, May 21st, 2026
9:30 am
1021 O Street – Room 1200

PART B

Consultants: Nora Brackbill and Scott Ogus

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PUBLIC COMMENT

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4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview of May Revision Proposals

Summary of Expenditures at May Revision. The May Revision includes \$3.2 billion for the Department of State Hospitals (DSH) in 2026-27, an increase of \$31.4 million as compared to Governor’s budget. Major budget adjustments are outlined below.

Metropolitan: Central Utility Plant Replacement - Revert and Fund New Construction BCP. The May Revision includes a reversion of \$50.4 million and a new appropriation of \$58.1 million one-time Public Buildings Construction Fund for the construction phase of the Central Utility Plant Replacement Project at DSH-Metropolitan, for a net increase of \$7.7 million. This project will upgrade the plant, lines, and connections to provide hot water and chilled water to over 30 buildings at Metropolitan State Hospital. The increase is due to the addition of a new roof and the relocation of the control room to the scope of the project.

Total project costs are estimated at \$62.6 million. The project was funded for preliminary plans in the 2022 Budget Act, and funding for construction was provided in the 2024 Budget Act. Preliminary plans were completed in September 2024. Working drawings began in September 2024 with an estimated completion date by February 2027. Construction is scheduled to begin in February 2027 and be completed by April 2029.

Continuum Electronic Health Record System BCP. The May Revision includes \$27.6 million one-time General Fund in 2026-27 and a reappropriation of up to \$6.3 million from the 2024 Budget Act to support the implementation of the Continuum Electronic Health Record (EHR) System project. DSH currently relies on paper medical records. The proposal assumes that in the budget year, EHR will be implemented at DSH-Coalinga, and preparation activities will occur for DSH-Metropolitan and DSH-Atascadero, as shown in the timeline below. The proposed budget includes provisional language allowing the Department of Finance to appropriate additional funding, after 30 days written notification to Chairperson of the Joint Legislative Budget Committee to maintain that timeline if needed.

Objective	Start Date	Completion Date
CDT Completes edits and releases EHR RFO		August 2024
EHR Procurement complete — contract awarded		March 2026
EHR Vendor comes on board		April 2026
Site 1 - Coalinga EHR implementation	May 2026	March 2027
Site 2 – Metropolitan EHR implementation ¹	March 2027	June 2027
Site 3 – Atascadero EHR implementation ¹	June 2027	September 2027
Site 4 – Napa EHR implementation ¹	September 2027	December 2027
Site 5 – Patton EHR implementation ¹	December 2027	March 2028
System Stabilization	March 2028	July 2028

¹A subsequent BCP will be submitted as system integrator payments won't be due until implementation at each location.

CDT: California Department of Technology
 EHR: Electronic Health Record
 RFO: Request for Offer

Incompetent to Stand Trial (IST) Program Update. The updated savings for IST related programs are \$55.0 million in 2023-24, \$128.8 million in 2025-26, and \$102.2 million in 2026-27. This represents reduced savings from 2023-24 (-\$59 million), and increased savings in 2025-26 and 2026-27 (\$11 million and \$8 million, respectively), as compared to Governor’s budget.

The additional \$59 million in 2023-24 is to support seven IST infrastructure projects that have progressed significantly since the Governor’s budget was developed in the fall. The projects represent a total of 625 beds across Fresno, Humboldt, Orange, Riverside, San Luis Obispo, Santa Barbara, and Stanislaus counties. The Administration had proposed reverting the funding from these projects in the Governor’s budget due to stalled progress.

The increased savings in 2025-26 and 2026-27 are due to delayed program activations and lower than projected census in various community-based programs.

County Bed Billing Reimbursement Authority Program Update. The May Revision includes a decrease in reimbursements by \$12.4 million in 2025-26 and \$5.8 million in 2026-27 and ongoing to reflect a delay in the implementation of a new bed billing allocation methodology for the treatment of Lanterman-Petris-Short patients.

Limited Public Contract Code Exemption Authority. The May Revision includes provisional language to provide DSH with limited Public Contract Code exemption authority for contracts associated with online services and subscriptions providing health care or pharmaceutical information.

Reversion of Unspent Funds. The May Revision reverts \$20 million unspent General Fund from the 2024 Budget Act.

Workforce Development Fund Shift. The May Revision shifts \$10.3 million from General Fund to Behavioral Health Services Act (BHSA) Behavioral Health Workforce Initiative reimbursement in 2026-27, and \$10.9 million in 2027-28 and ongoing, to support its existing workforce development programs. DSH also proposes \$3.8 million in 2026-27 and \$3.5 million in 2027-28 and ongoing in BHSA reimbursement to add an additional Psychiatric Technician Apprenticeship.

Independent Placement Panel (IPP) Trailer Bill Language. The May Revision contains statutory changes to remove the June 30, 2026 sunset date for the IPP program. IPP was established in the 2022 budget package to facilitate placements in Conditional Release Programs (CONREPs) and increase availability of DSH beds for IST placements (SB 184 [Committee on Budget and Fiscal Review], Chapter 47, Statutes of 2022). Through the IPP program, a panel of independent evaluators help identify, evaluate, and find placements for individuals at appropriate CONREPs throughout the state. The 2022 budget package included 8 positions and \$1.7 million annually for the program.

DSH developed policies and procedures for IPP in June 2023 with the input of stakeholder workgroups. As of the 2026-27 Governor’s budget, 17 CONREPs and all 58 counties were participating in the IPP program. As of March 31, 2026, IPP had received a total of 238 referrals, of which 226 had completed evaluations submitted to the courts.

DSH published an evaluation of the IPP program in May 2026¹. In the evaluation, DSH notes that the program led to more consistent placements across the state and better collaboration between CONREP and the state hospitals.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the major adjustments to the DSH budget included in the May Revision.

¹ https://www.dsh.ca.gov/Legislation/docs/DSH_IPP_Report_05182026.pdf

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 2: May 2026 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – May Revision. The May 2026 Medi-Cal Local Assistance Estimate includes \$194.4 billion (\$48.6 billion General Fund, \$117 billion federal funds, and \$28.8 billion special funds and reimbursements) for expenditures in 2025-26, and \$216.7 billion (\$44.9 billion General Fund, \$132.5 billion federal funds, and \$39.3 billion special funds and reimbursements) for expenditures in 2026-27.

Medi-Cal Local Assistance Funding Summary – May Revision <i>(dollars in thousands)</i>			
Fiscal Year:	2025-26 (CY)	2026-27 (BY)	CY to BY
<u>Benefits</u>			
Fund Source	Revised	Proposed	Change
General Fund	\$46,040,975	\$43,105,235	(\$2,935,740)
Federal Funds	\$112,185,807	\$126,036,910	\$13,851,103
Special Funds/Reimbursements	\$28,683,971	\$39,012,457	\$10,328,486
Total Expenditures	\$186,910,753	\$208,154,602	\$21,243,849
<u>Administration</u>			
Fund Source	Revised	Proposed	Change
General Fund	\$2,579,631	\$1,838,000	(\$741,631)
Federal Funds	\$4,775,530	\$6,455,563	\$1,680,033
Special Funds and Reimbursements	\$119,911	\$239,404	\$119,493
Total Expenditures	\$7,475,072	\$8,532,967	\$1,057,895
<u>TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES</u>			
Fund Source	Revised	Proposed	Change
General Fund	\$48,620,606	\$44,943,235	(\$3,677,371)
Federal Funds	\$116,961,337	\$132,492,473	\$15,531,136
Special Funds and Reimbursements	\$28,803,882	\$39,251,861	\$10,447,979
Total Expenditures	\$194,385,825	\$216,687,569	\$22,301,744

Caseload. For 2024-25, the budget assumes annual Medi-Cal caseload was 14.9 million beneficiaries, a decrease of 8,600, or 0.06 percent, compared to assumptions in the January budget. The department estimates in 2024-25 about 14 million beneficiaries, or 93.7 percent, received services through the managed care delivery system while 931,448 beneficiaries, or 6.3 percent, received services through the fee-for-service delivery system.

For 2025-26, the budget assumes annual Medi-Cal caseload of 14.4 million, a decrease of 134,100 beneficiaries, or 0.9 percent, compared to assumptions in the January budget, and a decrease of 483,300, or 3.3 percent, compared to the revised caseload estimate for 2024-25. The department estimates in 2025-

26 about 13.8 million beneficiaries, or 94.9 percent, will receive services through the managed care delivery system while 747,321 beneficiaries, or 5.1 percent, will receive services through the fee-for-service delivery system.

For 2026-27, the budget assumes annual Medi-Cal caseload of 13.9 million, a decrease of 165,900, or 1.2 percent, compared to assumptions in the January budget, and a decrease of 540,200, or 3.8 percent, compared to the revised caseload estimate for 2025-26. The department estimates in 2026-27 about 13.3 million beneficiaries, or 94.7 percent, will receive services through the managed care delivery system while 741,809 beneficiaries, or 5.3 percent, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The May 2026 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures since the January budget:

Current Year (2025-26) Adjustments – The May 2026 Medi-Cal Local Assistance Estimate includes \$194.4 billion (\$48.6 billion General Fund, \$117 billion federal funds, and \$28.8 billion special funds and reimbursements) for expenditures in 2025-26, an increase in General Fund expenditures of \$2.2 billion, or 4.8 percent, compared to assumptions in the January budget. According to DHCS, the primary drivers of increased General Fund expenditures in 2025-26 are as follows:

- *Hospital Quality Assurance Fee Delay and Timing of Reconciliations.* A decrease of \$1.2 billion General Fund savings in 2025-26 due to delayed timing of the Hospital Quality Assurance Fee (HQAF) approval, increased General Fund costs of \$286.8 million from shifting HQAF Program IX payments and including one quarter of estimated HQAF Program X payments in 2026-27, partially offset by the shift of reconciliation payments for previous HQAF programs from 2026-27 to 2025-26.
- *Retroactive Adjustments for State-Only Populations.* General Fund costs of \$288.9 million in 2025-26 from retroactive adjustments for state-only members, including those with unsatisfactory immigration status.
- *Centers for Medicare and Medicaid Services (CMS) Deferrals.* General Fund costs of \$444.6 million from deferrals of payments from the federal Centers for Medicare and Medicaid Services (CMS).

Budget Year (2026-27) Adjustments – The Estimate includes total expenditures of \$216.7 billion (\$44.9 billion General Fund, \$132.5 billion federal funds, and \$39.3 billion special funds and reimbursements) for expenditures in 2026-27, a decrease in General Fund expenditures of \$3.7 billion, or 7.6 percent, compared to the revised assumptions for 2025-26. According to DHCS, the primary drivers of these decreased General Fund expenditures since the January budget are as follows:

- *House Resolution (HR) 1 Medi-Cal Impacts.* Increased General Fund costs of \$363.1 million in 2026-27 compared to the January budget for costs related to HR 1.
- *County Administration Allocation.* Increased General Fund costs of \$73.9 million in 2026-27 to support county administration activities related to HR 1.

- *Unsatisfactory Immigration Status (UIS) Member Transition to Fee-for-Service.* \$471.6 million General Fund savings in 2026-27 from transitioning Medi-Cal members with UIS from the managed care delivery system to the fee-for-service delivery system.
- *Reinstate Asset Limit.* General Fund savings of \$215.7 million in 2026-27 from lowering the asset limit from \$130,000 to \$2,000.
- *California Advancing and Innovating Medi-Cal (CalAIM) Reforms.* General Fund savings of \$68.3 million in 2026-27 from reforms to enhanced care management and community supports services available under CalAIM.
- *Cap Program for All-Inclusive Care for the Elderly (PACE) Rates.* General Fund savings of \$33.7 million in 2026-27 from capping PACE rates at the lower bound of the actuarial rate ranges.
- *Eliminate Medi-Cal Optional Benefit – Acupuncture.* General Fund savings of \$5.4 million in 2026-27 from eliminating acupuncture as a Medi-Cal benefit.
- *Mobile Crisis Services Behavioral Health Services Fund (BHSF) Offset.* General Fund savings of \$20.1 million in 2026-27 from shifting costs for mobile crisis from General Fund to the BHSF.
- *Drug Medi-Cal Organized Delivery System (DMC-ODS) BHSF and Opioid Settlements Fund (OSF) Offset.* General Fund savings of \$135.4 million from supporting the non-federal share of expenditures in the DMC-ODS with BHSF (\$100 million) or OSF (\$35.4 million) instead of General Fund.
- *Managed Care Organization (MCO) Tax.* General Fund savings of \$575 million in 2026-27 from implementation of a new MCO tax effective January 1, 2027. In addition, General Fund savings of \$1.7 billion in 2026-27 from excess MCO tax revenue from Proposition 35.
- *MCO Tax Behavioral Health.* General Fund savings of \$122 million in 2026-27 from use of Proposition 35 funds to support behavioral health.
- *Children and Youth Behavioral Health Initiative (CYBHI) Wellness Coach Benefit BHSF Offset.* General Fund savings of \$5.1 million in 2026-27 from offsetting General Fund costs of the CYBHI wellness coach benefit with BHSF.
- *CYBHI Services and Support Platform BHSF Offset.* General Fund savings of \$56.5 million in 2026-27 from offsetting General Fund costs for the CYBHI Services and Supports Platform with BHSF.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2025-26 and 2026-27 fiscal years compared to the January budget.

Issue 3: November 2025 Family Health Local Assistance Estimate

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

Family Health Local Assistance Funding Summary - May Revision <i>(dollars in thousands)</i>			
Fiscal Year:	2025-26 (CY)	2026-27 (BY)	CY to BY
California Children’s Services (CCS)			
Fund Source	Revised	Proposed	Change
General Fund	\$86,520	\$87,033	\$513
Special Funds/Reimbursements	\$9,110	\$7,174	(\$1,936)
County Funds [non-add]	\$95,093	\$93,796	(\$1,297)
Total CCS Expenditures	\$95,630	\$94,207	(\$1,423)
Genetically Handicapped Persons Program (GHPP)			
Fund Source	Revised	Proposed	Change
General Fund	\$179,019	\$188,098	\$9,079
Special Funds and Reimbursements	\$1,090	\$1,925	\$835
Total GHPP Expenditures	\$180,109	\$190,023	\$9,914
Every Woman Counts Program (EWC)			
Fund Source	Revised	Proposed	Change
General Fund	\$0	\$0	\$0
Federal Funds	\$5,468	\$6,253	\$785
Special Funds and Reimbursements	\$11,499	\$7,434	(\$4,065)
Total EWC Expenditures	\$16,967	\$13,687	(\$3,280)
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	Revised	Proposed	Change
General Fund	\$265,539	\$275,131	\$9,592
Federal Funds	\$5,468	\$6,253	\$785
Special Funds and Reimbursements	\$21,699	\$16,533	(\$5,166)
County Funds [non-add]	\$95,093	\$93,796	(\$1,297)
Total Family Health Expenditures	\$292,706	\$297,917	\$5,211

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

The programs included in the Family Health Estimate are:

- **California Children’s Services (CCS):** The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child’s care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.

- Caseload Estimate (Medi-Cal): For 2024-25, the May Revision estimates Medi-Cal CCS caseload was 174,382, unchanged compared to assumptions in the January budget.

For 2025-26, the May Revision estimates Medi-Cal CCS caseload of 171,737, a decrease of 1,610, or 0.9 percent, compared to assumptions in the January budget.

For 2026-27, the May Revision estimates Medi-Cal CCS caseload of 172,670 173,347, a decrease of 677, or 0.4 percent compared to assumptions in the January budget.

- Caseload Estimate (State-Only): For 2024-25, the May Revision estimates State-Only CCS caseload was 13,231, unchanged compared to assumptions in the January budget.

For 2025-26, the May Revision estimates State-Only CCS caseload of 12,166, a decrease of 552, or 4.3 percent, compared to assumptions in the January budget.

For 2026-27, the May Revision estimates State-Only CCS caseload of 12,265 12,718, a decrease of 453, or 3.6 percent, compared to assumptions in the January budget.

- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington’s, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate

- Caseload Estimate (Medi-Cal): For 2024-25, the May Revision estimates Medi-Cal GHPP caseload was 598, unchanged compared to assumptions in the January budget.

For 2025-26, the May Revision estimates Medi-Cal GHPP caseload of 554, an increase of 19, or 3.6 percent, compared to assumptions in the January budget.

For 2026-27, the May Revision estimates Medi-Cal GHPP caseload of 611 525, an increase of 86, or 16.4 percent, compared to assumptions in the January budget.

- Caseload Estimate (State-Only): For 2024-25, the May Revision estimates State-Only GHPP caseload was 589, unchanged compared to assumptions in the January budget.

For 2025-26, the May Revision estimates State-Only GHPP caseload of 589 517, an increase of 72, or 13.9 percent, compared to assumptions in the January budget.

For 2026-27, the May Revision estimates State-Only GHPP caseload of 519, an increase of 1, or 0.2 percent, compared to assumptions in the January budget.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
 - Caseload Estimate: For 2024-25, the May Revision estimates Every Woman Counts caseload was 8,237, unchanged compared to assumptions in the January budget.

For 2025-26, the May Revision estimates Every Woman Counts caseload of 6,770, a decrease of 1,893, or 21.9 percent, compared to assumptions in the January budget.

For 2026-27, the May Revision estimates Every Woman Counts caseload of 6,526, a decrease of 2,336, or 26.4 percent, compared to assumptions in the January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2025-26 and 2026-27 fiscal years compared to the January budget.

Issue 4: Managed Care Organization (MCO) Tax and Proposition 35

Local Assistance and Trailer Bill Language Proposal – May Revision. DHCS proposes the renewal of a tax on managed care organizations (MCOs) effective January 1, 2027, that conforms with new, stringent HR 1 federal requirements that prohibit taxes that assess a higher rate on Medi-Cal plans than on commercial plans. If approved, this new MCO tax would result in General Fund savings of \$575 million in 2026-27, \$2.3 billion in 2027-28 and 2028-29, and \$1.7 billion in 2029-30.

In addition, DHCS proposes to implement a continuation of an MCO tax, also effective January 1, 2027, that is substantially similar to the current MCO tax, pursuant to the requirements of Proposition 35, approved by voters in 2024, which caps taxes on commercial plans to no more than \$36 million, and requires DHCS seek federal approval of a substantially similar tax.

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

- 1) Prohibits new or increased provider taxes after enactment of the bill (July 4, 2025)
- 2) Phases down the indirect hold-harmless threshold, which serves as a de facto maximum level for the tax to comply with hold-harmless provisions of federal Medicaid regulations, from six percent of total revenues to 3.5 percent.
- 3) Revises criteria for “generally redistributive” taxes to exclude taxes that impose a higher rate on Medi-Cal providers or plans than on other providers or plans, similar to the structure of the current MCO tax.
- 4) Provides the federal Health and Human Services Secretary with discretion to provide a transition period for noncompliant taxes of up to three years.

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

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

Two New MCO Taxes Would Comply With Separate Requirements of Proposition 35 and HR 1. The new MCO tax proposal in the May Revision has two components:

- 1) A “substantially similar” tax that complies with the provisions of Proposition 35 and would be distributed to support provider rate increases and other adjustments according to the requirements of the proposition. The Administration has indicated previously a “substantially similar” tax that adheres to the \$36 million limit on tax liability for non-Medi-Cal plans would result in General Fund resources of approximately \$6 million.
- 2) A tax that is not “substantially similar” and is not subject to the provisions of Proposition 35. According to DHCS, the resources available from this new tax would support the targeted rate increases for primary care, obstetrics, and non-specialty mental health implemented in 2024, as well as offset General Fund resources that support the non-federal share of expenditures in the Medi-Cal program.

DHCS also proposes trailer bill language to implement these new tax provisions.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the structure of the two MCO taxes proposed in the May Revision.
2. What is the total expected amount of allocations to provider rate increases, and to offset General Fund expenditures in the Medi-Cal program, under both taxes?

Issue 5: Behavioral Health Services Act – Redirection of Funding

Budget Change Proposal and Local Assistance – May Revision. The Administration proposes redirection of various allocations from the Behavioral Health Services Fund (BHSF) to offset General Fund expenditures in other state programs that are similar to the allowable activities under Proposition 1, the Behavioral Health Services Act, approved by voters in 2024.

In addition, DHCS requests 10 positions and expenditure authority of \$41.8 million (\$25.9 million BHSF and \$16 million federal funds) in 2026-27, \$1.8 million (\$920,000 BHSF and \$919,000 federal funds) in 2027-28 through 2029-30, and \$1.7 million (\$868,000 BHSF and \$868,000 federal funds) annually thereafter. If approved, these positions and resources would support continued implementation, operations, monitoring, and oversight activities related to the Behavioral Health Transformation.

Multi-Year Funding Request Summary – Budget Change Proposal		
Fund Source	2026-27	2027-28*
0890 – Federal Trust Fund	\$15,958,000	\$919,000
3085 – Behavioral Health Services Fund	\$25,858,000	\$920,000
Total Funding Request:	\$41,816,000	\$1,839,000
Total Requested Positions:	10.0	10.0

* Additional fiscal year resources requested – 2028-29 and 2029-30: \$1,839,000; 2030-31 and ongoing: \$1,736,000

Background. SB 326 (Eggman), Chapter 790, Statutes of 2023, and Proposition 1, approved by the voters in March 2024, authorized significant reforms to the state’s behavioral health programs over the next few years. Known as the Behavioral Health Services Act (BHSA), these reforms will have substantial impacts on the fiscal structure and programmatic operations of behavioral health programs administered by the county behavioral health departments, the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Health Care Access and Information (HCAI), and the Commission on Behavioral Health (CBH). The BHSA sets aside 10 percent of total revenue for the programs administered by state departments, including three percent for HCAI to implement a behavioral health workforce initiative, four percent for CDPH to implement a population-based behavioral health prevention grant program, and the remaining three percent for state-directed purposes.

The January budget included a placeholder for a one-time \$150 million General Fund offset using BHSA funds to support programs currently supported by General Fund resources. \$100 million was expected to offset programs at HCAI under the behavioral health workforce initiative, while \$50 million was expected

to offset programs at the Department of Public Health (CDPH) under the BHSA-funded population-based behavioral health initiative.

BHSF Redirection. The Administration proposes redirection of various allocations from the Behavioral Health Services Fund (BHSF) to offset General Fund expenditures in other state programs that are similar to the allowable activities under Proposition 1, the Behavioral Health Services Act, approved by voters in 2024. These redirections are reflected in the following chart:

2026-27 May Revision - Programs proposed for Behavioral Health Services Fund in Lieu of General Fund (Dollars in Millions)			
Department	Program	Estimated 2026-27 General Fund Savings	Estimated 2027-28 General Fund Savings
<i>Proposition 1 Behavioral Health Workforce Initiative</i>			
Department of Health Care Access and Information	Children and Youth Behavioral Health Initiative Workforce Carryover Funds	\$ 8.5	\$ -
Department of Health Care Services	Children and Youth Behavioral Health Initiative Wellness Coach Benefit	\$ 5.1	\$ 65.3
Department of Health Care Services	Children and Youth Behavioral Health Initiative Behavioral Health Service and Supports Platform	\$ 11.9	\$ 11.9
Department of State Hospitals	Psychiatry Workforce Pipeline Programs	\$ 10.3	\$ 10.9
Department of Corrections and Rehabilitation	Mental Health Training and Outreach Coordination Program	\$ 1.0	\$ 2.6
Subtotal		\$ 36.8	\$ 90.7
<i>Proposition 1 Population-Based Behavioral Health Prevention Programs</i>			
Department of Health Care Services	Children and Youth Behavioral Health Initiative Behavioral Health Service and Supports Platform	\$ 44.6	\$ 98.0
Department of Corrections and Rehabilitation	Staff Training Programs	\$ 1.3	\$ 1.3
Department of Industrial Relations	Equal Representation in Construction Apprenticeship Grant	\$ 3.5	\$ 3.5
Department of Public Health	Office of Suicide Prevention	\$ 2.8	\$ 2.8
Department of Public Health	Overdose Prevention Initiative	\$ 0.2	\$ 0.2
Department of Public Health	Alcohol Harms Prevention Initiative	\$ 0.8	\$ 0.8
Department of Public Health	Future of Public Health Behavioral Health Program	\$ 1.8	\$ 1.8
Subtotal		\$ 55.0	\$ 108.4
<i>Proposition 1 State-Directed Purposes</i>			
Department of Health Care Services	Community-Based Mobile Crisis Services	\$ 20.1	\$ -
Department of Health Care Services	Drug Medi-Cal Organized Delivery System	\$ 100.0	\$ 30.0
Subtotal		\$ 120.1	\$ 30.0
Total Estimated General Fund Savings		\$ 211.9	\$ 229.1

Staffing and Resource Request. DHCS requests 10 positions and expenditure authority of \$41.8 million (\$25.9 million BHSF and \$16 million federal funds) in 2026-27, \$1.8 million (\$920,000 BHSF and \$919,000 federal funds) in 2027-28 through 2029-30, and \$1.7 million (\$868,000 BHSF and \$868,000 federal funds) annually thereafter. If approved, these positions and resources would support continued implementation, operations, monitoring, and oversight activities related to the Behavioral Health Transformation. Specifically, DHCS requests the following:

Audits and Investigations – 10 positions

- **One Health Program Audit Manager II** position, **two Health Program Audit Manager** positions, **six Health Program Auditor III** positions, and **one Nurse Evaluator II** position would allow the DHCS Audits and Investigations unit to conduct behavioral health plan audits of expenditures for Medi-Cal the Behavioral Health Services Act, or grant funded services.

Contract Resources

- *Behavioral Health Oversight and Monitoring Division* - \$90,000 in 2026-27 and \$103,000 annually thereafter for a contractor to support behavioral health funding withholds and monetary sanctions.
- *Information Technology Strategy Services Division* - \$9.9 million in 2026-27 to support a Behavioral Health Transformation Project Management Support Team to manage program and system changes and prepare the department for impacts to programs, systems, and data owners.
- *Medi-Cal Enterprise System Modernization* - \$24 million in 2026-27 to support product development and engineering contracts to support the Integrated Plan application, the Licensing and Certification Portal, the Digital Policy Manual, the Consent Management solution, the Identity Management solution, and Person Matching. \$6 million in 2026-27 to support maintenance and operations for the new IT systems.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the redirections of BHSF proposed by the Administration.
2. How do each of these redirections conform with the required uses of BHSF under Proposition 1?
3. Please provide a brief overview of the positions and resources requested for implementation of the Behavioral Health Transformation.
4. What is the current balance of the State Administration Account for the BHSF? Is this fund balance sufficient to mitigate the volatility of the BHSF funding source?

Issue 6: Opioid Settlements Fund Redirections to Offset General Fund Expenditures.

Fund Shifts and Local Assistance – May Revision. The Administration proposes to redirect funding from the Opioid Settlements Fund to offset General Fund that supports the non-federal share of

expenditures on Drug Medi-Cal Organized Delivery System (DMC-ODS) services in the Medi-Cal program.

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

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

In a separate proposal, the Administration is proposing to revert expenditure authority from the Opioid Settlements Fund of \$19.6 million in HCAI that supported the CalRx Naloxone Initiative.

Opioid Settlements Fund to Support DMC-ODS Expenditures. The Administration proposes to redirect funding from the Opioid Settlements Fund to offset General Fund that supports the non-federal share of expenditures on Drug Medi-Cal Organized Delivery System (DMC-ODS) services in the Medi-Cal program. Specifically, \$35.4 million of OSF would offset General Fund expenditure authority. These resources are in addition to the \$100 million from BHSF funding for state-directed purposes that also would support DMC-ODS under the Administration's BHSF redirection proposal.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposed redirection of OSF.
2. Are these allowable uses of OSF funding according to the settlement agreements?
3. What is the current balance in the OSF?

Issue 7: UIS Transition to Fee-for-Service and Delayed Elimination of Coverage for Immigrants

Program Adjustments and Delayed General Fund Solutions – May Revision. DHCS proposes the following adjustments at May Revision related to individuals in Medi-Cal who have, or will have, unsatisfactory immigration status:

- 1) *Transition of Individuals with Unsatisfactory Immigration Status to Fee-for-Service.* DHCS estimates a reduction of \$583.8 million (\$471.6 million General Fund) in 2026-27 and \$1.5 billion (\$1.2 billion General Fund) annually thereafter from transitioning individuals with unsatisfactory immigration status (UIS) from the managed care delivery system to the fee-for-service delivery system.
- 2) *Delay in Proposed Elimination of Full-Scope Coverage for Qualified Immigrants.* DHCS proposes to delay the elimination of full-scope Medi-Cal coverage for qualified immigrants (e.g. asylees, victims of domestic violence, human trafficking victims, etc..) from October 1, 2026 to July 1, 2027. DHCS estimates this delay would result in General Fund costs of \$668.1 million in 2026-27. After loss of full-scope coverage, DHCS estimates

Background – UIS Transition to Fee-for-Service. DHCS reports that, on September 30, 2025, the federal Centers for Medicare and Medicaid Services (CMS) released guidance that prohibits states from claiming federal funds for emergency Medicaid coverage provided to UIS members ineligible for full-scope benefits through risk-based managed care capitation payments. Federal law authorizes federal Medicaid matching funds for emergency medical assistance furnished to UIS members, provided the members meet all other eligibility requirements under the state plan. CMS is interpreting the relevant section of law to apply only to specific payments made for care and services necessary for the treatment of an emergency medical condition actually furnished and to not apply to managed care payments. As a result of this interpretation, DHCS is proposing to transition UIS members from the managed care delivery system to the fee-for-service delivery system, effective January 1, 2027, to avoid federal enforcement actions.

As a result of this transition, UIS members would lose access to benefits and services that are only available in managed care, including CalAIM benefits like enhanced care management and community supports. The General Fund savings from this proposal are related to the following components:

- 1) Savings due to the loss of enhanced care management - \$50.1 million
- 2) Savings due to the loss of community supports - \$39.2 million
- 3) Savings due to not paying for managed care non-benefit rate components - \$239.3 million
- 4) Savings due to lower utilization of services - \$356.1 million

These savings are offset by \$224.7 million General Fund costs for higher utilization of services related to loss of services, such as enhanced care management and community supports.

Background – Loss of Coverage for Qualified Immigrants. The January budget proposed to eliminate full-scope Medi-Cal coverage for certain qualified immigrants including asylees, victims of domestic violence, human trafficking victims, and other immigrants admitted to the United States under humanitarian programs, effective October 1, 2026. The federal Administration will exclude these individuals from eligibility for federal matching funds for Medicaid coverage effective October 1, 2026, and the January budget proposed to transition these individuals to restricted-scope coverage only.

The May Revision proposes to delay this transition from October 1, 2026, until July 1, 2027, maintaining full-scope coverage for this population with state-only resources. Because this population would be considered part of the UIS population effective October 1, 2026, these individuals would first transition to the fee-for-service delivery system on January 1, 2027, and would subsequently lose full-scope Medi-Cal coverage six months later, on July 1, 2027. According to DHCS, the annual General Fund costs of maintaining full-scope coverage for this population would be \$1.3 billion.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview the proposal to transition UIS individuals to fee-for-service.
2. How is the department accounting for the increased costs of utilization for members who lose access to CalAIM enhanced care management and community supports services?
3. What is the timing of notifications for the qualified immigrant population for the two transitions they would endure before July 1, 2027?

Issue 8: General Fund Solutions – Reductions for Seniors, Immigrants, and Elimination of Benefits

General Fund Solutions and Trailer Bill Language Proposals – May Revision. DHCS proposes the following General Fund solutions to address the structural deficit:

Medi-Cal Eligibility for Seniors and Persons with Disabilities - Restoration of the Asset Limit. DHCS proposes to restore the asset limit of \$2,000 for an individual, and \$3,000 for a couple for seniors and persons with disabilities to qualify for Medi-Cal. The 2021 Budget Act increased the asset limit to \$130,000 in January 2022, and eliminated the limit entirely in January 2024. The 2025 Budget Act restored the asset limit to \$130,000 in January 2026. DHCS estimates General Fund savings for this proposal of \$278.3 million in 2026-27 and \$495.6 million annually thereafter. DHCS also proposes trailer bill language to implement this proposal.

Medi-Cal Coverage for Undocumented Californians – Premiums. DHCS proposes to increase monthly premiums for undocumented Californians age 19 and older enrolled in full-scope Medi-Cal coverage, effective July 1, 2027, from \$30 to \$50. The 2025 Budget Act approved implementation of premiums for this population of \$30. DHCS estimates General Fund savings for this proposal of \$427.3 million in 2027-28, decreasing to \$314.3 million annually by 2029-30. DHCS also proposes trailer bill language to implement this proposal.

California Advancing and Innovating Medi-Cal (CalAIM) Reforms. DHCS proposes to reform the eligibility criteria, service definitions, utilization management criteria, and payment adjustments for enhanced care management and community supports services under CalAIM. DHCS estimates General Fund savings of \$41.4 million in 2026-27 and \$99.2 million annually thereafter for the changes to

enhanced care management, and \$26.9 million in 2026-27 and \$51 million annually thereafter for the changes to community supports.

Cap Program for All-Inclusive Care for the Elderly (PACE) Rates. DHCS proposes to implement a rate cap on PACE organizations at the lower bound of the actuarially determined rate range. The 2025 Budget Act included a cap set at the midpoint of the range. DHCS estimates General Fund savings from this proposal of \$33.7 million in 2026-27 and \$80.9 million annually thereafter.

Medical Loss Ratio Remittances. DHCS proposes to redirect medical loss ratio remittances from Medi-Cal managed care plans to the General Fund beginning in 2027-28. DHCS estimates General Fund savings of \$25 million annually. DHCS also proposes trailer bill language to implement this proposal.

Elimination of Optional Benefits – Acupuncture. DHCS proposes to eliminate the acupuncture benefit in the Medi-Cal program. DHCS estimates General Fund savings from this proposal of \$5.4 million in 2026-27 and \$13.1 million annually thereafter. DHCS also proposes trailer bill language to implement this proposal.

Medi-Cal Efficiencies. DHCS proposes a General Fund reduction of \$68 million in 2026-27, increasing to \$552 million in 2029-30 to establish utilization management for applied behavioral analysis and transportation, and eliminating the quality withhold incentive component of the quality withhold and incentive program for Medi-Cal managed care.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of each of these General Fund solutions.
2. How many seniors and persons with disabilities does DHCS estimate would be denied Medi-Cal coverage due to the proposed reinstatement of the asset test?
3. DHCS has asserted that CalAIM enhanced care management and community supports result in net savings to the Medi-Cal program. How would the proposed restrictions on these benefits and services ensure that the program does not see a spike in higher-cost, higher-acuity medical services utilization?
4. What utilization controls for applied behavioral analysis and transportation would be implemented? What does the department consider to be inappropriate utilization of these benefits that these controls would prevent?

Issue 9: County Administration Allocation

Local Assistance and Trailer Bill Language Proposal – May Revision. DHCS requests expenditure authority of \$262 million (\$74 million General Fund) in 2026-27 and \$33 million (\$16.7 million General Fund) in 2027-28 and 2028-29. If approved, these resources would support county workload for implementation of Medi-Cal eligibility changes pursuant to HR 1.

DHCS also proposes trailer bill language to implement new county administration funding and related provisions.

Background. HR 1 imposes several new eligibility changes to the Medi-Cal program, including new work and community engagement requirements and eligibility redeterminations every six months instead of annually. On January 29, 2026, DHCS released its “Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1”, which outlines the actions it plans to implement in the following categories:

- Revise eligibility policies and procedures – expansion and streamlining of review processes at renewal that do not require beneficiary contact, known as *ex parte*.
- Establish a streamlined beneficiary process – allow applicants to easily report their work activities or exemptions online or through other commonly used modalities.
- Issue county policy guidance and resources – guidance and resources for counties to update systems and maximize automation.
- Communication and outreach campaigns – campaigns to educate Medi-Cal member and applicants about the new eligibility requirements.

Despite all of this planning, DHCS provided no additional funding in the January budget for county eligibility workers to perform all of the additional workload related to implementing new HR 1 requirements, as well as implementing DHCS planning designed to ensure individuals can maintain coverage.

Local Assistance and Trailer Bill Language. DHCS requests expenditure authority of \$262 million (\$74 million General Fund) in 2026-27 and \$33 million (\$16.7 million General Fund) in 2027-28 and 2028-29. If approved, these resources would support county workload for implementation of Medi-Cal eligibility changes pursuant to HR 1.

DHCS also proposes trailer bill language to implement new county administration funding and related provisions.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 10: Waiver Personal Care Services Backlog

Budget Change Proposal – May Revision. DHCS requests expenditure authority of \$901,000 (\$451,000 General Fund and \$450,000 federal funds) in 2026-27 and \$740,000 (\$370,000 General Fund and \$370,000 federal funds) in 2027-28. If approved, these resources would support administration of the Waiver Personal Care Services benefit in Medi-Cal.

Multi-Year Funding Request Summary – Budget Change Proposal		
Fund Source	2026-27	2027-28
0001 – General Fund	\$451,000	\$370,000
0890 – Federal Trust Fund	\$450,000	\$370,000
Total Funding Request:	\$901,000	\$740,000
Total Requested Positions:	0.0	0.0

Background. The Waiver Personal Care Services (WPCS) benefit in Medi-Cal is designed to assist the waiver member with gaining independence with activities of daily living, preventing social isolation, and with maintaining independence in their home and the community. WPCS is provided in the home by an unlicensed caregiver of the members’ choosing who bills the state directly for hours worked. The caregiver is often a family member or acquaintance of the member and sometimes lives in the same home. Eligible In-Home Supportive Services (IHSS) members can apply to receive additional personal care services hours through the WPCS benefit under the HCBA Waiver.

According to DHCS, waiver members receiving WPCS has nearly tripled since December 2020, from 2,950 to 7,800 members. DHCS expects that WPCS utilization will continue to grow as there is currently unmet demand for these services.

Resource Request. DHCS requests expenditure authority of \$901,000 (\$451,000 General Fund and \$450,000 federal funds) in 2026-27 and \$740,000 (\$370,000 General Fund and \$370,000 federal funds) in 2027-28 to support administration of the Waiver Personal Care Services benefit in Medi-Cal. Specifically, DHCS requests the following:

Integrated Systems of Care Division – Resources equivalent to four positions

- Resources equivalent to **one Supervisor II** position would oversee two units focused on the administration of the WPCS benefit and the WPCS Public Hotline.
- Resources equivalent to **one Supervisor I** position would manage a new WPCS unit and would hire, train, and manage all analyst staff responsible for a newly developed call center.
- Resources equivalent to **two Analyst II** positions would handle incoming calls and inquiries from clients, caregivers, and service providers, and provide technical assistance regarding eligibility, services, and authorization requests.

Business Operations Technology Services Division – Software licensing costs

- Software licensing costs of \$224,000 (\$112,00 General Fund and \$112,000 federal funds) in 2026-27 and \$99,000 (\$49,000 General Fund and \$50,000 federal funds) in 2027-28.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 11: Healthcare Payments Data Program

Budget Change Proposal – April Finance Letter. DHCS requests four positions to be transferred from HCAI and expenditure authority of \$829,00 (\$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. If approved, these positions and resources would support management and transmission of Medi-Cal data to HCAI and utilization of the Healthcare Payments Database (HPD) to support management of the Medi-Cal program.

Multi-Year Funding Request Summary – Budget Change Proposal		
Fund Source	2026-27	2027-28*
0143 – CA Health Data and Planning Fund	\$207,000	\$198,000
0890 – Federal Trust Fund	\$622,000	\$595,000
Total Funding Request:	\$829,000	\$793,000
Total Requested Positions:	4.0	4.0

* Positions and 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.

Staffing and Resource Request. DHCS request four positions to be transferred from HCAI and expenditure authority of \$829,00 (\$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 support management and transmission of Medi-Cal data to HCAI and utilizing the Healthcare Payments Database (HPD) to support management of the Medi-Cal program. Specifically, DHCS requests the following:

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 12: Narcotic Treatment Program and DUI Program Licensing Trust Fund

Budget Change Proposal – May Revision. DHCS requests expenditure authority of \$2 million (\$1 million Narcotic Treatment Program (NTP) Licensing Trust Fund and \$1 million DUI Licensing Trust Fund) in 2026-27. If approved, these resources would support existing licensing and compliance monitoring activities of the NTP and DUI programs.

Multi-Year Funding Request Summary – Budget Change Proposal		
Fund Source	2026-27	2027-28
0139 – DUI Program Licensing Trust Fund	\$1,000,000	\$-
0243 – Narcotic Treatment Program Licensing Trust Fund	\$1,000,000	\$-
Total Funding Request:	\$2,000,000	\$-
Total Requested Positions:	0.0	0.0

Background. DHCS is responsible for licensing and compliance monitoring of California’s NTP and DUI programs to fulfill statutory and regulatory requirements. NTPs provide medication-assisted treatment in conjunction with care planning, behavioral therapies, and medical services for individuals diagnosed with an opioid use disorder. DUI programs provide substance use disorder assessments, educational resources, and counseling services to individuals mandated by a court or the Department of Motor Vehicles to complete DUI program requirements.

Resource Request. DHCS requests expenditure authority of \$2 million (\$1 million Narcotic Treatment Program (NTP) Licensing Trust Fund and \$1 million DUI Licensing Trust Fund) in 2026-27 to support existing licensing and compliance monitoring activities of the NTP and DUI programs. Specifically, DHCS requests the following:

- \$1 million from the NTP Licensing Trust Fund would support projected labor costs and expenses for oversight of NTP programs. The current appropriation from the fund is \$2.5 million and the additional request would support ongoing, annual costs.
- \$1 million from the DUI Licensing Trust Fund would support projected labor costs and expenses for oversight of DUI programs. The current appropriation from the fund is \$1.5 million and the additional request would support ongoing, annual costs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 13: 2027 Medi-Cal CalAIM Waiver Planning and Implementation

Budget Change Proposal – May Revision. DHCS requests conversion of 10 limited-term positions to permanent and expenditure authority of \$17.5 million (\$8.8 million General Fund and \$8.8 million federal funds) in 2026-27. If approved, these positions and resources would support planning and ongoing implementation of the California Advancing and Innovating Medi-Cal (CalAIM) waivers, which expire on December 31, 2026.

Multi-Year Funding Request Summary – Budget Change Proposal		
Fund Source	2026-27	2027-28
0001 – General Fund	\$8,750,000	\$-
0890 – Federal Trust Fund	\$8,750,000	\$-
Total Funding Request:	\$17,500,000	\$-
Total Requested Positions:	10.0	0.0

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

Beginning January 1, 2022, CalAIM implemented a mandatory enhanced care management (ECM) benefit and voluntary community supports benefits delivered by Medi-Cal managed care plans in each county. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Medi-Cal beneficiaries with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch, and person-centered. Community supports are services or service settings that Medi-Cal managed care plans may offer as a medically appropriate, cost-effective alternative to Medi-Cal eligible services or settings. Provision of community supports is voluntary for Medi-Cal managed care plans to provide and voluntary for Medi-Cal beneficiaries to receive. Plans may change their election of which community supports they provide every six months.

According to DHCS, sustaining and expanding these initiatives over the next several years will require substantial investments in staff resources and contract funding. A well-supported workforce and adequate financial backing are important to support the services that are essential to DHCS' ability to execute on the principles and goals of CalAIM. As California renews its federal waivers and advances its vision for Medi-Cal in 2027 and beyond, these strategic investments will support the ongoing policy development, implementation activities, Technical Assistance (TA), and stakeholder engagement needed for an initiative of this scale. As such, securing these resources will be paramount to achieving the DHCS' vision of the Medi-Cal transformation.

Staffing and Resource Request. DHCS requests conversion of 10 limited-term positions to permanent and expenditure authority of \$17.5 million (\$8.8 million General Fund and \$8.8 million federal funds) in 2026-27. If approved, these positions and resources would support planning and ongoing implementation of the California Advancing and Innovating Medi-Cal (CalAIM) waivers, which expire on December 31, 2026. Specifically, DHCS requests the following:

- **One Supervisor II** position would manage ongoing monitoring of CalAIM initiatives, provide strategic leadership for county operational support, manage training materials for counties, and serve as a key communicator in internal and external forums.
- **Three Supervisor I** positions would provide leadership and direct supervision to analysts, who are responsible for technical assistance to counties.
- **Two Health Program Specialist I** positions would be responsible for project management activities, review of complex policy frameworks, identification of gaps, and recommendations of corrective actions to maintain program integrity.
- **Four Analyst II** positions would perform day-to-day oversight and monitoring, confirming compliance with CalAIM requirements.

Contract Costs

- \$15 million (\$7.5 million General Fund and \$7.5 million federal funds) in 2026-27 would support extension of a contract to support CalAIM reauthorization, including: 1) policy strategy, design, and implementation; 2) oversight and monitoring; 3) project management; and 4) strategic communications, stakeholder engagement, and technical assistance.
- \$861,000 (\$431,000 General Fund and \$430,000 federal funds) in 2027-28 through 2030-31 and \$430,000 (\$215,000 General Fund and \$215,000 federal funds) in 2031-32 would support a contract with the University of California, Los Angeles to support the contingency management benefit, including delivering training, orientations, readiness reviews, and ongoing fidelity reviews.
- \$10 million from 2026-27 through 2031-32 to continue use of the Incentive Manager vendor through the CalAIM renewal period, including: 1) calculation, management, tracking, and distribution of incentives; 2) provision of a secure, web-based incentive management system; and 3) provide controls to reduce the risk of fraud, waste, and abuse.

- \$1.1 million (\$550,000 General Fund and \$550,000 federal funds) in 2027-28 through 2030-31 and \$600,000 (\$300,000 General Fund and \$300,000 federal funds) in 2031-32 to support a training and technical assistance contract and clinical consultant support for both CalAIM and the Recovery Incentives Program.
- \$1.5 million (\$750,000 General Fund and \$750,000 federal funds) in 2026-27 would support a contract with an external evaluator to develop the evaluation design required by CMS.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 14: Medi-Cal Provider Oversight

Trailer Bill Language Proposal – May Revision. DHCS proposes trailer bill language to strengthen oversight of Medi-Cal providers to prevent fraud, waste, or abuse in the Medi-Cal program.

Background. The Medi-Cal Provider Enrollment Division is responsible for the enrollment and re-enrollment of fee-for-service health care service provider into the Medi-Cal program. There are approximately 300,000 providers who serve the needs of the Medi-Cal population.

Trailer Bill Language – Provider Oversight. DHCS proposes trailer bill language to strengthen oversight of Medi-Cal providers to prevent fraud, waste, or abuse in the Medi-Cal program. Specifically, the language would:

- 1) Add affiliation within the previous five years of a person or entity with a disclosable event to grounds for denial or suspension of provider status if the department determines the affiliation poses an undue risk of fraud, waste, or abuse to the Medi-Cal program.
- 2) Require providers to continuously comply with all federal, state, and local requirements.
- 3) Applies enforcement authority to provider with full enrollment status, in addition to those with provisional provider status or preferred provisional provider status.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 15: Technical Adjustments

Technical Adjustments – May Revision. DHCS requests the following technical adjustments:

- *Ensuring Access to Medicaid Services Budget Change Proposal Adjustment.* DHCS requests additional General Fund expenditure authority of \$882,000 in 2026-27 through 2029-30 to reflect a technical adjustment to align resources proposed in the Ensuring Access to Medicaid Services budget change proposal in the January budget.
- *Centers for Medicare and Medicaid Services Grant.* DHCS requests federal fund expenditure authority of \$20.5 million in 2026-27 to support administrative and eligibility system costs associated with the implementation of federal work and community engagement requirements.
- *Breast Cancer Control Account Adjustments.* DHCS requests transfer of expenditure authority from the Breast Cancer Control Account of \$3 million from Item 4260-114-0009 to Item 4260-001-0009 to support costs for the Every Woman Counts Program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these technical adjustments.

4265 DEPARTMENT OF PUBLIC HEALTH**Issue 16: AIDS Drug Assistance Program May Revision Estimate**

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

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

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

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

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

ADAP Estimate – May Revision. The May Revision 2026 ADAP Estimate reflects revised 2025-26 expenditures of \$436.4 million (\$333 million ADAP Rebate Fund and \$103.4 million federal funds), a decrease of \$7.6 million compared to the January budget. According to CDPH, this decrease is primarily due to lower medication and medical out-of-pocket expenditures due to decreased caseloads and decreased cost per client month than previously estimated.

For 2026-27, CDPH estimates ADAP expenditures of \$511 million (\$407.6 million ADAP Rebate Fund and \$103.4 million federal funds), an increase of \$67.3 million compared to the January budget. According to CDPH, this increase is primarily due to the funding extension for the Disease Intervention Specialist, as well as a \$60 million allocation for stakeholder proposals.

ADAP Local Assistance Funding Summary		
Fund Source	2025-26	2026-27
0890 – Federal Trust Fund	\$103,389,000	\$103,389,000
3080 – AIDS Drug Assistance Program Rebate Fund	\$332,965,000	\$407,604,000
Total ADAP Local Assistance Funding	\$436,354,000	\$510,993,000

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2025-26 and 2026-27 will be as follows:

<u>Caseload by Client Group</u>	<u>2025-26</u>	<u>2026-27</u>
Medication-Only	7,477	7,874
Medi-Cal Share of Cost	99	374
Private Insurance	9,722	10,225
Medicare	6,709	6,709
PrEP Assistance Program	4,514	4,569
TOTAL	28,520	29,750

<u>Expenditures by Client Group</u>	<u>2025-26</u>	<u>2026-27</u>
Medication-Only	\$203,603,970	\$224,789,959

Medi-Cal Share of Cost	\$1,563,398	\$1,856,374
Private Insurance	\$114,247,522	\$133,977,388
Medicare	\$17,466,637	\$19,745,767
PrEP Assistance Program	\$19,379,444	\$25,422,779
TOTAL	\$356,260,971	\$405,792,269

Costs for administration of ADAP are estimated to be \$4.2 million in 2025-26 and \$4.5 million in 2026-27. Costs for administration of PrEP-AP are estimated to be \$5.4 million in 2025-26 and \$5.4 million in 2026-27. Enrollment costs are estimated to be \$7.3 million in 2025-26 and \$7.8 million in 2026-27.

In addition, ADAP's pharmacy benefit manager, Magellan Rx Management, contracts with a safety net recovery vendor, Health Management Systems (HMS) to pursue recovery of paid claims when a liable third party is identified post-payment. CDPH estimates recoveries of \$10.4 million in 2025-26 and \$10.4 million in 2026-27.

Disease Intervention Specialists. AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, authorized ADAP Rebate Fund resources of \$9 million to support state and local disease intervention specialists (DIS) to address jurisdictional prevention and response needs for sexually transmitted infections (STIs), HIV, hepatitis C, and mPox. The May Revision Estimate includes \$22.5 million ADAP Rebate Fund (\$18.7 million local assistance and \$3.8 million state operations) in 2026-27 to continue support for these specialists.

ADAP Rebate Fund Backfill of Lost Federal Funding. The May Revision also includes expenditure authority from the ADAP Rebate Fund of \$60 million. Of this amount, \$50 million would support services for those living with and at risk of HIV, especially services impacted by the loss of federal funds, consistent with funding in the 2025 Budget Act. \$10 million would support LGBTQ+ community centers in California experiencing a loss of federal funds.

ADAP Rebate Fund Loans to the General Fund. The 2024 Budget Act authorized a \$500 million from the ADAP Rebate Fund to the General Fund to support the General Fund shortfall. The 2023 Budget Act similarly included a \$400 million loan from the fund to the General Fund. According to CDPH, the fund is expected to maintain a reserve of \$189.5 million after program expenditures in 2025-26. The \$400 million loan is expected to be repaid in 2027-28 and the \$500 million loan is expected to be repaid in 2028-29.

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

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

1. Please provide a brief overview of the major changes to the ADAP Estimate since the January budget.
2. Please describe the allocation of \$60 million ADAP Rebate Fund to backfill lost federal funds and for LGBTQ+ community centers. What types of programs would benefit from the backfill?

Issue 17: Genetic Disease Screening Program (GDSP) Estimate

Genetic Disease Screening Program Estimate – May Revision. The May Revision 2026 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of \$166.7 million (\$37.1 million state operations and \$129.6 million local assistance) in 2025-26, and \$172.1 million (\$36.7 million state operations and \$135.3 million local assistance) in 2026-27.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2025-26	2026-27	BY to CY
Fund Source	<i>Revised</i>	<i>Proposed</i>	<i>Change</i>
0203 – Genetic Disease Testing Fund			
State Operations:	\$37,070,000	\$36,747,000	(\$323,000)
Local Assistance:	\$129,588,000	\$135,309,000	\$5,721,000
Total GDSP Expenditures	\$166,658,000	\$172,056,000	\$5,398,000

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

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

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

NBS Caseload Estimate: The May Revision estimates NBS program caseload of 394,136 in 2025-26, a decrease of 2,847 or 0.7 percent, compared to 2024-25 actual total caseload of 396,993. The May Revision estimates NBS program caseload of 390,727 in 2026-27, a decrease of 3,420 or 0.9 percent, compared to the revised 2025-26 estimate. These estimates are based on state projections of the number of live births in California.

PNS Caseload Estimate: The May Revision estimates PNS program caseload of 171,619 cfDNA specimens in 2025-26, a decrease of 16,092 or 7.9 percent, compared to 2024-25 actual total caseload of

187,711 specimens. The May Revision estimates PNS program caseload of 170,353 cfDNA specimens in 2026-27, a decrease of 1,266 or 0.7 percent, compared to the revised 2025-26 estimate. These estimates are based on state projections of the number of live births in California.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 18: Women, Infants, and Children (WIC) Program Estimate

WIC Program Estimate – May Revision. The May Revision 2026 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of \$1.4 billion (\$1.2 billion federal funds and \$165.6 million WIC manufacturer rebate funds) in 2025-26 and \$1.4 billion (\$1.2 billion federal funds and \$147.5 million WIC manufacturer rebate funds) in 2026-27. The federal fund amounts include state operations costs of \$71.1 million in 2025-26 and 2026-27.

Women, Infants, and Children (WIC) Funding Summary			
Fund Source	2025-26 <i>Revised</i>	2026-27 <i>Proposed</i>	BY to CY <i>Change</i>
0890 – Federal Trust Fund			
State Operations:	\$71,105,000	\$71,105,000	\$-
Local Assistance:	\$1,222,617,000	\$1,249,281,000	\$26,664,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	\$165,550,000	\$147,506,000	(\$19,044,000)
Total WIC Expenditures	\$1,459,272,000	\$1,467,892,000	\$8,620,000

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

The WIC program’s food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole

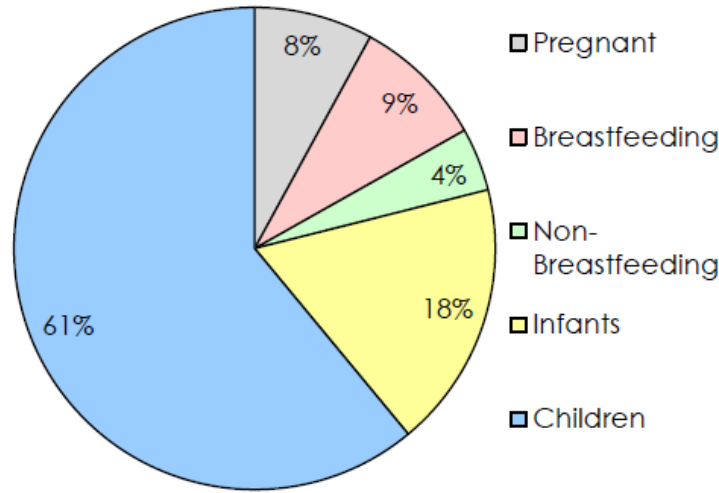
supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures,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

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

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

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

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



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

Caseload Estimates. The budget assumes 984,777 average monthly WIC participants in 2025-26, a decrease of 20,839 or two percent compared to assumptions in the January budget. The budget assumes 959,795 average monthly WIC participants in 2026-27, a decrease of 46,909, or 4.7 percent, compared to assumptions in the January budget.

Food Expenditures Estimate. The budget includes \$1 billion (\$873 million federal funds and \$165.6 million WIC Manufacturer Rebate Fund) in 2025-26 for WIC program food expenditures, a decrease of \$48.4 million or 4.5 percent, compared to assumptions in the January budget. According to CDPH, the decrease in costs is due to a slowing food inflation rate and a slight decrease in participation growth. In addition, WIC manufacturer rebate revenue is projected at \$165.6 million, which is an increase of \$19.3 million or 13.2 percent compared to assumptions in the January budget. According to CDPH, this increase in rebate revenue is attributable to subsidized amounts from the new infant formula rebate contracts not decreasing as much as initially projected.

The budget includes \$1 billion (\$899.7 million federal funds and \$147.5 million WIC Manufacturer Rebate Fund) in 2026-27 for WIC program food expenditures, an increase of \$71.7 million or 6.4 percent compared to assumptions in the January budget. According to CDPH, this increase in costs is driven by a decrease in participation projections offset by a slight increase in food inflation projections. In addition,

WIC manufacturer rebate revenue is projected at \$147.5 million, an increase of \$13.1 million or 9.8 percent compared to assumptions in the January budget.

Nutrition Services and Administration (NSA) Estimate. The budget includes \$349.6 million for other local assistance expenditures for the NSA budget in 2025-26 and 2026-27, unchanged from assumptions in the January budget. The budget also includes \$71.1 million for state operations expenditures in 2025-26, and 2026-27, unchanged compared to assumptions in the January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 19: Public Health Information Technology Systems

Budget Change Proposal – May Revision. CDPH requests total expenditure authority of \$113.3 million (\$96.3 million General Fund and \$17 million special funds) in 2026-27 to support maintenance and operations of four public health information technology projects.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28
0001 – General Fund	\$96,300,000	\$-
0098 – Clinical Lab Improvement Fund	\$5,000,000	\$-
0099 – Health Statistics Special Fund	\$8,000,000	\$-
3080 – ADAP Rebate Fund	\$2,000,000	\$-
3098 – Licensing and Certification Fund	\$2,000,000	\$-
Total Funding Request:	\$113,300,000	\$-
Total Requested Positions:	0.0	0.0

Background. The January budget included 15 positions and General Fund expenditure authority of \$24.5 million in 2026-27, \$18.5 million in 2027-28, and \$3.7 million annually thereafter to support maintenance and operations of the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system, an integrated data system that provides 24-hour processing of lab results for all reportable infectious diseases.

While the January budget requested resources for ongoing maintenance and operations for SaPHIRE, the budget did not include funding for several other public health IT systems supported by prior year appropriations that will soon expire. These systems included the California Confidential Network for Contact Tracing (CalCONNECT), the California Immunization Registry 3 (CAIR3), the California Vaccine Management System (myCAVax), and the Future Disease Surveillance System (FDSS).

Resource Request. CDPH requests total expenditure authority of \$113.3 million (\$96.3 million General Fund and \$17 million special funds) in 2026-27 to support maintenance and operations of four public health information technology projects. These projects include SaPHIRE, funded in the January budget, as well as new funding for CalCONNECT, myCAVax, CAIR3, and FDSS.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 20: Laboratory Licensing Resources

Budget Change Proposal – April Finance Letter. CDPH requests nine positions and expenditure authority from the Clinical Laboratory Improvement Fund of \$3.8 million in 2026-27 and 18 positions and \$4.3 million annually thereafter. If approved, these positions and resources would support growing demand for laboratory license processing.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28*
0098 – Clinical Laboratory Improvement Fund	\$3,810,000	\$4,327,000
Total Funding Request:	\$3,810,000	\$4,327,000
Total Requested Positions:	9.0	18.0

* Positions and resources ongoing after 2027-28.

Background. Clinical and public health laboratories testing specimens of California patients provide safe, effective, and reliable clinical laboratory testing and that tissue banks, blood banks, and biologics production facilities provide Californians with safe and reliable blood and tissue products for transfusion and transplantation. The California Department of Public Health (CDPH), Laboratory Field Services (LFS) accomplishes its mission through three functions: 1) licensure and oversight of clinical laboratories and public health laboratories; 2) licensure and oversight of clinical and public health laboratory personnel, as well as oversight of training programs, continuing education programs, and licensure examination agencies; and 3) licensure and oversight of blood banks, tissue banks, biologics production facilities, and laboratories and personnel certified in cytology. According to CDPH, an increase in expenditure authority is needed due to the increase in clinical laboratory and personnel licensing, the creation of four license classification types, and requirement for on-site survey.

Staffing and Resource Request. CDPH requests nine positions and expenditure authority from the Clinical Laboratory Improvement Fund of \$3.8 million in 2026-27 and 18 positions and \$4.3 million annually thereafter. If approved, these positions and resources would support growing demand for laboratory license processing. Specifically, CDPH requests the following positions and resources:

- **Two Supervisor I** positions (one in 2026-27 and one in 2027-28) would oversee team operations, validating accuracy, compliance and timely deliverables.

- **Three Health Program Specialist I** positions (two in 2026-27 and one in 2027-28) would lead quality improvement and modernization initiatives for laboratory surveys, databases, and communication platforms.
- **Four Analyst II** positions (two in 2026-27 and two in 2027-28) would approve and review applications for laboratories, personnel, training programs, and certifying organizations.
- **Nine Analyst I** positions (four in 2026-27 and five in 2027-28) would review and approve applications for laboratories, personnel, training programs, and certifying organizations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 21: Childhood Lead Poisoning Prevention Program Resources

Budget Change Proposal – April Finance Letter. CDPH requests expenditure authority from the Childhood Lead Poisoning Prevention Fund of \$1.8 million annually between 2026-27 and 2028-29. If approved, these resources would support local health jurisdictions to provide services to children with blood lead levels that meet or exceed the Centers for Disease Control and Prevention’s Blood Lead Reference Value.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28*
0080 – Childhood Lead Poisoning Prevention Fund	\$1,800,000	\$1,800,000
Total Funding Request:	\$1,800,000	\$1,800,000
Total Requested Positions:	0.0	0.0

* Additional fiscal year resources requested – 2028-29: \$1,800,000.

Background. The California Department of Public Health (CDPH), Childhood Lead Poisoning Prevention Branch (CLPPB) is supported by fees assessed and collected annually and distributed to local health jurisdictions (LHJs) to support childhood lead poisoning prevention and case management services in their jurisdictions under a contract with CLPPB. LHJ allocations are calculated based on the number of children with elevated Blood Lead Levels (BLLs) within each jurisdiction, defined as no higher than the blood lead reference value specified by the Centers for Disease Control and Prevention (CDC).

In October of 2021, CDC updated the Blood Level Reference Value (BLRV) from 5 µg/dL to 3.5 µg/dL. The lower BLRV increased the number of children eligible for basic case management services.

Resource Request. CDPH requests expenditure authority from the Childhood Lead Poisoning Prevention Fund of \$1.8 million annually between 2026-27 and 2028-29 to support local health jurisdictions to provide services to children with blood lead levels that meet or exceed the Centers for Disease Control

and Prevention’s Blood Lead Reference Value. CDPH reports these resources would allow continuation of services for approximately 100 to 200 increased number of full cases and approximately 6,000 increased number of basic cases resulting from the updated CDC guidance.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 22: Lesbian, Bisexual, and Queer Women’s Health Program Operational Support

Budget Change Proposal – May Revision. CDPH requests shift of General Fund expenditure authority of \$2.5 million from local assistance to state operations. If approved, this fund shift would support activities that address lesbian, bisexual, and queer women’s health disparities.

Background. The 2019 Budget Act included General Fund expenditure authority of \$15.5 million to support a local comprehensive grant program to address Lesbian, Bisexual, and Queer (LBQ) women’s health disparities and to fund research targeting LBQ women’s health needs and an inventory of existing programs. These resources were reappropriated in the 2025 Budget Act and the sunset date was extended through June 30, 2028. According to CDPH, the program needs additional state operations support to maintain staffing levels required to meet responsibilities through the expiration of the funding authority on June 30, 2028.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.
2. What additional staffing resources are needed for this program and does this redirection reduce the amounts available for grants?

Issue 23: Sickle Cell Centers for Excellence

Local Assistance – May Revision. CDPH requests General Fund expenditure authority of \$6 million annually over five years. If approved, these resources would support continued funding for Sickle Cell Disease Centers for Excellence.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28*
0001 – General Fund	\$6,000,000	\$6,000,000
Total Funding Request:	\$6,000,000	\$6,000,000

Total Requested Positions:	0.0	0.0
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* Additional fiscal year resources requested – 2028-29 through 2031-32: \$6,000,000.

Background. The 2019 Budget Act included one-time \$15 million General Fund allocation to establish five new Sickle Cell Center of Excellence to provide care to adults with Sickle Cell Disease. According to the Department of Public Health, the anticipated five centers have been established, and they operate as a network.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 24: Menopause Public Awareness

Local Assistance – May Revision. CDPH requests General Fund expenditure authority of \$3 million in 2026-27. If approved, these resources would support implementation of a statewide perimenopause and menopause public awareness campaign.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28*
0001 – General Fund	\$6,000,000	\$6,000,000
Total Funding Request:	\$6,000,000	\$6,000,000
Total Requested Positions:	0.0	0.0

* Additional fiscal year resources requested – 2028-29 through 2031-32: \$6,000,000.

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

- 1) Required health care service plans and health insurers to include coverage for evaluation and treatment options for symptoms of perimenopause and menopause, if deemed medically necessary by a contracted provider.
- 2) Required coverage to be provided without discrimination on the basis of gender expression or identity
- 3) Required health care service plans and health insurers to annually provide current clinical care recommendations for hormone therapy from the Menopause Society or other nationally recognized professional associations to all contracted primary care providers who treat enrollees or insureds with perimenopause and menopause.
- 4) Authorized a California-licensed physician certified as a general internist, family physician, obstetrician and gynecologist, cardiologist, endocrinologist, neurologist, or psychiatrist and whose patient population is composed of 25 percent or more of adult women under 65 years of age, who

completes continuing medical education (CME) coursework in perimenopause, menopause, and postmenopausal, to receive two hours of credit for each hour of the coursework, not to exceed eight hours.

After a well-publicized outcry from advocates of the bill, the January budget included positions and resources and proposed trailer bill language to implement menopause coverage requirements similar, though not identical, to those contained in AB 432. These resources for a public awareness campaign are part of this effort.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 25: Special Deposit Fund Transfers to New Special Funds

Fund Transfers – May Revision. CDPH requests transfer of funding from obsolete special deposit funds to newly created special funds approved in the 2025 Budget Act. These fund transfers include the following:

- \$1.2 million and 8.1 positions transferred to Item 4265-001-3477, the Internal Departmental Quality Improvement Account
- \$1.4 million to Item 4265-001-3479, the State Health Facilities Citation Penalties Account
- \$471,000 and 0.3 positions in 2026-27 and \$478,000 ongoing to Item 4265-001-8510, the Federal Health Facilities Citation Penalties Account
- \$8.1 million in 2026-27 and \$575,000 ongoing to Item 4265-111-8510, the Federal Health Facilities Citation Penalties Account

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 26: Center for Health Care Quality Internal Department Quality Improvement

Budget Change Proposal and Budget Bill Language – May Revision. CDPH requests expenditure authority from the Internal Departmental Quality Improvement Fund of \$1.8 million in 2026-27 and \$74,000 annually thereafter, as well as \$450,000 from the Licensing and Certification Fund. If approved these resources would support expenditures for a Skilled Nursing Facility Surveillance Pilot Program, the Litmos Learning Management System, Program Flex Waiver Software, and Health Application Licensing Migration.

Program Funding Request Summary		
Fund Source	2026-27	2027-28*
3098 – Licensing and Certification Fund	\$450,000	\$-
3477 – Internal Departmental Quality Improvement Fund	\$1,765,000	\$74
Total Funding Request:	\$2,215,000	\$-
Total Requested Positions:	0.0	0.0

* Resources ongoing after 2027-28.

Background. State law establishes the Internal Departmental Quality Improvement Account (IDQIA) and provides that “moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.” The account is funded by administrative penalties that CDPH imposes on health facilities for violations that cause harm to a patient, or administrative penalty associated with breaches of medical information. Since fiscal year 2010-11, the Legislature has appropriated moneys in IDQIA to be expended for internal quality improvement activities.

Resource Request. CDPH requests expenditure authority from the Internal Departmental Quality Improvement Fund of \$1.8 million in 2026-27 and \$74,000 annually thereafter, as well as \$450,000 from the Licensing and Certification Fund. If approved these resources would support expenditures for a Skilled Nursing Facility Surveillance Pilot Program, the Litmos Learning Management System, Program Flex Waiver Software, and Health Application Licensing Migration.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 27: Los Angeles County Contract Extension

Budget Change Proposal – May Revision. CDPH requests expenditure authority from the Licensing and Certification Fund of \$24.2 million annually. If approved, these resources would support extension and augmentation of the Los Angeles County Department of Public Health contract for updated indirect cost and employee benefit rates, personnel costs, and lease costs.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28*
3098 – Licensing and Certification Fund	\$24,186,000	\$24,186,000
Total Funding Request:	\$24,186,000	\$24,186,000
Total Requested Positions:	0.0	0.0

* Resources ongoing after 2027-28.

Background. For over 30 years, DPH has contracted with Los Angeles (LA) County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for

approximately 2,900 health care facilities in the LA County area. Roughly one third of licensed and certified health care facilities in California are located in LA County, and 20 percent of the long-term care complaints and entity-reported incidents received statewide each year are generated in LA County.

Both the current and future contract include quantity, quality, and customer service performance metrics and penalties for failure to meet those metrics. CDPH assigns an LA County Contract Manager to monitor monthly compliance with performance metrics including conducting audits of workload performed, monitoring vacancy rates, data tracking and financial reviews prior to payment to promote compliance with the terms of the contract.

LA County and CDPH negotiated a one-year contract extension to the current July 1, 2023, to June 30, 2026, contract. This extension is to assist with workload and financial planning. In addition to financial planning, a one-year contract extension allows flexibility to align with unknown federal expectations for workload under CMS.

Resource Request. CDPH requests expenditure authority from the Licensing and Certification Fund of \$24.2 million annually to support extension and augmentation of the Los Angeles County Department of Public Health contract for updated indirect cost and employee benefit rates, personnel costs, and lease costs. Specifically, CDPH requests these resources to support salary and benefit increases for LA County staff, and reduction in the vacancy rate for LA County staff to five percent.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 28: Nursing Home Staff Recruitment Campaign

Budget Change Proposal – April Finance Letter. CDPH requests expenditure authority from the Federal Health Facilities Citation Penalties Account in 2026-27 to support a Centers for Medicare and Medicaid Services Nursing Home Staffing Campaign.

Multi-Year Funding Request Summary		
Fund Source	2026-27	2027-28
8510 – Fed Health Facilities Citation Penalties Account	\$7,449,000	\$-
Total Funding Request:	\$7,449,000	\$-
Total Requested Positions:	0.0	0.0

Background. According to CDPH, the federal Centers for Medicare and Medicaid Services (CMS) is partnering with state governments to expand their Nursing Home Staffing Campaign, which is aimed at augmenting the number of individuals pursuing nursing home employment. CMS plans to implement financial incentives for nurses, enhanced training opportunities, and training resources for nursing home staff.

Resource Request. CDPH requests expenditure authority from the Federal Health Facilities Citation Penalties Account in 2026-27 to support a Centers for Medicare and Medicaid Services Nursing Home Staffing Campaign. Specifically, CDPH requests resources to support financial incentives including up to \$40,000 tuition reimbursement and/or a \$10,000 stipend in return for working three years in a qualifying nursing home. CMS is requiring states to obligate around 35 percent of their federal citation accounts, which is estimated at \$7.5 million.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal

Issue 29: Patient Safety Reporting Systems Reappropriation (AB 3161)

Reappropriation – May Revision. CDPH requests reappropriation of expenditure authority from the Licensing and Certification Fund of \$1.1 million, previously approved in the 2025 Budget Act, to support Stage 2 Alternatives Analysis or Project Delegation Request approval for Patient Safety Reporting Systems.

Background. Assembly Bill 3161 (Bonta), Chapter 757, Statutes of 2024, requires specified facilities to update their reporting system for patient safety events to include a process for anonymous reporting. The bill requires that facilities add specified sociodemographic factors to the analysis of patient safety events. The bill also requires that health care facility patient safety plans include a process for addressing racism and discrimination. Specified facilities would be required to develop interventions to remedy known disparities and encourage facility staff to report suspected instances of racism and discrimination. Facilities must submit their patient safety plans to California Department of Public Health beginning January 1, 2026, and biannually thereafter. The bill also requires CDPH to publicly post the patient safety plans on the department’s website.

Reappropriation Request. CDPH requests reappropriation of expenditure authority from the Licensing and Certification Fund of \$1.1 million, previously approved in the 2025 Budget Act, to support Stage 2 Alternatives Analysis or Project Delegation Request approval for Patient Safety Reporting Systems. CDPH reports the Patient Safety Plan Submission initiative has experienced delays due to the extended time required to plan and align on a two-phase implementation approach. This request reflects the extended timeline to include the formal Project Approval Lifecycle process.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this reappropriation proposal.

0000 PROPOSALS FOR INVESTMENT**Issue 30: Proposals for Investment**

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

Medi-Cal Reimbursement Rate Increase for Interfacility Transports. The California Ambulance Association requests General Fund expenditure authority of \$50 million in 2026-27. If approved, these resources would support an increase in reimbursement rates for interfacility transports in the Medi-Cal program. According to the California Ambulance Association, when transporting a Medi-Cal patient, private ambulances are paid through an established and set rate, roughly \$110 per transportation. **This rate has not been increased since 1999.** It is estimated that private ambulance providers lose \$165 million annually due to below-cost reimbursement rates set by the Medi-Cal program. This, in addition to rising costs in equipment, gas, labor, and other expenses, has made it difficult for private ambulance companies to afford to transport Medi-Cal patients. In 2022, the largest U.S. private provider of ambulance services announced its decision to no longer provide non-emergency transports in Los Angeles County due to low reimbursement rates. This decision amounted to a loss of around 28,000 non-emergency transports a year. Unfortunately, those in underserved and lower-income communities are who hurt the most from these losses of services.

To address this issue, the California Ambulance Association is seeking a **one-time \$50 Million** Budget allocation to lessen this funding gap. The California Ambulance Association reached this number from multiple conversations and suggestions from the Legislature in that an appropriate figure would be to get the Medi-Cal reimbursement rate to 80 percent of Medicare allowable. Through data obtained from the Department of Health Care Services via the Public Records Act, the math shows that 80 percent of Medicare allowable equals to around \$100 Million annually. However, the California Ambulance Association understands the current constraints of the State Budget, as well as the wish of the Governor and Legislature to obtain a balanced budget for the foreseeable future. For these reasons, instead of a \$100 Million ongoing ask, the California Ambulance Association is respectfully requesting a one-time \$50 Million allocation.

Children’s Hospital Los Angeles Augmentation. Children’s Hospital Los Angeles requests General Fund expenditure authority of \$63 million in 2026-27. According to Children’s Hospital Los Angeles (CHLA), it is currently losing approximately \$180 million per year due to low reimbursement rates for children who require extensive hospitalization and who qualify as “outliers.” Because of these ongoing losses, CHLA is now facing the possibility of service reductions that could adversely impact the statewide CCS program.

The objective of this \$63 million one-time request is to give CHLA the resources it needs to avoid having to eliminate any service lines for CCS children in the current calendar year. Without this investment from the state, CCS children would be at risk of losing access to critical care, and the statewide CCS program would be negatively impacted.

Accountability and Transparency for Utilization and Access to CHW/P/R Medi-Cal Benefit. The Latino Coalition for a Healthy California requests General Fund expenditure authority of \$750,000 in 2026-27, available for expenditure until June 30, 2028, to support a public report on the utilization of the Community Health Worker/Promotora/Representative (CHW/P/R) benefit. According to the Latino Coalition for a Health California, this report would include the dollar amount of reimbursements to providers for services, the number and demographics of beneficiaries who have accessed the benefit, and the demographics of the CHW/P/R workforce providing services within the Medi-Cal program. Additionally, it would support DHCS in providing guidance to managed care plans on how to properly utilize community health workers, promotoras, and representatives to meet the new H.R. 1. Medi-Cal eligibility requirements, including work requirements and biannual renewals. Investing in CHW/P/R services will help California assess whether state resources align with the Administration's health access and equity goals. It will also identify opportunities to enhance program effectiveness and ensure that beneficiaries receive the services they need.

Increase Medi-Cal Rates for Emergency Physicians. The California Chapter of the American College of Emergency Physicians (CalACEP) requests General Fund expenditure authority of \$50 million in 2026-27 and \$100 million annually thereafter to support increased reimbursement rates in Medi-Cal for emergency physicians. According to CalACEP:

Medi-Cal reimbursement rates for emergency physicians are shockingly low and have not been increased in over twenty years:

- Emergency physicians see a higher percentage of Medi-Cal patients than other specialty.
 - Medi-Cal patients make up 42% of patients seen by emergency physicians statewide.
 - For some emergency physician groups at certain urban and rural hospitals as many as 75% of patients treated are insured by Medi-Cal
- Emergency physician rates are extremely low at 54-56% of Medicare. Medi-Cal reimbursement for the most complex and acute patient visit is \$108. Rates have not increased in over 20 years.

Demand for Emergency Care is Likely to Increase

- The demand on EDs is already high and will continue to increase as a result of state and federal cuts and as millions of vulnerable Californians lose access to health insurance due to H.R.1.

Just as California Has Stepped up to fund Planned Parenthood clinics due to the critical nature their services, regardless of MCO tax revenues, the Legislature must do the same for emergency care.

- We understand the magnitude of the deficit California is facing. However, preserving access to care in the ED is a small financial piece of the total for such a crucial investment. This is the last line of defense for all Californians with critical conditions and limited access to care.
- California must adopt a rate increase for emergency physicians so that they can adequately staff EDs
- The funding listed in this proposal continues the funding that has been allocated for Emergency Medicine payments as a part of the MCO tax.

California HealthTech Jobs Resilience and Career Accelerator. The California Telehealth Network and OCHIN request General Fund expenditure authority of \$4 million in 2026-27, \$8.1 million in 2027-28, and \$8 million in 2028-29 to support expansion of the health information technology (IT) workforce. According to the California Telehealth Network and OCHIN, California's rural and low-resourced

healthcare providers are facing a convergence of pressures that directly threaten access to care: persistent workforce shortages, rising operating costs, constricting Medi-Cal coverage and payment, and rapid technology change driven by health IT modernization, automation, and artificial intelligence (AI).

Just as providers are being asked, by policy, regulation, and necessity, to rely more heavily on digital systems, AI-supported workflows, and automated operations to remain financially viable, the state's existing targeted health IT workforce investment in rural and low-resourced communities is set to expire. This creates a timing mismatch at the worst possible moment: demand for advanced health IT and AI skills across healthcare teams is accelerating while training and workforce support are sunseting.

Medi-Cal HIPP Expansion. Patient Funding Alternatives requests expenditure authority of \$1.5 million (\$750,000 General Fund and \$750,000 federal funds) annually to support expansion of the Health Insurance Premium Payment (HIPP) program in Medi-Cal. This proposal would allow more Medi-Cal members to access commercial health insurance through their work-based insurance.

Medi-Cal Renewal Relief Strategies. Western Center on Law and Poverty (WCLP) requests expenditure authority to support four strategies included in the previous federal unwinding flexibilities to keep individuals covered in Medi-Cal, effective January 1, 2027. According to WCLP, now more than ever, it is important that California utilizes every tool at its disposal to reduce the workload burden on county workers and administrative barriers facing low-income Californians who bear the immediate impacts of HR 1 work requirements and increased eligibility checks. This proposal would reinstate four proven Medi-Cal eligibility strategies to streamline the Medi-Cal renewal process and minimize coverage terminations for low-income Californians:

- 1) **Auto-verify zero income:** Would auto-verify income when at \$0 when there is no conflicting electronic data available.
- 2) **Auto-verify income at or below 100% of FPL:** Would auto-verify income when income is at or below 100% of FPL when there is no conflicting electronic data available.
- 3) **Auto-verify stable income and assets:** Would auto-verify stable sources of income and stable assets.
- 4) **Streamline Asset Verification System (AVS) automatic renewals:** Would streamline the AVS workflow to assume there is no change in previously verified assets that are not likely to appreciate in value if an AVS request does not return any information or if information is not returned within a reasonable timeframe.

Reject HR 1 Medi-Cal Work Requirements and Six-Month Redeterminations for State-Only Populations. Western Center on Law and Poverty, Health Access California, the National Health Law Program, and Disability Rights California request General Fund expenditure authority of between \$250 and \$300 million to support exempting state only populations in Medi-Cal from the work requirements and six-month redeterminations implemented by HR 1. According to the advocates, HR 1 policies, specifically Medicaid work requirements and more frequent eligibility redeterminations, do not promote a healthy California. Rather, these policies threaten access to life-saving care by increasing administrative barriers and cutting eligible individuals from coverage. This is supported by research that finds work requirements in safety net programs not only fail to meaningfully increase employment rates or average earnings, but also delay access to care and decrease program participation by creating an additional barrier to accessing much needed support.

HR 1’s work requirement and six-month redetermination provisions apply only to federally funded Modified Adjusted Gross Income (MAGI) Medicaid “expansion” enrollees pursuant to section 1902(e)(14) of the Social Security Act. These eligibility rules do not apply to any other Medicaid enrollees. Medi-Cal state-only funded applicants and enrollees who are not federally eligible for Medicaid are not governed by § 1902(e)(14) and should not be subject to these harmful federal requirements. To impose such federal requirements on state-only funded Medi-Cal coverage is not only bad health policy but also punitive to immigrants who have no other coverage options.

Subcommittee Staff Comment and Recommendation—Hold Open.