California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, March 17, 2025

2:30 P.M. – State Capitol, Room 127

Items To Be Heard

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4260 Department of Health Care Services

Issue 1: Budget Overview, & Medi-Cal Estimate

Overview of the Department of Health Care Services' Budget

The Department of Health Care Services (DHCS) is the state agency responsible for financing and administering the state's Medicaid program, known as Medi-Cal, which provides health care services to low-income persons and families who meet defined eligibility requirements. Medi-Cal is authorized and jointly funded through a federal-state partnership, and covers physical health, mental health, substance use disorder, services, pharmacy, dental, and long-term services and supports.

The 2025-26 Governor's Budget projects **$193.3 billion in total funds** expenditure ($42.7 billion General Fund) for DHCS and proposes **4,821 staff positions.** This represents a dollar increase of 16.3% compared to the 2024-25 Enacted Budget, which appropriated a total of $166.3 billion total funds ($35.7 billion General Fund) for DHCS. These amounts capture both DHCS' state operations and local assistance programs, as shown below:

Fund Source	FY 2024-25 (Enacted Budget)	FY 2024-25 (Revised Budget)	FY 2025-26 (Proposed Budget)
General Fund	$35,730,880	$38,479,359	$42,780,432
Federal Fund	$99,545,314	$108,523,293	$119,030,777
Other Funds	$31,027,065	$33,114,886	$31,572,435
TOTAL	**$166,303,259**	**$180,117,538**	**$193,383,644**
Staff Positions	*4,688*	*4,688*	*4,821*

**Dollars in thousands*

Medi-Cal Funding (Local Assistance Estimate)

This section summarizes spending specifically for the Medi-Cal program. The table on the next page shows a high-level breakdown of Medi-Cal spending by source of funds.

Fund Source	2024-25 (Enacted Budget)	2024-25 (Revised Budget)	2025-26 (Proposed Budget)
MEDICAL CARE SERVICES**			
General Fund	$33,384,085	$36,184,830	$40,611,176
Federal Fund	$92,944,778	$101,365,419	$112,116,006
Other Funds	$27,357,278	$29,452,300	$27,734,516
TOTAL	**$153,686,141**	**$167,002,549**	**$180,461,698**
COUNTY ADMINISTRATION***			
General Fund	$1,638,646	$1,452,009	$1,477,744
Federal Fund	$5,565,830	$6,101,880	$5,937,215
Other Fund	$71,438	$55,647	$262,506
TOTAL	**$7,275,914**	**$7,609,536**	**$7,677,465**
TOTAL MEDI-CAL PROGRAM EXPENDITURES			
General Fund	$35,022,731	$37,636,839	$42,088,920
Federal Fund	$98,510,608	$107,467,299	$118,053,221
Other Fund	$27,428,716	$29,507,947	$27,997,022
TOTAL	**$160,962,055**	**$174,612,085**	**$188,139,163**

*dollars in thousands

**Medical Care Services captures a wide range of expenditures related to health care delivery (payments to plans and providers, pharmacy benefits, behavioral health services, long-term services and supports, etc.)

***County Administration refers to funding provided to counties to support administrative functions of the Medi-Cal program, such as eligibility determination and enrollment.

Increases in Medi-Cal Program Costs

Current Year Cost Increases

The Budget Act of 2024 appropriated $160.9 ($35 billion General Fund) for the Medi-Cal program. In its January 10 Budget, DHCS anticipated that current-year expenditure for medical care services would increase to $174.6 billion ($37.6 billion General Fund), representing a $2.6 billion increase in General Fund spending, or an 7.5% increase in the current year. DHCS highlighted the following major factors driving the change in estimated General Fund spending:

1. An estimated $540 million General Fund increase due to growth in Medi-Cal pharmacy expenditures. Similar to other state Medicaid programs, California's Medi-Cal program has experienced a notable increase in overall pharmacy costs.

2. An approximately $1.1 billion increase in costs from smaller than previously assumed impacts related to redeterminations.

3. An approximately $2.7 billion increase in costs for unsatisfactory immigration status (UIS) members. This increase is primarily driven by higher than anticipated enrollment and increased pharmacy costs.

4. A $1 billion reduction in General Fund costs related to the Managed Care Organization (MCO) tax, with an additional $453.7 million reduction in General Fund costs related to Proposition 35 passed by voters in November 2024, and an additional $478.7 million reduction in General Fund costs related to approval of an amendment to the MCO tax related to consideration of Medicare revenue back to January 2024 instead of April 2024.

2025-26 Budget Cost Increases

After accounting for the current year cost increases described above, DHCS projected needing an appropriation of $188.1 billion ($42 billion General Fund) in 2025-26 for the Medi-Cal program, representing a $4.4 billion increase in General Fund spending, or a 11.8% increase from current year expenditures. DHCS highlighted the following major factors driving the change in estimated General Fund spending from 2024-25 to 2025-26:

1. An approximately $3.6 billion increase in costs due to changes in the use of available MCO tax revenues. Of this amount, $2.7 billion is related to implementation of Proposition 35 and another $478.7 million relates to a one-time adjustment in 2024-25 to reflect the full year of additional MCO revenues from consideration of Medicare revenue back to January 2024 instead of April 2024.

2. An approximately $215.2 million increase due to the projected growth in Medi-Cal pharmacy expenditures.

3. A net $268.5 million increase in other base costs, reflecting the net impact of growth in average managed care rates, changes in projected enrollment, growth in Medicare premium and Part D costs, and projected fee-for-service utilization other than pharmacy.

Medi-Cal Caseload

In Fiscal Year 2024-25, the Medi-Cal program had an estimated caseload of 14,952,400 beneficiaries. For 2025-26, DHCS anticipates a caseload of 14,489,700 beneficiaries enrolled into the program. A high-level overview of caseload by categories is provided below:

Population Category	2024-25 Caseload	2025-26 Caseload
Seniors	1,444,200	1,590,200
Persons with Disabilities	1,041,100	1,022,800
Families and Children	7,348,000	6,919,900

Affordable Care Act Optional Expansion	5,051,300	4,884,000
Miscellaneous	67,800	72,800
TOTAL	**14,952,400**	**14,489,700**

DHCS notes that Medi-Cal caseload declined most months from July 2023 through June 2024, the 12 months following the end of the COVID-19 pandemic continuous enrollment requirement (discussed in a later sections of this agenda). Recent data suggest that the downward caseload trend has stopped. In its November 2024 Estimate, DHCS assumes that caseload will be generally steady or only slightly decline through 2024-25. The Governor's Budget assumes the end of discretionary pandemic unwinding flexibilities that result in fewer discontinuances in June 2025. Consistent with this assumption, enrollment is expected to fall more steeply in 2025- 26.

Panel

- Michelle Baass, Director, Department of Health Care Services
- Nick Mills, Staff Finance Budget Analyst, Department of Finance
- Lizbeth Castillo, Finance Budget Analyst, Department of Finance
- Ryan Miller, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

LAO Comments

Recent Growth in Medi-Cal Senior Caseload Due Mostly to Eligibility Expansions. As of December 2024, the senior caseload in Medi-Cal stands at 1.4 million, about 40 percent higher than at the start of the continuous coverage period that began in 2020 as a response to the COVID-19 pandemic. We find that the senior caseload is around 225,000 higher than it would have been under a pre-pandemic law and policy baseline. We estimate that at least 165,000 of these individuals are enrolled due to eligibility expansions, with the remaining up to 60,000 individuals enrolled due to the continuous coverage requirement and the related flexibilities implemented during its unwinding.

Growth Raises Issues for Legislative Consideration. Our findings show that, to a greater extent than initial estimates suggested would be the case, the Legislature's policy choices to expand Medi-Cal eligibility for seniors are having their intended effects. In particular, asset test elimination appears to have been particularly effective at extending Medi-Cal coverage to seniors. That said, it will be important for the Legislature to monitor the extent to which senior growth continues to grow in the context of a constrained state budget. Given this sizable growth in the senior caseload—many of whom are enrolled in Medi-Cal for the first time—we raise issues that we think merit legislative oversight:

- **Enrollee Educational Efforts.** With so many seniors enrolling in Medi-Cal for the first time, educational efforts specifically aimed at seniors could be worth considering. For example, in 2017, the scope of the state's estate recovery policy was narrowed considerably. Generally speaking, only those deceased members whose estates are subject to probate and who received specified nursing facility or home- and community-based care services are subject to recovery. Despite this narrowed scope, with so many seniors enrolling in Medi-Cal for the first time, should the department consider any educational communications to help enrollees understand the estate recovery rules?

- **Access to Services.** As of December 2024, the senior caseload in Medi Cal stands at 1.4 million, about 40 percent higher than at the start of the continuous coverage period. Given the particular health care needs of seniors, should the state consider any actions to ensure sufficient access to services for this population?

- **Potential Cost Pressures in Long Term Care**. LAO analysis shows that the increases in senior caseload have been concentrated in the Medically Needy aid category and have not resulted in corresponding increases in the relatively costly long term care aid category, which has been largely flat since 2021. The Legislature may wish to ask the Administration about the potential for additional seniors in Medi Cal to eventually shift to the long term care aid category, which would substantially increase state costs. Should the state consider additional actions to facilitate more transitions to less costly home and community based services in order to help prevent this cost growth?

Staff Comments

Current Year General Fund Loan to Medi-Cal

Existing law allows the Administration to issue a General Fund loan to the Medi-Cal program in the event of a budget shortfall during the fiscal year. This loan mechanism ensures continued payments to Medi-Cal providers. Statutorily, the loan cannot exceed 10% of the General Fund allocation for Medi-Cal benefit costs as appropriated in the most recent Budget Act.

On March 12, the Administration notified the Legislature that it had approved a request for a loan of $3.44 billion – the maximum allowed in statute – to enable DHCS to complete payments to various Medi-Cal providers.

Cost Pressures for Medi-Cal Indicated in January Budget

Staff notes that DHCS had already indicated substantial cost increases in the January Governor's budget announcement, as outlined in the Medi-Cal November 2024 Estimate and

summarized in this agenda. These cost increases are driven by a variety of factors, from the growth of pharmacy expenditures, automatic enrollment policies, increase in UIS members costs, and impacts from Proposition 35 and change in use of the MCO tax.

In addition, the Legislative Analyst's Office issued a detailed analysis on the recent increases in the Medi-Cal Senior caseload, and the potential added cost pressure, particularly in the area of long-term care.

Regarding the recent General Fund loan to the Medi-Cal program, the subcommittee may wish to ask:

1. Will the approved $3.44 billion loan be sufficient to cover current payment obligations, or is there a risk of further shortfalls later in the fiscal year?
2. Is this loan responding to additional cost pressures that were not identified in the January budget, and if so, what are those new cost drivers?
3. Does the Department have updated projected Medi-Cal expenditures for the current fiscal year and for the 2025-26 Budget?

Regarding cost increases in the Medi-Cal program, the Subcommittee may wish to ask:

1. Health care spending is generally increasing across the United States. How much of the budget growth is driven by capitation rate increases for Medi-Cal Managed Care plans?
2. Can the Department provide additional details on the rising pharmacy costs? Are these pressures driven by higher utilization, increased unit costs, or new high-cost drugs and therapies?
3. Has the Administration updated its UIS-related enrollment and cost-estimates? What pharmacy cost drivers are contributing to this increase?
4. Can the Department respond to the LAO's analysis of the increase in Senior caseload? Is enrollment for this population anticipated to increase? Does the Department anticipate corresponding increases in long-term care spending?
5. Are other State Medicaid programs experiencing similar cost increases?
6. What cost-containment strategies is the Administration considering for the Medi-Cal program in the May Revision? If enacted, what is the expected timeline for these measures to begin generating savings and stabilizing program costs?

Staff Recommendation: HOLD OPEN

Issue 2: Family Health Estimates & Various Budget Issues

Family Health Local Assistance Estimate

This section summarizes spending for DHCS's three Family Health programs: California Children's Services, the Genetically Handicapped Persons Program, and Every Woman Counts. These programs assist families and individuals by providing services for low-income children and adults with special health care needs who do not qualify for enrollment in Medi-Cal. The three Family Health programs are:

- **California Children's Services (CCS):** The CCS program, 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. Children enrolled in the CCS State Only program do not qualify for full-scope Medi-Cal.

- **Genetically Handicapped Persons Program (GHPP):** The GHPP program provides medically necessary services and administrative case management for individuals aged 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.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured Californians who do not qualify for Medi-Cal.

In its November 2024 Estimate, DHCS projected Family Health Spending to be $269.6 million total funds ($238.2 million General Fund) in Fiscal Year 2024-25 and **$272.1 million total funds** ($241.4 million General Fund) in 2025-26.

Fund Source	*FY 2024-25*	*FY 2025-26*
CALIFORNIA CHILDREN'S SERVICES		
General Fund	$85,680,000	$89,650,000
Other Fund	$7,421,000	$6,256,000
TOTAL CCS	**$93,101,000**	**$ 95,906,000**
GENETICALLY HANDICAPPED PERSONS PROGRAM		
General	$154,337,000	$151,777,000
Other Fund	$486,000	$529,000
TOTAL GHPP	**$154,823,000**	**$152,306,000**
EVERY WOMAN COUNTS PROGRAM		
General Fund	$(1,776,000)	$0

Other Fund	$23,441,000	$23,967,000
TOTAL EWC	**$21,665,000**	**$23,967,000**
GRAND TOTAL	**$269,589,000**	**$272,179,000**

Family Health Caseload

The table below provides a snapshot of the enrollment caseload for each Family Health programs.

Program	2024-25 Caseload	2025-26 Caseload
California Children's Services (State-Only)	15,052	15,052
Genetically Handicapped Persons Program	701	701
Every Woman Counts	12,668	12,845

Oversight Issue: California Children's Services Program Funding Methodology

The California Children's Services program is administered in partnership with county health departments to provide specialty health care services to children and youth with complex medical conditions.

The CCS program is jointly funded by the state General Fund, federal funds, and county contributions, with cost-sharing ratios varying based on an enrollee's Medi-Cal eligibility. For example, children and youth who do not qualify for Medi-Cal may enroll in the CCS State-Only program, which is funded equally by the General Fund (50%) and county funds (50%). In contrast, Medi-Cal-eligible enrollees may participate in a CCS program that receives federal funding.

DHCS allocates CCS General Fund to counties annually. These allocations support eligibility determination, medical case management, and other administrative functions performed by counties. Broadly, DHCS uses a specific methodology for determining these allocations, which considers county enrollee caseload, expenditure history, and staffing standard requirements.

As part of the California Advancing and Innovating Medi-Cal (CalAIM), DHCS is implementing a Monitoring and Oversight (M&O) program to establish, implement, and evaluate statewide performance, quality, and reporting standards for county administration of the CCS program. As part of this M&O, DHCS has developed a template Memorandum of Understanding (MOU) and will require each county to enter an MOU with the state to document each country's obligations

in administering the CCS program. The County Monitoring & Oversight Initiative has a planned implementation date of July 1, 2025.

Oversight Issue: Medi-Cal Continuous Coverage Unwinding

During the COVID-19 pandemic, Congress enacted a temporary increase in federal Medicaid funding. In exchange, states were required to adhere to several conditions, the most significant being the continuous coverage requirement, which prohibited states from disenrolling Medi-Cal beneficiaries except in limited circumstances. This policy led to a significant increase in Medi-Cal caseload and expenditures across all funding sources.

In response to the anticipated end of continuous coverage, DHCS developed the Medi-Cal COVID-19 Public Health Emergency Operational Unwinding Plan in May 2022, outlining the state's approach to resuming normal eligibility determinations. Recognizing the immense administrative burden on counties, the 2022-23 state budget allocated $146 million ($73 million General Fund) over multiple fiscal years to support county workload for processing eligibility redeterminations.

California formally resumed eligibility processing in April 2023, and as expected, Medi-Cal caseloads began to decline in July 2023. To mitigate disruptions in coverage, DHCS obtained federal approval for several flexibilities, simplifying eligibility processes for counties and enrollees

The Governor's Budget assumes that several discretionary flexibilities will remain in place through June 2025, helping to maintain a generally steady caseload. However, with these flexibilities set to expire, the state anticipates a steeper enrollment decline in 2025-26.

Oversight Issue: Overdose Prevention and Harm Reduction Initiative, Naloxone Distribution Project, and the Opioid Settlement Fund

At its February 24, 2025 hearing, this Subcommittee heard a California Department of Public Health budget proposal to decrease funding for the Overdose Prevention and Harm Reduction Initiative by $8.4 million. The initiative provides grants to local health jurisdictions and community-based organizations to support overdose prevention and harm reduction activities, including treatment navigators. Funding is provided through the Opioid Settlement Fund (OSF), which was established to manage and allocate the state's share of settlement monies received from opioid-related lawsuits against manufacturers, distributors, and pharmacies that allege that such companies fueled the opioid crisis.

The proposed reduction to the Overdose Prevention and Harm Reduction Initiative corresponds to a requested 8.4 million increase in OSF expenditure authority for DHCS in the 2025-26 Governor's budget for the Naloxone Distribution Project (NDP). The NDP allows eligible entities

(first responders, law enforcement, community organizations, harm reduction organizations, schools, etc.) to apply and receive free naloxone nasal spray.

Panel

- Michelle Baass, Director, Department of Health Care Services
- Nick Mills, Staff Finance Budget Analyst, Department of Finance
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Staff Comments

California Children's Services: Funding Methodology

The Subcommittee has received numerous letters from counties and stakeholders expressing concerns about the current funding methodology used to allocate resources in the CCS program. Counties are allegedly receiving significantly less funding than requested, making it challenging to meet program demands. Additionally, stakeholders have raised concerns that staffing allocation standards do not accurately reflect caseload complexity or administrative workload, limiting the number of positions counties can request. Finally, counties have also noted that CCS budget categories are rigid, preventing them from reallocating funds between program areas even when allocations do not align with existing needs. According to stakeholders, this restriction limits their ability to maximize available resources and ensure efficient service delivery.

The Subcommittee has also received feedback regarding implementation of the Whole Child Model (WCM), which aims to transition the coordination of care for Medi-Cal-eligible California Children's Services beneficiaries from county-based CCS programs to Managed Care Plans (currently, 21 counties are designated WCM). As part of this transition, funding previously allocated to County CCS programs was redirected to Managed Care Plans, leading to a reduction in county CCS staffing while counties still play a critical role in case management and eligibility determination. Counties report issues with Managed Care Plans, and the lack the specialized expertise and infrastructure needed to adequately serve medically complex children, leaving families dependent on county CCS programs despite the funding shift.

Regarding the CCS program, the Subcommittee may wish to ask DHCS the following questions:

1. Can the Department describe the funding methodology used by DHCS to allocate funding to its county partners?

2. Has the Department engaged with stakeholders regarding concerns about the funding methodology? If so, how has stakeholder feedback been considered for implementation?

3. How were the staffing standards used by the Department developed, and how are they updated to reflect changing caseload needs?

4. How many jurisdictions have signed the Monitoring & Oversight MOU between DHCS and county CCS programs to date?

5. Can the Department provide an update on the implementation of the CCS Monitoring & Oversight Initiative, including key anticipated milestones?

Medi-Cal Continuous Coverage Unwinding

The 2025-26 Governor's Budget assumes that certain unwinding flexibilities will expire in June 2025, resulting in a steeper enrollment decline in 2025-26. Given these changes, the Subcommittee may wish to ask:

1. Which specific unwinding flexibilities will expire in June 2025, and what are the expected impacts on Medi-Cal caseload?

2. How will the expiration of these flexibilities affect counties' ability to process renewals?

3. Are there any unwinding flexibilities that can be made permanent?

Overdose Prevention and Harm Reduction Initiative, Naloxone Distribution Project, and the Opioid Settlement Fund

1. What is the Administration's rationale for reducing funding for OPHRI and shifting limited resources to the Naloxone Distribution Project?

2. At the February 24 hearing, the Administration explained that declining OSF revenues are due in part to pharmaceutical companies undergoing restructuring. Can the Administration clarify how these legal maneuvers allow companies to avoid payments, and what actions, if any, the state can take in response?

Staff Recommendation:

HOLD OPEN

Issue 3: Proposition 35 Implementation

This background was adapted from content provided by the Legislative Analyst's Office.

Background on the Managed Care Organization Tax

For over a decade, California, along with other states, has charged a specific tax on health insurance plans called the Managed Care Organization (MCO) tax. In recent years, this tax has been based on each plan's monthly enrollment in the Medi-Cal program and the commercial market. The MCO tax currently generates more than $12 billion in gross revenue annually, but approximately $8 billion in net revenue is available for the state to spend. This is because the state uses a portion of the tax revenue to increase Medi-Cal payments to health plans, which in turn draws down federal matching funds and offsets the tax burden on plans.

The Legislature most recently renewed the MCO tax in the 2023-24 budget, extending it through the end of 2026. Broadly, California has used the MCO tax for two key uses:

- **Supporting Existing Medi-Cal Program (Offsetting General Fund Spending).** A portion of MCO tax revenue was to support existing service levels in the Medi-Cal program (the historic use of the MCO tax). This use would continue freeing up General Fund spending for other purposes.

- **Supporting Augmentations.** The remaining portion of MCO tax revenue was to support health program augmentations (a new use of MCO tax fund). Most were increases for Medi-Cal provider rates, such as rates for physician and hospital services. A few augmentations also supported certain health programs outside of Medi-Cal, such as workforce initiatives at the University of California and the Department of Health Care Access and Information.

Use of the MCO Tax under the Budget Act of 2024

Although the MCO tax spending plan evolved overtime, the Budget Act of 2024 outlined uses of MCO revenues to both offset General Fund spending for the Medi-Cal program and provide rate increases to providers.

Notably, the budget included trailer bill language stating that if voters approve Proposition 35 in November 2024, the Medi-Cal provider rate increases and investments in the budget will become inoperable due to the General Fund's inability to sustain both the investments in the Budget and those outlined in the initiative.

Proposition 35 Implementation:

In November 2024, California voters approved Proposition 35, which notably changes the spending plan for the state's MCO tax. Accordingly, the Governor's budget includes an initial spending plan to implement the measure, with many key details still forthcoming.

Under Proposition 35, the MCO tax is now permanent under state law. That is, the tax no longer requires approval from the Legislature to go into effect. However, the tax must still receive federal approval. This means that DHCS, which administers the MCO tax, must periodically submit new versions of the tax for federal approval. Proposition 35 allows DHCS to change the MCO tax structure to get federal approval, within certain limits.

Proposition 35 also creates new rules around how to spend the MCO tax revenue. Generally, these rules require more MCO tax funding to go for augmentations than in the most recent state spending plan. The rules differ in the short term (during the term of the existing tax) and in the long term (beginning in 2027, when the tax is renewed), described below:

- **Short Term (2025 and 2026).** In the first two years, the state must spend specified amounts of money on certain augmentations and to offset General Fund spending on Medi-Cal, totaling $4.7 billion. Some of the provider rate increases and investments are outlined below:

    - General Fund Offset: $2 billion
    - Primary Care (including obstetrics and nonspecialty mental health services): $691 million
    - Specialty Care: $575 million
    - Community and Outpatient Procedures: $245 million
    - Abortion and Family Planning Services: $90 million
    - Primary Care Services and Supports: $50 million
    - Emergency Room Facilities and Physicians: $355 million
    - Designated Public Hospitals: $150 million
    - Ground Emergency Medical Transportation: $50 million
    - Behavioral Health Facility Throughputs: $300 million
    - Graduate Medical Education: $75 million
    - Medi-Cal Workforce: $75 million

- **Long Term (2027 and Onward).** Beginning in 2027, the measure creates new rules, depending on how much net revenue the tax raises. For example, for the first $4.3 billion, the state must spend 92 percent of the funds on specified augmentations and 8 percent to offset General Fund spending in Medi-Cal. For funds above $4.3 billion, other rules apply.

Proposition 35 does not just change how much MCO tax funding goes for augmentations. It also changes which services and programs receive increases, with somewhat different services affected in the short and long term. As the next figure shows, while there is crossover between the state's previous spending plan and Proposition 35, there also are a number of key differences. For example, Proposition 35 includes more Medi-Cal rate increases for certain kinds of facilities (like hospitals), whereas the state's previous plan—but not Proposition 35—included increases for certain long-term supports. In the long term, some services and programs only receive increases if net revenue exceeds a certain threshold.

Different Services Will Get MCO Tax-Funded Increases Over Time

What Was in Last Year's Budget Package, and What Is Now Law Under Proposition 35 (2024)

	2024-25 Budget Package	Proposition 35	
		2025 and 2026	2027 and Onward
Physician and Professional Services			
Primary care	✓	✓	✓
Maternity care	✓	✓	✓
Mental health	✓	✓	✓[a]
Specialty care	✓	✓	✓
Emergency care	✓	✓	✓
Dental care			✓
Facilities			
Hospital inpatient services			✓
Outpatient procedures and services		✓	✓
Designated public hospitals		✓	✓
Emergency rooms		✓	✓
Behavioral health facilities		✓	✓
Clinics and health centers	✓	✓[b]	✓
Medical Transport			
Ground emergency	✓	✓	✓
Emergency air	✓		✓
Nonemergency	✓		
Workforce			
Medi-Cal workforce pool	✓	✓	✓
Graduate medical education		✓	✓
Health worker loan repayments			✓[c]
Long-Term Supports			
Community-based adult services	✓		
Congregate living health facilities	✓		
Pediatric day health centers	✓		
Other Services and Programs			
Reproductive health and family planning	✓	✓	✓
Community health workers	✓		✓[c]
Drug affordability programs			✓[c]
Private duty nursing	✓		
Continuous Medi-Cal coverage for children up to five years old	✓		

[a]Not specifically described in measure, but potentially allowable.

[b]Specifically for "services and supports for primary care."

[c]Only if more than $4.7 billion net revenue is raised.

MCO = managed care organization.

Stakeholder Advisory Group

While Proposition 35 is fairly prescriptive on which kinds of services and programs receive increases, it is much more open-ended on how these increases are to be structured. Accordingly, the measure requires DHCS to convene a new stakeholder committee to advise the department on implementing the augmentations. The committee is advisory only, with DHCS having final decision-making authority. The committee has ten members, representing providers, health plans, and other related stakeholders. Proposition 35 tasks the Governor, the Speaker of the Assembly, and the Senate President pro Tempore with appointing members, as outlined below:

Appointed by the Governor:

1. **Physician Representative:** One member representing both primary and specialty physicians statewide.

2. **Hospital Representative:** One member representing both public and private hospitals statewide, regardless of licensure type.

3. **Emergency Ambulance Provider:** One member representing a private emergency ambulance provider performing 500,000+ emergency ground transports per year.

4. **Family Planning & Reproductive Health:** One member representing family planning and reproductive health providers statewide.

5. **Medi-Cal Managed Care Plans:** One member representing commercial, non-governmental Medi-Cal managed care plans statewide.

6. **Clinics:** One member representing clinics statewide.

Appointed by the Speaker of the Assembly:

1. **Public Medi-Cal Managed Care Plans:** One member representing public, nonprofit Medi-Cal managed care plans statewide.

2. **Dentists:** One member representing dentists statewide.

Appointed by the Senate President Pro Tempore:

1. **Labor Groups:** One member representing organized labor groups statewide.

2. **Air Ambulance Provider:** One member representing a private emergency air ambulance transport provider that bills for 2,000+ emergency transports per year.

Governor's Budget

The Governor's budget assumes MCO tax net revenue of $27 billion through 2026-27, a $603 million increase over last year's spending plan. The increase is not the result of higher tax rates, but rather an additional quarter of funding. Last year's spending plan assumed some of the MCO tax rate increases would begin in April 2024. The federal government, however, later approved these increases to begin in January 2024, three months earlier.

As the next table shows, the Governor's budget spends $7 billion on augmentations through 2026-27, an increase of $3.6 billion over last year's spending plan. Most of the increase ($2.5 billion) is from implementing Proposition 35's rules in the short term (through 2026). The remainder ($1.2 billion) will be spent in 2027 according to the measure's long-term rules. (This breakout does not precisely add due to rounding.) The plan is based on the administration's interpretation of how to implement Proposition 35's provisions.

Governor's Budget Increases Spending for Augmentations

MCO Tax Spending Plan (In Billions)

	2023-24	2024-25	2025-26	2026-27	Totals
2024-25 Budget Act					
Net revenue	$4.8	$7.5	$7.6	$6.6	$26.5
General Fund offset	4.5	7.1	6.6	5.0	23.2
Augmentations	0.3	0.4	1.0	1.6	3.3
2025-26 Governor's Budget					
Net revenue	$4.4	$8.8	$7.6	$6.3	$27.1
General Fund offset	4.4	8.1	4.4	3.3	20.1
Augmentations	—	0.7	3.3	3.1	7.0
Change					
Net revenue	-$0.4	$1.3	—	-$0.3	$0.6
General Fund offset	-0.1	1.0	-$2.2	-1.8	-3.1
Augmentations	-0.3	0.2	2.2	1.5	3.6

MCO = managed care organization.

Pursuant to last year's trigger language, the Governor's budget assumes that specific augmentations under the state's previous spending plan (those scheduled to begin in 2025 and 2026) are no longer in effect. In their place, the Administration's spending plan supports new augmentations, pursuant to Proposition 35's rules. That said, the administration has not provided

more detail on the structure of these augmentations. This is because DHCS must first convene and consult with the required stakeholder advisory committee. At the time of writing, not all appointments have been made to the stakeholder advisory committee.

Panel

- Michelle Baass, Director, Department of Health Care Services
- Lindy Harrington, Assistant State Medicaid Director, Department of Health Care Services
- Nick Mills, Staff Finance Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

LAO Comments

While Limited in Detail, Administration's Approach to Proposition 35 Appears Reasonable. At the moment, the Administration does not have a complete Proposition 35 implementation plan to assess. The lack of a detailed plan is understandable and expected, given the measure's recent enactment and its stakeholder consultation requirements. It also appears that the administration is taking the required actions to implement Proposition 35. The measure itself raises complex issues, owing in large part to its being drafted in fall 2023, prior to subsequent changes made to the MCO tax in 2024. Nonetheless, we follow the department's initial spending plan and raise no concerns with it at this time.

Legislature Has Role in Overseeing Implementation Plan. Though we have no concerns so far with the Administration's plans, we think now is an appropriate time for the Legislature to begin providing oversight over the measure's implementation. Proposition 35 itself does not require legislative appropriation to implement its provisions. In fact, the measure limits the Legislature's ability to change the MCO tax's structure and spending plan moving forward. However, as with any enacted ballot measure, the Legislature can play an important role in ensuring the administration implements the measure as intended by voters. Legislative oversight is particularly warranted given the measure's interaction with General Fund spending in Medi-Cal. Moreover, Proposition 35 presents an opportunity to notably expand Medi-Cal provider rates and other services, a longstanding area of interest to the Legislature.

Consider Key Oversight Issues. Given that the Administration is still in the early stages of implementation, we recommend the Legislature focus its initial oversight over Proposition 35 on a few key issues, as it relates to the measure's overall implementation of the MCO tax-funded augmentations, as well as fiscal uncertainties around the tax and measure.

Staff Comments

The Subcommittee may wish to ask the following questions:

1. What is the Administration's proposed timeline to convene the advisory committee and begin implementing Proposition 35?

2. Can the Administration convene the advisory committee now if a quorum of members has been already appointed?

In addition, the LAO highlights the following questions as part of its oversight recommendations:

1. When will the department begin implementing augmentations?

2. How will the department structure the augmentations?

3. When will providers receive rate increases?

4. Will the General Fund have capacity to cover more costs in 2027?

5. Will federal policy changes reduce the size of the managed care organization tax?

6. Will the augmentations create cost pressure on the General Fund?

Staff Recommendation:

This item is informational only.

Issue 4: Children and Youth Behavioral Health Initiative Fee Schedule

Segments of this background was adapted from content provided by the Assembly Committee on Health and the Assembly Committee on Education.

Background on the Children and Youth Behavioral Health Initiative

The Children and Youth Behavioral Health Initiative (CYBHI) is a $3.8 billion multiyear package launched in 2022 to promote the mental health and wellness of California's children and teens. As part of the broader CYBHI effort, DHCS is responsible for implementing the **CYBHI Fee Schedule program**, which aims to create a sustainable funding source for behavioral health services in schools and school-linked settings.

State law requires DHCS to develop and maintain a multi-payer, school-linked statewide fee schedule for medically necessary outpatient mental health and substance use disorder services provided to students 25 years of age or younger at or near a school site. Additionally, Medi-Cal managed care plans and commercial insurers must reimburse for these school-based services at or above the established fee schedule rate, regardless of whether the school-site provider is in-network. These services cannot be subjected to prior authorization, copayments, coinsurance, or deductibles.

The CYBHI Fee Schedule ensures that Local Educational Agencies (LEAs) and Institutions of Higher Education (IHEs) are reimbursed for behavioral health services delivered on school sites. LEAs may either provide these services directly using their own staff or partner with community-based providers to serve students. Key design details of the CYBHI Fee Schedule are shown below:

Category	Description
Services	Outpatient mental health and substance use disorder services identified by in the reimbursement schedule published by DHCS, under four separate categories: • Psychoeducation • Screening and Assessment • Therapy • Case Management
Eligibility	Student 25 years of age or younger at a schoolsite*.
Providers	Local educational agencies or institutions of higher education
Payers	Applies to: • State-regulated commercial health plans and insurers** • Medi-Cal managed care plans • Medi-Cal county behavioral health plans

* "School site" means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. It also includes a community-based facility or location, if the school or school district provides or arranges for the provision of services to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

** Applies to plans and insurers to the extent the plan or insurer is required to provide coverage for medically necessary treatment of mental health and substance use disorders.

Implementation Update

To implement the fee schedule, DHCS must develop and maintain a school-linked statewide provider network of behavioral health counselors. Each LEA and IHE must submit a roster of their behavioral health providers to be approved prior to being able to bill. LEAs and IHEs are onboarded in implementation "cohorts", with each cohort selected based on operational readiness. The selection process considers factors such as Medi-Cal enrollment, service delivery infrastructure and capacity, data collection and documentation, and billing infrastructure. In addition, the state has selected Carelon as the third-party administrator who serves as the statewide clearinghouse that receives and adjudicates claims from LEAs, and pays these claims on behalf of health plans. Carelon is also responsible for credentialing school-based providers for participation in the fee schedule on behalf of the state, as well as providing training and technical assistance to participating LEAs.

To support implementation, CYBHI provides a multi-year School-Linked Partnership and Capacity grant program that helps LEAs and IHEs cover operational costs and infrastructure investments necessary to participate in school-based reimbursement programs. Up to $400 million has been earmarked for these efforts, nearly all of which has been distributed.

The following timeline describes DHCS' implementation of the various cohorts:

- **January 2024:** 47 LEAs were approved as the first cohort and participated in a learning collaborative to inform state-level policy and operational guidance for the CYBHI Fee Schedule.
- **July 2024:** 91 LEAs were approved as the second cohort.
- **October 2024:** 160 LEAs and IHEs were approved as the third cohort.
- **February 2025:** 183 LEAs and 3 IHEs were approved as the fourth cohort.

As implementation progresses, only a handful of LEAs have successfully filed claims and received reimbursements under the fee schedule program in the one year that the program has been in place. Full-scale adoption has been much slower than anticipated.

Panel

- Tyler Sadwith, State Medicaid Director, Department of Health Care Services
- Lizbeth Castillo, Finance Budget Analyst, Department of Finance
- Joel Cisneros, Executive Director of Student Mental Health & Wellness Services, Los Angeles Unified School District
- Trina Frazier, Assistant Superintendent of Student Services, Fresno County Superintendent of Schools
- Ryan Miller, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

The CYBHI Fee Schedule Program is a critical component of the Children and Youth Behavioral Health Initiative. While many of the other components of CYBHI are one-time investments, the Fee Schedule has the potential to have the most significant long-term impact, as it is the only initiative designed to create a sustainable funding source to support the delivery of behavioral health in schools and in school-linked settings. This is significant because many schools and school partner organizations already provide many behavioral health services to students that are enrolled in Medi-Cal or a commercial health plan, but receive no reimbursement.

Despite progress in selecting and onboarding LEAs and IHEs, nearly all participating entities have faced challenges establishing the necessary infrastructure to deliver services and receive reimbursements. The onboarding process has been complex and hindered by technical, operational, and administrative barriers. Examples include:

- **Collection of Student Health Plan Information:** LEAs have struggled to gather accurate and complete health plan data from students, making it difficult to process reimbursement claims. This issue is exacerbated by inconsistent data-sharing practices across schools and health plans.

- **Delay in Receiving Technical Guidance from DHCS and Its Third-Party Administrator:** Many LEAs and IHEs have noted issues obtaining the necessary technical guidance to implement the program, such as receiving policy and technical manuals outlining billing instructions and program compliance requirements. To date, no written guidance has been provided to LEAs.

- **Navigating Complex Health and Education Regulations:** Health and education systems operate under different regulatory frameworks, creating disconnects between schools, health plans, and administrators. For example, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA) govern health data privacy and educational records, respectively. These

regulations were designed for separate sectors, making data-sharing and reimbursement coordination between schools and health plans difficult. Other compliance challenges include state Medicaid policies, provider credentialing rules, and administrative billing processes that do not align easily with educational settings.

As the CYBHI implementation progresses more slowly than anticipated, LEAs explain that they are facing growing fiscal challenges in sustaining their behavioral health services. The continued inability to receive reimbursements under the Fee Schedule threatens their capacity to maintain essential infrastructure and staffing, putting the delivery of critical services to students at risk. Of note, LEAs are required to issue layoff notices to employees by March 15th each year if there is a possibility that their positions may be cut. The behavioral health infrastructure that has been developed in schools, with significant state investments, is described to be in jeopardy.

The Subcommittee may wish to ask the following questions:

For DHCS:

1. How is DHCS addressing the delays that are leading to financial challenges for LEAs with the program coming online?
2. What specific steps has DHCS taken to accelerate implementation and ensure more LEAs can successfully get reimbursed for services?
3. What is the expected timeline for full implementation, and how many LEAs are projected to successfully bill under the Fee Schedule by the end of the year? When can LEAs realistically expect to see regular and ongoing reimbursements of their claims?
4. How does DHCS or the Third Party Administrator support LEAs in navigating administrative and regulatory requirements, such as Medi-Cal billing, provider credentialing, and data-sharing compliance?
5. What financial support is available for LEAs facing fiscal challenges and potential loss of critical behavioral staff due to implementation delays?

For LEAs:

1. What are the major implementation challenges LEAs face with the CYBHI Fee Schedule?
2. How has the implementation timeline impacted your ability to provide behavioral health services to students?
3. Have LEAs been able to establish partnerships with providers for service delivery?
4. Are there any successful implementation strategies or best practices LEAs have identified that could be shared more widely?

Staff Recommendation: HOLD OPEN

Issue 5: Waiver Implementation Updates

Segments of this agenda has been adapted by content provided by the Legislative Analyst's Office

This issue will provide updates on the California Advancing and Innovating Medi-Cal (CalAIM) and the Home and Community-Based Alternative (HCBA) Waiver program.

Background on CalAIM

Medi-Cal Waiver Intended to Improve Care for High-Cost, High-Need Members. Medi-Cal provides health care coverage to almost 40 percent of Californians, but the program's complexity makes it difficult for some individuals to access appropriate care. The state received federal approval for the CalAIM waiver that, in part, allows the state to draw down additional federal funding for two new benefits: Enhanced Care Management (ECM) and Community Supports. These benefits are provided by managed care plans (MCPs) and are intended to provide cost-effective services to high-cost, high-need Medi-Cal members to improve health outcomes and reduce reliance on more costly medical services. The ECM benefit provides personalized care management to eligible members and Community Supports services—largely of a social services nature—are substitutes to traditional, often more costly, medical services. Members may be eligible for both benefits, as the two benefits serve broadly overlapping populations. However, the overlap is limited by the fact that each of the ECM benefit and the 14 Community Supports services has distinct eligibility criteria.

ECM Benefit Provides Care Coordination to Highest-Need Medi-Cal Members. ECM is intended to be a comprehensive, whole-person care management benefit that coordinates all aspects of a member's care across physical and behavioral health delivery systems. Each eligible member is assigned a personal ECM Care Manager who helps to identify all resources to address all needs of the member, including the development of a care management plan.

Community Supports Provide Medically Appropriate and Cost-Effective Substitutes for Other Covered Services. The table below provides a full list of the currently approved Community Supports along with a brief description. Community Supports are services or settings—largely of a social services nature—that can substitute for, and potentially decrease utilization of, a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department use. For example, a member may receive home modifications that would allow them to remain in their home rather than need to move to an assisted living facility (which has a much higher cost to the state).

Available Community Supports Services

Benefit	Description
Housing-Related Services ("Housing Trio")	
Housing transition navigation services	Assistance with obtaining housing. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.
Housing deposits	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.
Housing tenancy and sustaining services	Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services, to develop financial literacy.
Recuperative Services	
Recuperative care (medical respite)	Short-term residential care for beneficiaries who no longer require hospitalization, but still need to recover from injury or illness.
Respite services	Short-term relief provided to caregivers of beneficiaries who require intermittent temporary supervision.
Short-term, post-hospitalization housing	Setting in which beneficiaries can continue receiving care for medical, psychiatric, or substance use disorder needs immediately after exiting a hospital.
Sobering centers	Alternative destinations for beneficiaries who are found to be intoxicated and would otherwise be transported to an emergency department or jail.
Services to Enable Members to Remain in a Home-Like Setting	
Day habilitation programs	Programs provided to assist beneficiaries with developing skills necessary to reside in home-like settings, often provided by peer mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.
Nursing facility transition/diversion to assisted living facilities	Services provided to assist beneficiaries transitioning from nursing facility care to community settings, or prevent beneficiaries from being admitted to nursing facilities.
Nursing facility transition to a home	Services provided to assist beneficiaries transitioning from nursing facility care to home settings in which they are responsible for living expenses.
Personal care and homemaker services	Services provided to assist beneficiaries with daily living activities, such as bathing, dressing, housecleaning, and grocery shopping.
Environmental accessibility adaptations	Physical adaptations to a home to ensure the health and safety of the beneficiary. These may include ramps and grab bars.
Medically tailored meals	Meals delivered to the home that are tailored to meet beneficiaries' unique dietary needs, including following discharge from a hospital.
Asthma remediation	Physical modifications to a beneficiary's home to mitigate environmental asthma triggers.

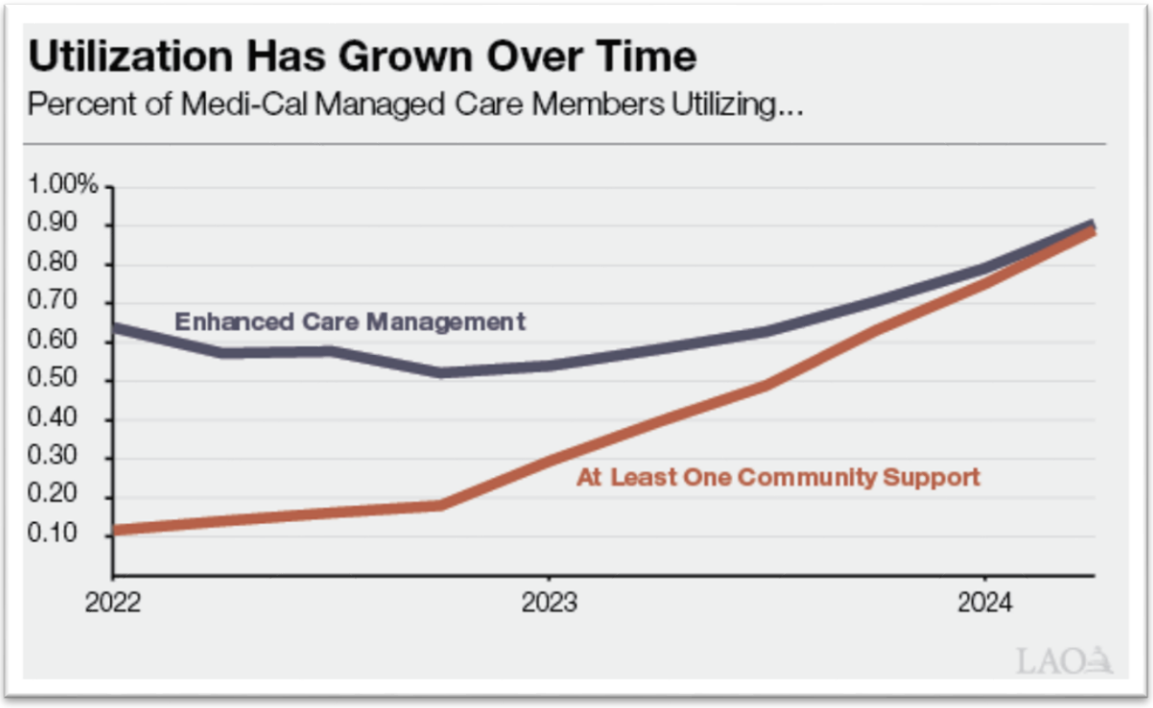
State Provides Grants to MCPs and Providers to Develop ECM and Community Supports Program Infrastructure. In order to support the implementation of ECM and Community Supports, the state implemented the PATH initiative and the Incentive Payment Program (IPP) to help create and expand program infrastructure.

- ***PATH Initiative Provides Funding to Help Providers Participate in CalAIM.*** The state received approval under the waiver to provide $1.85 billion in total funds (incorporating the federal match) for the PATH initiative. PATH consists of multiple initiatives intended to build up the capacity and infrastructure of CalAIM providers. This was needed as these providers were not traditionally part of the health care delivery system. To support ECM and Community Supports services, PATH provides funding for (1) a virtual marketplace for technical assistance; (2) regional facilitators to support collaborative planning efforts among MCPs, providers, and other behavioral health organizations; and (3) Capacity and Infrastructure Transition, Expansion and Development (CITED) grants that provide direct funding to providers. PATH CITED grants could be used to hire and train staff; expand service capacity; or improve organizational infrastructure, such as upgrading information technology systems. In addition, the state provided an additional $40 million General Fund to support ECM and Community Supports capacity in clinics.

- ***IPP Provides Additional Funding to MCPs to Expand Provider Network and Expand Access to Community Supports.*** The state received approval under the waiver to provide $1.5 billion in total funds (incorporating the federal match) as incentive payments to MCPs. To receive funding, MCPs submit data to demonstrate they are meeting certain performance measures on ECM and Community Supports implementation. MCPs have flexibility in how they use IPP funds. For example, this funding can be used to hire and train staff, provide technical assistance to providers, or provide supplemental payments to providers to incentivize participation in ECM and Community Supports.

Funding Has Increased Over Time as More Beneficiaries Access ECM and Community Supports. The Governor's 2025-26 budget proposes ECM spending at $956 million (total funds) and Community Supports spending at $231 million (total funds), a $67 million (7.5 percent) and $11 million (5 percent) increase over revised 2024-25 levels, respectively. The General Fund share of the ECM and Community Supports benefit is approximately 40 percent. General Fund spending for these programs has increased substantially since 2021-22, with ECM spending increasing by $308 million (466 percent) and Community Supports spending increasing by $68 million (317 percent). Both IPP and PATH—incentives funding have fixed, limited-term funding availability that ends in 2025-26 and 2026-27, respectively.

Benefit Utilization Has Been Low, but Steadily Growing. As the next figure shows, both ECM and Community Supports utilization began relatively low during the initial period when the benefits became available. Initially, ECM utilization started much higher than Community Supports, though the gap has narrowed in recent years. This initial gap is somewhat expected as the previous WPC and HHP pilot demonstrations provided services most similar to those in ECM, so plans were better able to transition to providing the ECM benefit. Utilization rates across the state were relatively flat until 2023, when ECM utilization began to gradually increase and Community Supports utilization increased much more quickly.



Medically Tailored Meals and Housing Trio Were Most Utilized Community Supports. Community Supports utilization has grown in recent years, though the majority of growth is concentrated in a handful of services. Medically Tailored Meals is the most utilized Community Support by a fairly large margin. However, this is driven primarily by utilization within two health plans in two counties. CalOptima health plan in Orange County accounts for almost one-third of all Community Supports utilization statewide, with the majority of those services being Medically Tailored Meals. Beginning in 2024, Community Health Plan Imperial Valley in Imperial County has also begun to rapidly increase the number of members receiving Medically Tailored Meals. The other set of Community Supports that have been the most utilized are the "housing trio". Among these housing-related services, Housing Transition Navigation Services is almost three times more common than Housing Tenancy and Sustaining Services and Housing Deposits.

Home and Community-Based Alternatives Waiver

Note: The Administration was unable to provide the subcommittee with requested updated information on the HCBA Waiver Program in time for publication. Information presented here may not be complete or accurate.

Home and Community-Based Services (HCBS) are programs offered as alternatives to nursing homes that allow participants to remain in their homes and community safely by receiving the care and support they need. One of the primary HCBS programs is the Home and Community-Based Alternatives (HCBA) Waiver, which provides care management services to persons at

risk of nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team (CMT) comprised of a nurse and social worker. The CMT coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member. In addition to children, the HCBA Waiver serves people with disabilities, including seniors.

The HCBA Waiver is approved by CMS in five year increments and was most recently approved on February 2, 2023 for the 2023-2027 waiver period. Because HCBA operates under a federal Medicaid waiver, the program has a capped number of enrollment slots. This has been a long-standing issue, with thousands of eligible individuals placed on waitlists before they can obtain access to care. The HCBA Waiver program currently serves approximately 9,200 individuals statewide, and as of November 2024, over 5,400 individuals were waiting for a slot due to the federal enrollment caps.

In response to the growing demand, DHCS submitted an amendment to CMS in late 2023 to increase waiver capacity by 1,800 slots per year through 2027, but it is unclear if this expansion remains sufficient to meet demand.

Additionally, DHCS is planning to transition HCBS programs, which include the HCBA waiver, into managed care as part of the CalAIM initiative (the program currently operates under a fee-for-service model). Other programs that are planned to be folded in managed care include Assisted Living Waiver and Multipurpose Senior Services Program. Stakeholders have expressed concerns about the timeline for transitioning these programs into managed care models, citing the potential lack of managed care plan readiness regarding integration.

Panel

- Tyler Sadwith, State Medicaid Director, Department of Health Care Services
- Xin Ma, Finance Budget Analyst, Department of Finance
- Sabrina Adams, Finance Budget Analyst, Department of Finance
- Megan Sabbah, Principal Program Budget Analyst, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst’s Office

LAO Comments

LAO Comments Regarding CalAIM:

Utilization of ECM and Community Supports Benefits Have Grown, but There Is an Opportunity for Further Increases. The LAO analysis of ECM and Community Supports implementation through the first half of the demonstration highlights that while utilization of the benefit may be lower than anticipated, it has grown and may continue to grow as MCPs, providers, and MCP members gain more experience with the benefits. The Legislature will need more information from both DHCS and MCPs to more fully assess whether utilization of the ECM and Community Supports benefits are meeting its expectations, whether utilization will continue to increase, and what possible future state costs could be. DHCS has already indicated it is looking to expand the information available in the quarterly implementation report, and the Legislature could work with the department to ensure that the information provided is sufficient to allow for a robust evaluation of program implementation. While some variation in utilization across counties and MCPs is to be expected, more information is needed to assess what portion of the variation is due to MCPs' implementation of the benefits. There will also be an evaluation of the PATH initiative to determine whether it expanded ECM and Community Supports provider networks and increased benefit utilization. Some of the key questions the Legislature may wish to have answered by the administration at budget hearings are:

1. How many MCP members are potentially eligible for ECM in each MCP and county?

2. What Community Supports services do MCPs plan to offer? Why these particular services?

3. What is the capacity of plans' current provider networks to provide ECM and Community Supports services? How can the state facilitate capacity that meets the demand for ECM and Community Supports services?

4. What barriers do plans face to increasing access to ECM and Community Supports services?

5. What barriers do providers face to contracting with plans to provide ECM and Community Supports services?

More Information Is Needed to Assess Cost-Effectiveness and Improvements in Health Outcomes. Increasing utilization of the ECM and Community Supports benefit may be an immediate goal of the Legislature, but additional analyses will be needed to determine whether the benefits meet the goals outlined in the program. Based on the evaluations of the WPC and HHP pilot demonstrations, there appears to be some evidence that the ECM benefit may lower costs and improve health outcomes for the state's high-cost, high-need population of Medi-Cal members. While the terms of the CalAIM waiver require some evaluation of cost-effectiveness

and health outcomes, the Legislature will want to ensure that systems are in place to allow for a robust evaluation of the program's impacts to the state and MCPs. For example, the Legislature, could consider directing DHCS to conduct an evaluation of the ECM benefit as implemented under CalAIM (even though the waiver does not require this). In the case of Community Supports, an interim evaluation of the benefit is forthcoming from DHCS. That evaluation will assess the cost-effectiveness of the benefit as well as its impact on the health outcomes of participants. In addition, the Legislature may wish to direct ongoing evaluations to determine whether ECM and Community Supports result in net savings to the state and/or improved health outcomes to beneficiaries. This information would be particularly helpful as the state considers renewing the waiver next year. In the meantime, some of the key questions the Legislature may wish to have answered by the administration at budget hearings are:

1. How does DHCS plan to evaluate—on an ongoing basis—the cost-effectiveness and impacts on health outcomes of the ECM and Community Supports benefits outside of the evaluations required in waivers? What data does it plan to collect, and what reporting from MCPs and providers may it require, to enable the required evaluation under the waiver as well as any ongoing evaluations?

2. Does DHCS anticipate renewing the CalAIM waiver? How could the results of the Community Supports interim evaluation impact the CalAIM waiver renewal?

Staff Comments

Regarding HBCA Waiver and HCBS programs, the Subcommittee may wish to ask:

1. Can DHCS provide an update on current HCBA Waiver enrollment capacity and what is the current waitlist?

2. Does DHCS plan to expand HCBA waiver slots beyond current availability?

3. What stakeholder engagement has the Department conducted regarding transitioning HCBS programs into managed care?

4. Has there been an assessment of the sustainability of HCBA providers under managed care reimbursement models?

5. What is the Department's timeline to fully carving-in services over to managed care model?

Staff Recommendation:

This item is informational only.

Issue 6: PACE and HCBA Related Proposals

Background on Proposal

The Program of All-Inclusive Care for the Elderly (PACE) is an integrated healthcare model that provides comprehensive medical and social services to older adults who would otherwise require nursing home care. PACE uses an interdisciplinary team to coordinate and deliver a full-service, preventive, primary, acute, and long-term care services at a PACE Center.

In order to be eligible for PACE, individuals must be 55 years or older, living in a PACE service area, be certified by the DHCS as requiring a nursing home level of care, and be able to live safely in their home or community at the time of enrollment.

PACE Organizations must receive approval from both DHCS and the federal government via the Centers for Medicare and Medicaid Services (CMS) before becoming operational and providing services within a designated state service area. They must also enter into a three-party agreement with CMS and DHCS. In California, PACE organizations are additionally required to establish a direct contract with DHCS.

DHCS notes that since the enactment of the PACE Modernization Act (SB 833, Committee on Budget and Fiscal Review, Chapter 30, Statutes of 2016) DHCS has experienced a surge in new PACE Organization applications and the expansion of existing PACE Organizations. There are currently 27 operational PACE Organizations in California. DHCS is currently screening inquiries from 37 entities which have submitted an intent to apply or are exploring opportunities to implement PACE expansions over the next four years.

The Administration explains that the steady growth of eight to 12 new PACE Organizations or PACE expansions per year has added substantial workload to the existing DHCS staff allocated to PACE, both in terms of the effort required to assess applications and establish PACE Organizations; as well as the effort required to maintain, operate and oversee the increased number of PACE Organizations in California.

The Governor's budget includes one budget change proposal and two trailer bills related to PACE. These proposals would expand fees and sanctions DHCS can administer, and add staffing capacity for DHCS related to the administration of PACE.

Budget Change Proposal: PACE Growth and Expansion

DHCS request expenditure authority of $6,269,000 in Fiscal Year 2025-26, $5,972,000 Fiscal Year 2026-27, $5,971,000 in Fiscal Year 2027-28, and $5,805,000 in Fiscal Year 2028-29 and ongoing for 33 permanent staff positions to support DHCS ability to meet federal and state

requirements related to the administration, operation, and monitoring and oversight of PACE programs. The requested funding is split between the PACE Oversight Fund (46 percent) and matching federal funds (54 percent) and no state General Fund.

Of note, the PACE Oversight Fund derives its revenues from existing administrative fees that DHCS can levy on PACE organizations upon enrollment and annually.

Trailer Bill: PACE Fees

In order to finance the staff expansion and expand DHCS's administrative capabilities of PACE, the Administration proposes a trailer bill that would expand fees to all PACE Organizations.

Broadly, there are 3 categories of fees involved with this proposal:

Application and Site Readiness Review Fees

These fees include PACE application processing fees, site readiness review fees, service area expansion applications, and service area expansion site readiness review fees.

Service area expansion refers to PACE Organizations expanding their programs and submitting an application to expand into a new county, add zip codes to an existing county, or open a new PACE Center in their existing service area.

DHCS proposes charging entities depending on the nature of their application, the commensurate work effort, as well as onsite review needs. For example, if an application includes establishing a new PACE Center, DHCS will need to conduct a PACE Center review as part of the PACE Organization assessment process; and fees will be used to cover the costs to DHCS required to process applications for new and existing PACE Organizations seeking to expand their operations. DHCS expects an application fee to range from approximately $55,000 to $95,000 depending on the nature of the application and whether onsite review is warranted.

Annual Maintenance and Operations Fees

DHCS proposes charging PACE organizations an annual maintenance and operation fee, determined by DHCS, to support oversight activities. These activities include handling inquiries and complaints, determining and auditing levels of care, maintaining contracts and policies, assessing compliance, reviewing and updating rates, and meeting with PACE organizations and stakeholders. According to DHCS, the fee will not exceed 1% of the current capitation rate set by DHCS for each PACE organization.

Marketing Fee

PACE Organizations have the option to participate in the mass mailer process for marketing purposes. All PACE Organizations who choose to participate in this process will pay a fee every time they submit a mass mailer request. This amount of the fee will be based on the staff work effort for each mass mailer request as well as the cost of the mailer itself. This fee is estimated to range between $1,000 to $8,000 based on DHCS' prior past experience administering marketing mailers.

Trailer Bill: PACE and HCBA Sanctions

DHCS proposes to expand the definition of "contractors" subject to sanctions to include providers of the HCBA Waiver Agencies and PACE Organizations. According to DHCS, this change would improve DHCS' ability to enforce compliance and improve California's performance outcomes for HCBA and PACE.

DHCS currently contracts with HBCA Waiver Agencies and PACE Organizations to perform administrative, care management, and service delivery functions as described in other sections of this agenda. DHCS monitors and oversees each program by conducting various compliance activities to ensure HBCA Waiver Agencies and PACE Organizations are operating in compliance with applicable state and federal laws and regulations, and that they are in compliance with contractual requirements.

When HCBA Waiver Agencies and PACE Organizations are not in compliance with program and contract requirements, DHCS issues a notice of findings and requires an HBCA Waiver Agency or a PACE Organization to submit a corrective action plan to remedy the deficiencies. However, according to DHCS, when HCBA Waiver Agencies and PACE Organizations do not adequately remediate deficiencies, or if deficiencies are egregious to the point of beneficiary or participant harm, DHCS does not have the authority to issue financial sanctions as it does for Medi-Cal managed care plans and county behavioral health plans.

DHCS notes that it has failed to meet CMS compliance thresholds and reported negative performance to CMS over the past several reporting periods due to the HCBA Waiver Agencies' lack of compliance. In a look back of quality assurance reviews conducted from 2021-2023, Waiver Agencies only passed an average of five reviews out of the twelve conducted. DHCS is also engaged in ongoing compliance actions with multiple PACE organizations due in part to the inability to apply effective enforcement actions (e.g., financial sanctions). For example, currently there are seven active corrective action plans with various PACE organizations and an average of 10-12 per year.

Panel

- Susan Philp, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
- Megan Sabbah, Principal Program Budget Analyst
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

The Subcommittee may wish to ask the following questions:

On PACE Fees and Program Expansion:

1. What are the current fees that DHCS can administer under current law? How would this proposal change existing fee levels?

2. How did the Department develop these new fee, and what is the expected financial impact on new and existing PACE organizations?

3. Has the Department conducted the relevant stakeholder outreach for this proposal? What feedback has DHCS received?

4. With PACE expansion expected to continue, does DHCS anticipate needing further staffing increases beyond this request in future budget cycles?

On PACE and HCBA sanctions proposal:

1. What specific compliance issues have DHCS identified among PACE organizations and HCBA waiver agencies that justify expanding sanction authority?

2. Will there be a process to contest or appeal sanctions?

3. What has DHCS done to address the repeated quality assurance failures among HCBA Waiver Agencies, and what additional corrective measures—beyond financial penalties—are being considered?

Staff Recommendation:

HOLD OPEN

Issue 7: Hospital Related Proposals

Background on Proposal

Hospitals receive payment in two main ways under Medi-Cal:

1. **Base Payments.** These payments are negotiated directly between hospitals and Medi-Cal Managed Care Plans.

2. **Supplemental Payments.** These supplemental payments are made by DHCS to hospitals to cover costs, particularly when base payments are too low. Supplemental payments have been made through two types of mechanisms:

    a. ***Pass-Through Payments (PTPs).*** These are time-limited arrangements that are subject to federal phasedown and sunset timeframe.

    b. ***State-Directed Payments (SDPs).*** These are generally approved for one-year terms and must satisfy a robust list of requirements relating to factors such as, but not limited to, the appropriateness of payment levels, alignment with and achievement of the goals and objectives.

As of 2024, DHCS operates six SDPs and five PTPs specific to hospitals totaling nearly $14 billion total funds annually. In most of these programs, the non-federal share is “self-financed” by the hospitals, or their affiliated governmental entities, rather than relying on state General Funds.

The Administration notes that all PTPs will be sunset or transitioned to SDPs on or before January 1, 2027, to comply with federal rules. In addition, supplemental reimbursement are expected to grow in 2025 and beyond.

To ensure SDPs comply with federal requirements, and to ensure SDPs prioritize quality health care delivery rather than financial incentives, DHCS is proposing a plan to develop, implement, and sustain a comprehensive value strategy for state-directed payments to hospitals in the Medi-Cal managed care delivery system. According to DHCS, this value strategy will enable the Department to continue to increase Medi-Cal Managed Care reimbursement for hospital services using SDPs while being prudent on the fiscal stewardship of these programs and implementing long-term solutions in alignment with Medi-Cal’s comprehensive quality strategy, federal Medicaid requirements and guidance, and the economic and efficient provisioning of services in the Medi-Cal program.

The value strategy lists four core objectives:

1) Achieving improved, sustainable levels of Medi-Cal reimbursement for hospital (and health system) services relative to other payers.

2) Advancing appropriate incentives for care delivery that support the economic and efficient provisioning of services, Medi-Cal members' access to care, and improved member health outcomes.

3) Aligning with Medi-Cal's comprehensive quality strategy and leveraging SDPs to advance population health, quality of care, and health equity for Medi-Cal members.

4) Certifying the continued federal approvability of SDPs.

The Governor's budget includes a budget change proposal and a trailer bill to implement the objectives described above.

Budget Change Proposal: Value Strategy for Hospital Payments in Medi-Cal Managed Care

DHCS requests $11,276,000 Fiscal Year 2025-26, $11,015,000 for Fiscal Year 2026-27 through FY 2028-29, and $8,015,000 for Fiscal Year 2029-30 and ongoing and 29 permanent staff positions to develop, implement, and sustain a comprehensive value strategy for state-directed payments to hospitals in the Medi-Cal program's managed care delivery system. The requested funding is split between the Hospital Quality Assurance Fee, Reimbursements, and Federal Funds.

At a high-level, DHCS explains that the resources will be used for staff and for contracts to:

- Develop, in consultation with stakeholders, and publish a comprehensive value strategy that includes recommendations for changes to hospital reimbursement methodologies and considerations for obtaining the necessary federal approvals for, and any conforming state law changes necessary to effectuate, recommended changes to reimbursement methodologies.

- Implement the value strategy through, as applicable, new or modified reimbursement methodologies, including seeking any necessary federal approvals and conforming state law changes

- Sustain the new or modified reimbursement methodologies on an ongoing basis including, but not limited to, associated recurring policy and guidance development, analyses and calculations, data exchange or management, quality or performance

measurement, payment processing, oversight and monitoring, stakeholder education and technical assistance, and ad-hoc solutioning.

Trailer Bill: Hospital Financing

To implement the value strategy, DHCS proposes trailer bill language that would:

1. Require DHCS, in consultation with public and nonpublic hospital stakeholders, to develop, publish, and implement a comprehensive value strategy, as specified, for Medi-Cal reimbursement to public and nonpublic hospitals through Medi-Cal supplemental and directed payments.

2. Authorize DHCS to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis.

3. Authorize DHCS to implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

4. Requires DHCS to publish the initial comprehensive value strategy on its internet website no later than March 31, 2026, and may revise and republish the comprehensive value strategy periodically

5. Increase the limit on the use of the HQAF proceeds to pay for DHCS's staffing and administrative costs that are directly attributable to implementing the HQAF and associated supplemental payment programs from $500,000 each quarter, which is equivalent to $2 million each fiscal year, to the greater of: (a) $4 million each fiscal year, or (b) 0.05 percent of all HQAF proceeds. According to DHCS, this change is necessary to maintain federal approval of the HQAF. By expanding the use of moneys in the Hospital Quality Assurance Revenue Fund for additional staffing and administrative costs, this change would make an appropriation.

6. Declare that its provisions further the purposes of the Medi-Cal Hospital Reimbursement Improvement Act of 2013 within the meaning of a specified provision of the California Constitution.

Panel

- Lindy Harrington, Assistant State Medicaid Director, Department of Health Care Services
- Xin Ma, Finance Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

The proposed trailer bill grants DHCS significant authority to develop, publish, and implement a new value strategy for hospital payments without requiring Legislative approval or formal regulatory rulemaking. Aside from consulting with stakeholders and publishing the initial strategy online by March 31, 2026, the trailer bill gives DHCS broad discretion to reshape a hospital payment system that distributes nearly $14 billion annually.

Given the fiscal and operational impact, the Subcommittee may wish to consider what oversight and accountability mechanisms should be implemented, if any, to ensure that the strategy that is adopted aligns with state policy goals, maintains hospital financial stability, and upholds access to care.

In addition, the Subcommittee may wish to ask the following questions:

1. What specific issues in current hospital reimbursement methodologies prompted DHCS to develop the value strategy?

2. What safeguards will be in place to ensure that new hospital reimbursement methodologies proposed and implemented remain federally compliant and financially sustainable beyond 2027?

3. What level of legislative or stakeholder engagement will be in place to review changes implemented under the value strategy, and how often will adjustments be made?

Staff Recommendation:

HOLD OPEN

Issue 8: Other Budget Change Proposals and Trailer Bills

The Governor's Budget includes 6 additional budget change proposals and 2 trailer bills, described below:

Budget Change Proposals:

1. **Medi-Cal Administrative Activities for CalAIM Justice Involved Initiative.** Allocates $798,000 in 2025-26 and $753,000 in 2026-27 and ongoing (split between General Fund and Federal Funds) and 5 staff positions for local administrative expenses related to the implementation of the Justice-Involved Initiative in CalAIM, which establishes a targeted set of Medi-Cal services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release

2. **Program Workload.** Appropriates $7,878,000 in 2025-26 and $7,772,000 in 2026-27 and ongoing (split between the General Fund, the Long-Term Care Quality Assurance Fund and federal funds) and 27 staff positions to maintain ongoing workloads. Staffing requests are for the California's Money Follows the Person Rebalancing Demonstration, Administrative positions, and develop a Comprehensive Value Strategy for Skilled Nursing Facilities (SNF) Services.

3. **Civil Rights Compliance.** Proposes $1,973,000 in 2025-26 and $1,865,000 in 2026-27 and ongoing (split between the General Fund and federal funds) and 12 staff positions to support increased workload for the Civil Rights Compliance program housed in DHCS' Office of Civil Rights. As an example, the Office of Civil Rights notes that it continues to experience an increase in the total complaints/grievances received from Managed Care Plans and counties, with the OCR workload increasing to almost 300 percent from complaints and grievances alone.

4. **California Electronic Visit Verification (CalEVV) Resources.** Provides $1.39 million ($1.05 million General Fund, remaining Federal Fund) in ongoing funding and 4 staff positions to ensure Medicaid-funded care providers are compliant with the 21st Century Cures Act federal requirement on quarterly reporting of key performance indicators. This proposal is a multidepartment proposal involving Health Care Services, Public Health, Developmental Services, and Department of Aging.

5. **AB 186 SNF Workforce Standards & Accountability Sanctions.** Allocates $2,897,000 2025-26 and $2,771,000 in 2026-27 and ongoing (split between the Long-Term Care Quality Assurance Fund and federal funds) and 14 staff positions to implement and provide program integrity for the Workforce Standards Program and the Accountability Sanctions Program, two new Skilled Nursing Facility financing programs authorized by AB 186 (Committee on Budget, Chapter 46, Statutes of 2022).

6. **Department of Health Care Services Chaptered Legislative Proposals.** The Department requests resources from the General Fund coupled with federal funds to implement statutory requirements for legislation chaptered in 2024. The following bills are being implemented:

    a. SB 1120 on Utilization Review (Becker, Chapter 879, Statutes of 2024)
    b. AB 3275 on Claim Reimbursement (Soria, Chapter 763, Statutes of 2024)
    c. SB 1184 on Antipsychotic Medication (Eggman, Chapter 643, Statutes of 2024)
    d. SB 1131 on Family Planning (Gonzalez, Chapter 880, Statutes of 2024)
    e. SB 1289 on Call Centers Standards and Data (Roth, Chapter 792, Statutes of 2024)
    f. SB 1238 on Health Facilities (Eggman, Chapter 644 Statutes of 2024)

Trailer Bills:

1. **Medi-Cal Anti-Fraud Special Deposit Fund.** DHCS proposes to establish a permanent Medi-Cal Anti-Fraud Special Deposit Fund in order to house Medi-Cal provider payments withheld while a Credible Allegation of Fraud is being investigated. According to DHCS, when audits & investigations places Medi-Cal providers who have a Credible Allegation of Fraud on payment suspension, the State Controller's Office (SCO) intercepts the payments and deposits them into the SCO's Special Deposit Fund. These monies are held in the account until DHCS' investigation has concluded and funds are either released to the provider or maintained by the Department if an overpayment is identified. Due to the lack of an established permanent fund for the withheld Medi-Cal payments, DHCS is required to periodically work with the Department of Finance to request an extension for the use of the SCO's Special Deposit Fund. Currently, the use of SCO's Special Deposit Fund (0942) for this purpose is set to administratively expire June 30, 2027. DHCS proposes to establish a permanent Medi-Cal Anti-Fraud Special Deposit Fund in order to appropriately house withheld Medi-Cal payments while a fraud investigation is in progress.

2. **Cognitive Health Assessment Training and Reporting.** DHCS proposes to remove the cognitive health assessment training and biannual reporting requirement currently funded by the Home and Community-Based Services Spending Plan Dementia Care Aware initiative, which is set to end January 31, 2025. The cognitive health assessment benefit will continue to be available to providers for screening Medi-Cal beneficiaries as currently specified under existing law.

Panel

- Lori Walker, Chief Financial Officer and Deputy Director of Fiscal, Department of Health Care Services
- Lindy Harrington, Assistant State Medicaid Director, Department of Health Care Services
- Andrew Huitt, Finance Budget Analyst, Department of Finance
- Megan Sabbah, Principal Program Budget Analyst, Department of Finance
- Will Owens, Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

Staff does not have concerns about these proposals.

Staff Recommendation:

HOLD OPEN.

This agenda and other publications are available on the Assembly Budget Committee's website at: Sub 1 Hearing Agendas | California State Assembly. You may contact the Committee at (916) 319-2099. This agenda was prepared by Patrick Le.