California State Assembly

Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

February 23, 2026

2:30 P.M. – State Capitol, Room 437

California's Response to HR 1: Defending Health Care Affordability & Access – Part 1

Physician Workforce Development in the Wake of H.R.1: Education, Training, & Retention

Items To Be Heard

Background of Physician Shortage in California

California is facing a shortage of physicians. According to the California Health Care Foundation, about 11.4 million Californians, or nearly one quarter of the state's population, live in a federally designated Primary Care Health Professional Shortage Area. This shortage is compounded by several factors, including insufficient physician training capacity, reduced state support financing key pipeline programs like graduate medical education, and an aging physician workforce.

According to the 2025 Healthforce Center at UCSF report, California has significantly fewer medical trainees per capita than the national average. Specifically:

- California has 23 medical students per 100,000 population, compared to 41 per 100,000 nationally.

- California has 37 residents and fellows per 100,000 population, compared to 48 nationally.

Although California trains a large number of physicians, the state's training capacity does not keep pace with the size of its population. The National Center for Health Workforce Analysis projects that California faces a shortage of 3,490 primary care physicians in 2025, and earlier expert estimates suggest that by 2030 the state will need approximately 10,500 additional primary care providers to meet demand.

An Aging Workforce

California's physician shortage is compounded by the aging workforce. In 2023, 25 percent of active physicians in the state were age 65 or older, slightly higher than the national average. Many physicians are also working fewer hours than in prior decades. In regions such as Northern and Sierra counties, large shares of family medicine, internal medicine, emergency medicine, and obstetrics/gynecology physicians are approaching retirement age. Although the number of medical school graduates has increased substantially over the past decade, growth in the pipeline is not sufficient to replace all physicians expected to retire or reduce their practice hours.

Maldistribution of Workforce

The physician shortage is not evenly distributed across California. Urban areas tend to have significantly higher physician-to-population ratios than rural, semi-rural, and inland regions. For example, some urban areas have roughly one primary care physician for every 160 residents, while certain rural communities have ratios closer to one physician per 1,100 residents. Residency programs, which are key predictors of where physicians ultimately practice, are concentrated in major metropolitan regions such as Los Angeles and the Bay Area, with fewer programs located in rural areas. This geographic imbalance matters because California retains

a high share of physicians who train in the state: 75 percent of physicians who complete residency training in California remain in the state to practice medicine. Expanding training capacity in underserved regions is therefore a key workforce strategy.

Consequences for Patients

A physician shortage has direct consequences for patients and communities. Research shows that greater access to primary care is associated with lower health care costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. When patients cannot access timely primary care, they experience longer wait times and delays in preventive services, chronic conditions may worsen, and emergency departments increasingly serve as a source of care for non-emergency conditions. These effects are particularly pronounced in rural communities and medically underserved populations, where shortages are most acute.

Key Strategies to Strengthen the Workforce

Addressing California's physician shortage requires sustained investment in both the educational pipeline and financial incentives that influence specialty and practice location decisions. Medical education is expensive, and graduates frequently carry between $200,000 and $300,000 in educational debt. High debt burdens can influence specialty choice, often steering graduates toward higher-paying specialties rather than primary care.

California operates loan repayment programs designed to support physicians who commit to practicing in underserved communities. For example, the Steven M. Thompson Physician Corps Loan Repayment Program provides up to $105,000 toward educational debt for qualifying primary care physicians. In the context of federal changes to student loan policies under HR1, state-level loan repayment programs may become even more important in supporting access to medical education and encouraging service in high-need communities.

Graduate Medical Education, commonly referred to as residency training, is another critical lever. Completing medical school alone does not produce a practicing physician; residency training is required for independent practice and board certification. California's CalMedForce and Song-Brown programs provide state funding to residency programs in high-need specialties because physicians are highly likely to practice where they complete residency, expanding residency positions, particularly in underserved and rural areas, offers one of the most effective strategies for strengthening the long-term workforce.

Items To Be Heard

4140 Department of Health Care Access and Information
6440 University of California

Issue 1: HR1 and Impact on Medical Student Loans, and Overview of State Student Loan Repayment Programs

Overview of HR1 Changes Related to Student Loans

Note: This section uses excerpts from the Legislative Analyst's Office handout prepared for this hearing. For the full content, please refer to the document "Impact of H.R.1 on Access to Medical School and Student Debt"

Medical school is among the most expensive graduate programs in the country, with annual tuition and fees in California ranging from approximately $40,000 to nearly $75,000, depending on the institution. As the figure below illustrates, University of California (UC) medical schools generally have lower tuition levels than private medical schools. However, even at public institutions, the total cost of attendance — including living expenses, fees, books, and health insurance — can substantially exceed tuition alone, often pushing annual borrowing needs well above $70,000.

Prior to H.R. 1, medical students were generally able to finance the full cost of their education through federal student loan programs. Graduate students could borrow up to approximately $47,000 per year in Direct Unsubsidized Loans, subject to an aggregate lifetime cap of roughly $224,000 (including undergraduate borrowing). For costs exceeding those limits, students could rely on the federal Graduate PLUS Loan program, which allowed borrowing up to the full cost of attendance as determined by the institution. Unlike Direct Unsubsidized Loans, Grad PLUS loans did not have a fixed annual or lifetime dollar cap. As a result, most medical students were able to fully finance their education through federal loans without turning to private lenders.

H.R. 1 makes major changes to this structure, effective July 1, 2026. First, it imposes an annual cap of $50,000 on Direct Loans for graduate students in specified professional programs, including medicine, and sets an aggregate program cap of $200,000. Second, it eliminates the Graduate PLUS Loan program, removing the mechanism that previously allowed students to borrow up to the full cost of attendance.

Together, these changes significantly limit the amount of federal financing available to medical students. In high-cost states such as California, students may face funding gaps that must be filled through private loans, institutional aid, or personal resources. These financing constraints

have implications not only for access to medical education, but also for specialty choice, practice location decisions, and the long-term physician workforce pipeline.

Overview of California's Three Physician Loan Repayment Programs

California administers three ongoing physician-focused state loan repayment programs through the Department of Health Care Access and Information (HCAI):

1. Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)
2. California State Loan Repayment Program (SLRP)
3. County Medical Services Program Loan Repayment Program (CMSP-LRP)

Collectively, these programs represent the state's primary direct financial incentive to recruit and retain physicians in medically underserved communities. In exchange for service commitments in shortage areas, physicians receive partial repayment of educational debt. While each program differs in structure and funding source, they are all designed around strengthening access to care in high-need regions of California.

Programs At a Glance (All Programs Combined)

Between FY 2021-22 and FY 2024-25, the three programs collectively awarded:

- 298 physician awards
- Approximately $22.6 million in total loan repayment assistance.

Below is a breakdown of annual awards and total awards for all three programs:

Fiscal Year	Physician Awards	Total Dollars Awarded
2021–22	101	$7.08 million
2022–23	97	$8.66 million
2023–24	50	$3.24 million
2024–25	50	$3.60 million

This data set indicates that California's physician loan repayment programs support approximately 50 to 100 physician awards per year statewide, depending on funding availability.

Total Demand and Program Capacity

The table below outlines the total number of applicants, awards made, and qualified applicants **not** funded by year across all three programs.

Fiscal Year	# of Applicants	Number of Awards Made	Qualified Applicants Not Funded
2021–22	136	101	6
2022–23	126	97	7
2023–24	114	50	35
2024–25	162	60	16

The data indicates that broadly, the number of qualified applicants exceeded available funding for loan repayment. For example, in FY 2023-24, the lowest year in total dollars awarded, roughly four in ten qualified applicants did not receive an award due to limited funding.

Total Service Completion Rates

The table below outlines service completion rates by individual programs.

Program	FY 2021–22	FY 2022–23
STLRP	80%	75%
SLRP	74%	67%
CMSP-LRP	92%	100%

Because SLRP cohorts are small in certain years (for example, four physician awards in FY 2022–23), a single non-completion can materially affect the annual completion percentage. Overall, completion rates indicate that most participants fulfill their contractual obligations.

Of note, HCAI does not currently collect long-term retention data beyond the required service period.

Individual Program Detail: Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)

Established in 2003, this program aims to increase access to healthcare and promote the retention of primary care physicians in medically underserved areas of California. The purpose of this program is to increase the number of appropriately trained physicians providing direct patient care in a qualified facility or area in California.

Award Structure

The Steven M. Thompson Physician Corps Loan Repayment Program provides up to $105,000 in educational loan repayment in exchange for a three-year service obligation at an eligible site serving medically underserved communities. Examples of eligible practice sites include children's hospitals, rural health clinics, or Primary Care Shortage Area. These practice sites

must also meet practice settings requirements, such as being owned by a public hospital system, or that at least 50 percent of patients are from Medi-Cal or uninsured.

Funding Source

STLRP is funded primarily through a $25 physician licensure surcharge collected by the Department of Consumer Affairs. In certain years, the program has also received supplemental workforce-related appropriations, including geriatric care workforce and reproductive health clinical infrastructure funding. Because of its reliance on special funds and periodic supplemental allocations, annual award levels can fluctuate. Between 2021 and 2025, annual resources for the program ranged between $1.8 million to $6.2 million.

Previously, the program received additional funding collected from the Health Professions Education Foundation, a state/non-profit organization formed in 1987 and housed in HCAI until its dissolution in 2021. The Foundation collected one-time donations or gifts from business, industry, foundations, and other private or public sources, and was a sizeable source of program funding, bringing approximately $2 million each year in additional funds in 2021 and 2022. The Foundation was dissolved as part of a state department reorganization that transitioned the Office of Statewide Health Planning and Development into the Department of Health Care Access and Information.

Program Scale (FY 2021–22 to FY 2024–25)

Between FY 2021–22 and FY 2024–25, STLRP awarded 209 physician grants totaling approximately $19.8 million. Average award amounts ranged from roughly $94,000 to $100,000 per physician. During this period, STLRP accounted for the majority of state-funded physician loan repayment dollars distributed statewide.

Participant Debt Levels

Physicians entering STLRP carried average educational debt of approximately $252,936. The average award size during this period was approximately $94,957. As structured, the award typically offsets roughly one-third to one-half of total educational debt.

Individual Program Detail: California State Loan Repayment Program (SLRP)

This program provides loan repayment assistance to healthcare professionals who provide healthcare services in federally designated California Health Professional Shortage Areas.

Award Structure

The California State Loan Repayment Program provides up to $50,000 in loan repayment assistance in exchange for a two-year service obligation at a federally designated Health Professional Shortage Area. The program requires a dollar-for-dollar employer match, meaning participating practice sites must contribute equivalent funding toward the award.

Funding Source

SLRP is typically funded through an annual federal Health Resources and Services Administration grant of approximately $1 million, along with $333,000 in General Fund support allocated through Song-Brown. In some years, additional workforce funds have provided supplemental funding to the base allocation. Because the program primarily depends on federal grant cycles, funding levels are uncertain. For example, in FY 2024–25, federal funds were not awarded because the federal government did not open a grant cycle, limiting program activity that year.

Program Scale (FY 2021–22 to FY 2024–25)

Between FY 2021–22 and FY 2024–25, SLRP awarded 64 physician grants totaling approximately $2.12 million.

Participant Debt Levels

Physicians entering SLRP carried average educational debt of approximately $222,313. The average award during this period was approximately $41,250. Because the award requires employer matching funds, participation depends partly on the financial capacity of eligible practice sites.

Individual Program Detail: County Medical Services Program Loan Repayment Program (CMSP – LRP)

This program assists with the repayment of qualified educational loans for healthcare professionals who provide primary care or dental services at an approved site located in one of the 35 County Medical Services Program (CMSP) counties. The CMSP is a state-county partnership that provides health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health care programs like Medi-Cal. HCAI serves as the program administrator of the loan repayment program.

Award Structure

The County Medical Services Program Loan Repayment Program provides up to $50,000 in loan repayment assistance in exchange for a two-year service obligation at an approved site located in one of 35 participating CMSP counties. The program is focused on rural and semi-rural communities served by the County Medical Services Program.

Funding Source

The program receives up to $1.71 million annually from CMSP under a service agreement, with approximately $217,000 allocated to state operations. Funding availability and award cycles depend on the terms and timing of the CMSP service agreement.

Program Scale (FY 2021–22 to FY 2023–24)

Between FY 2021–22 and FY 2023–24, CMSP-LRP awarded 25 physician grants totaling approximately $615,000. No award cycle was conducted in FY 2024–25 due to service agreement timing.

Participant Debt Levels

Physicians entering CMSP-LRP carried average educational debt of approximately $122,159. The average award during this period was approximately $24,612. Although smaller in scale than the other programs, CMSP-LRP primarily serves rural and semi-rural communities.

Other Notable Workforce Development Programs:

1. **BH-CONNECT:** The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative is a California Medicaid waiver approved by the federal government in 2024 focused on transforming California's behavioral health delivery system. The waiver includes a $1.9 billion workforce initiative supporting the training, recruitment, and retention of behavioral health practitioners, and will include various Medi-Cal behavioral health student loans, scholarships, and residency program funding.

2. **Rural Health Transformation Program:** California has been awarded $233.6 million in 2026 through the federal Rural Health Transformation Program to support rural and frontier communities. The program, which will be implemented by HCAI, will include a workforce development component, with a focus on strengthening training pathways and clinical placement networks, as well as recruitment and retention.

3. **CalHealthCares (DISCONTINUED):** CalHealthCares, then administered by the Department of Health Care Services, was a loan repayment on educational debt for California physicians and dentists who provided care to Medi-Cal patients. Originally funded through Proposition 56 and state tobacco tax revenues and then supported by the General Fund, the program was discontinued as part of the 2025 Budget.

Panel

- Florence Bouvet, Economist, Legislative Analyst's Office
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Dr. Sunita Mutha, MD, FACP, Director, Healthforce Center at the University of California San Francisco
- Dr. Grant Hartzog, University of California Santa Cruz
- Libby Abbott, Deputy Director for Health Workforce Development, Department of Health Care Access and Information
- Sonal Patel, California Department of Finance
- Joseph Donaldson, California Department of Finance

Staff Comments

Staff offers the following observations regarding the three-state student loan repayment programs, based on the data provided by the Administration:

- **Scale of Programs:** California's physician-focused loan repayment programs support approximately 50-100 physicians annually statewide. Although the programs have profound impact at the local level for providers and significantly expand access to care for targeted communities, this scale remains modest relative to projected statewide physician shortages.

- **Demand Exceeds Supply.** Data on awards made and qualified applicants not funded indicates evidence of unmet demand, particularly within the Steven M. Thompson program. In certain years, a substantial share of eligible applicants did not receive awards due to funding limitations. Although it is too early to assess the full impact, demand for state loan repayment programs may increase as federal student loan changes under H.R. 1 take effect.

- **Funding volatility:** Funding levels for the programs are volatile and can fluctuate year-to-year due to reliance on federal grants, special funds, and one-time appropriations. For example, the federal government did not open a grant cycle for SLRP in one fiscal year, significantly limiting awards; STLRP funding depends on revenue generated by physician licensure surcharges; and CMSP skipped an award cycle due to service agreement

timing. The lack of stable, predictable funding can make long-term workforce planning difficult.

- **Award Offset:** Current state loan repayment awards generally cover only a portion of total physician educational debt. As a result, participants generally need to rely on additional financial strategies to address remaining loan balances.

- **High-Service Completion Rates:** Most participants fulfill their required service obligations under each program, indicating that the programs function as intended in terms of contractual compliance and short-term workforce placement.

- **Limited Retention Data:** HCAI does not currently collect data on provider retention beyond the required service period. As a result, the state has limited visibility into whether participants remain in underserved communities or continue practicing in California after completing their commitments. The long-term workforce impact of these programs is therefore not fully measurable at this time.

- **HPEF's Role:** The Health Profession Education Foundation, which collected private donations to support the STLRP program, contributed substantial supplemental funding in earlier years and materially increased award levels before the Foundation's dissolution in 2021.

The Subcommittee may wish to ask witnesses the following questions:

Regarding HR1 & Medical Education Debt:

1- What are current average debt levels for graduating medical students in California, and how have those levels changed over the past decade?

2- If federal loans will no longer cover the full cost of medical education under HR1, what financing options will future physicians likely turn to? Are private loans likely to fill this gap, and if so, what are the implications for interest rates, borrower protections, and repayment flexibility?

3- Should California consider modifying its loan repayment structure to respond specifically to federal changes under H.R. 1?

4- How might federal loan caps disproportionately affect first-generation students, students from lower-income backgrounds, or underrepresented communities?

5- What does the research show about the relationship between medical school debt and specialty choice? Does higher debt push graduates toward higher-paying specialties, and further discourages entry into primary care?

6- Is there evidence that debt burden influences willingness to practice in rural or underserved areas?

Regarding State Physician Student Loan Repayment Programs:

1- Do you anticipate that H.R. 1 will increase demand for California's state loan repayment programs?

2- If federal financing options shrink, will existing state award levels be sufficient to meaningfully influence practice decisions?

3- How does HCAI determine whether awards are being targeted to the highest-need geographic areas and specialties?

4- Funding for these programs fluctuates year to year based on federal cycles, special funds, and contract timing. How does this variability affect the state's ability to engage in long-term workforce planning?

5- Completion rates appear strong overall. What factors contribute to successful service completion?

6- HCAI does not currently collect post-obligation retention data. Does the Administration have plans to track whether participants remain in underserved communities after completing their commitment?

Staff Recommendation:

This item is informational only.

Issue 2: Oversight of CalMedForce and Song-Brown Residency Programs

Graduate Medical Education (GME) in California

California's physician workforce pipeline depends heavily on Graduate Medical Education (GME), which is the period of clinical residency and fellowship training that follows medical school. Residency training is required for physicians to practice independently and become board certified. Following four years of medical school, physicians complete between three and seven years of residency, with additional years for fellowship specialization.

Because physicians are far more likely to practice in the state where they complete residency training, GME capacity plays a central role in shaping California's long-term physician workforce. According to the Association of American Medical Colleges, approximately 75 percent of physicians who complete residency training in California remain in the state to practice medicine. As a result, residency training capacity directly affects future physician supply.

How Graduate Medical Education Is Financed

Graduate medical education is financed through a combination of federal, state, and institutional funding sources. At the federal level, Medicare is the primary public funder of residency training nationally. Medicare provides payments to hospitals to offset a portion of training costs, with payments based on the number of Medicare inpatient days at the hospital, and the number of residents trained, subject to a hospital-specific cap.

Federal law capped the number of Medicare-funded residency positions at existing hospitals, limiting the ability of institutions to expand training capacity. Although recent federal legislation authorized 1,200 additional Medicare-funded residency positions nationally, the expansion remains limited relative to projected workforce needs.

The Health Resources and Services Administration has estimated that the cost to train a resident is approximately $210,000 per resident per year. Medicare payments typically cover only a portion of these costs, requiring hospitals and training institutions to finance remaining expenses through operating revenue, Medicaid GME, state support, or other sources.

California's State-Level GME Investment Programs

In light of federal funding constraints, California has made significant state-level investments in residency training through two primary programs:

1. CalMedForce
2. Song-Brown Primary Care Residency Program

CalMedForce

Program Overview

Proposition 56, approved by voters in 2016, increased California's tobacco tax and allocated up to $40 million annually to the University of California to sustain, retain, and expand residency training programs statewide. UC contracts with Physicians for a Healthy California to administer these funds through the CalMedForce Graduate Medical Education grant program.

CalMedForce provides grants to residency programs in five priority specialties: emergency medicine, family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology, as well as combined programs (e.g., internal medicine/pediatrics). Although authorized to fund additional specialties in areas of shortage, CalMedForce has historically focused on these primary care and emergency medicine disciplines due to sustained demand.

Importantly, Proposition 56 funding supports residency programs across California, not solely those sponsored by UC. On average, UC-sponsored programs account for approximately 18 percent of CalMedForce award recipients.

Grant funds may be used exclusively for costs directly associated with GME, including resident salaries and benefits, training resources, and educational activities. Administrative costs or indirect expenses that do not directly benefit resident training are not allowable. Funding is awarded for the full duration of the supported resident position.

Program Funding

Over several years, declining Proposition 56 tobacco-tax revenues required General Fund backfill to maintain funding levels for CalMedForce. The state discontinued this General Fund backfill during the 2024–25 budget cycle. As a result, total Proposition 56 support dropped to approximately $20.7 million for FY 2025–26.

In 2024, voters approved Proposition 35, which directed additional funding from the Managed Care Organization (MCO) tax to support GME. Proposition 35 allocates $75 million annually in calendar years 2025 and 2026 and is administered through a related program, CalMedForce+.

CalMedForce+ prioritizes new and expanding residency and fellowship positions and expands eligibility to all accredited specialties and subspecialties. In 2025, UC-sponsored programs accounted for approximately 25 percent of CalMedForce+ award recipients.

Program Scale

Since FY 2018-19 (eight award cycles), CalMedForce:

- Awarded over $276 million
- Funded 1,655 residency positions
- Issued 859 total awards across 33 counties statewide

CalMedForce Data Summary

	Applications received	Applications awarded	Requested positions	Positions Funded	Funding Requested	Funds Awarded
All CalMedForce Cycles to Date	1,145	859	5,101	1,655	$1,035,595,500	$276,090,000
FY 2025-26 CalMedForce	185	73	821	74	$233,195,000	$20,760,000
FY 2025-26 CalMedForce+	274	162	830	200	$231,210,000	$63,960,000*

To date, approximately 80 percent of graduates from CalMedForce-supported programs remain in California, compared to the statewide retention average of approximately 75 percent. Ninety percent of those graduates practice primarily in primary care or emergency medicine settings in California. The majority of supported graduates come from family medicine residency programs.

CalMedForce+ (Proposition 35)

In its inaugural September 2025 grant cycle, CalMedForce+ awarded $63.96 million to support 200 new and expanding physician training positions across 24 counties. A total of 162 residency and fellowship programs received awards, representing approximately 83 percent of applicant programs.

Awards spanned 63 specialties and subspecialties. By share of total funds awarded, the top three disciplines were:

- Family Medicine (20.16%)
- Internal Medicine (14.44%)
- Psychiatry (10.97%)

Geographically, awards were concentrated in Los Angeles County (26.54%), the Inland Empire (24.69%), and the San Joaquin Valley (15.43%).

CalMedForce+ significantly expands the scope of eligible specialties but is focused primarily on

supporting new and expanding positions rather than sustaining existing ones.

Funding Volatility and Long-Term Sustainability

Proposition 56 revenues have declined substantially in recent years. The discontinuation of General Fund backfill in 2024–25 reduced available funding for existing residency support in FY 2025–26.

At the same time, demand for funding has increased. In FY 2025–26, 185 residency programs requested $233.2 million to support 821 positions under CalMedForce. Based on available funding of approximately $20.7 million, only 73 programs were awarded funding supporting 74 positions.

This dynamic illustrates a widening gap between program demand and available resources. Further complicating the funding outlook, new federal law enacted under H.R. 1 has invalidated the Managed Care Organization tax that funds Proposition 35, introducing uncertainty regarding CalMedForce+ funding beyond 2026.

Song-Brown Primary Care Residency Program

Program Overview

The Song-Brown Health Care Workforce Training Program supports primary care residency training programs in California. Its Primary Care Residency (PCR) component provides state funding to help establish new residency programs, expand existing programs, and sustain current training slots in high-need specialties.

Eligible specialties include:

- Family Medicine
- General Internal Medicine
- General Pediatrics
- Obstetrics/Gynecology

Funding is awarded to residency programs and is intended to offset a portion of the costs associated with training physicians in primary care.

Importantly, Song-Brown funding does not cover the full cost of a residency “slot.” Instead, it supplements other funding sources (e.g., Medicare GME, Medi-Cal GME, hospital support, institutional funds). Because residency financing involves multiple funding streams, HCAI tracks use of funds at the program level rather than per individual filled slot.

Program Funding

The Song-Brown program receives $33 million in General Fund annually, of which $31 million is for the program and $2 million is for state operation costs.

Program funding is administered according to the following:

- Existing PCR slots: $18.667 million
- Teaching Health Center (THC) existing slots: $5.667 million
- New slots in existing programs (expansion): $3.333 million
- New residency programs: $3.333 million

Program Scale (FY 2021-22 through FY 2025-26)

Over five fiscal years, Song-Brown PCR has supported:

- 1,562 total residency slots, of which
    - 1,150 are existing slots
    - 412 are new or expanding slots

The breakdown of slots are shown in the table below:

Fiscal Year	Existing Slots	New / Expansion Slots	Total Slots
2021–22	224	50	274
2022–23	261	88	349
2023–24	276	199	475
2024–25	194	22	216
2025–26	195	53	248
TOTALS	**1,150**	**412**	**1,562**

Assessment of California's Physician Residency Grant Programs.

The Legislative Analyst's Office has prepared supplemental materials for this hearing assessing the CalMedForce and Song-Brown program. Please refer to the document "Overview of California's Physician Residency Grant Programs"

Panel

- Dr. Sunita Mutha, MD, FACP, Director, Healthforce Center at the University of California San Francisco
- Libby Abbott, Deputy Director for Health Workforce Development, Department of Health Care Access and Information
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Dr. Robert Assibey, MD, California Academy of Family Physicians
- Sonal Patel, California Department of Finance
- Joseph Donaldson, California Department of Finance

Staff Comments

Staff offers the following observations:

- **State Funding Offsets But Does Not Fully Fund Residencies:** State GME funding programs provide partial financial support for residency slots. Residency programs rely on multiple funding sources (including Medicare GME, hospital support, and private payers) to finance full training costs. As a result, state grants work more like supplemental payments rather than stand-alone financing.

- **Funding for CalMedForce is unsustainable.** CalMedForce programs rely on Proposiiton 56 tobacco tax (which is declining) and now Proposition 35 MCO tax revenues (which is uncertain beyond 2026). This volatility complicates short and long-term program sustainability for the program.

- **Coordination Between Programs May Be Limited.** Although CalMedForce and Song-Brown emphasize different strategies regarding GME programs, their mission remains the same. Two residency grant programs administered by separate entities may bring duplicative administrative structures and coordination challenges.

The Subcommittee may wish to ask witnesses the following questions:

1- To what extent have Song-Brown and CalMedForce grants resulted in net increases in residency slots, versus simply sustaining slots?

2- How does HCAI or UC assess whether state GME investments are producing measurable increases in physician supply?

3- What is the estimated full cost of maintaining a residency slot, and what percentage is typically covered by state grants?

4- How do programs finance the remaining share of slot costs?

5- Are some residency programs more financially dependent on state grants than others?

6- What mechanisms ensure that state-funded residency expansion occurs in the regions of greatest shortage?

7- Given the high-demand and limited resources, how is HCAI or UC determining awards among qualified programs?

8- What data exists on whether residents remain in shortage areas after completing training?

9- Given significant overlap in grant recipients, how is HCAI and UC coordinating to ensure an overall efficient grant structure?

10- How will CalMedForce+ adjust if Proposition 35 funding declines or is eliminated after 2026?

Staff Recommendation:

This item is informational only.