

California State Assembly



Assembly Budget Agenda

Assembly Budget Subcommittee No. 1 on Health

Assemblymember Dawn Addis, Chair

Monday, April 6, 2026

Upon Adjournment of the Joint Hearing of
Assembly Budget Sub No. 1 and Senate Budget Sub No. 3

State Capitol, Room 127

California's Response to HR 1: Defending Health Care Affordability & Access – Part 3
Financing California's Health Care Safety Net Under HR 1

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Items To Be Heard

0820 Department of Justice

4260 Department of Health Care Services

4150 Department of Managed Health Care

Issue 1: Oversight Gender Affirming Care

This issue is covered in separate materials as part of the Joint Hearing between Senate Committee on Budget and Fiscal Review Subcommittee #3 Health and Human Services and Assembly Committee on Budget Subcommittee #1 on Health.

4140 Department of Health Care Access and Information

Issue 2: Oversight of Reproductive Health State Investments

Overview of State's Investment Supporting Reproductive Health

Background

In June 2022, the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* eliminated the federal constitutional right to abortion established under *Roe v. Wade*. In response, the 2022-23 state budget included \$200 million in reproductive health care investments, of which \$120 million was administered through the California Department of Health Care Access and Information (HCAI). HCAI established five programs designed to support and expand access to abortion, abortion-related care, and reproductive health services across California.

The five programs, described and summarized in the next section, include (1) the Uncompensated Care Program, (2) the Abortion Practical Support Fund, (3) the Clinical Infrastructure, (4) the Capital Infrastructure, and (5) the Reproductive Health Services Corps

HCAI Programs

1. Uncompensated Care Program (\$40 million)

HCAI contracted with Essential Access Health to administer the Uncompensated Care Fund, which provides grants to Medi-Cal participating providers that deliver abortion and abortion-related care to individuals without coverage for such services and with incomes at or below 400

percent of the federal poverty level. To date, 39 grantees, awarded across all 58 counties, have served approximately 200,000 eligible patients. Of note, the program has fully expended its allocation.

2. Abortion Practical Support Fund (\$20 million)

Also administered by Essential Access Health, the Abortion Practical Support Fund provides grants to nonprofit organizations to help individuals seeking abortion care access the practical supports necessary to obtain services. Eligible support includes travel, lodging, childcare, food, and other ancillary costs. To date, \$11.1 million has been issued across three funding cycles, with \$8.2 million remaining to be issued in a fourth and final funding cycle. The program is anticipated to exhaust its allocation following the fourth cycle.

3. Clinical Infrastructure (\$20 million)

Through the Clinical Infrastructure program, HCAI awarded scholarships and loan repayment assistance to support a broad spectrum of health care providers offering abortion-related care and reproductive health services. Most funding for the program has been issued. HCAI is holding \$2.9 million in contingency in anticipation of potential further federal action affecting program-eligible providers.

4. Capital Infrastructure (\$20 million)

In partnership with the California Governor's Office of Emergency Services, HCAI implemented the Physical and Digital Infrastructure Security Grant Program to strengthen the physical safety and cybersecurity of health care facilities and practitioners providing abortion-related care and reproductive health services statewide. HCAI is holding \$4.5 million in contingency, also in anticipation of potential further federal action.

5. Reproductive Health Services Corps (\$20 million)

The Reproductive Health Services Corps was designed to recruit, train, retain, and financially support a diverse workforce of health care professionals who commit to providing reproductive health services, including abortion care, for at least three years. HCAI partnered with Training in Early Abortion for Comprehensive Healthcare and Birth Control Pharmacist to administer the program. All funds have been expended.

State Response to H.R. 1: Planned Parenthood Financing

H.R. 1 included a targeted provision prohibiting federal Medicaid funds from being paid to providers meeting specific criteria: nonprofit organizations that are essential community providers primarily engaged in family planning or reproductive services, provide abortions

outside of the Hyde Amendment exceptions, and received \$800,000 or more in Medicaid payments in 2023. This provision effectively eliminated Planned Parenthood's eligibility for federal Medicaid reimbursement.

In response, the 2025-26 Budget Act included approximately \$140 million to support Planned Parenthood and preserve access to family planning and reproductive health services. This included approximately:

- \$90 million from Proposition 35 funding for family planning and abortion care
- \$50 million redirected from excess balances paid to qualified health plans under Covered California for abortion services. Under federal law, health plans selling coverage through an Exchange must charge enrollees a separate \$1 per member per month premium for abortion coverage. This appropriation redirects a portion of the accumulated excess balances from that premium.

In January 2026, the Legislature took early budget action to appropriate an additional \$90 million to address ongoing financing gaps for Planned Parenthood and cover non-abortion services that are no longer eligible for federal reimbursement under H.R. 1.

Federal Update: Title X Family Planning Program

Background

Title X of the Public Health Service Act is the only federal program in the United States dedicated solely to providing family planning services to low-income individuals, particularly those who are uninsured or underinsured. Title X supports a broad range of medically approved services including pregnancy prevention, birth spacing counseling, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection services, and other preconception health services.

Essential Access Health has served as California's sole Title X grantee since the 1970s and is the primary conduit for Title X funding to family planning providers across the state.

2025 Federal Funding Freeze

In 2025, the federal government froze funding for 22 Title X grants nationwide, including \$13.2 million designated for California. Affected organizations were directed to certify compliance with federal civil rights requirements and Executive Orders related to Diversity, Equity, and Inclusion activities. Following an extended period without funding, federal Title X dollars were ultimately restored at the end of 2025.

To backfill funding losses, and in anticipation of future disruptions, the 2025-26 state budget included \$15 million in one-time funding to help mitigate the impact of federal Title X funding freezes on California providers.

2026 Ongoing Funding Delay

As of the date of this agenda's publication, a similar situation appears to be unfolding. The United States Department of Health and Human Services has not released the guidance that health care organizations across the country need to apply for the Title X funding cycle beginning April 1, 2026. Organizations representing the majority of Title X providers nationally have reported receiving no explanation from the federal government for the delay.

Related Committee Member Budget Requests:

The Subcommittee is reviewing a budget request to invest \$30 million over three years to sustain the Uncompensated Care Abortion Access Grant Program and ensure access to essential and time-sensitive abortion and contraceptive services to eligible patients statewide (Bonta).

Panel

- Department of Health Care Access and Information
- Dr. Nicole Barnett, President & CEO of Planned Parenthood NorCal
- Kathy Mossburg, on behalf of Essential Access Health
- Victoria Rappleye, Finance Budget Analyst, Department of Finance
- Joseph Donaldson, Principal Program Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

Staff Comments

HCAI One-Time Reproductive Health Funding Winding Down: The five reproductive health programs established by HCAI in response to the Dobbs decision were funded through a one-time \$120 million appropriation. As described above, several of these programs have already fully expended their allocations, while others are projected to exhaust remaining funds in the near term following their final funding cycles. None of the five programs have an ongoing appropriation. Staff notes that the conditions that prompted the original investment (reduced access to abortion care, workforce gaps, provider security concerns, and the need for practical support for individuals seeking reproductive health care) have not resolved. In several respects, those conditions have intensified under H.R.1 and targeted federal actions. Yet the funding infrastructure California put in place to respond to those conditions is winding down.

Planned Parenthood and the H.R. 1 Defunding Provision: Staff notes that the H.R. 1 provision prohibiting federal Medicaid reimbursement to entities meeting the specified criteria, which effectively defunded Planned Parenthood, is currently set to expire in July of 2026. At that time, affected entities would regain eligibility for federal Medicaid reimbursement, absent further congressional action. However, it is unclear at the time of this agenda's publication whether Congress may act to extend or make permanent the defunding provision before that expiration date.

Title X Funding Stability: The \$15 million in one-time state backfill funding provided in the 2025-26 budget appeared to have successfully stabilized California's Title X network and mitigated the operational disruptions caused by the 2025 temporary federal funding freeze. However, as described above, funding uncertainty appears to be repeating in 2026, with the federal government having not yet released guidance for the April 1 funding cycle and no explanation provided to Title X providers.

The Subcommittee may wish to ask:

1. Can HCAI provide an assessment of the demand for each of the five programs beyond their current funding cycles, and whether any programs have demonstrated a level of impact that warrants consideration for additional appropriations? What are the consequences for providers and patients in California when program funds are fully exhausted and no replacement funding is in place?
2. Can Planned Parenthood for a status update on its current financial position, how it has restructured its operations and financing in response to H.R. 1, and what scenarios it is preparing for depending on whether the provision is extended or allowed to expire?
3. Can Essential Access Health provide an overview of how the \$15 million appropriation allocated in 2025 addressed federal funding disruptions, and what contingency plans may be in place to protect continuity of care for California's Title X network, considering possible additional disruptions in 2026?

Staff Recommendation:

Hold Open

4260 Department of Health Care Services

Issue 3: Long-Term Care Services and Supports

California's long-term services and supports system encompasses a wide range of programs designed to serve individuals whose care needs would otherwise require nursing facility placement. These programs range from fully integrated care models, like the Program for All-Inclusive Care to the Elderly (PACE), to community-based waiver programs like the Home and Community Based Alternative (HBCA) and Assisted Living Waiver (ALW) programs, to residential skilled nursing settings like Congregate Living Health Facilities (CLHF). All of the programs discussed in this issue serve Medi-Cal beneficiaries, and all are premised on the concept that community-based care is both better for participants and less costly to the Medi-Cal program.

This issue examines four specific long-term services and supports programs. Taken together, these programs represent a part of California's community-based long-term care infrastructure, the network of services that allows frail elderly and disabled individuals to remain in their homes and communities rather than entering institutional settings.

The Subcommittee will examine the following issues:

- The status of waitlists for the Home and Community-Based Alternatives (HCBA) and Assisted Living Waiver (ALW) programs.
- The transition of Congregate Living Health Facilities (CHLF) into managed care.
- The status of the moratorium enacted on the Program for All-Inclusive Care for the Elderly (PACE)

Background on the Home and Community Based Alternative (HBCA) Waiver Program

The Home and Community-Based Alternatives Waiver is a 1915(c) HCBS waiver program authorized under Section 1915(c) of the Social Security Act and administered by CMS in five-year increments. The most recent HCBA waiver renewal was approved by CMS on February 2, 2023 for the 2023-2027 period.

The HCBA waiver provides care management services to Medi-Cal beneficiaries who are at risk of nursing home or institutional placement. Care management is delivered by a multidisciplinary Care Management Team consisting of a nurse and social worker, who coordinate the full range of services a participant needs to remain safely in the community, including medical care, behavioral health, In-Home Supportive Services, and other long-term services and supports. Participants must reside in their own home, a family member's home, or a rental residence in

the community. The HCBA waiver is available statewide through a network of waiver agencies that cover all 58 counties.

Background on the Assisted Living Waiver (ALW) Program

The Assisted Living Waiver is a separate 1915(c) HCBS waiver created by state legislation directing DHCS to test the efficacy of assisted living as a Medi-Cal benefit. The program is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility. The program provides specified benefits to eligible seniors and persons with disabilities. Although Medi-Cal reimburses for the services provided to residents enrolled in the ALW, the resident is responsible to pay for their own room and board. The current five-year waiver term runs from March 1, 2024 through February 28, 2029.

To be eligible for the ALW, an individual must be 21 years of age or older, have full-scope Medi-Cal eligibility with zero share of cost, have care needs equivalent to nursing facility level of care, and be willing and able to reside in an assisted living setting. The ALW is currently available in 15 counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma.

HBCA and ALW Waitlist

As waiver programs approved by the federal government, both the HCBA and ALW waivers are operating with waitlists. This means that the state can only offer waiver benefits to a limited number of individuals. When program is at capacity, a person applying for waiver benefits is placed on a waitlist until more slots are available to be filled.

The HCBA waiver reached maximum enrollment capacity and implemented a waitlist effective July 12, 2023. When a slot becomes available, applicants on the waitlist who meet Reserve Capacity criteria — including individuals transitioning from similar HCBS waivers, applicants under 21, or applicants who have been residing in a health care facility for at least 60 days — are prioritized for intake.

The HCBA maximum capacity is approximately 12,000 slots. According to DHCS, the current waitlist is approximately 6,030 individuals. DHCS plans to increase the capacity number by 1,800 each year for the next two years until the waiver is subject to renewal with the federal government.

Advocates and stakeholders have noted that the HBCA and ALW programs typically do not reach their total enrollment capacity, meaning slots are theoretically available for placement. However, the waitlist continues to grow. This dynamic suggests that the waiver programs are not necessarily experiencing a shortage of authorized slots, but may face structural issues, such

as geographic mismatch between where slots exist and where applicants live, insufficient administrative resources at DHCS or at waiver agency to process enrollments, provider shortages in specific communities, or administrative barriers that prevent eligible individuals from accessing slots exist.

In discussion with the Subcommittee, the Administration notes that that various factors can lead to the growing waitlist despite the availability of slots: for example, DHCS only releases slots in blocks, so the programs do not accidentally go over the authorized cap and do not exceed waiver provider capacity. In addition, programs may experience attrition with deaths outpacing enrollment.

The Subcommittee has requested the Administration provide additional, in-depth data regarding the HCBA and ALW waiver programs, including total authorized enrollment slots, total enrolled participants, total waitlist counts, and average wait time from application to enrollment. However, due to timing constraints, these data points were not available at time of publication. The subcommittee may wish to ask for these data insights during the hearing.

Congregate Living Health Facilities: Transition to Managed Care

Congregate Living Health Facility (CLHF) is residential medical option for persons requiring more medical care than a skilled nursing home, but less than an acute care hospital. CLHFs are waiver providers operating under the HCBA waiver program described above.

CLHFs provide 24-hour skilled nursing and supportive care in a residential, home-like environment, and serve individuals who require medical devices such as ventilators, BIPAPs, and feeding and medication pumps, as well as maximum assistance with all activities of daily living. The population served by CLHFs is small but medically complex: residents are typically between 18 and 60 years of age and include individuals who are terminally ill, catastrophically or severely disabled, or mentally alert but physically disabled. Common pathways to CLHF placement include catastrophic accidents, ALS, muscular dystrophy, stroke, and work-related injuries. Most CLHF residents are discharged from general acute care hospitals.

DHCS proposes to transition CLHFs from HBCA to an authorized benefit and provider type under the 1915(i) Home and Community-Based Services Optional State Plan authority and to carve CLHF services into Medi-Cal managed care. According to DHCS, this approach will standardize eligibility and provider qualifications, draw down federal financial participation, strengthen care coordination, and ensure that managed care plans appropriately contract with and reimburse CLHFs based on member acuity and needs.

The 1915(i) authority is significant for two reasons. First, unlike the current HCBA Waiver authority under which CLHFs currently operate, which carries enrollment caps and slot limitations, a 1915(i) state plan benefit carries no enrollment cap. It is available to anyone who

meets the eligibility criteria, making access a matter of clinical eligibility rather than slot availability. Second, recent legal and policy review has confirmed that CLHFs can meet the federal HCBS Settings Rule requirements, reinforcing their role as a home and community-based setting rather than an institutional long-term care facility, which is a prerequisite for the 1915(i) authorization to work.

DHCS is implementing the 1915(i) transition through two separate State Plan Amendments. Community-Based Adult Services (CBAS), currently operating under demonstration waiver authority, will transition first, with a planned effective date of January 1, 2027. CLHFs will follow in a separate State Plan Amendment with a planned effective date of January 1, 2028. Both timelines are dependent on CMS feedback and approval.

PACE: Status of the Application Moratorium

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.

Effective November 20, 2025, DHCS imposed a minimum two-year pause on PACE applications. This moratorium means DHCS has paused accepting PACE applications, including applications for new PACE organizations and existing PACE organization service area expansions.

The moratorium follows concerns from the Administration regarding capacity and funding constraints with the PACE program. The Administration previously proposed, and the Legislature rejected, budget proposals that would have authorized DHCS to charge application, maintenance and operations, and marketing fees to PACE organizations to fund the administrative workload associated with program oversight and expansion. Without a sustainable funding mechanism for oversight paired with growing workload demands, DHCS has concluded it cannot responsibly continue accepting new applications.

Related Committee Member Budget Requests:

The Subcommittee is reviewing the following related budget requests:

- \$1.5 million General Fund appropriation (\$3.0 million total funds) ongoing and appropriate staffing or contract authority to allow the Department of Health Care Services to clear the Medi-Cal HCBA Waiver waitlist and serve all eligible individuals who want to enroll in the HCBA Waiver to the maximum extent possible (Bonta)
- \$7.7 million for one year of bridge funding for Congregate Living Health Facilities (CLHFs) as the payment structure for CLHFs transition to managed care (Schiavo)
- \$700,000 annually for the Department of Health Care Services to hire four critical nursing staff positions who evaluate the applications of frail, older Californians applying to enroll in a Program of All-Inclusive Care for the Elderly (Solache)

Panel

- Department of Health Care Services
- Mariam Voskanyan, President, CA Congregate Living Health Facility Association
- Maria Zamora, Chair, CalPACE / Chief Executive Officer, Center for Elders' Independence
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst's Office
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Eugene Parrish, Finance Budget Analyst, Department of Finance
- Natalie Griswold, Principal Program Budget Analyst, Department of Finance

Staff Comments

The Subcommittee may wish to ask the following questions:

HCBA and ALW:

1. Can DHCS provide data on the total authorized enrollment slots, total enrolled participants, total waitlist counts, and average wait time from application to enrollment for the HBCA and ALW programs?
2. DHCS plans to increase HCBA capacity by 1,800 slots per year for the next two years ahead of the waiver renewal. With those new slots, how long would it take to clear the current waitlist? Are there any other actions taken by the Administration to clear the waitlist?

3. Can DHCS provide more details about why waitlist numbers may be outpacing available slots?

CHLF:

1. Has CMS provided any preliminary feedback on the proposed 1915(i) approach and include CLHFs into managed care?
2. The transition from the HCBA Waiver to an uncapped 1915(i) state plan benefit removes the enrollment ceiling that currently limits CLHF access. Has DHCS modeled potential demand under the uncapped structure?
3. For CHLF providers: what does the transition to 1915(i) authority and managed care mean practically? How will the contracting and reimbursement relationship with managed care plans change current CHLF operations?

PACE:

- 1- The PACE moratorium was imposed effective November 20, 2025, for a minimum of two years. Can DHCS describe what specific benchmarks or conditions would need to be met for the moratorium to be lifted?
- 2- Does the moratorium impact eligible beneficiaries' ability to access PACE programs?

Staff Recommendation:

Hold Open

Issue 4: DHCS Program Budget, January Proposals, and Trailer Bills

Overview of the Department of Health Care Services’ Total 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 2026-27 Governor’s Budget projects **\$229.1 billion in total funds** expenditure (\$49.5 billion of which is General Fund) for DHCS and proposes 4,745 staff positions. This represents a dollar increase of 13% compared to the 2025-26 Enacted Budget, which appropriated a total of \$202.7 billion total funds (\$45.6 billion General Fund) for DHCS. These amounts capture both DHCS’ state operations and all local assistance programs, as shown below:

Fund Source	FY 2025-26 (Enacted Budget)	FY 2025-26 (Revised Budget)	FY 2026-27 (Proposed Budget)
General Fund	\$45,603,677	\$47,110,472	\$49,525,882
Federal Fund	\$120,718,549	\$120,603,394	\$138,466,912
Other Funds	\$36,423,994	\$35,954,512	\$41,147,286
TOTAL	\$202,746,220	\$203,668,378	\$229,140,080
<i>Staff Positions</i>	<i>4,978</i>	<i>4,687</i>	<i>4,745</i>

**Dollars in thousands*

Medi-Cal Funding (Local Assistance Estimate)

This section summarizes spending specifically for the Medi-Cal program. The 2026-27 Governor's Budget projects a total of **\$222.4 billion in total expenditures for the Medi-Cal program**, of which \$48.8 billion is General Fund. Of this total, \$214.7 billion is for medical care services (\$47.0 billion General Fund) and \$7.7 billion is for program administration (\$1.8 billion General Fund).

This represents an increase of 13.5 percent compared to the 2025-26 Enacted Budget, which appropriated a total of \$196.0 billion for the Medi-Cal program (\$44.2 billion General Fund), of which \$188.5 billion was for medical care services (\$42.9 billion General Fund) and \$7.5 billion was for program administration (\$1.3 billion General Fund).

The table below shows a high-level breakdown of Medi-Cal spending by fund source.

Fund Source	FY 2025-26 (Enacted Budget)	FY 2025-26 (Revised Budget)	FY 2026-27 (Proposed Budget)
MEDICAL CARE SERVICES			
General Fund	\$42,897,916	\$44,056,718	\$46,981,325
Federal Fund	\$113,667,820	\$113,895,044	\$131,674,297
Other Funds	\$31,978,191	\$30,731,831	\$36,083,861
TOTAL	\$188,543,927	\$188,683,593	\$214,739,483
PROGRAM ADMINISTRATION			
General Fund	\$1,308,102	\$2,318,556	\$1,812,166
Federal Fund	\$6,020,686	\$5,552,599	\$5,802,792
Other Fund	\$123,096	\$137,387	\$82,783
TOTAL	\$7,451,884	\$8,008,542	\$7,697,741
TOTAL MEDI-CAL PROGRAM EXPENDITURES			
General Fund	\$44,206,018	\$46,375,274	\$48,793,491
Federal Fund	\$119,688,506	\$119,447,643	\$137,477,089
Other Fund	\$32,101,287	\$30,869,218	\$36,166,644
TOTAL	\$195,995,811	\$196,692,135	\$222,437,224

**Dollars in thousands*

Increases in Medi-Cal Program Costs

Current Year Cost Estimate Changes: May 2025 Estimate vs. November 2025 Estimate

The Medi-Cal estimate is updated twice a year in May and November to reflect the most current projections of program costs. The November 2025 update projects no change in total Medi-Cal spending for the current fiscal year compared to the May estimate, but projects that the state's General Fund share of those costs will be \$1.4 billion higher (a 3.2 percent increase). In other words, overall spending stayed flat, but the state ended up with higher General Fund costs than originally expected. Compared to what was assumed when the 2025-26 budget was enacted last June, the General Fund increase is even larger, approximately \$2 billion.

The primary drivers of the higher General Fund costs are:

- Higher Medicare costs (\$638.7 million)
- Higher costs related to members with Unsatisfactory Immigration Status (\$819.3 million), primarily from corrections to federal claiming errors and pharmacy deferrals

- Higher CMS deferrals (\$617.6 million)
- Updated timing and technical adjustments for budget solutions included in the 2025 Budget Act (\$195.1 million)
- These costs are partially offset by lower pharmacy and managed care costs (\$547.2 million in savings) driven by lower enrollment and reduced utilization.

Year-over-Year Change from FY 2025-26 to FY 2026-27

The November 2025 Estimate projects that total spending will increase by \$25.7 billion (13.1 percent), and General Fund spending will increase by \$2.4 billion (5.2 percent) between 2025-26 and 2026-27. Major factors driving the changes in estimated GF spending from 2025-26 and 2026-27 include:

- The budget assumes the MCO Tax will continue through the transition period ending December 31, 2026. Additional reductions in GF savings between 2025-26 and 2026-27 due to the MCO Tax sunset and Proposition 35 funding provider payment adjustments result in an increase of \$1.1 billion GF.
- An approximate \$471.9 million GF increase between fiscal years for H.R. 1 policies effective in 2026-27, including:
 - Work and Community Engagement: \$102.4 million GF cost reduction.
 - Six-Month Redetermination: \$74.1 million GF cost reduction.
 - Reduced Retroactive Coverage: \$9.6 million GF cost reduction.
 - UIS FMAP Adjustment: \$658 million GF cost increase.
- An increase of \$2.7 billion GF for Managed Care base projections, primarily from base rate increases and enrollment growth, including \$445.3 million GF for PACE. A projected \$554.1 million GF decrease in other managed care items due to the net impact of updated estimated expenditures for various policies and updated projected recoupments and savings.
- A projected net decrease of \$897.2 million GF is estimated in 2026-27 resulting from projected caseload reductions likely relating to the COVID-19 End of Unwinding Flexibilities and savings from the implementation of improvements for residency verification.

- An estimated \$897.8 million GF increase primarily driven by fee-for-service pharmacy rate growth.
- From 2025-26 to 2026-27, there is an approximately \$648.3 million GF increase in Medicare costs due to projected growth in the Medicare population and increases in Buy-In premiums and Part D Per Member Per Month (PMPM) costs.
- Costs related to State-Only claiming adjustments for UIS members are projected to decline by approximately \$395.8 million in 2026-27 as retroactive repayments are completed in 2025- 26.
- An approximate \$515.5 million decrease in GF cost is estimated for CMS deferrals as ongoing deferrals are projected to be lower, and no further State-Only administrative deferrals are estimated in 2026-27.
- 2026-27 estimates included in the budget for ongoing savings from Budget Act of 2025 solutions reflect a decrease of \$648.9 million in GF spending:
 - \$2.16 billion GF savings from budget solutions effective in 2026-27.
 - Full Scope Medi-Cal Expansion Enrollment Freeze – an additional \$659.2 million GF cost reduction in 2026-27.
 - Reinstatement of Asset Limit – an additional \$302.1 million GF cost reduction in 2026-27.
 - Utilization Management for Hospice – an additional \$50 million GF savings in 2026-27.
 - Eliminate Prospective Payment System for State Only – an additional \$1 billion GF savings in 2026-27.
 - Eliminate Dental for Adult UIS – an additional \$134.6 million GF cost reduction in 2026-27.
 - \$901.2 million additional GF savings from pharmacy and pharmacy rebate solutions in 2026-27.
 - \$132.4 million additional GF savings from the elimination of the SNF WQIP in 2026-27.

- The 2026-27 budget does not include Medical Provider Interim Payment Loan funds to offset GF costs, resulting in an additional \$2.5 billion GF.
- Hospital Quality Assurance Fee (HQAF) Children's Health Care Coverage savings shift to 2026-27 resulting in increased GF savings of \$142.1 million GF.

Medi-Cal Caseload

In Fiscal Year 2025-26 the Medi-Cal program had an estimated caseload of 14,530,300 beneficiaries. For 2026-27, DHCS anticipates a caseload of 14,021,900 beneficiaries enrolled into the program. The caseload projections estimate a total drop of 3.5% in enrolled beneficiaries.

A high-level overview of caseload by categories is provided below:

Population Category	2025-26 Caseload	2026-27 Caseload
Affordable Care Act Expansion	4,916,800	4,591,000
Long-Term Care	45,000	44,500
Seniors and Persons with Disabilities	2,545,300	2,574,400
Title 19 Adults	2,257,600	2,133,600
Title 19 Children	3,543,000	3,458,300
Title 21	1,215,200	1,212,000
Miscellaneous	7,400	7,400
TOTAL	14,530,300	14,021,900

Note: In previous Medi-Cal Estimates, the caseload pages were published using 18 aid categories. Beginning with the November 2025 Estimate, the Department has decided to consolidate these 18 aid categories to 6 new aid categories: Title 19 Children, Title 19 Adults, Title 21, ACA Expansion, Seniors and Persons with Disabilities (SPDs) and Long-Term Care (LTC) aid codes to better align with Department rate setting.

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 2025 Estimate, DHCS projected Family Health Spending to be \$292.9 million total funds (\$264.8 million General Fund) in Fiscal Year 2025-26 and **\$307 million total funds** (\$281 million General Fund) in 2026-27. This projects a total spending increase by \$14.2 million, or 4.8 percent, and General Fund spending increase by \$16.1 million, or 6.1 percent, between 2025-26 and 2026-27. These modest changes appear to be related to minor technical adjustments.

<i>Fund Source</i>	<i>FY 2025-26 (Revised)</i>	<i>FY 2026-27 (Proposed)</i>
CALIFORNIA CHILDREN’S SERVICES		
General Fund	\$83,376,000	\$87,706,000
Other Fund	\$8,289,000	\$6,292,000
TOTAL CCS	\$91,665,000	\$93,998,000
GENETICALLY HANDICAPPED PERSONS PROGRAM		
General	\$181,385,000	\$193,124,000
Other Fund	\$539,000	\$539,000
TOTAL GHPP	\$181,924,000	\$193,663,000
EVERY WOMAN COUNTS PROGRAM		
General Fund	\$0	\$117,000
Other Fund	\$19,222,000	\$287,544,000
TOTAL EWC	\$19,222,000	\$19,330,000
GRAND TOTAL	\$292,811,000	\$306,991,000

Family Health Caseload

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

Program	2025-26 Caseload	2026-27 Caseload
California Children’s Services (State-Only)	12,718	12,718
Genetically Handicapped Persons Program	517	518
Every Woman Counts	8,663	8,862

Budget Change Proposals

The Administration proposes the following 9 budget change proposals:

(Note: the Value Strategy for Hospital Payments in Medi-Cal Managed care is discussed in subsequent issues, and behavioral health related budget change proposals will be examined at a later hearing)

- 1. H.R. 1 Planning and Implementation.** DHCS requests 17 limited-term staff positions (four-year term) and 12 limited-term positions (two-year term) to implement the provisions of HR1. The positions will focus on development of an implementation plan, aligning state laws with federal requirements, implementation of system changes, and development of policy guidance, training and outreach. The proposal also includes resources to procure an outreach and media contractor, as discussed in more details in the Subcommittee’s March 9 hearing.

Resources requested: \$33,049,000 (\$15,549,000 General Fund (GF); \$17,500,000 Federal Fund (FF)) in FY 2026-27, \$11,325,000 (\$5,662,000 GF; \$5,663,000 FF) in FY 2027-28, and \$3,277,000 (\$1,639,000 GF; \$1,638,000 FF) in FY 2028-29 and FY 2029-30.

- 2. Department of Health Care Services: Chaptered Legislative Proposals.** DHCS requests various resources to implement statutory requirements associated with legislation chaptered as Statutes of 2025. The pieces of legislation being implemented include:
 - SB 660 (Menjivar, Chapter 325 Statutes of 2025) - California Health and Human Services Data Exchange Framework
 - SB 246 (Grove, Chapter 308, Statutes of 2025) - Medi-Cal: graduate medical education payments

- AB 543 (M. Gonzalez, Chapter 374, Statutes of 2025) - Medi-Cal: field medicine

- 3. Managed Care Operations.** DHCS requests the conversion of 4 limited-term resources to permanent positions to support the implementation, monitoring, and enforcement of federal and state requirements across a broad range of Medi-Cal Managed Care activities, including network adequacy and access.

Resources requested: \$607,000 (\$236,000 General Fund; \$371,000 Federal Fund) in fiscal year 2026-27 and ongoing.

- 4. California Community Transitions (CCT) Program Federally Funded Limited-Term Position.** DHCS requests limited-term resources equivalent to 1 position and expenditure authority to support California Community Transitions Program operations. This program enables DHCS to draw down enhanced match funding to transition eligible individuals who have resided in an in-patient facility for at least 60 days, with at least one day paid by Medi-Cal, to the community setting of their choice. Under the CCT program, eligible individuals of all ages with disabilities can receive transition coordination services to assist them with the transition process from an institution to the community, and to connect them with the Long-Term Services and Supports they require to remain at home or in the community

Resources requested: \$165,000 Federal Fund (FF) in fiscal year (FY) 2026-27 and \$90,000 FF in FY 2027-28.

- 5. Human Resources Plus Modernization (HR+ Mod).** DHCS requests 3 permanent positions, and expenditure authority for the planning, procurement, and project implementation costs to modernize human resources and related fiscal systems business technology and processes.

Resources requested: \$4,535,000 (\$2,268,000 General Fund (GF); \$2,267,000 Federal Fund (FF)) in fiscal year (FY) 2026-27, \$2,022,000 (\$1,011,000 GF; \$1,011,000 FF) in FY 2027-28, \$312,000 (\$156,000 GF; \$156,000 FF) in FY 2028-29, and a reduction of \$1,677,000 (\$839,000 GF; \$838,000 FF) in FY 2029-30 and ongoing.

- 6. Long-Term Care Payment Transparency Final Rule Extension.** DHCS requests ongoing funding authority to continue to implement the Medicaid Institutional Payment Transparency Reporting provisions of the federal LTC Final Rule.

Resources requested: \$2,537,000 (\$1,208,000 Long-Term Care Quality Assurance Fund (LTC QAF); \$1,329,000 Federal Fund (FF)) in Fiscal Year (FY) 2026-27 and \$1,330,000 (\$604,000 LTC QAF; \$726,000 FF) in FY 2027-28 and ongoing

- 7. Advancing Interoperability and Improving Prior Authorization Processes Final Rule.** DHCS requests three-year limited term resources equivalent to 18 positions to plan and implement the federal Centers for Medicare and Medicaid Services Advancing Interoperability and Improving Prior Authorization Processes final rule, published on February 8, 2024

Resources requested: \$3,479,000 (\$523,000 General Fund (GF); \$2,956,000 Federal Fund (FF)) in fiscal year (FY) 2026-27, \$2,946,000 (\$456,000 GF; \$2,490,000 FF) in FY 2027-28 and FY 2028- 29

- 8. Managed Care Final Rule Implementation and Operations.** DHCS requests 6 one-year limited-term (LT) positions, four-year LT resources equivalent to 33 positions to support the implementation and operations of the Managed Care Final Rule requirements

Resources requested: \$12,310,000 (\$6,023,000 General Fund (GF); \$6,287,000 Federal Fund (FF)) in Fiscal Year (FY) 2026-27 and \$10,456,000 (\$5,228,000 GF; \$5,228,000 FF) in FY 2027-28 through FY 2029-30

- 9. Ensuring Access to Medicaid Services (Access Rule).** DHCS requests one-year limited-term (LT) resources equivalent to 7 positions, four-year LT resources equivalent to 15 position to continue to support DHCS' ability to meet all federal and state requirements related to the Ensuring Access to Medicaid Services Final Rule.

Resources requested: \$7,275,000 (\$1,788,000 General Fund (GF); \$5,487,000 Federal Fund (FF)) in fiscal year (FY) 2026-27 and \$5,336,000 (\$1,497,000 GF; \$3,839,000 FF) in FY 2027-28 through FY 2029-30.

Budget Trailer Bills

The Administration proposes the following trailer bills:

(Note: behavioral health related trailer bills will be covered in a subsequent hearing)

- 1. HR1 – Conforming State to Federal Law.** This trailer bill implements the provisions of HR1 into state law. Specifically, the trailer bill would 1) modify existing Medi-Cal eligibility rules to regularly check and update member addresses; 2) conduct six-month eligibility redeterminations for certain adults; 3) reflect eligibility updates for federally funded full-scope Medi-Cal based on immigration status; 4) reduce retroactive coverage periods; and 5) establish work/community engagement requirements, including on individuals with unsatisfactory immigration statuses. According to DHCS, these proposed changes are necessary to align state law with mandatory provisions of the federal reconciliation bill.

- 2. Skilled Nursing Facility Financing Reauthorization.** Existing law governs the financing of freestanding Skilled Nursing Facilities and Subacute units in the Medi-Cal Program, including the methodologies used for provider reimbursements. Those statutes routinely sunset and require reauthorization by the legislature. Existing governing statutes are set to sunset on December 31, 2026.

DHCS proposes a trailer bill to provide a one-year extension of currently authorized methodologies in order to provide additional time for the development of the SNF Value Strategy in consultation with the stakeholder advisory workgroup to inform a further multi-year reauthorization effective January 1, 2028.

According to DHCS, the SNF Value Strategy will include a landscape analysis of payment methodologies utilized by Medi-Cal, Medicare, and other payers and a multiyear roadmap to drive system transformation and integration over a five-year horizon. DHCS aims to publish the initial draft of the SNF Value Strategy in early 2027. Subject to legislative approval of necessary statutory changes through the annual budget process, the SNF Value Strategy will guide the further reauthorization of these methodologies effective on or after January 1, 2028.

- 3. Breast-Cancer Control Fund and Breast Cancer Research Account Technical Cleanup.** This technical clean-up trailer bill corrects erroneous statutory references and ensures that the appropriate state departments are designated to the correct funding accounts.

Panel

- Department of Health Care Services
- Sabrina Adams, Staff Finance Budget Analyst, Department of Finance
- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Min Lee, Economist, Legislative Analyst's Office

Staff Comments

Per-enrollee cost growth is a major driver of Medi-Cal spending increases, but is currently not well understood. The LAO notes that base Medi-Cal spending (spending on core health care services to enrollees) has been the primary driver of spending growth in Medi-Cal over the last decade. The LAO estimates that General Fund base spending in Medi-Cal increased by approximately \$25 billion from 2017-18 to 2025-26, and that growth in per-enrollee costs accounts for a larger share of that increase than changes in caseload level and composition.

Several contributors are driving those per-enrollee cost increases: managed care capitation rates (averaging 4.6 percent annually), higher utilization of services, pharmacy cost growth (nearly 13 percent per year), rising Medicare-related costs, and higher fee-for-service unit costs. But the LAO notes in its analysis that it could not fully account for the growth in per-enrollee costs, noting that approximately \$8 billion (roughly one-third of total base spending growth) remains unexplained. The LAO attributes this remainder likely to major policy changes enacted since 2017-18, such as the expansions of comprehensive coverage to undocumented adults and the creation of Enhanced Care Management and Community Supports benefits, but notes that limited data make it difficult to precisely estimate their fiscal effects.

Cost-growth in Medi-Cal will continue unless addressed directly. Looking at the year-over-year drivers of General Fund cost growth for 2026-27, several of the largest items appear structural rather than one-time: managed care base rate increases of \$2.7 billion, pharmacy cost growth of \$897.8 million, and Medicare-related cost growth of \$648.3 million are all driven by underlying trends in health care prices and utilization that do not automatically correct. The Subcommittee may wish to ask DHCS and LAO to identify which components of current-year and budget-year spending reflect permanent structural trends versus one-time or transitional factors.

Increased data transparency may improve oversight of the Medi-Cal program. The LAO identifies data limitations as a significant barrier to its own analysis; and by extension, to the Legislature's ability to exercise informed oversight over the Medi-Cal program. As the LAO notes: "most data on utilization and costs in managed care – Medi-Cal's primary delivery system – are confidential." This means the Legislature is being asked to appropriate tens of billions of General Fund dollars for managed care, the largest single component of Medi-Cal spending, without access to the underlying data that would allow it to assess whether those dollars are being spent efficiently.

The LAO specifically recommends the Legislature direct the administration to provide, at minimum: (1) more recent managed care rate trend information; (2) more data on caseload, costs, and utilization for members with UIS; and (3) more detailed pharmacy data on users, utilization, and net unit costs by therapeutic class and drug.

Stakeholders have expressed concerns regarding the Skilled Nursing Facility Financing Reauthorization Trailer Bill. The 2025 Budget eliminated the Workforce and Quality Incentive Program (WQIP), which had provided incentive payments to SNFs meeting specific quality of care metrics. Reinstatement of the WQIP has been an ongoing discussion between stakeholders and the Administration as part of the broader SNF financing reauthorization process. Because the proposed trailer bill extends the current methodology but does not include any WQIP reinstatement, stakeholders have expressed concern that an opportunity to restore the program is also being deferred alongside the broader reauthorization.

The Subcommittee may wish to ask:

- 1- The LAO estimates that roughly one-third of base spending growth over the last decade remains unexplained by the data currently available. What specific steps is DHCS taking to better understand and document the drivers of per-enrollee cost growth, particularly in managed care, where most spending occurs but data is most limited?
- 2- Can DHCS provide a more detailed breakdown of which service categories are driving utilization growth (e.g. inpatient hospital, behavioral health, long-term care, etc..) and whether the growth reflects increased frequency of services, increased intensity of services per episode, or both? Are there specific populations or service lines where utilization growth is concentrated?
- 3- Pharmacy costs per enrollee are growing quickly. How much of that growth is attributable to new high-cost drugs entering the formulary versus increased utilization of existing drugs, and what levers does the state have to manage it going forward?
- 4- The LAO recommends the Legislature direct DHCS to provide richer data on managed care costs, UIS population costs, and pharmacy spending. Is DHCS prepared to commit to specific data deliverables to support transparency and oversight of the Medi-Cal program?
- 5- The 2025 Budget eliminated the Workforce and Quality Incentive Program, and its reinstatement has been an ongoing discussion between stakeholders and the Administration. Given that this trailer bill extends the current SNF financing methodology for one year without addressing WQIP, can DHCS describe the status of those discussions? Specifically, whether WQIP reinstatement will be considered as part of the multi-year reauthorization process expected to take effect January 1, 2028, and what stakeholder engagement has occurred to date?

Staff Recommendation:

Hold Open

Issue 5: H.R.1 & Financing Impact on Medi-Cal and Providers

This issue examines the impact of H.R. 1 on the key financing mechanisms that support Medi-Cal providers, and the downstream consequences for hospitals, clinics, and the patients they serve. This issue is covered in greater detail in the companion brief provided by the Legislative Analyst's Office, "*H.R. 1 Financing Impact on Medi-Cal Providers.*"

Overview of Hospital Types

For the purposes of Medi-Cal financing, there are three key types of hospitals in California:

- **Private Hospitals:** private hospitals are owned and operated by private entities, either nonprofit health systems or for-profit corporations. Examples include large health systems like Sutter Health, Dignity Health, and Providence. Private hospitals are the most numerous hospital type in California, and serve both commercially insured and Medi-Cal patients. Private hospitals are diverse in size, geography, and patient population.
- **County & UC Hospitals:** Also known as "Designated Public Hospitals," these hospitals fall into two groups: the University of California medical centers, which includes UC Irvine, UCSF, UCLA, UC Davis, UC San Diego, and UC Riverside; and large county hospitals and their affiliated health systems, such as Los Angeles General Medical Center, Zuckerberg San Francisco General, and Natividad Medical Center in Monterey County. These hospitals tend to be relatively large and serve a patient population that is primarily Medi-Cal and uninsured. For purposes of Medi-Cal financing, the DPH designation determines which supplemental payment programs a hospital can access.
- **District & Municipal Hospitals:** Also known as "Non-Designated Public Hospitals," these government-owned hospitals are generally operated by special health care districts or municipalities, rather than by counties or the UC system. Examples include Salinas Valley Memorial Healthcare System, Antelope Valley Hospital, and Palomar Medical Center. The term "non-designated" can be counterintuitive: these hospitals are publicly owned and operated but are in a different category than county and UC hospitals for Medi-Cal financing purposes. That distinction means non-designated public hospitals access different supplemental payments through smaller programs than their DPH counterparts. District and municipal hospitals tend to be smaller than DPHs and often serve rural or suburban communities with fewer alternative providers nearby.

Overview of Health Care Taxes and Medi-Cal Provider Financing

Background

Like most providers, hospitals serving Medi-Cal patients are reimbursed primarily through contracts with managed care health plans, which pay for services on behalf of their enrolled Medi-Cal members. A smaller share of hospital services is reimbursed through fee-for-service payments using set rates.

Federal law also allows states to enact specific taxes on health care providers (known as "health care-related taxes" or "provider taxes") which states use to generate the non-federal share of Medicaid spending and draw down additional federal matching funds. The resulting combined revenue is used to support providers in the form of supplemental payments above their base reimbursement rates. Because these taxes leverage federal dollars, they are regulated by the federal government in both their structure and application.

Key Financing Mechanisms in California

This background will cover three key financing mechanisms that support Medi-Cal providers:

- 1. Managed Care Organization (MCO) Tax.** The MCO tax is a tax levied on Medi-Cal and commercial health plan enrollment. Nearly all of the revenue comes from taxing Medi-Cal enrollment, as the Medi-Cal tax rate is more than 100 times larger than the commercial tax. Because of this disparity, California requires a federal waiver from proportionality rules (explained below) to operate the tax in its current form. The MCO Tax currently generates between \$7 billion and \$8 billion in net annual revenue. Approximately 75 percent of that revenue offsets General Fund spending in Medi-Cal, while the remaining 25 percent funds programmatic augmentations, primarily Medi-Cal provider rate increases, including hospital services. The MCO Tax was made permanent in state law by Proposition 35 in November 2024, though periodic federal approval is still required to draw down federal matching funds. The current tax and its federal waiver are authorized through December 31, 2026.
- 2. Hospital Quality Assurance Fee (HQAF).** The HQAF is a fee assessed specifically on private hospitals based on their inpatient days and outpatient visits. Like the MCO Tax, the HQAF charges higher rates on Medi-Cal services than non-Medi-Cal services, requiring a federal proportionality waiver. The HQAF cycle works as follows: private hospitals pay the fee into a dedicated fund, the state uses that revenue as the non-federal share of supplemental Medi-Cal payments, and the combined state and federal money flows back to eligible private hospitals as supplemental payments above their base managed care rates through the Private Hospital Directed Payment Program. Approximately 75 percent of HQAF revenue funds supplemental payments back to private

hospitals, with the remaining 25 percent offsetting General Fund spending in Medi-Cal. The HQAF was made permanent in state law by Proposition 52 in 2016. The most recently approved version of the fee generated \$5.9 billion in revenue in 2024.

- 3. State Directed Payments.** State directed payments are a federal mechanism that allows states to direct how contracted Medi-Cal managed care health plans reimburse providers, effectively enabling supplemental payments above base managed care rates. Directed payments must receive annual federal approval and are subject to limits on total payment levels. For public hospitals, the county or government owner can transfer local public funds to the state, which then uses those funds as the non-federal share to draw down federal Medicaid matching funds. The combined state and federal dollars flow back to the hospital as a directed payment. This mechanism allows public hospitals to leverage their government status to generate federal matching funds, but the amount of federal match available is limited by the federal payment ceiling, which H.R. 1 has now significantly reduced.

The Impact of H.R. 1 on Financing Mechanisms

Understanding Proportionality and Hold Harmless Rules

To understand how H.R. 1 changes California's financing mechanisms, there are two key concepts to understand:

- **Proportionality** refers to the federal requirement that provider taxes must be broad-based and apply equally (or proportionately) across Medicaid and non-Medicaid services. States cannot charge higher tax rates on Medicaid services than on commercial services without obtaining a federal waiver. States can receive a waiver from proportionality requirements if they can demonstrate the tax redistributes funds from non-Medicaid toward Medicaid services, as measured by specific mathematical tests.
- **Hold Harmless / Safe Harbor** refers to the federal prohibition on states guaranteeing that providers will receive their tax payments back through Medicaid supplemental payments. However, federal rules allow states to indirectly cover the cost of the tax for providers, so long as the total tax revenue falls below a specified percentage of providers' net patient revenue. Prior to HR1, that safe harbor limit was 6 percent, known as the "safe harbor" limit.

How H.R. 1 Changes These Rules

H.R. 1 makes three significant changes to federal provider tax rules that directly affect California's financing mechanisms:

- First, H.R. 1 tightens proportionality requirements, generally prohibiting states from charging higher rates on Medicaid services than non-Medicaid services and substantially limiting the availability of proportionality waivers. This change is already technically in effect, though the federal Department of Health and Human Services may grant states additional time to comply.
- Second, H.R. 1 reduces the safe harbor revenue limit from 6 percent to 3.5 percent over a multi-year period beginning in federal fiscal year 2028, reaching its new floor by fiscal year 2032. This reduction will require states near the current revenue limit to gradually shrink their provider taxes over time.
- Third, H.R. 1 caps state directed payments at 100 percent of Medicare payment rates for hospital inpatient, outpatient, and nursing facility services, replacing the previous benchmark of average commercial rates, which is generally higher than Medicare. Existing directed payments above the new limit must be reduced by 10 percentage points annually beginning January 1, 2028, until they reach the new Medicare-based ceiling.

What These Changes Mean for California in Practice

1. **MCO Tax: Effectively Eliminated Beginning 2027.** The current MCO Tax and its federal waiver are authorized through December 31, 2026. To renew the tax after that date, California would need to restructure it to comply with H.R. 1's tightened proportionality rules, meaning the state could no longer charge Medi-Cal health plans a tax rate more than 100 times higher than the rate on commercial plans. However, Proposition 35 creates additional barriers, as it limits how much the state can tax commercial health plan enrollment to roughly current levels. Achieving proportionality under H.R. 1 would require charging more similar rates on both Medi-Cal and commercial enrollment, but Proposition 35 caps how high the commercial rate can go. Proposition 35 requires a three-fourths vote in each house of the Legislature to make changes to the measure.

Should the MCO tax be restructured to meet HR1's new requirements, the LAO estimated that a more proportionate tax netting around \$7 billion in revenue could cost around \$30 per member, per month—about a 5 percent increase on average to commercial health plan premiums.

- 2. HQAF & Private Hospitals: Similar Size in Near Term, Likely Smaller Over Time.** In the near term, the HQAF is expected to continue at roughly its current size. California had proposed in March 2025 to significantly expand the HQAF from \$5.9 billion to approximately \$9 billion for the 2025 program year. However, in November 2025, CMS informed the state that the submission was not approvable as structured under H.R. 1's new rules and required modifications. DHCS resubmitted a revised fee structure in March 2026, at approximately \$6.1 billion, which is currently pending federal review.

In the longer term, the HQAF faces pressure from both directions. The proportionality rules will require the fee structure to become more uniform between Medi-Cal and commercial services, potentially limiting revenue. The safe harbor reduction will further constrain the maximum size of the fee as the limit declines from 6 percent to 3.5 percent through 2032. DHCS has indicated that it may qualify for a multi-year transition period to come into compliance with the new proportionality rules, which would provide some near-term stability.

- 3. Reduced Supplemental Payments to Public Hospitals Over Time.** H.R. 1's directed payment cap at Medicare rates will reduce supplemental payments to public hospitals over time. The Medicare benchmark is generally significantly lower than the average commercial rate that served as the previous ceiling. For service lines where California's current directed payments substantially exceed Medicare rates, the reduction could be in the billions of dollars statewide.

Community Clinics and the Downstream Impact of H.R. 1 & State-Level Cuts

While the financing mechanisms described in this issue primarily affect hospitals directly, community clinics and health centers will face significant downstream consequences from H.R. 1. As Medi-Cal enrollment declines due to work requirements, six-month redeterminations, and new restrictions on immigration statuses, clinics will simultaneously see a reduction in reimbursed patient visits and an increase in uncompensated care.

Of note, clinics are reimbursed through a Prospective Payment System (PPS) rate, a federally-mandated, cost-based per-visit rate intended to reflect the full cost of providing comprehensive primary care in federally qualified settings. PPS rate is a central source of Medi-Cal reimbursement for clinics.

The 2025-26 budget eliminated the enhanced PPS rate for services provided to individuals with Unsatisfactory Immigration Status, a change estimated to yield approximately \$1 billion in annual savings. This reduction compounds the enrollment-driven revenue losses clinics are already facing under H.R. 1. The California Primary Care Association estimates the combined impact of H.R. 1 disenrollments and state budget policies, including the state-only PPS elimination, will

result in a minimum of \$1.6 billion in revenue losses for health centers in FY 2026-27, a figure projected to grow substantially in future years.

Related Budget Change Proposals

Value Strategy for Hospital Payments in Medi-Cal Managed Care

As California's hospital supplemental payment programs face significant restructuring under H.R. 1, DHCS is requesting 23 permanent positions and 3 one-year limited-term positions, along with \$10.7 million in expenditure authority in FY 2026-27, to develop, implement, and sustain a comprehensive value strategy for hospital payments in Medi-Cal managed care. This BCP is funded entirely through reimbursements and federal funds, and no General Fund is requested.

The value strategy work began in FY 2025-26 with one-time resources equivalent to 29 positions. This BCP converts that effort into ongoing permanent capacity. DHCS has organized the work into two phases:

The first phase, currently underway, is focused on compliance: ensuring that existing state directed payment programs are restructured to meet H.R. 1's new requirements by January 1, 2027. DHCS has been conducting stakeholder engagement primarily through existing channels and has consolidated related work into a newly created branch. Program deliverables for 2027 are expected to be submitted to CMS in Q4 2026.

The second phase involves the longer-term landscape analysis and multi-year strategy development. DHCS posted a Request for Information this month, expects to onboard a vendor by mid-2026, and plans to launch a broader stakeholder advisory workgroup in Q3 2026 to inform a comprehensive multi-year value strategy to be developed through 2027.

The BCP also funds two contract resources: a three-year Hospital Comprehensive Value Strategy Design and Implementation Contract (\$3 million total) to support stakeholder engagement and strategy development, and an ongoing Hospital Directed Payment Support Contract (\$2.4 million annually) to audit quality measure submissions and support ongoing program operations.

Resources requested: \$10,664,000 (\$5,332,000 Reimbursements; \$5,332,000 Federal Fund (FF)) in fiscal year (FY) 2026-27, \$9,809,000 (\$4,905,000 Reimbursements; \$4,904,000 FF) in FY 2027-28 and FY 2028-29, and \$6,809,000 (\$3,405,000 Reimbursements; \$3,404,000 FF) in FY 2029-30 and ongoing.

Panel

- Jason Constantouros, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- Department of Health Care Services
- Adam Dorsey, Vice-President, Financial Policy, California Hospital Association
- Dr. Susan Ehrlich, Chief Executive Officer, Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center
- Ryan Witz, Executive Director, District Hospital Leadership Forum
- Dr. Christine Park, Chief Medical Officer, Northeast Valley Health
- Albert Pineda, Staff Finance Budget Analyst, Department of Finance

Staff Comments

The financing architecture supporting Medi-Cal providers is under simultaneous pressure from multiple directions. Staff notes that the three financing mechanisms discussed in this issue will create significant multi-year fiscal pressures on Medi-Cal providers. The MCO tax faces effective elimination beginning 2027; the HQAF supporting private hospitals faces structural constraints that will shrink revenue over time; and state directed payments supporting public hospitals face a mandatory phase-down beginning 2028. These fiscal pressures will compound due to the significant added uncertainty from other HR1 provisions impacting Medi-Cal enrollment, including work requirements and six-month redeterminations.

The Value Strategy Budget Change Proposal appears to be the Administration's primary response to financing changes. The Value Strategy for Hospital Payments BCP requested in the January Governor's budget is the administration's primary vehicle for adjusting and protecting directed payment revenue under the new federal rules. The subcommittee may wish to better understand the near-term and long-term trajectory of this initiative, and understand what the value strategy work has produced to date and what stakeholder engagement has occurred. In addition, the subcommittee may wish to engage and understand what concrete options the Legislature has to address the MCO Tax before the end of calendar year 2026.

The Subcommittee may wish to ask:

On Health Care Taxes:

1. What is the anticipated timeline for CMS to act on the most recent Hospital Quality Assurance Fee submission, and what is the administration's contingency plan if CMS requests further modifications or does not approve the submission before the current program period ends?

2. The LAO notes that the state's options on the private hospital fee may be more limited moving forward. Can DHCS describe what redesign options remain available and what the revenue impact would be?
3. Has the administration modeled what a viable replacement to the Managed Care Organization would need to look like and what the timeline is for bringing a concrete proposal to the Legislature?

On the Impact on Hospitals and Clinics

4. Can hospitals walk the Subcommittee through projected cumulative revenue losses, and explain key drivers (e.g. SDP phase-down, MCO Tax wind-down, FMAP reductions, and enrollment losses)
5. How are hospitals planning through HR1's implementation? For example, what operational decisions (staffing, service lines, capital investments) are already being made?
6. Several California hospitals have closed or scaled back services in recent years, including labor and delivery units, due to financial pressures. How does HR1 factor into the financial stability of hospitals already operating on thin margins, and which hospital types or geographies are most at risk?
7. District hospitals often serve as the only hospital within a reasonable distance for rural communities. If directed payment revenue is reduced to the point where a district hospital can no longer sustain certain service lines, such as emergency care, obstetrics, behavioral health, what happens to the patients in those communities? Are there a realistic alternatives?
8. County public hospital systems are simultaneously facing reduced state directed payments and an indigent care demand surge (discussed in a separate panel). How are county health systems modeling the combined fiscal impact of those two simultaneous pressures?
9. Community clinics estimated facing a minimum of \$1.6 billion in combined revenue losses in FY 2026-27 from H.R. 1 disenrollments and the state-only PPS elimination. Can clinics break down that estimate for the Subcommittee, and how much is attributable to enrollment loss versus the PPS elimination, and how is that revenue loss translating into operational decisions at health centers across the state right now?

Staff Recommendation:

Hold Open

Issue 6: H.R.1 Impact on Counties

This issue examines the cumulative impact of H.R. 1 on California's 58 counties, which serve as the front-line administrators of Medi-Cal, CalFresh, and other health and human services programs. This issue is informed by several companion publications from the Legislative Analyst's Office, including *The 2026-27 Budget: County Administration* and *H.R. 1 Implementation and Realignment and County Indigent Health Care Programs*.

County Responsibilities in Administering Medi-Cal and CalFresh

While Medi-Cal is overseen at the state level by the Department of Health Care Services and CalFresh is overseen by the Department of Social Services, counties are responsible for ground-level program administration across both programs. County welfare departments are the primary point of contact for low-income Californians seeking health coverage and food assistance: they process applications, conduct eligibility determinations, distribute notices, manage renewals, and ensure that only individuals who continue to meet eligibility requirements remain enrolled.

County administrative responsibility is particularly focused on eligibility determination, and assessing whether applicants meet program requirements related to income, age, disability status, citizenship or immigration status, and household structure. This workload is substantial: approximately 90 percent of CalFresh enrollees are also enrolled in Medi-Cal, meaning county workers frequently administer multiple programs for the same individual simultaneously. Eligibility determination and renewal processes are integrated across programs to the extent possible. For example, a single consolidated application can be used to apply for Medi-Cal, CalFresh, and CalWORKs at the same time.

How County Administration Is Funded

The costs of county administration are shared across federal, state, and county governments, with different cost-sharing arrangements for each program. For Medi-Cal, the federal government covers up to 75 percent of administrative costs, with the state covering the remainder and no county share. For CalFresh, costs are currently split 50 percent federal, 35 percent state, and 15 percent county, though H.R. 1 reduces the federal share to 25 percent beginning October 2026, shifting substantially more cost to the state and counties.

The state budget limits the amount of state funds available for county administration, and counties are generally required to operate within those appropriated amounts. However, counties may in some cases spend above state-budgeted amounts and draw down additional federal funds using county funds (a practice sometimes referred to as county "overmatch.")

The Governor's proposed 2026-27 budget maintains Medi-Cal county administration funding at the same level as 2024-25 and 2025-26, making no adjustment for H.R. 1 implementation workload. The administration has indicated it is working with counties to assess H.R. 1 impacts on Medi-Cal administration and that county administrative funding will be revisited at a later time.

The Governor's budget currently proposes \$2.4 billion (\$644 million General Fund) for Medi-Cal county administration and \$2.7 billion (\$1.3 billion General Fund) for CalFresh administration in 2026-27.

County Indigent Care: History and Current Landscape

The County Mandate

Counties have been legally required to provide basic health care services to low-income residents who have no other means of receiving care since the 1930s, under Welfare and Institutions Code Section 17000. This mandate applies to individuals based on lawful residence and economic need, and operates as a program of last resort, meaning other programs such as Medi-Cal must be pursued first as a condition of eligibility. Court decisions over the years have clarified that counties are required to provide only the basic care necessary to prevent serious harm, pain, or infection. This is a significantly lower standard than what Medi-Cal covers. Counties have broad discretion in setting income eligibility thresholds and the scope of benefits offered, and practices vary considerably across the state's 58 counties.

Pre-ACA History

Prior to the implementation of the Affordable Care Act in 2014, county indigent care programs served a large population: an estimated 850,000 Californians were enrolled in county indigent health programs statewide. The state provided some funding support for these programs in the 1980s. For larger counties, direct General Fund support was provided through the budget process. For smaller counties, the County Medical Services Program (CMSP), which still exists today, provided General Fund support to contract with the state to administer their indigent care programs.

1991 Realignment

In 1991, the Legislature enacted a major realignment package that shifted significant fiscal and programmatic responsibility for health and human services programs from the state to counties. As part of this realignment, the state eliminated most of its direct General Fund support for county indigent health care. In exchange, counties were given a new dedicated ongoing revenue stream, coming from a portion of state sales tax and vehicle license fee revenues. Those revenue streams are deposited into special funds to support their realigned responsibilities. These revenues are allocated to various subaccounts, and counties may only use funds in the

Health Subaccount (referred to as "health realignment revenues") for public health and indigent care responsibilities. The key feature of realignment revenues is that they grow with the economy over time but do not automatically adjust to meet increased program costs or demand.

AB 85 and the ACA Redirection

In 2013, anticipating the dramatic expansion of Medi-Cal eligibility under the ACA beginning in 2014, the Legislature enacted AB 85. The ACA expansion was expected to dramatically reduce demand for county indigent care, as most adults who had previously relied on county programs would become eligible for Medi-Cal. Based on that assumption, AB 85 redirected a portion of the health realignment revenues that counties had historically used for indigent care to offset state General Fund costs for CalWORKs grants. Additionally, AB 85 reduced the percentage of growth available to the health account.

The redirection has grown substantially over time. An analysis by the LAO shows that the gap between what counties would have received without the AB 85 redirection and what they actually receive has widened considerably, leaving counties with significantly less health realignment revenue than they had prior to 2013.

Following the ACA expansion, county indigent care enrollment fell dramatically, from an estimated 850,000 before the ACA to approximately 10,000 currently enrolled statewide. As demand declined, many counties broadened their eligibility requirements or expanded the scope of benefits offered, using available realignment resources for populations not covered by Medi-Cal. Some counties chose to serve individuals with unsatisfactory immigration status or provide specialty care beyond the minimum statutory requirement. However, the administrative infrastructure for operating large-scale indigent care programs was largely dismantled or left unused as it was no longer needed.

H.R.1 Creates New Structural Funding Issues

As noted above, realignment revenues used to support county health and human services responsibilities do not automatically increase when program costs or demand spike. They grow with the economy, not with program needs. It is anticipated that when H.R. 1 drives a large surge in demand for county indigent care, the realignment funding available to counties does not adjust to meet it.

This structural mismatch is compounded by the AB 85 redirection. The redirection was premised on the assumption that ACA expansion had permanently resolved the county indigent care problem. H.R. 1 fundamentally invalidates that assumption. As the LAO notes, the AB 85 redirection formula does not consider increases in costs to any extent, meaning counties cannot recapture redirected funds even when the demand that justified the redirection is reversed.

Counties rely on approximately \$1.2 billion in health realignment revenues in 2026-27 to fund both indigent care and public health services. These two responsibilities share the same Health Subaccount, meaning that any increase in indigent care spending comes directly at the expense of public health programs, creating a funding competition within the same funding pot.

Anticipated H.R. 1 Impacts on County Workload and Costs

H.R. 1 is anticipated to create significant new county costs and workload pressure, which together represent an unprecedented simultaneous challenge across multiple program areas:

- 1. Eligibility Workload.** H.R. 1 substantially increases the administrative burden on county eligibility workers through several overlapping provisions: The new Medi-Cal work and community engagement requirement (effective January 1, 2027) requires counties to determine which enrollees are subject to the requirement, which qualify for exemptions, and which must manually verify compliance. During its March 9th hearing, this subcommittee examined the workload associated with eligibility determination, with the Administration estimating that roughly 2.8 million individuals would require manual county case review. The new six-month redetermination requirement (also effective January 1, 2027) is also anticipated to double the frequency of Medi-Cal renewals for approximately 4.6 million childless adult enrollees, creating a corresponding doubling of renewal workload for county workers. Layer on top of those changes are also the expanded CalFresh work requirement (effective June 2026) which similarly increases county workload around exemption assessment, compliance tracking, and discontinuance processing for CalFresh enrollees. Many of the same individuals are subject to both the Medi-Cal and CalFresh work requirements simultaneously, and county workers administer both programs, meaning the workload is anticipated to compound.
- 2. County Indigent Care Programs.** The LAO estimates that by 2030, nearly 2 million individuals could be disenrolled from Medi-Cal as a result of H.R. 1's eligibility changes, effectively doubling the number of uninsured Californians. The LAO estimates that between 20 and 50 percent of those individuals, or roughly 400,000 to 1 million people, may seek care through county indigent care programs.
- 3. County Behavioral Health.** In addition to Medi-Cal specialty mental health services and substance use disorder services, counties provide behavioral health coverage to other individuals. County stakeholders note that demand for these services is likely to increase as individuals lose eligibility for Medi-Cal.
- 4. County Public Hospital Systems.** Discussed in a separate issue in this hearing, H.R.1 is anticipated to reduce the ability of states to leverage state directed payments, which will significantly reduce public hospital system revenues.

Related Committee Member Budget Requests:

The subcommittee is reviewing a budget request to provide counties with the necessary funding for the eligibility workforce to support Medi-Cal beneficiaries navigating H.R. 1 new eligibility policies. The request also requests the reinstatement of counties’ annual Medi-Cal eligibility inflationary adjustment (based on CA Consumer Price Index), which has been frozen in previous budget acts (Schiavo).

The breakdown of the requested resources is as follows:

	FY 2026-27	FY 2027-28
HR1 Eligibility Resources	\$230,900,699.05	\$304,668,843.27
Medi-Cal Cola Restoration	\$39,233,782.50	\$39,233,782.50
Total General Fund Request	\$270,134,481.55	\$343,902,625.77
Total Funds w/ federal match funding	\$ 1,002,070,361.18	\$ 1,297,142,938.10

Panel

- Mimi Hall, County Supervisor, Plumas County
- Timothy Lutz, Director, Sacramento County Department of Health Services
- Scott DeMoss, County Administrative Officer, Glenn County and Chair, County Medical Services Program
- Devin Drake, Director, Department of Social Services, County of San Luis Obispo
- Christal Porras, Social Services Benefit Specialist, County of Santa Clara
- Department of Health Care Services
- Min Lee, Economist, Legislative Analyst’s Office
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst’s Office
- Andrew Huitt, Finance Budget Analyst, Department of Finance

Staff Comments

No Additional Resources for Counties in the Governor’s Budget. The Governor’s proposed 2026-27 budget maintains Medi-Cal county administration funding at the same level as prior fiscal years, making no adjustment for the significant eligibility workload imposed under H.R. 1. The administration has indicated that county administrative funding will be revisited at a later time, likely May Revision. Staff notes that several H.R. 1 implementation deadlines are approaching quickly, including the expanded CalFresh work requirement taking effect June 2026, and the Medi-Cal work requirement and six-month redetermination requirement taking effect January 1, 2027. This provides a compressed timeline for counties to adjust their fiscal

projections and hire, train, and deploy county eligibility workers to assist beneficiaries with the new federal requirements.

Realignment and AB 85 Redirections Create New Structural Funding Issues for Counties.

As noted earlier, AB 85 redirection was premised on the Affordable Care Act expansion which had significantly reduced county indigent care demand in the last decade. This made a portion of health realignment revenues available for redirection to CalWORKs. While that assumption was reasonable in 2013, H.R. 1 invalidates it entirely. With the anticipated coverage losses under H.R.1, from both Medi-Cal and Covered California, the state may potentially see a return of county indigent care demand. However, the AB 85 redirection formula does not automatically reverse if demand increases, and counties cannot recapture redirected funds regardless of what happens to their indigent care caseload. Counties are still legally required under WIC Section 17000 to provide basic health care to medically indigent adults, but the primary funding source historically used to meet that obligation has been partially redirected.

The Subcommittee may wish to ask:

- 1- The Governor's budget makes no adjustment to Medi-Cal county administration funding for H.R. 1 implementation, deferring that decision to a later date. Given that the CalFresh work requirement takes effect in June and the Medi-Cal work requirement takes effect January 2027, are counties already making staffing decisions based on anticipated need, and if so, without state resources to support those decisions, what is happening on the ground right now?
- 2- Can counties describe for the Subcommittee what county indigent care infrastructure looks like today? How many individuals are currently served, what the benefit structure looks like, and what it would take to rebuild the capacity that was unused or dismantled after the ACA expansion?
- 3- If indigent care demand surges under H.R. 1, what options do counties have to absorb those costs within existing realignment revenues? Is new state funding the only viable path?
- 4- Rural counties served by CMSP often have limited or no alternative providers beyond the county indigent care system. If CMSP cannot absorb new demand under H.R. 1, what happens to individuals in those communities who lose Medi-Cal and cannot access care through any other source?
- 5- For county eligibility workers assisting Medi-Cal and CalFresh beneficiaries, can you describe for the Subcommittee what current daily workload looks like (how many cases are being managed, how much time is available to spend with each individual, and whether there is have adequate time to ensure that eligible individuals are not being

disenrolled due to paperwork failures or administrative errors)? When H.R.1 provisions take effect, what are is the daily workload anticipated to look like?

- 6- Given that the 1991 health realignment funds both indigent care and public health, what will the impact be to public health should no resources be provided for indigent care?

Staff Recommendation:

Hold Open

Issue 7: Medi-Cal Dental & Proposition 56 Supplemental Payments

This issue examines the scheduled elimination of supplemental payments to dental providers in the Medi-Cal program, originally funded through Proposition 56 revenues.

Background on Proposition 56

Proposition 56, passed by California voters in November 2016, increased state taxes on tobacco products and dedicated the majority of the resulting revenues to Medi-Cal. The measure directed funding toward improving provider reimbursement rates to ensure timely access to care, limit geographic shortages of services, and ensure quality care for Medi-Cal beneficiaries. Medi-Cal began receiving Proposition 56 funding in 2017-18. Proposition 56 was a direct response to longstanding concerns about the adequacy of Medi-Cal provider reimbursement rates, which had not kept pace with the cost of providing care and had contributed to chronic provider participation shortages across multiple specialties.

How Proposition 56 Funding Has Been Used

In 2017-18, the Legislature and the administration reached an initial agreement on how to deploy Proposition 56 revenues in Medi-Cal. The agreement structured some Proposition 56 revenues as supplemental payments increases -- payments on top of existing base provider rates rather than increases to the base rates themselves. This structure created flexibility, as they are easier to reduce or eliminate if revenues decline or budget conditions deteriorate, unlike base rate increases which are more difficult to reverse.

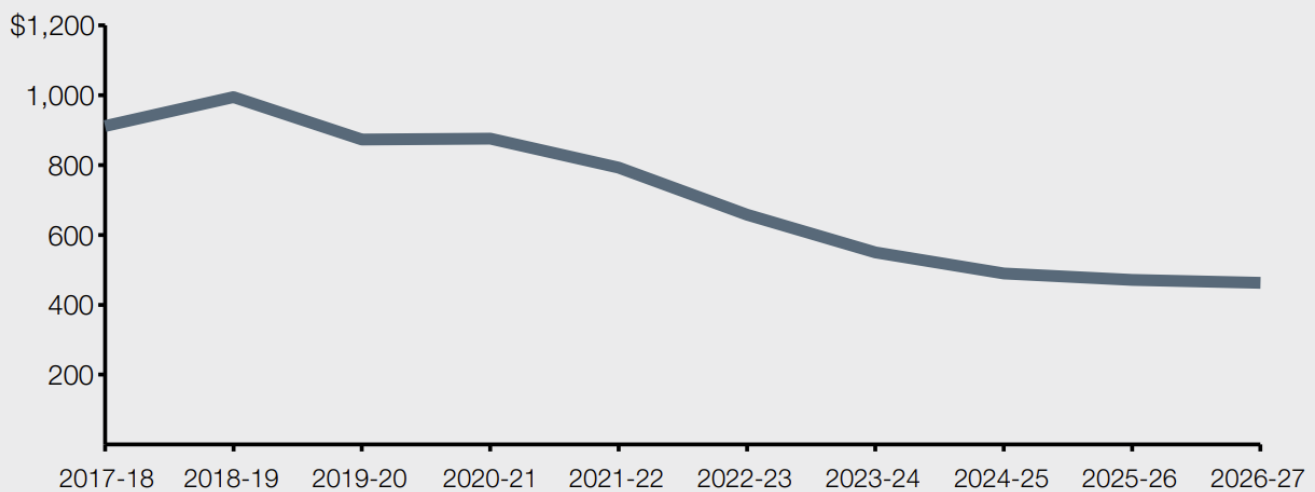
Proposition 56 revenues were used to fund supplemental payment increases across multiple provider types, including physicians, dentists, family planning providers, and women's health providers. For dental providers specifically, Proposition 56 supplemental payments represented a significant augmentation to base Medi-Cal dental reimbursement rates. According to the California Dental Association, Medi-Cal dental base rates had not been meaningfully increased for dentists since the 1990s, and Proposition 56 supplemental payments are fundamental to the viability of Medi-Cal dental participation for providers.

Decline in Proposition 56 Revenues and General Fund Backfill

Proposition 56 revenues have declined on a sustained, ongoing basis since the measure took effect. This decline is a direct consequence of the measure's own design: the tobacco tax increase that generates Proposition 56 revenues also reduces tobacco consumption over time, meaning the revenue base shrinks as the public health goal is achieved. As the LAO notes, this creates a structural budgetary challenge: Proposition 56 revenues have declined steadily year over year while Medi-Cal spending has increased over time.

Proposition 56 (2016) Annual Revenue Allocations to Medi-Cal Have Declined

(In Millions)



Note: Amounts for 2017-18 through 2023-24 are actuals. Amounts for 2024-25 and 2025-26 are estimated. The amount for 2026-27 is proposed.



By fiscal year 2022-23, Proposition 56 revenues were no longer sufficient to cover the full cost of the supplemental payments that had been established in prior budget agreements. Facing a choice between reducing supplemental payments or maintaining them with alternative funds, the state chose to backfill the shortfall with General Fund dollars. This decision had the practical effect of converting what had been intended as a tobacco-tax-funded augmentation into an ongoing General Fund obligation.

The administration estimates that Proposition 56 revenues in Medi-Cal are \$470 million in 2025-26 and \$462 million in 2026-27. The Department of Health Care Services states that all Proposition 56 revenues in 2025-26 and 2026-27 would be allocated to physician services base rate increases, and that any funding for supplemental payments in family planning and women’s health would come from the General Fund.

The State's Decision to Eliminate Dental Supplemental Payments

Facing a significant structural budget deficit, the Governor's 2025 May Revision proposed eliminating supplemental payments for dental services, family planning, and women's health, all originally established as part of earlier Proposition 56 spending plans. The final 2025-26 budget

agreement eliminated dental supplemental payments beginning July 1, 2026, but preserved supplemental payments for family planning and women's health.

The elimination of dental supplemental payments is estimated to generate approximately \$311 million in General Fund savings annually which, when combined with the loss of federal matching funds that would have been drawn down alongside the state payments, represents a total reduction of approximately \$828 million in payments to Medi-Cal dental providers annually.

Of note, the elimination of dental supplemental payments in Medi-Cal is contingent on federal approval under the Ensuring Access to Medicaid Services Final Rule, which requires states to demonstrate that access to services will remain sufficient after reducing provider rates. DHCS must post a public notice of its proposed submission by June 2026 and submit its final request to CMS by September 2026. If CMS determines California has not demonstrated sufficient access will be maintained, DHCS would be required to conduct a more extensive analysis before the elimination could take effect.

According to the Administration, DHCS is currently working on the various components required by the federal rules for submission to CMS.

Anticipated Impact on Provider Participation and Patient Access

The California Dental Association and dental providers serving Medi-Cal patients have raised significant concerns about the impact of eliminating dental supplemental payments. The association notes that the elimination would roll Medi-Cal dental reimbursement rates back to levels not seen since the 1990s, and would negatively impact provider participation in the Medi-Cal dental program.

In a survey conducted by the California Dental Association, nearly 50 percent of Medi-Cal dental providers who responded indicated they would leave the Medi-Cal dental program entirely if the planned cuts take effect, and an additional 30 percent indicated they would need to reduce the number of Medi-Cal patients they see.

Stakeholders have also highlighted the downstream cost implications of reduced dental access. When adult dental coverage was eliminated in 2009, advocates note that emergency dental visits by Medi-Cal patients increased by 32 percent. In addition, stakeholders point to recent data from HCAI showing that Medi-Cal paid for 63.5 percent of emergency department visits related to dental care in 2023. A reduction in access to routine and preventive dental care is likely to shift patients toward emergency settings.

Panel

- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst's Office
- Will Owens, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- Laura Marcus, Chief Executive Officer, Dientes Community Dental
- Jon E. Hollister, DDS, President, Tolosa Children's Dental Center
- Department of Health Care Services
- Isabella Alioto, Staff Finance Budget Analyst, Department of Finance

Staff Comments**Proposition 56 Dental Supplemental Payments Have Become a General Fund Obligation.**

When Proposition 56 supplemental payments for dental services were established in 2017-18, they were intended to be funded by tobacco tax revenues -- a dedicated, voter-approved revenue stream. Now, as Proposition 56 revenues have declined steadily year over year, the state has backfilled the shortfall with General Fund dollars. All remaining Proposition 56 revenues are currently directed entirely toward physician services base rate increases. This means that dental supplemental payments are today effectively funded entirely from the General Fund, with no Proposition 56 revenue supporting them.

Central to this issue is therefore not whether to protect a tobacco tax investment. It is whether to continue or eliminate a General Fund obligation of approximately \$300 million so support supplemental payments to dental providers serving Medi-Cal patients. It is also important to note that any General Fund investment is eligible to draw down significant federal matching funds. The Subcommittee may wish to weigh whether the General Fund savings are worth the total reduction in provider revenue.

The Subcommittee may wish to ask:

- 1- The elimination of dental supplemental payments is contingent on federal approval under the Ensuring Access to Medicaid Services Final Rule. Can DHCS provide a status update on its access analysis? Specifically, what methodology is being used to assess whether access will remain sufficient, and will that analysis include direct surveys of Medi-Cal dental providers to assess their likelihood of continued participation if the rate reduction takes effect?
- 2- The California Dental Association survey found that nearly 50 percent of responding Medi-Cal dental providers would leave the program entirely if the cuts take effect. Does DHCS believe that level of provider attrition is consistent with a finding that access will remain sufficient?

- 3- Can dental providers describe what attrition would look like on the ground? For example, which geographies and patient populations would be most immediately affected, and are there communities where Medi-Cal dental access would effectively disappear?

- 4- According to CDA, Medi-Cal dental base rates have not been meaningfully increased since the 1990s, and Proposition 56 supplemental payments represent the primary augmentation to those rates over the past decade. If the supplemental payments are eliminated and rates effectively return to 1990s levels, what does that mean for the economics and financing of operating a Medi-Cal dental practice?

Staff Recommendation:

Hold Open

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