Health Services
LOS ANGELES COUNTY

April 7, 2026

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell, Chair Pro Tem
Supervisor Lindsey P. Horvath
Supervisor Janice K. Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES' (DHS) FISCAL OUTLOOK**

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"To advance the health of our patients and our communities by providing extraordinary care"

This report provides an updated fiscal forecast for the Department of Health Services (DHS) covering Fiscal Years (FY) 2025-26 through 2028-29. For FY 2025-26, DHS projects an operating deficit of $257 million, for which we intend to use existing fund balance. Attachments I-A through I-D contain detailed projections for the Department's major operational and financial areas, which are summarized in the following sections.

INTRODUCTION

The Department's fiscal outlook remains challenging to project due to significant uncertainties at both the federal and state levels. Federally, H.R. 1 (the "big bill") enacted extensive changes to the Medicaid program, including major eligibility revisions and reductions in federal Medicaid funding. In addition, the Centers for Medicare & Medicaid Services (CMS) has several pending regulations that could materially affect key components of Medicaid financing. These issues are discussed in greater detail throughout this report.

At the state level, California is also facing significant budget uncertainty. The State has already implemented an enrollment freeze for the state-only Medi-Cal program for certain adult populations beginning in January 2026. Additionally, a new Governor will take office in January 2027, and a change in administration may result in further modifications to the Medi-Cal program.

The combined effect of these federal and state variables significantly complicates DHS' ability to produce reliable long-term fiscal projections. Given this environment, DHS has taken significant steps to incorporate all known factors and adopt the most conservative assumptions regarding the potential magnitude of adverse fiscal impacts on the Department's budget.

As it did in FY 2024-25, DHS anticipates that it will continue to experience shortfalls in FY 2025-26 and beyond, and that it will be necessary to rely on fund balance to address operating deficits. Historically, the Department has worked to limit the use of fund balance. These efforts were intended to ensure that sufficient reserves would be available during periods of fiscal stress. Using fund balance as bridge funding will provide DHS with the time needed to design and implement financial and clinical delivery systems that align with current regulations, program requirements, and fiscal realities.

FY 2025-26 FORECAST

In DHS' September 30, 2025 Fiscal Outlook, we outlined several major changes to the Medicaid program resulting from H.R. 1, including revised eligibility requirements and reductions in federal funding. At that time, we also anticipated the release of new federal regulations affecting multiple components of Medicaid financing and assumed these regulations would be issued in the near term. Based on that expectation, DHS projected a deficit of $410 million for FY 2025-26.

Although the federal regulations have not yet been released, we continue to expect their issuance soon. In the interim, the Medicaid program has continued to operate under existing rules. This status quo environment, combined with DHS' internal efforts to manage costs and optimize revenue, offset by negative impacts, e.g., decline in Medi-Cal enrollment, contributes to a reduction in the projected FY 2025-26 deficit from $410 million to $257 million.

MAJOR CUTS & UNCERTAINTY OVER THE NEXT FEW YEARS

Changes in the Medi-Cal program are already impacting DHS' Medi-Cal revenues, and it is projected that upcoming actions will further decrease revenues. The known changes are summarized below under their respective effective dates (a graphic timeframe is provided in Attachment II).

July 2025

Temporary federal waivers of COVID-era Medicaid flexibilities, including eligibility requirements, renewal processes, and verification policies expired. As shown in the table below, this has resulted in decreases in the overall numbers of DHS Medi-Cal assigned lives. The projected annual fiscal impact is a decrease of $65 million per 10% reduction in assigned lives. The downward trend is expected to continue going forward.

	ASSIGNED LIVES		VARIANCE	% CHANGE
	July 2025	January 2026		
DHS Assigned Medi-Cal Members	357,684	321,578	(36,106)	(10.1%)
Total LA County Medi-Cal Members	3,577,261	3,395,657	(181,604)	(5.1%)

In addition to declining numbers of assigned lives, DHS expects corresponding increases in the number of uninsured seeking care within DHS facilities, a factor that will put additional financial pressure on the Department.

January 1, 2026

California froze new enrollments in the state-only Medi-Cal expansion program for adults (19+ years) with Unsatisfactory Immigration Status (UIS). Since the freeze was initiated, DHS experienced a 2.5% decrease in enrollment in January 2026 and preliminary data shows a further decline of 3.5% in February 2026. Since this is only two months of information, additional data will be necessary to determine a trend factor.

October 2026

As required by H.R. 1, Federal Medical Assistance Percentage (FMAP) for limited scope UIS Medicaid Coverage Expansion (MCE) patients will be reduced from 90% to 50% for emergency services. This reduction in FMAP shifts costs from the federal government to states and local governments. The FMAP reduction applies only to emergency services. DHS is estimating a revenue decrease of $40 million for FY 2026-27 and $55 million annually going forward.

January 1, 2027

1115 Waiver: Based on our current understanding, the California Department of Health Care Services (DHCS) plans to submit an 1115 Waiver renewal request in April 2026 and is expecting CMS to provide its initial comments on the renewal request sometime in the summer of this year. DHS will most likely not know CMS' decision until late this Calendar Year. Unless CMS approves the Global Payment Program (GPP) component of the 1115 Waiver, GPP will expire and the funding transitions back to Disproportionate Share Hospital (DSH) funding. DSH funding is indicated for hospitals who serve a large number of Medi-Cal and uninsured patients. Under this scenario, the use of DSH funds would again be limited to hospital-based services only. Transitioning from GPP to DSH will have a negative impact on DHS' bottom line as costs for individuals without insurance seen in the Ambulatory Care Network will no longer be eligible for reimbursement. DHS is modeling multiple scenarios about how best to minimize the losses of this potential transition. DHS is also working closely with the State to advocate for continuation of GPP.

Medicaid Work Requirements for MCE: As required by H.R. 1, all MCE states must begin imposing the new "community engagement" requirements as a condition of eligibility for non-pregnant adults ages 19–64, with certain exemptions. In general, this provision requires MCE enrollees to perform 80 hours of work, community service, or education per month, otherwise their Medicaid coverage will be terminated. States can request the Secretary of Health and Human Services to delay implementation until December 31, 2028, provided they demonstrate a "good faith" effort to comply.

Medicaid Eligibility Redeterminations: As required by H.R. 1, states must begin conducting eligibility redeterminations for MCE expansion adults every six months. California's Medi-Cal program currently conducts yearly redeterminations. Requiring a 6-month redetermination period will increase administrative burden and result in increased loss of coverage for many people who may still be Medi-Cal-eligible but have not completed the renewal process. The implementation of Medicaid work requirements and redeterminations being conducted every six months is projected to result in over 700,000 individuals in LA county losing Medi-Cal coverage.

Single Payment Methodology for Managed Care: As newly required by CMS, state directed payments must be incorporated directly into Medicaid managed care base capitation rates. This new requirement will impact two major revenue streams: Enhanced Payment Program (EPP) and Quality Incentive Program (QIP). Currently, DHS receives EPP and QIP payments in a lump sum, after a full year's data is collected. Requiring these payments to be incorporated into the base capitation rates introduces uncertainty and revenue risk, as data points will be based on estimates and may fluctuate year to year. This introduces another significant element of instability into our budget; at best, we will maintain these revenue streams, or they may decline.

Changes to Emergency Services Payment for UIS Population: As newly required by CMS, federal payment will be eliminated for emergency services for UIS patients enrolled in managed care. Although these patients will still receive coverage for emergency services, they will lose more cost-effective managed care coordination and follow-up services. California will need to choose between absorbing costs to maintain coverage, shifting these patients to fee-for-service for compensation, or pursuing legal action. DHS is unable to determine the impact of these changes at this time.

July 1, 2027

As required in the Governor's 25-26 budget, state-only full scope Medi-Cal enrollees ages 19–59 who are not pregnant and undocumented must pay a $30 monthly premium to keep their Medi-Cal coverage. It is expected that an undetermined number of current Medi-Cal patients will not continue their coverage and will become uninsured.

October 2027

On February 3, 2026, Congress passed H.R. 7148, delaying the DSH cuts for two years and leaving one final year of DSH cuts scheduled to take effect on October 1, 2027. Since Congress has repeatedly eliminated the cuts over the past 10 years, DHS' forecast assumes that the DSH cuts will continue to be halted. There are no further DSH cuts currently in legislation after this last and final year.

J**anuary 1, 2028**

As required by H.R. 1, State Directed Payments (SDPs) will be reduced by 10% annually until payments reach 100% of Medicare rates. These are supplemental payments provided to designated public hospitals, e.g., DHS, through managed care plans. Two of

DHS' major revenue streams are SDPs, specifically the EPP and QIP programs. These reductions are incorporated into DHS' forecast.

LATEST CRITICAL DEVELOPMENTS

In addition to the challenges noted above, on February 27, 2026, CMS issued a Request for Information which solicits stakeholder feedback on proposed considerations that might be included in a potential "Comprehensive Regulations to Uncover Suspicious Healthcare" (CRUSH) rule. CRUSH is focused on determining ways to improve the identification of "fraud, waste, and abuse" in the Medicaid program and targets numerous areas for significant revision. The targeted areas include:

- Financing of the non-federal share, including intergovernmental transfers (IGT)
- Differential payments for public and private providers
- Supplemental payments, e.g., disproportionate share hospital (DSH) and state-directed payments (e.g., EPP and QIP)
- 1915 Waiver programs and 1115 Waiver demonstrations
- Services provided to individuals without satisfactory immigration status
- Services that CMS identifies as having high risk for fraud:
  - housing stabilization services
  - behavioral health services
  - personal care assistance services (IHSS in California)
  - non-emergency medical transportation

Also, on March 2, 2026, the Office of Management and Budget (OMB) posted notice that a proposed CMS rule for its review had been received. The rule is titled "Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments". However, beyond the title itself, we do not know what the rule will be since the text of the CMS rule is unavailable to the public while under OMB review. DHS will provide further information with respect to these two federal actions as it becomes available.

COST EFFICIENCIES

A critical challenge is the continued escalation of costs driven by rising labor expenses, medical inflation affecting pharmaceuticals and supplies, and the ongoing need for capital projects and facility investments. To address these pressures, DHS has implemented targeted cost efficiency measures to lessen the impact and reduce reliance on fund balance. In FY 2025–26, DHS implemented expenditure targets for each facility, supported by monthly reporting and biweekly deep-dive analyses with the Executive Leadership Team. To date, DHS is successfully managing its fiscal year expenditure targets, with a projected $30 million surplus above the departmentwide savings goal of $200 million. While a comprehensive list of cost-savings initiatives is beyond the scope of this report, several of the cost-saving activities contributing to this success are outlined below.

Hiring Freeze

Due to rising costs and federal revenue cuts, DHS implemented a hiring freeze effective July 18, 2025. DHS had already been taking action to reduce costs wherever possible, including limiting hiring on management positions, among other steps. By implementing a hiring freeze, DHS' goal is to minimize the impact of future reductions to patients and workforce members. The hiring freeze applies to DHS' four hospitals (LA General, Harbor, Olive View, Rancho), the Ambulatory Care Network, and Health Services Administration. No classification is deemed exempt from the hiring freeze; instead, any position deemed essential for hire needs to be approved by executive leadership to be hired on during the freeze.

Nursing Registry Reduction

Registry utilization across our hospitals and ambulatory care network for FY 2025–26 is projected to be $65 million, representing a 54% reduction compared to FY 2024–25 and demonstrating substantial progress in reducing reliance on premium contract labor. This improvement is largely driven by targeted recruitment efforts, the onboarding of nurses completing their residency programs, stronger oversight of registry use, and more effective workforce planning supported by the Acuity, Scheduling and Time Employee Resource (ASTER) tool.

Overtime Reduction

The Department implemented new controls on overtime and saw a large decline in overtime expenses as a result. Nursing overtime expenses are projected to total nearly $45 million in FY 2025-26, a 32% decrease from FY 2024–25, reflecting improved staffing stability and optimized scheduling practices through the ASTER scheduling platform. Significant overtime reductions have also been seen in other classifications beyond nursing, including physicians, laboratory, and administrative personnel.

	Savings in FY 2025-26	% Reduction from FY 2024-25
Nursing	$21.3M	32%
Administrative Personnel	$10.5M	47%
Physicians	$5.1M	19%
Laboratory	$1.4M	35%

Information Technology (IT)

DHS has achieved more than $10 million in savings through strategic cost reduction efforts across three major areas of IT expenditure. Approximately $2.85 million was saved by eliminating obsolete IT services and contracts that no longer aligned with business needs. An additional $2.0 million in savings was realized through vendor renegotiations, optimization of service levels, and securing discounted pricing during contract renewals. DHS IT also avoided $5.2 million in costs by implementing innovative

solutions, including upgrading hard drives for 6,000 PCs rather than purchasing new equipment outright.

Utilization Management

In 2025, the DHS Utilization Management (UM) division helped reduce costs and improve care coordination by bringing more patients and services back into the DHS network. UM transitioned 227 County (capitated or responsible) patients who had been receiving emergency or inpatient care at non-DHS hospitals back to DHS, saving an estimated $3.6 million. UM also reviewed requests for specialty care outside the DHS network. Of those requests, 263 were redirected back to DHS providers, generating an additional estimated $1.5 million in savings. Together, these efforts improved coordination of care while reducing costs.

Efforts to decrease ever increasing pharmaceutical costs are ongoing. Examples include aligning eligibility criteria for GLP-1 therapies with the approved State Medi-Cal Rx criteria and utilizing specialty pharmacies for physician administered drug costs. Multiple initiatives are also ongoing to reduce laboratory costs. Examples include renegotiating laboratory contracts, equipment, and supplies; improving appropriate utilization of high-cost tests; and decreasing the cost of lab test send outs.

Service Efficiency and Productivity

Each DHS facility has taken steps to enhance service efficiency and optimize use of resources, seeking to better match staffing with patient volumes.

Examples across the system:

- Redirecting infusion drugs to specialty pharmacies, complemented by reductions in ordering of inpatient albumin and other high-cost medications
- Curbing unnecessary lab testing and durable medical equipment use, including wound vacs
- Strengthening financial stewardship to drive medical supply expenditure reductions across high-cost clinical categories via standardization, improved vendor negotiations, and reductions in price index variation
- Implementing an in-house inventory management system to reduce unnecessary supply requests and minimize expired products
- Restructuring provider staffing to support expansion of beds, without additional hires
- Reassigning staff across clinics, reducing hours in select urgent care centers, and scaling back contracted physicians to minimize new hires and lower overtime, registry, and supply costs
- Streamlining operations via consolidation of nine call centers into a single system, without increasing staffing
- Updating rates for registry and specialty contracts to align with fair market value

To date, there have been no changes in service levels. All cost savings initiatives have maintained patient care.

ADDITIONAL AREAS OF FOCUS

In addition to the focus on cost-containment, DHS is pursuing other actions that are anticipated to help better align DHS' ongoing costs with ongoing revenue.

Pursuit of 340b Drug Pricing

Currently, only DHS' hospitals are able to access discounted drug pricing available through the federal 340b program. DHS is in the process of pursuing various options that would secure drugs for a greater share of DHS patients at 340b pricing. As one step, DHS is looking to seek FQHC status for its outpatient clinics, an action that would offer 340b status. Such applications will require federal exceptions/waivers due to the requirement that FQHC's be governed by a board comprised at least 51% of patients/community members.

Patient Accounting

Over the past year, we have restructured our workflows with Utilization Management to improve quality control within the revenue cycle. This new process has allowed us to reduce denials with no authorization. We have also observed improvements in the time it takes to submit bills for payment, from 45 days to 10 days.

Two Request for Proposals (RFP) were released related to DHS' patient accounting system. The first is for consulting services to assist with the implementation and change management workstreams of a new revenue cycle system to replace Affinity RCO and is in the final stages of negotiations. The second RFP is to resolicit our billing and insurance collections, a role currently outsourced to Sutherland. We are in the review and scoring phase and expect to have the top proposers identified in March.

The new revenue cycle system will link to DHS' electronic health record and provide more comprehensive patient-specific data, thereby allowing DHS to migrate from all-inclusive billing to itemized billing and separating institutional (hospital) billing and professional billing (physicians). The ability to itemize bills is expected to greatly improve our third-party billing which in turn will increase third-party revenues.

At this time, as noted above, there is a high level of fiscal uncertainty for DHS caused by federal and state actions. In this current unsettled environment, DHS is exploring what other potential alternatives may be available and assessing their capabilities and cost-effectiveness. It is vital that DHS' approach to acquiring and implementing the replacement of the patient accounting system is feasible and, most importantly, cost-effective. DHS expects many of the pending issues described in this report to be resolved by the end of this calendar year. Once these issues are resolved, we will reassess our fiscal position and recommend the most cost-effective proposal for the Board's approval.

Incentive Band

In 2017, CMS finalized a Medi-Cal Managed Care rule allowing states to pay managed care plans up to 5% above the actuarially sound rate to support targeted quality improvement initiatives. These funds are earned and paid to plans, which are then expected to pass them on to providers—particularly when provider activities are central to meeting the required performance metrics. DHS is working with DHCS and other public hospital systems to develop a proposal for January 2027 that would allow key providers to receive funding when they successfully advance plan initiatives. However, several critical challenges must be addressed before such a proposal can move forward.

Sales Tax

Los Angeles County voters will decide in June 2026 whether to approve a temporary half-of-a-percent (0.5%) general sales tax under a measure advanced by the Board of Supervisors, which will help mitigate severe federal cuts enacted by the President and Congress that would otherwise cause loss of essential healthcare services being provided to County residents. This would reduce the risk of closing County's public hospitals and/or clinics and prevent significant healthcare provider layoffs and other service cuts. The proposal—known as the Essential Services Restoration Act—would enact the general tax for a five-year period, through October 1, 2031. It is projected to generate approximately $1 billion annually, and the Board of Supervisors will need to adopt a spending plan to allocate these general tax revenues.

Request to State to Fund Non-Federal Share

Since 2005, California has not funded the non-federal share for inpatient fee-for-service patients across the state's 17 public hospital systems, even though it has maintained such payments for private hospitals. DHS, in collaboration with the other public hospital systems, is requesting that the State's FY 2026-27 budget include a $500 million appropriation to fund the non-federal share of Medi-Cal fee-for-service inpatient payments. If successful, this one-time proposal would benefit DHS by approximately $100 million.

Contracts for Services

In the upcoming year, DHS will pursue additional contracting opportunities to expand payer revenue streams and diversify its lines of business. These efforts will enable DHS to optimize productivity and maximize capacity within existing resources. Several service lines with excess capacity—such as OB—have been identified as strong candidates for referral arrangements with Independent Physician Associations and health plans. DHS plans to enter into new contracts, reimagine existing programs, and renegotiate current agreements to reduce costs and increase payment rates. Leveraging Board-delegated authority, DHS will also establish a streamlined framework that empowers facilities to enter into short-term arrangements and conduct the necessary analyses to support new contract development.

IHSS

IHSS Homecare Workers Health Care Plan is a commercial line of business contracted with the Personal Assistance Services Council (PASC) and operated by L.A. Care. As of February 2026, there were 52,436 enrolled members, with DHS serving approximately 88%. Historically, DHS' costs exceeded capitation revenue due to stagnant rates. Effective October 1, 2025, rates were increased by 56%. Nevertheless, DHS is still projecting losses for CY 2026 of $52.7 million, driven primarily by out-of-network utilization.

There are specific rules that govern how the IHSS health care plan rates can be increased that interplay with IHSS provider wage increases. DHS is concerned there is limited ability to secure rate increases in the future and DHS will need to explore other options to make the plan cost effective. DHS will need to work with the County, L.A. Care, and PASC to assess and implement options to maintain annual program costs, that grow each year based on medical cost inflation, within existing revenue. DHS has also been surveying other counties Statewide to see how their programs are operated. A preliminary list of options for evaluation include limiting eligibility for health benefits, reducing benefit scope, and/or increasing premiums and cost-sharing. More analysis is needed to determine the best path forward and DHS will provide updates in future briefings.

CORRECTIONAL HEALTH SERVICES (CHS)

While DHS manages CHS operations, CHS is primarily funded with net County cost. DHS requests additional funding for CHS, as needed, through the County's budget process. For FY's 2025-26 through 2027–28, based on FY 2024-25 expenditure levels, one-time funds of $18.7 million per year have been committed by the Chief Executive Office (CEO) to mitigate CHS' deficit. Additionally, another $8.2 million per year has been allocated for FY 2025-26 through 2028-29 to support its operations. Altogether, these one-time funds have helped balance CHS' budget. DHS will continue to work with the CEO and the Sheriff's Department to address Department of Justice (DOJ)-related operational and staffing issues, and will discuss any supplemental funding needs with the CEO should additional funding be necessary to comply with the DOJ consent decree.

COMMUNITY PROGRAMS (CP)

Community Programs was previously comprised of two units: Housing for Health (HFH) and Office of Diversion and Reentry (ODR). Effective January 1, 2026, HFH was transferred to the County's newly created Department of Homeless Services and Housing, while ODR remains in DHS.

ODR estimates that its ability to remove individuals with serious mental illness from County jails, through mental health diversion in the ODR Housing program, will plateau at approximately 70 per month starting in July 2026, when currently budgeted ODR Housing slots are predicted to be filled. ODR's work in removing individuals who need subacute (P3) and acute (P4) levels of care in the jails is critical for compliance with DOJ

mandates and to support MCJ Closure. ODR will continue to work with the CEO DOJ Compliance team to evaluate the need for additional beds in the future.

CONCLUSION

For the patients we serve, losing Medi-Cal doesn't mean they stop getting sick — it means losing access to care. Health Services will still be here, but with over 600,000 more uninsured patients in LA County alone, the strain will be felt across our health system and across every emergency room in Los Angeles County. The combined impact of H.R. 1 and a potential non-renewal of the federal waiver will result in the loss of over $700 million annually for Health Services by FY 2027–28. This loss is far beyond what can be addressed through standard cost reductions, efficiencies, and revenue optimization strategies. Without substantial new revenue sources, Health Services will have no alternative but to consider planning for service curtailments — including possible facility closures and staff layoffs — beginning in early 2027.

If you have any questions or need additional information, please let me know, or you may contact Allan Wecker, Chief Financial Officer, at (626) 525-6279.

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Attachments (5)

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT I-A

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
FISCAL FORECAST
FISCAL YEARS 2025-26 THROUGH 2028-29
($ IN MILLIONS)

		A						
		DHS (Excluding Community Programs and Correctional Health Services)						
		Year 1		Year 2		Year 3		Year 4
		A	B	C	D	E	F	G
		FY 2025-26 FORECAST	Adjustments	FY 2026-27 FORECAST	Adjustments	FY 2027-28 FORECAST	Adjustments	FY 2028-29 FORECAST
(1)	**Expenses**							
(2)	Salaries & Employee Benefits	$ 4,182.298	$ 48.562	$ 4,230.860	$ 188.556	$ 4,419.416	$ 209.706	$ 4,629.122
(3)	Net Services & Supplies	2,566.141	84.617	2,650.758	104.777	2,755.535	108.637	2,864.172
(4)	Debt Service - Harbor Master Plan	71.325	(0.001)	71.324	(0.002)	71.322	-	71.322
(5)	Debt Service - Other	79.190	(8.155)	71.035	(0.417)	70.618	(0.449)	70.169
(6)	Other Charges	1,493.804	(220.383)	1,273.421	(26.106)	1,247.315	3.303	1,250.618
(7)	Capital Assets	34.058	-	34.058	-	34.058	-	34.058
(8)	Capital Projects & Deferred Maintenance	48.838	(13.282)	35.556	-	35.556	-	35.556
(9)	Intrafund Transfer	(163.200)	(5.712)	(168.912)	(5.912)	(174.824)	(6.119)	(180.943)
(10)	**Total Expenses**	$ 8,312.454	$ (114.354)	$ 8,198.100	$ 260.896	$ 8,458.996	$ 315.078	$ 8,774.074
(11)	**Revenues**							
(12)	Managed Care	1,310.131	(348.579)	961.552	(62.090)	899.462	(3.196)	896.266
(13)	Enhanced Payment Program (EPP)	758.606	7.382	765.988	(45.977)	720.011	(11.547)	708.464
(14)	Quality Incentive Program (QIP)	691.192	(36.379)	654.813	-	654.813	-	654.813
(15)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	2.305	(1.959)	0.346	(0.346)	-	-	-
(16)	Global Payment Program (GPP)	1,327.587	(73.796)	1,253.791	(17.974)	1,235.817	26.842	1,262.659
(17)	Medi-Cal Inpatient	347.330	13.893	361.223	19.867	381.090	15.244	396.334
(18)	Medi-Cal Outpatient - E/R	64.778	2.592	67.370	3.706	71.076	2.843	73.919
(19)	Medi-Cal CBRC	193.096	7.724	200.820	11.045	211.865	8.475	220.340
(20)	Medi-Cal SB 1732	12.107	-	12.107	-	12.107	-	12.107
(21)	Specialty Mental Health Services (SMHS)	180.025	-	180.025	-	180.025	-	180.025
(22)	Hospital Provider Fee	21.691	-	21.691	-	21.691	-	21.691
(23)	Medicare	452.425	20.657	473.082	4.751	477.833	4.893	482.726
(24)	Hospital Insurance Collection	173.092	25.963	199.055	5.972	205.027	6.151	211.178
(25)	Self-Pay	3.729	-	3.729	-	3.729	-	3.729
(26)	In-Home Supportive Services (IHSS)	131.251	17.781	149.032	-	149.032	-	149.032
(27)	Federal & State - Other	214.439	16.913	231.352	18.580	249.932	20.416	270.348
(28)	Other County Department (OCD)	608.421	21.295	629.716	22.040	651.756	22.811	674.567
(29)	Other	118.286	-	118.286	-	118.286	-	118.286
(30)	**Total Revenues**	$ 6,610.491	$ (326.513)	$ 6,283.978	$ (40.426)	$ 6,243.552	$ 92.932	$ 6,336.484
(31)	**Net Cost - Before PY**	$ 1,701.963	$ 212.159	$ 1,914.122	$ 301.322	$ 2,215.444	$ 222.146	$ 2,437.590
(32)	Prior-Year Surplus / (Deficit)	290.292	(290.292)	-	-	-	-	-
(33)	**Net Cost - After PY & AB 85 Redirection**	$ 1,411.671	$ 502.451	$ 1,914.122	$ 301.322	$ 2,215.444	$ 222.146	$ 2,437.590
(34)	**Operating Subsidies**							
(35)	Sales Tax & VLF	438.221	-	438.221	-	438.221	-	438.221
(36)	County Contribution	354.448	4.596	359.044	4.900	363.944	5.558	369.502
(37)	Tobacco Settlement	50.654	-	50.654	-	50.654	-	50.654
(38)	Measure B	311.366	-	311.366	-	311.366	-	311.366
(39)	**Total Operating Subsidies**	$ 1,154.689	$ 4.596	$ 1,159.285	$ 4.900	$ 1,164.185	$ 5.558	$ 1,169.743
(40)	**Surplus / (Deficit) = (39) - (33)**	**$ (256.982)**	$ (497.855)	**$ (754.837)**	$ (296.422)	**$ (1,051.259)**	$ (216.588)	**$ (1,267.847)**
(41)	**Beginning Fund Balance**	**$ 1,475.436**	$ (32.124)	**$ 1,443.312**	$ (234.859)	**$ 1,208.453**	$ (1,051.259)	**$ 157.194**
(42)	Surplus / (Deficit)	(256.982)	(497.855)	(754.837)	(296.422)	(1,051.259)	(216.588)	(1,267.847)
(43)	Long-Term Receivables Reserve	224.858	295.120	519.978	(519.978)	-	-	-
(44)	**Available Fund Balance**	**$ 1,443.312**	$ (234.859)	**$ 1,208.453**	$ (1,051.259)	**$ 157.194**	$ (1,267.847)	**$ (1,110.653)**

ATTACHMENT I-B

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
FISCAL FORECAST
FISCAL YEARS 2025-26 THROUGH 2028-29
($ IN MILLIONS)

Community Programs - Office of Diversion & Re-entry and Harm Reduction Division

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2025-26 FORECAST	Adjustments	FY 2026-27 FORECAST	Adjustments	FY 2027-28 FORECAST	Adjustments	FY 2028-29 FORECAST	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 33.776	$ 1.267	$ 35.043	$ 2.285	$ 37.328	$ 2.546	$ 39.874	(2)
(3)	Net Services & Supplies	303.086	4.348	307.434	(4.524)	302.910	(12.318)	290.592	(3)
(4)	Debt Service - Harbor Master Plan	-	-	-	-	-	-	-	(4)
(5)	Debt Service - Other	-	-	-	-	-	-	-	(5)
(6)	Other Charges	3.627	1.604	5.231	(3.175)	2.056	(0.279)	1.777	(6)
(7)	Capital Assets	-	-	-	-	-	-	-	(7)
(8)	Capital Projects & Deferred Maintenance	-	-	-	-	-	-	-	(8)
(9)	Intrafund Transfer	(43.389)	(0.964)	(44.353)	0.130	(44.223)	1.717	(42.506)	(9)
(10)	**Total Expenses**	$ 297.100	$ 6.255	$ 303.355	$ (5.284)	$ 298.071	$ (8.334)	$ 289.737	(10)
(11)	**Revenues**								(11)
(12)	Managed Care	-	-	-	-	-	-	-	(12)
(13)	Enhanced Payment Program (EPP)	-	-	-	-	-	-	-	(13)
(14)	Quality Incentive Program (QIP)	-	-	-	-	-	-	-	(14)
(15)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	7.258	(1.696)	5.562	(5.562)	-	-	-	(15)
(16)	Global Payment Program (GPP)	-	-	-	-	-	-	-	(16)
(17)	Medi-Cal Inpatient	-	-	-	-	-	-	-	(17)
(18)	Medi-Cal Outpatient - E/R	-	-	-	-	-	-	-	(18)
(19)	Medi-Cal CBRC	-	-	-	-	-	-	-	(19)
(20)	Medi-Cal SB 1732	-	-	-	-	-	-	-	(20)
(21)	Specialty Mental Health Services (SMHS)	-	-	-	-	-	-	-	(21)
(22)	Hospital Provider Fee	-	-	-	-	-	-	-	(22)
(23)	Medicare	-	-	-	-	-	-	-	(23)
(24)	Hospital Insurance Collection	-	-	-	-	-	-	-	(24)
(25)	Self-Pay	-	-	-	-	-	-	-	(25)
(26)	In-Home Supportive Services (IHSS)	-	-	-	-	-	-	-	(26)
(27)	Federal & State - Other	217.767	11.475	229.242	(2.372)	226.870	(2.987)	223.883	(27)
(28)	Other County Department (OCD)	-	-	-	-	-	-	-	(28)
(29)	Other	4.630	1.357	5.987	(3.865)	2.122	(2.122)	-	(29)
(30)	**Total Revenues**	$ 229.655	$ 11.136	$ 240.791	$ (11.799)	$ 228.992	$ (5.109)	$ 223.883	(30)
(31)	**Net Cost - Before PY**	$ 67.445	$ (4.881)	$ 62.564	$ 6.515	$ 69.079	$ (3.225)	$ 65.854	(31)
(32)	Prior-Year Surplus / (Deficit)	1.528	(1.528)	-	-	-	-	-	(32)
(33)	**Net Cost - After PY & AB 85 Redirection**	$ 65.917	$ (3.353)	$ 62.564	$ 6.515	$ 69.079	$ (3.225)	$ 65.854	(33)
(34)	**Operating Subsidies**								(34)
(35)	Sales Tax & VLF	-	-	-	-	-	-	-	(35)
(36)	County Contribution	65.917	(3.353)	62.564	6.515	69.079	(3.225)	65.854	(36)
(37)	Tobacco Settlement	-	-	-	-	-	-	-	(37)
(38)	Measure B	-	-	-	-	-	-	-	(38)
(39)	**Total Operating Subsidies**	$ 65.917	$ (3.353)	$ 62.564	$ 6.515	$ 69.079	$ (3.225)	$ 65.854	(39)
(40)	**Surplus / (Deficit) = (39) - (33)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	(40)

ATTACHMENT I-C

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
FISCAL FORECAST
FISCAL YEARS 2025-26 THROUGH 2028-29
($ IN MILLIONS)

C

Correctional Health Services

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2025-26 FORECAST	Adjustments	FY 2026-27 FORECAST	Adjustments	FY 2027-28 FORECAST	Adjustments	FY 2028-29 FORECAST	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 411.058	$ 9.864	$ 420.922	$ 18.374	$ 439.296	$ 20.303	$ 459.599	(2)
(3)	Net Services & Supplies	159.661	4.348	164.009	6.285	170.294	6.546	176.840	(3)
(4)	Debt Service - Harbor Master Plan	-	-	-	-	-	-	-	(4)
(5)	Debt Service - Other	-	-	-	-	-	-	-	(5)
(6)	Other Charges	7.160	-	7.160	-	7.160	-	7.160	(6)
(7)	Capital Assets	5.372	-	5.372	-	5.372	-	5.372	(7)
(8)	Capital Projects & Deferred Maintenance	-	-	-	-	-	-	-	(8)
(9)	Intrafund Transfer	(2.109)	-	(2.109)	-	(2.109)	-	(2.109)	(9)
(10)	**Total Expenses**	$ 581.142	$ 14.212	$ 595.354	$ 24.659	$ 620.013	$ 26.849	$ 646.862	(10)
(11)	**Revenues**								(11)
(12)	Managed Care	-	-	-	-	-	-	-	(12)
(13)	Enhanced Payment Program (EPP)	-	-	-	-	-	-	-	(13)
(14)	Quality Incentive Program (QIP)	-	-	-	-	-	-	-	(14)
(15)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	-	-	-	-	-	-	-	(15)
(16)	Global Payment Program (GPP)	-	-	-	-	-	-	-	(16)
(17)	Medi-Cal Inpatient	-	-	-	-	-	-	-	(17)
(18)	Medi-Cal Outpatient - E/R	-	-	-	-	-	-	-	(18)
(19)	Medi-Cal CBRC	-	-	-	-	-	-	-	(19)
(20)	Medi-Cal SB 1732	-	-	-	-	-	-	-	(20)
(21)	Specialty Mental Health Services (SMHS)	-	-	-	-	-	-	-	(21)
(22)	Hospital Provider Fee	-	-	-	-	-	-	-	(22)
(23)	Medicare	-	-	-	-	-	-	-	(23)
(24)	Hospital Insurance Collection	-	-	-	-	-	-	-	(24)
(25)	Self-Pay	-	-	-	-	-	-	-	(25)
(26)	In-Home Supportive Services (IHSS)	-	-	-	-	-	-	-	(26)
(27)	Federal & State - Other	41.758	-	41.758	-	41.758	-	41.758	(27)
(28)	Other County Department (OCD)	0.003	-	0.003	-	0.003	-	0.003	(28)
(29)	Other	8.208	-	8.208	-	8.208	-	8.208	(29)
(30)	**Total Revenues**	$ 49.969	$ -	$ 49.969	$ -	$ 49.969	$ -	$ 49.969	(30)
(31)	**Net Cost - Before PY**	$ 531.173	$ 14.212	$ 545.385	$ 24.659	$ 570.044	$ 26.849	$ 596.893	(31)
(32)	Prior-Year Surplus / (Deficit)	1.628	(1.628)	-	-	-	-	-	(32)
(33)	**Net Cost - After PY & AB 85 Redirection**	$ 529.545	$ 15.840	$ 545.385	$ 24.659	$ 570.044	$ 26.849	$ 596.893	(33)
(34)	**Operating Subsidies**								(34)
(35)	Sales Tax & VLF	-	-	-	-	-	-	-	(35)
(36)	County Contribution	525.240	15.840	541.080	24.659	565.739	26.849	592.588	(36)
(37)	Tobacco Settlement	4.305	-	4.305	-	4.305	-	4.305	(37)
(38)	Measure B	-	-	-	-	-	-	-	(38)
(39)	**Total Operating Subsidies**	$ 529.545	$ 15.840	$ 545.385	$ 24.659	$ 570.044	$ 26.849	$ 596.893	(39)
(40)	**Surplus / (Deficit) = (39) - (33)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	(40)

ATTACHMENT I-D

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FISCAL FORECAST

FISCAL YEARS 2025-26 THROUGH 2028-29

($ IN MILLIONS)

D = A + B + C

DHS Total

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2025-26 FORECAST	Adjustments	FY 2026-27 FORECAST	Adjustments	FY 2027-28 FORECAST	Adjustments	FY 2028-29 FORECAST	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 4,627.132	$ 59.693	$ 4,686.825	$ 209.215	$ 4,896.040	$ 232.555	$ 5,128.595	(2)
(3)	Net Services & Supplies	3,028.888	93.313	3,122.201	106.538	3,228.739	102.865	3,331.604	(3)
(4)	Debt Service - Harbor Master Plan	71.325	(0.001)	71.324	(0.002)	71.322	-	71.322	(4)
(5)	Debt Service - Other	79.190	(8.155)	71.035	(0.417)	70.618	(0.449)	70.169	(5)
(6)	Other Charges	1,504.591	(218.779)	1,285.812	(29.281)	1,256.531	3.024	1,259.555	(6)
(7)	Capital Assets	39.430	-	39.430	-	39.430	-	39.430	(7)
(8)	Capital Projects & Deferred Maintenance	48.838	(13.282)	35.556	-	35.556	-	35.556	(8)
(9)	Intrafund Transfer	(208.698)	(6.676)	(215.374)	(5.782)	(221.156)	(4.402)	(225.558)	(9)
(10)	**Total Expenses**	$ 9,190.696	$ (93.887)	$ 9,096.809	$ 280.271	$ 9,377.080	$ 333.593	$ 9,710.673	(10)
(11)	**Revenues**								(11)
(12)	Managed Care	1,310.131	(348.579)	961.552	(62.090)	899.462	(3.196)	896.266	(12)
(13)	Enhanced Payment Program (EPP)	758.606	7.382	765.988	(45.977)	720.011	(11.547)	708.464	(13)
(14)	Quality Incentive Program (QIP)	691.192	(36.379)	654.813	-	654.813	-	654.813	(14)
(15)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	9.563	(3.655)	5.908	(5.908)	-	-	-	(15)
(16)	Global Payment Program (GPP)	1,327.587	(73.796)	1,253.791	(17.974)	1,235.817	26.842	1,262.659	(16)
(17)	Medi-Cal Inpatient	347.330	13.893	361.223	19.867	381.090	15.244	396.334	(17)
(18)	Medi-Cal Outpatient - E/R	64.778	2.592	67.370	3.706	71.076	2.843	73.919	(18)
(19)	Medi-Cal CBRC	193.096	7.724	200.820	11.045	211.865	8.475	220.340	(19)
(20)	Medi-Cal SB 1732	12.107	-	12.107	-	12.107	-	12.107	(20)
(21)	Specialty Mental Health Services (SMHS)	180.025	-	180.025	-	180.025	-	180.025	(21)
(22)	Hospital Provider Fee	21.691	-	21.691	-	21.691	-	21.691	(22)
(23)	Medicare	452.425	20.657	473.082	4.751	477.833	4.893	482.726	(23)
(24)	Hospital Insurance Collection	173.092	25.963	199.055	5.972	205.027	6.151	211.178	(24)
(25)	Self-Pay	3.729	-	3.729	-	3.729	-	3.729	(25)
(26)	In-Home Supportive Services (IHSS)	131.251	17.781	149.032	-	149.032	-	149.032	(26)
(27)	Federal & State - Other	473.964	28.388	502.352	16.208	518.560	17.429	535.989	(27)
(28)	Other County Department (OCD)	608.424	21.295	629.719	22.040	651.759	22.811	674.570	(28)
(29)	Other	131.124	1.357	132.481	(3.865)	128.616	(2.122)	126.494	(29)
(30)	**Total Revenues**	$ 6,890.115	$ (315.377)	$ 6,574.738	$ (52.225)	$ 6,522.513	$ 87.823	$ 6,610.336	(30)
(31)	**Net Cost - Before PY**	$ 2,300.581	$ 221.490	$ 2,522.071	$ 332.496	$ 2,854.567	$ 245.770	$ 3,100.337	(31)
(32)	Prior-Year Surplus / (Deficit)	293.448	(293.448)	-	-	-	-	-	(32)
(33)	**Net Cost - After PY & AB 85 Redirection**	$ 2,007.133	$ 514.938	$ 2,522.071	$ 332.496	$ 2,854.567	$ 245.770	$ 3,100.337	(33)
(34)	**Operating Subsidies**								(34)
(35)	Sales Tax & VLF	438.221	-	438.221	-	438.221	-	438.221	(35)
(36)	County Contribution	945.605	17.083	962.688	36.074	998.762	29.182	1,027.944	(36)
(37)	Tobacco Settlement	54.959	-	54.959	-	54.959	-	54.959	(37)
(38)	Measure B	311.366	-	311.366	-	311.366	-	311.366	(38)
(39)	**Total Operating Subsidies**	$ 1,750.151	$ 17.083	$ 1,767.234	$ 36.074	$ 1,803.308	$ 29.182	$ 1,832.490	(39)
(40)	**Surplus / (Deficit) = (39) - (33)**	**$ (256.982)**	$ (497.855)	**$ (754.837)**	$ (296.422)	**$ (1,051.259)**	$ (216.588)	**$ (1,267.847)**	(40)
(41)	**Beginning Fund Balance**	**$ 1,475.436**	$ (32.124)	**$ 1,443.312**	$ (234.859)	**$ 1,208.453**	$ (1,051.259)	**$ 157.194**	(41)
(42)	Surplus / (Deficit)	(256.982)	(497.855)	(754.837)	(296.422)	(1,051.259)	(216.588)	(1,267.847)	(42)
(43)	Long-Term Receivables Reserve	224.858	295.120	519.978	(519.978)	-	-	-	(43)
(44)	**Available Fund Balance**	**$ 1,443.312**	$ (234.859)	**$ 1,208.453**	$ (1,051.259)	**$ 157.194**	$ (1,267.847)	**$ (1,110.653)**	(44)

ATTACHMENT II

MAJOR CUTS & UNCERTAINTY OVER THE NEXT FEW YEARS

KEY:

- FEDERAL PROVISIONS
- FEDERAL PROVISIONS WITH GREATEST IMPACT
- STATE PROVISIONS
- PENDING PROVISIONS

JULY 2025

End of COVID-era Medicaid Flexibilities: Temporary waivers on eligibility requirements, renewal processes, and verification policies expired.

JANUARY 2026

Freeze Enrollment for UIS Adults: California freezes new enrollments for undocumented adults (19yrs+) who currently qualify for full-scope Medi-Cal through state-funded adult expansions.

OCTOBER 2026

Reduction in FMAP for Emergency Services for Undocumented Childless Adults: Federal match for emergency care for undocumented adults drops from 90% to 50%.

JANUARY 2027

CalAIM 1115 Waiver Expiration: GPP reverts to DSH if renewal is not granted. DHS is working with DHCS to submit for renewal in Spring 2026.

Changes to Emergency Coverage for UIS Population: CMS letter may force UIS population out of risk-based managed care.

Medicaid Community Engagement (Work) Requirements: States must begin enforcing work requirements for adults ages 19–64.

Medicaid Eligibility Redeterminations: States must begin conducting eligibility checks for expansion adults every six months.

Single Payment Methodology for Managed Care: State directed payments (SDP) must be incorporated directly into base capitation rates.

JULY 2027

$30 Monthly Premium for UIS Adults: Full coverage Medi-Cal members aged 19-59, not pregnant, and undocumented or UIS will be required to pay a monthly premium to keep their coverage.

OCTOBER 2027

DSH Cuts Take Effect: $8 billion in Disproportionate Share Hospital (DSH) cuts move forward as scheduled.

JANUARY 2028

State Directed Payment (SDP) Phase-Down Begins: Grandfathered SDPs begin 10% annual reductions until they reach 100% of Medicare rates

Date?

Pending CRUSH Regulation

Pending OMB Rule