SENATE THIRD READING
SB 246 (Grove and Caballero)
As Introduced January 30, 2025
Majority vote

SUMMARY

Requires the Department of Health Care Services (DHCS) to implement a program to allow district and municipal hospitals to draw down federal Medicaid funding for graduate medical education (GME) costs.

COMMENTS

GME Funding. GME includes physician residency and fellowship training after graduation from medical school. Residency is the next step in a physician's training after medical school, and California requires an applicant for a physician license to complete an accredited training program lasting a minimum of three years. Some specialties, such as general surgery and psychiatry, require additional years to complete.

According to an October 2024 report by the California Health Care Foundation (CHCF), a well-developed network of high-quality GME programs in California is necessary to develop a robust supply of physicians who will stay and practice in the state. According to a 2021 CHCF report, studies have shown physicians tend to stay and practice near where they complete their residency, and 71% of physicians remain in California after residency training in the state. There are significant physician shortages in the state, as well as maldistribution across primary care and specialties.

According to the CHCF report, "*The Role of State and Federal Funding for Graduate Medical Education in California*," GME is financed by the federal and state governments as well as from clinical revenue generated by the care that residents and fellows provide under supervision. Regardless of its source, consistent and stable funding is key to GME's success. It can cost millions of dollars and take three to seven years to start a new GME program, and the annual cost to train a resident in an established program can reach a quarter of a million dollars. Despite recent increases in federal and state funding for GME, California still ranks in the bottom half of states in terms of the number of GME slots per capita. Recent ballot propositions, including Proposition 56 in 2016 and Proposition 35 in 2024, contained funding for GME programs, although the recently passed federal One Big Beautiful Bill Act jeopardizes Proposition 35 funds for GME by restricting the source of GME financing. A number of one-time state funds authorized through the state budget in recent years have also targeted professions with significant provider shortages.

Medi-Cal Funding of GME. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, the health trailer bill, included a GME funding program for designated public hospitals. Through this program, designated public hospitals (generally county and University of California hospitals) can transfer funds to the state to use as the non-federal share in claiming federal financial participation for Medicaid. In other words, these hospitals can use their own funds to "draw down" a federal match, receiving reimbursement for a portion of their GME costs. This bill allows district and municipal public hospitals to use the same financing mechanism authorized for designated public hospitals.

According to the Author
There are 33 district and municipal public hospitals in California, which are independent public hospitals, and classified in the Medi-Cal program as "non-designated public hospitals" with publicly elected boards. The author notes two-thirds of these hospitals are located in rural areas and 18 have "critical access" designation. The intent of this bill is to expand on a current, successful program that funds GME in designated public hospitals, by creating a new Medi-Cal GME supplemental payment program for non-designated public hospitals. The author explains the program would depend on intergovernmental transfers, not General Fund, to support the new payments and draw down federal funds. The author notes that currently, five of 33 of these hospitals have established GME programs. The author argues these hospitals struggle every day to keep their doors open and notes that 30% of the recipients of the Distressed Hospital Loan Program were district hospitals. The author concludes that this bill creates a new funding stream that could mean the difference between continuing a GME program and closing it.

Arguments in Support
The District Hospital Leadership Forum, sponsor of this bill, writes that two-thirds of California's district and municipal hospitals are in rural areas and 18 have critical access designations. These hospitals provide care to some of the most underserved communities throughout California. This bill will provide a new funding stream without impacting the state General Fund.

Arguments in Opposition
None.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations, DHCS expects the addition of GME payments for district and municipal hospitals would increase the annual amount of payments by approximately $18.4 million in total funds (50% federal funds and 50% intergovernmental transfers (IGTs), which would be provided by the hospitals). DHCS would also need one Health Program Specialist I at an estimated cost of $150,000 per year, ongoing (50% federal funds and 50% IGTs) to establish and administer the new program.

VOTES

SENATE FLOOR: 38-0-2
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Limón, Reyes

ASM HEALTH: 15-0-1
YES: Bonta, Chen, Addis, Aguiar-Curry, Caloza, Carrillo, Flora, Mark González, Krell, Patel, Patterson, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins
ABS, ABST OR NV: Stefani

ASM APPROPRIATIONS: 15-0-0

YES: Wicks, Sanchez, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Ahrens, Pacheco, Pellerin, Solache, Ta, Tangipa

UPDATED

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