Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

Board Retreat 2024

Date: Wednesday, September 25, 2024

Time:
Arrive and Refreshments..................9:00 a.m.
Call to Order..9:30 a.m.
Catered Lunch...12:00 – 12:45 p.m.
Adjourn...3:30 p.m.

Location:
Seascape Golf Club
Monarch Room
610 Clubhouse Drive
Aptos, CA 95003

Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.

a. Email comments by 5:00 p.m. on Monday, September 23, 2024 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
    i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
    ii. Comments will be read during the meeting and are limited to three minutes.
b. In person, during the meeting, when that item is announced.
    i. State your name and organization prior to providing comment.
    ii. Comments are limited to three minutes.

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1. **Call to Order by Chairperson Jimenez. 9:30 a.m.**
   A. Roll call; establish quorum.
   B. Supplements and deletions to the agenda.

2. **Oral Communications. 9:35 a.m.**
   A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed three minutes in length, and any individuals may speak only once during Oral Communications.
   B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to three minutes per item.

3. **Comments and announcements by Commission members.**
   A. Board members may provide comments and announcements.

4. **Comments and announcements by Chief Executive Officer.**
   A. The Chief Executive Officer (CEO) may provide comments and announcements.

<u>Consent Agenda Items</u>: (5. – 8.): 9:45 p.m.

5. **Approve Proposed CY 2025 Provider Incentive Programs.**
   - Reference materials: Staff report and recommendation on above topic.

   Pages 5-01 to 5-04

6. **Approve 2025 Supplemental Payment Methodology.**
   - Reference materials: Staff report and recommendation on above topic.

   Pages 6-01 to 6-02

<u>Minutes</u>:

7. **Approve Commission meeting minutes of August 28, 2024.**
   - Reference materials: Minutes as above.

   Pages 7-01 to 7-06

<u>Reports:</u>

8. **Authorize the Chairperson to sign Amendments to the Alliance's primary Medi-Cal contract 23-30241 to extend the term of the contracts through December 31, 2025.**
   - Reference materials: Staff report and recommendation on above topic.

   Page 8-01

<u>Regular Agenda Items</u>: (9. – 13.): 9:50 a.m.

9. **Board Discussion: Overview of Alliance Priorities and Initiatives. (9:50 – 10:20 a.m.)**
   A. Mr. Michael Schrader, Chief Executive Officer, will review, and the Board will discuss an overview of Alliance priorities and initiatives.

10. **Board Discussion: Local Plans in the Evolving Medi-Cal Environment. (10:20 – 11:30 a.m.)**
    A. Ms. Linnea Koopmans, Chief Executive Officer, Local Health Plans of California (LHPC), will review and Board will discuss dynamics impacting healthcare policy in 2024 including local plan priorities and pressures
    - Reference materials: LHPC: Voices from the Community, LHPC: Local Plans Invest in Communities, and LHPC: The Development & Evolution of California's Local Health Plans

    Pages 10-01 to 10-11

11. **Board Discussion: Quality and Health Equity. (11:30 a.m. – 12:00 p.m.)**

A. Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management, California Department of Health Care Services, will review and Board will discuss quality and health equity at the state level.

- Reference materials: Dr. Palav Babaria biography.

Page 11-01

Lunch: 12:00 – 12:45 p.m.

12. **Board Discussion: Workforce and Provider Supply. (12:45 – 2:15 p.m.)**

A. Dr. Margo Vener, Director of Undergraduate Medical Education, UC Merced, will review and Board will discuss workforce and provider supply in the Central Valley.

B. Dr. Walt Mills, Residency Program Director, Dominican Hospital Family Medicine Residency Program, will review and Board will discuss the Dominican Family Medicine Residency Program and the benefits to workforce issues on the coast.

- Reference materials: Dr. Margo Vener biography and Dr. Walt Mills biography.

Pages 12-01 to 12-06

13. **Board Action: Proposition 35 – Managed Care Organization (MCO) Tax Initiative. (2:15 – 3:20 p.m.)**

A. Mr. Dustin Corcoran, Chief Executive Officer, California Medical Association (CMA) and Dr. Donaldo Hernandez, Alliance Board Member/Immediate Past President, CMA, will review and Board will discuss Proposition 35 – MCO Tax Initiative.

- Reference materials: Mr. Dustin Corcoran biography and Dr. Donaldo Hernandez biography.
- Reference materials: Proposition 35: Legislative Analyst's Office Analysis

B. Board will consider and take action on a position of support for Proposition 35

- Reference materials: Staff report on above topic.

Pages 13-01 to 13-09

Announcements:

Meetings of Advisory Groups and Committees of the Commission
The next meetings of the Advisory Groups and Committees of the Commission are:

- Finance Committee
  Wednesday, November 6, 2024; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, November 7, 2024; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, December 5, 2024; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, December 19, 2024; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, November 4, 2024; 1:30 – 3:00 p.m.

The above meetings will be held in person unless otherwise noticed.

The next regular meeting of the Commission, after September 25, 2024 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced-San Benito-Mariposa Managed Medical Care Commission
  Wednesday, November 6, 2024; 3:00 – 5:00 p.m.

Locations for the meeting (linked via videoconference from each location):

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, CA

In Monterey County:
Central California Alliance for Health
950 E. Blanco Road, Suite 101, Salinas, CA

In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, CA

In Mariposa County:
Mariposa County Health and Human Services Agency
5362 Lemee Lane, Mariposa, CA

In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, CA

Members of the public interested in attending the Board meeting should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings. Audio livestreaming will be available to listen/view the meeting. Note: Livestreaming for the public is listening/viewing only.

The complete agenda packet is available for review on the Alliance website at www.ccah-alliance.org/boardmeeting.html. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: September 25, 2024

TO: Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

FROM: Kay Lor, Payment Strategy Director

SUBJECT: Proposed CY 2025 Provider Incentive Programs

Recommendation. Staff recommend the Board approve the proposed:

- Hospital Quality Incentive Program (HQIP) for contracted hospitals
- Specialty Provider Incentive (SCI)
- Risk Adjustment Incentive (RAI)

Summary. An incentive program is a value-based payment (VBP) strategy to promote high-quality care and improve the member care experience. This report provides an overview of the 2025 HQIP and SCI and makes a recommendation for changes. In addition, the Alliance introduces a new Risk Adjustment Incentive (RAI) program.

Background. The Board-approved payment policy aligns payments with revenue, utilization trends, and industry benchmarks. In addition, on June 28, 2023, the Board approved the allocation of $46.1M of the operating reserve to guarantee incentive payments even when the Alliance experiences financial losses to promote VBP.

To improve member experience and health outcomes and reward providers for quality care, staff continue developing more value-based payment (VBP) models to improve provider compensation. Staff initiated the HQIP in 2022, reinstated SCI in 2023, and developed a new RAI for 2025. We will update our programs yearly to learn from our experience and address emerging issues.

Discussion.

1. Hospital Quality Incentive Program (HQIP)

Program Overview: The incentive programs encourage partnership with Managed Care Plans (MCP) by meeting operational efficiencies, which will further improve transitional care services, reduce unnecessary healthcare costs, and improve service delivery with a focus on improving members' access to comprehensive care based on member needs.

Participation Requirements: All contracted hospitals with 50 or more hospital admissions or emergency visits in the calendar year 2024 are eligible to participate.

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Measurements and Payment Methodology:

Measurements	Payment Method	Payout
Transitional Care Services (TCS) – Inpatient Discharge	- Electronic Version - $400 per discharge - Paper Version - $200 per discharge	Quarterly – 45 days after the end of the quarter
ED Follow-Up Discharge	- Electronic Version - $50 per discharge - Paper Version - $25 per discharge	Quarterly – 45 days after the end of the quarter
Decrease of 30-day readmission rate Target*: 15.4% Increase Post Discharge follow-up within 14 days Target: 36.8% Decrease of Avoidable Emergency Visit Target: 17.3%	Hospitals can earn the maximum available funds for each metric by meeting the established performance target. *Two-Tier Approach:* - Tier 1: 40% of the target - Tier 2: Additional 60%, totaling 100% maximum payout	Annual - 45 days after the ending of the first quarter in 2026
Data Exchange Incentive	Quarterly payout of an *annual maximum* of $200,000 per hospital that connects to SCHIO	Quarterly – 45 days after the end of the quarter

**The target is based on the actual 2023 results for in-area hospitals.*

2. Specialty Provider Incentive (SCI)

Program Overview: SCI is designed to improve member access to specialty services, improve member care through incentivizing referrals when appropriate, decrease emergency visits through better coordination between providers when appropriate, and further advance value-based payment.

Participation Requirements: All contracted Specialty Providers

Measurements and Payment Methodology:

Measurements	Payment Methods	Payout
Reduce OB C-Section Rate Target 29%	By meeting the established performance target, providers can earn the maximum available funds for each metric. *Two-Tier Approach*: - Tier 1: 40% of the target - Tier 2: Additional 60%, totaling 100% maximum payout	Annual - payout 45 days after the ending of the first quarter in 2026
Increase OB Doula Referrals	$100 per referral	Billing via Claim
Increase California Children Services (CCS) referral Rate to the county	$1,000 per referral	Billing via Claim
Increase Palliative Care Referrals	$100 per referrals	Billing via Claim
Specialist Coordination with PCP	$25 per member	Billing via Claim
Provider Completion of Surveys	$100 per survey	Quarterly – 45 days after the end of the quarter
Provider Completion of training to Support DHCS	$200 per training per provider	Quarterly – 45 days after the end of the quarter
Increase New Member Seen *baseline year - 2024	Four Tiers: 1. 5% - $50 2. 10% - $100 3. 15% - $150 4. 20% - $200	Quarterly – 45 days after the end of the quarter
ED f/u visit	$50 per visit	Quarterly – 45 days after the end of the quarter

3. 2025 Risk Adjustment Incentive (RAI)

Program Overview: Risk Adjustment is a payment model implemented by both the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to determine payment to health plans. The payment model for DHCS is CDPS+Rx and for CMS-Hierarchical Condition Category (CMS-HCC). DHCS and CMS assign a Risk Adjustment Factor (RAF) to each Diagnosis Group at the beginning of the year. The Diagnosis Groups are associated with qualifying diagnoses that providers report on their claims. DHCS and CMS reimburse based on the health status of the patient. The risk adjustment incentives will compensate for any administrative burden providers may incur in reporting this risk-adjusted diagnosis so that we can submit the appropriate health status to DHCS/CMS.

Participation Requirements: Contracted providers

Measurements and Payment Methodology:

Measurements	Payment Methods	Payout
90 percent or more of appropriate ICDs addressed	$100 Per member (maximum of 4 per member)	Quarterly – 45 days after the end of the quarter
Completion of AHA exam	$100 per member (maximum of 1 per member)	Quarterly – 45 days after the end of the quarter
Completion of educational sessions	$250 per provider (maximum of 1 per provider)	Quarterly – 45 days after the end of the quarter

Fiscal Impact. Staff estimate the cost of the three incentive programs at $33.5M and will include this amount in the 2025 medical budget.

1. $20M - Hospital Quality Incentive Program (HQIP) for contracted hospitals
2. $12.5M - Specialty Provider Incentive (SCI)
3. $1M - Risk Adjustment Incentive (RAI)

Attachments. N/A

DATE: September 25, 2024

TO: Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

FROM: Kay Lor, Payment Strategy Director

SUBJECT: 2025 Supplemental Payment Methodology

Recommendation. Staff recommend the Board approve the 2025 supplemental payment methodology for our contracted providers to address realized network access and health equity.

Summary. The Alliance will execute the framework using the supplemental payment methodology to increase realized access and close health equity gaps.

Background. The Alliance's strategic priorities are to advance health equity and promote person-centered system transformation, which requires staff partnering with our providers. During the April 24, 2024, Board meeting, the Board reviewed the Alliance access framework, including the concept of realized access. Omar Guzman, MD, Chief Health Equity Officer, also led the discussion on opportunities to improve health equity. On June 26, 2024, the Board approved a one-time strategic allocation of $152.4M for provider supplemental payment over multiple years. The Board further authorized staff to develop a methodology that addresses realized network access and health equality. Staff also solicited feedback from the Board's Finance Committee on the methodology on June 26, 2024.

Discussion. To *improve realized network access*, encourage specialists to open the appointment time for Medi-Cal members, and reduce the authorization to the appointment time, staff recommend increasing the current 100% Medicare reimbursement rate to 110%. For all other non-specialists, such as stand-alone dialysis centers, community-based adult services centers, home health, non-emergency transportation, durable medical equipment, and various allied health providers (physical therapy, speech therapy, acupuncture, chiropractic, and audiology), staff recommend increasing the provider payment to 90% of Medicare. For our primary care providers (PCP), the current Targeted Rate Increase (TRI) proposal from the State Managed Care Organization (MCO) tax initiative will increase PCP compensation to 90% of Medicare in 2025.

To *advance health equity*, staff recommend continuing the Equity Practice Transformation (EPT) funding even after the State stops funding after the initial year, totaling a maximum of $18.6M over three years. In addition, staff recommend paying $250 per provider for bilingual capabilities to increase member access to culturally and linguistically appropriate healthcare and reimbursing providers $50 per member for successfully connecting the member to a community-based organization (CBO) or community health worker (CHW). Lastly, staff recommend offering providers $100 per patient to collect social determinants of health (SODH) data, such as Z or G codes. The data collected will further help design future programs to address health equity effectively.

Staff estimate the payout will be approximately $52.6M for 2025, as shown in the table below. Staff expect the funding to last three years through 2027. Staff will learn from the experience and may return to the Board to update the methodology as necessary.

Framework	Methodology	Estimated Payout in 2025
Improve Realized Access	Specialists	$20.0M
	Non-Specialists	$16.2M
	Other Providers	$6.5M
	Subtotal	**$42.7M**
Advance Health Equity	EPT	$6.2M
	Bilingual	$0.5M
	CBO	$0.8M
	SDOH data collection	$0.4M
	Subtotal	**$7.9M**
Total		**$52.6M**

Fiscal Impact. The expected payout will be included in the 2025 medical budget, and the Board already allocated $152.4M over multiple years. The estimated payout is $52.6M in 2025 and may last for three years until 2027.

Attachments: N/A

SANTA CRUZ – MONTEREY – MERCED – SAN BENITO – MARIPOSA MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, August 28, 2024
3:00 p.m. – 5:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

Ms. Anita Aguirre,	At Large Health Care Provider Representative
Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Supervisor Wendy Root Askew,	County Board of Supervisors
Ms. Dorothy Bizzini,	Public Representative
Ms. Janna Espinoza,	Public Representative
Supervisor Zach Friend,	County Board of Supervisors
Dr. Donaldo Hernandez,	Health Care Provider Representative
Ms. Elsa Jimenez,	County Director of Health Services
Dr. Kristina Keheley	Interim Health and Human Services Agency Director
Mr. Michael Molesky,	Public Representative
Ms. Mónica Morales,	County Health Services Agency Director
Supervisor Josh Pedrozo,	County Board of Supervisors
Dr. James Rabago,	Health Care Provider Representative
Dr. Allen Radner,	At Large Health Care Provider Representative

Commissioners Absent:

Ms. Leslie Abasta-Cummings,	At Large Health Care Provider Representative
Ms. Tracey Belton,	County Health and Human Services Agency Director
Dr. Maximiliano Cuevas,	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader,	Chief Executive Officer
Ms. Lisa Ba,	Chief Financial Officer
Mr. Scott Fortner,	Chief Administrative Officer
Dr. Omar Guzman,	Chief Health Equity Officer
Dr. Dennis Hsieh,	Chief Medical Officer
Ms. Jenifer Mandella,	Chief Compliance Officer
Mr. Cecil Newton,	Chief Information Officer
Ms. Van Wong,	Chief Operating Officer
Ms. Danita Carlson,	Government Relations Director
Ms. Kay Lor,	Payment Strategy Director
Ms. Anne Brereton,	Deputy County Counsel, Monterey County
Ms. Dulcie San Paolo,	Finance Administrative Specialist

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 3:00 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

Chair Jimenez opened the floor for any members of the public to address the Commission on items not listed on the agenda.

1. Ms. Susan Skotzke, a resident of Santa Cruz County and a mother of a disabled former member of California Children Services (CCS), spoke to the Board about the challenges around obtaining in-home nursing care in one of the most expensive areas in the nation. She emphasized the importance of aligning caregiver compensation with the high cost of living and requested resolution to the concerns she outlined related to nursing care for her daughter.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Commissioner Molesky spoke about the commencement of the 2024 Paralympics, emphasizing the impressive accomplishments achievable by individuals with access to appropriate medical care and equipment

4. .Comments and announcements by Chief Executive Officer.

Chair Jimenez opened the floor for Mr. Michael Schrader, Chief Executive Officer (CEO).

[Commissioner Morales arrived at this time: 3:07 p.m.]

Mr. Schrader announced that Becky Nanyonjo resigned her position as Merced County Director of Public Health and thus her seat on the Alliance Board, further saying that Alliance staff were especially grateful for her Board service since 2018. Mr. Schrader described that Kathy Stagnaro, Clerk of the Board, is currently out on leave through at least mid-October, and that Dulcie San Paolo is filling in. Mr. Schrader announced that the annual Board retreat will take place on

[Commissioner Hernandez arrived at this time: 3:09 p.m.]

Wednesday, September 25, from 9:30 am to 3:30 pm at the Seascape Golf Club in Aptos, with all Board members in a single location, and he described the planned sessions and speakers. Mr. Schrader shared that he had participated in a ribbon cutting held by Mercy Medical Center in Merced to launch its mobile van and street medicine unit, which the Alliance helped fund. Mr. Schrader shared that the Alliance has agreed to host individual residents from the Dominican Family Medicine Residency Program for sessions on Medi-Cal and managed care. Lastly, Mr. Schrader highlighted two items from the Consent Calendar: Item 9A, Amendments to our Medi-Cal contract with DHCS, and Item 9C, the Mid-Year Report for our Medi-Cal Capacity Grant Program.

<u>Consent Agenda Items</u>: (5. – 9F.): 3:17 p.m.

Chair Jimenez opened the floor for approval of Consent Agenda items 5 through 9F.

<u>MOTION</u>: Commissioner Bizzini moved to approve Consent Agenda items 5 through 9F, seconded by Commissioner Askew.

<u>ACTION</u>: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Askew, Bizzini, Espinoza, Friend, Hernandez, Jimenez, Keheley, Molesky, Morales, Pedrozo, and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Belton, Cuevas, Rabago.

Abstain: None.

<u>Regular Agenda Items</u>: (10. – 12.): 3:20 p.m.

10. Staff recommend the Board review, consider and take action on the request for a position of support for Measure Z, the City of Santa Cruz Beverage tax, which is on the November 5, ballot. (3:20 – 3:51 p.m.)

City of Santa Cruz Councilmember Shebreh Kalantari-Johnson gave a presentation encouraging the board take a position of support for Measure Z. The presentation included health and nutrition statistics regarding sugar sweetened beverages and their effects on public health, focusing on vulnerable members of the population. The presentation cited case studies from the cities of Berkeley and San Francisco that showed how such taxes can result in decreased soda consumption, as well as how youth, young adults, and minorities account for the most consumption of sugary drinks.

Ms. Kalantari-Johnson also noted exemptions to the proposed tax, as well as provided details of the proposed community oversight panel that would report annually on tax impact. Economic impact was also addressed, which noted that the estimated $1.3 million in revenue would be allocated to local recreation such as parks facilities, youth programs, active recreation programs, and facilities for seniors.

Dr. Catherine Forest reiterated Ms. Kalantari-Johnson's comments and noted the endorsement of such taxes among notable health organizations like the W.H.O., and other local communities.

Chair Jimenez opened the floor for public comment. Ms. Susan Skotzke provided public comment from Santa Cruz County.

MOTION: Commissioner Aguirre moved to approve the recommendation to take action for a position of support for Measure Z, the City of Santa Cruz Beverage tax, which is on the November 5 ballot, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Askew, Bizzini, Espinoza, Friend, Hernandez, Jimenez, Keheley, Morales, and Radner.

Noes: Commissioners Molesky and Pedrozo.

Absent: Commissioners Abasta-Cummings, Belton, Cuevas, Rabago.

Abstain: None.

11. Consider approving proposed CY 2025 Provider Incentive Programs. (3:51 – 4:19 p.m.)

Chair Jimenez advised the Board that this item carried potential conflict of interest. Board members who perceived that they were at risk for conflict of interest were advised to abstain from discussion and voting on this item.

Ms. Kay Lor, Provider Payment Strategy Director, introduced the proposed provider incentive programs for the calendar year (CY) 2025. These programs include the Hospital Quality Incentive Program (HQIP), the Specialist Care Incentive Program (SCI), and the Risk Adjustment Provider Incentive Program (RAI). A detailed review of the proposed program measures, payment methods, and potential payouts was provided for each program.

First, Ms. Lor outlined the proposed CY 2025 HQIP. The incentive program aims to foster collaboration between hospitals and the Managed Care Plan (MCP), with the objective of achieving better outcomes for members, improved coordination of care, the opportunity for hospitals to generate extra revenue, as well as reducing the overall cost of care and advancing value-based payment. All contracted hospitals with 50 or more hospital admissions or emergency visits in 2024 are eligible to participate. Ms. Lor explained that the 2025 HQIP will continue two measures from 2024 and introduce a new data exchange incentive to encourage hospitals to join SCHIO for electronic data sharing with the Alliance.

[Commissioners Friend and Radner departed at this time: 4:04 p.m.]

Next, Ms. Lor presented the proposed CY 2025 SCI program. She explained that the program aims to achieve several objectives. These include improving member access to specialty services, enhancing member care by incentivizing appropriate referrals, reducing emergency

department utilization, improving care coordination for members, and increasing revenue for specialist providers through the continuous advancement of value-based payment.

[Commissioner Rabago arrived at this time: 4:08 p.m.]

Lastly, Ms. Lor presented the proposed CY 2025 Risk Adjustment Provider Incentive program (RAI). She explained that risk adjustment is a method used to account for the differing health statuses and costs of different patient populations. Its goal is to guarantee a fair comparison and to ensure that providers and health plans are not penalized for treating sicker or higher-risk patients who might naturally incur higher costs.

In a review of the proposed program measures, Ms. Lor emphasized that the measures were specifically designed with a goal to offset any administrative burdens that providers may encounter when reporting risk-adjusted diagnoses which is vital to ensure that the appropriate health status can be accurately submitted to DHCS/CMS.

Chair Jimenez opened the floor for public comment. Ms. Susan Skotske provided public comment from Santa Cruz County.

MOTION: Commissioner Askew moved to approve the proposed CY 2025 Provider Incentive Programs, seconded by Commissioner Bizzini.

ACTION: The motion did not pass with the following vote:

Ayes: Commissioners Askew, Bizzini, Espinoza, Molesky, and Pedrozo.

Noes: None.

Absent: Commissioners Abasta-Cummings, Belton, Cuevas, Friend, Radner

Abstain: Commissioners Aguirre, Armstrong, Hernandez, Jimenez, Keheley, Morales, Rabago

Chair Jimenez directed staff to include this item on the September 25, 2024 consent agenda for ratification due to insufficient non-conflicted commissioners being in attendance and eligible to vote.

12. Consider approving 2025 Supplemental Payment Methodology. (4:19 – 4:27 p.m.)

Ms. Kay Lor, Provider Payment Strategy Director, provided background information on the provider supplemental payment. On June 26, 2024, the Board approved a one-time strategic allocation of $152.4 million to be used for provider supplemental payments over multiple years. The Board also authorized staff to develop a supplemental payment methodology to address realized network access and health equity. Ms. Lor went on to present the proposed payment methodology and reviewed the various data points included to identify specialty access challenges. A comprehensive review of the proposed payment methodology was provided along with a breakdown of the estimated 2025 payout.

This item will be placed on the September 25, 2024 consent agenda for ratification due to insufficient non-conflicted commissioners in attendance and eligible to vote. No action was taken by the Board on this recommendation.

Adjourn to Closed Session

13. Conference with legal counsel – anticipated litigation (Gov. Code section 54956.9(d)(2).): (One matter). (4:35 – 4:51 p.m.)

Chair Jimenez reported from Closed Session that no action was taken by the Board in Closed Session.

The Commission adjourned its regular meeting of August 28, 2024 at 4:55 p.m. to the regular meeting of September 25, 2024 at 9:30 a.m. at Seascape Golf Club in Aptos, unless otherwise noted.

Respectfully submitted,

Ms. Dulcie San Paolo
Administrative Specialist

DATE: September 25, 2024

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services (DHCS) Contract Extension

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Recommendation. Staff recommends the board authorize the Chair to sign an Amendment to the Alliance's Medi-Cal contract number 23-30241 to extend the term of the contract through December 31, 2025

Summary. The Alliance's Medi-Cal contract with DHCS currently extends through December 31, 2024. DHCS is seeking to extend the term of the agreement an additional 12 months.

Background The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance entered into the primary Agreement 23-30241 effective January 1, 2024. The agreement has subsequently been amended twice via written contract amendment to include required regulatory and statutory provisions and program changes.

Discussion. DHCS has offered to extend the term of the agreement through December 31, 2025, to obtain a continuation of the services identified in the original agreement. Board authorization for the Chair to sign the Amendments is required.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

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LINNEA KOOPMANS, MSW
CEO, LOCAL HEALTH PLANS OF CALIFORNIA

Linnea Koopmans is the Chief Executive Officer for the Local Health Plans of California (LHPC), the statewide trade association representing all 17 of California's not-for-profit and community-based Medi-Cal managed care plans. Ms. Koopmans leads the largest state trade association of Medicaid managed care plans, with a membership that collectively provides vital health coverage for 9.7 million Californians – representing approximately 70 percent of the Medi-Cal managed care population.

As the Medi-Cal program continues to grow and evolve, both in population covered and the services and benefits offered to enrollees, Ms. Koopmans guides LHPC's advocacy for locally delivered, high-quality health care for California's vulnerable Medi-Cal population.

Working to strengthen California's safety net programs has been a constant throughout Ms. Koopmans' career. Her success in representing local health plans is informed by her extensive experience in healthcare policy, particularly her knowledge of behavioral health, and her years spent working to support California's unhoused residents. Her passion for serving others has been essential to her work at the organization. She brings energy and expertise to her role as LHPC's CEO.

VOICES FROM THE COMMUNITY

INTRODUCTION

Local Medi-Cal managed care plans have a long history of investing their reserves in the communities they serve. These local plans have **tailored their approach to community investment**, which reflects the value of locally based and mission-driven managed care**.** They are committed to **improving the health of the populations they serve through strategic investments** that enhance access, improve quality, and address social drivers of health.

What sets Local Health Plans of California members apart is their commitment to not only **providing quality care to nearly 70% of Medi-Cal enrollees in 51 counties** but also investing beyond Medi-Cal requirements into the communities they serve. This is best told by **VOICES FROM THE COMMUNITY.**

CATEGORIES

Health Equity and Quality

Housing

Workforce Development

Community Health and Wellbeing

Food Stability

> My local Medi-Cal plan is not just a health care provider but a **trusted partner and advocate for the health and well-being of the entire community**, working tirelessly to ensure that all members have access to equitable, high-quality care.
>
> – Heather Alexander Program Director at Wellchild

HEALTH EQUITY & QUALITY

L.A. Care Health Plan invests in Black maternal health programs that provide quality health care and education for Black mothers. The investments are designed to decrease Black maternal and infant mortality and connect Black mothers with doula services. St. John's Community Health's Committed to Black Wellness and Health Program (CBWH) offers educational classes tailored to Black mothers and families, and Diversity Uplifts Inc.'s Black Doulas Connection Initiative connects Black families with Black doulas to fulfill the need for conscious health care connections.

L.A. Care HEALTH PLAN®

> **Alameda Alliance for Health was bold and visionary in seeing the possibility of Food as Medicine** and investing in Recipe4Health, which allowed us to develop a nationally recognized model. We are lifted up as a Food as Medicine model that equitably sources food from BIPOC farmers growing food regeneratively and organically.
>
> – Steven Chen, Chief Medical Officer and Founder of Recipe4Health

FOOD STABILITY

Alameda Alliance for Health invested critical seed funding to support the establishment of Recipe4Health, which is a clinically integrated food as medicine program that prescribes food (regenerative and organic produce) as well as health coaching, to treat, prevent, and reverse chronic conditions.

ALAMEDA Alliance FOR HEALTH

VOICES FROM THE COMMUNITY

LHPC
Local Health Plans of California

HOUSING

> **The Alliance [CCAH] has recognized housing as a foundational building block to health** and invests in permanent supportive housing and capacity building for supportive services.
>
> – Natalie Magana Boyles, MidPen Housing

The Central California Alliance for Health (CCAH) invested in MidPen Housing's development of 261 affordable housing units in Santa Cruz and Monterey counties, including a total of 41 units that will be designated as permanent supportive housing for medically complex CCAH members.

WORKFORCE DEVELOPMENT

> All my life I have held menial positions at dead-end jobs and I know furthering my education is the only way to change all of that. Being a single parent living far below the poverty line, **financial assistance is imperative to my success as a student.**
>
> – Southwestern Community College student

Community Health Group has been growing the local non-physician healthcare workforce by supporting scholarships for students at San Diego State University and Southwestern Community College. This investment has helped foster academic achievement and alleviate financial burdens for students who are pursuing degrees in nursing and public health.

COMMUNITY HEALTH & WELLBEING

> The only way that we can **create a healthy sustainable farmworker community is to ensure that we educate and inform** them of the importance of having Medi-Cal and long-term health care plan. Everyone should have a doctor that they can call their own.
>
> – Darrell Muniz, COO of the California Farmworker Foundation

Kern Family Health Care funds rural mobile clinics for the California Farmworker Foundation, offering one to two health clinics per week that provide preventive health care exams and deliver accessible health care services to farm workers with chronic illnesses. For many workers this is the first time they have seen a doctor.

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LOCAL PLANS INVEST IN COMMUNITIES

LHPC Local Health Plans of California

Local Health Plans of California's members are dedicated to giving back to the communities they serve through targeted investments using funds that are outside Medi-Cal reimbursable benefits or DHCS incentive programs. They support initiatives that align with community priorities and the transformative goals of CalAIM. This commitment is reflected in a recent survey showing local plan community investments across five key categories, each making an impact on health outcomes and community needs. Investments are selected through a collaborative process, with input from members and the community, along with staff assessments of need. This ensures they are impactful and relevant. Locally based and governed, local plans are uniquely positioned to understand and address challenges their communities face, reinforcing their role as committed partners in fostering healthier, more vibrant communities.

HEALTH EQUITY & QUALITY
- Street medicine
- Rural mobile vision care
- Socio-emotional intervention programs

HOUSING
- Capital grants for low-income housing construction
- Permanent supportive housing
- Temporary shelters
- Recuperative care

FOOD STABILITY
- Meal Delivery
- Emergency food provision

WORKFORCE DEVELOPMENT & PROVIDER RECRUITMENT
- Clinic recruitment grants
- MSW stipends
- Health career scholarships
- Provider loan repayment
- IHSS caregiver training

COMMUNITY RESOURCE CENTERS
- Community based centers for members and non-members
- Partnerships with local organizations that provide needed services to the community
- Education classes to improve health

COMMITTED TO HEALTHY COMMUNITIES

L.A. Care
Awarded $20 million to house people experiencing homelessness with serious health conditions in permanent supportive housing, resulting in 8,100 monthly rental payments for 332 households over a 5-year period . 90%+ maintained housing for over a year.

Inland Empire Health Plan (IEHP)
Free to all Inland Empire residents, three community resource center locations provide ongoing fitness classes, wellness workshops, health care and health plan information. In 2023, IEHP invested $2.8 million in its CRCs and served 55,000 visitors. With plans to expand CRC reach and capacity, IEHP recently purchased two additional properties for $12.1 million.

Partnership Health Plan
$9.3 million dedicated to clinic workforce recruitment since 2014. To date, over 672 providers have secured positions at community clinics as a result of the recruitment efforts. In 2024, the plan launched a pilot program recruit and retain high-quality health professionals to their region.

Alameda Alliance for Health
Partnering with First 5 Alameda County to support members ages 3-5 years, by connecting them to well-child visits and supporting pediatric practices with improving screening and referring practices. Initially developed as a pilot program, of the families reached, a majority completed a well child visit or had one scheduled. First 5 staff also supports providers to improve ACEs or ASQ screening practices.

Central California Alliance for Health
Prior to the Community Support of medically tailored meals, piloted a 2-year post-discharge medically tailored meal program, which provided 494 Medi-Cal members with serious illness and at high-risk for hospital admission with 14 ready-made medically tailored nutritious meals per week for 14 weeks. The program showed a 360% return on investment.

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The Development & Evolution of California's Local Health Plans

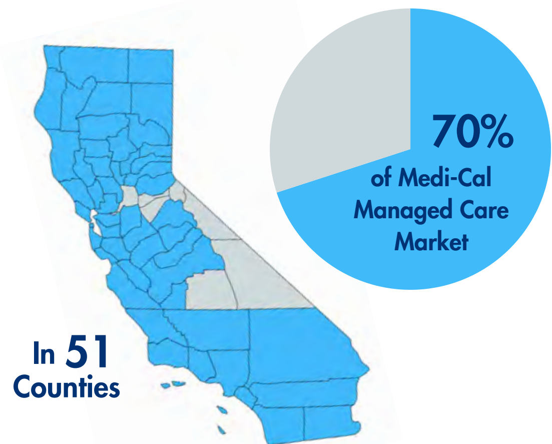
APRIL 2024

OVERVIEW

Collectively, local health plans (LHPC plans) are more than 70% of today's Medi-Cal managed care market across 51 counties, with commercial managed care organizations (MCO) comprising the balance. The local plans' market segment has developed through a series of evolutions in Medi-Cal policymaking over the last 40 years in which the concepts **of local control and local accountability** in Medi-Cal have been prominent policy features.

This paper provides a brief history of local plans, state policy drivers of the Medi-Cal program, and considerations for local plans moving into the future. It will be the basis for discussion with the LHPC board about how local plans' collective history could inform the future, including how local plans can position themselves to continue to play a critical role in Medi-Cal and the safety net more broadly.

Learn more about the local plans and find links to resources at www.LHPC.org.



HISTORICAL HIGHLIGHTS

1970s

California has long been the national leader in providing Medicaid (Medi-Cal) services to vulnerable populations through managed care. In fact, **California has more individuals enrolled under Medi-Cal managed care than any other state.** However, in the early years of Medi-Cal managed care, enrollment slowed as commercial prepaid health plans found the Medi-Cal business only marginally profitable. A highly public spate of marketing and enrollment abuses in the 1970s and increased scrutiny by state government further dampened commercial interest in Medi-Cal prepaid health care.

Contra Costa
Health Plan
1973

1980s

Publicly sponsored health plans (local health plans) in California came to life in the early 1980s. Following the prepaid health plan scandals, the Medi-Cal program was faced with spiraling state budget costs, uneven and sometimes very poor quality, and widespread provider dissatisfaction. In response, county executives in Monterey and Santa Barbara Counties suggested a novel local public and private partnership to reform Medi-Cal. **By making a single, countywide plan responsible for all Medi-Cal eligibles in the county and creating a larger risk pool, organizers hoped to realign financial incentives, emphasize primary care case management, respond more promptly to provider and beneficiary concerns, and improve access to services and quality of care.** The Monterey and Santa Barbara efforts, termed "County Organized Health Systems," were granted status as Federal Medicaid Demonstration projects in 1981.

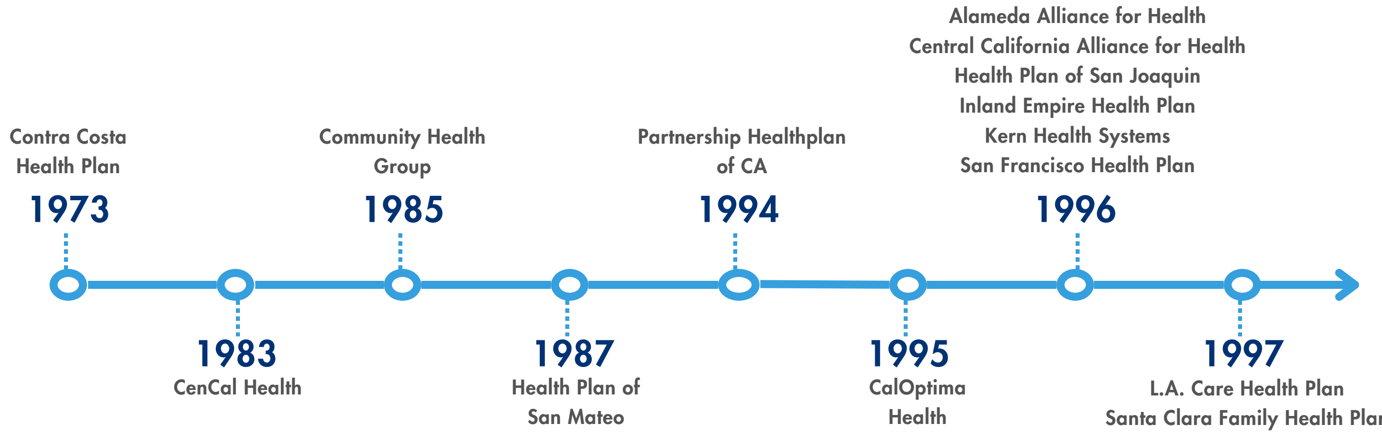
Medi-Cal managed care grew slowly during the 1980s, with the only significant expansion being the implementation of a new COHS in San Mateo County. By the early 1990s, however, continuing concerns about rising costs led the DHCS to conclude that a more organized system of care could be more cost-effective than fee-for-service delivery for most Medi-Cal beneficiaries and that it should accelerate the development of managed care systems.

The federal government had limited states' ability to expand COHS plans, primarily because of perceived abuses in other states where commercial carriers had been given responsibility for the programs. California was able to argue successfully for three additional COHS plans by demonstrating that its "public" version of COHS provided cost-effective, high-quality care, and was accountable to the local community by its public governance model.

1990s

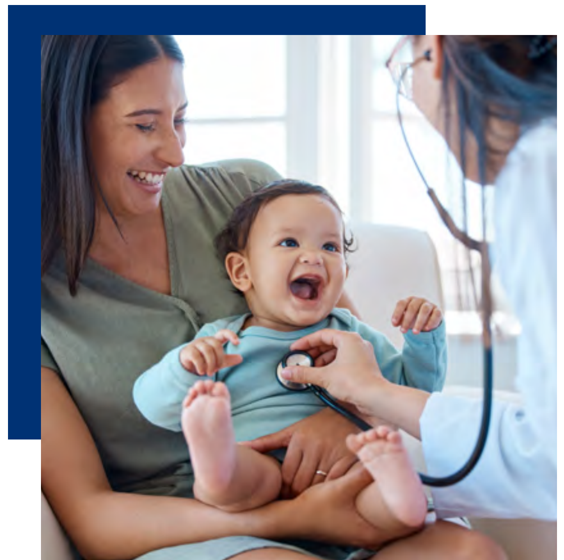
Still, the political and legislative difficulty of creating more COHS plans required DHCS to develop an additional model if the state was to move toward greater managed care enrollment. DHCS' decision to move to mandatory enrollment in managed care in some counties piqued the interest of commercial plans, which recognized that they would have reduced marketing costs in a mandatory environment. At the same time, county health and hospital systems and other safety-net providers feared that to the extent commercial plans did participate in Medi-Cal, they would seek to enroll only the healthier beneficiaries, putting the safety net at risk. DHCS' managed care expansion proposal, in March 1993, addressed these concerns with a radical new plan that attempted both to protect the safety net and to spread the cost-savings anticipated from managed care more widely by incorporating a local community plan based on the COHS model (the term "local initiative" was coined for these plans) and having it compete with a commercial plan. This became known as the Two-Plan Model.

Since the development of the Two-Plan Model, Local Community Plans became the State's primary policy solution to help the state transition Medi-Cal into managed care. While commercial plans had a presence in various markets, the State supported local plans' dominant market, which is a trend that has continued over time. In other instances, **LHPC plans reflect the successful outcome of local communities organizing to counter unilateral state actions that would hurt the viability of the safety net and its reliance on Medi-Cal funding.**



2000s

Once established and operational, LHPC plans were successfully improving access for Medi-Cal beneficiaries; improving quality and the standard of care for Medi-Cal over fee-for-service; and tackling local health care delivery challenges. **By the year 2000, LHPC plans were frequently the policy drivers taking on new issues like universal coverage for children (above Medi-Cal thresholds), health coverage for IHSS workers, and other products for communities in need.** The Children's Health Initiative (CHI) and the Healthy Kids insurance product was an example of providing coverage where none had been available before and a policy initiative that led the way to policy changes where Medi-Cal was made available to all children. **It was also a case study on how the LHPC plans in partnership with others can exercise influence to advance health policy.** The *Coverage Expansion for Uninsured Children* was a local community plan that conceived, developed, launched, and championed what has become the most significant health insurance expansion in California since the adoption of the State Childrens Health Insurance Program (SCHIP).



2010s

LHPC plan development and overall performance helped quell skepticism of Medi-Cal managed care, and LHPC plans helped expand managed care as evidenced by the seniors and persons with disabilities (SPD) shift to managed care (2011), the Coordinated Care Initiative (2012), and Medi-Cal expansion (2014). The State also authorized the carve-in of California Childrens Services (CCS) into most COHS plans, bringing yet another program serving a very vulnerable population into managed care through local plans.

2020s

The state facilitated an expansion of local plans through the single plan models effective 2024. Through this expansion, 15 counties passed county ordinances to join or establish a local health plan, and two counties passed an ordinance to pursue a shift from the Two-Plan Model to a Single Plan Model, eliminating the commercial plan presence in their counties. While a special statewide contract was created for Kaiser through statute passed in 2022, **the State supported counties and local plans that chose to pursue the path to expand the local plan presence or footprint, in large part because of the community trust garnered by local plans, advocacy by counties who wanted to join a local plan, and the history of local plan quality performance.** As a part of this transition, the State, through DHCS, negotiated a waiver which was approved by Centers for Medicare & Medicaid Services (CMS) to authorize the expansion of COHS and the Single Plan Model.

HISTORICAL PERSPECTIVE

Local Plans Provided Leadership & Influenced Policy Change

The Children's Health Initiative (CHI) and the Healthy Kids (HK) insurance product were an example of how the local health plans in 29 counties throughout the state provided the leadership necessary to expand coverage to undocumented children where none had been available before and a policy initiative that led the way to policy changes where Medi-Cal was made available to all children.

CHI was a case study on how the LHPC plans in partnership with others can exercise political influence in collaboration with local community groups and county governments. The work was started in Santa Clara County and ultimately led by the SCFHP. The effort was to design a system to make sure every child had access to insurance coverage. CHI had two parts; the first is a new insurance product, Healthy Kids, which covered children in households with income up to 300 percent of the federal poverty level who were ineligible for the two major state insurance programs, Medi-Cal and Healthy Families. The second part of CHI was a comprehensive outreach campaign that found uninsured children and enrolled them in the appropriate program. Twenty-nine counties ultimately developed Children's Health Initiative (CHI) programs before the state expanded Medi-Cal to cover undocumented children. The number of uninsured children dropped significantly in the State under CHI. This paved the way for a policy imitative for the State to expand Medi-Cal to cover these children.

TIMELINE OF LHPC PLANS

LOOKING AHEAD

At the macro level, pre-ACA, California's health policymaking was driven by two dominant issues – coverage and access. California had decades of debate on different pathways on how to expand coverage and how to achieve access. Now a decade post-ACA implementation and following multiple expansions of Medi-Cal coverage to undocumented Californians, policymakers are focused on different issues – access, execution, and maximizing the reach of Medi-Cal. **LHPC plans are leading the charge to be exemplars on quality, equity and access, and on new initiatives policymakers are expecting of Medi-Cal MCOs such as reaching into new sectors like housing, food delivery, social services and working with the justice involved population. Through initiatives like CalAIM, the State also expects Medi-Cal MCOs to be the chassis of local coordination, which has been a strength of LHPC plans for decades.**

As the next iteration of the Medi-Cal program evolves over the next decade, local plans will continue demonstrate their value and leadership through their community relationships and partnerships with providers that lead to better outcomes for Medi-Cal members.

Dr. Palav Babaria was appointed Chief Quality Officer and Deputy Director of Quality and Population Health Management of the California Department of Health Care Services beginning in March 2021. Prior to joining DHCS, she served as Chief Administrative Officer for Ambulatory Services at the Alameda Health System (AHS) where she was responsible for all outpatient clinical operations, quality of care, and strategy for primary care, specialty care, dental services, and integrated and specialty behavioral health, as well as executive sponsor for value-based programs including the Medi-Cal 1115 Waiver. She also previously served as Medical Director of K6 Adult Medicine Clinic, where she managed a large urban hospital-based clinic, overseeing all practitioners, improving quality of care, and patient safety programs. In addition, she served on the Clinical Advisory Committee with the California Association of Public Hospitals/Safety Net Institute. She also has over a decade of global health experience and her work has been published in the New England Journal of Medicine, Academic Medicine, Social Science & Medicine, L.A. Times, and New York Times. Dr. Babaria received her bachelor’s degree from Harvard College, as well as her MD and Masters in Health Science from Yale University. She completed her residency training in internal medicine and global health fellowship at the University of California, San Francisco.

Dr Margo Vener earned her MD at University of California San Francisco (UCSF) and her MPH at UC Berkeley. She completed residency in Family and Community Medicine and a medical education fellowship at UCSF. She is a UCSF Professor of Family and Community Medicine. Dr Vener's career has centered on caring for medically underserved patients and educating students and residents to care vulnerable patients and communities. For over two decades, Dr Vener has practiced family medicine in the Refugee Clinic at the Family Health Center and served in leadership roles in the UCSF School of Medicine. In 2022, Dr Vener got her dream job - to come to UC Merced and serve as Director of Medical Education. In this role, she helped launch the UC Merced Department of Medical Education. Dr. Vener is collaborating with teams from UC Merced, UCSF-Fresno, and UCSF to launch the SJV PRIME+ BS/MD Pathway. She seeks to help build enduring opportunities for students from the Valley to become outstanding physicians and health care professionals and care for their communities.

Walt Mills, MD, MMM, CPE

Program Director

Dr. Mills, prior to becoming Program Director, was on faculty at UCSF Natividad Family Medicine Residency as DIO/Director of Undergraduate and Graduate Medical Education and Associate Program Director, having been Program Director at several other programs in the past. He was clinical professor for UCSF, being on Clinical Faculty since 1986 and on the Advisory Board for Volunteer Clinical Faculty representing Family Medicine. As a student of leadership, he has been President & CEO of a multispecialty medical group, Medical Director, FQHC CMO, Chief of Staff and Department Chair.

He was President of the California Academy of Family Physicians (2019-2020), President of the Sonoma County Medical Association (2012-2013), was selected for the CAFP Heroic Leadership Award and nominated twice as CAFP Family Physician of the Year. He received a Masters in Medical Management from USC and as a Certified Physician Executive, is a Fellow of the American College of Physician Executives. He attended University of Notre Dame, UCSD Medical School and UCLA-Santa Monica FM Residency.

He is certified in Geriatrics and Integrative and Holistic Medicine, with training in Ayurveda. Dr. Mills works for the AAFP as a consultant helping develop or improve other residency programs nationally. Dr. Mills is dedicating the remainder of his career to health equity for all. He enjoys hiking and biking with his wife, Elizabeth, adaptive surfing, meditation and spending time with his family.

https://www.dignityhealth.org/bayarea/locations/dominican/about-us/family-medicine-residency-program

Family Medicine Residency

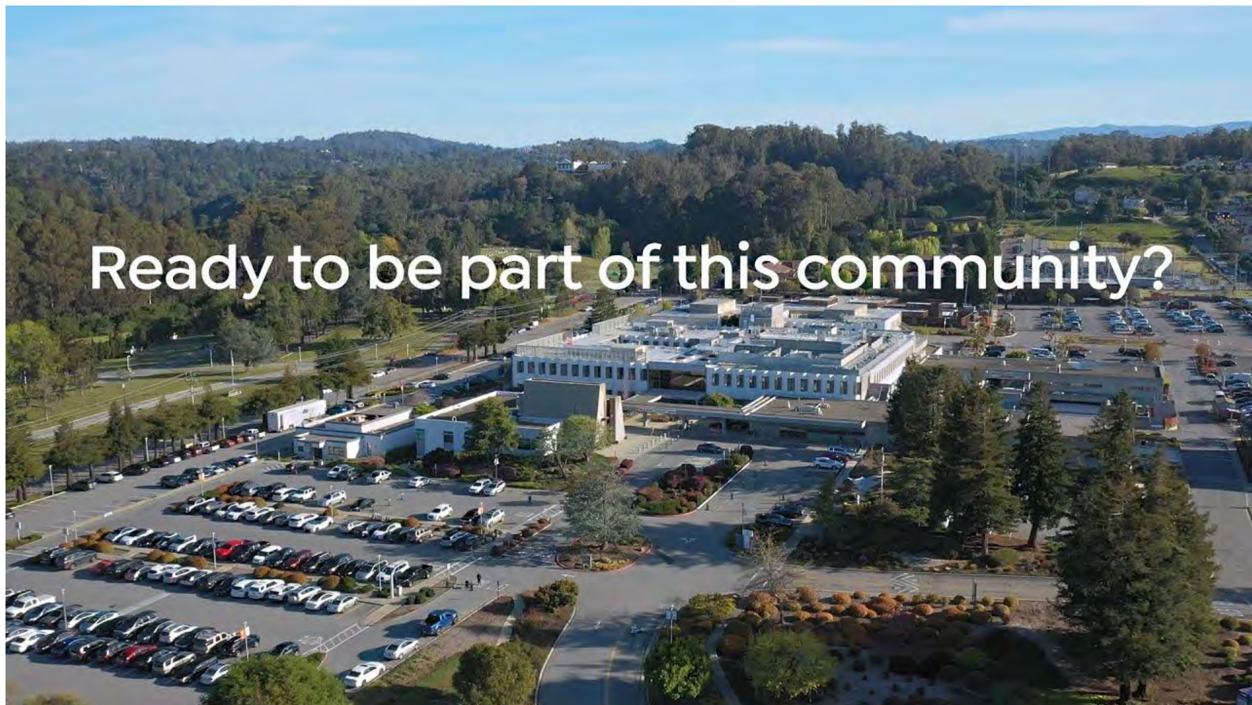
The Morehouse School of Medicine Dominican Hospital Family Medicine Residency Program in Santa Cruz, California, was established in 2022 to address health equity in our local and global communities. As an 8-8-8 program, we welcomed our first class of 8 amazing residents June 24, 2024! We are excited to now be recruiting our second class of 8 PGY1 residents.

While 'new', our program is well-grounded as part of graduate medical education that was started at Morehouse School of Medicine in 1981 and CommonSpirit/Dignity Health, who sponsors hundreds of GME programs which have served communities for more than half a century, currently training more than 2,000 residents nationally.

Welcome!

As an unopposed program (the only residency in Santa Cruz County) serving the Central Coast of California, we offer a well-rounded curriculum and experiences with additional

focus on areas designed to meet our mission to eliminate healthcare disparities. Specifically, we emphasize Community oriented Primary Care (COPC) in all facets with some specific strong areas that include: Point of Care Ultrasound (POCUS) in all rotations as well as whole person care with integrative & functional medicine for the underserved (IFM4US) and Integrated Behavioral Health. Our program is firmly committed to providing quality healthcare to the underserved and to our community outreach programs by training our Residents in full spectrum family medicine.



Family Medicine Residency Program ... What Makes Our Program Unique?

- Dominican Hospital Santa Cruz is a 222-bed community hospital, operating as a safety net for the most vulnerable in our community. As one of the most diverse populations in California, our patients and their illnesses offer deep learning experiences, rivaling those found at a large teaching hospital and the opportunity to learn how to impact the structural components impacting health equity. 2024 Santa Cruz Dignity Health / Dominican Hospital Value Report

- The hospital provides a birth center, Level III NICU, invasive cardiac services, oncology, stroke center, robust emergency medicine and many other services that support resident experience. Schwartz Rounds are a special way for the hospital to support our mission of providing a clinical learning environment that highlights patient experience as well as our learners and staff.

- Our faculty is diverse, sponsored by multiple organizations including Dominican Hospital, Dignity Health Medical Foundation/Santa Cruz Medical Group, Palo Alto Medical Foundation/Sutter, Santa Cruz Community Health, Salud Para La Gente and independent practitioners. The exposure to multiple groups and practice models provides a well-rounded set of perspectives to augment our residents' education and development.

- Our Family Medicine Practice (FMP) resident continuity clinic is sponsored by a Federally Qualified Health Center (FQHC), Santa Cruz Community Health Center, operating with "Clinic First" principles, serves a diverse, underserved and appreciative community modeling excellence in diversity, equity and inclusion.

- Our partner hospital, Watsonville Community Hospital, is also a safety net for the South County, providing rich, rewarding inpatient experiences in Maternity and Pediatric care (staffed by Stanford Pediatric Faculty) in a longitudinal, integrated 6 month curriculum for our PGY1-2s called "Family Centered Pediatrics-OB-Gyn" (POG) coordinating ambulatory resident experience on the hospital campus at Salud Para La Gente (which also sponsors the inpatient L&D faculty).

- Salud Para La Gente, an award-winning FQHC, dedicated to diversity, equity and inclusion (DEI) serving Watsonville's predominately Latinx population and farmworker community, provides inspiring resident experience in pediatrics, gynecology/women's health, family medicine, school-based medicine and community-centered primary care, all focused on health equity.

- Our inpatient medicine service rivals those in internal medicine residencies, with teaching by both internists and family doctors. The ICU teachers are excellent, complementing the resident experience where their inpatient attendings model full-spectrum inpatient care by providing ICU care in our 'open' ICU.

Our Point of Care Ultrasound (POCUS)

Our point of Care Ultrasound (POCUS) program is robust with each resident having their own POCUS probe to utilize in all inpatient/outpatient/community clinical learning experiences with the intent that every graduate will be competent and certified in POCUS. Truly, "POCUS for the Underserved" is an evidence based way to meet our mission to reduce healthcare disparities.

- Important parts of every resident's experience include Emergency Medicine, Sports and Musculoskeletal Medicine, Acute Rehabilitation, Palliative and Geriatric Care, Integrative/Functional Medicine and Wellness, Addiction Medicine, and home-based care. We have enthused, talented faculty teaching and modeling each.

- Community Medicine, led by Dr. Eric Sanford, who was a director of Community Medicine curriculum for 20 years at Natividad and Oriana Nolan MPH (who also leads the county Health Improvement Program in addiction medicine) will provide a longitudinal, integrated experience for residents in best practices proven to effect sustainable improvements in social determinants of health and upstream medicine, in alignment with our local Managed Medi-Caid HMO's Partnership in Health and other community partners.

- Our Leadership & Practice Management training is provided by the CMO, other hospital and FQHC executive leadership including immediate past President of the California Medical Association, Dr. Don Hernandez. Dr. Hernandez is faculty for our inpatient teaching service and founded the CMA's JEDI-A (Justice, Equity, Diversity, Inclusion and Anti-Racism/Oppression) Committee.

- We provide robust, equitable support for each resident starting from the very first day, emphasizing the unique individual learning styles and path ('tracks' are available) that best supports you during residency—respecting it as one of the most dynamic times of personal and professional growth in your career.

Dustin Corcoran is Chief Executive Officer (CEO) for the California Medical Association (CMA), a non-profit professional organization of nearly 50,000 physicians dedicated to protecting public health and promoting the science and art of medicine. As CEO, Mr. Corcoran has the responsibility for the overall supervision, direction and control of the business and staff of CMA.

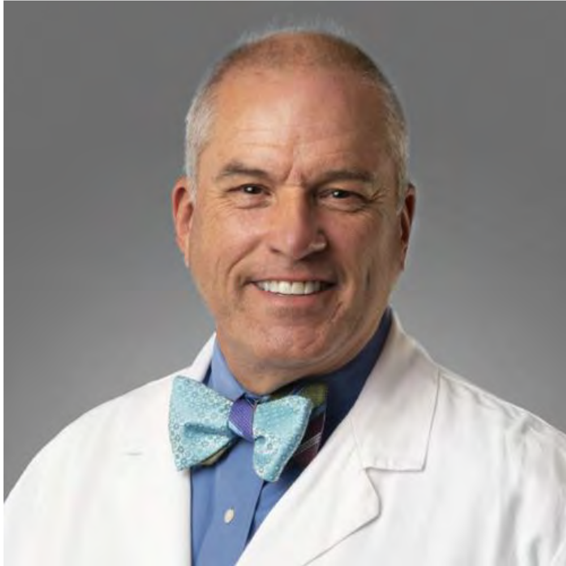
Mr. Corcoran has advocated tirelessly for California physicians and the patients that they serve since 1998. He started at CMA as the membership coordinator for the association's political action committee. Within a year, Mr. Corcoran moved to CMA's Center for Government Relations, where he worked under the guidance of the legendary Steve Thompson as a staff lobbyist. When Mr. Thompson passed away in 2004, Dustin succeeded him as Vice President of Government Relations, where he managed CMA's overall legislative program, representing physicians' interests before the State Legislature and the Governor. In 2009, Mr. Corcoran was promoted to Senior Vice President, where he oversaw the day-to-day operations of CMA, as well as the Center for Government Relations, and ultimately became CEO in February of 2010.

Dustin's career has been marked by years of leadership, service and entrepreneurship.

- Since 2009, Mr. Corcoran has been listed annually on *Capitol Weekly's* top 100 power brokers in California – most recently, in 2023, listed at number 12.
- In 2014, Mr. Corcoran chaired the campaign to defeat Proposition 46, successfully protecting the Medical Injury Compensation Reform Act (MICRA) from an attack by the trial lawyers.

- In 2016, Mr. Corcoran spearheaded the launch of a startup company dedicated to providing physicians the population health tools and services necessary to embrace value-based contracts.
- Also in 2016, Mr. Corcoran was co-chair of the coalition to pass Prop. 56, raising California's tobacco tax by $2 per pack to invest in Medi-Cal, save lives, reduce smoking rates, prevent thousands of children from starting in the first place, and triple the funding for California's anti-smoking programs.
- In 2021, Mr. Corcoran was named one of Sacramento's 100 Notable Business Leaders by Sacramento Magazine.
- In 2022, Mr. Corcoran, as a board member of Californians Allied for Patient Protection (CAPP), successfully led negotiations with the Consumer Attorneys of California, resulting in the passage of a landmark MICRA modernization act into law.
- Mr. Corcoran serves as President of the Physicians Advocacy Institute; Chair of Californians Allied for Patient Protection; and on the Board for the Neuropathy Action Foundation, Physicians Foundation, Physicians for a Healthy California, PSO Services, LLC, California Foundation on the Environment and the Economy, and Street Soccer USA: Sacramento.

Mr. Corcoran earned a Master's in Business Administration (MBA) from the University of Southern California Marshall School of Business. He lives in Sacramento with his wife, Glenda Corcoran, and their children.



Donaldo Hernandez

IMMEDIATE PAST PRESIDENT

Donaldo (Don) M. Hernandez, MD, FACP, is the immediate past president of the California Medical Association. He is an Internist in full-time, hospital-based practice in Santa Cruz County and has been a member of the active medical staffs at all of the county's hospitals. He is a Shareholder in the Palo Alto Foundation Medical Group and serves as a CMA Trustee for the geographically and ethnically diverse District 7 which includes Monterey, Santa Cruz, San Benito, Santa Clara, and San Mateo Counties. He currently chairs the CMA Justice, Equity, Diversity, and Inclusion Committee.
Raised in a bicultural/bilingual household, he came to the Monterey Bay at the conclusion of his Fellowships, joining a small practice in order to serve the largely Latin communities in Salinas and the Salinas Valley. There, he was on staff at Salinas Valley Memorial and Community Hospital of the Monterey Peninsula where he served as the Medical Director for Hospice of the Central Coast. He chaired several committees at Salinas Valley Memorial Hospital.

He returned to Hospital Medicine at the Santa Cruz Medical Clinic (now merged into the Palo Alto Medical Foundation) when they were inaugurating their Hospital Medicine program, now considered one of the highest quality Hospital Medicine programs in Central and Northern California and is one of longest-serving Hospitalists in the Monterey Bay Area.

Dr. Hernandez has been a member of the Santa Cruz County Medical Society and the CMA since 2003. He was first named to the CMA House of Delegates from Santa Cruz in 2007. He was elected to two terms as President of SCCMS from 2009 to 2011 during which SCCMS initiated several distinguished

community health projects most notably programs to combat childhood obesity, substance use disorder treatment, and behavioral health access issues. He was elected to his current role on the CMA Board of Trustees for District 7 in 2011. He was appointed to the Diversity Technical Advisory Committee and has served as its Chair since 2016. He is also a member of the Ethnic Medical Organizations Section.

DATE: September 25, 2024

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Proposition 35: Managed Care Organization (MCO) Tax Initiative

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Recommendation. Staff recommend the Board review, consider and take action on a position of support for Proposition 35 which provides permanent funding for Medi-Cal health care services and is on the November 5, 2024 ballot.

Summary. A Managed Care Organization (MCO) tax has been in place in various forms since first implemented in 2009. Essentially, the MCO tax assesses a fee on managed care plans based on enrollment with the tax rate being higher for Medi-Cal enrollees. The State uses the funds generated by the MCO tax to draw down additional federal funding.

Discussion. The current MCO tax is approved through 2026 and requires legislative and federal approvals to continue. Proposition 35 would make the existing tax permanent, subject to federal approval, and prescribes how funds may be used.

The attached Legislative Analyst Office analysis provides an in-depth background on the MCO tax, a summary of Proposition 35, and an analysis of the fiscal effects.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

LAO

PROPOSITION 35
Provides Permanent Funding for Medi-Cal Health Care Services. Initiative Statute.

ANALYSIS OF MEASURE

BACKGROUND

State Charges a Specific Tax on Health Plans. Since 2009, California typically has charged a specific tax on certain health plans, such as Kaiser Permanente. This tax is called the Managed Care Organization Provider Tax ("health plan tax"). The tax has worked differently over time. Currently, it charges plans based on the number of people to whom they provide health coverage, including those in Medi-Cal. The tax rate is higher for those in Medi-Cal compared to other kinds of health coverage. (Medi-Cal is a federal-state program that provides health coverage for low-income people. The federal government and the state share the cost of the program. By charging the health plan tax, the state can receive more federal funding.)

State Uses Tax for Two Purposes. The amount of revenue raised by the health plan tax has changed over time. Based on recent legislative action, we estimate the tax is expected to result in between $7 billion to $8 billion each year (annually) to the state. The state uses this money for two purposes.

- ***Paying for Existing Costs in Medi-Cal.*** Some revenue helps pay for existing costs in the Medi-Cal program. Using the tax revenue in this way allows the state to spend less money from the General Fund on Medi-Cal. (The General Fund is the account the state uses to pay for most public services, including education, health care, and prisons. Medi-Cal is expected to get around $35 billion from the General Fund this year.) In other words, the health plan tax revenue reduces costs to the state General Fund.
- ***Increasing Funding for Medi-Cal and Other Health Programs.*** Some of the revenue increases funding for Medi-Cal and other health programs. For example, the state is increasing Medi-Cal payments to doctors and other health care providers. This is a new use of health plan tax revenue. Some of these funding increases began in 2024, but most will begin in 2025 and 2026. Once they all begin in 2026, the increases likely would result in around $4 billion more for Medi-Cal annually.

Around half of this amount will come from the health plan tax. (The rest will come from increased federal funding.)

Tax Will End, Unless It Is Approved Again. The Legislature has not permanently approved this tax. Instead, it has approved it for a few years at a time. The federal government also must approve the tax. The tax was most recently approved in 2023. It will expire at the end of 2026, unless the Legislature and federal government approve it again.

PROPOSAL

Makes Existing Health Plan Tax Permanent. Proposition 35 makes the existing health plan tax permanent beginning in 2027. The state would still need federal approval to charge the tax. The tax would continue to be based on the number of people to whom health plans provide health coverage. The proposition allows the state to change the tax, if needed, to get federal approval, within certain limits.

Creates Rules on How State Uses Tax Revenue. In addition to making the health plan tax permanent, Proposition 35 creates rules on how to use the revenue. Generally, these rules require the state to use more of the revenue to increase funding for Medi-Cal and other health programs. The rules are different in the short term (in 2025 and 2026) and the long term (in 2027 and after). Proposition 35 also changes which Medi-Cal services and other health programs get funding increases compared to current law. Figure 1 shows these changes in the short term.

Figure 1

Proposition 35 Changes Which Services Get Funding Increases

Funding Increases in the Short Term (in 2025 and 2026)

	Current Law	Proposition 35[a]
Doctors and other related providers[b]	✓	✓
Specified hospital services		✓
Outpatient facilities		✓
Safety net clinics	✓	✓
Behavioral health facilities		✓
Reproductive health and family planning	✓	✓
Emergency medical transportation	✓	✓
Nonemergency medical transportation	✓	
Private duty nursing	✓	
Certain long-term supports	✓	
Community health workers	✓	c
Continuous Medi-Cal coverage for children up to five-years old	✓	
Medi-Cal workforce programs	✓	✓
Doctor postgraduate training programs		✓

[a] More services are eligible for funding increases in the long term (beginning in 2027).

[b] Current law and Proposition 35 include some differences over which related providers get funding increases.

[c] Eligible for funding increases in the long term (beginning in 2027), depending on how much money is raised by the health plan tax.

FISCAL EFFECTS

In Short Term, Three Key Fiscal Effects. In the short term (in 2025 and 2026), Proposition 35 would have the following key fiscal effects:

- ***No Change to State Tax Revenue.*** Proposition 35 does not change the existing temporary tax on health plans, which expires at the end of 2026. For this reason, the proposition would have no effect on state tax revenue over this period of time.
- ***Increased Funding for Health Programs.*** Proposition 35 would increase funding for Medi-Cal and other health programs. This is because the proposition requires the state to use more health plan tax revenue for funding increases. The total increase in funding likely would be between roughly $2 billion and $5 billion annually. About half of this amount would come from the tax on health plans. (Because the federal government shares the cost of Medi-Cal with the state, the rest of the funding increase would come from federal funds. Including all fund sources, Medi-Cal is expected to get over $150 billion this year.)
- ***Increased State Costs.*** Proposition 35 would increase state costs. This is because it reduces the amount of health plan tax revenue that can be used to help pay for existing costs in Medi-Cal. Instead, the state likely would have to use more money from the General Fund for this purpose. **The annual cost would be between roughly $1 billion to $2 billion in 2025 and 2026.** These amounts are between one-half of 1 percent and 1 percent of the state's total General Fund budget.

In Long Term, Unknown Fiscal Effects. In the long term (2027 and after), Proposition 35 makes the temporary tax on health plans permanent and creates new rules about how to spend the money. The fiscal effect of these changes depends on many factors. For example, the state could approve the tax in the future, as it has done in the past, even if the proposition is not passed by voters. Also, it is uncertain how large of a tax the federal government would approve in the future. Given these uncertain factors, the proposition's long-term effects on tax revenue, health program funding, and state costs are unknown.

Temporarily Increases State Spending Limit. The California Constitution has various rules that impact the state budget. One rule limits how much state tax revenue can be spent on any purpose annually. Voters may increase this limit for up to four years at a time. In line with these rules, Proposition 35 temporarily increases the limit by the size of the health plan tax for four years. After the temporary increase ends, the long-term effect of the proposition on the state's spending limit is uncertain. This is because it is unknown how Proposition 35 would affect state tax revenue in the future.

YES/NO STATEMENT

A **YES** vote on this measure means: An existing state tax on health plans that provides funding for certain health programs would become permanent. New rules would direct how the state must use the revenue.

A **NO** vote on this measure means: An existing state tax on health plans would end in 2027, unless the Legislature continues it. The new rules would not become law.

SUMMARY OF LEGISLATIVE ANALYST'S ESTIMATE OF NET STATE AND LOCAL GOVERNMENT FISCAL IMPACT

- In the short term, increased funding for Medi-Cal and other health programs between roughly $2 billion and $5 billion annually (including federal funds). Increased state costs between roughly $1 billion to $2 billion annually to implement funding increases.
- In the long term, unknown effect on state tax revenue, health program funding, and state costs. Fiscal effects depend on many factors, such as whether the Legislature would continue to approve the tax on health plans in the future if Proposition 35 is not passed by voters.

BALLOT LABEL

Fiscal Impact: Short-term state costs between roughly $1 billion and $2 billion annually to increase funding for certain health programs. Total funding increase between roughly $2 billion to $5 billion annually. Unknown long-term fiscal effects.