Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Date: Wednesday, April 26, 2023

Time: Call to Order.....10:00 a.m.
Catered Lunch.....12:30 p.m. – 1:00 p.m.
Adjourn.....2:30 p.m.

Location: El Capitan Hotel
Sentinel Conference Room
609 W Main Street
Merced, CA 95340

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, April 24, 2023 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 five 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 five minutes.

Call to Order by Chairperson Jimenez. 10:00 a.m.

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome Mr. Michael Schrader, Chief Executive Officer, to the Alliance.
D. Welcome Ms. Julie Peterson, Hospital Representative, Santa Cruz County and Ms. Leslie Abasta-Cummings, Provider Representative, Merced County to the Board.
E. Recognize Board service of Mr. Tony Weber.

2. Oral Communications. 10:05 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 five 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 five 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.

Consent Agenda Items: (5. – 9H.): 10:10 a.m.

5. Accept Executive Summary from the Chief Executive Officer (CEO).

- Reference materials: Executive Summary from the CEO; April 2023 Bill List; and letters of support.

Pages 5-01 to 5-57

6. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the second month ending February 28, 2023.

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

Appointments: (7A. – 7C.)

7A. Approve appointment of Commissioner Josh Pedrozo to the Finance Committee.

- Reference materials: Staff report and recommendation on above topic.

Page 7A-01

7B. Approve appointment of Ms. Melissa Raya to the Member Services Advisory Group.

- Reference materials: Staff report and recommendation on above topic.

Page 7B-01

7C. Approve appointment of Lena Malik, MD to the Whole Child Model Clinical Advisory Group.

- Reference materials: Staff report and recommendation on above topic.

Page 7C-01

Minutes: (8A. – 8C.)

8A. Approve Commission meeting minutes of March 22, 2023.

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

Back to Agenda

8B. **Accept Compliance Committee meeting minutes of February 15, 2023.**
- Reference materials: Minutes as above.

Pages 8B-01 to 8B-03

8C. **Accept Finance Committee meeting minutes of October 26, 2022.**
- Reference materials: Minutes as above.

Pages 8C-01 to 8C-03

Reports: (9A. – 9H.)

9A. **Approve recommendation authorizing the Chairperson to sign Medi-Cal Contract 08-85216 A-48 to incorporate updated Capitation Payment rates for period July 1, 2019 through December 31, 2020.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9A-01

9B. **Approve recommendation for revised 2023 Finance Committee meeting schedule.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9B-01

9C. **Approve recommendation for the addition of a staff bonus program as a component of the Alliance's compensation philosophy, effective for fiscal year 2023.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9C-01 to 9C-02

9D. **Approve recommendation to update Local Agency Investment Fund (LAIF) Authorization Resolution and Santa Cruz County Bank Authorization Resolution.**
- Reference materials: Staff report and recommendation on above topic; and Resolutions of Santa Cruz-Monterey-Merced Managed Medical Care Commission (LAIF and Santa Cruz County Bank).

Pages 9D-01 to 9D-03

9E. **Approve recommendation to allocate Medi-Cal Capacity Grant Program funds to establish a Disaster Response Fund.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9E-01 to 9E-03

9F. **Accept Medi-Cal Capacity Grant Program (MCGP) Performance Dashboard – October 2015 through March 2023.**
- Reference materials: MCGP Performance Dashboard.

Pages 9F-01 to 9F-08

9G. **Approve Medi-Cal Capacity Grants Funding Recommendations. (Group A)**

A. Action on grants with no Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.

Pages 9G-01 to 9G-18

9H. **Approve Medi-Cal Capacity Grants Funding Recommendations. (Group B)**

A. Action on grants with Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.

Pages 9H-01 to 9H-09

Back to Agenda

<u>Regular Agenda Items</u>: (10. – 16.): 10:15 a.m.

10. **Annual Election of Officers of the Commission. (10:15 – 10:25 a.m.)**

A. Board will nominate and elect Chairperson and Vice Chairperson.

- Reference materials: Staff report and recommendation on above topic.

Page 10-01

11. **Consider approving new Medi-Cal Capacity Grant Program (MCGP) Funding Opportunities (2023 – Phase 2). (10:25 – 10:45 a.m.)**

A. Ms. Jessica Finney, Grants Director, will review and Board will consider approving recommendations for new MCGP funding opportunities and associated MCGP budget allocations.

- Reference materials: Staff report and recommendation on above topic; MCGP Framework; and MCGP Focus Areas, Goals and Priorities.

Pages 11-01 to 11-10

12. **Discuss Dual Eligible Special Needs Plans (D-SNPs) Operational Readiness and Governance Considerations. (10:45 – 11:30 a.m.)**

A. Ms. Van Wong, Chief Operating Officer (COO) and Ms. Margaret Tatar, Health Management Associates, will review and Board will discuss findings from D-SNP Operational Gap Assessment conducted by Health Management Associates

B. Ms. Wong, COO, will facilitate a discussion with Ms. Tatar, Mr. Michael Schrader, CEO and the Board regarding governance of a D-SNP.

- Reference materials: Staff report on above topic; and Ms. Margaret Tatar biography.

Pages 12-01 to 12-03

Break: 11:30 – 11:45 a.m.

13. **Discuss Alliance Quality Program. (11:45 a.m. – 12:30 p.m.)**

A. Dr. Dale Bishop, Chief Medical Officer and Ms. Andrea Swan, RN, Quality Improvement and Population Health Director, will review and Board will discuss performance in the Alliance Quality Program, including 2022 performance, roadmaps to improve quality performance, 2022 Care-Based Incentive program results and progress towards 2024 contract requirements.

- Reference materials: Staff report on above topic.

Pages 13-01 to 13-06

Lunch: 12:30 – 1:00 p.m.

14. **Discuss State of the Alliance Network. (1:00 – 1:40 p.m.)**

A. Ms. Wong, COO and Ms. Jessie Dybdahl, Provider Services Director, will review and Board will discuss the current state of the Alliance network, including members' realized access and the current network development strategy.

- Reference materials: Staff report on above topic; California Physicians Almanac, 2021: A Portrait of Practice by California Healthcare Foundation; and California Healthcare Almanac, August 2021 by California Healthcare Foundation.

Pages 14-01 to 14-116

15. **Discuss Behavioral Health Program: Gaps and Opportunities. (1:40 – 2:10 p.m.)**

A. Dr. Shaina Zurlin, LCSW, PsyD., Behavioral Health Director, will review and Board will discuss staff's current assessment of gaps and opportunities to improve the behavioral health services and systems to be person centered and equitable.

- Reference materials: Staff report on above topic.

Pages 15-01 to 15-08

Back to Agenda

Break: 2:10 – 2:15 p.m.

16. Discuss Key Takeaways and Next Steps. (2:15 – 2:25 p.m.)

A. Mr. Michael Schrader, CEO, will review and Board will discuss Board calendar for 2023 and key topics for the remainder of 2023.

Information Items: (17A. – 17B.)

Back to Agenda

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, June 28, 2023; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, May 11, 2023; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, June 1, 2023; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee [*In-person and remote teleconference*]
  Thursday, June 15, 2023; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [*In-person and remote teleconference*]
  Monday, May 8, 2023; 1:30 – 3:00 p.m.

The above meetings will be held in person unless otherwise noticed. Audio livestreaming will be available to listen and view the meeting.

The next regular meeting of the Commission, after this April 26, 2023 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, May 24, 2023; 3:00 – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

The above meeting will be held in person unless otherwise noticed. Audio livestreaming will be available to listen and view the meeting.

Locations for the meeting:

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

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. 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.

Back to Agenda

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

2023 Legislative Session. At your Board's meeting on February 22, 2023 your Board adopted 2023 Policy Principles and Priorities to guide staff's efforts to monitor and advocate on emerging legislative, budget, and policy issues. The Board's approved areas of focus include access to care, local innovation, eligibility and benefits, financing and rates, health equity, and person-centered delivery system transformation. Staff utilize the Board adopted policy priorities to identify specific legislative, budget, and policy issues to monitor. At this time, staff are monitoring and tracking 57 newly introduced bills within these priority areas and have identified four priority bills on which to take an advocacy position. Staff have submitted letters of support or opposition on these four priority bills. The full bill list and the advocacy letters for each of the four priority bills are attached to this report for the Board's awareness and review.

2023-24 State Budget. As previously discussed with your Board, Governor Newsom's January State budget proposal projected a $22.5B deficit for the upcoming 2023-24 State fiscal year. The January budget proposal maintained previous funding commitments to health care, including CalAIM initiatives, and included a proposal to renew the State's Managed Care Organization (MCO) Tax for a three-year period from 2024-2026, which is estimated to garner $2B annually. The Governor will release his May Revision to the January proposal in mid-May, which is expected to include an increased budget deficit due to lower than assumed tax revenue. Staff will review the proposal and apprise your Board on relevant proposals.

MCO Tax – SB 870 (Caballero). Senator Anna Caballero has introduced a bill with the intention to implement the MCO Tax. The MCO Tax offers an important opportunity to leverage federal funds to support the Medi-Cal program. Staff are working with the Local Health Plans of California to develop proposed MCO Tax funding priorities and to ensure that appropriate funding mechanisms and protections are included in the final bill. These proposed mechanisms and protections would ensure that any revenue generated is supplemental, without offsetting decreases in funding, and would ensure that provider payment increases through managed care be made available to contracted providers. Ultimately, staff will advocate for and support a final MCO Tax to bring in additional revenue supporting the Medi-Cal delivery system.

Voluntary Rate Range Program. The Alliance works in coordination with the Department of Health Care Services (DHCS), contracted public hospitals, and other qualified entities to implement the Voluntary Rate Range Intergovernmental Transfer program, leveraging available federal funds as authorized by the Centers for Medicare and Medicaid Services. The Alliance received $50.35M in supplemental federal funds from DHCS for the 2021 Rate Range which was paid out this month to contracted, qualified, participating providers.

San Benito and Mariposa County Expansion. Expansion activities remain in progress, with staff working towards a January 1, 2024 expansion of the Alliance's services to San Benito and Mariposa Counties. Staff continue to meet with DHCS leadership, including the Capitated Rate Development Division and its consulting actuaries, the Managed Care Operations Division, Managed Care and Quality Monitoring Division, and the Integrated Systems of Care Division, to discuss issues and address barriers to a successful expansion. Additionally, staff continue provider network building efforts by actively recruiting providers in both expansion counties and by continuing to engage with community leaders. Staff will return to your Board in June 2023 with an update on these efforts, including a report and an update on Staff's assessment of the financial viability of the expansion.

Community Involvement. On April 13, 2023, Ms. Stephanie Sonnenshine attended the Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and the Local Health Plans of California April Board meeting in Sacramento on April 17, 2023. On April 20, 2023, Ms. Sonnenshine attended the HIPSCC Executive Committee meeting.

Health Services

In late March, the Health Services Division welcomed Marwan Kanafani, MBA MPH as the Health Services Officer and Andrea Swan, RN as the Quality Improvement and Population Health Director. Marwan will assist with oversight of Health Services operations and Health Services department integration as we continue to advance development of Alliance CalAIM programs including Population Health, Enhanced Care Management, Community Supports and Behavioral Health improvement. Andrea is leading the measurement year 2022 Managed Care Accountability Sets audit and the effort to improve care and care equity for Alliance members with emphasis on the pediatric population.

Quality Improvement and Population Health

Health Effectiveness and Data Information Systems/Managed Care Accountability Sets Report 2023. On April 19, 2023, the Alliance will participate in National Committee for Quality Assurance's Health Effectiveness and Data Information Systems (HEDIS) annual compliance audit, administered by Health Services Advisory Group. In advance of the audit, all reporting milestones have been met. Final rates are expected to be reported in June upon completion of all audit deliverables.

Pediatric Equity Roadmap. The Pediatric Equity Task Force was formed in 2022 with a goal to achieve pediatric equity by December 31, 2023 demonstrated by achieving the HEDIS P50 or 10% gap closure in the children's domain measures. The task force is a cross functional collaborative group made up of stakeholders across the organization. Areas of focus include development of member interventions, provider interventions, and interventions aimed at increasing data capture. The task force meets on a biweekly basis to discuss interventions, activities, and any identified barriers.

Care-Based Quality Improvement Program. Applications for the Alliance's one-time Care-Based Quality Improvement Program (CB QIP) opened in March and will be available for submission through the Alliance's Incentive Programs Online Portal until May 19, 2023. The aim of this program is to provide financial investment for practices to make quality improvement interventions that target staffing, processes, and technology to practices. All practices receiving a 25%-100% CBI payment reduction in 2022 CBI Q4 payments will be eligible to

participate in the performance improvement project. Applications will be reviewed by Alliance's Quality Improvement and Population Health staff, and providers accepted to the program will need to sign a letter of agreement for participation. The operations for the program will run June through December 2023.

Utilization Management

The DHCS 2023 Medical Audit concluded with no findings with the corresponding DHCS report confirming that all findings for the Alliance's 2022 survey were corrected. The audit was conducted from February 6, 2023 through February 17, 2023 for the audit period November 1, 2021 through October 31, 2022. The audit included a review of the plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine the effectiveness of the policies. Documents were reviewed and interviews were conducted with plan personnel. Auditors were complimentary of Alliance programs.

Inpatient and Emergency Department. Overall admissions increased in 2022 compared to 2021, likely due in part to increased membership and pandemic rebound impacts associated with previously delayed or deferred care. While membership totals increased, the average length of stay decreased from 2021 to 3.9 for Child and Family Aid codes. Additionally, the overall readmission rates decreased by 1% with an average of 12% for the year. Reduced California Children's Services/Whole Child and Ambulatory Care Sensitive Admissions bed days were noted in 2022 as compared to 2021 and the overall Average Length of Stay reduced from 5.1 to 4.7 days in 2022. Early gains in these areas may be partially attributed to the work underway in readmission reduction and transition of care across the counties with facility and plan providers.

Required Preadmission Screening and Resident Review (PASRR) training, began in March for the PASRR program, which is scheduled to go live on May 1, 2023 and requires general acute care hospitals to submit the PASRR prior to transfer to Long Term Care and Skilled Nursing Facilities (LTC/SNF). The Alliance concurrent review team continues work with acute care and LTC/SNF facilities across the counties in routine Interdisciplinary Team meetings to address the transition of care needs of the plan's most complex members, building partnerships with providers and facilities across the counties.

Prior Authorization (PA). While Q4 reflected a turnaround time (TAT) rate of 99.6% throughout Q4 (29,496 of 29,605 authorizations), the PA team processed authorizations timely and at a rate greater than 99% each quarter throughout the full 2022 year, sustaining this metric well into 2023. Prior authorization process development was reflected throughout the year with sustained TATs in an environment of increasing authorization activity as members resume care to exceed 2019 levels and overall membership has increased. Continued PA cross training, subject matter expert development and process improvement continues to carry into 2023.

Prior Authorization denial rates remained at approximately 2% throughout 2022 and are a driver in continued efforts for reducing unnecessary authorization requirements. Less than 1% of denied authorizations resulted in an appeal throughout 2022, with this trend continuing into 2023. Sixty-eight percent of appeals were upheld and 32% of these denials were overturned.

Out of Network (OON) specialty referral volumes increased in Q4 and OON denials remain low (n-2.8%), with total approvals lower than activity seen in prior quarters, a reflection of successful redirection efforts in network. Work is underway in 2023 to automate in network specialty

referrals as a mechanism to further reduce administrative burden for providers and support timely access for members.

Member Benefits. Member Benefits efforts into 2023 are focused on the further automation of specialty in network Authorized Referral authorizations, self-referrals for Medication Assisted Therapy, and increased vaccine access through public health and alternate immunization providers. Community Health Worker and doula benefits have been operationalized and while these do not require authorization, utilization oversight continues through monitoring of claims activity which has been minimal heading into Q1 2023.

Pharmacy

Site of Care Program. The Alliance initiated the Site of Care Program in December 2022 to improve access for our members, quality of care and patient convenience. The goal of the program is to transition members from hospital-based outpatient infusion of the medication to a more convenient site of care, such as home-based infusion. The member and prescribing provider can opt in or out of the Site of Care Program depending on the member's clinical and social needs. Currently, staff are focusing on members who are on infliximab (Remicade), its biosimilars, vedolizumab (Entyvio), and intravenous immune globulin (IVIG). Thus far, five members have accepted the program. Of those five members, three of their providers have also accepted the program and the other two are pending provider decision. The members who have declined the program have done so for multiple reasons, including not wanting anyone in their home or they would like to continue at their current site of care because they receive other services from that site at the same time. Another barrier to this program has been the time it takes for prescribers to send clinical information and medication orders to the infusion pharmacy. The infusion pharmacy must follow up with the provider multiple times to obtain all the necessary information from the prescriber. We are currently training more pharmacy team members on the program and in the future, we will begin targeting members on other infusion medications.

Drug Utilization Review (DUR) Program

Antidepressant Medications in Children. Drug utilization review was performed on Alliance members who were less than or equal to 18 years of age and had a prescription for an antidepressant medication during the period of January 2022 through January 2023, excluding members with other healthcare coverage. 2,867 pediatric members were on an antidepressant during this time. Of these pediatric members there were more female members on antidepressants than male members; 1,939 females versus 928 males. This trend is consistent with a recent CDC report that states "nearly 3 in 5 (57%) U.S. teen girls felt persistently sad or hopeless in 2021 - double that of boys." We also looked at the monthly trend of pediatric member counts filling an antidepressant over this time period, which was unremarkable. We will continue to monitor this DUR topic annually for inappropriate prescribing and trends.

Deprescribing of Benzodiazepines in Older Adults. Benzodiazepines are used to treat a variety of conditions, including generalized anxiety disorder, insomnia, seizures, social phobia, and panic disorder. Benzodiazepines are also used as a premedication before some medical procedures. The long-term use of these medications is not supported by scientific evidence due to the potential for adverse events, dependence, and abuse. The Pharmacy department reviewed 2022 pharmacy claims to analyze the use of benzodiazepines in older adults 65 years of age and older. There were 878 claims for benzodiazepines for 262 members. This

constituted only 1% of our members who received benzodiazepines. The top three medications utilized were lorazepam, clonazepam and diazepam, and the highest number of claims were in Monterey followed by Merced and Santa Cruz County. Data was also analyzed for members and providers for specific utilization or prescribing patterns. 133 members (51%) only had occasional fill(s) most likely associated with a procedure or the like. 129 (49%) members had multiple fills. Eleven members using more than one pharmacy were reviewed, and none of them showed any concern for fraud, waste, and abuse. Among the providers, the highest number of members were associated with providers in the fields of vascular surgery, internal medicine and family practice with focus on wound care. No patterns or concerns were detected. An educational article will be published in Provider Digest recommending assessment of the members, the appropriate use of the medication and possible tapering/deprescribing of the medication. It will also include recommendations on how to taper slowly to avoid any withdrawal symptoms.

Statin Therapy for Members with Diabetes. Pending analytics report. It will be performed and reported in future reports.

Pharmacist-Led Academic Detailing Program: Diabetes. The Alliance Pharmacy Team initiated this program to assist clinicians in managing Alliance members with uncontrolled diabetes (A1C of 9% or greater). The goal of this program is to improve the quality and appropriateness of prescribing practices and to ensure that Alliance members with diabetes receive optimal, evidence-based care. The program encompasses ten weekly, 45-minute interactive virtual sessions with a small group of two to three clinicians over ten weeks. Alliance pharmacist will be leading the program, by directly engaging with clinicians, assessing their needs, identifying areas for change in practice and educating on the 2023 American Diabetes Association Standards of Care. Pharmacist will support the clinicians by equipping them with specific tools such as motivational interviewing, communication strategies to engage and empower members (while avoiding stigmatizing language), as well as pharmacotherapy related clinical pearls to overcome therapeutic inertia. Additionally, this program will be offered as part of CB QIP to provide financial investment for practices to make quality improvement interventions. Outreaches to several clinics were conducted during Q4 2022 and Q1 2023 and as a result, two clinics are lined up to start the program during Q2 2023. A program summary will be published in April 2023 in the Provider Digest to ensure providers are aware of this program and its benefits. Lastly, a program summary flyer was created to promote this new benefit offered by the Alliance.

Community Care Coordination

Complex Care Management (CCM). The work to prepare for the implementation of 2024 DHCS contractual requirements is underway and deliverables related to CCM are being provided for DHCS review and approval. These include both departmental as well as interdepartmental information that demonstrate policy changes required, as well as new Memorandum of Understandings, staff training, and desktop workflows to implement the new requirements. These deliverables are staggered over the next few months and are an ongoing work in progress.

The next phased of the Population Health Management interdepartmental project work will be initiated at the beginning of May. The department will support this project work by providing business lead strategy, as well as subject matter leadership of the CCM components of the Program. Staff have implemented the new requirements for CCM, and now processes are

being monitored and areas are being identified to develop process improvement strategies. Several new internal reporting metrics have been implemented to assess the effectiveness of the implementation.

Enhanced Care Management (ECM)/Community Supports (CS). Staff are working internally to prepare the newly identified providers who will serve the new Populations of Focus for ECM in July 2023. The new Populations of Focus include Children and Youth enrolled in CCS Whole Child Model (WCM) with additional needs beyond their CCS condition, as well as children and youth involved with the Child Welfare System. Several existing contracted ECM providers also have experience serving these populations and are willing to expand their ECM populations to serve these children, youth, and families.

The Alliance will also be adding two additional optional CS in July. These include Respite Care Services and Personal Care and Homemaker Services. These new CS services will require some modifications within the internal operational processes included in CS, and structures are being refined to align them with the guidance provided by DHCS. Additionally, both of these CS services will require the contracted CS providers to utilize the state's new Electronic Visit Verification system, and additional support for providers will be given as needed to support this requirement.

Staff have also developed an internal executive dashboard to monitor ECM network capacity, existing enrollment, as well as the DHCS estimates for ECM enrollment for this year. This information is being utilized to refine strategies to expand provider network development, identify areas where expanded community outreach can be made, and ultimately increase member enrollment.

Whole Child. DHCS has recently released the final report of the WCM Evaluation. The evaluation assessed the overall impact of the implementation of the WCM across California. The WCM was either positive or neutral in access and quality. This evaluation was a broad study of the CCS program, and the Alliance has begun the review of the 600+ document with additional appendixes. We will plan to present a summary of the report to the Alliance's WCM Family Advisory Committee and WCM Clinical Advisory Committee in the future. The links to the WCM Evaluation Report can be found here:
https://www.dhcs.ca.gov/services/ccs/Documents/WCM-Report-Master.pdf
https://www.dhcs.ca.gov/services/ccs/Documents/AppendixA-H.pdf
https://www.dhcs.ca.gov/services/ccs/Documents/Appendix-I-Y.pdf

The Pediatric CCM team continues engagement in Alliance proactive outreach initiatives, having participated in the call campaign activated in March related to the impacts of inclement weather within the Alliance's service area. Current population health management initiatives are aimed at effectively addressing preventive care, member education, disease management, and in identifying additional case management needs. The current PHM campaign is well underway and is specific to high-risk pediatric members.

The Alliance also continues ongoing collaborative meetings with County CCS agencies, Medical Therapy Units/Clinics, Specialty Care Providers, as well as participating in the Alliance's WCM Family Advisory Group and WCM Clinical Advisory Group. These meetings allow for continuous process improvement identification and relationship building.

Behavioral Health (BH). On March 1, 2023, our behavioral health delegate finalized their rebranding. Formerly Beacon, the organization is now known as Carelon Behavioral Health. We have been working to coordinate notification to all impacted, including providers, members and Alliance staff. This includes a major lift by the Communications department to address a large volume of branded materials on and linked to our website. One complexity which has added to the challenge of managing the rebranding project is the departure of our key executive contact at Carelon. We are awaiting appointment of a new executive lead from Carelon.

In response to storms, BH has been working with community partners across Santa Cruz and Monterey counties to ensure appropriate support to those impacted. With hundreds of evacuated Pajaro residents staying at the Watsonville Fair Grounds Emergency Shelter, BH partnered with Carelon to have an on-site presence. The BH staff at the shelter have seen as many as 28 individuals each day, providing various types of counseling and support. As the situation evolves and members move on from the shelter, BH will continue to evaluate the need for support in this venue.

In acknowledgement of the BH needs across our membership, the team has been working to recruit and hire an additional full time BH Program Manager. The addition of this role will support deeper collaboration towards integrated care, more detailed attention to member experience accessing BH care, and more hours working towards improvement of the system. The team hopes to make an offer to a candidate in April.

Progressing towards our overarching goal of an improved behavioral health ecosystem, the BH Director has been engaged in preparation activities to lead high-level discussions with key groups throughout April. This includes a presentation at the Operations Committee as well as with the Board of Directors

Employee Services and Communications

Human Resources

Alliance Workforce. As of March 27, 2023, the Alliance has 549.1 budgeted positions of which our active workforce number is 524.5 (active FTE and temporary workers). There are 31 positions in active recruitment, and we are 95.5% staffed. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources continues to partner with Finance to ensure alignment in this area.

Competencies and Career Development. This project continues to move forward with the approval of core and leadership competencies. Human Resources has started work with each department, validating competencies by classification. We expect this work to run through the end of August 2023. Once this body of work is complete, Training & Development will begin work on the navigation and career development module, scheduled to start in August 2023. Human Resources will provide a status update to Operations Committee in May 2023.

Quarterly Goal Check-in. Human Resources has implemented a new Quarterly Goal Check-in process. With a focus on goal attainment across the organization, all supervisors will conduct a goal check-in meeting with staff to ensure we are progressing as needed to complete assigned goals. Supervisors have access to a user-friendly template and will provide this check-in during a regularly scheduled one-on-one. Adding quarterly goal check-ins will assist

leadership in tracking incremental advancements that lead to goal attainment. In addition, check-ins will assist in identifying barriers early on, so they can course correct when needed.

Facilities and Administrative Services

Alliance Footprint Reduction. The Facilities Department is working to clear out employee workstations and offices in the areas targeted for footprint reduction. The team is proceeding with an 80,000 square foot reduction of Alliance occupied office space and an increase of potential space for leasing which was included in the Annual Facilities Management report.

1098 38th Avenue (Capitola Manor). The Alliance sold the vacant lot to Mid-Pen Housing on March 10, 2023.

Winter Storm Clean Up and Mitigation. Facilities is continuing efforts to clean up, repair, and mitigate areas impacted by flooding in the Scotts Valley location due to the unprecedented rainfall in March 2023.

Service Area Expansion. Facilities is actively working with Mariposa and San Benito counties to coordinate leasing space with a targeted occupancy of October 1, 2023 in both service areas.

Communications

Member Texting Pilot. The member texting pilot is continuing, with the expectation that we will wrap up the feasibility report in June. Previously, we texted 116,000 members to let them know about redetermination. In May, we will begin sending targeted texts to members who are up for redetermination and who have received packets from the county.

Redetermination. A paid campaign promoting Redetermination launched March 26, 2023 and will run through spring. The revised messaging and media tactics received approval from DHCS. Tactics include website copy, social media ads, Member Bulletin articles, The Beat articles, mobile ads, and bus ads.

Member Incentives. In conjunction with Health Services, staff worked on rebranding the Member Incentives program and a new brand for the incentives program for well-checks and immunizations. The umbrella program is called Health Rewards Program, and the new well-checks/immunizations is called Healthy Start. The rebranding consists of new brochures and flyers, new website content, social media ads, member, community, and provider newsletter articles. To support enhanced awareness of the new program, we are launching a paid media campaign on May 8, 2023. Messaging will encourage people to see their doctor for checkups and to remain on track with vaccinations. The bi-lingual paid media campaign will run in all three counties and will include internal and exterior bus ads, mobile ads, Facebook ads, clinic, ads, Peachjar ads (flyers to 72 schools), website copy and newsletter articles.

Operations

Member Services. The Member Services Department is actively collaborating with our county partners to share member information regarding address updates and redetermination dates. The continuous coverage requirement has now ended, and the redetermination process resumed April 1, 2023. The Alliance will use the data provided by the counties to engage with our members by conducting outreach to ensure awareness of the resumption of the Medi-Cal

eligibility redetermination process and respond to redetermination packet requests timely. The Alliance will be conducting targeted text campaigns including live outreach to members who have not returned their packets, risking disenrollment within the next 30-days. We continue to experience increased member calls to update addresses and are actively sharing this information with our county partners to assist in the redetermination process. In our Merced office, through a collaborative effort with Merced County Human Services Agency, we arranged for an eligibility worker on-site once per week to assist our members with eligibility concerns and/or completion of the redetermination process.

Provider Services. Santa Cruz County continues to see restriction to specialty services due to a multitude of reasons including physician attrition and the impending arrival of Kaiser Permanente, introducing competition for commercial payers. Santa Cruz County members have seen reduced access to cardiology, OB/GYN services, general surgery, and most recently allergy services. This has a direct impact on the safety net providers in Santa Cruz County, specifically our Federally Qualified Health Center (FQHC) primary care physician clinics. There are a few different solutions that have been proposed and some implemented to support the current specialty constraints including:

1. Collaboration between specialty groups and FQHC to develop clinical guidelines for specific specialties, e.g. cardiology, allergy to streamline referrals
2. Pilot of AristaMD's RN Navigator with Santa Cruz Community Health Center

Additional information on the above can be found under the Alliance Provider Network Adequacy and Realized Access.

The team continues to recruit for San Benito and Mariposa County providers as we look towards expansion in 2024. Relations Representatives are going out to visit providers in both counties on an ongoing basis. The team is focused on listening to provider needs and understanding member utilization to ensure the Alliance is well informed of provider access areas needed for the January 1, 2024 go live.

As part of our continuous improvement efforts, Credentialing staff reviewed our 2022 provider applications for timeliness and opportunities to streamline workflows. Overall, 99% of all new applications were processed timely with almost 50% of applications processed within 60 days of receipt. Only 4% of applications received in 2022 required approval from the Peer Review Credentialing Committee. Applications requiring more than 60 days typically involve missing or additional information needed for successful credentialing and is highly dependent on response time from the applicants. Staff have initiated education and training sessions to assist provider offices with completeness of initial credentialing application submission as well as leveraging the roster process for facility-based providers where credentialing applications are not required.

Community Engagement Santa Cruz/Monterey/Merced. In Merced County, the Community Engagement Department collaborated with Mercy Medical Center Rural Health Clinics, Mercy Medical Center Foundation and the Merced City School district to pilot our first school-based vaccine clinic at Givens Elementary school. Tdap vaccines were provided for students who were entering middle school. In this collaborative effort, the school made telephone calls to parents to make them aware of this event. The rural health clinic provided the vaccination and educated students and parents about any missing vaccine and the importance of getting caught up on well child exams. The Mercy Medical Center Foundation helped provide

backpacks, socks and hygiene products to students and their families. Alliance staff provided onsite support and coordination and educated families about Alliance benefits. The event was very well received, and members thanked us for making this process so easy for them. More than two dozen students received their vaccine, and we are planning additional clinics with the school district soon.

With a second storm in 2023, there was significant flooding in each county with most of the damage to homes and businesses in Santa Cruz and Monterey County. The Alliance was able to make direct calls to members living in the areas that were flooded to offer support and assistance with medical care and access to medications if needed. The Alliance also provided financial contribution to each County Food Bank to meet the urgent need for food distribution to residents impacted by the recent storms and flooding.

Claims. The Alliance has been working with Salud Para La Gente to ease referral requirements for services provided to Alliance members at the Santa Cruz County Fairgrounds in support of those who were impacted by the recent storm. This temporary referral waiver highlights the collaboration between the Alliance and our provider partners to ensure members have timely and equitable access to needed health care during the time they were evacuated as a result of the Pajaro flood.

The first three months of the claims processing audits have been produced. 264 claims were randomly selected and audited each month. These claims were stratified by paid dollars to assure that all types of claims were audited. The sample was broken out into 11 financial groups ranging from paid amounts in $0.01 to and over $50,000. The results of these audits will be used to measure the plans Financial Accuracy, Payment Accuracy, and Processing Accuracy. The Alliance is targeting audit results in the 98% or more for Financial Accuracy and 95% or more for both Payment and Processing Accuracy. These targets are set at or above the standards that all health plans are required to maintain in the state of California (Cal. Code Regs. tit. 28 § 1300.71(a)(8)(K)).

Financial *Accuracy* is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

	Claims Paid Dec 2022	***Claims Paid Jan 2023***	***Claims Paid Feb 2023***
Total Paid Dollars	$3,917,628.69	$2,711,504.74	$4,042,051.32
Total Dollars Paid Correctly	$3,841,112.48	$2,696,028.39	$4,037,930.01
Financial Accuracy	98.05%	99.43%	99.90%

Payment *Accuracy* is calculated by dividing the number of claims not containing a financial error by the total number of claims audited.

	Claims Paid Dec 2022	***Claims Paid Jan 2023***	***Claims Paid Feb 2023***
Total claims audited	264	264	264
Total claims with no financial error	238	242	247
Financial Accuracy	90.15%	91.67%	93.56%

Processing *Accuracy* is calculated by dividing the number of claims with a processing error that did not impact the financial payment of claim by the total number of claims audited.

	Claims Paid Dec 2022	***Claims Paid Jan 2023***	***Claims Paid Feb 2023***
Total claims audited	264	264	264
Total claims with no processing error	259	263	259
Processing Accuracy	98.11%	99.62%	98.11%

A root-cause analysis assessment was completed for each audit. Internal solutions and controls have been proposed, some of which have already been implemented.

Attachments.

1. April 2023 Bill List
2. Letters of Support

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

Central California Alliance for Health
April 2023 Bill List

Priority Bills	
AB 1379 **Papan** **Status:** Re-referred to the Committee on Local Government on March 27, 2023. Last amended March 23, 2023. Introduced February 17, 2023.	**Open meetings: local agencies: teleconferences** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. This bill, with respect to those general provisions on teleconferencing, would require a legislative body electing to use teleconferencing to instead post agendas at a singular designated physical meeting location, as defined, rather than at all teleconference locations. The bill would remove the requirements for the legislative body of the local agency to identify each teleconference location in the notice and agenda, that each teleconference location be accessible to the public, and that at least a quorum of the members participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The bill would instead provide that, for purposes of establishing a quorum of the legislative body, members of the body may participate remotely, at the designated physical location, or at both the designated physical meeting location and remotely. The bill would require the legislative body to have at least 2 meetings per year in which the legislative body's members are in person at a singular designated physical meeting location. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing provisions without complying with the general teleconferencing requirements that agendas be posted at each teleconference, that each teleconference location be identified in the notice and agenda, and that each teleconference location be accessible to the public, if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. Under existing law, these alternative teleconferencing provisions require the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. Under existing law, these alternative teleconferencing provisions authorize a member to participate remotely if the member is participating remotely for just cause, limited to twice per year, or due to emergency circumstances, contingent upon a request to, and action by, the legislative body, as prescribed. Existing law

	specifies that just cause includes travel while on official business of the legislative body or another state or local agency. This bill would revise the alternative provisions, operative until January 1, 2026, to make these provisions operative indefinitely. The bill would delete the restriction that prohibits a member, based on just cause, from participating remotely for more than 2 meetings per calendar year. The bill would delete the requirement for the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. The bill would also delete a provision that requires a member participating remotely to publicly disclose at the meeting before action is taken whether there are individuals 18 years of age present in the room at the remote location and the general nature of the member's relationship to those individuals. The bill would further delete a provision that prohibits a member from participating remotely for a period of more than 3 consecutive months or 20% of the regular meetings within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year. The bill would expand the definition of just cause to include travel related to a member of a legislative body's occupation. The bill would make related, conforming changes. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose. This bill would make legislative findings to that effect.
SB 282 **Eggman and McGuire** **Status:** Set for hearing April 10, 2023. Last amended March 13, 2023. Introduced February 1, 2023.	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified.

	This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.
SB 311 **Eggman** **Status:** Set for hearing April 10, 2023. Introduced February 6, 2023.	**Medi-Cal: Part A buy-in** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Existing federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums. This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
SB 424 **Durazo** **Status:** Set for hearing April 12, 2023. Last amended March 29, 2023 and re-referred to the Committee on Health.	**California Children's Services Program** **Summary:** (1) Existing law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Under existing law, CCS-eligible medical conditions include, among others, cystic fibrosis and hemophilia, and other conditions set forth by the Director of Health Care Services. This bill would statutorily expand the list of CCS-eligible medical conditions to include those conditions that are specified in existing CCS-related regulations. The bill would, commencing no later than January 1, 2026, and every 5 years thereafter,

	require the department to consult with, at a minimum, CCS medical directors and experts from the department's CCS technical advisory committees, to consider the addition of other medical conditions to the list, by regulation. The bill would make conforming changes to related provisions. (2) This bill would, commencing on January 1, 2025, and subject to an appropriation, for a child who has an eligible medical condition, but who is not financially eligible for the CCS Program, require the department to provide financial assistance for out-of-pocket costs not covered by the child's health care coverage, as specified, if those costs are for medically necessary services to treat a CCS-eligible medical condition. The bill would require the department to establish a procedure for providing that financial assistance. (3) This bill would require the department, on or before December 31 of each year, commencing on December 31, 2025, to provide an annual sustainability and access grant, under a certain formula, to each CCS-approved hospital that operates one or more CCS special care centers, as specified. For medically necessary treatments provided during the 2025 calendar year, the bill would require the department to adjust CCS payment rates for physician services, reflecting the cumulative effect of inflation, as specified. Under the bill, commencing on January 1, 2026, those payments would be updated annually to reflect the effect of inflation. Under the bill, the adjustments and updates would apply to both CCS payments made under the Medi-Cal program and CCS payments that are not made under the Medi-Cal program, as specified. For lifesaving specialty drugs, as defined, that are provided by a hospital on an inpatient basis, the bill would require the department to reimburse the hospital for the cost incurred by the hospital to acquire and administer the drug. Under the bill, the reimbursement would apply to both lifesaving specialty drugs furnished to a CCS-enrolled child for a CCS-eligible condition reimbursed under the Medi-Cal program and lifesaving specialty drugs that are not reimbursed under the Medi-Cal program but that are reimbursed directly by the CCS Program, as specified. The bill would condition implementation of the provisions in this paragraph on receipt of any necessary federal approval and, for purposes of the physician-related payment rate increases and drug-related reimbursements, on the availability of federal financial participation. The bill would also condition implementation of the provisions in this paragraph on an appropriation. The bill would state the intent of the Legislature that any consideration of a future appropriation for these provisions be made in accordance with legislative findings concerning subsequent deficits. (4) By increasing the duties of counties relating to the administration of the CCS Program through the above-described provisions, the bill would impose a state-mandated local program. (5) Existing law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care

	services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a Medi-Cal managed care plan served by a county organized health system or Regional Health Authority, or, commencing no sooner than January 1, 2024, an alternate health care service plan, in certain listed counties. This bill would specify that only those listed counties are authorized for the Whole Child Model program. Existing law prohibits the incorporation of CCS-covered services into a Medi-Cal managed care contract entered into after August 1, 1994, pursuant to specified provisions, until January 1, 2022, and until a certain related evaluation has been completed, except for contracts entered into under the Whole Child Model program or for county organized health systems or Regional Health Authority, as specified. This bill would extend that prohibition indefinitely by removing the expiration set for January 1, 2022, and for completion of the evaluation. (6) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
Assembly Bills	
AB 55 **Rodriguez** **Status:** Re-referred to the Committee on Health on April 3, 2023. Last amended March 30, 2023. Introduced December 5, 2022.	**Medi-Cal: workforce adjustment for ground ambulance transports** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency or nonemergency medical transportation services, as specified. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under existing law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Existing law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on federal maximum allowances based on the point of pickup and whether the service was for an emergency or nonemergency.

	The bill would require that the workforce adjustment meet a certain workforce standard, as determined by the department, which would apply to specified classes of employees, including emergency medical dispatchers, emergency medical technicians, paramedics, and registered nurses. The bill would set forth criteria for a provider to meet the workforce standard, with formulas taking into account the fiscal year and base hourly wage rates within a class of employees, and whether the provider is a new provider of ground ambulance services. The bill would require the department to direct each Medi-Cal managed care plan to implement a value-based purchasing model that provides for reimbursement to a network provider that meets the workforce standard requirement and that furnishes ambulance transport services, as specified. The bill would require the department to establish the manner and format for participating providers to report the required data, as specified. The bill would require a provider that has received the workforce adjustment to certify under penalty of perjury that it met the workforce standard, as specified. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. The bill would authorize the department to recoup any workforce adjustments paid to a provider that did not meet the workforce standard. The bill would prohibit implementation of the workforce adjustment from affecting the calculation of the above-described QAF-based add-on, and would prohibit adjustments to the workforce adjustment, except as specified to comply with federal requirements. The bill would condition implementation of the workforce adjustment on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would make conforming changes. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 236 **Holden** **Status:** Re-referred to the Committee on Appropriations on March 21, 2023. Last amended March 20, 2023. Introduced January 13, 2023.	**Health care coverage: provider directories** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60%

	accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 317 **Weber** **Status:** Re-referred to the Committee on Appropriations on March 22, 2023. Introduced on January 1, 2026.	**Pharmacist service coverage** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer. This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 365 **Aguiar-Curry** **Status:**	**Medi-Cal: diabetes management** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed

Re-referred to the Committee on Appropriations on March 22, 2023. Last amended on March 15, 2023. Introduced February 1, 2023.	and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The bill would make related findings and declarations.
AB 412 **Soria** **Status:** In committee April 10, 2023 – hearing postponed by Committee (on Health). March 28, 2023 hearing canceled, by request of author. Last amended March 13, 2023. Introduced February 2, 2023.	**Hospital Emergency Loan Program** **Summary**: The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities. This bill would create the Hospital Emergency Loan Program, until January 1, 2029, for the purpose of providing loans to prevent the closure of a hospital, as defined, or facilitate the reopening of a closed hospital, as defined. The bill would permit the authority to provide secured loans to certain hospitals at risk of closure, or governmental entities trying to facilitate the reopening of a hospital that meets specified criteria. The bill would require a hospital or a closed hospital to provide the authority with financial information, in a format determined by the authority, demonstrating the hospital's need for assistance due to financial hardship. The bill would specify that, in administering this loan program, the authority is exempt from rulemaking provisions of the Administrative Procedure Act. The bill would also exempt the authority from the rulemaking provisions of the Administrative Procedure Act for guidelines made pursuant to its general authority to make loans from the California Health Facilities Financing Authority Fund. This bill would create the Hospital Emergency Loan Program Fund, a continuously appropriated fund, for use by the authority to administer the loan program. The bill would authorize the Treasurer to invest moneys in the fund that are not required for its current needs in eligible securities, and to transfer moneys in the fund to the Surplus Money Investment Fund for investment, as specified. By creating a continuously appropriated fund, the bill would make an appropriation.
AB 424 **Bryan** **Status:** Re-referred to the Committee on Health on March 27, 2023.	**Neurodegenerative disease registry** **Summary:** Existing law, until January 1, 2028, and to the extent funds are made available for these purposes, requires the State Department of Public Health to collect data on the incidence of neurodegenerative disease in California, and requires a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to a patient for a neurodegenerative disease to report each case of a neurodegenerative disease to the department, as prescribed. Existing law specifies that for this purpose, "neurodegenerative disease" may include, but need not be limited to, amyotrophic lateral sclerosis (ALS), among other diseases.

Last amended on March 23, 2023. Introduced February 6, 2023.	This bill would require the term "neurodegenerative disease" to include, but not be limited to, ALS.
AB 425 **Alvarez** **Status:** Re-referred to the Committee on Appropriations on April 3, 2023. Last amended March 30, 2023. Introduced February 5, 2023.	**Medi-Cal: pharmacogenomic testing** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program. This bill would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but it not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications, including medications prescribed for behavioral or mental health, oncology, hematology, pain management, infectious disease, urology, reproductive or sexual health, neurology, gastroenterology, or cardiovascular diseases. The bill would also make related legislative findings.
AB 459 **Haney** **Status:** Re-referred to the Committee on Health on March 27, 2023. Last amended March 23, 2023. Introduced February 6, 2023.	**California Behavioral Health Outcomes and Accountability Review** **Summary:** Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including prevention and early intervention programs. This bill would require the California Health and Human Services Agency, by July 1, 2026, to establish the California Behavioral Health Outcomes and Accountability Review (CBH-OAR), consisting of performance indicators, county self-assessments, and county and health plan improvement plans, to facilitate an accountability system that fosters continuous quality improvement in county and commercial behavioral health services and in the collection and dissemination of best practices in service delivery by the agency. The bill would require the agency to convene a workgroup, as specified, to establish a workplan by which the CBH-OAR shall be conducted. The bill would require the agency to establish specific process measures and uniform elements for the county and health plan improvement plan updates. The bill would require the agency to report to the Legislature, as specified. By imposing new requirements on counties, this bill would impose a state-mandated local program. This bill would require the agency to request the University of California to enter into a contract with the state to provide specific services, including preparing an analysis of how data pertaining to the provision of behavioral health services and client outcomes collected by the counties and health plans may be used to demonstrate

	the impact of services on life outcomes. The bill would require the analysis to be delivered to the agency, the Legislature, and the workgroup on or before July 1, 2026. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
AB 492 **Pellerin** **Status:** Committee on Health hearing date set for April 18, 2023. Re-referred to the Committee on Health on March 27, 2023. Last amended March 23, 2023. Introduced February 7, 2023.	**Medi-Cal: reproductive and behavioral health integration pilot programs** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services, among other reproductive health services, and specialty or nonspecialty mental health services and substance use disorder services, among other behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to a federal waiver, as part of the schedule of Medi-Cal benefits. Under existing law, the Family PACT Program provides comprehensive clinical family planning services to a person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the waiver. Under the Family PACT Program, comprehensive clinical family planning services include, among other things, contraception and general reproductive health care, and exclude abortion. Abortion services are covered under the Medi-Cal program. This bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. The bill would define "qualified provider" as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion- and contraception-related services. For funding eligibility, the bill would require a Medi-Cal managed care plan to identify the qualified providers and the services that will be provided through the pilot program, as specified. The bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs, in order to support development and expansion of services, infrastructure, and capacity for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. For funding eligibility, the bill would require a qualified provider to identify both the patient population or gap in access to care and the types of services provided, as specified. The bill would require the department to convene a working group, with a certain composition, to develop criteria for evaluating applications and awarding funding, to

	conduct an evaluation of the pilot programs, and to submit a report to the Legislature, as specified.
AB 557 **Hart** **Status:** Referred to the Committee on Local Government on February 17, 2023. Introduced February 8, 2023.	**Open meetings: local agencies: teleconferences** **Summary:** (1) Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health, as specified. If there is a continuing state of emergency, or if state or local officials have imposed or recommended measures to promote social distancing, existing law requires a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures. Existing law requires a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures to give notice of the meeting and post agendas, as described, to allow members of the public to access the meeting and address the legislative body, to give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity for all persons to attend via a call-in option or an internet-based service option. Existing law prohibits a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures from requiring public comments to be submitted in advance of the meeting and would specify that the legislative body must provide an opportunity for the public to address the legislative body and offer comment in real time. This bill would extend the above-described abbreviated teleconferencing provisions when a declared state of emergency is in effect, or in other situations related to public health, as specified, indefinitely. The bill would also extend the period for a legislative body to make the above-described findings related to a continuing state of emergency and social distancing to not later than 45 days after the first teleconferenced meeting, and every 45 days thereafter, in order to continue to meet under the abbreviated teleconferencing procedures. The bill would additionally make nonsubstantive changes to those provisions and correct erroneous cross references.

	(2) The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose. This bill would make legislative findings to that effect.
AB 564 **Villapudua** **Status:** Committee on Health hearing set for April 11, 2023. Re-referred to the Committee on Health on April 6, 2023. Last amended on April 5, 2023. Introduced on February 8, 2023.	**Medi-Cal: claim or remittance forms: signature** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Existing law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Existing law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.
AB 576 **Weber** **Status:** Hearing set for April 11, 2023. Re-referred to the Committee on Health on April 3, 2023. Last amended March 30, 2023. Introduced February 8, 2023.	**Medi-Cal: reimbursement for abortion** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that abortion is a covered benefit under Medi-Cal. Existing regulation authorizes reimbursement for specified medications used to terminate a pregnancy through the 70th day from the first day of the recipient's last menstrual period. This bill would require the department, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines. The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.
AB 586 **Calderon** **Status:** Hearing set for April 11, 2023.	**Medi-Cal: community supports: climate change or environmental remediation devices** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Re-referred to the Committee on Health on April 3, 2023. Last amended on March 30, 2023. Introduced on February 9, 2023.	Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or other climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.
AB 608 **Schiavo** **Status:** Hearing set for April 11, 2023. Referred to the Committee on Health on February 17, 2023. Introduced on February 9, 2023.	**Medi-Cal: comprehensive perinatal services** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would require the department to seek any necessary federal approvals to cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.

	The bill would condition implementation of the provisions above on an appropriation by the Legislature and on receipt of any necessary federal approvals and the availability of federal financial participation.
AB 614 **Wood** **Status:** Hearing set for April 25, 2023. Referred to the Committee on Health on February 17, 2023. Introduced on February 9, 2023.	**Medi-Cal** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans. Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children's Health Initiative Program (CCHIP). This bill would revise certain provisions to rename that program as CCHIP. Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program. The bill would also make technical changes to some of the provisions described above.
AB 632 **Gipson** **Status:** Re-referred to the Committee on Appropriations on March 22, 2023.	**Health care coverage: prostate cancer screening** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under existing law, the application of a deductible or copayment for those services is not prohibited.

Introduced on February 9, 2023.	This bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is 55 years of age or older or who is 40 years of age or older and is high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 666 **Arambula** **Status:** Hearing set for April 18, 2023. Re-referred to the Committee on Health on April 7, 2023. Last amended on April 6, 2023. Introduced on February 13, 2023.	**Health systems: community benefits plans** **Summary:** Existing law establishes the Department of Health Care Access and Information to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. benefits plans. Existing law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Existing law defines the term "community" as the service areas or patient populations for which the hospital provides health care services, defines "vulnerable populations" for these purposes to include a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs, and defines "community benefit" to mean the hospital's activities that are intended to address community needs, such as support to local health departments, among other things. Existing law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Existing law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital's fiscal year ends. Existing law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things. This bill would require the department to define the term "community" by regulation within certain parameters, would redefine the term "community benefit" to mean services rendered to those eligible for, but not enrolled in the above-described programs, the unreimbursed costs as reported in specified tax filings, and the support to local health departments as documented by those local health departments, among other things, and would redefine the term "vulnerable populations" to include those eligible for, but not enrolled in the above-described programs, those below median income experiencing economic disparities, and certain socially disadvantaged groups, such as those who are incarcerated. The bill would require that a community needs assessment include the needs of the vulnerable populations and

	include a description of which vulnerable populations are low or moderate income, coordination with a local health department, and require that it be updated at least once every 2 years. The bill would require that a community benefits plan demonstrate alignment with the State Health Improvement Plan and the Community Health Improvement Plan, include the proportion and amount of community benefit spending on vulnerable populations, and include measurable objectives that outline equity benchmarks. The bill would additionally require a hospital to annually submit a copy of a specified Internal Revenue Service form to the department. The bill would increase the maximum fine for failure to adopt, update, or submit, a community benefits plan to $25,000 and would authorize the department to impose a maximum fine of $50,000 for a hospital's failure to demonstrate implementation of a community benefits plan. The bill would require the department to include in its annual report the amount of community benefits spending attributable to public health needs and a list of hospitals that fail to comply with specified requirements.
AB 719 **Horvath** **Status:** Hearing set for April 11, 2023. Referred to the Committee on Health on February 23, 2023. Introduced on February 13, 2023.	**Medi-Cal benefits** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including nonmedical transportation for a beneficiary to obtain covered Medi-Cal services. Existing law requires nonmedical transportation to be provided by the beneficiary's managed care plan or by the department for a Medi-Cal fee-for-service beneficiary. This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service.
AB 815 **Wood** **Status:** Hearing set for April 18, 2023. Re-referred to the Committee on Health on March 14, 2023. Last amended on March 13, 2023. Introduced on February 13, 2023.	**Health care coverage: provider credentials** **Summary:** Existing law establishes the California Health and Human Services Agency, which includes departments charged with the administration of health, social, and other human services. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. Existing law sets forth requirements for provider credentialing by a health care service plan or health insurer. This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons and other health care providers in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025. This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing

	additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity.
AB 817 **Pacheco** **Status:** Re-referred to the Committee on Local Government on March 20, 2023. Last amended on March 16, 2023. Introduced on February 13, 2023.	**Open meetings: teleconferencing: subsidiary body** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, each legislative body of a local agency to provide notice of the time and place for its regular meetings and an agenda containing a brief general description of each item of business to be transacted. The act also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. This bill would authorize a subsidiary body, as defined, to use alternative teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws

	relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose. This bill would make legislative findings to that effect.
AB 847 **Luz Rivas** **Status:** Hearing set for April 18, 2023. Re-referred to the Committee on Health on March 27, 2023. Last amended on March 23, 2023. Introduced on February 14, 2023.	**Medi-Cal: pediatric palliative care services** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life. Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified. Existing federal law makes individuals less than 21 years of age eligible for both hospice care and treatment for their underlying illness for which a physician has made a terminal diagnosis. This bill would extend eligibility for pediatric palliative care services and concurrent treatment for an underlying illness for those individuals who have been determined eligible for those services prior to 21 years of age, after 21 years of age. To the extent that these provisions would alter the eligibility of individuals for these services, the bill would create a state-mandated local program. The bill would require a managed care plan to be liable for payment of these services received in a county different from the individual's county of residence if they are not available in that county. The bill would implement these provisions only to the extent that necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

	This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
AB 931 **Irwin** **Status:** Hearing set for April 11, 2023. Referred to the Committee on Health on February 23, 2023. Introduced on February 14, 2023.	**Prior authorization: physical therapy** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified prior authorization limitations for health care service plans and health insurers. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 948 **Berman** **Status:** Re-referred to the Committee on Appropriations on March 22, 2023. Introduced February 14, 2023.	**Prescription drugs** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law, until January 1, 2024, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law, until January 1, 2024, requires a nongrandfathered individual or small group plan contract or policy to use specified definitions for each tier of a drug formulary. This bill would delete the January 1, 2024, repeal date of those provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

	This bill would provide that no reimbursement is required by this act for a specified reason.
AB 1036 **Bryan** **Status:** Hearing set for April 25, 2023. Introduced on February 15, 2023.	**Health care coverage: emergency medical transport** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or large group health insurance policy to provide an enrollee or insured with basic health care services, which include emergency health care services. Existing law prohibits a health care service plan that provides basic health care services from requiring prior authorization or refusing to pay for an ambulance or ambulance transport services if the request was made for an emergency medical condition and the services were required or if an enrollee reasonably believed the medical condition was an emergency that required ambulance transport services. Existing law requires a policy of disability insurance issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical coverage with coverage for emergency health care services to include coverage for emergency medical transportation services without regard to whether or not the emergency provider contracts with the insurer or to prior authorization. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including various emergency medical services. This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following completion of the emergency medical transport. The bill would specify for Medi-Cal benefits, these provisions do not apply to various specified provisions relating to nonemergency transport services or any other law or regulation related to reimbursement or authorization requirements for services provided for emergency services and care. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

	This bill would provide that no reimbursement is required by this act for a specified reason.
AB 1085 **Maienschein** **Status:** Re-referred to the Committee on Appropriations on March 28, 2023. Last amended on March 27, 2023. Introduced on February 15, 2023.	**Medi-Cal: housing support services** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy and sustaining services. Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would require the department to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the above-described analysis. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined. If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and the timeline for creating sufficient capacity consistent with the analysis findings.
AB 1122 **Bains** **Status:** Hearing set for April 18, 2023. Re-referred to the Committee on Health on March 13, 2023. Last amended on March 9, 2023.	**Medi-Cal provider applications** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified.

Introduced on February 15, 2023.	Existing law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the department, as specified. This bill would authorize an applicant or provider to submit any primary authoritative source documentation as proof of the above-described information, and would require the Director of Health Care Services to reasonably accept alternative formats and sources of that documentation so long as it is verified as authentic and comes from a primary source. Existing law authorizes the department to make unannounced visits to an applicant or provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Existing law requires, at the time of the visit, the applicant or provider to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as specified. This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department. If the department exercises its authority to conduct background checks, preenrollment inspections, or unannounced visits, existing law requires that the applicant or provider receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either (1) the applicant or provider being granted provisional provider status for a period of 12 months, or (2) discrepancies or failure to meet program requirements having been found to exist during the preenrollment period. Existing law requires that the notice identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Under existing law, failure to remediate discrepancies and failures, or notification that remediation is not available, results in denial of the application by operation of law. Existing law authorizes the applicant or provider to reapply by submitting a new application package that is reviewed de novo. Under this bill, if the department fails to provide notice of a remediation period for discrepancies or areas of noncompliance that are reasonably remediable within a 30-day period, a denial of the application would not be effective and the provider would be authorized to give notice to the department that the deficiencies have been remedied within this period of time. The bill would require the department to consider the newly submitted information and proceed with consideration of the enrollment. Under the bill, these provisions would be implemented to the extent not in conflict with federal law.
AB 1202 **Lackey**	**Medi-Cal: time or distance standards: children's health care services**

Status: Re-referred to the Committee on Appropriations on March 30, 2023. Last amended on March 29, 2023. Introduced on February 16, 2023.	**Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes, until January 1, 2026, certain time or distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth various limits on the number of miles or minutes from the enrollee's place of residence, depending on the type of service or specialty and, in some cases, on the county. Existing law authorizes a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with those standards. Existing law authorizes the department, upon request of a Medi-Cal managed care plan, to authorize alternative access standards for those standards under certain conditions, with the request being approved or denied on ZIP Code and provider type basis, as specified. This bill would, no later than January 1, 2025, require each Medi-Cal managed care plan to conduct, and report to the department the results of, an analysis to identify the number and, as appropriate, the geographic distribution of Medi-Cal providers needed to ensure the Medi-Cal managed care plan's compliance with the above-described time or distance and appointment time standards for pediatric primary care, across all service areas of the plan. The bill would, no later than January 1, 2026, require the department to prepare and submit a report to the Legislature that includes certain information, including a summary of the results reported by Medi-Cal managed care plans, specific steps for Medi-Cal managed care plan accountability, evidence of progress and compliance, and level of accuracy of provider directories, as specified. The bill would, no later than July 1, 2024, require the department to submit a report to the Legislature, and to make it publicly available, with certain information for the 2019, 2020, 2021, and 2022 calendar years, including (1) the number of children 0 to 5 years of age, inclusive, and the number of children 6 to 18 years of age, inclusive, who are Medi-Cal beneficiaries receiving any of specified early childhood preventive or developmental services, and (2) the number of pregnant persons, and the number of postpartum persons, who are Medi-Cal beneficiaries receiving any of specified services. The bill would require that the report also include, for those populations, information about any disparities across racial or ethnic groups, primary languages spoken at home, service areas or counties, or age groups. The bill would repeal the analysis and reporting provisions on January 1, 2030.
AB 1230 **Valencia** **Status:**	**Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed

Referred to the Committee on Health, on March 2, 2023. Introduced on February 16, 2023.	and funded by federal Medicaid program provisions. Existing federal law establishes the Medicare Program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Existing law sets forth various provisions, including within the Coordinated Care Initiative (CCI) and the California Advancing and Innovating Medi-Cal (CalAIM) initiative, relating to beneficiaries who are dually eligible for the Medicare Program and the Medi-Cal program, for purposes of promoting more integrated care through those beneficiaries' aligned enrollment in a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), as defined. This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries. The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract.
AB 1241 **Weber** **Status:** Re-referred to the Committee on Appropriations on March 29, 2023. Last amended on March 23, 2023. Introduced on February 16, 2023.	**Telehealth** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, in-person, face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing Existing law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified. This bill would additionally authorize a provider to meet the above-described requirement by maintaining protocols for outpatient clinical referral to appropriate in-person care, when the standard of care cannot be met by video synchronous interaction or audio-only synchronous interaction. instead require, under the above-described circumstance, a provider to maintain the ability to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.
AB 1316 **Irwin and Ward**	**Emergency services: psychiatric emergency medical conditions**

Status: April 10, 2023 hearing canceled at the request of the author. Introduced on February 16, 2023.	**Summary:** Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified. Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program. The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the beneficiary. The bill would require coverage, including by a Medi-Cal managed care plan, for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, including emergency room professional services. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

	This bill would provide that no reimbursement is required by this act for a specified reason.
AB 1338 **Petrie-Norris** **Status:** Set for hearing on April 18, 2023 in the Committee on Health. Introduced February 16, 2023.	**Medi-Cal: community supports** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services. This bill would add fitness, physical activity, recreational sports, and mental wellness memberships to the above-described list of community supports.
AB 1437 **Irwin and Quirk-Silva** **Status:** Set for hearing on April 11, 2023 in the Committee on Health. Introduced February 17, 2023.	**Medi-Cal: serious mental illness** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under existing law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Existing law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request. After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified. Under this bill, a treatment authorization request would not be required for the provision of a prescription drug prescribed to prevent, assess, or treat a serious mental illness, as defined. Under the bill, a prescription for a drug for serious mental illness would automatically be approved if the department verifies a record of a paid claim that documents a diagnosis of a serious mental illness within 365 days before the date of that prescription. The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.
AB 1451	**Behavioral health crisis treatment**

Jackson **Status:** Set for a hearing in the Committee on Health on April 25, 2023. Introduced February 17, 2023.	**Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition, as specified. The bill would authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care. The bill would require the treatment to be provided without preauthorization, and would authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
AB 1470 **Quirk-Silva** **Status:** Re-referred to the Committee on Health on March 27, 2023. Last amended March 23, 2023. Introduced February 17, 2023.	**Medi-Cal: behavioral health services: documentation standards** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities. Existing law, as part of CalAIM, requires the department to develop documentation standards and changes to the department's clinical auditing standards, and authorizes the department to require the use of those documentation standards by Medi-Cal behavioral health delivery systems, as specified.

	This bill would instead require the department to require Medi-Cal behavioral health delivery systems to use those documentation standards. The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions. The bill would authorize the department to develop and maintain a list of department-approved nonstandard forms. The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, exclusively using the standard forms, unless it uses department-approved nonstandard forms. The bill would require providers of applicable entities to use those forms, as specified. The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare annual reports containing findings from the analysis, and, commencing on July 1, 2026, and each year thereafter, to submit the most recent report to the Legislature and to post it on the department's internet website.
AB 1481 **Horvath and Bauer-Kahan** **Status:** Re-referred to the Committee on Health on March 20, 2023. Last amended on March 16, 2023. Introduced on February 17, 2023.	**Medi-Cal: presumptive eligibility** **Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. Under existing law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage

	of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
AB 1549 **Carrillo** **Status:** Set for hearing on April 25, 2023. Re-referred to the Committee on Health on March 27, 2023. Last amended on March 23, 2023. Introduced on February 17, 2023.	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center services and rural health clinic services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific methods and processes used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.
AB 1608 **Patterson** **Status:** Re-referred to the Committee on Health on March 27, 2023. Last amended on March 23, 2023.	**Medi-Cal: managed care plans** **Summary:** The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. The act requires regional centers to pursue all possible sources of funding for consumers receiving regional center services, including, among others, Medi-Cal. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the

Introduced on February 17, 2023.	California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.
AB 1644 **Bonta** **Status:** Re-referred to the Committee on Health on March 27, 2023. Last amended on March 23, 2023. Introduced February 17, 2023.	**Medi-Cal: medically supportive food and nutrition services** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition intervention plans, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the department. The bill would require medically supportive food and nutrition intervention plans be covered when determined to be medically necessary by a health care provider or health care plan. In order to qualify for coverage under the Medi-Cal program, the bill would require medically supportive food and nutrition intervention plans include at least 3 of 6 specified medically supportive food and nutrition interventions. The bill would only provide coverage for nutrition support interventions when combined with the minimum 3 interventions. The bill would require health care providers or health care plans to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention plan and include culturally appropriate foods whenever possible.

	The bill would establish the Medically Supportive Food and Nutrition Benefit Committee to assist the department in developing final guidance related to eligible populations, the duration and dosage of medically supportive food and nutrition intervention plans, the ratesetting process, determination of permitted providers, and continuing education for health care providers and health care plans, as specified. The bill would require the committee to include certain stakeholders knowledgeable in medically supportive food and nutrition interventions and stakeholders from Medi-Cal consumer advocacy organizations. The bill would require the committee to meet at least quarterly and would require the department to issue final guidance on or before July 1, 2026. The bill would also include findings and declarations of the Legislature relating to the need for medically supportive food and nutrition intervention coverage under the Medi-Cal program.
AB 1690 **Kalra** **Status:** Introduced February 17, 2023.	**Universal health care coverage** **Summary:** Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements, including the Medi-Cal program administered by the State Department of Health Care Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers. This bill would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.
Senate Bills	
SB 238 **Wiener** **Status:** Hearing set for April 12, 2023 in the Committee on Health. Last amended on March 29, 2023. Introduced on January 24, 2023.	**Health care coverage: independent medical review** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service that is a covered benefit based in whole or in part on medical necessity, to automatically submit a decision regarding a disputed health care service to the Independent Medical Review System, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the

	enrollee or insured that they or their representative may cancel the independent medical review within 5 days, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 299 **Eggman** **Status:** Committee placed bill on suspense file on April 10, 2023 (7 Ayes, 0 Noes, 0 Abstain). Last amended March 27, 2023. Introduced February 2, 2023.	**Medi-Cal eligibility: redetermination** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. In response to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, existing law requires the county to send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. Under existing law, if the purpose for a redetermination is loss of contact with the beneficiary, as evidenced by the return of mail, as specified, a return of the prepopulated form requires the county to immediately send a notice of action terminating Medi-Cal eligibility. This bill would delete the above-described requirement for a county to send a notice of action terminating eligibility if the prepopulated form is returned and the purpose for the redetermination is loss of contact with the beneficiary. To the extent that the bill would modify county duties relating to the redetermination of Medi-Cal eligibility, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

	This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
SB 324 **Limón** **Status:** Hearing set for April 12, 2023. Last amended March 30, 2023. Introduced February 6, 2023.	**Health care coverage: endometriosis** **Summary:** (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. (2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would add any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines, as a covered benefit under Medi-Cal without prior authorization or other utilization review. (3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 411 **Portantino** **Status:** Hearing set for April 19, 2023. Introduced February 9, 2023.	**Open meetings: teleconferences: bodies with appointed membership** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over

	which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. This bill would authorize a legislative body to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would alternatively define "legislative body" for this purpose to mean a board, commission, or advisory body of a local agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body is otherwise subject to the act. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose. This bill would make legislative findings to that effect. This bill would declare that it is to take effect immediately as an urgency statute.
SB 496 **Limón** **Status:** April 12, 2023 hearing cancelled at the request of the author.	**Biomarker testing** **Summary:** (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1,

Introduced February 14, 2023.	2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. (2) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill, by July 1, 2024, would expand the Medi-Cal schedule of benefits to include biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medi-Cal beneficiary's disease or condition to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would authorize the department to implement this provision by various means without taking regulatory action. (3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 502 **Allen** **Status:** Set for hearing on April 12, 2023.	**Medi-Cal: children: mobile optometric office** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, with specified coverage for eligible children and pregnant persons funded by the federal Children's Health Insurance Program (CHIP).

Last amended March 27, 2023 Introduced February 14, 2023.	Pursuant to existing law, the department established a 3-year pilot program, from 2015 through 2017, in the County of Los Angeles that enabled school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider, limited to vision examinations and providing eyeglasses. Existing law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Existing law defines "mobile optometric office" as a trailer, van, or other means of transportation in which the practice of optometry is performed and which is not affiliated with an approved optometry school in the state. Under existing law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator registering with the State Board of Optometry. This bill would require the department, subject to an appropriation, to file all necessary state plan amendments to exercise the option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would require implementation of these provisions by January 1, 2025, or the date that any necessary federal approvals have been obtained, whichever date is later. The bill would state the intent of the Legislature that General Fund moneys not be used for any future appropriation for these provisions.
SB 535 **Nguyen** **Status:** Referred to the Committee on Rules, on February 22, 2023. Introduced on February 14, 2023.	**Knox-Keene Health Care Service Plan Act of 1975** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Among other provisions, existing law requires a health care service plan to meet specified requirements, including, but not limited to, furnishing services in a manner providing continuity of care, ready referral of patients to other providers at appropriate times, and making services readily accessible to all enrollees, as specified. This bill would make technical, nonsubstantive changes to those provisions.
SB 537 **Becker** **Status:** Hearing set for April 19, 2023 in the Committee on Governance and Finance.	**Open meetings: local agencies: teleconferences** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over

Last amended on March 22, 2023. Introduced on February 14, 2023.	which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would authorize certain legislative bodies to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would also require a legislative body to provide a record of attendance on its internet website within 7 days after a teleconference meeting, as specified. The bill would define "legislative body" for this purpose to mean a board, commission, or advisory body of a multijurisdictional cross county agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body is otherwise subject to the act. The bill would also define "multijurisdictional" to mean a legislative body that includes representatives from more than one county, city, city and county, special district, or a joint powers entity. With respect to the alternative teleconferencing provisions operative until January 1, 2026, the bill would expand the circumstances of "just cause" to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.

	This bill would make legislative findings to that effect. This bill would declare that it is to take effect immediately as an urgency statute.
SB 598 **Skinner** **Status:** Hearing set for April 12, 2023 in the Committee on Health. Last amended on March 22, 2023. Introduced February 15, 2023.	**Health care coverage: prior authorization** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers. On or after January 1, 2025, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 694 **Eggman** **Status:** Hearing set for April 19, 2023 in the Committee on Health.	**Medi-Cal: self-measured blood pressure devices and services** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The department

Introduced February 16, 2023.	announced that, effective June 1, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item. This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program for the treatment of high blood pressure. The bill would state the intent of the Legislature that those covered devices and services be consistent in scope with devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.
SB 770 **Wiener** **Status:** Hearing set for April 19, 2023 in the Committee on Health. Last amended on March 20, 2023. Introduced on February 17, 2023.	**Health care: unified health care financing** **Summary:** Prior state law established the Healthy California for All Commission for purposes of developing a plan that included options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified health care financing system, including, but not limited to, a single-payer financing system, for all Californians. This bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would require the secretary to provide quarterly reports to the chairs of the Assembly and Senate Health Committees on the status and outcomes of waiver discussions with the federal governments and the progress of the workgroup. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would include legislative findings related to the findings of the commission and declare the intent of the Legislature in implementing a unified health care financing system in California.
SB 819 **Eggman** **Status:** Re-referred to the Committee on Health on March 29, 2023. Last amended on March 20, 2023.	**Medi-Cal: certification** **Summary:** Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. Existing law–establishes the Medi-Cal program, which is administered by the State Department of Health Care–Services (department) and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Introduced on February 17, 2023.	Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.
SB 870 **Caballero** **Status:** Re-referred to the Committee on Health on March 29, 2023. Last amended on March 20, 2023. Introduced on February 17, 2023.	**Medi-Cal: managed care organization provider tax** **Summary:** Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law, inoperative on January 1, 2023, and to be repealed on January 1, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22, fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified. Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. In April 2020, CMS approved a modified tax structure that the department had submitted as part of a waiver request, involving taxing tiers that were based on cumulative Medi-Cal or other member months for certain fiscal years. This bill would extend the above-described MCO provider tax to an unspecified date and would make conforming changes to the timeline of related provisions by incorporating other unspecified dates. The bill would reorganize the taxing tiers of

	the MCO provider tax, in a manner consistent with the above-described modified tax structure under the previous waiver, but with unspecified tax rate amounts. By extending the authority to fund the nonfederal share of Medi-Cal managed care rates from the continuously appropriated fund, the bill would make an appropriation. This bill would make these provisions inoperative on an unspecified date, and would repeal the provisions as of an unspecified date. This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^{2}/_{3}$ of the membership of each house of the Legislature.

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 11, 2023

The Honorable Susan Talamantes Eggman
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: SB 424 – OPPOSE UNLESS AMENDED

Dear Senator Eggman,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 426,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's position of "Oppose Unless Amended" on AB 424 (Durazo), which would, among other things, limit the California Children's Services (CCS) Whole Child Model (WCM) to operating only in the counties in which the program currently operates.

The WCM is currently offered in twenty-two counties through one of five County Organized Health System (COHS) Medi-Cal managed care plans, including the Alliance, which has been operating the WCM program in its current service area since 2018. The Alliance's WCM program provides a coordinated approach to health care services and case management for eligible children, their families, and caregivers. Through the WCM, the Alliance provides case management and care coordination to support and improve the overall care for children with CCS qualifying conditions. The Alliance works closely with county CCS programs and CCS providers to ensure the unique needs of each child are met.

While opportunities for improvement exist, the results of a recent independent analysis of the WCM program indicate either a positive or neutral impact on access and quality, whereby access to specialty and primary care services were maintained, grievances decreased, requests for authorizations and continuity of care were approved at a high rate, and numbers of in-network pediatric providers were increased through the WCM.

The Medi-Cal managed care program is a significant transformation under the direction of DHCS to be effective January 2024, which includes the expansion of counties to be served through the COHS model of managed care. As part of the Department of Health Care Services (DHCS) "model change" process, counties were offered the opportunity to select the model of managed care to operate in their county. Notably, twelve counties opted to partner with existing COHS to expand services into their counties.

Prohibiting the expansion of the WCM in counties that will be joining a COHS plan, like the Alliance, that is already operating a WCM program will create a bifurcated system of care for CCS children

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

enrolled in the health plan. CCS children in neighboring counties served by the same health plan would receive services through different systems, and doctors contracting with the same health plan would be required to bill differently for the same services based on the child's county of residence. This would create confusion and complexity for children, their families, and caregivers and providers, and would create unnecessary operational complexities for the COHS plan.

For these reasons, the Alliance opposes SB 424 unless it is amended to remove the provisions that prohibit the expansion of the WCM.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 18, 2023

The Honorable Cecilia M. Aguiar-Curry
Chair, Assembly Local Government Committee
1020 N Street, Room 157
Sacramento, CA 95814

RE: AB 1379 – SUPPORT

Dear Assemblymember Aguiar-Curry,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), I am writing to express support for AB 1379, which removes limitations on members of local legislative bodies surrounding remote participation in public meetings via telephone or video conference, while ensuring public access to, and participation in, public proceedings.

AB 1379 represents a continued modernization to the Brown Act, improving access for members of the public via a teleconferencing or videoconferencing option, while enabling participation of members of the legislatively body from non-public, remote locations under specified circumstances.

Throughout the COVID-19 public health emergency, local agencies subject to the Brown Act, such as the Alliance, were able to utilize remote participation in public meetings. The experience of the Alliance's governing body, throughout this period was that less restrictive teleconferencing provisions were effective, transparent and allowed for greater public access and participation in public meetings as well as increased attendance and participation by members of the governing body.

AB 1379 strikes an appropriate balance, allowing members of a local legislative body to participate remotely for just cause whilst ensuring that public participation in the meeting is available, including via a two-way telephonic or audiovisual platform. In addition, AB 1379 requires that a legislative body hold at least two meetings per calendar year in which the body's members meet in person at a singular designated physical location.

Thus, the provisions of AB 1379 protect the right of the public to access and participate in public meetings whilst recognizing advances in technology and communications that offer increased opportunities for remote participation.

For these reasons, I am pleased to support AB 1379, on behalf of the governing body of the Central California Alliance for Health.

Sincerely,

Michael Schrader
Chief Executive Officer

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 18, 2023

The Honorable Anthony J. Portantino
State Capitol, Room 412
Sacramento, CA 95814

RE: SB 282 – SUPPORT

Dear Senator Portantino,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 426,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for SB 282, which would allow reimbursement of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for two visits by a Medi-Cal beneficiary taking place on the same day and the same site, under certain circumstances.

FQHCs and RHCs are essential network providers for Medi-Cal managed care plans, like the Alliance. The Alliance works with our safety-net providers to increase access to care and improve Medi-Cal beneficiaries' overall care experience. This effort includes reducing barriers to treatment for individuals with mental health conditions.

Under the current law, Medi-Cal patients receiving services at FQHCs or RHCs for a physical health problem who also require a mental health service must return to the clinic another day to be seen for the second visit – even if an appointment is available the same day and at the same place as their medical visit. This results in many Medi-Cal beneficiaries not receiving needed care. Individuals with untreated mental illness may have problems managing their physical health conditions, exacerbating physical health problems for individuals and increasing health care costs. This is inefficient, costly, and creates the risk that members with mental health needs will go without care because of the built-in delay. Allowing same day reimbursement for mental health services will result in better outcomes and lower overall health care costs.

SB 282 will improve access and help health plans and clinics ensure that patients receive timely, efficient, and better integrated mental health services. For these reasons, the Alliance is pleased to support SB 282.

Sincerely,

Michael Schrader
Chief Executive Officer

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 18, 2023

The Honorable Anthony J. Portantino
Chair, Senate Appropriations Committee
State Capitol, Room 412
Sacramento, CA 95814

RE: SB 311 – SUPPORT

Dear Senator Portantino,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 426,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for SB 311, which would require the Department of Health Care Services (DHCS) to submit a State Plan Amendment to become a Medicare Part-A Buy-in State, which would simplify the enrollment process for low-income seniors and persons with disabilities who rely on Medicare and Medi-Cal but struggle to pay costly Medicare Part A premiums.

Medicare Part A covers inpatient hospital stays, short-term rehabilitation stays, home health and hospice and is generally free for those with sufficient work history. Those without the necessary work history can purchase Part A coverage through a monthly premium payment. This often includes individuals in low wage jobs, those prevented from working due to caregiving needs, or older immigrants with limited English proficiency.

California will pay the Part A premiums for individuals in the Qualified Medicare Beneficiary (QMB) program. However, individuals must navigate the QMB application process each year. The QMB application process is cumbersome, complex, and a multi-step process involving both the Social Security Administration and the Medi-Cal program. Should California become a Medicare Part A Buy-in State, the State could bypass the Social Security Administration enrollment process and directly enroll qualified individuals into Part A at any time during the year, providing financial relief for low income individuals and ensuring enrollment into no-cost Medicare Part A coverage for these individuals.

SB 311 simplifies the enrollment process into QMB for low income individuals otherwise faced with high Medicare Part A premiums. For these reasons, the Alliance is pleased to support SB 311.

Sincerely,

Michael Schrader
Chief Executive Officer

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Second Month Ending February 28, 2023

For the month ending February 28, 2023, the Alliance reported an Operating Income of $11.5M. The Year-to-Date (YTD) Operating Income is $27.7M, with a Medical Loss Ratio (MLR) of 84.4% and an Administrative Loss Ratio (ALR) of 5.4%. The Net Income is $29.3M after accounting for Non-Operating Income/Expenses.

The budget expected a $25.0M Operating Income for YTD February. The actual result is favorable to budget by $2.7M or 10.6%, driven primarily by the boosted enrollment from the Public Health Emergency (PHE).

Feb-23 ($ In 000's)				
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*421,478*	*412,231*	*9,247*	*2.2%*
Revenue	133,583	131,070	2,513	1.9%
Medical Expenses	114,728	107,103	(7,625)	-7.1%
Administrative Expenses	7,358	7,686	328	4.3%
Operating Income	11,497	16,281	(4,784)	-29.4%
Net Income	8,532	13,597	(5,064)	-37.2%
MLR %	*85.9%*	*81.7%*	*-4.2%*	
ALR %	*5.5%*	*5.9%*	*0.4%*	
Operating Income %	*8.6%*	*12.4%*	*-3.8%*	
Net Income %	*6.4%*	*10.4%*	*-4.0%*	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

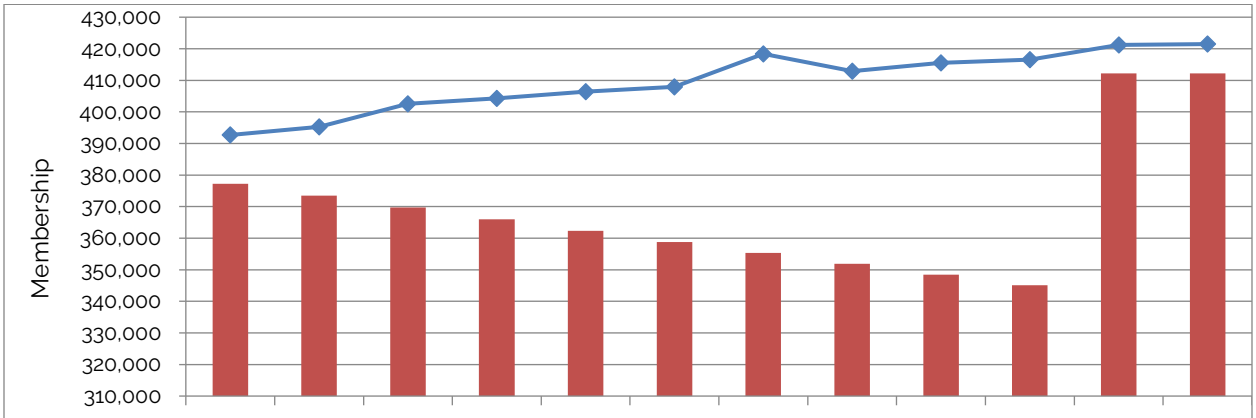
Feb-23 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*842,690*	*824,462*	*18,228*	*2.2%*
Revenue	271,269	262,139	9,129	3.5%
Medical Expenses	228,830	221,463	(7,367)	-3.3%
Administrative Expenses	14,744	15,644	900	5.8%
Operating Income/(Loss)	27,695	25,032	2,662	10.6%
Net Income/(Loss)	29,337	19,664	9,673	49.2%
PMPM				
Revenue	321.91	317.95	3.96	1.2%
Medical Expenses	271.55	268.62	(2.93)	-1.1%
Administrative Expenses	17.50	18.97	1.48	7.8%
Operating Income/(Loss)	32.86	30.36	2.50	8.2%
MLR %	84.4%	*84.5%*	*0.1%*	
ALR %	*5.4%*	*6.0%*	*0.5%*	
Operating Income %	*10.2%*	*9.5%*	*0.7%*	
Net Income %	*10.8%*	*7.5%*	*3.3%*	

Per Member Per Month. Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not usually correspond with enrollment and should be evaluated at the dollar amount.

At a PMPM level, YTD revenue is $321.91, which is favorable to budget by $3.96 or 1.2%. Medical cost PMPM is $271.55, which is unfavorable by $2.93 or 1.1%. The resulting operating income PMPM is $32.86, which is favorable by $2.50 compared to the budget.

Membership. February 2023 membership is favorable to budget by 2.2%. Please note that the 2023 budget assumed the PHE would end in January 2023, with membership beginning to decline in April 2023. The Health and Human Services Department announced that the PHE would end on May 11, 2023. The current Department of Healthcare Services (DHCS) states that the redetermination begins in April 2023 for the July 2023 renewal date, with the actual enrollment loss expected to begin in July 2023.

Membership. Actual vs. Budget (based on actual enrollment trend for Feb-23 rolling 12 months)



	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Budget	377,272	373,452	369,700	366,008	362,379	358,808	355,301	351,849	348,456	345,117	412,231	412,231
Actual	392,688	395,252	402,517	404,261	406,414	407,983	418,380	412,859	415,506	416,529	421,212	421,478
Variance	15,416	21,800	32,817	38,253	44,035	49,175	63,079	61,010	67,050	71,412	8,981	9,247
Variance %	4.1%	5.8%	8.9%	10.5%	12.2%	13.7%	17.8%	17.3%	19.2%	20.7%	2.2%	2.2%

Revenue. The 2023 revenue budget was based on the current DHCS 2022 draft rate package and included a 1.2% rate increase. Furthermore, the budget assumed breakeven for Enhanced Care Management (ECM) and Community Supports, both were new programs in 2022. The prospective CY 2023 draft rates from DHCS (dated December 8, 2022, including Maternity) are favorable to the rates assumed in the CY 2023 budget by 0.7%. February 2023 capitation revenue of $133.2M is favorable to budget by $2.5M or 1.9%, mainly attributed to higher enrollment of $2.9M which offsets minor rate variances of $0.4M.

February 2023 YTD capitation revenue of $270.5M is favorable to budget by $9.1M or 3.5%. Of this amount, $5.5M is from boosted enrollment, and $3.6M is due to rate variance.

Feb-23 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	55,857	55,829	28	553	(526)
Monterey	115,231	112,178	3,053	2,768	284
Merced	99,445	93,444	6,001	2,171	3,829
Total	**270,532**	**261,451**	**9,081**	**5,493**	**3,588**

Note: Excludes Feb-23 YTD In-Home Supportive Services (IHSS) premiums revenue of $0.7M.

Medical Expenses. The 2023 budget assumed a 5% increase in utilization from 2019 and a 3% unit cost increase that included case mix and changes in fee schedules, 2023 incentives include $15M Care-Based Incentive (CBI), $10M for the Hospital Quality Incentive Program (HQIP), and $5M for the Specialist Care Incentive (SCI).

February 2023 Medical Expenses of $114.7M are $7.6M or 7.1% unfavorable to budget. February 2023 YTD Medical Expenses of $228.8M are above budget by $7.4M or 3.3%. Of this amount, $2.5M is due to rate, and $4.9M is due to higher enrollment. Other Medical expense is unfavorable to budget by $8.8M or 27.7% due to higher utilization in behavioral health services and medical transportation.

Feb-23 YTD Medical Expense Summary (In $000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	85,453	82,825	(2,628)	(1,831)	(797)
Inpatient Services (LTC)	27,620	29,664	2,044	(656)	2,700
Physician Services	46,336	46,301	(35)	(1,024)	989
Outpatient Facility	28,077	30,667	2,590	(678)	3,268
Pharmacy	732	198	(534)	(4)	(530)
Other Medical	40,612	31,808	(8,804)	(703)	(8,101)
Total	**228,830**	**221,463**	**(7,367)**	**(4,896)**	**(2,471)**

Note: Other Medical Actual includes Allied Health, Non-Claims HC Cost, transportation, ECM, ILOS, BHT, Lab, CBI, SCI, and HQIP. The budget for HQIP is under Inpatient Services (Hospital), SCI, and CBI are under Physician Services.

At a PMPM level, YTD Medical Expenses are $271.55, which is unfavorable by $2.93 or 1.1% compared to the budget. Please note that the rate (PMPM) is the unit cost for a service multiplied by the utilization.

Feb-23 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	101.40	100.46	(0.95)	-0.9%
Inpatient Services (LTC)	32.78	35.98	3.20	8.9%
Physician Services	54.99	56.16	1.17	2.1%
Outpatient Facility	33.32	37.20	3.88	10.4%
Pharmacy	0.87	0.24	(0.63)	-100.0%
Other Medical	48.19	38.58	(9.61)	-24.9%
Total	**271.55**	**268.62**	**(2.93)**	**-1.1%**

Administrative Expenses. February YTD Administrative Expenses are favorable to budget by $0.9M or 5.8% with a 5.4% ALR. Salaries are favorable by $0.2M due to savings from vacant positions and employee benefits. Non-Salary Administrative Expenses are favorable by $0.7M or 13.7% due to the timing of the actual spending versus the budget.

Non-Operating Revenue/Expenses. February YTD Total Non-Operating Revenue is favorable to budget by $5.7M, attributed to $3.4M in unrealized gain on investments and $2.4M in interest income. Non-Operating Expenses are favorable by $1.3M due to the timing of grant expenses, resulting in a net Non-Operating income of $7.0M compared to the budget.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $29.3M, with a MLR of 84.4% and an ALR of 5.4%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Second Month Ending February 28, 2023
(In $000s)

Assets	
Cash	$158,074
Restricted Cash	300
Short Term Investments	676,462
Receivables	156,531
Prepaid Expenses	5,375
Other Current Assets	17,454
Total Current Assets	**$1,014,196**
Building, Land, Furniture & Equipment	
Capital Assets	$83,938
Accumulated Depreciation	(45,129)
CIP	663
Total Non-Current Assets	**39,471**
Total Assets	**$1,053,667**
Liabilities	
Accounts Payable	$29,033
IBNR/Claims Payable	304,716
Accrued Expenses	0
Estimated Risk Share Payable	15,000
Other Current Liabilities	6,415
Due to State	0
Total Current Liabilities	**$355,165**
Deferred Inflow of Resources	$2,437
Total Long-Term Liabilities	**$2,437**
Fund Balance	
Fund Balance - Prior	$666,727
Retained Earnings - CY	29,337
Total Fund Balance	**696,065**
Total Liabilities & Fund Balance	**$1,053,667**
Additional Information	
Total Fund Balance	**$696,065**
Board Designated Reserves Target	406,895
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	172,871
Total Reserves	**636,465**
Total Operating Reserve	**$59,599**

* MCGP includes Additional Contribution of $43.6M

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2023
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*421,478*	*412,231*	*9,247*	*2.2%*	*842,690*	*824,462*	*18,228*	*2.2%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$133,215	$130,726	$2,489	1.9%	$270,532	$261,451	$9,081	3.5%
Premiums Commercial	368	344	24	6.9%	736	688	48	7.0%
Total Operating Revenue	**$133,583**	**$131,070**	**$2,513**	**1.9%**	**$271,269**	**$262,139**	**$9,129**	**3.5%**
Medical Expenses								
Inpatient Services (Hospital)	$44,072	$40,053	($4,019)	-10.0%	$85,453	$82,825	($2,628)	-3.2%
Inpatient Services (LTC)	14,311	14,345	34	0.2%	27,620	29,664	2,044	6.9%
Physician Services	22,131	22,393	262	1.2%	46,336	46,301	(35)	-0.1%
Outpatient Facility	14,010	14,831	821	5.5%	28,077	30,667	2,590	8.4%
Pharmacy	440	99	(341)	-100.0%	732	198	(534)	-100.0%
Other Medical	19,764	15,382	(4,382)	-28.5%	40,612	31,808	(8,804)	-27.7%
Total Medical Expenses	**$114,728**	**$107,103**	**($7,625)**	**-7.1%**	**$228,830**	**$221,463**	**($7,367)**	**-3.3%**
Gross Margin	**$18,854**	**$23,967**	**($5,112)**	**-21.3%**	**$42,439**	**$40,676**	**$1,762**	**4.3%**
Administrative Expenses								
Salaries	$5,255	$5,283	$28	0.5%	$10,553	$10,786	$232	2.2%
Professional Fees	219	208	(11)	-5.2%	399	414	15	3.5%
Purchased Services	804	897	93	10.4%	1,594	1,822	228	12.5%
Supplies & Other	730	935	205	22.0%	1,411	1,868	456	24.4%
Occupancy	87	100	13	13.3%	238	202	(37)	-18.1%
Depreciation/Amortization	263	262	(1)	-0.4%	547	553	6	1.0%
Total Administrative Expenses	**$7,358**	**$7,686**	**$328**	**4.3%**	**$14,744**	**$15,644**	**$900**	**5.8%**
Operating Income	**$11,497**	**$16,281**	**($4,784)**	**-29.4%**	**$27,695**	**$25,032**	**$2,662**	**10.6%**
Non-Op Income/(Expense)								
Interest	$2,190	$1,025	$1,165	100.0%	$4,407	$2,049	$2,357	100.0%
Gain/(Loss) on Investments	(5,049)	(2,364)	(2,684)	-100.0%	(1,367)	(4,729)	3,362	71.1%
Other Revenues	154	155	(1)	-1.0%	291	310	(19)	-6.2%
Grants	(259)	(1,500)	1,240	82.7%	(1,688)	(2,999)	1,312	43.7%
Total Non-Op Income/(Expense)	**($2,964)**	**($2,684)**	**($280)**	**-10.4%**	**$1,643**	**($5,368)**	**$7,011**	**100.0%**
Net Income/(Loss)	**$8,532**	**$13,597**	**($5,064)**	**-37.2%**	**$29,337**	**$19,664**	**$9,673**	**49.2%**
MLR	*85.9%*	*81.7%*			*84.4%*	*84.5%*		
ALR	*5.5%*	*5.9%*			*5.4%*	*6.0%*		
Operating Income	*8.6%*	*12.4%*			*10.2%*	*9.5%*		
Net Income %	*6.4%*	*10.4%*			*10.8%*	*7.5%*		

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2023
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*421,478*	*412,231*	*9,247*	*2.2%*	*842,690*	*824,462*	*18,228*	*2.2%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$316.07	$317.12	($1.05)	-0.3%	$321.03	$317.12	$3.92	1.2%
Premiums Commercial	0.87	0.83	0.04	4.6%	0.87	0.83	0.04	4.7%
Total Operating Revenue	**$316.94**	**$317.95**	**($1.01)**	**-0.3%**	**$321.91**	**$317.95**	**$3.96**	**1.2%**
Medical Expenses								
Inpatient Services (Hospital)	$104.57	$97.16	($7.40)	-7.6%	$101.40	$100.46	($0.95)	-0.9%
Inpatient Services (LTC)	33.95	34.80	0.84	2.4%	32.78	35.98	3.20	8.9%
Physician Services	52.51	54.32	1.81	3.3%	54.99	56.16	1.17	2.1%
Outpatient Facility	33.24	35.98	2.74	7.6%	33.32	37.20	3.88	10.4%
Pharmacy	1.04	0.24	(0.80)	-100.0%	0.87	0.24	(0.63)	-100.0%
Other Medical	46.89	37.31	(9.58)	-25.7%	48.19	38.58	(9.61)	-24.9%
Total Medical Expenses	**$272.20**	**$259.81**	**($12.39)**	**-4.8%**	**$271.55**	**$268.62**	**($2.93)**	**-1.1%**
Gross Margin	**$44.73**	**$58.14**	**($13.41)**	**-23.1%**	**$50.36**	**$49.34**	**$1.02**	**2.1%**
Administrative Expenses								
Salaries	$12.47	$12.82	$0.35	2.7%	$12.52	$13.08	$0.56	4.3%
Professional Fees	0.52	0.50	(0.01)	-2.9%	0.47	0.50	0.03	5.6%
Purchased Services	1.91	2.18	0.27	12.4%	1.89	2.21	0.32	14.4%
Supplies & Other	1.73	2.27	0.54	23.7%	1.67	2.27	0.59	26.1%
Occupancy	0.21	0.24	0.04	15.2%	0.28	0.24	(0.04)	-15.5%
Depreciation/Amortization	0.62	0.64	0.01	1.8%	0.65	0.67	0.02	3.1%
Total Administrative Expenses	**$17.46**	**$18.64**	**$1.19**	**6.4%**	**$17.50**	**$18.97**	**$1.48**	**7.8%**
Operating Income	**$27.28**	**$39.50**	**($12.22)**	**-30.9%**	**$32.86**	**$30.36**	**$2.50**	**8.2%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Second Month Ending February 28, 2023
(In $000s)

	MTD	YTD
Net Income	$8,532	$29,337
Items not requiring the use of cash: Depreciation	263	547
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(3,986)	14,249
Prepaid Expenses	(995)	(1,325)
Current Assets	(633)	(1,499)
Net Changes to Assets	**($5,614)**	**$11,424**
Changes to Payables:		
Accounts Payable	2,550	(41,641)
Accrued Expenses	-	-
Other Current Liabilities	90	(1,293)
Incurred But Not Reported Claims/Claims Payable	(4,304)	17,302
Estimated Risk Share Payable	2,500	5,000
Due to State	-	-
Net Changes to Payables	**$836**	**($20,632)**
Net Cash Provided by (Used in) Operating Activities	**$4,017**	**$20,677**
Change in Investments	3,253	(467)
Other Equipment Acquisitions	(471)	(475)
Net Cash Provided by (Used in) Investing Activities	**$2,782**	**($941)**
Deferred Inflow of Resources	-	-
Net Cash Provided by (Used in) Financing Activities	**$0**	**$0**
Net Increase (Decrease) in Cash & Cash Equivalents	**$6,800**	**$19,735**
Cash & Cash Equivalents at Beginning of Period	**$151,274**	**$138,338**
Cash & Cash Equivalents at February 28, 2023	**$158,074**	**$158,074**

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Finance Committee: Commissioner Appointment

Recommendation. Staff recommend the Board approve the appointment of Commissioner Josh Pedrozo to the Finance Committee.

Background. Pursuant to Article 5.1 of the Commission's Bylaws, the Commission may create standing and ad hoc committees and appoint members to those committees. Only Commissioners may serve on the committees and all committees must be comprised of less than a quorum of voting Commissioners.

Discussion. Commissioner Pedrozo has indicated his interest in serving on the Finance Committee and Board appointment is required.

Finance Committee members include:

1. Commissioner Jimenez
2. Commissioner Radner
3. Commissioner Molesky
4. Commissioner Kalantari-Johnson

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

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the appointment of the individual listed below to the Member Services Advisory Group (MSAG).

Background. The Board established the MSAG authorized in the Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Discussion. The following individual has indicated interest in participating on the MSAG.

Name	Affiliation	County
Melissa Raya	Community Partner	Monterey

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

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

---

Recommendation. Staff recommend the Board approve the appointment of the individual listed below to the Whole Child Model Clinical Advisory Committee (WCMCAC).

Background. The Board established the WCMCAC authorized in the Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Discussion. The following individual has indicated interest in participating on the WCMCAC and is recommended.

Name	Affiliation	County
Lena Malik, MD	Provider Representative	Monterey

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, March 22, 2023

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

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Julie Edgcomb	Public Representative
Ms. Janna Espinoza	Public Representative
Supervisor Zach Friend	County Board of Supervisors
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Ms. Leslie Conner	Provider Representative
Dr. Maximiliano Cuevas	Provider Representative
Dr. Larry deGhetaldi	Provider Representative
Ms. Mónica Morales	County Health Services Agency Director

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Ms. Rebecca Nanyonjo	Director of Public Health
Mr. Rob Smith	Public Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Ms. Van Wong	Chief Operating Officer
Ms. Jessica Finney	Grants Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 3:01 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Chair Jimenez recognized the Board service of Commissioner Inda. This was her last meeting.

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.

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

4. Comments and announcements by Chief Executive Officer.

Chair Jimenez opened the floor for Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO).

Ms. Sonnenshine informed the Board that staff have engaged an internal Incident Management Team who are monitoring impacts of the storm with respect to members and providers, and staff and facilities in all three counties.

Commissioner Inda was acknowledged and thanked her for her service on the Board.

Mr. Michael Schrader's start date is April 17, 2023 and will be attending the April 26, 2023 meeting in Merced County at the El Capitan Hotel. Onboarding is going well and individual introductory meetings with Commissioners and Mr. Schrader are being scheduled. She also acknowledged that this was her final meeting as the CEO of the Alliance and thanked Commissioners for their leadership on the Board, their commitment to people with Medi-Cal and acknowledged their perseverance in creating local healthcare solutions.

[Commissioner Harris arrived at this time: 3:05 p.m.]

Consent Agenda Items: (5. – 9B.): 3:06 p.m.

Chair Jimenez opened the floor for approval of the Consent Agenda.

MOTION: Commissioner Askew moved to approve the Consent Agenda seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Edgcomb, Espinoza, Friend, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Rabago, Radner, Schuller and Weber.

Noes: None.

Absent: Commissioners Conner, Cuevas, deGhetaldi, Morales, Nanyonjo, Pedrozo and Smith.

Abstain: None.

[Vice Chair Pedrozo arrived at this time: 3:07 p.m.]

Regular Agenda Item: (10. - 13.): 3:12 p.m.

10. Consider approving the Alliance's legal and regulatory Compliance Program Report for 2022 and receive required Board training in Compliance. (3:12 – 3:46 p.m.)

Ms. Jenifer Mandella, Chief Compliance Officer, presented the Alliance Compliance Program Report for 2022 and provided required annual Board training in compliance.

Key takeaways from the presentation included 1) a highly regulated and constantly evolving environment; 2) the Compliance Program mitigates risk through prevention, identification and corrective action; and 3) the Alliance Board is a key participant in the Compliance Program, providing oversight and ensuring an effective program.

Key accomplishments included readiness efforts for large-scale program changes, assessed organizational engagement in Compliance Program processes, and created a Compliance Division with subordinate Compliance and Legal Services Departments.

MOTION: Commissioner Bizzini moved to approve the Alliance's legal and regulatory Compliance Program Report for 2022, seconded by Commissioner Kalantari-Johnson.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Edgcomb, Espinoza, Friend, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Pedrozo, Rabago, Radner, Schuller and Weber.

Noes: None.

Absent: Commissioners Conner, Cuevas, deGhetaldi, Morales. Nanyonjo and Smith.

Abstain: None.

11. Consider approving new Medi-Cal Capacity Grant Program (MCGP) Funding Opportunities (2023 - Phase 1). (3:46 – 4:30 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. Jessica Finney, Grants Director, introduced new grantmaking opportunities and a policy change responsive to the new MCGP focus areas, goals and funding priorities adopted by the Board last year. The policy change to the Provider Recruitment Program would allow the Chief Executive Officer approval of awards four times per year.

The first round of two phases of grant making opportunities were presented, responsive to the grantmaking framework, priorities and goals the Board adopted last year to ensure continued contribution to capacity in the Medi-Cal delivery system. Staff plan to return in April with an additional slate of recommendations for offering in 2023.

Commissioners discussed and provided the following comment: evaluate for future consideration, the amount of recruitment grants for provider opportunities; educate home visit staff to durable medical equipment needs; consider environmental home health evaluations and applications to provide a safe home; opportunities to support providers contracting with the Alliance; speeding up the credentialling process; exploring opportunities to support playgroups and physical/healthy activities; opportunities for connecting families to other services; building and recruiting the provider workforce; and consider new technology options such as home monitoring systems.

MOTION: Commissioner Edgcomb moved to approve change to Provider Recruitment Program policy to allow Chief Executive Officer approval of awards four times per year and approve implementation of Phase 1 funding opportunities, seconded by Commissioner Espinoza.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Edgcomb, Espinoza, Friend, Kalantari-Johnson and Pedrozo,

Noes: Commissioner Molesky.

Absent: Commissioners Conner, Cuevas, deGhetaldi, Morales, Nanyonjo, Radner and Smith.

Abstain: Commissioners Harris, Inda, Jimenez, Rabago, Schuller and Weber.

12. Consider approving Proposed Urgent Care Payment Rates and Access Policy. (4:30 – 4:39 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. Lisa Ba, Chief Financial Officer, informed the Board that in 2018 the Alliance implemented an Urgent Visit Access Initiative to improve member access for members' same-day urgent care needs and to decrease avoidable emergency room utilization. As part of this initiative, the Board

approved members' direct access to urgent care visits at Alliance contracted primary care provider practices who enrolled in the program and offered after-hours and weekend urgent care access. Under this initiative, reimbursement was approved at 150% Medi-Call fee schedule.

As members resume care after the pandemic, the Alliance network hospital and local urgent care facilities are experiencing increased utilization for members seeking what would be avoidable emergency department and urgent care services. The implementation of this policy change will support Alliance member access to the right care, in the right place and at the right time and alleviate contracted hospitals' avoidable emergency department visit rates.

MOTION: Commissioner Molesky moved to approve: 1) a change in the payment rate for urgent care services from 150% of the Medi-Cal fee schedule to 100% of the Medicare fee schedule, and 2) member access to any contracted urgent care and any contracted primary care practice that offers after-hours and weekend care, regardless of member primary care linkage, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Edgcomb, Espinoza, Friend, Kalantari-Johnson, Molesky and Pedrozo.

Noes: None.

Absent: Commissioners Conner, Cuevas, deGhetaldi, Morales, Nanyonjo and Smith.

Abstain: Commissioners Harris, Inda, Jimenez, Rabago, Radner, Schuller. and Weber.

13. Discuss County Expansion. (4:39 – 4:58 p.m.)

Ms. Sonnenshine, CEO, provided the Board with an update on the expansion into San Benito County and Mariposa County and provided an overview of each county.

Staff have a comprehensive implementation plan to effectuate model change as well as implementation of the 2024 Department of Health Care Services (DHCS) contract. Staff have identified factors and challenges influencing the feasibility of the model change and are in discussion with DHCS as to potential actions to address those factors. Provider and community engagement are underway and will continue towards the development of an adequate network to meet member needs. Staff plan to return to the Board with an analysis of the expected network and financial performance to inform the final recommendation to the Board around contract execution. Staff also plan to return to the Board with a plan for the convening of the new five county commission in the fall of 2023. A future item may come forward to the Board to consider how the Alliance can more proactively advance capacity in the San Benito County and Mariposa County networks to ensure the quality performance and network adequacy targets expected by the State can be achieved.

Commissioners discussed and provided the following comment: recommended Alliance Chair and/or Vice Chair attend community engagement meetings with Mariposa County and San Benito County and commented that network development and rates do not support expansion.

[Vice Chair Pedrozo departed at this time: 4:55 p.m.]

[Commissioners Bizzini and Molesky departed at this time: 4:57 p.m.]

Information and discussion item only; no action was taken by the Board.

The Commission adjourned its regular meeting of March 22, 2023 at 4:58 p.m. to the regular meeting of April 26, 2023 at 10:00 a.m. at the El Capitan Hotel in Merced County unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, February 15, 2023
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Chief Compliance Officer (Chair)
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kate Knutson	Compliance Manager
Kay Lor	Payment Strategy Director
Linda Gorman	Communications Director
Lisa Ba	Chief Financial Officer
Lisa Artana	Human Resources Director
Luis Somoza	Member Services Director
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley	Compliance Director
Shaina Zurlin	Behavioral Health Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Dianna Diallo	Medical Director
Jennifer Mockus	Community Care Coordination Director

Committee Members Excused:

Lilia Chagolla	Community Engagement Director
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive Officer

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Ka Vang	Compliance Specialist II
Kat Reddell	Compliance Specialist II
Rebecca Seligman	Compliance Supervisor

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 9:02 a.m.

2. Review and Approval of December 21, 2022 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of January 21, 2023 meeting.

3. Consent Agenda.
1. **Policy Hub Approvals**
2. **Regulatory and All Plan Letter Updates**
3. **Open APLs**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. HIPAA Privacy & Security Report

Chairperson Mandella and McMurray, Information Security Analyst, presented the Q4 2022 HIPAA Privacy & Security Report. Mandella reported on recent updates to the HIPAA Program reporting process as follows:

- Successful implementation of changes to state reporting for low-risk mitigated incidents
- Successful interim process for Confidential Communication Requests with additional planned implementation steps

Mandella reviewed HIPAA disclosure notifications received in Q4 2022, noting that of the 24 referrals received, 9 were determined to be incidents with 3 requiring state reporting. 200 members were impacted as a result of the incidents in Q4 2022. Other remains the top root cause of HIPAA disclosures in the quarter, followed by incorrect selection/entry information, and incorrect contact information.

Mandella reviewed HIPAA program metrics included on the Alliance Dashboard for Q4 2022 reporting that quality metrics met the target performance, while efficiency metrics did not. Mandella reiterated the importance of timely reporting of suspected incidents and requested committee members' support with engaging their teams on this matter.

McMurray reported results of the Security Assessment and outlined the number of HIPAA/NIST (National Institute of Standards and Technology) and Cybersecurity risks identified as well as the associated level of risk for each.

McMurray reported successful implementation of CrowdStrike as our Endpoint Detection and Response (EDR) program provider which resulted in an additional level of member identity protection.

McMurray reviewed planned security efforts for 2023 including micro-segmentation and vulnerability scanning.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2022 HIPAA Privacy & Security Quarterly Report.

2. Compliance Committee Participant Training

Mandella presented Annual Compliance Committee Member Training. Mandella reviewed Compliance Program guiding principles and provided an overview of Compliance Committee structure and oversight responsibilities emphasizing specific activities and committee roles directly related to the Compliance Program.

3. 2024 Medi-Cal Contract Implementation Status Update

Mandella indicated that Compliance was requesting input from all departments to ascertain the status of 2024 contract implementation. Mandella noted that after the status of implementation was better understood, Compliance Division staff will bring forward a recommendation on how best to ensure complete implementation of items that remain open. The committee explored the idea of scheduling a cross-functional meeting, with a number of participants in favor of the idea.

4. APL Discussion

The Committee discussed APL processes and shared ideas about process improvement.

The meeting adjourned at 9:56 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, October 26, 2022

Teleconference Meeting
(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Members Present:

Ms. Elsa Jiménez	County Health Director
Mr. Michael Molesky	Public Representative
Allen Radner, MD	Provider Representative
Mr. Tony Weber	Provider Representative

Members Absent:

Ms. Shebreh Kalantari-Johnson	Public Representative

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Dulcie San Paolo	Finance Administrative Specialist

1. Call to Order. (1:29 p.m.)

The meeting was called to order at 1:29 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:30 – 1:31 p.m.)

Chairperson Molesky opened the floor for any members of the public to address the Committee on items not listed on the agenda.

No members of the public addressed the Committee.

Consent Agenda Items:

3. Approve minutes of the August 24, 2022 meeting of the Finance Committee. (1:31–1:32 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the August 24, 2022 meeting.

MOTION: Commissioner Radner moved to approve the minutes, seconded by Commissioner Weber.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Molesky, Radner, Weber

Noes: None

Absent: Commissioners Jiménez, Kalantari-Johnson

Abstain: None

Regular Agenda Items:

4. August YTD Financial Results. (1:32 – 1:39 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financial performance for the eight months ending on August 31, 2022

[Commissioner Elsa Jiménez arrived at this time: 1:36 p.m.]

5. Preliminary 2023 Budget. (1:39 – 2:28 p.m.)

Ms. Ba oriented the commissioners to the preliminary 2023 budget.

An overview of the financial performance trend from 2019 to 2022 was reviewed. Next, the CFO discussed the assumptions upon which the budget was based, including enrollment, revenue, and medical cost.

Regarding enrollment, Ms. Ba explained that redetermination is expected to begin in April 2023. Staff anticipates that the process will take eighteen months to complete, with the full impact of the enrollment decrease likely evident in 2024. She explained that as enrollment reduces, the acuity and the Per Member Per Month (PMPM) medical cost will increase. The preliminary budget assumes that members will continue resuming the delayed care throughout 2023 and that the overall annual utilization will be 5% above 2019.

With regard to revenue, the CFO noted that a 1.2% rate increase from the current 2022 draft rate is included in the 2023 budget. This is based on Rate Development Template (RDT) walkthrough data that the California Department of Health Care Services (DHCS) provided in

September. It is expected that the Enhanced Care Management (ECM) rates will be received in November and the draft rate will be received in December.

In summary, the preliminary budget includes a $66.6M operating income or 4.3%, with a Medical Loss Ratio (MLR) of 89.5% and an Administrative Loss Ratio (ALR) of 6.1%. Ms. Ba pointed out that this budget does not include Dual Special Needs Plan (D-SNP) related activities in 2023. Staff will submit a separate D-SNP budget once the Operation Gap Assessment has been completed.

Next, the CFO provided a future financial outlook for the commissioners. She outlined several factors impacting the Alliance's financial state over the next four years.

Ms. Ba offered a view of the five-year projection and noted that it is anticipated that the Alliance will experience three years of losses beginning in 2024. One contributing factor is that the State will likely have a budget deficit in SFY 2023-2024. This could mean that Medi-Cal revenue will be constrained.

Of additional note, with the full impact of the decreased enrollment being realized in 2024, it is expected that the reduced enrollment will result in higher acuity and higher PMPM medical cost. Therefore, medical costs are expected to be higher from 2024 through 2026.

Ms. Ba went on to explain that the upcoming regional rate poses a significant threat to the Alliance's finances, and it is likely that revenue may decrease by 2%. Under the regional rate, the Alliance's revenue will be risk- and quality-adjusted. The Alliance will have to compete with other local and commercial Medi-Cal managed care plans for funding. As a result, the Alliance may experience operating losses for up to three years once the regional rate is implemented.

The CFO oriented the commissioners to a projected view of the fund balance with grant funding and the D-SNP reserve removed. She advised that although the plan is expected to continue to build a healthy fund balance in 2022 and 2023, the subsequent loss cycle could result in the fund balance falling below the Board Designated Reserves Target.

Lastly, Ms. Ba described how D-SNP would be another critical element to consider regarding the Alliance's financial future. She noted that once D-SNP is implemented, the Alliance will need to build a reserve to meet the three-month premium revenue requirement for the D-SNP line of business per the reserve policy.

The Commission adjourned its meeting on October 26, 2022, at 2:28 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract 08-85216 A-48

Recommendation. Staff recommend the Board authorize the Chair to sign Medi-Cal Contract 08-85216 A-48 as described below to incorporate updated Capitation Payment rates for the period July 1, 2019 through December 31, 2020.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties. The Alliance entered into the primary Agreement 08-85216 with DHCS on January 1, 2009. The agreement has subsequently been amended via written amendments (A-1 through A-47, A-49, A-50, A-54 and A-55).

Discussion. DHCS has prepared A-48, an amendment to the Alliance's State Medi-Cal contract to incorporate Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into an SIS version and UIS version, as required by the Centers for Medicare and Medicaid Services.

Fiscal Impact. There is no anticipated financial impact. DHCS has indicated the change in rates is expected to be revenue neutral and staff have reviewed the rates and concur with this assessment.

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Revised 2023 Finance Committee Meeting Schedule

Recommendation. Staff recommend the Board approve a revised 2023 Finance Committee meeting schedule.

Background. The Finance Committee typically meets four times a year, once a quarter at 1:30 to 2:45 p.m. immediately preceding a Board meeting.

Discussion. When the 2023 Finance Committee schedule was drafted, a Board meeting date had not been confirmed for August. Considering that there is now a Board meeting confirmed to take place on August 23, 2023, staff propose the following revised 2023 Finance Committee meeting schedule to include the addition of a Finance Committee meeting in August. Inclusion of a Finance Committee meeting in August will provide for most favorable timing for the Committee to have an opportunity to review and provide feedback related to topics scheduled for presentation to the Board in the fourth quarter.

1. March 22, 2023
2. June 28, 2023
3. August 23, 2023 (additional meeting)
4. October 25, 2023
5. December 6, 2023

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

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Bonus Plan Implementation

Recommendation. Staff recommend the Board approve the addition of a staff bonus program as a component of the Alliance's compensation philosophy, effective for fiscal year 2023.

Summary. To advance achievement of organizational goals, staff designed a staff bonus plan to be administered on an annual basis as a component of the Alliance's annual performance management process and annual compensation review. This report summarizes the goals and implementation details for the staff bonus program.

Background. In 2018, the Alliance's Board adopted a compensation philosophy which established competitive pay practices for staff recruitment and retention. This philosophy was adopted to create communication and transparency regarding compensation strategy which is market-driven, performance-oriented, flexible and adaptable, consistent and fair, and aligns with the marketplace. In that same year, the Board adopted a strategic plan which set forth the organizational priorities and goals to guide organizational performance. In 2022, the Board adopted the current 5-year strategic plan centered around health equity and person-centered system transformation. Organizational objectives are established annually to advance the Alliance's operational as well as strategic priorities and goals. Staff goals are established in line with the Alliance's operational and strategic objectives and merit compensation adjustments are available based on staff's performance. The Alliance did not offer staff incentives supportive of organizational achievement of targeted operational and strategic performance.

Discussion. There is an opportunity to advance the Alliance's achievement of organizational objectives through incentivizing staff's engagement in organizational goals through a staff bonus program. The goals of the Alliance bonus plan are to:

- Incent staff toward supporting and completing operational and strategic objectives above and beyond their normal job responsibilities,
- Enhance engagement, collaboration and further strengthen work relationships across the organization, and
- Further motivate staff performance and productivity.

The bonus plan will be based on annual organizational goals with success evaluated via a points accrual system focusing on the following areas:

- Defined breakthrough objectives specific to improving the delivery of Alliance services connected to our strategic plan,
- Adapting health plan operations, and
- Achieving regulatory compliance.

The bonus program is designed such that all employees in good standing (those meeting minimum performance expectations) are eligible for participation in the bonus plan. Most importantly, the Alliance must achieve its annual financial performance metrics for the bonus to be paid, and the maximum amount is 3% of the employee's salary. The bonus payout is expected to be in March or April each calendar year after full assessment and reporting is completed to determine goal achievement.

Several other California not-for-profit health plans offer performance bonus/incentive plans for staff. Implementation of an incentive plan at the Alliance further positions the organization as an employer of choice for managed care professionals.

Fiscal Impact. Payout of the bonus will be dependent on the achievement of metrics. Staff expect that the approved 2023 budget will cover the bonus pay out, and payments will not result in an administrative budget variance or adjustment.

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Updated Local Agency Investment Fund Authorization Resolution and Santa Cruz County Bank Resolution

---

Recommendation. Staff recommend that the Board approve the updated Local Agency Investment Fund (LAIF) Authorization Resolution and the Santa Cruz County Bank Resolution to include the following Alliance staff to be authorized users:

1. Michael Schrader – Chief Executive Officer (CEO)
2. Lisa Ba – Chief Financial Officer (CFO)
3. Jimmy Ho – Accounting Director

Background. LAIF was established in 1977 as an investment alternative for local agencies providing the opportunity to participate in a major investment portfolio through the California State Treasurer's Office. Local governmental agencies may participate in LAIF by filing a resolution adopted by the agency's governing board with the State Treasurer's Office.

Discussion. The Alliance's LAIF Resolution was approved by the Board on May 26, 2021, to grant the CEO and Finance Director authorization to manage the monies in the LAIF account and to add or remove authorized users. Staff seek approval from the Board to update the LAIF Authorization Resolution and the Santa Cruz County Bank Resolution due to organizational growth and position title changes. The updated resolutions allow for the CFO to oversee the treasury function and the addition of authorized users will ensure sufficient coverage to appropriately manage Alliance investments.

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

Attachment:

1. Resolution of Santa Cruz-Monterey-Merced Managed Medical Care Commission (LAIF)
2. Resolution of Santa Cruz-Monterey-Merced Managed Medical Care Commission (Santa Cruz County Bank)

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

RESOLUTION OF SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSION

AUTHORIZING INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND

WHEREAS, The Local Agency Investment Fund is established in the State Treasury under Government Code section 16429.1 et. seq. for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the BOARD OF DIRECTORS hereby finds that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein is in the best interests of the SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS;

NOW THEREFORE, BE IT RESOLVED, that the BOARD OF DIRECTORS hereby authorizes the deposit and withdrawal of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS monies in the Local Agency Investment Fund in the State Treasury in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein.

BE IT FURTHER RESOLVED, as follows:

Section 1. The following SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS officers holding the title(s) specified hereinbelow **or their successors in office** are each hereby authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund and may execute and deliver any and all documents necessary or advisable in order to effectuate the purposes of this resolution and the transactions contemplated hereby:

MICHAEL SCHRADER – CHIEF EXECUTIVE OFFICER

LISA BA – CHIEF FINANCIAL OFFICER

JIMMY HO – ACCOUNTING DIRECTOR

Section 2. This resolution shall remain in full force and effect until rescinded by BOARD OF DIRECTORS by resolution and a copy of the resolution rescinding this resolution is filed with the State Treasurer's Office.

PASSED AND ADOPTED, by the BOARD OF DIRECTORS of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS of State of California on APRIL 26, 2023.

ATTEST:

_____

Kathy Stagnaro, Executive Assistant, Clerk to the Board

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

RESOLUTION OF SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSION

AUTHORIZING INVESTMENT OF MONIES IN SANTA CRUZ COUNTY BANK

WHEREAS, The Local Agency Investment Fund is established in the State Treasury under Government Code section 16429.1 et. seq. for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the BOARD OF DIRECTORS hereby finds that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein is in the best interests of the SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS;

NOW THEREFORE, BE IT RESOLVED, that the BOARD OF DIRECTORS hereby authorizes the deposit and withdrawal of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS monies in the Local Agency Investment Fund in the State Treasury in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein.

BE IT FURTHER RESOLVED, as follows:

Section 1. The following SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS officers holding the title(s) specified hereinbelow **or their successors in office** are each hereby authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund and may execute and deliver any and all documents necessary or advisable in order to effectuate the purposes of this resolution and the transactions contemplated hereby:

MICHAEL SCHRADER – CHIEF EXECUTIVE OFFICER

LISA BA – CHIEF FINANCIAL OFFICER

JIMMY HO – ACCOUNTING DIRECTOR

Section 2. This resolution shall remain in full force and effect until rescinded by BOARD OF DIRECTORS by resolution and a copy of the resolution rescinding this resolution is filed with the State Treasurer's Office.

PASSED AND ADOPTED, by the BOARD OF DIRECTORS of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS of State of California on APRIL 26, 2023.

ATTEST:

_____

Kathy Stagnaro, Executive Assistant, Clerk to the Board

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Disaster Response Fund

---

Recommendation. Staff recommend the Board approve a $1,000,000 allocation of unallocated Medi-Cal Capacity Grant Program (MCGP) funds to establish a Disaster Response Fund to address immediate member need in the event of a disaster. Staff also recommend the Board approve Chief Executive Officer (CEO) authority to approve future grants to rapidly deploy resources to community-based organizations that provide essential social and health services to Medi-Cal members most affected in a disaster. Lastly, staff recommend implementing a retrospective round of grant awards from the Disaster Response Fund for contracted Alliance providers who incurred qualifying expenses during the extreme weather events in January and March 2023.

Summary. This report includes background on the impact of natural disasters on the Alliance's membership and recommendations for a MCGP Disaster Response Fund.

Background. Over the past three years, the Alliance service area has experienced a pandemic, wildfires and floods. During disasters, many residents in the Alliance service area are severely impacted by evacuations and limited access to resources. While all populations are affected, the disruption caused by such events disproportionately impacts the most vulnerable in our communities and puts those who are already experiencing a serious health condition at even greater risk of further complications.

The health plan has become experienced in disaster response and incident management. An aspect of the health plan's response is identifying immediate member needs, including immediate food, shelter and medical needs that require support and attention during the period of a disaster. The experience of the MCGP's COVID-19 Response Fund administered in 2020 demonstrates that a nimble grant program that can be activated quickly when a crisis arises is critical for the Alliance to provide financial resources in a community-wide response. There is an opportunity to build into our overall emergency response and incident management plans the use of grant funding to meet members' immediate healthcare or health related needs.

Medi-Cal members also receive support during disasters from several community-based organizations who are funded by the community foundations in Santa Cruz and Monterey counties. The foundations' disaster response funds quickly disperse funding to non-profits providing aid to impacted individuals and families in the communities they serve. Funds are used for immediate needs like food, emergency shelter and financial assistance to those evacuated.

The recent atmospheric river storm events in January 2023 and March 2023 severely impacted people in the Alliance's service area. Alliance staff were in close contact with providers and community partners in order to respond to and communicate about the priority needs of our impacted members and resources available to them during the events.

At the end of March, the Alliance donated $54,000 to Merced County Food Bank, $67,200 to Food Bank for Monterey County and $28,799 to Second Harvest Food Bank of Santa Cruz County. Lack of access to nutritious food is one of the most significant challenges facing Medi-Cal members, which results in poor health outcomes and reduced quality of life. The food banks provided direct support at this critical time, stretching beyond their normal efforts to provide emergency support to the community. The donation was made from the MCGP unallocated budget and approved by the CEO per expenditure authority of nonbudgeted expenditures up to $149,999.99 (policy #105-0013).

Discussion. In recognition of the urgent challenges facing Alliance members and the community at large when a disaster occurs, an established fund could provide immediate financial support to organizations on the front lines serving those most in need. This would allow the Alliance to rapidly deploy financial resources to community-based organizations to meet the basic, health-related needs of our members in each county in the event of a natural, technological or biological disaster.

Staff recommend allocating $1M of unallocated MCGP funds to establish a Disaster Response Fund. To the extent Alliance reserves are available for strategic use, the Disaster Response Fund will be funded annually up to $1M. The funds would not be required to be expended if no disaster occurs within the year. Due to the nature of this fund available to respond to future, unknown events, the $1M would be allocated from each county's MCGP unallocated budget based on membership, but the awards would be made wherever the member need occurs within the Alliance's service area. The Disaster Response Fund would support community organizations in their efforts to respond to disasters in our region through procurement, distribution, and delivery of food, services and supplies to local residents, including Alliance members.

Staff propose the Board give the CEO authority to approve grants each up to the maximum amount allocated to the Disaster Response Fund for each county. Funding would be allocated at the time of the disaster event which activates the fund. The Disaster Response Fund would become available for grantmaking when deemed appropriate by the Incident Management Team (IMT), which is activated per the Alliance's Business Continuity and Disaster Recovery Plan in response to a disaster/emergency. The funds would be administered through the MCGP grantmaking structure through a simple online application process for organizations that meet existing basic MCGP eligibility requirements.

The health plan's and community partners' experience in disaster response have allowed staff to identify additional Medi-Cal member needs beyond food, supplies and services that would benefit from Alliance financial support though a Disaster Response Fund. These needs include financial assistance and hotel stays for displaced Medi-Cal members with medical needs that prohibit staying in a shelter. More research is needed to determine how to operationalize MCGP support of medically necessary hotel stays in the event of a disaster to explore all facets, including eligibility criteria, Health Insurance Portability and Accountability Act compliant referrals, authorization process, expense limits and health plan liability. Research is also needed to determine if a donation to a community-based organization to support cash aid would be feasible under the MCGP.

If the Disaster Response Fund is approved, staff further recommend implementing a retrospective round of grant awards from the fund for contracted Alliance providers who incurred qualifying expenses during the flooding evacuations in the Alliance service area in January 2023 and March 2023. Qualifying expenses may include those incurred by the contracted Alliance provider for hotel stays for Alliance members during the evacuation order period whereby the provider determined the member was unable to stay at an evacuation shelter due to medical reasons.

Next Steps. If approved, staff would include a report in the consent agenda of each Board packet listing all Disaster Response Fund awards when they are made. Staff would return to the Board with a report on findings and recommendation as to whether to include hotel stays and cash aid under the Disaster Response Fund and, if included, how hotel stays would be operationalized under the fund.

Fiscal Impact. This recommendation would allocate $1M from the MCGP unallocated budget to fund a Disaster Response Fund. Amounts remaining in the unallocated MCGP budget per county, after proposed allocations for new funding opportunities proposed in this April 26, 2023 Board meeting packet and the proposed Disaster Response Fund allocation, are as follows: Merced County $50.8M; Monterey County $51M; and Santa Cruz County $20M.

Attachments. N/A

Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

October 2015 through March 2023

About the MCGP

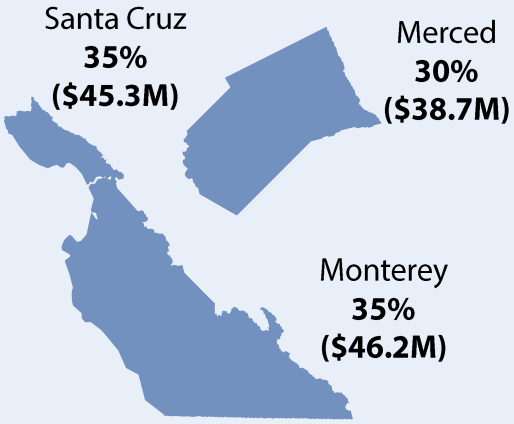
The Alliance invests in the communities it serves through the Medi-Cal Capacity Grant Program (MCGP) to realize the Alliance's vision of healthy people, healthy communities.

Since 2015, grants were awarded to local organizations under four focus areas to improve the availability, quality and access of health care and supportive resources for Medi-Cal members in Santa Cruz, Monterey and Merced counties.

The October 2023 dashboard will reflect new grant programs launching in April and May 2023 under the new focus areas: *Access to Care, Healthy Beginnings and Healthy Communities*. New funding opportunities respond to the current health care landscape, align with organizational and State priorities, and address current and emerging needs of Alliance members and the social drivers that influence health and wellness.

Total Awarded:

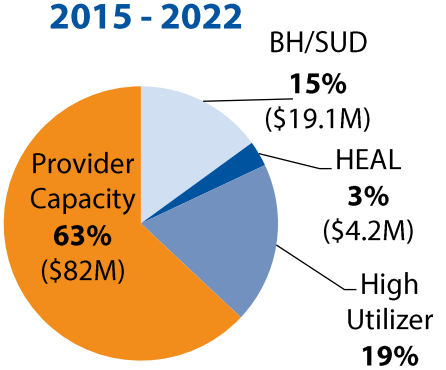
$130.2M



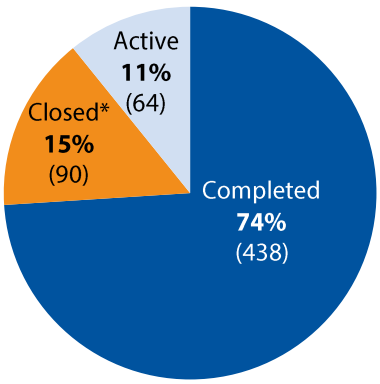
Number of Organizations Awarded:

142

Awards by Focus Area 2015 - 2022

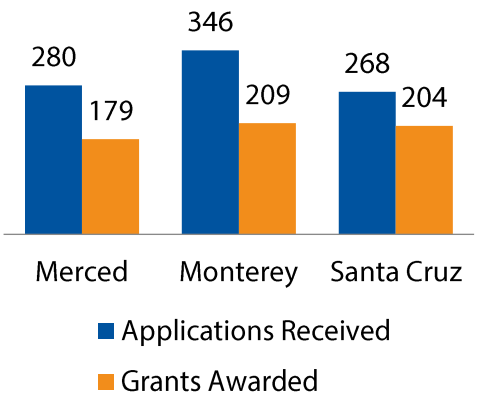


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 592



Provider Recruitment Program

289 grants totaling $35.2M awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.

205 new providers hired to date.

79% retention of new recruits.

23 recruited primary care physicians specialize in Pediatrics.

38% increase in primary care sites open to accepting new members.

	Merced		Monterey		Santa Cruz		Total	% of Total
Type Recruited	Physician	Non-Physician	Physician	Non-Physician	Physician	Non-Physician		
Primary Care	29	18	20	19	12	6	104	51%
Specialty Care	4	4	28	2	12	3	53	26%
Allied		9				2	11	5%
Behavioral Health	2	2	3	1	8	8	24	11%
Dental	3				4		7	3%
Other				3		3	6	3%
Total Recruited	38	33	51	25	36	22	205	100%
	35% of total		37% of total		28% of total			

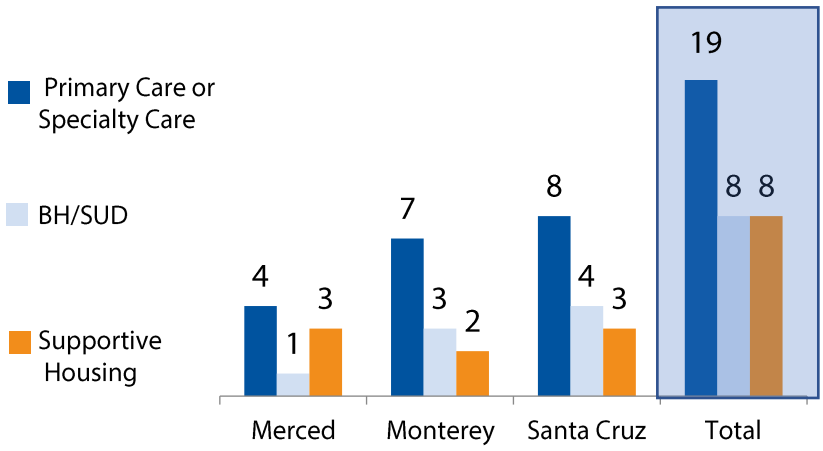
Specialties Recruited

Capital Program

58 grants* totaling $73.8M awarded for the expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service area. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance's most medically fragile Medi-Cal members.

* Applicants may apply for both planning and implementation grants for one project.

35 Capital Projects



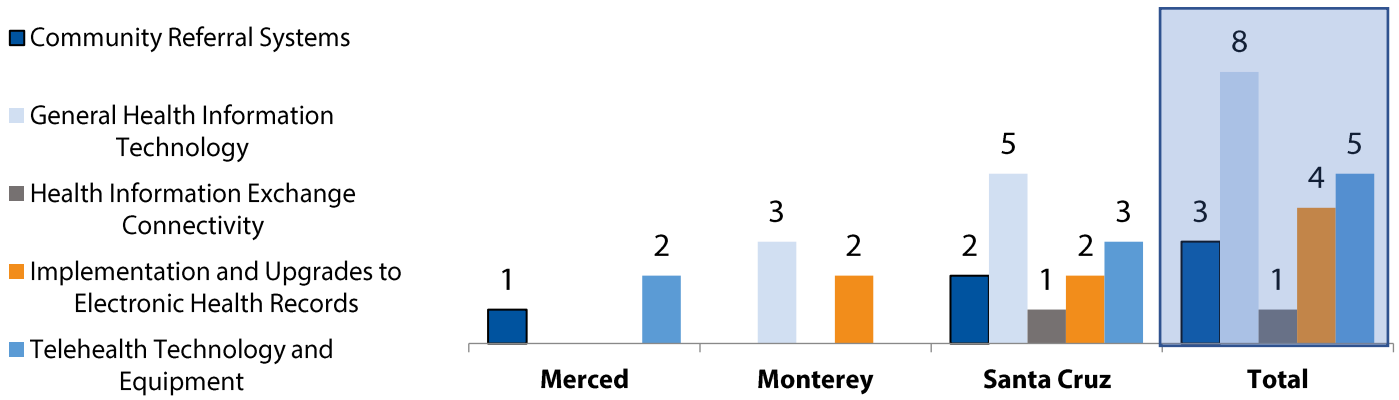
176.4K Medi-Cal members anticipated to be served by new and expanded facilities.

Infrastructure Program

29 grants* totaling $3.8M awarded for information technology systems that expand Medi-Cal capacity in the Alliance service area.

* Applicants may apply for both planning and implementation grants for one project.

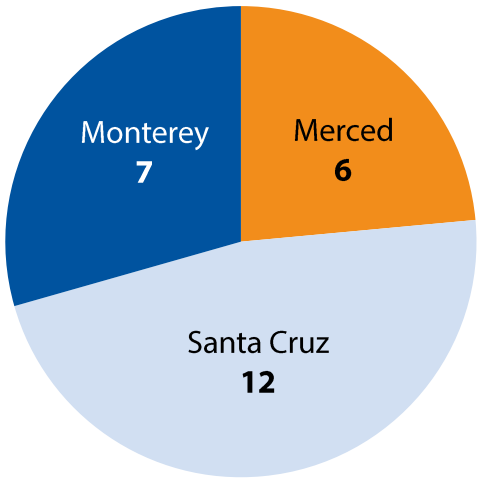
21 Infrastructure Projects



Partners for Healthy Food Access Program

25 grants* totaling $3.6M awarded to support a variety of innovative partnerships between health care providers, community-based organizations and/or government agencies implementing community-based nutritious and medically supportive food projects to improve member health and food security in the Medi-Cal population.

* One grant terminated.



Total Number of Projects: 25

Food Access Projects Focus On:

Food Insecurity Screening

Chronic Disease Screening

Healthy Food Prescription/Distribution

- Food Bank Access Point
- Mobile Market/Farmers Market
- Produce Box Home Delivery

Referrals to Supportive Services

- Cal-Fresh Enrollment

Knowledge & Skill Building

- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

Workforce Development Investments

3 grants totaling $1M awarded to support the development of new educational programs for health care professionals that will serve the Medi-Cal population.

- **58** Physician Assistant graduates to date (starting 2020).
- Master of Science - Physician Assistant Program, CSU Monterey Bay.
- Serves Monterey and Santa Cruz counties.

- **55** Family Nurse Practitioner graduates to date (starting 2019).
- Master of Nursing - Family Nurse Practitioner Program, CSU Stanislaus.
- Serves Merced County.

- **70 anticipated** Community Health Workers (CHW).
- Monterey County Workforce Development Board CHW Certificate Training Program.
- Serves Monterey County.

Children's Saving Account Pilot

1 grant totaling $230K awarded to support a 2 ½ year pilot program to build on existing children's savings account (CSA) program in Santa Cruz County for eligible Alliance members 0-2 years old who achieve preventative care milestones.

A CSA is a special savings account to save money for children's use for college or vocational education.

For each milestone achieved, $25 will be deposited into the Alliance member's CSA.

Preventative Care Milestones:

- Childhood Immunization Status Combo 10
- Well-Child Visits in the First 15 Months of Life (6 or More Visits)

It is estimated there will be a 5% increase in the number of children achieving the milestones year over year from 2021 baseline. A program evaluation will inform potential for future expansion of CSA health milestone contributions to other counties.

Retired Programs

Equipment Program: 103 grants totaling $1.7M awarded to subsidize equipment purchases that expand health care provider's capacity to serve the Medi-Cal population in the Alliance service area and impact direct patient care. Program was retired as of October 2017.

Practice Coaching Program: 23 grants totaling $619K awarded to practices for consultant engagements to adopt the Patient Centered Medical Home (PCMH) model of care. Program was retired as of October 2017.

Intensive Case Management Program: 11 grants totaling $4.9M awarded to high-volume primary care practices to add staff to provide intensive case management services for medically complex Medi-Cal patients within the patient centered medical home. Three-year pilot launched 01/01/18 and was retired on 12/31/20.

Post-Discharge Meal Delivery Pilot: 3 grants totaling $651K awarded to fund the delivery of 12 weeks of ready-made, nutritious meals to Medi-Cal members recovering from an inpatient hospital stay. Two-year pilot launched 11/01/18. The Alliance Board approved the transition of the successful pilot to an Alliance-only Medi-Cal benefit, effective 01/01/21.

COVID-19 Response Fund: 27 grants totaling $1M awarded to community-based organizations to meet the basic health-related needs of Medi-Cal members impacted by COVID-19, such as food, hygiene and sanitation supplies. Program was retired as of April 2021.

Technical Assistance Program: 13 grants totaling $470K awarded to provide support for training or consulting engagements that directly result in increased access, coordination of care and integration of services. Program was retired as of April 2020.

Recuperative Care Pilot: 13 grants totaling $470K awarded to community-based organizations to support 30–60-day recuperative care stays for Medi-Cal members experiencing homelessness and recovering from an illness or injury. This short-term housing solution is an alternative to hospital care for individuals experiencing homelessness who no longer need hospital care but have medical needs that would worsen if living on the street or in a shelter. Funding also supported temporary bridge housing for members exiting recuperative care temporary housing while awaiting a more permanent housing placement.

The pilot created the foundation for a successful transition to Community Support implementation under CalAIM. These services are now reimbursable through Medi-Cal as Recuperative Care and Short-Term Post-Hospitalization Housing.

Grants in the Community

Provider Recruitment

Coastal Kids Home Care (Coastal Kids) was the recipient of a Provider Recruitment grant in October 2022 to hire Nefertari Rossell, MA, LMFT to add to their growing team of behavioral health care providers for the children they serve. Nefertari works full-time with a caseload of 25 counseling clients per week and provides culturally and linguistically competent care for Coastal Kids' predominantly multi-cultural families.

In the past few years, Coastal Kids has grown its capacity to respond to the increasing demand for critical services for vulnerable children, including bilingual mental health counseling for children with mild to moderate mental health conditions. Coastal Kids' services include 1:1 counseling with a licensed provider, a walk-in clinic which offers brief (six week) therapy for individuals with emergent needs, and resourcing for families and referrals to other community providers.

Coastal Kids received the MCGP's new Linguistic Competence Provider Incentive in hiring Nefertari, who speaks Spanish. The incentive is a new option within the Provider Recruitment Program that supports grantee organizations in hiring bilingual providers to reduce health disparities and achieve equitable health care for our members.

Photo Credits: Coastal Kids Home Care

Grants in the Community

Capital Implementation

Mission Merced, Inc. was awarded a Capital Implementation grant for $2.5M in October 2019 for Hope Respite Care, a recuperative care services facility on Mission Merced's five-acre campus, Village of Hope. This was preceded by a Capital Planning grant award for $150,000 for pre-development of the facility. Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who do not require hospital-level care but need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. Additionally, within the recuperative care model, some individuals who are exiting recuperative care have the option to participate in short-term post-hospitalization housing while awaiting a more permanent housing placement.

With this new facility Mission Merced increased its bed capacity by 220% from 10 beds to 52 beds. Hope Respite Care began operations in March 2022 and has steadily increased enrollment.

From March 2022 to January 2023, Mission Merced had provided recuperative care to a total of 191 Alliance Medi-Cal members.

Mission Merced participated in the Alliance's Recuperative Care Pilot. Now that the pilot has successfully transitioned its services to Medi-Cal covered services, Mission Merced continues to offer both Recuperative Care and Short-Term Post Hospitalization Housing under the Department of Health Care Services' CalAIM Community Supports menu of services that addresses health-related social needs.

Photo Credits: www.mercedcountyrescuemission.org

Grants in the Community

Partners for Healthy Food Access

Community Health Trust of Pajaro Valley (CHT) received a Partners for Healthy Food Access grant in April 2020 for their project El Mercado del Valle de Pajaro, a Medi-Cal patient-centered farmers market focused on the promotion of individual and overall community health. CHT partnered with the Diabetes Health Center and Salud Para La Gente in the Veggie Rx (VRx) produce prescription program, which provided participants the opportunity to take home a subsidized, fixed amount of fresh, organic produce upon every visit to El Mercado. 600 Medi-Cal members living with diet-related illness and identified via pre-surveys as food insecure were referred to the VRX program.

During the first season in 2021, El Mercado was held at Ramsay Park. During 2022, markets were held at both Ramsay Park and Pinto Lake. The market was held 27 times in 2021 and 28 times in 2022, averaging 600 – 1,200 visitors per market. Out of 28,740 VRX tokens CHT that distributed, 95% (27,280) were redeemed in 2022.

Due to its success, El Mercado is continuing its operations with equity at its center and connecting people to existing health and food resources in a culturally relevant way. CHT was awarded a second Food Access grant award in October 2022.

Photo Credits: pvhealthtrust.org

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group A)

Recommendation. Staff recommend the Board approve grant recommendations that total $4,377,726 for Group A of funding recommendations under Consent Agenda Item 9G.

Summary. This report includes a brief background on the Alliance's Medi-Cal Capacity Grant Program (MCGP) awards to date, an overview of the grant review process and award recommendations for the current funding cycle.

Background. Since the launch of the MCGP in July 2015, the Alliance has awarded 592 grants totaling over $130 million to 143 organizations in the Alliance's service area to strengthen the local health care delivery system. Consent Agenda Item 9F includes the MCGP Performance Dashboard which provides details on grants awarded to date.

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on January 20, 2023. This funding cycle, the Alliance received 23 applications from 20 organizations. Staff carefully reviewed each application to determine eligibility and is recommending approval of 22 out of the 23 eligible applications received.

An internal committee reviewed and selected applications to recommend to the Board for approval based on the eligibility and program criteria previously approved by the Board. The internal review committee included: Stephanie Sonnenshine, Chief Executive Officer; Dr. Dale Bishop, Chief Medical Officer; Lisa Ba, Chief Financial Officer; Van Wong, Chief Operating Officer; Jessie Dybdahl, Provider Services Director; and Jessica Finney, Grants Director. All applicants received a letter notifying them whether their application was being recommended for approval in April 2023.

Of the 22 grant applications being recommended for approval, 22.5% (5) are from Merced County, 55% (12) are from Monterey County and 22.5% (5) are from Santa Cruz County. Of the 22 applications recommended for approval 82% (or 18 applications) fall under the Access to Care focus area and 18% (or 4 applications) fall under the Healthy Communities focus area. The 22 grant applications recommended for approval are distributed across programs as follows:

Grant Program	**Number of Awards Recommended**	**Award Amount Recommended**
Provider Recruitment	16	$2,054,407
Partners for Healthy Food Access	4	$645,926.00
Capital Implementation	2	$4,999,975
Total	**22**	**$7,700,308**

Grant Award Recommendations. Funding recommendations are grouped for two separate approval actions so that Board members with a conflict may abstain from voting where applicable. The two groups are included in the Consent Agenda as two separate items, as follows: Item 9G (Group A) includes applications not affiliated with Board members; and Item 9H (Group B) includes applications affiliated with Board members.

Grant award recommendations are listed in the table below with totals by county and grouped by Board member affiliation so that Board members with potential fiscal interests in grant awards may abstain from voting on Group B. Details for each grant award recommendation are included in the reference materials listed below.

County	**Group A | Not Board Affiliated**	**Group B | Board Affiliated**
Santa Cruz	$2,800,000	$241,857
Monterey	$1,278,726	$230,750
Merced	$299,000	$2,849,975
Total	$4,377,726	$3,322,582
Total Grant Award Recommendation: $7,700,308		

Fiscal Impact. Recommended grant awards totaling $7,700,308 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

1. Grant Recommendations by Program. (Group A)
   - List of grant award recommendations organized by county and grant type.
2. Recommendation Summaries by Organization. (Group A)
   - Detailed application summaries of grant award recommendations organized alphabetically by organization. All application summaries were prepared by Alliance staff based on information in the grant application.

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP A: Not Affiliated with Alliance Board Members

Capital Implementation

County	Page*	Organization	Award**
Santa Cruz	15	Salud Para La Gente	$2,500,000
		Subtotal	**$2,500,000**

Partners for Healthy Food Access

County	Page*	Organization	Award**
Monterey	12	Central Coast VNA & Hospice, Inc	$200,000
	13	Pacific Cancer Care	$45,926
	14	Santa Lucia Medical Group, Inc.	$200,000
		Subtotal	**$445,926**

Provider Recruitment

County	Page*	Organization	Award**
Merced	6	Kenneth R Grossman MD INC	$150,000
	5	Golden Valley Health Centers	$149,000
Monterey	1	Big Sur Health Center	$150,000
	2	Coastal Kids Home Care	$70,000
	4	Doctors on Duty Medical Group, Inc.	$72,800
	7	Pacific Rehabilitation & Pain	$150,000
	9	Sani Eye Center, Inc.	$150,000
	10	St. Junipero Clinic, Inc.	$150,000
	11	Therasens Inc.	$90,000
Santa Cruz	3	Dientes	$150,000
	8	Salud Para La Gente	$150,000
		Subtotal	**$1,431,800**

*Page number of Recommendation Summary is listed for each Group A grant recommendation on the following pages.

**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Big Sur Health Center**
County:	**Monterey**
Medi-Cal Services:	Alliance PCP
Grant Award History:	Capital Planning (1) $88,050 Equipment (1) $1,200 Provider Recruitment (2) $130,750

Provider Recruitment Program

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	Family Practice
Provider Hours:	Full Time; Part Time
Practice Name:	Big Sur Health Center
Practice Location:	46896 Highway 1, Big Sur, CA 93920
***Recruitment Language(s):**	Spanish
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,00**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Coastal Kids Home Care**
County:	**Monterey**
Medi-Cal Services:	Beacon BH
Grant Award History:	Capital Implementation (1) $1,200,000 Capital Planning (1) $8,000 Provider Recruitment (1) $74,482

Provider Recruitment Program

Services:	Pediatric Behavioral Health
Provider Type:	Licensed Marriage and Family Therapist (LMFT)
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	Coastal Kids Home Care
Practice Location:	427 Pajaro St., Ste. 1, Salinas, CA 93901
***Recruitment Language(s):**	Spanish
Amount Requested:	**$70,000**
****Recommended Award:**	**$70,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Dientes**
County:	**Santa Cruz**
Medi-Cal Services:	State Medi-Cal
Grant Award History:	Capital Implementation (1) $2,500,000 Capital Planning (1) $150,000 Equipment (1) $20,000 Infrastructure Implementation (1) $250,000 Provider Recruitment (4) $371,725

Provider Recruitment Program

Services:	Dentistry
Provider Type:	Pediatric Dentist
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	Dientes Community Dental Care
Practice Location:	1500 Capitola Rd., Santa Cruz, CA 95062
***Recruitment Language(s):**	Spanish
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Doctors on Duty Medical Group, Inc.**
County: **Monterey**
Medi-Cal Services: Beacon BH
Grant Award History: Provider Recruitment (5) $513,000

Provider Recruitment Program

Services: Behavioral Health; Substance Use Disorder
Provider Type: Licensed Clinical Social Worker (LCSW)
Provider Specialty: N/A
Provider Hours: Full Time; Part Time
Practice Name: Doctors on Duty
Practice Location: 3130 Del Monte Blvd., Marina, CA 93933
***Recruitment Language(s):** Spanish
Amount Requested: **$72,800**
****Recommended Award:** **$72,800**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Golden Valley Health Centers**
County:	**Merced**
Medi-Cal Services:	Alliance PCP
Grant Award History:	Provider Recruitment (8) $930,149 Practice Coaching (1) $25,000 Intensive Care Management (1) $300,000 Infrastructure Planning (1) $40,000 Equipment (8) $112,071 Capital Planning (1) $150,000 Capital Implementation (1) $2,500,000

Provider Recruitment Program

Services:	Primary Care
Provider Type:	Nurse Practitioner
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	Merced Suites
Practice Location:	847 W Childs Ave., Merced, CA 95341
***Recruitment Language(s):**	Spanish; American Sign Language
Amount Requested:	**$149,000**
****Recommended Award:**	**$149,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Kenneth R Grossman MD INC**
County: **Merced**
Medi-Cal Services: Alliance Specialty
Grant Award History: N/A

Provider Recruitment Program

Services: Specialty Care
Provider Type: Ophthalmologist
Provider Specialty: N/A
Provider Hours: Full Time
Practice Name: Kenneth R Grossman MD INC
Practice Location: 580 Collins Dr., Merced, CA 95348
***Recruitment Language(s):** Spanish
Amount Requested: **$150,000**
****Recommended Award:** **$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Pacific Rehabilitation & Pain**
County:	**Monterey**
Medi-Cal Services:	Alliance Specialty
Grant Award History:	Equipment (2) $23,448 Provider Recruitment (5) $750,000

Provider Recruitment Program

Services:	Specialty Care; Substance Use Disorder
Provider Type:	Physician
Provider Specialty:	PM&R /Pain Medicine
Provider Hours:	Full Time
Practice Name:	Pacific Rehabilitation & Pain
Practice Location:	1010 Cass St., Monterey, CA 93940; 300 Canal St., King City, CA 93930
***Recruitment Language(s):**	Spanish; Indigenous language (Triqui, Mixteco, Zapoteco, other from Mexico and/or Central America); Hmong; American Sign Language; Arabic; Farsi, Hindi; Vietnamese; Mandarin, Taiwanese; Cantonese; Korean; Japanese; Swahili
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Salud Para La Gente**
County:	**Santa Cruz**
Medi-Cal Services:	Alliance PCP
Grant Award History:	Capital Planning (1) $150,000 Equipment (3) $60,000 Infrastructure Implementation (1) $250,000 Intensive Care Management (1) $494,688 Practice Coaching (3) $72,150 Provider Recruitment (9) $1,193,900 Technical Assistance (1) $40,000 TeleSpecialty Care Pilot (1) $52,095.00

Provider Recruitment Program

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	OB/GYN
Provider Hours:	Full Time
Practice Name:	East Beach Clinic (Main)
Practice Location:	204 East Beach St., Watsonville, CA 95076
***Recruitment Language(s):**	Spanish
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Sani Eye Center, Inc.**
County: **Monterey**
Medi-Cal Services: Alliance Specialty
Grant Award History: Provider Recruitment (1) $150,000

Provider Recruitment Program

Services: Specialty Care
Provider Type: Ophthalmologist
Provider Specialty: Retina
Provider Hours: Full Time
Practice Name: Salinas and King City Offices
Practice Location: 153 Cayuga St., Salinas, CA 93910 and 522 Broadway St. Ste. C, King City, CA 93930
***Recruitment Language(s):** N/A
Amount Requested: **$150,000**
****Recommended Award:** **$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **St. Junipero Clinic, Inc.**
County: **Monterey**
Medi-Cal Services: Alliance PCP
Grant Award History: Provider Recruitment (1) $150,000

Provider Recruitment Program

Services: Primary Care
Provider Type: Physician
Provider Specialty: N/A
Provider Hours: Full Time
Practice Name: St. Junipero Children's Clinic
Practice Location: 333 Abbott St., Ste. C, Salinas, CA 93901
***Recruitment Language(s):** Spanish
Amount Requested: **$150,000**
****Recommended Award:** **$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Therasens Inc.**
County: **Monterey**
Medi-Cal Services: Alliance Allied
Grant Award History: N/A

Provider Recruitment Program

Services: Allied
Provider Type: Physical Therapist
Provider Specialty: N/A
Provider Hours: Full Time; Part Time
Practice Name: TheraSens, Inc.
Practice Location: 1900 Garden Rd., Ste. 200, Monterey, CA 93940
***Recruitment Language(s):** Spanish
Amount Requested: **$90,000**
****Recommended Award:** **$90,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Central Coast VNA & Hospice, Inc.**
County: **Monterey**
Grant Award History: N/A

Partners for Healthy Food Access Program

Project Name: VNA Food Access
Project Partners: Aggrigator
Proposed Start/End Dates: 3/1/2023-7/1/2024 (16 months)
Total Project Budget: $200,000
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Central Coast VNA & Hospice, Inc (CCVNA) seeks funding for the VNA Food Access project to increase Medi-Cal member access to nutritious, medically supportive food. The overall goal of this project is to support and engage CCVNA's Medi-Cal members in managing their own health and expand awareness about healthy, nutritious food. Members who are food insecure and/or have a chronic disease such as diabetes are eligible to participate in this program. CCVNA staff will refer eligible patients to the program using a customized four-question screener shared during regular check-ups. If a member opts in, CCVNA will partner with Aggrigator to deliver biweekly medically tailored healthy food boxes for 24 weeks. CCVNA staff will assess participant progress through scheduled phone check-ins and through self-reported glucose and weight levels collected every two weeks.

Objectives: The project objectives are to: 1) Provide biweekly medically-tailored healthy food boxes for up to 120 Medi-Cal members who are food insecure and/or have a chronic disease such as diabetes; 2) Assess participant progress through scheduled phone check-ins and self-reported glucose and weight levels collected every two weeks; 3) Evaluate program impact through participant health outcomes; and 4) Connect participants to other healthy food resources, including county food banks and CalFresh.

Impact: The project will enroll up to 120 Medi-Cal members (and their families) in Monterey County. CCVNA's members are primarily Hispanic/Latinx with an average age range of 65-70.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Pacific Cancer Care**
County: **Monterey**
Grant Award History: Equipment (1) $17,059
Provider Recruitment (5) $750,000

Partners for Healthy Food Access Program

Project Name: Doctor's Order
Project Partners: Camacho Produce
Proposed Start/End Dates: 05/01/23 – 12/02/24 (19 months)
Total Project Budget: $94,720
Request Amount: **$45,926**
***Recommended Award:** **$45,926**

Proposal Summary: Pacific Cancer Care (PCC) seeks funding for Doctor's Order, a food distribution and nutritional cooking class program that aims to decrease food insecurity and improve health outcomes for members living with two or more chronic diseases. Eligible members will be referred to the program by PCC's medical staff and can enroll at any point through the 5-class series. Participants have the option to pick up a weekly produce box after each cooking class or receive a $25 produce voucher to Camacho Produce's storefront in Seaside. The overall goal of the program is to introduce participants to unfamiliar healthy ingredients, demonstrate how nutrition reduces the risk of developing common chronic diseases and teach the skills to prepare nutritious dishes at home. Participant knowledge will be assessed by post-class quizzes. Dietary changes will be assessed by comparison of 3-day food journals administered before and after program completion. Doctor's Order builds upon PCC's previously awarded Food Access grant program project.

Objectives: The project objectives are to: 1) Distribute nutritious food and deliver cooking classes to 95 Medi-Cal members living with food insecurity and/or two chronic diseases in Monterey County; 2) Provide participants nutrition education and cooking demonstrations; 3) Evaluate participant knowledge using post-class quizzes and food journals administered before and after program completion.

Impact: The Doctor's Order program is estimated to serve 95 Medi-Cal members living with food insecurity and/or chronic diseases in Monterey County. It is expected that the program will foster self-efficacy through the nutrition education and cooking demonstrations which will continue to benefit the participant after program completion.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Santa Lucia Medical Group, Inc.**
County: **Monterey**
Grant Award History: Provider Recruitment (3) $431,250
Equipment (1) $8,761

Partners for Healthy Food Access Program

Project Name: Alliance in Wellness through Nutrition
Project Partners: Food Bank for Monterey County
Proposed Start/End Dates: 05/01/2023 - 04/30/2025 (24 months)
Total Project Budget: $200,000
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Santa Lucia Medical Group seeks funding for their Alliance in Wellness through Nutrition program with the goal of improving the health of members with diabetes, prediabetes, and obesity and addressing food insecurity. The overall goal of the project is to build participant knowledge and skills to last a lifetime and to improve both participant health and the health of their families. Members identified with chronic illnesses and food insecurity will be offered nutritional counseling and education by a fully bilingual licensed nutritionist and will receive a personalized condition-specific food prescription. The food prescription will be filled by the Food Bank for Monterey County (FBMC). The funds will be used primarily for supporting the Certified Nutritional Educator/FNP, project director and lead staff who will help with scheduling and oversight, as well as food prescription boxes from the Monterey County Food Bank.

Objectives: The project objectives are to: 1) Provide nutritional counseling, education and condition-specific food prescription for approximately 100 Medi-Cal members who have diabetes, prediabetes, and/or obesity and are food insecure; 2) Deliver 104 food prescription boxes for the duration of the two-year program, in collaboration with FBMC; 3) Build participant knowledge and skills to last a lifetime and to improve both participant health and the health of their families; 4) Connect participants with other resources in Monterey County such as WIC and SNAP to improve their well-being and to establish longevity to the success of the program; and 5) Evaluate program efficiency with written surveys and with multiple health metrics collected from cohort members.

Impact: The project will serve approximately 100 Medi-Cal members who have diabetes, prediabetes, and/or obesity and are food insecure. Most of the members served by the project will likely be those that reside in the 93905 and 93906 zip codes of Monterey County, the vast majority being low income, agricultural workers in the Latinx community.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Salud Para La Gente**
County: **Santa Cruz**
Grant Award History: Capital Planning (1) $150,000
Equipment (3) $60,000
Infrastructure (1) $250,000
Intensive Case Management (1) $300,000
Practice Coaching (3) $70,000
Provider Recruitment (6) $782,081
Technical Assistance (1) $40,000
Tele Specialty Care (1) $52,095

Capital - Implementation

Project Name: Clinica del Valle del Pajaro
Project Site Address: 45 Nielson St., Watsonville, CA 95076
Type of Capital Project: Expansion; Renovation
Proposed Start/End Dates: 4/17/24 – 8/17/25 (16 months)
Total Project Budget: $12,259,208
Request Amount: **$2,500,000**
***Recommended Award:** **$2,500,000**

Proposal Summary: Salud Para La Gente (Salud) seeks funding to complete the remodel and expansion of Salud's second largest clinic, Clinica del Valle del Pajaro. They successfully completed a Capital Planning grant for this project in April 2020. The project will include demolishing and remodeling the existing clinic and converting a large portion of a wall-adjacent warehouse to increase total clinic square footage by 20%. The result will add 14 exam rooms for medical, dental and optometry services and 36 support areas (health education, behavioral health screening, medical provider stations and receptionist intake areas). The remodel would create a more organized, efficient and welcoming patient-centered space that will both increase the number of individuals served and improve the quality and efficiency of services.

Objectives: By August 2028, Salud will increase total patient visits at Clinica del Valle de Pajaro from 30,075 to 47,256 (57%). By August 2028, they will increase the total number of patients who access one primary care medical visit and at least one additional integrated healthcare service (i.e., behavioral health, optometry, OBGYN, dental and chiropractic) from 60% to 65%. Salud will use their electronic health record to document and track patient visits for both outcomes.

Impact: 9,500 individuals will be served at the clinic per year, 73% of whom are anticipated to be Medi-Cal members. It is estimated that the project will increase total patient by 57%.

.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group B)

Recommendation. Staff recommend the Board approve grant recommendations that total $3,322,582 for Group B of funding recommendations under Consent Agenda Item 9H, voted upon separately due to potential conflicts of interest.

Summary. See report at Item 9G for content, background, and process for this agenda item. This is the second of two recommendations to allow a separate vote on those items for which Board members may have a conflict.

Discussion.

Grant Award Recommendations. Grant award recommendations are listed in the table below with totals by county and grouped by Board member affiliation so that Board members with potential financial interests in grant awards may abstain from voting on Group B. Details for each grant award recommendation are included in the reference materials listed below.

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Santa Cruz	$2,800,000	$241,857
Monterey	$1,278,726	$230,750
Merced	$299,000	$2,849,975
Total	$4,377,726	$3,322,582
Total Grant Award Recommendation: $7,700,308		

Fiscal Impact. Recommended grant awards totaling $7,700,308 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

1. Grant Recommendations by Program. (Group B)
   - List of grant award recommendations organized by county and grant type.
2. Recommendation Summaries by Organization. (Group B)
   - Detailed application summaries of grant award recommendations organized alphabetically by organization. All application summaries were prepared by Alliance staff based on information in the grant application.

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP B: Affiliated with Alliance Board Members

Capital Implementation

County	Page*	Organization	Award**
Merced	7	Mercy Medical Center	$2,499,975
		Subtotal	**$2,499,975**

Partners for Healthy Food Access

County	Page*	Organization	Award**
Merced	6	Merced County Food Bank	$200,000
		Subtotal	**$200,000**

Provider Recruitment Program

County	Page*	Organization	Award**
Merced	3	Mercy Medical Center Merced	$150,000
Monterey	4	Salinas Valley Medical Clinic	$150,000
	5	Taylor Farms Family Health & Wellness Center	$80,750
Santa Cruz	2	County of Santa Cruz, Health Services Agency, Clinic Services Division	$91,857
	1	Coastal Health Partners	$150,000
		Subtotal	**$622,607**

*Page number of Recommendation Summary is listed for each Group B grant recommendation on the
**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Coastal Health Partners**
County: **Santa Cruz**
Medi-Cal Services: Alliance Specialty
Grant Award History: Equipment (1) $20,000
Provider Recruitment (6) $900,000

Provider Recruitment Program

Services: Specialty Care
Provider Type: Physician
Provider Specialty: Gastroenterology
Provider Hours: Full Time
Practice Name: Coastal Health Partners
Practice Location: 1820 Main St., Watsonville, CA 95076
***Recruitment Language(s):** Spanish
Amount Requested: **$150,000**
****Recommended Award:** **$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**County of Santa Cruz, Health Services Agency, Clinic Services Division**
County:	**Monterey**
Medi-Cal Services:	Beacon BH
Grant Award History:	Capital Implementation (1) $2,500,000 Equipment (5) $88,450 Intensive Care Management (2) $600,000 Practice Coaching (3) $77,150 Provider Recruitment (7) $985,551 TeleSpecialty Care Pilot (1) $56,895

Provider Recruitment Program

Services:	Behavioral Health
Provider Type:	Licensed Clinical Social Worker (LCSW)
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	Watsonville Health Center; Emeline Health Center; and Homeless Person's Health Project
Practice Location:	1430 Freedom Blvd., Watsonville, CA 95076; 1080 Emeline Ave., Santa Cruz, CA 95060; 115-A Coral St., Santa Cruz, CA 95060
***Recruitment Language(s):**	Spanish
Amount Requested:	**$91,857.34**
****Recommended Award:**	**$91,857.34**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Mercy Medical Center Merced**
County:	**Merced**
Medi-Cal Services:	Alliance Specialty
Grant Award History:	Capital Planning (1) $150,000 Infrastructure Planning (1) $40,000 Infrastructure Implementation (1) $22,563 Practice Coaching (1) $25,000 Provider Recruitment (2) $230,274 TeleSpecialty Care Pilot (1) $61,995

Provider Recruitment Program

Services:	Specialty Care
Provider Type:	Physician
Provider Specialty:	Ear/Nose/Throat
Provider Hours:	Full Time
Practice Name:	Family Practice Clinic
Practice Location:	315 E. 13th St., Merced, CA 95341
***Recruitment Language(s):**	N/A
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Salinas Valley Medical Clinic**
County:	**Monterey**
Medi-Cal Services:	Alliance Specialty
Grant Award History:	Equipment (2) $19,000 Provider Recruitment (18) $2,409,125

Provider Recruitment Program

Services:	Specialty Care
Provider Type:	Physician
Provider Specialty:	Cardiology
Provider Hours:	Full Time
Practice Name:	Salinas Valley Medical Clinic Central Coast Cardiology
Practice Location:	230 San Jose St., Salinas, CA 93901; 5 Lower Ragsdale Dr., Ste. 102, Monterey, CA 93940
***Recruitment Language(s):**	N/A
Amount Requested:	**$150,000**
****Recommended Award:**	**$150,000**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Taylor Farms Family Health & Wellness Center**
County:	**Monterey**
Medi-Cal Services:	Alliance PCP
Grant Award History:	Capital Implementation (1) $2,500,000 Capital Planning (1) $150,000 Equipment (2) $22,500 Provider Recruitment (6) $600,525

Provider Recruitment Program

Services:	Primary Care
Provider Type:	NPMP
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	Taylor Farms Family Health & Wellness Center
Practice Location:	850 5th St., Gonzales, CA 93926
***Recruitment Language(s):**	Spanish
Amount Requested:	**$80,750**
****Recommended Award:**	**$80,750**

*Applicant indicated that they would emphasize recruitment of a provider who speaks language(s) listed or have already hired provider who speaks language(s) for the Linguistic Competence Provider Incentive.
**Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Food Bank**
County: **Merced**
Grant Award History: COVID-19 Response Fund (1) $208,000
Partners for Healthy Food Access (1) $200,000

Partners for Healthy Food Access Program

Project Name: Merced Medically Supported Food Project
Project Partners: Castle Family Health Centers
Food for Health Equity Lab at Stanford Medicine
Merced County Department of Public Health
Proposed Start/End Dates: 07/01/2023 - 06/30/2024 (12 months)
Total Project Budget: $454,746
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Merced County Food Bank (MCFB) seeks funding for their Merced Medically Supported Food Project with the goal of improving the health and food security for members with diabetes. In partnership with Castle Family Health Centers (CFHC), members identified as food insecure with diabetes will be offered medically supported food coupled with bilingual nutritional education and skill building interventions delivered by CFHC and Merced County Department of Public Health (MCDPH) staff. Nutritious food will deliver to cohort members at three CFHC clinic sites on a weekly basis. At the end of the project period, Stanford's Food for Health Equity Lab will analyze member health indicators collected by CFHC throughout the project period to evaluate the project's effectiveness and feasibility to scale this medically supportive food model in a rural community. This proposal is an expansion of MCFB's previous Partners for Healthy Food Access grant program project which served patients at Livingston Community Health clinics and became a permanent part of their service model and distribution network.

Objectives: The project objectives are to: 1) Enroll approximately 113 Medi-Cal members who are participating in a diabetes health management program at Castle Family Health Centers and have A1C levels of 9 or higher; 2) Distribute weekly nutritious food boxes to Medi-Cal members at three Castle Family Health Center clinic sites for 52 weeks; 3) Deliver quarterly in-person bilingual nutrition education classes; and 4) Evaluate program efficiency with an analysis conducted by Stanford's Food for Health Equity Lab.

Impact: The project will serve approximately 113 Medi-Cal members who have diabetes and are food insecure. Most of the members served by the project will be low-income and reside in Atwater and Winton in Merced County.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Mercy Medical Center Merced**
County:	**Merced**
Grant Award History:	Capital Planning (1) $150,00 Infrastructure Planning (1) $40,000 Infrastructure Implementation (1) $225,637 Practice Coaching (1) $25,000 Provider Recruitment (2) $230,274 Tele Specialty Care Pilot (1) $61,995

Capital - Implementation

Project Name:	Family Care Clinic
Project Site Address:	315 E 13th St., Merced, CA 95341
Type of Capital Project:	Expansion; Renovation
Proposed Start/End Dates:	6/1/2023-12/1/2024 (18 months)
Total Project Budget:	$3,333,300
Request Amount:	**$2,499,975**
***Recommended Award:**	**$2,499,975**

Proposal Summary: Mercy Medical Center Merced (MMCM) seeks funding to expand and renovate their Family Care Clinic to provide increased access to services to the high volume of Medi-Cal members who they serve. MMCM successfully completed a Capital Planning grant for this project in September 2022. Expansion to the existing clinic footprint will allow MMCM to expand current services, add priority services, and receive NCQA designation as a Patient-Centered Medical Home. The project will allow MMCM to expand behavioral health, OB, radiology, and laboratory services and create space for educational offerings, an enhanced family medicine residency program, increased Comprehensive Perinatal Services Program (CPSP) outreach, and patient connection to community resources for comprehensive care coordination. They will also implement CalAIM Enhanced Care Management services at the renovated clinic.

Objectives: By December 2025, MMCM will increase annual patient visits by 430 (180 for regular patient visits and 250 Enhanced Care Management visits). MMCM will also improve efficiency by 30% as shown through patient visit data. MMCM will increase patient satisfaction from 68% to 78%. Finally, MMCM will improve staff morale and satisfaction which will be assessed by employee engagement and family medicine resident physician surveys.

Impact: The project will increase patient visits by 430 in the first full year of operation through an expanded clinic footprint and new and enhanced services.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Annual Election of Officers of the Commission

Recommendation. Staff recommend the Board nominate one member of the Santa Cruz-Monterey-Merced Managed Medical Care Commission (SCMMMMCC) to serve as Chairperson and one member to serve as Vice Chairperson.

Background. The SCMMMMCC is due for its annual election of Chairperson and Vice Chairperson, pursuant to section 3.2 of the bylaws.

Discussion. The SCMMMMCC shall elect officers (Chairperson and Vice Chairperson) for one-year terms, at the first meeting in April of each year. Officers shall serve a term which begins on the day of the election and ends at the first meeting in April of the following calendar year.

Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

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

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Jessica Finney, Grants Director

SUBJECT: New Medi-Cal Capacity Grant Program Funding Opportunities (2023 – Phase 2)

Recommendation. Staff recommend the Board approve recommendations for new Medi-Cal Capacity Grant Program (MCGP) funding opportunities in 2023 and associated MCGP budget allocations.

Summary. This report provides a brief background on the MCGP and outlines staff recommendations for a second phase of new MCGP funding opportunities to be implemented in 2023 that align with the MCGP Framework and funding goals under the three focus areas to advance the Alliance's vision of *Healthy People, Healthy Communities.*

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through investment of a portion of the Alliance's reserves, the MCGP provides grants to local health care and community organizations in Merced, Monterey and Santa Cruz counties to increase the availability, quality and access of health care and supportive services for Medi-Cal members and address social drivers that influence health and wellness in our communities. The MCGP serves as a vehicle for the Alliance to invest in areas outside of core health plan responsibility and where other funds are not available. It also serves as an incubator to test new concepts that could be integrated into the health care system in the future. The MCGP has proven to be a strategic tool to advance the Alliance's vision and mission responsive to the needs of Medi-Cal members and the Medi-Cal delivery system. Since 2015, the Alliance has awarded 592 grants totaling $130,152,133 to 143 organizations in the Alliance's service area. Over the life of the program, the MCGP developed a portfolio of 16 funding opportunities designed to advance MCGP focus areas goals.

Over the course of 2022, the Alliance Board evolved the MCGP to respond to the current health care landscape, address the current and emerging needs of Alliance members, and align with organizational and State priorities. Through this process, the Board approved a revised and expanded MCGP Framework (see attached) that clarifies the financial strategy, investment criteria and guiding principles for the MCGP. The Board also approved funding goals (see attached) under three new focus areas: *Access to Care, Healthy Beginnings* and *Healthy Communities*. Staff committed to return to the Board with proposed new funding opportunity recommendations responsive to funding goals, priorities and outcomes approved by the Board in August 2022.

The Board approved the first phase of new funding opportunities on March 22, 2023. The MCGP now offers six grant programs which are currently accepting applications. There are typically two application cycles per year with awards in April and October, however, one rapid round was added starting April 10, 2023 with applications due May 5, 2023 and awards approved by the Board June 28, 2023. This rapid round allows for the integration of new programs into the program portfolio. The current grant programs are: 1) Provider

Recruitment; 2) Community Health Worker Provider Recruitment; 3) Healthcare Technology; 4) Home Visiting; 5) Partners for Active Living; and 6) Partners for Healthy Food Access.

In its report to the Board for the Phase 1 opportunities, staff committed to return to the Board in April 2023 with detailed recommendations for Phase 2 funding opportunities. The Board provided feedback on existing gaps, including: 1) parent education and childhood development support; 2) technical assistance for home visiting staff regarding durable medical equipment and environmental health evaluation; 3) capacity building for community-based organizations joining the Medi-Cal provider network; and 4) increased financial support for provider recruitment. Some of these gaps would be met through proposed Phase 2 funding opportunities. Others are being addressed through current health plan operational activities and Department of Health Care Services incentive programs. Additional gap-closing strategies will be explored in future grant program development.

Discussion. New funding opportunities proposed for 2023 make strategic use of MCGP investments to achieve the goals in each focus area and address identified needs related to Medi-Cal provider workforce, member access to culturally responsive care, children's preventative care and family wellbeing, and community engagement in health care access and health equity. All funding opportunities offered by the Alliance's grant program adhere to the MCGP Framework and are linked to a MCGP focus area goals and intended outcomes on the MCGP Theory of Change. They are broadly designed to support community partners in developing local, innovative solutions.

The proposed Phase 2 Funding Opportunities are as follows:
1. Medical Assistant Provider Recruitment
2. Equity Learning for Health Professionals
3. Parent Education and Support
4. Community Health Champions

The recommendations for Phase 2 include funding opportunity descriptions, objectives, eligibility criteria, eligible expenses and maximum award amount. Applications for funding must meet the MCGP Investment Criteria outlined in the MCGP Framework. In addition to adherence to funding requirements, where applicable, application review criteria will include evaluation of:

- Opportunities for inclusion of member voice to inform community investments;
- Commitment to strategies that promote linguistic and cultural competence and health equity;
- Data-driven case about geographic need where project will be implemented and/or population(s) of focus (e.g., youth, individuals with developmental disabilities, and/or specific chronic conditions or health topics)
- Use of evidence-based practices or recognized effective practices;
- Evaluation of access to preventative health and supportive services; and
- Leveraging other funding sources and initiatives.

These new grant programs will synchronize with the regular regularly scheduled application cycles twice per year (January application/April award and July application/October award). The first application deadline for these new opportunities would be July 18, 2023 and awards would be approved October 25, 2023.

1. Funding Opportunity: Medical Assistant Provider Recruitment
MCGP Focus Area: Access To Care
Funding Goal: A robust health care workforce that can deliver coordinated, person-centered care and the full array of Medi-Cal services.
Objective: Expand the Provider Recruitment Program to include support for Medical Assistants in the primary care setting.
Funding Description: Grants to support recruitment, hiring and training of Medical Assistants to expand the capacity of primary care practices to serve more Medi-Cal members in Merced, Monterey and Santa Cruz counties. MAs are integrated into the patient-centered medical home model to serve a critical role in supporting patient engagement, care coordination, population health management, quality improvement and practice management to ensure that patients receive high-quality care and that all care team members are practicing at the top of their training and licenses.
Eligibility: Applicants must be a health care provider contracted with the Alliance for primary care services.
Eligible Expenses: Recruitment-related expenses such as first year salary/benefit costs, sign-on bonuses, relocation expenses, costs of maintaining professional liability insurance, fees for professional recruitment agency services, immigration legal fees, costs associated with advertising and training/certifications.
Maximum Grant Award: $65,000 (+ $10,000 linguistic competency incentive per each qualifying language)

2. Funding Opportunity: Equity Learning for Health Professionals Program
MCGP Focus Area: Access To Care
Funding Goal: Improved patient-provider communication and trusted relationships, resulting from an expanded network of Medi-Cal providers who are linguistically and culturally responsive.
Objective: Increase in number of providers trained in cultural competence and cultural humility, trauma-informed care and equity in the health care delivery system.
Funding Description: Grants to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care. Through engagement in training, coaching or consultation, health professionals will:

- Understand and respect the cultural backgrounds and experiences of their patients;
- Acknowledge the role that trauma, racism, historical and systemic inequities, and social determinants of health play in shaping their patients' health outcomes; and
- Commit to actively working towards eliminating health disparities and achieving health equity for all Medi-Cal members.

Eligibility: Applicants must be a health care provider organization with at least 25% Medi-Cal patient volume, or a 501(c)(3) nonprofit or governmental agency that provides safety net services to a significant volume of Medi-Cal members in the Alliance service area.
Eligible Expenses: Cost of virtual or in-person training program registration/tuition, consultant scope of work to deliver group training, training materials.
Maximum Grant Duration: 12 months
Maximum Grant Award: $40K

3. Funding Opportunity: Parent Education and Support
MCGP Focus Area: Healthy Beginnings
Funding Goals: 1) Children are healthy and thriving by age 5; 2) Children and their parents/caregivers have access to preventative health care services and supportive

resources to support their families' health and well-being; and 3) Parents and caregivers have the knowledge, resources and support they need to provide safe, nurturing environments for their children.
Objectives: 1) Increase parents' knowledge of infant and child development, parenting skills and children's health needs; 2) Increase access to services and resources that support the health and well-being of young children and their parents and caregivers; and 3) Strengthened parent/caregiver-child relationships and improved child and maternal socio-emotional well-being.
Funding Description: Grants to support the implementation or expansion of education and supportive resources with trained educators/facilitators for parents of children up to age 5 that promote:

- Parent/caregiver knowledge of children's physical and cognitive development, parenting skills and coping strategies;
- Parent/child interaction that supports social and emotional development;
- Preventing, identifying and healing adverse childhood experiences;
- Parent/caregiver efficacy in accessing physical and behavioral health care services and social support resources for themselves and their families; or
- Promotores and parent leadership in providing peer support.

Eligibility: Applicants must be a 501(c)(3) nonprofit, governmental entity, or local education agency that serves a significant volume of Medi-Cal members in the Alliance service area. An applicant is limited to one Parent Education and Support grant award, which may be used to implement model(s) at more than one site.
Eligible Expenses: Personnel/consultants, staff training/development, project-specific equipment and technology, project material/implementation costs, data reporting and evaluation, and indirect costs up to 15% of project budget.
Maximum Grant Duration: 24 months (including planning period)
Maximum Grant Award: $100K

4. Funding Opportunity: Community Champions for Health
MCGP Focus Area: Healthy Communities
Funding Goal: 1) Medi-Cal members have access in their communities to what is needed to live their healthiest lives, support healthy options and reduce risk of chronic disease; 2) Medi-Cal members have the knowledge and resources to effectively manage their health; 3) Medi-Cal members are empowered to advocate for policy and systems changes that promote good health for themselves and their communities.
Objectives: 1) Increase member awareness and knowledge of Medi-Cal benefits, community resources and how to access care; 2) Increase the number of community resource access points; and 3) Engage youth and adult Medi-Cal members in advocacy that positively impacts individual and community health and reduces stigma and barriers to care.
Funding Description: Grants for organizing, training and supporting youth and adults to: 1) educate their peers and families on specific health topics and how to confidently manage their health; 2) promote available health care services and resources and health literacy among peers and families; 3) destigmatize use of behavioral health and substance use disorder services; 4) engage trusted community gatekeepers and local decision-makers to remove barriers to health; and 5) advocate on behalf of their community to promote wellness and health equity.
Eligibility: Applicants must be a 501(c)(3) nonprofit (or community group with a fiscal agent) or governmental entity that serves a significant volume of Medi-Cal members in the

Alliance service area. An applicant is limited to Community Champions for Health funding for one project at a time, which may be implemented at more than one site.
Eligible Expenses: Personnel/consultants, project-specific equipment and technology, project material/implementation costs, participant incentives, participant/staff training and development, and indirect costs up to 15% of project budget.
Maximum Grant Duration: 24 months (including planning period)
Maximum Grant Award: $100K

Allocations for New Funding Opportunities. The proposed amounts below for each of the Phase 2 funding opportunities are recommended to be allocated from the MCGP unallocated budget.

County	Provider Recruitment MAs ($75K x 6 per county)	Cultural Learning for Health Professionals ($40K x 7)	Parenting Education & Support ($100K x 6)	Community Champions for Health ($100K x 5)	Total All Phase 2	Remaining MCGP Unallocated Budget after Phase 2
Merced	$450,000	$280,000	$600,000	$500,000	$1,830,000	$51,145,379
Monterey	$450,000	$280,000	$600,000	$500,000	$1,830,000	$51,337,020
Santa Cruz	$450,000	$280,000	$600,000	$500,000	$1,830,000	$20,361,394
Total	$1,350,000	$840,000	$1,800,000	$1,500,000	$5,490,000	$122,843,793

* Total Remaining after 4/26/23 approval of $1M Disaster Response Fund recommendation: $121,843,793

Next Steps. If approved, staff will prepare Phase 2 funding opportunities and communication materials and open the applications on May 15, 2023.

Future program development will be contingent on the outcome of foundation planning, development of an annual spending plan, as well on the assessment of gaps and opportunities related to State initiatives and incentive programs for health care workforce, children and youth behavioral health, and housing. Staff will return at a later date with additional recommendations for grant opportunities that address identified capacity gaps and priority strategies.

Fiscal Impact. This recommendation would allocate $5,490,000 from the MCGP unallocated budget to fund new funding opportunities ($1.35M MA Provider Recruitment Program; $840K Cultural Learning Program; $1.8M Parenting Education and Support Program; and $1.5M Community Champions for Health Program. Amounts remaining in the unallocated MCGP budget per county after Phase 1 allocations are as follows: Merced County $51.1M; Monterey County $51.3M; and Santa Cruz County $20.3M.

Attachments.
1. Medi-Cal Capacity Grant Program Framework
2. Medi-Cal Capacity Grant Program Focus Areas, Goals and Priorities

Medi-Cal Capacity Grant Program (MCGP) Framework

MCGP Investment Strategy. The MCGP is a part of the Alliance's financial plan, which creates prudent health plan reserves and enables the use of surplus funds to expand access and improve Alliance member benefits. The Alliance allocates funding to the MCGP from its earned net income, after meeting regulatory and Board designated reserve requirements and ensuring adequate funding for augmented provider reimbursements and successful implementation of Medi-Cal program requirements. The MCGP's financial strategy is founded on the following elements:

1. Funding Allocations. MCGP funding is allocated by county and funding opportunity. Funding allocations also consider equity in impact of programs, and not just equity in allocation.
2. Annual Spending Plan. The MCGP develops and adheres to an annual spending plan to ensure transparency to potential grantees about the level of funding to be made available in the community for activities within the focus areas.
3. Member Benefit. The MCGP makes strategic use of Alliance reserves to strengthen the delivery system to meet Medi-Cal member needs.
4. Local Innovation. The MCGP ensures strategic use of reserves to enable local innovation rather than supplanting state resources for ongoing program administration. Covered Service benefit expansions, provider payment augmentation and other services managed by the health plan are addressed via the health plan's operating budget, not through the MCGP.
5. Funding Decisions Free from Conflicts of Interest. The MCGP relies on an administrative decision-making structure which avoids conflicts of interest in the approval of programs and specific grants.

MCGP Investment Criteria. These key criteria are used to evaluate funding requests and will be used to guide planning for future MCGP investments:

1. Medi-Cal Purpose: All grants must benefit Medi-Cal beneficiaries.
2. Sustainability: The Alliance makes investments with the goal of creating lasting change in the Medi-Cal delivery system or in member and community health that is sustainable past the grant funding period. Grants are generally one-time investments to build capacity or ensure adequate local infrastructure to meet Alliance member needs.
3. Service Area: Grantees must maintain ongoing operations, including staffing and programs, in the Alliance service area.
4. Alignment with Vision, Mission and Priorities: The Alliance invests in organizations and efforts that advance the Alliance's vision, mission and strategic priorities.
5. Focus Areas: Funding awards must be associated with at least one of the MCGP focus areas and support the identified goals for that focus area.
6. Supplanting: MCGP funding should not be used to supplant or duplicate other funding in order to focus investments on areas where limited funding is available or where other funding sources can be leveraged to have a greater impact.

MCGP Guiding Principles. The following principles guide MCGP grantmaking.

1. Equity in impact.
   - The MCGP will ensure grantmaking is tailored to local needs and prioritizes resources and attention to communities and populations who experience inequities.
   - The MCGP will engage the community to understand the diversity of health-related needs and opportunities to advance the Alliance's vision of *Healthy People. Healthy Communities.*
   - The MCGP will create opportunities for members to play a central role in crafting solutions through grantmaking to improve health and well-being for themselves, their families and their communities.
2. Trusting relationships with partners.
   - The MCGP is committed to building trusting, collaborative relationships with community partners based on mutual respect, collaborative learning and aligned priorities.
3. Transparent, accessible and responsive grantmaking.
   - The MCGP seeks to minimizes administrative burden on grantees and ensure the level of effort is commensurate with the grantee organization's scale and administrative ability.
   - The MCGP ensures accountability for grant funds and transparency about funding decisions and requirements.
   - The scale and impact of MCGP investments on the Medi-Cal system, infrastructure and members is measured and communicated.
4. Grantmaking informed by Medi-Cal delivery system expertise and experience.
   - Grantmaking is responsive to funding gaps and infrastructure needs to meet the challenges of Medi-Cal transformation.
   - Investments support systems change and innovations in the safety net health care delivery system to address root causes that impact health.
   - Grantmaking is developed in close coordination with Alliance staff, Board and community stakeholders.
5. Holistic view of health.
   - Grantmaking promotes a holistic view of health that includes supporting Medi-Cal members in achieving and maintaining optimum physical, mental and social well-being.
   - Investments to address disease prevention and disease management are made upstream from the medical model to address root causes and prevention.

Medi-Cal Capacity Grant Program (MCGP) Focus Areas, Goals and Priorities

Focus Area 1. Access to Care
The Alliance will focus on strengthening and expanding the provider workforce to address provider shortages and increase the number of providers who reflect the diversity of the Alliance's membership. The Alliance will also make investments to improve coordination across the health care system and address infrastructure and capacity gaps to ensure that Medi-Cal members are able to access high-quality care when, where and how they need it.

Funding Need
1. Health care workforce shortages in the Alliance service area impact Medi-Cal members' access to timely health care services.
2. New provider types are being integrated in the Medi-Cal health care continuum to deliver a range of new non-medical services to address social drivers of health.
3. The existing health care workforce is challenged to reflect the racial, ethnic, cultural and linguistic diversity of Alliance members.
4. Organizations that serve the Medi-Cal population need expanded capacity and infrastructure to increase access to services.

Funding Goals
1. A robust health care workforce that can deliver coordinated, person-centered care and the full array of Medi-Cal services.
2. Improved patient-provider communication and trusted relationships, resulting from an expanded network of Medi-Cal providers who are linguistically and culturally responsive.
3. Medi-Cal members are able to access high-quality care when, where and how they need it.

Funding Priorities
1. Address workforce shortages, infrastructure and capacity gaps.
2. Increase the racial, ethnic, cultural and linguistic diversity of the provider network to better reflect the Alliance's membership.
3. Improve the coordination, integration and capacity of the behavioral health system, including coordination between the physical health system and behavioral health system.

Focus Area 2. Healthy Beginnings
By investing in early childhood development, the Alliance will positively impact the health and well-being of its youngest members and their families in the short and long term, as well as ensure they have the resources and support needed to thrive.

Funding Need
1. The first five years of life are critical to health and brain development.
2. Historical and persistent trauma (including systemic racism) and adverse childhood experiences can negatively impact physical, mental, emotional and behavioral health.
3. Barriers to preventative services affect maternal, infant and child health.
4. Investing in early childhood development has proven benefits for children, families and society.

Funding Goals

1. Families with a new child receive timely prenatal and post-natal care to ensure optimal physical and mental health for mothers and to promote healthy birth outcomes.
2. Children are healthy and thriving by age 5.
3. Children (prenatal through age 5) and their parents/caregivers have access to preventative health care services and community resources to support their families' health and well-being.
4. Parents and caregivers have the knowledge, resources and support they need to provide safe, nurturing environments for their children.

Funding Priorities

1. Increase access and use of preventative health services, early identification and intervention services, behavioral health interventions and early childhood development interventions.
2. Provide parents with social support and education about child development and parenting.
3. Assist families in navigating the health care system and connecting to health and community resources that support child development and family well-being.
4. Promote strategies for systems change that allow families to fulfill aspirations for children's long-term health and economic opportunities.

Focus Area 3. Healthy Communities

By investing in the non-medical factors that impact health, such as food and housing, the Alliance can ensure that Medi-Cal members have access to what is needed to live their healthiest lives at every stage of life. Creating communities where healthy options are easy and available to all can reduce health disparities, support healthy and active lifestyles and reduce risk of chronic disease.

Funding Need

1. Social, economic and environmental factors shape individual health and well-being. These factors influence risk for chronic conditions such as diabetes, asthma and cardiovascular disease.
2. Lack of access to healthy food, safe and stable housing, quality schools and safe places to exercise and play create barriers to health.
3. Geographic communities experience differences in environmental factors and distribution of resources, which contribute to disparities in health risks and quality-of-life outcomes.
4. Medi-Cal members experience barriers such as: limited English proficiency, transportation, childcare, and health literacy; food insecurity; overcrowded housing; insecure employment; and low wages. These barriers impede their ability to access services and manage their health.

Funding Goals

1. Medi-Cal members have access in their communities to what is needed to live their healthiest lives, support healthy options and reduce risk of chronic disease, including access to:
    - Fresh, affordable, healthy food.
    - Safe places to play and be active.
    - Permanent supportive housing for Medi-Cal members experiencing homelessness.
2. Medi-Cal members have the knowledge and resources to effectively manage their health.

3. Medi-Cal members are empowered to advocate for policy and systems changes that promote good health for themselves and their communities.

Funding Priorities

1. Focus on individuals, families and communities experiencing disparities in health.
2. Invest in drivers of individual and community health and well-being, such as nutritious food, supportive housing and safe places to be active.
3. Engage trusted community-based organizations to promote available health care services and resources to reduce disparities.
4. Support community/youth leadership development and civic engagement efforts that transform infrastructure and promote wellness and health equity for individuals and the community.

DATE: April 26, 2026

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Van Wong, Chief Operating Officer

SUBJECT: Dual Eligible Special Needs Plans Operational Gap Assessment Update

---

Recommendation. There is no recommended action associated with this agenda item.

Summary. The Department of Health Care Services (DHCS) is requiring that all non-Coordinated Care Initiative (CCI) County Managed Care Plans (MCPs), of which the Alliance is one, offer a Dual Eligible Special Needs Plan (D-SNP) product by January 1, 2026. In preparation, the Alliance initiated planning for the 2026 launch of a D-SNP, including a consultant-led financial feasibility assessment and a consultant-led operational gap assessment (OGA). The Alliance contracted with Health Management Associates (HMA), an experienced vendor to conduct an OGA to ascertain our readiness and identify an implementation roadmap to close any operational gaps timely for a successful D-SNP launch.

Background. DHCS is implementing policies to promote integrated care for beneficiaries dually eligible for Medicare and Medi-Cal as a component of the CalAIM initiative. These policies include enrolling all dually enrolled beneficiaries in Medi-Cal Managed Care Plans in 2023, aligning Medi-Cal plan enrollment with the beneficiary's choice of a Medicare Advantage (MA) plan (if the beneficiary enrolls), and requiring that all non-CCI county Medi-Cal MCPs, of which the Alliance is one, operate a D-SNP by January 1, 2026.

The Alliance has initiated planning for a D-SNP launch no earlier than January 2026. In addition to a Milliman study of financial feasibility of a D-SNP program, the Alliance retained HMA to conduct an OGA to ascertain our readiness and identify an implementation roadmap to close any operational gaps timely for a successful D-SNP launch. The OGA began in October 2022, looking at current Alliance operations compared against requirements to operate a D-SNP program. Key functions in an MA plan that are not necessary to a County Organized Health System model Medicaid Managed Care plan are benefit design, sales and marketing, Star program management and enrollment. These functions will need to be developed and integrated into existing Alliance operations as part of the D-SNP implementation. In addition, existing functions and systems will need to be enhanced to align with CMS regulations.

Discussion. HMA concluded its D-SNP OGA and shared key findings and next steps with staff. The OGA deliverables comprised an operational gap narrative, a multi-year implementation workplan, and a high-level staffing model, including staffing for the ramp-up period starting in 2023. In italics below is an excerpt of the Executive Summary from the OGA outlining functional areas requiring material attention from staff.

[The] following chart summarizes those functional areas requiring the most material attention and capacity building. We group these critical functional areas into three categories. The first column captures those MA program requirements without a corresponding Medi-Cal program counterpart, the 'new' requirements. The second column captures those MA program requirements that have a counterpart in Medi-Cal but which differ substantially from Medi-Cal program requirements. The third

column captures areas of plan management that CCAH will seek to address as it plans for its MA line of business. Not only will this help to summarize salient areas of focus, it will also help to inform CCAH in hiring/recruitment as the plan contemplates, and plans for, its new line of business."

Functional Areas for Material Attention		
New MA program requirements	***MA program requirements that differ materially from Medi-Cal***	***Areas of Plan Management impacted by MA***
1. *Marketing and sales* 2. *Broker management* 3. *STARS management* 4. *Finance: 3-year finance cycle* 5. *Model of Care* 6. *Benefit Design*	1. *Compliance* 2. *Provider Contracting* 3. *Finance: Risk Adjustment* 4. *Care Coordination* 5. *Case management* 6. *Member engagement*	1. *Systems* 2. *Organizational design/structure*

"[Additionally, HMA recommends] a near term focus on the following elements of the Multi-year Readiness Work Plan so that CCAH executives use their increased MA fluency to launch a successful planning process for this critical juncture in the plan's history: "

Near Term Actions: Foundational Planning
1. *Digest HMA's proposed Multi-year Readiness Work Plan to ensure alignment with HMA's rationale for recommended start dates and planning interdependencies* 2. *Consider optimal organizational structure for managing the Multi-year Readiness Work Plan, using HMA's recommendations for staffing and specific approaches for staff training/education on this new line of business and the organizational approach CCAH will take to ensure success* 3. *Consider the decisions that CCAH executives should make in near term as a team in launching its Multi-year Readiness Work Plan including:* a. *Proxy organizational structure for CCAH to operate the MA line of business* b. *Analysis of MA providers in CCAH service areas to inform overall network design* c. *Critical 'build versus buy' decisions* d. *Specific decisions that would require procurements ahead of 2026, such as claims payment and medical management systems* 4. *Begin [Knox Keene] licensure* 5. *Reach agreement as an executive team on those CCAH positions that may be, or become open, in the period 2023 – 2025 that militate in favor recruiting for both Medi-Cal and MA experience*

Staff and Ms. Margaret Tatar will review the functional areas and near term actions with the Board. The Board's discussion will inform staff recommendations regarding the final implementation plan and a proposed D-SNP implementation budget. Staff expect to bring that proposed implementation budget to the Board in June 2023. In addition, Ms. Tatar and Mr. Michael Schrader, Chief Executive Officer, will address governance considerations.

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

Attachments. N/A

Biography for Margaret Tatar

Margaret Tatar has more than 25 years of public and private sector experience in managed care program and policy development, health policy, program development, advocacy, and government/legislative affairs.

She has a strong track record in managed care plan leadership, leading large-scale managed care initiatives and multi-disciplinary teams in complex operating environments while fostering professional development and mentoring staff. She has served in the federal government's Health Care Financing Administration (HCFA) and the executive and legislative branches in Colorado and California. In her capacity as Acting Deputy Director, Delivery Systems, in California's Department of Health Care Services (DHCS), she was responsible for the network of 23 contracted health plans that deliver health care services to over 9 million Californians. She was also responsible for the Long-Term Care Division and California's Children Services (CCS) program. During her tenure at DHCS, she oversaw a significant expansion of managed care as the primary delivery system for California's Medicaid program (Medi-Cal). She also served as the operational lead for the design, development, and implementation of California's Medicare-Medicaid Plan (MMP) program, known as CalMediconnect.

Margaret has served in leadership positions in several Medi-Cal managed care plans, most recently serving as GCHP's CEO from 2019 to 2022. She has launched PACE programs and Medicare Advantage D-SNP plans so she has direct operational experience as well as policy expertise in Medicare.

Margaret earned her undergraduate degree in Latin at Bryn Mawr College in Bryn Mawr, Pennsylvania, and her law degree at Villanova University School of Law in Villanova, Pennsylvania.

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Dale Bishop, MD, Chief Medical Officer and
Andrea Swan, RN, Quality Improvement & Population Health Director

SUBJECT: Alliance Quality Program

Recommendation. There is no recommended action associated with this agenda item.

Summary. The 2022 five-year Alliance Strategic Plan and the recently released Department of Health Care Services (DHCS) Quality Strategy are aligned in prioritizing achievement of equity and improving quality in the managed care environment. In this discussion, we will review results of Alliance quality metrics and the results of the Care-Based Incentive (CBI) Program in 2022. We will describe the 2023 Quality Improvement and Health Equity Transformation Plan focusing on investments and partnerships needed to address underperforming quality and equity metrics. We will conclude with changes being put in place for 2024 to improve equity and quality of care for Alliance members.

Background. Over its 27-year history, the Alliance has successfully improved quality and access to health care for Alliance members through innovation and partnerships with local providers and organizations through efforts that include CBI. From stakeholder engagement in the development of the Alliance five-year Strategic Plan, staff recognized opportunities to improve member health through prioritizing equity and transforming the delivery system to put our member's goals and needs at the center of their health care. Along with the Strategic Plan, the DHCS Quality Strategy and the DHCS Population Health Management Program outline specific efforts needed toward achieving high quality of care and equity for member health.

Discussion. The Alliance five-year Strategic Plan priorities align with the DHCS Quality Strategy as the Alliance Health Equity priorities are to eliminate health disparities and achieve optimal health outcomes for children and youth and to increase member access to culturally and linguistically appropriate health care. Tactics in 2022 to address health equity priorities include monitoring of Healthcare Effectiveness Data and Information Set (HEDIS) quality measure performance by race/ethnicity stratification with special attention to child access, maternal and children's preventive care, and child immunizations.

Alliance Quality Results are accounted for through Medi-Cal Accountability Set (MCAS) measures in comparison to the National Committee for Quality Assurance (NCQA) Medicaid 50th percentile which DHCS has defined as the minimal performance level (MPL). Effort to measure the 2022 results is currently underway and includes both evaluation of claims, vaccine registry, supplemental and medical record review information. Medical record review is ongoing at this time so results presented here are approximate and have not been finalized by the auditor.

Alliance performance on quality indicators reflect overall above average performance in Monterey and Santa Cruz compared to state and national Medicaid benchmarks with a geographic disparity evident in Merced. Preliminary Alliance results for measurement year (MY) 2022 for all 13 measures in Monterey and Santa Cruz Counties are above the MPL and four metrics including diabetes control, childhood immunizations, immunizations for adolescents, and postpartum follow-up are trending above the NCQA 90th percentile which is considered High-Performance Level. Ten measures are below the MPL in Merced, with cervical cancer screening, timeliness of prenatal care, and postpartum follow-up above the 50th percentile. Finalized MCAS rates for MY 2022 will be provided to HSAG and DHCS in June.

Table of MCAS Metrics

MEASURE	MY2022 Preliminary Rates			
HYBRID MEASURES	SC/MON	2021-2022 TREND	Merced	2021-2022 TREND
Controlling High Blood Pressure	60.83%	↑	50.85%	↓
Cervical Cancer Screening	63.99%	↑	60.57%	↓
HbA1c Poor Control (Inverse)	28.22%	↓	43.89%	↑
Childhood Immunizations - Combo 10	51.09%	↑	16.06%	↓
Immunizations for Adolescents - Combo 2	56.48%	↑	33.09%	↓
Timeliness of Prenatal	87.50%	↓	90.75%	↓
Postpartum Follow Up	94.57%	↑	79.56%	↓
Lead Screening in Children	78.83%	N/A	46.23%	N/A
ADMINISTRATIVE MEASURES	SC/MON	2021-2022 TREND	Merced	2021-2022 TREND
Breast Cancer Screening	60.05%	↑	49.62%	↓
Chlamydia Screening in Women	61.21%	↑	52.53%	↑
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	77.76%	↑	58.05%	↑
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.63%	↑	36.72%	↑
Child and Adolescent Well-Care Visits	59.67%	↑	45.03%	↑

Below 25th	25th to 50th	Above 50th	Above 75th	Above 90th

Challenges to achieving high preventive and effective care metrics in all counties have been identified though member and provider outreach and Advisory Group meetings. Through the middle of the second quarter, COVID-19 outbreaks were occurring which led to

low preventive care appointment availability and requests as preventive care was deferred while acute care was prioritized. The pandemic effects were much more pronounced in Merced due to significantly fewer available providers relative to members in need of care as discussed further below. It is of note that the metrics that require multiple visits over time such as immunizations and well child visits to age two cannot be recovered once they are off track.

Social drivers and environmental conditions including access and geography have contributed to the disparate outcomes. Throughout 2022 providers reported shortages of support staff during and following the pandemic and these shortages affected Merced (provider to population ratio 1:2,220) more significantly than Monterey (provider to population ratio 1:1,590) and Santa Cruz (provider to population ratio 1:990). In addition, member anti-vaccine sentiment has been noted to be more prevalent in Merced than in the coastal communities. Addressing these systemic issues will require partnership with community leadership and DHCS to seek policy changes.

In addition to geographic disparities, results show race/ethnicity disparities for black (smaller population), and white populations compared to LatinX and Asians in well-child visits, immunizations, and diabetes control across all counties. For spoken language, Arabic and Hmong have lower rates of well-child visits compared to Spanish, Vietnamese, and English speakers. These findings are consistent with a DHCS *Asian Subpopulations Health Disparities Focused Study Report (January 11, 2021)* in which Hmong speakers had lower rates in certain MCAS measures compared to other Asian sub-populations.

Alliance CBI quality metrics evaluate primary care provider medical home care and include selected MCAS metrics with emphasis on pediatric access and preventive care, care of diabetes and asthma, depression screening, as well as care coordination and access. CBI quality metrics are aligned with DHCS priority MCAS results and benchmarks for 2022 and 2023. Trends for CBI Care Coordination and quality metrics are listed below and indicate improvement in most metrics from 2021-2022. Note that the percentages listed in the table are administrative data as determined from claims only.

MEASURE	2021	2022	2021-2022 TREND	% CHANGE
Application of Dental Fluoride Varnish	16.62%	17.78%	↑	1.15%
Developmental Screening in the First 3 Years	24.98%	30.79%	↑	5.81%
Initial Health Assessments (IHA)	44.82%	44.94%	↑	0.12%
Post-Discharge Care	30.61%	31.58%	↑	0.79%
Unhealth Alcohol Use in Adolescents and Adults	10.46%	13.22%	↑	2.76%
Ambulatory Care Sensitive Conditions	7.41%	6.60%	↓	-0.81%
Plan All-Cause Readmissions	16.52%	15.69%	↓	-0.83%

Preventable Emergency Visits	12.46%	14.45%	↑	1.99%
MEASURE	2021	2022	2021-2022 TREND	% CHANGE
Asthma Medication Ratio	74.92%	79.66%	↑	4.74%
Body Mass Index (BMI) Assessment: Children & Adolescents	46.51%	62.46%	↑	15.95%
Breast Cancer Screening	52.90%	56.44%	↑	3.54%
Cervical Cancer Screening	60.49%	60.66%	↑	0.17%
Child and Adolescent Well-Care Visits (3-21)	50.57%	54.44%	↑	3.87%
Diabetic HbA1c Poor Control >9.0%	47.94%	42.64%	↓	-5.30%
Immunizations: Adolescents	46.98%	44.72%	↓	-2.26%
Immunizations: Children (Combo 10)	37.91%	36.58%	↓	-1.33%
Screening for Depression and Follow-up Plan	N/A	16.75%	-	N/A
Well-Child Visit In The First 15 Months	47.23%	54.66%	↑	7.43%

2023 Roadmap to Address Underperformance

It is important to consider where the Alliance Quality Improvement System is heading in 2023 and beyond to achieve expected continued improvement. Guiding principles in Alliance QIS efforts include coordinating efforts to achieve maximal impact, offering whole person care through a population health approach stratifying risk, prioritizing efforts. and keeping in mind that primary care is the critical starting point to improvement.

Historically, we have focused action and resources on measures with low performance through the DHCS Performance Improvement and Plan Do Study Act processes. Starting in 2020 there have been challenges with provider and member engagement due to the pandemic that limited making significant strides in improvement. A proactive approach is necessary to prevent future CAPs/sanctions and achieve top performance for HEDIS/MCAS measures.

Children's Domain. The Alliance recognizes the importance of Health Equity, and the 2026 strategic goal is to eliminate health disparities and achieve optimal health outcomes for children and youth with the 2023 Breakthrough Objective to achieve the 50th percentile or 10% of the delta to the minimum performance level. A Pediatric Equity Taskforce consisting of Alliance Health Services, Operations, Analytics and Communications has been organized and has developed a roadmap to address root causes and health disparities in children's preventive care. Efforts outlined include the CBI Program (described below), school-based clinics, expanded immunization access, Healthy Start outreach to pregnant women,

improved member outreach and communications and an expanded member incentive program.

Women's Domain. The overall strategy to address the women's domain measures is to activate resuming care for women's preventive screenings and services. During the pandemic, utilization of women's services decreased as these preventive screenings were often deferred and providers prioritized acute visits for members. As the public health emergency ends, it will require efforts to "recover" from the pandemic and consider customary (and new) best practices to promote screenings and encourage members to come in for their visits. Key efforts include CBI performance improvement (provider investment to improve), practice coaching, member reminders and recall, heavy promotion and health education on the importance of preventive screenings.

The Alliance Quality Improvement Health Equity program for 2023 includes the Pediatric Equity Roadmap, interventions to promote resuming care in the women's domain and for improving care of chronic conditions. In response to provider, member and community outreach an interventional approach has been developed for 2023 that includes Alliance Communications and plan-wide collaboration among all departments. New CBI measures for breast cancer and chlamydia screening are in place for 2023 to feature improvement efforts in these areas. Member outreach, community-wide health promotion campaigns, robust communication and improved data capture and more robust provider reports are planned.

The Alliance is currently partnering with practices in offering a Care-Based Quality Improvement Program. The aim of the program is to provide significant financial investment to support quality improvement practices for practices that have CBI quality metrics below the 50th percentile for Medicaid, and therefore will be receiving a CBI 2022 payment reduction between 25-100%. Your Board approved an investment of five million dollars for this one-time program.

The application opened in March 2023, and prioritizes pediatric well care visits and vaccines, in addition to diabetes control and preventive screenings for women. The program is based on a Plan-Do-Check-Act rapid cycle improvement process and support includes best-practice model sharing, practice coaching, monthly metric updates, and collaborative meetings wherein challenges, and successes will be shared. Payments for improvement consider total linkage, size of gap to achieve the Medicaid 50th percentile, and overall difficulty to achieve gap correction by weighting the measures on a scale of 1-5. Payments will be provided to participating practices based on an 80/10/10 model – 80% upfront and 20% contingent on participation in meetings to share experiences and successes.

2024 Contract Readiness. Upcoming 2024 DHCS contract requirements include an emphasis on equity, population health program integration and alignment with NCQA requirements in anticipation of upcoming NCQA and NCQA Health Equity accreditation requirements in 2026.

.

To promote Plan engagement and leadership in advancing equity the 2024, the DHCS contract includes a requirement to bring on a Chief Health Equity Officer (CHEO) to ensure progress toward equity for members, providers, contractors and plan staff. Responsibilities of the CHEO include oversight of Diversity, Equity, and Inclusion training for staff,

contractors, and providers. Committee name and organizational changes to promote equity are included in the 2024 contract. The Continuous Quality Improvement Committee is to be renamed the Quality Improvement and Health Equity Transformation Committee and the annual Quality Improvement Program becomes the Quality Improvement Health Equity Transformation Program. These changes are being put in place in 2023 and with these changes, equity considerations are embedded in all quality improvement efforts including policies and procedures.

The 2024 contract includes required completion of the Population Health Management program, which was developed in 2022, and is operational in 2023. The goal of the program is to create a system of care that proactively addresses member needs across the continuum of care by focusing on upstream health and wellness/prevention strategies, understanding local needs and solutions, addressing health disparities and social determinants of health, and embracing intersectoral actions and partnerships. The program includes risk stratification identifying needs for all members and segmenting populations for interventions including health education, basic case management, complex care management as well as enhanced care management, and community supports. To support population health, integration of patient assessment tools and use of multiple data sources (i.e., claims, business intelligence tool data from DHCS, clinical data, etc.) is being used to predict risk levels, including incorporation into the Alliance care management software system to guide outreach efforts and care needs. There are contractual requirements for outreach to specific populations including care transitions and pregnancy in the population health management effort.

Population Health program requirements include NCQA alignment in the 2024 contract. This is in anticipation of the CalAIM roadmap for plans to complete NCQA Health Plan and NCQA Health Equity accreditations in 2026. The Alliance has started a NCQA readiness assessment for both accreditations.

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

Attachments. N/A

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Van Wong, Chief Operating Officer

SUBJECT: Alliance Provider Network Adequacy and Realized Access

---

Recommendation. There is no recommended action associated with this agenda item.

Summary. In California, Medi-Cal is a key source of health coverage for approximately one-third of all Californians with over 10.8 million low-income children, adults and people with disabilities covered under a Medi-Cal managed care plan. The Alliance ensures access to quality, accessible healthcare for 415,000 of those Medi-Cal members in Santa Cruz, Monterey and Merced Counties. An important Alliance core function is to develop and maintain a provider network to meet these diverse member needs. In 2020, staff provided a Provider Network Adequacy Report detailing provider network adequacy requirements and shared the Alliance's performance against those requirements and standards. Specifically, the Alliance leveraged the Centers for Medicare and Medicaid Services (CMS) Access Framework to ascertain realized access for our members as indicated by their health outcomes. This updated report describes current performance, additional components driving realized access and the resultant impact to achieving health equity for our members. In addition, staff will outline our approach to monitoring and evaluating realized access to care including efforts to continuously improve for our members.

Background. Realized access has evolved over the years for the Alliance. However, Alliance staff have consistently aligned with the 5 A's of Access under the CMS Access Framework. This framework can be described as follows, with realized access occurring when the answer to each question is yes, or the barrier to achieving one of the components is overcome (e.g. the provider was not in close proximity, but transportation was provided, so access was realized):

1. Availability: was there a provider available in the network?
2. Accessibility: was the provider in close proximity to the member?
3. Accommodation: was the member able to obtain an appointment at an acceptable time?
4. Acceptability: were the member and provider a good fit?
5. Affordability: were members knowledgeable about their Medi-Cal benefits when accessing care since Medi-Cal covered services are provided at no cost to members?

The history of realized access for the provider network has transformed from regulatory monitoring starting with member to provider ratio and transitioning to more robust measurements including traditional providers' geographic locations based on population density, third next available appointments and member feedback. The following 5 A's of Access are answered based on the most recent data related to the provider network.

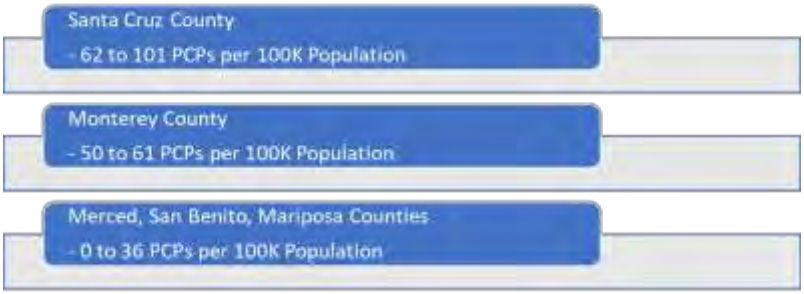
Availability: was there a provider available in the network? The Alliance continues to maintain a high percentage of available practicing physicians in our network ready and available to serve our members across the tri-counties. The below table represents the Alliance's

market share of primary care providers (PCPs) and specialists in our service area as of December 2022.

ALLIANCE PROVIDER NETWORK MARKET SHARE				
Provider Type	**Tri-Counties**	**Santa Cruz**	**Monterey**	**Merced**
PCP	87%	93%	87%	72%
Specialist	86%	93%	81%	88%

While the Alliance maintains a high market share based on provider availability, the provider attrition across the nation has severely impacted access, particularly in more rural areas such as Merced and Monterey Counties. A study published by the California HealthCare Foundation in 2021 showed physician supply varied by region with the Central Coast having an average of 58 PCPs and 117 Specialists per 100,000 population which is just below the recommended provider supply of 60-80 PCPs/100K and above the 85-105 Specialists/100K recommendation, respectively. However, as we drill into the Alliance's specific service areas, we see that PCP supply for Monterey and Merced as well as the Alliance's future service area in San Benito and Mariposa are well short of the recommended supply as denoted by the below graphic.

PCP Landscape in Alliance Counties (and expansion counties)



The limited supply of providers is compounded by the fact that about 32% of the contracted PCPs and 35% of specialists in our service area are over 60 years of age. This is in line with the statewide average of 34% of physicians being 60 or over. Unless we have an influx of new providers to replace the aging physicians who retire, the pool of available providers will decrease, resulting in less access for our members.

While Merced has the lowest PCP availability, 94% of our Merced contracted PCPs are open to new patients compared to Monterey and Santa Cruz where practices open to new patients are around 46% and 60%, respectively. Note that assignment to a PCP does not indicate timely access to needed care which will be covered further under the Accommodation section.

The year over year Healthcare Effectiveness Data and Information Set (HEDIS) results consistently show a lower level of performance in Merced, with some pediatric measures falling well under the 50th percentile, in line with a smaller supply of providers by county.

Accessibility: was the provider in close proximity to the member? The Alliance leverages the Department of Healthcare Services' (DHCS) Annual Network Certification tool to ascertain member's proximity to care. The Network Certification Standards varies depending on

population density with Monterey and Merced having a longer time and distance standard due to them being categorized as rural counties.

Provider Type	Time and Distance Standard
Primary Care (adult and pediatric)	10 miles or 30 minutes from the member's residence
Specialty Care (adult and pediatric)	Based on county population density ***Santa Cruz County*** 30 miles or 60 minutes from the member's residence ***Merced and Monterey Counties*** 45 miles or 75 minutes from the member's residence
Hospital	15 miles or 30 minutes from the member's residence

The Alliance monitors the average maximum distance (in miles) and average maximum time (in minutes) to care by zip codes for our member. As expected, the more rural counties have a longer travel time and distance to see their PCP with some zip codes having no PCP availability. We see similar results for access to hospital services.

Time & Distance for PCPs

County	Average Max Distance	Max Distance	Average Max Time	Max Time
Merced	8.4	14.2	9.4	21.2
Monterey	9.5	36.7	10.8	40
Santa Cruz	4.5	12.3	5.1	13.4

Time & Distance for Hospitals

County	Average Max Distance	Max Distance	Average Max Time	Max Time
Merced	16	27.5	18.6	30
Monterey	14.2	36.8	17	40.1
Santa Cruz	10.8	24.7	12.2	27.4

While many of our members live within DHCS allowable time and distance standards for access to the nearest PCP, specialist or hospital, the reality is that members in rural areas must travel further and longer to seek out care, compounded by potential transportation limitations. From a provider landscape standpoint, we are seeing a handful of rural hospitals statewide facing financial troubles, leading to closure and a huge disruption to access and longer travel for neighboring hospital services. We continue to monitor the financial solvency of these rural hospitals to determine impact to our members.

Accommodation: was the member able to obtain an appointment at an acceptable time?
There are several measures we use to monitor providers' ability to accommodate the member timely, 1) Provider Availability and Appointment Survey (PAAS), 2) Provider Appointment Monitoring Surveys (PAMS), and 3) hours of operation for PCPs, including Urgent Visit Access and After-Hours Care.

Provider Availability and Appointment Survey (PAAS). Timely Access Standards measured through the annual PAAS are as follows:

Appointment Type	Timely Access Standard
Urgent Appointment: Wait Times	
For services that do not require prior authorization	48 hours
For services that do require prior authorization	96 hours
Non-Urgent Appointments: Wait Times	
Primary care appointment (including first pre-natal visit and preventive visits)	10 business days
Mental health care appointment (with a non-physician provider)	10 business days
Non-urgent follow up appointment with a Mental health care (nonphysician provider) or substance use disorder provider	10 business days from the prior appointment
Specialist/Specialty Care appointment (including Psychiatrists)	15 business days
Ancillary service appointment for the diagnosis or treatment of injury, illness, or other health condition	15 business days

The Alliance made some notable improvements relative to MY 2021 in some key areas such as access to specialist and psychiatry appointments while access to non-Physician Mental Health (NPMH) and ancillary routine appointments continue to be impacted. Access to both routine and urgent PCP appointments continue to be relatively stable year over year. There are no passing standards established by DHCS on PAAS results. However, Department of Managed Health Care (DMHC) and the Alliance have established targets and thresholds for monitoring timely access. Overall, the Alliance's timely access to behavioral health provider types (non-physician mental health, psychiatrist, and child and adult psychiatrist) is comparable to 2021 results reported by behavioral health plans to DMHC for the Medi-Cal product for both urgent and non-urgent appointments. As reported by DMHC, the percentage of surveyed providers meeting appointment wait time standards ranged from 73% - 83% for non-urgent appointments and 56% - 70% for urgent appointments. The Alliance's 2022 combined results for NPHM and psychiatry for urgent and routine appointments are comparable to results reported by behavioral health plans statewide. While improvements have been observed in 2022, there is an opportunity to increase access to mental health services overall, particularly for the youth in the community (see discussion section for Alliance initiatives that are underway).

Appointment Compliance: MY 2020, MY 2021 and MY 2022 Comparison

Category	MY 2020 Compliance Medi-Cal (sample size)	MY 2021 Compliance Medi-Cal (sample size)	MY 2022 Compliance* Medi-Cal (sample size)
Urgent Appointment			
PCP	96% (329)	99% (644)	98% (700)
Specialist	54% (97)	45% (157)	61% (191)
NPMH	65% (165)	70% (103)	66% (364)
Psychiatry	59% (22)	33% (3)	55% (20)
Routine Appointments			
PCP	98% (330)	99% (644)	98% (711)

Specialist	66% (100)	58% (179)	59% (250)
Ancillary	94% (18)	86% (21)	81% (37)
NPMH	84% (188)	80% (118)	74% (390)
Psychiatry	74% (27)	47% (15)	70% (30)

**Color indicates performance trend compared to MY 2021, with green indicating higher compliance and red indicating lower compliance.*

Provider Appointment Monitoring Surveys (PAMS). PAMS surveys are done quarterly by Alliance staff to ensure ongoing monitoring of provider availability which includes the Third Next Available Appointment (TNAA) metric. TNAA is a measurement of how long it takes for a member to access providers when they want to schedule an appointment. TNAA is the most accurate metric compared to first or second appointments as it considers potential cancellations and other unforeseen events. Below is the Q1 2023 data for PCP and OB/GYN depicting average days to the third next available appointment by county:

Provider Type	Merced	Monterey	Santa Cruz
PCP	7	9	8
OB/Gyn	10	15	8

Ideally, the time to the third next available appointment should be either the same day or one day. The above results indicate members do not have timely access to primary care and obstetric service which may result in usage of Emergency Departments (ED) as a stop gap as evident by increases in the number of avoidable ED visits (AED) equivalent to pre-pandemic levels across all three counties. Note that the AED visits/1K members is below pre-pandemic levels due to an increase of 100,000+ Alliance members since December 2019. The average days to TNAA correlates with the limited provider supply noted under Availability.

Office Hours and Urgent Visit Access Initiative Hours. Access is not synonymous with afterhours and/or weekend access. The California Health Care Foundation Health Care Almanac indicates that 78% of Medi-Cal enrollees work and 63% of Medi-Cal enrollees work full time. Ensuring availability of appointments after 6:00 p.m. on weekdays and availability of weekend appointments is imperative to increasing access to care for this population who may be challenged with taking time off for routine preventive appointments. In reviewing our network, we see differences in availability in urgent care access and afterhours and weekend access to either PCP or urgent care across our service areas.

Urgent Care Offices:
- 22% in Merced
- 32% in Monterey
- 12% in Santa Cruz

PCP Offices: After hours and/or weekend hours
- 16% in Merced
- 19% in Monterey
- 27% in Santa Cruz

Urgent Visit Access Sites: (PCP sites willing to see nonlinked members)
Afterhours/Weekend hours

- 60% in Merced
- 19% in Monterey
- 75% in Santa Cruz

Notably, the more rural counties of Merced and Monterey have less afterhours and weekend access to PCP services. Monterey has less than 20% of their urgent care sites with afterhours and weekend access, leading to greater prevalence of ED usage with avoidable ED/1K rate almost at pre-pandemic level in 2022 – 85/1K member.

Telehealth. In addition to traditional in office visits, the Alliance tracks alternative access options as represented by telehealth availability in addition to the Nurse Advise Line offered by the health plan. Across our network, more than half of contracted PCPs offer telehealth option compared to under 15% of our specialists and roughly 14% of mental health providers.

COUNTY	PCP PROVIDERS			SPECIALIST PROVIDERS			MENTAL HEALTH PROVIDERS		
	COUNT	TOTAL	%	COUNT	TOTAL	%	COUNT	TOTAL	%
MERCED	53	100	53%	34	433	8%	33	127	26%
MONTEREY	130	195	67%	109	894	12%	37	322	11%
SANTA CRUZ	124	248	50%	77	537	14%	23	374	6%

Expanding alternative access options would greatly increase members' access to timely care, especially for those members who may have transportation challenges.

Member Perception of Accommodation. In addition to standard measures by DMHC and DHCS, the Alliance relies on member experience indicators based on their perception about their ability to get needed care and get care quickly which are captured in the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS is an annual survey which is used for rating a patient's health care experiences. In 2022, the Alliance requested to include an augmented sample of Spanish speaking members and the results are called out below. The CAHPS survey for 2022 shows mixed results compared to 2021 but remains high relative to all California health plans, especially for our adult population which represents more than half our membership. Our Spanish speaking members, which represented 159 responses, scored slightly higher than non-Spanish speaking members. This speaks to the availability of our provider network for our members to access care when needed. Notable is that California benchmarks are well below the U.S. benchmark for both getting needed care and getting care quickly for both adults and children.

Survey Population		Getting Needed Care				
Response Rate	2022	2021	2020	2022 CA Benchmark	2022 CA %tile Rank	2022 US Benchmark
Child (17%)	79.2%	83.4%	80.4%	76.0%	75th -90th	84.2%
Adult (15.4%)	82.9%	85.3%	83.0%	75.1%	Above 90th	81.9%
Spanish Speakers	85.0%	-	-	75.1%	Above 90th	81.9%

Survey Population		Getting Care Quickly				
Response Rate	2022	2021	2020	2022 CA Benchmark	2022 CA %tile Rank	2022 US Benchmark
Child (17%)	84.5% ↑	83.1%	86.8%	79.8%	75th -90th	84.2%
Adult (15.4%)	73.4%	84.5%[1]	80.3%	71.6%	75th -90th	80.2%
Spanish Speakers	78.2%	-	-	71.6%	75th -90th	80.2%

***Note**: Response rate represents percentage of responses received out of a total eligible sample size of 2,012 adult members and 1,650 child members.*

As we look towards the horizon with the expansion to Mariposa and San Benito Counties by 2024, these network adequacy indicators and our prior experience will provide a strong foundation for building out a provider network to meet the needs of the residents in these rural counties.

Acceptability: Were the member and provider a good fit? To ascertain acceptability, the Alliance monitors member and provider language compatibility, including those of the office staff. Additionally, the Alliance assesses members' perception regarding provider fit utilizing key indicators in our annual CAHPS survey results. As part of our strategic goal of ensuring health equity through increasing culturally and linguistically appropriate care, the Alliance included three supplemental questions in the 2022 CAHPS survey focused on possible disparities in care and cultural humility. Outcomes are shared under the *Member Perception of Acceptability* section that follows.

Threshold Language. Threshold language means a language that has been identified as the primary language by DHCS based on 3,000 beneficiaries or 5% of the beneficiary population, whichever is lower, in an identified geographic area. For the Alliance, the threshold language is Spanish in all three counties and Hmong in Merced. The Alliance assesses the network in language adequacy by comparing a member's primary language to that of existing provider and their office staff in their region. As shown in the table below, the Alliance network has adequate language compatibility for our existing membership as defined by an acceptable ratio of one PCP to 2,000 members. However, there is an opportunity to increase Spanish and Hmong speaking PCPs in Merced.

County	Threshold Language	Threshold language-speaking PCP Physician	Members with primary language	Physician to Member Ratio	Physician Language Ratio Met	% Open Status
Santa Cruz	Spanish	57	33,782	1:593	Yes	56%
Monterey	Spanish	90	89,623	1:996	Yes	40%
Merced	Spanish	29	44,338	1:1,529	Yes	97%
Merced	Hmong	2	1,960	1:980	Yes	50%

**Required physician to member ratio: 1:2000 per DHCS standard*

Member Perception of Acceptability. The Alliance leverages several key indicators from the CAHPS survey as a proxy for determining members' perception of provider fit. Specifically,

members consistently rated their personal doctors and specialist high, with significant increases compared to prior years for the adult population.

Survey Population		Rating of Personal Doctor				
Response Rate	2022	2021	2020	2022 CA Benchmark	2022 CA %tile Rank	2022 US Benchmark
Child (17%)	93.10%	93.50%	92.60%	91.80%	75th-90th	94.20%
Adult (15.4%)	83.1% ↑	82.10%	78.70%	78.60%	75th-90th	82.40%
Spanish Speakers	89.40%	-	-	78.60%	Above 90th	82.40%

Survey Population		Rating of Specialist				
Response Rate	2022	2021	2020	2022 CA Benchmark	2022 CA %tile Rank	2022 US Benchmark
Child (17%)	93.4% ↑	83.30%	83.10%	N/A[1]	N/A[1]	86.50%
Adult (15.4%)	85.7% ↑	77.80%	82.20%	81.80%	75th-90th	83.50%
Spanish Speakers	88.70%	-	-	81.80%	75th-90th	83.50%

Survey Population		How Well Doctors Communicate				
Response Rate	2022	2021	2020	2022 CA Benchmark	2022 CA %tile Rank	2022 US Benchmark
Child (17%)	93.10%	93.50%	92.60%	91.80%	75th-90th	94.20%
Adult (15.4%)	91.5% ↑	89.30%	90.80%	89.30%	Above 90th	92.50%
Spanish Speakers	92.40%	-	-	89.30%	Above 90th	92.50%

[1]CA Benchmark for Rating of Specialist is not available since NCQA does not calculate state-level benchmarks for measures that have less than 5 health plans with reportable results
***Note**: Response rate represents percentage of responses received out of a total eligible sample size of 2,012 adult members and 1,650 child members.*

Members also indicated satisfaction with how well their doctors communicate when accessing care and this is particularly high in the Spanish speaking members. The cultural competency questions that were included in the 2022 CAHPS survey are:

1. In the last six months, how often were you treated unfairly at your personal doctor's office because you did not speak English very well?
2. In the last six months, how often have you been treated unfairly at your personal doctor's office because of your race or ethnicity?
3. In the last six months, how often did your personal doctor (or office staff) say or do something that made you feel that they did not understand your culture or language?

We had not previously relied on data regarding member perception of acceptability, implementing this review with the implementation of the 2022 Strategic Plan. Results were very favorable across all population with Spanish speaking members noting never almost 90% of the time or higher to each of the questions as shown below, indicating strong results as to the cultural care and humility of their providers. Results reaffirm the Alliance's focus on recruiting a network of culturally competent providers and should also refocus its strategic efforts to push for more points of access for members.

Cultural Humility Questions	Child Never	Adult Never	Spanish Speaker Never
Treated unfairly at Drs. Office due to language barrier	93.6%	90.8%	89.4%
Treated unfairly at Drs Office due to cultural differences	95.2%	94.3%	95.3%
Misunderstanding of culture by Dr./Staff	93.3%	92.4%	94.1%

Affordability: Medi-Cal covered services are provided at no cost to members; were members knowledgeable about their Medi-Cal benefits when accessing care? The Alliance assesses affordability based on how knowledgeable members are about their benefits when accessing care. While the CAHPS survey provides a good indication of members satisfaction with the health plan overall, we rely on utilization data and member voice to understand what benefits are potentially being under-utilized and rationale including lack of awareness of the benefit, such as mental health and non-medical transportation services. The Alliance's Your Health Matters Program is one key avenue for staff to connect and educate our members in the community about these services. Additionally, through those engagements, staff learn about areas of focus that we then follow up on with broader member communication via our Member Bulletins, direct outreach from the clinical team and other appropriate mediums. The Alliance also partners with our providers to ensure our network is aware of new benefits that are being rolled out as part of CalAIM and other state initiatives. Provider awareness allows for referrals of eligible members for specific services, e.g., community support services which also bridges any potential member knowledge gaps regarding benefits.

Discussion. Reviewing the Alliance's performance relative to the 5 A's of the CMS access framework provides a deeper understanding into areas of strengths and opportunities to enhance the network to enable realized access for our members. The opportunities which the Alliance can pursue to ensure realized access for equitable health outcome are:

1. Expansion of access to care via alternatives to primary care including telehealth, non-traditional providers like community health workers and doulas, expanded afterhours and weekends for timely access to care
2. Expansion of urgent care access
3. Improved access to NPMH providers
4. Streamline access to specialty care
5. Increase providers who speak Spanish and Hmong

What follows outlines the pathway and the associated initiatives underway or being explored by the Alliance to capitalize on those opportunities and ensure an equitable delivery system for our members.

Alliance Payment Policy and Grant Funding. The Alliance reinvests in our community through the strategic use of reserve via grant funding as well as advancing payment policies that is in line with revenue rate, utilization and industry benchmarks. The Alliance recently instituted a rapid grant cycle, thus increasing the number of times provider recruitment grants can be received within a given year while also expanding the types of services, like telehealth and community health workers (CHW) that can be eligible for

grants. Advancing alternative access options such as non-traditional providers, e.g., CHWs, and telehealth will alleviate the constraint on primary care providers and aim to improve timely access to care.

The Alliance's grant program continues to support provider recruitment through grants for high-demand specialty. To increase the number of Merced providers that speak threshold languages, the Alliance grant team incentivized recruitment grant applicants with an additional $10,000 for providers fluent in threshold languages as well as providers who are proficient in one of the Alliance's indigenous languages, and sign language. Additional partnerships are being explored to see how the Alliance and the residency programs in Merced County may support residents joining local Merced provider practices.

The Alliance also recently modified our payment policy as is relates to urgent care services by increasing rates from 150% of the Medi-Cal fee schedule to 100% of the Medicare fee-schedule. In 2018, the Alliance implemented a program called the Urgent Visit Access Program. This program allowed PCPs to provide urgent visits to non-linked Alliance members if their office was open for an extended hour each weekday (beyond the typical Monday through Friday, 8:00 a.m. to 5:00 p.m.) or if their office was open for a minimum of four hours on the weekends. The rate increase included contracted urgent care providers or Urgent Visit Access providers. The annual access plan contemplates recruitment of free-standing urgent care facilities to assist with avoidable ED visits.

The Alliance leverages incentive payments to our PCPs and specialists to ensure access and optimal health outcomes. The existing Care Based Incentive (CBI) program was recently augmented to include a practice improvement component targeted at provider practices with key HEDIS rates below the targeted 50th percentile. Additionally, the Alliance Board approved the implementation of the Specialty Care Incentive at the end of 2022 which awarded funds to specialty providers for taking on new specialty referrals as well as sustaining existing referral members. Both programs are designed to improve realized access.

Lastly, the Alliance worked closely with our provider partners to streamline the specialty referral process given the constraint on the specialty network in Santa Cruz County. Our provider partners worked together to identify usage of AristaMD's RN Navigator (RNN) to assist in eliminating unneeded in-person specialty referrals. The AristaMD RNN allows AristaMD nursing staff access to clinic EMRs where triage of specialty referrals can be assessed for potential alternative visits via eConsult. The Alliance allocated funding to initiate a six-month AristaMD RNN pilot with Santa Cruz Community Health Centers (SCCHC). The goal is to route referrals to eConsult where appropriate, thus reducing unneeded in-person specialty visits and ensuring those limited appointments are available to those requiring in-person care. Additional areas to explore to expand specialty access include more telehealth options and streamlining office workflows.

Department of Health Care Services Incentives. DHCS also recognizes the need to ensure a robust delivery system and as part of the CalAIM initiative, have allocated funding via incentives including Health Equity and Practice Transformation (HEPT) Payment and Student Behavioral Health Incentive Program (SBHIP).

HEPT provides payments for delivery system transformation activities to pediatric, PCP, OB/Gyn and behavioral health providers focused on advancing DHCS' equity goals in the

"50 by 2024: Bold Goals" initiative. Further exploration as to the feasibility of leveraging these payments to expand PCP afterhours and weekend access and/or offer telehealth is being initiated.

SBHIP goals and metrics are associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools. Through this funding stream, the Alliance created partnership with School Based Mental Health Services to ensure streamlined efforts of mental health care are prominent in the lives of our young members which account for over 50% of our membership. Early identification and treatment through school-affiliated behavioral health services can reduce emergency room visits, crisis situations, inpatient stays, and placement in high-cost special education settings and/or out of home placement. Efforts in this area will improve access to non-physician mental health providers.

Additional focus in non-physician mental health providers is going to be a component of this year's access plan. This will entail creating a stronger partnership with our mental health subcontractor, Carelon (formerly Beacon). This year the Alliance and Carelon were able to provide services at the Emergency Shelter at the Watsonville Fair Grounds to support victims of the floods in Parajo. The mental health services were provided in various languages, supporting members' immediate needs.

Provider and Community Partnerships. The Alliance seeks to build collaborative partnerships between community-based organizations and providers to provide timely care to our members, especially in Merced County where provider availability and accommodation are low and health outcomes reflect the lower realized access. One such partnership is between the Alliance, Mercy Medical Center Rural Health Clinics, Mercy Medical Center Foundation, and the Merced City school district to provide immunizations to children this past quarter. It was such a success that three additional immunization clinics will be scheduled for the remainder of the school year. The Alliance looks to expand school immunization partnerships to other school districts.

State and Federal Policy. The Alliance supports policies and proposals which advance the following priorities and principles aimed at developing and maintaining a provider network that meets members' needs:

1. Access to Care
    - Increase provider pathways to increase the total number of culturally competent providers available to people with Medi-Cal and Medicare coverage.
    - Provide immediate solutions to shortages in, or which expand the capacity of, the Medi-Cal and Medicare healthcare workforce.
2. Financing and Rates
    - Encourage and support provider participation in Medi-Cal and Medicare through adequate rates.
    - Increase federal funding for Medi-Cal.
3. Health Equity
    - Optimize health outcomes and eliminate health disparities for children.
    - Improve outcomes and reduce disparities between the Medi-Cal and commercially insured populations.

- Increase member access to culturally and linguistically appropriate and culturally competent health care.
- Prioritize allocation of resources to address disparities and to remove barriers to equitable access to high-quality services.

Realized access cannot be measured by regulatory requirements alone. The Alliance relies on additional indicators to monitor and ensure the health plan develops a network that meets our members' needs. As the Alliance continues to forge forward against the backdrop of an increasingly challenged provider landscape, we continue to rely on local innovation, strong community and provider partnerships, an experienced Board, and highly engaged staff to reduce health disparities and ensure a person-centered delivery system transformation and deliver on our vision of *Healthy People, Healthy Communities*.

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

Attachments.
1. California Physicians Almanac, 2021: A Portrait of Practice by California Healthcare Foundation
2. California Healthcare Almanac, August 2021 by California Healthcare Foundation

CALIFORNIA

Health Care Almanac

CHCF

MARCH 2021

California Physicians:
A Portrait of Practice

Executive Summary

Although the number of active physicians increased by 21% between 2006 and 2018, and exceeded the 10% population growth, many areas in California face substantial shortages of primary care providers and specialists. *California Physicians: A Portrait of Practice* presents detailed information about the supply, distribution, and demographic characteristics of the state's physicians and provides important context for understanding the challenges of caring for people during a public health emergency like COVID-19, as well as the complexity of caring for an aging and increasingly racially/ethnically diverse population.*

KEY FINDINGS INCLUDE:

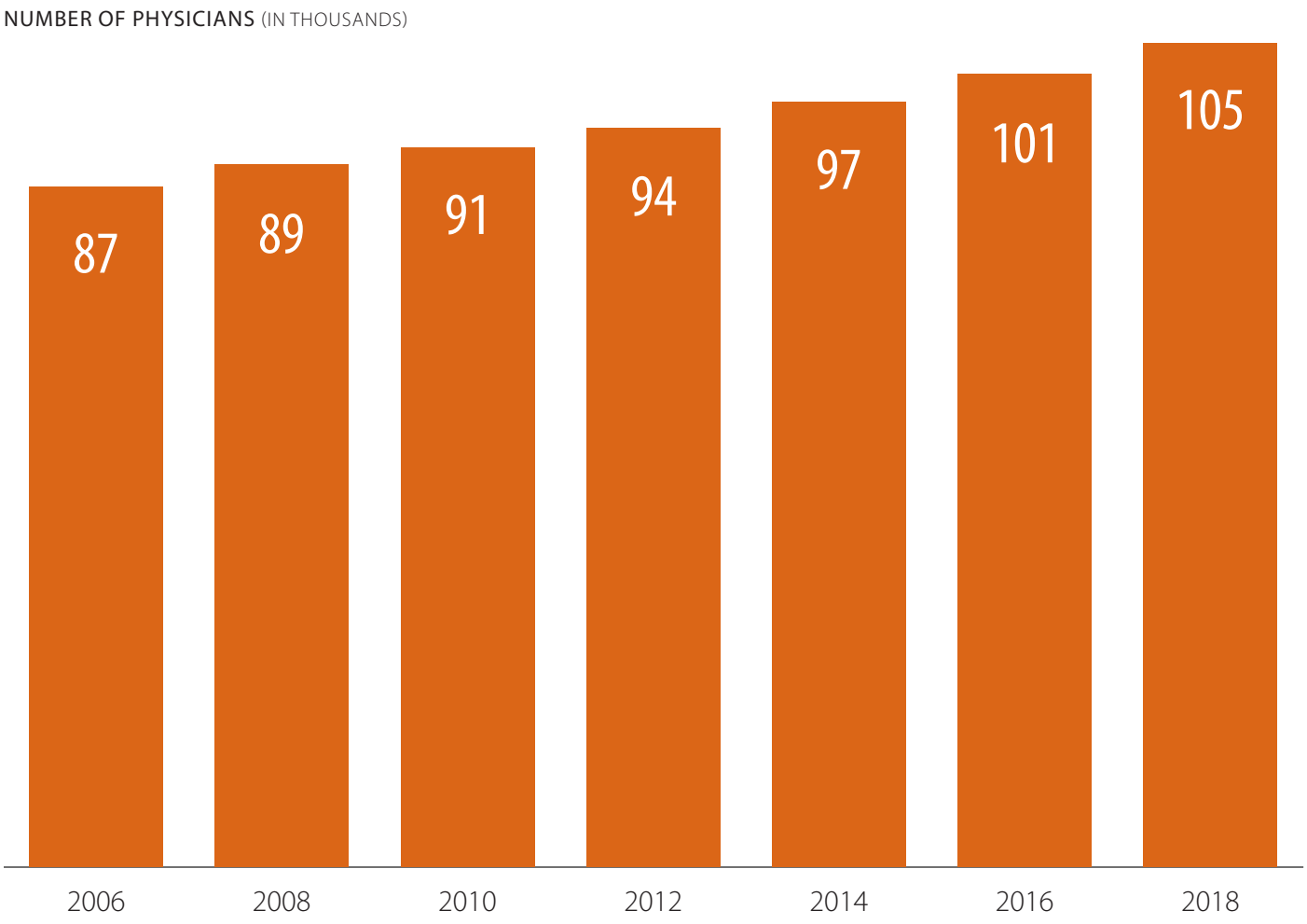
- The supply of licensed physicians does not adequately reflect their availability to provide care. Less than half of California's physicians provided patient care 40 or more hours per week.
- Physician supply varied by region. Out of nine regions in the state, only four regions (Greater Bay Area, Orange County, Sacramento Area, San Diego Area) had the recommended supply of primary care physicians (PCPs). The Inland Empire and San Joaquin Valley had the lowest supply of PCPs and specialists.
- Over one-third of California's physicians were over 60. Physicians over 50 work fewer hours per week on patient care than their younger counterparts.
- The Latinx population is underrepresented among physicians. Latinx people represented 39% of California's population, but only 6% of the state's physicians and 8% of the state's medical school graduates.
- Physicians were less likely to accept uninsured patients than patients with any type of insurance, including Medi-Cal.
- California ranked first in the nation in the percentages of both medical students and residents who remain in the state to practice.
- Twenty-eight percent of physicians (39% of PCPs and 23% of specialists) attended an international medical school.

*Data presented were collected prior to the onset of the COVID-19 pandemic. Some findings, most notably the amount of time spent providing care via telemedicine, may have changed since the pandemic began.

CONTENTS

Active Physicians

California, 2006 to 2018, Selected Years



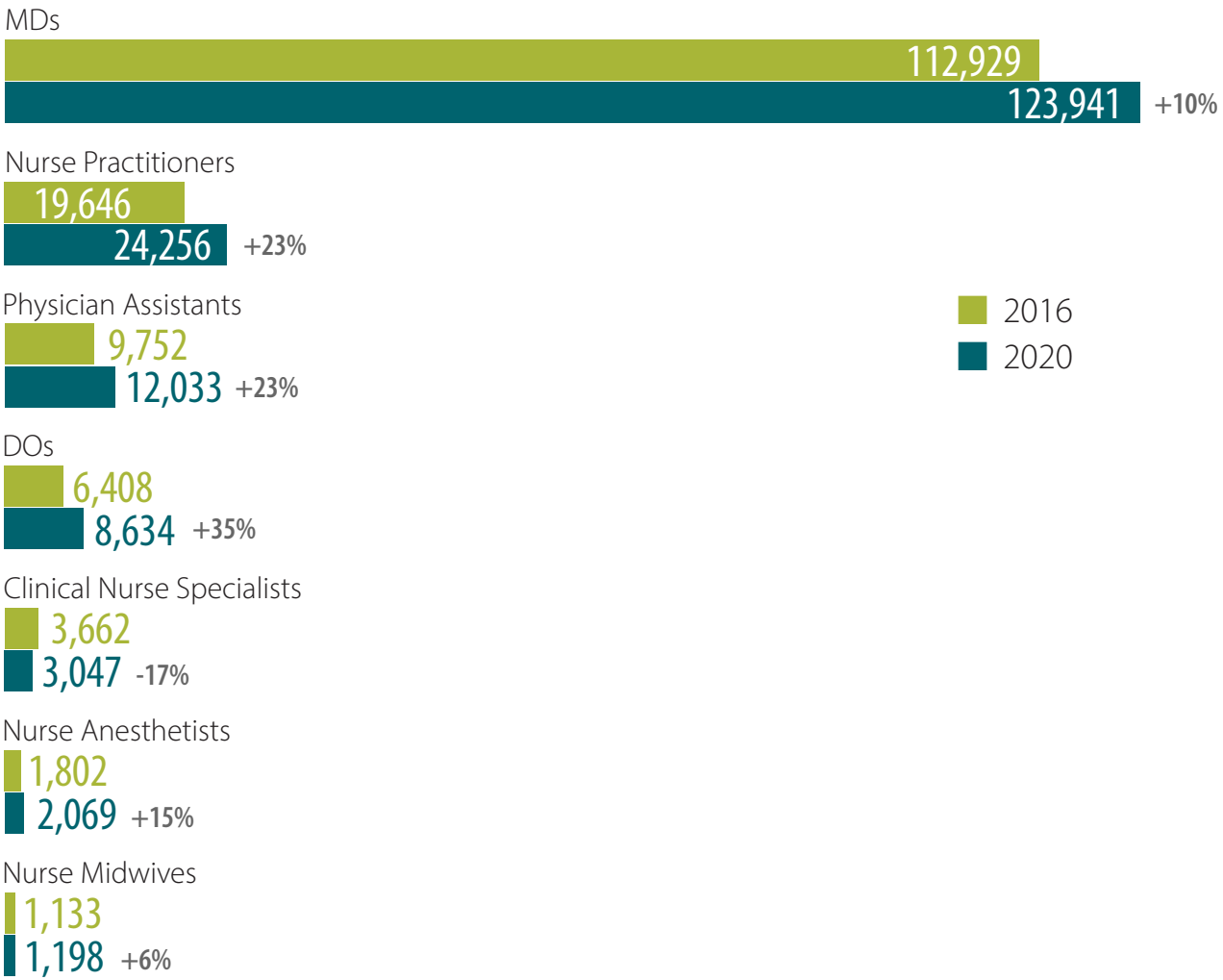
Note: Data include MDs who indicated they worked 20 or more hours per week, except residents, fellows, and MDs who are retired, semiretired, working part-time, temporarily not in practice, or not active for other reasons.

Sources: *State Physician Workforce Data Report* (2007, 2009, 2011, 2013, 2015, 2017, and 2019), Assn. of American Medical Colleges.

The number of active physicians (MDs) practicing in California has grown steadily, increasing 21% from 2006 to 2018. During this time, growth in the state's supply of physicians exceeded population growth, which increased by 10% (not shown).

Supply of Select Providers

California, 2016 and 2020



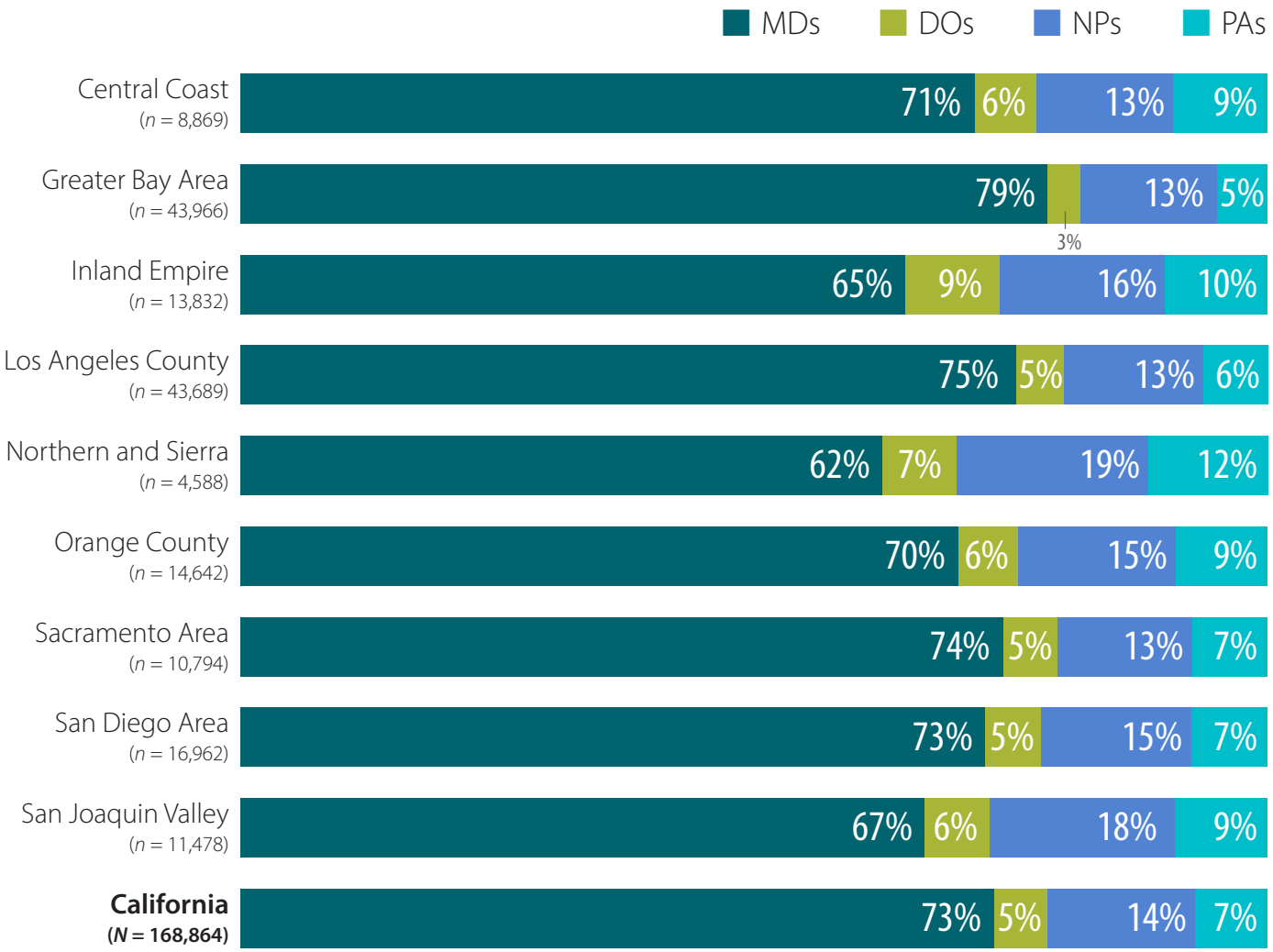
Notes: *DO* is doctor of osteopathic medicine. Data include all providers with an active California license and a California address. The Agency for Healthcare Research and Quality (AHRQ) has estimated that 52% of nurse practitioners and 43% of physician assistants are primary care practitioners. See *Primary Care Workforce Facts and Stats No.2: The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States* (PDF), AHRQ, October 2011.

Sources: Survey of Licensees (private tabulation), California Dept. of Consumer Affairs (DCA), 2016; and *DCA Annual Licensing Statistics*, DCA, 2020.

Supplies of physicians, physician assistants, and three types of advanced practice nurses in California grew between 2016 and 2020, while the supply of clinical nurse specialists decreased. Doctors of osteopathic medicine (DOs) had the highest rate of growth while MDs had the largest increase in the number of professionals.

Health Care Providers, by Type and Region

California, 2020



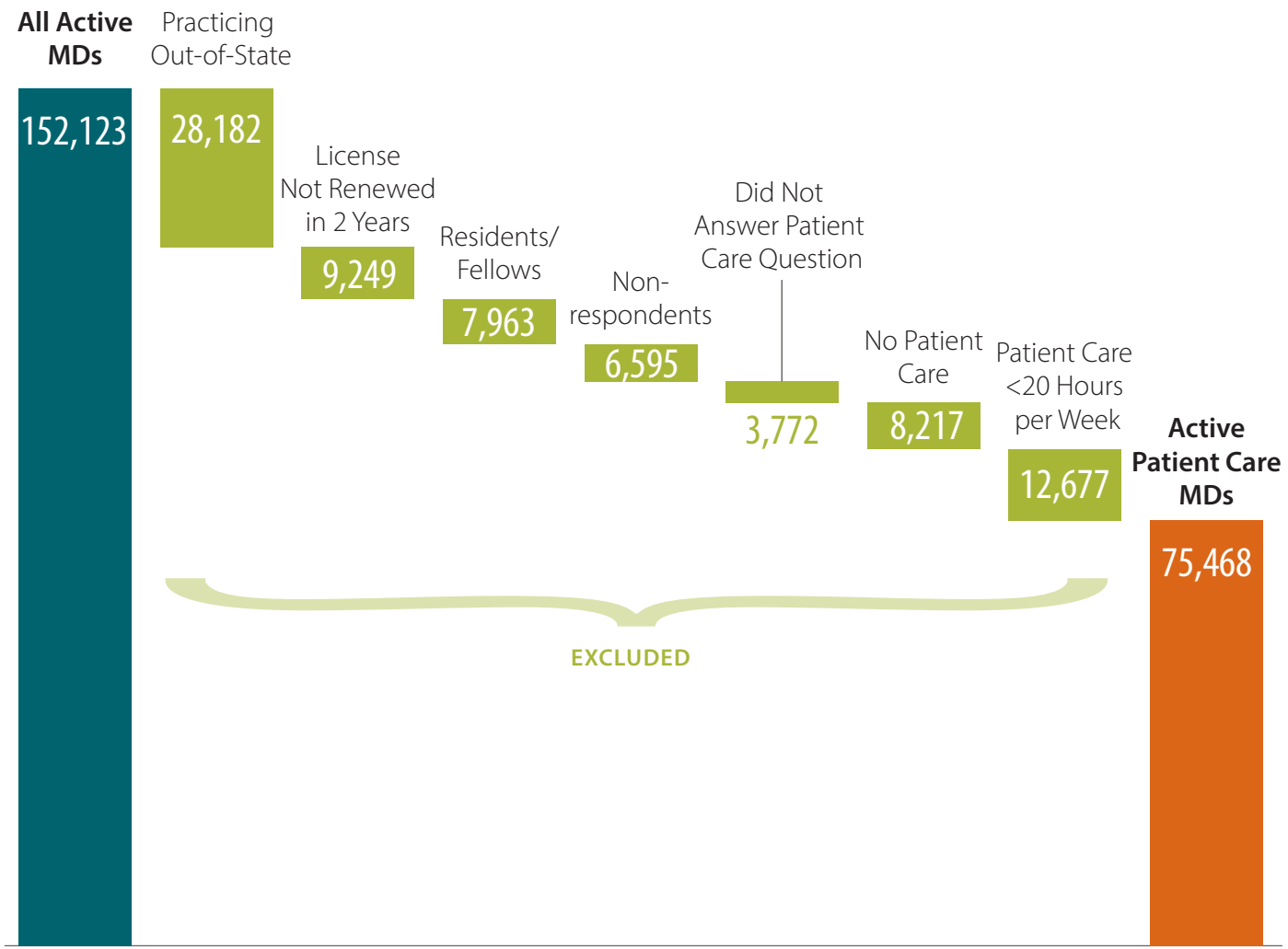
Notes: *DO* is doctor of osteopathic medicine. *NP* is nurse practitioner. *PA* is physician assistant. Data include all providers with an active California license and a California address. The total number of MDs in California includes 44 physicians who could not be allocated to a region because a valid zip code was not provided. Segments may not add to 100% due to rounding. See Appendix A for a list of counties within each region.

Sources: Survey of Licensees (private tabulation), California Dept. of Consumer Affairs (DCA), 2016; and *DCA Annual Licensing Statistics*, DCA, 2020.

Medical care can be obtained from physicians (MDs and DOs), nurse practitioners, and physician assistants. In 2020, MDs and DOs composed 78% of these health care providers in California. In the Northern and Sierra region, they composed 69% of health care providers.

Estimating the Number of Active Patient Care Physicians

California, 2020



Notes: The Medical Board of California surveys MDs when they obtain or renew their licenses. *Nonrespondents* include MDs who did not complete the survey and those who did not respond to questions about hours worked. Physicians who did not renew their licenses between February 2018 and January 2020 are excluded.

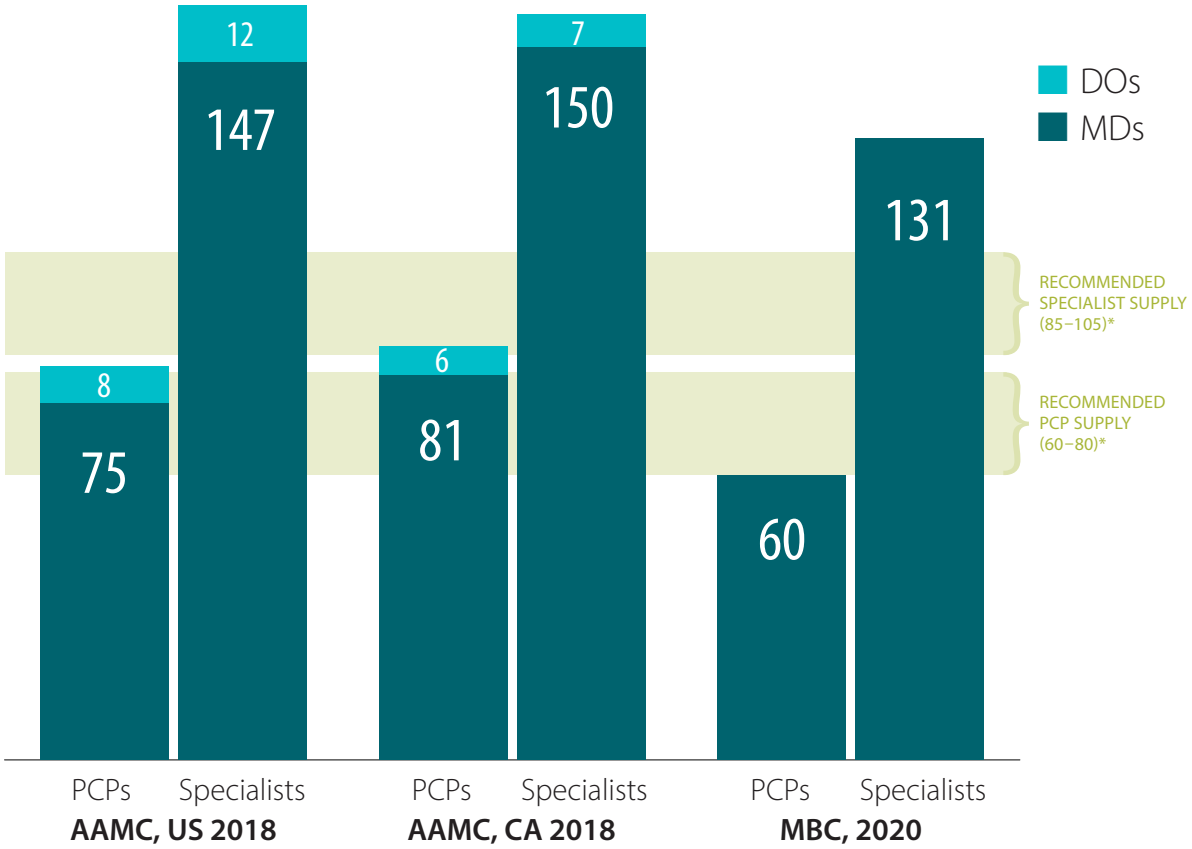
Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

Counting physicians in California is not clear-cut. Many physicians with active California licenses are not considered "active patient care physicians" because they do not practice in California, did not renew their licenses during the last biannual renewal cycle, are residents or fellows, did not respond to the medical board's mandatory survey, or do not provide patient care.

Primary Care Physicians and Specialists

California vs. United States, 2018 and 2020

NUMBER PER 100,000 POPULATION



*The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include DOs and are shown as ranges in the chart above. MBC data do not include DOs.

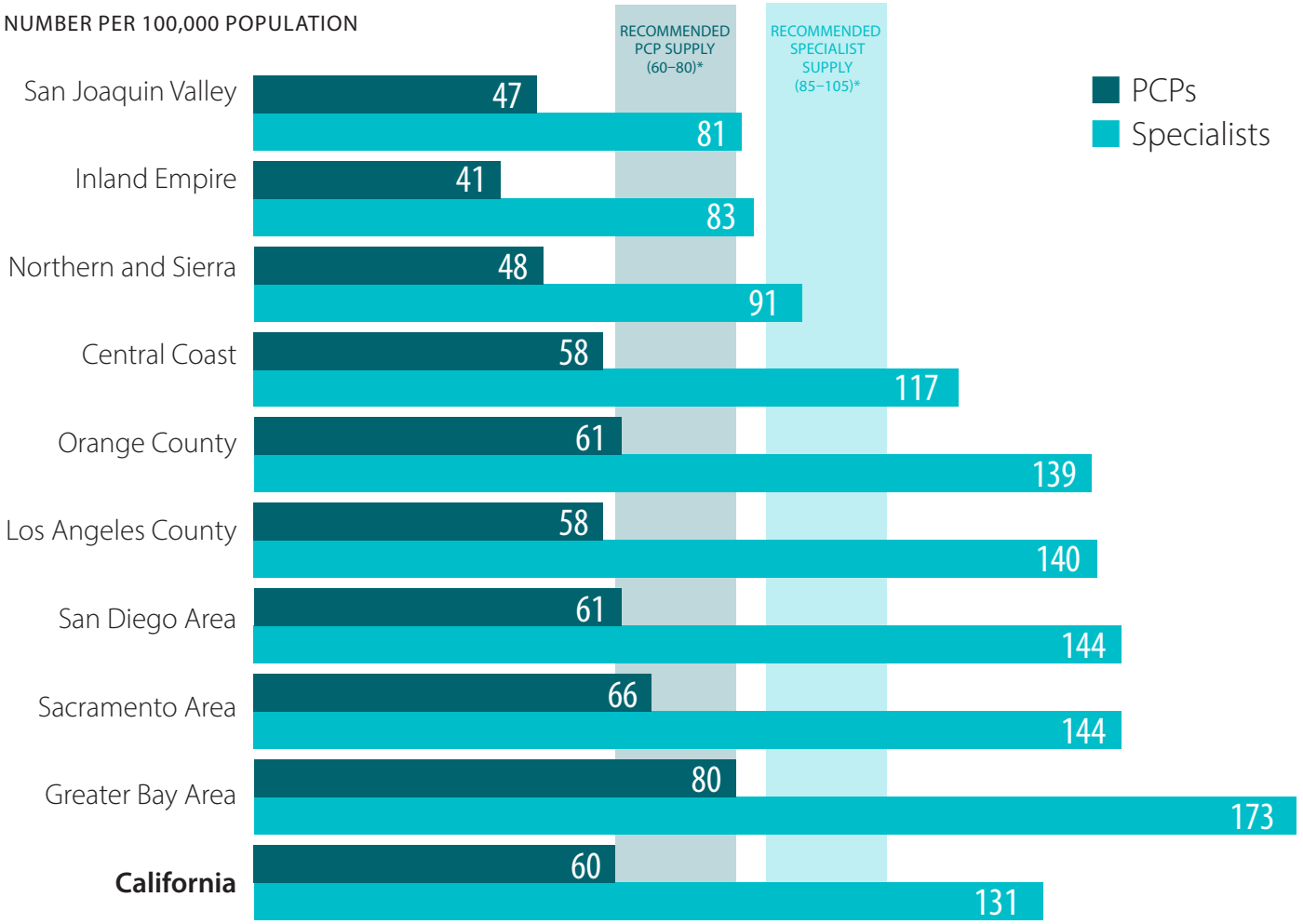
Notes: *PCP* is primary care physician. The Assn. of American Medical Colleges (AAMC) data include those physicians who self-reported their type of practice as "direct patient care." For the AAMC data, the number of specialists per 100,000 was estimated by subtracting the ratio of active patient care primary care physicians per 100,000 population from the ratio of all active patient care physicians per 100,000 population. The Medical Board of California (MBC) data include MDs who renewed their license between February 2018 and January 2020, answered the question on MBC's survey regarding their specialty, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the MBC survey or did not answer questions about specialty). Of the 75,468 active patient care physicians in California, 163 (0.2%) did not report their specialty or board certification.

Sources: *2019 State Physician Workforce Data Report*, Assn. of American Medical Colleges, November 2019, tables 1.2, 1.4; Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2019* (NC-EST2019-ASR6H), US Census Bureau, June 2020.

Based on data collected by the Association of American Medical Colleges in 2018 and by the Medical Board of California (MBC) in 2020, California's supply of primary care physicians (PCPs) and specialists met the minimum per capita ratios recommended by the Council on Graduate Medical Education. According to MBC data, the supply of PCPs in California just barely met the minimum recommended supply.

Primary Care Physicians and Specialists, by Region

California, 2020



*The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include DOs and are shown as ranges in the chart above.

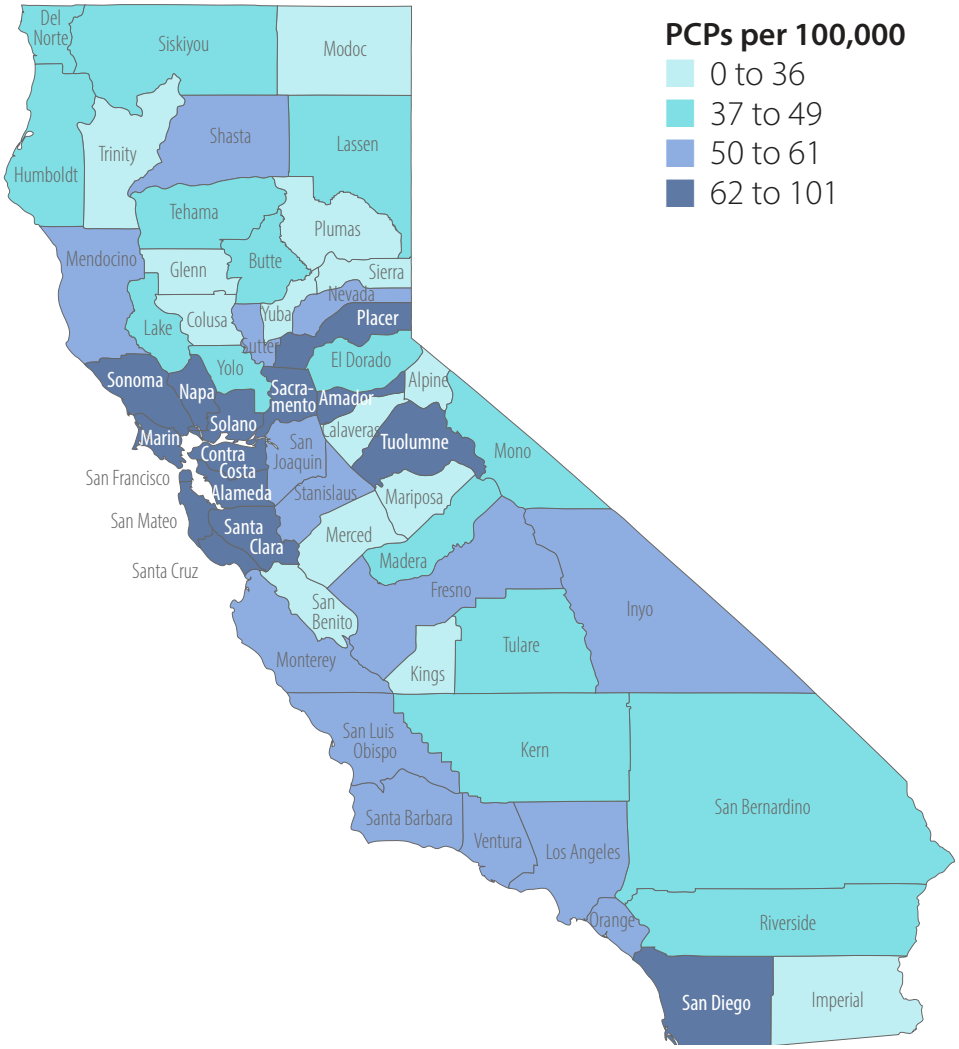
Notes: *PCP* is primary care physician. Data include MDs who renewed their license between February 2018 and January 2020, answered the question on the Medical Board of California (MBC) survey regarding their specialty, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the MBC survey or did not answer questions about specialty). Of the 75,468 active patient care physicians in California, 163 (0.2%) did not report their specialty or board certification. There were 19 physicians who did not provide geographic information.

Sources: Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2019* (NC-EST2019-ASR6H), US Census Bureau, June 2020.

Physician supply varied by region. Out of nine regions, five regions fell short of the recommended supply of PCPs, and two regions were below the recommended supply of specialists. The Inland Empire and San Joaquin Valley regions had the lowest ratios (number per 100,000 population) of both PCPs and specialists of all regions in the state.

Primary Care Physicians per 100,000 Population, by County

California, 2020



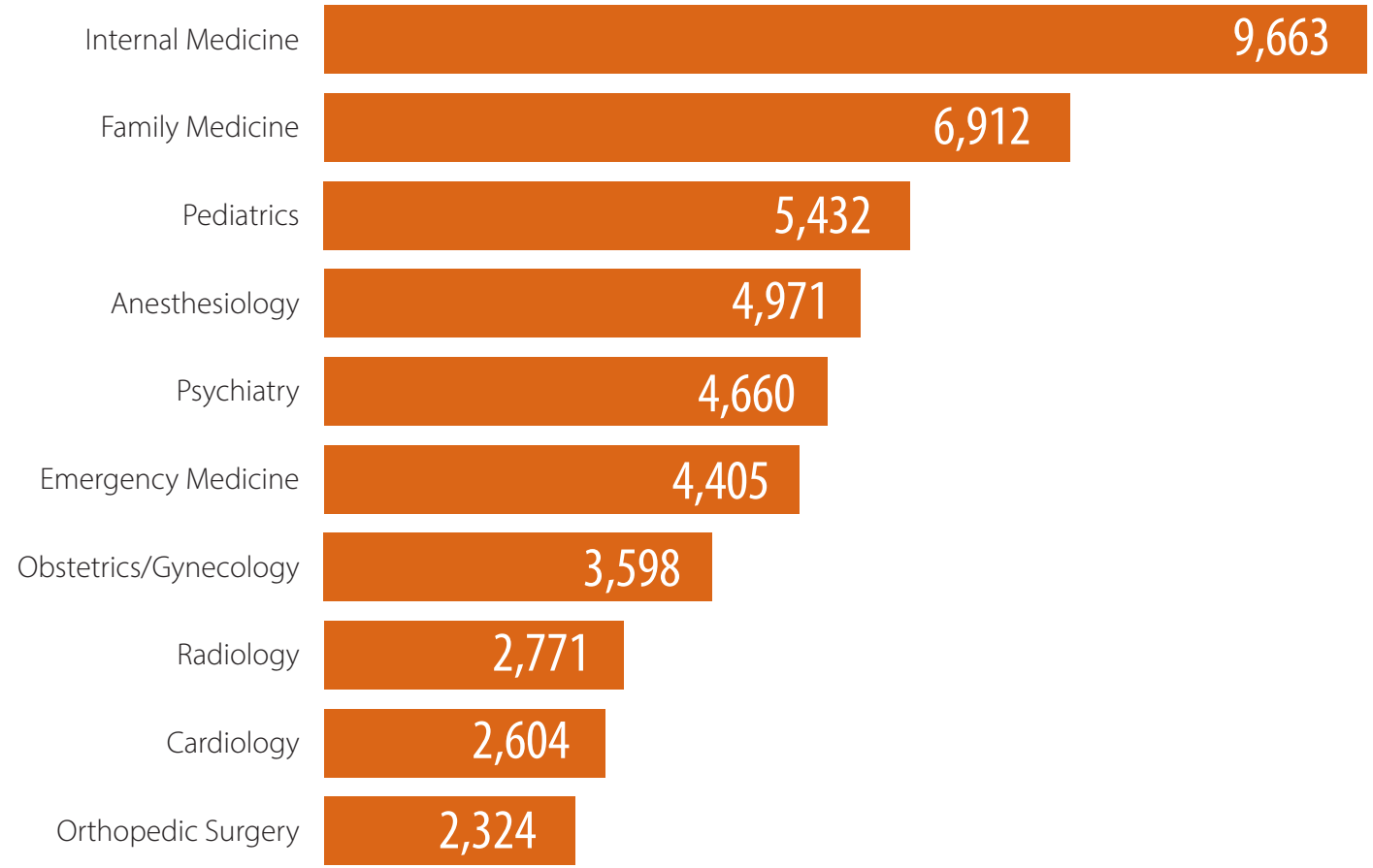
Notes: *PCP* is primary care physician. Data include PCPs who renewed their license between February 2018 and January 2020, answered the question on the Medical Board of California survey regarding their specialty, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the survey or did not answer questions about specialty).

Sources: Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2019* (NC-EST2019-ASR6H, SC-EST2019-ASR6H-06), US Census Bureau.

PCPs were concentrated in urban counties along the California coast. Many rural and inland counties had low ratios of PCPs per 100,000 population.

Top Ten Specialties
California, 2020

NUMBER OF ACTIVE PATIENT CARE PHYSICIANS



Notes: Data include MDs who renewed their license between February 2018 and January 2020, answered the question on the Medical Board of California survey regarding their specialty, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the survey or did not answer questions about specialty). Physician self-reported primary, secondary, and board certification specialties were used to determine the specialty. Physicians whose primary specialty was internal medicine and who listed a secondary specialty (e.g., cardiology) were assigned to the secondary specialty. Similarly, pediatricians with a subspecialty were assigned to the secondary specialty. Of the 75,468 active patient care physicians in California, 163 (0.2%) did not respond to the question on the survey regarding their specialty.

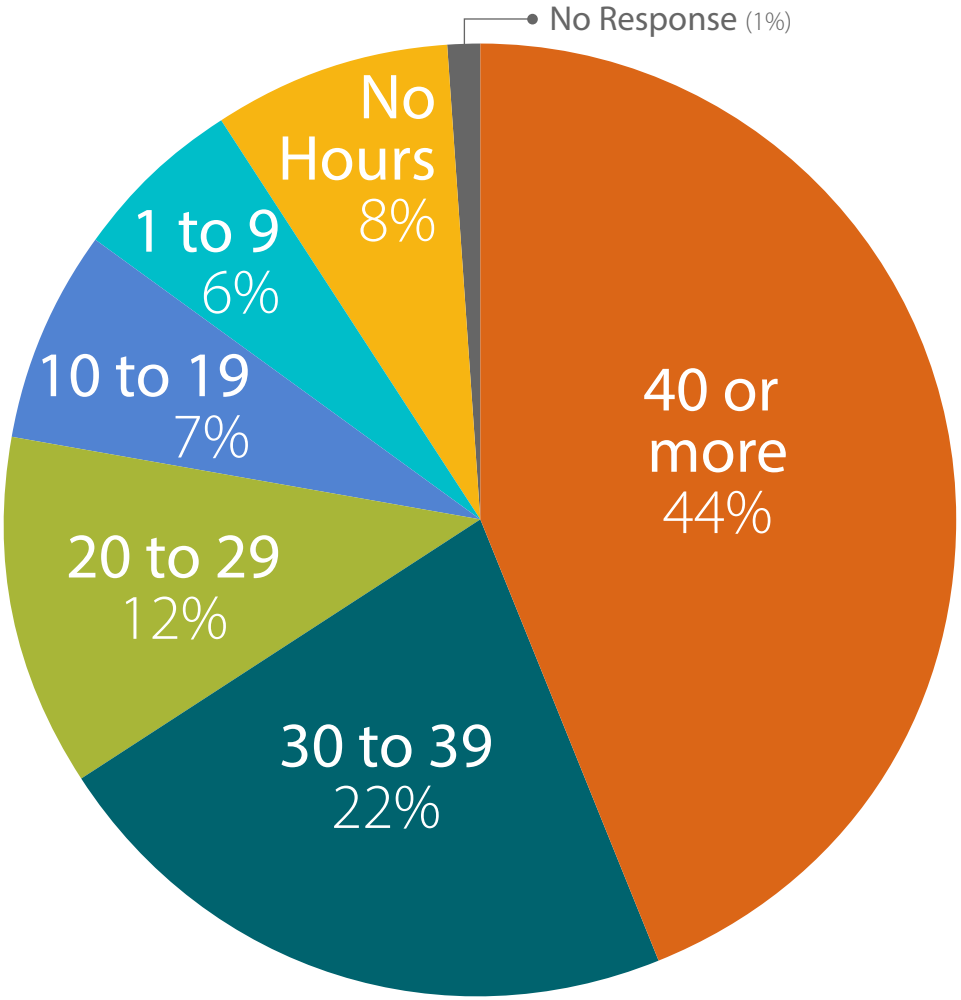
Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

The three largest specialties in California were primary care specialties. Among physicians who reported their specialty, internal medicine, family medicine, and pediatrics together represented 29% of all active patient care physicians in the state.

Patient Care Hours Worked

California, 2020

AVERAGE WEEKLY HOURS



Notes: Data include MDs who renewed their license between February 2018 and January 2020, had a California address, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the the Medical Board of California survey). In 2020, 1% of physicians who responded to the survey did not answer the question about patient care hours. Segments may not total 100% due to rounding.

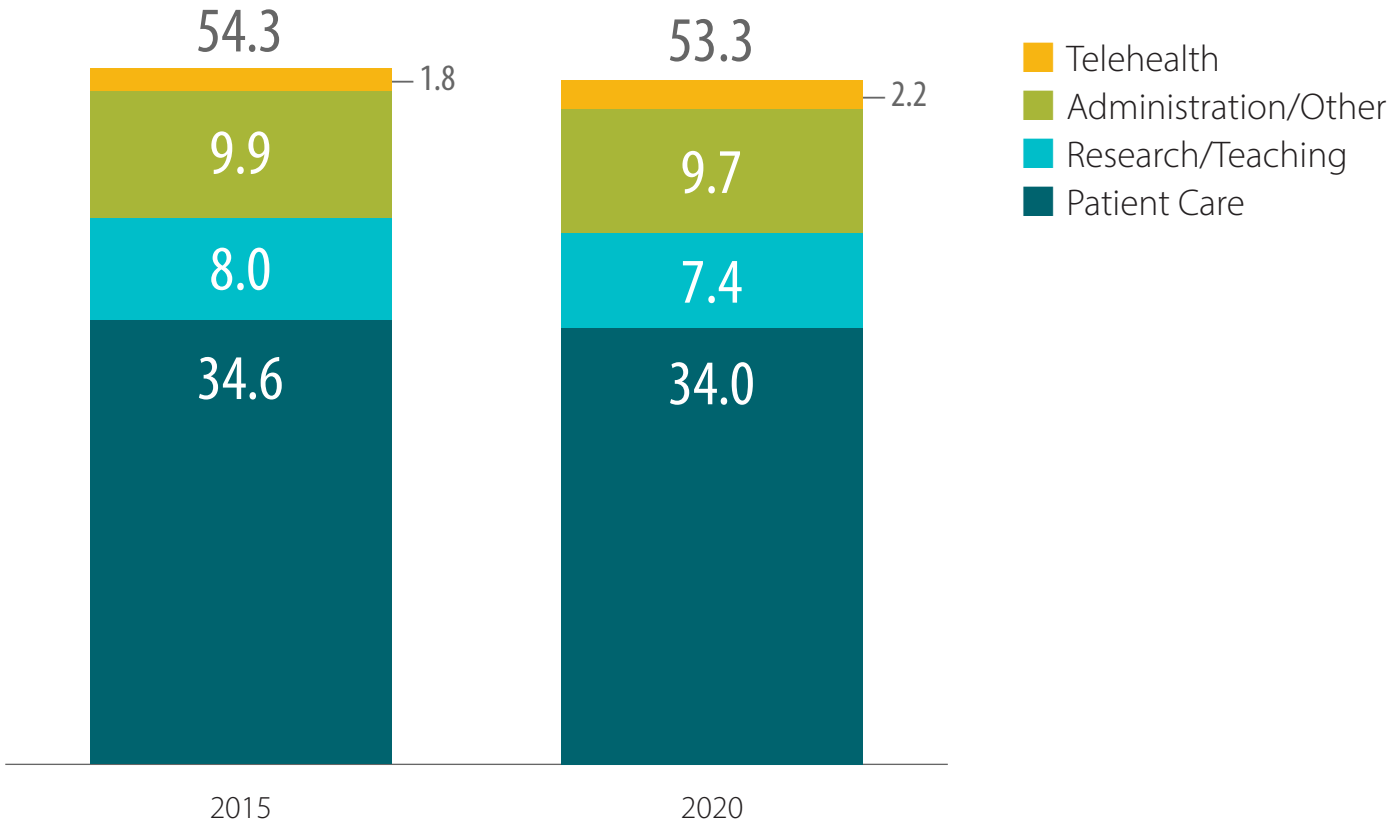
Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

The total number of physicians with active licenses does not accurately reflect the availability of physicians to provide care. Less than half of California physicians devoted 40 hours or more per week to patient care. Eight percent of active physicians did not provide patient care. Physicians also spent time on other professional activities, such as administration, research, and teaching.

Physician Hours Worked, by Activity

California, 2015 and 2020

AVERAGE WEEKLY HOURS



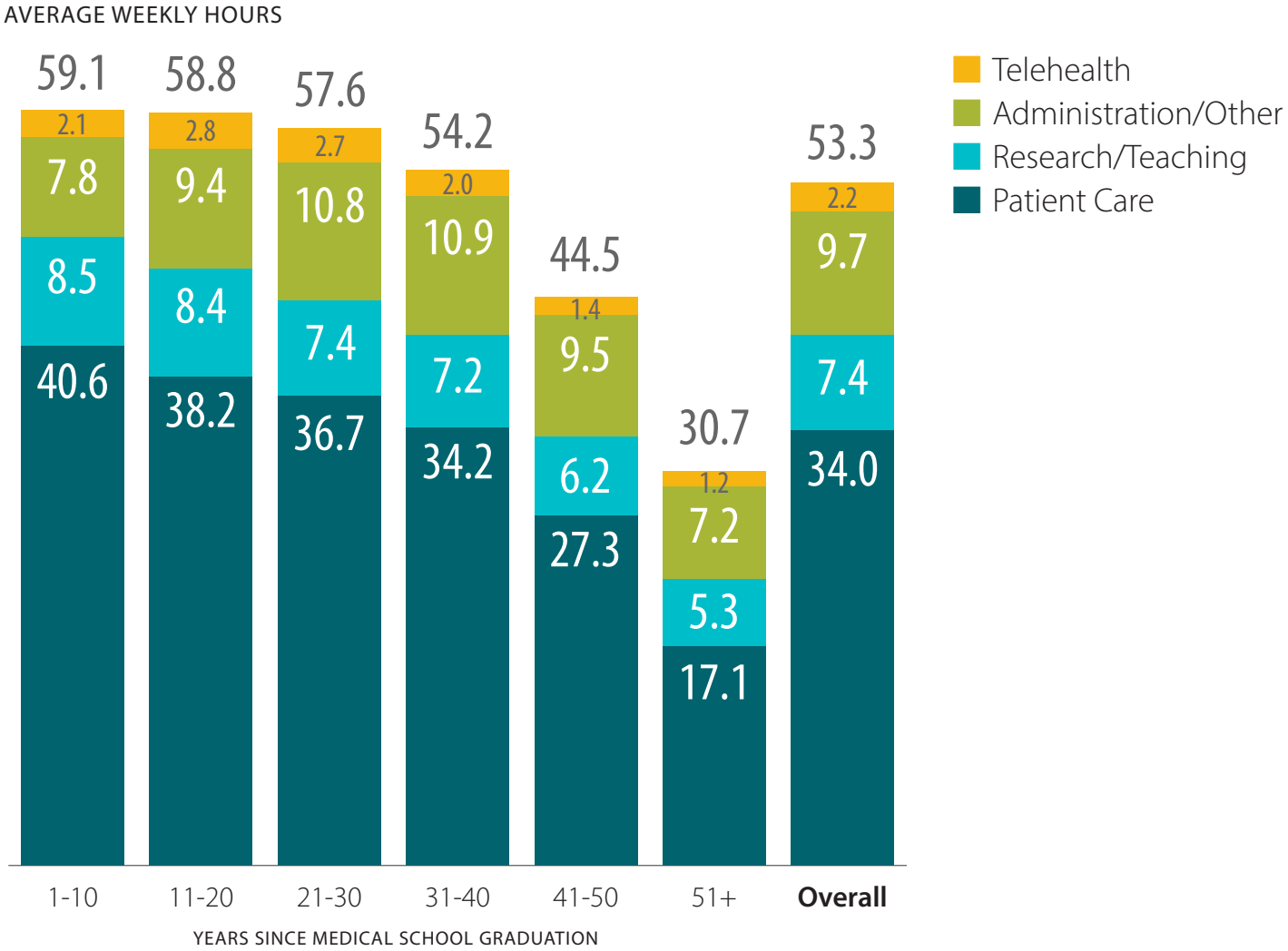
Notes: Data include MDs who renewed their license between February 2018 and January 2020, had a California address, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the the Medical Board of California survey or did not answer questions about hours worked). Data were collected before the COVID-19 pandemic and therefore do not reflect the number of hours physicians devoted to telemedicine during the COVID-19 pandemic.

Source: Survey of Licensees (private tabulation), Medical Board of California, 2015 and 2020.

The hours worked per week by physicians has stayed constant over the past five years. The average physician's workweek was 53 hours in 2020. Of those hours, 34 were spent on patient care.

Physician Hours Worked, by Activity and Years Since Graduation

California, 2020



Notes: Data include MDs who renewed their license between February 2018 and January 2020 and had a California address, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey or did not answer questions about hours worked). Data were collected before the COVID-19 pandemic and therefore do not reflect the number of hours physicians devoted to telehealth during the COVID-19 pandemic.

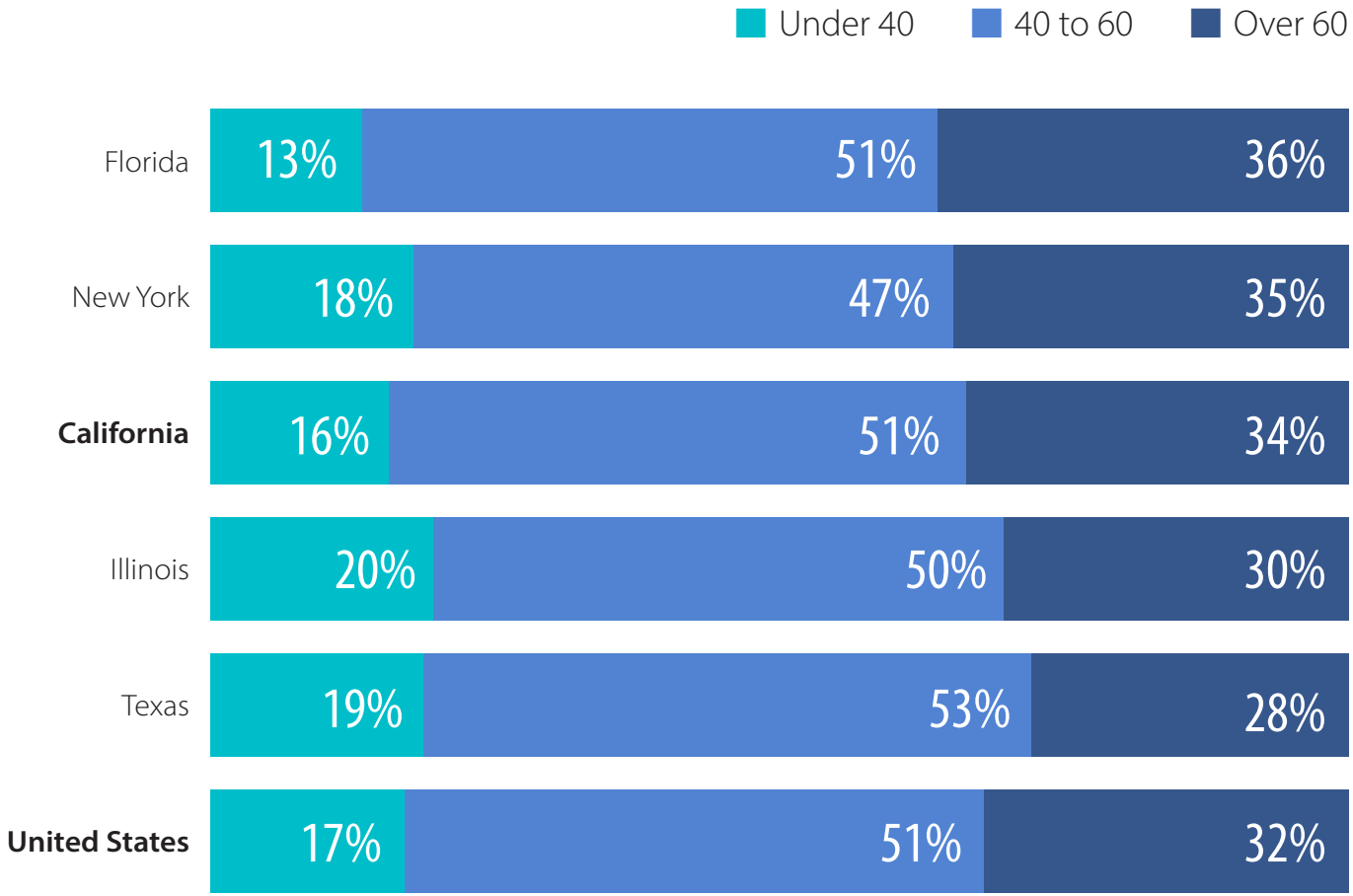
Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

Later in their careers, physicians work fewer hours per week and dedicate less time to providing patient care.

Age of Physicians

Select States vs. United States, 2018

PERCENTAGE OF TOTAL PHYSICIANS



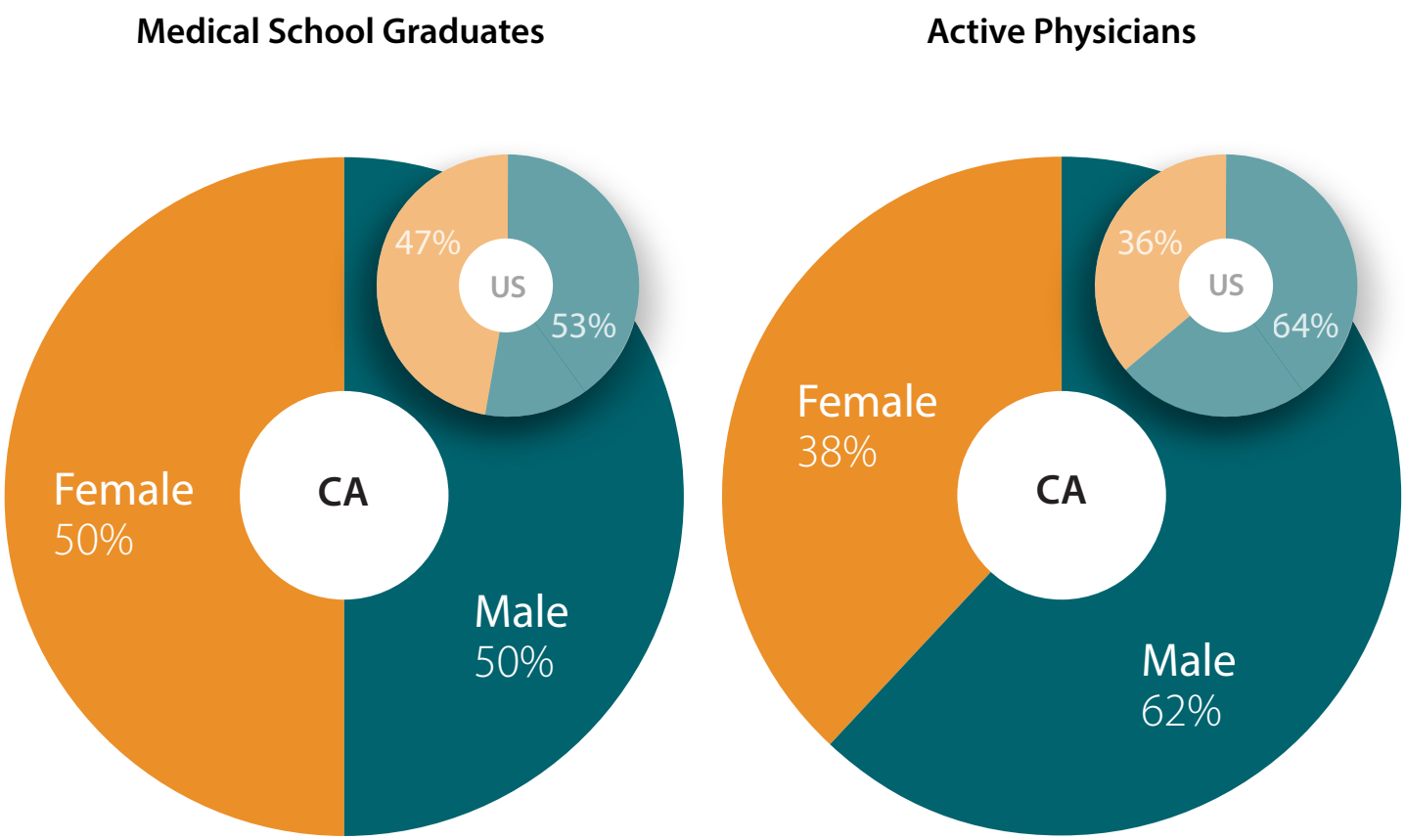
Note: Data include all active MDs and doctors of osteopathic medicine (DOs). Segments may not total 100% due to rounding.

Source: *2019 State Physician Workforce Data Report*, Assn. of American Medical Colleges, 2019, table 1.9.

Like many states, a large percentage of California's physicians are over 60. One-third of physicians in California were in this age group in 2018.

Gender of Medical School Graduates and Physicians

California vs. United States, 2018



Notes: Data include active MDs and doctors of osteopathic medicine (DOs). Segments may not add to 100% due to rounding.

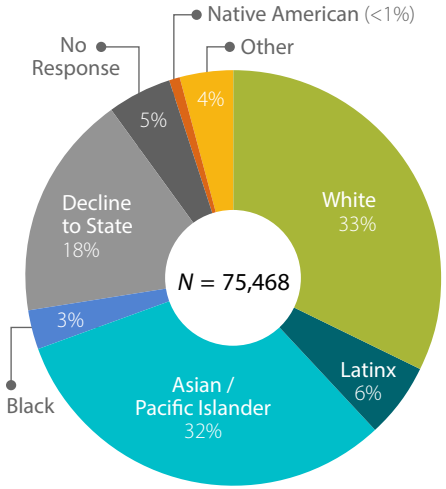
Sources: *2019 State Physician Workforce Data Report*, Assn. of American Medical Colleges (AAMC), 2019, table 1.7; and *B-2.2: Total Graduates by US Medical School, Sex, and Year, 2014-2015 Through 2018-2019*, AAMC, October 16, 2019.

The proportion of males and females among California medical school graduates were equal in 2018. The share of female graduates has grown significantly, from 9% in 1966 (not shown) to 50% in 2018. Males still represented the majority of physicians in California and nationwide, largely due to the gender gap in medical school graduates in the past.

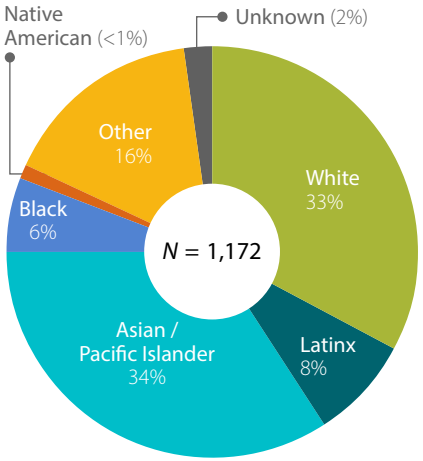
Race/Ethnicity of Medical School Graduates, Physicians, and Population

California, 2019 and 2020

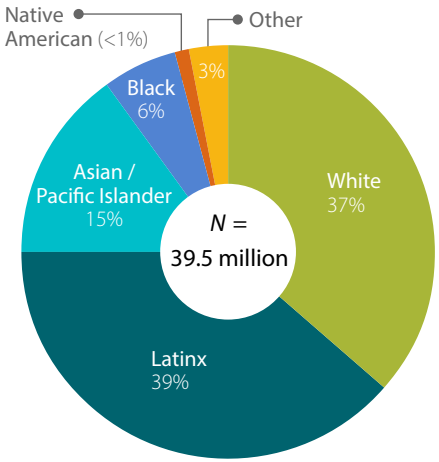
Active Patient Care MDs, 2020



California Medical School Graduates (MD), 2019



Total California Population, 2019



Notes: Data include all MDs who renewed their license between February 2018 and January 2020, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey). *Other* includes those of two or more races, and those of unknown race/ethnicity. The Association of American Medical Colleges uses *American Indian and Alaska Native*, *Black or African American*, and *Hispanic, Latino, or of Spanish Origin*. The Census Bureau uses *Black or African American*, *American Indian and Alaska Native*, and *Hispanic*. Segments may not add to 100% due to rounding.

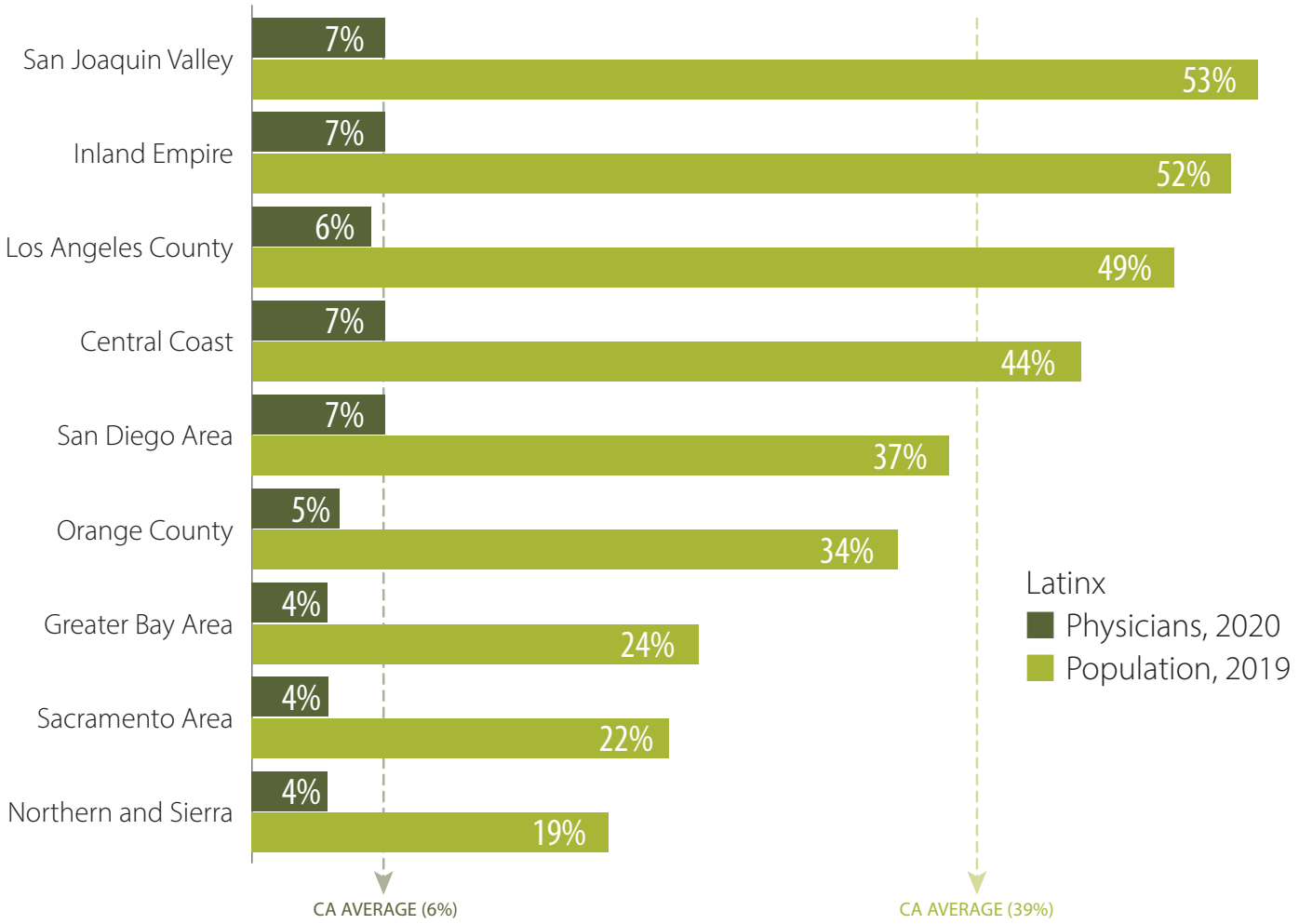
Sources: Survey of Licensees (private tabulation), Medical Board of California, January 2020; *B-6.1: Total Graduates by U.S. Medical School and Race/Ethnicity (Alone), 2018-2019*, Assn. of American Medical Colleges, October 16, 2019; and *Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for California: April 1, 2010 to July 1, 2019* (SC-EST2019-SR11H-06), US Census Bureau, June 2020.

The racial/ethnic breakdown of California physicians is not representative of the state's diverse population. Latinx people represented 39% of the population but 6% of active patient care physicians and 8% of medical school graduates. Studies have found that minority patients in race/ethnic concordant provider relationships are more likely to use needed health services, are less likely to postpone or delay seeking care, and report greater satisfaction and better patient-provider communication.*

*Ana H. Traylor et al., "The Predictors of Patient-Physician Race and Ethnic Concordance: A Medical Facility Fixed-Effects Approach," *Health Services Research* 45, no. 3 (June 2010): 792–805, doi:10.1111/j.1475-6773.2010.01086.x.

Latinx Physicians and Population, by Region

California



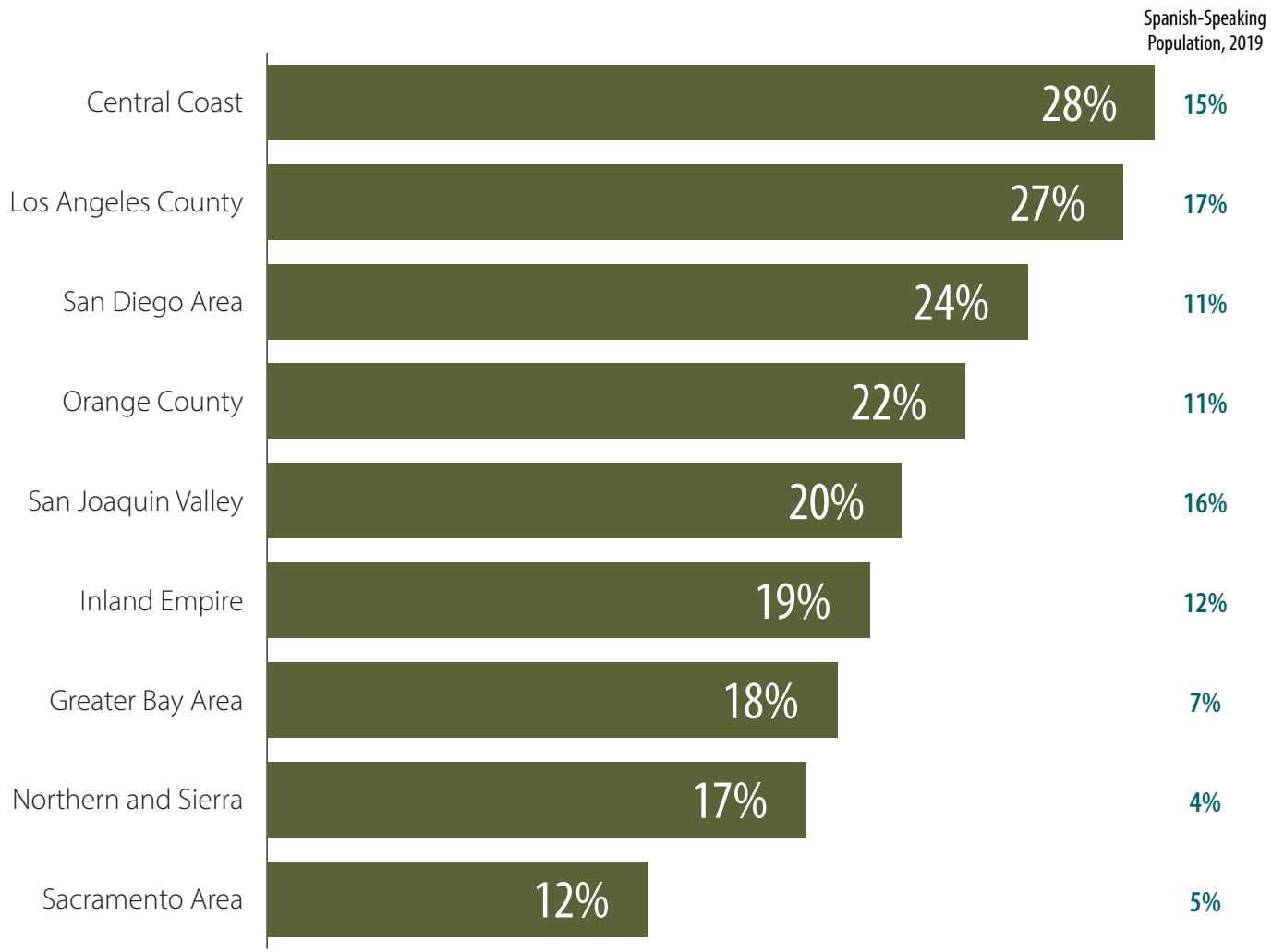
Note: Data include all MDs who renewed their license between February 2018 and January 2020, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey).

Sources: Survey of Licensees (private tabulation), Medical Board of California, January 2020; and *Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for California: April 1, 2010 to July 1, 2019* (SC-EST2019-SR11H-06), US Census Bureau, June 2020.

Latinx physicians were underrepresented in all regions of California, particularly in regions with the highest proportion of Latinx population: the Inland Empire, Los Angeles, and the San Joaquin Valley.

Spanish-Speaking Physicians, by Region

California, 2020



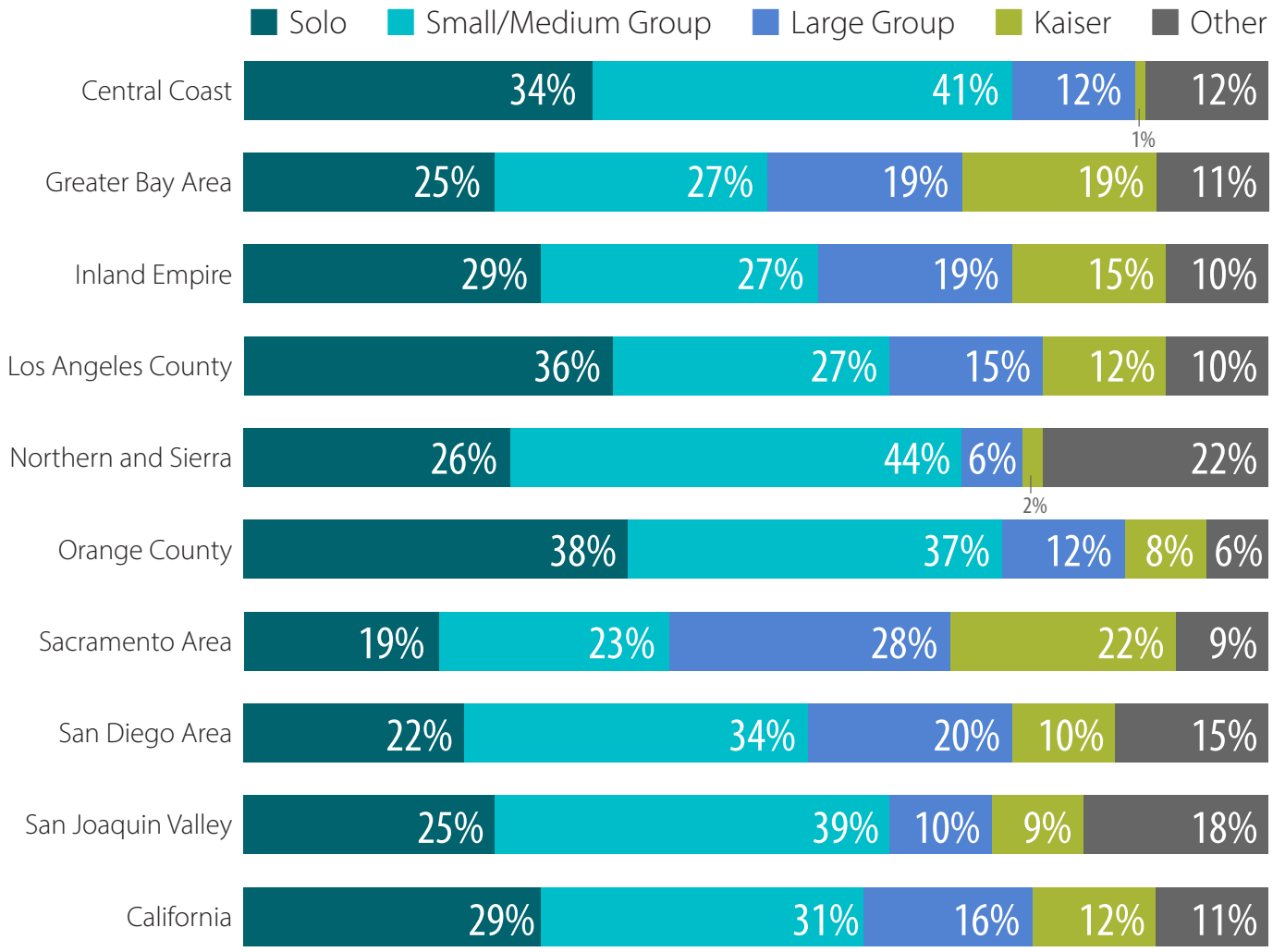
Notes: Data include MDs who renewed their license between February 2018 and January 2020, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey or did not answer questions about specialty). *Spanish-speaking population* includes all people 5 and older who are Spanish speakers and speak English "less than very well."

Sources: Survey of Licensees (private tabulation), Medical Board of California, January 2020; and 2019 ACS 1-Year Estimates, US Census Bureau, n.d., table S1601.

In six of the nine regions of California, over 10% of the population primarily spoke Spanish. In all nine regions, the percentage of physicians who reported that they speak Spanish exceeded the percentage of the population that primarily spoke Spanish.

Physicians, by Practice Setting and Region

California, 2015

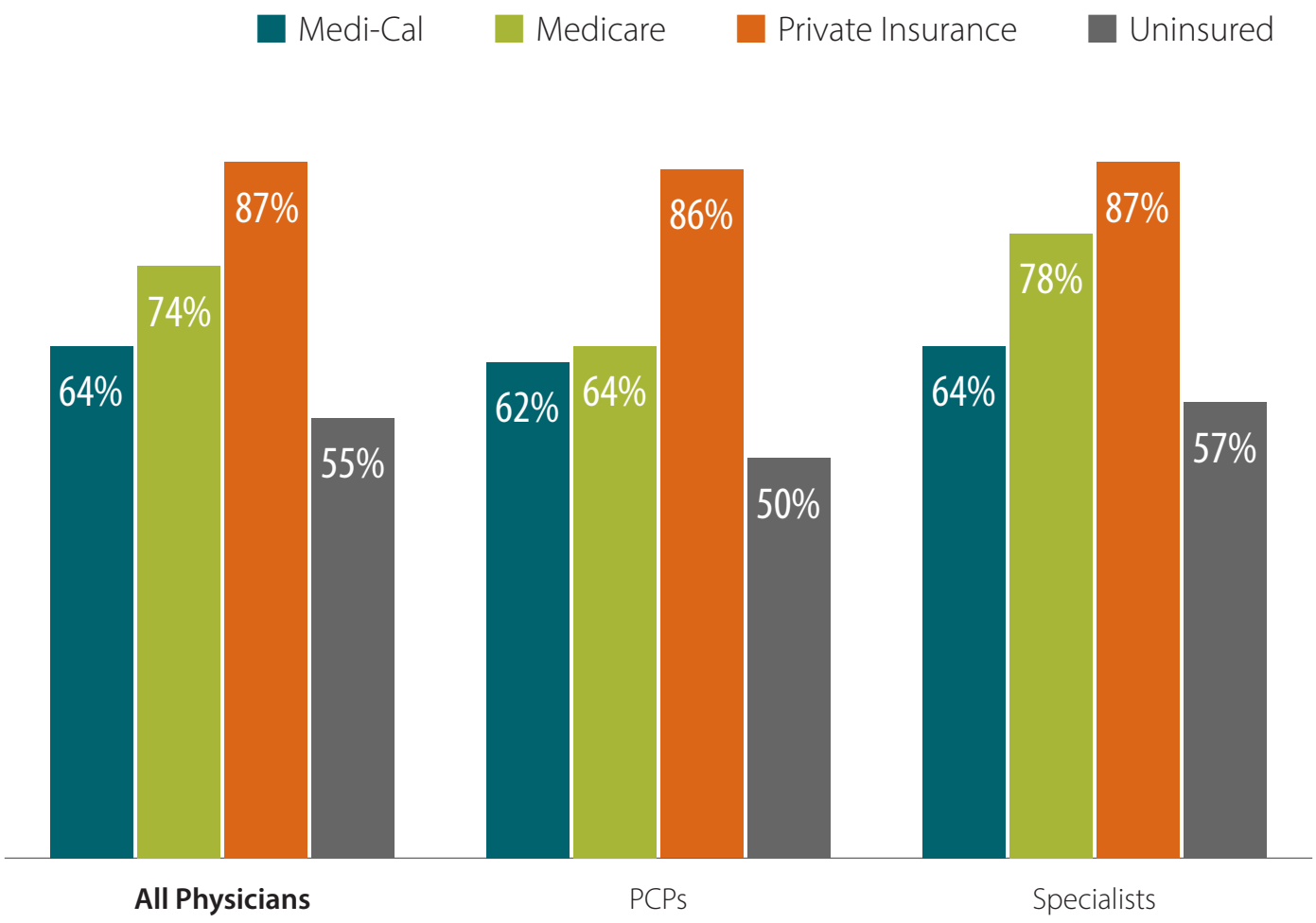


Notes: Data include MDs with active California licenses, California addresses, and who provided at least 20 hours of patient care per week and are based on a supplemental survey that elicited responses from 8% (approximately 5,200) of the active patient care physicians whose licenses were due for renewal between March and December 2015. Percentages are of those physicians who reported a practice type. *Small/medium group practice* consists of practices with no more than 49 physicians, excluding Kaiser Permanente. *Other* includes community clinics, public clinics, rural clinics, military facilities, Department of Veterans Affairs medical centers, and other settings. One percent of respondents to the supplemental survey did not provide a practice setting. Segments may not total 100% due to rounding.

Source: Voluntary Supplemental Survey (private tabulation), Medical Board of California, 2015.

Most California physicians practice in a group setting. The Kaiser Permanente medical groups, the largest group practices in the state, accounted for over 10% of physicians in four of the nine regions. Solo practices were most prevalent in the Central Coast and in Orange and Los Angeles Counties.

Physicians with Patients in Practice, by Coverage Type
California, 2015



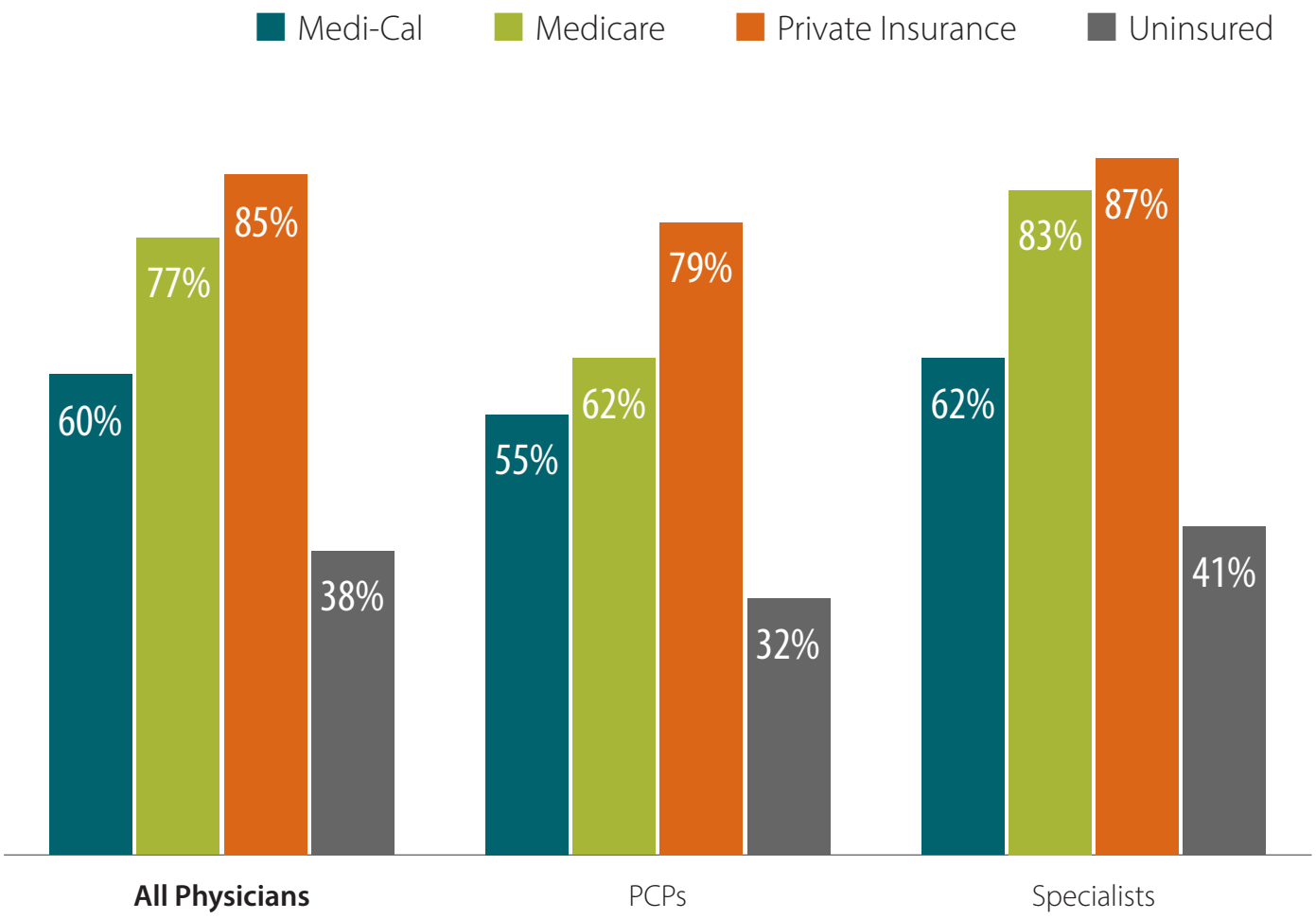
Notes: *PCP* is primary care physician. Data are based on a supplemental survey that elicited responses from 8% of MDs with active California licenses, California addresses, and who provided at least 20 hours of patient care per week whose licenses were due for renewal between March and December 2015. Physicians who reported having any patients in a payer category were included in the reported percentage. All differences are statistically significant at $p < .05$ except for the difference between Medi-Cal and Medicare for primary care physicians.

Source: Voluntary Supplemental Survey (private tabulation), Medical Board of California, 2015.

PCPs and specialists were less likely to have patients who were uninsured than patients with any type of health insurance. About 60% of PCPs and specialists had Medi-Cal patients in 2015.

Physicians Accepting New Patients, by Payer

California, 2015



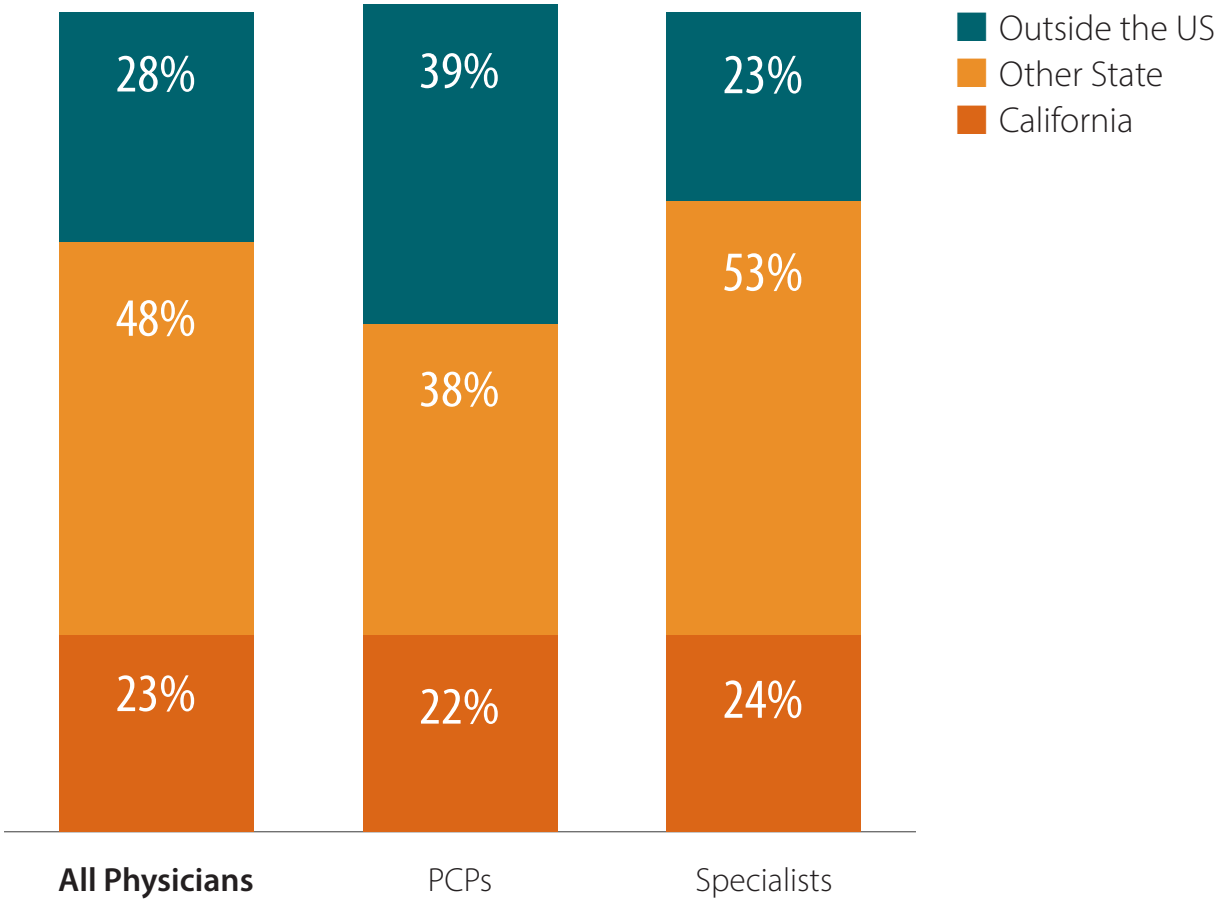
Notes: Data are based on a supplemental survey that elicited responses from 8% of MDs with active California licenses, California addresses, and who provided at least 20 hours of patient care per week whose licenses were due for renewal between March and December 2015. Physicians who reported accepting any new patients in a payer category were included in the reported percentage. All differences across insurance types are statistically significant at $p < .05$.

Source: Voluntary Supplemental Survey (private tabulation), Medical Board of California, 2015.

In 2015, physicians were less likely to accept patients without health insurance than patients with insurance. Physicians of all types were less likely to accept Medi-Cal compared with other types of insurance.

Physicians, by Medical School Location and Specialty

California, 2020



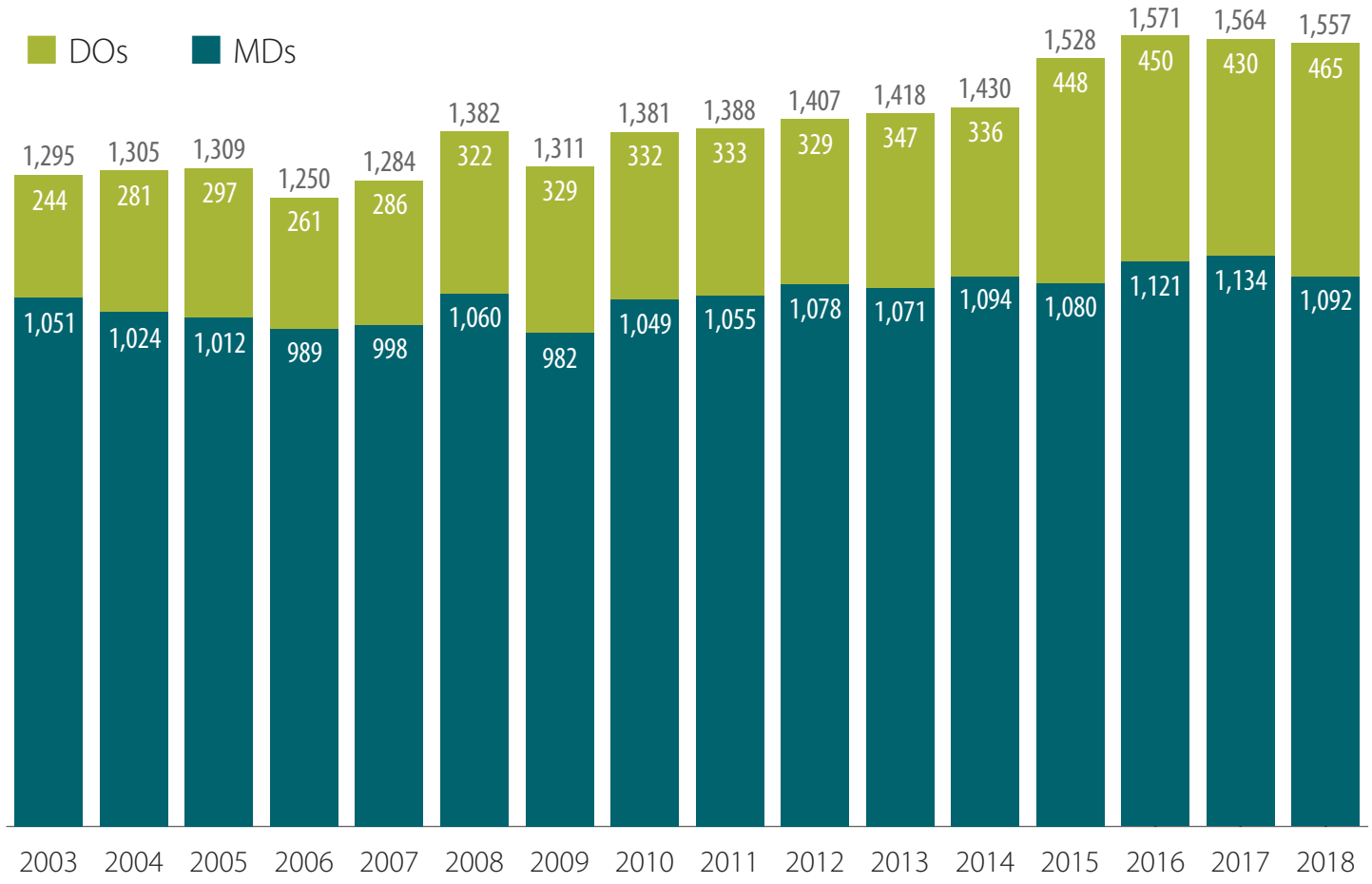
About one-quarter of California's physicians attended medical school in the state. Nearly 40% of the state's primary care physicians graduated from a medical school outside the US.

Notes: Data include MDs who renewed their license between February 2018 and January 2020, had a California address, and provided patient care at least 20 hours per week, and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey or did not answer questions about specialty). Medical school location could not be determined for 58 physicians. Among physicians whose medical school location could be determined, 163 did not report their specialty. Segments may not total 100% due to rounding.

Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

Medical School Graduates, by Degree

California, 2003 to 2018



The number of graduates from California's MD-granting universities grew by 4% between 2003 and 2018. During the same time, doctor of osteopathic medicine (DO) graduates increased by 91%. The number of medical school graduates will likely increase because three medical schools have opened since 2018, two of which grant the MD degree and one of which grants the DO degree.

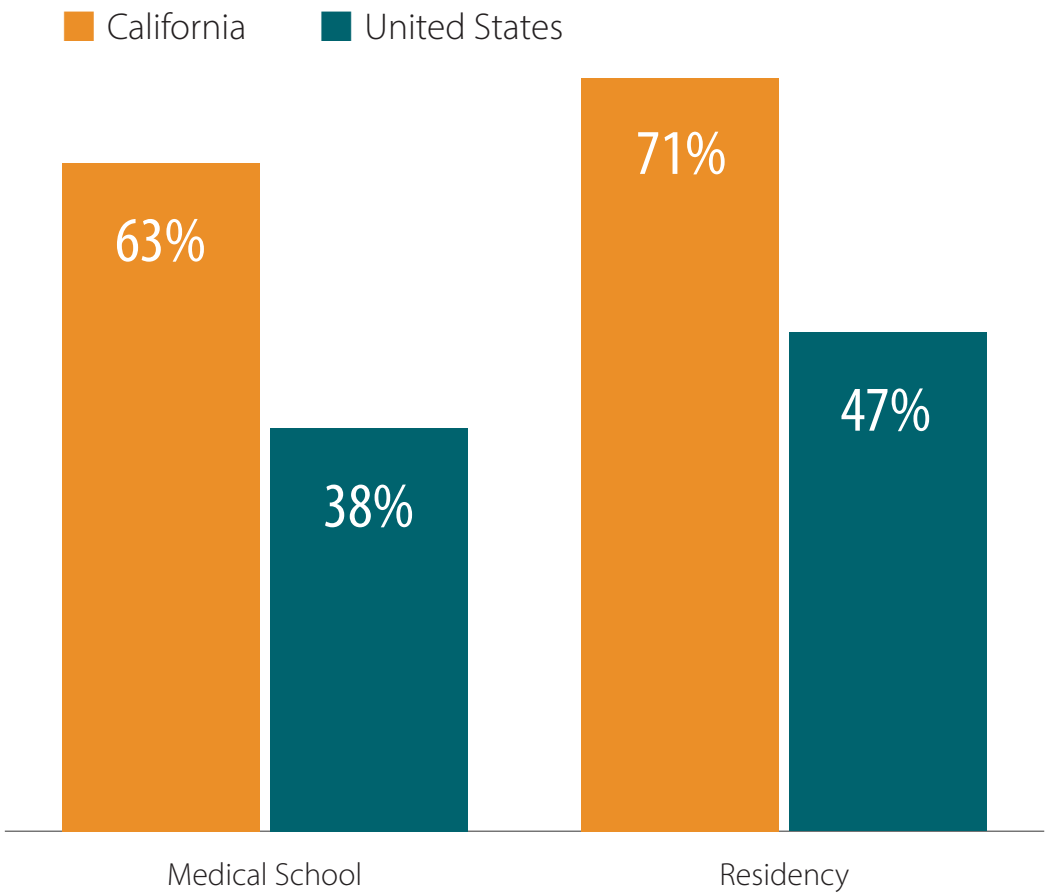
Note: Data include graduates of allopathic (MD) and osteopathic (DO) medical schools.

Sources: *Graduates by Osteopathic Medical College and Gender 2000-18*, American Assn. of Colleges of Osteopathic Medicine, February 11, 2015; *B-2.2: Total Graduates by U.S. Medical School, Sex, and Year, 2010-2011 Through 2014-2015*, Assn. of American Medical Colleges (AAMC), accessed June 16, 2020; and *B-2.2: Total Graduates by U.S. Medical School, Sex, and Year, 2014-2015 Through 2018-2019*, AAMC, October 16, 2019.

Retention of Medical Students and Residents

California vs. United States, 2018

PERCENTAGE OF PHYSICIANS PRACTICING IN SAME STATE WHERE EDUCATED



California retains a relatively high proportion of physicians who completed medical school or residency in the state. In 2018, California ranked first in the nation for the percentages of both medical students and residents who remain in the state to practice.

Note: Data include graduates of allopathic (MD) and osteopathic (DO) medical schools.

Source: *2019 State Physician Workforce Data Report*, Assn. of American Medical Colleges, 2019, tables 4.1, 4.3.

Medical Student Education Debt

United States, 2019

Graduates with Education Debt

Median Total Education Debt
(in thousands)

Note: Education debt include both premedical and medical education debt.

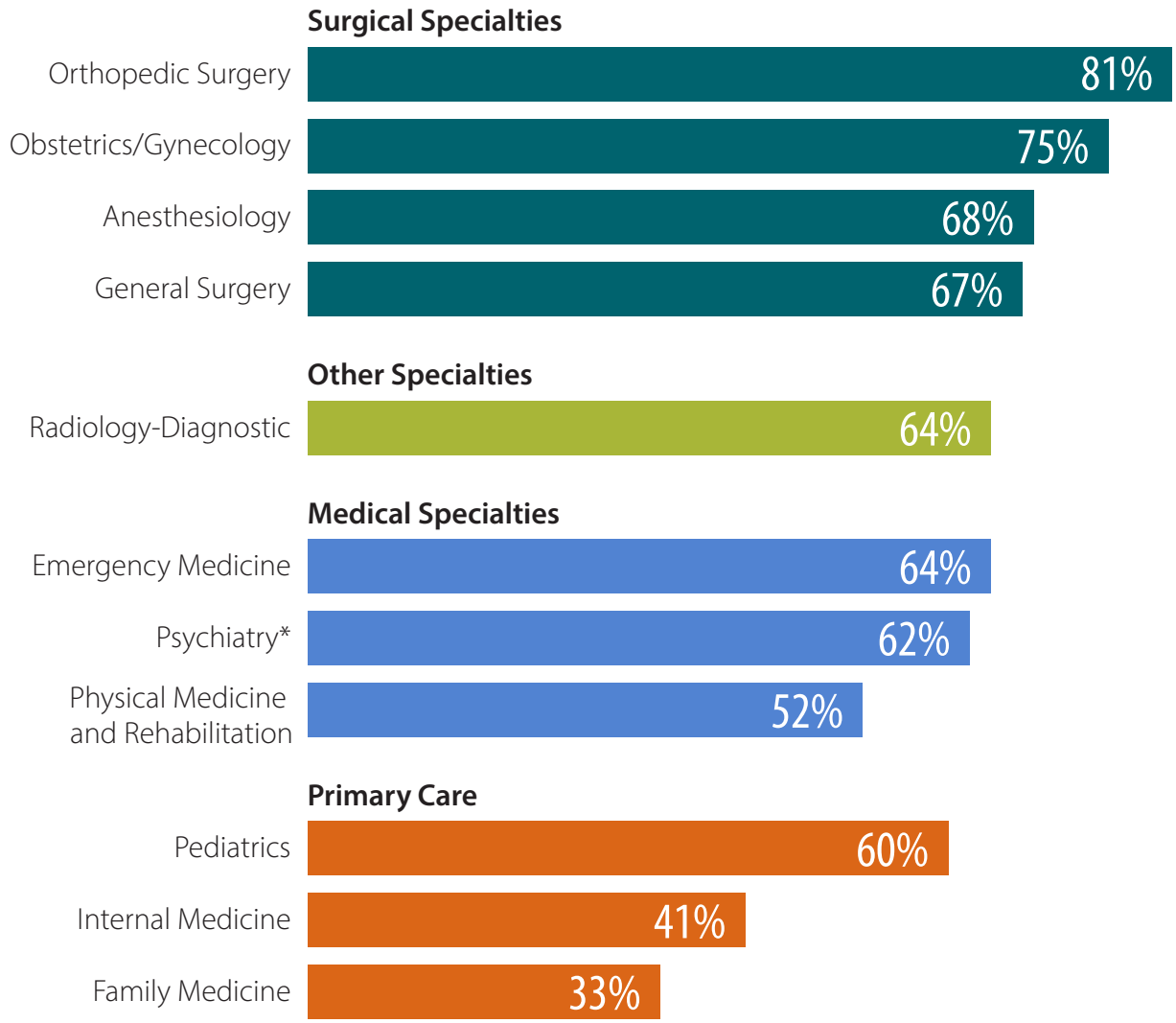
Source: *Medical Student Education: Debt, Costs, and Loan Repayment Fact Card* (PDF), Assn. of American Medical Colleges, October 2019.

Over 70% of all medical school graduates had education debt in 2019. A higher proportion of public medical school graduates had debt than private medical school graduates. However, the median educational debt for graduates of private medical schools was $15,000 higher than for graduates of public medical schools.

Medical School Specialty Choices Compared to Available Slots

United States, 2020

PERCENTAGE OF SENIORS RANKING THIS SPECIALTY ONLY OR FIRST COMPARED TO AVAILABLE SLOTS



*Includes family medicine / psychiatry, internal medicine / psychiatry, pediatrics/psychiatry/child, and psychiatry.

Source: *Results and Data: 2020 Main Residency Match*, National Resident Matching Program, May 2020.

Orthopedic surgery and obstetrics/gynecology were the most popular specialties among US medical school seniors ranking residency choices in 2020. Seniors choosing internal medicine and family medicine as their first or only choice filled just 41% and 33% of the available slots, respectively.

Employed Physician Earnings, Selected Specialties

California, 2015 to 2019, Selected Years

	AVERAGE ANNUAL INCOME (REAL)			% CHANGE
	2015	2017	2019	2015 TO 2019
Primary Care				
Family and General Practitioners	$ 198,380	$ 190,626	$ 188,801	-5%
Internists, General	$ 199,200	$ 193,483	$ 197,335	-1%
Pediatricians, General	$ 197,800	$ 177,616	$ 185,969	-6%
Specialists				
Anesthesiologists	$ 264,040	$ 275,824	N/A	N/A
Obstetricians/Gynecologists	$ 209,100	$ 214,860	$ 219,826	5%
Psychiatrists	$ 250,090	$ 252,222	$ 220,011	-12%
Surgeons	$ 238,440	$ 222,848	$ 230,384	-3%
Consumer Price Index **(2015 = $100,000 base)**	$ 100,000	$ 102,913	$ 107,690	8%

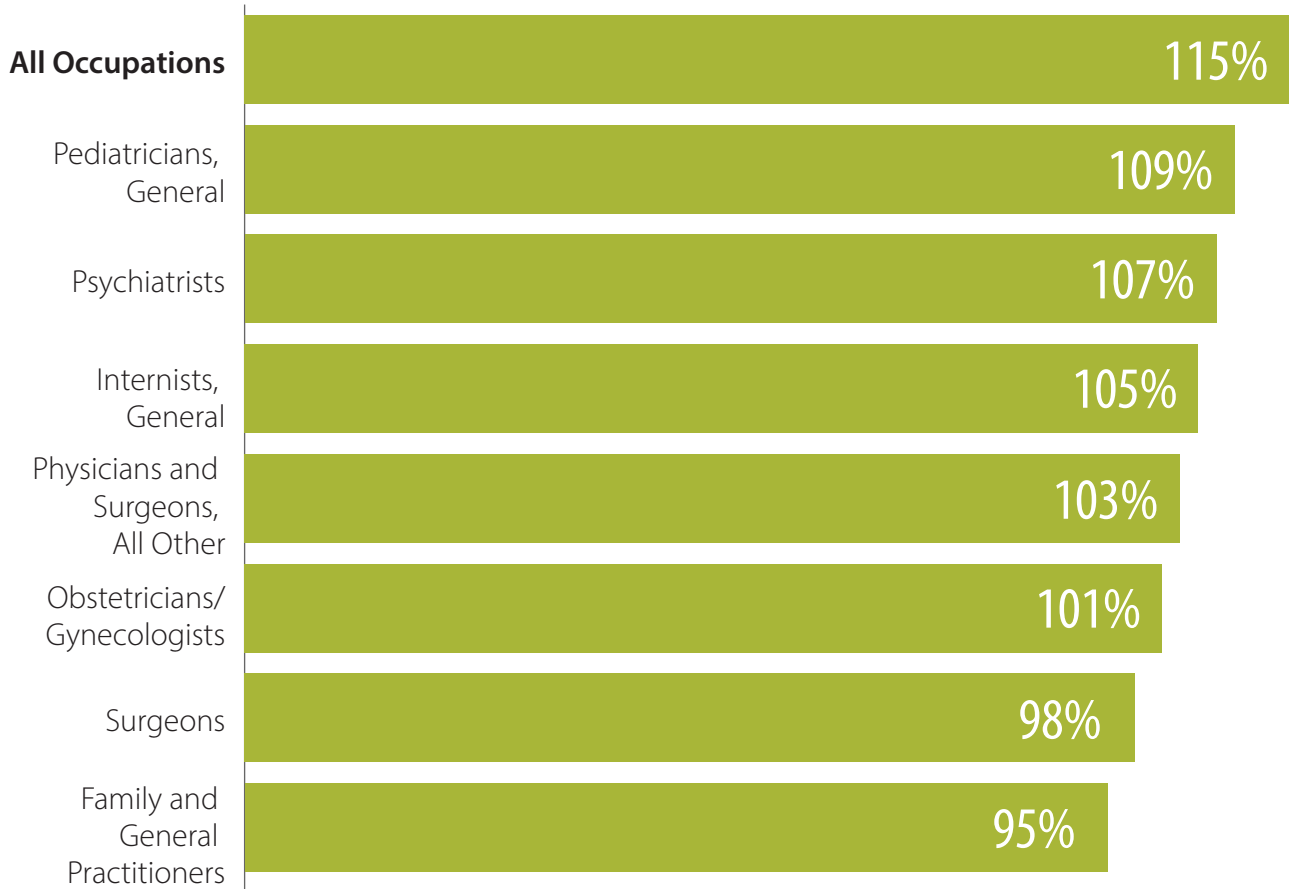
Since 2015, average Incomes for physicians in most specialties have not kept pace with the increase in the Consumer Price Index. Among specialties listed, only obstetricians/gynecologists experienced an increase in real wages. Psychiatrists experienced the largest decrease (—12%).

Notes: Wages were adjusted for inflation using estimates of the change in the Consumer Price Index from May 2015 to May 2017 and from May 2015 to May 2019. Does not include self-employed or government-employed physicians. Does not include ancillary income from sources such as directorships or call coverage. The Bureau of Labor Statistics did not report an estimate of average income for anesthesiologists in California in 2019.

Source: "*Occupational Employment Statistics*," US Bureau of Labor Statistics, accessed May 6, 2020.

Employed Physician Earnings, Selected Specialties
California, 2019

AVERAGE ANNUAL INCOME AS A PERCENTAGE OF NATIONAL AVERAGE



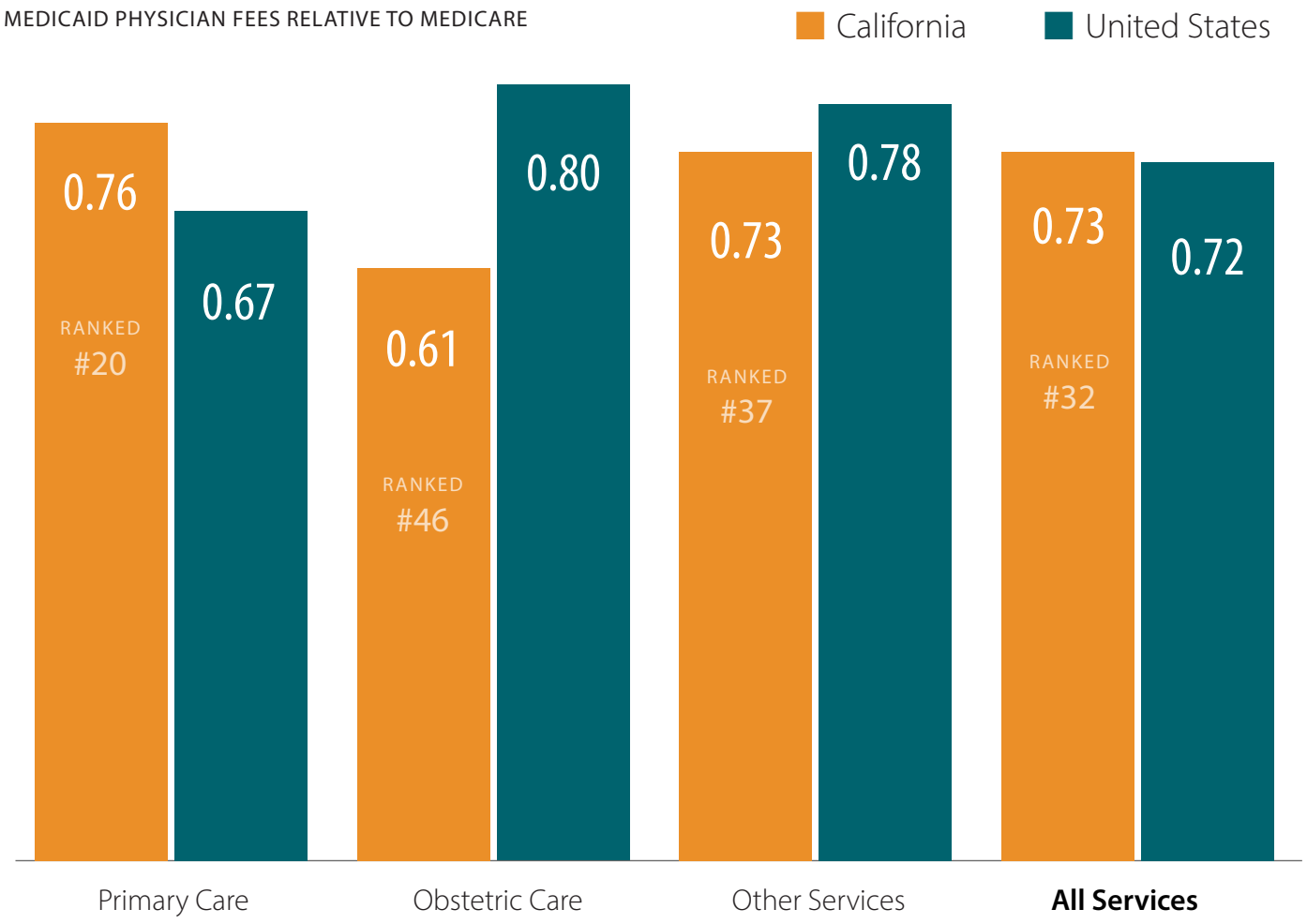
For the specialties shown, the average income for California physicians was near the national average for their specialties in 2019, despite California's higher cost of living.

Note: The Bureau of Labor Statistics did not report an estimate of average income for anesthesiologists in California.

Source: "*Occupational Employment Statistics*," US Bureau of Labor Statistics, accessed April 22, 2020.

Medicaid-Medicare Fee Index

California vs. United States, 2019



Notes: The *Medicaid-to-Medicare fee index* measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute to the 49 states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid.

Source: Stephen Zuckerman, Laura Skopec, and Joshua Aarons, "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019," *Health Affairs* 40, no. 2 (Feb. 2021): 343–48, doi:10.1377/hlthaff.2020.00611.

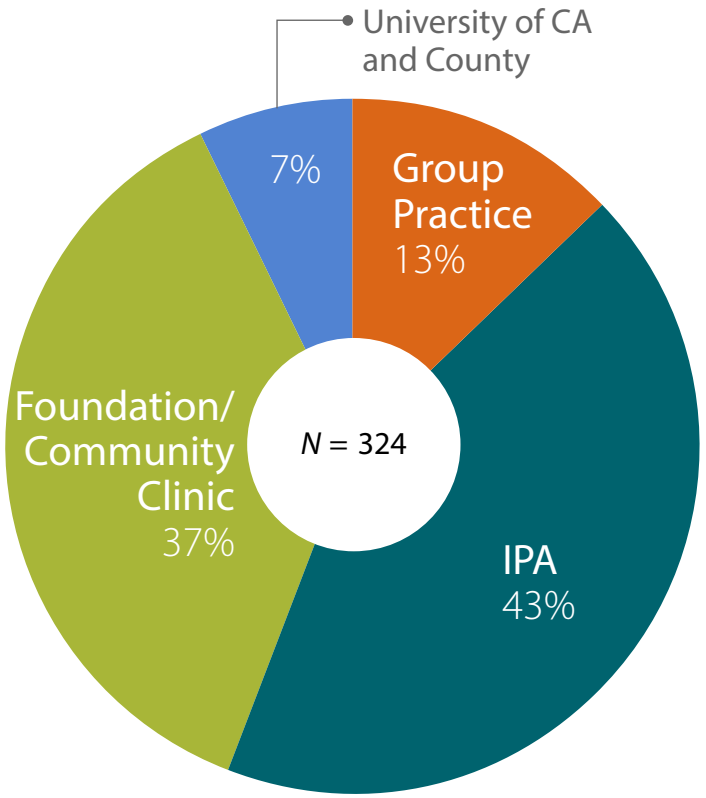
Physicians
Income

Medi-Cal, California's Medicaid program, paid physicians substantially less than Medicare and less than Medicaid programs in most other states. Overall, Medi-Cal paid physicians only 73% of what Medicare paid them. It ranked 46th among all states in the ratio of Medicaid fees to Medicare fees for obstetrical care.

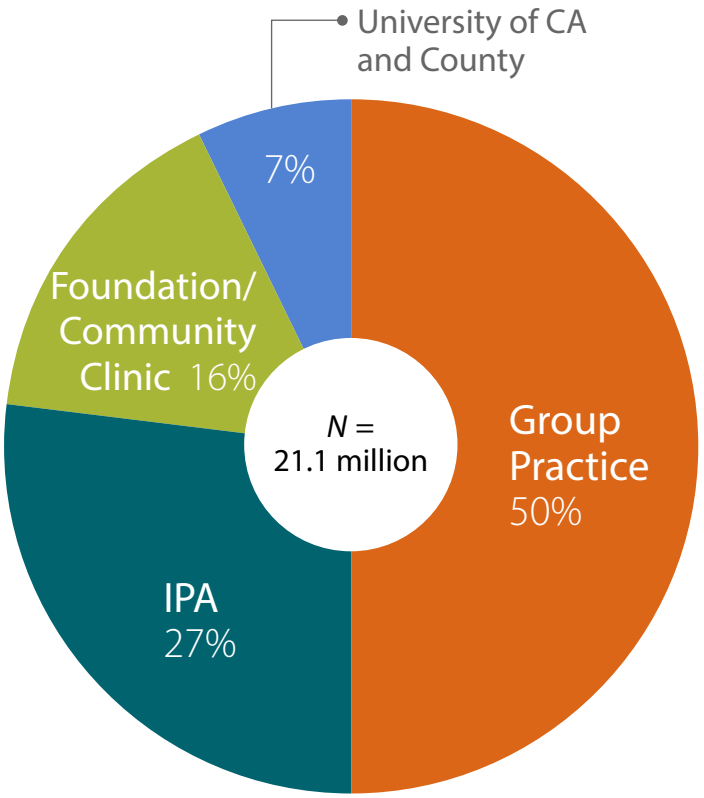
Medical Groups, by Type and HMO Enrollment

California, 2019

Prevalence of Group



HMO Enrollment



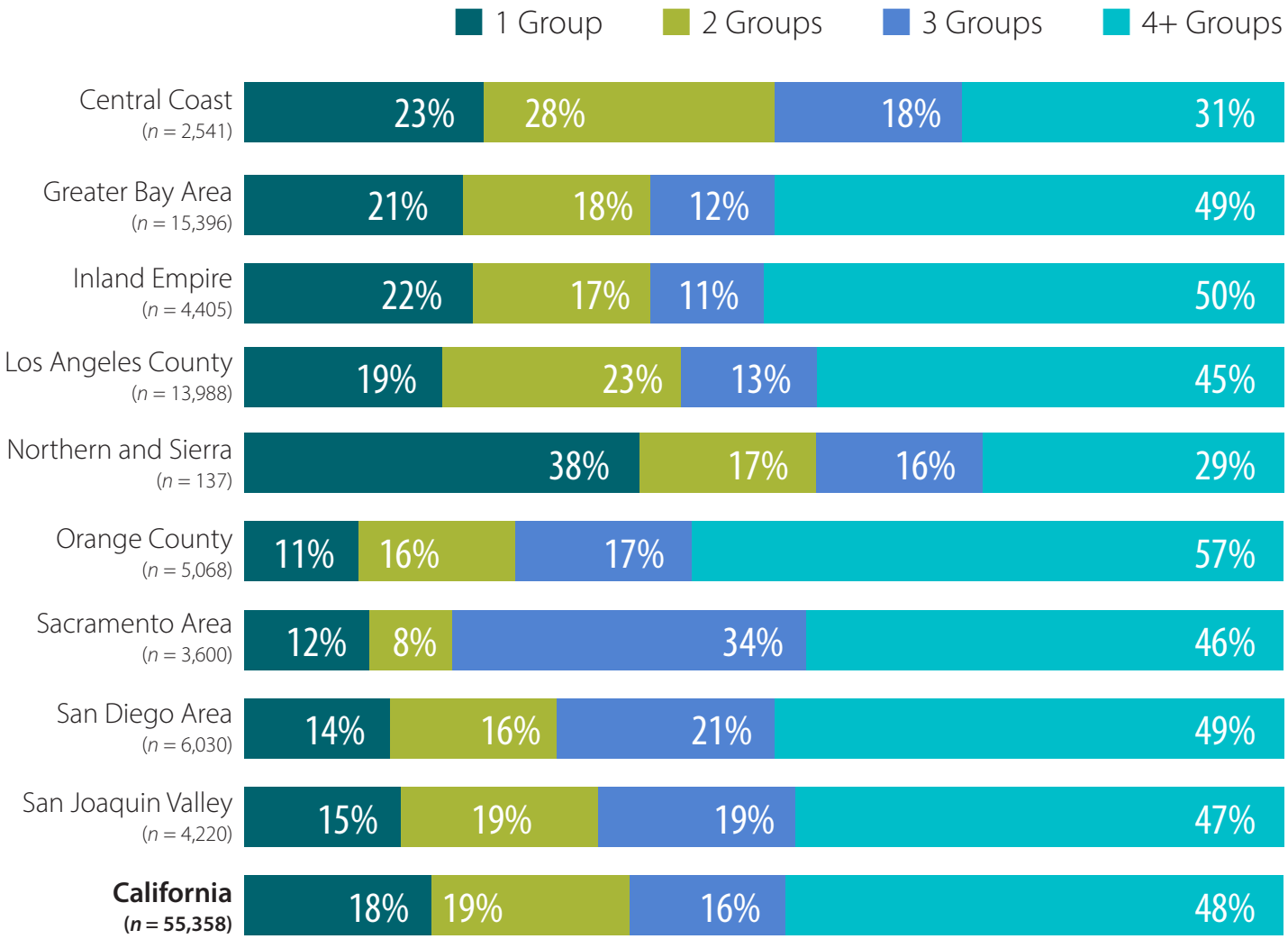
In 2019, over 300 medical groups provided care to 21 million Californians enrolled in HMOs. While 43% of these medical groups were IPAs, they accounted for only 27% of enrollment. In contrast, group practices, which include the Permanente Medical Groups, represented only 13% of medical groups but 50% of enrollment.

Notes: *HMO* is health maintenance organization. *IPA* is independent practice association. Data include medical groups with at least six primary care physicians (PCPs) that accept contracts directly from HMOs. *Group practice* includes Kaiser Permanente Medical Groups. Physicians frequently participate in more than one IPA. See Appendix B for definitions of medical groups. Segments may not add to 100% due to rounding.

Source: *#1 – The Active California Medical Group Market* (as of Mar. 15, 2019), Cattaneo & Stroud, n.d.

Physician Participation in HMO Medical Groups, by Region

California, 2018



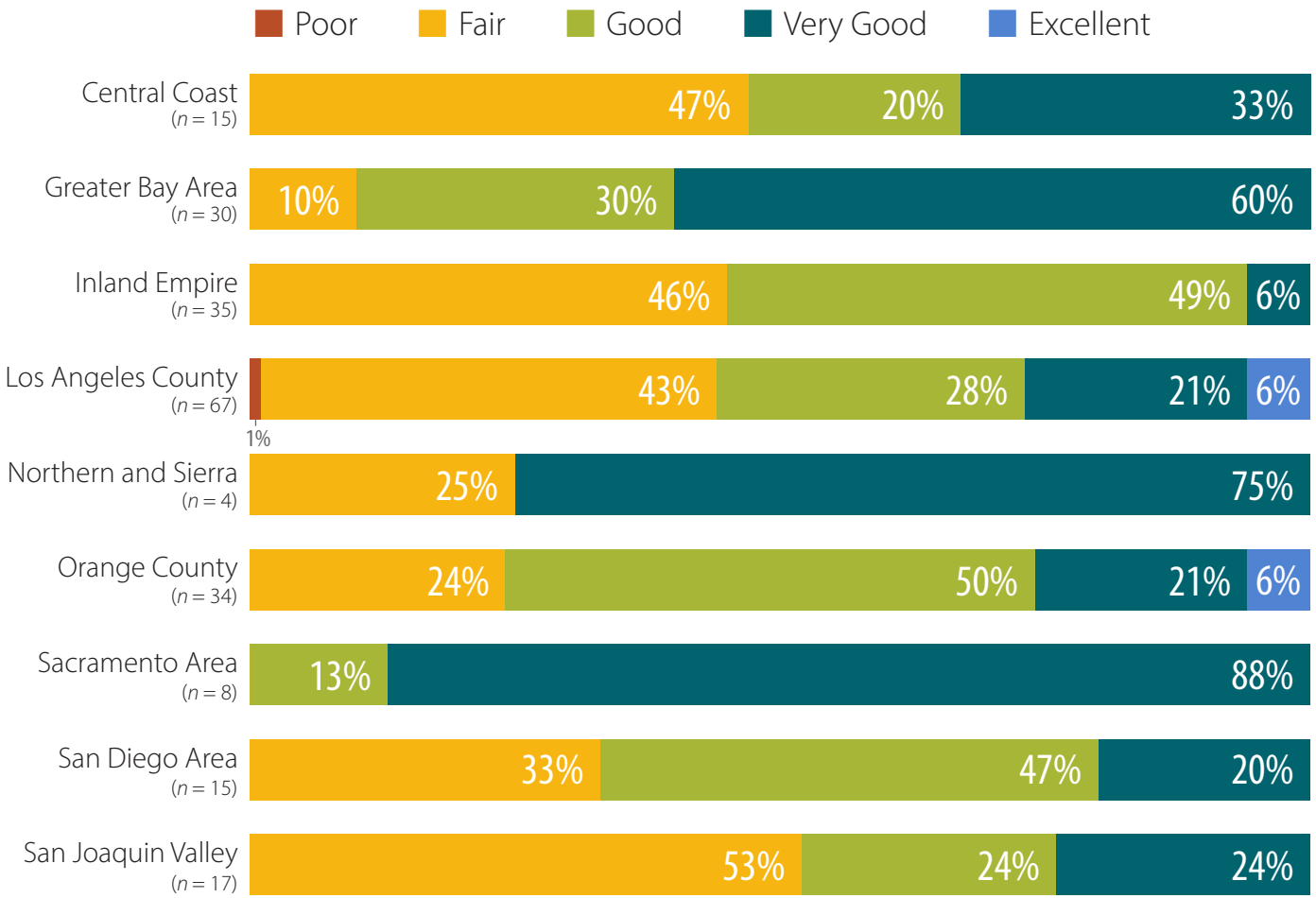
Notes: *HMO* is health maintenance organization. Data include physicians who reported California licenses and valid medical groups. Excludes physicians in the Permanente Medical Group and physicians who work for the Department of Veterans Affairs, correctional facilities, and other entities that do not contract with HMOs. Segments may not add to 100% due to rounding. See Appendix A for a list of counties within each region.

Source: Public records request (private tabulation), Dept. of Managed Health Care, 2018.

Among California physicians who contract with HMOs, physicians in the Northern and Sierra region were less likely in 2018 to participate in multiple medical groups than those in other parts of the state.

Medical Groups Meeting National Standards of Care, by Region

California, 2018



Notes: Performance results are reported for physician organizations with commercial HMO health plan members. Each medical group's patient records are compared annually to a set of national standards for quality of care to ensure that medical groups are offering quality preventive care to members. Quality measures include immunizations for children, diabetes care, and cancer screening. Each group is awarded an aggregate quality score of excellent, very good, good, fair, or poor. Segments may not add to 100% due to rounding. Medical groups unwilling to report or who had too few patients to report were omitted from the analysis. See Appendix A for a list of counties within each region.

Source: "Medical Group Report Card for Commercial HMO Plan Members," Office of the Patient Advocate, accessed May 15, 2020.

Los Angeles County and Orange County were the only regions in 2018 with any medical groups whose quality of care was rated excellent. The quality of care provided by more than half of the medical groups in the San Joaquin Valley was rated fair.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

AUTHORS

Janet M. Coffman, MPP, PhD

Emmie Calimlim, MPH

Margaret Fix, MPH

Healthforce Center and Philip R. Lee Institute for Health Policy Studies

University of California, San Francisco

FOR MORE INFORMATION

California Health Care Foundation

1438 Webster Street, Suite 400

Oakland, CA 94612

510.238.1040

www.chcf.org

Appendix A: California Counties Included in Regions

REGION	COUNTIES
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Greater Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Inland Empire	Riverside, San Bernardino
Los Angeles County	Los Angeles
Northern and Sierra	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Orange County	Orange
Sacramento Area	El Dorado, Placer, Sacramento, Yolo
San Diego Area	Imperial, San Diego
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare

Appendix B: Definitions

Medical Groups

Medical groups are organized and managed differently:

- **Community clinic.** A clinic that operates under California Health and Safety Code 1204(a), which requires that it provide care to low-income and underserved populations, and charge fees based on patients' ability to pay. A community clinic is operated by a tax-exempt nonprofit corporation and is supported by either public or private donations and contributions.
- **County group.** A county-formed group of physicians that typically provides services through the county health department.
- **Foundation.** A type of group practice under California Health and Safety Code 1206(l), which stipulates that a medical foundation must operate a nonprofit, tax-exempt clinic, conducting research as well as providing patient care and health education. The foundation must have at least 40 physicians, at least 10 of whom have to be board-certified, and at least two-thirds of all physicians must practice on a full-time basis at the clinic. The physicians are independent contractors to the foundation, but the foundation owns the facilities, equipment, and supplies, and employs all nonphysician personnel.
- **Group practice.** A corporation, foundation, partnership, or other type of organization formed for the purpose of providing patient care. Group practices are more regulated than IPAs. To be recognized by the Center for Medicare & Medicaid Services as a group practice, the organization must direct the majority of its physicians' bills through the organization, pay for its own overhead, and follow other regulations specified under California Health and Safety Code 1206(l).
- **Independent practice association (IPA).** An association that contracts with independent physician practices so that they may work together as one when contracting with HMOs and other payers.
- **University of California Medical Center.** A medical group operated by the University of California as part of one of its medical schools.

Physicians

Physician classifications can differ between organizations. This report relies on two organizations for physician counts: the American Medical Association (AMA) and the Medical Board of California (MBC).

Active physicians are licensed physicians who are:

- Not retired, semiretired, working part-time, temporarily not in practice, or not active for other reasons and who work 20 or more hours per week (AMA)
- Currently licensed (MBC)

Active patient care physicians are active physicians who:

- Identify their major professional activity as direct patient care (AMA)
- Provide patient care at least 20 hours per week (MBC)

Primary care physicians (PCPs) are those physicians whose primary specialty is:

- Family medicine / general practice, internal medicine, or pediatrics, including the respective subspecialties (AMA)
- Family medicine, internal medicine, general pediatrics, or geriatrics and do not have a secondary specialty that suggests they may provide specialty care (MBC)

Specialists are those physicians whose primary specialty is not considered primary care. (MBC)

Appendix C: Physicians per 100,000 Population, by County, California

	NON-PRIMARY CARE	PRIMARY CARE	UN-KNOWN	TOTAL
Alameda	2,396	1,301	6	**3,703**
Alpine	0	0	0	**0**
Amador	32	30	0	**62**
Butte	285	107	0	**392**
Calaveras	15	13	0	**28**
Colusa	8	3	0	**11**
Contra Costa	1,543	882	8	**2,433**
Del Norte	13	13	0	**26**
El Dorado	144	80	1	**225**
Fresno	980	521	3	**1,504**
Glenn	2	5	0	**7**
Humboldt	139	67	0	**206**
Imperial	101	48	1	**150**
Inyo	23	11	0	**34**
Kern	633	363	0	**996**
Kings	69	53	1	**123**
Lake	43	24	0	**67**
Lassen	21	13	0	**34**
Los Angeles	14,059	5,776	39	**19,874**
Madera	173	75	0	**248**
Marin	526	222	0	**748**
Mariposa	4	3	0	**7**
Mendocino	77	49	1	**127**
Merced	114	74	0	**188**
Modoc	7	2	0	**9**
Mono	28	6	0	**34**
Monterey	453	217	4	**674**
Napa	217	97	0	**314**
Nevada	107	55	0	**162**
Orange	4,408	1,928	13	**6,349**
Placer	694	361	2	**1,057**
Plumas	20	6	0	**26**
Riverside	1,771	940	9	**2,720**
Sacramento	2,380	1,012	3	**3,395**
San Benito	32	12	0	**44**
San Bernardino	2,103	990	13	**3,106**
San Diego	4,954	2,083	12	**7,049**
San Francisco	2,539	894	10	**3,443**
San Joaquin	619	419	3	**1,041**
San Luis Obispo	382	150	1	**533**
San Mateo	1,247	556	4	**1,807**
Santa Barbara	611	260	2	**873**
Santa Clara	3,665	1,601	10	**5,276**
Santa Cruz	293	199	3	**495**
Shasta	212	104	2	**318**
Sierra	1	1	0	**2**
Siskiyou	34	20	0	**54**
Solano	604	305	0	**909**
Sonoma	671	367	2	**1,040**
Stanislaus	586	332	2	**920**
Sutter	93	56	0	**149**
Tehama	19	27	0	**46**
Trinity	2	1	1	**4**
Tulare	267	181	0	**448**
Tuolumne	63	39	2	**104**
Ventura	984	519	3	**1,506**
Yolo	178	109	2	**289**
Yuba	38	22	0	**60**
Unknown	11	8	0	**19**
Total	51,693	23,612	163	**75,468**

Notes: Data include MDs who renewed their license between February 2018 and January 2020, had a California address, provided patient care at least 20 hours per week and exclude residents, fellows, and nonrespondents (i.e., those MDs who did not respond to the Medical Board of California survey).

Source: Survey of Licensees (private tabulation), Medical Board of California, January 2020.

CALIFORNIA

Health Care Almanac

CHCF

AUGUST 2021

Medi-Cal Facts and Figures:

Essential Source of Coverage for Millions

Back to Agenda

Executive Summary

Medi-Cal, California's Medicaid program, is the state's health insurance program for Californians with low income, including nearly 4 in 10 children, one in five nonelderly adults, and two million seniors and people with disabilities. It also pays for more than 50% of all births in the state and 55% of all patient days in long-term care facilities.* In total, over 13 million Californians — one in three — rely on the program for health coverage. Medi-Cal pays for essential primary, specialty, acute, behavioral health, and long-term care services.

The Affordable Care Act allowed states the option to expand Medicaid, and California added over four million adults with low income to the program. Using only state resources, California also expanded Medi-Cal to cover three groups in households with low income regardless of immigration status: children, adults under 26, and in 2022, adults age 50 and over.

Medi-Cal Facts and Figures: Essential Source of Coverage for Millions presents findings about the Medi-Cal program based on the most recent data available.

KEY FINDINGS INCLUDE:

- In fiscal year 2019–20, Medi-Cal brought in more than $65 billion in federal funds and accounted for nearly 16% of all state general fund spending.
- People with disabilities composed 9% of Medi-Cal enrollees, but accounted for 31% of spending. Meanwhile, children accounted for 17% of enrollees, but just 6% of spending.
- 85% of people served by Medi-Cal were enrolled in one of six managed care models.
- More than three out of four Medi-Cal enrollees are in households where they or another family member works part- or full-time.
- Starting in March 2020, the COVID-19 pandemic, ensuing economic downturn, and related policy changes resulted in hundreds of thousands of people enrolling in, or retaining, Medi-Cal coverage.
- The state has proposed innovations and changes aimed at improving care for Medi-Cal members.

The Medi-Cal program faces numerous changes in the coming years, including procuring new contracts with managed care plans, which provide services to 11 million Medi-Cal enrollees in all 58 counties, and transitioning pharmaceutical benefits from managed care plans to the centralized Medi-Cal Rx program. Medi-Cal will also address the needs and costs of an aging population and implement strategies to address disparities in access, quality, and outcomes of care for enrollees of color.

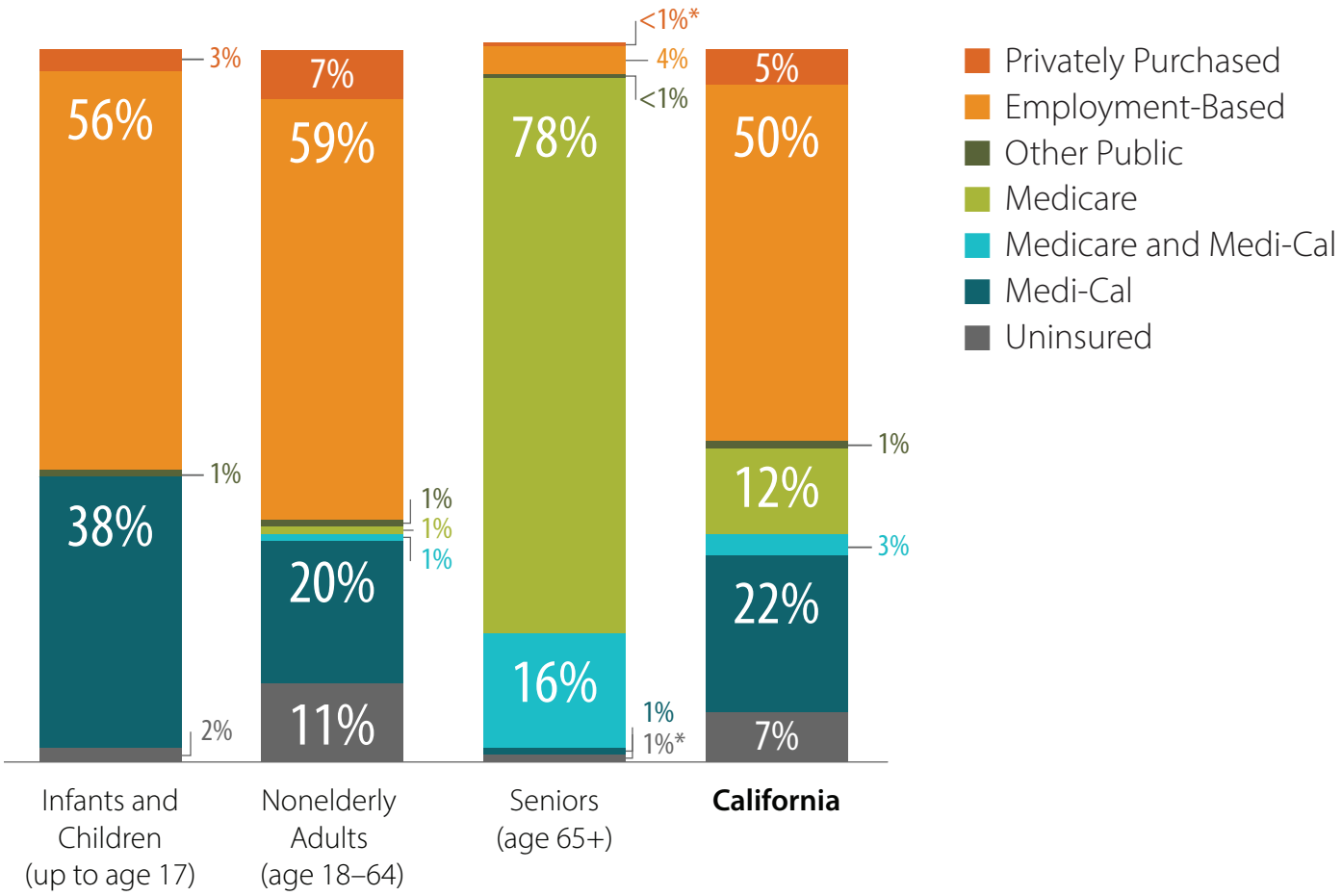
* Fee-for-service only. Does not include patient days paid through Medi-Cal managed care contracts.

Note: See the current and past editions of *Medi-Cal Facts and Figures* at www.chcf.org/collection/medi-cal-facts-figures-almanac.

CONTENTS

Sources of Insurance Coverage, by Age Group

California, 2019



* Indicates that results are statistically unstable.

Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported they have Medi-Cal coverage only, and may include those with restricted-scope benefits. See "About the Data" on page 69 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other. *Privately purchased* includes those that purchased health insurance directly from an insurance company or HMO, or through Covered California. *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents. Percentages may not add to 100% due to rounding.

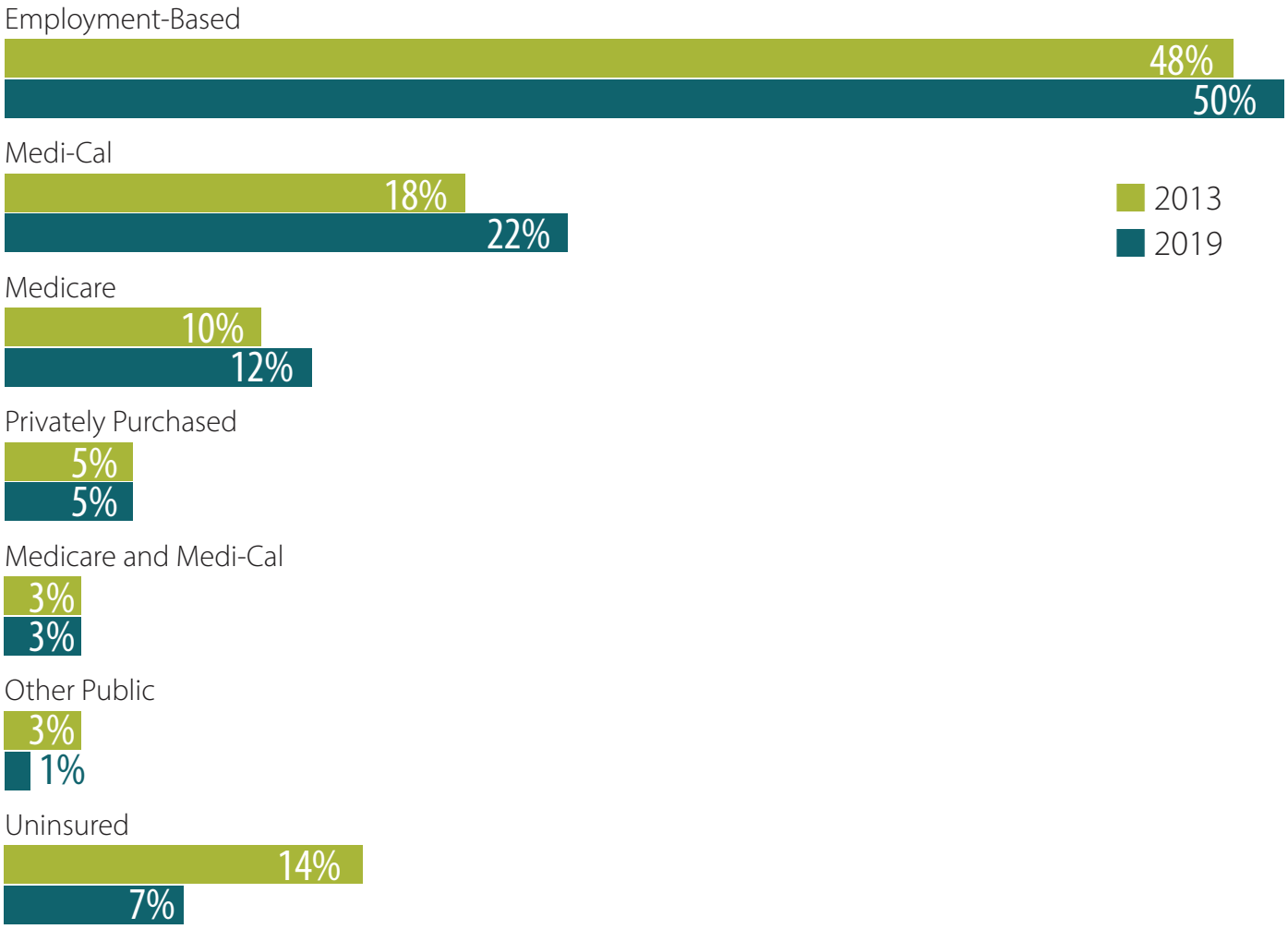
Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal is an important source of health care coverage for Californians of all ages. According to the California Health Interview Survey, nearly 40% of all children in the state, and one in five nonelderly adults, were covered by Medi-Cal. Almost all seniors are eligible for Medicare, and 16% of Californians over age 65 are reportedly also covered by Medi-Cal (known as "dually eligible enrollees").

For more information, see *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.

Health Insurance, by Source of Coverage

California, 2013 and 2019

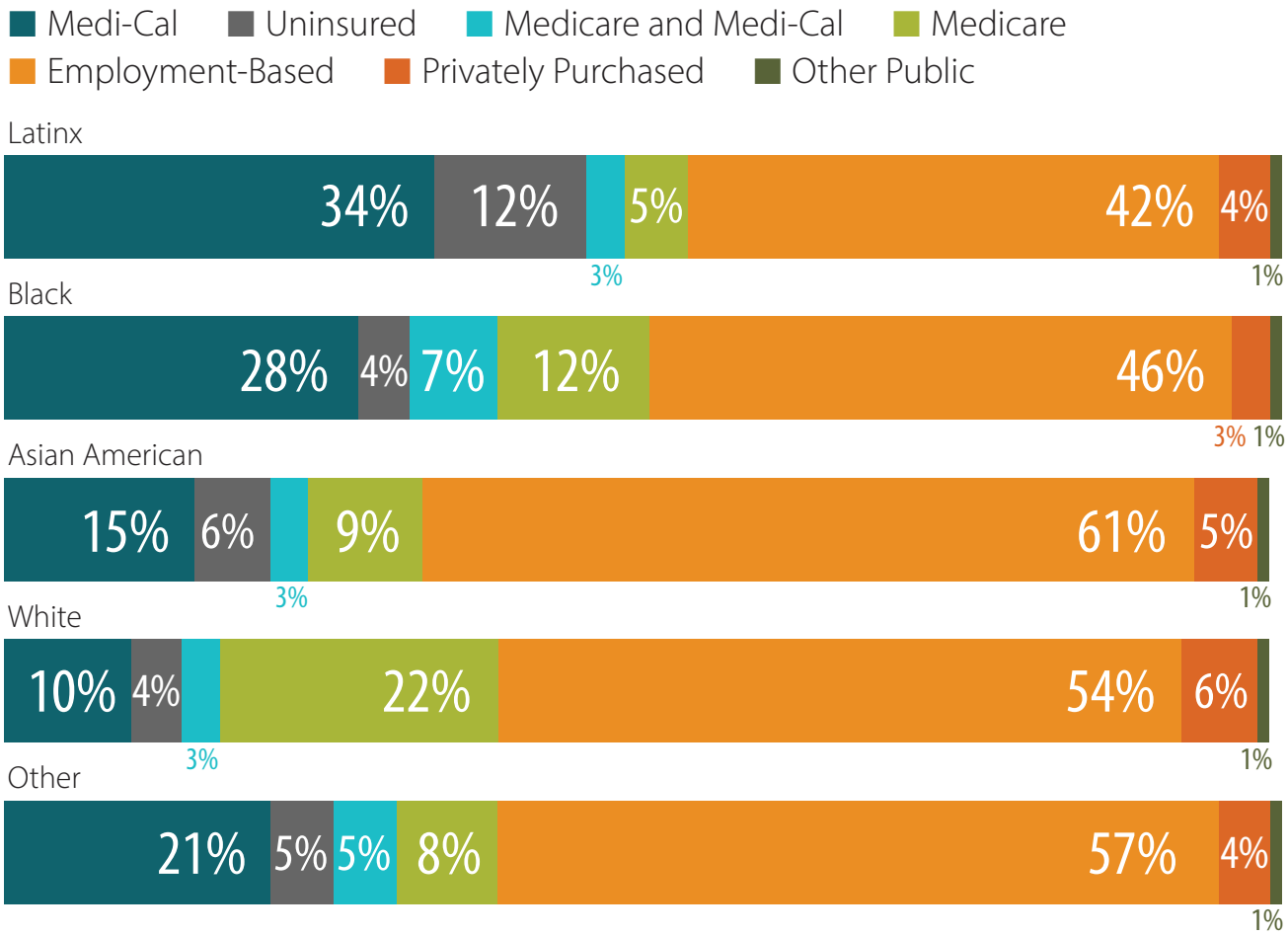


Notes: Insurance status is self-reported. *Medi-Cal* includes those who reported they had Healthy Families (2013) and may include those with restricted-scope benefits. See "About the Data" on page 69 for a full explanation of how this could impact findings. *Medicare* includes people who have only Medicare as well as Medicare and other (not Medi-Cal). *Other public* includes those enrolled in county indigent programs and those with coverage for military personnel, retirees, and dependents.

Source: 2019 and 2013 California Health Interview Survey, UCLA Center for Health Policy Research.

Between 2013 and 2019, the distribution of health insurance coverage shifted, due in part to the implementation of the Affordable Care Act in 2014. The percentage of Californians who reported being enrolled in Medi-Cal increased from 18% to 22%, while the percentage of Californians who were uninsured decreased from 14% to 7%.

Health Insurance Coverage, by Race/Ethnicity, 2019



Medi-Cal provided health insurance coverage for about one-third of Latinx Californians. Similarly, 28% of Black Californians were covered by Medi-Cal.

Notes: Insurance coverage is self-reported. See "About the Data" on page 69 for a full explanation of how this could impact findings. *Other* includes those of two or more races, Native Hawaiian / Pacific Islander, and American Indian / Alaska Native. Source uses *Black or African American* and *Asian*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

About Medicaid

- Federal program created by Title XIX of the Social Security Act in 1965. In California, the program is called Medi-Cal.
- Provides health care coverage to 69 million Americans, including children in families with low incomes, parents, seniors, people with disabilities, and adults with low incomes.
- Each state administers its program within federal rules, and financing is shared between state and federal governments. The program must provide benefits to certain mandatory groups meeting eligibility requirements.
- Medicaid programs vary significantly across the nation, as states have the option to cover additional groups and use waivers to amend some eligibility requirements, use different care delivery and payment models, and develop other innovations.
- Eligibility was expanded to adults with low incomes under the Patient Protection and Affordable Care Act (ACA), passed in 2010 and implemented in 2014. Enrollment has grown by 14.8 million in the 39 states that chose this option.
- Nationwide Medicaid expenditures, including both federal and state funds, totaled $604 billion in 2019.

Sources: "Program History," Centers for Medicare & Medicaid Services (CMS); "Medicaid Expansion Enrollment" (June 2019), KFF; "Updated July 2020 Applications, Eligibility, and Enrollment Data," CMS, last updated April 2, 2021; "Status of State Medicaid Expansion Decisions: Interactive Map," KFF, last updated May 10, 2021; and "Total Medicaid Spending" (FY 2019), KFF, accessed October 29, 2020.

The Affordable Care Act gave states the option to expand the program significantly. Medicaid served 69 million people nationwide in 2020.

About Medi-Cal

- A source of health care coverage for:
  - Nearly one in three Californians
  - Nearly 40% of the state's children
  - 43% of people with disabilities
  - About one in six of all California workers age 19 to 64
- Pays for:
  - More than 50% of all births in the state
  - 55% of all patient days in long-term care facilities*
- Medi-Cal accounts for nearly two-thirds of net patient revenues in California's city/county hospitals and nearly 75% of net patient revenues for primary care clinics.
- Medi-Cal brought in $65 billion in federal funds in FY 2019–20.
- Medi-Cal enrollment increased by more than 700,000 between March and December 2020 during the COVID-19 pandemic and economic downturn.

Medi-Cal plays a major role in the health care system, providing insurance for one-third of all Californians. California has the nation's largest Medicaid program.

* Medi-Cal patient days are fee-for-service only and do not include patient days paid through Medi-Cal managed care contracts.

Sources: "Month of Eligibility, Dual Status, by County, Medi-Cal Certified Eligibility," California Dept. of Health and Human Services (CHHS), last updated April 27, 2021; *Medicaid in California* (PDF), KFF, October 2019; *Medi-Cal Explained Fact Sheets: Maternity Care and Paying for Maternity Services*, California Health Care Foundation, September 2020; "Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report Data & Pivot Tables" (2019), CHHS; "Hospital Annual Financial Data - Selected Data & Pivot Tables" (2019), CHHS; "Primary Care Clinic Annual Utilization Data" (2019), CHHS; and *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), DHCS, accessed August 6, 2020.

Medi-Cal vs. Medicare

	MEDI-CAL	MEDICARE
Population	Children in families with low incomes and adults with low incomes, including but not limited to: • People who are pregnant • People with disabilities • Seniors (65+) with low incomes • Children, regardless of immigration status	• Seniors (65+) • People with permanent disabilities • People with end-stage renal disease
Enrollment	13.6 million Californians	6.4 million Californians
Services Covered	Primary care, specialty care, acute care, long-term care, and mental health and substance use disorder services	Primary, specialty, and acute care
Cost Sharing	No premiums or copayments for enrollees with the lowest incomes	Enrollees must pay premiums and deductibles
Funded By	Federal, state, and county governments	Federal government and enrollees
Administered By	California with oversight by CMS	Federal government through CMS

Note: *CMS* is Centers for Medicare & Medicaid Services.

Sources: *Medi-Cal Monthly Eligible Fast Facts, January 2021.* (PDF), California Dept. of Health Care Services, April 2021; and "Total Number of Medicare Beneficiaries" (2020), KFF.

Medi-Cal and Medicare provide coverage to different populations, cover different services, and are administered separately. However, 1.4 million California seniors and people with disabilities are eligible for both Medi-Cal and Medicare; they are referred to as "dually eligible enrollees."*

* For more information, see *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, CHCF, September 2020.

Medi-Cal and the COVID-19 Pandemic

As of March 2021, a year after a state of emergency was declared, more than 3.5 million Californians have been diagnosed with COVID-19, and over 54,000 have died from the disease. The pandemic dramatically reduced economic activity, resulting in increased unemployment. Unemployment skyrocketed from 4.3% in February 2020 to 16.4% in May 2020. It has since declined but remained high at 9.0% in December 2020. The Medi-Cal program played a critical role in providing health services to those Californians most affected by the pandemic.

As of April 2021, Latinx Californians represented 56% of cases and 47% of deaths. Medi-Cal provides health insurance coverage to 34% of all Latinx Californians.

Black Californians represent 4% of cases and 6% of deaths, and 28% of Black Californians are enrolled in Medi-Cal.

Nursing home residents represent 24% of all deaths from COVID-19 in the state, and Medi-Cal paid for 55% of patient days in long-term care facilities.

Between March and December 2020, Medi-Cal enrollment increased 8% or just over 1 million.* During the same period in 2019, enrollment decreased by 2%.

The COVID-19 pandemic has had deep social, public health, and economic impacts on California. Medi-Cal provides health services for those disproportionately impacted by the pandemic: Latinx Californians and residents of long-term care facilities.

* It is likely that most of this enrollment increase has resulted from suspending eligibility redeterminations for current enrollees as directed by Executive Orders N-29-20 and N-71-20 during the COVID-19 public health emergency. DHCS assume that about 104,000 enrollees lose eligibility each month and would continue on Medi-Cal due to the redetermination suspension.

Sources: "COVID-19: California Case Statistics," California Dept. of Public Health, accessed March 9, 2020; "Tracking the Coronavirus in California Nursing Homes," *Los Angeles Times*, accessed March 9, 2021; *Medi-Cal Enrollment Update* (PDF), California Dept. of Health Care Services (DHCS), April 8, 2021; Exec. Order N-29-20 (PDF), State of California, March 17, 2020; Exec. Order N-71-20 (PDF), State of California, June 30, 2020; and Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21, DHCS, accessed July 8, 2021.

Medi-Cal and the COVID-19 Pandemic (continued)

Federal COVID-19 emergency resources and regulatory relief has allowed the Medi-Cal program to temporarily:

- Provide free COVID-19 testing and treatment to those without insurance
- Pay for services delivered via telehealth at the same rates to those delivered in person
- Ease some eligibility and enrollment processes and place a moratorium on redetermining current enrollees' eligibility
- Increase payment rates for some services, notably clinical laboratories and skilled nursing facilities
- Ease limitations on specific services, such as telehealth and substance use disorder services
- Waive requirements such as pre-authorizations and utilization controls

Federal COVID-19 funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act has provided emergency resources to Medi-Cal providers, including those that provide health care services to patients with Medi-Cal.

Federal regulatory flexibilities and funding have allowed Medi-Cal to play an important role in the COVID-19 pandemic response.

Sources: "Federal COVID-19-Related Funding to California," California Legislative Analyst's Office, April 28, 2020; State Plan Amendment #20-0024 (PDF), California Dept. of Health Care Services (DHCS), May 13, 2020; *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* (PDF), Centers for Medicare & Medicaid Services, last updated January 6, 2021; *Request for Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency* (PDF), DHCS, March 16, 2020; "CARES Act Provider Relief Fund: For Providers," US Dept. of Health and Human Services, last reviewed May 7, 2021; "The 2021-22 Budget: Medi-Cal Fiscal Outlook," Legislative Analyst's Office, November 18, 2020. Department of Health Care Services 2020; and *Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)*, DHCS, January 5, 2021.

The Affordable Care Act (ACA) and Medi-Cal

Eligibility Expansions

- Starting in 2014, the ACA allowed states to expand Medicaid eligibility to adults under 65 with low incomes. In 2020, California covered four million "expansion" adults, which accounted for 30% of all enrollees. Forty-four percent of expansion adults were Latinx, and over one-third were between age 46 and 64.
- The ACA raised the income eligibility threshold for parent and adult caretaker relatives. In addition, eligibility for youth in foster care who are enrolled in Medicaid was extended from age 18 up to age 26.
- The ACA included a "maintenance of effort" (MOE) provision prohibiting states from reducing eligibility for children to levels prior to March 2010, imposing new or increased waiting periods, or increasing premiums. The MOE expired in September 2019.

Benefit Expansions

- California expanded benefits to include mild-to-moderate mental health services and substance use disorder services.
- California implemented the ACA's Health Homes provision in 12 counties to provide enhanced care management and coordination for enrollees' complex medical needs and chronic conditions.

Eligibility and Enrollment Simplification

- The ACA simplified and streamlined eligibility requirements for people without disabilities. California also improved its enrollment system, creating a single online portal to initiate applications for insurance affordability programs, in addition to existing ways to apply.

Impact on California

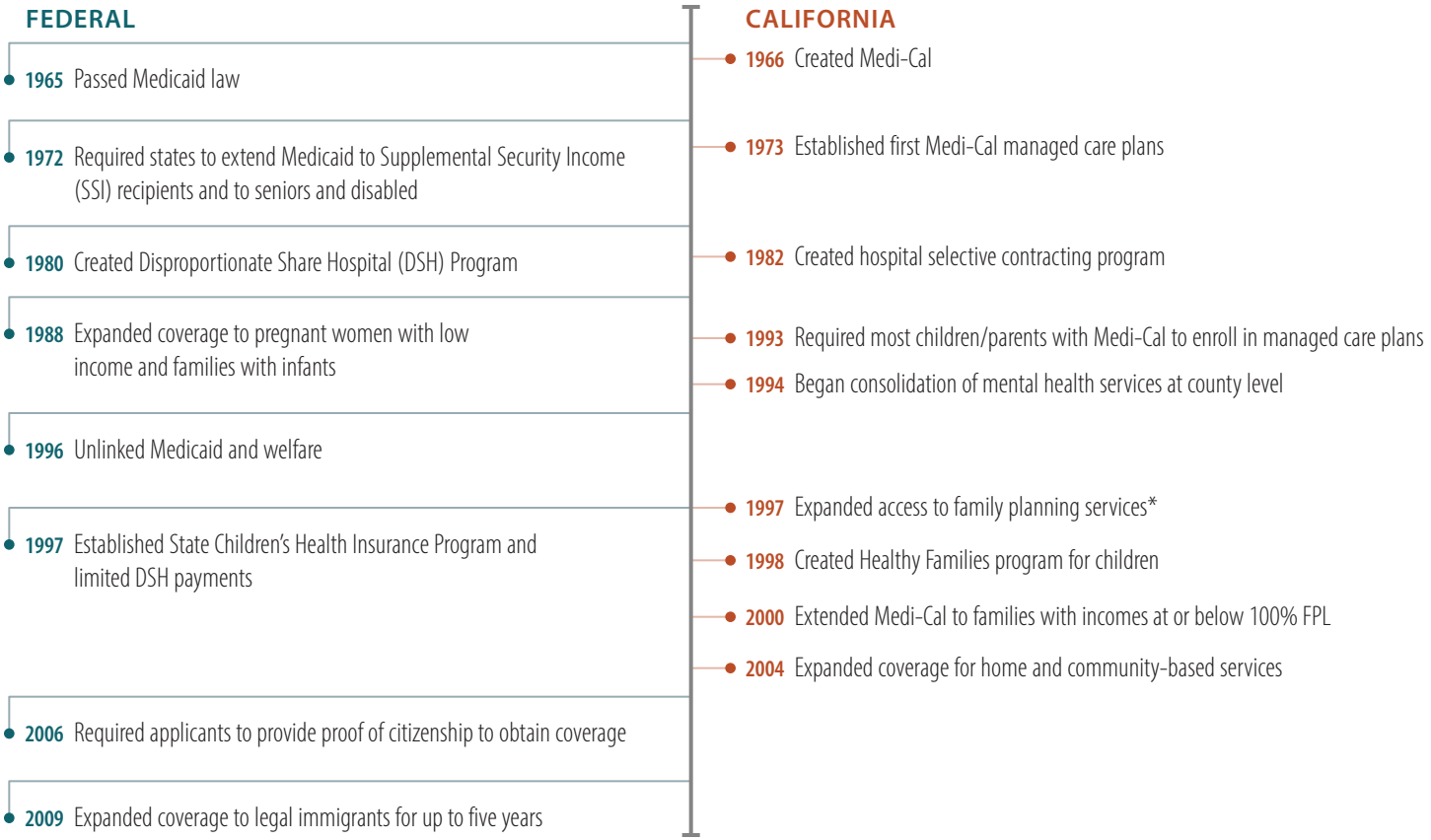
- The Medi-Cal expansion contributed significantly to reducing the percentage of Californians without insurance, which declined from 14% in 2013 to 7% in 2019.*
- While Medi-Cal's share of the state budget has remained the same, increased federal matching contributions have financed most of the eligibility and enrollment expansions in California.

* Self-reported. See "About the Data" on page 69 for a full explanation of how this could impact findings.

Sources: *Medi-Cal Monthly Eligible Fast Facts* (Sept. 2020) (PDF), California Dept. of Health Care Services (DHCS), December 2020; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1101, 124 Stat. 119, 141-43 (2010); Summary of the Affordable Care Act, KFF, April 25, 2013; *The Maintenance of Effort (MOE) Provision in the Affordable Care Act* (PDF), Georgetown Health Policy Institute, May 2017; *California Health Homes Program: September 2020 Update* (PDF), DHCS; California Health Interview Survey, UCLA Center for Health Policy Research; and "Status of State Medicaid Expansion Decisions: Interactive Map," KFF, last updated May 13, 2021.

The ACA allows states the option to expand Medicaid to adults with income levels that made them previously ineligible. In 2019, California had the largest number of adults enrolled through this expansion and has been a leader in enrollment among the 39 states and the District of Columbia that expanded their programs.

Medicaid Legislative History, Selected Milestones



* Family Planning, Access, Care and Treatment (Family PACT) Program

Note: *FPL* is federal poverty level.

Source: "Program History," Centers for Medicare & Medicaid Services, accessed July 27, 2021.

Medi-Cal has evolved in response to changing federal and state policies.

Medicaid Legislative History, Selected Milestones (continued)

Medi-Cal has evolved in response to changing federal and state policies.

FEDERAL

2010 Under ACA, state option to provide Medicaid coverage for all individuals under 133% FPL at enhanced federal matching rate

2012 Supreme Court upholds ACA and rules that Medicaid expansion is optional for states

2016 Final Managed Care Rule to align Medicaid with other insurance regulations and to strengthen consumer protections

2017 Tax overhaul legislation reduced the penalty for not having insurance to $0

2018 CHIP funding reauthorized through FY 2027

CALIFORNIA

2010 Under ACA, expanded coverage for uninsured adults, and required seniors and people with disabilities to enroll in managed care (excluding those with Medicare)

2012 Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties

2013 Expanded Medi-Cal under ACA state option

2015 Expanded full-scope Medi-Cal to eligible children regardless of immigration status using state funds starting May 16, 2016

2019 Created financial penalty for failure to maintain health coverage starting January 1, 2020
Medi-Cal eligibility extended to adults 19–25 regardless of immigration status starting January 1, 2020
Expanded income eligibility up to 138% FPL for seniors and people with disabilities starting December 1, 2020
Extended Medi-Cal coverage by 12 months after delivery for women with a maternal mental health condition starting August 1, 2020
Executive order moved pharmacy benefit from managed care to statewide administration

2021 Expanded full-scope Medi-Cal to eligible adults age 50 and over regardless of immigration status starting no earlier than May 2022
State will seek federal approval to eliminate the asset test as an eligibility requirement
With newly allowable federal matching funds, extended Medi-Cal eligibility from 60 days to 12 months for eligible postpartum individuals, targeted to start April 2022

* Family Planning, Access, Care and Treatment (Family PACT) Program

Note: *FPL* is federal poverty level.

Sources: Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget (PDF), Committee on Budget and Fiscal Review, January 6, 2009; "California's Medicaid State Plan (Title XIX)," California Dept. of Health Care Services, last modified May 5, 2020; "The Affordable Care Act in California," California Health Care Foundation, June 28, 2012; *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, March 2021; S.B. 78 (Cal. 2019); S.B. 104 (Cal. 2019–20); H.R. 1, 115th Cong. (2017–18); and H.R. 1319 - American Rescue Plan Act of 2021, 117th Cong. (2021).5, 2020; A.B. 133 (Cal. 2021-22).

Medi-Cal Governance

FEDERAL

Centers for Medicare & Medicaid Services (CMS)

- Provides regulatory oversight
- Reviews and monitors waivers to program rules

COUNTY

County Health and Social Services Department

- Conducts eligibility determination
- Oversees enrollment and recertification

STATE

California Department of Health Care Services (DHCS)

- Administers Medi-Cal
- Sets eligibility and benefits, contracts with managed care plans and other providers, and determines payments

California Legislature

- Passes legislation enabling programs, eligibility requirements, waivers, and benefits within federal law
- Provides oversight through hearings and audits
- Approves overall budget

Medi-Cal is governed by the federal, state, and county governments. The California legislature provides oversight and approves the overall budget.

Financing the Medi-Cal Program

Medi-Cal is paid for with a mix of federal, state, and local funds.

Source of Funds

- The federal government contributes a percentage of every dollar states spend on qualified Medicaid expenditures. This federal medical assistance percentage (FMAP), also known as the federal financial participation, varies by state and is calculated using the state's average per capita income relative to the national average. California's standard FMAP is 50%.
- California's nonfederal share of Medi-Cal expenditures is financed through the state general fund, county revenues, and taxes and fees on managed care organizations, hospitals, and tobacco products.

FMAP Enhancement

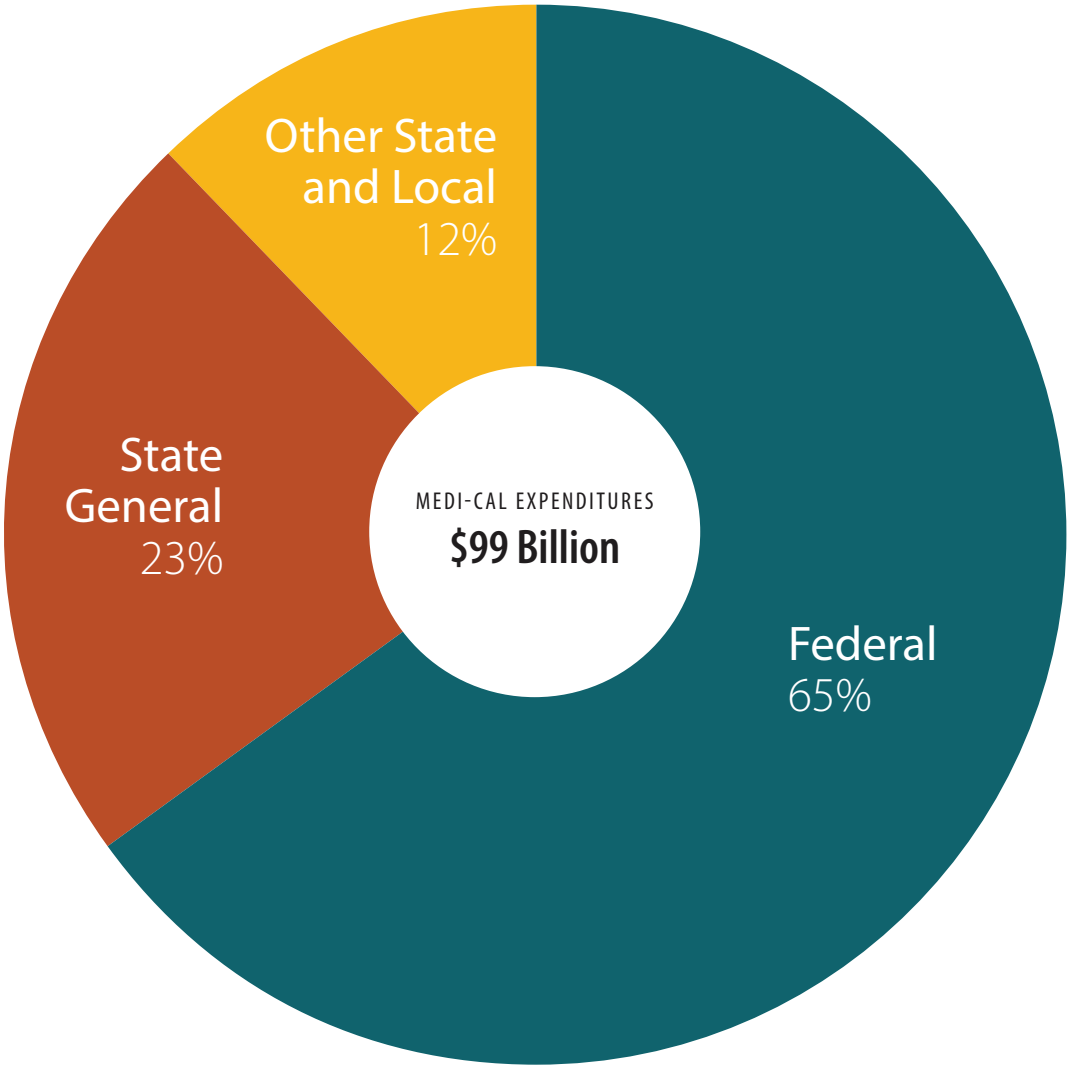
- The FMAP may be "enhanced," or increased, for specific services. For example, the FMAP is 90% for services provided through the Health Homes pilots. Other services with enhanced FMAPs include breast and cervical cancer treatment, and Indian Health Services and Tribal Facility Services.
- The FMAP is enhanced for specific populations such as refugees, pregnant women, and children.

Affordable Care Act (ACA) Effects on FMAP

- The ACA enhanced the FMAP for the expansion to nonpregnant, childless adults under age 65. From 2014 to 2016, the federal share was 100% and was reduced to 90% in 2020.
- The ACA enhanced the FMAP to 88% for pregnant women and newborns covered by the Children's Health Insurance Program through September 2019 and is reduced to 65% thereafter.

Sources: Laura Snyder and Robin Rudowitz, "Medicaid Financing: How Does It Work and What Are the Implications?," KFF, May 20, 2015; and *Aid Code Master Chart* (PDF), California Dept. of Health Care Services, May 1, 2019.

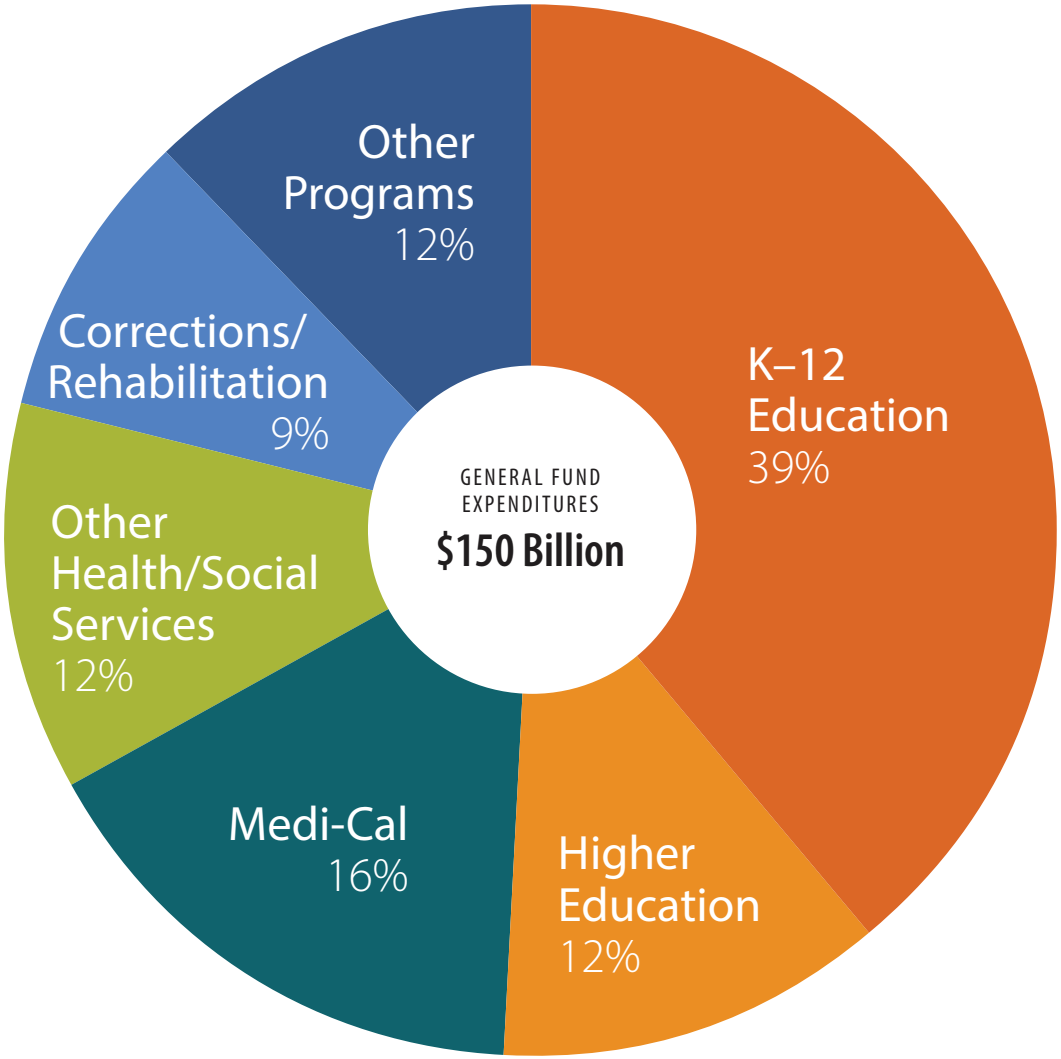
Medi-Cal Funding Sources
FY 2019–20



Source: Author calculation based on *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health of Health Care Services, accessed August 6, 2020.

The federal government provided nearly two-thirds of total Medi-Cal funding. The state contribution to Medi-Cal was 23%, while other state and local funds composed the remaining 12% of the total.

General Fund Distribution, California
FY 2019–20



Notes: 2019–20 general fund expenditures as reported in the 2020-21 budget. Includes expenditures for medical care services, eligibility (county administration), fiscal intermediary management, and benefits (medical care and services).

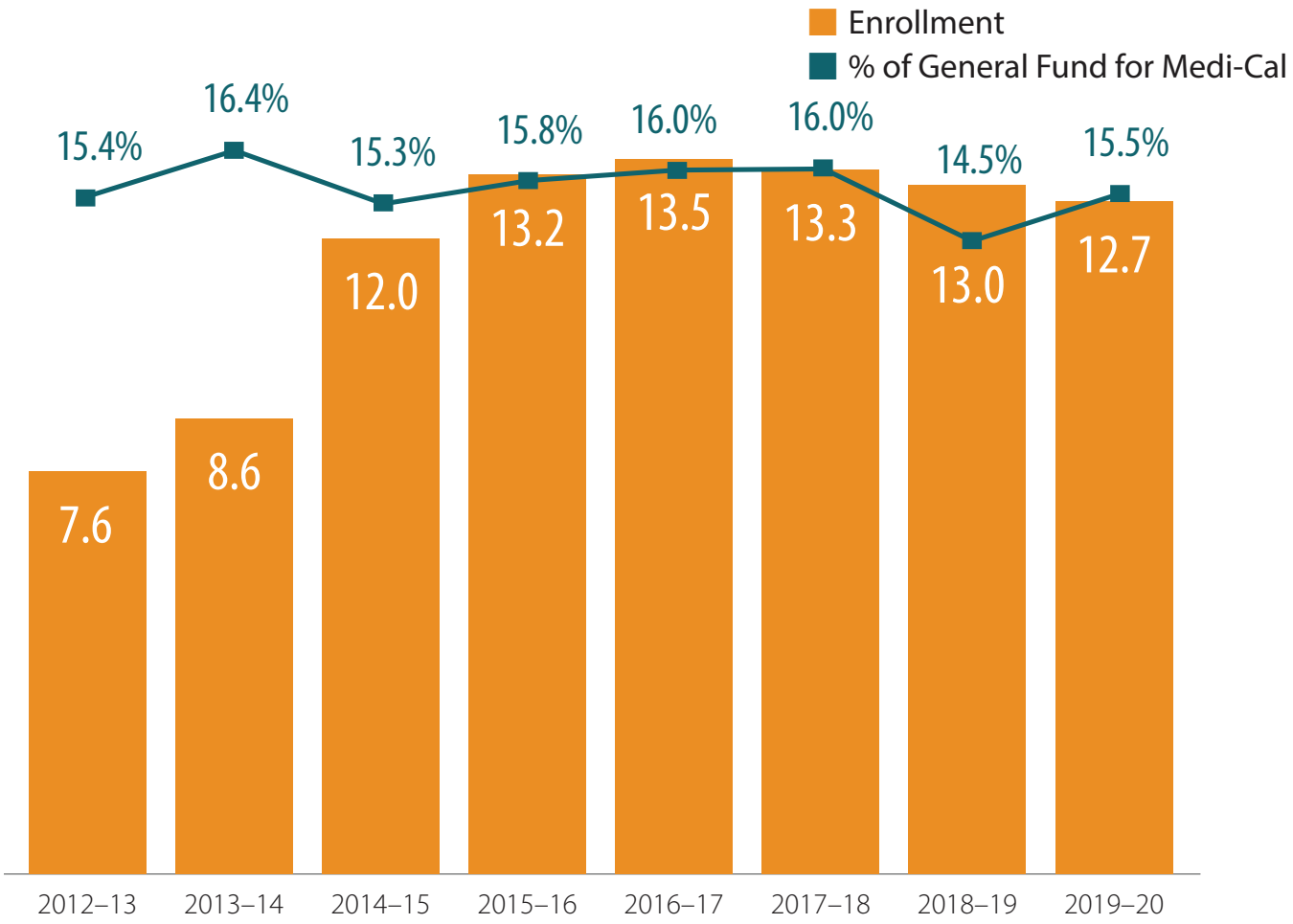
Sources: Estimates for 2019-20 Medi-Cal spending are from *2020–21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF) and total general fund spending from *Governor's Budget Summary 2020-21: Summary Charts* (PDF), DOF.

California invested more than $23 billion from its general fund annually in the Medi-Cal program, making Medi-Cal the second-largest category of general fund spending after K–12 education.

Medi-Cal Enrollment and Share of General Fund

FY 2013 to FY 2020

ENROLLMENT IN MILLIONS



Sources: Estimates for 2019–20 Medi-Cal spending are from *2020-21 Governor's Budget: 4260 State Department of Health Care Services* (PDF), California Dept. of Finance (DOF) and total general fund spending from *Governor's Budget Summary 2020-21: Summary Charts* (PDF), DOF; estimates for 2018–19 Medi-Cal spending are from *2019-20 Governor's Budget: 4260 State Department of Health Care Services* (PDF), DOF, and total general fund spending from *Governor's Budget Summary 2019-20: Summary Charts* (PDF), DOF; estimates for 2016–17 and 2017–18 are from *Governor's Budget Summary, 2018-19* (PDF), DOF; estimates for 2015–16 are from *Governor's Budget Summary, 2017-18* (PDF), DOF; estimates for 2014–15 are from *Governor's Budget Summary, 2016-17* (PDF), DOF; estimates for 2013–14 are from *Governor's Budget Summary, 2015-16* (PDF), DOF; and estimates for 2012–13 are from *Governor's Budget Summary, 2014-15* (PDF), DOF.

Over the past eight years, Medi-Cal has, on average, represented 16% of all general fund expenditures.

Medi-Cal Eligibility Requirements

For most enrollees, Medi-Cal eligibility is based on household income and size.

Medi-Cal eligibility is based on household income and other financial information, citizenship and immigration status, and enrollment in other public assistance programs.

- **Income.** Household income must be below certain thresholds of the federal poverty guidelines. Income thresholds, and factors used in calculating income, vary by eligibility group (see page 21) and take household size into account.
- **Property.** Enrollees in some aid categories must pass an asset test and demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than $3,300 for a family of four). Some types of property, such as a principal residence, are exempt.*
- **Citizenship and immigration status.** For adults, US citizenship or "qualifying immigration status" (e.g., lawful permanent resident) is required to be eligible for full-scope benefits. California allows children, teens, young adults under 26, and in 2022, adults age 50 and older who are undocumented and meet other eligibility requirements to also receive full-scope benefits. Full-scope Medi-Cal provides medical, dental, mental health, and vision care. It also covers alcohol and substance use disorder treatment and prescription drugs. Other residents without qualifying immigration status may be eligible for restricted-scope benefits that cover only pregnancy-related and emergency services. (See Immigration Status and Eligibility on page 22 for more information.)
- **Residence.** Enrollees must reside in California.
- **Public assistance program enrollment.** Eligibility for Medi-Cal is automatic for enrollees in the following public assistance programs: CalFresh, Supplementary Security Income / State Supplemental Payment, CalWORKS, Refugee Assistance, Foster Care / Adoption Assistance Program.

* AB133 in 2021 directs the state to seek federal approval to eliminate the asset test as an eligibility requirement.

Notes: The ACA created a streamlined financial eligibility test based on federal tax rules to determine gross income for all insurance affordability programs. The modified adjusted gross income (MAGI) standard eliminated the asset test for most adults, parents, children, and pregnant women.

Sources: "Poverty Guidelines" (2020), US Dept. of Health and Human Services; *Medi-Cal General Property Limitations* (PDF), California Dept. of Health Care Services (DHCS), April 2014; Jen Flory et al., *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; "Medi-Cal Eligibility and Covered California - Frequently Asked Questions," DHCS, last modified March 23, 2021; and "Do You Qualify for Medi-Cal Benefits?," DHCS, last modified March 23, 2021.

Eligibility Groups

MANDATORY GROUPS – *REQUIRED BY FEDERAL LAW*	INCOME THRESHOLD	NOTES
Children and youth under age 26 receiving adoption assistance or foster care	None	
Children under age 19	133% FPL cap	Income threshold is below 142% FPL for children age 1 to 5.
People in long-term care	100% FPL cap	Subject to asset test*
Parents and caretaker relatives	108% FPL cap	
Aged, blind, and people with disabilities	Must receive SSI	Subject to asset test*
Pregnant women, newborns, and infants under age 1	213% FPL cap	
Medicare enrollees with low incomes	FPL cap varies	Three categories: Qualified Medicare Beneficiary (100% FPL), Specified Low-Income Medicare Beneficiary (120% FPL), Qualifying Individual (135% FPL)
OPTIONAL GROUPS – *NOT REQUIRED BY FEDERAL LAW*	**INCOME THRESHOLD**	**NOTES**
ACA "expansion" adults under age 65	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA[†]
Parents and caretaker relatives	109%–138% FPL	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA[†]
Qualifying state and county inmates	138% FPL cap	Coverage for group added when California opted to expand Medi-Cal as allowed by the ACA. Medi-Cal pays for inpatient hospital services
Children under age 19	134%–266% FPL	Title XXI funded Optional Targeted Low-Income Children[‡]
Children under age 19 in specific counties[§]	267%–322% FPL	Title XXI (C-CHIP)[‡]
Pregnant women, newborns and infants under age 2	213%–322% FPL	Title XXI funded Optional Targeted Low-Income Children
Children and youth under age 19 regardless of immigration status	Below 266% FPL	State-only funding
Young adults age 19–25 regardless of immigration status	138% FPL cap	State-only funding
People in long-term care regardless of immigration status	100% FPL cap*	Subject to asset test*
Aged, blind, and people with disabilities — FPL program	138% FPL cap	Subject to asset test*
Working disabled	250% FPL cap	Subject to asset test*
Adults age 50 and older regardless of immigration status**	138% FPL cap	State-only funding

* People qualifying under specific aid categories must demonstrate that real and personal property do not exceed thresholds (e.g., countable property worth more than $3,300 for a family of four). This is commonly referred to as the "asset test." Some real and personal properties are exempt (e.g., principal residence). This requirement applies only to specific aid categories such as the aged, blind, and disabled. Those in long-term care may also have to pay a share of cost. AB 133 (2021) directs the state to seek federal approval to eliminate the asset test as an eligibility requirement.

[†] While the Supreme Court made it the state's option to implement this expansion, states opting to do so must implement the expansion group as written in statute.

[‡] Title XXI of the Social Security Act passed in 1997, also known as the Children's Insurance Program, allows states the option to provide coverage to uninsured pregnant women, infants, and children in families with household incomes higher than Medicaid thresholds and who cannot afford private insurance. States can create stand-alone programs, expand their Medicaid programs, or create a hybrid program. Originally, California created the Healthy Families program but transitioned enrollees into Medi-Cal in 2012–13 and uses the Title XXI funds to expand Medi-Cal eligibility thresholds.

[§] C-CHIP in San Mateo, Santa Clara, and San Francisco Counties only.

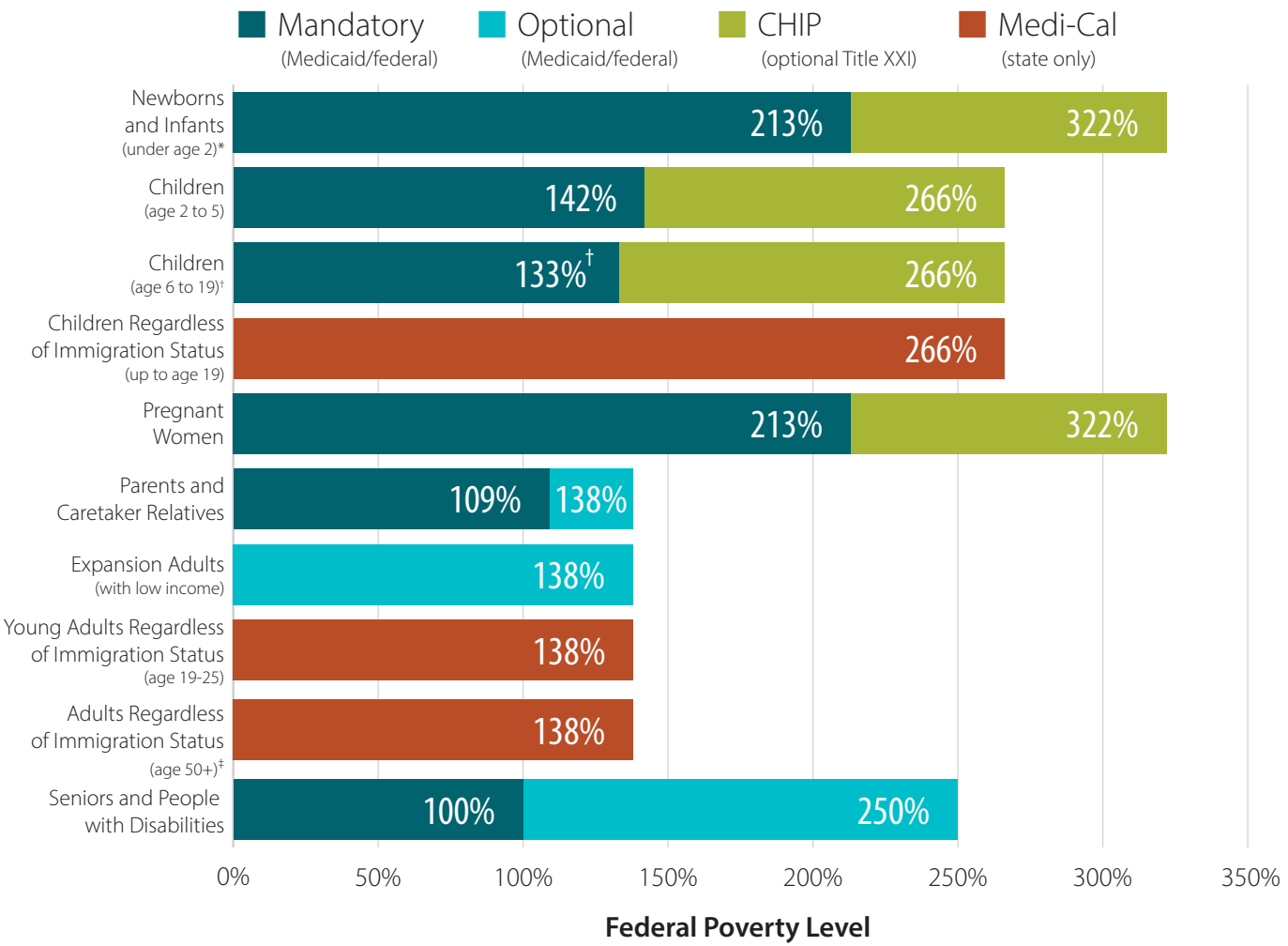
** Effective in 2022

Federal law requires all state Medicaid programs to cover the mandatory groups, and allows states to receive federal matching funds for the optional groups. Under the ACA, California expanded eligibility to adults with low incomes and without disabilities or dependent children, and to parents and caretaker relatives. Using state funds, California also expanded Medi-Cal to cover three groups in households with low income regardless of immigration status: children, adults under 26, and in 2022, adults age 50 and over.

Note: The 2021 federal poverty level (FPL) for a single person is $12,760; 138% FPL is $17,609.

Sources: "California Medicaid Eligibility Groups by Medi-Cal Aid Code," California Health and Human Services Agency, accessed October 22, 2020; *All-County Letter Welfare Letter 20-03* (PDF), California Dept. of Health Care Services (DHCS), February 5, 2020; *List of Medicaid Eligibility Groups* (PDF), Centers for Medicare & Medicaid Services, accessed October 18, 2020; *Medi-Cal Eligibility Division Informational Letter I 19–15* (PDF), DHCS, May 30, 2019; Tricia Brooks et al., "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," KFF, March 26, 2020; *Fact Sheet: Children's Health Insurance Program* (CHIP) (PDF), Medicaid and CHIP Payment and Access Commission, February 2018; *Young Adult Full Scope Expansion: Eligibility and Enrollment Plan* (PDF), DHCS, November 4, 2019; *Program Eligibility by Federal Poverty Level for 2021* (PDF), Covered California, accessed October 18, 2020; and AB 133 (Cal. 2021-22).

Medi-Cal Income Thresholds



Note: *CHIP* is Children's Health Insurance Program and is part of the Medi-Cal program.

* Medicaid requires mandatory coverage of newborns and infants up to age 1 and up to 213% FPL. Title XXI allows states the option to cover newborns and infants under age 2 and up to 322% FPL.

† 5% income disregard doesn't apply.

‡ Effective in 2022.

Sources: "California Medicaid Eligibility Groups by Medi-Cal Aid Code," California Health and Human Services Agency, accessed October 22, 2020; *All-County Letter Welfare Letter 20-03* (PDF), California Dept. of Health Care Services, February 5, 2020; *Program Eligibility by Federal Poverty Level for 2021* (PDF), Covered California, accessed October 18, 2020; and "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," KFF, March 26, 2020.

Medi-Cal income eligibility thresholds vary. In 2021, a single, childless adult with annual income below 138% of the federal poverty level (FPL), or $17,609, would be eligible for Medi-Cal. A pregnant person would be eligible if their annual income were below 322% of FPL, or $41,088.

Immigration Status and Eligibility

Immigrants who are not citizens may be eligible for Medi-Cal if they meet categorical, financial, and residency requirements. Two main groups are eligible.

Qualified Immigrants

- Legal permanent residents (LPRs), asylees, refugees, and other qualifying categories: Eligible for full-scope benefits and Federal Medical Assistance Percentage (FMAP) if they have resided in the US for more than five years (referred to as the "five-year bar").

Nonqualified Immigrants

- Permanently Residing Under Color of Law (PRUCOL): Entitled to full-scope Medi-Cal with state-only funding and no FMAP. The ACA recognizes Deferred Action for Childhood Arrivals (DACA) status as "lawfully present" under PRUCOL.
- Children who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP.
- Young adults age 19–25 who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP.
- Adults age 26–49 who are undocumented: Entitled only to restricted-scope (emergency and pregnancy-related) services. These services qualify for federal matching.
- Adults age 50 and older who are undocumented: Entitled to full-scope benefits with state-only funding and no FMAP, effective in 2022.

Some immigrants who are not citizens are eligible for full-scope Medi-Cal, while others may be eligible only for restricted-scope emergency and pregnancy-related services.

Notes: Other qualified groups include those (1) paroled into the US under specific conditions; (2) granted conditional entry pursuant to specific conditions; (3) Cuban or Haitian entrant; (4) battered spouses and children with a pending or approved: (a) self-petition for an immigrant visa or visa petition by a spouse or parent who is either a US citizen or LPR, or (b) application for cancellation of removal/suspension of deportation, where the need for the benefit has a substantial connection to the battery or cruelty (parent/child of such battered child/spouse are also "qualified"); (5) Victims of Severe Forms of Trafficking. The date someone receives their qualified status triggers the beginning of the "five-year bar." Some qualified immigrants are exempt from the five-year bar. Permanent Residence Under Color of Law (PRUCOL) is not an immigration status but a public benefits eligibility category; PRUCOL individuals are not US citizens but are considered to have the same rights as legal residents for welfare eligibility purposes. See 42 CFR § 435.408 for the federal definition and 22 CCR § 50301.3 for the state definition.

Sources: *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; Cal. Welf. and Inst. Code § 14007.8; "An Advocate's Guide to Medi-Cal Services," National Health Law Program, February 11, 2020; AB 133 (Cal. 2021-22); and *Young Adult Full Scope Expansion: Eligibility and Enrollment Plan* (PDF), California Dept. of Health Care Services, November 4, 2019.

Medi-Cal Individual Application Process

In person. May apply for Medi-Cal at local county social services office or at hospitals and clinics where county eligibility workers and certified application assisters are located. Medi-Cal applications, paper or electronic, can be submitted with the assistance of trained certified application assisters, many of whom work at community-based organizations.

Mail in. The paper version of the single streamlined application can be submitted to county offices or Covered California.

Online. Medi-Cal applications can be initiated electronically using the Covered California portal and benefitscal.org website, which links applicants to county eligibility systems. Most applicants will be required to follow up in person or by phone with county eligibility offices.

By phone. Interested people can call the Covered California service center or county social services office to initiate an application with a customer service representative or county eligibility worker. These applications require in-person follow-up with the county eligibility worker.

Presumptive eligibility. Participating providers in the Presumptive Eligibility Program for Pregnant Women, the Child Health and Disability Prevention Program, the Breast and Cervical Cancer Treatment and Prevention program, or the Hospital Presumptive Eligibility program can request immediate 60-day temporary, no-cost Medi-Cal coverage for qualified applicants. During the 60-day period, those receiving this temporary coverage apply for permanent Medi-Cal or other health coverage. During the COVID-19 public health emergency, the federal government expanded the use of presumptive eligibility.

Applications during the COVID-19 pandemic. In April 2019, 37% of applications were online and 38% were in-person. In April 2020 at the start of the COVID-19 Public Health Emergency, online applications rose dramatically to 72% and in-person applications dropped to 5%.

Notes: People eligible for temporary coverage through presumptive eligibility are pregnant women, foster youth age 18–26, children under 19, parent and caretaker relatives, and adults under 65 without dependent children. People must meet income and residency requirements and not have received presumptive eligibility benefits in the last 12 months. CalWORKs is a public assistance program that provides cash aid and services to eligible families that have children in the home.

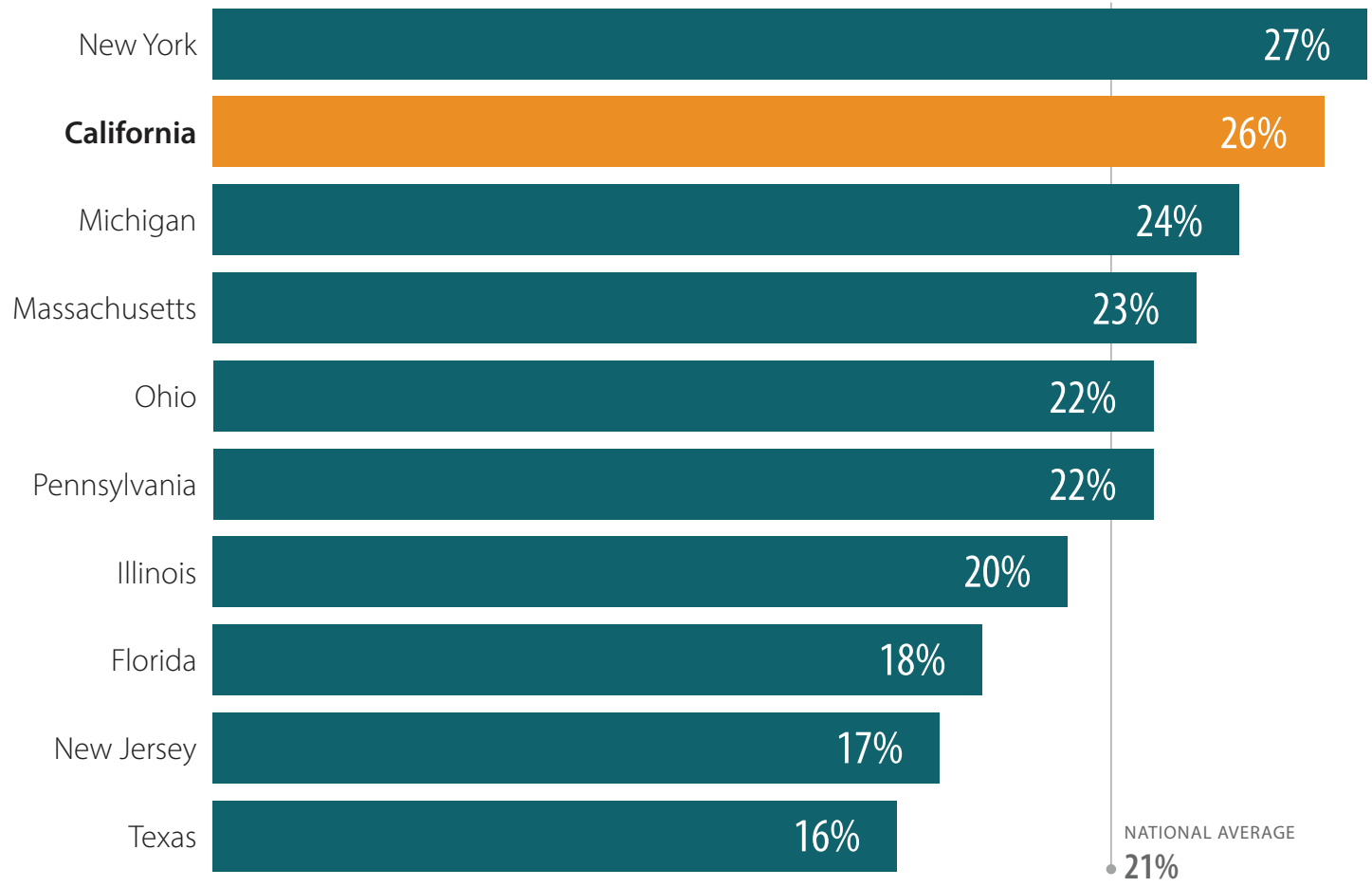
Sources: "Medi-Cal Eligibility and Covered California - Frequently Asked Questions," California Dept. of Health Care Services (DHCS), accessed October 18, 2020; *Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates* (PDF), Western Center on Law and Poverty, March 2016; and *Medi-Cal Enrollment Update* (PDF), DHCS, April 8, 2021.

To comply with the ACA, California created a single streamlined application for Medi-Cal and Covered California, the state's health care exchange. There are numerous pathways to submit an application.

Medicaid Enrollment

Selected States, 2019

PERCENTAGE OF NONELDERLY STATE POPULATION

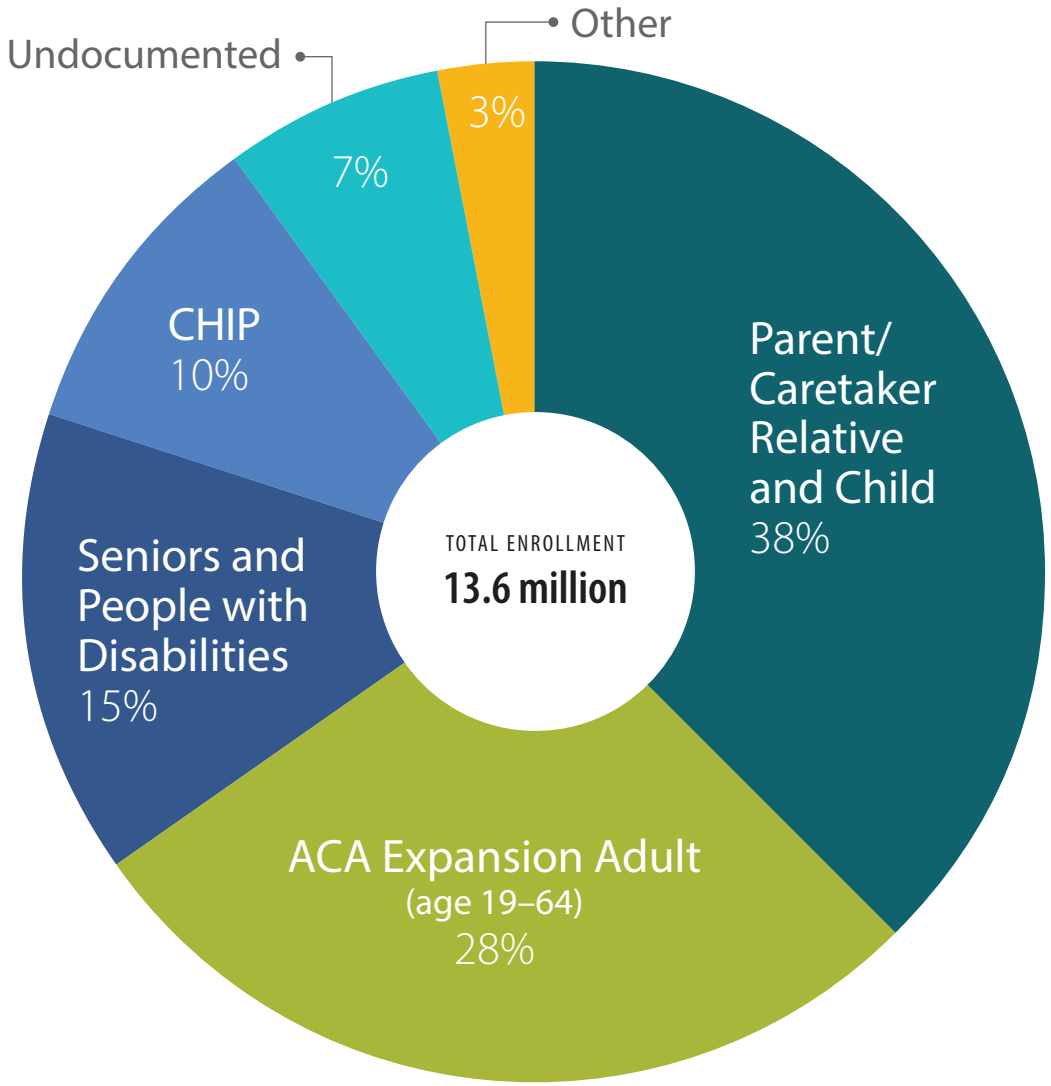


Notes: States with the 10 largest Medicaid expenditures in FY 2019, based on KFF's "Total Medicaid Spending (FY 2019)," are represented. *Nonelderly* is under age 65. Medicaid enrollment is self-reported and includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan, or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage such as dually eligible enrollees also covered by Medicare.

Source: "Health Insurance Coverage of Nonelderly 0-64" (2019), KFF.

California has more Medicaid enrollees in total (not shown), but New York had a slightly higher percentage of the state's nonelderly population enrolled in Medicaid. Texas and Florida did not expand their Medicaid programs under the Affordable Care Act.

Enrollment, by Aid Category, 2021



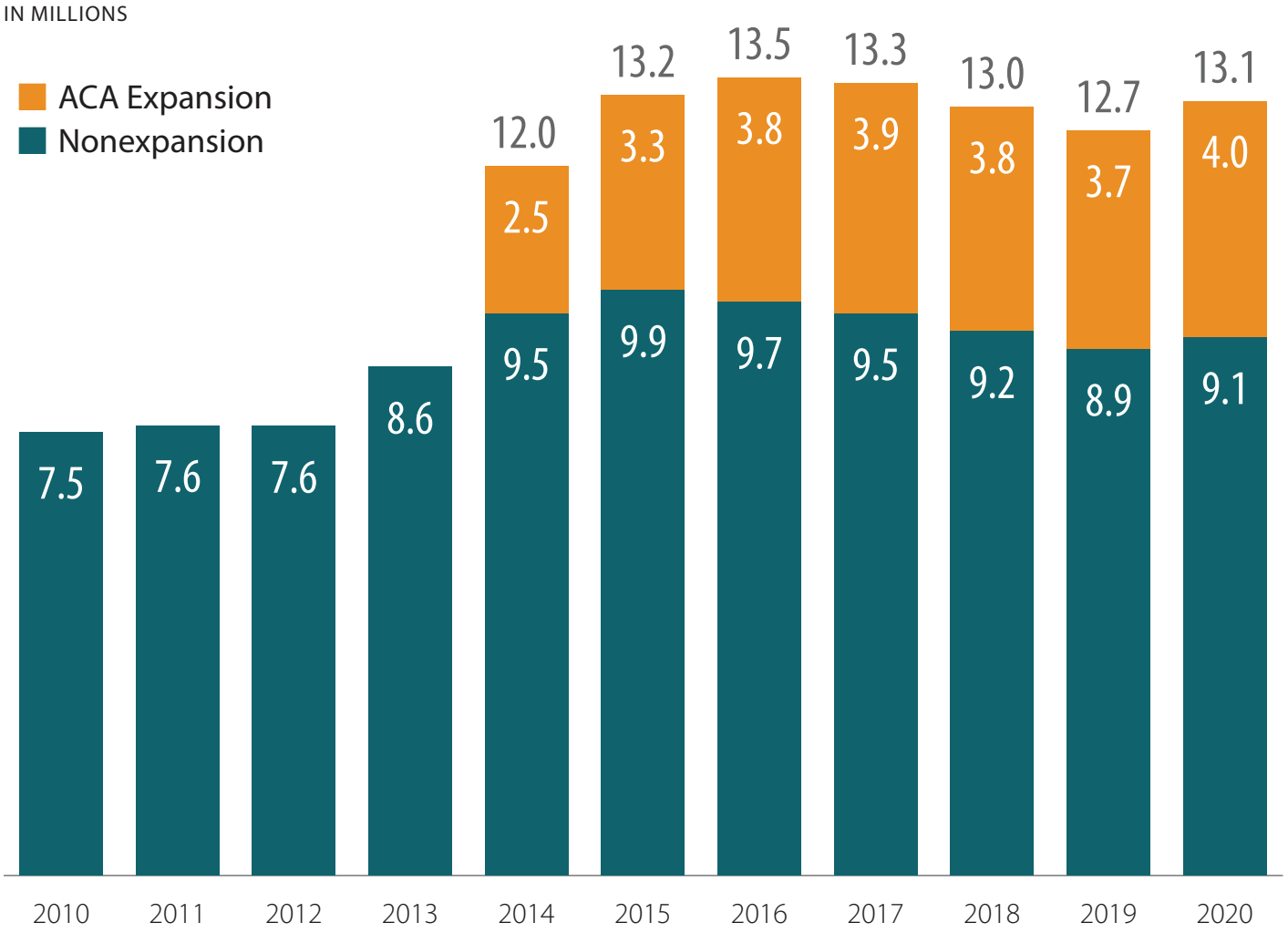
Notes: Enrollment month is January 2021. *CHIP* is Children's Health Insurance Program. *Undocumented* includes aid categories restricted to only pregnancy-related, long-term care, and emergency services for adults who do not have satisfactory immigration status, also known as restricted-scope benefits. *Other* includes long-term care and aid categories including Adoption/Foster Care, Refugee Medical Assistance / Entrant Medical Assistance, Breast and Cervical Cancer Treatment Program, Abandoned Baby Program, Minor Consent Program, Accelerated Enrollment in the Children Health and Disability Prevention Program (CHDP), Trafficking and Crime Victims Assistance Program, and state and county inmates. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

Nearly half of Medi-Cal enrollees were children and their parents/caretakers and children in CHIP. Nearly one in six enrollees was a senior or person with a disability. The Affordable Care Act (ACA) expansion group — adults under 65 with low incomes and no dependent children — was the second-largest group of Medi-Cal enrollees.

Medi-Cal Enrollment

2010 to 2020



Note: Enrollment month is November of each year.

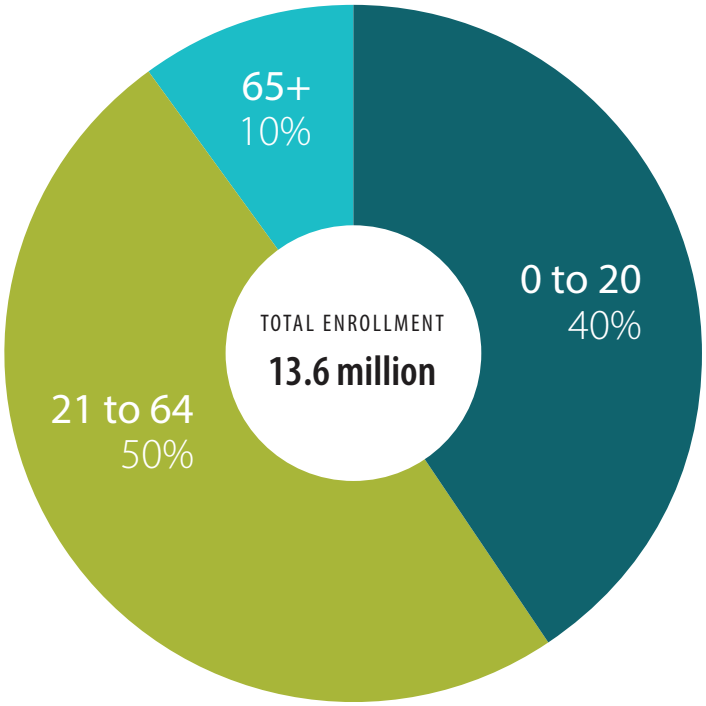
Sources: *Month of Eligibility, Aid Category by County, Medi-Cal Certified Eligibility*, California Dept. of Health Care Services (DHCS), November 25, 2020; and *Medi-Cal Enrollment Update* (PDF), DHCS, April 8, 2021.

Medi-Cal Facts and Figures
Eligibility and Enrollment

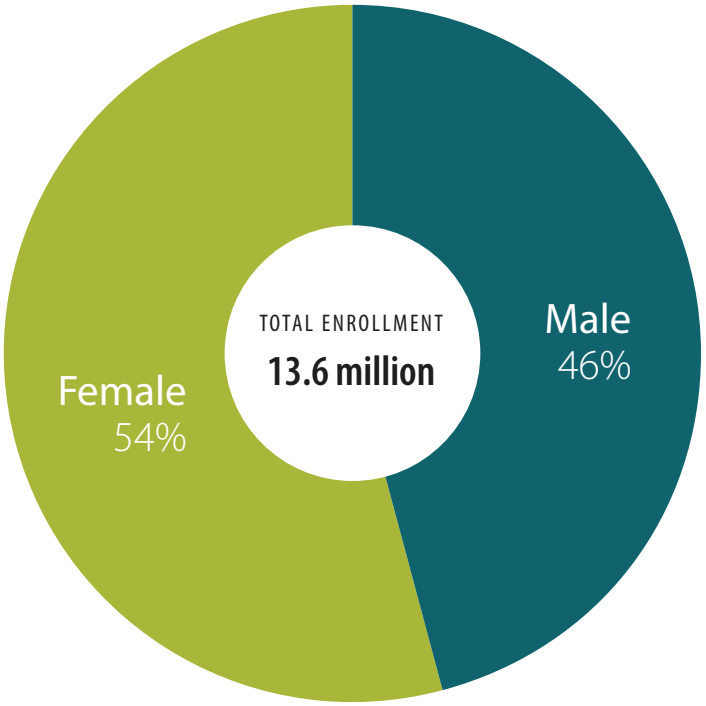
Medi-Cal enrollment has increased significantly since 2013, largely due to the ACA expansion. In 2014, nonexpansion enrollment increased sharply when Healthy Families enrollees were moved to Medi-Cal. Between 2016 and 2019 enrollment declined. In 2020, enrollment increased amid the COVID-19 pandemic, increased unemployment, and suspended eligibility redeterminations.

Medi-Cal Enrollee Profile
by Age and Gender, 2021

Age



Gender



Half of Medi-Cal enrollees are adults; children and youth (age 0–20) account for about 41% of enrollment. Medi-Cal enrollees are somewhat more likely to be female (54%) than male (46%).

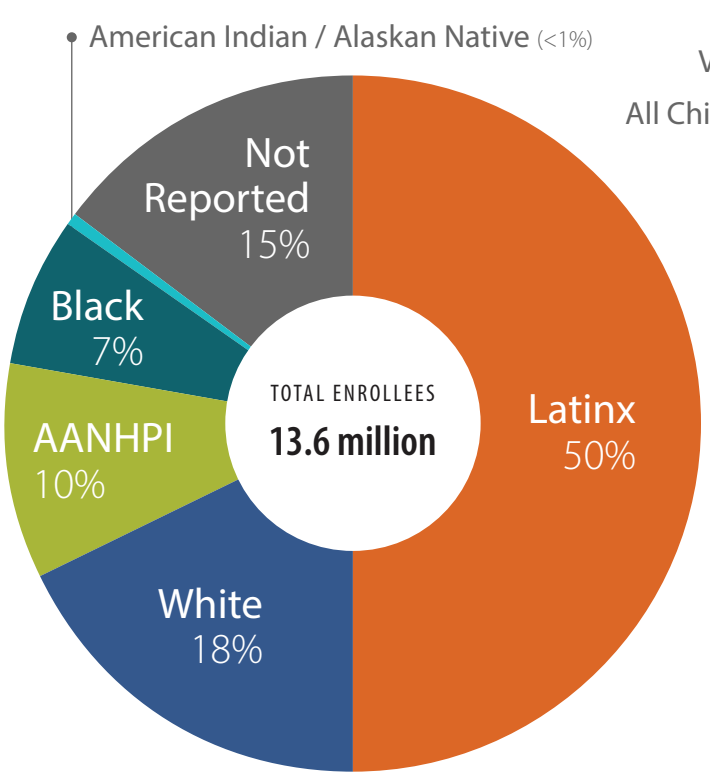
Note: Enrollment month is January 2021.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

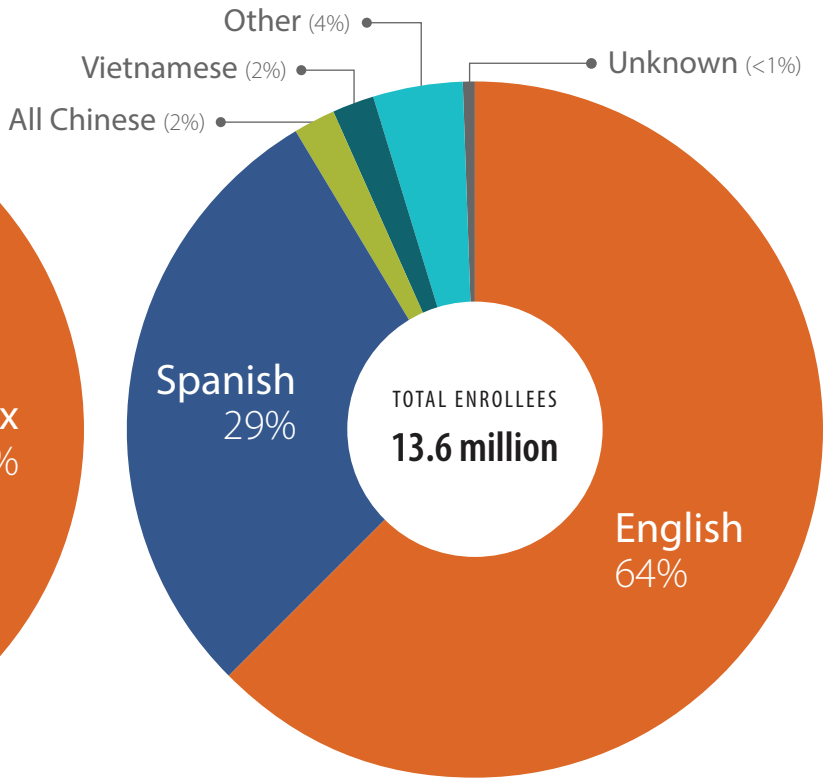
Medi-Cal Enrollee Profile

by Ethnicity and Primary Language, 2021

Race/Ethnicity



Primary Language



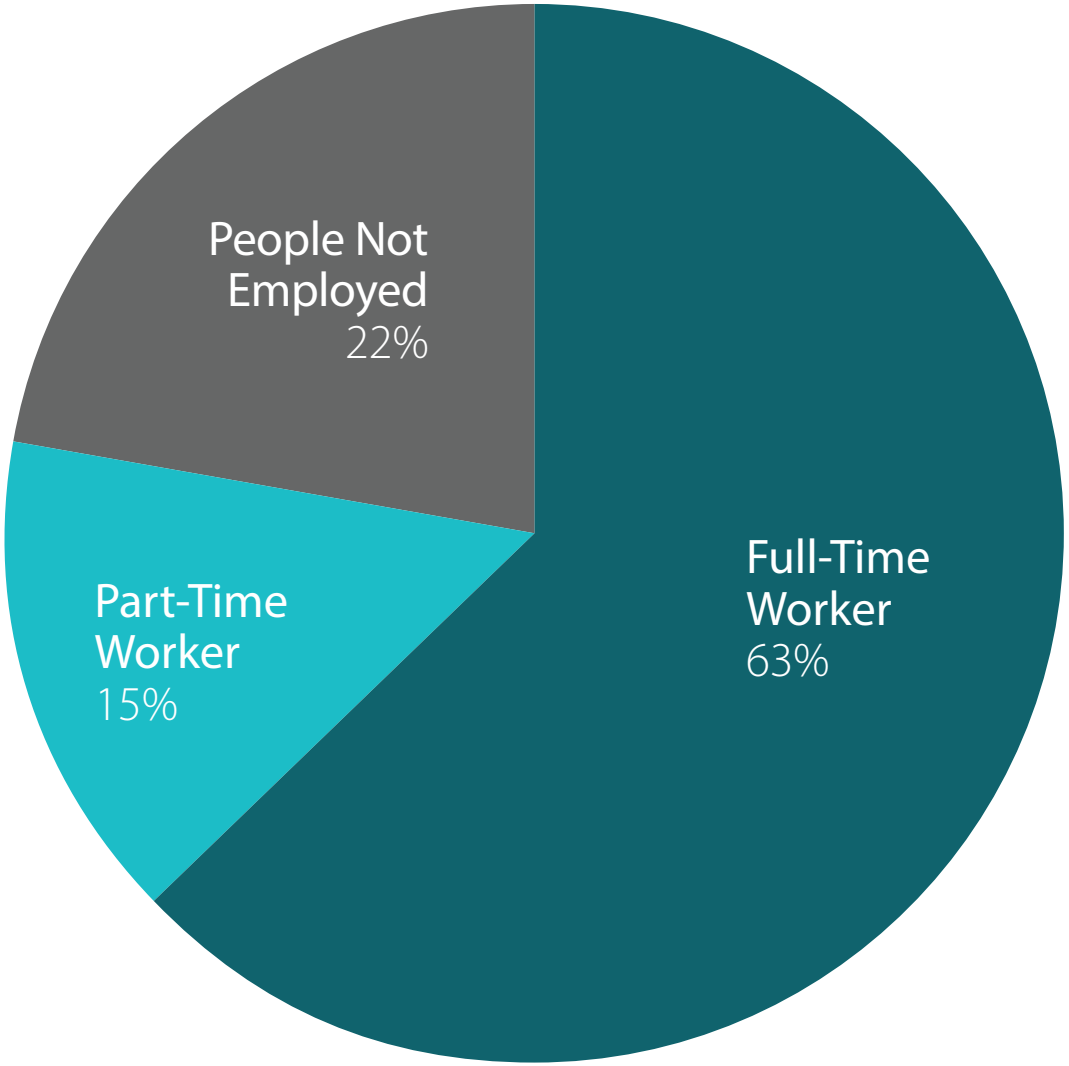
Notes: *AANHPI* is Asian American / Native Hawaiian and Pacific Islander. Enrollment month is January 2021. Source uses *Hispanic*, *African American*, and *Asian / Pacific Islander*. *All Chinese* includes Mandarin, Cantonese, and Other Chinese. *Other* includes American Sign Language, Arabic, Armenian, Cambodian, Farsi, French, Hebrew, Hmong, Ilocano, Italian, Japanese, Korean, Lao, Mien, Other Non-English, Other Sign, Polish, Portuguese, Russian, Samoan, Tagalog, Thai, and Turkish. Segments may not total 100% due to rounding.

Source: *Medi-Cal Monthly Eligible Fast Facts* (January 2021) (PDF), California Dept. of Health Care Services, April 2021.

Medi-Cal serves a large and diverse population, with Latinx Californians accounting for 50% of all enrollment. English is the most common language spoken (64% of enrollees). Spanish is the primary language spoken for 29% of enrollees.

Medi-Cal Enrollment

by Family Work Status, Nonelderly Population, 2019



Note: Source uses *Non Workers*.

Source: "Distribution of the Nonelderly with Medicaid by Family Work Status" (2019), KFF, accessed October 9, 2020.

About three out of four nonelderly Medi-Cal enrollees are in households where they or another family member work part- or full-time.

Medi-Cal Benefits

ESSENTIAL HEALTH BENEFITS	OPTIONAL SERVICES
• Ambulatory services	• Dental services for adults
• Emergency services	• Vision services for adults
• Prescription drugs	• Nonemergency medical transportation services
• Rehabilitative & habilitative services and devices	• Long-term services and supports
• Maternity and newborn care	
• Hospitalization	
• Preventive & wellness services and chronic disease management	
• Mental health and substance use disorder services, including behavioral health treatment	
• Pediatric services, including oral and vision care	
• Laboratory services	

The Affordable Care Act ensures that all Medi-Cal health plans offer 10 essential health benefits. In addition, California provides other services not required by the federal government.

Sources: "State Plan Section 3 - Services," California Dept. of Health Care Services (DHCS), last modified March 23, 2021; "Essential Health Benefits," DHCS, accessed October 25, 2020; and *Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary* (PDF), DHCS, January 2020.

Medi-Cal Pharmacy Benefit Management Transition

In January 2019, Governor Newsom directed the California Department of Health Care Services (DHCS) to transition the administration of pharmaceutical benefits from managed care plans to the state on January 1, 2022. The existing scope of Medi-Cal's pharmacy benefits does not change.

The new program, Medi-Cal Rx, aims to:

- Improve access to pharmacy services for Medi-Cal members
- Standardize the pharmacy benefit under one delivery system
- Apply statewide utilization protocols to all outpatient drugs
- Strengthen the state's ability to negotiate drug rebates with drug manufacturers

DHCS has contracted with Magellan Medicaid Administration, a national pharmacy benefit management firm, to administer Medi-Cal Rx.

DHCS estimates the transition will reduce state general fund expenditures by $238 million in FY 2021–22.

Starting in 2021, Medi-Cal will standardize and centralize pharmacy benefits and services across the state. Previously, managed care plans were responsible for administering pharmacy benefits.[1]

Sources: Exec. Order N-01-19 (PDF), State of California, January 7, 2019; *Medi-Cal November 2020 Local Assistance Estimate for Fiscal Years 2020-21 and 2021-22* (PDF), California Dept. of Health Care Services (DHCS), accessed March 11, 2021; "Medi-Cal Rx: Transition," DHCS; *Medi-Cal Rx Monthly Bulletin* (PDF) DHCS, accessed August 16, 2021; and "Medi-Cal Rx Background," DHCS, accessed October 25, 2020.

[1] Medi-Cal Rx will not apply to Programs of All-Inclusive Care for the Elderly (PACE) plans, Senior Care Action Network (SCAN) and Cal MediConnect health plans, or the Major Risk Medical Insurance Program (MRMIP).

Premiums and Cost Sharing, by Eligible Group

	PREMIUM OR COST SHARING
Children >160% FPL	• Children age 1 to 19 in families with incomes between 160% and 266% of the FPL have a monthly premium. • The premiums are $13 for each child but cannot exceed $39 per family per month.
250% Working Disabled Program	• People with a medical determination of physical or mental impairment lasting or proposed to last for one year whose countable monthly income is below 250% FPL. • Working people with disabilities and monthly income under 250% FPL. Disability income is excluded from income calculation. • Monthly premiums range from $20 to $250 for a single person depending on income.
Aged, Blind, and Disabled — Medically Needy Program Share of Cost*	• People over age 65 or who have a disability, with income above $1,596 per month (after numerous deductions). • People with a medical determination of a physical or mental impairment lasting or proposed to last for one year.

While most enrollees pay nothing for Medi-Cal, about 200,000 pay small premiums or are responsible for a share of the cost.*

Notes: *FPL* is federal poverty level. American Indian / Alaskan Native children may be eligible to have the premiums waived.

Sources: *All-County Welfare Letter 20-03* (PDF), California Dept. of Health Care Services (DHCS), February 5, 2020; "Medi-Cal Premium Payments for the 'Medi-Cal for Families' Program - Frequently Asked Questions," DHCS, accessed October 25, 2020; *Fact Sheet: Aged & Disabled Medi-Cal Program* (PDF), California Advocates for Nursing Home Reform, last updated July 30, 2019; and "Population Distribution for Medi-Cal Enrollees by Share of Cost (SOC)," California Health and Human Services Agency, accessed January 26, 2021.

* *Share of cost* is the amount of health care costs the enrollee must incur before Medi-Cal will pay for medically necessary goods and services. It is calculated as the monthly family income less a Maintenance Need Allowance based on family size.

Medi-Cal Waivers

1915(B) FREEDOM OF CHOICE

PURPOSE

Permits states to implement service delivery models that restrict choice of providers, such as managed care. States may also use these to waive statewide requirements (e.g., limited geographic area) and comparability requirements.

EXAMPLE

Specialty Mental Health Services. Waives freedom of choice and creates county mental health plans to deliver specialty mental health services.

1915(C) HOME AND COMMUNITY-BASED SERVICES

PURPOSE

Authorizes states to use home and community-based services as an alternative to placement in a nursing home, hospital, or other long-term care facility.

EXAMPLES

HCBS for the Developmentally Disabled. For enrollees of any age with developmental and intellectual disabilities, including autism, to assist with living in the community rather than in an institution.

Nursing Facility / Acute Hospital Waiver. Provides case management, habilitation services, home health nursing, and other services for medically fragile and technology-dependent people of any age.

HIV/AIDS Waiver. Provides care coordination, respite care, personal care, expressive therapies, family counseling and training, and other services for medically fragile and technology-dependent people up to age 20.

Other 1915(c) waivers. Include Multipurpose Senior Services Program, Assisted Living, and In-Home Operations.

1115(A) RESEARCH AND DEMONSTRATION PROJECTS

PURPOSE

Gives broad authority to waive certain provisions of the Medicaid statutes related to state program design for "any experimental, pilot, or demonstration project likely to assist in promoting the objectives" of the programs. These waivers must be "budget neutral" (i.e., require no additional federal spending).

EXAMPLES

Medi-Cal 2020. Composed of five main programs:

- **Public Hospital Redesign and Incentives in Medi-Cal.** Changes care delivery to maximize health care value and strengthens ability to perform under risk-based alternative payment models.
- **Global Payment Program.** Establishes a statewide pool of funding for the remaining uninsured and provides an incentive for primary and preventive care services.
- **Whole Person Care pilot program.** Coordinates physical health, behavioral health, and social services for enrollees with poor health outcomes who are high risk and have high costs.
- **Dental Transformation Initiative.** Provides incentives to improve access to preventive services and continuity of care for dental services for Medi-Cal children.
- **Drug Medi-Cal Organized Delivery System.** Aims to demonstrate how organizing substance use disorder services along a continuum of care increases enrollees' success while decreasing system health care costs.

Sources: Jennifer Ryan and Julie Stone, *Medi-Cal Explained Fact Sheet: Medicaid Waivers in California*, California Health Care Foundation, October 2019; and "Medi-Cal Waivers," California Dept. of Health Care Services, accessed October 25, 2020.

States may use statutory authority to waive certain Medicaid rules, subject to federal approval. As of January 2021, California has 12 waiver programs. Due to the COVID-19 pandemic, Medi-Cal received an extension to the end of 2021 for the Medi-Cal 2020 demonstration waiver and the 1915(b) waiver.

California Advancing and Innovating Medi-Cal (CalAIM)

Section 1115 and 1915(b) waivers, under which many Medi-Cal benefits and initiatives are delivered, are scheduled to expire at the end of 2021. A new proposal, California Advancing and Innovating Medi-Cal (CalAIM), provides a framework for new waivers and future reforms. Importantly, CalAIM envisions moving away from demonstration waivers and making systemic programmatic changes focused on population health improvement.

The CalAIM goals over six years are to:

- Identify and manage member risk and need through whole-person care approaches and addressing social determinants of health.
- Work toward a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

CalAIM proposes to:

- Create new benefits — Enhanced Care Management and In Lieu of Services — which would be delivered by managed care plans. These benefits demonstrated their effectiveness in the Whole Person Care pilots and Health Homes Program.
- Increase managed care plans' responsibility for care delivery and allow pilots wherein plans would manage and integrate services across multiple benefits (e.g., physical and behavioral health).
- Streamline county behavioral health services reimbursement, contracting, and program administration.

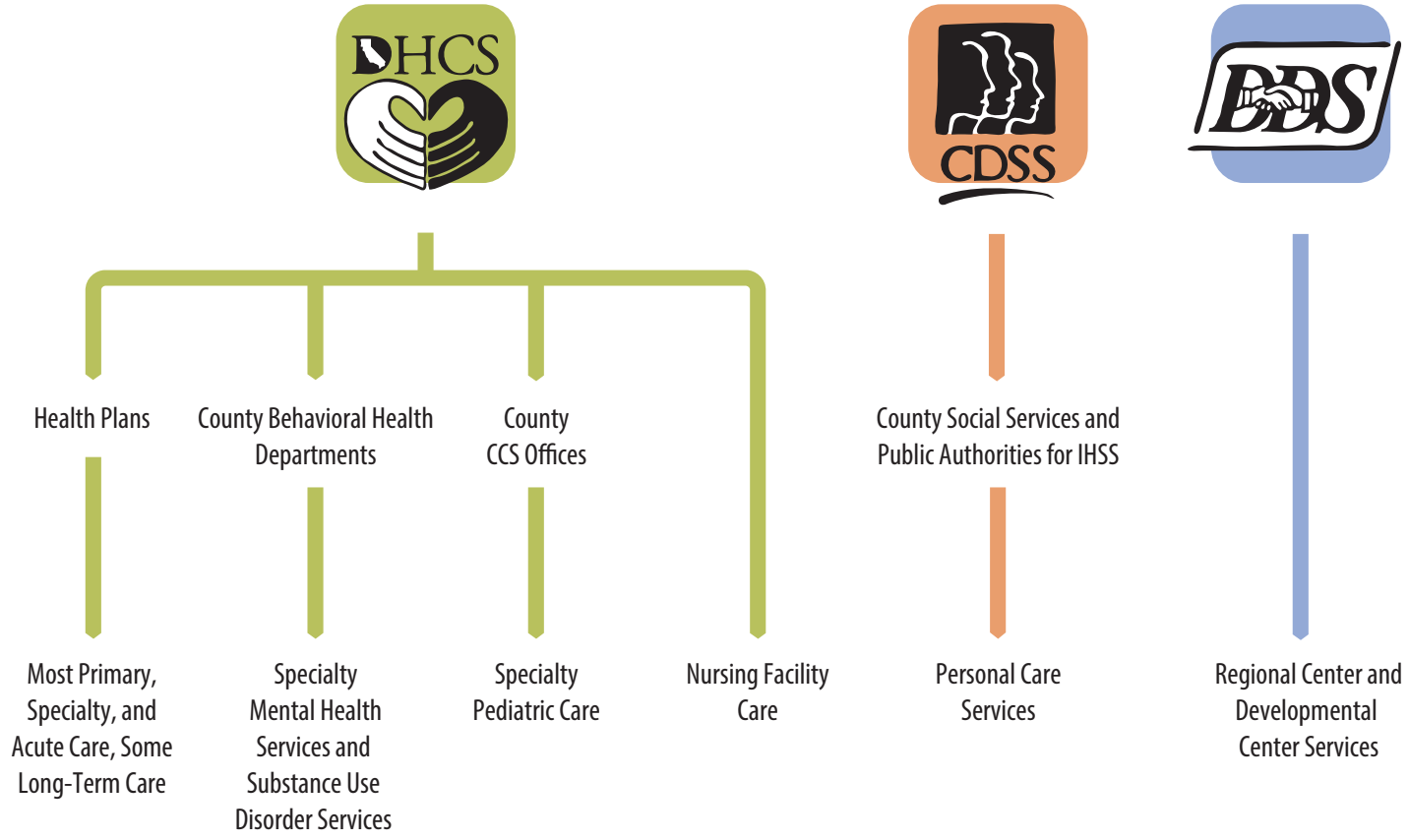
While the launch has been postponed to January 2022 due the COVID-19 pandemic, DHCS has affirmed its commitment to CalAIM. The FY 2021–22 budget includes $1.6 billion for implementation.

The state has proposed innovations and changes aimed at improving care for Medi-Cal members.

Sources: *California Advancing and Innovating Medi-Cal (CalAIM)* (PDF), Insure the Uninsured Project, February 2020; *California Advancing and Innovating Medi-Cal: Executive Summary and Summary of Changes* (PDF), California Dept. of Health Care Services (DHCS), accessed January 26, 2021; and *2021-22 Governor's Budget: Department of Health Care Services Highlights* (PDF), DHCS, January 8, 2021.

Systems for Delivering Care

Medi-Cal services are financed and administered through an array of state departments and local intermediaries.



Notes: *DHCS* is the California Department of Health Care Services. *CDSS* is the California Department of Social Services. *DDS* is the California Department of Developmental Services. *CCS* is the California Children's Services program for children with special health care needs. *IHSS* is the In-Home Supportive Services program. Public authorities are the employers of record and maintain a provider registry for those eligible for personal care services through IHSS. Developmental centers (for facility-based care) and regional centers (for community-based care) serve people with developmental disabilities. This is not a complete list of services provided by Medi-Cal. The budgets of other departments (e.g., aging, corrections, public health) also include some general fund spending for Medi-Cal services.

Medi-Cal and Telehealth

Many Medi-Cal enrollees report difficulty accessing specialty services, a problem exacerbated by the COVID-19 pandemic. Telehealth can improve access to care by decreasing wait times between a referral and subsequent visit.

Telehealth is a collection of methods or means for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

Telehealth technologies can be used for diagnostic and monitoring activities as well as education across most health services disciplines, including medicine, dentistry, counseling, occupational and physical therapy, and chronic disease management.

Telehealth is particularly valuable to deliver care to residents of rural areas.

The COVID-19 public health emergency forced swift action by federal and state governments to support telehealth during the pandemic, including increased flexibility and enhanced payment to providers for telehealth visits.

From March to September 2020 during the COVID-19 pandemic, the average monthly rate of outpatient telehealth visits per 100,000 Medi-Cal enrollees increased to 8,587 from 287 during the same period in 2019.*

Nearly 7 in 10 Californians reported receiving care via telehealth in 2020.

The use of telehealth by Medi-Cal providers increased dramatically during the COVID-19 pandemic.

* Outpatient telehealth visits per 100,000 enrollees provided by both managed care and fee-for-service providers. Visits by phone or video. Does not include mental health visits.

Sources: "What Is Telehealth," Center for Connected Health Policy, accessed October 24, 2020; *The State of Telehealth in Medi-Cal Managed Care: Taking Stock in the Era of COVID-19*, California Health Care Foundation (CHCF), April 2020; Shira H. Fischer et al., "Prevalence and Characteristics of Telehealth Utilization in the United States," *JAMA Network Open* 3, no. 10 (Oct. 26, 2020): e2022302; Rebecca Catterson, Lucy Rabinowitz, and Emily Alvarez, *The 2021 CHCF California Health Policy Survey*, CHCF, January 2021; and *Stakeholder Advisory Committee Meeting* (PDF), California Dept. of Health Care Services, February 11, 2021.

Managed Care vs. Fee-for-Service, November 2020

	MANAGED CARE	FEE-FOR-SERVICE
Availability	All 58 counties	All 58 counties
Market Share	85% of all enrollees	15% of all enrollees
Enrollment Categories	**Mandatory** • Children • Pregnant people • Parents / caretaker relatives • Adults without dependents • Seniors and people with disabilities (not also in Medicare) **Voluntary** • Seniors and people with disabilities (dually eligible for Medicare) • Foster children and youth • All enrollees in San Benito County	• Dually eligible enrollees • Foster children • Long-term services and supports • Those with other health insurance • Share of Cost (SOC) Medi-Cal • Family PACT • Other enrollees without full-scope Medi-Cal • Enrollees who have received a medical exemption • Those receiving restricted-scope benefits
Expenditures	50%	28%*
Covered Services	All essential health benefits required by the ACA, including: • Ambulatory services • Emergency services • Mental health and substance use disorder services • Hospitalization • Pediatric services • Prescription drugs	• Most long-term services and supports • Specialty mental health • Substance use disorder services • Dental services† • California Children's Services for the seriously ill and disabled children and youth in certain counties‡
Payment	The state pays plans a fixed monthly capitation rate for each member, also known as a per-member per-month payment. Plans negotiate payment rates with most contracted network providers.	The state pays providers according to a fee schedule.
Carve-Outs	• Pharmaceuticals§ • Specialty mental health • Substance use disorder services • Most long-term services and supports • Dental services† • California Children's Services for the seriously ill and disabled children and youth in certain counties‡	N/A

* Fee-for-service expenditures include "carved-out" services received by managed care enrollees such as dental and specialty mental health.

† Dental services are provided by Dental Managed Care (DMC) plans in Sacramento and Los Angeles Counties. In Sacramento County, enrollment is mandatory, with few exceptions. In Los Angeles County, an enrollee must opt in to participate in the DMC program.

‡ CCS children enroll in managed care plans that provide non-CCS services. For their CCS-related needs, they use fee-for-service CCS providers typically outside of the managed care plan. CCS services are delivered by the five County Organized Health Systems to CCS children in 21 counties under a model called "CCS Whole Child Model."

§ Medi-Cal intends to transition the pharmaceutical benefit responsibility away from managed care plans in 2022 and centralize benefit administration within DHCS and a contracted pharmacy benefit management vendor.

More than 8 in 10 Medi-Cal enrollees are enrolled in managed care plans, and account for 50% of all Medi-Cal expenditures. The state determines mandatory or voluntary managed care enrollment, subject to federal approval.

Notes: *Family PACT* is the Family Planning, Access, Care and Treatment Program. Medi-Cal enrollees in San Benito County may elect not to enroll in the single managed care plan and instead have all services provided to them by FFS providers. Enrollees with restricted-scope benefits are all in FFS Medi-Cal.

Sources: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Health and Human Services Agency, accessed December 11, 2020; *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health Care Services (DHCS), accessed August 6, 2020; *Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes* (PDF), DHCS, December 3, 2018; "California Children's Services Whole Child Model," DHCS; "Medi-Cal Dental Managed Care," DHCS, accessed December 19, 2020; and "Medi-Cal Rx: Medi-Cal Rx Background," DHCS, accessed October 25, 2020.

Medi-Cal Managed Care and Fee-for-Service Enrollment Trends

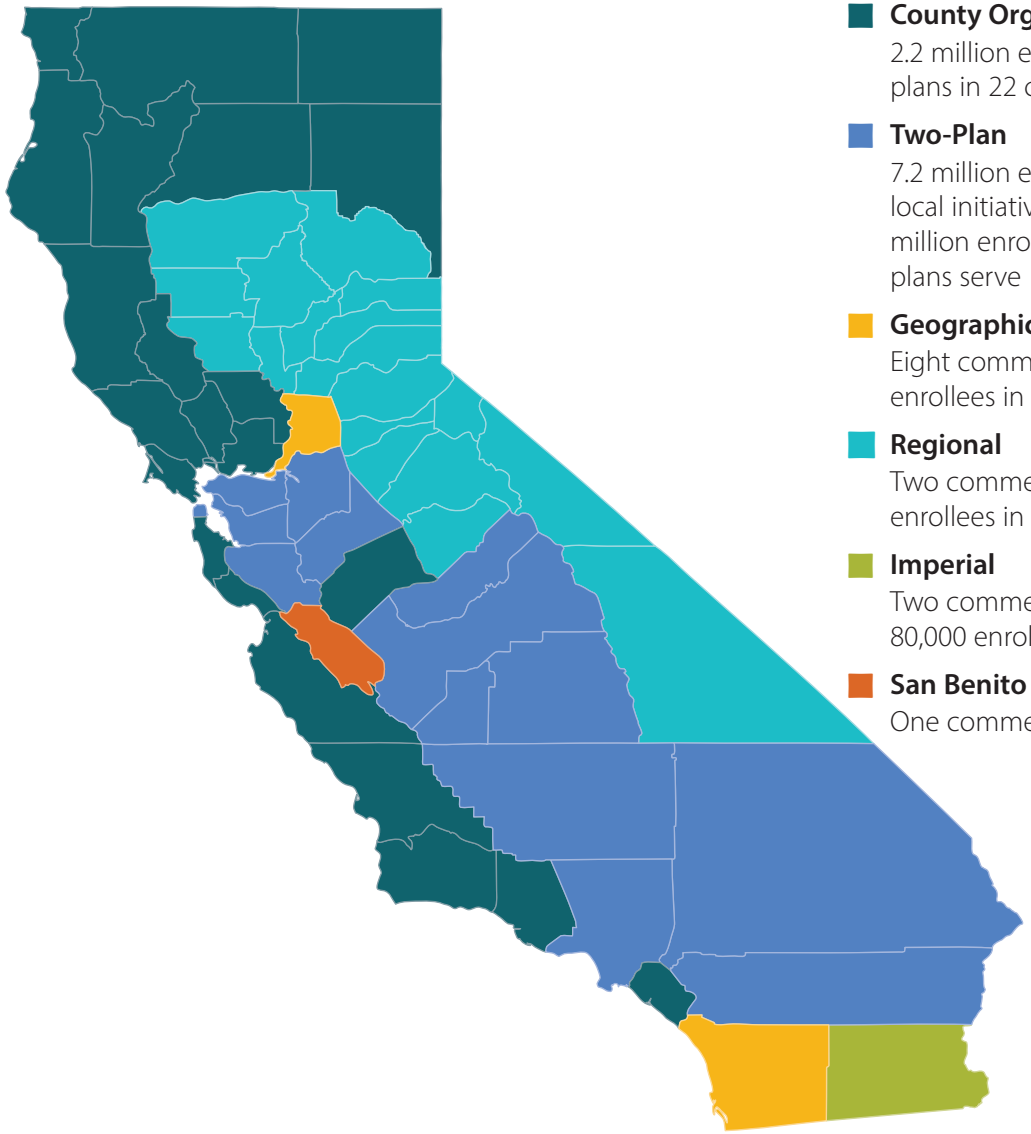
2010 to 2020, Selected Years

The majority of Medi-Cal members are enrolled in managed care plans. The share of members enrolled in fee-for-service Medi-Cal has decreased from 2010 to 2020.

Note: Enrollment is from November of each year.

Source: "Month of Eligibility, Delivery System and Health Plan, by County, Medi-Cal Certified Eligibility," California Dept. of Health Care Services, accessed December 11, 2020.

Medi-Cal Managed Care Models by Model and County, November 2020



County Organized Health Systems (COHS)
2.2 million enrollees served by six health plans in 22 counties.

Two-Plan
7.2 million enrollees in 14 counties. Nine local initiatives (county-organized) serve 5.3 million enrollees, and three commercial plans serve 1.8 million enrollees.

Geographic Managed Care (GMC)
Eight commercial plans serve 1.1 million enrollees in 2 counties.

Regional
Two commercial plans serve 315,000 enrollees in 18 counties.

Imperial
Two commercial plans serve about 80,000 enrollees.

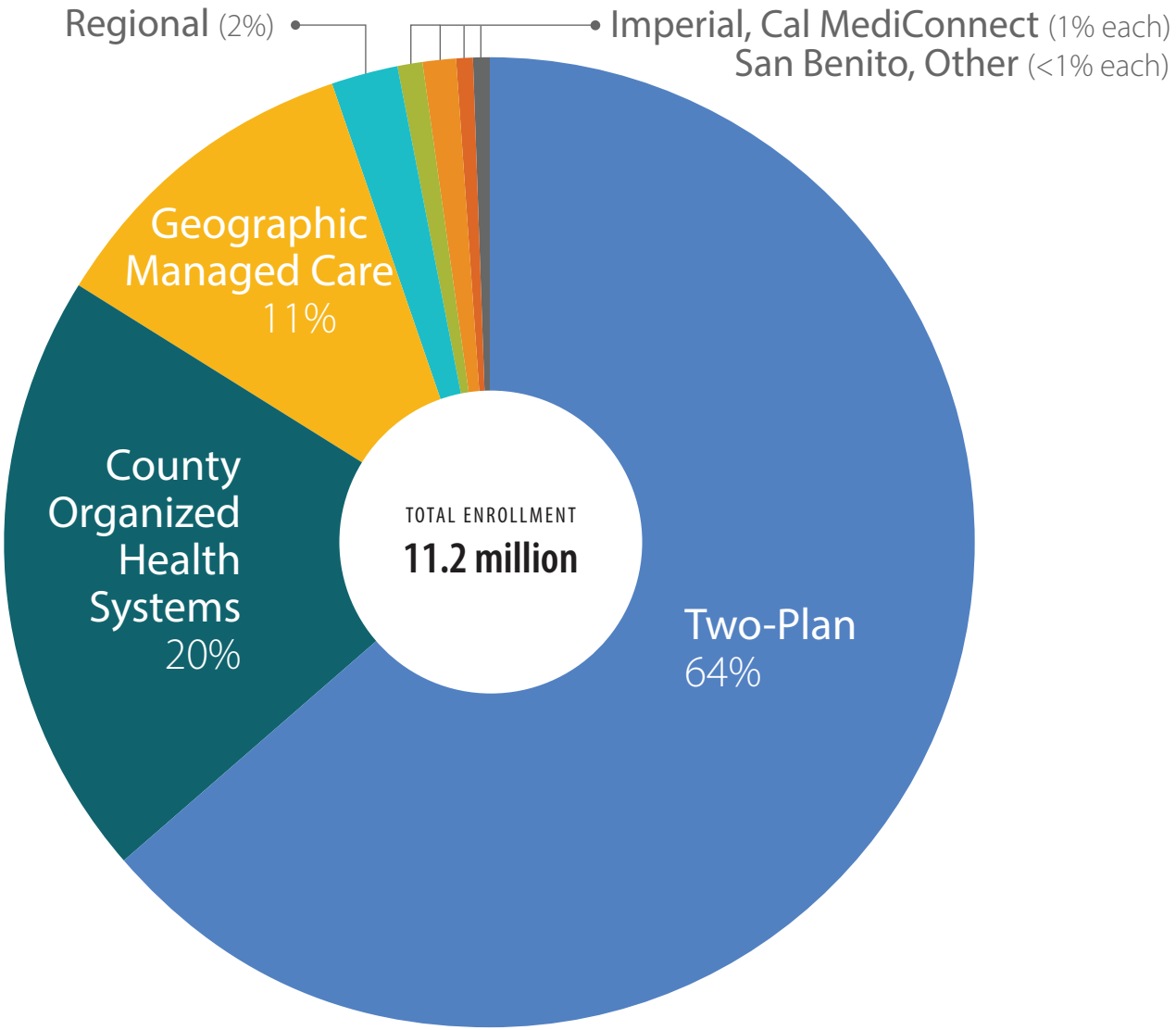
San Benito
One commercial plan serves 8,800 enrollees.

In California, there are six models of managed care.

Notes: The figures above include Cal MediConnect enrollees but exclude SCAN, Primary Care Case Management, Special Project, and PACE plan enrollees. While Tulare is a Two-Plan Model county, there is no county-run local initiative and instead the county contracts with Anthem Blue Cross as the local initiative. Tulare's enrollment is included in commercial plans.

Sources: *Medi-Cal Managed Care Program Fact Sheet - Managed Care Models* (PDF), California Dept. of Health Care Services, January 2, 2020; and "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed December 15, 2020.

Managed Care Enrollment, by Plan Type
November 2020



Notes: *Other* includes Primary Case Management, PACE, and SCAN plans. Segments do not total 100% due to rounding.

Source: "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed December 15, 2020.

The Medi-Cal program uses a variety of managed care models, including county health plans and private health plans. The Two-Plan Model, in which a government-run local initiative competes with a private health plan, had the largest enrollment.

Medi-Cal Managed Care Carve-Outs

Certain Medi-Cal services are "carved out" of managed care plan contracts. Carved-out services have separate funding mechanisms and delivery systems.

Services offered under Medi-Cal but not provided by the managed care plan are referred to as "carve outs," and include the following services:

- **Specialty Mental Health Services (SMHS)** are provided by county mental health plans to adults with a serious mental illness and to children with a serious emotional disturbance. SMHS include targeted case management, partial hospitalization, and outpatient and inpatient mental health services.
- **Substance use disorder services** are provided through the Drug Medi-Cal program, which provides on-demand treatments, including outpatient drug-free services, intensive outpatient services, detoxification services, medication-assisted treatment, and residential recovery services.
- **Dental services** are available on a fee-for-service basis through the Denti-Cal program. Denti-Cal provides preventive, diagnostic, restorative, and periodontal services. In Los Angeles and Sacramento Counties, dental services are provided through dental managed care plans.
- **Long-term services and supports (LTSS)** include the use of home and community-based services intended to keep enrollees out of long-term care facilities. LTSS are carved out of managed care except for Community-Based Adult Services and the nursing home benefit in County Organized Health System (COHS) counties.* For the Coordinated Care Initiative, 11 Medi-Cal managed care plans refer and coordinate LTSS, but the services remain carved out except the nursing facility home benefit.
- **Institutional long-term care services** are provided under most managed care contracts for only two months. A member requiring a longer stay in the long-term care facility is disenrolled from the plan and moved to fee-for-service, where DHCS is responsible for all covered services. DHCS has proposed a statewide carve-in of this benefit into managed care under its CalAIM initiative.
- **California Children's Services (CCS)** provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Five COHS plans will manage these children's benefits in 21 counties in a program called the CCS Whole Child Model.
- **Prescription drug** benefit in managed care plans will transition to Medi-Cal Rx in 2021. (See page 31 for details.)

* Health Plan of San Mateo, a County-Organized Health System, has also fully integrated Multipurpose Senior Services Program benefits.

Sources: *2019 Medi-Cal Dental Services Member Handbook* (PDF), California Dept. of Health Care Services (DHCS), accessed October 26, 2020; "Medi-Cal Specialty Mental Health Services," DHCS, accessed October 26, 2020; "California Children's Services Whole Child Model," DHCS, accessed October 26, 2020; and Amber Christ and Georgia Burke, *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care*, California Health Care Foundation, September 2020.

Medi-Cal Long-Term Services and Supports

Medi-Cal enrollees who have a disability or chronic illnesses may need services to support their daily living. They may receive these services in an institutional setting, at home, or in the community. These services are referred to as long-term services and supports (LTSS).

The majority of California skilled nursing facility residents are Medi-Cal enrollees, and most using long-term services and supports are dually eligible for Medicaid and Medicare.

There are nearly a dozen LTSS programs for which Medi-Cal coordinates benefits, financing, and oversight with four other state agencies. This patchwork creates challenges for providers and Medi-Cal enrollees.

Qualifying enrollees are entitled to receive these LTSS benefits:

- Skilled nursing facility services
- Personal care services
- Self-directed personal assistance services
- Community first choice option (in-home supportive services)
- Home and community-based services

Eligibility requirements for Medi-Cal support of LTSS are based on income and having limited assets. Some enrollees with higher incomes may pay a share of the cost.

Additional benefits may include case management, private duty nursing, home health aides, community transition services, and respite care for caregivers. However, these may not be available statewide.

Medi-Cal spent $3.3 billion on skilled nursing facilities in FY 2019–20.

Medi-Cal prioritizes keeping seniors and people with disabilities living in the community with in-home and other services and supports. Medi-Cal spends three out of four long-term services and supports dollars on home health and personal care.

Sources: Athena Chapman and Elizabeth Evenson, *Long-Term Services and Supports in Medi-Cal* (PDF), California Health Care Foundation, October 2020; *If You Think You Need a Nursing Home: A Consumer's Guide to Financial Considerations and Medi-Cal Eligibility* (PDF), California Advocates for Nursing Home Reform, revised January 2021; "Integrated Care: What Choices Exist for Californians with Medicare and Medi-Cal?," SCAN Foundation, last updated October 16, 2019; and *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health of Health Care Services, accessed August 6, 2020.

Medi-Cal Coordinated Care Initiative

The Coordinated Care Initiative (CCI) was enacted in 2012 and implemented in seven counties.* The goal is to better serve the state's seniors with low incomes, people with disabilities, and enrollees dually eligible for Medi-Cal and Medicare.

The first component of the CCI is a mandatory Managed Long-Term Services and Supports (MLTSS) program. Through MLTSS, Medi-Cal enrollees, including those who are dually eligible, must enroll in a Medi-Cal managed care plan to receive their benefits, including long-term care services and Medicare wraparound benefits.

The second component, a demonstration project for dually eligible members called Cal MediConnect (CMC), creates a single plan covering all Medi-Cal and Medicare benefits. Eleven managed care plans participate in CMC. Dually eligible enrollees voluntarily enroll in a CMC plan and receive coordinated medical, behavioral health, long-term institutional, and home- and community-based services. As of February 2021, 112,968 members were enrolled in CMC plans.

The initial CMC demonstration has ended but California received extensions through December 31, 2022.

The Coordinated Care Initiative is a demonstration project to better serve seniors with low incomes, people with disabilities, and enrollees who are dually eligible for Medi-Cal and Medicare. The demonstration has laid the groundwork for proposed statewide changes.

* Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara

Sources: "Coordinated Care Initiative Overview," California Dept. of Health Care Services (DHCS), accessed October 29, 2020; *Cal MediConnect Performance Dashboard Metrics Summary* (PDF), DHCS, September 2020; Amber Christ, *Advocates Guide to California's Coordinated Care Initiative* (PDF), Justice in Aging, December 2017; and "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, accessed March 16, 2021.

Behavioral Health Services in Medi-Cal

Medi-Cal benefits include mental health and substance use disorder services. Service delivery is bifurcated between managed care plans and county mental health plans depending on an enrollee's needs. The CalAIM initiative proposes to integrate speciality mental health and SUD services into one system, making access and use easier for enrollees.

Managed Care Plans

- Medi-Cal managed care plans are responsible for individual and group psychotherapy, psychological testing, psychiatric consultation, and medication management, as required by the ACA's essential health benefits.
- These outpatient services, which address lower-acuity behavioral health conditions, are also referred to as "mild-to-moderate" services.

County Mental Health Plans

- County mental health plans are responsible for the assessment and treatment of enrollees with serious mental illness or substance use disorder needs.
- Adults with a serious mental illness and children with a serious emotional disturbance can receive specialty mental health services, which include crisis intervention, rehabilitation, targeted case management, partial hospitalization, and outpatient and inpatient mental health services. In FY 2017–18, about 4% of Medi-Cal enrollees (341,710 adults and 267,991 children and youth) received specialty mental health services.

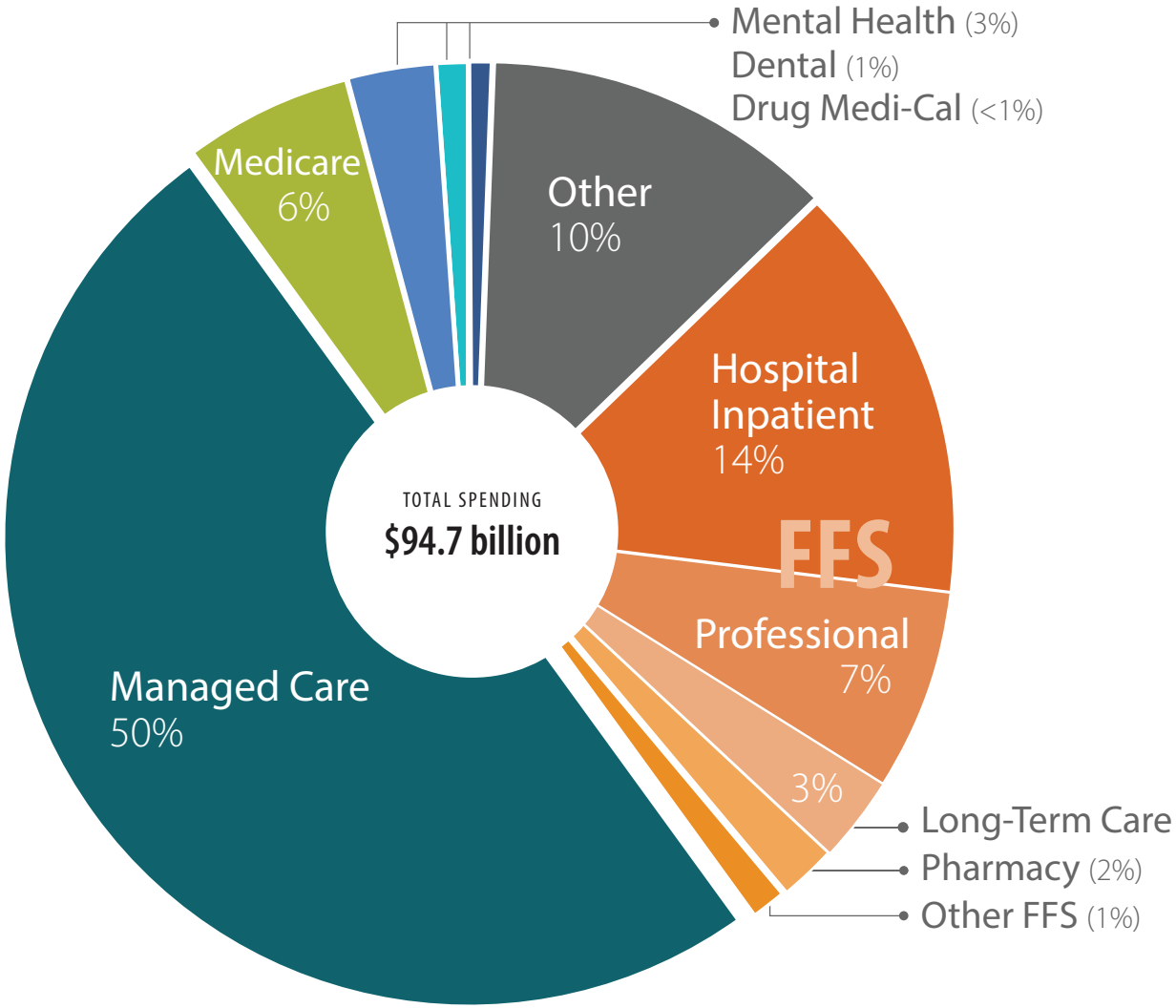
County Substance Use Disorder Programs

- Substance use disorder (SUD) services are delivered by county mental health plans through the Drug Medi-Cal program. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program aimed at improving care, increasing efficiency, and reducing societal and health care costs associated with substance use.* Thirty-seven of California's 58 counties have implemented the DMC-ODS pilot.
- The California Department of Health Care Services requires managed care plans and county mental health plans to have memorandums of understanding that specify policies and procedures for screening, referral, care coordination, information exchange, and dispute resolution in each county.

* The Drug Medi-Cal Organized Delivery System pilot is part of the Medi-Cal 2020 Section 1115 waiver.

Sources: "Behavioral Health Services," California Dept. of Health Care Services, accessed December 19, 2020; Don Kingdon, Molly Brassil, and Erynne Jones, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*, California Health Care Foundation (CHCF), August 2016; Allison Valentine, Patricia Violett, and Molly Brassil, *How Medi-Cal Expanded Substance Use Treatment and Access to Care: A Close Look at Drug Medi-Cal Organized Delivery System Pilots*, CHCF, August 2020; and "Performance Dashboard AB 470 Report Application," California Health and Human Services Agency, accessed January 26, 2021.

Medi-Cal Expenditures
by Service Category, FY 2019–20



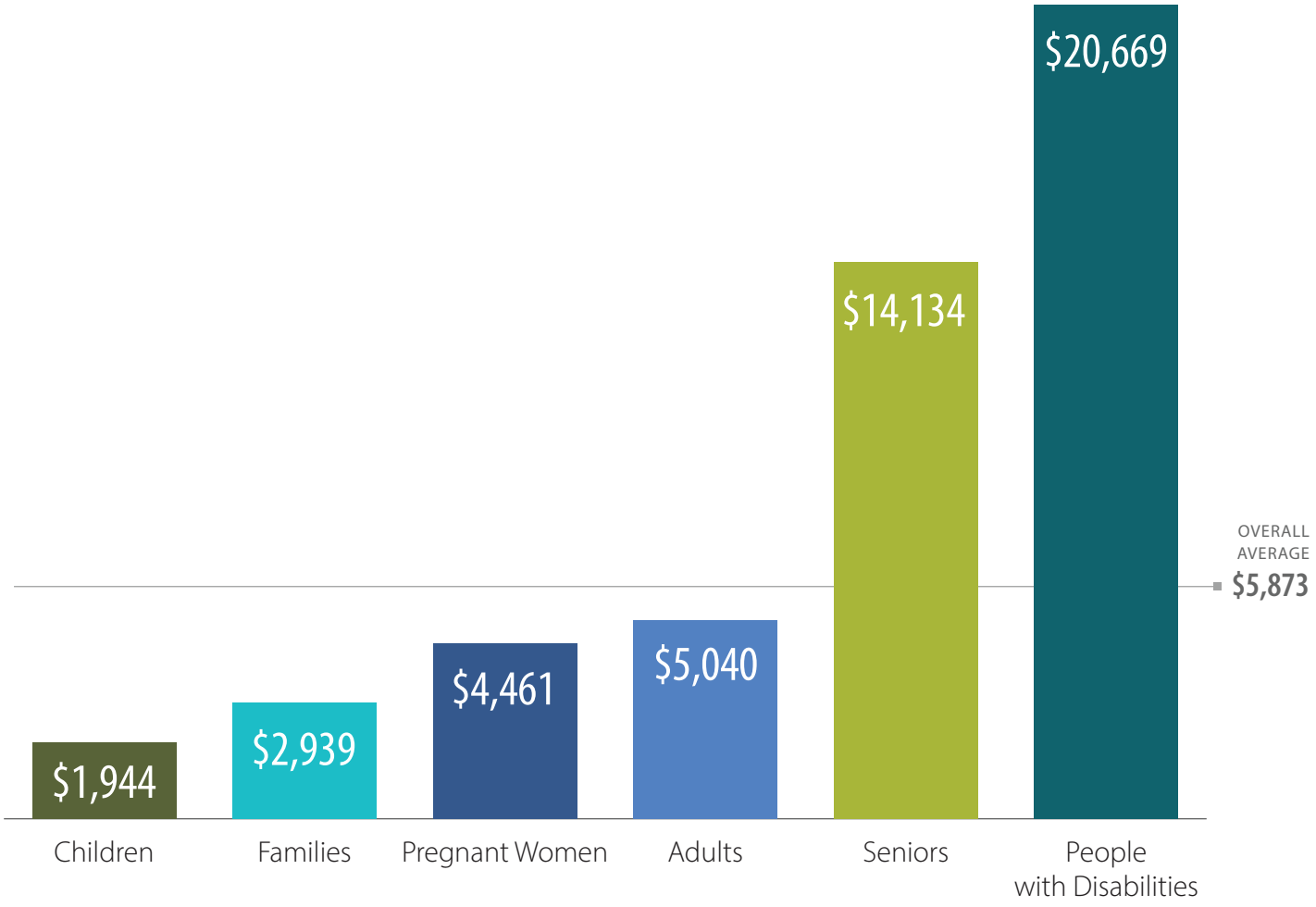
Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020 and reflect annual spending. The Drug Medi-Cal program provides services to treat enrollees with substance use disorders. *FFS* is fee-for-service. *Other FFS services* includes medical transportation, home health, and other services. *Other* includes audits/lawsuits, state hospitals / developmental centers, recoveries, and miscellaneous services. Segments may not total 100% due to rounding. Hospital services are FFS.

Source: *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019-20 and 2020-21* (PDF), California Dept. of Health Care Services, accessed August 6, 2020.

Managed care organizations were the largest category of service providers to the Medi-Cal program, accounting for half of all service payments. Hospital inpatient services, paid on a fee-for-service basis, were the next largest category, accounting for 14% of Medi-Cal spending.

Medi-Cal Annual Spending per Eligible Enrollee

FY 2019–20

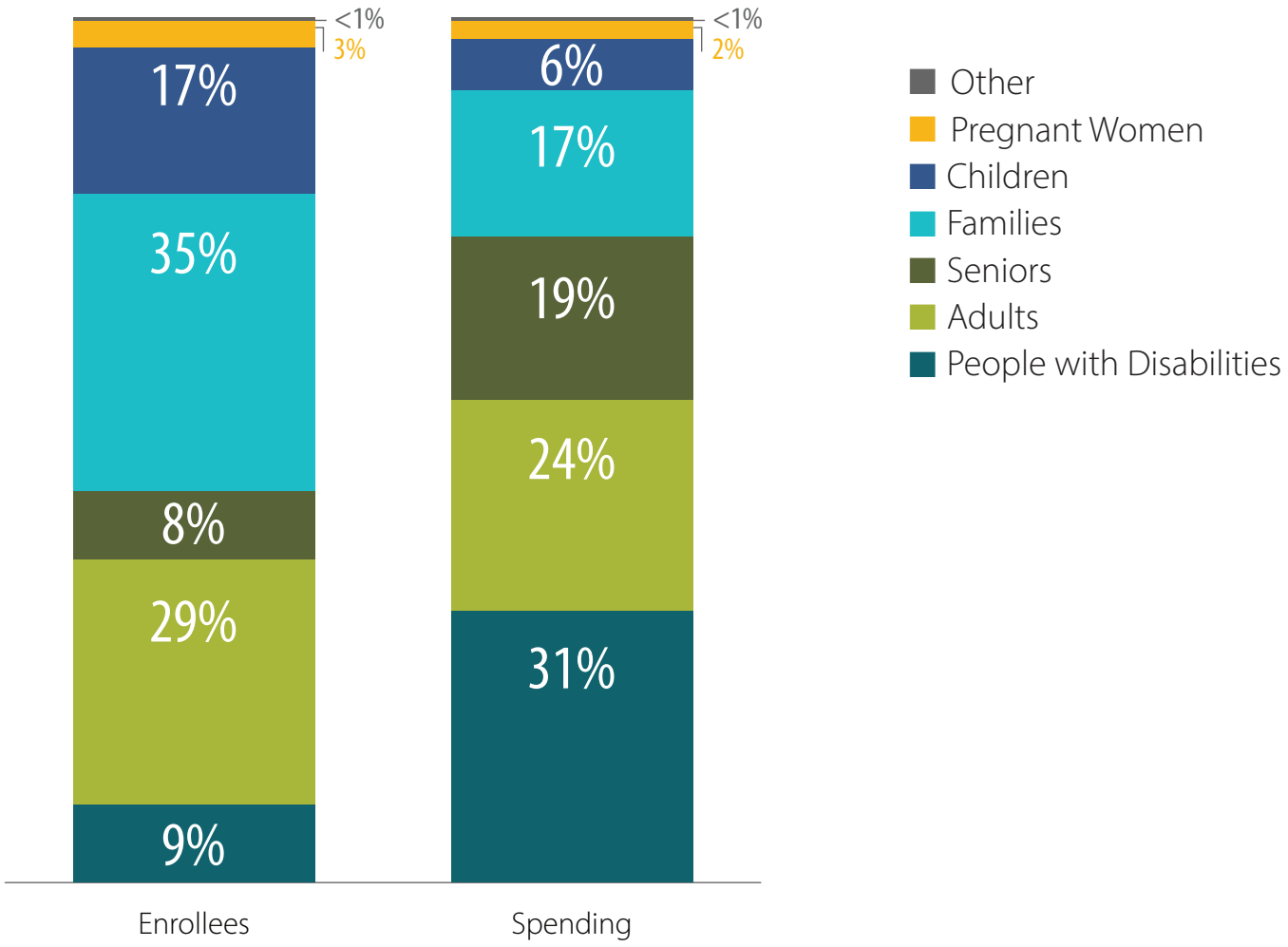


Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020 and reflect annual spending. Reported values exclude Hospital Presumptive Eligibility and other aid codes totaling 0.3% of enrollees. For additional information about Medi-Cal spending on maternity care, please see CHCF's report *Maternity Care and Paying for Maternity Services*.

Source: "Fiscal Year 2019-20 Cost per Eligible Based on May 2020 Estimate," in *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019–20 and 2020–21* (PDF), California Dept. of Health Care Services.

Medi-Cal spending per enrollee varied by eligibility category. Medi-Cal spent about $2,000 annually per child. The program spent over $20,000 annually per enrollee with disabilities.

Medi-Cal Enrollees and Spending
by Eligibility Category, FY 2019–20



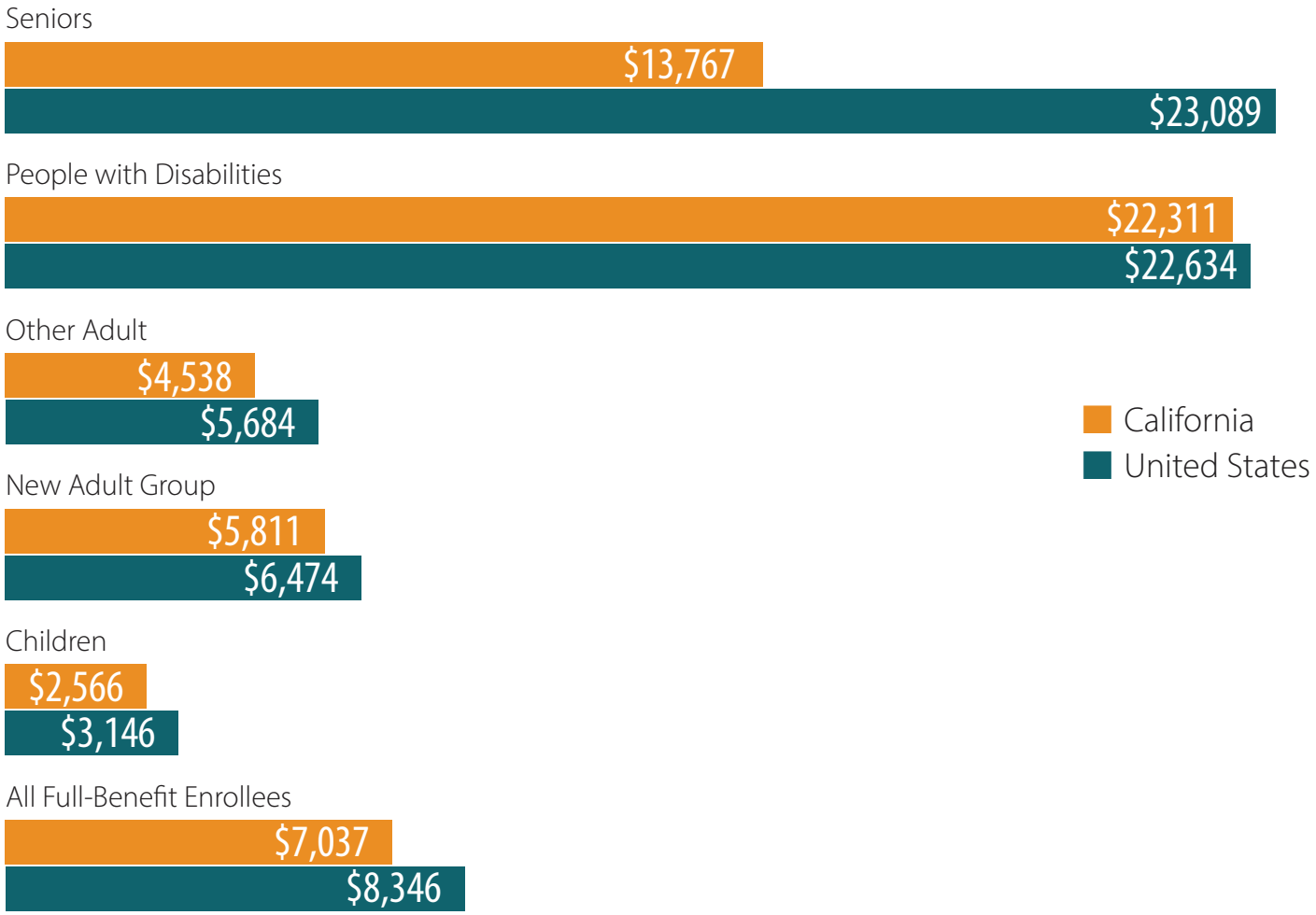
Notes: Figures presented are estimates for FY 2019–20 calculated as of May 2020. *Other* includes Hospital Presumptive Eligibility and other aid codes. For additional information about Medi-Cal spending on maternity care, please see CHCF's report *Maternity Care and Paying for Maternity Services*.

Source: "Fiscal Year 2019-20 Cost per Eligible Based on May 2020 Estimate," in *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019–20 and 2020–21* (PDF), California Dept. of Health Care Services.

People with disabilities represented 9% of Medi-Cal enrollees, but accounted for 31% of spending. Children accounted for 17% of enrollee, but just 6% of spending.

Medicaid Spending per Full-Year Equivalent Enrollees

California vs. United States, FY 2018



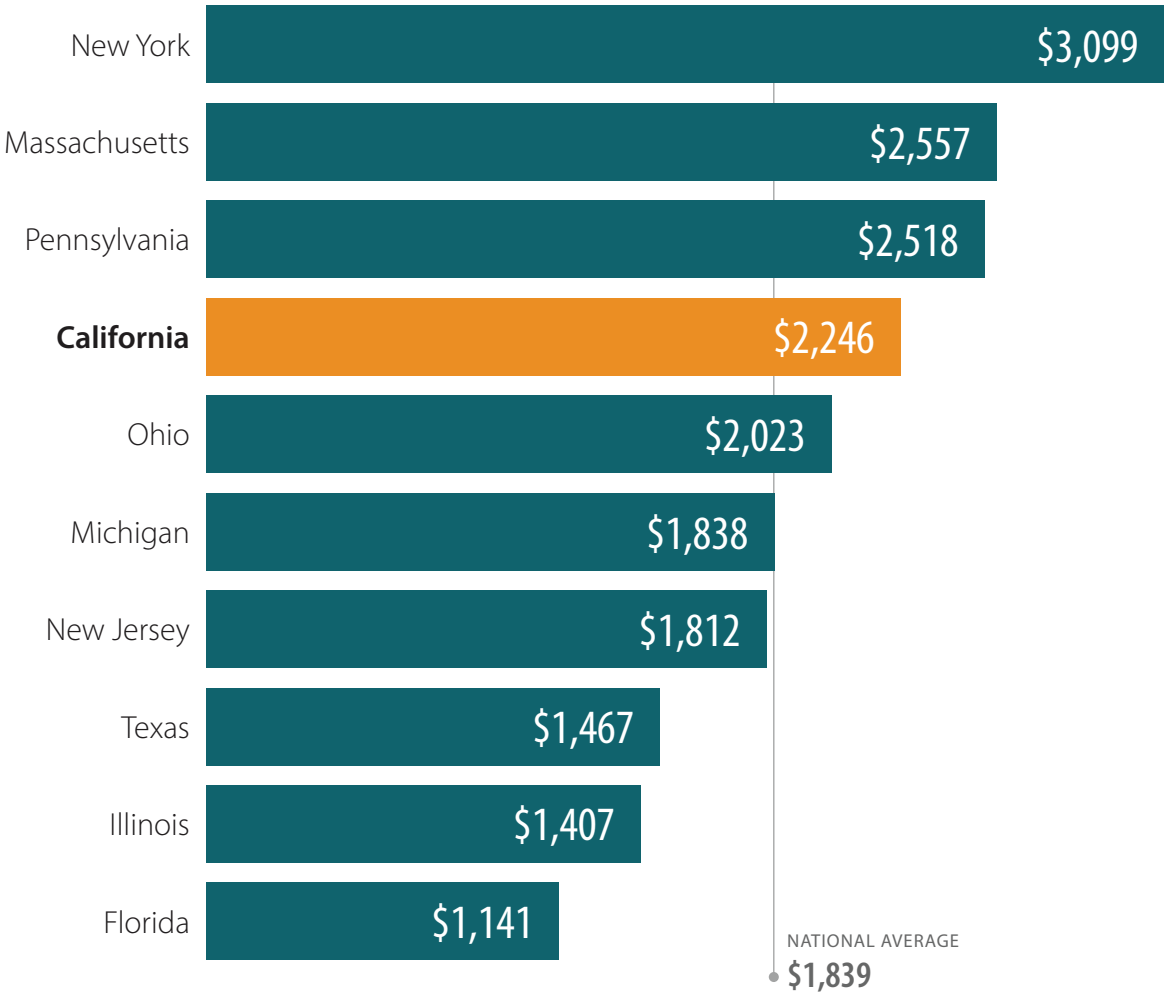
Notes: Full-year equivalent (FYE) may also be referred to as average monthly enrollment. Data are for full-benefit enrollees and exclude those receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. *Other adult* includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant people). *New adult group* is the ACA "expansion" population.

Source: "Exhibit 22. Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2018," in *MACStats: Medicaid and CHIP Data Book*, Medicaid and CHIP Payment and Access Commission.

Across all enrollee groups, California's per enrollee spending is lower than the national average.

Medicaid Spending per Resident

Selected States, FY 2019



Note: The 10 states chosen for comparison had the largest Medicaid expenditures in FY 2019.

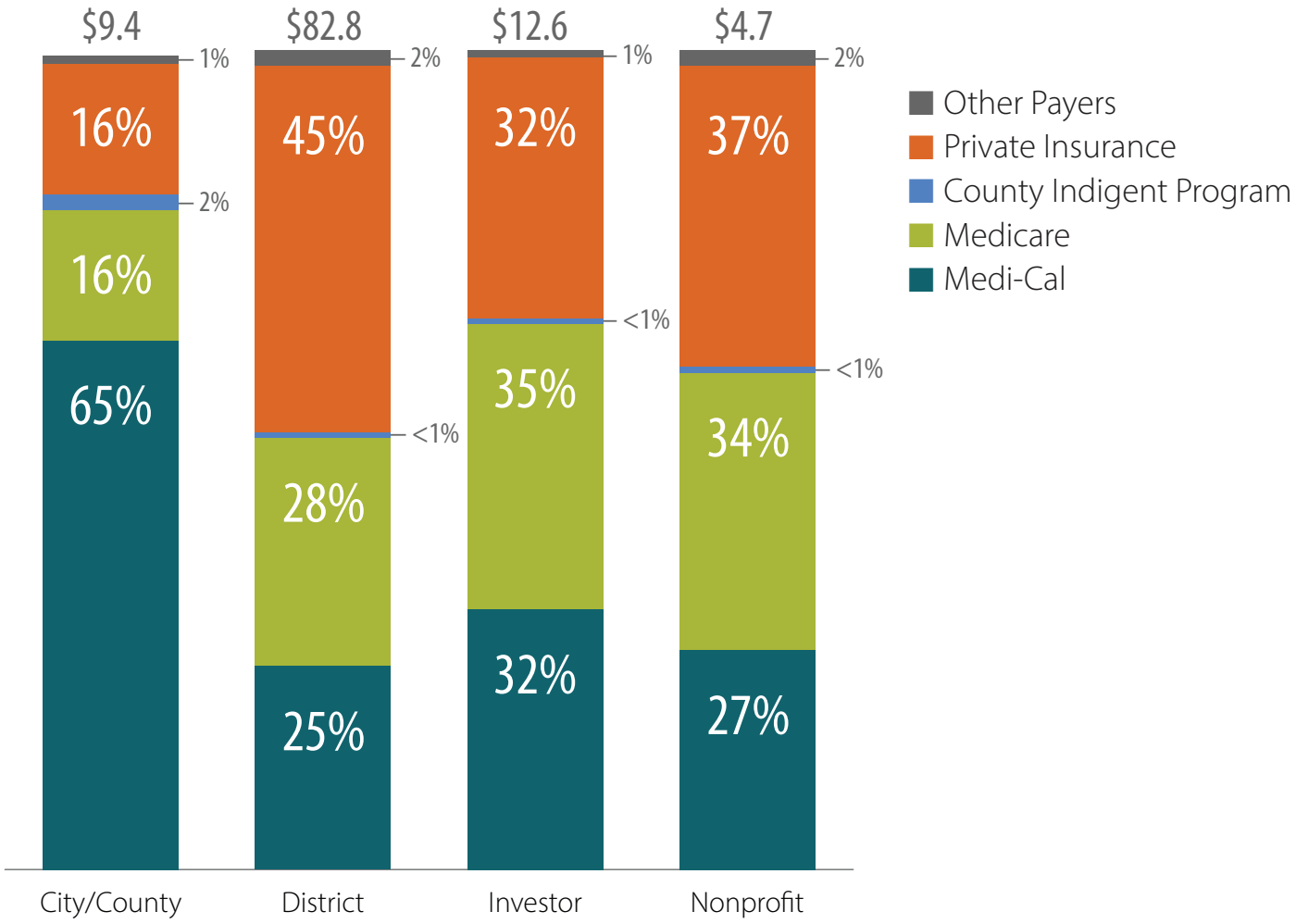
Sources: "Total Medicaid Spending" (FY2019), KFF, accessed October 24, 2020; and *Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2019* (NST-EST2019-01), US Census Bureau, accessed October 30, 2020.

While California's Medicaid program has the largest enrollment in the nation, spending per resident ($2,246) was lower than in New York ($3,099), Massachusetts ($2,557), and Pennsylvania ($2,518). The national average Medicaid spending per resident was $1,839 in 2019.

Net Patient Revenues

by Hospital Ownership Type and Payer, California, 2019

IN BILLIONS



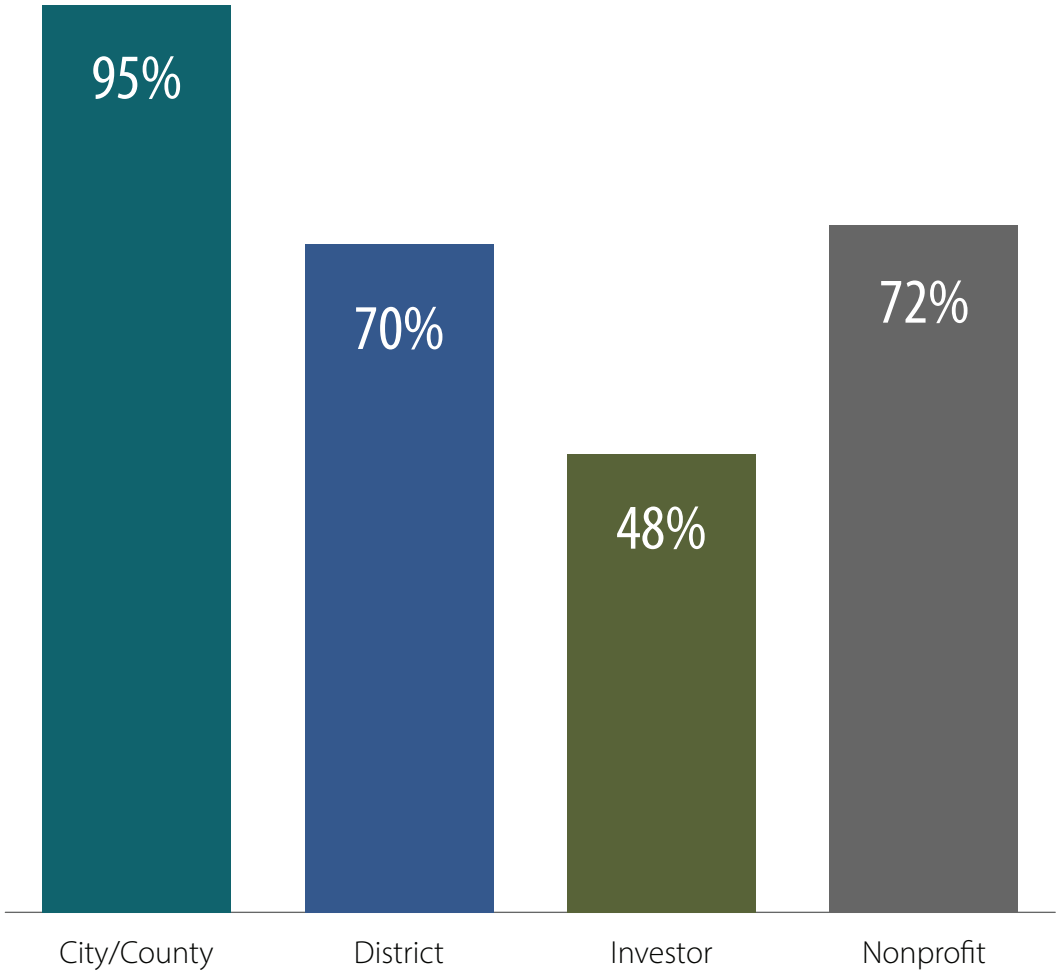
Notes: Data are only for hospitals classified as comparable by the Office of Statewide Health Planning and Development and thus do not include state-run and Kaiser hospitals or facilities classified as psychiatric or long-term care. Segments may not total 100% due to rounding.

Source: *2019 Pivot Table - Hospital Annual Selected File (November 2020 Extract)*, California Health and Human Services Agency, December 10, 2020.

Medi-Cal Facts and Figures
Role in the System

Medi-Cal is a key source of funding for hospitals. Medi-Cal provided nearly two-thirds (65%) of the net patient revenue for city/county hospitals and nearly a third (32%) for investor-owned hospitals.

Change in Medi-Cal Net Patient Revenue
by Hospital Ownership Type, 2013 to 2019

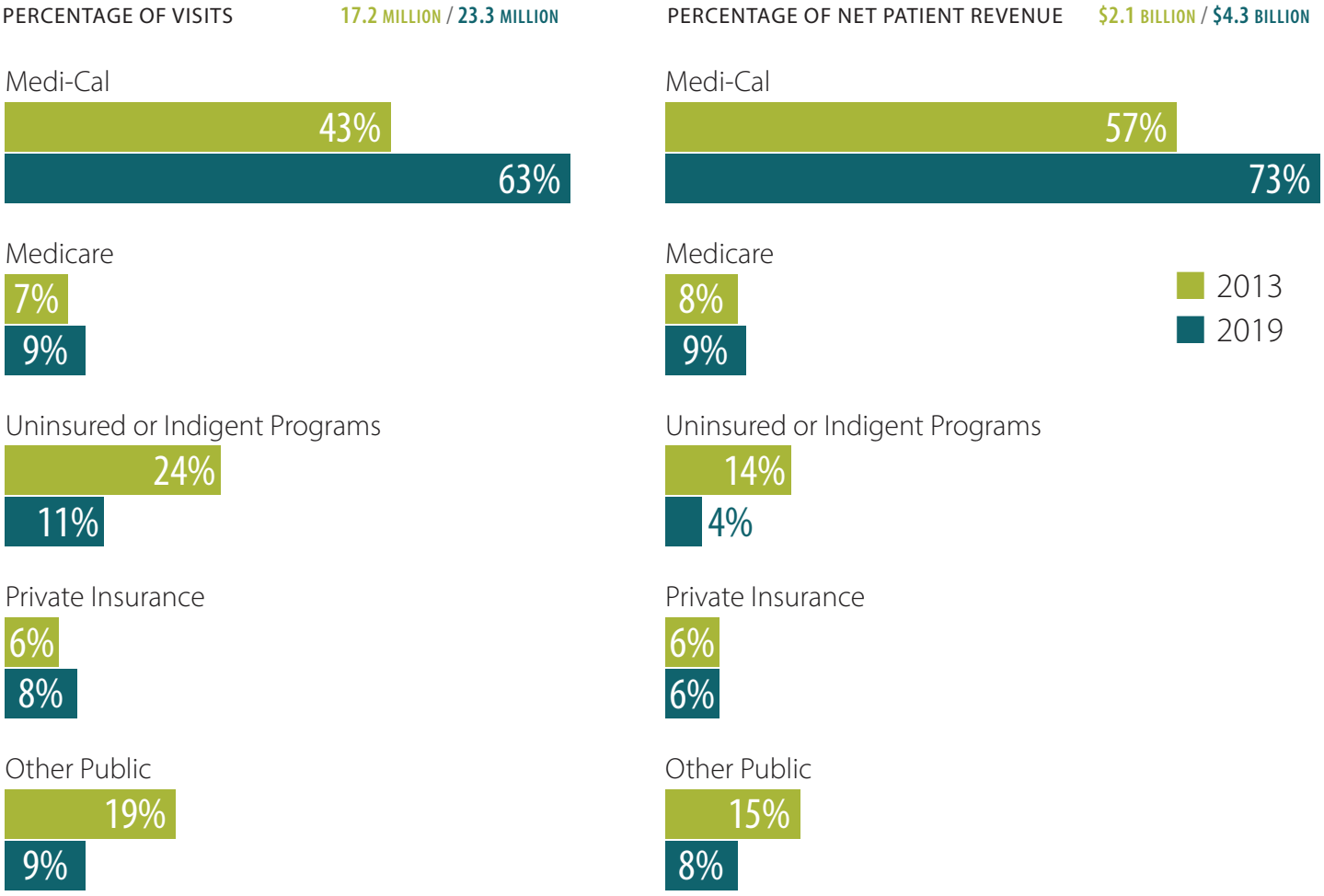


All hospital types experienced a growth in Medi-Cal net patient revenue between 2013 and 2019, likely as a result of the ACA expansion in 2014. Net patient revenue from Medi-Cal grew by 95% at city/county hospitals.

Note: Data are only for hospitals classified as comparable and thus do not include state-run and Kaiser hospitals or facilities classified as psychiatric or long-term care.

Source: *2019 Pivot Table - Hospital Annual Selected File (November 2020 Extract)*, California Health and Human Services Agency, December 10, 2020.

Primary Care Clinic Visits and Net Patient Revenue
by Payer, 2013 and 2019

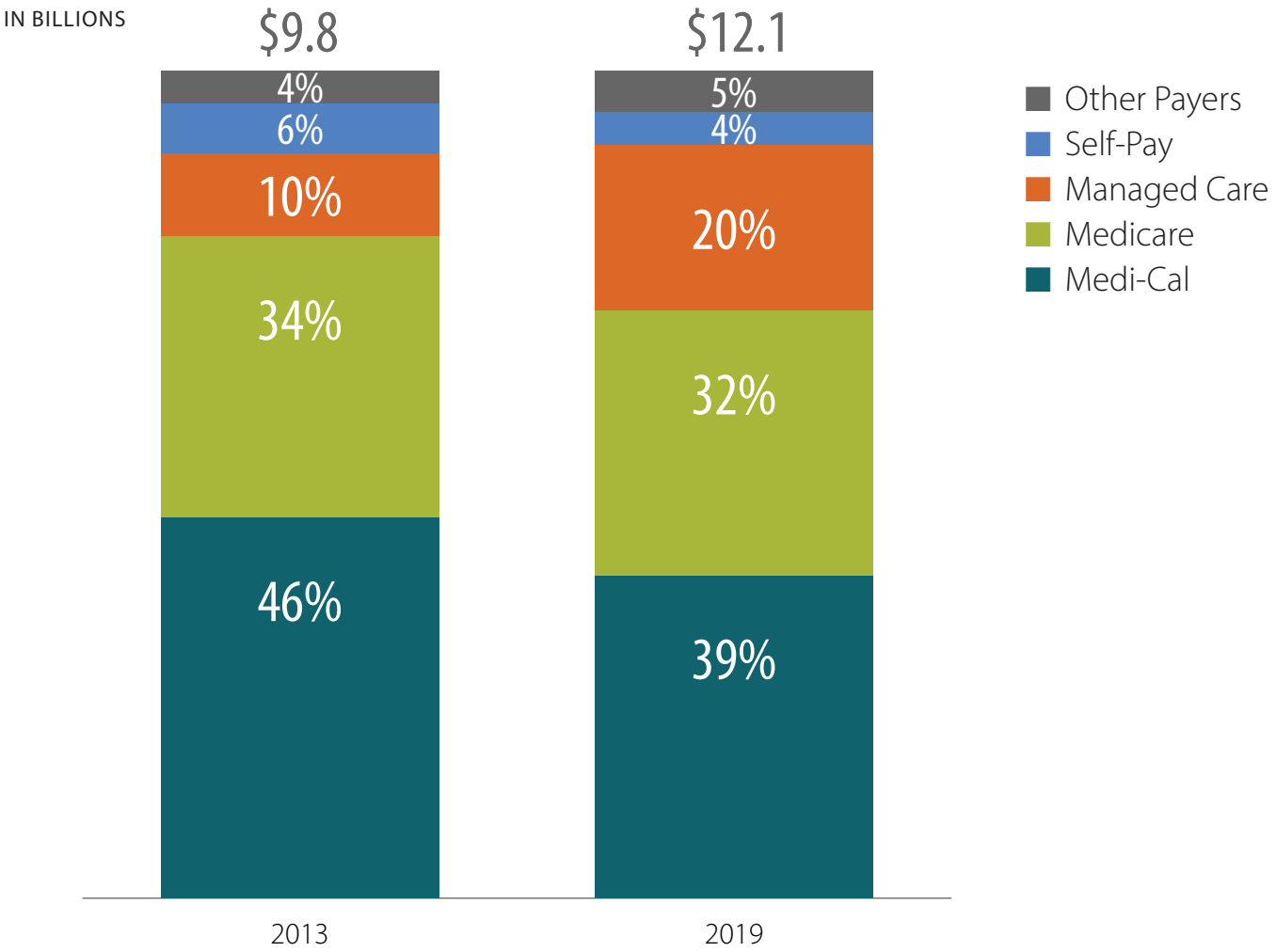


Notes: Includes Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, and other clinic types. Uninsured and indigent coverage are combined due to data-reporting inconsistencies, and include self-pay/sliding scale, free, and county indigent program patients. *Other public* includes Alameda Alliance for Health, Family PACT, and all other payers, except for the PACE program, which is excluded from all categories. Excludes county-run clinics. Segments may not total 100% due to rounding.

Source: Blue Sky Consulting Group analysis of *2019 Pivot Table - Primary Care Clinic Utilization Data*, California Health and Human Services Agency (CHHS), last updated December 4, 2020, and *2013 Pivot Table - Primary Care Utilization Data*, CHHS, last updated May 8, 2018.

Primary care clinics experienced significant growth in Medi-Cal visits and net patient revenue since the implementation of the Affordable Care Act. Medi-Cal visits increased from 43% of visits in 2013 to 63% of visits in 2019. Both visits and revenue from uninsured patients declined as more patients were enrolled in Medi-Cal and private insurance.

Net Patient Revenues, Long-Term Care Facilities
by Payer, 2013 and 2019



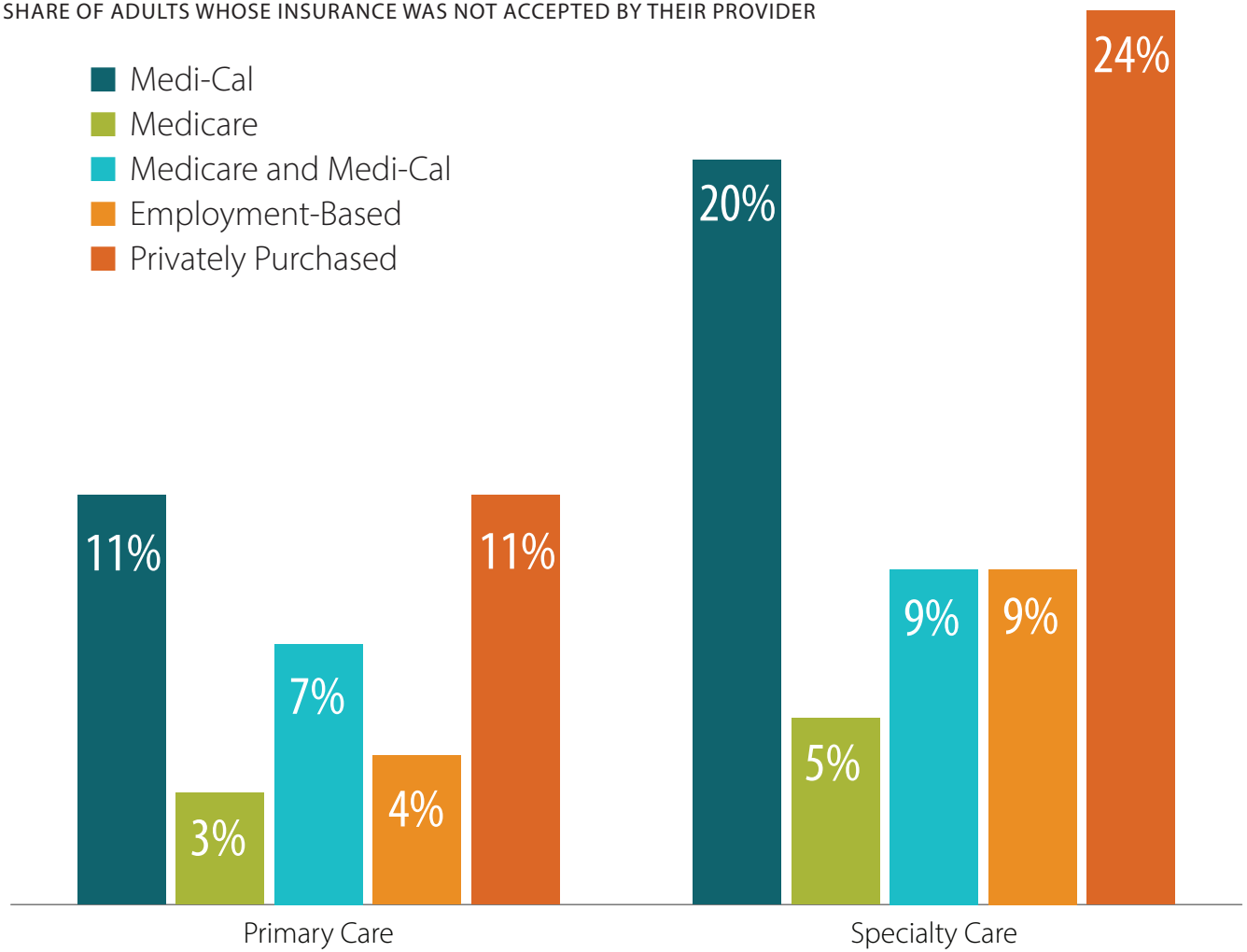
Notes: *Long-term care facilities* includes those facilities providing sub acute and intermediate care, skilled nursing, and facilities for the developmentally disabled. Managed care patients are those enrolled in a managed care health plan who receive all or part of their health care from providers on a prenegotiated or per diem basis, usually involving utilization review. This includes health maintenance organizations (HMOs), HMOs with point-of-service option, preferred provider organizations, exclusive provider organizations (EPOs), EPOs with point-of-service option, etc. Also includes patients enrolled in Medicare and Medi-Cal managed care health plans. Segments may not total 100% due to rounding.

Sources: *2019 - Pivot Profile - Long-Term Care Annual Financial Data (December 2020)*, California Health and Human Services Agency (CHHS), last updated December 14, 2020; and *2013 - Pivot Profile - Long-Term Care Annual Financial Data*, CHHS, last updated May 3, 2018.

Medi-Cal provided an important source of net patient revenue for long-term care facilities. Even though the share of revenues from Medi-Cal was down from 2013, Medi-Cal accounted for 39% of all long-term care facilities' net patient revenues in 2019.

Insurance Not Accepted by Provider
by Source of Coverage, Adults, California, 2019

SHARE OF ADULTS WHOSE INSURANCE WAS NOT ACCEPTED BY THEIR PROVIDER



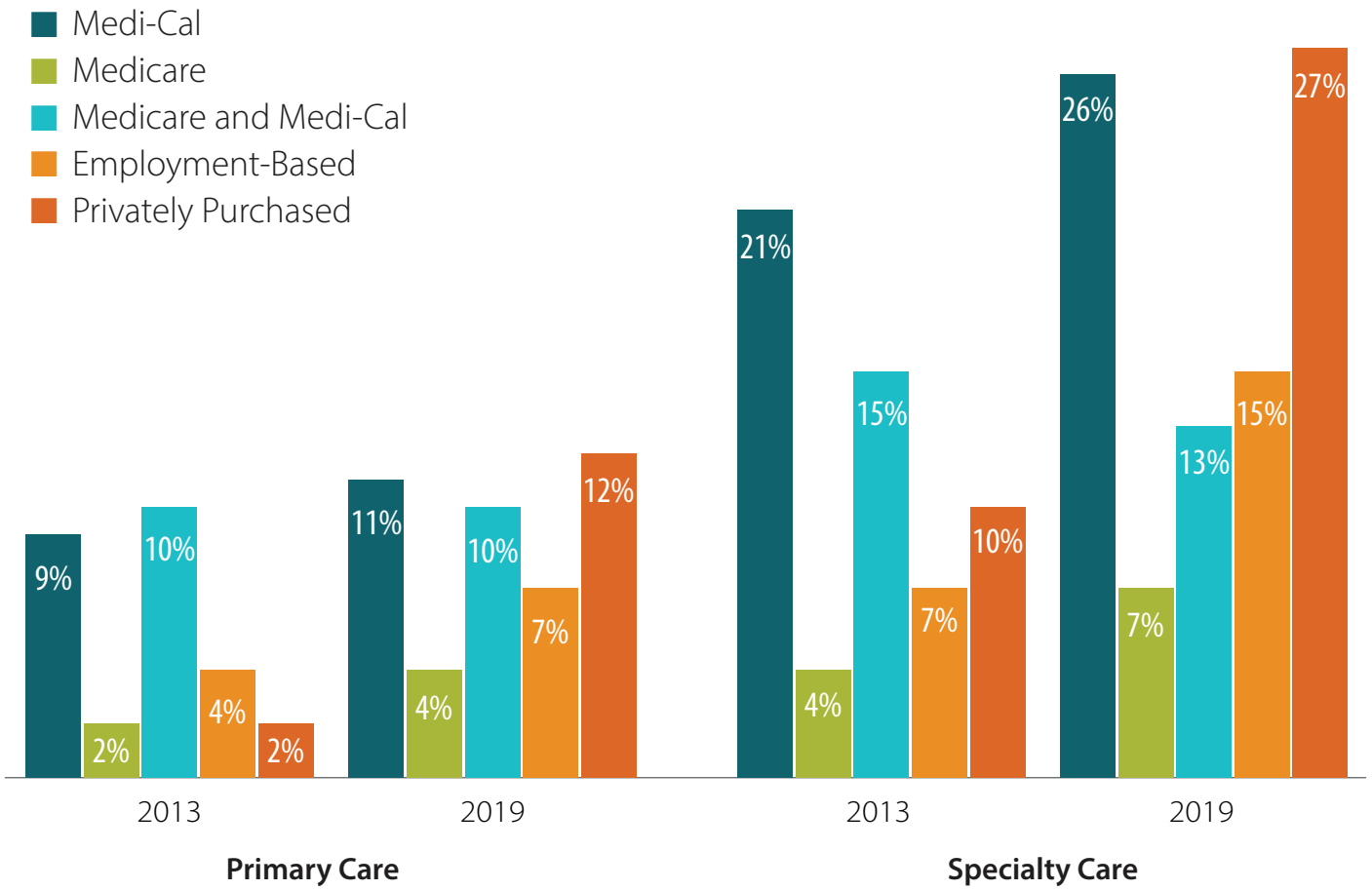
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Adults enrolled in Medi-Cal were more than twice as likely to report difficulty finding a provider that accepted their insurance when compared to those with employer-based insurance or Medicare. This pattern held for both primary and specialty care.

Difficulty Finding Primary and Specialty Care
by Source of Coverage, 2013 and 2019

PERCENTAGE OF ADULTS WHO HAD DIFFICULTY FINDING PRIMARY AND SPECIALTY CARE



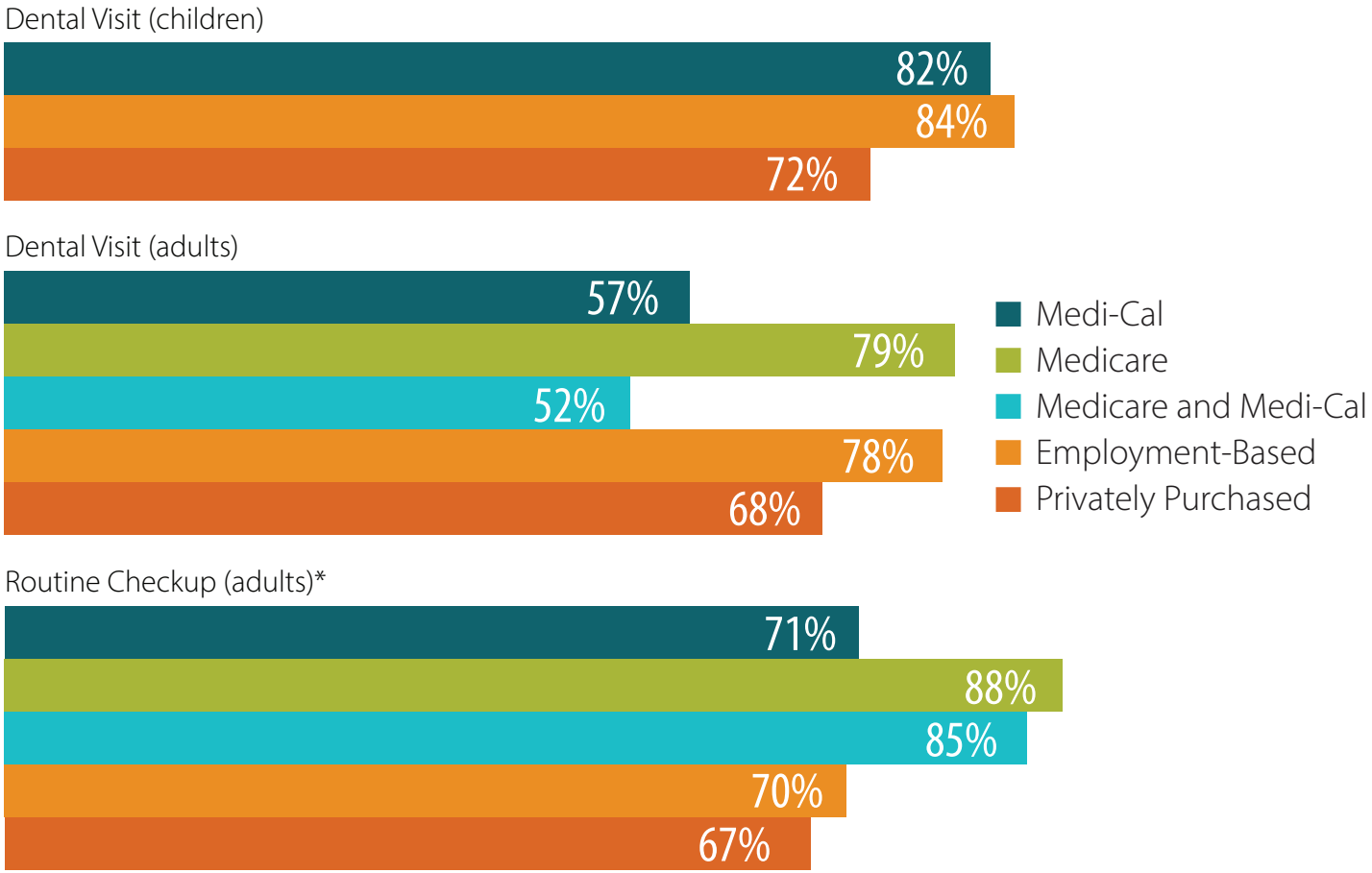
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2013 and 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Of all adults enrolled in Medi-Cal, the percentage reporting difficulty finding primary care increased slightly, while the percentage reporting difficulty finding specialty care increased from 21% in 2013 to 26% in 2019.

Preventive Care Visits
by Source of Coverage, California, 2019

PERCENTAGE WHO HAD THE FOLLOWING PREVENTIVE CARE WITHIN THE PAST YEAR



* With a doctor or medical provider.

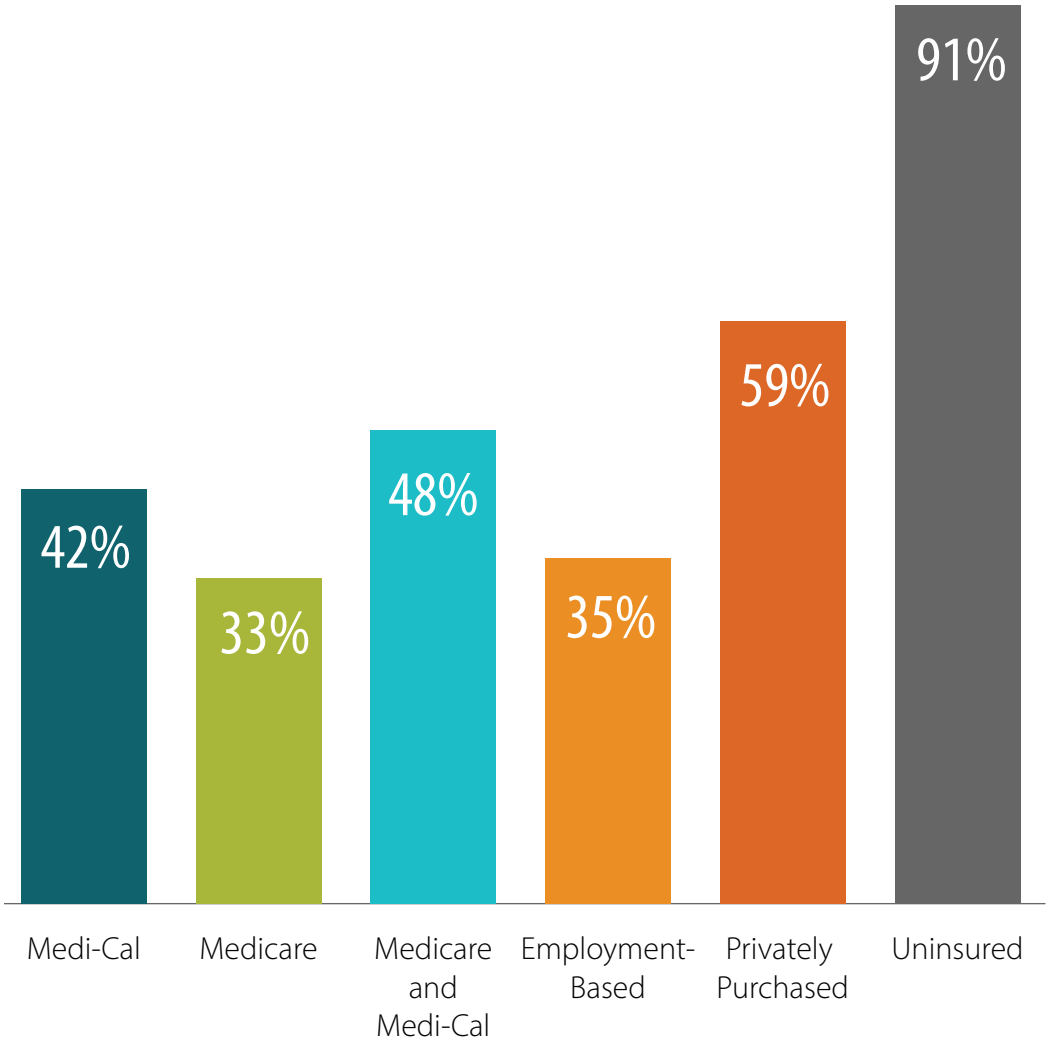
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

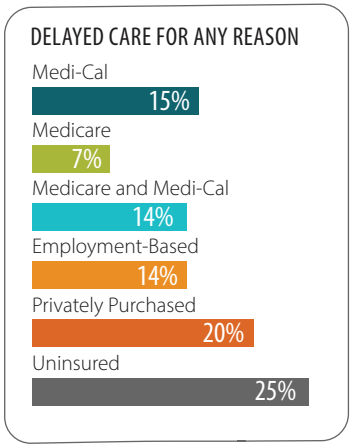
Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

Medi-Cal enrollees reported having a routine checkup at the same rates as people with employer-based or private insurance. Adult enrollees were less likely to have visited a dentist during the past 12 months, compared to those with employer-based or private insurance.

Delay of Care
by Source of Coverage, California, 2019

SHARE OF POPULATION THAT DELAYED CARE DUE TO COST OR LACK OF INSURANCE, BY INSURANCE TYPE





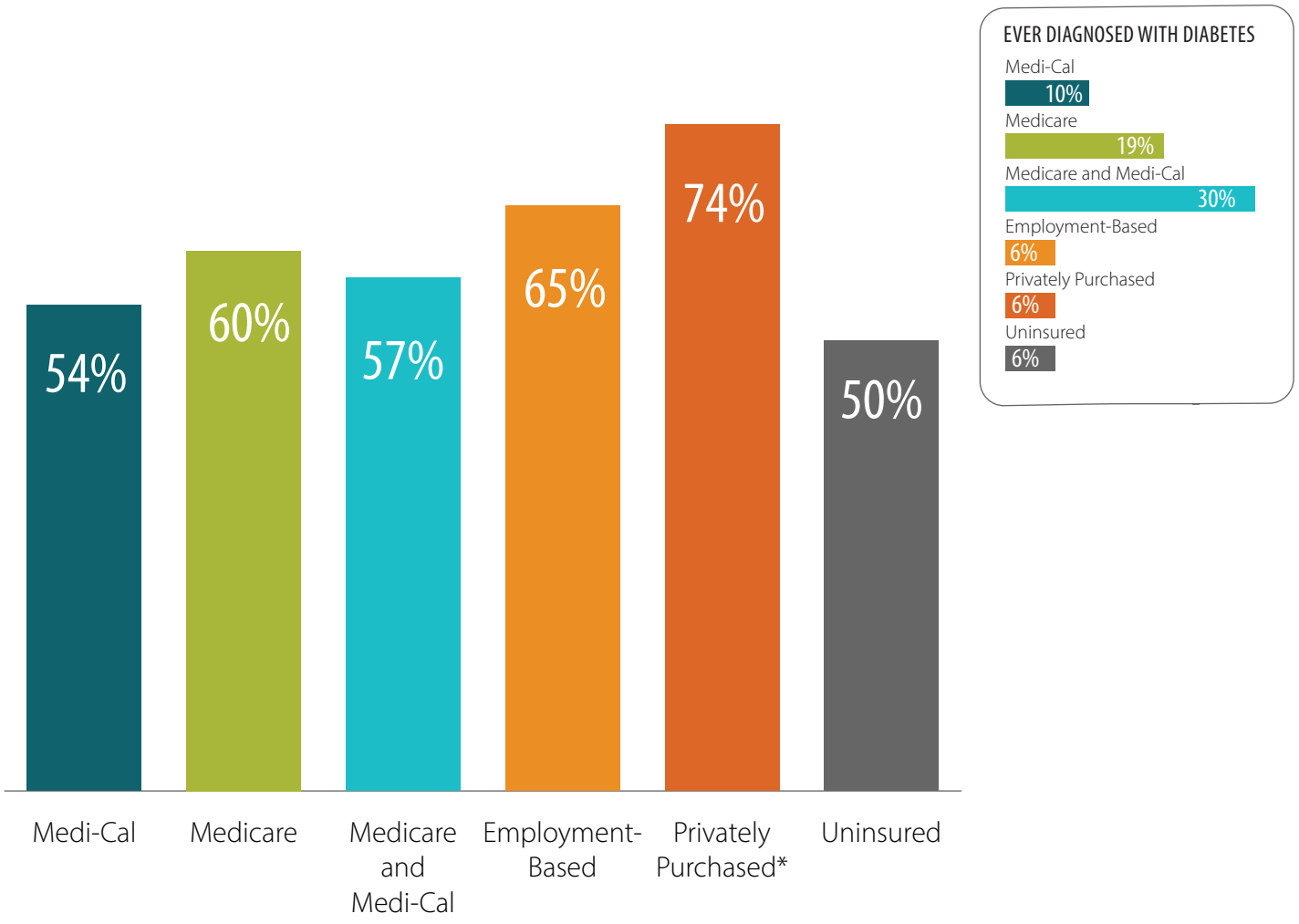
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

One in seven Medi-Cal enrollees reported delaying care, roughly the same percentage as Californians overall (not shown). Among those who delayed care, Medi-Cal enrollees were much less likely to report cost or lack of insurance as reasons for delaying care, compared with the those that were uninsured or those with privately purchased insurance.

Diabetes Care
by Source of Coverage, California, 2018

ADULTS EVER DIAGNOSED WITH DIABETES WHO REPORTED THEY WERE VERY CONFIDENT IN THEIR ABILITY TO CONTROL/MANAGE IT



* Statistically unstable.

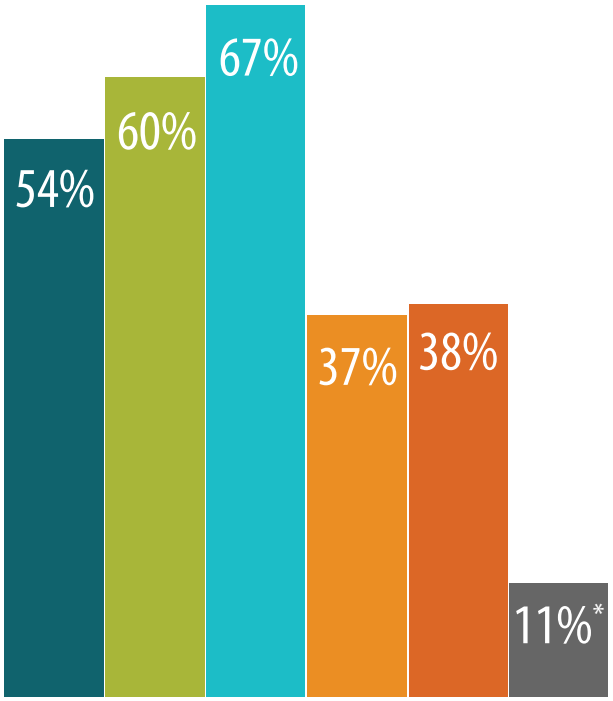
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

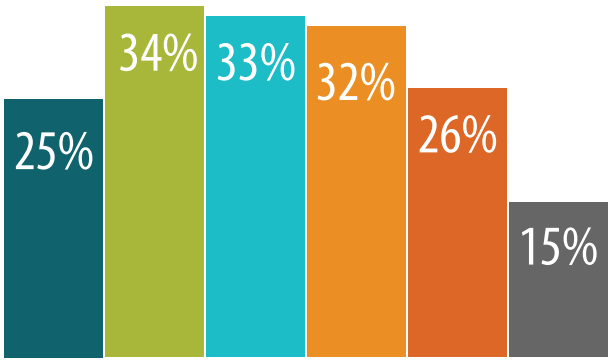
Medi-Cal enrollees were less likely than those with other types of insurance to report that they were confident that their diabetes was under control.

Asthma Care
by Source of Coverage, California, 2019

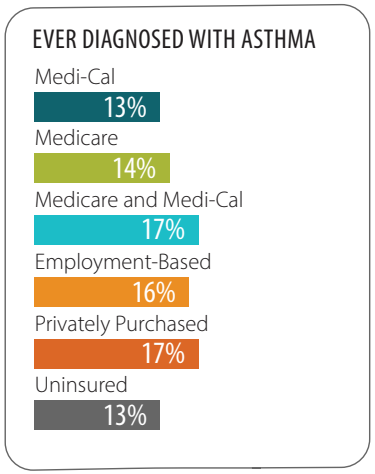
- Medi-Cal
- Medicare
- Medicare and Medi-Cal
- Employment-Based
- Privately Purchased
- Uninsured



Population with Asthma Who Take Daily Medication to Control It



Population Ever Diagnosed with Asthma Who Had an Attack in the Past 12 Months



* Statistically unstable

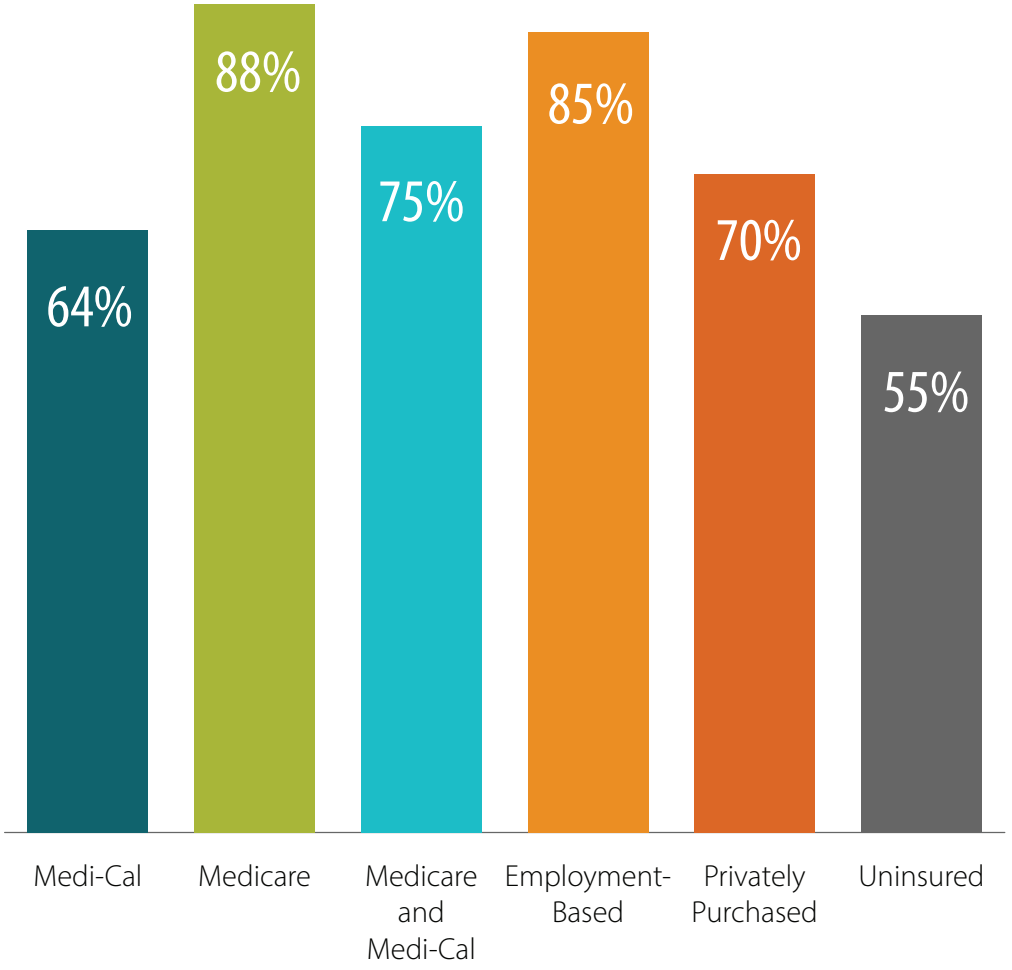
Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

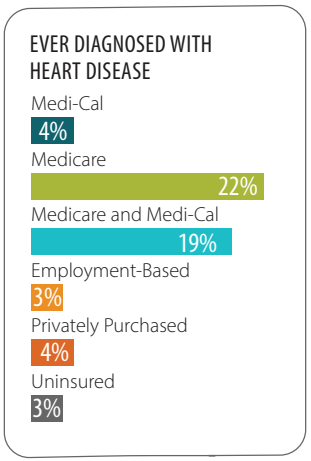
Source: 2019 California Health Interview Survey, UCLA Center for Health Policy Research.

One in four Medi-Cal enrollees diagnosed with asthma reported they had an asthma attack in the past 12 months, and one in two took daily medication to control their asthma.

Heart Disease Care
by Source of Coverage, 2018

SHARE OF ADULTS DIAGNOSED WITH HEART DISEASE WITH A MANAGEMENT PLAN





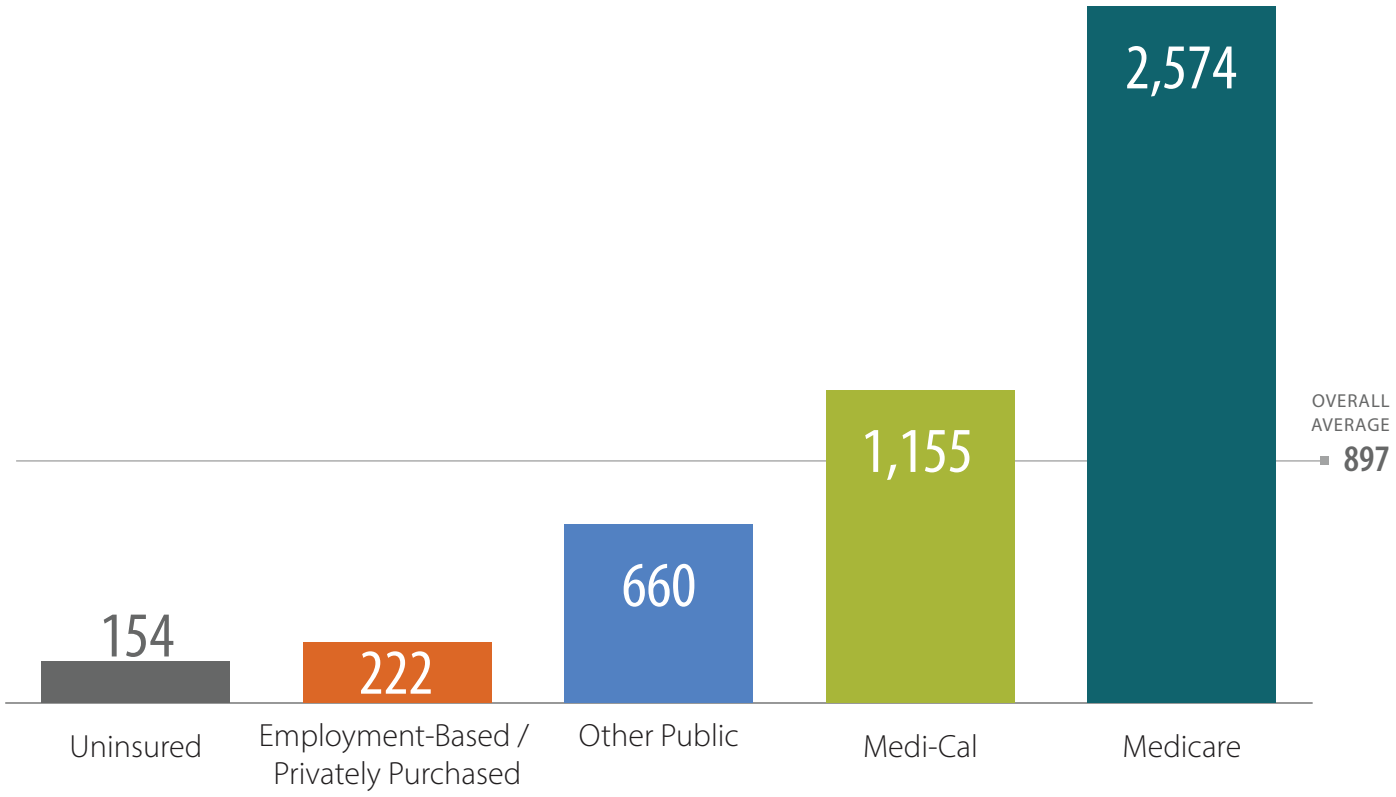
Slightly more than 6 in 10 Medi-Cal enrollees diagnosed with heart disease were provided a heart disease management plan by their provider.

Note: Insurance status is self-reported. *Medicare* includes people who have only Medicare, and *Medicare and other*.

Source: 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

Preventable Hospitalizations
by Source of Coverage, California, 2018

PER 100,000 POPULATION



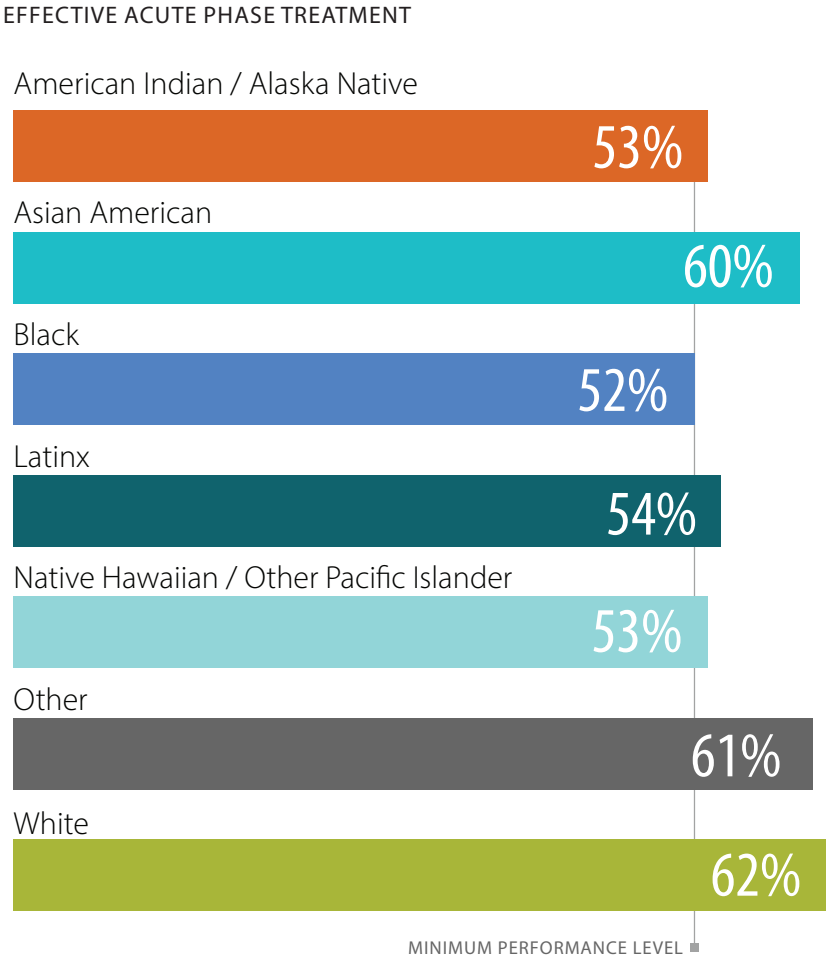
Notes: PQI 90 (Prevention Quality Indicator 90) is an overall composite measure of avoidable hospitalizations. The rate of avoidable hospitalizations was calculated as the number of hospitalizations for a particular payer category divided by the corresponding adult population according to the California Health Interview Survey. Rates presented are overall rates, not adjusted for age, gender, or other demographic characteristics. For additional information about this measure, see www.oshpd.ca.gov.

Sources: Blue Sky Consulting Group analysis of Agency for Healthcare Research and Quality PQI applied to custom data request, Office of Statewide Health Planning and Development Hospital Inpatient Discharge data; and the 2018 California Health Interview Survey, UCLA Center for Health Policy Research.

Rates of avoidable hospitalizations for ambulatory care–sensitive conditions (including diabetes complications, adult asthma or other lung diseases, hypertension, heart failure, and other conditions) are widely used as a marker of access to primary care. Those with public coverage experienced higher rates of avoidable hospitalizations when compared to those without insurance or those with private or employment-based coverage.

Antidepressant Medication Management

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Effective acute phase treatment* measures the percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 60%. Source uses *Asian*, *Black or African American*, and *Hispanic or Latino*.

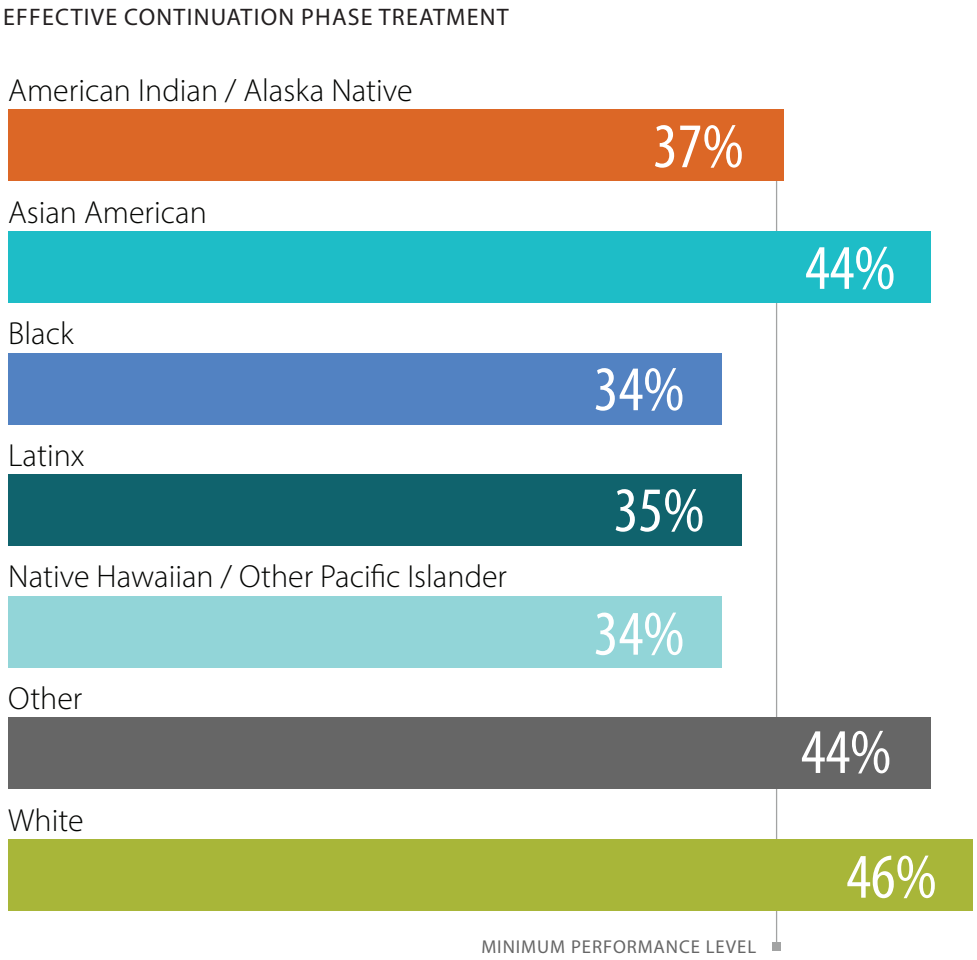
Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

Medi-Cal managed care enrollees reporting their race/ethnicity as Latinx, Black, American Indian / Alaska Native or Native Hawaiian / Other Pacific Islander had slightly lower rates of remaining on antidepressant medication for at least 84 days than other races/ethnicities. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.*

* "Antidepressant Medication Management (AMM)," National Committee for Quality Assurance.

Antidepressant Medication Management

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Effective continuation phase treatment* measures the percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 43%. Source uses *Asian*, *Black or African American*, and *Hispanic or Latino*.

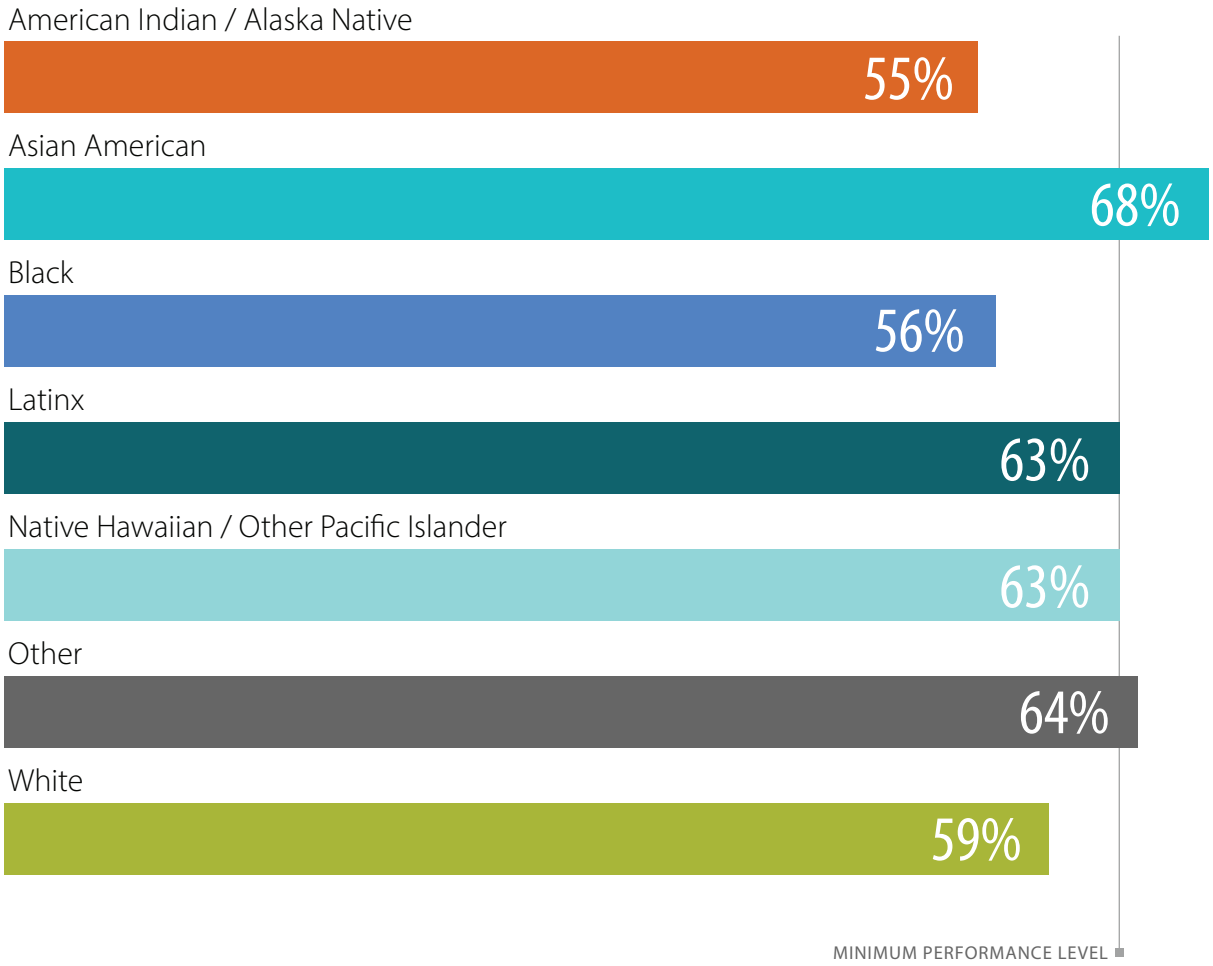
Source: 2019 Health Disparities Report, California Dept. of Health Care Services, December 2020.

Medi-Cal managed care enrollees reporting their race/ethnicity as Latinx, Black, or Native Hawaiian / Other Pacific Islander had lower rates of continuing antidepressant medication for at least 180 days than other races/ethnicities. Effective medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.*

* "Antidepressant Medication Management (AMM)," National Committee for Quality Assurance.

Asthma Medication Ratios

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Asthma medication ratio* measures the percentage of members age 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 69%. Source uses *Asian*, *Black or African American*, and *Hispanic or Latino*.

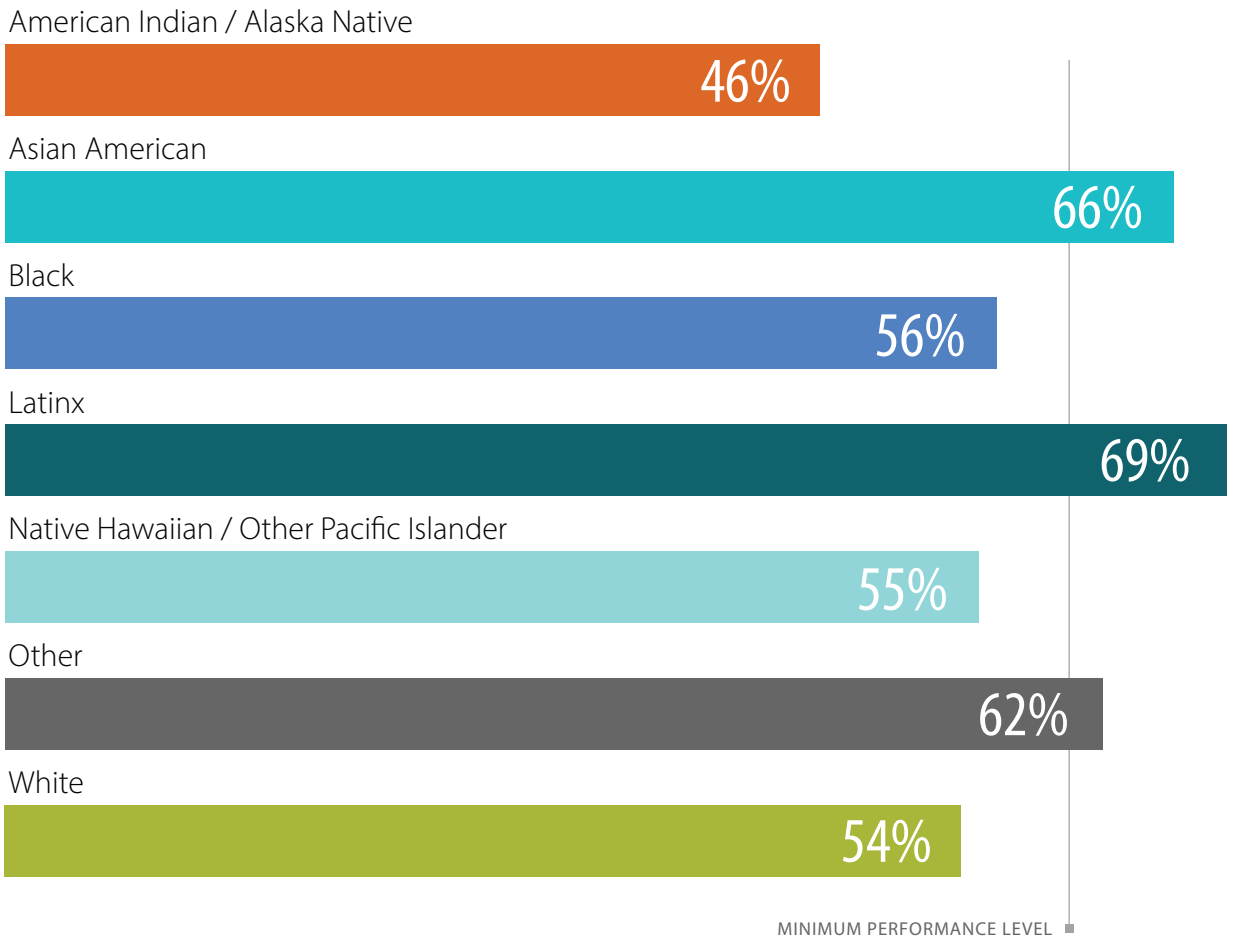
Source: 2019 Health Disparities Report, California Dept. of Health Care Services, December 2020.

Black and American Indian / Alaska Native managed care enrollees with persistent asthma had the lowest rates for receiving medications to control their condition. Appropriate medication management for patients with asthma could reduce the need for rescue medication as well as the costs associated with emergency room visits, inpatient admissions, and missed days of school and work.*

* "Medication Management for People with Asthma and Asthma Medication Ratio (MMA, AMR)," National Committee for Quality Assurance.

Breast Cancer Screening

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Breast cancer screening* measures the percentage of women age 50 to 74 who had a mammogram to screen for breast cancer. *Minimum performance level* represents the national Medicaid 50th percentile for the indicator and is used as a proxy display to provide information about overall performance and is not a statistical benchmark. The rate for unknown/missing race/ethnicity was 57%. Source uses *Asian*, *Black or African American*, and *Hispanic or Latino*.

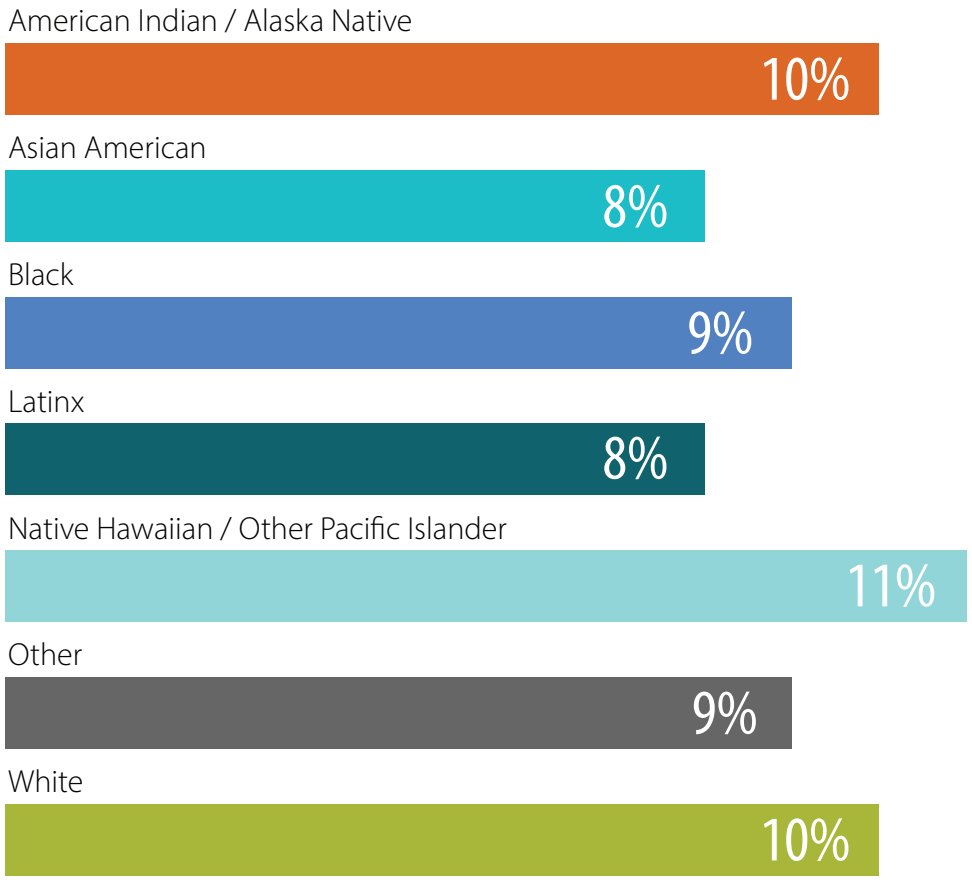
Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

While Latinx and Asian American women enrolled in Medi-Cal managed care plans had the highest rates of breast cancer screening, American Indian / Alaska Native enrollees had the lowest rates. Early detection can reduce the risk of dying from breast cancer and can lead to a greater range of treatment options.*

* "Breast Cancer Screening (BCS)," National Committee for Quality Assurance.

Plan All-Cause Readmissions

Among Medi-Cal Managed Care Enrollees, by Race/Ethnicity, California, 2019



Notes: Based on measures reported by 25 full-scope Medi-Cal managed care health plans. *Plan all-cause readmissions-observed readmission rate-total* measures the percentage of members age 18 and older who had an acute inpatient and observation stay during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 of discharge. The rate for unknown/missing race/ethnicity was 9%. Source uses *Asian*, *Black or African American*, and *Hispanic or Latino*.

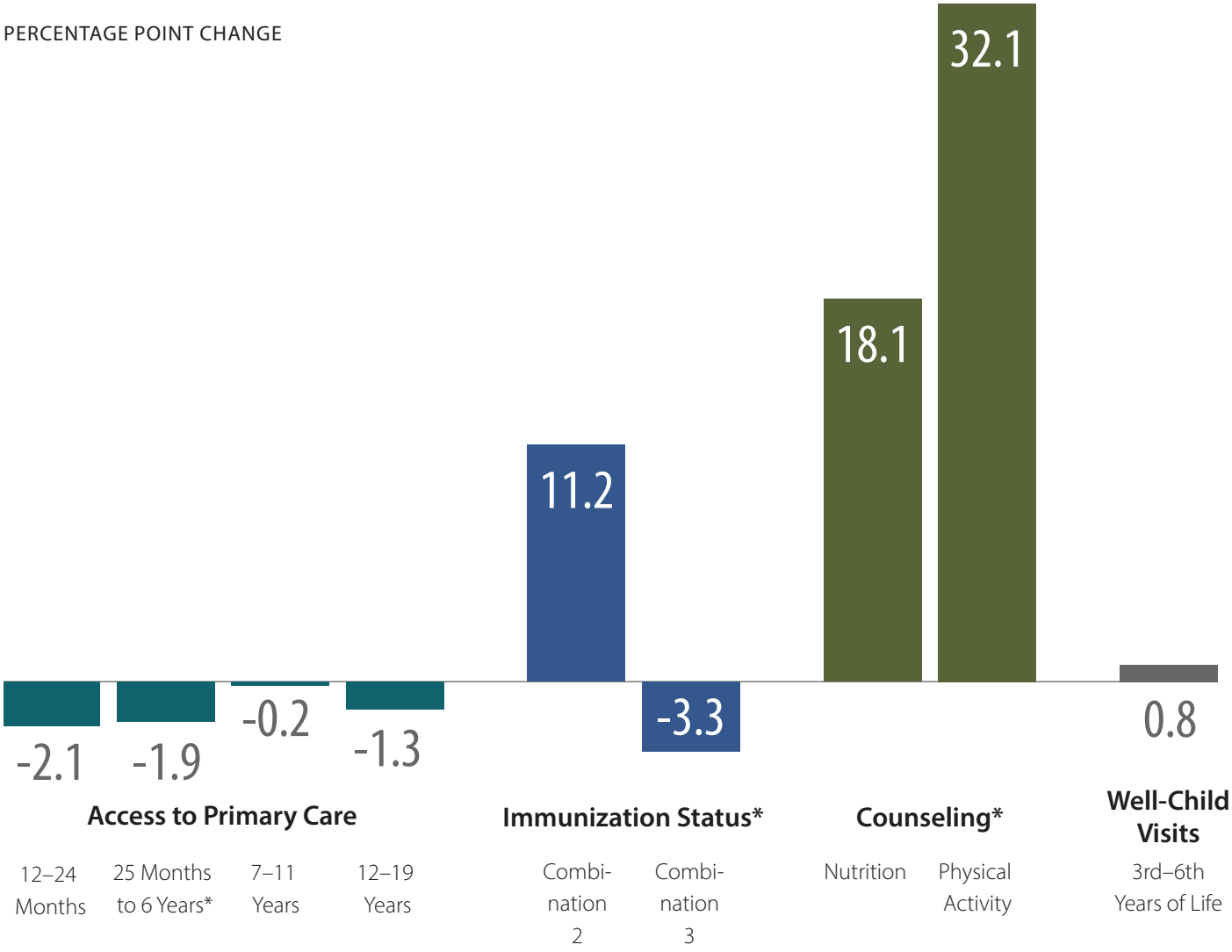
Source: *2019 Health Disparities Report*, California Dept. of Health Care Services, December 2020.

Native Hawaiian / Other Pacific Islanders had a slightly higher rate of readmission to the hospital than Medi-Cal managed care enrollees of other races/ethnicities. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.*

* "Plan All-Cause Readmissions (PCR)," National Committee for Quality Assurance.

Medi-Cal Managed Care Quality, Childhood Measures

2009 to 2018



* Change is statistically significant.

Notes: Not every measure was reported every year. *Change over time* represents percentage points.

Source: Andrew Bindman et al., *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, California Health Care Foundation, September 2019.

From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant on over half of 41 measures (not shown). Among the nine quality measures currently in use for children, six declined or stayed the same.

Looking Ahead

The Medi-Cal program faces numerous changes in the coming years. Some of this change is driven by leadership decisions from the executive branch and also from the California legislature. DHCS will:

- Continue to support Medi-Cal enrollees, providers, and Californians who are undocumented during the COVID-19 public health emergency, working with waivers provided by the federal government.
- Accommodate increased enrollment in 2021 due in part to the COVID-19 pandemic.
- Seek CalAIM approval from the federal government and then prepare for implementation of several initiatives in January 2022. See page 34 for more information on CalAIM.
- Begin the process to procure contracts for all commercial health plans providing services and to recontract with local plans. Starting in 2024, this may bring a change of health plans to some portion of the 11 million Medi-Cal enrollees in managed care in 58 counties.
- Assess the outcome of a planned transition to carved-out pharmacy benefits with the Medi-Cal Rx program.
- Possible expansion of full-scope coverage of adults with low incomes regardless of immigration status if the legislature continues to pursue this goal.

In addition, DHCS will have to address:

- An aging enrollee population as California's over-60 population increases at a rate three times faster than overall population growth. This will likely increase Medi-Cal's spending on long-term services and supports.
- Disparities in access, quality of care, and health outcomes for enrollees of color.

The Medi-Cal program faces numerous changes and challenges in the coming years as it evolves in response to new policies and unprecedented funding approved by the governor and legislature, to health care inequities laid bare by the COVID-19 pandemic, and to a growing desire for the program to contribute more to addressing longstanding health disparities and social determinants of health.

Sources: *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type* (PDF), California Dept. of Health Care Services, last updated February 27, 2020; and "Facts About California's Elderly," California Dept. of Aging, accessed March 18, 2021.

About the Data

The survey data used in this publication rely on self-reported insurance status. When asked by survey researchers about health coverage, some immigrants who are undocumented and who have used restricted-scope Medi-Cal may respond that they have Medi-Cal coverage. Restricted-scope Medi-Cal, which covers only emergency and pregnancy-related services, is not comprehensive coverage. If these adults who are undocumented and reporting Medi-Cal were instead considered uninsured, the number of Californians without insurance would be higher. Furthermore, some respondents with Medi-Cal may mistakenly report having private coverage.

ABOUT THIS SERIES

The California Health Care Almanac is an online clearinghouse for data and analysis examining the state's health care system. It focuses on issues of quality, affordability, insurance coverage and the uninsured, and the financial health of the system with the goal of supporting thoughtful planning and effective decisionmaking. Learn more at **www.chcf.org/almanac**.

AUTHORS

Len Finocchio, James Paci, Matthew Newman

Blue Sky Consulting Group

DESIGNERS

D. Johnson, J. Black, A.B. Goldin, K. Costantinidis

Dennis Johnson Design

FOR MORE INFORMATION

California Health Care Foundation

1438 Webster Street, Suite 400

Oakland, CA 94612

510.238.1040

www.chcf.org

DATE: April 26, 2023

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Shaina Zurlin, LCSW, PsyD, Behavioral Health Director

SUBJECT: Behavioral Health Program: Assessment and Next Steps

---

Recommendation. There is no recommended action associated with this agenda item.

Summary. This report provides an analysis of the current landscape of behavioral health services available to people with Medi-Cal within and beyond the Alliance. The background of service requirements and history of how the Alliance has met the needs are summarized. A brief synopsis of the relationship with and performance of Carelon Behavioral Health (formerly Beacon Health Options) as a contractor is provided. The report shares information about the options available to managed care plans for furnishing non-specialty mental health services and outlines statewide trends for meeting the obligation. Finally, the report addresses staff's approach towards improving behavioral health services and systems to be person centered and equitable.

Background. In response to the implementation of the Mental Health Parity and Addiction Equity Act, the requirement to cover essential health benefits implemented by the Affordable Care Act, and the principles of the Triple Aim, the department of Health Care Services (DHCS) allocated responsibility for non-specialty mental health services to the Medi-Cal managed care plans (MCPs) effective January 1, 2014. The goal of carving-in non-specialty mental health services was to provide integrated care for patients with Medi-Cal managed care coverage, ensuring a coordinated system combining medical and behavioral health services, and move towards whole person care. While counties would administer specialty mental health services as well as the substance use disorder continuum, MCP responsibilities would include member servicing, network development and credentialing, claims processing, utilization management, care coordination, and appeals and grievances.

The Alliance considered three options at the time of the Medi-Cal non-specialty mental health service benefit implementation, namely insourcing the benefit to administer it directly, retaining the existing Managed Behavioral Healthcare Organization (MBHO) Optum Health with a scope expansion beyond In-Home Supportive Services and Healthy Kids, or soliciting a partnership with a new MBHO. Given limited time between the DHCS announcement and the launch date, the Board accepted that insourcing was not a viable option. A set of criteria for selection of the MBHO to carry the Alliance into the future were developed and Beacon Health Strategies/College Health Independent Physicians Association (now Carelon) was selected as the best candidate. An inaugural contract with Carelon was executed in December of 2013.

The suite of services to which the Alliance is responsible for delivering has evolved since the execution of the initial contract to include behavioral health therapy for members with a diagnosis of autism spectrum disorder and most recently, the addition of dyadic therapy. Per DHCS guidance, MCPs must provide or arrange for provision of mental health evaluation and treatment, including individual, group and family psychotherapy;

psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies and supplements. MCPs are further responsible for substance use screening, assessment, brief interventions and referral to treatment (SABIRT), access to medications for addiction treatment, and emergency stabilization services. Care management and coordination and the coverage of any relevant physical health care services remain within MCP scope.

MBHO Performance. Throughout the Alliance's relationship with Carelon as the MBHO, performance has fluctuated between adequate and substandard. Carelon typically meets minimum utilization benchmarks and quality requirements. Since October 2013, the Board has periodically monitored behavioral health program performance and specified areas requiring improvement.

While the Alliance had some success working with Carelon as measured by delivery of member access to behavioral health care that meets basic State expectations and overall average statewide performance, Carelon continued to struggle with other identified gaps. Expansion of access to services in Merced and Monterey Counties was needed to address significant disparities in utilization. Increased MBHO awareness of local needs of communities served and integration between delivery systems remains lacking. Further, coordination of member care between the MCPs and county behavioral health services needs improvement. Adding to recent challenges, since 2021, Carelon leadership has undergone significant turnover, was acquired by Anthem, and was rebranded from Beacon to Carelon in April 2023.

Beginning with discussions that would ultimately shape the California Advancing and Innovating Medi-Cal (CalAIM) and other aggressive statewide improvement approaches, DHCS and Centers for Medicare & Medicaid Services indicated that the behavioral health landscape would be undergoing significant changes with the opportunity to update expiring waivers. Raised expectations to offer the best possible behavioral health program required a renewed emphasis on improving care access coordination with key stakeholders and partners. The relationship with Carelon itself was undergoing changes and the contract was set to expire on December 31, 2020.

A request for proposal for behavioral health services was issued in January of 2020 to identify a vendor who could better meet the objectives of comprehensive, coordinated and integrated services that improve health outcomes and reduce cost. Staff considered but did not recommend insourcing of behavioral health due to the pending CalAIM implementation and other competing priorities. In identifying its final recommendation, staff considered years of experience, local service area knowledge, established network and cost. With an absence of clear advantage to changing MBHO vendors, acknowledgement of the disruption of change to members as well as complications brought by the onset of the COVID-19 pandemic, the Alliance elected to continue its MBHO relationship with Carelon pursuant to a renegotiated agreement. The decision to renew the Carelon agreement was accompanied by direction to increase Alliance staff efforts to improve Carelon performance.

While the Alliance has focused more time on Carelon monitoring, including the reinstatement of and hiring for the previously eliminated Behavioral Health Director role in July of 2022, the two-year term for Carelon's contract has yet to be initiated. This is due

primarily to Department of Managed Health Care (DMHC) holding approval of the Carelon agreement. In the period from July 1, 2021, to the present, the Alliance has periodically extended the contract with Carelon to ensure continual service delivery while Carelon negotiates with DMHC. Staff will be extending the agreement to ensure an adequate network both for the Alliance's existing counties and the expansion counties as of January 1, 2024.

Key Carelon performance issues that persist include late or unmet deliverables requiring repeated follow up to ensure completion, providers report of delay in credentialing and payment, and declining provider satisfaction rate of referral from 60% in 2021 to 33% in 2022.

The Alliance has steadily communicated dissatisfaction with these metrics to Carelon leadership, including most recently meeting with the Chief Executive Officer, Chief Network Officer, National Accounts President and other key executives to discuss expected improvements. While the Alliance's concerns were acknowledged, no formal action plan has yet been initiated. It is noteworthy that many of the issues present are longstanding, with Carelon unable to demonstrate a pattern of sustaining improvements over time.

Alliance Objectives for Behavioral Health. In 2022, the Alliance's Board adopted a new strategic plan, including prioritizing *Health Equity* and *Person Centered Delivery System* and setting the goal to *Improve behavioral health services and systems to be person centered and equitable*. The measures of performance for this strategic goal include:

- 90th percentile in members (adult and child) reporting very good, or excellent mental health.
- 95% compliance with timely access to care.
- 90th percentile for follow up after emergency room visits for mental health.
- 90th percentile for follow up after emergency room visits for substance use disorder.

While the current operation of the behavioral health program through the MBHO is adequate from a regulatory perspective, as evidenced by zero findings from the February 2023 DHCS behavioral health focused audit, there is significant opportunity to improve the behavioral health system to yield positive member mental health, to close disparities in utilization and to ensure care is accessible in the right place at the right time.

Discussion. Upon joining the Alliance, the Behavioral Health Director was tasked with conducting a comprehensive landscape assessment of behavioral health services across the state as well as a gap analysis of the experience of members in Merced, Monterey and Santa Cruz counties. This was a foundational step towards putting forth a set of recommendations for the future state of behavioral health care for Alliance members. The initial scope was for the full continuum of specialty and non-specialty services, with an emphasis on identifying improvements in the Alliance's area of accountability, non-specialty services.

As noted above, this assessment includes a review of gaps and opportunities in the current Alliance behavioral health program, a statewide landscape assessment, a regional gap assessment, and a review of approaches to benefit administration.

Statewide Landscape Assessment. Upon initiating the research, existing resources which outline the current state of *specialty services* and general health needs were discovered. This included the DHCS 2022 report entitled "Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications." The DHCS report highlighted that Santa Cruz residents experience Serious Emotional Disturbance (SED) and Severe Mental Illness (SMI) of 3.2% and 8.7%. While this is very similar to the statewide SED prevalence of 3.36%, rates of SMI are higher than California's average 7.58%. Substance Use Disorder also rated slightly elevated, at 5.4% as compared to 4.28% statewide. The county lacks community mental health clinics, a partial hospitalization mental health program, psychiatric acute care units or beds, or any level of social rehabilitation residential beds. There is one psychiatric health facility (PHF) in the county. For providers Santa Cruz has 4.3 non-psychiatrist behavioral health providers per 10,000 residents, more than the 3.7 average. Psychiatrists are available at a rate of 19 per 100,000 residents, far exceeding the 12.9 average.

Overall, Monterey experiences a lower rate of SED and SMI at rates of 2.2% and 5.3% as compared to 3.36% and 7.58% respectively across California. The SUD rate is also slightly lower, at 3.6% compared to 4.28%. DHCS highlighted the absence of any community mental health clinics, mental health rehabilitation facilities, crisis stabilization units, partial hospitalization for mental health or long-term social rehabilitation beds. However, DHCS showed that the county has 14.5 psychiatrists per 100,000 residents, higher than the statewide average of 12.9. In further favor for the system, statewide rates of non-psychiatrist behavioral health providers are 3.7 per 10,000 residents, while Monterey has 5.8.

In Merced, prevalence of SED is reported at 2.1% in contrast to the higher 3.36% California average. SMI and SUD also fall slightly below, at 5.9% compared to 7.59% and 3.3% compared to 4.28%. Merced does not have community mental health clinics, partial hospitalization treatment, social rehabilitation beds, or psychiatric beds in hospital facilities. There is one PHF in the county. While these facilities are lacking, Merced County has an average of 5.4 non-psychiatrist behavioral health providers, higher than the 3.7 average. This is not paralleled in psychiatrist access, where the average of 2.6 per 1000,00 residents falls significantly below state mean of 12.9.

As a result of the gap in SMI acute/inpatient care in all three counites, Alliance contracted Emergency Department (ED) facilities generally have Alliance members with acute psychiatric conditions on prolonged hold waiting evaluation and bed placement. Alliance members with acute SMI admitted for medical conditions generally wait several days on hold in medical units for discharge to psychiatric facilities.

Care coordination gaps have a financial impact as well. The top ten utilizers of mental health care in the medical network from each county account for an average expenditure of $1,366 per member in 2022, with the single highest utilizer receiving $12,840 in services. Many were seen more than 20 times, with the highest being seen by the medical network for 160 distinct visits.

These statistics across the Alliance service area demonstrate both challenges and resources which can be leveraged through partnership with the Mental Health Plans (MHPs) to render a more comprehensive continuum of care. It is important to note that the reports do not delve deeply into variables like race and ethnicity which impact both rate of

diagnosis for various mental health concerns as well as access variables like language and cultural stigma.

However, we do know that noted gaps and concerns within the existing non-specialty network of care render it difficult to partner towards improvement. In interviews with behavioral health leadership across Merced, Monterey and Santa Cruz counties, it was reported that opportunities included increasing the adequacy of the continuum of care data exchange and consistency in relationships across the MCP and County leadership in overseeing the behavioral health continuum (whether MCP responsibilities are executed by an MBHO or the plan itself).

Regional Gap Assessment. Looking to non-specialty service data, evidence of these challenges within our member experience across Merced, Monterey and Santa Cruz substantiates the MHP experience. One example is the decline of timely access to routine care. In their 2021 annual self-evaluation Carelon reported that, according to claims data 91.61% of members requesting routine appointments were offered care and saw a provider within 10 business days and a total of 18,401 unique utilizers were served Timely access declined to 81.28% in 2020 while total unique utilizers dropped slightly to 18,307. In 2021, 73.08% of members reported timely access out of an increased utilization of 20,073 unique members.

When polling members about their experience, 54.7% reported to Carelon that they received access to timely routine care in 2021. Once connected to care, routine follow up rates have fluctuated. Claims data shows that the percentage of members who received a second outpatient therapy visit following initial connection within 30 days was 48.09% in 2019, 60.69% in 2020 and 59.95% in 2021. For members receiving psychopharmacology services, a second visit occurred within 90 days for 25.63% in 2019, 50.77% in 2020 and 52.09% in 2021. Because this system is often heavily based on self-referral, the data may not accurately capture the members who attempt to access care but are not successfully connected. It is also noteworthy that the pandemic complicated the logistics of care. Qualitative data from primary care practices shows that members may abandon their efforts to connect with mental health support after failing to easily access an available provider. These attempts would not be reflected in rates of access.

Member experience when contacting Carelon via telephone was an additional area cited by the MBHO for needing improvement. Reporting that monthly goals were not met in the areas of personalizing calls by using the caller's name, avoiding dead air and using the required call closing questions. They articulated that they had inadequate staff to field the calls, and that existing call center staff navigating the 13,514 incoming calls in 2021 needed increased monitoring for customer service, proper transfer and hold procedures, accuracy of information given and proper documentation.

Care coordination and integration in the current landscape for non-specialty services has improved in some areas but has remained steady or declined in others. For example, from 47.73% to 50% of members indicated that their mental health provider always or usually knew about their physical health care between 2019 and 2021. For the inverse, where members felt their physical health care providers always or usually knew about their mental health care, the rates were 50% in 2019 were 56.25% in 2020, with a significant improvement of 89.47% in 2021.

It has been recognized and acknowledged by both Carelon and the Alliance that care coordination efforts are not optimally meeting member need, particularly in the wake of new CalAIM requirements for closed-loop referrals and member access to non-duplicative mental health care in both MCP and MHP systems. While both the existing and pending contracts do not incorporate the necessary improvements to care management staffing ratios, the Alliance has been unable to remedy this due to Carelon delays in implementation of the agreement. Upon solicitation of DMCH approval of their network adequacy, the contract will need to be executed and promptly bolstered with an amendment in this area.

Inequities in utilization are present, wherein in 2022 the Caucasian service utilization rate was 6.31% as compared to utilization by Hispanic members of 3.01%. Across counties in the same period similar inequities exist, with Santa Cruz utilization averaging 12.4%, Monterey at 6.47% and Merced at 5.92%.

One gap that requires further analysis is the number and characteristics of members who are not utilizing Carelon but are accessing mental health care through the medical network, primarily delivered by Primary Care Providers. In Santa Cruz County in 2022, 30.6% of mental health services were rendered by the physical health network outside of Carelon. In Merced this number rose to 41.1% Residents of Monterey utilized the physical health network for mental health needs at the highest utilization rate of 43.3%. Hypotheses for this range from cultural mistrust of mental health providers, historic lack of access to mental health providers, and difficulty accessing Carelon services to logistical access and siloed systems.

Further, utilization varies greatly by ethnicity, with slightly more than half of all mental health claims for Hispanic members coming through the medical care system in 2022. In comparison, other people of color utilized the medical care system slightly less than half of the time, while Caucasians did so significantly less than half the time. These numbers represent a discrepancy within our system that will require deeper analysis to ensure that members are getting the correct care in the correct system to meet their complex needs.

These data points confirm a member experience that is often confusing, a system and processes which are challenging to navigate and do not center on individualized needs but around existing systems. Members may be required to contact multiple providers from a list only to find that none can offer them care. When trying to navigate the system, members can be over-informed which causes overwhelm, or under-informed which yields difficulty getting needs met. Misunderstandings can cause rejection from care systems. With unclear rules for access and disconnected providers in a bifurcated system, members can be assigned two or more care managers and experience repetitive screenings and assessments, delving into personal information more than once for the convenience of the provider. These system issues create undue burden for vulnerable individuals who are struggling with mental health concerns.

For providers, significant concerns are also seen within the current system. As previously mentioned, Alliance leadership is regularly involved in supporting providers to get their needs met with Carelon, often requiring multiple requests and interventions for issues like rate changes and completion of the credentialing process. Qualitative data gathered over the last six months also indicates that a small number of providers have stopped accepting Medi-Cal patients because of the undue administrative burden created by the Carelon relationship. Others report that they are on the verge of refusing members or would like to

stop but remain diligent for the clinical benefit of the member. As shortages of mental health clinicians are well documented nationally and state-wide, any loss of available provider network due to administrative issues is a significant concern, contributing to an existing gap and threatening to widen that gap. Action should be taken to avoid this occurrence.

Future of Behavioral Health Program Administration. To administer required behavioral health benefits assigned to MCPs, there have historically been three potential pathways to engage, namely outsourcing to an MBHO, outsourcing to the MHP operated by County Behavioral Health, or insourcing the services to provide them directly to members in a similar fashion to other MCP benefits. Research by the Behavioral Health Director has not identified any additional viable pathways for providing the services.

Since inception of the MCP responsibility for non-specialty services, the Alliance has elected to outsource to an MHBO, the varied results of which have been described above. It is reasonable to assume that continued engagement will have analogous results.
The second option of outsourcing to the MHP has potential benefits because it centralizes the full continuum of behavioral health care for members across specialty and non-specialty categories. The approach can eliminate the impact of service bifurcation for members and provide stronger coordination, as their care is centrally managed. While offering potential advantages, the path represents a significant expansion of work for counties. Currently, counties report being heavily overburdened with implementation of CalAIM initiatives in combination with a multi-year staffing deficit.

The third potential pathway of insourcing carries the expansion of workload for the Alliance. This would require a multi-year effort to develop the internal infrastructure to ensure appropriate clinical oversight, network development and care coordination to ensure improved results. Such an approach offers significant benefits, such as more control over service provision and credentialing, stronger integration of non-specialty services with primary care, and the nimble ability to be highly responsive to issues as they arise for members and providers. This option would assign the Alliance with direct responsibility for compliance and quality of care, but in turn give the organization flexibility and opportunity to raise the standard for behavioral health and bring services parallel to the high quality demonstrated in other care arenas.

Looking to other MCPs statewide offers insight into trends and preferences. Specifically, the current and future states of other County Organized Health System (COHS) plans is indicative of how analogous MCPs are looking to provide a high-quality behavioral health care experience to members. Three of the six COHS plans made the shift to insource behavioral health in recent years, with two plans continuing on with an MBHO. Outside of COHS plans, many of the Local Initiative and commercial plans conduct their non-specialty services in house,

The next steps in exploring the best future state for Alliance for the Alliance to administer the behavioral health benefit to be person centered and equitable is to engage a consultant with expertise in supporting MCPs in building out behavioral health systems. This effort will include leveraging the consultant's experience to develop a recommended approach and prospective project plan and timeline aiming for a 2025 execution.

Conclusion. The Alliance is charged with providing a broad array of mental health services, screenings and care coordination to its members. In 2021, responsive to the feedback of its members, providers and community partners, the Alliance adopted a strategic goal to improve behavioral health services and systems to be person centered and equitable by 2026. Such improvement will be measured through member's report of good or excellent mental health, increases in access to timely care, and increases in follow up after ED visits relating to mental health or SUD.

Further assessment by staff have indicated additional opportunities to improve member satisfaction with behavioral health services, to address disparities in access and utilization by racial groups and across geographies, to increase provider satisfaction and engagement, to improve care coordination across the continuum, and to ensure administrative efficiency in the execution of the program.

Staff will develop a proposal for the future administration of the behavioral health program to achieve the Alliance's strategic goals as measured by improvements in the above identified areas.

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

Attachments. N/A

Information Items: (17A. – 17B.)

April 2023 Board Report

Total Online + Print Audience
1,005,895

Total Online + Print Publicity
USD $8,175

Total Number of Clips 3

Alliance urges members to update Medi-Cal information

1

Date Collected Mar 30, 2023 10:07 PM EDT
Category Digital News
Source Register Pajaronian

Est. Audience 1,630
Est. Publicity Value USD $21
Market Watsonville, CA
Language English

Alliance urges members to update Medi-Cal information

Central California Alliance for Health, the Medi-Cal managed health care plan for residents of Merced, Monterey and Santa Cruz counties, is urging people with Medi-Cal to update their county with any changes to their information to ensure they do not lose their coverage.
During the pandemic, Medi-Cal members were able to continue their ...

Richman Celebrates Grand Opening of The Retreat

2

Powered by LexisNexis

Date Collected Mar 24, 2023 10:34 AM EDT
Category Digital News
Source PR Newswire

Est. Audience 956,443
Est. Publicity Value USD $7,797
Market United States
Language English

PR Newswire

Affordable community delivers next-level convenience and comfort in Merced, Calif.

The Richman Group of California, an innovator in apartment development, in partnership with long-time non-profit collaborator the Central Valley Coalition for Affordable Housing and Richman Property Services, a national leader in multifamily management, on March 1, 2023 celebrated the ribbon-cutting for their newest affordable community, The Retreat at Merced, in Merced, Calif.

Merced Mayor Matthew Serratto spoke during the ribbon-cutting event along with Arturo Martinez on behalf of Senator ...

Richman Celebrates Grand Opening of The Retreat

3

Date Collected Mar 24, 2023 10:13 AM EDT
Category Digital News
Source Times of San Diego

Est. Audience 47,822
Est. Publicity Value USD $357
Market Del Mar, CA
Language English

... was attended by City Manager Stephanie Dietz, Central Valley Coalition for Affordable Housing Board Member Steve Simmons, Council Member Jesse Ornelas and Ronnie De Anda and others representing the City and County of Merced, Merced County Association of Governments, Central Valley Opportunity Fund, **Central California Alliance for Health** and Richman.

The Retreat is funded through various federal, state, county and city programs including:

30 Project-based Housing Vouchers from the County of Merced Housing Authority
$14,000,000 from the Affordable Housing & Sustainable Communities Program resulting in the investment in affordable ... housing and regional infrastructure including a new multi-modal bus station, electric City bus, and other road, bike lane, sidewalk and run-off improvements
$2,500,000 from **Central California Alliance for Health** (the Alliance) through the Medi-Cal Capacity Grant Program that will include 20 homes

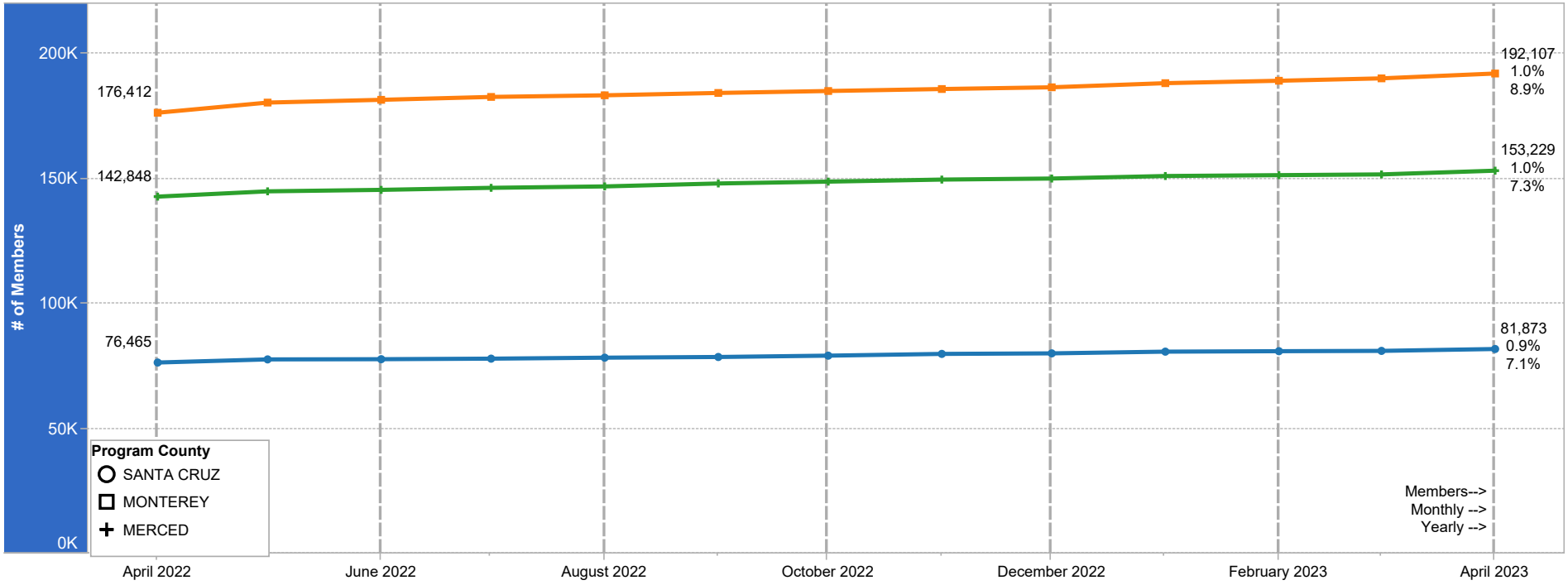
designated for Alliance members who are currently experiencing homelessness and have complex health and social needs $6,580,000 of other funds coordinated by the City of Merced including HOME, Community ...

Enrollment Report

Year: *2022 & 2023* **County:** *All* **Program:** *AIM, IHSS, Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *4/6/2023*

StaticDate
4/1/2022 12:00:00 AM to 4/30/2023 11:59:59 PM

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



Program..	ProgramCo..	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023
Medi-Cal	SANTA CRUZ	76,465	77,714	77,797	78,013	78,410	78,680	79,214	79,914	80,131	80,816	80,996	81,123	81,873
	MONTEREY	175,788	179,826	180,924	182,086	182,729	183,670	184,453	185,243	185,938	187,592	188,561	189,520	191,459
	MERCED	142,848	144,965	145,550	146,365	146,930	148,107	148,847	149,666	150,083	151,093	151,438	151,732	153,229
IHSS	MONTEREY	624	650	657	654	660	658	654	656	654	652	651	646	648
Total Members		**395,725**	**403,155**	**404,928**	**407,118**	**408,729**	**411,115**	**413,168**	**415,479**	**416,806**	**420,153**	**421,646**	**423,021**	**427,209**