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

Meeting Agenda

Wednesday, June 25, 2025

3:00 p.m. – 5:00 p.m.

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 473 855 197#

2. 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, June 23, 2025, to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to three minutes.

1. **Call to Order by Chairperson Jimenez. 3:00 p.m.**
   A. Roll call; establish quorum.
   B. Supplements and deletions to the agenda.

2. **Oral Communications. 3:05 p.m.**
   A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed three minutes in length, and any individuals may speak only once during Oral Communications.
   B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to three minutes per item.

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

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

Consent Agenda Items: (5. – 9A.): 3:30 p.m.

5. **Accept Chief Executive Officer (CEO) Report.**
   - Reference materials: Chief Executive Officer (CEO) Report.

   Pages 5-1 to 5-6

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the fourth month ending April 30, 2025.**
   - Reference materials: Financial Statements as above.

   Pages 6-1 to 6-10

Minutes: (7A. – 7B.):

7A. **Approve Commission regular meeting minutes of May 28, 2025.**
   - Reference materials: Minutes as above.

   Pages 7A-1 to 7A-7

7B. **Accept Compliance Committee meeting minutes of April 16, 2025.**
   - Reference materials: Minutes as above.

   Pages 7B-1 to 7B-4

Appointments: (8A. – 8B.)

8A. **Approve reappointment of Aluriel Ceballos to the Member Services Advisory Group (MSAG).**
   - Reference materials: Staff report and recommendation on above topic

   Pages 8A-1

8B. **Approve appointment of Kelley Sandoval to the Whole Child Model Family Advisory Committee (WCMFAC).**
   - Reference materials: Staff report and recommendation on above topic

   Pages 8B-1

Reports: (9A. -9B.):

9A. **Approve the 2025 Bill List.**
- Reference materials: Staff report and recommendation on above topic
  Pages 9A-1 to 9A-43

9B. **Approve updated Whole Child Model Clinical Advisory Group Committee Schedule for 2025.**
- Reference materials: Staff report and recommendation on above topic
  Pages 9B-1 to 9B-2

Regular Agenda Items: (10. – 12.): 3:35 p.m. – 4:50 p.m.

10. **Strategic Allocation of Reserves (3:35 p.m. – 4:15 p.m.)**

A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will consider and approve a one-time strategic allocation of $12,933,075 to the Medi-Cal Capacity Grant program.
- Reference materials: Staff report and recommendation on above topic
  Page 10-1

11. **Medi-Cal Capacity Grant Program Funding Allocation and Equity Grantmaking Methodology Recommendation (4:15 p.m. – 4:40 p.m.)**

A. Ms. Jessica Finney, Community Grants Director, will review and Board will consider and approve the proposed Medi-Cal Capacity Grant Program (MCGP) funding allocation methodology and equity-based grantmaking methodology.
- Reference materials: Staff report and recommendation on above topic.
  Pages 11-1 to 11-4

12. **CBI 2026 Program Proposal (4:40 p.m. – 5:00 p.m.)**

A. Dr. Dianna Myers, Medical Director, will review and Board will consider and approve the Care-Based Incentive program proposal for 2026.
- Reference materials: Staff report and recommendation on above topic.
  Pages 12-1 to 12-3

Information Items: (13A. – 13C.)

A.	Alliance in the News	Page 13A-1 to 13A-4
B.	Membership Enrollment Report	Page 13B-1
C.	Alliance Fact Sheet	Pages 13C-1 to 13C-2
D.	Letters of Support	Pages 13D-1 to 13D-2

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, August 27, 2025; 1:30-2:45 p.m.
- Member Services Advisory Group
  Thursday, August 14, 2025; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, September 4, 2025; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, July 10, 2025; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, August 4, 2025; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this June 25, 2025 meeting, unless otherwise noticed:

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, August 27, 2025; 3:00 – 5:00p.m.

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

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

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

Members of the public interested in attending should call the Alliance at (831) 430-2568 to verify meeting date and location prior to the meeting.

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) 430-2568. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE June 25, 2025

TO Governing Commission of the Central California Alliance for Health

FROM Michael Schrader, Chief Executive Officer

SUBJECT CEO Report

Alliance Membership Since January, our Medi-Cal membership has remained relatively stable, with a modest decline of 1,000 members, totaling 442,705 as of June. The Alliance call center handles thousands of incoming member calls each month, with common inquiries about transportation, ID cards, and primary care provider (PCP) changes. Newer members typically seek information about covered benefits and services. Additionally, our five offices receive approximately 370 member walk-ins per month.

Government Relations. The Alliance as a public entity that administers a public benefit program, is impacted by Federal and State legislation, policy, and funding. As such, we closely monitor, inform, and advocate at the local, state, and federal levels.

DHCS Statement on Federal Use of Medi-Cal Data and Member Privacy. On June 13 the AP reported that the Trump administration provided deportation officials with personal data, including immigration status, for millions of Medicaid enrollees. DHCS released a statement that afternoon indicating that DHCS reached out to the Centers for Medicare and Medicaid Services (CMS) to confirm whether this occurred, and if so, what data was shared. To date, DHCS has not received confirmation and are working closely with state leaders, legal experts, and community organizations to understand the situation, provide accurate information, and support affected communities. Staff are continuing to seek clarification on the situation and will explore need for potential action upon a clear understanding of what information may have been released and to whom.

State Budget Fiscal Year 2025-26. On June 9, the California Senate and Assembly announced a legislative budget agreement that included reversing some of the most severe proposals included in the Governor's May Revise. Some of these changes include:

- Restoring the asset limit to $130K for an individual and $195K for a couple, instead of the Governor's proposed $2K limit
- Modifying the enrollment freeze for individuals with Unsatisfactory Immigration Status (UIS) age 19 and older by specifying that individuals do not "age out" and establishing a 6-month re-enrollment grace period for those that fall off the eligibility rolls
- Reducing the proposed monthly premiums for UIS members from $100/month to $30/month for individuals ages 19-59 only
- Rejecting the elimination of Prop 56 fund for family planning and women's health.

- Postponing the elimination of Prop 56 supplemental payments for dental until July 1, 2027.
- Postponing the elimination of dental benefits for UIS until January 1, 2027.
- Rejecting the proposal to eliminate Long Term Care and In-Home Supportive Services for UIS adults.
- Delaying the proposed $1.1B cuts to Health Centers and Rural Health Clinics until July 1, 2027.
- Proposing the development of a large employer contribution requirement for employers with employees enrolled in Medi-Cal.
- Removing the increased Minimum Loss Ratio for Medi-Cal managed care plans

Legislative budget hearings continue to take place with the deadline for the legislature to adopt a spending plan to send to the Governor for the coming fiscal year, is June 15. The Governor must sign the budget by June 30.

Meetings with State Legislators. To ensure Alliance priorities and concerns are known particularly related to State budget proposals, staff has continued efforts to meet with legislators and their staff including having met with **Lilliana Udang, Policy Analyst for Senator Anna Caballero** on June 4 and with **Assemblymember Dawn Addis**, who is Chair of the Assembly Budget Subcommittee on Health on June 12.

Federal "One Big Beautiful Bill Act". The United States Senate continues its work on H.R. 1, titled the "One Big Beautiful Bill Act", with a stated deadline of July 4 to pass the Senate version of the bill. The Alliance, through its association with the Local Health Plans of California and the Association of Community Affiliated Plans continues efforts to inform and influence members of congress of the potentially devastating impacts of various provisions of this bill to the health care safety net. Reports from our contracted federal lobbyists and consultants are that dissension remains and competing demands pull lawmakers in different directions. However, reports also indicate that Senate discussions appear to be pulling the bill even further to the right and towards deeper spending cuts which could present challenges when the bill returns to the House for passage.

2025 Legislation. Staff continues to monitor and advocate for legislation in alignment with the Board's adopted 2025 Policy Principles. Attached as Agenda Item 9B you will find the 2025 bill list that includes ninety-six (96) bills that staff are monitoring. The status of each bill is indicated Staff will continue to monitor these bills to assess potential impact and consider necessary planning and implementation steps should bills be enacted and signed into law by the Governor.

Kaiser in Monterey County. DHCS has informed the Alliance that Kaiser will begin the approval process in September 2025 to expand its Medi-Cal services into Monterey County. A final decision is anticipated by September 2026, with implementation planned for 2027. Enrollment will follow the same criteria and member-choice approach used in Santa Cruz and Mariposa counties—limited to individuals with prior Kaiser membership or family linkage, current or former foster youth, or those dually eligible for Medicare.

Community and Member Engagement/Marketing and Communications. The Alliance is a local plan that is invested in the communities we serve across our five counties.

Community Engagement. The team has been shifting efforts to increase participation at community events geared towards seniors, including the Meals on Wheels Senior Socials in Monterey County where participants have an opportunity to enjoy music, food and learn about Alliance services. In Mariposa County, the team participated in the Health and Human Service Agency's Senior Health Fair. In May, we also celebrated Mental Health Awareness Month by sharing resources and information with members through several community events including those hosted by behavioral health departments in Merced and San Benito counties. We also engaged in the first community resource fair of the season held at Reiter Farms fields. The resource fair is coordinated in collaboration with Community Action Board of Santa Cruz County and Reiter Farms and brings resources to farm employees directly to the fields (cuadrillas) at which they work. Community Engagement plans to be at each monthly event throughout the season.

Marketing and Communications. The team has been working on a new brand awareness media campaign, which will launch July 1 through the rest of the year. This bi-lingual campaign highlights that we are a locally managed health care plan with deep experience and knowledge of the needs of our communities. The campaign includes radio interviews and ads, mobile ads, social media, website content, connected TV ads and ads in local DMV offices. Our current campaign, "vaccines prevent 20 diseases," wraps up June 30 and a brief recap will be included in next month's report.

In May, we sent over 13,000 targeted text messages to members on these topics: new mothers, new member campaign series and redetermination. Text messaging has demonstrated its effectiveness in delivering appropriate communications to our members at the most opportune moments. For example, an SMS campaign on our diabetes workshop drove registrations to the workshops, and we are seeing significant increases in web page conversions (visits) as a result.

Alliance Workforce. Our robust culture is built on the premise that the Alliance exists to serve members, and most of our employees live in the communities we serve across our five counties. To enrich our culture there are All-Staff meetings, interactive town halls, coffee talks with members of the executive team, talent acquisition efforts, and biannual performance reviews.

Employee Engagement Survey. Each year, the Alliance conducts a confidential employee engagement survey, administered by a third-party vendor. The 2025 survey was just completed, and results show that 84% of our workforce is engaged, which is a four-point increase from the 2024 survey. Engagement is a measure of people's connection and commitment to the company and its goals. The trend in engagement score for the prior five years is as follows:

- 2021: 75%
- 2022: 75%

- 2023: 82%
- 2024: 80%
- 2025: 84%

The survey asks questions that fall into 18 different categories, including environment, leadership, work-life balance, wellbeing, service and quality, etc. One category remained flat with a score of 79 out of 100 points while all other factors increased anywhere from one to seven points. HR is currently in the process of sharing survey results with leadership and staff.

Alliance Priority Initiatives. The Alliance team has made tremendous progress in our **two-year marathon through 2024 and 2025 to implement six priority initiatives**. This has involved a heavy workload, competing priorities, regulatory submissions, and strict deadlines. Despite these challenges, the team is motivated by the chance to more fully and better serve our members.

Three of the initiatives have been successfully completed. We are proud to have achieved what we originally set out to accomplish on three of our priority initiatives: 1) We increased our ECM enrollment by a factor of six, such that approximately three percent of our Medi-Cal membership is now enrolled in ECM, such that our enrollment rate is now within the range expected by DHCS; 2) In collaboration with 15 clinics across Merced County, we improved quality scores, reflecting higher percentages of children receiving preventative care, including immunizations, lead screenings, and well-child visits; and 3) We successfully completed a major systems conversion to the Jiva Care Management System, enhancing our operational capabilities.

Three of the initiatives remain active. The Alliance team has dedicated its full attention, ensuring steady progress continues to implement the three remaining impactful and larger-scale initiatives, as described below.

TotalCare HMO D-SNP. The Alliance is preparing to launch a Medicare Dual Special Needs Plan (D-SNP) by January 1, 2026. This new offering will enable the Alliance to serve as a single, comprehensive plan for individuals eligible for both Medi-Cal and Medicare, including low-income seniors and people with disabilities.

Key progress since last month includes the submission of our D-SNP bid to CMS on June 2nd. We are also preparing for the execution of the State Medicaid Agency Contract (SMAC) this month in addition to various vendor contracts to support the operationalization of our D-SNP program.

The Alliance is preparing communications for the new program by updating website content and developing materials for members, sales, and marketing. We're drafting a Provider Bulletin article for September and a direct mail postcard to reach eligible member households in October. We're also building documentation, workflows, and

scripts to launch a compliant D-SNP texting and email program in January.

Behavioral Health Insourcing Plan – The Alliance team has been diligently working to bring the behavioral health benefit in-house, effective July 1, 2025. Bringing behavioral health in-house will grant us direct control and a better opportunity to improve access for members, support providers, and collaborate with counties and schools.

The Alliance has contracted, credentialed, and onboarded hundreds of providers who have served our members through Carelon, ensuring continuity of care after go-live. Member notifications about the upcoming July-1 transition from Carelon to the Alliance were sent in late May. In this final month leading up to go-live, the Alliance has intensified outreach to members and providers through our website, Member and Provider Bulletins, community newsletter *The Beat*, and social media. We've also developed flyers and brochures to support member-facing staff. Additionally, in June, two text message campaigns will be sent to 24,000 member households previously served by Carelon to inform them of the change.

NCQA Accreditations. As part of CalAIM, DHCS requires that by January 1, 2026 all Medi-Cal managed care plans achieve two separate NCQA accreditations.

1. Health Equity Accreditation ensures plans address health disparities and promote equitable care. **The Alliance earned full accreditation for three years with a perfect score of 100% following a recent NCQA survey**.

2. Health Plan Accreditation evaluates plans based on quality, accountability, and transparency**. The Alliance earned full accreditation for three years following a recent NCQA survey.**

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights. Like all Managed Care Plans, the Alliance is in a continuous state of preparing routine audits, experiencing them, or following up on regulators' requests. Following is a summary of regulatory audit activity that occurred since my last report.

2025 DHCS Medi-Cal Audit. DHCS auditors conducted a limited scope annual audit in January of 2025, and preliminary results were shared with the Alliance in May of 2025. The Preliminary Findings Report included only two findings, related to resolution of quality grievance, oversight of grievance and appeals, which the plan did not dispute. We received the Final Findings Report on June 5, 2025, and are meeting with DHCS on June 16, 2025, to review corrective action plan expectations and procedures.

2025 DMHC Financial Examination. DMHC auditors initiated their virtual audit in January of 2025, reviewing the Alliance's fiscal and administrative affairs, including claims payment practices. We received our Preliminary Findings Report in June 2025, in which there were three findings related to Claims, Provider Disputes, and our Anti-FWA Plan filing. We have submitted plan to respond in a timely manner and address all issues stated in the DMHC's Report.

2025 DMHC Medical Survey. We received DMHC's preliminary report from its 2024 Medical Survey of the Alliance that occurred in March 2024. Agenda item 10, There were preliminary audit findings in the areas of Grievances, Utilization Management, Pharmacy, and Behavioral Health. As is standard process, we accepted certain findings as opportunities to improve and have clarified or contested others. We provided the DMHC with our response in May 2025.

2025 DHCS Network Adequacy Validation Audit. DHCS contracts with the Health Services Advisory Group (HSAG) to assess whether the Alliance is able to meet the DHCS' time and distance standards for provider access. This audit, which kicked off in June 2025, reviews the Alliance's data systems, methodologies, and outputs to ensure we're accurately calculating and reporting our provider network adequacy.

Alliance Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to strengthen health care and community organizations across the five counties we serve. The purpose is to pursue the Alliance's vision of heathy people, healthy communities. These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members. They also address social drivers that influence health and wellness.

MCGP Funding Allocation Methodology. At the June 25, 2025 Board meeting, the Board will consider staff's recommendation to shift from a county-specific funding allocation model to a unified MCGP budget for the entire service area. The proposed policy change includes an equity-based methodology to guide grant awards in each county and ensures investments in each county. This approach promotes equitable investments, aligns with recent State policy shifts, and increases flexibility to prioritize funding where the greatest need exists.

Trends in the Number of Awards and Total Spend. The MCGP has paid out $12.6M year to date. New MCGP awards year-to-date total $8M, which is 23% of the 2025 total award amount target of $35M. Currently in the second of three funding rounds this year, the MCGP received 81 eligible applications by the May 6, 2025 deadline for a total requested amount of $13M across eight programs in the five-county service area. These applications are currently under review for award decisions on July 18, 2025. The application deadline for the third round is August 19, 2025 with award decisions on October 31, 2025. Details of all 2025 awards will be included in the mid-year report in the August 2025 Board packet and in the end-of-year report in the January 2026 Board packet.

DATE: June 25, 2025

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Fourth Month Ending April 30, 2025

For the month ending April 30, 2025, the Alliance reported an Operating Loss of $8.7M. The Year-to-Date (YTD) Operating Loss is $0.5M with a Medical Loss Ratio (MLR) of 94.9% and an Administrative Loss Ratio (ALR) of 5.2%. The Net Income is $20.2M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Loss of $9.6M for YTD April. The actual result is favorable to the budget by $9.1M or 94.4%, driven primarily by rate variances.

	Apr-25 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*445,244*	*438,815*	*6,429*	*1.5%*
Revenue	$195,684	$173,831	$21,854	12.6%
Medical Expenses	194,418	165,625	(28,793)	-17.4%
Administrative Expenses	9,918	9,689	(229)	-2.4%
Operating Income	(8,651)	(1,483)	(7,168)	-100.0%
Net Income	($3,434)	$171	($3,605)	-100.0%
MLR %	99.4%	95.3%	-4.1%	
ALR %	5.1%	5.6%	0.5%	
Operating Income %	-4.4%	-0.9%	-3.6%	
Net Income %	-1.8%	0.1%	-1.9%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

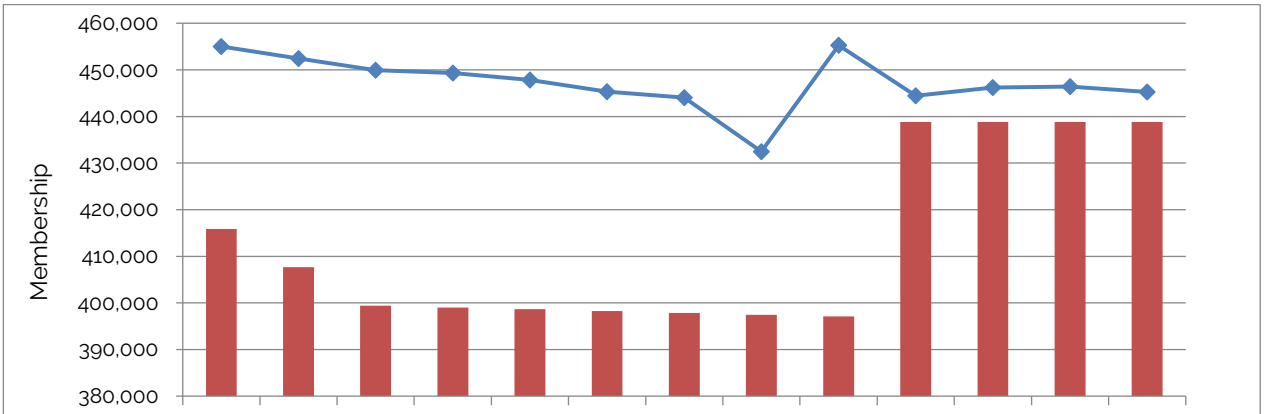
	Apr-25 YTD (In $000s)			
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,782,323*	*1,755,295*	*27,028*	*1.5%*
Revenue	$755,312	$695,324	$59,988	8.6%
Medical Expenses	716,830	666,922	(49,908)	-7.5%
Administrative Expenses	39,021	38,044	(977)	-2.6%
Operating Income/(Loss)	(538)	(9,642)	9,104	94.4%
Net Income/(Loss)	$20,168	($1,064)	$21,232	100.0%
PMPM				
Revenue	$423.78	$396.13	$27.65	7.0%
Medical Expenses	402.19	379.95	(22.24)	-5.9%
Administrative Expenses	21.89	21.67	(0.22)	-1.0%
Operating Income/(Loss)	($0.30)	($5.49)	$5.19	94.5%
MLR %	94.9%	95.9%	- 1.0%	
ALR %	5.2%	5.5%	-0.3%	
Operating Income %	-0.1%	-1.4%	1.3%	
Net Income %	2.7%	-0.2%	2.8%	

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, revenue is $423.78, which is favorable to the budget by $27.65 or 7.0%. Medical cost is $402.19 PMPM, which is unfavorable by $22.24 or 5.9%. This results in a favorable gross margin of $5.41 or 33.4% compared to the budget. The operating loss PMPM is ($0.30), compared to the budget of ($5.49).

Membership: April 2025 membership is favorable to the budget by 1.5%. The 2025 budget assumed a flat budget with 438k members per month for all of 2025. The SIS membership continues to decrease every month through redetermination, while the UIS membership grows.

Membership. Actual vs. Budget (based on actual enrollment trend for Apr-25 rolling 13 months)



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Budget	415,884	407,648	399,413	399,023	398,633	398,242	397,852	397,462	397,072	438,833	438,827	438,821	438,815
Actual	455,001	452,430	449,959	449,311	447,805	445,356	444,059	432,469	455,255	444,442	446,213	446,424	445,244
Variance	39,117	44,782	50,546	50,288	49,172	47,114	46,207	35,007	58,183	5,609	7,386	7,603	6,429
Variance %	9.4%	11.0%	12.7%	12.6%	12.3%	11.8%	11.6%	8.8%	14.7%	1.3%	1.7%	1.7%	1.5%

Revenue: The 2025 revenue budget was based on the Department of Health Care Services (DHCS) 2025 draft rate package (dated 10/21/24), which reflected a –0.1% rate decrease, over the CY 24 Final Amended rates (dated 12/30/24), not including the Targeted Rate Increase (TRI) and Enhanced Care Management (ECM). Furthermore, the budget assumed breakeven performances for the San Benito Region and for our Unsatisfactory Immigrant Status (UIS) population. The CY 2025 Prospective rates from DHCS (dated 1/27/2025, including Maternity) represented a 5.0% increase over the CY 2024 Final Amended Rates, excluding TRI and ECM.

Apr-25 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$559,675	$524,361	$35,314	9,972	25,342
CEC UIS	157,503	139,690	17,813	518	17,295
SBN SIS	28,627	22,964	5,663	575	5,089
SBN UIS	6,089	6,629	(540)	(983)	443
Total*	**$751,893**	**$693,643**	**$58,250**	**$10,081**	**$48,169**

*Excludes Apr-25 In-Home Supportive Services (IHSS) premiums revenue of $1.9M and State Incentive Revenue of $1.6M.

The actual revenue in April exceeded the budget by $21.9 million, representing a 12.6% positive variance. This is driven by favorable enrollment, contributing $2.6M, and rate variances totaling $19.2M. Of the $19.2M, $9.5M is from the higher-than-budget receivable from the ECM risk corridor, resulting from higher enrollment than the budgeted amount. Please note that the ECM expenses are higher than the budget as well, and the net loss is limited to 5% of the ECM revenue.

The YTD April operating revenue stands at $755.3M, surpassing the budget by $60.0M or 8.6%. This favorable variance includes $10.0M from increased enrollment and $50.0M from positive rate variances.

Medical Expenses: The 2025 budget assumed a 3.3% increase in utilization over the 2024 forecast, based on data from 2022 through September 2024, and a 4.2% increase in unit cost driven by changes in case mix and fee schedule adjustments. 2025 incentives include a $20M for the Hospital Quality Incentive Program (HQIP), $15M Care-Based Incentive (CBI), $12.5M for the Specialist Care Incentive (SCI), $4M Data Sharing Incentives, $3.7M Behavioral Health Value Based Program (BH VBP) and $1M Risk Adjustment Incentives.

Apr-25 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient - Hospital	$200,440	$189,683	($10,757)	($2,916)	($7,841)
Inpatient - LTC	69,656	68,372	(1,284)	(1,035)	(249)
Physician Services	156,567	170,791	14,224	(2,644)	16,867
Outpatient Facility	83,539	73,452	(10,087)	(1,128)	(8,959)
ECM	52,567	36,495	(16,073)	(565)	(15,508)
Community Supports	22,907	13,469	(9,438)	(208)	(9,230)
Behavioral Health	29,526	28,605	(921)	(442)	(480)
Other Medical*	100,064	86,056	(14,008)	(1,303)	(12,705)
State Incentives	1,563	-	(1,563)	-	(1,563)
TOTAL COST	$716,830	$666,922	($49,908)	($10,240)	($39,668)

*Other Medical actuals include Allied Health, Non-Claims HC Cost, Transportation, and Lab.

April 2025 Medical Expenses of $194.4M are $28.8M or 17.4% unfavorable to the budget. April 2025 YTD Medical Expenses of $716.8M are above budget by $49.9M or 7.5%. Of this amount, $10.2M is due to higher enrollment, and $39.7M is due to rate variances. The unfavorability is primarily driven by ECM and Community Supports (CS) from the higher-than-budget enrollment, followed by the Other Medical category, specifically from transportation and Hospice.

Back to Agenda

At a PMPM level, YTD Medical Expenses are $402.19, unfavorable by $22.24 or 5.9% compared to the budget.

Apr-25 YTD Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$112.46	$108.06	($4.40)	-4.1%
Inpatient Services - LTC	39.08	38.95	(0.13)	-0.3%
Physician Services	87.84	97.30	9.46	9.7%
Outpatient Facility	46.87	41.85	(5.02)	-12.0%
ECM	29.49	20.79	(8.70)	-41.9%
Community Supports	12.85	7.67	(5.18)	-67.5%
Behavioral Health	16.57	16.30	(0.27)	-1.7%
Other Medical	56.14	49.03	(7.12)	-14.5%
State Incentives	0.88	-	(0.88)	-100.0%
TOTAL MEDICAL COST	**$402.19**	**$379.95**	**($22.24)**	**-5.9%**

Inpatient Services: Inpatient Services remain slightly unfavorable to the budget due to prior period claims totaling $11M, which were paid in April 2025.

Inpatient Services—Long Term Care (LTC): LTC utilization is generally trending in line with the expected seasonal fluctuations within the budget. April PMPM trends higher by 5.5% at $41.73, driven by a 2% higher rate increase for 2024 and 2025 than the initial budget.

Physician Services: Favorability is influenced by lower utilization of the Targeted Rate Increase (TRI) and Provider Supplemental Payment (PSP) budgets. DHCS will add new provider types to TRI eligibility in 2025, which is expected to improve budget alignment as more TRI-eligible payments are processed. Lower utilization of the TRI and PSP spend is driving favorable unit costs for FQHC, PCP, and Specialty compared to the budget, despite a utilization spike in January and February due to the flu season.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. ER continues to show an upward trend in both utilization and unit cost.

ECM: The ECM budget for 2025 was based on a cautious enrollment growth projection with an anticipated 15.4k enrollments by year-end, as the program is on its path toward stabilization. However, ECM enrollments started the year at 16k and have increased to 21k as of April, averaging 7.9% monthly growth. Before adjusting for the risk corridor, ECM's YTD loss through April is $36M and is projected to total approximately $135.5M for the whole year. We anticipate this growth will continue, with the program remaining under the risk corridor framework to help mitigate the higher expenses associated with this expansion.

Community Supports: Enrollments for the Community Support (CS) program were kept modest due to its newness and limited history. Since the budget preparation, there has

been a significant increase in CS enrollments. The 2025 PMPM expense is trending at $13.15, 67% higher than the budget and 54% higher than the revenue PMPM of $8.51. As a result, our monthly loss for CS is averaging $2M, with a YTD loss of $8.5M through April. Based on current trends, full-year losses are projected to reach $26M. We expect the unfavorable variance in ECM and CS to continue throughout the year.

We have actively engaged with the State, sharing this most recent ECM and CS data to underscore the need for a rate adjustment, as the current revenue is insufficient to offset the higher expenses.

Behavioral Health: Behavioral Health is tracking close to the budget. The budget also accounts for anticipated growth in utilization and unit costs in the second half of the year, when we bring this service in-house, rather than through Carelon.

Other Medical: The Other Medical category is over budget primarily due to increased utilization, higher unit costs, and elevated IBNR. Transportation is the largest contributor, which accounts for a $6.4M unfavorable variance. This is driven by higher utilization in Non-Medical Transportation and increased unit costs in both Air Transportation and Non-Emergency Medical Transportation (NEMT). The higher NEMT costs reflect add-on payments associated with bariatric transport, which require specialized equipment and support. Hospice services also contributed a $2.6M variance, due to higher-than-expected utilization and under-budgeted unit costs.

Administrative Expenses: April YTD Administrative Expenses are unfavorable to budget by $1.0M or 2.6% with 5.2% ALR. Salaries are unfavorable by $1.2M due to salaries and temporary services. Non-salary administrative expenses are favorable by $0.2M, or 2.0%, due to savings and unspent budgets.

Non-Operating Revenue/Expenses: April YTD Net Non-Operating Income is $20.7M, which is favorable to budget by $12.1M. The favorability is from the YTD Investment Income of $28.5M, which is favorable to the budget by $9.9M due to the higher interest rates. The YTD Other Revenue is $0.7M and is slightly below budget by $39k.

The YTD Non-Operating Expense is $8.4M and is favorable to budget by $2.2M driven by lower Grant disbursements of $3.3M offsetting the unbudgeted Community Reinvestment of $1.1M,

Summary of Results: Overall, the Alliance generated a YTD Net Income of $20.2M, with an MLR of 94.9% and an ALR of 5.2%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Fourth Month Ending April 30, 2025
(In $000s)

Assets	
Cash	$113,166
Restricted Cash	304
Short Term Investments	1,061,756
Receivables	242,824
Prepaid Expenses	2,041
Other Current Assets	2,715
Total Current Assets	**$1,422,805**
Building, Land, Furniture & Equipment	
Capital Assets	$83,630
Accumulated Depreciation	(48,460)
CIP	1,618
Lease Receivable	4,133
Subscription Asset net Accum Depr	13,214
Total Non-Current Assets	**54,135**
Total Assets	**$1,476,940**
Liabilities	
Accounts Payable	$73,184
IBNR/Claims Payable	425,961
Provider Incentives Payable	50,035
Other Current Liabilities	12,007
Due to State	(10,081)
Total Current Liabilities	**$551,105**
Subscription Liabilities	10,590
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$14,489**
Fund Balance	
Fund Balance - Prior	$891,178
Retained Earnings - CY	20,168
Total Fund Balance	**911,345**
Total Liabilities & Fund Balance	**$1,476,940**
Additional Information	
Total Fund Balance	**$911,345**
Board Designated Reserves Target	502,422
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	132,408
Value Based Payments	46,100
Provider Supplemental Payments	145,778
Total Reserves	**883,409**
Total Operating Reserve	**$27,937**

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2025
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*445,244*	*438,815*	*6,429*	*1.5%*	*1,782,323*	*1,755,295*	*27,028*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$190,172	$173,416	$16,756	9.7%	$751,893	$693,643	$58,250	8.4%
State Incentive Programs	1,563	-	1,563	100.0%	1,563	-	$1,563	100.0%
Prior Year Revenue*	3,498	-	3,498	100.0%	-	-	$0	0.0%
Premiums Commercial	451	415	36	8.7%	1,856	1,681	175	10.4%
Total Operating Revenue	**$195,684**	**$173,831**	**$21,854**	**12.6%**	**$755,312**	**$695,324**	**$59,988**	**8.6%**
Medical Expenses								
Inpatient Services (Hospital)	$52,930	$47,106	($5,823)	-12.4%	$200,440	$189,683	($10,757)	-5.7%
Inpatient Services (LTC)	20,463	16,979	(3,484)	-20.5%	69,656	68,372	(1,284)	-1.9%
Physician Services	40,017	42,128	2,112	5.0%	156,567	170,791	14,224	8.3%
Outpatient Facility	24,413	18,241	(6,172)	-33.8%	83,539	73,452	(10,087)	-13.7%
ECM	14,206	9,063	(5,143)	-56.7%	52,567	36,495	(16,073)	-44.0%
Community Supports	5,764	3,345	(2,419)	-72.3%	22,907	13,469	(9,438)	-70.1%
Behavioral Health	8,276	7,391	(885)	-12.0%	29,526	28,605	(921)	-3.2%
Other Medical**	26,785	21,371	(5,414)	-25.3%	100,064	86,056	(14,008)	-16.3%
State Incentive Programs	1,563	-	(1,563)	-100.0%	1,563	-	(1,563)	-100.0%
Total Medical Expenses	**$194,418**	**$165,625**	**($28,793)**	**-17.4%**	**$716,830**	**$666,922**	**($49,908)**	**-7.5%**
Gross Margin	**$1,267**	**$8,206**	**($6,939)**	**-84.6%**	**$38,483**	**$28,402**	**$10,081**	**35.5%**
Administrative Expenses								
Salaries	$6,915	$6,738	($178)	-2.6%	$27,095	$25,870	($1,226)	-4.7%
Professional Fees	484	407	(78)	-19.1%	1,790	1,816	27	1.5%
Purchased Services	1,037	1,079	42	3.9%	4,101	4,407	307	7.0%
Supplies & Other	(332)	703	1,035	100.0%	3,200	3,040	(161)	-5.3%
Occupancy	121	126	5	3.8%	487	507	21	4.1%
Depreciation/Amortization	1,692	637	(1,055)	-100.0%	2,348	2,404	55	2.3%
Total Administrative Expenses	**$9,918**	**$9,689**	**($229)**	**-2.4%**	**$39,021**	**$38,044**	**($977)**	**-2.6%**
Operating Income	**($8,651)**	**($1,483)**	**($7,168)**	**-100.0%**	**($538)**	**($9,642)**	**$9,104**	**94.4%**
Non-Op Income/(Expense)								
Interest	$4,340	$3,704	$636	17.2%	$17,501	$16,028	$1,473	9.2%
Gain/(Loss) on Investments	4,369	500	3,869	100.0%	11,120	2,750	8,370	100.0%
Bank & Investment Fees	(40)	(62)	21	34.6%	(168)	(247)	78	31.7%
Other Revenues	165	179	(14)	-7.7%	674	713	(39)	-5.5%
Grants	(2,555)	(2,667)	112	4.2%	(7,359)	(10,667)	3,308	31.0%
Community Reinvestment	(1,061)	-	(1,061)	-100.0%	(1,061)	-	(1,061)	-100.0%
Total Non-Op Income/(Expense)	**5,217**	**1,654**	**3,563**	**100.0%**	**20,706**	**8,578**	**$12,128**	**100.0%**
Net Income/(Loss)	**($3,434)**	**$171**	**($3,605)**	**-100.0%**	**$20,168**	**($1,064)**	**$21,232**	**100.0%**
MLR	*99.4%*	*95.3%*			*94.9%*	*95.9%*		
ALR	*5.1%*	*5.6%*			*5.2%*	*5.5%*		
Operating Income	*-4.4%*	*-0.9%*			*-0.1%*	*-1.4%*		
Net Income %	*-1.8%*	*0.1%*			*2.7%*	*-0.2%*		

**Other Medical includes Pharmacy and IHSS.

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2025
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*445,244*	*438,815*	*6,429*	*1.5%*	*1,782,323*	*1,755,295*	*27,028*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$427.12	$395.19	$31.93	8.1%	$421.86	$395.17	$26.69	6.8%
State Incentive Programs	3.51	-	3.51	100.0%	0.88	-	0.88	100.0%
Prior Year Revenue*	7.86	-	7.86	100.0%	-	-	-	0.0%
Premiums Commercial	1.01	0.95	0.07	7.1%	1.04	0.96	0.08	8.7%
Total Operating Revenue	**$439.50**	**$396.14**	**$43.36**	**10.9%**	**$423.78**	**$396.13**	**$27.65**	**7.0%**
Medical Expenses								
Inpatient Services (Hospital)	$118.88	$107.35	($11.53)	-10.7%	$112.46	$108.06	($4.40)	-4.1%
Inpatient Services (LTC)	45.96	38.69	(7.27)	-18.8%	39.08	38.95	(0.13)	-0.3%
Physician Services	89.88	96.00	6.13	6.4%	87.84	97.30	9.46	9.7%
Outpatient Facility	54.83	41.57	(13.26)	-31.9%	46.87	41.85	(5.02)	-12.0%
ECM	31.91	20.65	(11.25)	-54.5%	29.49	20.79	(8.70)	-41.9%
Community Supports	12.94	7.62	(5.32)	-69.8%	12.85	7.67	(5.18)	-67.5%
Behavioral Health	18.59	16.84	(1.75)	-10.4%	16.57	16.30	(0.27)	-1.7%
Other Medical**	60.16	48.70	(11.46)	-23.5%	56.14	49.03	(7.12)	-14.5%
State Incentive Programs	3.51	-	(3.51)	-100.0%	0.88	-	(0.88)	-100.0%
Total Medical Expenses	**$436.65**	**$377.44**	**($59.22)**	**-15.7%**	**$402.19**	**$379.95**	**($22.24)**	**-5.9%**
Gross Margin	**$2.84**	**$18.70**	**($15.86)**	**-84.8%**	**$21.59**	**$16.18**	**$5.41**	**33.4%**
Administrative Expenses								
Salaries	$15.53	$15.35	($0.18)	-1.2%	$15.20	$14.74	($0.46)	-3.2%
Professional Fees	1.09	0.93	(0.16)	-17.4%	1.00	1.03	0.03	3.0%
Purchased Services	2.33	2.46	0.13	5.2%	2.30	2.51	0.21	8.4%
Supplies & Other	(0.75)	1.60	2.35	100.0%	1.80	1.73	(0.06)	-3.7%
Occupancy	0.27	0.29	0.01	5.1%	0.27	0.29	0.02	5.5%
Depreciation/Amortization	3.80	1.45	(2.35)	-100.0%	1.32	1.37	0.05	3.8%
Total Administrative Expenses	**$22.28**	**$22.08**	**($0.20)**	**-0.9%**	**$21.89**	**$21.67**	**($0.22)**	**-1.0%**
Operating Income	**($19.43)**	**($3.38)**	**($16.05)**	**-100.0%**	**($0.30)**	**($5.49)**	**$5.19**	**94.5%**

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.
**Other Medical includes Pharmacy and IHSS.

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Fourth Month Ending April 30, 2025
(In $000s)

	MTD	YTD
Net Income	($3,434)	$20,168
Items not requiring the use of cash: Depreciation	250	967
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	(2,798)	181,419
Prepaid Expenses	33	(1,205)
Current Assets	333	1,145
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(2,432)**	**181,359**
Changes to Payables:		
Accounts Payable	(123,536)	(310,250)
Other Current Liabilities	828	486
Incurred But Not Reported Claims/Claims Payable	(104,474)	(51,232)
Provider Incentives Payable	(6,284)	6,575
Due to State	(7,545)	(26,751)
Subscription Liabilities	0	0
Net Changes to Payables	**(241,011)**	**(381,172)**
Net Cash Provided by (Used in) Operating Activities	**(246,627)**	**(178,678)**
Change in Investments	(8,456)	(23,081)
Other Equipment Acquisitions	(746)	(1,314)
Net Cash Provided by (Used in) Investing Activities	**(9,203)**	**(24,395)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**(255,830)**	**(203,073)**
Cash & Cash Equivalents at Beginning of Period	**368,995**	**316,238**
Cash & Cash Equivalents at April 30, 2025	**$113,166**	**$113,166**

Back to Agenda

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

Meeting Minutes

Wednesday, May 28, 2025
3:00 p.m. – 5:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
San Benito County Health and Human Services Agency
1111 San Felipe Road, Building B, Hollister, CA
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

Ms. Leslie Abasta-Cummings,	At Large Health Care Provider Representative
Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Ms. Tracey Belton,	County Health and Human Services Agency Director
Dr. Maximiliano Cuevas,	Health Care Provider Representative
Ms. Kim De Serpa	County Board of Supervisors
Ms. Janna Espinoza,	Public Representative
Mr. Mark Hendrickson	Assistant County Executive Officer
Dr. Donaldo Hernandez,	Health Care Provider Representative
Ms. Elsa Jimenez,	County Director of Health Services
Dr. Kristina Keheley	Interim Health and Human Services Agency Director
Mr. Michael Molesky,	Public Representative
Supervisor Josh Pedrozo,	County Board of Supervisors
Dr. James Rabago,	Health Care Provider Representative
Dr. Allen Radner,	At Large Health Care Provider Representative

Commissioners Absent:

Ms. Anita Aguirre,	At Large Health Care Provider Representative
Ms. Dorothy Bizzini,	Public Representative
Ms. Mónica Morales,	County Health Services Agency Director
Ms. Wendy Root Askew	County Board of Supervisors

Staff Present:

Mr. Michael Schrader,	Chief Executive Officer
Mr. Scott Fortner,	Chief Administrative Officer
Dr. Omar Guzman,	Chief Health Equity Officer
Ms. Jenifer Mandella,	Chief Compliance Officer
Ms. Lisa Ba,	Chief Financial Officer
Ms. Van Wong,	Chief Operating Officer
Ms. Anne Brereton,	Deputy County Counsel, Monterey County
Ms. Hayley Tut,	Interim Clerk of the Board
Ms. Lisa Demmert,	Executive Assistant
Dr. Mike Wang,	Medical Director

1. Call to Order by Chair Jimenez.

Commission Vice Chairperson Abasta-Cummings called the meeting to order at 3:00 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Vice Chair Abasta-Cummings acknowledged Commissioner Morales's contributions to the board since March 2022 and wished them well in their future endeavors.

[Commissioner Rabago arrived at this time: 3:02 p.m.]

2. Oral Communications.

Vice Chair Abasta-Cummings opened the floor for any members of the public to address the Commission on items not listed on the agenda.

There was no public comment.

3. Comments and announcements by Commission members.

Vice Chair Abasta-Cummings opened the floor for Commissioners to make comments.

Commissioner Espinoza expressed concerns about the state budget proposal for in-home support services, highlighting the potential negative impact on families and providers. The proposed overtime cap at 50 hours would significantly reduce income for many families, potentially leading to homelessness and inability to meet basic needs such as rent and food.

Additional concerns were raised about asset limits, which could further negatively impact families by restricting their ability to save and maintain financial stability. The potential

elimination of long-term care, in-home supportive services, and dental coverage for adults with unsatisfactory immigration status was also highlighted as harmful.

It was noted that Assembly Member Robert Rivas, who represents parts of Monterey and San Benito counties and serves as the Speaker of the Assembly, has been open to communication and is aware of the concerns regarding in-home support services. Efforts are being made to engage with legislators to address these issues.

The closure of the only commercial pharmacy in the county, Rite Aid, was announced and the potential impact on prescription services for residents was also discussed.

[Commissioner De Serpa arrived at this time: 3:06 p.m.]
[Commissioner Hernandez arrived at this time: 3:06 p.m.]

4. Comments and announcements by Chief Executive Officer.

Michael Schrader announced that CMS conditionally approved the Alliance's application to offer a Medicare D-SNP program across our five counties for contract year 2026. The application included a model of care and provider network; our model of care received a perfect score of 100% from CMS. The provider network included hundreds of signed contract amendments and a letter of intent.

Mr. Schrader reported that the Alliance received full accreditation for Health Equity from NCQA with a perfect survey score of 100%. Additionally, this week NCQA completed its survey of the Alliance for the more extensive health plan accreditation, and we await the result.

Mr. Schrader highlighted the results of a routine and broad DHCS Medical Audit, including the preliminary report, containing only two findings. Additionally, the independent outside auditors from Moss Adams issued the Alliance clean audit report for our 2024 financial statements.

Commissioners addressed concerns about United Health's Medicare Advantage Plan, and Mr. Schrader assured that the Alliance is paying attention.

[Commissioner Pedrozo departed at this time: 3:15 p.m.]

Consent Agenda Items: (5. – 12C.): 3:16 p.m.

Vice Chair Abasta-Cummings opened the floor for approval of Consent Agenda items 5-12D.

MOTION: Commissioner Molesky moved to approve Consent Agenda items 5 through 12D, seconded by Commissioner Espinoza.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Belton, Cuevas, De Serpa, Espinoza, Hendrickson, Hernandez, Keheley, Molesky, Rabago and Radner.

Noes: None.

Absent: Commissioners Aguirre, Askew, Bizzini, Jimenez, Morales and Pedrozo.

Abstain: None.

Regular Agenda Items: (13. – 15.): 3:17 p.m.

13. Consider and accept Moss Adams audited financial statements and findings (3:17 – 3:41 p.m.)

Michael Schrader, CEO, introduced Moss Adams staff, Chris Pritchard, Engagement Reviewer and Rianne Suico, Coordinating Partner, who presented the audited financial statements for FY 2024, highlighting the Alliance's strong financial position.

Ms. Suico presented the audited financial statements for FY 2024, issuing an unmodified audit opinion, which is the highest level of assurance. The financial statements were found to be free of material misstatements, reflecting the Alliance's strong financial position. The presentation included a detailed analysis of the Alliance's assets, liabilities, and net position. Key points included the confirmation of cash balances, capitation receivables, and investments, as well as the methodology used to estimate medical claims liabilities.

Mr. Pritchard reviewed the Alliance's operating revenues and expenses, noting an increase in revenues due to membership expansion and premium taxes. The largest expense was capitation payments to providers, which remained consistent with the prior year.

The auditors discussed the Alliance's compliance with regulatory requirements, including the maintenance of tangible net equity well above the required levels. The Alliance's reserves were noted as being among the highest seen by the auditors, providing a strong buffer for future challenges.

Vice Chair Abasta=Cummings opened the floor for acceptance of the audited financial statement and findings of independent auditors, Moss Adams.

MOTION: Commissioner De Serpa moved to approve the audited financial statements seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Belton, Cuevas, De Serpa, Espinoza, Hendrickson, Hernandez, Keheley, Molesky, Rabago and Radner.

Noes: None.

Absent: Commissioners Aguirre, Askew, Bizzini, Morales and Pedrozo.

Abstain: Commissioner Jimenez.

14. Discuss May Revise and Federal Budget Proposals. (3:41 – 4:35 p.m.)

Mr. Michael Schrader, CEO discussed the May Revise which outlines major provisions for the State Fiscal Year 2025-2026. Key points include that the state faces a $12 billion deficit, with the Medi-Cal program contributing $5 billion to this deficit. DHCS projects a 5% decrease in Medi-Cal enrollment, impacting the Alliance proportionally with lower revenue and increased administrative responsibilities.

Major provisions include an enrollment freeze starting January 1, 2026, for adults aged 19 and older with unsatisfactory immigration status. Beginning January 1, 2027, adults with unsatisfactory immigration status will be required to pay a $100 monthly premium, potentially reducing enrollment by 25%. Long-term care, in-home supportive services, and dental coverage for adults aged 19 and older will be eliminated. Elimination of state wrap-around payments for FQHCs for the UIS population. Additionally, reinstatement of asset limits for seniors and disabled individuals to qualify for certain Medi-Cal programs, reducing the limit to $2,000 for individuals and $3,000 for couples. Coverage for GLP-1 drugs for weight loss, acupuncture, and certain over-the-counter drugs will be eliminated. Increase in the medical loss ratio requirement for managed care plans from 85% to 90%, which does not impact the Alliance as it already exceeds 90%. Redirection of $2 billion in Prop 35 MCO tax revenue to support the Medi-Cal program.

Budget hearings are currently taking place, with the constitutional deadline for the legislature to pass a balanced budget by June 15. He also mentioned that IHSS provider time and travel pay will be capped at 50 hours per week, down from 60-70 hours, impacting many families. Mr. Schrader highlighted the potential negative impact on provider networks, rural hospitals, and vulnerable populations, emphasizing the need for strategic navigation for these changes. The Alliance and other state officials will navigate these changes, potentially seeking litigation and adjustments to maintain services levels.

Additionally, Federal Budget Proposals were discussed highlighting that the House passed a budget reconciliation bill with 13 proposed changes to Medicaid. Mr. Schrader discussed the potential impact of these federal budget proposals on Medicaid, including cuts to provider taxes and changes to eligibility and enrollment redeterminations.

Mr. Schrader outlined several proposed changes to Medicaid in the federal budget, including the elimination of the reasonable opportunity period for verifying immigration status, a reduction in the federal match for Medicaid expansion, and the prohibition of federal funds for gender transition therapy.

Proposed changes to provider taxes were discussed, including a freeze on new provider taxes, tightening rules on existing taxes, and capping state-directed payments for inpatient hospital services at 100% of Medicare rates. These changes could significantly impact the financial stability of healthcare providers.

The federal budget proposals include more frequent redeterminations for Medicaid expansion adults, work requirements for able-bodied adults without dependents, and a reduction in the retroactive coverage period from 90 days to one month. These changes could lead to a loss of coverage for many individuals.

Mr. Schrader explained the legislative process for the federal budget proposals, noting that the Senate is expected to modify the House-approved bill, aiming to complete the process by July 4th weekend.

15. Consider approving the Alliance's legal and regulatory Compliance Program Report for Q3-4 2024 (4:35 p.m. – 4:46 p.m.)

Ms. Jenifer Mandella, Chief Compliance Officer, reviewed the Compliance Program report for Q3-4 2024. She emphasized the importance of the compliance program in navigating regulatory changes and ensuring the organization remains in good standing, highlighting the board's role in

overseeing the effectiveness of the compliance program, ensuring risks are identified and resolved timely.

Ms. Mandella reported on HIPAA incidents, noting a higher number of impacted members due to recent system conversions and incorrect email transmissions. Corrective actions and training are in place to address these issues. She discussed the investigation and reporting of fraud and abuse, indicating concerns regarding medically tailored meals and COVID testing were trending during the report period. There is a proactive identification of risks through internal audits, with a high bar set for passing scores.

Ms. Mandella reviewed the oversight of entities subcontracted for administrative functions, noting several corrective action plans (CAPs) in place. She provided updates on various audits and enforcement actions, including the DMHC medical audit, DHCS medical audit, and DMHC financial audit, highlighting the reduction of a sanction from $100,000 to $20,000.

Later this year, Ms. Mandella will distribute required compliance training to all board members via email and will offer live training upon request.

Chair Jimenez opened the floor for approval of the Alliance's legal and regulatory Compliance Program Report for Q3-4 2024.

MOTION: Commissioner Molesky moved to approve the Compliance report for Q3-4 2024, seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Belton, Cuevas, De Serpa, Espinoza, Hendrickson, Hernandez, Jimenez, Keheley, Molesky, Rabago and Radner.

Noes: None.

Absent: Commissioners Aguirre, Askew, Bizzini, Morales and Pedrozo.

Abstain: None.

Adjourn to Closed Session

Chair Jimenez moved the commission into Closed Session at 4:49 p.m.

16. **Closed Session Conference with legal counsel – Pending litigation (Gov. Code section 54956.9(d)(1)): Aggrigator, Inc. v. Central California Alliance for Health; Monterey County Superior Court case number 25CV000738.**

Return to Open Session

Chair Jimenez reconvened the meeting to Open Session at 5:00 p.m.

17. **Open session pursuant to Pending litigation (Gov. Code section 54956.9(d)(1)): Aggrigator, Inc. v. Central California Alliance for Health; Monterey County Superior Court case number 25CV00073**

There was no action to report out during closed session.

The Commission adjourned its regular meeting of May 28, 2025, at 5:01 p.m. to the regular meeting of June 23, 2025, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Hayley Tut
Interim Clerk of the Board

Minutes were supported by AI-generated content.

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, April 16, 2025
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Dianna Myers	Medical Director
Fabian Licerio	Risk Adjustment Director
Jenifer Mandella	Chief Compliance Officer
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Kelsey Riggs	Care Management Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisette Podwalny	Health Services Operations Manager
Michael Schrader	Chief Executive Officer
Michael Wang	Medical Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Nicolette Shalita Vega	NCQA Compliance Program Manager
Omar Guzman	Chief Health Equity Officer
Ronita Margain	Community Engagement Director
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley (Chair)	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Committee Members Excused:

Adam Sharma	Operational Excellence Director
Gray Clarke	Behavioral Health Medical Director
Jessie Dybdahl	Provider Services Director
Krishan Patel	Data Analytics Services Director
Lisa Ba	Chief Financial Officer
Tammy Hoeffel	Enhanced Health Services Director

Ad-Hoc Attendees:

Anita Guevin	Medicare Compliance Program Manager
Ka Vang	Compliance Specialist
Kat Reddell	Compliance Specialist
Paige Harris	Regulatory Affairs Specialist
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

1. **Call to Order by Chairperson Markley.**

   Chairperson Ryan Markley called the meeting to order at 9:04 a.m.

2. **Review and Approval of March 19, 2025 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of March 19, 2025, meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Updates to Notice of Privacy Practices**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Compliance Committee Restructure**

   Markley, Chair, discussed the need for restructuring the Compliance Committee to increase collaboration and engagement. Changes include reducing membership to Executives and select Directors, with ad-hoc attendance from other Directors as needed; leveraging the Alliance Dashboard to be metric-driven and provide real-time oversight and feedback on operations, and using technology to improve monitoring and reporting. These changes will improve the Compliance Committee's ability to provide oversight, improve decision-making, and foster a culture of compliance across the organization. Estimated timeline for implementation of restructuring is early Q4 2025.

Committee members were supportive of the changes. Brass, UM Director, indicated that this would be helpful in ensuring Compliance staff and leadership have visibility into departmental activities that support overall compliance, including corrective actions implemented at the workgroup and staff level. Wang, Medical Director, inquired about the process for conducting risk assessment; Markley indicated a desire to collaborate with the business in developing the risk assessment, to ensure Compliance oversight is targeting the highest risk areas.

2. Internal Audit & Monitoring

Halward, Compliance Specialist III, presented the Q4 2024 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 4 internal audits were conducted, 2 of which received a passing score. One audit remained in progress during the reporting period and outcomes will be presented at a later date.

Annually, there were a total of 17 assigned audits in 2024. 20 audits were closed. 14 of which received a passing score.

Halward reported performance metrics from the Alliance Dashboard noting that Q424 efficiency metrics met target performance while CY24 quality metrics did not meet targeted performance. Halward informed the Committee of a formal CAP process for failed audits was implemented in Q125 to track action items more closely.

Halward reviewed one exemplar internal audit, related to continuity of care requests and ensuring they are reviewed, accepted, processed and completed according to requirements. Halward also reviewed outcomes of the monitoring of 35 Alliance Dashboard metrics related to regulatory requirements, noting that 34 metrics met their established thresholds during the review period.

Halward provided an overview of the Q125 internal audit workplan which identified areas of focus.

Halward reported updates on regulatory audits highlighting preliminary findings of the 2024 DMHC Medical Audit, which included 13 findings in Grievance, Pharmacy and Behavioral Health.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2024 Internal A&M Quarterly Report.

3. Corrective Action Plans Monthly Update

Mandella, Chief Compliance Officer, provided an update on various Corrective Action Plans (CAPs) including internal, delegate, regulator, provider and potential CAPs emphasizing the purpose of reviewing CAPs is to proactively identify and resolve risks and ensure organizational awareness to enable cross-functional solutions.

Closed CAPs:

- DMHC Enforcement Action stemming from the 2020 Medical Survey was resolved, with the Plan negotiating the removal of 2 findings not supported by regulation and the plan's acceptance a reduced administrative penalty.

Opened CAPs:

- Assisted Living Process Gaps (informal and focused on process improvement)
- DMHC 2024 Medical Survey; 13 findings in Grievance, Pharmacy and Behavioral Health

Ongoing CAPs:

- Provider Payable Conditions remains open to streamline recovery process; Wang indicated an interest in discussing his ideas to resolve the CAP.
- ECM Provider Encounter data: 15 providers placed on a CAP. 3 were closed without penalty, 3 CAPs were extended and 9 were closed with payment change and recoveries
- 6 CAPs remain open in a monitoring status, with non-substantive updates since the March update.

The meeting adjourned at 9:54 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

DATE: June 25, 2025

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

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

Background. The Board established MSAG pursuant to Welfare and Institutions Code §14094.17(b)(1) (SB 586 – Statutes 2015).

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

Name	Affiliation	County
Aluriel Ceballos	Community Partner	Merced

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

Attachments. N/A

DATE: June 25, 2025

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Whole Child Model Family Advisory Committee: Member Appointment

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

Background. The Board established WCMFAC pursuant to Welfare and Institutions Code §14094.17(b)(1) (SB 586 – Statutes 2015).

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

Name	Affiliation	County
Kelley Sandoval	Parent/Guardian	Santa Cruz

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: June 26, 2025

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

FROM: Danita Carlson, Government Relations Director

SUBJECT: 2025 Legislation

Recommendation. This report is informational only.

Background. Each legislative session staff works with its health plan associations, including the Local Health Plans of California (LHPC) and California Association of Health Plans (CAHP) as well as the Alliance's legislative advocates in Sacramento, Edelstein, Gilbert, Robson and Smith (EGRS) to identify, review and monitor newly introduced State legislation in the following areas of focus as adopted by the board:

- Access to Care
- Local Innovation
- Eligibility and Benefits
- Financing and Rates
- Health Equity
- Person Centered Delivery System Transformation

Proposed bills in these categories are compiled into a bill list that staff will monitor throughout the legislative session providing legislative updates to the board at its regular board meetings and as needed.

The updated 2025 bill list is attached for the board's information.

Discussion. Several key deadlines in the 2025 legislative session have occurred including June 6, 2025, which was the last day for a bill to pass out of its house of origin to continue moving this year. The bill list includes approximately ninety-six (96) bills in the aforementioned areas of focus.

Staff will "watch" bills on this list for any amendments or changes of significance to the Alliance and will work with our associations and representatives in Sacramento to discuss any areas of interest or concern.

Fiscal Impact The is no fiscal impact.

Attachments. Central California Alliance for Health 2025 Bill List

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Central California Alliance for Health
2025 Bill List

Priority Bills	
AB 4 **Arambula (D)** **Status: 5/23/2025- Set first hearing; referred to suspense file. -HELD** **Position: Watch/Study**	**Covered California expansion.** **Summary:** Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange, no sooner than January 1, 2027, and upon appropriation by the Legislature for this purpose, to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible, consistent with federal guidance and given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment, which would begin on October 1, 2028. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program, and report to the Department of Finance and the Legislature on progress toward implementation, as specified. The bill would establish the Covered California for All Fund in the General Fund, to be administered by the Exchange, into which user fees, appropriations, and other funds would be deposited to be used upon appropriation to pay for the administration of the program
AB 29 **Arambula (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to suspense file.-HELD** **Position: Watch/Study**	**Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.** **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 that Medi-Cal provider payments and payments for specified non- Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Existing law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified.

	This bill would require the department, as part of its above-described duties, to include (!)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings.
AB 37 **Elhawary (D)** **Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2)** **Position: Watch/Study**	**Workforce development: mental health service providers: homelessness.** **Summary**: Existing law establishes the California Workforce Development Board as the body responsible for assisting the Governor in the development, oversight, and continuous improvement of California's workforce investment system and the alignment of the education and workforce investment systems to the needs of the 21st century economy and workforce. This bill would state the intent of the Legislature to enact legislation relating to expanding the workforce of those who provide mental health services to "homeless persons" or "homeless people," as specified .
AB 40 **Bonta (D)** **Status: 5/7/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**Emergency services and care.** **Summary**: 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, 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 requires a health facility to provide emergency services and care upon request or when a person is in danger of loss of life or serious injury or illness and requires a health care service plan to reimburse providers for emergency services and care. Existing law defines "emergency services and care" for these purposes to mean medical screening, examination, and evaluation by a physician and surgeon, or other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, among other things. This bill would additionally define "emergency services and care" for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 45 **Bauer-Kahan (D)** **Status: 6/04/2025-In Senate. Read first time. To Com. on RLS. for assignment.**	**Privacy: health care data.** **Summary**: Under the California Constitution, the state is prohibited from denying or interfering with an individual's reproductive freedom in their most intimate decisions, including their fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of

Position: Watch/Study	the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. Existing law prohibits a person or business, as defined, from collecting, using, disclosing, or retaining the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, as defined, except as necessary to perform the services or provide the goods requested and not sold or shared. This bill would state the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services and to prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act. This bill contains other existing laws.
AB 50 **Bonta (D)** **Status: 5/7/2025-Referred to Com. on B. P. & E.D.** **Position: Watch/Study**	**Pharmacists: furnishing contraceptives.** **Summary**: Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate followup care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only, and would authorize a pharmacist to furnish over-the- counter contraceptives without following those standardized procedures or protocols. The bill would make related conforming changes. This bill would declare that it is to take effect immediately as an urgency statute.
AB 54 **Krell (D)** **Status: 5/21/2025-Referred to Coms. on HEALTH and JUD** **Position: Watch/Study**	**Access to Safe Abortion Care Act** **Summary:** Existing law sets forth provisions, under the California Constitution, regarding the fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. This bill, the Access to Safe Abortion Care Act, would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. The bill would state the intent of the Legislature to enact legislation that would ensure access to medication abortion.
AB 55 **Bonta (D)** **Status: 5/29/2025-From committee**	**Alternative birth centers: licensing and Medi-Cal reimbursement.** **Summary:** Existing law provides for the licensure and regulation of various types of clinics, including alternative birth centers, by the State Department of Public Health, and makes a violation of those provisions a crime. Existing law defines an

chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH. **Position: LHPC Support**	alternative birth center as a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility. Existing law requires a licensed alternative birth center specialty clinic, and a licensed primary care clinic that provides services as an alternative birth center, to meet certain criteria, including, among others, being located in proximity to a facility with the capacity for management of obstetrical and neonatal emergencies. 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 certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs. Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. The bill would delete the above-described proximity requirement and instead require a written policy for hospital transfer, as provided. The bill would also make a technical change to an obsolete reference within a related provision. By creating a new requirement for an alternative birth center or a primary care clinic that provides services as an alternative birth center, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.
AB 67 **Bauer-Kahan (D)** **Status: 5/23/2025-In committee: Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**Attorney General: Reproductive Privacy Act: enforcement.** **Summary:** Existing law, the Reproductive Privacy Act, prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a woman or pregnant person who is exercising their reproductive rights as specified in the act. Existing law authorizes a party whose rights are protected by the Reproductive Privacy Act to bring a civil action against an offending state actor when those rights are interfered with by conduct or by statute, ordinance, or other state or local rule, regulation, or enactment in violation of the act, as specified, and require a court, upon a motion, to award reasonable attorneys' fees and costs to a prevailing plaintiff. This bill would authorize the Attorney General, if it appears to them that a person has engaged, or is about to engage, in any act or practice constituting a violation of the Reproductive Privacy Act, to bring an action in the name of the people of the State of California in the superior court to enjoin the acts or practices or to enforce compliance with the act, as specified. In this context, the bill would authorize the Attorney General to make public or private investigations, publish information concerning violation of the Reproductive Privacy Act, and subpoena witnesses, compel their attendance, take evidence, and require the production of documents or records that they deem relevant or material to the inquiry. This bill contains other related provisions.
AB 96 **Jackson (D)** **Status: 5/1/2025-Failed Deadline**	**Community Health Workers** **Summary:** Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the department, as part of developing those requirements, to, among other

pursuant to Rule 61(a)(2). **Position: Watch/Study**	things, determine the necessary curriculum to meet certificate program objectives. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist and would deem a certified peer support specialist to have satisfied all education and training requirements developed by the department for certification as a community health worker.
AB 220 **Jackson (D)** **Status: 5/29/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Medi-Cal Subacute Care Services** **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 requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a health facility that provides pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would require the department to develop and implement procedures, and authorize the department to impose sanctions, to ensure that a Medi-Cal managed care plan complies with these provisions.
AB 224 **Bonta (D)** **Status: 5/29/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Health care coverage: essential health benefits.** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.
AB 260 **Aguiar-Curry (D)**	**Sexual and reproductive health care.** **Summary:** Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs. Existing law

Status: 6/02/2025- Read second time, amended, and re-referred to Com. on HEALTH. **Position: Watch/Study**	establishes the California Reproductive Health Equity Program within the department to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. Existing law establishes the California Reproductive Health Service Corps within the department for the purposes of recruiting, training, and retaining a diverse workforce of reproductive health care professionals who will be part of reproductive health care teams to work in underserved areas. Existing law defines reproductive health, for purposes of the corps, to mean health services relating to abortion care, sexual health counseling, contraception, sexually transmitted infections, reproductive tract infections, HIV, gynecology, perinatal care, midwifery care, gender-affirming care, and gender-based violence prevention. This bill would state the intent of the Legislature to enact legislation to ensure that patients can continue to access care, including abortion, gender-affirming care, and other sexual and reproductive health care in California, and to allow patients to access care through asynchronous modes.
AB 277 **Alanis (R)** **Status: 5/01/2025- In committee: Set, first hearing. Hearing canceled at the request of author.** **Position: Watch/Study**	**Behavioral health centers, facilities, and programs: background checks.** **Summary:** Existing law generally provides requirements for the licensing of business establishments. Existing law requires a business that provides services to minors, as defined, to provide written notice to the parent or guardian of a minor participating in the service offered by the business regarding the business policies relating to criminal background checks for employees, as specified. Existing law requires the Department of Justice to maintain state summary criminal history information, as defined, and to furnish this information as required by statute to specified entities, including a human resource agency or an employer. Under existing law, the disclosure of state summary criminal history information to an unauthorized person is a crime. This bill would require a person who provides behavioral health treatment for a behavioral health center, facility, or program to undergo a background check, as specified. By expanding the scope of the crime of unlawful disclosure of state summary criminal history information, this 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 278 **Ransom (D)** **Status: 5/1/2025- Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Health Care Affordability** **Summary:** Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to support the

	board's decisionmaking. This bill would require the board, on or before June 1, 2026, to establish a Patient Advocate Advisory Standing Committee, as specified, that is required to publicly meet, and receive public comments, at least 4 times annually. The bill would require the committee to include specified data from the meetings to the board as part of its annual report.
AB 280 **Aguiar-Curry (D)** **Status: 6/03/2025: In Senate. Read first time. To Com. on RLS. for assignment.** **Position: LHPC Oppose**	**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. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. 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. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. 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. This bill contains other related provisions and other existing laws.
AB 298 **Bonta (D)** **Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2).**	**Health care coverage cost sharing** **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's requirements a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would prohibit a health care service plan contract or disability

Position: Watch/Study	insurance policy issued, amended, or renewed on or after January 1, 2026, from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for services provided to an enrollee or insured under 21 years of age, except as otherwise specified. The bill would prohibit an individual or entity from billing or seeking reimbursement for services provided to an enrollee or insured under 21 years of age, except as otherwise 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. This bill contains other related provisions and other existing laws
AB 302 **Bauer-Kahan (D)** **Status: 6/04/2025- Referred to Coms. on HEALTH and JUD.** **Position: Watch/Study**	**Confidentiality of Medical Information Act** **Summary:** Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act punishes a violation of its provisions that results in economic loss or personal injury to a patient as a misdemeanor. Existing law requires a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by law or if the disclosure is compelled by, among other things, a court order or a search warrant lawfully issued to a governmental law enforcement agency. This bill would instead require a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by California law. The bill would revise the disclosure requirement relating to a court order to require disclosure if compelled by a California state court pursuant to an order of that court or a court order from another state based on another state's law so long as that law does not interfere with California law, as specified. The bill would revise the disclosure requirement relating to a search warrant to require disclosure if compelled by a warrant from another state based on another state's law so long as that law does not interfere with California law. By narrowing the exceptions for disclosing medical information, and thereby expanding the crime of violating the act, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws
AB 315 **Bonta (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: Watch/Study**	**Medi-Cal: Home and Community-Based Alternatives Waiver.** **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, home- and community-based services (HCBS) approved by the United States Department of Health and Human Services are covered for eligible individuals to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with certain federal provisions. Existing law authorizes the Director of Health Care Services to seek waivers for any or all approvable HCBS. Existing law sets forth provisions for the implementation of the Nursing Facility/Acute Hospital Transition and Diversion Waiver, which is the predecessor of the Home and Community-Based Alternatives (HCBA) Waiver, for purposes of providing care management services to individuals who are at risk of nursing facility or institutional placement.

	This bill would recast those provisions to refer to the HCBA Waiver. The bill would delete a provision authorizing the expansion of the number of waiver slots up to 5,000 additional slots, and would instead require the enrollment of all eligible individuals who apply for the HCBA Waiver. The bill would require the department, by March 1, 2026, to seek any necessary amendments to the waiver to ensure that there is sufficient capacity to enroll all eligible individuals who are currently on a waiting list for the waiver, as specified. The bill would require the department, by March 1, 2026, to submit a rate study to the appropriate fiscal and policy committees of the Legislature addressing the sustainability, quality, and transparency of rates for the HCBA Waiver. The bill would require that the study include an assessment of the effectiveness of the methods used to pay for services under the waiver, with consideration of certain factors. The bill would make related legislative findings.
AB 350 **Bonta (D)** **Status: 6/03/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Health care coverage: fluoride treatments** **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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. 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 and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children Oto 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age. 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. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. This bill contains other related provisions and other existing laws.
AB 360 **Papan (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to suspense file. -HELD**	**Menopause.** **Summary:** Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs and to collect health data. Existing law establishes the Medical Board of California and the Osteopathic Medical Board of California for the licensure and regulation of physicians and surgeons and osteopathic physicians and surgeons. Existing law requires the boards to adopt and administer standards, including for the continuing education of those licensees.

Position: Watch/Study	This bill would require the department to work with the Medical Board of California, the Osteopathic Medical Board of California, and state higher education entities to assess, among other things, physicians and surgeons education and training, as specified, relating to menopause diagnosis and treatment. The bill would require the department to prepare a report to the Legislature on or before January 1, 2027, that, among other things, identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.
AB 371 **Haney (D)** **Status: 5/23/2025-In committee: Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**Dental 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 and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services. Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies. If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. This bill contains other related provisions and other existing laws.
AB 375 **Nguyen (D)** **Status: 4/30/2025-In committee: Set,**	**Medical Practice Act: Health Care Providers: Qualified Autism Service Paraprofessional** **Summary:** Existing law, the Medical Practice Act, establishes the Medical Board of California and charges it with administrative and enforcement duties related to the

first hearing. Hearing canceled at the request of author. **Position: Watch/Study**	provision of medical services under the act. Existing law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the act is a crime. Under existing law, a health care provider, for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of health care provider to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, 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 384 **Connolly (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**Health care coverage: mental health and substance use disorders: inpatient admissions.** **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 to ensure that processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee or insured in a timely manner appropriate for the enrollee's or insured's condition, as specified. This bill, the California Mental Health Protection Act, would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for mental health and substance use disorders from requiring prior authorization (1) for an enrollee or insured to be admitted for medically necessary 24-hour care in inpatient settings for mental health and substance use disorders, as specified, and (2) for any medically necessary health care services provided to an enrollee or insured while admitted for that care. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violations of these provisions. 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. This bill contains other related provisions and other existing laws.
AB 403 **Ortega (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: Watch/Study**	**Medi-Cal: community health worker 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. Under existing law, community health worker (CHW) services are a covered Medi-Cal benefit subject to any necessary federal approvals. CHW is defined as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees with regard to the CHW services benefit, as specified. Existing law requires the department to inform stakeholders about implementation of the

	benefit. This bill would require the department to annually review the above-described outreach and education efforts conducted by Medi-Cal managed care plans. The bill would require the department to annually conduct an analysis of the CHW services benefit, submit each analysis to the Legislature, and publish each analysis on the department's internet website, with the first analysis due July 1, 2027. This bill contains other related provisions and other existing laws.
AB 408 **Berman (D)** **Status: 6/04/2025-Referred to Coms. on B. P. & E.D. and JUD.** **Position: Watch/Study**	**Physician Health and Wellness Program.** **Summary:** Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the programs administration in accordance with specified provisions of the Public Contract Code. Existing law provides that participation in the program shall not be a defense to any disciplinary action that may be taken by the board. Existing law requires the program to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs. Existing law establishes the Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Medical Board of California for the support of the program. This bill would revise and recast those provisions and would instead authorize the board to establish a Physician Health and Wellness Program to support, treat, monitor, and rehabilitate physicians and surgeons and other professionals licensed by the board with impairing physical and mental health conditions that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. The bill would require the administering entity to be a nonprofit entity and would require the contract with the administering entity to include procedures on specified topics. The bill would exempt the program from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The bill would exempt program records relating to program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity, and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account, and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who, in good faith, reports information or takes action in connection with the bills provisions immune from civil liability for reporting information or taking the action. The bill would make the program inapplicable to the Osteopathic Medical Board of California.

	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 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 510 **Addis (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: LHPC Oppose Unless Amended**	Health care coverage: utilization review appeals and grievances 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 generally authorizes a health care service plan or disability 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 disability insurer to include in a response regarding decisions to deny, delay, or modify health care services, among other things, information on how the provider, enrollee, or insured may file a grievance or appeal with the plan or insurer. Existing law requires a health care service plans grievance system to resolve grievances within 30 days, except as specified. Existing law requires a contract between a health insurer and a provider to contain provisions requiring a dispute resolution mechanism, and requires an insurer to resolve each provider dispute within 45 working days, as specified. This bill would, upon request, require that an appeal or grievance regarding a decision by a health care service plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician, or a licensed health care professional under specified circumstances, who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider. The bill would authorize review of a grievance or appeal by a licensed health care professional if the provider requesting review is not a physician. The bill, notwithstanding the above-described timelines, would require these reviews to occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollees or insureds condition, as specified. If a health care service plan or health insurer fails to meet those timelines, the bill would deem the request for the health care service as approved and supersede any prior delay, denial, or modification. The bill would make conforming changes to related provisions.
AB 512 **Harabedian (D)**	**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

Status: 6/03/2025- In Senate. Read first time. To Com. on RLS. for assignment. **Position: LHPC Oppose unless amended**	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 generally authorizes a health care service plan or disability insurer to use utilization review, 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. For a request prior to or concurrent with the provision of health care services, existing law requires utilization review decisions to be made within 5 business days from the plans or insurers receipt of the information reasonably necessary and requested by the plan or insurer to make the determination, or within 72 hours if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health, as specified. This bill would shorten the timeline for prior authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests from the plans or insurers receipt of the information reasonably necessary and requested by the plan or insurer to make the determination. 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.
AB 517 **Krell (D)** **Status: 5/23/2025- In committee: set first hearing. Referred to suspense file. -HELD** **Position: LHPC Oppose Unless Amended**	**Medi-Cal: complex rehabilitation technology: wheelchairs.** **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 prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed $1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT- powered wheelchair has already been approved for use by the patient. This bill contains other existing laws.
AB 539 **Schiavo (D)** **Status: 5/21/2025- Referred to Com. on HEALTH.** **Position: LHPC Oppose Unless Amended**	**Health care coverage: prior authorizations** **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 provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This bill would require a prior authorization for a health care service by a health care service plan or a health insurer to remain valid for a period of at least one year from the date of approval. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 543	**Medi-Cal: street medicine.**

Gonzalez, Mark & Elhawary (D) **Status: 6/03/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**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 various provisions for Medi-Cal coverage of community health worker services, enhanced care management, and community supports, subject to any necessary federal approvals. Under existing law, these benefits are designed to, respectively, provide a link between health and social services and the community; address the clinical and nonclinical needs on a whole- person-care basis for certain target populations of Medi-Cal beneficiaries, including individuals experiencing homelessness; and provide housing transition navigation services, among other supports. Existing law establishes mechanisms for Medi-Cal presumptive eligibility for certain target populations, including, among others, pregnant persons, children, and patients of qualified hospitals, for purposes of Medi-Cal coverage while other Medi-Cal eligibility determination procedures are pending, as specified. This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness for purposes of full-scope Medi-Cal benefits without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons. This bill contains other related provisions and other existing laws.
AB 546 **Caloza (D)** **Status: 6/04/2025- Referred to Com. on HEALTH.** **Position: Watch/Study**	**Health care coverage: portable HEPA purifiers and filters** **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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers and filters for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease. The bill would prohibit a portable HEPA purifier and filter covered pursuant to these provisions from being subject to a deductible, coinsurance, or copayment requirement. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 554 **Gonzalez, Mark (D)** **Status: 6/04/2025- In Senate. Read first time. To Com. on RLS. for assignment.**	**Health care coverage: antiretroviral drugs, drug devices, and drug products** **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 prohibits a health care service plan, excluding a

Position: Watch/Study	Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/ AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill would instead prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified. This bill contains other related provisions and other existing laws.
AB 577 **Wilson (D)** **Status: 5/23/2025-2-year bill** **Position: Watch/Study**	**Health care coverage: antisteering.** **Summary:** Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes the willful violation of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. For a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, this bill would prohibit a health care service plan, health insurer, or pharmacy benefit manager from engaging in specified steering practices, including, among others, requiring an enrollee or insured to use a retail pharmacy for dispensing prescription oral medications, as specified, and imposing any requirements, conditions, or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. 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. This bill contains other existing laws.
AB 618 **Krell (D)** **Status: 6/03/2025-In Senate. Read first time. To Com. on RLS. for assignment.** **Position: LHPC Support/Cosponsor**	**Medi-Cal: behavioral health: data sharing** **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 fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing Medi-Cal provisions, behavioral health services, including specialty mental health services and substance use disorder treatment, are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi- Cal Treatment Program, and the Drug Medi-Cal organized delivery system (DMC-ODS) program, as specified. This bill would require each Medi-Cal managed care plan, county specialty mental health plan, Drug Medi-Cal certified program, and DMC-ODS program to electronically provide data for

	members of the respective entities to support member care. The bill would require the department to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027, in compliance with privacy laws.
AB 636 **Ortega (D)** **Status: 5/23/2025- In committee. Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**Medi-Cal: diapers** **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 by, and funded pursuant to, federal Medicaid program provisions. Under existing law, incontinence medical supplies are covered by the Medi-Cal program. This bill would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary. The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature.
AB 669 **Haney (D)** **Status: 6/04/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: LHPC Support**	**Substance use disorder 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, 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 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 health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to 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. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity for the first 28 days of an inpatient substance use disorder stay during each plan or policy year, and would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would require specified review for day 29 and days thereafter of that stay or service. On and after January 1, 2027, the bill would prohibit the imposition of prior authorization or other prospective utilization management requirements for outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's physician, psychologist, or psychiatrist. Because a willful 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. This bill contains other existing laws.
AB 682	**Health care coverage reporting**

Ortega (D) **Status: 6/04/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**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 requires a plan to submit financial statements to the Director of Managed Health Care at specified times. Existing law provides for the regulation of health insurers by the Department of Insurance and requires a health insurer or multiple employer welfare arrangement to annually report specified information to the department. This bill would require the above-described reports to include specified information for each month, including the total number of claims processed, adjudicated, denied, or partially denied. Because a violation of this requirement by a health care service plan would be a crime, the bill would create a state-mandated local program. The bill would require each department to publish on its internet website monthly claims denial information for each plan or insurer. This bill contains other related provisions and other existing laws.
AB 688 **Gonzalez, Mark (D)** **Status: 6/03/2025: In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Telehealth for All Act of 2025** **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 under the Medi-Cal program when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law required the department, on or before January 1, 2023, to develop a research and evaluation plan that, among other things, proposes strategies to analyze the relationship between telehealth and access to care, quality of care, and Medi-Cal program costs, utilization, and program integrity. The department created that plan in December of 2022 and published the Biennial Telehealth Utilization Report in April of 2024. This bill, the Telehealth for All Act of 2025, would require the department, commencing in 2028 and every 2 years thereafter, to use Medi-Cal data and other data sources available to the department to produce analyses in a publicly available Medi-Cal telehealth utilization report. The bill would authorize the department to include those analyses in each of the department's Biennial Telehealth Utilization Reports, as specified. This bill contains other related provisions and other existing laws.
AB 787 **Papan (D)** **Status: 5/14/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**Provider directory disclosures.** **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 specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee

	or insured to contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within 24 hours if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 789 **Bonta (D)** **Status: 5/7/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**Health care coverage: unreasonable rate increases.** **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. Existing law requires a health care service plan offering a contract in the individual or small group market to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the department at least 120 days before implementing a rate change. This bill would make technical, nonsubstantive changes to that provision.
AB 804 **Wicks (D)** **Status: 5/23/2025-In committee: Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**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 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 delete the requirement for the department to complete that analysis, and instead would make housing support services for specified populations a covered Medi-Cal benefit when the Legislature has made an appropriation for purposes of the housing support services. The bill would require the department to seek federal approval for the housing support services benefit, as specified. Under the bill, subject to an appropriation by the Legislature, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness. Under the bill, the services would include housing transition navigation services, housing deposits, and housing tenancy sustaining services, as defined. This bill contains other related provisions and other existing laws.
AB 836 **Stefani (D)** **Status: 6/03/2025-In Senate. Read first**	**Midwifery Workforce Training Act.** **Summary:** Existing law requires the Office of Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives in accordance with the

time. To Com. on RLS. for assignment. **Position: Watch/Study**	global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse-midwife or as a licensed midwife. Existing law requires these provisions to be implemented only upon an appropriation by the Legislature for these purposes in the annual Budget Act or another act. This bill would require the Department of Health Care Access and Information, upon appropriation from the Legislature for this purpose, to administer funding for a statewide study on midwifery education. The bill would require the study to be conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that would, among other things, identify viable education programs that can serve both rural and urban geographic areas. The bill would require the department to submit a report from the study's findings to the Legislature, to post the report on the department's internet website, and to notify all persons in the department's reproductive health and maternity care electronic mailing list, as specified
AB 843 **Garcia (D)** **Status: 6/03/2025-In Senate. Read first time. To Com. on RLS. for assignment** **Position: Watch/Study**	**Health care coverage: language access.** **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, which is under the control of the Insurance Commissioner. Existing law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Existing law requires the Department of Managed Health Care and commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. This bill would require a health care service plan or health insurer to take reasonable steps to provide meaningful access to each individual with limited English proficiency, including companions with limited English proficiency, eligible to receive services or likely to be directly affected by its programs and activities. The bill would require a health care service plan or health insurer to offer a qualified interpreter or to utilize a qualified translator when interpretation or translation services are required, as specified. The bill would prohibit a health care service plan or health insurer from requiring an individual with limited English proficiency to provide or pay for the costs of their own interpreter. The bill would require a health care service plan or health insurer to comply with specified requirements when providing remote interpreting services. The bill would make a health care service plan or health insurer that violates these provisions liable for civil penalties, as specified. This bill contains other related provisions and other existing laws.
AB 876 **Flora (AM)** **Status: 5/28/2024-Referred to Com. on B. P. & E.D.**	**AB-876 Nurse anesthetists: scope of practice.** **Summary:** Existing law, the Nurse Anesthetists Act, provides for the certification and regulation of nurse anesthetists by the Board of Registered Nursing. Existing law requires the utilization of a nurse anesthetist to provide anesthesia services in an acute care facility to be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist, or podiatrist. Existing law makes a nurse anesthetist who is not an employee of an acute care facility subject to the bylaws of the facility.

Position: Watch/Study	This bill would provide that, in an acute care facility, outpatient setting, or dental office where the nurse anesthetist has been credentialed to provide anesthesia, the anesthesia services include preoperative, intraoperative, and postoperative care and pain management for patients receiving anesthesia requested by a physician, dentist, or podiatrist. The bill would authorize a nurse anesthetist to provide direct and indirect patient care services that include the administration of medications and therapeutic agents, as specified. The bill would provide that an order entered on the chart or medical record of a patient constitutes authorization for the nurse anesthetist to select the modality of anesthesia and to abort or modify the modality during the course of care. The bill would state that ordering and administering controlled substances and other drugs pursuant to those provisions does not constitute a prescription. The bill would also provide that, in an acute care facility, outpatient setting, or dental office, anesthesia services may also include services performed outside of the perioperative setting, including, among others, ordering, evaluating, and interpreting diagnostic laboratory and radiological studies, and initiating orders to registered nurses and other appropriate staff, as specified. The bill would require a trainee, as defined, to satisfy specified requirements to provide anesthesia services in an acute care facility, outpatient setting, or dental office, including being enrolled in an accredited doctoral program of nurse anesthesia. The bill would provide that a nurse anesthetist is not limited to the scope of practice of a registered nurse while performing anesthesia services and is not required to, among other things, perform nurse anesthesia services pursuant to standardized procedures. The bill would revise the definition of nurse anesthetist and would define the terms acute care facility, outpatient setting, and dental office for purposes of the act. .
AB 877 **Dixon (R)** **Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Health care coverage: substance use disorder: residential facilities.** **Summary:** 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 requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. 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 medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. Existing law provides for the regulation of community care facilities that provide nonmedical care, including residential facilities, short-term residential therapeutic programs, and group homes by the State Department of Social Services. Existing law requires the care and supervision provided by a short-term residential therapeutic program or group home to be nonmedical, except as otherwise permitted by law. This bill would require the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to prepare and send one letter to each chief financial officer of a health care service plan, health insurer, or Medi-Cal managed care plan that provides coverage, including out-of-network benefits, in California for substance use disorder in residential facilities, as defined. The bill would require the letter to include, among other things, a statement informing the plan or insurer that substance use disorder treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions. The bill would authorize the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult with each other, and would require

	those departments to consult with the State Department of Social Services, when preparing the contents of the letter. The bill would require the letters to be sent on or before an unspecified date. This bill contains other related provisions and other existing laws
AB 910 **Bonta (D)** **Status: 5/23/2025-2-year bill** **Position: Watch/Study**	**Pharmacy benefit management.** **Summary:** Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements. This bill would make a technical, nonsubstantive change to that provision.
AB 951 **Ta (R)** **Status: 5/7/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**Health care coverage: behavioral diagnoses.** **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 contract or health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. 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. This bill contains other related provisions and other existing laws.
AB 955 **Alvarez (D)** **Status: 5/21/2025-In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: Watch/Study**	**Mexican prepaid health plans: individual market** **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. Existing law requires a prepaid health plan to apply for licensure as a health care service plan if the prepaid health plan operating lawfully under the laws of Mexico elects to operate a health care service plan in this state. Existing law requires the application for licensure to demonstrate compliance with specified requirements, including that the prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of Mexican nationals legally employed in the County of San Diego or the County of Imperial, and their dependents, that pay for the delivery of health care services that are provided wholly in Mexico, except as specified. This bill would instead require an application for licensure to demonstrate that the prepaid health plan offers and sells in this state only employer-sponsored group plan contracts exclusively for the benefit of individuals legally employed in the County of San Diego or the County of Imperial, and their dependents, that pay for the delivery of health care services that are provided wholly in Mexico, except as specified.

AB 970 **McKinnor (D)** **Status: 4/29/2025- In committee: Set, first hearing. Hearing canceled at the request of author.** **Position: Watch/Study**	**Child abuse and neglect reporting** **Summary:** Existing law, the Child Abuse and Neglect Reporting Act, establishes procedures for the reporting and investigation of suspected child abuse or neglect. The act requires certain professionals, including specified health practitioners and social workers, known as "mandated reporters," to report by telephone known or reasonably suspected child abuse or neglect to a local law enforcement agency or a county welfare or probation department, as specified. Existing law authorizes a county welfare agency to develop a program for internet-based reporting of child abuse and neglect, as specified. Existing law authorizes a mandated reporter in a county where the program is active to use the internet-based reporting tool in lieu of the required initial telephone report. This bill would authorize the County of Los Angeles to establish a pilot program beginning January 1, 2026, through October 31, 2028, to test a new model for the mandatory reporting of child abuse or neglect. The bill would require the pilot program to include a comprehensive County of Los Angeles mandated reporter training that may be made available to all mandated reporters in the county. The bill would require the pilot program to also include an internet-based, or other type of, decision support tool for mandated reporters who have completed that training. The bill would require the decision support tool to, among other things, make a recommendation on whether or not to report. The bill would, during the time the pilot program is in effect, deem a mandated reporter to have satisfied their reporting duties if the reporter completed the training, used the decision support tool, and complied with the recommended action. The bill would shield a mandated reporter who satisfied their reporting duties pursuant to these provisions from civil liability or criminal penalty, and from penalties impacting their professional licenses, credentials, and certifications, for failing to report known or suspected child abuse or neglect, as well as the reporter's supervisor, employer, superior, or principal, as specified. The bill would repeal its provisions on January 1, 2030. This bill contains other related provisions and other existing laws.
AB 974 **Patterson (R)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to suspense file. -HELD** **Position: Watch/Study**	**Medi-Cal managed care plans enrollees with other health care coverage.** **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, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under this bill, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, the department would be required to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face **administrative** requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under either of the

	following circumstances: (1) if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified, or (2) if an enrollee requires a covered service and meets the requirements for continuity of care or the completion of covered services through a Medi-Cal managed care plan pursuant to specified provisions under existing law regarding services by a terminated or nonparticipating provider.
AB 980 **Arambula (D)** **Status: 5/1/2025- Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Health care service plan: managed care entity: duty of care.** **Summary:** Under existing law, a health care service plan or managed care entity has a duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers or enrollees and is liable for all harm legally caused by its failure to exercise that ordinary care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee and the subscriber or enrollee suffers substantial harm, as defined. This bill would define "medically necessary health care service" for purposes of the above- described provision to mean legally prescribed medical care that is reasonable and comports with the medical community standard.
AB 1012 **Essayli (R)** **Status: 2/21/2025- From printer. May be heard in committee March 23.** **Position: Watch/Study**	**Medi-Cal: immigration status** **Summary:** Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who does not have satisfactory immigrant status if they are otherwise eligible for those benefits, as specified. This bill would create the Serving Our Seniors Fund, would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits, and would transfer funds previously appropriated for the provision of Medi-Cal benefits to those individuals to that fund. The bill would appropriate the moneys in that fund to the State Department of Health Care Services to restore and maintain payments for Medicare Part B premiums for eligible individuals. By making the moneys available without regard to fiscal years, the bill would create a continuous appropriation.
AB 1032 **Harabedian (D)** **Status 6/03/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Coverage for behavioral health visits.** **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 contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would generally require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits

	per year with a licensed behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. Under the bill, an enrollee or insured would be entitled to those benefits until one year from the date the local or state emergency is lifted, whichever is later. 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. This bill contains other related provisions and other existing laws.
AB 1037 **Elhawary (D)** **Status: 5/27/2025-Read second time. Ordered to third reading.** **Position: Watch/Study**	**Public health: substance use disorder.** **Summary:** Existing law, until January 1, 2026, authorizes a physician or pharmacist, without a prescription or permit, to furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and authorizes a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist, as a public health measure, as specified. Existing law requires a pharmacist that provides nonprescription syringes to provide information on access to testing and treatment for HIV and hepatitis C. This bill would extend this authority indefinitely and would additionally require a pharmacist to provide information on other bloodborne diseases. This bill contains other related provisions and other existing laws.
AB 1041 **Bennett (D)** **Status: 6/04/2025-In Senate. Read first time. To Com. on RLS. for assignment.** **Position: LHPC Oppose Unless Amended**	**Health care coverage: health care provider credentials.** **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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require those departments to review specified credentialing requirements and adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in physician credentialing. The bill would also require those departments to adopt regulations to develop, on or before July 1, 2027, a standardized credentialing form to be used by health care service plans and health insurers for credentialing and recredentialing purposes. The bill would require every health care service plan or health insurer to use the standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later. The bill would require those departments to update the form every three years, or as necessary to comply with changes in laws, regulations, and guidelines, as specified. This bill contains other related provisions and other existing laws.
AB 1063 **Dixon (R)** **Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Search warrants: newborn screening program** **Summary:** Existing law requires the State Department of Public Health to establish a genetic disease unit to, among other responsibilities, promote a statewide program of information, testing, and counseling services related to genetic diseases, and administer that information, testing, and counseling to each child born in the state, as specified. Existing law requires all information obtained from persons involved in hereditary disorders programs to be held strictly confidential. Existing law sets forth the grounds and procedures for the issuance of a search warrant and authorizes the issuance of a search warrant upon specified grounds, including that the property or things to be seized consist of an item or constitute evidence that tends to show a felony has been committed or that a particular person has committed a felony. This bill would authorize the department to release a physical blood test taken from a newborn to law enforcement in response to a search warrant only if the objective of

	the warrant is to obtain the DNA of a missing person suspected to be a victim of homicide, child abuse resulting in death, or manslaughter in order to compare the DNA to other samples in the Department of Justice Missing Persons DNA Database and to upload the sample for future identification of the person. This bill contains other related provisions and other existing laws.
AB 1090 **Davies (R)** **Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Alcoholism or drug abuse treatment facilities: County of Orange pilot program.** **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. Existing law requires a health care service plan to annually provide to enrollees a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age. This bill would make a technical, nonsubstantive change to that provision.
AB 1113 **Gonzalez (D)** **Status: 5/23/2025-2-year bill** **Position: Watch/Study**	**Federally qualified health centers: mission spend ratio.** **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 as described by federal law. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require each FQHC to have an annual mission spend ratio, as defined, of no less than 90% and would provide a methodology for calculation of that ratio, as specified, until the State Department of Public Health (department) has adopted a methodology for this purpose, with a goal of implementation of the latter methodology by January 1, 2027.
AB 1161 **Harabedian (D)** **Status: 5/23/2025-In committee: Set, first hearing. Referred to APPR suspense file. -HELD** **Position: Watch/Study**	**Public social services: state of emergency or health emergency** **Summary:** Existing law establishes various public social services programs under the jurisdiction of the State Department of Social Services, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, the CalFresh program, the California Food Assistance Program (CFAP), the In-Home Supportive Services (IHSS) program, and the Cash Assistance Program for Immigrants (CAP!). 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, the Knox-Keene Health Care Service Plan Act of 1975, requires a health care service plan to provide an enrollee who has been displaced or whose health may otherwise be affected by a state of emergency, as declared by the Governor, or a health emergency, as declared by the State Public Health Officer, with access to medically necessary health care services, as specified. This bill would require the State Department of Social Services, for purposes of CalWORKs, CalFresh, CFAP, IHSS, and CAP!, and the State Department of Health Care Services, for Medi-Cal purposes, to provide continuous eligibility for the applicable programs to a recipient or beneficiary who has been displaced by, or who has otherwise been affected by, a state of emergency or a health emergency, as described above. This bill contains other related provisions and other existing laws.

AB 1328 **Rodriguez, Michelle (D)** **Status: 6/03/2025- In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Medi-Cal reimbursements: nonemergency ambulance transportation.** **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 or nonmedical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under this bill, commencing on January 1, 2026, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to maximize federal financial participation in implementing the above-described provision to the extent allowable. To the extent that federal financial participation is unavailable, the bill would require the department to implement the provision using state funds, as specified.
AB 1366 **Flora (R)** **Status: 5/1/2025- Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Reimbursement for pharmacist services.** **Summary:** Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, pharmacist services are a benefit under Medi-Cal program, subject to federal approval, and the rate of reimbursement for pharmacist services is 85% of the fee schedule for physician services, except for medication therapy management (MTM) pharmacist services. Existing law requires the department to implement an MTM reimbursement methodology relating to the dispensing of qualified specialty drugs by an eligible contracting pharmacy, which would be intended to supplement Medi-Cal payments to eligible pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would instead require the rate of reimbursement for pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible pharmacists or pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories.
AB 1386 **Bains (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: Watch/Study**	**Health facilities: perinatal services** **Summary:** Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. This bill would, beginning, include perinatal services as a basic service. The bill would require, on or before the department to establish a process to approve or deny a "perinatal service compliance plan" to meet the requirement to provide perinatal services. The bill

	would require, on or before _____any general acute care hospital that does not provide perinatal services to submit a "perinatal service compliance plan to the department, with specified information. By expanding the scope of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 1415 **Bonta (D)** **Status: 5/28/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**California Health Care Quality and Affordability Act** **Summary:** Existing law, the California Health Care Quality and Affordability Act, establishes within the Department of Health Care Access and Information the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Existing law defines multiple terms relating to these provisions, including a health care entity to mean a payer, provider, or a fully integrated delivery system and a provider to mean specified entities delivering or furnishing health care services. This bill would update the definitions applying to these provisions to include a management services organization, as defined, as a health care entity. The bill would also update a provider to mean specified private or public health care providers and would include a health system, as defined, and an entity that owns, operates, or controls an entity specified in the existing definition, regardless of whether it is currently operating, providing services, or has a pending or suspended license. The bill would include additional definitions, including, but not limited to, a health system to mean specified entities under common ownership or control and a hedge fund to mean a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of strategies used to manage the funds, subject to certain exceptions. This bill contains other related provisions and other existing laws.
AB 1418 **Schiavo (D)** **Status: 6/04/2025-In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**Department of Health Care Access and Information.** **Summary:** Existing law requires the Department of Health Care Access and Information to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. Existing law requires the department to prepare an annual report to the Legislature that, among other things, identifies education and employment trends in the health care profession and describes the health care workforce program outcomes and effectiveness. This bill would additionally require the department's report to include health care coverage trends for employees subject to waiting periods before receiving employer-sponsored health care coverage and provide recommendations for state policy necessary to address gaps in health care coverage for those same employees. The bill would also specify the format for the above-described report.
AB 1419 **Addis (D)** **Status: 6/04/2025-In Senate. Read first time. To Com. on RLS. for assignment.** **Position: Watch/Study**	**California Health Benefit Exchange: automatic health care coverage enrollment** **Summary:** Existing law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the federal Patient Protection and Affordable Care Act. Existing law requires the Exchange to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from an insurance affordability program.

	Existing law requires enrollment to occur before coverage through the insurance affordability program is terminated and prohibits the premium due date from being sooner than the last day of the first month of enrollment. This bill would make a technical, nonsubstantive change to those provisions.
AB 1429 **Bains (D)** **Status: 5/23/2025- In committee: Set, first hearing. Referred to APPR. suspense file. -HELD** **Position: Watch/Study**	**Behavioral health reimbursement.** **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 requires a health care service plan contract issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would require Kaiser Foundation Health Plan to fully reimburse an enrollee who incurs out-of-pocket costs for behavioral health care services obtained from non-Kaiser providers or facilities or mental health prescription medication obtained from a non- Kaiser pharmacy on or after October 12, 2023, until the department certifies that Kaiser has successfully completed implementation of the corrective action work plan resulting from its 2023 settlement agreement with the department. The bill would require an enrollee to submit specified documents for reimbursement and would require Kaiser to pay the reimbursement within 60 calendar days of an enrollee's submission of documented expenses. If Kaiser fails to provide this reimbursement, the bill would require it to pay the original amount plus 10% interest to the enrollee, as well as a $5,000 fine per incident. The bill would require Kaiser to establish specified procedures and would require Kaiser to submit a monthly report to the department with specified information. Because a willful violation of the bill's provisions would be a crime, the bill would impose a state- mandated local program. This bill contains other related provisions and other existing laws.
AB 1474 **Patterson (R)** **Status: 5/1/2025- Failed Deadline pursuant to Rule 61(a)(2).** **Position: Watch/Study**	**Health care cost targets.** **Summary:** Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, implementation and administration of a community-based system of comprehensive perinatal care for eligible women and infants. Existing law states the goals of the community-based comprehensive perinatal health care system as decreasing and maintaining the decreased level of perinatal, maternal, and infant mortality and morbidity and supporting methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight. This bill would make technical, nonsubstantive changes to those goals.
Senate Bills	
SB 7 **McNerney (D)** **Status: 6/03/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Employment: Automated Decisions Systems.** **Summary:** Existing law establishes within the Government Operations Agency the Department of Technology, which is supervised by the Director of Technology. Existing law authorizes the director and the department to exercise various powers in creating and managing the information technology policy of the state. This bill would declare the intent of the Legislature to enact legislation relating to artificial intelligence.

SB 32 **Weber Pierson (D)** **Status: 6/03/2025-In Assembly. Read first time. Held at Desk.** **Position: LHPC Oppose**	**Health care coverage: timely access to care** **Summary:** Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.
SB 40 **Wiener (D)** **Status: 5/28/2025-In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Health care coverage: insulin** **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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would generally prohibit a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or disability insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin. 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. This bill contains other related provisions and other existing laws.
SB 41 **Wiener (D)** **Status: 5/28/2025-In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Pharmacy benefits.** **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 requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. The bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring a pharmacy benefit manager to file specified reports with the department, the contents of which are not to be disclosed to the public. The bill would require the department, at specified intervals, to submit reports to the Legislature based on the reports submitted by pharmacy benefit managers and would require the department to post

	the reports on the department's internet website. This bill would make a violation of these provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines, and administrative penalties would be deposited. This bill contains other related provisions and other existing laws.
SB 62 **Menjivar (D)** **Status: 5/28/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Health care coverage: essential health benefits.** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year
SB 85 **Umberg (D)** **Status: 5/29/2025- Referred to Com. on JUD.** **Position: Watch/Study**	**Civil actions: service of summons.** **Summary:** Existing law generally governs a patients access to the patients own health records. Existing law establishes procedures for providing access to health care records or summaries of those records by patients and by those persons who have responsibility for decisions regarding the health care of others, as described. Existing law sets forth the Legislatures findings and declarations regarding the right of access to that information, as specified. This bill would make technical, nonsubstantive changes to those findings and declarations.
SB 228 **Cervantes (D)** **Status: 6/04/2025- Read third time. Passed. Ordered to the Assembly.** **Position: Watch/Study**	**Comprehensive Perinatal Services Program.** **Summary:** Existing law establishes the Comprehensive Perinatal Services Program, the goals of which are to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity in the State of California and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low-birth-weight infants. Under the program, the State Department of Public Health is required to develop and maintain a statewide comprehensive community-based perinatal services program and enter into contracts, grants, or agreements with health care providers to deliver these services in a coordinated effort. Existing law also requires the department to monitor the delivery of services under those contracts, grants, and agreements through a uniform health data collection system that utilizes epidemiologic methodology. This bill would specify that the State Department of Health Care Services is responsible for implementing comprehensive community-based perinatal services for purposes of the Medi-Cal program. By July 1, 2027, the bill would require the State Department of Health Care Services, in consultation with the State

	Department of Public Health, to clarify each departments roles and responsibilities in the Comprehensive Perinatal Services Program by regulation. The bill would, among other things, require the State Department of Health Care Services to develop a training on administering the program, require all perinatal providers in the program to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training. The bill would require the State Department of Health Care Services, no later than July 15, 2026, to submit to the Assembly Health Committee and the Senate Health Committee, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received Comprehensive Perinatal Services Program services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care Services, commencing January 1, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received Comprehensive Perinatal Services Program services during the previous 3 years. The bill would also state the intent of the Legislature to enact additional legislation relating to the program in order to implement several legislative recommendations made in a specified report issued by the California State Auditors office including by, among other things, requiring the State Department of Health Care Services to create and use a perinatal services data form to engage in additional data collection duties.
SB 239 **Arreguin (D)** **Status: 6/03/2025-Ordered to inactive file on request of Senator Arreguín.** **Position: Watch/Study**	**Open meetings: teleconferencing: subsidiary body.** **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, except as specified. Existing law, until January 1, 2026, authorizes specified neighborhood city councils to use alternate teleconferencing provisions related to notice, agenda, and public participation, as prescribed, if, among other requirements, the city council has adopted an authorizing resolution and 2/3 of the neighborhood city council votes to use alternate teleconference provisions, as specified. This bill would authorize a subsidiary body, as defined, to use alternative teleconferencing provisions and would impose requirements for notice, agenda, and public participation, as prescribed. The bill would require the subsidiary body to post the agenda at the primary physical meeting location. The bill would require the members of the subsidiary body to visibly appear on camera during the open portion of a meeting that is publicly accessible via the internet or other online platform, as specified. The bill would also require the subsidiary body to list a member of the subsidiary body who participates in a teleconference meeting from a remote location in the minutes of the meeting.

	The bill would require the legislative body that established the subsidiary body electing to use teleconferencing pursuant to these provisions to establish 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. The bill would require the subsidiary body to approve the use of teleconference by 2/3 vote before using teleconference pursuant to these provisions. The bill would exempt from these alternative teleconferencing provisions a subsidiary body that has subject matter jurisdiction over police oversight, elections, or budgets. The bill would require any member of a subsidiary body who is an elected official to comply with specified agenda and quorum requirements to participate in a meeting through teleconferencing pursuant to this section, and would require any final recommendations adopted by a subsidiary body to be presented at a regular meeting of the legislative body that established the subsidiary body. 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 246 **Grove (R)** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Medi-Cal: graduate medical education payments.** **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, subject to any necessary federal approvals and the availability of federal financial participation, to make Medi-Cal payments to designated public hospitals (DPHs) and their affiliated government entities, as defined, in recognition of the Medi-Cal managed care share of graduate medical education (GME) costs. Existing law requires that the payments consist of direct and indirect GME payments made in recognition and support of the direct costs incurred in the operation of GME programs and the increased operating and patient care costs associated with teaching programs, respectively. Under existing law, the nonfederal share of these payments consist of voluntary intergovernmental transfers (IGTs) of funds provided by DPHs or their affiliated government entities, or other eligible public entities, as specified. Under existing law, the continuously appropriated DPH GME Special Fund is established for these purposes. This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation,

	to make additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as nondesignated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified. This bill contains other related provisions and other existing laws.
SB 250 **Ochoa Bogh (R)** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Medi-Cal: provider directory: skilled nursing facilities.** **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, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The department has administratively created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options. This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types. The bill would require that this provision be implemented in conjunction with implementation of the above-described provisions
SB 278 **Cabaldon (D)** **Status: 05/29/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Health data: HIV test results** **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, public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, are generally confidential and are prohibited from being disclosed. Under existing, in the form of exceptions, certain disclosures of the information are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, including disclosures by state or local public health agency staff to agency staff, the designated health care provider, or the HIV-positive person who is the subject of the record, as specified. This bill would additionally authorize specified staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-cal managed care plan if applicable, the HIV-positive person who is the

	subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs designed to improve HIV care for Medi-Cal beneficiaries. The bill would make a conforming change to a related provision regarding authorized disclosure of HIV test results for the purpose of administering quality improvement programs under Medi-Cal as described above.
SB 306 **Becker (D)** **Status: 5/28/2025- In Assembly. Read first time. Held at Desk.** **Position: LHPC Oppose Unless Amended**	**Health care coverage: prior authorizations** **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. This bill would prohibit a health care service plan or health insurer from imposing prior authorizations, as defined, on a covered health care service for a period of one year beginning on April first of the current calendar year, if specified conditions exist, including that the health care service plan approved 90% or more of the requests for a covered service in the prior calendar year. The bill would also require a health care service plan or health insurer to list any covered services exempted from prior authorization on their internet website by March 15 of each calendar year. The bill would also clarify how to calculate a plan or insurer's approval rate for purposes of determining whether a service may be exempted from prior authorization. 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. This bill contains other related provisions and other existing laws.
SB 324 **Menjivar (D)** **Status: 5/28/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Medi-Cal: enhanced care management and 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, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law, subject to CalAIM implementation, authorizes a Medi-

	Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. The bill would require a managed care plan to honor member preference with regard to the applicable ECM or community support by authorizing service delivery to the contracted provider who is submitting a request for approval of services to the managed care plan. This bill contains other related provisions and other existing laws. (Based on text date 4/7/2025)
SB 338 **Becker (D)** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Mobile Health for Rural Communities Pilot Program.** **Summary:** Existing law establishes various programs to address the needs of migrant agricultural families. Existing law also provides funding to enhance and maintain rural health services. This bill would establish the Mobile Health for Rural Communities Pilot Program, and require the State Department of Health Care Services to administer the program to expand access to health services for farmworkers in rural communities. The bill would require the department, among other things, to deploy mobile units, as defined, in 2 rural counties based on farmworker population and access to health care. Under the bill, the mobile units would include, at a minimum, computers, Wi-Fi, cubicles for virtual visits, and exam rooms for telemedicine. The bill would require the department, on or before January 1, 2027, to report the outcomes of the program to the Legislature. The bill would make findings and declarations in support of its provisions.
SB 339 **Cabaldon (D)** **Status: 5/23/2025- May 12 hearing: Placed on APPR. suspense file. -HELD** **Position: Watch/Study**	**Medi-Cal: laboratory rates.** **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 prohibits Medi-Cal reimbursement to providers for clinical laboratory or laboratory services from exceeding the lowest of the following: (1) the amount billed; (2) the charge to the general public; (3) 100% of the lowest maximum allowance established by the federal Medicare Program; or (4) a reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying. This bill would carve out, from the above-described provision, Medi-Cal reimbursement to providers for clinical laboratory or laboratory services related to the diagnosis and treatment of sexually transmitted infections, and would apply the above-described threshold but excluding the reimbursement rate described in paragraph (4). The bill would exempt data on those services from certain data-reporting requirements that are applicable to the reimbursement rate described in paragraph (4). This bill contains other related provisions and other existing laws.
SB 344 **Weber Pierson (D)**	**Disposition of human remains: scattering at sea.** **Summary:** Existing law provides for the disposition of human remains and makes specified acts

Status: 5/29/2025-Referred to Com. on B. & P. **Position: Watch/Study**	relating to human remains, including improperly disposing of human remains, a crime. Existing law authorizes cremated remains or hydrolyzed human remains to be taken by boat from any harbor in this state, or by air, and scattered at sea. Existing law defines the phrase "at sea" to include the inland navigable waters of this state, exclusive of lakes and streams, provided that no such scattering may take place within 500 yards of the shoreline. Existing law specifies that these provisions do not allow the scattering of cremated human remains or hydrolyzed human remains from a bridge or pier. This bill would additionally specify that these provisions do not allow the scattering of cremated human remains or hydrolyzed human remains from a dock attached to the shore. By expanding the definition of a crime, this bill would impose a state-mandated local program. This bill contains other existing laws.
SB 363 **Wiener (D)** **Status: 5/28/2025-In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**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 health 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 health 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 health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plans or health insurers treatment denials and modifications to (1) the number of successful independent medical review overturns of the plans or insurers treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. The bill would make a health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports.
SB 418 **Menjivar (D)** **Status: 5/28/2025-In Assembly. Read first time. Held at Desk.**	**Health care coverage: nondiscrimination** **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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are

Position: Watch/Study	in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from participation in, being denied the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer, in providing or administering health insurance coverage or other health- related coverage, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health insurance coverage or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, as specified. 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. This bill contains other related provisions and other existing laws.
SB 439 **Weber Pierson (D)** **Status: 6/03/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**California Health Benefit Review Program: extension.** **Summary:** Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and health insurers for the 2022-23 to 2026-27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding $2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028. This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2032, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026-27 to 2032-33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to $3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation. This bill would make these provisions inoperative on July 1, 2032, and would repeal it as of January 1, 2033. This bill contains other related provisions.

SB 449 **Valladares (R)** **Status: 02/26/2025 - Referred to Com. on RLS.** **Position: Watch/Study**	**Health care service plan requirements.** **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. Existing law requires a health care service plan to meet specified requirements and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would make technical, nonsubstantive changes to those provisions.
SB 530 **Richardson (D)** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk..** **Position: LHPC Oppose Unless Amended**	**Medi-Cal: time and distance 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, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would extend the operation of those standards indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks. This bill contains other related provisions and other existing laws.
SB 535 **Richardson (D)** **Status: 5/28/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Obesity Treatment Parity Act.** **Summary:** Existing l aw, 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's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies. This bill, the Obesity Treatment Parity Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2026, to include coverage for intensive behavioral therapy for the treatment of obesity, bariatric surgery, and at least one antiobesity medication approved by the United States Food and Drug Administration. 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. This bill contains other related provisions and other existing laws.
SB 588 **Ochoa Bogh (R)** **Status: 5/1/2025- April 30 set for first hearing. Testimony taken. Further hearing to be set** **Position: Watch/Study**	**Health facilities: freestanding emergency center study.** **Summary:** Existing law authorizes a general acute care hospital, as defined, to offer special services, including, but not limited to, emergency medical services. Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs related to health care infrastructure, such as health policy and planning, health professions development, and facilities design review and construction, among others. This bill would require the Department of Health Care Access and Information to conduct a feasibility study on the implementation of freestanding emergency departments, as defined, in rural, disadvantaged, and underserved areas with limited access to emergency care. The bill would require that the study be conducted in collaboration with certain stakeholders and that the department issue a report to the Legislature, on or before

	January 1, 2027, with its findings and recommendations. The bill would appropriate an unspecified amount from the General Fund to the department for those purposes. The bill would repeal these provisions on January 1, 2031.
SB 660 **Menjivar (D)** **Status: 6/03/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**California Health and Human Services Data Exchange Framework.** **Summary:** Existing law establishes the Center for Data Insights and Innovation, within the California Health and Human Services Agency, to ensure the enforcement of state law mandating the confidentiality of medical information. The center is administered by a director who also serves as the California Health and Human Services Chief Data Officer. Existing law further establishes the California Health and Human Services Data Exchange Framework to require the exchange of health information among health care entities and government agencies in the state, among other things. Existing law requires the agency to convene a stakeholder advisory group to advise on the development of implementation of the California Health and Human Services Data Exchange Framework. This bill would require the center, on or before January 1, 2026, and subject to an appropriation in the annual Budget Act, to take over the establishment, implementation, and all of the functions related to the California Health and Human Services Data Exchange Framework, including the data sharing agreement and policies and procedures, from the agency. The bill would expand the California Health and Human Services Data Exchange Framework to include social services information. The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework and authorize the center to determine other categories of entities required to execute a data sharing agreement. The bill would require the center, no later than July 1, 2025, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the center to annually report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements.
SB 669 **McGuire (D)** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk.** **Position: LHPC Support**	**Rural Hospitals: standby perinatal medical services.** **Summary:** Existing law finds and declares that prenatal care, delivery service, postpartum care, and neonatal and infant care are essential services necessary to assure maternal and infant health, and that these services are not currently distributed so as to meet the minimum maternal and infant health needs of many Californians. Existing law requires the State Department of Public Health to develop and maintain a statewide community-based comprehensive perinatal services program, as specified, to deliver services in medically underserved areas or areas with demonstrated need. This bill would require the department, in consultation with specified stakeholders, to establish a 5-year pilot project to allow critical access and individual and small system rural hospitals to establish standby perinatal medical services, as defined. To qualify for participation in the pilot project, the bill would require a critical access or individual and small system rural hospitals to meet specified requirements, including, among others, that the hospital (1) be greater than 60 minutes from the nearest hospital providing full maternity services, (2) not have closed a full maternity or labor and delivery department within the past 3 years, and (3) agree to provide routine labor and delivery services or have an agreement with a freestanding birth center, as specified. The bill would require a hospital selected for a pilot program to comply with certain requirements, including among others, having and maintaining

	specified staff, services, and equipment. The bill would require a physician, as specified, to have overall responsibility for a pilot program under these provisions. This bill would require the department, in consultation with specified stakeholders, to develop a monitoring plan and reporting template to collect and evaluate data on safety, outcomes, utilization, and populations served using stratified demographic data to the extent statistically reliable data is available and complies with medical privacy laws and practices. The bill would require the department to compile the data and prepare an evaluation to be submitted to the Legislature on or before 2 years after the completion of the pilot project and made publicly available.
SB 812 **Allen (D)** **Status: 5/28/2025- In Assembly. Read first time. Held at Desk.** **Position: Watch/Study**	**Qualified youth drop-in center health care 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 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 contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a schoolsite. This bill would additionally require a contract or policy that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a qualified youth drop-in center. Because a violation of this requirement relative to health care service plans would be a crime, the bill would create a state-mandated local program. This bill contains other related provisions and other existing laws.
SB 823 **Stern (D)** **Status: 5/23/2025- April 28 hearing: Placed on APPR. suspense file. -HELD** **Position: Watch/Study**	**Mental health: the CARE Act.** **Summary:** Existing law, the Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. This bill would include bipolar I disorder in the criteria for a person to receive services under the CARE Act. By increasing the duties on the county behavioral health agencies, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
SB 862 **Committee on Health** **Status: 5/29/2025- In Assembly. Read first time. Held at Desk.**	**Health.** **Summary:** Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, established the Mental Health Services Oversight and Accountability Commission to oversee the implementation of the MHSA. Existing law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee, specified members of the Legislature, and 12 members appointed by the Governor, as prescribed. Existing law, the Behavioral Health Services Act (BHSA), an initiative measure enacted by the voters as Proposition 1 at the March 5, 2024, statewide

Position: Watch/Study	primary election, recast the MHSA by, among other things, renaming the commission to the Behavioral Health Services Oversight and Accountability Commission and changing its composition and duties. This bill would make technical changes to reflect the correct name of the commission.

DATE: June 25, 2025

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

FROM: Dr. Dianna Myers, Medical Director

SUBJECT: Whole Child Clinical Advisory Committee (WCMCAC) Updated 2025 Schedule

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Recommendation. Staff recommend the Board approve the Whole Child Clinical Advisory Committee (WCMCAC) updated 2025 schedule.

Background. The Whole Child Clinical Advisory Committee (WCMCAC) is a Brown Act advisory committee providing input and recommendations to the health plan on important strategic issues that impact California Children's Services (CCS) members, families, and providers.

Discussion. The primary responsibility of the WCMCAC is to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions. Rescheduling of two meeting dates required for 2025 to ensure attendance due to conflicts.

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

Attachments.

1. Whole Child Clinical Advisory Committee (WCMCAC) 2025 Calendar v2

WHOLE CHILD MODEL CLINICAL ADVISORY COMMITTEE
MEETING CALENDAR FOR 2025

Thursday, March 20	12:00 PM to 1:00 PM
Thursday, July 10	12:00 PM to 1:00 PM
Thursday, September 18	12:00 PM to 1:00 PM
Tuesday, December 16	12:00 PM to 1:00 PM

All meetings will be held via MS Teams

DATE: June 25, 2025

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Strategic Allocation of Reserve

Recommendation. Staff recommend that the Board make a one-time strategic allocation of $12,933,075 to the Medi-Cal Capacity Grant program.

Summary. This action item proposes a one-time strategic allocation to the Medi-Cal Capacity Grant Program (MCGP). The MCGP supports the Alliance's strategic priorities to enhance the availability, quality, and accessibility of healthcare and supportive resources for Medi-Cal members, while also addressing the social factors that influence health and wellness in our communities.

Background. On August 1, 2022, the Alliance's Board approved an updated Health Care Expense Reserve Policy, recognizing the Board-designated reserve target at three times the average monthly premium capitation. The Reserve Target is a component of the Alliance's financial plan, which provides that surplus funds are used to expand access, improve benefits, or augment provider reimbursement. The policy states that annually, following the acceptance of the annual independent financial audit, the Alliance Board may strategically allocate a fund balance that exceeds the Reserve Target to enable the implementation of future programs or to support the MCGP in strengthening the local delivery system for the future.

Discussion. On May 28, 2025, the Board approved the audited financial statements for calendar year 2024, recognizing a net income of $56.4M. The fund balance was $891.2M. Of this amount, our Board already set aside $483.3M for the Board-designated reserve target, $139.8M for the MCGP, $56.7M to cover the potential loss from Dual Special Needs Plan (D-SNP), $46.1M to guarantee the distribution of existing Value-based Payment (VBP), and $152.4M to improve network access and health equity through Provider Supplemental Payments over three years. This leaves $12.9M available for strategic allocation.

The MCGP awarded $46.4M grants in 2024, targets $35M in awards in 2025, and has a decreasing annual target thereafter. The program is on track to sustain grantmaking through 2029. Allocating an additional $12.9M now will strengthen the program's long-term sustainability and ensure continued investment in critical community needs across our service area.

Fiscal Impact. There is no financial impact. The Alliance fund balance remains unchanged. The internal fund balance reporting will show the amount for each strategic use.

Attachments. N/A

DATE: June 25, 2025

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Funding Allocation and Equity Grantmaking Methodology Recommendations

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Recommendation. Staff recommends the Board approve: 1) the adoption of a revised methodology for allocating Alliance reserves into one Medi-Cal Capacity Grant Program (MCGP) budget for the service area and 2) the adoption of an equity methodology to guide grantmaking.

Summary. This report includes background on MCGP funding allocations and proposes a shift from the current county-specific funding allocation model to a unified MCGP budget for the entire service area. It also proposes a new equity methodology to guide grant award decision making. These two proposals support an approach for MCGP administration that promotes equitable investments, aligns with recent State policy shifts, and increases flexibility to prioritize grantmaking where the greatest need exists.

Background. In 2014, the Alliance Board approved the initial policy framework for the MCGP. In 2024, the MCGP governance policy was clarified to state that the Board provides strategic direction for the MCGP through an annual investment plan and makes funding allocations for Board-directed strategies and directs staff to manage program-level implementation and county budgets based on allocated funding.

In 2022, the Board adopted the Health Care Expense Reserve Policy which enables strategic allocation of the fund balance to the MCGP. The current MCGP allocation methodology designates funds from the fund balance to the MCGP budget by county. The MCGP utilizes a spend down model, whereby funding opportunities based on Board-directed strategies approved in an annual investment plan are made available in each county and grants are awarded based on each county's available funding.

In total, $271.6M has been allocated to the MCGP. The Board approved three allocations in 2014, 2016 and 2022 totaling $266.6M. In June 2023, the Board approved an initial allocation of $5M to the MCGP specifically for grantmaking in San Benito and Mariposa counties in anticipation of these counties joining the Alliance's service area in January 2024.

Since the Alliance began awarding grants in 2015, a total of $213.8M has been awarded through the MCGP in the five counties as follows: Mariposa County $4.5M; Merced County $65.5M; Monterey County $75.6M; San Benito County $3.1M; and Santa Cruz County $65M. Some awarded funds have been returned to the MCGP budget due to unspent grants funds and grant withdrawals/terminations. There is $78.2M remaining in the MCGP unallocated budget. The "unallocated budget" is funding that has not yet been awarded or allocated to an existing funding opportunity.

Discussion. While allocating grant funds by county was intended to ensure fairness across the original three counties in the Alliance's service area when the MCGP was established, this model has now become outdated with the addition of two new counties and changes in State policy. In 2024, Mariposa and San Benito counties joined the Alliance's service area and the Department of Health Care Services (DHCS) shifted away from a county-level revenue model to a regional model. The existing MCGP funding allocation model creates barriers to addressing disparities, impact and efficiency and often undermine equity and flexibility, especially in our dynamic, cross-county service regions.

The current MCGP allocation model fails to reflect differences in health disparities and discourages cross-county collaboration and scaling of innovation. It creates artificial geographic barriers for funding capacity-building when Alliance members are often crossing county lines to receive care. It also limits flexibility to respond to emergent needs, shared regional priorities and strategic opportunities. County-specific allocations also increase administrative complexity. Counties with limited organizational capacity may struggle to apply for and intake grant funding, while higher capacity counties may be constrained by artificial funding limits, leaving unused funds in one county's budget and depleted funds in another. This complicates MCGP promotion and community engagement by having fragmented availability of funds in each county.
A more flexible, equity-based approach would enable targeted investment where most needed, support cross-county partnerships and investments, and improve the overall effectiveness of the grant program.

There are two components to an equity-based approach: one MCGP budget for the entire Alliance service area and an equity methodology for grantmaking.

Service Area MCGP Budget. The proposed MCGP funding allocation methodology would combine each county's remaining unallocated budget into one service area budget. Per the MCGP governance policy, the MCGP budget would still be used for the annual MCGP investment plan to allocate percentages of the budget to specific Board-directed strategies, but this service area MCGP budget would no longer guarantee a specific amount of funding for each county. Moving away from county-specific allocations toward a flexible funding pool for the service area would allow for more strategic, needs-driven investments across the five counties.

Equity Grantmaking Methodology. The proposed equity methodology for grantmaking is not a rigid structure that dictates exact investment amounts in each county. It is a model to guide grant award decision making in each county and regionally. By decoupling awards from geographic formulas, this methodology allows for targeted investments in emerging priorities and regional solutions.

An equity methodology ensures that funding is responsive to current conditions rather than historical or political boundaries. It offers several key benefits for guiding grant award decision making, including aligning funding with Alliance service area need and health care quality performance, encouraging data-driven decision making, supporting strategic flexibility and strengthening regional impact. The number and source of grant applications in each funding round is an unknown factor until the Alliance receives all applications by the deadline. This new methodology, along with existing application scoring criteria, can serve as guidance in

responding to applicant organizations with available funding in each round who demonstrate readiness and need.

Using clearly defined, measurable factors to guide funding decisions improves transparency and accountability. It allows stakeholders to understand how awards are determined and provides a foundation for regular evaluation and refinement. This approach enables general targets for funding amounts in each county, promotes greater coordination and more efficient use of limited resources, and gives greater consideration to communities that have historically been under-resourced.

The proposed equity grantmaking methodology includes three weighted factors to create general funding amount guidance at the county and regional level: 1) Medi-Cal membership volume; 2) number of Managed Care Accountability Set (MCAS) measures below minimum performance level; and 3) Healthy Places Index (HPI)® score. The HPI, promoted by DHCS in Medi-Cal managed care plans' community investment planning, combines 25 community characteristics (e.g., access to healthcare, housing, education) into a single indexed HPI score. A higher score indicates a healthier community.

The methodology ensures a minimum amount invested in each county. This minimum level of investment is further reinforced by the new DHCS Community Reinvestments requirement in 2024 Medi-Cal contract being implemented in 2026 which requires Medi-Cal Managed Care Plans with positive net income in any given year to reinvest a portion of their profits back into the communities they serve. The Quality Achievement obligation included in this requirement is an additional investment of net income in counties where the MCP operates in which they do not meet minimum quality measure performance thresholds for the applicable calendar year. The Alliance's initial plan based on 2024 net income will be presented to the Alliance Board for approval prior to submission to DHCS in Q326 and will be aligned with the MCGP annual investment planning process.

Next Steps. If the above recommendations are approved, the funding allocation methodology and equity methodology for grantmaking would be applied in January 2026. The remaining county-level unallocated budgets and new 2025 allocation from the fund balance, if approved, would be combined into one MCGP budget for the service area and the grantmaking methodology would be applied to grant award decisions beginning in the first funding round of 2026.

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

Attachments. Model for Proposed Equity Grantmaking Methodology

Attachment: Board Report June 25, 2025

Medi-Cal Capacity Grant Program | MODEL for proposed equity methodology to guide grantmaking

MCGP Unallocated Budget	
June 2025 Allocation	$12,993,075
Remaining Unallocated Budget	$78,219,893
Total Unallocated Budget	**$91,212,968**

The unallocated budget is funding that has not yet been awarded or allocated to an existing funding opportunity.

County Specific Data							
		Mariposa County	**Merced County**	**Monterey County**	**San Benito County**	**Santa Cruz County**	**TOTAL**
Med-Cal Membership		5,567	149,141	188,050	20,543	77,294	440,595
Percent of Total Membership		1.26%	33.85%	42.68%	4.66%	17.54%	100%
Number of MCAS Measures Below Minimum Performance Level (MPL) (2024)		7	3	1	5	2	18
Percent of Measures Below MPL		38.89%	16.67%	5.56%	27.78%	11.11%	100%
County Healty Places Index Quartile (HPI)		2	1	2	3	4	
Percent Allocation by Quartile		25%	50%	25%	0	0	100%

Weighted Factors							
		Mariposa County	**Merced County**	**Monterey County**	**San Benito County**	**Santa Cruz County**	**TOTAL**
25% Split Evenly	22,803,242.00	4,560,648.40	4,560,648.40	4,560,648.40	4,560,648.40	4,560,648.40	22,803,242.00
40% Based on Membership	36,485,187.20	459,713.36	12,350,235.87	15,571,877.90	1,700,209.72	6,399,501.83	36,481,538.68
20% Based on % Measures Below MPL	18,242,593.60	7,411,965.78	4,560,648.40	1,140,162.10	3,991,479.48	1,140,162.10	18,244,417.86
15% Based on HPI Quartile (Additional Funding for Counties in Bottom Two Quartiles)	13,681,945.20	3,420,486.30	6,840,972.60	3,420,486.30	-	-	13,681,945.20
	91,212,968.00	**15,852,813.84**	**28,312,505.27**	**24,693,174.70**	**10,252,337.60**	**12,100,312.33**	**91,211,143.74**
		Regional		*Regional*			

DATE: June 25, 2025

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

FROM: Dr. Dianna Myers, Medical Director and Dr. Omar Guzman, Chief Health Equity Officer, Interim Chief Medical Officer

SUBJECT: Care-Based Incentive Program 2026

Recommendation. Staff recommend that the Board approve the Care-Based Incentive (CBI) Program proposal described below for 2026.

Summary. This report provides an overview of the Care-Based Incentive Program and makes a recommendation for structural program changes to CBI 2026.

Proposed changes to 2026 programmatic measures are:

- Change Controlling High Blood Pressure from Exploratory to a Paid Measure.

Background. Since 2010, the Alliance's CBI program has encouraged primary care physicians to adopt and implement the Patient Centered Medical Home model. CBI aligns with the Alliance's Strategic Priorities for Health Equity to eliminate health disparities and achieve optimal health outcomes for children and youth, offering an upside-risk value-based payment to primary care providers. This promotes better health outcomes, improved access to care, and promotes the delivery of high-value care. These health outcomes are reflected in part by the health plan's annual reporting to the Department of Health Care Services (DHCS) for the National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness and Data Information Set (HEDIS), referred to as Medi-Cal Managed Care Accountability Set (MCAS). This includes measures from NCQA HEDIS, the Centers for Medicare and Medicaid Services (CMS), and the Dental Quality Alliance (DQA).

Historically, CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters (APL), and California Governor directives. Measure selection for CBI has also taken into consideration preventive service measure gaps with a focus on health equity in alignment with the DHCS Comprehensive Quality Strategy and the Alliance Strategic Plan as a way to support the Medi-Cal population. Prior to bringing recommended changes to our Board, we also solicit provider feedback through our Physician Advisory Group (PAG).

Discussion. The following tables show each measure in the different categories, with an explanation of the recommendations following each table.

Application of Dental Fluoride Vanish to accept dental claims via the Alliance Provider Portal Data Submission Tool, and change the application from one to two occurrences, which will align more with the MCAS Topical Fluoride Varnish Measure.

Measure Category	Measure Name
Care Coordination – Access Measures	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
	Application of Dental Fluoride Varnish
	Developmental Screening in the First 3 Years
	Initial Health Appointment
	Post-Discharge Care
Care Coordination – Hospital & Outpatient Measures	Plan All-Cause Readmission
	Preventable Emergency Visits
	Ambulatory Care Sensitive Admissions

The proposed 2026 programmatic Quality of Care measures will transition the Controlling High Blood Pressure measure from an exploratory to a programmatic status. All other Quality of Care measures will stay the same.

Measure Category	Measure Name
Quality of Care Measures	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits (3-21)
	Chlamydia Screening in Women
	Colorectal Cancer Screening
	Controlling High Blood Pressure
	Diabetic Poor Control >9%
	Immunizations: Adolescents
	Immunizations: Children (Combo 10)
	Lead Screening in Children
	Screening for Depression and Follow-up Plan
	Well-Child Visit in The First 15 Months
	Well-Child Visits for Age 15 months–30 months of Life

For CBI 2026 Fee-For-Service measures, as part of the board approved provider supplemental payments, the Social Determinants of Health (SDOH) measure will be updated to pay $100.00 per visit per member for Z or G SDOH diagnostic codes. A $50 per member referral for ECM will be added as part of the board approved supplemental payments. All other Fee-For-Services measures will stay the same.

Measure Category	Measure Name
Fee-For-Service	Adverse Childhood Experiences (ACEs) Training and Attestation
	Behavioral Health Integration
	Cognitive Health Assessment Training and Attestation
	Diagnostic Accuracy and Completeness Training
	ECM Referrals
	Patient-Centered Medical Home (PCMH) Recognition
	Quality Performance Improvement Projects
	Social Determinants of Health (SDOH) ICD-10 Z Code

	Submission

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

Attachments. N/A

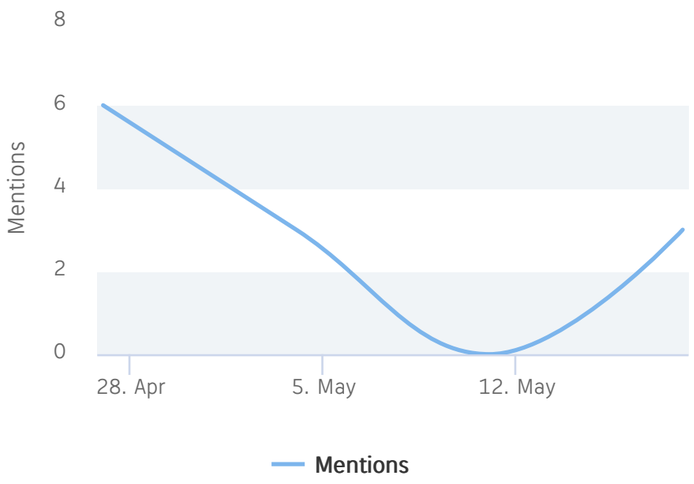
Back to Agenda

Information Items: (13A. – 13D.)

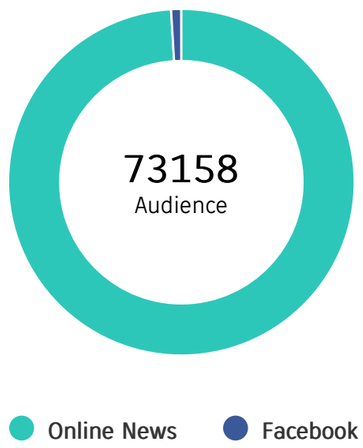
June 2025 Board Report

Mention Analytics

Mentions by Time



Audience by Media Type



Publicity by Media Type

Total Online + Print Audience
72,468

Total Online + Print Publicity
USD $717

Total Social Followers
690

Total Number of Clips 12

King City's supportive housing project moves forward with full funding, legal settlement

1

Date Collected May 22, 2025 7:21 PM EDT
Category Digital News
Source King City Rustler

Est. Audience 217
Est. Publicity Value USD $6
Market King City, CA
Language English

The former Days Inn property in King City, soon to be transformed into a permanent supportive housing facility following full project funding and a legal settlement with the state. (Jon Allred/File Photo)

KING CITY — King City's plan to convert the former Days Inn property into a permanent supportive housing facility is officially moving forward, after the City secured an additional $16 million in grants to fully fund the project.

According to city officials on Thursday, the City is now in escrow to purchase the property using entirely grant funds. Once the purchase is complete, the site ...

Aptos church addresses concerns over new housing project near Seacliff Park

2

Date Collected May 22, 2025 12:50 AM EDT
Category Digital News
Source KION546
Author Briana Mathaw

Est. Audience 61,632
Est. Publicity Value USD $570
Market Salinas, CA
Language English

... to address the local housing crisis.

The project has generated a mixed response from the community, with many raising questions about safety and who exactly this new housing is for.

A ten unit building will sit on the far corner of the church property, funded by a $1.1 million grant from the Central Coast Alliance for Health, which is tied to

Medicaid, meaning residents must meet Medicaid eligibility.

The plan has received mixed reviews.

"They're afraid about drug dealing. Afraid about the park and kids. This is not the population that's going to be living on this campus," Jon Showalter said.

Jon Showalter, a member ...

Aptos church addresses concerns over new housing project near Seacliff Park

3

Date Collected May 21, 2025 1:23 PM EDT
Category Digital News
Source kion546.com
Author Briana Mathaw

Market United States
Language English

... to address the local housing crisis.

The project has generated a mixed response from the community, with many raising questions about safety and who exactly this new housing is for.

A ten unit building will sit on the far corner of the church property, funded by a $1.1 million grant from the Central Coast Alliance for Health, which is tied to Medicaid, meaning residents must meet Medicaid eligibility.

The plan has received mixed reviews.

"They're afraid about drug dealing. Afraid about the park and kids. This is not the population that's going to be living on this campus," Jon Showalter said.

Jon Showalter, a member ...

Bright Beginnings Monterey County

4

Time May 9, 2025 1:46 PM EDT
Type Post
Language English

Followers 690

Did you hear!? With help from Central California Alliance for Health and partners, the Maternal Mental Health Task Force has been able to recruit and train 43 new birth doulas to Monterey County. On Tuesday, May 6, the Monterey County Board of Supervisors highlighted the Maternal Mental Health Task Force's efforts in honor of Maternal Mental Health Awareness Week ...

The Housing Authority acquires a senior housing project and a former Homekey project.

5

Date Collected May 8, 2025 3:28 AM EDT
Category Digital News
Source Monterey County Weekly
Author Pam Marino, Dave Faries, Celia Jiménez, Daniel Driefuss, Housing Authority

Market United States
Language English

... . (Shangri–La foreclosed on its loans on that hotel and others around the state in early 2024, including three in Salinas.)

King City's leaders were determined to save the project. Using funds from a state encampment grant and help from several agencies, including the County of Monterey, Central California Alliance for Health and HACM, the City Council signed a deal on April 22.

That deal included purchasing the hotel for $4.4 million, then immediately selling it to HACM for $1. HACM will be responsible for turning the hotel rooms into deed–restricted apartments — the estimated cost is $16.7 million, with money coming ...

The Housing Authority acquires a senior housing project and a former Homekey project.

6

Date Collected May 7, 2025 8:00 PM EDT
Category Digital News
Source Monterey County Weekly
Author Pam Marino, Dave Faries, Celia Jiménez, Daniel Driefuss, Housing Authority

Market United States
Language English

... . (Shangri–La foreclosed on its loans on that hotel and others around the state in early 2024, including three in Salinas.)

King City's leaders were determined to save the project. Using funds from a state encampment grant and help from several agencies, including the County of Monterey, Central California Alliance for Health and HACM, the City Council signed a deal on April 22.

That deal included purchasing the hotel for $4.4 million, then immediately selling it to HACM for $1. HACM will be responsible for turning the hotel rooms into deed–restricted apartments — the estimated cost is $16.7 million, with money coming ...

Local government provides a platform for real people to make real change.

7

Date Collected May 1, 2025 3:28 AM EDT
Category Digital News
Source Monterey County Weekly
Author Sara Rubin, Daniel Driefuss, Karen Loutzenheiser

Market United States
Language English

... of CSUMB's Otter Dreamers Club in the Assembly chamber of the California Capitol

SARA RUBIN

This came just a month after President Donald Trump had been sworn into a second term, and Republicans were moving swiftly to slash spending. Askew — who also serves back home on the governing board of the Central California Alliance for Health, which administers Medicaid (called Medi–Cal in California) locally — has traveled to the Capitol for legislative conferences like these before. But the backdrop this time felt different to her — it was crisis mode.

As she met with congressional representatives, however, it felt like something else ...

The Buzz 05.01.25

8

Date Collected May 1, 2025 3:28 AM EDT
Category Digital News
Source Monterey County Weekly
Author Sara Rubin

Market United States
Language English

... for 1pm Thursday, May 1, at the MST Salinas Transit Center.

GREAT:

It's great news for Monterey County families: The

Maternal Mental Health Task Force

has recruited and trained 43 new birth doulas, with the help of partners and an $800,000 grant last year from the region's Medi–Cal provider,

Central California Alliance for Health

. Doulas have been shown to increase positive birth outcomes and reduce anxiety in mothers. The Task Force's efforts will be highlighted by the

Monterey County Board of Supervisors

on Tuesday, May 6 (at 10:30am) in honor of

Maternal Mental Health Awareness Week

. Other events include a forum ...

Online News

(Requires Critical Mention login)

YOLO COUNTY; County welcomes new director of HHSA

9

Powered by LexisNexis

Date Collected Apr 30, 2025 11:28 AM EDT
Category Print
Source The Daily Democrat (Woodland, California)
Author Daily Democrat

Est. Audience 8,826
Est. Publicity Value USD $119
Market Woodland, CA
Language English

... to 15,000 patients, and public health services countywide.

She holds a Master of Public Administration in public policy and administration from

Columbia University and a Bachelor of Arts in sociology from the University of California, Santa Cruz. Morales also serves as a commissioner with the Central California

Alliance for Health and participates in several statewide public health and policy committees.

Stepping into the role during a time of significant policy transformation, Morales will focus on ensuring Yolo County remains responsive and resilient by preserving essential services, meeting mandated responsibilities, ...

Yolo County welcomes new director of Health and Human Services Agency

10

Date Collected Apr 30, 2025 9:31 AM EDT
Category Digital News
Source Woodland Daily Democrat
Author Daily Democrat

Est. Audience 1,087
Est. Publicity Value USD $16
Market Woodland, CA
Language English

... to 15,000 patients, and public health services countywide.

She holds a Master of Public Administration in public policy and administration from Columbia University and a Bachelor of Arts in sociology from the University of California, Santa Cruz. Morales also serves as a commissioner with the Central California Alliance for Health and participates in several statewide public health and policy committees.

Stepping into the role during a time of significant policy transformation, Morales will focus on ensuring Yolo County remains responsive and resilient by preserving essential services, meeting mandated responsibilities, and ...

Monterey County hospitals, organizations partner on countywide health assessment

11

Date Collected Apr 30, 2025 8:21 PM EDT
Category Digital News
Source King City Rustler

Est. Audience 217
Est. Publicity Value USD $2
Market King City, CA
Language English

... County Health Department and United Way Monterey County. The Collaborative was formed to more effectively identify, address and improve the health and well–being of the local community.

This year, two additional partners have joined the Collaborative; California State University Monterey Bay and Central California Alliance for Health.

Nonprofit hospitals must complete a community health needs assessment every three years, and health departments are required to do a health assessment every five years. Typically, organizations do the assessment and address issues independently.

Through the Monterey County Health Needs ...

Monterey County hospitals, organizations partner on countywide health assessment

12

Date Collected Apr 30, 2025 8:07 PM EDT
Category Digital News
Source Salinas Valley Tribune

Est. Audience 489
Est. Publicity Value USD $4
Market King City, CA
Language English

... County Health Department and United Way Monterey County. The Collaborative was formed to more effectively identify, address and improve the health and well–being of the local community.

This year, two additional partners have joined the Collaborative; California State University Monterey Bay and Central California Alliance for Health.

Nonprofit hospitals must complete a community health needs assessment every three years, and health departments are required to do a health assessment every five years. Typically, organizations do the assessment and address issues independently.

Through the Monterey County Health Needs ...

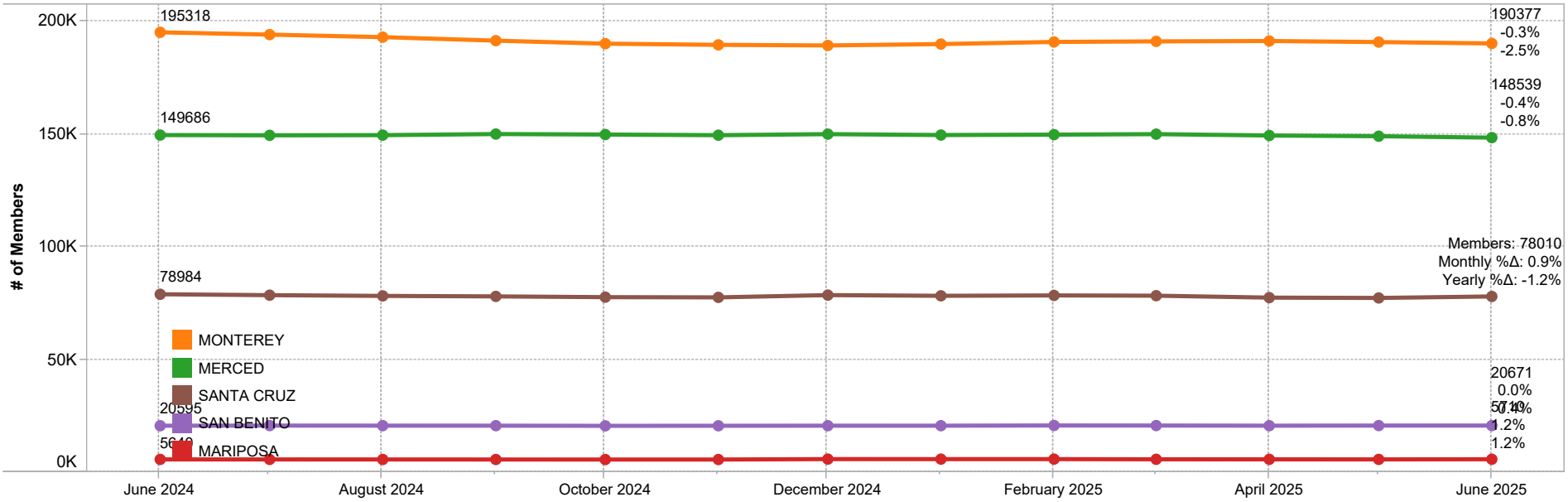
Back to Agenda

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *6/5/2025 6:36:36 AM*

Enrollment Month
6/1/2024 to 6/30/2025

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



LOB	County	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025
Medi-Cal	SANTA CRUZ	78,984	78,576	78,251	78,034	77,699	77,603	78,604	78,297	78,466	78,348	77,491	77,348	78,010
	MONTEREY	194,587	193,564	192,452	190,899	189,566	189,050	188,797	189,414	190,365	190,622	190,794	190,335	189,728
	MERCED	149,686	149,573	149,648	150,131	149,919	149,625	150,092	149,694	149,870	150,091	149,492	149,175	148,539
	MARIPOSA	5,640	5,625	5,611	5,597	5,580	5,579	5,769	5,760	5,761	5,688	5,668	5,641	5,710
	SAN BENITO	20,595	20,655	20,630	20,617	20,548	20,574	20,611	20,608	20,710	20,680	20,611	20,663	20,671
IHSS	MONTEREY	731	729	723	717	709	702	693	684	680	675	663	654	649
Total Members		**450,223**	**448,722**	**447,315**	**445,995**	**444,021**	**443,133**	**444,566**	**444,457**	**445,852**	**446,104**	**444,719**	**443,816**	**443,307**

Back to Agenda

Alliance Fact Sheet
Q2 2025

About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **443,373 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts

1996
Year Established

642
Number of Employees

$2.09B[1]
Annual Revenue

5.7%[1]
Administrative Overhead

$46.4M[2]
Community Grants

VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

MISSION

Accessible, quality health care guided by local innovation.

VALUES

Collaboration:
Working together toward solutions and results.

Equity:
Eliminating disparity through inclusion and justice.

Improvement:
Continuous pursuit of quality through learning and growth.

Integrity:
Telling the truth and doing what we say we will do.

What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

Who We Serve

Our members represent 41%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

Provider Partnerships

The Alliance partners with 100% of hospitals in our service areas and a network of approximately 13,830 providers (99% of primary care physicians and 99% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 4,650 providers to deliver behavioral health and vision services.

Our Members[4]

1 out of every 3
Mariposa County residents.

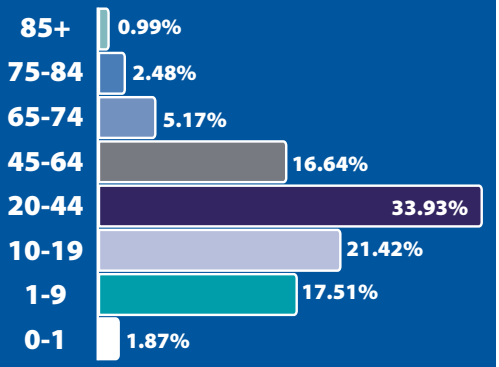
1 out of every 2
Merced County residents.

1 out of every 2
Monterey County residents.

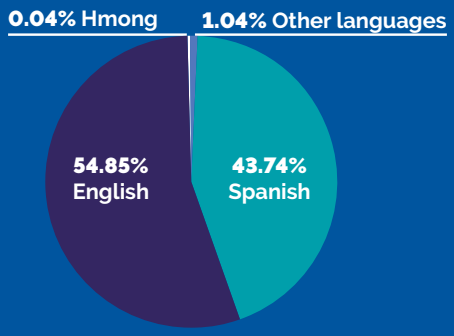
1 out of every 3
San Benito County residents.

1 out of every 3
Santa Cruz County residents.

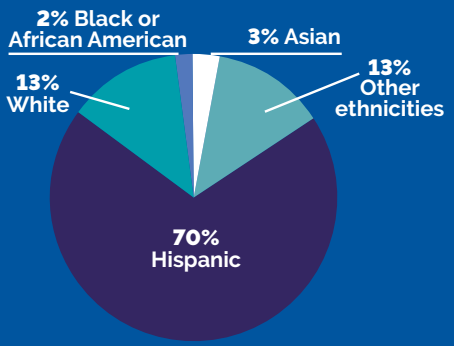
Membership by Age Group



Preferred Language



Race/Ethnicity



Executive Leadership

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Jenifer Mandella
Chief Compliance Officer

Scott Fortner
Chief Administrative Officer

Cecil Newton
Chief Information Officer

Omar Guzmán, MD
Chief Health Equity Officer and
Interim Chief Medical Officer

Van Wong
Chief Operating Officer

Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, Alliance Board Vice Chairperson, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Dorothy Bizzini,** Public Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Kimberly De Serpa,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Janna Espinoza,** Public Representative
- **Mark Hendrickson,** Interim Chief Executive Officer, Merced County, County Health Department Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, Alliance Board Chairperson, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Vacant,** County Health Department Representative

Unless otherwise stated, Fact Sheet data as of April 1, 2025.

[1]*Amounts based on 2025 annual budget.*

[2]*Represents 2024 investments through the Alliance's Medi-Cal Capacity Grant Program.*

[3]*County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).*

[4]*Represents an approximate visual representation. Membership percentage by county: Mariposa (34 percent) Merced (51 percent); Monterey (44 percent); San Benito (30 percent); Santa Cruz (30 percent).*

June 10, 2024

To Whom It May Concern,

Central California Alliance for Health (the Alliance) supports the Coalition of Homeless Services Providers' (CHSP) application as a lead agency for the Flexible Housing Subsidy Pools (Flex Pools) Technical Assistance Academy.

The Alliance is not able to participate as a member of the TA Recipient Team or implement this optional model due to current competing mandates and priorities, however, we do support CHSP and its partners, Monterey County Behavioral Health Department and Monterey County Homeless Strategies and Initiatives Division, in learning more about the feasibility of implementing the model in Monterey County.

As the local CA-506 Continuum of Care (CoC) for Monterey and San Benito counties. CHSP serves as an important partner in the ecosystem of housing services. There are over 20 agencies that subscribe to CHSP membership, which creates a cohesive network of services that can be wrapped around individuals once placed into housing. CHSP is responsible for data management and ensuring the data quality and integrity of the Homeless Management Information System. CHSP is familiar with handling pass-through dollars to local homeless service providers to house people experiencing or at risk for homelessness within two counties in the Alliance's service area.

The Alliance has partnered successfully with CHSP on Health and Homelessness Incentive Program (HHIP) and Homeless Housing, Assistance and Prevention (HHAP) grant deliverables. We can attest to their ability to meet outcomes of funded programs and lead as a reliable partner in planning efforts. We are also a participant with CHSP in the Coastal Collaborative supporting ECM and Community Supports implementation in Monterey and San Benito counties.

If you require any further information regarding our partnership with CHSP as one of our local CoCs or our partnership with the County of Monterey, please feel free to contact us at pdincentives@ccah-alliance.health.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer
Central California Alliance for Health

June 2, 2025

Robert Wood Johnson Foundation
50 College Road East
Princeton, NJ 08540-6614

RE: Systems for Action – 2025 Call for Proposals

To Whom It May Concern:

I am writing this letter of partnership on behalf of Ventures to express our support for Ventures' proposal, *Semillitas: Aligning Health and Financial Systems to Advance Early Childhood Equity*

Central California Alliance for Health (the Alliance) is an award-winning regional non-profit health plan that serves over 443,000 members in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. The Alliance makes investments to health care and community organizations in these counties through the Medi-Cal Capacity Grant Program.

The Alliance is proud to collaborate with Ventures on the Children's Savings Account (CSA) Pilot to expand the Semillitas program. Semillitas is an innovative effort to align medical, public health, and social service systems through milestone-linked College Savings Account contributions for Medi-Cal-covered families. This project reflects a shared commitment to advancing health equity and improving early childhood outcomes through cross-sector collaboration.

The CSA pilot partnership between the Alliance and Ventures launched in November 2022 and has been funded $330,000 through the Alliance's Medi-Cal Capacity Grant Program to support the addition of two health-related milestone contributions for Alliance members 2 years old and younger in Santa Cruz County. Through our partnership with Ventures, the Alliance provides grant funding, collaborates on data sharing agreement, supports evaluation design, and assists with program promotion to Alliance members.

We are collaborating closely with Ventures to ensure the successful implementation and evaluation of this program, which is rooted in equity and invests in the long-term wellbeing of the Medi-Cal members we serve in Santa Cruz County. The CSA pilot will allow the Alliance to evaluate the sustainability and scalability of this approach in other counties we serve.

Thank you for your consideration.

Sincerely,

Michael Schrader
Chief Executive Officer