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

Meeting Agenda

Wednesday, March 26, 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:
San Benito County Health & Human Services Agency
1111 San Felipe Rd. Suite 205, 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: 421 079 126#

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, March 24, 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 individual 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. – 11G.): 3:10 p.m.

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

   Pages 5-1 to 5-5

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the Twelfth month ending December 31, 2024 – Unaudited as of 1/30/2025.**
   - Reference materials: Financial Statements as above noted.

   Pages 6-1 to 6-10

7. **Accept Alliance Dashboard for Q4 2024.**
   - Reference materials: Alliance Dashboard – Q4 2024.

   Page 7-1

8. **Authorize Chairperson and the Chief Executive Officer (CEO) to sign necessary implementing amendments to facilitate the Voluntary Rate Range program for rating period CY 2024.**
   - Reference materials: Staff report and recommendation on above topic

   Pages 8-1 to 8-2

9. **Approve revisions to Alliance Policies and Procedures on Letters of Support, Administrative Decision-Making Controls and Expenditure Authority.**
   - Reference materials: Staff report and recommendation on above topic

   Pages 9-1 to 9-14

Appointments: (10A. – 10C.):

10A. **Approve renewal of Janna Espinoza, Humberto Carrillo, Frances Wong, and Candi Walker, to the Member Services Advisory Group.**
   - Reference materials: Staff report and recommendation on above topic.

   Page 10A-1

10B. **Approve appointment of Adriana Zoghlami to the Member Services Advisory Group.**
- Reference materials: Staff report and recommendation on above topic

Page 10B-1

10C. **Approve appointment of Katrina Hodges and Alicia Zambrano to the Whole Child Model Family Advisory Committee.**
- Reference materials: Staff report and recommendation on above topic

Page 10C-1

Minutes: (11A. – 11G.):

11A. **Approve Commission regular meeting minutes of January 22, 2025.**
- Reference materials: Minutes as above.

Pages 11A-1 to 11A-5

11B. **Accept Whole Child Model Family Advisory Committee meeting minutes of November 4, 2024.**
- Reference materials: Minutes as above.

Pages 11B-1 to 11B-5

11C. **Accept Compliance Committee meeting minutes of December 18, 2024.**
- Reference materials: Minutes as above.

Pages 11C-1 to 11C-5

11D. **Accept Member Services Advisory Group meeting minutes of May 9, 2024, August 8, 2024 and November 7, 2024.**
- Reference materials: Minutes as above.

Pages 11D-1 to 11D-12

11E. **Accept Member Services Advisory Group Selection Committee meeting minutes of February 8, 2024, May 9, 2024, and August 8, 2024.**
- Reference materials: Minutes as above.

Pages 11E-1 to 11E-6

11F. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of December 19, 2024.**
- Reference materials: Minutes as above.

Pages 11F-1 to 11F-4

11G.` **Accept Physicians Advisory Group meeting minutes of December 5, 2024.**
- Reference materials: Minutes as above.

Page 11G-1 to 11G-5

Reports: (12A. – 12C.)

12A. **Accept Alliance Business Continuity and Disaster Recovery Program 2024 Annual Report.**
- Reference materials: Staff report on above topic.

Pages 12A-1 to 12A-2

12B. **Accept Alliance Owned Facilities 2024 Annual Report.**
- Reference materials: Staff report on above topic.

Pages 12B-01 to 12B-2

12C. **Accept 2025 Bill List.**

- Reference materials: Staff report on above topic.

Pages 12C-1 to 12C-37

Regular Agenda Items: (13. – 15.): 3:20 p.m. – 5:00 p.m.

13. **Discuss Community Presence and Communications. (3:20 p.m. – 3:40 p.m.)**
Ms. Linda Gorman, Marketing and Communications Director and Ms. Ronita Margain, Community Engagement Director will review, and Board will discuss community. presence strategies and Communication tactics.

- Reference materials: Staff report on above topic.

Page 13-1

14. **Discuss Federal Policy Proposals and consider approving 2025 Policy Priorities (3:40 p.m. – 4:40 p.m.)**
Mr. Michael Shrader, Chief Executive Officer, will review and board will discuss federal policy priorities and Board will consider approving the Alliance's 2025 policy priorities.

- Reference materials: Staff report and advocacy letters on above topic.

Pages 14-1 to 14-8

15.. **Consider approving the Alliance's legal and regulatory Compliance Program Report for Q3-4 2024. (4:40 p.m. – 5:00 p.m.)**
Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider. approving the Alliance's Compliance Program Report for Q1-2 2024.

- Reference materials: Staff report on above topic.

Pages 15-1 to 15-13

Information Items: (16A. – 16E.)

A.	Alliance in the News	Page 16A-1 to 16A-4
B.	Membership Enrollment Report	Page 16B-1
C.	Member Appeals and Grievances Report – Q4 2024	Page 16C-1
D.	2025 Community impact Report	Page 16D-1 to 16-14
E.	Alliance Annual Report to Board of Supervisors – 2024	Pages 16E-1 to 16E-18

Announcements:

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

- Finance Committee
  Wednesday, June 25, 2025; 1:30-2:45 p.m.
- Member Services Advisory Group
  Thursday, May 8, 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, June 26, 2025; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, May 5, 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 March 26, 2025, meeting, unless otherwise noticed:

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

Date: Wednesday, April 23, 2025

Time: 10:00 a.m. - 3:00 p.m.

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

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 March 26, 2025

TO Governing Commission of the Central California Alliance for Health

FROM Michael Schrader, Chief Executive Officer

SUBJECT CEO Report

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.

Federal Budget. At our meeting on March 26th, I will be presenting an in-depth look at the federal budget proposals currently being considered in Congress and the potential impact on Medicaid funding as well as efforts underway to educate and inform Congress of the effects of these proposals on the Medi-Cal program. Your Board will be asked to approve updated Policy Priorities for 2025 to affirm your strong support for the Medicaid program and the people which it serves.

2025 Legislative Session. February 21, 2025, was the deadline for Legislators to introduce new legislation in the 2025 Legislative Session. Staff continue to work closely with the Local Health Plans of California and our representatives in Sacramento to monitor legislative activity and to identify bills aligned with the board's Policy Priorities. Staff have developed an initial 2025 bill list, which is included on the Consent Agenda in Agenda Item 16E. Staff continue to review bills on this list for policy implications and possible implementation issues for any bills which pass later in the legislative session. Staff will provide reports to your board throughout this legislative session as issues of Board interest, importance, or action arise. The volume of health-related bills is notable. However, given the significant potential impacts of the outcomes of the federal budget discussions, it is unclear how many of these bills will move successfully through the legislature this session.

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

- Outreach and Community Events. We continue to educate and inform members about the importance of getting in for care through face-to-face community events including the Santa Cruz Community Health Patient Open House, the San Benito County Family Wellbeing Festival, Delhi Tk/Kindergarten Roundup, and several Monterey County Immigration forums. We are looking forward to continuing our participation in the Mariposa Butterfly Festival this year.

- Marketing and Communications. In February, the Alliance published the 2025 Community Impact Report, themed, "Community. Connection. Care." which highlights the Alliance's community investments and commitments in 2024, including the $93 million in financial investments we made in our five counties. These transformative investments and initiatives aim to move us closer toward our vision of Healthy People, Healthy Communities. A press release was distributed February 20, 2025. Link to the Community Impact Report.

Staff have prepared to launch a paid media campaign in March in Merced and Mariposa counties. The campaign, *Vaccines prevent 20+ diseases,* encourages members to call their doctor to schedule their vaccines. The omnichannel campaign includes print and digital tactics, including geotargeted ads in physical locations frequented by our members (pharmacies, laundromats, apartments, convenience stores and day cares). The campaign will run through the end of June.

We continue to execute our text messaging campaigns. February campaigns included: new member welcome, redetermination/discontinuances, new mothers' campaign, NAL (tied to flu), and health education programs. We are currently in the process of evaluating the success of these campaigns beyond just successful sends and will be sharing the results in a future report.

Media pickup: Santa Cruz Sobering Center Benefits Patients and Justice System - California Health Care Foundation

Alliance Six Priority Initiatives. Our staff is deeply engaged in executing the state-mandated CalAIM initiatives. Consequently, we face a significant workload with competing priorities and strict DHCS deadlines. Yet, we are excited by the work because of the opportunity to more fully serve our members.

ECM Enrollment, Quality & Health Equity in Merced County, and Jiva Care Management System. We are proud to have achieved what we originally set out to accomplish on three of our six 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.

We will now dedicate our full attention to the remaining three initiatives, described below, to ensure they are successfully completed by the imposed deadlines.

Medicare Dual Special Needs Plan (D-SNP). Staff are preparing to launch a D-SNP product by January 1, 2026. This product will allow the Alliance to serve as the single plan for members eligible for both Medi-Cal and Medicare, streamlining their healthcare experience.

The Alliance successfully submitted its comprehensive Medicare D-SNP application and materials to the Centers for Medicare and Medicaid Services (CMS) by the February 12, 2025 deadline. On March 13, 2025, CMS issued a deficiency notice and reopened the Health Plan Management System (HPMS), a routine step in the process, allowing corrections to be made, The deficiencies identified primarily relate to network adequacy and some miscellaneous areas. At the time of submission, our network was approximately 96% complete in meeting CMS standards. During the four weeks between the application submission and the deficiency notice, staff worked to finalize the network build-out to fully comply with CMS standards. Through the end of 2025, staff will continue to expand the provider network

beyond CMS adequacy requirements. All other deficiencies appear minor and are expected to be straightforward for staff to address and update in HPMS.

We have developed a final draft of the Marketing and Communications plan to support the launch of our Medicare D-SNP program. The plan name, TotalCare HMO D-SNP, has been submitted for trademark review.

Behavioral Health Insourcing. In June 2024, the Alliance formally notified Carelon that we will not renew the contract when it expires on June 30, 2025. Effective July 1, 2025, the Alliance will internally manage the behavioral health benefit, including non-specialty mental health (i.e., mild to moderate mental health) and behavioral health therapy. Bringing behavioral health in-house will give us direct control and better opportunity to improve access for members, support providers, and collaborate with counties and schools.

The Alliance team has been working diligently to build relationships with behavioral health providers. Staff continue to focus on contacting behavioral health providers who have high utilization and/or in our 5-county service area. Over 30% of targeted behavioral health providers have executed contracts with the Alliance and we anticipate ramping up over the next 3 months as we prepare for our July 1, 2025 launch.

National Committee for Quality Assurance (NCQA) Accreditation. The NCQA standards embody our commitment to quality, excellence, and health equity. We are actively pursuing two distinct accreditations from NCQA: Health Plan Accreditation and Health Equity Accreditation. The NCQA will conduct a survey of the Alliance on April 1, 2025, with a lookback period extending six months back to October 1, 2024. To achieve accreditation, we must meet at least 80 percent of the NCQA standards and fulfill all must-pass elements.

Medi-Cal Capacity Grants Program (MCGP). We make investments to health care and community organizations to realize 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, as well as to address social drivers that influence health and wellness.

- Our MCGP received 46 eligible applications across nine programs in the five-county service area by the January 21, 2025, deadline for a total requested amount of $8.1 million. These applications are currently under review for award decisions on April 4, 2025. This is the first of three funding rounds in 2025. The application deadline for the second round is May 6, 2025.

- The Alliance will host two MCGP informational webinars on March 27 and April 1 to provide updates on funding opportunities and changes outlined in the 2025 MCGP Investment Plan. These webinars will focus on the Healthy Beginnings and Healthy Communities areas, specifically:

    1. Parent Education and Support: Continuing to promote child development and preventive care access, while strengthening organizations' capacity to align

existing home visiting programs with the Enhanced Care Management program.

2. Community Health Champions: Expanding funding to integrate behavioral health into community settings, promote healthy eating and active living, and enhance capacity building for trusted community partners, particularly those supporting the community health worker pipeline."

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.

- Regulatory Audits. Like all Medi-Cal Managed Care Plans, the Alliance is in a constant state of preparing for routine audits, experiencing them, or following up.

  Active audits
  - 2025 DHCS Medi-Cal Audit. DHCS auditors conducted the annual audit virtually in January of 2025. This was a limited scope audit covering UM, case management, coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. DHCS indicated we would receive preliminary findings in February, however, we have yet to receive them. DHCS indicated at the close of the virtual audit that we may expect findings related to resolution of quality grievance, oversight of grievance and appeals, and enhanced case management.
  - 2025 DMHC Financial Examination. DMHC auditors initiated their virtual audit in January of 2025, reviewing the Alliance's fiscal and administrative affairs. The financial portion of the review is complete, and auditors continue to review claims payment practices.

  Under follow up
  - 2023 DHCS Focused Audit of Behavioral Health and Transportation. DHCS issued a final report from its 2023 DHCS Focused Audit of Behavioral Health and Transportation, and the Alliance team is remediating the identified deficiencies. Five of eight deficiencies have been closed, with the remaining three pending review of supporting documentation.
  - 2024 DMHC Medical Survey. We continue to await DMHC's preliminary report from its 2024 Medical Survey of the Alliance that took place in March 2024.

- Enforcement Actions. No new Enforcement Actions were imposed. The Alliance continues to work with DMHC to reduce the penalties associated with the two Enforcement Actions issued in 2024, including (1) an administrative penalty of $15,000 for two violations in the measurement year 2019 Timely Access monitoring report; and (2) an administrative penalty of $100,000 for four violations identified in the 2022 DMHC Follow-Up Survey.

Q4 2024 Organizational Dashboard: The Alliance Dashboard measures the Alliance's responsibility to our members and providers through key performance indicators and provides oversight of health plan performance across all organizational processes.

Target and Threshold levels for processes are established by Alliance leadership and informed by contractual requirements and best practice standards. The Dashboard is brought to the Board's attention on a quarterly cadence and offers a summary snapshot of the previous quarter's organizational performance.

The Q4 2024 Alliance Dashboard is comprised of 138 metrics monitoring 62 health plan core, support, and managerial processes. These 62 health plan processes are rolled up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology. The accompanying *Executive View* can be found on page 7-1 of this Board Packet.

Results for 10 of 13 Level 1 processes met or exceeded 95% of the target. Key exceptions to the 95% standard and other notable performance (including a comparison to the Q324 performance) are as follows:

Level 1 Process	Q4 Result	Qtr over Qtr Change	Key Drivers
Pay Providers	88.9%	-0.3 percentage points	Performance can mainly be attributed to a very high claims inventory, which is due to a dramatic increase in ECM claim receipts, driven by a focus on having ECM providers submit their encounters. The organization is hiring temp staff to bring the claims inventory down. Further attributing to the low performance is a measure focusing on CBI payments in Merced County. Merced County has more challenges to meeting the quality performance measures to receive CBI payments than, e.g., Santa Cruz or Monterey. The available data at this point is from MY 2023. New data will become available in Q225.
Manage Alliance Compliance Commitments	92.1%	-5.2 percentage points	Performance can be attributed to failed internal audits and adequate correction of identified issues. Performance is expected to increase as process improvement efforts are underway.
Manage Organizational Communications and Branding	100%	+5.0 percentage points	Performance is due to better results for the metric *Grow organic Google search website traffic*. Some search terms (e.g., nurse advice line) are bringing us much broader traction and getting us in search results/traffic nationally rather than locally compared to the previous quarter.

DATE: March 26, 2025

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Twelfth Month Ending December 31, 2024- Unaudited as of 1/30/2025

For the month ending December 31, 2024, the Alliance reported an Operating Income of $10.3M. The Year-to-Date (YTD) Operating Income is $25.9M, with a Medical Loss Ratio (MLR) of 93.4% and an Administrative Loss Ratio (ALR) of 5.3%. The Net Income is $53.1M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Income of $22.3M for YTD December. The actual result is favorable to budget by $3.6M or 16.1%, driven primarily by membership favorability and rate variances.

	Dec-24 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*455,255*	*397,072*	*58,183*	*14.7%*
Revenue	$199,572	$134,339	$65,233	48.6%
Medical Expenses	178,232	132,564	(45,668)	-34.4%
Administrative Expenses	11,024	8,952	(2,073)	-23.2%
Operating Income	10,316	(7,177)	17,493	100.0%
Net Income	$5,497	($6,012)	$11,510	100.0%
MLR %	89.3%	98.7%	9.4%	
ALR %	5.5%	6.7%	1.2%	
Operating Income %	5.2%	-5.3%	10.5%	
Net Income %	2.8%	-4.5%	7.3%	

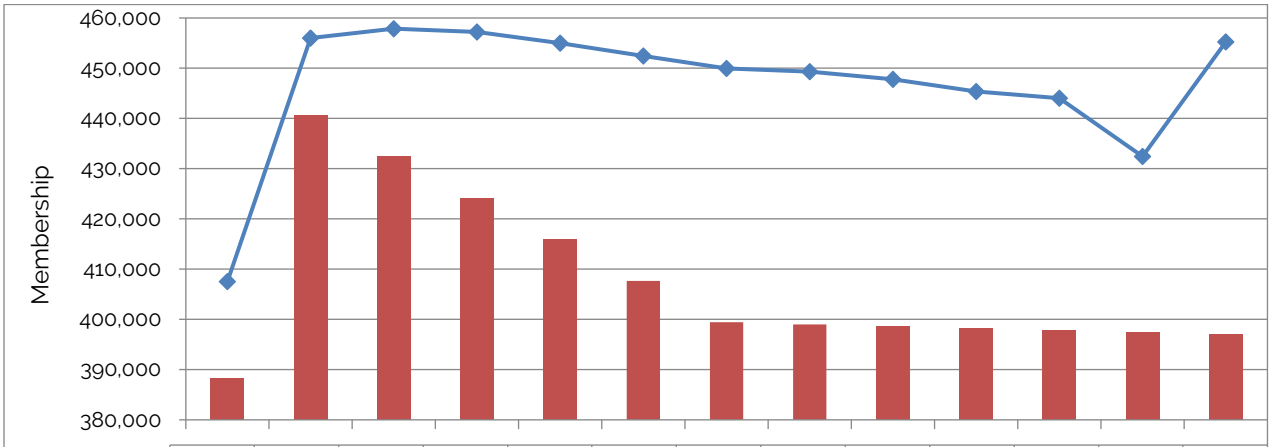
Dec-24 (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*5,402,715*	*4,908,292*	*494,423*	*10.1%*
Revenue	$1,981,811	$1,660,129	$321,683	19.4%
Medical Expenses	1,851,182	1,532,466	(318,717)	-20.8%
Administrative Expenses	104,759	105,376	617	0.6%
Operating Income/(Loss)	25,870	22,288	3,583	16.1%
Net Income/(Loss)	$53,106	$38,328	$14,778	38.6%
PMPM				
Revenue	$366.82	$338.23	$28.59	8.5%
Medical Expenses	342.64	312.22	(30.42)	-9.7%
Administrative Expenses	19.39	21.47	2.08	9.7%
Operating Income/(Loss)	$4.79	$4.54	$0.25	5.5%
MLR %	93.4%	92.3%	-1.1%	
ALR %	5.3%	6.3%	1.0%	
Operating Income %	1.3%	1.3%	0.0%	
Net Income %	2.7%	2.3%	0.4%	

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

At a PMPM level, YTD revenue is $366.82, which is favorable to budget by $28.59 or 8.5%. Medical cost PMPM is $342.64, which is unfavorable by $30.42 or 9.7%. Overall, this results in an unfavorable gross margin of $1.83 or 7.0% compared to the budget. The operating income PMPM is $4.79, which is favorable to the budget by $0.25 or 5.5%.

Membership: December 2024 membership is favorable to budget by 14.7%. This is primarily attributed to an 834 data discrepancy in the SPD Dual COA, resulting in November's figures being understated and subsequently recorded in December. The 2024 budget assumed a 17% decrease over the course of redetermination (July 2023 to June 2024) based on Mercer projections. Mercer later updated their projections to be less impactful than originally estimated and now only assumes an 11% decrease. The actual decrease during the unwinding period from July 2023 to June 2024, is approximately 7.6%, excluding the new counties / new Unsatisfactory Immigration Status (UIS) members. Redetermination losses continued in December and total loss between July 2023 and December 2024 is 9.7%.

Membership. Actual vs. Budget (based on actual enrollment trend for Dec-24 rolling 13 months)



	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budget	388,255	440,590	432,354	424,119	415,884	407,648	399,413	399,023	398,633	398,242	397,852	397,462	397,072
Actual	407,542	456,002	457,871	457,197	455,001	452,430	449,959	449,311	447,805	445,356	444,059	432,469	455,255
Variance	19,287	15,412	25,517	33,078	39,117	44,782	50,546	50,288	49,172	47,114	46,207	35,007	58,183
Variance %	5.0%	3.5%	5.9%	7.8%	9.4%	11.0%	12.7%	12.6%	12.3%	11.8%	11.6%	8.8%	14.7%

Revenue: The 2024 revenue budget was based on the Department of Health Care Services (DHCS) 2024 draft rate package (dated 10/13/2023), which reflected a 0.4% rate increase, not including the Targeted Rate Increase (TRI). Furthermore, the budget assumed breakeven performances for the San Benito Region. The CY 2024 Prospective rates from DHCS (dated 12/5/2023, including Maternity) represented a 2.1% increase over CY 2023 Rates excluding TRI. A new Amended Rate Package was received for CY 2024 (dated 9/24/2024) that now represents a 1.6% increase over CY 2023 Rates excluding TRI. Overall, revenue is favorable due to higher enrollment, favorable category of aid (COA) mix, and increased prospective rates. Please note that on December 30, 2024, we received the final amended rates for CY2024, which includes a few adjustments, particularly the reversion of the TRI and acuity rates to a prospective basis resulting in a 5.1% increase over Final CY 2023 Rates.

As of December MTD, actuals exceed the budget by $65.2M, representing a 48.6% positive variance. This is driven by favorable enrollment, contributing $20.9M, and rate variances totaling $44.3M. The rate variance of $44.3M includes $17.3M from the CalAIM incentive payment and $1.7M from prior year revenue. The remaining $25.5M favorability is due to favorable rates and other rate-related variances, such as risk corridors, which mitigate financial risk by offering protection between the health plan and the state. Specifically, a gain of $8.1M was realized from the ECM Risk Corridor, representing about 90% of the expected receivable, along with $32K from the San Benito Risk Corridor. On the downside, there was an $11.7M reduction from the UIS Adult and Adult Expansion Risk Corridor, partially offset by a $12.7M reversal of the rate adjustment between the Amended Rates and the Final Amended Rates.

As of December 2024 YTD, operating revenue is $1,981.8M, surpassing the budget by $321.7M or 19.4%. This favorable variance includes $175.9M from increased enrollment and

$145.7M from favorable rate variances, state incentives, and prior year revenue. The rate variance of $145.7M comprises $82.0M from favorable amended rates, $43.3M from State Incentive Programs, and $20.4M from prior year revenue due to MCO tax liability relief for CY 2021 and CY 2022, ECM risk corridor for 2022, 2022 Prop 56 MEP Payment, 2023 GEMT revenue, and 2023 ECM Risk Corridor.

The State Incentive Programs consist of $22.1M for HHIP, $3.0M for SBHIP, $17.3M for CalAIM, and $0.8M for EPT, which are offset by the State Incentive Programs expense. These incentives are assumed to be budget neutral.

Beginning January 2024, the new general ledger structure is reported by region and immigration status. Central California (CEC) includes the counties of Santa Cruz, Monterey, Merced, and Mariposa, and San Benito (SBN) includes San Benito. Immigration status is reported as UIS (Unsatisfactory Immigration Status) or SIS (Satisfactory Immigration Status).

Dec-24 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	1,444,178	1,249,850	194,328	107,836	86,491
CEC UIS	376,645	345,866	30,779	57,073	(26,294)
SBN SIS	76,917	49,799	27,118	8,106	19,012
SBN UIS	14,874	10,484	4,390	2,153	2,238
Total*	**1,912,615**	**1,655,999**	**256,615**	**175,168**	**81,447**

*Excludes Dec-24 In-Home Supportive Services (IHSS) premiums revenue of $5.5M, State Incentive Programs revenue of $43.3M, and Prior Year Revenue of $20.4M.

Medical Expenses: The 2024 budget assumed a 3.7% increase in utilization over the base data spanning from 2018 through June 2023 and a 2.9% unit cost increase that included case mix and changes in fee schedules. 2024 incentives include a $15M Care-Based Incentive (CBI), $4M Data Sharing Incentives, $18M for the Hospital Quality Incentive Program (HQIP), and $10M for the Specialist Care Incentive (SCI).

Dec-24 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient- Hospital	562,376	560,328	(2,048)	(56,443)	54,395
Inpatient Services - LTC	211,013	131,491	(79,522)	(13,245)	(66,277)
Physician Services	355,648	325,736	(29,912)	(32,812)	2,900
ECM/CS	115,035	19,100	(95,935)	(1,924)	(94,011)
Outpatient Facility	238,671	190,114	(48,557)	(19,151)	(29,407)
Other Medical*	325,171	305,696	(19,475)	(30,793)	11,319
State Incentive Programs	43,267	-	(43,267)	-	(43,267)
TOTAL COST	**1,851,182**	**1,532,466**	**(318,717)**	**(154,369)**	**(164,348)**

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

December 2024 Medical Expenses of $178.2M are $45.7M, or 34.4%, unfavorable to budget. December 2024 YTD Medical Expenses of $1,851.2M are above budget by $318.7M, or 20.8%. Of this amount, $154.4M is due to higher enrollment, and $164.3M is due to rate variances, which include $43.3M for State Incentive Programs. The YTD December unfavorability is primarily driven by ECM and Community Supports, followed by LTC and ER.

The State Incentive Programs consist of $22.1M for HHIP, $3.0M for SBHIP, $17.3M for CalAIM, and $0.8M for EPT. These are also included under revenue and assumed to be budget neutral.

Dec-24 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$104.09	$114.16	$10.07	8.8%
Inpatient Services - LTC	39.06	26.79	(12.27)	-45.8%
Physician Services	65.83	66.36	0.54	0.8%
ECM/CS	21.29	3.89	(17.40)	-100.0%
Outpatient Facility	44.18	38.73	(5.44)	-14.1%
Other Medical	60.19	62.28	2.09	3.4%
State Incentive Programs	8.01	-	(8.01)	-100.0%
TOTAL MEDICAL COST	**$342.64**	**$312.22**	**$(30.42)**	**-9.7%**

At a PMPM level, YTD Medical Expenses are $342.64, unfavorable by $30.42 or 9.7% compared to the budget.

Inpatient Services: Inpatient Services continue to be favorable to budget due to lower utilization than budgeted. Inpatient utilization was budgeted at 344 days per 1,000 members, but actual utilization is closer to 312 days per 1,000. Unit costs are comparable between budget and actuals, which results in a 10.1% PMPM variance between budget and actual.

Inpatient Services – LTC: LTC's unfavorability is primarily driven by unit cost and utilization. Utilization is trending 12% higher than budget. The budget also underestimated the baseline cost and did not consider the continuation of the 10% COVID add-on for specific codes or the 3% annual fee schedule increase. The budget was based on a -96% free-standing SNF service mix for both regions; however, San Benito's utilization is 95% hospital-based SNF, resulting in higher costs. As San Benito is a new county, the risk corridor will assist in managing the higher-cost hospital-affiliated service mix.

Outpatient Facility: The Outpatient Facility consists of both Outpatient and Emergency Rooms. ER continues to significantly trend upwards for utilization per 1k and unit cost and is unfavorable to budget for both utilization and unit cost by 9% and 13%, respectively, partially offset by favorable other Outpatient to budget both in utilization and unit cost.

Physician Services: Utilization has risen 14% compared to the previous year across SIS and UIS populations, driven by increased utilization at Federally Qualified Health Center (FQHC) clinics and Primary Care Physicians (PCP). The budget underestimated FFS unit cost in PCP and FQHC.

ECM/CS: ECM enrollments have increased more than sevenfold since the beginning of the year, as of December YTD and continue to grow at an average rate of 20%. As ECM is a newer program, the risk corridor will help offset the higher expenses from this growth. Another factor contributing to the unfavorable variance is the upward trend in Community Supports (CS) expenses, driven by the ramp-up of CS benefits, while revenue streams are lagging significantly, with more than nine times shortfall through December YTD. We have communicated these ongoing increases to DHCS for consideration in rate adjustments.

Other Medical: Other Medical shows an unfavorable variance against the budget, primarily driven by increased utilization in key service areas. Behavioral Health services have experienced higher-than-expected demand, significantly contributing to additional costs. Similarly, the Transportation and Allied Health category has seen a notable rise in usage. This variance is partially offset by favorable Non-Claims Health Care Costs to budget.

Administrative Expenses: December YTD Administrative Expenses are favorable to budget by $0.6M or 0.6% with a 5.3% ALR. Salaries are favorable by $2.2M, driven by savings from vacant positions, employment taxes, benefits, and PTO. Non-Salary Administrative Expenses are unfavorable by $1.6M or 4.8% due to the year-end Loss Adjustment Expense (LAE) reserve.

Non-Operating Revenue/Expenses: December YTD Net Non-Operating Income is $27.2M, which is favorable to budget by $11.2M. The favorability is from the YTD Investment Income of $51.5M, which is favorable to budget by $20.5M due to the higher interest rates. The YTD Other Revenue is $2.4M, slightly below budget by $0.2M. The YTD Non-Operating Expense is $26.7M and is unfavorable to budget by $9.1M due to higher Grant disbursements.

Summary of Results: Overall, the Alliance generated a YTD Net Income of $53.1M, with an MLR of 93.4% and an ALR of 5.3%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Twelfth Month Ending December 31, 2024
(In $000s)
Unaudited as of 1/30/2025

Assets	
Cash	$316,238
Restricted Cash	304
Short Term Investments	1,038,675
Receivables	223,946
Prepaid Expenses	3,324
Other Current Assets	3,860
Total Current Assets	**$1,586,347**
Building, Land, Furniture & Equipment	
Capital Assets	$83,268
Accumulated Depreciation	(47,493)
CIP	666
Lease Receivable	4,133
Subscription Asset net Accum Depr	10,510
Total Non-Current Assets	**51,085**
Total Assets	**$1,637,432**
Liabilities	
Accounts Payable	$178,485
IBNR/Claims Payable	485,189
Provider Incentives Payable	43,459
Other Current Liabilities	11,521
Due to State	18,314
Total Current Liabilities	**$736,968**
Subscription Liabilities	8,687
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$12,586**
Fund Balance	
Fund Balance - Prior	$834,772
Retained Earnings - CY	53,106
Total Fund Balance	**887,878**
Total Liabilities & Fund Balance	**$1,637,432**
Additional Information	
Total Fund Balance	**$887,878**
Board Designated Reserves Target	479,524
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	139,767
Value Based Payments	46,100
Provider Supplemental Payments	152,410
Total Reserves	**874,501**
Total Operating Reserve	**$13,377**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelfth Month Ending December 31, 2024
(In $000s)
Unaudited as of 1/30/2025

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*455,255*	*397,072*	*58,183*	*14.7%*	*5,402,715*	*4,908,292*	*494,423*	*10.1%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$180,046	$133,995	$46,052	34.4%	$1,912,615	$1,655,999	$256,615	15.5%
State Incentive Programs	17,312	-	17,312	100.0%	43,267	-	$43,267	100.0%
Prior Year Revenue*	1,737	-	1,737	100.0%	20,448	-	$20,448	100.0%
Premiums Commercial	476	344	132	38.3%	5,481	4,129	1,352	32.7%
Total Operating Revenue	**$199,572**	**$134,339**	**$65,233**	**48.6%**	**$1,981,811**	**$1,660,129**	**$321,683**	**19.4%**
Medical Expenses								
Inpatient Services (Hospital)	$43,702	$48,382	$4,680	9.7%	$562,376	$560,328	($2,048)	-0.4%
Inpatient Services (LTC)	17,033	11,354	(5,678)	-50.0%	211,013	131,491	(79,522)	-60.5%
Physician Services	46,203	28,124	(18,079)	-64.3%	438,188	325,736	(112,452)	-34.5%
Outpatient Facility	21,357	16,415	(4,942)	-30.1%	259,291	190,114	(69,178)	-36.4%
Other Medical**	32,625	28,289	(4,337)	-15.3%	337,045	324,796	(12,249)	-3.8%
State Incentive Programs	17,312	-	(17,312)	-100.0%	43,267	-	(43,267)	-100.0%
Total Medical Expenses	**$178,232**	**$132,564**	**($45,668)**	**-34.4%**	**$1,851,182**	**$1,532,466**	**($318,717)**	**-20.8%**
Gross Margin	**$21,340**	**$1,775**	**$19,565**	**100.0%**	**$130,629**	**$127,663**	**$2,966**	**2.3%**
Administrative Expenses								
Salaries	$5,942	$6,219	$277	4.5%	$70,222	$72,420	$2,198	3.0%
Professional Fees	506	295	(211)	-71.6%	4,267	3,945	(323)	-8.2%
Purchased Services	921	944	23	2.5%	11,966	11,791	(175)	-1.5%
Supplies & Other	3,261	1,089	(2,172)	-100.0%	13,634	12,004	(1,630)	-13.6%
Occupancy	164	122	(42)	-34.5%	1,488	1,511	23	1.5%
Depreciation/Amortization	231	283	52	18.4%	3,182	3,704	522	14.1%
Total Administrative Expenses	**$11,024**	**$8,952**	**($2,073)**	**-23.2%**	**$104,759**	**$105,376**	**$617**	**0.6%**
Operating Income	**$10,316**	**($7,177)**	**$17,493**	**100.0%**	**$25,870**	**$22,288**	**$3,583**	**16.1%**
Non-Op Income/(Expense)								
Interest	$4,606	$1,858	$2,748	100.0%	$52,312	$28,190	$24,122	85.6%
Gain/(Loss) on Investments	(2,856)	550	(3,406)	-100.0%	(194)	3,300	(3,494)	-100.0%
Bank & Investment Fees	(49)	(36)	(12)	-33.9%	(593)	(436)	(158)	-36.2%
Other Revenues	298	256	43	16.7%	2,386	2,540	(155)	-6.1%
Grants	(6,818)	(1,463)	(5,355)	-100.0%	(26,675)	(17,554)	(9,121)	-52.0%
Total Non-Op Income/(Expense)	**(4,818)**	**1,165**	**(5,983)**	**-100.0%**	**$27,235**	**$16,040**	**$11,195**	**69.8%**
Net Income/(Loss)	**$5,497**	**($6,012)**	**$11,510**	**100.0%**	**$53,106**	**$38,328**	**$14,778**	**38.6%**
MLR	*89.3%*	*98.7%*			*93.4%*	*92.3%*		
ALR	*5.5%*	*6.7%*			*5.3%*	*6.3%*		
Operating Income	*5.2%*	*-5.3%*			*1.3%*	*1.3%*		
Net Income %	*2.8%*	*-4.5%*			*2.7%*	*2.3%*		

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

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelfth Month Ending December 31, 2024
(In PMPM)
Unaudited as of 1/30/2025

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*455,255*	*397,072*	*58,183*	*14.7%*	*5,402,715*	*4,908,292*	*494,423*	*10.1%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$395.48	$337.46	$58.03	17.2%	$354.01	$337.39	$16.62	4.9%
State Incentive Programs	38.03	-	38.03	100.0%	8.01	-	8.01	100.0%
Prior Year Revenue*	3.82	-	3.82	100.0%	3.78	-	3.78	100.0%
Premiums Commercial	1.05	0.87	0.18	20.7%	1.01	0.84	0.17	20.6%
Total Operating Revenue	**$438.37**	**$338.32**	**$100.05**	**29.6%**	**$366.82**	**$338.23**	**$28.59**	**8.5%**
Medical Expenses								
Inpatient Services (Hospital)	$95.99	$121.85	$25.85	21.2%	$104.09	$114.16	$10.07	8.8%
Inpatient Services (LTC)	37.41	28.59	(8.82)	-30.8%	39.06	26.79	(12.27)	-45.8%
Physician Services	101.49	70.83	(30.66)	-43.3%	81.11	66.36	(14.74)	-22.2%
Outpatient Facility	46.91	41.34	(5.57)	-13.5%	47.99	38.73	(9.26)	-23.9%
Other Medical**	71.66	71.24	(0.42)	-0.6%	62.38	66.17	3.79	5.7%
State Incentive Programs	38.03	-	(38.03)	-100.0%	8.01	-	(8.01)	-100.0%
Total Medical Expenses	**$391.50**	**$333.85**	**($57.64)**	**-17.3%**	**$342.64**	**$312.22**	**($30.42)**	**-9.7%**
Gross Margin	**$46.87**	**$4.47**	**$42.40**	**100.0%**	**$24.18**	**$26.01**	**($1.83)**	**-7.0%**
Administrative Expenses								
Salaries	$13.05	$15.66	$2.61	16.7%	$13.00	$14.75	$1.76	11.9%
Professional Fees	1.11	0.74	(0.37)	-49.7%	0.79	0.80	0.01	1.7%
Purchased Services	2.02	2.38	0.36	14.9%	2.21	2.40	0.19	7.8%
Supplies & Other	7.16	2.74	(4.42)	-100.0%	2.52	2.45	(0.08)	-3.2%
Occupancy	0.36	0.31	(0.05)	-17.3%	0.28	0.31	0.03	10.6%
Depreciation/Amortization	0.51	0.71	0.21	28.9%	0.59	0.75	0.17	22.0%
Total Administrative Expenses	**$24.22**	**$22.54**	**($1.67)**	**-7.4%**	**$19.39**	**$21.47**	**$2.08**	**9.7%**
Operating Income	**$22.66**	**($18.07)**	**$40.73**	**100.0%**	**$4.79**	**$4.54**	**$0.25**	**5.5%**

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Twelfth Month Ending December 31, 2024
(In $000s)
Unaudited as of 1/30/2025

	MTD	YTD
Net Income	$5,497	$53,106
Items not requiring the use of cash: Depreciation	251	3,284
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	(4)	(4)
Receivables	(42,642)	267,642
Prepaid Expenses	1,430	(1,097)
Current Assets	(887)	1,746
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(42,099)**	**268,292**
Changes to Payables:		
Accounts Payable	48,900	(227,391)
Other Current Liabilities	602	2,330
Incurred But Not Reported Claims/Claims Payable	108,407	196,815
Provider Incentives Payable	3,826	3,459
Due to State	2,839	7,613
Subscription Liabilities	0	0
Net Changes to Payables	**164,575**	**(17,173)**
Net Cash Provided by (Used in) Operating Activities	**128,224**	**307,508**
Change in Investments	(396)	(192,843)
Other Equipment Acquisitions	(264)	(3,423)
Net Cash Provided by (Used in) Investing Activities	**(660)**	**(196,266)**
Deferred Inflow of Resources	(83)	(83)
Net Cash Provided by (Used in) Financing Activities	**(83)**	**(83)**
Net Increase (Decrease) in Cash & Cash Equivalents	**127,481**	**111,159**
Cash & Cash Equivalents at Beginning of Period	**188,761**	**205,083**
Cash & Cash Equivalents at December 31, 2024	**$316,238**	**$316,238**

Alliance Dashboard

Quarter 4, 2024

Purpose: To provide oversight of health plan performance across all organizational processes, to enable timely and targeted intervention as needed.

Context & Limitations: *Target* and *Threshold* levels are established by Alliance leadership and informed by contractual requirements and best practice standards (where available). This dashboard is produced using composites, meaning the performance of multiple sub-processes is combined for aggregate performance scores. All metrics are normalized to a 100 point scale to create the composites, so *Target* performance is always 100%.

Legend | Target = desirable performance | Threshold = lowest acceptable performance | ≥ to 95% of *Target* | < 95% of *Target* and >*Threshold* | <*Threshold*

Core Processes

Deliver value to our members, providers and community

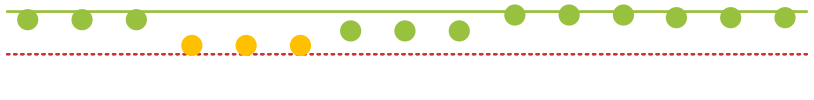
Engage & Support Members

98.8% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 97.8 Help Members Navigate
- 98.7 Member Experience

Manage & Improve Care

99.0% Of Target



SUBPROCESSES
- 97.9 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network

98.3% Of Target

SUBPROCESSES
- 100 Develop the Network
- 96.7 Maintain the Network

Pay Providers

88.9% Of Target

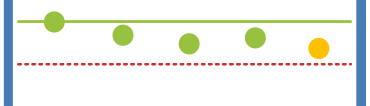
SUBPROCESSES
- 100 Payment Models and Rates
- 75.7 Provider Payments
- 98.2 Payment Integrity
- 81.8 Incentivize Providers

Managerial Processes

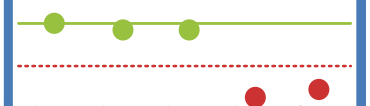
Guide core and support processes

97.3 Enhance Operational Effectiveness

92.1 Manage Compliance Commitments



87.8 Manage Finances

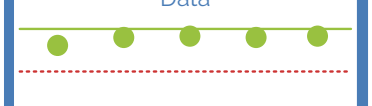


99.6 Manage Governmental & Community Relations

Support Processes *Enable core processes to work*

99.2 Optimize Alliance Workforce

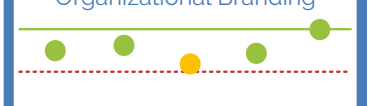
99.3 Manage Data



96.9 Manage Technology

100 Provide Administrative Services

100 Communications & Organizational Branding



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DATE: March 26, 2025

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Voluntary Rate Range Intergovernmental Transfer Program: Rating Period CY 2024

Recommendation. Staff recommends that the Board authorize the Chairperson and the Chief Executive Officer (CEO) to sign the necessary contract amendments to facilitate the Voluntary Rate Range Intergovernmental Transfer (VRRIGT) program for rating period CY 2024 with interested qualified local governmental entities, as approved by DHCS, assuming that staff determines the contract language is appropriate, revenue is sufficient to meet the Alliance's VRRIGT program payment obligations and sufficient funds remain available within the Alliance's actuarial rate range to ensure adequate capitation revenue.

Summary. The VRRIGT program provides an opportunity for interested qualified local governmental entities to use local funds to draw down federal matching funds for Medi-Cal and health care services in the Alliance's service area through increased capitation rates paid to the Alliance. Qualified entities include local government entities with taxing authority. DHCS has issued a Request for Medi-Cal Managed Care Plan's (MCP) Proposal for the Voluntary Rate Range Program for the CY 2024 Rating Period.

Background. With the Board's approval, the Alliance has been facilitating supplemental payments for interested qualified local governmental entities through the Voluntary Intergovernmental Transfer Rate Range program (IGT) since FY 2009-10. Provisions in the federal Medicaid Managed Care regulations restricting DHCS' directing of managed care payments required DHCS to make changes to the IGT program beginning in 2017-18 when DHCS renamed this payment program the Voluntary Rate Range Intergovernmental Transfer Program.

Discussion. The VRRIGT program includes qualified governmental funding entities voluntarily transferring funds to the State via intergovernmental transfer (IGT) which, combined with federal financial participation (FFP), are used to fund capitation payment increases to Managed Care Plans (MCPs). DHCS estimates the available Rate Range funds within each rating region in the Alliance's service area. The Alliance determines the allocation of the rate range funds based upon utilization and historical funding agreements. The interested qualified local entities decide their requested level of financial participation up to the maximum available as estimated by DHCS.

Implementing the Voluntary Rate Range Program for Rating Period CY 2024 The Alliance will develop the necessary documents to implement the Voluntary Rate Range program for rating period CY 2024 including an amendment to the participating providers' current provider agreements.

This amendment is intended to achieve the objectives of the VRRIGT program (i.e., provide increased funding to qualified local providers for health care services) and includes protections for the Alliance to ensure the Alliance is held harmless for its participation in this payment program. The provider agreement facilitates Alliance payments to the participating provider in an amount equal to the Rate Range funded capitation revenue increase. The Alliance does not retain any of the Rate Range funds. However, given the amount of staff resources required to implement the Voluntary Rate Range program, the Alliance may apply a 2% administrative fee on the governmental entities' contribution.

To implement the Rate Range program, DHCS calculates new capitation rates for the Alliance to equal the amount of the qualified governmental entities' contribution plus the FFP. DHCS develops an amendment to the Alliance Medi-Cal contract to implement these capitation rate increases. Alliance staff review the proposed rates to ensure they are sufficient to meet the Alliance's payment obligation under the VRRIGT agreement.

The Alliance is working with the following qualified local governmental entities to determine participation interest in the Rate Range Program for rating period CY 2024:

- County of Santa Cruz
- County of Monterey
- Salinas Valley Health System
- County of Merced
- San Benito Health Care District
- John C Fremont Healthcare District
- Pajaro Valley Health Care District

Action Required. It is necessary for the Board to authorize the Chairperson and the CEO to sign the implementing agreements, including amendment(s) to the Alliance-DHCS Medi-Cal contract containing VRRIGT capitation rates for the CY 2024 rating period and amendments to the participating provider agreements to enable the supplemental VRRIGT payments.

Fiscal Impact. There is no fiscal impact on the Alliance.

Attachments. N/A

DATE: March 26, 2025

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Policy and Procedure Approval

Recommendation. Staff recommend the Board approve revised Policies and Procedures:

#110-0003 – Letters of Support
#800-0012 – Administrative Decision-Making Controls
#800-0013 – Expenditure Authority

Background. Alliance policies and procedures are reviewed for accuracy and relevance annually. Revisions to policies and procedures that include board delegation of its authorities to staff require Board approval.

Discussion. The following Board approved policies and procedures have been reviewed and revised to incorporate changes necessary to reflect current procedures and require Board approval or to comply with other statutory, contractual or regulatory requirements.

- #110-0003 – Letters of Support which establishes guidelines for responding to a request for a Letter of Support from external entities.

- #800-0012 – Administrative Decision-Making Controls which outlines the policy on administrative decision-making controls.

- #800-0013 – Expenditure Authority which outlines the policy on expenditure authority.

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

Attachments.

1. #110-0003 – Letters of Support
2. #800-0012 – Administrative Decision-Making Controls
3. #800-0013 – Expenditure Authority

	POLICIES AND PROCEDURES
Policy #: 110-0003	**Lead Department:** Government Relations
Title: Letters of Support	
Original Date: 08/27/2019	**Date Published:** 12/18/2024
Approved by: Danita Carlson, Government Relations Director	

Purpose:

To establish guidelines for responding to a request for a Letter of Support from external entities.

Policy:

I. Letter(s) of support (LOS) may be requested from Central California Alliance for Health (the Alliance) by or on behalf of external entities within the Alliance Service Area for things including, but not limited to, grant applications, community initiatives or general endorsement. As a public agency, the Alliance must protect and preserve its name and reputation by ensuring that any endorsement by or support from the Alliance is consistent with the Alliance's mission, vision and values (VMV) and/or aligned with the plan's priority activities. Therefore, requests must be carefully reviewed and considered to ensure such letters of support are in alignment with VMV and priority activities. This policy outlines the processes and guidelines related to requests for LOS.

II. The Alliance may consider requests for LOS from the following types of external entities: community based, non-profit organizations, governmental entities, or not-for-profit health care providers or partners that serve Alliance members or provide services in support of the Alliance VMV or priority activities.

III. The Alliance shall not provide LOS to endorse any commercial product or service, any religion or religious activity, any ballot measure or any candidate for public office.

IV. LOS for any state or federal legislation or policy initiatives must be aligned with board approved Policy Priorities reviewed and approved by the Alliance board. LOS related to legislation or policies in areas not contemplated under the Board's Policy Priorities must be approved by the Board.

V. Requests for LOS meeting the above requirements should be considered based on:

   a. The potential for the LOS to create positive visibility for the Alliance.
   b. Whether the LOS promotes or advocates for positions consistent with the Alliance's VMV and/or board adopted policy priorities.
   c. Whether the LOS conflicts with any Alliance policies, contractual obligations, regulations or laws.
   d. Whether the LOS constitutes any conflict(s) of interest for the Alliance whether real or perceived.
   e. Whether the LOS has a potential or actual financial or business impact on the Alliance.

VI. Requests for LOS from external entities meeting the criteria stated above require approval of the Chief Executive Officer (CEO) after consideration of the above.

VII. The CEO shall report any LOS that have been provided meeting the above criteria and standards to the Alliance Board in writing via CEO Report to the Board at the next regularly scheduled board meeting.

VIII. Requests for LOS not meeting the above criteria and requirements can only be approved by the Alliance board.

Definitions:

I. Alliance Service Area: The Alliance Service Area consists of Santa Cruz, Monterey, Merced, Mariposa and San Benito counties.

II. Letter(s) of Support**:** A LOS is a letter from a partner organization, legislative representative, or other key stakeholder that details a compelling reason why an organization or project is credible and of value to the community or a particular initiative. A LOS may be written from the perspective of a partner who is collaborating on a project, or as a separate entity offering support as a community leader or advisor.
   a. A LOS conveys how the partner will support the project (as applicable), describes the convergence of work between the organizations, and lends credibility to the organization requesting support. It is often submitted with an application for grant funds.
   b. A LOS as defined in this policy is different than a formal partnership agreement, interagency agreement, or memorandum of agreement, which explain each partner's specific responsibilities and use of funds in implementing a project. Therefore, a LOS is not considered a contractual or legal obligation or a monetary pledge. A LOS is also not a letter of commitment, which promises a gift-in-kind to support a project. However, specific commitments may be made in a LOS as deemed appropriate by the CEO. Generally, Alliance LOS are considered a reference in support of an organization or effort, without a promise or offer of any action, compensation, or committal to any plan, project or initiative, unless specifically noted.

Procedures:

The following procedure outlines the process for request, review and fulfillment of a LOS.

1. All requests for LOS should be forwarded to the Executive Assistant – Clerk of the Board (EA-COB) who is the designated lead for tracking and maintaining LOS requests.
2. The LOS request must be approved by the relevant department director (if applicable) prior to being submitted to the EA-COB.
3. The staff member requesting the LOS on behalf of the external organization is responsible for providing all pertinent information including, but not limited to:
   a. The name of the organization seeking a LOS and their contact information;
   b. The reason for the request (e.g., funding application);
   c. The date the LOS is due to the organization;
   d. A template letter provided by the organization, if any; and

   e. Description of the relationship between the organization's work and the Alliance Service Area, programs/lines of business, vision, mission, values and/or scope of services.
4. Requests should be emailed by the department director to the EA-COB with copy to the Government Relations Director (GRD).
5. If approved by the CEO, a final letter will be drafted by the EA-COB or GRD for the CEO's signature.
   a. The EA-COB will prepare the LOS for inclusion in the next month's Board packet.
6. If approval is deemed required by the Board, the GRD or staff designated by the CEO will prepare a report for the Board.
7. If it is determined that a presentation to the Board is appropriate, The GRD or other staff as designated by the CEO will present the report.
   a. The requesting entity's representative may be invited to present directly to the board, at the discretion of the Board Chair, IF the following criteria are met:
      i. The entity requesting the LOS is a public entity and
      ii. The intent of the agenda item is to advance the public benefit, in line with the Alliance's mission/vision/values
8. A portable document format (PDF) copy and hard copy (if needed) of the LOS will be sent to the staff member who submitted the request, unless instructed to be sent directly to the requesting organization's contact.
9. If the request is denied, the EA-COB will prepare a letter for the requestor advising of the denial of the request.

Tracking

1. All LOS are tracked by the EA-COB in the Alliance LOS Tracking document located in the EA-COB's LOS folder.
2. Commitments agreed to by the Alliance, such as provision of data or collaborative participation, are carefully and specifically documented in the LOS Tracking document. Staff requesting LOS are responsible for fulfillment of stated commitment(s).

References:
Alliance Policies:
Impacted Departments:
All Departments
Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract):
DHCS All Plan Letter:
NCQA:
Supersedes:

	POLICIES AND PROCEDURES
Policy #: 110-0003	**Lead Department:** Government Relations
Title: Letters of Support	
Original Date: 08/27/2019	**Date Published:** 12/18/2024
Approved by: Danita Carlson, Government Relations Director	

Policy 104-0004 – Letters of Support
Other References:
Attachments:

Lines of Business (LOB) This Policy Applies To	**LOB Effective Dates**
☐ DSNP	(01/01/2026- present)
☐ Medi-Cal	(01/01/1996 – present)
☐ Alliance Care In-Home Supportive Services (IHSS)	(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
09/02/2021	09/02/2021	Danita Carlson, Government Relations Director	Ilsa Branch, Government Relations Manager
08/15/2023	08/15/2023	Evan Eurs, Government Relations Specialist	Danita Carlson, Government Relations Director
12/16/2024	12/16/2024	Daisy Gomez, Temporary Government Relations Specialist	Danita Carlson, Government Relations Director

	POLICIES AND PROCEDURES
Policy #: 800-0012	**Lead Department:** Compliance
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

Purpose:
To outline the policy of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) on administrative decision-making controls, as approved by the Alliance Board of Commissioners (the Board).

Policy:
Alliance Bylaws (Bylaws) provide that the Chief Executive Officer (CEO) has the authority to carry out the policies, procedures, and practices of the Board, and act as the representative of the Alliance in all matters that the Board has not authorized someone else to do.[i] Any authority not specifically addressed by the Board, the Bylaws, or this policy is reserved to the CEO or the CEO's designee.

Definitions:
Administrative Controls – Procedures necessary to ensure decisions are made in compliance with requirements governing Alliance operations.

Unavailable – Absent and unreachable due to vacation, illness, injury, or other circumstance inhibiting decision-making abilities essential to support business operations.

Procedures:

1. Advocacy
    a. The Board delegates authority to Alliance staff for representation in advocacy matters relating to federal and state legislation.
        i. With the exception of lobbying, the Alliance is prohibited from partisan advocacy as a public agency. As such, Board advocacy shall focus on policy and legislative issues, including, but not limited to, member eligibility and/or benefits, Medi-Cal provider payments, Medi-Cal health plan revenue, and Medi-Cal managed care policies and initiatives.[ii]
    b. The CEO, or designee, maintains authority to represent the Alliance in professional or industry associations, including but not limited to, the Association for Community Affiliated Plans (ACAP), the California Association of Health Plans (CAHP), and the Local Health Plans of California (LHPC).

2. Legal Settlements

a. The CEO maintains authority to approve legal settlements related to actions against the Alliance, subject to expenditure authority outlined in policy 800-0013 – Expenditure Authority. The CEO will keep the Board apprised of any issue of pending or potential litigation up to the limits of the CEO's expenditure authority.[iii]

3. Alliance Staff
    a. The CEO will submit to the Board, annually, for approval, an administrative budget that provides for necessary personnel, equipment, supplies, and other necessary expenditures to ensure that the work of the Alliance can be carried out effectively and efficiently.
    b. The Board delegates to the CEO the responsibility for the management and hiring of personnel, subject to personnel policies, which are the responsibility of the CEO to establish and carry out. In doing so, the CEO will ensure all applicable laws, regulations and rules regarding personnel are followed and documented in personnel policies.
    c. Only the CEO has authority to approve involuntary staff terminations. In these instances, the Human Resources Director (HRD) recommends separation to the Chief Administrative Officer (CAO). If approved, the CAO forwards the separation request to the CEO for final approval.
    d. The Chief Financial Officer (CFO) maintains authority to approve and sign the payroll register.

4. Executive Line of Succession
    a. Specific authorities may be delegated in accordance with this policy if the CEO is Unavailable, as defined in this policy.
    b. The CEO may proactively activate the Executive Line of Succession or delegate their authority to any individual listed in the Executive Line of Succession (Alternate) if they anticipate being Unavailable. In the event that the CEO activates the Executive Line of Succession, the CEO may opt to wholesale delegate responsibilities in accordance with the Executive Line of Succession or may choose to delegate specific functions to Alternates.
        i. Should the CEO choose to delegate specific functions to certain Alternates, this will be documented vida memorandum and distributed to the Board and Alliance Chiefs.

c. In the event that the Executive Line of Succession is activated on behalf of the CEO, Alternates listed in the table below may act in the CEO's absence, in accordance with this policy, beginning with the First Alternate and progressing thorough each alternate, as necessary.

Primary	CEO
First Alternate	COO
Second Alternate	CFO
Third Alternate	CAO

   i. Only the Alternates named above are included in the Executive Line of Succession. The Board assumes authority when all named Alternates are Unavailable.

d. Alternates acting in accordance with the Executive Line of Succession shall retain such authorities until:
   i. Authority is resumed by the Primary; or
   ii. Authority is assumed by the Board.

e. The Acting CEO must notify the Board, Alliance Chiefs, and Department Directors in the event the Executive Line of Succession is activated based on CEO Unavailability due to incapacity, as determined by the Acting CEO.

f. For any action in which two Officers' signatures or approvals are required, and in the event the authorized Officer is Unavailable to provide approval, the Executive Line of Succession may be used to obtain the signature or approval of the next Alternate in the Executive Line of Succession.

g. All Designees, including Alternates, must provide approvals and signatures in accordance with the Alliance's applicable internal policies and procedures.

References:

Alliance Policies:

101-1028 – Paid Time Off
101-1032 – Recruitment and Selection
101-1043 – Job Changes - Promotion – Reclassification
101-1051 – Bilingual Compensation Program
800-0013 – Expenditure Authority
106-1044 – Tuition Reimbursement

	**POLICIES AND PROCEDURES**
Policy #: 800-0012	**Lead Department:** Compliance
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

500-3053 - Remote Access to Alliance Systems
701-1400 – Accounts Payable
701-1500 – Expense Reimbursement
701-4400 – Purchase Orders

Impacted Departments:
Executive
Finance Division
Government Relations
Human Resources
Legal Services

Regulatory:
Legislative:
Contractual:
DHCS All Plan or Policy Letter:
NCQA:
Supersedes:
Policy 105-0012 –Administrative Decision-Making Controls
Other References:
By-Laws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission
2023 Policy Priorities presented to the Board February 22, 2023
Alliance Compliance Plan
Attachments:

Lines of Business This Policy Applies To	**LOB Effective Dates**
☒ Medi-Cal	(01/01/1996 – present)
☒ Alliance Care IHSS	(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
			Jenifer Mandella
04/16/2019	05/13/2019	Ilsa Branch, Compliance Manager	Jenifer Mandella, Compliance Officer
03/04/2021	03/04/2021	Jenifer Mandella, Compliance Officer	Alliance Board

	POLICIES AND PROCEDURES
Policy #: 800-0012	**Lead Department:** Compliance
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

12/20/2022			Jenifer Mandella, Chief Compliance Officer
08/23/2023	08/23/2023	Dave McDonough, Legal Services Director	Alliance Board
11/04/2024	11/04/2024	Dave McDonough, Legal Services Director	Alliance Board

[i] SC-M-MMC Bylaws, Article IX, Provisions 9.2.1 and 9.2.2
[ii] 2023 Policy Priorities presented to the Board February 22, 2023
[iii] Alliance Expenditure and Signature Authority Policy, adopted by the Board on 6/28/2000, and revised 9/26/2012 and 3/28/2018

	POLICIES AND PROCEDURES
Policy #: 800-0013	**Lead Department:** Legal Services
Title: Expenditure Authority	
Original Date: 03/12/2018	**Date Published:** 02/03/2025
Approved by: Alliance Board	

Purpose:
To outline Central California Alliance for Health's (the Alliance's) policy on expenditure authority, as approved by the Board of Commissioners (Board).

Policy:
Alliance Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Bylaws) provide that the Alliance Board may authorize officers, agents or employees to authorize expenditures on behalf of the Commission.[i]

Expenditures authorized pursuant to the Board's authority, as identified in this policy, may only be authorized by the person expressly authorized to approve. An Alliance officer, agent, or employee may not expend funds unless the Board has authorized such expenditure or delegated its power to that office, agent, or employee, subject to express general or specific standards.

The Chief Executive Officer (CEO) has the authority to carry out the policies, procedures and practices of the Board, and acts as the representative of the Commission in all matters that the Commission has not authorized someone else to do.[ii]

Definitions:
Budgeted expenditures – All items that are included within the Administrative and Medical Budgets, as approved by the Board.

Non-operating budget expenditures – Budgeted expenditures for non-operating items, such as investments and Alliance Medi-Cal Capacity Grant Program.

Expenditure Authority – Authority, as given by the Board, to approve expenditures.

Expenditure – The act of spending money for goods or services to attain new assets, improve existing ones, or reduce a liability.

Non-budgeted expenditures – All items that are not approved by the Board within the Administrative or Medical Budgets.

Unavailable – Absent and unreachable due to vacation, illness, injury, or other circumstance inhibiting decision-making abilities essential to support business operations.

Procedures:
1. Budget:
   a. The Board maintains authority to approve the annual Alliance Medical budget, including, but not limited to, provider payment rates, incentives and new payment models, and conceptual design pilot programs.

i. The Chief Financial Officer (CFO) is responsible for managing medical spend within each category in the Medical budget. Any variances from the original categorization must be approved by the CFO or designee through submission of a Medical Budget Allocation Approval Form.

b. The Board maintains authority to approve the annual Alliance Administrative budget.
   i. The Board maintains authority to approve Non-budgeted expenditures of $150,000 and over.
   ii. For non-budgeted expenditures, Division Chiefs can approve up to $9,999.99, the Chief Financial Officer (CFO) can approve up to $49,999.99, and the CEO can approve up to $149,999.99, as outlined in the grid below.

c. Medi-Cal Capacity Grant Program budgets are approved by the Board and implemented via Alliance policy numbers 107-0001 through 107-0004.

d. DHCS incentives programs are approved by the Board and implemented via Alliance policy number 450-0001.

e. The CEO maintains authority to implement both the Administrative and Medical budgets.[iii]
   i. The CFO is responsible for appropriate internal controls, financial oversight and monitoring, identifying controls deficiencies, ensuring necessary corrections related to provider payments, and effective management of medical cost and budget.
   ii. The Chief Operating Officer (COO) is responsible for accuracy and timeliness of claims processing in compliance with the provider contracts and ensuring appropriate system and process controls over authorization of claims payment.
   iii. Managers and above approve staff reimbursement requests, as outlined in Alliance policy 701-1500 – Expense Reimbursement.
      1. The CFO has authority to approve the reimbursement of expenses incurred by the CEO.
   iv. Authority for approval of all other expenditures subject to Purchase Order or invoice requirements is outlined in the grid below.

	Expenditure Approval Authority							
Expenditure	Budget Status	Unit Managers	Department Directors	Non-Chiefs with Directors as direct reports[iv]	Division Chiefs	CFO	CEO	Alliance Board
$0 - $2,499.99	Budgeted expenditures	X						
	Non-budgeted expenditures				X			

$2,500 - $9,999.99	Budgeted expenditures		X					
	Non-budgeted expenditures				X			
$10,000 - $49,999.99	Budgeted expenditures			X	X			
	Non-budgeted expenditures					X		
$50,000 - $149,999.99	Budgeted expenditures					X		
	Non-budgeted expenditures						X	
> $150,000	Budgeted expenditures						X	
	Non-budgeted expenditures							X
Notes: **1)** Grid reflects minimum approval level required **2)** Grid excludes claims payments and PAFs								

2. Executive Line of Succession:
   a. Expenditure authority may be delegated in accordance with this policy if the CEO is Unavailable as defined in this policy. Alliance Policy 800-0012 - Administrative Decision-Making Controls contains the Executive Line of Succession.

References:

Alliance Policies:
- 800-0012 – Administrative Decision-Making Controls
- 701-1500 – Expense Reimbursement

Impacted Departments:
- Administration (CEO)
- Finance Division

Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract):
DHCS All Plan Letter:
NCQA:
Supersedes:
- Policy 105-0013 – Expenditure Authority
- Policy 105-0003 - Contract Signature Authority, Expenditure Authority, and Decision-Making Administrative Controls

	POLICIES AND PROCEDURES
Policy #: 800-0013	**Lead Department:** Legal Services
Title: Expenditure Authority	
Original Date: 03/12/2018	**Date Published:** 02/03/2025
Approved by: Alliance Board	

Other References:

By-Laws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, adopted October 23, 2023.

Board-Approved Contract Signature Authority Policy, number 800-0014.

Attachments:

Lines of Business This Policy Applies To

☐ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
04/20/2020	04/20/2020	Kat Reddell, Compliance Specialist	Luis Somoza, Interim Compliance Officer
06/27/2022	06/27/2022	Jenifer Mandella, Compliance Officer	Jenifer Mandella, Compliance Officer
08/23/2023	08/23/2023	Dave McDonough, Legal Services Director	Alliance Board
02/-8/2024	02/08/2024	Dave McDonough, Legal Services Director	Jenifer Mandella, Compliance Officer
12/18/2024	12/18/2024	Dave McDonough, Legal Services Director	Jenifer Mandella, Compliance Officer
02/03/2025	02/03/2025	Stephanie Vue, Regulatory Affairs Specialist	Dave McDonough, Legal Services Director

[i] Commission Bylaws, Article X, Provision 10.1
[ii] Commission Bylaws, Article IX, Provision 9.2.1
[iii] Commission Bylaws, Article IX, Provision 9.2.1
[iv] An example is the Health Services Officer

DATE: March 26, 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 individuals 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 individuals have indicated interest in participating on MSAG.

Name	Affiliation	County
Janna Espinoza	Consumer Commissioner	Monterey
Humberto Carrillo	Consumer	Monterey
Frances Wong	Consumer	Monterey
Candi Walker	Consumer	Santa Cruz

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

Attachments. N/A

DATE: March 26, 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 appointment 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
Adriana Zoghlami	Community Parter	San Benito

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

Attachments. N/A

DATE: March 26, 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 individuals 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 individuals have indicated interest in participating on the WCMFAC.

Name	Affiliation	County
Katrina Hodges	Parent/Guardian	Monterey
Alicia Zambrano	Parent/Guardian	Merced

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

Attachments. N/A

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

Meeting Minutes

Wednesday, January 22, 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:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

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

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Commissioners Absent:

Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Ms. Tracey Belton,	County Health and Human Services Agency Director
Mr. Mark Hendrickson	Assistant County Executive Officer

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
Mr. Cecil Newton,	Chief Information Officer
Ms. Van Wong,	Chief Operating Officer
Ms. Anne Brereton,	Deputy County Counsel, Monterey County
Ms. Hayley Tut,	Interim Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 3:03 p.m.

Chair Jimenez announced a new board member. Mark Hendrickson was appointed as the acting Director of Public Health to serve on the Santa Cruz, Monterey, Merced, San Benito, Mariposa managed Medical Care Commission for an unexpired term ending March 31, 2027, or until a new Director of Public Health in Merced County is appointed. He was unable to attend the meeting today.

[Commissioner Keheley arrived at this time: 3:05 p.m.]
[Commissioner Abasta-Cummings arrived at this time: 3:07 p.m.]

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

Chair Jimenez opened the floor for any members of the public to address the Commission on items not listed on the agenda. There were no public comments.

[Commissioner Hernandez arrived at this time: 3:10 p.m.]

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Commissioners shared updates, including the loss of a physician in the community and concerns about recent executive orders affecting healthcare and immigration.

Dr. Quinn, a long-time physiatrist who contributed significantly to the community and the Alliance recently passed. Dr. Quinn was active in the senior and disabled community and served on the physician advisory group.

Commissioners expressed concerns about recent executive orders, including one that recognizes only two sexes and another that revokes the prohibition on ICE arrests in sensitive locations like schools and hospitals. These orders have caused fear and uncertainty in the community.

Commissioners discussed the importance of supporting the community during these challenging times. They highlighted efforts by local school districts to reassure families about the safety of their children and the distribution of red ICE cards to inform individuals of their rights.

[Commissioner Rabago arrived at this time: 3:13 p.m.]
[Commissioner Morales arrived at this time: 3:15 p.m.]
[Commissioner Askew arrived at this time: 3:16 p.m.]

4. Comments and announcements by Chief Executive Officer.

The written CEO Report was included in the Commission packet.
Mr. Schrader provided a verbal summary of the governor's proposed FY 2025/26 state budget, which was released in January, focusing on the Medi-Cal program. He highlighted that the governor's proposed budget:

- Assumes no changes to Medi-Cal eligibility for those with unsatisfactory immigration status;
- Projects that total MCal enrollment will be 3% lower for FY 2025-26 than for FY 2024/25, due to the coming end in June 2025 of the pandemic unwinding flexibilities that have resulted in fewer discontinuances;
- Continues ECM and community supports, including the addition of transitional rent, as well as the MCO Tax targeted rate increases that were implemented in 2024; and
- Requires that, based on proposition 35 by voters in November 2024, DHCS consults with a stakeholder advisory committee to develop and implement the program.

Mr, Schrader noted that there is concern that the May Revise could bring unfavorable news as compared to this January version of the budget, since the governor cautions that stated policy changes by the incoming federal administration could negatively affect state revenues. Additionally, the budget anticipates shortfalls in subsequent fiscal years driven by expenditures outpacing revenue.

Mr. Schrader described that item 8 on the agenda is to obtain Board approval for staff to submit the required application for our Medicare D-SNP to CMS by the February 12 deadline, so that the program can start on January 1, 2026.

Mr. Schrader described that item 9 on the agenda is an amendment to our Medi-Cal contract that includes our capitation rates from DHCS for the calendar year 2025. He reported that there has been positive movement since staff presented the Alliance CY 2025 budget to the Board in December. Since then, DHCS increased our rates by another 5.1% over what we included in the budget. This additional 5.1% is expected to prevent the Alliance from experiencing the operational loss that we projected in our 2025 budget.

Consent Agenda Items: (5. – 11F.): 3:30 p.m.

Chair Jimenez opened the floor for approval of Consent Agenda items noting that we would need to vote on consent item 7 separately due to possible conflicts of interest. Consent agenda items 5 through 11F were reviewed.

MOTION: Commissioner Molesky moved to approve Consent Agenda items 5 through 6 and 8 through 11D, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Aguirre, Askew, Bizzini, Cuevas, Espinoza, Hernandez, Jimenez, Keheley, Molesky, Morales, Pedrozo, Rabago and Radner.

Noes: None.

Absent: Commissioners Armstrong, Belton, and Hendrickson

Abstain: None.

Chair Jimenez opened the floor for approval of Consent Agenda item 7.

MOTION: Commissioner Askew moved to approve Consent Agenda items 7, seconded by Commissioner Espinosa.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Armstrong, Belton, and Hendrickson

Abstain: Commissioners Abasta-Cummings Aguirre, Cuevas, Hernandez, Jimenez, Morales, Rabago and Radner.

Regular Agenda Items: (12. – 13.): 3:34 p.m.

Chair Jimenez made a statement that we will be starting with Agenda Item 13 instead of 12.

13. Consider approving Medi-Cal Grant Program 2025 Investment Plan (3:34 – 4:05 p.m.)

Ms. Jessica Finney, Community Grants Director, presented the 2025 investment plan for the Medi-Cal Capacity Grant Program, outlining the available funding, proposed allocations, and strategic priorities. The board approved the plan with some abstentions.

Highlighting the available funding of $89.9 million and the proposed allocation of $35 million for 2025, plan includes strategic priorities such as healthcare workforce development, healthcare infrastructure, and social drivers of health.

Ms. Finney outlined the proposed allocation percentages for the 2025 investment plan, with 80% allocated to access to care, 10% to healthy beginnings, 5% to healthy communities, and 5% to an innovation fund. The plan aims to address identified community needs and streamline funding opportunities.

Ms. Finney reviewed the highlights of the 2024 grant program, including the awarding of $46 million across 14 funding opportunities. The program focused on workforce development, capital investments, and targeted interventions to close care gaps and support community health workers and doulas.

An approval would allow for the implementation of the proposed allocations and strategic priorities for the year.

MOTION: Commissioner Bizzini moved to approve the Grant Program 2025 investment Plan seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Askew, Bizzini, Cuevas, Espinoza, Jimenez, Keheley, Morales, Pedrozo, Rabago and Radner.

Noes: None.

Absent: Commissioners Armstrong, Belton, and Hendrickson

Abstain: Commissioners Aguirre, Hernandez, Molesky,

[Commissioner Abasta-Cummings departed at this time: 4:05 p.m.]

12. Discuss Alliance 2022-2026 Strategic Plan Update (4:05 – 4:48 p.m.)

Ms. Van Wong. Chief Operation Officer, reviewed the 2024 strategic performance and the 2025 strategic objectives, focusing on pediatric measures, cultural and linguistic services, behavioral health insourcing, and care for high-risk members.

Ms. Wong reviewed the 2024 strategic performance, highlighting improvements in pediatric measures, with three out of six measures projected to meet or exceed the 50th percentile. The review also covered the performance of cultural and linguistic services, behavioral health insourcing, and care for high-risk members.

She outlined the 2025 strategic objectives, including maintaining and improving pediatric measures, increasing the use of interpretive services for non-English speaking members, and ensuring the successful insourcing of behavioral health services by July 1, 2025.

She discussed the goals for behavioral health insourcing, including developing an adequate network, ensuring operational readiness, and maintaining or improving utilization rates. The objectives also include achieving performance metrics similar to other Alliance operations.

Ms. Wong emphasized the importance of improving care for high-risk members with complex medical and social needs. The 2025 objectives include enrolling at least 3.5% of the total population in the Enhanced Care Management (ECM) program and ensuring 90% engagement with monthly visits.

[Commissioner Aguirre departed at this time: 4:25 p.m.]

The Commission adjourned its regular meeting of January 22, 2025, at 4:48 p.m. to the regular meeting of February 26, 2025, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister, and Mariposa. unless otherwise noted.

Respectfully submitted,

Ms. Hayley Tut
Interim Clerk of the Board/Executive Assistant

Minutes were supported by AI-generated content.

Meeting Minutes

Monday, November 4, 2024

Teleconference Meeting

Members Present:

Janna Espinoza	Monterey County – CCS WCM Family Member, WCMFAC Chair
Frances Wong	Monterey County – CCS WCM Family Member
Susan Skotzke	Santa Cruz County – CCS WCM Family Member
Manuel López Mejia	Monterey County – CCS WCM Family Member
Paloma Barraza	Monterey County – CCS WCM Family Member
Kevin Smith	Merced County – Local Consumer Advocate
Kim Pierce	Monterey County – Local Consumer Advocate
Michael Molesky	Santa Cruz County – Alliance Commissioner

Members Absent:

Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Heloisa Junqueira, MD	Monterey County – Provider
Irma Espinoza	Merced County – CCS WCM Family Member

Staff Present:

Cristina Farias-Gonzalez	Care Coordination Supervisor - Pediatric
Dennis Hsieh, MD, JD	Chief Medical Officer
Dianna Myers, MD	Medical Director
Jenna Stromsoe, RN	Complex Case Management Supervisor - Pediatric
Kayla Zoliniak	Community Engagement Administrative Specialist
Kelsey Riggs, RN	Complex Case Management Manager - Pediatric
Lilia Chagolla	Member Services Director
Ronita Margain	Community Engagement Director
Tammy Brass, RN	Utilization Management Director

Guest:

Anna Rubaclava	Merced County
Christine Betts	Monterey County

Denise Sanford Santa Cruz County

1. **Call to Order by Chairperson Espinoza.**
   Chairperson Espinoza called the meeting to order.

   Committee introductions and roll call was taken.

2. **Oral Communications.**
   Chairperson Espinoza opened the floor for any members of the public to address the Committee on items not listed on the agenda. No oral communications from the public.

Consent Agenda Items:

3. **Accept WCMFAC Meeting Minutes from Previous Meeting**
   J. Espinoza opened the floor for approval of the meeting minutes of the previous meeting on July 15, 2024. Minutes were approved with no further edits.

Regular Agenda Items:

4. **Election of Chairperson and Vice Chairperson**
   Commissioner Molesky nominated Chairperson Espinoza for Chairperson. Chairperson Espinoza accepted the nomination.

   Chairperson Espinoza nominated Kevin Smith for Vice Chairperson. Kevin Smith accepted the nomination.

   Action: Nominations were approved. Chairperson Espinoza was elected to serve as Chairperson and Kevin Smith was elected to serve as Vice Chairperson.

5. **CCS Advisory Group Representative Report**
   S. Skotzke provided updates on topics of concern for the CCS population. Health plans shared lead readiness for members under 21 years of age. Plans shared areas of success and opportunities for improvement for Family Advisory Boards; several ideas were shared including meeting times, incentives, and outreach strategies. The meeting covered CCS compliance in the five domains: access to care administration, authorization, case management, care coordination, and eligibility. CCS Enrollment data for August 2023 – 2024 is available on the DHCS website. Children Now launched a website at www.childrennow.org.

6. **Recent Issues | Impact of Members**
   Chairperson Espinoza inquired about the time of the meeting and if the current time was a barrier for potential committee members and wondered if evenings or weekends may be more accessible for families. Committee member shared they appreciate the meeting is held via teleconference and they can call in from anywhere.

Dr. Myers extended an invitation for a committee member to speak at a Whole Child Model Clinical Advisory Committee meeting to speak to pediatricians who may be able to help recruit WCMFAC committee members. Chairperson Espinoza confirmed interest.

Committee member raised the topic of the 21 – 26-year-old transition. There was conversation around resources and a roadmap for the aging out process.

Committee member expressed they were pleased with the Enhanced Care Management (ECM) providers involved.

Committee member expressed concern around authorizations. Two concerns were the frequency of needing items replaced and the time to approval versus outgrowing the item.

Committee member expressed concern around the lack of allied providers. Two examples were the lack of access to orthotists in Santa Cruz County and only one wheelchair vendor for the five-county service area. One reason cited was the cost of living and not being able to replace individuals that retire or move. Committee member asked what the Alliance is doing to keep providers once recruited. T. Brass, Utilization Manager, confirmed orthotics DME and complex DME are challenge areas and recommended inviting the Providers Services team to a WCMFAC meeting.

The Alliance is making updates to the authorization process to reduce the burden.

Committee member shared an experience with a special agreement between a provider and vendor that the Alliance didn't know about which further complicated the process.

Committee members shared their experiences and discussed issues around the burden for families and providers to get necessary equipment and enquired about the ability to order from companies like Amazon when the necessary item is available. T. Brass confirmed the Alliance is trying creative solutions.

Committee members discussed the idea of a way to donate outgrown DME. One committee member recalled a previous discussion that identified space and liability as limitations.

Committee member shared positive experience being reimbursed for eligible DME.

Committee member enquired about the status of the ADA concern at the MTU. The Alliance responded that it may be while before an update can be provided as it is outside the Alliance's scope.

7. CCS Expansion

K. Riggs, RN, Complex Case Management Manager – Pediatric, shared the Alliance is anticipating 400 new children in Mariposa and San Benito. Alliance staff have been building relationships with families and CCS staff in the new counties. Member noticing and outbound calls from Member Services have begun. The Alliance will be holding provider trainings to share information about the Whole Child Model expansion. WCMFAC has been shared with CCS partners.

All deliverables submitted to the Department of Health Care Services so far have been approved. Memorandums of Understanding are with the Board of Supervisors for signature in each county.

8. 2024 Roadmap

R. Margain, Community Engagement Director, confirmed the Whole Child Model Resource Guide was updated and shared with families and community partners including SELPA, IHSS providers, and clinics.

Commissioner Espinoza recommended emergency preparedness as a future agenda topic with resources from the Alliance and community organizations. Committee member provided examples of PG&E's generator program and Red Cross' housing assistance. Santa Cruz County recently updated their emergency protocols. Committee member shared about the Access and Functional Needs Assessment and Laney Davidson as potential resources.

Committee members may suggest agenda topics at any time.

Committee member shared another committee they serve on offers a higher compensation amount and recommended the Alliance considers this for WCMFAC.

9. 2025 Schedule

K. Zoliniak proposed a quarterly cadence for WCMFAC meetings. There was discussion about the potential change. A committee member proposed creating subcommittees to assist with advancing WCMFAC goals. The proposed schedule was accepted by the majority of committee members present and will be submitted to the Alliance Board.

Review Action Items
R. Margain reviewed the actions items.

Future Agenda Items

- WCMFAC meeting time and outreach to potential WCMFAC members.
- WCM CCS aging out process.
- Network adequacy and network development strategies.
- Emergency preparedness.

Adjourn:
The meeting adjourned at 3:18 p.m.

The meeting minutes are respectfully submitted by Kayla Zoliniak, Community Engagement Administrative Specialist.

Next Meeting: To be determined.

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, December 18, 2024
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anita Guevin	Medicare Compliance Program Manager
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Fabian Licerio	Risk Adjustment Director
Jenifer Mandella (Chair)	Chief Compliance Officer
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Krishan Patel	Data Analytics Services Director
Kristynn Sullivan	Program Development Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Marwan Kanafani	Health Services Officer
Michael Schrader	Chief Executive Officer
Navneet Sachdeva	Pharmacy Director
Omar Guzman	Chief Health Equity Officer
Ryan Inlow	Facilities & Administrative Services Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Tammy Hoeffel	Enhanced Health Services Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Anne Lee	Financial Planning and Analysis Director

Committee Members Excused:

Bryan Smith	Claims Director
Dennis Hsieh	Deputy Chief Medical Director
Dianna Myers	Medical Director
Jessica Finney	Community Grants Director
Kate Knutson	Compliance Manager
Michael Wang	Medical Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director
Ryan Markley	Compliance Director
Tammy Brass	Utilization Management Director

Ad-Hoc Attendees:

Anita Guevin	Medicare Compliance Program Manager
Daisy Gomez	Government Relations Specialist (Temp)
Ka Vang	Compliance Specialist
Kat Reddell	Compliance Specialist
Lisa Heffner	Contracts Manager
Margarita Shull	Program Integrity Specialist
Nicolette Shalita Vega	NCQA Compliance Program Manager
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

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

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

2. **Review and Approval of November 20, 2024 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of November 20, 2024 meeting.

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

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. NCQA Accreditation Update

Shalita-Vega, NCQA Compliance Program Manager, presented an update on the progress towards the Plan's NCQA accreditation. Shalita-Vega reviewed the accreditation timeline and deliverables, provided guidance on documentation standards, and highlighted the actions needed from business units to meet NCQA standards. Shalita-Vega and Mandella requested leadership support to ensure staff are engaging in the work and completing action items. Committee members agreed to provide the needed support and requested a list of outstanding tasks so they could focus staff efforts in those areas. The Executive team (ET) also requested a presentation and further discussion in the ET Tactical meeting.

2. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q3 2024 Program Integrity Activity Report. Siwajek reported that 43 concerns were referred to Program Integrity in the quarter, 27 of which resulted in the opening of a matter under investigation (MUI). There were 66 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting the following:

- 17 provider related
- 3 member related
- 3 state request
- 1 waste referral
- 3 categorized as other

Siwajek reported performance of the Program Integrity performance metrics from the Q3 2024 Alliance Dashboard noting that both efficiency and quality metrics met target performance.

Siwajek reviewed 1 exemplar case regarding provision of COVID testing by a non-contracted provider. She noted that Program Integrity staff implemented a new process to conduct member interviews, described interactions with regulatory and law enforcement agencies on the matter, and next steps for the investigation.

Siwajek reviewed Q324 Program Integrity Financials reporting the total requested recoupment was $8,992.42 and completed recoupment was $6,686.50.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2024 Program Integrity Report.

3. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist III, presented the Q3 2024 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 3 of the 5 planned internal audits were

conducted, all of which received a passing score. Two audits remained in progress during the reporting period and outcomes will be presented at a later date.

Halward reported performance metrics from the Q3 2024 Alliance Dashboard noting that both efficiency metrics met target performance; quality metrics are reported annually and unavailable for this reporting period. Halward informed the Committee of upcoming changes to internal audit and monitoring metrics, noting that Timely Management Response will be replaced by a new efficiency metrics for timely resolution of corrective action plans (CAPs).

Halward reviewed one exemplar internal audit, which verified that translation requests were addressed timely and completely. Halward also reviewed outcomes of the monitoring of 35 Alliance Dashboard metrics related to regulatory requirements, noting that all 33 metrics met their established thresholds during the review period of Q1 2024 – Q2 2024.

Halward provided an overview of changes to the dashboard monitoring process, As a result of the shift from quarterly to monthly dashboard reporting, thresholds for CAP implementation were adjusted. In addition, to align with Medicare standards, CAPs will be implemented for all failed metrics in the future.

Halward reviewed the Q4 2024 Internal Audit Workplan identifying upcoming planned audit activity, noting a focus on areas typically audited by regulators. Halward noted that work was under way to identify and schedule audits for Q1 2025.

Halward reported updates on regulatory audits. The plan is currently on a CAP from the 2023 DHCS Focused Audit on Behavioral Health and Transportation and is making good progress towards resolution. The Alliance is also preparing for an additional 2 audits in early 2025: the 2025 DHCS Financial Examination and the 2025 DHCS Medical audit.

Finally, Halward reviewed CAP activities for Q3 2024 reporting on activities related to the internal CAPs, as follows:

- Provider Payment Accuracy – staff are working with a consultant to prioritize and implement interventions to ensure effective payment implementation and ongoing auditing.
- Provider Preventable Conditions – new reporting was put in place in Q3 and staff will recommend closure of the CAP.
- Adult Complex Case Management (CCM) - implemented to ensure capacity to all eligible members who desire CCM can be enrolled, and to ensure alignment with NCQA standards; staff conducted root cause and are identifying actions to address those.
- Enhanced Case Management Encounter and Capitation Monitoring – process improvements are in place to ensure that services billed were rendered and encounter data is being submitted.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2024 Internal A&M Quarterly Report.

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4. CAPs Review and Discussion

Mandella, Chief Compliance Officer, provided an update on the PCP to FTE Ratio CAP issued by DHCS. Staff audited the November 274 and identified LOOSA (Local Out of Service Area) PCPs were omitted from the state reporting. A revised file was submitted to DHCS on 12/10/2024. In the interim, our internal analysis shows that we do meet the ratio requirements. This will remain open as DHCS reviews our most recently submitted file.

The meeting adjourned at 9:56 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Meeting Minutes

Thursday, May 9, 2024
10 – 11:30 a.m.

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

Members Present:	
Alma Mandujano-Orta	Community Advocate
Doris Drost	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
John Beleutz	Community Advocate
Juana Chávez de Guízar	Consumer
Michael Molesky	Consumer, Commissioner
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate

Members Absent:	
Candi Walker	Consumer
Carolina Meraz	Consumer
Francis Wong	Consumer
Humberto Carrillo	Consumer
Janna Espinoza	Consumer, Commissioner

Juana Chávez de Guízar	Consumer
Margaret O'Shea	Consumer
Mimi Park	Consumer

Staff Present:

Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Gabriela Chavez	Community Engagement Program Manager
Janet Kruppner	Provider Data Manager
Jessie Dybdahl,	Providers Services Director
Jessie Newton, RN	Continuum of Health Manager - Adult
Julie Norton	Behavioral Health Program Manager
Maria Colomer	Community Engagement Coordinator
Maura Middleton	MS Administrative Assistant
Ronita Margain	Community Engagement Director
Stacie Simmons	Community Engagement Program Manager
Veronica Olivarria	Member Services Supervisor

Visitor:

Jamie Berry	Mariposa Community Member

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:05 a.m.

Roll call was taken and a quorum was present.

An addition to the agenda was added. See topic # 9.

2. Oral Communications.

Chairperson Beleutz opened the floor for any members of the public to address the Advisory Group on items not listed on the agenda.

Jamie Berry, a community member from Mariposa was present. She requested that the Alliance provide more options at events for those that are hard of hearing. She also requested more events in the Mariposa community on topics such as mental health awareness, suicide prevention and women's health and safety. She encouraged the Alliance to provide more information to the community about any upcoming events.

3. Comments and announcements by Member Services Advisory Group (MSAG) members.

Chairperson Beleutz opened the floor for Advisory Group members to make comments.

Advisory Group Member Doris Drost noted that she is receiving feedback from members in the community that they are potentially being released by their doctors but do not know

why. She was reminded to encourage members to call the Member Services department, using the number on the back of their cards and for help getting (re) assigned to a provider.

Community partner Alma Mandujano-Orta updated that Natividad Medical Center has a weekly Farmers Market. They also do outreach in the community and help community members with any needs they may have.

Commissioner Molesky updated that effective May 1, 2024, the 504 Rule to Strengthen Protections Against Disability Discrimination has been enacted. The rule advances the promise of the Rehabilitation Act and helps protect people with disabilities from being discriminated against in any programs or activities funded by HHS.

4. Comments and announcements by Alliance staff.

Chairperson Beleutz opened the floor for Alliance staff to make comments.

No members of the Alliance Staff addressed the Advisory Group

Consent Agenda Items (5 – 6):

Chairperson Beleutz opened the floor for approval of the Consent Agenda.

Action: Consent Agenda approved.

Regular Agenda Items (7 – 8):

7. Community Resources

R. Margain presented on the resources available to the community. The purpose of this presentation was to solicit feedback from the group in regard to the information that is provided on the Alliance website, the e-newsletter called the Beat and the community engagement report, that is provided with the meeting packet. The group was asked if these outlets disseminate information for useful and helpful.

- Not all members of the group are familiar with these channels for information but will now view them, especially the website.
- J. Beleutz noted that he uses the Alliances website regularly for understanding who's providing what and understanding the scope of services for the Alliance offers. He also reviews both The Beat and the community engagement report.
- D. Drost noted that she has received The Beat and enjoyed it and found it useful. She also likes to go back and re-read issues.

8. **Alliance Provider Directory**

J. Kruppner provided a demo of the Provider Directory, located on the Alliance website. The goal was to gain feedback on understandability and usefulness to members. She moved through the online Provider Directory highlighting areas that would be helpful, such has how to sort, find a provider, change the language etc. As well as how to find information for our providers such as Carelon for Mental Health, VSP for eye care and Pharmacy.
In reviewing the site some committee members noted:

- Nurse Advice Line should be more prominent.
- Track openings for VSP providers somehow.
- Help members understand that they need to contact Carelon, VSP and Delta Dental for their list of providers as our site does not list them.

9. Provider Network Development

J. Dybdahl followed up the Provider Directory presentation by soliciting feedback on the Provider Network. She asked for feedback on the following topics:

- ***What should providers know about the Alliance members; how can we help educate providers***?
    - Better education for the front office staff in order to help better educate the doctor. Doctors often do not seem to be too knowledgeable about the Alliance and services offered. Especially important when providers are developing a treatment plan for members.
    - Refresher training for PSR to update provider offices on new and updated benefits.

- ***What other providers would you like to see in the Alliance network*?**
    - Better women's healthcare providers, especially for women over 60.
    - Alternative medicine such as Chinese medicine.
    - More acupuncture providers

Adjourn:

The meeting adjourned at 11:30 a.m.

Respectfully submitted,
Maura Middleton
Administrative Assistant
Member Services Advisory Group Coordinator

Meeting Minutes

Thursday, August 8, 2024
10 – 11:30 a.m.

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

Members Present:

Alma Mandujano-Orta	Community Advocate
Doris Drost	Consumer
Humberto Carrillo	Consumer
Janna Espinoza	Consumer, Commissioner
John Alexander	Community Advocate
John Beleutz	Community Advocate
Michael Molesky	Consumer, Commissioner
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate

Members Absent:

Candi Walker	Consumer

Carolina Meraz	Consumer
Debra Barcellos	Community Advocate
Dr. Ceballos	Community Advocate
Francis Wong	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Juana Chávez de Guízar	Consumer
Mimi Park	Consumer

Staff Present:

Adourin Malco	Community Engagement Specialist
Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Gabriela Chavez	Community Engagement Program Manager
Ivonne Munoz	Quality and Health Programs Supervisor
Linda Gorman, APR, M.A.	Marketing and Communications Director
Maura Middleton	MS Administrative Assistant
Osiris Ramon	Cultural and Linguistics Program Advisor
Ronita Margain	Community Engagement Director

Visitor:

Jamie Berry	Mariposa Community Member
Stephanie Auld	Santa Cruz Community Member

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:05 a.m.

Roll call was taken and a quorum was **not met**.

2. Oral Communications.

Chairperson Beleutz opened the floor for any members of the public to address the Advisory Group on items not listed on the agenda.

A Mariposa community member requested more in person and print outreach and education in Mariposa County to increase awareness of Alliance benefits and services.

3. Comments and announcements by Member Services Advisory Group (MSAG) members.

Chairperson Beleutz opened the floor for Advisory Group members to make comments.

4. Comments and announcements by Alliance staff.

Chairperson Beleutz opened the floor for Alliance staff to make comments.

No members of the Alliance Staff addressed the Advisory Group.

Consent Agenda Items (5 – 6):

Chairperson Beleutz opened the floor for approval of the Consent Agenda.

Action: Consent Agenda items **not** approved due to lack of quorum.

Regular Agenda Items (7 - 8):

7. Alliance Communications Update

Linda Gorman, Marketing and Communications Director, provided an update and solicited feedback on Alliance marketing and communications.

MSAG member inquired about a potential message to be sent through the member texting program. L. Gorman clarified that the texting program has several constraints limiting campaigns.

Text message campaigns for healthcare benefits and services are an automatic opt-in and members are able to opt-out.

L. Gorman encouraged parents with children in a school without a communication system like Peachjar to share the idea with the school. L. Gorman requested parents who use a different communication system to share the name with the Alliance.

Marketing and communication campaigns are measured through metrics such as visits to the website and number of calls. Anecdotally, the Alliance has heard of provider offices receiving more calls during the immunization campaign.

8. **Alliance Language Assistance Services**

Desirre Herrera, Quality and Health Programs Manager; Ivonne MunozQuality and Health Programs Supervisor; and Osiris RamonCultural and Linguistics Program Advisor provided information and solicited feedback regarding the Alliance's Language Assistance Services.

Alliance staff responded to several questions with additional information including: all future documents should be sent in designated language, the benefit is available at all services, the benefit applies to Medi-Medi members, and the benefit follows members and can be used at providers not contracted with the Alliance.

Alliance member shared challenges with coordinating interpreting services especially ASL in a rural area and with providers rescheduling appointments.

Adjourn:
The meeting adjourned at 11:30 a.m.

Respectfully submitted,
Kayla Zoliniak
Administrative Specialist
Member Services Advisory Group Coordinator

Meeting Minutes

Thursday, November 7, 2024
10 – 11:30 a.m.

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

Members Present:

Alma Mandujano-Orta	Community Advocate
Candi Walker	Consumer
Doris Drost	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Janna Espinoza	Consumer, Commissioner
John Beleutz	Community Advocate
Michael Molesky	Consumer, Commissioner
Mimi Park	Consumer
Stephanie Auld	Consumer

Members Absent:

Carolina Meraz	Consumer
Debra Barcellos	Community Advocate

Dr. Ceballos	Community Advocate
Francis Wong	Consumer
Humberto Carrillo	Consumer
John Alexander	Community Advocate
Juana Chávez de Guízar	Consumer
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate

Staff Present:

Adourin Malco	Community Engagement Specialist
Desirre Herrera	Quality and Health Programs Manager
Elvia Contreras	Call Center Quality Analyst
Gabriela Chavez	Community Engagement Program Manager
Jessica Finney	Community Grants Director
Jessie Newton, RN	Adult Care Management Manager
Kate Nester	Program Development Manager
Kayla Zoliniak	Administrative Specialist
Ronita Margain	Community Engagement Director
Sarina King	Quality and Performance Improvement Manager
Vanessa Paz	Health Equity Program Manager

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:05 a.m.

Roll call was taken and a quorum was **not met**.

2. Oral Communications.

Chairperson Beleutz opened the floor for any members of the public to address the Advisory Group on items not listed on the agenda.

No members of the public addressed the Advisory Group.

3. Comments and announcements by Member Services Advisory Group (MSAG) members.

Chairperson Beleutz opened the floor for Advisory Group members to make comments.

A. Mandujano-Orta shared she has benefited from serving on MSAG and wishes to continue serving on MSAG. Natividad providers translators to all patients.

J. Espinoza shared concerns members may have following the election and enquired how the Alliance can help minimize disruptions to accessing care.

4. Comments and announcements by Alliance staff.

Chairperson Beleutz opened the floor for Alliance staff to make comments.

No members of the Alliance Staff addressed the Advisory Group.

Consent Agenda Items (5 – 6):

Chairperson Beleutz opened the floor for approval of the Consent Agenda.

Action: Consent Agenda items **not** approved due to lack of quorum.

Regular Agenda Items (7 - 8):

7. Medi-Cal Capacity Grant Program

Jessica Finney, Community Grants Director, provided an overview and solicited feedback on critical needs and emerging priorities for funding strategies for the Medi-Cal Capacity Grant Program.

MSAG member enquired about Denta-Cal including the lack of access to specialists and the denial and appeals process. J. Finney stated Denta-Cal is a separate program although there are some capital grants for dental programs such as Community Health Workers, education, and integration.

MSAG member appreciated the grow our own concept and encouraged educating families so they can be local advocates and educate other families.

MSAG member recommended supporting infrastructure. The member shared their experience with medical records not being able to be shared between hospitals and their experience of a surgery center not accepting the Alliance's wheelchair transportation after procedures.

MSAG member shared their experience of the Alliance not supporting constant glucose monitors.

MSAG member enquired about what the grant program can do to support housing and unhoused individuals. J. Finney stated along with state funding, the Alliance's capital grants have been used for permanent supportive housing. The Alliance supports Community Supports providers through workforce and infrastructure grants. MSAG member enquired about the possibility of Medi-Cal being responsible for housing in the future.

8. Community Health Assessment and Community Health Improvement Plan

Kate Nester, Program Development Manager, provided an overview and solicited feedback on the Medi-Cal managed care health plan-local health jurisdictions collaborations on Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

MSAG member enquired about diabetes and substance use disorder, especially for Santa Cruz County. MSAG member recommended consulting Sutter and pharmacies, including private pharmacies.

MSAG member recommended diabetes and nutrition, especially for Monterey County.

MSAG member shared there is confusion around the Alliance, especially for seniors, and recommended having staff in the community to provide education. MSAG member also recommended providing the education in Spanish.

MSAG member recommended providing pharmacists education on how to get support from the medical system, for example, the correct codes to assist with access to durable medical equipment.

MSAG member shared access to eye care and quality glasses is limited, especially in Santa Cruz.

MSAG member shared about the lack of access and comprehensive care for dental care.

9. Diversity, Equity, and Inclusion Training

Vanessa Paz, Health Equity Program Manager, provided an overview and solicited feedback on the Diversity, Equity, and Inclusion (DEI) training content.

MSAG member recommended to look at segmentations of types of diseases and socioeconomic factors. MSAG member shared experience of receiving different information and access for managing their condition based on income level.

10. Member Satisfaction Survey

Sarina King, Quality and Performance Improvement Manager, provided an overview and solicited feedback on the member satisfaction survey.

MSAG member recommended providers think of Enhanced Care Management and Community Supports providers.

MSAG member shared experience of providers having a bias against them for their previous substance use and only looking at their past and not their recovery.

MSAG member recommended a provider version of MSAG to help education around programs and resources. S. King shared the Alliance has Physicians Advisory Group (PAG).

MSAG member shared experience of multiple doctors not being aligned on the next steps which created uncertainty and fear.

MSAG member recommended cultural differences be considered.

MSAG member recommended providers work with patients are partners.

MSAG member shared members may use specialists as primary care providers and recommended specialists be educated too, especially on the Enhanced Care Management process.

MSAG member shared for some members, this is their first time accessing services this way and that they may feel ashamed, especially in the public health clinics. MSAG member shared experience of not being treated with respect and dignity by office staff and

recommended the clinics keep up the facility and front office and train office staff to treat all patients with respect and dignity.

11. 2025 Schedule

Kayla Zoliniak, Administrative Specialist, proposed and solicited feedback on the proposed 2025 schedule. There were no objections.

Adjourn:

The meeting adjourned at 12:03 p.m.

Respectfully submitted,
Kayla Zoliniak
Administrative Specialist
Member Services Advisory Group Coordinator

Member Services Advisory Group
Selection Committee

Meeting Minutes

Thursday, February 8, 2024
9:30 – 9:45 a.m.
In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:

Guadalupe Barajas-Iniguez	Consumer Advocate
Janna Espinoza	Consumer, Commissioner
John Beleutz	Community Advocate

Staff Present:

Clarisa Gutierrez	Community Engagement Coordinator
Kayla Zoliniak	Administrative Specialist
Maria Colomer	Community Engagement Coordinator
Ronita Margain	Community Engagement Director
Stacie Simmons	Community Engagement Program Manager
Veronica Olivarria	Member Services Supervisor

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 9:33 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Selection Committee.

Regular Agenda Items (3. – 4.):

3. Acceptance of Advisory Group Members
Selection Committee reviewed current Advisory Group members.

Action: Advisory Group members were accepted.

4. Acceptance of Advisory Group Applicants
Selection Committee reviewed Advisory Group applicants.

Action: Advisory Group applicants were accepted.

Adjourn:
The meeting adjourned at 9:42 a.m.

Respectfully submitted,
Kayla Zoliniak
Member Services Advisory Group Coordinator

Meeting Minutes

Thursday, May 9, 2024
9:45 – 10:00 a.m.
In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:

Guadalupe Barajas-Iniguez	Consumer Advocate
John Beleutz	Community Advocate

Members Absent:

Janna Espinoza	Consumer, Commissioner

Staff Present:

Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Gabriela Chavez	Community Engagement Program Manager
Janet Kruppner	Provider Data Manager
Jessie Dybdahl,	Providers Services Director
Jessie Newton, RN	Continuum of Health Manager - Adult
Julie Norton	Behavioral Health Program Manager
Maria Colomer	Community Engagement Coordinator

Maura Middleton	MS Administrative Assistant
Ronita Margain	Community Engagement Director
Stacie Simmons	Community Engagement Program Manager
Veronica Olivarria	Member Services Supervisor

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 9:55 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Selection Committee.

Regular Agenda Items (3. – 4.):

3. Acceptance of Advisory Group Applicants
Selection Committee reviewed Advisory Group applicants.

Action: Advisory Group applicants were accepted.

Adjourn:
The meeting adjourned at 10:00 a.m.

Respectfully submitted,
Maura Middleton
Member Services Advisory Group Coordinator

Meeting Minutes

Thursday, August 8, 2024
9:45 – 10:00 a.m.
In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:	
John Beleutz	Community Advocate
Janna Espinoza	Consumer, Commissioner
Members Absent:	
Guadalupe Barajas-Iniguez	Consumer Advocate
Staff Present:	
Maura Middleton	MS Administrative Assistant
Ronita Margain	Community Engagement Director

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 9:33 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Selection Committee.

Regular Agenda Items (3. – 4.):

3. Acceptance of Advisory Group Applicants
Selection Committee reviewed Advisory Group applicants.

Action: Advisory Group applicants were accepted.

Adjourn:
The meeting adjourned at 9:40 a.m.

Respectfully submitted,
Maura Middleton
Member Services Advisory Group Coordinator

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, December 19, 2024
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Salvador Sandoval, MD	Provider Representative
John Mark, MD	Provider Representative
Lena Malik, MD	Provider Representative
Sarah Smith, MD	Provider Representative
James Rabago, MD	Board Representative
Ibraheem Al Shareef, MD	Provider Representative
Camille Guzel. MD	Provider Representative
Nicole Shelton, PA	Provider Representative
Devon Francis, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
Michelle Perez, MD	Provider Representative
Jennifer Yu, MD	Provider Representative
Cal Gordon, MD	Provider Representative

Committee Members Absent:

Staff Present:

Dianna Myers, MD	Medical Director
Dennis Hsieh, MD, JD	Chief Medical Officer
Tammy Hoeffel	Enhanced Health Services Director
Andrea Swan, RN	QI & Population Health Director
Tammy Brass, RN	Utilization Management Director
Lisa Moody, RN	Senior Complex Case Manager
Jasmin Galindo-Romero	Provider Relations Representative
Ronita Margain	Community Engagement Director
Cynthia Bali	Provider Relations Supervisor
Kelsey Riggs, RN	Pediatric Complex Case Mgmt. Manager
Jenna Stromsoe, RN	Complex Case Management Supervisor
Ashley McEowen, RN	Complex Case Management Supervisor
Jacqueline Morales	Provider Relations Representative
Sarah Sanders	Grievance & Quality Manager
Tracy Neves	Clerk of the Committee

Other Representatives Present:

Becky Shaw	Provider Representative
Laurie Soman	Provider Representative
Kevin McBride	Provider Representative

1. **Call to Order by Chairperson Dr. Dianna Myers.**
   Chairperson Myers called the meeting to order at 12:00 p.m.
   Roll call was taken.

Welcome to Dr. Michelle Perez from Camarena Health.

2. Oral Communications.
Chairperson Dr. Myers opened the floor for any members of the public to address the Committee on items not listed on the agenda.

No members of the public addressed the Committee.

3. Consent Agenda Items.
A. Approval of WCMCAC Minutes
Minutes from the September 19, 2024, meeting were reviewed.
B. Grievance Update
Grievance data was provided to the Committee.

M/S/A Consent agenda items approved.

4. Regular Business Items.
A. Enhanced Care Management and Community Supports (ECM & CS)
Tammy Hoeffel, RN provided an overview of ECM and CS. The ECM program is focused on a whole person approach that can address medical and social needs of Alliance members. Currently there are 33 ECM providers across the Alliance's 5 counties with 19,347 children and youth eligible for ECM services. There are 4,844 enrolled in services. The various populations of focus were shared with the Committee. In Community Supports, there are 3,764 children and youth enrolled. Populations of focus for 2025 include child welfare, pregnancy and post-partum and homelessness. Population of focus for adults and children and youth was further reviewed The criteria for children, youth and families with members under 21 years of age experiencing homelessness was reviewed and includes those sharing the housing of other persons due to loss of housing, economic hardship, or similar reason; living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations, are living in emergency or transitional shelters; abandoned in hospitals, The team works to assist children and youth enrolled in CCS or CCS WCM that are experiencing at least one complex social factor influencing their health.

ECM services are provided to individuals at risk for avoidable hospital and emergency department (ED) utilization, The goal is to utilize resources to ensure members have timely access and long-term care. A provider inquired about timely access for mental health services. Tammy noted the Alliance works with the county and they are provided with eligible members on a monthly basis based on populations of focus. The county will reach out to the members within 30-60 days. The ECM team conducts an evaluation with members, and if services are needed, the team will reach out. If referrals come directly to the Alliance, the process can be more quickly expedited. The criteria for individuals with serious mental health and/or substance use disorder (SUD), adult and children/youth and children and youth involved in child welfare and birth equity was reviewed.

There are 14 pre-approved Community Supports that were developed to help Alliance members to obtain care in the least restrictive setting possible. Members do not need to be enrolled in ECM to receive Community Supports. Members can access Community Supports through provider referrals or through self-referral. There are guidelines for qualifications and services provided. The Community Supports were developed and/or enhanced through the CalAIM initiatives to provide services that are cost effective alternatives to help members remain in their communities. The types of services were reviewed with the most popular highlighted: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and

Sustaining Services, Short-Term Post Hospitalization Housing, Personal Care and Homemaker Services, Environmental Accessibility Adaptations (Home Modifications), Medically-Supported Food/Meals/Medically Tailored, and Asthma Remediation – Pending Rollout in 2025.

There was a question regarding improving access if members are connected with ECM. Tammy noted ECM is there to assist members with services. The team advocates and provides resources for the members. The ECM team can assist members to navigate through any issues in the network, including the counties. Dr. Myers stated it is important to note that behavioral health is a bifurcated system. A provider inquired about what diagnoses are approved for medically supported meals. **Action:** Tammy will share the meal guidelines. Another provider asked about the 33 providers for kids and what pediatric experience have they provided. Tammy is still familiarizing herself with the providers within the various counties. Tammy is researching providers and if they work with children and youth and investigating services. Work is also being done on the Alliance website to make it more user friendly. The ECM team is currently working on outreach to providers to further understand the populations and services provided. It was noted this is a vulnerable population that requires providers with expertise. **Action:** Dr. Hsieh suggested Tammy report back in 6 months with her findings. There was a question whether providers are providing in-person services to children and families. It was noted, the Alliance has a diverse group of providers and is requesting providers have local teams 'on the ground." The Alliance is setting expectations that some of the of the provider meetings will be in-person. Tammy noted, this year the focus will be on the quality and depth of services provided. A provider asked about closed looped referrals and communication back to the referring party. Also, she asked whether there is good coordination between the ECM provider and the plan and CCS programs. The Alliance team has set-up monthly meetings and complex care rounds with providers. A provider requested at a follow-up meeting if information regarding the providers in each county can be shared. The provider also asked how we measure success. Also suggested was to compare multi-state data to local providers. Tammy noted she is meeting with providers regarding goals and evaluating the provider network. **Action:** Tammy will bring county provider information to the Q2 meeting. A provider noted there is a new Health Equity Officer at Stanford, and she would be a good ally to work with the Alliance. He also suggested the Alliance work with the CORE team and hospital staff to assist members.

B. WCM Referral Volumes

Jenna Stromsoe RN shared CCS referral data trends from January 2023 to January 2024 for Merced, Monterey, and Santa Cruz. A provider asked for CCS trends prior to WCM. Dr. Gordon will look into this request and obtain the data. The Committee decided to move onto the WCM expansion topic.

C. WCM Expansion

Lisa Moody, RN provided an Overview of the WCM Expansion. It was noted the plan took responsibility for intensive case management for children with CCS conditions. including accessing care and coordination of services, appeals, transportation, and meals and lodging. The Alliance has been supporting the WCM program in Santa Cruz, Monterey, and Merced since 2018 and the program will expand to Mariposa and San Benito counties in January 2025. The pediatric team has reached out to members in the new CCS counties beginning January 2024. In Mariposa County, members 19 years and younger, there are 1,883 members with 60 members CCS, and in San Bentio there are 8,467 members and 343 identified as CCS. Annually the pediatric team conducts a pediatric health risk assessment for kids with high-risk needs. and outreach is conducted. Members are assigned a nurse, social worker, or care coordinator. Santa Cruz, Monterey, and Merced are considered independent CCS counties while Mariposa and San Benito are dependent counties. In preparation for the expansion, the team has been meeting with San Benito and Mariposa counties on a regular basis. Outreach communication to

members has been done by mail and phone as well as participation in webinars. In January virtual drop-in office hours will be offered. For continuity of care (COC), Members Service and Case Management departments have assisted with COC requests. Provider Services has actively recruited providers for Mariposa and San Bentio counties. Providers can reach out to case management by completing an online referral form on the website or by reaching out to the pediatric leadership team.

5. Open Discussion.

Dr. Myers opened the floor for the Committee to have an open discussion.
A provider noted Santa Cruz received a grant from the Alliance for MTU online. Another provider requested an updated contact list from the Alliance. He also noted he is seeing lots of viral illnesses and reminded providers to encourage members to get vaccinated.

Adjourn.

The meeting adjourned at 1:05 p.m.

Respectfully submitted.

Ms. Tracy Neves
Clerk of the Advisory Committee

The Whole Child Model Clinical Advisory Committee is a public meeting.

Physicians Advisory Group

Meeting Minutes

Thursday, December 5, 2024
12:00 - 1:30 p.m.

Santa Cruz County:
Central California Alliance for Health – Board Room
1600 Green Hills Road, Suite 101, Scotts Valley, CA
Monterey County:
Central California Alliance for Health - Board Room
950 East Blanco Road, Suite 101, Salinas, CA
Merced County:
Central California Alliance for Health – Board Room
530 West 16th Street, Suite B, Merced, CA
Mariposa County:
Mariposa County Health & Human Services – Alliance Suite
5362 Lemee Lane, Mariposa, CA
San Benito County:
Community Services & Workforce Development Building - Conference Room
1161 Felipe Road, Bldg. B, Hollister, CA

Group Members Present:

Dr. Shirley Dickinson	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Mimi Carter	Provider Representative
Dr. Cheryl Scott	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Mai-Khanh Bui-Duy	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Amy McEntee	Provider Representative

Group Members Absent:

Dr. Jason Novick, DPM	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Cristina Mercado	Provider Representative
Dr. Charles Harris	Provider Representative
Dr. Ralph Armstrong	Board Member
Dr. Donaldo Hernandez	Board Member

Staff Present:

Dr. Dennis Hsieh	Chief Medical Officer
Dr. Mike Wang	Medical Director
Mr. Marwan Kanafani	Health Services Officer
Ms. Andrea Swan	QI & Population Health Director
Ms. Tammy Brass	Utilization Management Director
Ms. Kristynn Sullivan	Program Development Director

Ms. Jessica Finney	Community Grants Director
Ms. Jessie Dybdahl	Provider Services Director
Ms. Vanessa Paz	Health Equity Manager
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Sarina King	Quality & Performance Improvement Mgr.
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Provider Representative

1. Call to Order by Dr. Dennis Hsieh.

   Group Chairperson Hsieh called the meeting to order at 12:05 p.m.
   Roll call was taken.

2. Oral Communications.
   Chairperson Hsieh opened the floor for any members of the public to address the Group on items not listed on the agenda.

   No members of the public addressed the Group.

   Consent Agenda Items:
   A. The Group reviewed the September 12, 2024 Physicians Advisory Group (PAG) minutes.

      Action: Minutes approved.

3. **Regular Agenda Items:**
   A. Behavioral Health (BH) Insourcing Update
      Kristynn Sullivan provided an update on the Behavioral Health integration program, including the objectives, benefits, and challenges of insourcing BH services. Kristynn explained that the Alliance will create an integrated model for providing insourced BH services effective July 1, 2025, and discussed the strategic goals and key program components. The Behavioral Health Integration Program (BHIP) aims to create an integrated model for providing insourced BH services. The objectives include developing an NCQA-compliant behavioral health model, integrating behavioral health services into core organizational functions, and preparing Alliance staff to meet behavioral health member and provider needs. The benefits of insourcing behavioral health services, include maximum flexibility and control over service delivery, simplification of care integration, and leveraging the Alliance's strengths in behavioral health. Insourcing will allow for better coordination of care and improved quality and equity of service delivery. It was acknowledged there are challenges with insourcing, including the significant lift across the organization, the lengthy planning process, and the competition with other large initiatives such as D-SNP and ECM. Despite these challenges, the insourcing effort aligns with the Alliance's vision and values.

      A provider asked about North American Mental Health Services. Jessie noted they are partnered with the Alliance. Jessie also discussed the recruitment of behavioral health providers, emphasizing the importance of contracting with the existing network and addressing concerns about credentialing and referrals. Also noted was the need for providers to be enrolled in Medi-Cal before contracting with the Alliance, The goal is to maintain continuity of care for members by ensuring that they can continue seeing their

current providers. Jesse detailed the credentialing process which requires providers to be credentialed before the insourcing date. The Alliance has contracted with CAQH to expedite the credentialing process and offers a sign-on bonus to encourage timely submission of credentialing applications. Dr. Hsieh clarified that the Alliance will not require a prior authorization for initial non-specialty mental health services as long as the provider is in-network. This approach aims to streamline access to care and reduce barriers for members seeking behavioral health services. The strategic goals of the BHIP include eliminating health disparities, achieving optimal health outcomes for children and youth, and transforming the delivery system to be more person-centered. The program aims to integrate physical and behavioral health services to better meet the needs of members. Kristynn outlined the member centered care components of the BHIP. A provider asked about the school based clinics in Merced. Kristynn noted the clinics are run by FQHCs in the county that are contracted with the Alliance for both physical and behavioral health services. The BHIP key components were reviewed and are designed to ensure a seamless transition to insourced behavioral health services.

Behavioral Health Therapy Services
Kristynn Sullivan and Marwan Kanafani presented on Behavioral Health Therapy Services Marwan detailed the Carelon corrective action plan, which involved holding Carelon accountable for resolving the waitlist problem and ensuring that families were connected to services. The plan addressed 11 deficiencies, which were resolved by October. Issues were addressed with accessing ABA services and the corrective action plan implemented to resolve the waitlist problem. Marwan sought feedback from the Group on their experiences with BHT services and any additional concerns. A provider emphasized the importance of timely access to services and the need for a robust provider network. Dr. Hsieh noted if there are still issues with the waitlist, please reach out to the Alliance. Dr. Hsieh also noted for Medi-Cal patients, treatment for behavioral health symptoms can begin even without a formal diagnosis. This approach aims to minimize delays in starting treatment and ensure that children receive the care they need promptly. A provider inquired about schools and learning services. It was noted the Alliance cannot provide duplicative services, but the CM team is available to assist with coordination of care. The Alliance will be hiring staff to work with schools and clinics to help bridge care gaps. Marwan noted there is underutilization of adult services with ABA the highest utilization of visits. There are fewer than five hundred adult utilizers per year, It would be of interest to explore where there. is underutilization. **Action:** Dr. Hsieh noted adult non-specialty utilization will be added to future PAG topics.

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B. Medi-Cal Capacity Grant Program Investment Priorities
Jessica Finney presented the Medical Capacity Grant Program (MCGP) and reviewed details of the MCGP annual plan governance and noted the 2025 investment plan will be presented for Board approval in January 2025. The Board provides strategic direction for the MCGP through an annual investment plan. Also highlighted were the focus areas of access to care, healthy beginnings, and healthy communities and related strategies.

Jessica shared insights from stakeholder interviews and community health assessments, emphasizing the need for workforce recruitment and support for social determinants of health. Background and priorities from the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) was shared with the Group. Stakeholder interviews were conducted with 11 community leaders to gather insights on critical needs and opportunities to inform development of the MCGP's Investment Plan. Critical needs identified by stakeholders was reviewed. Challenges/opportunities identified were

access to care, behavioral health, workforce development and cultural competence, housing and homelessness, social determinants of health and community outreach and education.

There are 235 organizations that have been funded in 9 years, and those with current grants were surveyed.

Emerging 2025 priorities include:

- Workforce Development
- Behavioral Health Access
- Parent Support and Engagement
- Community Education and Engagement
- Social Drivers of Health

A provider suggested the implementation of fellowship or residency programs for new graduates to provide them with the necessary support and training. These programs would help new graduates become productive and confident in their roles more quickly.

Also discussed were the difficulties in recruiting physicians and new graduates citing financial barriers and the inflated cost of living in the area. There is a need for competitive salaries to attract and retain providers. It was noted there is a need for workforce development initiatives, such as growing local talent and supporting educational institutions. These initiatives aim to increase the number of healthcare providers in the area and address the ongoing workforce shortage. The importance of retention strategies was highlighted, such as offering competitive salaries and providing support for existing providers. Retaining experienced providers is crucial for maintaining continuity of care and ensuring high-quality services for members.

A provider in San Benito raised concerns about the impact of the justice system on health outcomes and health equity for families. The provider emphasized the need to address racism and discrimination within the justice system and its effects on public health.

C. Oral Health
Sarina King sought input from the Group on the need for oral health resources and training. Also discussed was the availability of resources for fluoride varnish application, pregnant patients, and education for patients with diabetes, and how that effects oral health. A provider noted access is important for dental care, and the CBI program provides minimal support for fluoride vanish. The cost for fluoride varnish is not covered in the FQHC setting. A provider noted they have an oral health coach in their clinic, and it has been successful. The oral health consultation is included as part of the well visit. It was noted pediatrics, pregnant patients and seniors are prioritized and there is a need for adult oral care. Another provider noted that patients cannot receive their drug replacement until they have had their teeth fixed. **Action:** Dr Hsieh offered to share information for Denti-Cal.

D. Health Equity
Vanessa Paz noted Health Equity has contracted with a subcontractor to develop health equity inclusion training, this is a new training for providers. Community, provider, and member input is being requested to co-create the training. The curriculum is going to the state for approval and a pilot will be implemented. Any input provided will be considered for incorporation into the training. The training will be required for network providers and

subcontractors. Dr. Hsieh noted the Alliance has an existing diversity and inclusion training. More information will be shared at the next PAG meeting.

4. **Open Discussion**
There was no further discussion.

Adjourn:
The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

The Physicians Advisory Group is a public meeting governed by the provisions of the Ralph M. Brown Act. As such, items for discussion and/or action must be placed on the agenda prior to the meeting.

DATE: March 26, 2025

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Business Continuity and Disaster Recovery Program 2024 Annual Report

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

Background. The purpose of the program is to prevent or mitigate the impacts of a business interruption on Alliance, members, providers, employees, partners, and communities. Should an incident occur, the Emergency Management Team (EMT) is responsible for managing response to the event and the subsequent recovery. The Business Continuity and Disaster Recovery Plan (BCDRP) is designed to be used to respond to the business impacting event to ensure the delivery of critical operational functions, minimize potential loss exposure, maintain compliance with regulatory and contractual requirements, and promote employee safety.

Summary of 2024 Activities

Post COVID-19 Pandemic
Throughout 2024, we continued to monitor COVID-19 following public health guidelines for our service areas. Alliance offices are open.

Power Outages
• Monitored all Public Safety Power Shutdown (PSPS)
• December 15, 2024, due to Scotts Valley tornado

Weather
• French Fire in Mariposa County in July4-19, 2024

Technology Interruptions
• CrowdStrike/Windows issue July 19

The EMT Advisory Group met monthly in 2024 to manage the oversight of the BCDRP. Using the ISO 22301 Gap Analysis and Maturity Assessment of 2023, program objectives were identified and approved by the EMT Advisory Group. And a Maturity Assessment was conducted, measuring the extent to which the Alliance is making use of the standard practices. Based upon the findings the plan for 2024 was made and approved by the EMT Advisory Team. The following initiatives were executed:

- Remediate gaps from 2023 ISO 22301 Gap Analysis
- Successfully conducted annual Disaster Recovery exercise November 1-2, 2024, failing over from the production data center in Scotts Valley to the backup data center in Merced within the 4-hour Recovery Point and Time Objective.
- Evaluated, acquired, and began implementation of business continuity software
- Conducted EMT Tabletop Exercise using ransomware scenario on May 21, 2024

- Supported requirements from new DHCS contract, creating Emergency Preparedness Fact Sheets (digital webpages) for members and providers
- Conducted Home Preparedness Training for all Alliance employees
- Executed Annual BIA update for all departments
- Executed Annual ISO Gap Assessment and Maturity Assessment Update

The EMT Advisory Group met on December 10th and approved the plan for 2025 below:

- Remediate gaps from 2024 ISO 22301 Gap Analysis
- Conduct annual Disaster Recovery exercise in Q4 2025
- Complete implementation of business continuity software (BIA migration, business unit contingency plans, EMT training and use of tools)
- Conduct EMT Tabletop Exercise in May 2025
- Execute Annual BIA update for all departments
- Execute Annual ISO Gap Assessment and Maturity Assessment Update
- Execute OCR Risk Assessment
- Executive Level Risk Assessment
- Execute Stakeholder Assessment

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

Attachments. N/A

DATE: March 26, 2025

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance owned Facilities 2024 Annual Report

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

Summary of 2024 Leasing Activity. Rental revenue increased in 2024 by $380.2k or 25.9%. This was mostly attributed to adding new tenants in Salinas and Merced. The Salinas and Merced buildings are 100% occupied.

In the fall of 2024, the Alliance began plans to consolidate the Scotts Valley Alliance occupied offices from both the 1700 and 1600 buildings to just the 1600 building. The consolidation is estimated to be complete in the first quarter of 2025. Once complete, additional space for lease will be available at 1700 Green Hills Rd. The 1800 building had four tenants vacate in the fall of 2024 and occupancy has decreased 30% from 2023.

Summary of Current Property Holdings, Leases, and Status. The Alliance owns five buildings with a total of 280,859 square feet of office space. The Alliance is currently leasing office space in San Benito County or Mariposa County and does not own any real estate in those counties.

Santa Cruz County
Scotts Valley

- 1600 Green Hills Road:
  - 57% Alliance Occupied
  - 43% Vacant/On Market
- 1700 Green Hills Road:
  - 45% Occupied Alliance Occupied
  - 3% Leased to Tenants
  - 52% Vacant/On Market
- 1800 Green Hills Road:
  - 47% Occupied
  - 53% Vacant/On Market

Monterey County

- 950 East Blanco Road, Salinas: 100% Occupied
  - 34% Alliance Occupied
  - 66% Leased to Tenants

Merced County

- 530 West 16th Street, Merced: 100% Occupied

- 67% Alliance Occupied
- 33% Leased to Tenants

Fiscal Performance and Impact.

2024 Financial Performance

Annual Gross Rental Income:	$1,847,866.72
Annual Rental Expenses:	$783,427.93
Annual Net Income:	$1,064,438.79

**Expenses calculated based on average actuals from January 2024 to December 2024.

DATE: March 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

Newly introduced 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 initial 2025 bill list is attached for the board's information.

Discussion. The 2025 Legislative Session officially convened on December 3, 2024 with the deadline to introduce new legislation on February 21 2025. Staff has developed a bill list that includes approximately ninety-two(92) 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: Referred to Com. on Health.** **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: 2/3/2025-Referred to Com. on Health.** **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: 12/3/2024- From printer. May be heard in committee January 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: 2/3/2025- 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: 12/3/2024- From printer. May be heard in committee January 2.** **Position: Watch/Study**	**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 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: 2/18/2025-Referred to Coms. on B. & P. and Health.** **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: 12/3/2024-From printer. May be heard in committee January 2.** **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: 2/3/2025-Referred to Com. on Health.** **Position: Watch/Study**	**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 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: 1/6/2025-Read first time.** **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: 2/12/2025-Re-referred to Com. on Health.** **Position: Watch/Study**	**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 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: 2/3/2025-Referred to Com. on Health.** **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: 2/3/2025-Referred to Com. on Health.** **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)** **Status: 1/17/2025-From printer. May be heard in committee February 16.** **Position: Watch/Study**	**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 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: 2/21/2025-Re-referred to Com. on HUM. S.** **Position: Watch/Study**	**Behavioral health centers, facilities, and programs: background checks.** **Summary:** Existing law authorizes the State Department of Developmental Services (DDS) to perform various duties relating to the prevention, diagnosis, and treatment of persons with intellectual and developmental disabilities, including disseminating educational information, providing advice, conducting educational and related work, and organizing, establishing, and maintaining community mental health clinics and overseeing regional centers for people with developmental disabilities. 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 the agency or entity identified in a statute. Under existing law, the disclosure of state summary criminal history information to an unauthorized person is a crime. This bill would require DDS to establish a certification process for behavioral technicians, as defined, including, among others, qualified autism service providers. The bill would require the certification process to include, at a minimum, a criminal background check, except as specified. The bill would prohibit the department from certifying an individual who has been convicted of a crime involving a minor. The bill would require a behavioral technician to request certification from the department if their duties include, or would include, working with a patient who is under 18 years of age. The bill would prohibit a developmental center, facility, or program that provides services to a person who is under 18 years of age from employing a behavioral technician who is not certified by the department. 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: 2/10/2025-Referred to Com. on Health.** **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: 2/10/2025-Referred to Com. on Health.** **Position: Watch/Study**	**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: 2/10/2025-Referred to Com. on Health** **Position: Watch/Study**	**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 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: 1/24/2025-From printer. May be heard in committee February 23.** **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: 2/10/2025-Referred to Com. on Health.** **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. This bill contains other related provisions and other existing laws.
AB 350 **Bonta (D)** **Status: 2/18/2025-Referred to Com. on Health.**	**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

Position: Watch/Study	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: 1/31/2025-From printer. May be heard in committee March 2.** **Position: Watch/Study**	**Health care coverage for menopause** **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 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. This bill would state the intent of the Legislature to enact legislation relating to menopause that ensures patients experiencing menopause have access to health care providers who are well equipped to offer effective treatments and support and to promote greater awareness and education within the medical community to address gaps in care
AB 371 **Haney (D)** **Status: 2/18/2025-Referred to Com. on Health** **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: 2/18/2025-Referred to Com. on B. & P.** **Position: Watch/Study**	**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 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: 2/18/2025-Referred to Com. on Health.** **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: 2/18/2025-Referred to Com. on Health.** **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: 2/5/2025-From printer. May be heard in committee March 7.** **Position: Watch/Study**	**Healing Arts** **Summary:** Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. This bill would state the intent of the Legislature to enact legislation to revise the authority of the Medical Board of California to establish a physician health and wellness program.
AB 510 **Addis (D)** **Status: 2/11/2025-From printer. May be heard in committee March 13.** **Position: Watch/Study**	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 plan's 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 disability insurer delaying, denying, or

	modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician 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, 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 enrollee's or insured's condition, as specified. If a health care service plan or disability insurer fails to meet those timelines, the bill would deem the prior authorization request as approved and supersede any prior delay, denial, or modification. The bill would make conforming changes to related provisions. Because a 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 512 **Harabedian (D)** **Status: 2/11/2025-From printer. May be heard in committee March 13.** **Position: Watch/Study**	**Health care coverage: prior authorization.** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of 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 plan's or insurer's 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 plan's or insurer's 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. This bill contains other related provisions and other existing laws.
AB 517 **Krell (D)** **Status: 2/11/2025-From printer. May be heard in committee March 13.** **Position: Watch/Study**	**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: 2/12/2025-From printer. May be**	**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

heard in committee March 14. **Position: Watch/Study**	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 **Gonzalez, Mark & Elhawary (D)** **Status: 2/12/2025-From printer. May be heard in committee March 14.** **Position: Watch/Study**	**Medi-Cal: street medicine.** **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: 2/12/2025-From printer. May be heard in committee March 14.** **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: 2/12/2025- From printer. May be heard in committee March 14.** **Position: Watch/Study**	**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 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: 2/13/2025- From printer. May be heard in committee March 15.** **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: 2/14/2025- From printer. May be heard in committee March 16.** **Position: Watch/Study**	**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: 2/14/2025- From printer. May be heard in committee March 16.** **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: 2/15/2025- From printer. May be heard in committee March 17.** **Position: Watch/Study**	**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 **Ortega (D)** **Status: 2/15/2025-From printer. May be heard in committee March 17.** **Position: Watch/Study**	**Health care coverage reporting** **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: 2/15/2025-From printer. May be heard in committee March 17.** **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: 2/19/2025-From printer. May be heard in committee March 21.** **Position: Watch/Study**	**Hospitals: community benefits.** **Summary:** Existing law requires a private not-for-profit acute hospital to annually adopt and update a community benefits plan that describes the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Under existing law, "community benefit" includes, among other things, health care services rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and persons eligible for specified public health care programs. Existing law requires the hospital to annually submit its community benefits plan to the Department of Health Care Access and Information. This bill would make technical, nonsubstantive changes to certain definitions for purposes of the above-described provisions.

AB 789 **Bonta (D)** **Status: 2/19/2025-From printer. May be heard in committee March 21.** **Position: Watch/Study**	**Health care coverage: rate 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. 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: 2/19/2025-From printer. May be heard in committee March 21.** **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: 2/20/2025-From printer. May be heard in committee March 22.** **Position: Watch/Study**	**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 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: 2/20/2025-From printer. May be heard in committee March 22.** **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 877 **Dixon (R)** **Status: 2/20/2025-From printer. May be heard in committee March 22** **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: 2/20/2025- From printer. May be heard in committee March 22.** **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: 2/21/2025- From printer. May be heard in committee March 23.** **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: 2/21/2025- From printer. May be heard in committee March 23.** **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: 2/21/2025- From printer. May be heard in committee March 23.** **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: 2/21/2025- From printer. May be heard in committee March 23.** **Position: Watch/Study**	**Medi-Cal managed care plans: exemption from mandatory enrollment.** **Summary:** Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide community services and supports for persons with developmental disabilities and their families. 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. Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, as specified. If the department standardizes those populations, existing law exempts certain dual eligible and non-dual-eligible beneficiary groups from that mandatory enrollment. Under existing law, a dual eligible beneficiary is an individual 21 years of age or older who is enrolled for benefits under the federal Medicare Program and is eligible for medical assistance under the Medi-Cal program. This bill would state the intent of the Legislature to enact legislation that would exempt, from mandatory enrollment in a Medi-Cal managed care plan, dual eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use a Medi-Cal fee-for-service delivery system as a secondary form of health care coverage.

AB 980 **Arambula (D)** **Status: 2/21/2025- From printer. May be heard in committee March 23.** **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: 2/21/2025- From printer. May be heard in committee March 23** **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: 2/21/2025- From printer. May be heard in committee March 23.** **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: 2/21/2025- From printer. May be heard in committee March 23.** **Position: Watch/Study**	**Health care coverage: physician and 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: 2/21/2025- From printer. May be heard in committee March 23** **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: 2/21/2025- From printer. May be**	**Behavioral health and wellness screenings** **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

heard in committee March 23. **Position: Watch/Study**	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 1161 **Harabedian (D)** **Status: 2/21/2025-From printer. May be heard in committee March 23.** **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: 2/21/2025-Introduced. To print** **Position: Watch/Study**	**Medi-Cal reimbursements: nonemergency interfacility transfers** **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. Existing law sets forth various provisions relating to nonemergency medical or nonmedical transportation with regard to scope, prior authorization, reimbursement rates, and payments, and other provisions relating to transfers between facilities. This bill would state the intent of the Legislature to enact legislation that would, upon appropriation, provide an unspecified amount of additional funding for Medi-Cal reimbursements for nonemergency interfacility transfers.
AB 1386 **Bains (D)** **Status: 2/21/2025-Introduced. To print** **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: 2/21/2025-Introduced. To print** **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: 2/21/2025-Introduced. To print** **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: 2/21/2025-Introduced. To print** **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: 2/21/2025-Introduced. To print** **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: 2/21/2025-Introduced. To print** **Position: Watch/Study**	**Community-based perinatal care.** **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: 1/29/2025-Referred to Com. on RLS.** **Position: Watch/Study**	**Artificial intelligence.** **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: 1/29/2025-Referred to Com. on RLS.**	**Public health: maternity ward closures** **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.

Position: Watch/Study	
SB 40 **Wiener (D)** **Status: 1/29/2025-Referred to Com. on RLS.** **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: 1/29/2025-Referred to Coms. on HEALTH and JUD.** **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)**	**Health care coverage: essential health benefits.**

Status: 1/29/2025-Referred to Com. on HEALTH. **Position: Watch/Study**	**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: 1/29/2025-Referred to Com. on RLS.** **Position: Watch/Study**	**Patient access to health records** **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: 2/5/2025-Referred to Com. on HEALTH.** **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 transfer administration of the Comprehensive Perinatal Services Program from the State Department of Public Health to the State Department of Health Care Services. The bill would, among other things, authorize the State Department of Health Care Services to enter into memoranda of understanding or interagency agreements or contracts with the State Department of Public Health, as necessary to implement those provisions. The bill would also state the intent of the Legislature to enact additional legislation relating to the program in order to implement legislative recommendations made in a specified report issued by the California State Auditor's 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)**	**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

Status: 2/14/2025-Referred to Coms. on L. GOV. and JUD. **Position: Watch/Study**	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: 2/14/2025-Referred to Com. on HEALTH** **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: 2/14/2025-Referred to Com. on HEALTH.** **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: 2/14/2025-Referred to Com. on HEALTH.** **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: 2/19/2025-Referred to Com. on HEALTH.** **Position: Watch/Study**	**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: 2/19/2025-Referred to Com. on HEALTH.** **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 give preference to contracting 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. This bill contains other related provisions and other existing laws.
SB 338 **Becker (D)** **Status: 2/19/2025-Referred to Com. on HEALTH.** **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: 2/19/2025-Referred to Com. on HEALTH and JUD** **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)** **Status: 2/19/2025-Referred to Com. on RLS.** **Position: Watch/Study**	**Health care service plans: financial risk requirement** **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 to demonstrate that it has a fiscally sound operation and adequate provision against the risk of insolvency, that it assumes full financial risk on a prospective basis for the provision of covered health care services, and that it has a procedure for the prompt payment or denial of provider and subscriber or enrollee claims. This bill would make technical, nonsubstantive changes to these provisions.
SB 363 **Wiener (D)** **Status: 2/14/2025-From printer. May be acted upon on or after March 16.** **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 its number of treatment denials or modifications, separated by type of care and disaggregated by age, to the appropriate department, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's 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 half 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 the specified 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 specify that these provisions do not apply to Medi-Cal managed care plan contracts. 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.
SB 418 **Menjivar (D)** **Status: 2/19/2025-From printer. May be**	**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

acted upon on or after March 21. **Position: Watch/Study**	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 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: 2/19/2025- From printer. May be acted upon on or after March 21.** **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: 2/19/2025- From printer. May be acted upon on or after March 21.** **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: 2/19/2025- From printer. May be acted upon on or after March 23.** **Position: Watch/Study**	**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: 2/21/2025- From printer. May be acted upon on or after March 23.** **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: 2/21/2025- From printer. May be acted upon on or after March 23.** **Position: Watch/Study**	**Health facilities: freestanding emergency center pilot program.** **Summary:** Existing law provides for the licensure and regulation of health facilities, including general acute care hospitals, by the State Department of Public Health. Existing law authorizes a general acute care hospital, as defined, to offer special services, including, but not limited to, emergency medical services. This bill would express the intent of the Legislature to enact legislation to implement a pilot project to authorize a freestanding emergency center in the Desert Health District.
SB 660 **Menjivar (D)**	**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

Status: 2/21/2025- From printer. May be acted upon on or after March 23. **Position: Watch/Study**	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: 2/21/2025- From printer. May be acted upon on or after March 23.** **Position: Watch/Study**	**Rural Hospitals** **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: 2/21/2025-Introduced. To Com. on RLS. for assignment. To print.** **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: 2/21/2025-Introduced. To Com. on RLS. for assignment. To print.** **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.

DATE: March 26, 2025

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

FROM: Linda Gorman, Marketing and Communications Director
Ronita Margain, Community Engagement Director

SUBJECT: Overview of the Alliance's Community Presence

Recommendation. This report is informational only.

Summary. The Alliance has a robust community and brand presence that is demonstrated through outreach, engagement and communications activities. The strong partnerships we developed support our strategic priorities and further our mission.

Background. As a County Organized Health System Medi-Cal managed care plan, the Alliance has a commitment to be present in the communities it serves. With recent county expansion and ongoing CalAIM efforts, including launching a D-SNP program, we continue to focus on developing and cultivating local relationships, elevating brand awareness, and finding innovative ways to engage and support our members and communities.

Collaboration is one of our core values at the Alliance. We understand that realizing our vision of Healthy People, Healthy Communities is only possible by collaborating with our community peers and partners. When communities and the Alliance embrace a shared vision and come together to achieve optimal results, a stronger, healthier community emerges.

Discussion. We continue to reach members and our communities with our presence at over 100 community events annually. We will deploy outreach activities to engage members in their own health care. Lastly, we will continue to increase brand awareness through targeted and timely marketing and communication efforts to reach members where they are, with the right message, at the right time.

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: March 26, 2025

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: 2025 Policy Priorities

Recommendation. Approve the Alliance's 2025 Policy Priorities and authorize staff to undertake legislative, budgetary, policy and regulatory advocacy aligned with these policy priorities.

Background. In February 2024, your Board adopted Policy Priorities which reflect your Board's priorities and principles and serve to provide general direction for Alliance legislative, policy, and budgetary advocacy efforts in service of the Alliance's mission of accessible, quality health care guided by local innovation. Thus, providing direction to staff to respond effectively and efficiently to proposals that could significantly impact Alliance strategic and operational interests.

The proposed Policy Priorities contemplate the Alliance's board adopted 5-year Strategic Plan, the current health care policy environment and the board's historical areas of legislative focus.

The Alliance Government Relations Director, under the direction and supervision of the Chief Executive Officer, is responsible for identifying, monitoring, tracking and reporting on policy, legislative and budget initiatives. Upon approval by the board, the Government Relations Director coordinates and centralizes advocacy efforts within the parameters of the Board's Policy Priorities.

Discussion. Staff reviewed the Board's 2024 Policy Priorities within the context of today's legislative, policy and budget environment and determined that the 2024Policy Priorities adopted by the Board required augmenting to address the current federal policy and legislative environment.

The Board's approval of the 2025 Policy Priorities will enable Alliance staff to engage in activities to protect Medi-Cal including legislative, regulatory, and budget advocacy actions during the year in support of the Alliance's Strategic Plan and help advance its Mission, Vision and Values in support of the Alliance, its members, providers and partners and to take actions towards protecting Medicaid. Staff will support policies and proposals which advance these priorities and principles and may oppose policies and proposals that impede these priorities.

Staff may employ various strategies, tactics and advocacy activities to advance the 2025 Policy Priorities including, but not limited to, educating legislators at the federal, state, and local level, collaborating with vested stakeholders, consensus building, message alignment; testifying at public hearings and forums and drafting letters of support or opposition for legislative, budgetary or policy proposals that are aligned with the Board-approved Policy Priorities. Staff will provide regular reports to the Board on these activities.

Official Alliance legislative and regulatory positions not contemplated under the 2025 Policy Priorities will be brought to the Board for separate consideration and action as needed.

Upon approval of the Board, staff will share a copy of the final 2025 Policy Priorities document with the Board for your information and reference.

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

Attachments. 2025 Policy Priorities - DRAFT

~~2024~~ 2025 Policy Priorities*

Federal Level Priorities

- Advocate for the protection of state Medicaid funding from proposals that impose block grants or per member caps, ensuring stable, predictable funding for Medi-Cal and preventing cuts to critical health services for low-income Californians.
- Champion the preservation of Medicaid expansion and safeguard the program's funding from federal rollback efforts that threaten health coverage for millions of low-income Californians.

Access to Care

- Increase provider pathways to increase the total number of culturally competent providers available to people with Medi-Cal and Medicare coverage.
- Provide immediate solutions to shortages in, or which expand the capacity of, the Medi-Cal and Medicare healthcare workforce.

Local Innovation

- Strengthen and improve the safety net healthcare delivery system.
- Preserve and strengthen the local health plans and the public, not-for-profit managed care model
- Support ~~for~~ local solutions that facilitate ~~-~~health information and data exchange

Eligibility and Benefits

- ~~Increase~~ Protect or add to the benefits available to Medi-Cal and Medicare beneficiaries
- Protect ~~Increase~~ access to publicly-sponsored health care at no or low-cost coverage for uninsured and low-income populations

Financing and Rates

- Demonstrate alignment between financial and programmatic policy and which ensure health plan revenue is adequate to enable effective, financially viable operations
- Encourage and support provider participation in Medi-Cal and Medicare through adequate rates of payment
- Support funding of Medicare to enable the ~~development~~ financial viability of a Medicare Advantage D-SNP to provide services to dual eligible members
  ~~Increase federal funding for Medi-Cal~~

Health Equity

- Optimize health outcomes and eliminate health disparities for children
- Improve outcomes and reduce disparities between the Medi-Cal and commercially insured populations
- Increase member access to culturally and linguistically appropriate and culturally competent health care
- Prioritize allocation of resources to address disparities and to remove barriers to equitable access to high-quality services.

Person-Centered Delivery System Transformation

- Support integrated delivery and whole person models that are designed to improve quality of care and empower patients to be a partner in their own care.
- Improve the system of care for members with complex medical and social needs
- Aid information exchange between systems and providers

The Alliance supports policies and proposals which advance the above priorities and principles and may oppose those which may impede these priorities.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

March 3, 2025

The Honorable Mike Crapo, Chairman, Committee on Finance, U.S. Senate
The Honorable Brett Guthrie, Chairman, Energy and Commerce Committee, U.S. House of Representatives
The Honorable Ron Wyden, Ranking Member, Committee on Finance, U.S. Senate
The Honorable Frank Pallone, Ranking Member, Energy and Commerce Committee, U.S. House of Representatives

Dear Congressional Leaders,

As a coalition of stakeholders serving individuals relying on the Medicaid and Children's Health Insurance Programs (CHIP), we write to convey the critical importance of these programs, and to encourage you to continue to strengthen both in the years to come. The flexibility, efficiency and positive impact of Medicaid in every state across the country is a hallmark of how federal-state partnerships can deliver results tailored to local needs.

As you know, Medicaid serves a broad spectrum of Americans across all walks of life, including children, mothers, the aged, blind and disabled, individuals with substance use disorder (SUD), persons with mental health conditions and mental illness, and low-income individuals, all of whom depend on the program to provide them with access to health care services and life-saving treatments.

Medicaid shines as a bright example of what can be accomplished when the Federal government works with state partners to deliver for the American people. The flexibility and accountability of the program enables efficient coverage for over 79 million individuals in 50 states and the District of Columbia, as of October 2024. The Medicaid program allows states the ability to tailor their programs to meet the needs of their unique populations, while creating efficiencies and innovations that might not be possible in other delivery systems.

With the ability to design their own programs, states have leveraged the Medicaid program to ensure access to care for our most vulnerable populations; populations that would have no other source of insurance coverage. Individuals with disabilities rely on the Medicaid program to receive long-term services and supports, both at in person nursing facilities and through home and community-based services, allowing them to find employment and serve as active members of their communities. Medicaid plays a key role in providing mental health and SUD services, as 40% of the nonelderly adult Medicaid population (13.9 million enrollees) had a mental health condition or SUD in 2020. And more than 37 million children receive health coverage through Medicaid and CHIP, representing 47.4% of overall Medicaid and CHIP program enrollment. Nearly two out of every three adult women enrolled in Medicaid are in their reproductive years, and Medicaid currently covers about 42% of all births in the United States. Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit keeps children healthy and provides them with critical behavioral health services. EPSDT is also a benefit with strong bipartisan support that was recently strengthened by the Safer Communities Act.

In addition to the vulnerable populations covered by Medicaid, it is a crucial source of coverage for many safety net facilities and the clinicians relied on by patients in these settings. Insurance coverage through Medicaid ensures that our safety net facilities, including rural hospitals, health centers, mental health centers, nursing homes, critical access hospitals, and others, remain open and can provide primary and specialty care services, as well as 24/7 emergency care, to the communities surrounding them. Without comprehensive Medicaid coverage these facilities may be forced to close, and millions of people would need to travel hundreds of miles to access a health care facility to receive necessary care from trusted clinicians.

It is vital that Medicaid and CHIP continue to receive strong support from the Federal government, so that the program can continue to serve mothers, children, the aged, blind and disabled, individuals with SUD, persons with mental health conditions and mental illness, and low-income Americans, all who depend on the program to stay healthy and to receive life-saving treatments. Interruptions in health coverage, even temporary, have been shown to lead to a deterioration of

health conditions which later leads to higher costs for payers, challenging the sustainability of the program and making it more difficult for Americans depending on Medicaid to continue to work and contribute as members of their communities. Further, reductions in Medicaid funding could lead to hospital closures and reduced access to healthcare providers in rural and underserved areas, that are already struggling to meet the needs of their populations. Medicaid and CHIP have historically received bipartisan support, and we respectfully encourage you to continue this tradition, in order to strengthen and enhance this vital program serving millions of Americans across the country.

We sincerely thank you for your consideration and remain available to work with you and your colleagues to continue to meet the needs of the American people through a flexible, accountable, and efficient Medicaid program.

Respectfully,

National
Advocates for Community Health
Alliance of Community Health Plans
Allies for Independence
American Academy of Pediatric Dentistry
American Association of Nurse Practitioners
American Association on Health and Disability
American Dental Association
American Nurses Association
Association for Community Affiliated Plans
Association of Clinicians for the Underserved (ACU)
CommunicationFIRST
Federation of American Hospitals
Institute for Exceptional Care
Lakeshore Foundation
Medicaid Health Plans of America (MHPA)
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Disability Rights Network (NDRN)
National Health Care for the Homeless Council
National MLTSS Health Plan Association
The National Council of Urban Indian Health

State
Access Living (Illinois)
Coalition of New York State Public Health Plans (New York)
Kentucky Association of Health Plans (Kentucky)
Local Health Plans of California (California)
Michigan Association of Health Plans (Michigan)
Minnesota Association of County Health Plans (Minnesota)
National Council on Independent Living (District of Columbia)
Ohio Association of Health Plans (Ohio)
Pennsylvania's Medicaid Managed Care Organizations (PAMCO) (Pennsylvania)

February 24, 2025

TO: Members of the California Congressional Delegation
RE: Protect Access to Care and Oppose Medicaid Cuts

On behalf of the undersigned organizations and the 15 million Medi-Cal (California's Medicaid program) patients we serve, we urge you to reject the severe proposed Medicaid funding cuts that would harm the care that is delivered to all Californians, not just those on Medicaid.

California's Medi-Cal program is among the most efficient and cost effective in the nation, thanks in part to the critical role of local Medi-Cal managed care plans. Adjusted for cost of living, California ranks 14th lowest in per-enrollee Medicaid spending nationwide.

Ultimately, the proposed Medicaid cuts amount to an added tax burden on all Californians, as newly uninsured patients are forced to forgo vital preventive care and instead end up in hospital emergency departments with more costly, difficult-to-treat conditions — leading to higher health care costs for everyone.

In particular, the health care of our patients – children, pregnant women, seniors, disabled individuals, veterans, and low-income working families who cannot afford insurance or are not offered it by employers will be directly impacted. Additionally, having a regular source of care that includes preventive care and treatment for chronic conditions plays an important role in family stability and productivity. Medicaid provides essential health care services, and it must be protected. Medicaid is particularly important in rural areas, where 50% of Californians would lack health care coverage without it.

With nearly 40% of Californians enrolled in Medi-Cal, California voters have made clear that we need to protect this health care coverage, and increase funding, not tear it down. In November 2024, voters overwhelmingly supported increased funding for Medi-Cal, through Proposition 35, the Protect Access to Health Care Act, which passed with 68% of the vote and strong bipartisan support.

Three-fourths of Americans have favorable views of Medicaid, including a majority of Republicans, Independents, and Democrats and a recent Hart Poll shows two-thirds of Trump voters believe Medicaid is an important source of health coverage for people who could not otherwise afford healthcare.

The proposals to reduce federal Medicaid matching funds, establish per capita caps that end the guarantee of Medicaid, and eliminate managed care organization and provider levies—

which are dedicated to health care in California—disproportionately harm California's rural and at-risk communities that rely on Medicaid. These significant cuts would shift the health care burden to physicians and other healthcare providers, may result in the closure of more hospitals and their services, along with physician/healthcare provider practices, strain community health centers that care for one third of all Medi-Cal enrollees in our state and make it more difficult for us to care for Medi-Cal patients and those who lose coverage.

California's healthcare system serves everyone. Medi-Cal, 15 million people enrolled, is a critical funding and critical to the health and well-being of your constituents. It protects our most vulnerable by providing essential services to half of California's children. It ensures vital access to primary and preventive care, improving health outcomes and reducing overall costs by keeping people out of emergency rooms.

Medicaid cuts will hurt California disproportionately. A vote to strip funding away from California is a vote against what California voters supported when they passed Proposition 35. We urge you to protect your constituents by rejecting Medicaid cuts that threaten patient care, coverage, and California provider viability. Please protect our Medicaid program.

DATE: March 26, 2025

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

FROM: Jenifer Mandella, Chief Compliance Officer

SUBJECT: Q3-4 2024 Compliance Program Report

Recommendation. Staff recommend the Board approve the Compliance Program Report for Q3-4 2024.

Summary. This report summarizes the Alliance's Compliance Program activities for Q3-4 2024 and includes a recommendation to approve the Compliance Program Report.

Background. The Alliance is required to implement an effective Compliance Program that meets the requirements set forth in 42 C.F.R. § 438.608. Modeled off the United States Federal Sentencing Guidelines' (FSG's) seven elements of an effective compliance program, and articulated in the Compliance Plan, the Alliance's Compliance Program takes a systematic and strategic approach to decreasing risk posed by non-compliance.

The FSG states "The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program." The Board has delegated authority for overseeing the Compliance Program to the Compliance Committee and receives updates on the efficacy of the Compliance Program through the routine submission of Compliance Committee minutes, the inclusion of key Compliance Program metrics in the Alliance Dashboard, and the receipt of bi-annual reporting from the Chief Compliance Officer.

Discussion. This report serves to inform the Board of the Alliance's Compliance Program activities for Q3-4 2024.

Key Accomplishments

- Led organizational efforts to obtain National Committee for Quality Assurance (NCQA) health plan and health equity accreditations, as required by the Department of Health Care Services (DHCS). Compliance staff led the project, overseeing the organization's implementation of NCQA-compliant processes, expanded member and provider data collection, and more targeted data reporting methodologies to ensure readiness for its April 2025 Survey. The Plan expects to receive the two NCQA accreditations in June of 2025.
- Supported efforts to launch a Medicare Dual Special Needs Plan (DSNP) product:
    - Timely submission of the Notice of Intent to Apply to the Centers for Medicare and Medicaid Services (CMS).
    - Assisted with developing the Alliance's Part C and Part D applications, which were timely submitted in early 2025.

    - Revised compliance program operations to align with Medicare program requirements. Significant revisions included formalizing the corrective action plan (CAP) process to ensure that any deficiencies identified within Alliance or delegate operations resulted in a formal CAP; developed a process to identify and risk rate first tier, downstream, and related entities (FDRs); and revised the contents and frequency of board reporting. Program changes will continue through 2025 to ensure a fully compliant program is in place by January 1, 2026.
    - In anticipation of increased volume and complexity resulting from additional regulatory scrutiny, modified the Compliance Department's structure to ensure sufficient staffing resources and leadership oversight are in place to meet requirements promulgated by DHCS, Department of Managed Health Care (DMHC), NCQA, and CMS.
- Supported insourcing of the behavioral health benefit via management of regulatory filings to secure necessary approvals.
- Identified and remediated two significant instances of suspected fraud, waste, or abuse (FWA), which resulted in overpayment recoveries and internal process improvements to mitigate risk of future issues:
    - Emergency COVID-19 Testing - staff discovered potentially fraudulent billing practices by non-contracted COVID-19 testing providers. Under the guise of California's emergency COVID-19 testing requirements, providers submitted a high-volume of inappropriate claims for reimbursement for COVID-19 tests, which the Alliance recovered as overpayments. Program Integrity staff continue to partner with the Alliance's Claims department to ensure these claims are flagged for further review to prevent inappropriate payments.
    - Medically Tailored Meals - staff found evidence that meals were not provided in alignment with regulatory requirements, including delivering food to ineligible members and lack of proper dietary assessments. Program Integrity staff recovered overpayments as required and continue to partner with organizational leadership to refine and oversee the delivery of this benefit.

Legal and Regulatory Updates

Compliance staff track and an analyze new requirements and manage a process to ensure the implementation of legislation, contract changes, and sub-regulatory guidance. A brief description of significant regulatory developments are included below for Board awareness.

- While the impact is still uncertain, Compliance staff are monitoring changes resulting from the 2024 election. Staff are reviewing relevant Executive Orders to determine impact, including identifying any mitigating factors such as litigation, injunctions, and conflicting state requirements. Potential impacts may include efforts to eliminate the Affordable Care Act's Medicaid expansion, cuts to federal funding through block grants or per-capita grants, changes to Medicaid eligibility criteria, and the introduction of new requirements for approving waiver requests from states.
- Regulators have issued implementation specifications for requirements issued in previous years, including:

    - Implementation specifications for the CMS' Managed Care Access, Finance, and Quality rule, which intends to increase access through establishing timely access studies; enhance quality through value-based purchasing agreements; and ensure transparency with medical loss ratio requirements and enhanced public reporting of plan performance.
    - Implementation specifications for provisions of the revised DHCS Medi-Cal contract that were not effective until 2025 or later, such as community reinvestment and emergency preparedness requirements.
    - Evolving requirements for the enhanced case management (ECM) and community supports (CS) benefits, which largely aim to ensure program integrity in the delivery of services.
- Significant proposed changes to security requirements in response to the increasing risk of breaches and cyberattacks across the healthcare industry, including the increasing prevalence of cyberattacks of business associates. In response, Health and Human Services (HHS) Office for Civil Rights (OCR) issued a proposed rule that would modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule in a way that removes existing flexibility to determine which requirements to implement based on a risk assessment. In addition, DHCS recently notified plans that as a state contractor, we are subject to the State Chief Information Officer's policies which specify that physical data centers must be within the continental United States and that remote access to data from outside the continental United States may only be provided with approval from the State Chief Information Security Officer. While neither rule is final yet, this signals that regulators are prioritizing the security of program data.

Regulatory Audits

The Alliance undergoes routine audits and examinations of its finances and operations by its regulatory oversight agencies, as well as by independent auditing firms. Following is a list of audits and examinations that the Alliance was involved in during Q3-4 2024, including the auditing entity and a description of the audit status.

- DHCS Targeted Behavioral Health and Transportation Audit – which is a statewide review conducted in 2022 to ensure that members are receiving support in coordinating care between the various systems responsible for providing mental health and substance use disorder services as well as a review of plan processes for ensuring transportation is provided to enable members to access covered services. In early 2024, the Alliance received 8 findings; 6 related to coordination of care between the Alliance, its managed behavioral health organization Carelon and the County Mental Health Plan (MHP) for members accessing specialty mental health, non-specialty mental health, and substance use disorder services; and two findings related to the provision of transportation services. Five of the findings have been closed and the remaining findings are pending DHCS' review of supporting documentation such as reports and workflows. Staff anticipate the closure of the remaining findings in early 2025.
- 2024 DMHC Medical Audit – which is a routine review of the Alliance's performance in providing health care benefits and meeting the health care needs of enrollees for the Alliance's Alliance Care In-Home Supportive Services (IHSS) line of business in the areas of: grievances and appeals, prescription drugs, utilization management

(UM), quality management, language assistance, continuity of care, access and availability, and access to emergency services and payment. The Alliance has not yet received the results of this survey.
- Health Services Advisory Group Network Adequacy Validation Audit – which is a review conducted by a DHCS-contracted organization to confirm the validity of the data, systems, and methods used by the Alliance to calculate results for its Annual Network Certification filing. The Alliance received findings indicating that all audited elements met requirements.

In addition, staff prepared for regulatory audits scheduled in early 2025, as follows.
- 2025 DMHC Financial Audit – which is a routine review of the Alliance's fiscal and administrative affairs, including an examination of the financial report and claims practices. The audit commenced in January of 2025 and remains ongoing.
- 2025 DHCS Medical Audit – the 2025 audit was limited in scope, covering UM, case management, coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. As of publication of this report, DHCS has not formally issued findings, however, feedback provided at the close of the interview sessions indicate the Alliance may expect findings related to resolution of quality grievance, oversight of grievance and appeals, and enhanced case management.

Regulatory Notices of Non-Compliance

The Alliance's regulators routinely monitor plan activities to confirm compliance with requirements. Where regulators have found the Alliance to be non-compliant, they may issue warning letters or notices of non-compliance, may implement corrective action plans (CAPs), and may impose sanctions (collectively referred to in this report as "notices of non-compliance"). Following is a list of active concerns addressed during Q3-4 2024.
- DMHC audit sanctions – As previously reported, DMHC imposed an Enforcement Action regarding four findings from the 2020 DMHC Medical Survey which remained uncorrected during the 2022 Follow-Up Survey. The results uncorrected deficiencies related to processing appeals and grievances, pharmacy denial notices, and communications to members regarding grievance resolution and utilization management denials. Notably, the latter two findings were issued because the Alliance erroneously underlined the DMHC's website in our member letters. The Department indicated a willingness to resolve the matter with the payment of a $100,000 administrative penalty. The Alliance continues to negotiate the administrative penalty with DMHC.
- DMHC timely access sanctions – DMHCS imposed an Enforcement Action for failure to submit two required documents with the measurement year (MY) 2019 timely access report, which was submitted in 2020. This was a result of staff oversight, which was corrected immediately when DMHC notified the plan; nevertheless, DMHC is pursuing financial penalties of $15,000 for this omission. The Alliance continues to negotiate the administrative penalty with DMHC.
- DHCS Primary Care Provider (PCP) ratio CAP – DHCS issued a CAP indicating that the Alliance had failed to meet the requirement to ensure the full-time equivalent ratio of one PCP to every 2,000 members in Monterey and Merced counties. Staff revised

network reporting procedures, which addressed the deficiency in Merced County. Staff continue to work collaboratively with DHCS to resolve the ratios in Monterey County as there appears to be a discrepancy in the network data DHCS is reviewing and internal reporting sources.

HIPAA

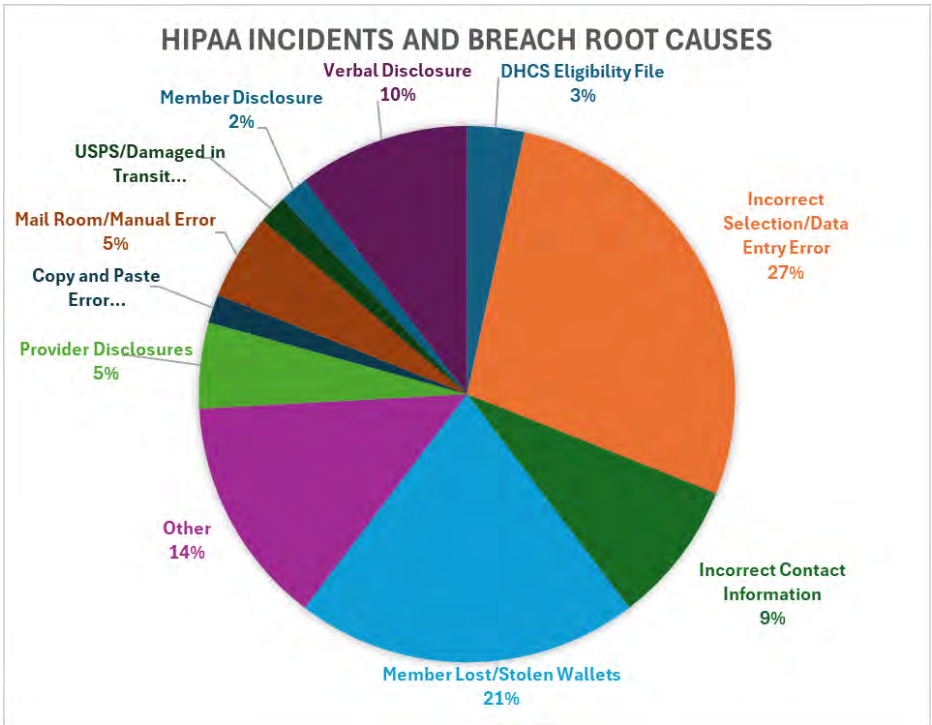
The Alliance maintains a comprehensive process to investigate suspected disclosures of protected health information (PHI) and report disclosures to relevant oversight bodies. The table below summarizes HIPAA Program activity for Q3-4 2024,

		Q3 2024	Q4 2024	Trend
Referrals Received		27	32	22% decrease
Investigation Outcome	Breach	0	0	n/a
	Incident	8	9	47% decrease
	Non-reportable	18	23	10% increase
	Pending	1	0	n/a
Members Impacted		196	229	82% increase

In the second half of 2024, referral volume normalized, with 27 referrals in Q3 and 32 referrals in Q4. 30% of referrals required DHCS notification pursuant to the DHCS Medi-Cal contract, a slight decrease from the first half of the year. Zero referrals were deemed breaches.

425 members were impacted by incidents, meaning that their PHI was disclosed to a covered entity that they did not have a treating relationship with. This is a significant increase from the first half of 2024 and is largely attributed to misconfigurations of the Alliance's new care management system, which resulted in inaccurate provider contact information in limited instances. As a routine practice, corrective action is put in place to prevent recurrence. Notably, staff have not identified any additional disclosures related to the care management system, indicating effective corrective action.

Compliance staff conduct root cause analysis on all referrals, whether a disclosure occurred or not. Incorrect selection/entry, lost/stolen wallets, and verbal disclosures are typically the main drivers of HIPAA referrals, and the first 2 of those 3 root causes are reflected in Q3-4 data. For this reporting period, 'other' replaced verbal disclosure as a top root cause. Examples of these include the afore-mentioned configuration errors and disclosures resulting from errors in the DHCS eligibility file, The chart below shows the root causes of suspected disclosures of PHI during Q3-4 2024.



FWA Prevention, Detection, and Investigation
The Alliance Program Integrity function is responsible for ensuring the Plan has controls in place to prevent and detect FWA, and to investigate, report, and resolve suspected and/or actual FWA. In limited instances, Alliance delegates may conduct some FWA-related activities at the Plan's direction. These activities are represented in this report. The table below summarizes Program Integrity activity for Q3-4 2024,

	Q3 2024	Q4 2024	Trend
Referred	43	35	30%
Opened	15	42	16%
Reported	25	12	38%

Referral volume continued to trend down, with a 30% decrease in referrals and a 16% decrease in cases opened for investigation. Nevertheless, due to an increase in complexity of cases, the total number of cases worked during the time period remained high, with 89 cases active. 55% of referrals met the threshold for DHCS reporting pursuant to the DHCS Medi-Cal contract.

Where FWA is suspected, Plan staff prevents recurrence of the identified behavior by providing education, issuing CAPs, and/or implementing internal controls. Compliance's reporting indicates these corrective actions are effective as there were minimal repeat concerns during the reporting period.

Where the Alliance identifies overpayments, it is required to pursue those recoupments. The table below includes the Program Integrity-related claim recoveries for Q3-4 2024.

Recoupment	Alliance initiated	Delegate initiated
Requested Recoupment	$100,119.77	$7,065.28
Completed Recoupment	$103,182.68	

Provider-related concerns continued to make up the bulk of Program Integrity investigations, with concerns related to over-utilization, duplicate billing, and billing for services not rendered. As previously mentions (Key Accomplishments), significant cases related to billing for COVID-19 testing and medically tailored meals.

Program Integrity staff continue to attend California Department of Justice (DOJ) meetings to stay up to date on current trends and collaborate with regulators, law enforcement, and staff from other health plans. Where information shared may impact the Alliance, staff open referrals and/or work with relevant departments to implement internal controls, in line with standard process.

Delegate Oversight
Where plan functions are carried out by a subcontractor, the Alliance is obligated to ensure those operations are compliant. Prior to delegating any functions, the Alliance conducts a predelegation audit to ensure adequate procedures are in place, and oversees the performance of those core functions through annual desk audits and review of quarterly reporting. Where delegate documentation does not demonstrate full compliance, staff request clarification and/or implement CAPs, as indicated,

The Alliance contracts with 12 entities considered delegates for administrative functions like credentialing and claims processing and clinical functions such as UM. During the reporting period, 62 delegate reviews were initiated, and 71 were closed. In addition to managing ongoing oversight of delegates, Compliance staff oversaw delegate CAP completion, with 3 CAPs closed, one newly opened, and one ongoing. Details are in the table below.

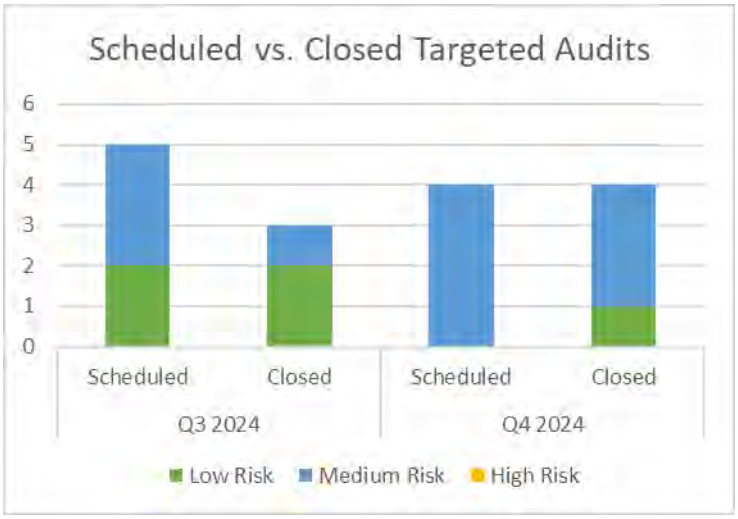
Status	Entity	Concern
Closed	Carelon	Timely processing of credentialing and recredentialing applications
Closed	Carelon	Timely and complete support of contracted providers to ensure network adequacy
Closed	MedImpact	Clear, concise description of denial rationale in member communications related to formulary exclusion requests.
Ongoing	Carelon	Timely access to Behavioral Health Therapy (BHT) services
Opened	MedImpact	Extends clear, concise requirement to all member communications

During the latter half of 2024, staff began tracking and trend opportunities for improvement in delegate performance, as required by NCQA. Staff also began building tools and resources needed to comply with Medicare oversight requirements for FDRs. Staff

conducted their first predelegation audit for our DSNP line of business, approving MedImpact for delegation to enable them to support development of the Part D application.

Internal A&M Program
The Alliance's Internal Audit & Monitoring (IA&M) Program proactively assesses compliance with regulatory and contractual obligations, ensures internal controls are in place to prevent and detect non-compliance, and implements corrective action when non-compliance is identified. The IA&M program includes conducting targeted audits of risk areas and routine monitoring of compliance-related metrics on the Alliance Dashboard.

As shown in the table below, staff are completing planned audits, although closure may lag due to the time needed to obtain corrective action from business units. Q3-4 audit activity focused on similar operational areas as the previous report, including grievance and UM as these are areas of high focus for our regulators; these areas were classified as medium risk. Low-risk areas scheduled for audit were transportation and translation.



During the second half of 2024, a total of 9 internal audits were assigned for review 7 audits were closed (77%). An audit is considered closed when results are shared with business units and a plan for correction is provided. For the two audits that were not closed, Compliance staff had issued findings and were awaiting management response prior to closing the audits. In Q4 2024, staff time was diverted from internal audit to preparation for the scheduled 2025 regulatory audits.

Risk levels and passing results for closed audits are provided in the table below.

		Q3 2024	Q4 2024
Total		3	4
Risk Level	High	0	0
	Medium	1	3

	Low	2	1
Result	Pass	3	2
	Fail	0	2
	Unable to Audit	0	0

2 audits received a failed result during the report period, with details as follows.

- Timeliness of Response to Continuity of Care (COC) Requests – which assessed the timeliness of COC processing, timeliness of member notification, and completeness of content for member notifications. Staff found that that COC requests are processed timely, however, member notification requirements are inconsistently applied, and system documentation to demonstrate compliance is variable.
- UM Authorizations Regulatory Notices - which reviewed UM notices to members and providers to ensure timeliness and required content. While the majority of notices contain the required content, provider notification of authorization decisions were not sent within the required timeframes.

For all aforementioned areas, Compliance staff ensured the implementation of corrective action – either through documented action plans or formal CAPs - and will assess the need to re-audit to confirm full remediation. Effective 01/01/2025, all failed internal audits will be mitigated via formal CAP.

Routine monitoring of compliance-related metrics on the Alliance Dashboard did not identify significant deficiencies. Three regulatory metrics did not meet threshold – timely reporting of HIPAA incidents, timely reporting of suspected FWA, and timely completion of facility site reviews for contracted PCP offices.

		Q3 2024 monitoring; Q2 2024 performance	Q4 2024 monitoring; Q3 2024 performance
Total Metrics Monitored		35	35
Result	Pass	33	34
	Fail	2	1

Confidential Reporting

In support of the requirement to ensure effective lines of communication from staff to the Compliance Officer, the Alliance maintains a confidential hotline, which Alliance staff may use to report compliance issues anonymously. During Q3-4 2024, two reports were received rough the hotline. One was an employee-related concern and managed by Human Resources; the other was a report that a member had threatened their provider. The latter report was responded to by the clinical team in contact with the provider with advice from Compliance staff.

The Alliance also maintains a reporting mechanism on its public website that allows members, providers, contractors, or any other person or entity to submit reports of non-compliance, including anonymous reports if desired. During the report period, Compliance

received a total of 4 reports of potential compliance concerns via this mechanism. Each report was subject to a preliminary review to determine the presence of non-compliance and appropriate next steps.

- 3 of the 4 reports did not identify any instances of non-compliance. These reports were subsequently forwarded to the appropriate department for further follow-up and resolution as needed.
- 1 report was initially identified as a potential HIPAA-related event and was processed accordingly. Upon further investigation, it was determined that the concern did not constitute a reportable event.

Training and Education

All Alliance staff receive web-based compliance training, which reviews FWA prevention, HIPAA policies and procedures, the Alliance's Compliance Plan and Code of Conduct, the Alliance's DHCS Medi-Cal contract, and mechanisms for reporting non-compliance. New hires must complete training within two weeks for staff-level positions, or four weeks for supervisory-level positions. Existing staff are enrolled in the web-based module annually as a refresher. New hires also receive supplemental training which provides a high-level overview of the content and structure of the Alliance's Medi-Cal Contract, regulatory audits, the Internal A&M Program, and HIPAA and FWA processes and reporting mechanisms. In Q3-4 2024, 145 of 146 (99%) of staff enrolled in training completed it timely. The one outstanding training has since been completed, outside the reporting period.

During the reporting period, Compliance staff conducted a routine review of our new hire and annual training content to ensure the content remains relevant and current. No changes were made to the training in 2024 as Compliance staff plan to make significant changes in 2025 to incorporate Medicare's provided training content into the Alliance's current web-based required training modules. All Alliance staff will be required to complete this expanded Medicare training prior to DSNP's planned go-live.

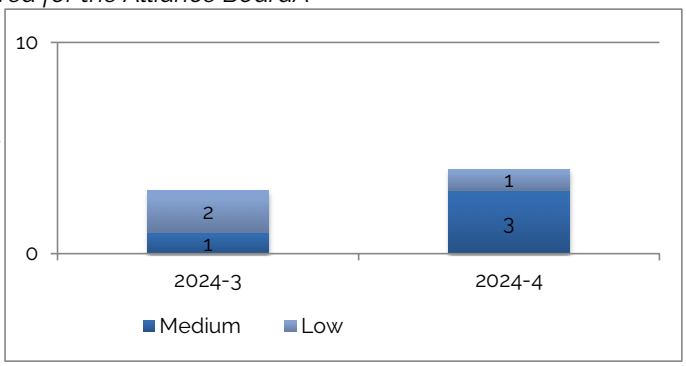
Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments.

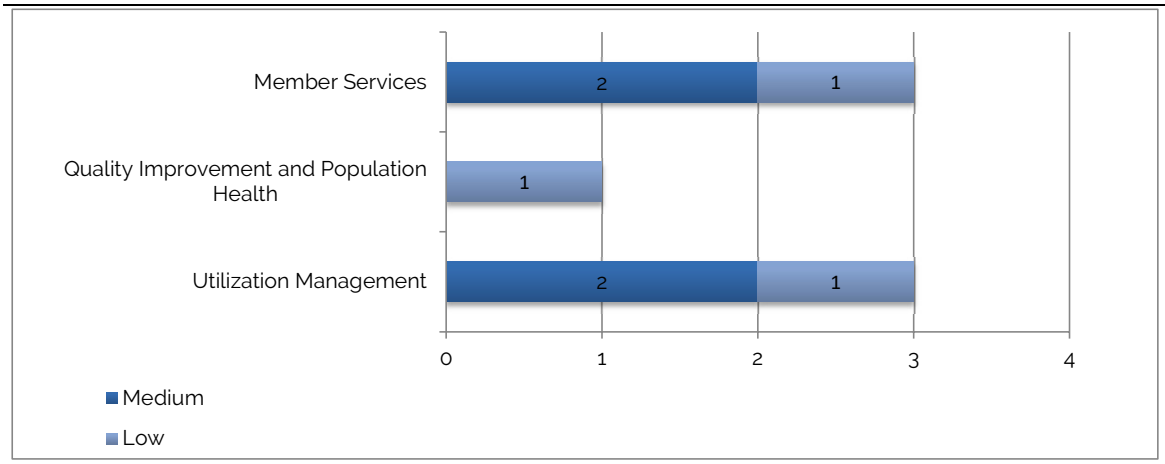
1. Q3-4 2024 Internal A&M Dashboard
2. Q3-4 2024 HIPAA Dashboard
3. Q3-4 2024 Program Integrity Dashboard

Compliance
Internal Audit Dashboard - Q3-Q4 2024
Prepared for the Alliance BoardA

Reviews Closed by Risk Level
Compliance closed a total of 7 risk-based internal reviews during Q3-Q4 2024. The internal audit program assesses and mitigates risk to ensure Plan readiness for regulatory audits and forthcoming accreditations. Items were selected for the work plan based on recent audit findings, new requirements, and regulatory sanctions.

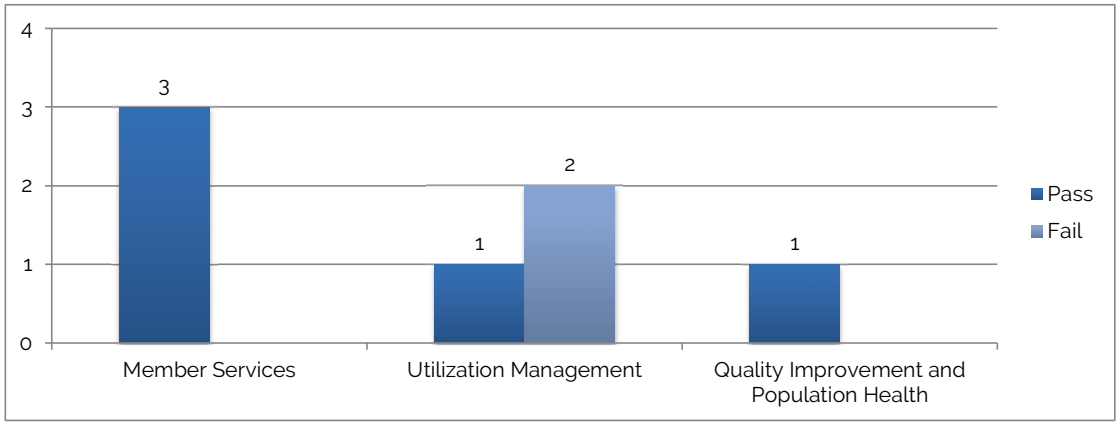


7 Total Reviews Closed in Q3-Q4 2024



Q3-Q4 Reviews by Operational Area & Risk Level
Each review is assigned to a SME department with oversight responsibility of the requirement. The reviews are assigned a risk level based on objective risk criteria such as impact and complexity. The chart shows the number of reviews conducted, separated by department within each risk level.

Q3-Q4 2024 Review Results by Operational Area
5 of 7 closed reviews received a passing score
2 of 7 closed reviews received a failing score



Mitigation for Failed Reviews
In response to failed reviews, Compliance partners with SME departments to ensure deficiencies are corrected through the following:
- Recommending process improvements
- Requesting action plans from departments to cure deficiencies
- Re-auditing to ensure correction

Compliance

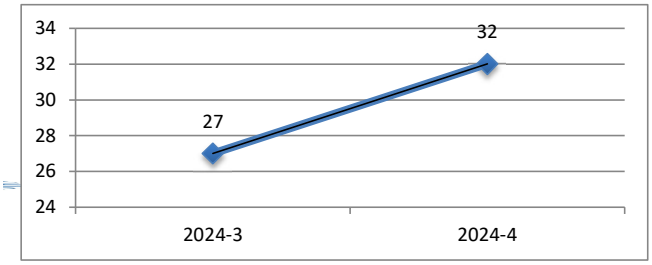
HIPAA Dashboard - Q3-Q4 2024

Prepared for the Alliance Board

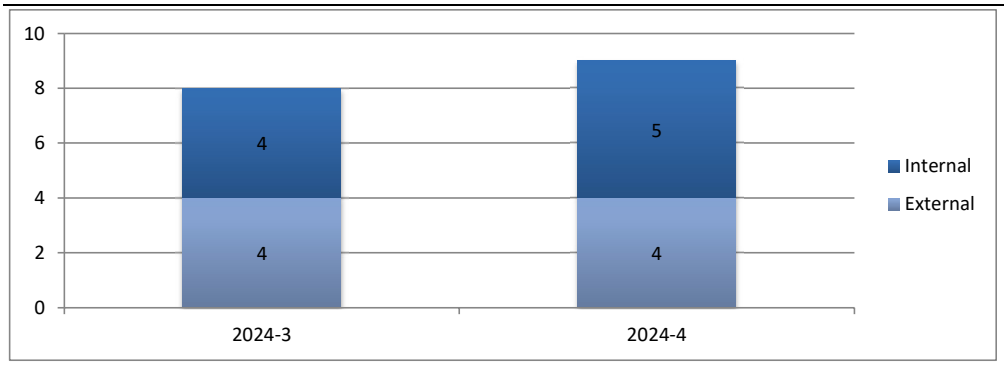
Reports of Suspected Disclosures

Compliance received a total of 59 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q3-Q4 2024.

(This is all suspected events, whether or not they were deemed reportable upon investigation)



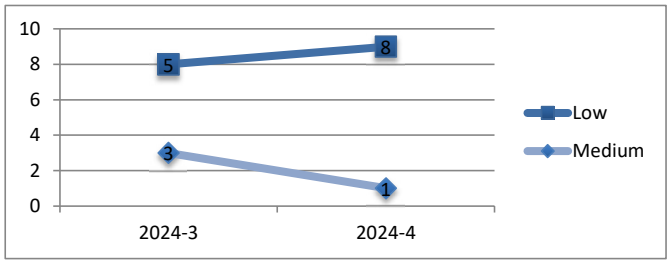
59 Total HIPAA Reports in Q3-Q4 2024



Sources of Disclosures: Internal (Alliance) & External (Non-Alliance

Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegat

**Excludes Non-Events, Duplicates and Non-Reportable Incide*



Impact of Events

(excludes Non-Events and Events Pending Investigation)

8 of 17 events had an impact of low;
9 of 17 had an impact of of medium;
0 of 17 had an impact of high.

Impact levels are determined by analyzing whether PHI was disclosed to a HIPAA covered entity, whetl the PHI has been destroyed or recovered, and the amount of time passed between discovery and

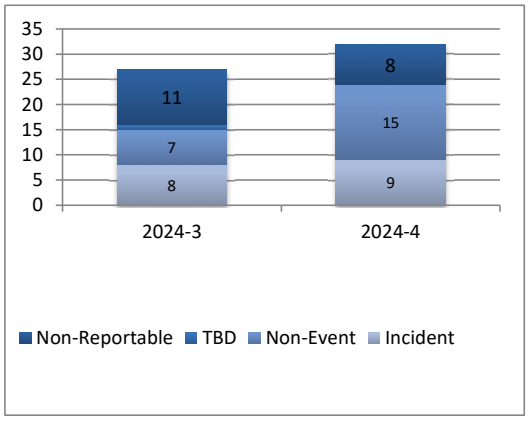
Final Classification

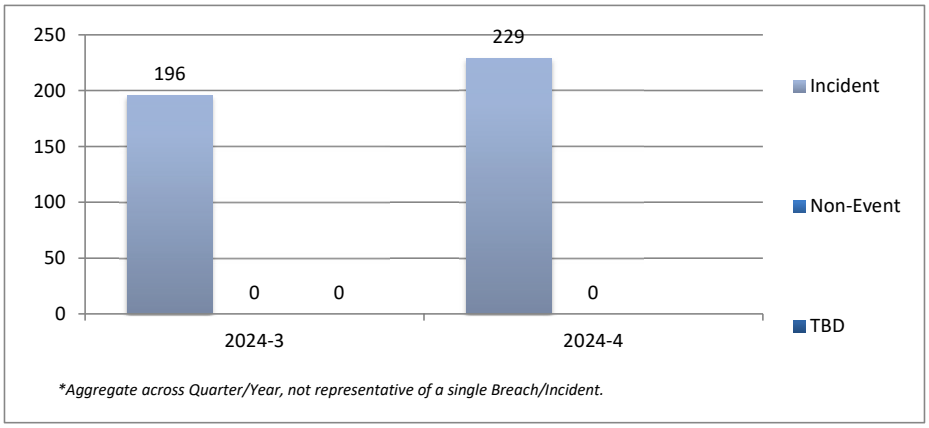
Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; Non-events are when the investigation reveals that no unauthorized disclosure of PHI occured; Mitigated incidents are when the Plan is able to mitigate the disclosure within the 24-hour reporting window.

Member Impact

425 members were impacted by HIPAA events in Q3-Q4 2024; all of which were classified as incidents. Ther were zero breaches.

An incident occurs when PHI has been compromised or has a high probabiliy of being compromised. A breach is whe has been compromised and can only be determined as such by the Alliance Privacy Officer.





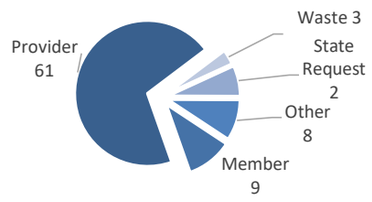
**Aggregate across Quarter/Year, not representative of a single Breach/Incident.*

Program Integrity
Special Investigations Unit Dashboard - Q3-Q4-2024

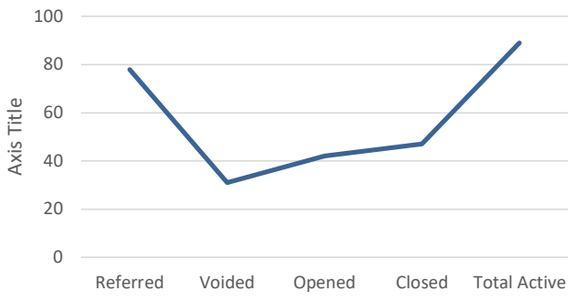
Prepared for the Alliance Board

Note: Unless otherwise indicated, statistics represent data for the quarter only.

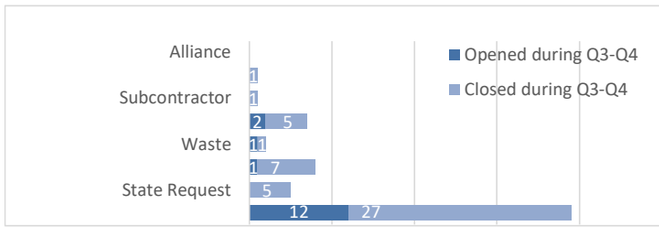
Matters Under Investigation (MUIs)
MUIs are classified by the target of the allegation/concern. ("Other" example: If a member alleges a non-Alliance member may be using his/her Alliance ID card to fraudulently obtain services.)



89
Total

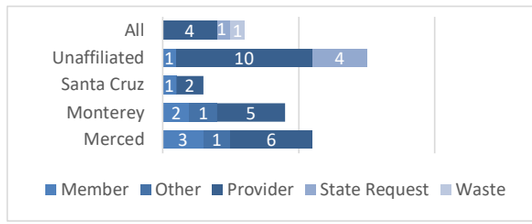


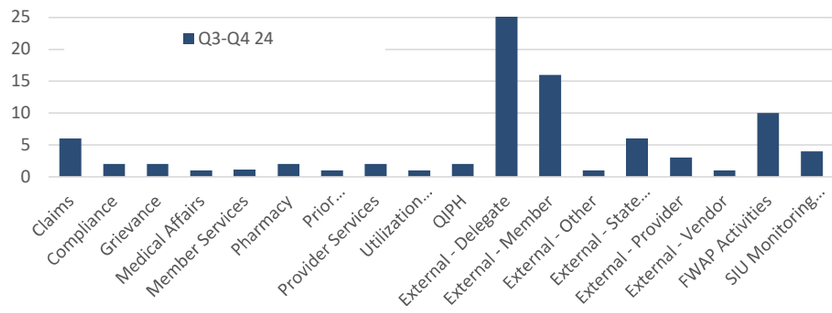
Referral Trends
Referrals come from various sources (internal, delegate, etc.) These referrals are either opened or voided depending on the scope of the referral. MUIs are closed when an investigaton is complete.



MUIs by Status
If MUIs undergo a status change in a single quarter, they are reported once under current status at end of quarter. MUIs by status does not account for MUIs not in an Opened or Closed status

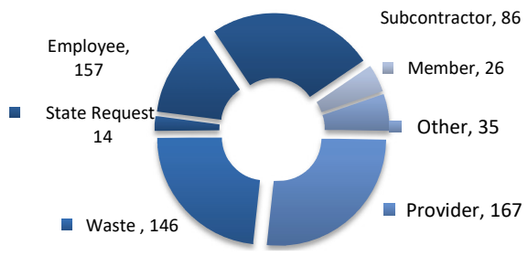
MUIs by County
Most MUIs are assigned a county affiliation. Where a provider serves multiple Alliance counties, or a member receives services in multiple Alliance counties, the county affiliation is identified by the billing address or mailing



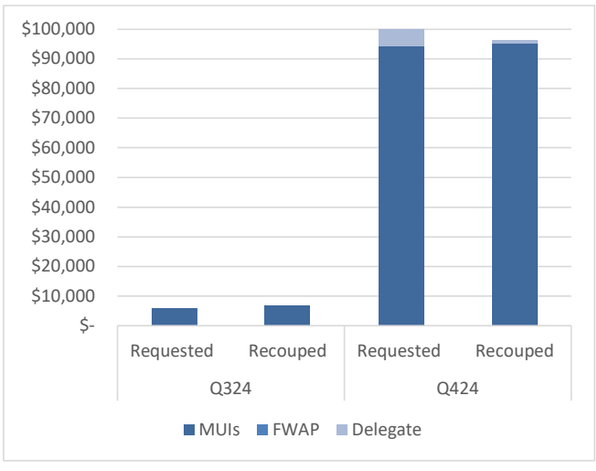


MUI Reporting Department
The referral source represents the origin of the referral, not the nature of the allegation/ concern.

Investigation Duration Average
- Statistics are in business days, excluding Alliance holidays.
- Statistics represent the average of all MUIs closed in previous 12 months.



98
Days



Financial Reporting

MUIs and FWAP: represent claims requested for recovery by the SIU during the review period, subsequent to the resolution of an MUI or a FWAP Program audit.

Recoupment: represent claims on which reoupment was completed during the review period.

Q3-Q424 Requested Recoupment:
- MUI: $100,119.77
- FWAP: $0
- Delegate: $7,065.28

Completed Recoupment:
- MUI/FWAP: $101,888.59
- Delegate: $1,294.09

Information Items: (16A. – 16E.)

Alliance in the News

Board Meeting Date: March 26, 2025

Alliance in the News
California Health Care Foundation
January 25, 2025

Santa Cruz Sobering Center Benefits Patients and Justice System - California Health Care Foundation

Luis's last binge started in late August. On the 13th straight day of heavy drinking, he was feeling "really, really bad, like I was gonna pass out."

He walked into his regular liquor store in Santa Cruz to buy more booze. "The people know me," he said. "The state I was in, they told me to hold off. I said, 'No, forget this.'"

He knew he was not far from the sobering center, so he went there instead, where the staff helped stabilize him for a day. Then Luis spent eight days in detox, after which he went into a residential center. "I decided to stay and keep on with the program," he said.

The day of this interview, Luis had been off the sauce for 17 days. "It feels great," he said. "Now I wake up full of energy. I am ready for the day. I want to complete the program and graduate from there and continue with AA [Alcoholics Anonymous] meetings as well."

That's how it's supposed to work at the Santa Cruz County Sheriff's Office Sobering Center. Opened in February 2024, the sobering center is a low-barrier entry point to substance use treatment and mental health care. People who have been picked up by police for the first time for driving under the influence or for public inebriation can be brought to the sobering center for up to 24 hours to dry out. This way, they can avoid the traditional criminal justice system pathway that puts them in the county jail with people potentially facing more serious charges. Instead, sobering center clients will be cited and given a notice to appear in court.

And now, under the state's California Advancing and Innovating Medi-Cal (CalAIM) initiative, the cost of these services can be paid for by Medi-Cal managed care plans as a covered Community Support.

There are around 17 sobering centers operating in California right now, and many counties are looking into the concept. What makes the Santa Cruz project unique and successful is strong support from County Sheriff Jim Hart as well as effective management from Janus of Santa Cruz, the nonprofit organization that operates the county's sobering center. Janus CEO Amber Williams and her staff coordinated all the transitions Luis made, which can be difficult or impossible in other counties.

Under Hart's leadership, law enforcement and public health are joined in mutual respect for and belief in this new approach. His distinctive innovation is the requirement that any arresting agency in the county that wants to use the county jail must also commit to bringing eligible people to the sobering center.

When it comes to first-time offenders for driving under the influence or being intoxicated in public, "no other county in California mandates usage of a sobering center," said Williams.

Sobering Center a Good Match for Large Student Population

Santa Cruz County's unusual demographic makeup — shaped in large part by the student bodies of local universities, most notably UC Santa Cruz — makes a sobering center especially constructive. "There's 50,000 kids here, and some of these kids are going to make mistakes. For them to be brought in and sit in the drunk tank, it's inhumane. It's scary," Hart said. "We can do better by them."

The center will also help people who struggle with chronic alcohol use or substance use disorder, Hart explained, and will save county resources by reducing calls for service and limiting unnecessary bookings. Said Hart, "We can keep arresting them over and over. It's like banging your head against the wall. Why not try to interrupt that and try to get a company or treatment center like Janus involved?"

Janus has been operating a full continuum of mental health and addiction care for many years, with services ranging from high-risk detox to residential treatment to services for people charged with driving under the influence, or DUI. At the sobering center, the availability of these services is near immediate. As soon as a person who has been driving under the influence is brought in, Janus counselors ask them if they would like to enroll in a DUI program and explain to them that doing so will help their case in court. "When you go before the judge, you can already show you are resolving the matter," Williams said.

The sobering center is located adjacent to the county jail, which makes it easy and convenient for arresting officers to direct people to the correct setting. Most visitors come once to the sobering center. Some make two or more visits. "There is a population in the community that keeps cycling through the jail, with high costs and high medical needs," Williams said. "Now we are able to manage them in our setting."

Hart estimates that roughly 200 people a month are being diverted from the jail to the sobering center. That comprises about a quarter of the people coming into the jail. “It allows our staff to address people who are more violent or dealing with a mental health crisis. It allows us to prioritize people coming in other than being drunk in public.”

“Bad things happen in jail,” he said. “Our jail admissions are led by mental health challenges, addiction, and poverty. That is what drives the system. We want to reduce that incidence of bad things happening.” Hart thinks the sobering center will have diverted 2,000 people from jail over its first 12 months in operation.

“Jim [Hart] has been in leadership in Santa Cruz County for 36 years,” Williams said. “People trust him here. Same for Janus. I’ve been here 23 years. I understand the population, I love the population.”

Policy Continuity Expected

Sheriff Hart will be leaving office soon, and his successor, Undersheriff Chris Clark, will take office on December 6.

He is a strong supporter of the sobering center. “We see a lot of substance use disorder and mental health,” Clark said. “Usually, it’s both. We respond to 300 crisis-related calls a month. That is a lot for an agency our size. How do we deal with people in those situations? How do we train our deputies to interact with people in those incidents? How do we respect the sanctity of life and the safety of everybody involved?”

Clark thinks the culture of the sheriff’s office is “somewhat special. I chose to work here because of the forward-thinking, progressive nature of the office as a whole. There could be a perception that Santa Cruz is left leaning, but the support for law enforcement has always been good.”

The sobering center fulfills the public’s desire for order in the streets, Clark believes. “You’ll have people high on drugs, acting out, suffering significant mental illness, laying on the sidewalk. Are they a danger? No, not necessarily. But people feel threatened. What the sobering center does for us, when a person is in a crisis, high or drunk, it allows them to be directly connected to services at Janus.”

The budget of the sheriff’s office is about $140 million. The office uses part of those funds to pay for a share of the sobering center’s operating expenses. And law enforcement agencies get a return on this investment: For low-level crimes such as public drunkenness or DUI, there is reduced turnaround time for staff. A person can be delivered and admitted to the sobering center in 10 minutes or less, whereas a jail booking can take much longer.

As a result, the local agencies “get their officer back on the street faster, in a world where staffing is critical,” Clark said. It’s a direct effect, and it happens right away. “That ought to get the attention of most agencies in the state,” he added.

Emergency Departments Appreciate Sobering Center

The benefit to the healthcare system is equally significant. From a clinical standpoint, many people end up in the emergency department who would be better served

elsewhere. “The sobering center is a good example of that,” said Dennis Hsieh, MD, an emergency physician and chief medical officer of the **Central California Alliance for Health**, the managed care plan that contracts with Medi-Cal to cover residents of Santa Cruz County.

When people who are drunk or high are brought to the emergency department, “not much is done for them except giving them a place to sober up,” Hsieh said in an interview. “It prevents other patients who need to be seen from being moved through the ED as quickly as they should be.”

Emergency departments carry enormous, fixed costs that make them expensive to operate, including qualified staffing, specialized equipment, and oxygen hookups that are not usually needed for sobering up. The ED can do the job “but it’s overkill,” Hsieh said, comparing the process to “using a bulldozer to dig a hole in your back yard for a seed, as opposed to using a small shovel.”

The sobering center also helps the health plan meet its goal of assuring that members receive rapid and safe access to services. From the health plan perspective, he said, the sobering center is “a way to provide the right care at the right place at the right time. They get a place that specializes in focusing on them.”

Furthermore, the sobering center is well-positioned to help connect patients to longer-term services and is cost-effective for the health plan. It offers “compassionate, supportive, and professional patient-centered care” that enables patients to avoid jail and focus on recovery, Hsieh said.

A Big Step

That is how it has worked out for Luis.

“In my personal life, I was having a lot of problems,” he said in an interview from the residential treatment center. He was having DUIs and losing jobs. “Everything kept stacking up. I started arguing constantly with my wife.

“I am tired of that. I wanted to break that routine. I went to the sobering center, now I’m here.

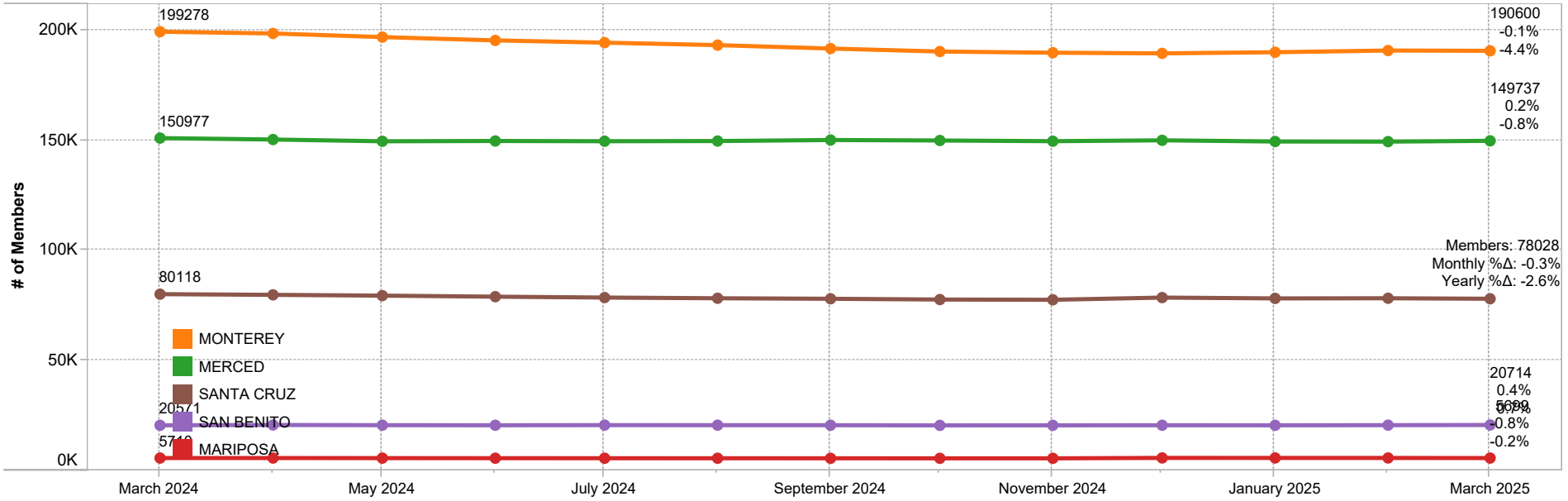
“Without the sobering center, to be honest, I don’t know what I’d be doing,” he continued. “In some ways it is helpful to listen to other people. I am learning, doing group meetings, talking about our feelings. All that helps me out. I think it’s a big step for me.”

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *3/3/2025 6:36:16 AM*

Enrollment Month
3/1/2024 to 3/31/2025

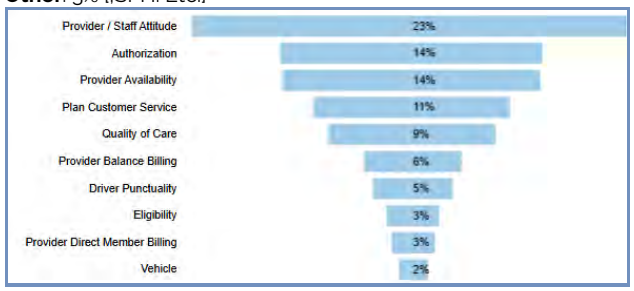
Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



LOB	County	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Medi-Cal	SANTA CRUZ	80,118	79,800	79,449	78,976	78,570	78,253	78,019	77,672	77,561	78,558	78,187	78,252	78,028
	MONTEREY	198,574	197,766	196,108	194,606	193,576	192,464	190,915	189,564	189,037	188,754	189,278	190,056	189,925
	MERCED	150,977	150,324	149,527	149,663	149,551	149,631	150,104	149,886	149,564	149,963	149,424	149,370	149,737
	MARIPOSA	5,710	5,708	5,671	5,640	5,623	5,609	5,595	5,577	5,575	5,763	5,750	5,746	5,699
	SAN BENITO	20,571	20,723	20,627	20,592	20,653	20,630	20,614	20,534	20,563	20,592	20,571	20,635	20,714
IHSS	MONTEREY	704	719	725	731	729	723	717	709	702	693	684	680	675
Total Members		**456,654**	**455,040**	**452,107**	**450,208**	**448,702**	**447,310**	**445,964**	**443,942**	**443,002**	**444,323**	**443,894**	**444,739**	**444,778**

Member Appeals and Grievance Report
Q4, 2024

Q4 2024 Appeals and Grievances: 1206* including Carelon.
Appeals: 13% [84% in favor of Plan; 16% in favor of Member]
Exempt: 38%
Grievances: 46%
Other: 3% [,SFH. Etc.]



Analysis and Trends

- 10% appeals increase involving Community Support benefits
- Quality of Care concerns decreased again during Quarter 4

Highest Grievances Filed by County

1. **Monterey**: 37%
2. Merced: 35%
3. Santa Cruz: 21%
4. San Benito: 4%
5. Mariposa: 2%

Behavioral Health Carelon Grievances: #40

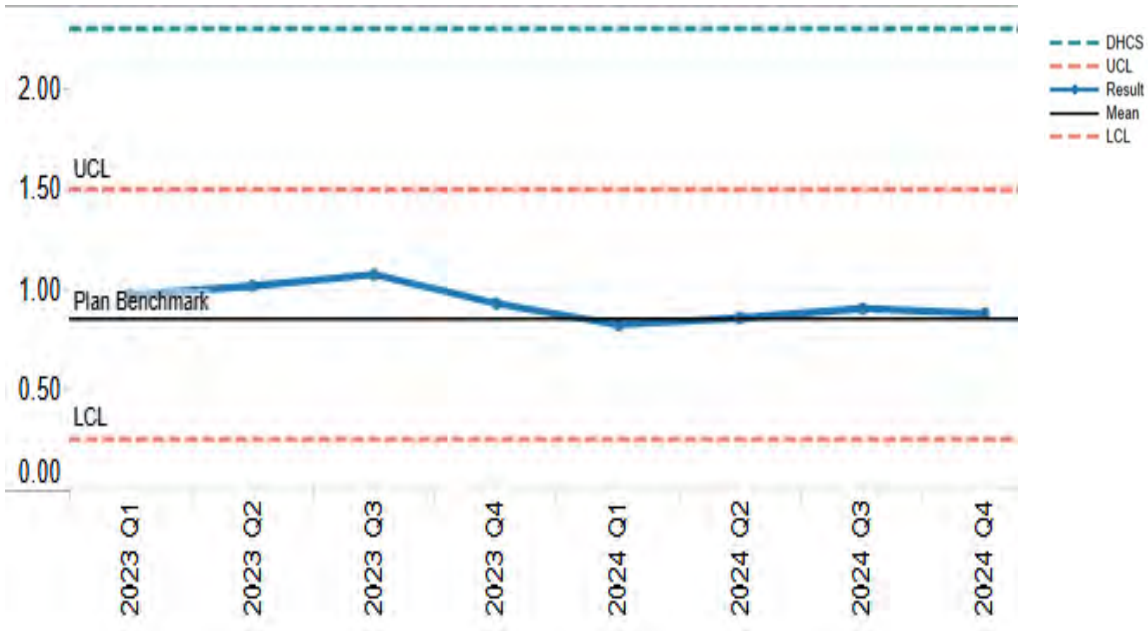
- **Monterey**: 15
- Santa Cruz: 14
- Merced: 7
- San Benito: 4

IHSS Summary: #11

- Member Grievances: 2
- Exempt Complaints: 9

☒ **In Control**
☐ **Not in Control**

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL). Control limits represent three (3) standard deviations from mean or average performance.



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	MemberMonths	420,218	421,740	423,191	426,109	427,751	428,849	427,117	425,602	419,723	415,702	411,428	407,693
	Case Count	321	425	480	376	488	436	448	459	455	479	369	295
	Case Count Per 1000 MM	0.76	1.01	1.13	0.88	1.14	1.02	1.05	1.08	1.08	1.15	0.90	0.72
2024	MemberMonths	458,093	456,832	456,653	455,040	452,106	450,200	448,693	447,298	445,936	443,905	442,921	444,181
	Case Count	394	386	345	399	427	333	416	409	384	423	386	357
	Case Count Per 1000 MM	0.86	0.84	0.76	0.88	0.94	0.74	0.93	0.91	0.86	0.95	0.87	0.80

*Grievances Per 1,000 Member Month

Back to Agenda

Community Impact Report: the Alliance invested $93M in 2024 to improve health outcomes

Scotts Valley, Calif., February 20, 2025 — Central California Alliance for Health (the Alliance) is pleased to announce the release of its 2025 Community Impact Report, highlighting the organization's transformative investments and initiatives to close health disparities throughout 2024. The report, themed Community. Connection. Care., showcases how the Alliance has partnered with local organizations to address key social drivers of health and improve access to care for Medi-Cal members across Mariposa, Merced, Monterey, San Benito and Santa Cruz counties.

"At the Alliance, we recognize that achieving optimal health is much more than just receiving medical care—it's stable housing, access to nutritious food, support from trusted community health workers and more," said Michael Schrader, CEO of the Alliance. "Through meaningful partnerships and strategic investments, we are working toward our vision of Healthy People, Healthy Communities."

Key highlights from 2024:

- **$93 million in community investments**: Funding supported housing, healthcare workforce development and community education.
- **Alliance Housing Fund**: Over $30 million awarded to 17 housing projects, creating 824 permanent supportive housing units and 210 temporary beds.
- **Expanding the Community Health Worker (CHW) and Doula networks**: 38 CHWs and 12 doulas were added to support Medi-Cal members in 2024, with more to follow in 2025.
- **Enhanced Case Management and Community Supports**: $15 million invested in programs to address homelessness and other social drivers of health.
- **$16 million in health care facilities**: Funding supported 12 capital projects to improve access to primary care, specialty care, behavioral health services and other critical services for over 72,000 Medi-Cal members.

To read the full report, visit thealliance.health/community-impact-report-2024.
For questions, contact Linda Gorman, Marketing and Communications Director, at lgorman@thealliance.health.

About Central California Alliance for Health (the Alliance)

The Alliance is a regional Medi-Cal managed care health plan established in 1996, dedicated to improving access to health care for over 450,000 members in Merced, Monterey, Santa Cruz, Mariposa and San Benito counties. Operating under the state's County Organized Health System (COHS) model, the Alliance connects members with providers to deliver timely services and care, emphasizing prevention, early detection and effective treatment. With vision of "healthy people, healthy communities," the Alliance remains committed to enhancing access to quality health care for its members. For more information, visit www.thealliance.heath .

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

Impact Report

Community. Connection. Care.

2025

Community. Connection. Care.

Each word is an important piece of the puzzle when it comes to creating and cultivating thriving, healthy communities. However, the successful marriage of this triad—that's where the magic happens. It's the combination of our community investments, meaningful connections with our local partners and the care our partners provide that make our vision of Healthy People, Healthy Communities possible. And for that, we thank you.

You'll notice that 'care' is listed last in that triad. That's intentional. For our members to be able to obtain optimal health, they must first receive the support they need in other aspects of their life. Whether that's stable and safe housing, securing a nutritious meal, or receiving support from health workers in their community, these social drivers of health are critical components of health care. Addressing these socioeconomic factors has been a focus of our work this year and will remain so in the coming years.

As you read through this year's report, you'll find exemplary highlights of community, connection and care reflected in our actions and partnerships in the communities we serve. While we realize there is much left to do to realize our shared vision, we are humbled and energized by the work of our partners and the investments we've made to support this work.

We appreciate your ongoing collaboration and commitment to this mission-driven work as we continue to empathetically meet our members' needs where and when they need it most.

Michael Schrader

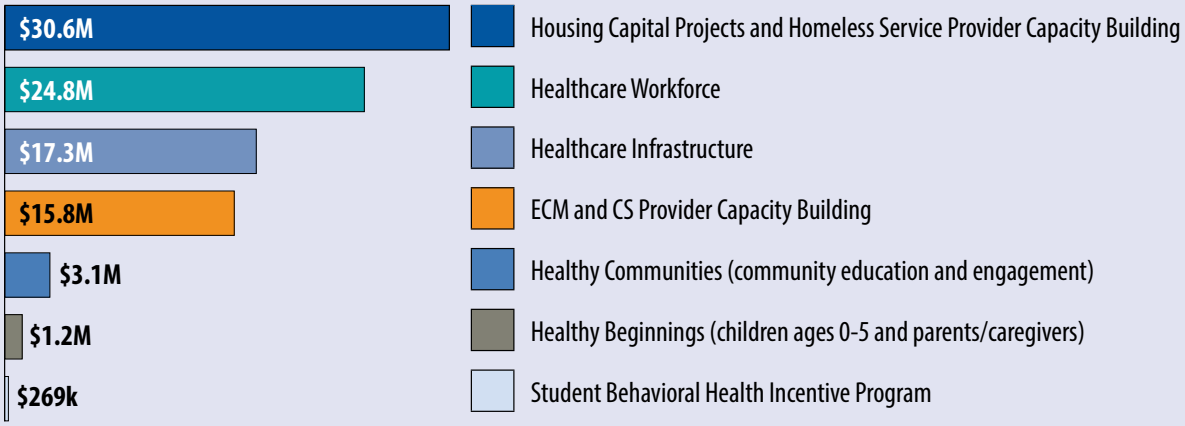
Michael Schrader, CEO

Community. Connection. Care.

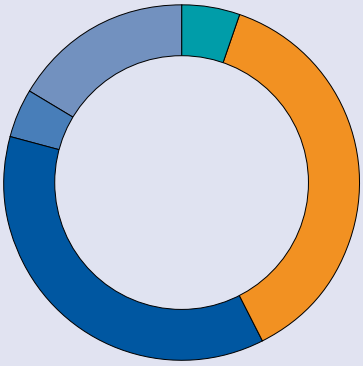
COMMUNITY INVESTMENTS BY THE NUMBERS

The Alliance makes investments to health care and community organizations through the Alliance's Medi-Cal Capacity Grant Program (MCGP) and by administering Department of Health Care Services incentive programs to realize the Alliance's vision of Healthy People, Healthy Communities.

2024 Community Investments by Funding Priority



2024 Investments by County



- **Mariposa** | $4.9M | 6%
- **Merced** | $34.6M | 38%
- **Monterey** | $34M | 36%
- **San Benito** | $4.1M | 4%
- **Santa Cruz** | $15.2M | 16%

2024 COMMUNITY INVESTMENTS

$93M
Total

$46.4M
MCGP

$46.7M
DHCS Incentive Programs

267
Investments

218
Grants

49
Awards

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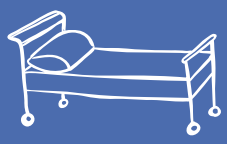
CAPITAL INVESTMENT/HOUSING FUND

The Alliance recognizes that housing is fundamental to healthcare. Without stable, safe housing, our members face significant challenges in maintaining their health. To address this, we committed resources to capital investments to build housing across the Alliance service area.

In May 2024, we formally launched the Alliance Housing Fund to provide capital funds to build, purchase, renovate and/or furnish permanent housing units, recuperative care facilities and short-term post-hospitalization housing units. Recuperative care facilities and short-term post-hospitalization housing are facilities where members can live for a set length of time while they recover. The Alliance Housing Fund will help expand temporary and permanent housing opportunities for Medi-Cal members. In July alone, we awarded more than **$30 million to 17 housing projects**.

In total, the Alliance Housing Fund has funded:

$34 million to permanent supportive housing projects, totaling **824 individual units**.



$5 million to recuperative care projects, totaling **97 beds**.

$3 million to short-term post hospitalization housing projects, totaling **113 beds**.

$3 million to shelter projects, totaling **75 beds**.

"The Alliance has recognized housing as a foundational building block to health and invests in permanent supportive housing and capacity building for supportive services."

- Natalie Magana Boyles, MidPen Housing

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BUILDING OUR CHW NETWORK

Community health workers (CHWs) bring a unique combination of lived experience and specialized training that enables them to build trust with Medi-Cal members by providing education and navigation of health care and social services. Through the CHW Recruitment Grant Program, we helped bring **38 CHWs** into our network, fostering a culturally competent and diverse workforce that reflects our membership. The program provides grants of up to **$65,000** per recruit to subsidize recruitment and first-year costs.

In addition, we invested **$1.6M** to support two CHW Training Programs offered by UC Merced University Extension and Monterey County Workforce Development Board. In 2024, 25 graduates completed the training, with more to follow in 2025. These programs offer free tuition to employees of Alliance-contracted providers, expanding their capacity to deliver CHW Benefit services. Participants are trained in core skills and competencies to address Medi-Cal members' medical and social support needs effectively.

Trilingual CHWs from **Centro Binacional para el Desarrollo Indígena Oaxaqueño** (CBDIO). CBDIO's staff provide services in English, Spanish and indigenous Central American languages including but not limited to Mixteco and Triqui for Alliance members residing in Monterey County.
(Photo Credit: CBDIO)

COMMUNITY COLLABORATIVES

We participate in **50 community collaboratives**, where community partners and stakeholders across our service area convene to discuss community health issues and their solutions. These meetings engage participants in critical health-related discussions and ensure our members' needs are heard and represented. These collaboratives have strengthened existing relationships between the Alliance and our partners and have fostered meaningful connections throughout the community.

In addition to these community collaboratives, we host the Public Information Officer (PIO) Roundtable in Merced County. This quarterly meeting brings together PIOs from partner organizations to align on priorities, share initiatives, and identify collaboration opportunities. Many great partnerships have resulted from the PIO Roundtable, including a co-branded media campaign in partnership with the Merced County Office of Education and Dignity Health-Mercy Medical Center that reached **nearly 862k community members in Merced**.

We participate in **50** community collaboratives.

Nearly 862k community members in Merced reached with a co-branded media campaign.

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COMMUNITY PARTNERSHIPS

October 2024 grand opening of **Merced County Community Action Agency's** Enhanced Care Management Facility in Merced, CA. (Photo Credit: Merced County Community Action Agency)

We foster strong community partnerships with health care providers, community-based organizations (CBOs), county health and social service agencies, schools and housing service providers. Together, these partnerships share data, enhance service capacity and plan responses to community health needs. In 2024, we divided **$750,000 equally among our five county health departments** to address key health issues and identify actionable solutions. We also contribute data to the county-level Community Health Assessments and Community Health Improvement Plans. We partner with homelessness Continuums of Care to better coordinate housing and health services. By supporting trusted CBOs and new, non-traditional Medi-Cal providers serving marginalized communities, we help educate Medi-Cal members, improve access to care and promote preventive health screenings. These collaborative efforts are essential to delivering person-centered care in the Medi-Cal delivery system.

COMMUNITY EDUCATION

We recognize that local organizations are trusted messengers in the community. To strengthen our relationship with these partners and ensure they feel connected to our health plan, we connect with community partners and stakeholders who may be less familiar with the Alliance through 'relational meetings.' These meetings provide an opportunity for our staff to connect with partner organizations and introduce them to the benefits and services we offer. We offer presentations tailored to address the organizations' particular needs and any questions they may have. In 2024, we held over **85 relational meetings** and more than **15 community presentations**.

These initiatives have expanded access to member resources, fostered new partnerships and provider collaborations, and created opportunities to invest in efforts that support our members' health.

85 relational meetings.

15+ community presentations.

PARTNERING WITH SERVICE PROVIDERS TO ADDRESS HOMELESSNESS

The Alliance supports efforts to end homelessness through initiatives like the **Housing Fund, street medicine investments,** funding **data system investments** in each service area through the Homelessness Management Information System (HMIS) and funding staffing and service delivery for other housing programs.

Partner organizations can use these investment opportunities to build sustainable programs that can then bill through normal medical claims. This means that programs that have previously relied on uncertain and variable funding sources can be maintained through a stable source of funding. These Alliance investments create a system where members experiencing homelessness can receive medical care where they live, access services to prepare for and secure housing, receive support to stay housed and even live in a unit funded by the Alliance.

Photo from the **Recuperative Care Center** featuring (from right) Case Managers Roman Gioglio and Abdul Rahmanyar meeting with two members.

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BUILDING OUR DOULA NETWORK

Doulas play a crucial role in supporting Medi-Cal members by providing them with culturally competent support and education before, during and after childbirth. This support from doulas helps improve maternal outcomes, especially for Black and Indigenous individuals who face higher rates of adverse birth outcomes. Doulas also assist with health navigation, lactation support, birth plans and connection to other essential resources.

We're building our network of doulas to provide services to Medi-Cal members. **Doula Recruitment grants totaling $65,000** helped offset first-year costs, enabling **12 new doulas** to join our network in 2024. We also invested **$1.6M** in training, mentorship and administrative support for new doulas entering the Medi-Cal delivery system and providing services to Alliance members.

The first doula cohort of the training program hosted and led by **The Parenting Connection of Monterey County** (PCMC). Trainees receive support from PCMC after graduation through mentors, continuing education, and Medi-Cal billing management. (Photo Credit: PCMC)

CONNECTION TO CARE

The Alliance invests in trusted community partners to support parents and caregivers through free parenting classes in multiple languages and home visits that provide safe, nurturing environments where young children can thrive. These programs strengthen parent-child relationships, provide vital information about child development and access to preventive care services, and offer members spaces to connect and share experiences with other parents. Home visits can also act as a bridge to other Medi-Cal services, such as Enhanced Care Management.

In 2024, we funded **18 active parent education and support projects** and **four home visiting projects**, with each grant award ranging from **$100,000 to $250,000**.

Parent graduates from **Positive Discipline Community Resources'** (PDCR) skill-building parenting classes for their children ages 0-5. These classes are facilitated in both Spanish and Mixteco in Pajaro Valley. (Photo Credit: PDCR)

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COMMUNITY OUTREACH

We understand that it's important to meet our members where they are at—in their communities. This is why we are committed to maintaining a local presence in the areas we serve.

We were proud to attend over **130 outreach events** in 2024, reaching more than **30,000 community members** across Mariposa, Merced, Monterey, San Benito and Santa Cruz counties! These events covered a range of topics including community health and safety, breastfeeding and healthy babies, celebrations of children, family empowerment and support and community and cultural celebrations. Our participation in these local events fosters connections with our members and partners and increases the community's understanding of our services.

"Your enthusiasm and partnership made a significant impact on the success of our event, and we are immensely thankful for your contribution. Your hard work and dedication played a vital role in creating a welcoming and organized environment for all attendees."

- Rachel Pedinoff, Development and Community Engagement Manager, Coastal Kids Home Care

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STREET MEDICINE

This year, the Alliance-funded Street medicine unit through Mercy Medical began serving members at locations convenient for them in Merced. Alliance street medicine providers go beyond brick-and-mortar offices to meet members where they are, such as on the street, in cars, RVs, abandoned buildings or homeless encampments. They address a full range of health care needs within their scope, including preventive care and treatment of acute and chronic conditions. Alternatively, providers may instead care for members in a non-PCP capacity as a referring or treating contracted provider. Street medicine minimizes barriers to accessing care and offers service delivery to this population on their own terms.

We now reimburse providers offering street medicine services—health and social services tailored to meet the needs of individuals experiencing homelessness, delivered directly to them in their own environment.

ENHANCED CASE MANAGEMENT AND COMMUNITY SUPPORTS

Enhanced Case Management (ECM) and Community Supports (CS) are non-medical support services intended to help members address social drivers of health, such as housing or access to nutritious foods. In 2024, we invested **$15 million** in start-up funds for provider organizations launching ECM/CS programs. Funds went towards increasing staffing and program materials such as vehicles, computers or office space. These investments expanded access to members across all five counties in the Alliance service area. We also expanded ECM service populations; now many members (individuals and families experiencing homelessness, people with mental health or substance use disorder needs, and children and youth in foster care adults and youth transitioning from incarceration, and pregnant and postpartum women) are eligible for these services.

$15 million
in start-up funds for provider organizations launching ECM/CS programs.

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BEHAVIORAL HEALTH

Our grant program invests in new health care facilities to ensure Medi-Cal members can access high-quality care when, where and how they need it. In April, the County of Monterey Health Department celebrated the opening of its Alisal Integrated Health Center, made possible by a **$2.65M capital grant**. This new clinic significantly enhances access to behavioral health services for children and their families in East Salinas. In its first year, approximately **400 Medi-Cal members** will receive services at this new facility.

In addition to comprehensive medical and preventive care, the center offers a wide range of behavioral health services in both Spanish and English, including walk-in options. By emphasizing early mental health intervention, this facility empowers young people and their families to achieve better health outcomes, build resilience and foster a better quality of life.

Alisal Integrated Health Center

Made possible by a
$2.65M capital grant.

~400 Medi-Cal members
will receive services
at this new facility.

April 2024 grand opening of **County of Monterey Health Department's** Alisal Integrated Health Center.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

ABOUT THE ALLIANCE

The Alliance is a regional Medi-Cal managed care health plan established in 1996. The Alliance is dedicated to improving access to health care for members in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. Operating under the state's County Organized Health System (COHS) model, the Alliance connects members with providers to deliver timely services and care, emphasizing prevention, early detection and effective treatment. With a vision of Healthy People, Healthy Communities, the Alliance remains committed to enhancing access to quality health care for its members.

www.thealliance.health · 800-700-3874

2024
ANNUAL REPORT
TO THE SANTA CRUZ, MONTEREY, MERCED, SAN BENITO, AND MARIPOSA COUNTY BOARDS OF SUPERVISORS
FROM
THE SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA MANAGED MEDICAL CARE COMMISSION

Central California Alliance for Health (the Alliance) is a locally governed and operated public agency established by Ordinances adopted by the counties of Santa Cruz, Monterey, Merced, San Benito, and Mariposa. The Alliance is governed by the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission (the Commission), whose members are appointed by the Boards of Supervisors in each county.

- The Alliance's Vision: Healthy people. Healthy communities.
- The Alliance's Mission: Accessible, quality health care guided by local innovation.
- The Alliance's Values: Improvement, Integrity, Collaboration, Equity

The Commission seeks to achieve the Alliance's mission through operation of a County Organized Health System (COHS) health plan, currently serving over 443,000 members in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties.

Commission Structure

The Alliance is governed by the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission, whose members are appointed by each counties' Boards of Supervisors including individuals representing interests of the public, providers, and government. Additionally, the Commission has established advisory groups consisting of member and physician representatives, which advise the Commission on policy matters.

The Commission meets regularly in public meetings governed by open meeting laws afforded through the Brown Act. In 2024, the Commission held 10 regular board meetings, including a day-long retreat to discuss key strategic issues. All meetings are accessible to members of the public in compliance with the Brown Act. During these meetings, the Commission discusses and decides upon policy issues and receives reports regarding on-going operations from Alliance staff.

Throughout 2024, Elsa Jimenez, Director of Health for the Monterey County Health Department, served as Chairperson of the Commission and Josh Pedrozo, Merced County Board of Supervisor served as Vice Chair.

At the November 2024 Commission meeting, Elsa Jimenez, was elected to continue to serve as the Commission Chairperson and Leslie Abasta-Cummings, Merced County provider representative, was elected as Vice Chairperson for 2025.

See Attachment A for a list of Commissioners who served during 2024, including each Commissioner's category of representation, and Attachment B for a report of Commissioner meeting attendance during 2024.

Commission Activities and Accomplishments in 2024

The 2024 calendar year brought forth another year of challenges as well as opportunities for the Alliance. The Alliance began 2024 with the expansion of its membership and its service area, with the expansion of eligibility to all income eligible adults regardless of immigration status, while also expanding services to eligible Medi-Cal beneficiaries in San Benito and Mariposa counties, adding a combined, approximately,50,000 new members.

Meanwhile, the Alliance continued its focus on supporting Alliance members, providers, and community organizations to address healthcare needs within the community. Activities and accomplishments of the Commission and the Alliance throughout 2024 included:

1. **Service Area Expansion.** On January 1, 2024, after approximately 2 years of planning and implementation efforts, the Alliance welcomed eligible Medi-Cal members in San Benito and Mariposa counties into the health plan. This included the addition of 20,453 beneficiaries in San Benito County and 5,735 beneficiaries in Mariposa County. To adequately serve these new enrollees, the Alliance onboarded a comprehensive provider network in the new service area while ensuring continuity of care for all new enrollees.

2. **Addition of Chief Health Equity Officer.** In February 2024, Dr. Omar Guzman was hired as the Alliance's first Chief Health Equity Officer (CHEO). The CHEO is dedicated to promoting health equity and improving access to quality healthcare for the communities served by the Alliance with a focus on building relationships with community organizations and provider partners and implementing impactful programs to reduce health disparities and ensure equitable access to healthcare services.

3. **Enhanced Care Management**. Enhanced Care Management (ECM) is a key component of the State's transformational CalAIM program designed to provide comprehensive, person-centered care to Alliance members with complex medical and social needs. ECM aims to improve health outcomes and reduce disparities by addressing both medical and social determinants of health through coordinated, whole-person care. Throughout 2024, the Alliance focused

on strengthening its ECM program through development of its ECM provider network and increasing enrollment of members in identified populations of focus. These efforts resulted in a six-fold increase in ECM enrollment equaling approximately 3% of Alliance members.

4. **Voluntary Rate Range Program.** With approval of the federal Centers for Medicare and Medicaid Services and DHCS, using the Alliance's Medi-Cal managed care contract as a funding mechanism, the Alliance facilitated the receipt and distribution of over $51.8M in increased federal funds to county public health departments and public hospitals by leveraging local funds contributed by interested, qualified governmental agencies through intergovernmental transfers to draw down federal matching funds, which in turn were distributed to identified providers to support the provision of services to Alliance members.

Community Investment Activities and Accomplishments in 2024

The Alliance makes investments in health care and community organizations through the Alliance's Medi-Cal Capacity Grant Program (MCGP) and by administering Department of Health Care Services incentive programs to realize the Alliance's vision of Healthy People, Healthy Communities.

Medi-Cal Capacity Grant Program (MCGP). In February 2024, the Board approved an annual investment plan policy for the MCGP to serve as a roadmap, defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's service area and allocating funding through investment of a portion of the Alliance fund balance to advance the goals under each focus area and strategy. In March 2024, it approved an inaugural plan for 2024 under the new policy. The 2024 MCGP Investment Plan included allocations for funding grants in Mariposa and San Benito counties which joined the Alliance in January 2024

In 2024, the Alliance awarded 218 grants totaling $46.4M to community partners to increase the availability, quality and access of health care and supportive resources for Medi-Cal members in the Alliance service area as well as to address social drivers that influence health and wellness. In May and June 2024, the Grant Program team conducted significant outreach and applicant support, including a webinar attended by 171 attendees from 150 organizations across our five counties. The result was the highest volume of grant applications ever received by the Alliance in July. The MCGP experienced a year-over-year increase of 97% in total dollar amount awarded, in part due to new Capital and Data Sharing Support programs launched this year as well as the following strategic investments:

- $3.8M targeted intervention with 15 primary care clinics in Merced to close preventative care gaps;
- $1.6M to support local Community Health Worker trainings in Monterey and Merced counties;
- $1.3M to provide technical assistance to build a network of doula providers; and
- $750K to each of the five counties' local health jurisdiction to support the development and/or implementation of their Community Health Assessment and/or Community Health Improvement Plan.

Workforce Recruitment grants awarded in 2024 will result in a combined 130 new primary and specialty care providers, community health workers, doulas and medical assistants joining the provider network in the Alliance's service areas, many of whom are bilingual. The Alliance continued to award grants to support health care technology to improve care quality and coordination, home visiting and parenting programs to support child development and increase access to health care services and supportive resources, and community-based programs that address social drivers of health.

Grant Program staff conducted a survey of active Alliance grantees. The results overall were positive, including these metrics:

- 76% of grantees responded "to a great extent" the MCGP funding priorities reflect a deep understanding of Medi-Cal member needs in their community.
- 95% strongly agree or agree that the Alliance has treated their organization fairly and that grant program staff are responsive.
- 84% reported the Alliance's grant program has a significant positive impact on their local community.

CalAIM Incentive Payment Program (IPP). The Alliance is participating in IPP, a program of the Department of Health Care Services (DHCS), which began January 1, 2022, to support capacity building through new investments in Enhanced Care Management (ECM) and Community Supports (CS) service delivery infrastructure for the Alliance's provider network. In 2024, the Alliance included dollars from the MCGP for Mariposa and San Benito counties to support ECM and CS providers in these counties for whom the Alliance had not yet earned IPP dollars from DHCS. A total of $15.8M was awarded in 2024 to ECM and CS providers serving all populations of focus including Justice Involved and Birth Equity. Through IPP, the Alliance has financially supported a total of 56 ECM and/or CS providers in the Alliance network.

Housing and Homelessness Incentive Program (HHIP). 2024 was the last year of the two-year HHIP that aimed to improve health outcomes and access to whole-person care services by addressing housing insecurity and instability as a social determinant of health for the Medi-Cal population. The Alliance established collaborative plans with Continuum of Care partners in the Alliance's service area and earned dollars from DHCS to pass through to housing and homelessness service providers to implement those plans. Under HHIP, the Alliance implemented a two-year Street Medicine Pilot program which is now operational as a compensable service under Medi-Cal.

Alliance Housing Fund. To better support housing partners in the Alliance service areas, the health plan simplified the funding process by combining funding from HHIP and the Alliance's MCGP into the Alliance Housing Fund. Viable projects were identified through the HHIP partnerships, and the Alliance conducted an open application process. The fund provides capital funding awards to build, purchase, renovate and/or furnish permanent housing units, recuperative care facilities and short-term post-hospitalization housing units. In June, the Alliance awarded more than $30 million for 17 housing projects across the Alliance service area.

The Alliance Housing Fund is also piloting, in partnership with Santa Cruz County, an investment in a Community Development Financial Institution, the Housing Accelerator Fund. Rather than funding direct projects, the investment is seed money to create a source of low interest loans for housing projects – this has the potential to make the investment sustainable and fund a greater number of projects over time. If successful, the pilot could be expanded to other counties.

Student Behavioral Health Incentive Program (SBHIP). 2024 was the last of the three-year SBHIP which aimed to build infrastructure, partnerships, and capacity for school behavioral health services and to improve coordination with Medi-Cal managed care plans. Through SBHIP, the Alliance established partnerships with local education agencies (LEAs), county behavioral health departments and county offices of education in all five service area counties. Since 2022, under SBHIP, participating districts in Alliance counties have earned 100% of the available allocation for Targeted Intervention projects, with a final payout to partners in 2024 totaling $11.5M to date.

In all, SBHIP projects directly impact approximately 30% of all student-aged Alliance members in the five counties, equivalent to approximately 42k children and youth. Systems capacity has been built in most counties for managing health data, formalizing and simplifying screening processes, and building capacity around billing under the existing DHCS Local Education Agency-Billing Option Program. All

but one Local Education Agency that participated in SBHIP across our five counties has been accepted into an upcoming Children and Youth Behavioral Health Incentive (CYBHI) Fee Schedule cohort, which will provide an ongoing source of funding for BH services in schools, through medical billing.

Equity and Practice Transformation (EPT). The EPT Program is for primary care practices to advance health equity and reduce disparities. The DHCS program incentivizes participating primary care practices to implement practice transformation and improve quality of service delivery. The Alliance is supporting 15 primary care providers (the fourth most projects out of all health plans in the state) in this pass-through payment program. The State Budget for Fiscal Year 2024/25 substantially reduced funding for the EPT program. As such, DHCS shortened the program duration from five to three years, cut down the total number of milestones from over 100 to 25, and reduced the amount earned per milestone. The Alliance has decided to supplement the funding lost from the State budget reduction and add in additional deliverables that will allow practices to earn the original allocation.

Alliance Members

As of December 31, 2024, the Alliance served approximately 442,475 Medi-Cal beneficiaries and 639 Alliance Care IHSS members with membership by county as follows.

- In Santa Cruz County, 78,412 Medi-Cal members.
- In Monterey County, 188,127 Medi-Cal members and 693 Alliance Care IHSS members.
- In Merced County, 149,615 Medi-Cal members.
- In Mariposa County, 5,761 Medi-Cal members.
- In San Benito, 20,560 Medi-Cal Members.

Alliance Medi-Cal Members

Alliance Medi-Cal members are lower income persons in eligible aid categories (e.g. aged, disabled, single-parent, childless adult), and include nearly all Medi-Cal beneficiaries in the region. The Alliance's current member demographic composition is as follows:

- 68.50% are Latino, 13.05% Caucasian, 11.15% Filipino, 1.86% African American, 0.72% Asian or Pacific Islander, 0.64% Asian Indian, 0.23% Vietnamese, 0.20% Chinese, 0.18% Alaskan Native or American Indian, 0.14% Laotian, 0.09% Korean, 0.05% Samoan, 0.05% Japanese, 0.04% Cambodian, 0.03% Hawaiian, 0.02% Guamanian, and 1.23% Other, and 0.00% not provided.
- 54.9% report primary language as English, 43.07% as Spanish, 0.04% as Hmong and 1.99% as other or not reported.

- 53.26% are female and 46.74% are male.
- 39.2% are 19 years old and younger, while 9.63% are 65 years or older.

Alliance Care IHSS Members

Alliance Care IHSS members are in-home caregivers that provide home care services for the recipients of IHSS program services in Monterey County.

Alliance Services for Members

The Alliance Member Services Department engages and supports members through the operation of a call center to respond to member requests, a Grievance System to resolve member issues, and an Operations Unit to train staff, monitor Call Center Quality and execute member informing materials. Member Services staff reside in the counties served by the Alliance and many staff are bilingual in English/Spanish or English/Hmong. Staff provide high quality service and support to Alliance members, providers, and community-based partners. Staff educate Alliance members regarding how to access Alliance health care benefits within the managed care environment. This includes providing new member orientations, helping members understand their benefits, answering questions, and resolving member concerns. Member Services develops and distributes member identification cards and member handbooks.

The Community Engagement Department assists in the facilitation of two public committees which seek feedback from members to inform programs and procedures, including the quarterly Member Services Advisory Group (MSAG) and the Whole Child Model Family Advisory Committee (WCMFAC).

Alliance Operations Management staff are also responsible for reviewing and resolving plan enrollment data issues through collaboration with the local county Medi-Cal offices, the Social Security Administration, and the Department of Health Care Services (DHCS).

Alliance Health Services Division

The Alliance's Health Services (HS) Division is responsible for ensuring that members receive the right care in the right place at the right time and assures that the care provided is evidence-based. The Alliance works closely with its network of providers including physicians, hospitals, pharmacies, and ancillary providers, to ensure that members receive appropriate and timely access to care. Throughout 2024, Dennis Hsieh, MD, JD, led the Health Services Division as the Alliance's Chief Medical Officer with the support of Health Services Officer, Marwan Kanafani and Alliance Medical Directors Dr. Dianna Myers and Dr. Michael Wang. In addition, Dr. Robert Dimand continued to work with the Alliance as a medical consultant. Physician clinical oversight responsibilities include Quality Improvement & Population Health (QI/PH), Utilization Management, Care Management, Pharmacy, and Behavioral Health.

The Alliance maintains a Quality Improvement (QI) System to monitor, evaluate, and take effective action to address any necessary improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The QI/PH Department monitors the quality of health care services provided and reviews quality of care at the individual member level, as well as for the Alliance's member population. The QI/PH department leads the Alliance's population health strategy and effectiveness efforts as well as efforts to increase the provision of preventive care services for members. Performance in these areas is measured through the National Committee for Quality Assurance (NCQA) HEDIS/MCAS measures and the Alliance rewards provider performance through its Care Based Incentives (CBI) program value-based payments. Health equity is a top priority that is woven into all of QI/PH's work as our service area communities continue to struggle gaining access to basic, preventive healthcare.

In addition, the QI/PH Department manages the Alliance's clinical safety program, including review of Potential Quality Issues, Facility Site Review audits, and on-going quality monitoring activities. To support providers with clinical improvement efforts, QI/PH provides technical assistance through practice coaching, learning collaboratives, and continuously accessible webinars. Further, QI/PH offers health education and cultural and linguistic programs to support members with preventive care and chronic care management interventions. Key achievements include:

- Launched a Medi-Cal Accountability Sets (MCAS) Provider Portal that allows providers monthly to view actionable quality improvement data.
- Expanded Care Based Initiative (CBI) training including resources available to new staff at clinics,
- Launched a new Provider Partnership Program.
- Improved 9 of 10 targeted performance measures in Merced County.
- Significantly improved MCAS measures with 6 out of 8 being either at or above the minimum performance level of the 50th percentile.
- Developed and launched new Diabetes workshops
- Expanded Health Education classes include the delivery of over 30 member workshops.

<u>Enhanced Case Management and Community Supports</u>

The Enhanced Health Services Department, which is inclusive of Enhanced Case Management and Community Supports, oversees a network of complex members to address their physical health, mental health and social determinants of health across all five counties. The program exceeded 15,000 members enrolled in the Enhanced Case Management program through our community partners. The Alliance currently serves close to 20,000 members through its Community Supports programs. The Enhanced Health Services program focuses on developing the

quality of the program with provider oversight, educational programs and the initiation of team rounds with providers to review complex cases.

Care Management

The Care Management team includes both adult and pediatric services. This department offers both complex case management and care coordination, including a comprehensive set of services to help members manage chronic or complex conditions more effectively. Care Coordination is focused on less complex member needs, while Care Management, for both adults and children, often includes more clinically oriented, longitudinal member support.

Within this department is the Whole Child Model (WCM) California Children's Services team that manages children with particularly acute and high-risk conditions. Throughout the year, the team has been working to ensure a successful WCM Expansion into San Benito and Mariposa counties in January, of 2025.

The Care Management teams successfully implemented a new electronic Care Management system this year and continue with preparation for accreditation by the National Committee for Quality Assurance. Additionally, preparation is underway to further develop a behavioral health case management team, which will support the Alliance's integration of Behavioral Health Services in 2025.

Utilization Management

In 2024, the Utilization Management (UM) Department achieved many significant milestones, navigating a series of complex projects that demanded exceptional teamwork, dedication, and perseverance. Among the most noteworthy accomplishments were the expansion into San Benito and Mariposa counties, preparations for NCQA accreditation, Behavioral Health (BH) program build growth in Transitions of Care (TCS) support, the development and enhancement of Enhanced Case Management (ECM) and Community Supports (CS) policy and processes, and the Case Management System Replacement (CMSR). Sustained reductions in inpatient lengths of stay, readmission rates and avoidable Emergency Department utilization were also noted.

A key achievement over the year was the successful expansion into San Benito and Mariposa counties. The adapted in 2024, managing increased membership and authorizations in these two new counties. The Alliance ensured timely access and continuous care for members, along with enhanced workflows and communications to ensure a smooth transition for both members and providers.

In addition, the UM team took a robust approach to Transitions of Care (TCS). Interdisciplinary Team Meetings (IDTs) were established with hospitals across our

counties for direct conferencing with external hospital and clinic teams to support care transitions, member access, and reduce readmission and ED utilization. These efforts resulted in reductions in readmission rates, reduced bed days, and reduced emergency department utilization, all notable achievements.

The Alliance also successfully developed processes for alternate placements to support member care at the most appropriate level of care and reducing inpatient lengths of stay for members not requiring inpatient or long-term levels of care. The processes developed through the development of IDTs and TCS processes will lend well to the Plan's future integration of Medicare services through a Dual Eligible Special Needs Program to launch in 2026.

Finally, the Case Management System Replacement (CMSR) was one of the department's most challenging projects. Months of preparation set the stage for a smooth transition, and although system replacement often presents difficulties, the department successfully minimized risks through thoughtful, collaborative planning, ensuring a seamless system replacement.

Pharmacy

The Pharmacy Department has demonstrated exceptional dedication to improving member health and community well-being through innovative programs and strategic initiatives. By successfully transitioning to the new care management system and adapting workflows to meet NCQA accreditation standards, the team streamlined processes for conducting medical necessity reviews. They resolved over 2,000 provider calls, ensuring seamless medication coordination and access for members. To combat the opioid epidemic, the department launched the Alliance Naloxone Distribution Program (NDP), distributing 396 naloxone kits to the community and saving two lives through reported overdose reversals.
The team also educated and recruited providers to participate in the DHCS naloxone program, expanding the program's reach. In 2024, the department expanded its clinical pharmacy programs, including the Pharmacist-Led Academic Detailing (PLAD) and Drug Utilization Review (DUR) programs. Through 46 interactive PLAD sessions with 18 primary care providers, pharmacists promoted evidence-based use of diabetes, asthma, and hypertension medications. Meanwhile, DUR reviews identified patterns of misuse, overuse, and fraud, resulting in 21 provider-focused and four member-focused educational articles to improve drug therapy practices.

Alliance Providers

The Alliance recognizes the critical importance of its providers in furthering its mission to ensure access to quality health care for members. The Alliance's contracted network of providers includes Primary Care Providers (PCPs), federally qualified health centers, rural health centers and community clinics, specialists,

hospitals, ancillary health services providers, pharmacies, and long-term care facilities in addition to Enhance Care Management and Community Support providers. The Alliance continues its efforts to strengthen its provider capacity to provide services, providing a robust network across all five counties in its service area. To that end, in 2024, the Alliance added 744 new providers to its provider networks including: 112 PCPs, 148 specialists, 201 non-physician medical practitioners, 92 allied providers, 32 provider organizations, 19 Doulas, 27 Behavioral Health Providers (with effective date 07/01/2025), 30 Community Health Workers (CHWs), and 83 ECM/CS Providers.

In 2024, the Alliance once again conducted its annual provider satisfaction survey to learn more about its providers' experience with the Plan. The 2024 survey indicated that 89.3% of physicians surveyed rated the Alliance as completely or somewhat satisfactory, and 97% indicated that they would recommend the Alliance to other physicians' practices.

Alliance Financial Performance

The Alliance's 2024 operating revenue was $1.88B through November 30, 2024.

The Alliance operated with a Medical Loss Ratio (MLR) of 93.9% and an Administrative Loss Ratio (ALR) of 5.3% of revenue for this period meaning that 94 cents out of every dollar goes directly to healthcare services.

Disenrollment resulting from redetermination following the unwinding of the federal COVID Public Health Emergency was less impactful than expected resulting in higher revenue, partially offset by a downward acuity rate adjustment. Meanwhile, medical costs are trending higher primarily due to the acuity shifts, increased utilization among the continuing population post-redetermination, and elevated costs from the ramp-up of Enhanced Care Management and Community Support programs. With these factors combined, the Alliance reported a net income of $47.6M for the eleven-month period through November 30, 2024.

The Alliance must maintain adequate financial reserves to ensure the health plan has sufficient funds to cover incurred claims liabilities. The Commission has established a target reserve fund balance for this purpose. As of November 30, 2024, the Alliance was operating at 102% of its targeted reserve fund balance.

Alliance Staff

As of December 31, 2024, the Alliance employees numbered 612 in the following divisions: Administration, Compliance, Employee Services, Communications, Finance, Health Services, Information Technology Services, and Operations. In 2024, the Alliance continued to successfully provide services and support to our members through a hybrid workforce strategy. This approach supported Talent Acquisition fulfilling 250 temporary and new positions in 2024 across five county service areas.

Alliance in the Community

In 2024, the Alliance outreach team was present at 130 community events where over 30,000 members were reached in our five-county region. Significant efforts were made to participate in community events held in our two newest counties, Mariposa and San Benito.

Community efforts involved over 85 relational meetings, where Alliance staff engaged with local organizations and county leaders to strengthen relationships and foster collaboration. The Alliance also provided more than 15 presentations in 2024 that educated and informed community organization staff about the services and benefits available to Alliance members. The Alliance remains dedicated to keeping our community-based organizations and community partners up to date through our bi-monthly community newsletter, *The Beat*.

Additionally, throughout 2024, the Alliance and its staff continued involvement in 50 regional and community coalitions and collaboratives that address public health issues, health care access, community networking and eligibility outreach in the Alliance service area. This includes Alliance involvement and participation in the following groups:

In Mariposa County

- Mariposa Health and Wellness Coalition
- Mariposa Community Health Improvement Plan (CHIP)
- Central Sierra CoC MCP Collaboration Meeting
- Mariposa County/Alliance/CVRC/Carelon BH Meeting

County Highlight: Mariposa Butterfly Festival

This 2-day festival is one of Mariposa County's largest community events. We connected with about 1,000 community members and provided education on the Alliance and our services. This event was a great opportunity to engage with the attendees about our expansion into Mariposa County as their new Medi-Cal health plan.

In Merced County

- ACEsINC Committee
- Maternal Wellness Coalition
- Outreach Committee Meetings
- BHRS Ongoing Planning Council
- Connected Care Network
- CPI Merced Collaborative
- Health and Mental Health Services Advisory Committee
- Help Me Grow Merced County Coalition

- HFA/PAT Community Advisory Board (CAB)
- Merced ACCT (Tobacco Prevention Coalition)
- Merced Breastfeeding Network
- Merced Public Information Officer (PIO) Roundtable
- Merced County Community Advisory Board
- Merced County and Alliance Convening
- Merced County Department of Public Health – CCAH Collaborative
- Merced County/Alliance/CVRC/Carelon BH Meeting

County Highlight: Dignity Health Mobile Care Clinic Pop-Up Tabling Events

We coordinated 7 pop-up tabling events in partnership with the Dignity Health Mobile Care Clinic to set up a resource table during the same time that the Mobile Clinic was out providing medical services to the community. We engaged with approximately 70 Alliance members at these events and connected these members to Enhanced Care Management, housing support resources, and other Alliance services as many of them were unhoused or did not have permanent housing.

In Monterey County

- Active Referral Network
- Community Alliance for Safety and Peace (CASP)
- Monterey County Collaborates
- Monterey County Caring Partners
- South County Outreach Efforts (SCORE)
- Blue Zones Project Worksite Committee Meeting
- Monterey County/Alliance/SARC/Carelon BH Meeting

County Highlight: Ciclovía Salinas

This youth-run event, focused on fostering a sense of community-building, brought families together to enjoy accessible recreation activities and participate in health and wellness conversations. The Alliance team engaged with approximately 2,000 community members and shared information about the Alliance and our services.

In San Benito County

- Adult Long Term Care Committee (ALTCC)
- Health Reimagined Workgroup
- Safe Kids Coalition of San Benito County
- Oral Health Advisory Committee
- South County Outreach Efforts (SCORE)
- Wellness Coalition of San Benito County
- Equity Diversity Inclusion Committee

County Highlight: Community Foodbank of San Benito Pop-Up Tabling Events

We coordinated 3 pop-up tabling events in partnership with the Community Foodbank of San Benito to set up a resource table and provide information about the Alliance and our member benefits. We engaged with approximately 725 Alliance members at these events. This event was a great opportunity to connect with the community about our expansion into San Benito County as their new Medi-Cal health plan.

In Santa Cruz County

- Cradle to Career CHW Leaders Collective
- Health Workforce Council
- Health Improvement Partnerships of Santa Cruz County (HIPSCC)
- Monterey Bay CHW Collaborative
- ParkRx Santa Cruz County
- Santa Cruz County PATH Collaborative
- Semillitas Advisory Committee
- Santa Cruz County/Alliance/SARC/Carelon BH Meeting

County Highlight: Santa Cruz County Trunk-or-Treat

This was a large community event that brought together families in Santa Cruz County through the planning efforts of the District Attorney's Office, Santa Cruz County Probation Department, CAL Fire, and the Community Action Board of Santa Cruz County. Our team engaged with approximately 2,000 community members, where over half of the event attendees were Alliance members.

Multi-County Convenings:

- CCS Advisory Group
- ITUP Regional Equity Collaborative
- LHPC Community Engagement Workgroup
- CPI Coastal Collaborative (Multi-County: Monterey & San Benito)
- K-16 Central Coast Coalition (Multi-County: Monterey & San Benito)
- Leadership Council Meeting (Multi-County: Monterey, San Benito & Santa Cruz)
- Uplift Central Coast (Multi-County: Monterey, San Benito & Santa Cruz)
- WCM FAC Network Meeting (Multi-County)
- Mariposa and Merced Healthcare Partnership for Emergency Preparedness (Multi-County: Merced & Mariposa)

Local Campaigns for Community Benefit

Alliance staff continued involvement with community food banks and United Way campaigns within Santa Cruz, Monterey, Merced, San Benito and Mariposa counties in 2024. Alliance staff raised $88,832 (equivalent to 266, 496 meals) for the food banks in the five-county service area as part of its holiday food drive efforts and raised about $21,799 in contributions to United Way.

Looking Ahead

Throughout 2025, the Alliance will continue its focus on core health plan obligations described within this report, while also advancing the two strategic priorities set forth in its five-year strategic plan: Health Equity and Person-Centered Delivery System Transformation.

The long-term goals to advance Health Equity include:

1) Eliminate health disparities and achieve optimal health outcomes for children and youth; and

2) increase member access to culturally and linguistically appropriate health care.

The long-term goals to advance Person-Centered Delivery System Transformation:

1) Improve behavioral health services and systems to be person-centered and equitable; and

2) improve the system of care for members with complex medical and social needs.

To that end, key priorities in 2025 include projects aligned to these strategic objectives including the following priority projects:

- Preparing for the insourcing of the behavioral health benefit in July 2025,
- Implementing a Medicare Advantage Dual Eligible Special Needs Program (D-SNP) by 2026.
- Continuing to strengthen the Enhanced Care Management program
- Obtaining health plan accreditation by the National Committee for Quality Assurance.

Successful completion of these projects will provide the foundation for the Alliance's continued and ongoing successes as it works in collaboration with the communities it serves towards its vision of Healthy People. Healthy Communities.

Further, the Alliance understands that the change in federal administration in 2025 may have unknown impacts on Alliance members, providers, services and funding and staff will continue to work collaboratively with community, state and federal stakeholders and partners to ensure members are served in the most effective manner possible.

The Alliance appreciates the opportunity to provide this report to the county Boards of Supervisors and is appreciative of the Supervisors' continued support.

Attachment A

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Roster for January 1, 2024 – December 31, 2024

The Alliance has seventeen board members (five from Santa Cruz County, five from Monterey County, four from Merced County, one from Mariposa County and two from San Benito County), in categories of representation including County government and health services, public representatives and health care provider representatives. Board members during January 1, 2024, through December 31, 2024, included:

From Santa Cruz County:	
Anita Aquirre *(effective 4/9/24)*	At Large Health Care Provider Representative
Leslie Conner *(through 1/24/24)*	At Large Health Care Provider Representative
Zach Friend *(through 12/31/24)*	Board of Supervisors
Donaldo Hernandez, MD	Health Care Provider Representative
Monica Morales	Health Services Agency Director
Michael Molesky	Public Representative
From Monterey County:	
Wendy Root Askew	Board of Supervisors
Maximiliano Cuevas, MD	Health Care Provider Representative
Janna Espinoza	Public Representative
Elsa Jimenez, Chair	Director of Health Services
Allen Radner, MD	At Large Health Care Provider Representative
From Merced County:	
Leslie Abasta-Cummings, Vice Chair *(Vice Chair effective 11/6/24)*	At Large Health Care Provider Representative
Dorothy Bizzini	Public Representative
Josh Pedrozo, Vice Chair *(Vice Chair through 11/6/24)*	Board of Supervisors
Rebecca Nanyonjo *(through 8/21/24)*	Public Health Director
James Rabago, MD	Health Care Provider Representative
From Mariposa County:	
Dr Eric Sergienko *(through 1/24/24)*	Public Health Officer
Kristina Keheley, PhD *(effective 6/4/24)*	County Health Department Representative
From San Benito County:	
Tracey Belton	Health and Human Services Agency Director
Ralph Armstrong, DO	At Large Health Care Provider Representative

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
2024 Meeting Attendance Log (January 1, 2024, through December 31, 2024)

Attachment B

Commissioner	Attendance Rate	1.24.24 (Regular)	2.28.24 (Regular)	3.27.24 (Regular)	4.24.24 (Regular)	5.22.24 (Merced)	6.26.24 (Regular)	8.28.24 (Regular)	9.25.24 (Retreat)	11.6.24 (Regular)	12.4.24 (Regular)
Abasta-Cummings, Leslie	80%	Present	Present	Present	EX	Present	Present	Present	Present	X	Present
Aquirre, Anita	100%	N/A	N/A	N/A	Present	Present	Present	Present	Present	Present	Present
Armstrong, Ralph	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present	Present
Askew, Wendy Root	90%	Present	Present	Present	Present	Present	Present	Present	Present	Present	EX
Belton, Tracey	80%	Present	Present	Present	Present	Present	Present	EX	Present	Present	EX
Bizzini, Dorothy	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present	Present
Conner, Leslie	100%	Present	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cuevas, Maximiliano	80%	Present	EX	Present	Present	Present	Present	EX	Present	Present	Present
Espinoza, Janna	90%	Present	Present	Present	Present	Present	Present	Present	Present	Present	EX
Friend, Zach	70%	Present	Present	EX	EX	Present	Present	Present	Present	Present	EX
Hernandez, Donaldo	80%	Present	EX	Present	Present	Present	Present	Present	Present	Present	X
Jimenez, Elsa	90%	Present	Present	Present	Present	EX	Present	Present	Present	Present	Present
Keheley, Kristina	80%	N/A	N/A	N/A	N/A	N/A	Present	Present	EX	Present	Present
Molesky, Michael	70%	Present	Present	EX	Present	Present	X	Present	Present	Present	EX
Morales, Monica	70%	Present	EX	Present	Present	EX	Present	Present	Present	EX	Present
Nanyonjo, Rebecca	83%	Present	Present	EX	Present	Present	Present	N/A	N/A	N/A	N/A
Pedrozo, Josh	90%	Present	Present	Present	Present	Present	Present	Present	EX	Present	Present
Rabago, James	80%	Present	Present	Present	Present	EX	Present	Present	EX	Present	Present
Radner, Allen	90%	Present	Present	Present	Present	Present	Present	Present	Present	Present	EX
Sergienko, Eric	100%	Present	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

X = Unexcused
EX = Excused
"N/A" indicates person was not a Commissioner at this time.