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

Meeting Agenda

Wednesday, March 27, 2024

3:00 p.m. – 5:00 p.m.

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 492 624 072#

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 Tuesday, March 26, 2024 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, 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.
C. Recognize Board service of Commissioner Eric Sergienko, MD.

2. **Oral Communications. 3:05 p.m.**

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

3. **Comments and announcements by Commission members.**

A. Board members may provide comments and announcements.

4. **Comments and announcements by Chief Executive Officer.**

A. The Chief Executive Officer (CEO) may provide comments and announcements.

Consent Agenda Items: (5. – 8A.): 3:25 p.m.

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

- Reference materials: Executive Summary from the CEO; and 2024 Bill List.

Pages 5-01 to 5-39

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the first month ending January 31, 2024.**

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-08

Minutes: (7A. – 7C.)

7A. **Approve Commission meeting minutes of February 28, 2024.**

- Reference materials: Minutes as above.

Pages 7A-01 to 7A-07

7B. **Accept Compliance Committee meeting minutes of December 20, 2023.**

- Reference materials: Minutes as above.

Pages 7B-01 to 7B-05

7C. **Accept Whole Child Model Family Advisory Committee meeting minutes of November 6, 2023.**

- Reference materials: Minutes as above.

Pages 7C-01 to 7C-03

Reports: (8A.)

8A. **Approve 2024 Medi-Cal Capacity Grant Program (MCGP) Investment Plan.**

- Reference materials: Staff report and recommendation on above topic; and MCGP Current Funding Opportunities.

Page 8A-01 to 8A-06

Regular Agenda Items: (9. – 10.): 3:30 p.m.

9. Consider approving the Alliance's legal and regulatory Compliance Program Report for 2023 and receive required Board training in Compliance. (3:30 – 4:00 p.m.)

A. Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider approving the Alliance's Compliance Program Report for 2023.
B. Ms. Mandella will provide required compliance training for Board members.

- Reference materials: Staff report and recommendation on above topic; 2023 Annual Internal A&M Dashboard; 2023 Annual HIPAA Dashboard; and 2023 Annual Program Integrity Dashboard.

Pages 9-01 to 9-12

10. Consider approving Medicare Dual Special Needs Plan (D-SNP) Primary Care Provider Rate recommendation. (4:00 – 4:30 p.m.)

A. Ms. Kay Lor, Payment Strategy Director, will review and Board will consider approving payment for Primary Care Providers at 100% of Medicare rates as part of the Medicare Dual Eligible Special Needs Plan (D-SNP) expansion, effective January 1, 2026.

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

Page 10-01

Information Items: (11A. – 11E.)

A. Alliance in the News — Page 11A-01
B. Membership Enrollment Report — Page 11B-01
C. Member Newsletter (English) – March 2024
https://thealliance.health/wp-content/uploads/MSNewsletter_202404-E.pdf
D. Member Newsletter (Spanish) – March 2024
https://thealliance.health/wp-content/uploads/MSNewsletter_202404-S.pdf
E. Provider Bulletin – March 2024
https://thealliance.health/wp-content/uploads/CCAH-Provider-March2024_Tagged.pdf

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, March 27, 2024; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, May 9, 2024; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, June 6, 2024; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, June 20, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, May 13, 2024; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this March 27, 2024 meeting, unless otherwise noticed:

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

  Date: Wednesday, April 24, 2024

  Time: 10:00 a.m. – 2:30 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) 430-5523 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) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: March 27, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

CommonSpirit Update. The Alliance and CommonSpirit reached final agreement on contract terms and rates of payment prior to the March 15, 2024 contract termination date, resulting in uninterrupted access to care for members. The executed agreement is a new three-year contract ensuring ongoing access to CommonSpirit hospitals and affiliated provider groups.

Change Health Care (CHC) Cyberattack. CHC, a subsidiary of UnitedHealth Group, experienced a cybersecurity attack on February 21, 2024, which resulted in CHC systems being taken off-line to further protect data. CHC serves as a national clearinghouse through which providers submit electronic claims and through which health plans issue electronic payments. Fortunately, most Alliance providers use an alternative clearinghouse called Office Ally, or they submit claim files directly to the Alliance. As such, the impact on submission of provider claims was not significant. The Alliance relies on CHC for outbound electronic payments to providers, and so, electronic payments to providers were impacted. In response, the Alliance is partnered with Echo Health to make claims payments via electronic funds transfer beginning the week of March 11, 2024. Prior to finalizing the partnership with Echo Health, the Alliance identified those providers most in need of claims payments and manually issued paper checks to them – either by mail or in person.

2024 Legislative Session. February 16, 2024 was the deadline for Legislators to introduce new legislation in the second year of this two-year legislative session. Staff continue to work closely with Local Health Plans of California and our representatives in Sacramento to monitor legislative activity and to identify bills aligned with the Policy Priorities adopted by your Board at your February meeting. Staff have developed an initial 2024 bill list, which is attached in full following this report, for your Board's awareness. 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 2024 as issues of Board interest, importance, or action arise. The volume of health-related bills is notable. However, given the State budget environment, it is unclear how many of these bills will move successfully through the legislature this session.

Whole Child Model (WCM) Expansion. Expansion of the Alliance's WCM program to San Benito and Mariposa counties is expected to occur on January 1, 2025, as provided in last year's State Budget Trailer Bill. Discussions and planning are underway between the Alliance, County California Children's Services programs, and the Department of Health Care Services Integrated Systems of Care Division, towards a seamless transition using the Alliance's previous WCM program implementation in its existing counties as a template for this work.

Community Involvement. On March 5, 2024, I attended the California Association of Health Plans (CAHP) Board meeting in Napa, and the Second Harvest Food Bank Annual Awards Dinner on March 7, 2024. On March 14, 2024 I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and on March 21, 2024, I attended the virtual HIPSCC Executive Committee meeting.

Health Services

One large focus for the Health Services team was the Department of Managed Health Care audit that occurred during the week of March 11, 2024. The Health Services team was able to work closely with Compliance and other teams to present the work that the Alliance has been engaged in during the audit period to our auditors. We are now awaiting the audit results.

Apart from this, the Health Services teams remain focused on the National Committee for Quality Assurance (NCQA) accreditation as well as our ZeOmega Jiva replacement system. At the same time, the team is working on advancing the Alliance's equity strategy for Merced and Mariposa counties through strategies including, but not limited to, Care-Based Incentives (CBI), practice coaching, naloxone distribution, and the Equity and Practice Transformation (EPT) program through the Department of Healthcare Services (DHCS).

At the individual member level, the team is focused on transitions of care across all of our partner facilities for all of our patients. Additionally, our teams are both engaging those who are highest risk in Enhanced Care Management (ECM) as well as partnering with both hospitals and county behavioral health on improving follow up after the emergency department for both mental health as well as substance use disorder (FUM and FUA). As part of this strategy, the Alliance is moving ahead with investments in housing through the Housing and Homelessness Incentive Program (HHIP), including exploring partnerships for permanent supportive housing.

Please see below for more details from each of the Health Service departments.

Quality Improvement and Population Health (QIPH)

2023 Care-Based Incentive. Measure data validation for the CBI 2023 programmatic and fee-for-service incentive payments will be underway in March to ensure appropriate payment is completed within the 180 days after the conclusion of the CBI program term.

Provider Partnership and Practice Coaching. The newly launched Provider Partnership program is working closely with our four largest providers in Merced to identify performance improvement projects that will close care gaps with the continued and shared goal to get our Managed Care Accountability Set measures to the 50th percentile and provide members with the care they need.

Our practice coaching team is working on four cohort-based lunch and learn sessions for this year. The first will be on best practices for administrative work such as scheduling, MA retention, member assignments, and transportation held in April. Future sessions will focus on pediatric and women's health.

Utilization Management (UM)

The transition to the ZeOmega (Jiva) system replacement is progressing as anticipated, with user acceptance testing moving towards final end-to-end system testing and training. Utilization Management (UM) team training efforts are ongoing to ensure all nurses are proficient in reviewing all PA authorization types in anticipation of the Essette system replacement and the rotation-based assignment of authorizations.

NCQA accreditation preparation continues in parallel with Essette replacement activity. NCQA sets standards and measures performance for healthcare organizations and providers, focusing on areas such as patient care, patient experience, and health plan operations. The UM teams have undergone initial NCQA mock auditing in preparation for the plan's NCQA accreditation. UM program and policy updates, as well as assessment and development of Jiva configurations continue in support of the plan's NCQA accreditation ahead.

Inpatient and Emergency Department. The Alliance's ongoing collaboration with external partners in post-acute care settings has led to increased participation in interdisciplinary team meetings (IDTs), with a focus on improving member transitions, reducing readmissions, and optimizing community resource utilization. The recent enhancements to the Transitional Care Pilot in October 2023 have contributed to sustained reductions in readmission rates, resulting in an overall 2% decrease in quarterly 30-day readmission rates from 12% to 10% in 2023. Merced's overall readmission rates have remained at 9%, below the average.

Collaborative efforts in hospital IDT case conferences and improving discharge processes for Residential Care for the Elderly (RCFE) are expanding across all counties, leading to increased utilization of Enhanced Care Management (ECM) and Community Support (CS) services. This transitional care work has resulted in five members being placed in RCFEs and eighteen members in Congregate Living Facilities over the past several months. Follow up site visits in February received positive feedback from newly placed members and families, highlighting their satisfaction with the care received. Concurrent Review LVNs and MSWs are actively involved in additional site visits for long-term care members and are working towards transitioning members to lower levels of care when appropriate.

Prior Authorization. Overall compliance with prior authorization turnaround times remains extremely high at 99.8%, supported by rigorous internal reporting processes. Overall denial activity remains low, with genetic testing, panniculectomy and power wheelchair accessories trends consistent with activity seen in the past. General utilization patterns reflect continued opportunities to increase utilization of ECM/CS, community health workers, doula and street medicine benefits. The UM program continues development of the authorization framework, along with assessment of opportunities to increase transitional care service support and utilization of benefits to support member wellness and engagement in care.

Additionally, the UM team has successfully managed the increased volume of County Expansion Continuity of Care requests for Mariposa and San Benito members, and they are now handling routine authorization requests from new CE members and providers. Special attention is being given to Special Populations, with collaborative efforts underway across departments.

The Non-Emergency Transportation (NEMT) team has continued positive trends with decreased member call wait times as well as decreased member call abandonment rates, with newly trained

staff supporting incoming call volumes across the five counties. NEMT Physician Certification Statement form oversight reflects sustained improvements, with robust reporting and direct provider outreach efforts continuously in flight. Overall authorization volumes have seen an increase month over month activity, with the Authorization Coordination team maintaining regulatory timelines through alternative staff scheduling.

Pharmacy

Prior authorization volume for physician-administered drugs stabilized in February, down from 22% increase seen in January. Compliance with turnaround time continues to be at goal (98.8%). Pharmacy technicians have been spending a significant amount of time testing the new care management system and updating workflows. Pharmacy processes are also under review to meet NCQA standards.

Drug Utilization Review (DUR) Program. Stimulants in Children: We are working with Advanced Analytics to create a DUR report in which the data analysis is automated for Stimulants in Children. We hope to use this as a template for future DURs.

Pharmacist-Led Academic Detailing (PLAD) Program. To enhance the visibility of our PLAD program, the Alliance Pharmacists presented information at several clinic Joint Operations Committee meetings during first quarter of 2024. These meetings are to continue over the next quarter as well to promote PLAD and help providers with any questions they may have regarding the program.

Diabetes: During Q1, we worked with three clinics for a total of eleven providers. Eight providers completed the PLAD program as of March 6, 2024. Three remaining providers are scheduled to complete their PLAD program by end of Q1. For Q2, we currently have one clinic with two providers scheduled, and one additional clinic expressing interest.

Hypertension: The hypertension PLAD program is in the planning stages. The purpose of this program is to improve provider knowledge on current hypertension guidelines, with a focus on hypertension medications. Provider sessions will be two, 45 minute sessions conducted over the course of two weeks. We are planning to target three provider clinics in Q2.

Naloxone Distribution Project. The Naloxone Distribution Project developed by DHCS aims to address the opioid crisis by reducing opioid overdose deaths by providing free naloxone. The Alliance Pharmacy team outreached 23 clinics in an opportunity to help them become a naloxone distribution site. The Pharmacy team is also coordinating with the Alliance Community Engagement group to facilitate distribution of naloxone during different community events. Non-clinical organization will be contacted as second part of this project over the next few months.

Community Care Coordination

Complex Care Management (CCM). We continue doing a lot of work with getting hard-to-place members that have had long hospital stays placed in Residential Care Facilities for the Elderly (RCFE). These members require close monitoring and collaboration between our CCM team and our UM department.

We continue with training and preparation for our Essette system replacement. We have been doing a lot of testing and reviewing of all workflows to ensure that we are able to meet our members' needs in a more streamlined approach as well as meeting NCQA standards.

Whole Child Model (WCM)/Pediatric Complex Care Management. Pediatric Complex Case Management (CCM) team continues work with the Essette system platform replacement (Jiva/ZeOmega). Work in the Jiva platform is in full swing across all teams. Optimization for both California Children's Services (CCS) and case management and other key health services functions is under design as the new platform is developed to best align with NCQA standards as well as other requirements. We are currently in the User Acceptance and Testing phase. This current phase includes full engagement of Peds team members to explore and validate system functionality as well as test critical business workflows.

The Alliance successfully completed the implementation of the County Expansion in January 2024. Unlike the existing WCM counties, the new counties are classic dependent county CCS service model, in alignment with County CCS programs, as well as DHCS.

We have quickly developed strong relationships with our County CCS partners, and new CCS families. We are concurrently working towards the transition of the two new counties into WCM come January 2025. The WCM Expansion planning for San Benito and Mariposa counties has begun. This project spans multiple departments and divisions and will build off the work that has been initiated for county expansion this past month. Collaborative meetings with both our new counties and DHCS continue. In our three WCM counties, CCS referrals continue at a steady rate. Q4 CCS referral volume totaled at 325. Our CCS enrollment remains steady at over 7,000 members.

Enhanced Care Management (ECM)/Community Supports (CS). There is continued programmatic focus to increase enrollment in ECM services. Engagement efforts through Joint Operation Committee meetings with hospitals, Federally Qualified Health Centers, and county partners, are leveraged to support awareness of the benefits, in addition to contracting and better understanding how to support sustained engagement for improvement in enrollment. Providing Access and Transforming Health (PATH) Collaborative groups are working with the ECM team to focus on collaborative working relationships across multiple sectors for increased awareness and referral volume into the program. Provider network support remains a priority to encourage capacity expansion as well as quality provision of services for members.

Office hours have been established at a cadence of four times a month and supplemental trainings for providers have been added to the calendar to support TA for the existing contracted network. A cohort of new providers will be onboarded at the end of Q1/beginning of Q2 with the updated process leveraging the Provider Academy and expedited onboarding. Work is being done to continue to support the Justice-Involved Population supporting the creation of a network to include those providers that have experiencing serving members in the incarcerated settings. The focus will remain on the post-release workflows to encourage proactive referrals and collaboration, keeping in mind the pre-release services timelines.

Behavioral Health

The Behavioral Health (BH) Department continued our ongoing proactive communication with Carelon Behavioral Health of California to foster growth and improvement. This included monthly

executive meetings, workshop sessions to address data needs, maintenance of our weekly tracker series, and addition of focus on BH treatment for autism spectrum and developmental disorders. Contract amendment negotiations concluded, and the document was submitted to our regulatory bodies for approval. The team also launched a new monthly Carelon issue tracker to be distributed to chiefs and directors in support of our strategic goals.

Concurrently, BH has been investing resources in leading the BH Integration Program to ensure all departments and staff are prepared to insource the benefit effective July 1, 2025. Project plans reached 90% completion and with support of Project Management, the bi-weekly status report is being prepared for dissemination beginning in March.

The BH Director led another BH learning session for all Alliance staff, focusing on the impact that CalAIM has had on BH policy, plan expectations and member experience. The team has continued to receive positive feedback from participants in the series, which has two more sessions until completion.

The BH team gathered for a full day in-person retreat and strategy session to support the cohesiveness of the recently expanded team. We discussed workload distribution and departmental collaboration, ensuring effective use of our resources and clear communication to others about how to solicit support. We further strategized about future training and learning sessions to facilitate the culture change necessary for successful BH integration.

Program Development

CalAIM Incentive Payment Program. The Alliance has the potential to earn $10.8M with Submission 4, which was submitted to DHCS on March 15, 2024 for the measurement period of July 1, 2023 – December 31, 2023. The Alliance is eligible to participate in Submission 5 in both Mariposa and San Benito counties, pending completion of the Managed Care Plan transition requirements, including a Needs Assessment and Gap-Filling Plan, due to DHCS by May 1, 2024. Staff continue to have discussions with Anthem Blue Cross (exiting Medi-Cal plan in Mariposa and San Benito counties) and California Health and Wellness (exiting Medi-Cal plan in Mariposa County) to prepare and submit Needs Assessments and Gap Filling Plans. Staff continue to execute LOAs for the newly contracted ECM/CS providers serving Populations of Focus that went live January 2024 (Justice Involved and Birth Equity), as well as to encourage expansion of ECM/CS in all five service areas.

Housing and Homelessness Incentive Program. Alliance staff received notice that the Alliance earned 92% of the total potential HHIP Submission 2 (S2) funding allocation ($21.5M) across our three 2023 counties (Santa Cruz, Monterey, and Merced).

County	S2 DHCS Allocation	S2 Payment	% Allocation Earned
Merced	$5,475,894.00	$4,683,232.63	86%
Monterey	$10,581,788.00	$10,060,129.22	95%
Santa Cruz	$7,317,837.00	$6,797,802.42	93%
TOTAL	**$23,375,519.00**	**$21,541,164.27**	**92%**

Alliance staff are awaiting detailed S2 scoring evaluations from DHCS, in order to understand where points were earned and to use in communications with community partners.

In combination with the existing $5.3M HHIP balance (Santa Cruz: $2.3M; Monterey: $2.6M; Merced: $327k) and a Medi-Cal Capacity Grants Program allocation (amount TBD), Alliance staff intend to allocate the earned HHIP S2 award towards development of Permanent Supportive Housing units and/or temporary housing units (Recuperative Care and/or Short-term Post-hospitalization Housing) across the Alliance's three 2023 counties (Santa Cruz, Monterey, and Merced).

Student Behavioral Health Incentive Program (SBHIP). Alliance staff received notice that DHCS accepted all 11 SBHIP Bi-Quarterly reports (reporting Period 2, July 1, 2023-December 31, 2023) for Merced, Santa Cruz, and Monterey counties and earned 100% of the potential $1.4M (12.5 of program total). For Mariposa and San Benito, the payments associated with bi-quarterly Report 2 will go through Anthem/Healthnet, which will be the last connection to those plans for SBHIP. Going forward, the report submission and payments will go through Alliance/Kaiser for Mariposa and the Alliance for San Benito.

Combined, the five counties are implementing 13 SBHIP Targeted Intervention Projects. SBHIP projects directly impact approximately 30% of all student-aged Alliance Members in the five counties, equivalent to approximately 42,000 children and youth.

Equity and Practice Transformation. The Alliance is supporting fifteen providers (the 4th most projects out of all health plans in the state) in the EPT pass-through payment program. DHCS contracted with The Population Health Learning Center to serve as the Program Office for the EPT Program. The Alliance will receive the Initial Provider Planning Incentive Payment by April 30, 2024, which can be used to further Alliance capacity building goals. The first EPT deliverable is completion of a survey tool (phmCAT) and is due from practices on May 1, 2024 and practices will be able to earn their first payment by October 2024.

Employee Services and Communications

Human Resources

Alliance Workforce. As of February 26, 2024, the Alliance has 590.9 budgeted positions of which our active workforce number is 560.4 (active FTE and temporary workers covering LOAs and vacancies). Additionally, the Alliance has 41.5 budgeted temporary workers, of which 24.5 are filled. Overall, the Alliance is 94.1% staffed. Additionally, there are 39 regular and temporary positions in active recruitment. Human Resources partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Competencies and Career Development. The Alliance is officially live with our new Position Competencies software platform outlining our new philosophy and framework of how we will use competencies both in performance management and career/professional development. Information sessions and training through various approaches kick-off this month and will include continued education and engagement under this new framework through August 2024.

Q4 Check-in and Annual Compensation Review (ACR). Human Resources has completed the work for the Q4 Check-in process and ACR on time, and within budget. In addition to the regular process of merit allocation, as needed compensation adjustments, and promotions, this year included the rollout of the new Workforce Strategy related to pay zone review.

Facilities and Administrative Services

Printing/Mailing Increase. The Administrative Services team has installed four new mailing/folding machines and are now processing and sending additional member notification letters because of NCQA requirements. We have additional staff onsite to support the increase and are training this month. February mailings have increased from an average of 4,000 per month to 13,000 per month.

Check Runs. The mailing team has been assisting with sending in-house check runs due to the recent breach at Change Healthcare.

Generator Installation. Facilities is working with an electrical contractor to install a permanent generator at the 1600 Green Hills Road building in Scotts Valley. The installation is expected to be completed by July 2024.

Tenant Improvement Projects. There are several tenant improvement projects underway in the Salinas office location for tenants that will be leasing vacant space from the Alliance. Construction is expected to last well into 2024.

Communications

Marketing Position Recruitment. Staff is currently recruiting for the marketing staff person who will oversee the development and execution of strategic marketing plans for the D-SNP product. First panel interviews will wrap up in early March, with final panel interviews expected to occur by the end of the month. The department director will be working with the Medicare business unit to develop onboarding and D-SNP training plans for the new hire.

Behavioral Health. Communication planning is underway for the behavioral health in-sourcing project that began in February. Initial intake meetings have occurred, and staff is prioritizing the communications plan to support provider recruitment. April is the target date for completing the communications plan for members, community and internal stakeholders.

Texting and Engagement Project. The member texting and engagement project team had their kick-off meeting in February. Initial planning work is underway, and the team is currently prioritizing data integration and texting policy discussions. We expect to finalize those details in March and will begin working on governance, campaign prioritization, workflows and member targeting. The project schedule is ambitious with tentative plans to launch full-scale texting in early summer. This will depend on several factors including the hiring of a budgeted PTE to execute campaigns and report on metrics. More details will be shared as the project unfolds.

County Expansion. The County expansion paid campaign has mostly wrapped up and below are key metrics:

- Flyers delivered to three schools with 657 impressions (English and Spanish)
- YouTube – 150k impressions (English)
- Streaming audio – 150k impressions (English and Spanish)
- Facebook – 44k reached (English and Spanish)
- Website – nearly 13k visits to expansion landing page (English and Spanish)

Spring Media Campaign. Staff are working on a spring media campaign targeting Merced families with school-aged children. The campaign intends to raise awareness of the importance of well-checks and create a sense of urgency to schedule these appointments early, versus waiting until school is out for the summer. In February, Communications and Community Engagement staff met with PIOs from Merced during our quarterly PIO Roundtable to ascertain interest in a co-branded campaign. Both Merced County of Education (MCOE) and Mercy Dignity elected to join the Alliance on a co-branded campaign. Campaign tactics are being finalized but will likely include billboards (provided by MCOE), flyers, newsletter articles, website content, social media content, Spanish and English terrestrial radio, radio interviews with SMEs, YouTube and Snapchat. The teams are also discussing holding a press conference in early April to launch the co-branded campaign, which would be hosted by MCOE. Details will be finalized in early March. The campaign will run for 10 weeks beginning early April.

Operations

County Expansion. The Alliance continues to have a presence in the community within Mariposa and San Benito counties. In celebration of Children's Oral Health Month, Community Engagement staff participated in an Oral Health event at the Creekside Terrace Apartments in Mariposa. In San Benito, staff have had an ongoing presence at the Community Food Bank where information about Alliance benefits and services were shared. In addition, staff will participate in Feria de Salud at Hollister High School and Jovenes de Antano Community Resource Fair.

The Alliance Call Center has seen a spike in member calls since the expansion in January 2024. The calls are from members seeking services such as transportation, behavioral health, and knowledge around the benefits and services provided to them. Additionally, member walk-ins have been very high with an average of 10 to 15 daily. Members in San Benito and Mariposa County prefer in person support where they seek information around primary care provider selection, soliciting a new member ID, and getting transportation services.

The Provider Services team continues to contract and credential providers in San Benito, Mariposa and nearby counties. Effective April 1, 2024, a new Enhanced Care Management (ECM) provider, Alliance for Community Transformations, will be added to the network to support members in Mariposa County.

Claims Operations. While the Alliance has continued to see our claim receipt volumes rise, which began in October, the average daily claims volume decreased in March. However, we know this recent decrease is, at least in part, a result of the Change Healthcare cyberattack event, in which certain providers were unable to utilize change as their clearinghouse to submit claims. We expect receipt volumes to pick up again towards the latter part of March and early April. While we failed to meet our Claims Finalized within 30-day target of 90%, we were able to meet both our Claims Finalized within 45 and 90-days respectively.

Additionally, the Alliance utilizes CHC as our provider payment vendor. The cyberattack resulted in a halt in the provider payment service. The Alliance quickly pivoted to provide alternative payment methods, e.g., paper checks or direct electronic funds transfer to our provider and ensure the financial viability of our network. As of today, the Alliance is back on schedule with our provider payment by leveraging our alternative solution as a direct result of the resilience and innovative thinking of the team.

Dual Special Needs Plans (D-SNPs) Implementation. Medicare Administration, along with Payment Strategy staff in Finance, have a payment strategy approach for the D-SNP program that will be shared with the Board at the March 2024 meeting.

Enhanced Care Management (ECM)/Community Support (CS) Network Development. The team continues to recruit new ECM and CS providers. On April 1, 2024, along with adding a new ECM provider in Mariposa as noted above, the Alliance will also be adding five new CS providers. Two of those CS providers are for all counties, one for Santa Cruz County members and one for Mariposa members. These providers will be providing medically tailored meals, grocery delivery, and housing navigation services.

Attachments.

1. 2024 Bill List

Central California Alliance for Health
2024 Bill List

Priority Bills	
AB 1379 **Papan** **Status:** Dead Bill **Position:** Support	**Open meetings: local agencies: teleconferences** **Summary:** This bill, with respect to existing general provisions on teleconferencing, would require a legislative body electing to use teleconferencing to post agendas at a singular designated physical meeting location, as defined, rather than at all teleconference locations. The bill would remove the requirements for the legislative body of the local agency to identify each teleconference location in the notice and agenda, that each teleconference location be accessible to the public, and that at least a quorum of the members participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The bill would instead provide that, for purposes of establishing a quorum of the legislative body, members of the body may participate remotely, at the designated physical location, or at both the designated physical meeting location and remotely. The bill would require the legislative body to have at least 2 meetings per year in which the legislative body's members are in person at a singular designated physical meeting location. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing provisions without complying with the general teleconferencing requirements that agendas be posted at each teleconference, that each teleconference location be identified in the notice and agenda, and that each teleconference location be accessible to the public, if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. Under existing law, these alternative teleconferencing provisions require the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. Under existing law, these alternative teleconferencing provisions authorize a member to participate remotely if the member is participating remotely for just cause, limited to twice per year, or due to emergency circumstances, contingent upon a request to, and action by, the legislative body, as prescribed. Existing law specifies that just cause includes travel while on official business of the legislative body or another state or local agency. This bill would revise the alternative provisions, operative until January 1, 2026, to make these provisions operative indefinitely. The bill would delete the restriction that prohibits a member, based on just cause, from participating remotely for more than 2 meetings per calendar year. The bill would delete the requirement for the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. The bill would also delete a provision that requires a member participating remotely to publicly disclose at the meeting before action is taken whether there are individuals 18 years of age present in the room at the remote location and the general nature of the member's relationship to those individuals. The bill would further delete a provision that prohibits a member from participating remotely for a period of more than 3 consecutive months or 20% of the regular meetings within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year. The bill would expand the definition of just cause to include travel related to a member of a legislative body's occupation.

SB 282 **Eggman (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23. **Position:** Support	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** This bill would authorize reimbursement for a maximum of 2 visits at a Federally Qualified Health Center or Rural Health Clinic that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.
SB 311 **Eggman** **Status:** Chaptered, 2023. **Position:** Support	**Medi-Cal: Part A buy-in** **Summary:** This bill would require the department to enter into a Medicare Part A buy-in agreement, as defined, for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment. Under the bill, the buy-in agreement would be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of these provisions, whichever date is later. The bill would authorize the department to implement these provisions through all-county letters or similar instructions until regulations are adopted. Under the bill, these provisions would be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.
SB 424 **Durazo (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 6/8/23 **Position:** Oppose unless Amended	**Medi-Cal: Whole Child Model Program** **Summary:** Existing law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Existing law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.
Assembly Bills	
AB 4 **Arambula (D)** **Status:** Active Bill - In Committee Process Re-referred to Com. on APPR, 7/13/23.	**Covered California: expansion** **Summary:** This bill would require the Exchange 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 given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, and would require the Exchange to provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program.
AB 236 **Holden (D)** **Status:** Active Bill – Pending Referral	**Health care coverage: provider directories** **Summary:** 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, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed

To Com. on RLS. for assignment, 1/30/24.	benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and 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 contracted 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. This bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and would authorize the departments to establish a methodology and processes to ensure accuracy of provider directories. The bill would require the health 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.
AB 365 **Aguiar-Curry (D)** **Status:** Active Bill – In Floor Process Senate Inactive File – Asm. Bills, 3/7/24.	**Medi-Cal: diabetes management** **Summary:** This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available. The bill would make related findings and declarations.
AB 412 **Soria (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 6/14/23.	**Distressed Hospital Loan Program** **Summary**: This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. Notwithstanding that methodology, the bill would deem a hospital applying for aid to be immediately eligible for state assistance from the program if the hospital has 90 or fewer days cash on hand and has experienced a negative operating margin over the preceding 12 months. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information, in a format determined by the authority, demonstrating the hospital's need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop a loan forgiveness application and approval process, as specified. The bill would specify that the authority and the department may implement these provisions by information notices or other similar instructions, without taking any further regulatory action. This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund, as specified.

	By creating a continuously appropriated fund, the bill would make an appropriation. Existing law generally requires a health care facility to report specified data to the department, including total inpatient and outpatient revenues by payer, including Medicare and Medi-Cal. Existing law requires the department to adopt regulations regarding the identification and reporting of charity care services, and specifies various obligations to provide hard copies of hospital data reports submitted pursuant to these provisions. This bill would additionally require data for total inpatient and outpatient revenues by payer to include commercial coverage payers. The bill would require a hospital subject to these data reporting requirements to submit a balance sheet detailing the assets, liabilities, and net worth at the end of the quarter as specified by the department. The bill would also remove the provisions regarding regulations related to charity care services and obligations to provide hard copies of hospital data reports. This bill would declare that it is to take effect immediately as an urgency statute.
AB 459 **Kalra (D)** **Status:** Active Bill – In Committee Process Re-referred to Com. on RLS, 9/14/23.	**Contracts against public policy: personal or professional services: digital replicas** **Summary:** This bill would provide that a provision in an agreement between an individual and any other person for the performance of personal or professional services is contrary to public policy and deemed unconscionable if the provision meets specified conditions relating to the use of a digital replica of the voice or likeness of an individual in lieu of the work of the individual or to train a generative artificial intelligence system. The bill would provide that it shall apply retroactively. The bill would require any person who is currently under, or has entered into, an agreement with an individual performing personal or professional services containing such a provision, by February 1, 2024, to notify that individual in writing that the provision is unenforceable.
AB 492 **Pellerin (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 6/14/23.	**Medi-Cal: reproductive and behavioral health integration pilot programs** **Summary:** This bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. The bill would define "qualified provider" as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion- and contraception-related services. For funding eligibility, the bill would require a Medi-Cal managed care plan to identify the qualified providers and the services that will be provided through the pilot program, as specified. The bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs, in order to support development and expansion of services, infrastructure, and capacity for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. For funding eligibility, the bill would require a qualified provider to identify both the patient population or gap in access to care and the types of services provided, as specified. The bill would require the department to convene a working group, with a certain composition, to develop criteria for evaluating applications and awarding funding, to conduct an evaluation of the pilot programs, and to submit a report to the Legislature, as specified.
AB 551 **Bennett (D)** **Status:** Active Bill – In Committee Process	**Medi-Cal: specialty mental health services: foster children** **Summary:** This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions. By extending the period during which a county agency is responsible for making determinations about presumptive transfer waivers and making certain notifications, the bill would impose a state-mandated local program.

Re-referred to the Com. on APPR, 7/5/2023.	
AB 564 **Villapudua (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 6/14/23.	**Medi-Cal: claim or remittance forms: signature** **Summary:** This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.
AB 815 **Wood (D)** **Status:** Active Bill – In Committee Process. Referred to Com. on HEALTH,, 6/7/23.	**Health care coverage: provider credentials** **Summary:** This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025. This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity.
AB 817 **Pacheco (D)** **Status:** Active Bill – Pending Referral To Asm. Com. on RLS for assignment, 1/25/24.	**Open meetings: teleconferencing: subsidiary body** **Summary:** This bill, until January 1, 2026, would authorize a subsidiary body, as defined, to use similar alternative teleconferencing provisions and would impose requirements for notice, agenda, and public participation, as prescribed. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter.
AB 869 **Wood (D)** **Status:** Active Bill – In Committee Process Second hearing cancelled, 7/10/23.	**Hospitals: seismic safety compliance** **Summary:** This bill would require the Department of Health Care Access and Information to give first priority to grants under the Small and Rural Hospital Relief Program for single- and 2-story general acute care hospitals located in remote or rural areas with less than 80 general acute care beds and general acute care hospital revenue of $75 million or less. The bill would require grants under the program to provide general acute care hospitals with funds to secure an SPC-4D assessment for purposes of planning for, and estimating the costs of, compliance with certain seismic safety standards, as specified. The bill would authorize specified general acute care hospitals to apply for a grant for purposes of complying with those seismic safety standards. This bill contains other related provisions and other existing laws.
AB 1092 **Wood (D)**	**Health care service plans: consolidation** **Summary:** This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the

Status: Active Bill – In Committee Process On Senate suspense file, 9/1/23.	director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General. The bill would revise the director's authority to conditionally approve a transaction or agreement, including authorizing the director to review information from federal agencies and other state agencies, including agencies in other states, that is relevant to any of the parties to the transaction, as specified. With respect to a conditional approval, the bill would also authorize the director to contract with an independent entity to monitor compliance with the established conditions and report to the department. The bill would prohibit the director from waiving, or delaying implementation of, certain requirements imposed under existing law and the bill, notwithstanding a specified provision. This bill contains other related provisions and other existing laws.
AB 1110 **Arambula (D)** **Status:** Active Bill – In Committee Process On Senate suspense file, 9/1/23.	**Public health: adverse childhood experiences** **Summary:** This bill would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.
AB 1117 **Irwin (D)** **Status:** Active Bill – In Committee Process. Referred to Com. on HEALTH, 6/7/23.	**Hospice agency licensure** **Summary:** This bill would require any hospice agency obtaining a license to obtain certification to participate in the federal Medicare program within 12 months of licensure and continuously serve patients as validated by data submission to the Department of Health Care Access and Information, or forfeit its license.
AB 1157 **Ortega (D)** **Status:** Active Bill – In Committee Process On Senate suspense file, 9/1/23.	**Rehabilitative and habilitative services: durable medical equipment and services** **Summary:** This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified. The bill would require the Secretary of California Health and Human Services to communicate to the federal Center for Consumer Information and Insurance Oversight that the coverage of durable medical equipment is necessary to comply with federal requirements for purposes of being considered essential health benefits not subject to defrayal payments. If the center overrules the state's determination that the additional coverage subjects the state to defrayal payments, the bill would require the secretary to reevaluate California's essential health benefits benchmark plan to incorporate the coverage without triggering the defrayal requirement. The bill would require the secretary, no later

	than one year after the center makes its determination, to submit a report to the Legislature recommending the corresponding changes to the essential health benefits benchmarking process in order for the Legislature to approve submission of a new benchmark plan proposal to the center.
AB 1282 **Lowenthal (D)** **Status:** Active Bill – In Floor Process Senate Inactive File – Asm. Bills, 3/7/24.	**Mental health: impacts of social media** **Summary:** This bill would require the Mental Health Services Oversight and Accountability Commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined. The bill would repeal these provisions on January 1, 2029
AB 1316 **Irwin (D) and Ward (D)** **Status:** Active Bill – Pending Referral To Com. on RLS. for assignment, 1/25/24.	**Emergency services: psychiatric emergency medical conditions** **Summary:** This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 1331 **Wood (D)** **Status:** Active Bill – In Committee Process On Sen. suspense file, 9/1/23.	**California Health and Human Services Data Exchange Framework** **Summary:** This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before January 1, 2024, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop recommendations and to review, modify, and approve any modifications to the Data Exchange Framework data sharing agreement, among other things. The bill would require the center to submit an annual report to the Legislature that includes required signatory compliance with the data sharing agreement, assessment of consumer experiences with health information exchange, and evaluation of technical assistance and other grant programs. The bill would require the center, by July 1, 2024, to establish a process to designate qualified health information organizations according to specified criteria.
AB 1359 **Schiavo (D)** **Status:** Active Bill – In Floor Process On Sen. Inactive File – Asm. Bills, 3/7/24.	**Paid sick days: health care employees** **Summary:** This bill would grant an employee of a covered health care facility health care worker sick leave, as those terms are defined. The bill would permit accrued leave, and would prescribe for the use and carryover of that leave, including permitting health care worker sick leave to carry over to the following year of employment for those employees, subject to certain conditions. The bill would prohibit a covered health care facility from limiting an employee's use of health care worker sick leave. The bill would exempt those employees from certain existing limits on the use of accrued paid sick days. The bill would authorize an employee of a covered health care facility to bring a civil action against an employer that violates this provision and would entitle the employee to collect specified legal and equitable relief to remedy a violation.

AB 1537 **Wood (D)** **Status:** Active Bill – In Floor Process On Sen. Inactive File – Asm. Bills, 3/7/24.	**Skilled nursing facilities: direct care spending requirement** **Summary:** This bill would require, no later than July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct patient-related services spending requirement, the bill would require that a minimum of 85% of a facility's total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents' direct patient-related services, as defined. This bill contains other related provisions and other existing laws.
AB 1783 **Essayli (R)** **Status:** Active Bill – Pending Referral Introduced 1/3/24.	**Health care: immigration** **Summary:** This bill would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget.
AB 1842 **Reyes (D)** **Status:** Active Bill – In Committee Process. Referred to Com. on HEALTH, 1/29/24.	**Health care coverage: Medication-assisted treatment** **Summary:** This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy.
AB 1895 **Weber (D)** **Status:** Active Bill – Pending Referral Introduced 1/23/24.	**Public health: maternity ward closures** **Summary:** This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.
AB 1926 **Connolly (D)** **Status:** Active Bill – In Committee Process Referred to the Assembly Committee on Health, 2/5/24.	**Health care coverage: chronic digestive diseases and inherited metabolic disorders** **Summary:** This bill would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2025, to provide coverage for formulas, as defined, for the treatment of other chronic digestive diseases and inherited metabolic disorders, as specified. The bill would specify that these provisions do not apply to Medi-Cal managed care plans to the extent that the services are excluded from coverage under the contract between the Medi-Cal managed care plan and the State Department of Health Care Services.
AB 1943 **Weber (D)** **Status:** Active Bill – In Committee Process Referred to Asm. Coms. on HEALTH,	**Health information** **Summary:** This bill would require the Department of Health Care Services, in collaboration with the California Health and Human Services agency, to collect appropriate data and identify indicators for tracking telehealth outcomes associated with impacting individual patient outcomes and overall population health. The bill would require the department to use the data collected to measure health outcomes of populations, as specified.

and P. and C.P., 2/20/24.	
AB 1970 **Jackson (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/12/24.	**Mental Health: Black Mental Health Navigator Certification Pilot Program** **Summary:** This bill would, commencing July 1, 2025, establish, until June 30, 2028, the Black Mental Health Navigator Certification Pilot Program, to be administered by the State Department of Health Care Services, to provide comprehensive training in mental health resources and awareness, as specified. This bill would require the department to collect specific data and submit a report to the Legislature and the relevant policy committees on or before December 31, 2028. The bill would make those provisions contingent upon appropriation and would repeal those provisions on January 1, 2030.
AB 1975 **Bonta (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/12/24.	**Medi-Cal: medically supportive food and nutrition interventions** **Summary:** This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention. The bill would require the department to define the qualifying medical conditions for purposes of the covered interventions. The bill would require a health care provider, to the extent possible, to match the acuity of a patient's condition to the intensity and duration of the covered intervention and to include culturally appropriate foods. The bill would require the department to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items. The bill would require the workgroup to issue final guidance on or before July 1, 2026.
AB 1977 **Ta (R)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/12/24.	**Health care coverage: behavioral diagnoses** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. 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 1995 **Essayli (R)** **Status:** Active Bill – Pending Referral Introduced 1/30/24.	**Health care facilities: small and rural hospitals** **Summary:** This bill would make technical, nonsubstantive changes to the definition of small and rural hospital.
AB 2028 **Ortega (D)** **Status:** Active Bill – In Committee Process	**Medical loss ratios** **Summary:** This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured.

Referred to Com. on HEALTH, 2/12/24.	
AB 2031 **Jones-Sawyer (D)** **Status:** Active Bill - In Desk Process Amended and re-referred to Com. on JUD., 3/7/24.	**One California program** **Summary:** Under existing law, a component of the State Department of Social Services' grants are aimed at legal services to unaccompanied undocumented minors who are transferred to the care and custody of the federal Office of Refugee Resettlement and who are present in the state. This bill would make changes to the criteria for organizations providing legal services to those minors, including adjustments to qualifications based on the organization's history of professional experience.
AB 2043 **Boerner (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/12/24.	**Medi-Cal: nonmedical and nonemergency medical transportation** **Summary:** This bill would require the department to require Medi-Cal managed care plans that are contracted to provide nonemergency medical transportation or nonmedical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers, for the purpose of establishing reimbursement rates for those transportation trips provided by a public paratransit service operator. The bill would require that the rates be based on the department's fee-for-service rates for the transportation service, as specified.
AB 2063 **Maienschein (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/12/24.	**Health care coverage** **Summary:** The bill would extend the period of time authorized for authorized pilot programs under which providers approved by the Department of Managed Health Care may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.
AB 2105 **Lowenthal (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/20/24.	**Coverage for PANDAS and PANS** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name.
AB 2110 **Arambula (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/20/24.	**Medi-Cal: Adverse Childhood Experiences trauma screenings: providers** **Summary:** This bill would require the Department of Health Care Services, to include (1) 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 2115 **Haney (D)** **Status:** Active Bill – In Committee Process Referred to Coms. on B. & P. and HEALTH., 2/26/24.	**Controlled substances: clinics** **Summary:** This bill would authorize a nonprofit or free clinic to dispense a narcotic drug for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified labeling and recordkeeping requirements. Because the bill would specify additional requirements under the Pharmacy Law, a violation of which would be a crime, it would impose a state-mandated local program.
AB 2198 **Flora (R)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Health information** **Summary:** This bill would exclude dental or vision benefits from application programming interfaces (API) requirements.
AB 2200 **Kalra (D)** **Status:** Active Bill – Pending Referral Introduced 2/7/24.	**Guaranteed Health Care for All** **Summary:** This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds. This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board, on or before July 1 of an unspecified year, to conduct and deliver a fiscal analysis to determine whether or not CalCare may be implemented and if revenue is more likely than not to pay for program costs, as specified. The bill would establish an Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports. The bill would require the board to convene a CalCare Public Advisory Committee to advise the board on all matters of policy for CalCare, an Advisory Committee on Public Employees'

	Retirement System Health Benefits to provide recommendations related to public employee retiree health benefits, and a CalCare Health Workforce Working Group to provide the board with input on issues related to health care workforce education, recruitment, and retention. The bill would establish an Office of Health Equity within CalCare and under the direction of the Director of the Department of Health Care Access and Information to ensure health equity under the program and other health programs of the California Health and Human Services Agency and to support the board through specified actions. This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person. This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget. This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. The bill would specify uses for moneys in the CalCare budget, including special projects for which not-for-profit or governmental entities may apply. Because the bill would create a continuously appropriated fund, it would make an appropriation. This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.
AB 2237 **Aguiar-Curry (D)** **Status:** Active Bill - Pending Referral Introduced 2/8/24.	**Foster children and youth: transfer of specialty mental health services** **Summary:** This bill would declare the intent of the Legislature to enact legislation requiring, when jurisdiction of a foster child or youth is being transferred from one county to another, the transfer county to assume financial responsibility for purposes of ensuring that the child or youth receives, or continues to receive, timely access to specialty mental health services when the child or youth has been transferred from the county of original jurisdiction, while the transfer county conducts its investigation and casework transfer process, if specified conditions are met, including, but not limited to, that the child or youth has been identified by the county of original jurisdiction as high risk or coming from a vulnerable population. The bill also would declare the Legislature's intent to enact related provisions, including requiring the State Department of Health Care Services and the State Department of Social Services to collaborate to create a system of standardized communication between counties that respects the procedures of the receiving county and the needs of the child that is without mental health services, and requiring the State Department of Social Services to establish care teams to help counties coordinate and expedite the transfer between counties.

AB 2250 **Weber (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Social determinants of health: screening and outreach** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. 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 would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified.
AB 2297 **Friedman (D)** **Status:** Active Bill – In Committee Process Referred to Coms. on HEALTH and JUD., 2/26/24.	**Hospital and Emergency Physician Fair Pricing Policies** **Summary:** This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of "high medical costs" means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing. Existing law requires a hospital's discount payment policy to clearly state the eligibility criteria based upon income, and authorizes a hospital to consider the income and monetary assets of the patient in determining eligibility under its charity care policy. This bill would define charity policy for those purposes. The bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of recent pay stubs or income tax returns. The bill would prohibit a hospital from imposing time limits for eligibility. The bill would authorize a hospital to waive Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program. This bill would eliminate the authorization for a hospital or an emergency physician to consider monetary assets in determining the amount of debt the hospital or emergency physician may seek to recover from patients who are eligible under these policies. This bill would prohibit a hospital or emergency physician from using liens on any real property as a means of collecting unpaid hospital or emergency physician bills, and would prohibit a collection agency from conducting a sale of any real property owned, in part or completely, by a patient or placing a lien on any real property as a means of collecting unpaid hospital or emergency physician bills.
AB 2303 **Carrillo (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Health and care facilities: prospective payment system rate increase** **Summary:** This bill would require the State Department of Health Care Services, on or before April 1, 2025, to submit a request for approval to the federal Centers for Medicare and Medicaid Services to authorize a waiver for specified health care facilities to request a change in its prospective payment system rate.
AB 2319 **Wilson (D)**	**California Dignity in Pregnancy and Childbirth Act** **Summary:** This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The

Status: Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal or prenatal care, as defined. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require, by February 1 of each year, that a facility provide the department with proof of compliance, with specified requirements. The bill would authorize the department to issue an administrative penalty if it determines that a facility has violated these provisions, and would require the department to annually post on its internet website a list of facilities that did not submit timely proof of compliance and have been issued administrative penalties. The bill would specify that, for these purposes, each health care provider that does not complete the required training constitutes a separate violation. The bill would vest the State Department of Public Health with full administrative power, authority, and jurisdiction to implement and enforce the California Dignity in Pregnancy and Childbirth Act. The bill would require the department to solicit participation and adopt regulations to further the purposes of the act, as specified.
AB 2332 **Connolly (D)** **Status:** Active Bill – Pending Referral Introduced 2/12/24.	**Corrections: health care** **Summary:** The bill would state the intent of the Legislature to enact legislation to improve inmate health outcomes in state prisons.
AB 2339 **Aguiar-Curry (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Medi-Cal: telehealth** **Summary:** This bill would expand an exception to the use of asynchronous store and forward when the visit is related to sensitive services, as specified. The bill would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the patient requests an asynchronous store and forward modality, as specified. Existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests that they do not have access to video, as specified. This bill would remove, from that exception, the option of the patient attesting that they do not have access to video.
AB 2340 **Bonta (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Medi-Cal: EPSDT services** **Summary:** This bill would prohibit limits on EPSDT behavioral health delivery system services when those services are medically necessary. The bill would require a Medi-Cal managed care plan to cover all medically necessary EPSDT services, unless otherwise carved out of the contract between the managed care plan and the department, regardless of whether those services are covered under the Medi-Cal State Plan. The bill would establish definitions for "EPSDT services" and "medically necessary" by making references to the above-described provisions. The bill would specify that EPSDT services also include all age-specific assessments and services listed under the most current periodicity schedule by the American Academy of Pediatrics (AAP) and Bright Futures, and any other medically necessary assessments and services that exceed those listed by AAP and Bright Futures. The bill would require the department and its contractors to accurately reflect these provisions in any model evidence-of-coverage documents, beneficiary handbooks, and related material.
AB 2342 **Lowenthal (D)**	**Medi-Cal: critical access hospitals: islands** **Summary:** This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located

Status: Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above. This bill would make legislative findings and declarations as to the necessity of a special statute for critical access hospitals operating on those islands.
AB 2352 **Irwin (D)** **Status:** Active Bill – Pending Referral Introduced 2/12/24.	**Psychiatric advance directives** **Summary:** This bill would declare the intent of the Legislature to enact legislation relating to psychiatric advance directives.
AB 2356 **Wallis (R)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Medi-Cal: monthly maintenance amount: personal and incidental needs** **Summary:** This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.
AB 2376 **Bains (D)** **Status:** Active Bill – Pending Referral Introduced 2/12/24.	**Medi-Cal** **Summary:** This bill would state the intent of the Legislature to enact legislation to allow for acute care hospitals that accept Medi-Cal coverage to directly bill for inpatient detox services and Medically Assisted Treatment for substance abuse issues, as specified.
AB 2435 **Maienschein (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**California Health Benefit Exchange** **Summary:** This bill would extend the authority of the Covered California executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025.
AB 2446 **Ortega (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	**Medi-Cal: diapers** **Summary:** This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and colic, among others. The bill would establish diapers as a covered benefit for a child greater than 3 years of age with a condition that contributes to incontinence. The bill would require the department to seek any and all available federal funding to implement this provision and would implement these provision only to the extent that the department obtains any necessary federal approvals or waivers.
AB 2449 **Ta (R)**	**Health care coverage: qualified autism service providers** **Summary:** This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute.

Status: Active Bill – In Committee Process Referred to Com. on HEALTH, 2/26/24.	
AB 2466 **Carrillo (D)** **Status:** Active Bill – Pending Referral Introduced 2/13/24.	**Mental health** **Summary:** This bill would state the intent of the Legislature to enact legislation relating to mental health.
AB 2556 **Jackson (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Behavioral health and wellness screenings: notice** **Summary:** This bill would require a health care service plan or insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined. The bill would require a health care service plan or insurer to provide the notice at least once every 2 years in the preferred method of the legal guardian.
AB 2668 **Berman (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Coverage for cranial prostheses** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Commencing January 1, 2025, this bill would require coverage for cranial prostheses for individuals experiencing permanent or temporary medical hair loss. or treatment for those conditions as a Medi-Cal benefit, subject to the same requirements with respect to provider prescription, coverage frequency, and amount. The bill would not apply these provisions to a specialized health care service plan.
AB 2699 **Carrillo (D)** **Status:** Active Bill - Pending Referral Introduced 2/14/24.	**Health care service plans: provider directories** **Summary:** This bill would make technical, nonsubstantive changes to those provisions requiring health care services plans to publish and maintain provider directories as specified.
AB 2701 **Villapudua (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Medi-Cal: dental cleanings and examinations** **Summary:** This bill would restructure existing provisions so that 2 dental prophylaxis cleanings and 2 periodic dental examinations per year, as specified, would be covered Medi-Cal benefits for all beneficiaries, regardless of age.

AB 2703 **Aguiar-Curry (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Federally qualified health centers and rural health clinics: psychological associates** **Summary:** This bill would add a psychological associate to existing provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology.
AB 2726 **Flora (R)** **Status:** Active Bill - Pending Referral Introduced 2/14/24.	**Health care coverage: access to specialty care** **Summary:** This bill would state that it is the intent of the Legislature to enact legislation to increase access to specialty care to support whole-person care among California's most medically complex patients facing significant adverse social drivers of health.
AB 2753 **Ortega (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Rehabilitative and habilitative services: durable medical equipment and services** **Summary:** This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified. The bill would make related findings and declarations, including that coverage of durable medical equipment is necessary to comply with federal requirements for purposes of being considered essential health benefits not subject to defrayal payments.
AB 2843 **Petrie-Norris (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 3/4/24.	**Health care coverage: rape and sexual assault** **Summary:** This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault.
AB 2956 **Boerner (D)** **Status:** Active Bill - Pending Referral Introduced 2/16/24.	**Medi-Cal eligibility: redetermination** **Summary:** This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified. The bill would make various changes to redetermination procedures. The bill would, among other things, require the county, in the event of a loss of contact, to attempt communication with the intended recipient through all additionally available channels before completing a redetermination. The bill would require the county to make another review of certain obtained information in an attempt to renew eligibility without needing a response from a beneficiary. The bill would require the county to complete a determination at renewal without requesting additional information or documentation if specified conditions are

	met, relating to, among other things, prior income verification and no contradictory information on file. When income is found not reasonably compatible from electronically available sources, the bill would require the county to first attempt to obtain a reasonable explanation through a verbal or written explanation, in an attempt to resolve a discrepancy between the beneficiary's self-attestation and information received through electronic data sources on required eligibility factors. The bill would require the county to accept self-attestation of income in cases that meet certain conditions. Under the bill, for a beneficiary whose eligibility was discontinued due to failure to provide needed information and who submits to the county that information, as specified, the beneficiary would be entitled to a Medi-Cal eligibility determination for the 3 months immediately prior to the month in which the beneficiary provided the information, unless the beneficiary opts out. In the case of a redetermination due to a change in circumstances, each time a Medi-Cal beneficiary who is considered a member of a vulnerable or difficult-to-reach population, as defined, makes contact with the county, the bill would require the county to begin a new 12-month eligibility period if certain conditions are met. The bill would require the department to set a goal, in the form of a target rate of at least 50%, for successful ex parte renewals, and to post a related report. The bill would require counties to collect and submit to the department call-center data metrics, and would require the department to post a related report on a quarterly basis. The bill would require the department to seek any necessary federal approvals to make permanent all temporary eligibility rules, not already described above, that were originally implemented for Medi-Cal renewals that were due between June 2023 and May 2024, inclusive, as part of the COVID-19 Unwinding Period.
AB 2976 **Jackson (D)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Mental health care** **Summary:** This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.
AB 3129 **Wood (D)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Health care system consolidation** **Summary:** This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group, as those terms are defined, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the change in control or acquisition. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue. The bill would authorize the Attorney General to give the private equity group or hedge fund a written waiver or the notice and consent requirements if specified conditions apply, including, but not limited to, that the party makes a written waiver request, the party's operating costs have exceeded its operating revenue in the relevant market for 3 or more years and the party cannot meet its debts, and the acquisition or change of control will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 60 days, as prescribed. The bill would authorize the Attorney General to grant, deny, or impose conditions to a change of control or an acquisition between a private equity group or hedge fund and a health care facility, provider group, or both, if the change of control or acquisition may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or

	availability of health care services to the affected community, applying a public interest standard, as defined. The bill would authorize any party to the acquisition or change of control to apply to the Attorney General to reconsider the decision and to modify, amend, or revoke the prior decision, and to seek subsequent judicial review of the Attorney General's final determination on that reconsideration application if the Attorney General denies consent or gives conditional consent. The bill would prohibit a private equity group or hedge fund involved in any manner with a physician or psychiatric practice doing business in this state, from controlling or directing that practice, as specified. The bill would also prohibit a physician or psychiatric practice from entering into an agreement or arrangement with an entity controlled in part or in whole directly or indirectly by a private equity group or hedge fund in which that private equity group or hedge fund manages any of the affairs of the physician or psychiatric practice in exchange for a fee. The bill would authorize the Attorney General to adopt regulations to implement its requirements, as specified.
AB 3149 **Garcia (D)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Community health workers** **Summary:** This bill would state the intent of the Legislature to enact legislation related to community health workers.
AB 3156 **Patterson (R)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Medi-Cal: managed care plans** **Summary:** This bill would express the intent of the Legislature to enact legislation to exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage from mandatory enrollment in a Medi-Cal managed care plan.
AB 3215 **Soria (D)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Medi-Cal: mental health services for children** **Summary:** This bill would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.
AB 3221 **Pellerin (D)** **Status:** Active Bill – Pending Referral Introduced 2/16/24.	**Department of Managed Health Care: review of records** **Summary:** This bill would require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director's determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. .
AB 3245 **Patterson (R)**	**Coverage for colorectal cancer screening** **Summary:** This bill would require coverage without cost sharing for colorectal care screening test or examination if the test or screening examination is assigned either a grade

Status: Active Bill – Pending Referral Introduced 2/16/24.	of A or a grade of B by another accredited or certified guideline agency, in addition to the United States Preventive Services Task Force.
Senate Bills	
SB 70 **Wiener (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Prescription drug coverage** **Summary:** This bill would prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage.
SB 238 **Wiener (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Health care coverage: independent medical review** **Summary:** This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill. bill, and to issue interim guidance, as specified.
SB 242 **Skinner (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HUM. S., 6/8/23.	**California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program** **Summary:** This bill would, to the extent permitted by federal law, prohibit funds deposited and investment returns accrued in a California Hope, Opportunity, Perseverance, and Empowerment (HOPE) trust fund account from being considered as income or assets when determining eligibility and benefit amount for any means-tested program until an eligible youth withdraws or transfers the funds from the HOPE trust fund account, as specified. The bill would make these provisions operative on July 1, 2024, or on the date that the State Department of Social Services notifies the Legislature that the Statewide Automated Welfare System can perform the necessary automation to implement these provisions or no automation is necessary, whichever date is later.
SB 294 **Wiener (D)**	**Health care coverage: independent medical review** **Summary:** This bill, commencing July 1, 2025, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon

Status: Active Bill – Pending Referral In Assembly, held at desk, 1/29/24.	expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.
SB 324 **Limón (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Health care coverage: endometriosis** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 340 **Eggman (D)** **Status:** Active Bill – In Committee Process 6/27/23 first hearing cancelled at request of author.	**Medi-Cal: eyeglasses: Prison Industry Authority** **Summary:** This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.
SB 363 **Eggman (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Facilities for inpatient and residential mental health and substance use disorder: database** **Summary:** This bill would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.

SB 516 **Skinner** **Status:** Active Bill – In Committee Process Re-referred to Com. on APPR., 9/14/23.	**Health care coverage: prior authorization** **Summary:** On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time.
SB 537 **Becker (D)** **Status:** Active Bill – In Floor Process Asm. Inactive File, 3/11/24.	**Open meetings: multijurisdictional, cross-county agencies: teleconferences** **Summary:** This bill would expand the circumstances of "just cause" for a member of a legislative body of a local agency to use alternative teleconferencing, to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely. The bill would authorize the legislative body of a multijurisdictional, cross-county agency, as specified, to use alternate teleconferencing provisions if the eligible legislative body has adopted an authorizing resolution, as specified. The bill would also require the legislative body to provide a record of attendance and the number of public comments on its internet website within 7 days after a teleconference meeting, as specified. The bill would require at least a quorum of members of the legislative body to participate from one or more physical locations that are open to the public and within the boundaries of the territory over which the local agency exercises jurisdiction. The bill would require a member who receives compensation for their service, as specified, on the legislative body to participate from a physical location that is open to the public. The bill would require the legislative body to identify in the agenda each member who plans to participate remotely and to include the address of the publicly accessible building from which each member will participate via teleconference. The bill would prohibit a member from participating remotely pursuant to these provisions unless the remote location is the member's office or another location in a publicly accessible building and is more than 40 miles from the in-person location of the meeting. The bill would repeal these alternative teleconferencing provisions on January 1, 2026.
SB 589 **Alvarado-Gil (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Foster youth: disaster aid assistance** **Summary:** This bill would establish the Child Welfare Disaster Response Program, to be administered by the department. The bill would establish the Child Welfare Disaster Response Account to fund the program. The bill would require, upon appropriation by the Legislature, $2,000,000 to be allocated from the General Fund to the Child Welfare Disaster Response Account for purposes of the program and to support the needs of foster children and youth and their caregivers during a disaster. The bill would require the department to determine eligibility criteria for applicants and would authorize county child welfare departments to apply for funds. The bill would require funds awarded pursuant those provisions to be available to meet the housing, clothing, transportation, and other tangible needs of foster children and youth and their caregivers that occur within 180 days of a local emergency proclamation by a local government or a state of emergency proclamation by the Governor.

SB 598 **Skinner (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Health care coverage: prior authorization** **Summary:** On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time.
SB 729 **Menjivar (D)** **Status:** Active Bill – In Committee Process Com. hearing postponed, 9/1/23.	**Health care coverage: treatment for infertility and fertility services** **Summary:** This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.
SB 819 **Eggman (D)** **Status:** Active Bill – In Floor Process On Asm. Inactive File, 3/11/24.	**Medi-Cal: certification** **Summary:** This bill would exempt from specified Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by a government-run license-exempt clinic, as described, if that clinic has notified the department of its separate locations, premises, sites, or units.
SB 873 **Bradford (D)** **Status:** Active Bill – In Committee Process Held under submission, 9/1/23.	**Prescription drugs: cost sharing** **Summary:** This bill, commencing no later than January 1, 2025, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified. The bill would require the department and the commissioner to submit an annual report on the impact of these

	provisions to the appropriate policy committees of the Legislature, as specified. The bill would make these provisions inoperative on January 1, 2027.
SB 953 **Menjivar** **Status:** Active Bill – In Committee Process Set for hearing 3/20/24.	**Medi-Cal: menstrual products** **Summary:** This bill would add menstrual products, as defined, to that schedule of covered benefits. The bill would require the department to seek any necessary federal approvals to implement this coverage.
SB 966 **Wiener (D)** **Status:** Active Bill – In Committee Process Referred to Coms. on B., P. & E. D. and HEALTH, 2/14/24.	**Pharmacy benefits** **Summary:** This bill would require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the California State Board of Pharmacy to operate as a pharmacy benefit manager. The bill would establish application qualifications and requirements, and would establish an unspecified fee for initial licensure and renewal. This bill would require a pharmacy benefit manager, on or before April 1, 2027, and annually thereafter, to file with the board a report containing specified information. The bill would specify that the contents of the report shall not be disclosed to the public. The bill would require the board, on or before August 1, 2027, and annually thereafter, to submit a report to the Legislature based on the reports submitted by licensees, and would require the board to post the report on the board's internet website.
SB 975 **Ashby (D)** **Status:** Active Bill - In Committee Process Referred to Senate Com. on RLS, 2/14/24.	**Emergency medical services: community paramedicine** **Summary:** This bill would state the intent of the Legislature to enact legislation relating to the payment and reimbursement for mobile integrated health and community paramedicine programs.
SB 980 **Wahab (D)** **Status:** Active Bill – In Committee Process Set for hearing, 3/20/24.	**Medi-Cal: dental crowns and implants** **Summary:** This bill would provide Medi-Cal coverage, for persons 13 years of age or older, for laboratory-processed crowns on teeth when a lesser service would not suffice because of extensive coronal destruction and a crown is medically necessary to restore the tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.
SB 999 **Cortese (D)** **Status:** Active Bill – In Committee Process Amended and re-referred to Com. on HEALTH, 3/7/24.	**Health coverage: mental health and substance use disorders** **Summary:** This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment.

SB 1008 **Bradford (D)** **Status:** Active Bill – In Committee Process Referred to Com. on HEALTH, 2/14/24.	**Obesity Treatment Parity Act** **Summary:** This bill would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include comprehensive coverage for the treatment of obesity in the same manner as any other illness, condition, or disorder. The bill would prohibit an individual or group health care service plan contract or health insurance policy from requiring more than 6 months of intensive behavioral therapy prior to granting access to other treatment options. The bill would also require that at least one FDA-approved antiobesity medication within the class of the relevant United States Pharmacopeia therapeutic category appear on, and be covered under, tier one of the health care service plan's or insurer's drug formulary.
SB 1017 **Eggman (D)** **Status:** Active Bill – In Committee Process Set for hearing 3/20/24.	**Available facilities for inpatient and residential mental health or substance use disorder treatment** **Summary:** This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later. The bill would require the facilities subject to these provisions to submit accurate and timely data to the solution that includes, among other information, the facility's license type, whether a bed is available, and the target population served at the facility. The bill would require the solution and information contained in the solution to be maintained in compliance with state and federal confidentiality laws. The bill would also prohibit the solution and information contained in the solution from being publically available. The bill would authorize the State Department of Health Care Services to impose a plan of correction against a facility that failed to comply with the requirements of the solution, and if a facility fails to complete a plan of correction, would further authorize the department to impose civil penalties, subject to an appeal and hearing process. The bill would create the Available Care for Inpatient and Residential Mental Health or Substance Use Disorder Treatment Solution Maintenance and Oversight Fund for the receipt of any penalties. Because the bill would continuously appropriate moneys in the fund to the State Department of Health Care Services for the administrative costs of implementing these provisions, it would create an appropriation. The bill would authorize the State Department of Health Care Services and the State Department of Social Services to enter into exclusive or nonexclusive contracts or amend existing contracts for the purposes of administering or implementing the solution. The bill would exempt contracts entered into or amended or changes to existing information technology systems made pursuant to these provisions from the requirements of the California State Contracts Register, specified requirements for personal services contracts, the State Contract Act, the Statewide Information Management Manual, and the State Administrative Manual. The bill would further exempt these contracts and changes from review or approval by the Department of General Services.
SB 1112 **Menjivar (D)** **Status:** Active Bill - In Committee Process	**Medi-Cal: families with subsidized childcare** **Summary:** This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to enter into a memorandum of understanding to facilitate coordination between Medi-Cal managed care plans and alternative payment agencies. For purposes of children of families receiving subsidized childcare services through an alternative payment program, and upon the consent of the parent or guardian, the bill would require the plans and agencies to collaborate on assisting the family with the Medi-Cal enrollment

Set for hearing 3/20/24.	of a child who is eligible but not a beneficiary, and on referring a Medi-Cal beneficiary to developmental screenings that are available under EPSDT services and administered through the plan. The bill would authorize the agency to perform certain related functions.
SB 1120 **Becker (D)** **Status:** Active Bill - In Committee Process Set for hearing 3/20/24.	**Health care coverage: utilization review** **Summary:** This bill would require a health care service plan or health insurer to ensure that a licensed physician supervises the use of artificial intelligence decision making tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees or insureds.
SB 1131 **Gonzalez (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/21/24.	**Medi-Cal providers** **Summary:** This bill would make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning, under which comprehensive clinical family planning services are provided as a benefit under the Medi-Cal program. Existing law also creates the State-Only Family Planning Program, under which family planning services are provided to eligible individuals. This bill would, for both the Medi-Cal and Family PACT programs, require the department to allow a provider 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, state that a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, is not required to be a clinician and that certain clinic corporations can enroll multiple service addresses under a single site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, such as being offered in person and through a virtual platform and being offered at least once per month, among others.
SB 1180 **Ashby (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/21/24.	**Health care coverage: emergency medical services** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program.
SB 1213 **Atkins (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Health care programs: cancer** **Summary:** This bill would provide that an individual is eligible to receive breast and cervical cancer screening and treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.
SB 1236 **Blakespear (D)**	**Medicare supplement coverage: open enrollment periods**

Status: Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Summary:** This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period.
SB 1258 **Dahle (R)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Medi-Cal: unrecovered payments: interest rate** **Summary:** In the case of an assessment against any unrecovered overpayment due to the Department of Health Care Services, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.
SB 1268 **Nguyen (R)** **Status:** Active Bill - In Committee Process Referred to Com. on RLS. 2/29/24	**Health insurance** **Summary:** This bill would make technical, nonsubstantive changes to existing provisions related to a health authority, including reporting requirements, commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975
SB 1269 **Padilla (D)** **Status:** Active Bill - In Committee Process Set for hearing 3/20/24.	**Safety net hospitals** **Summary:** This bill would establish a definition for "safety net hospital" and would state the intent of the Legislature that this definition serve as a recommended definition for policymakers to elect to utilize when crafting policy aimed at focusing on or supporting those hospitals. Under the bill, the definition would not be construed as affecting existing or new references to safety net hospitals, unless future legislation or other action expressly makes reference to this definition, as specified. Under the bill, "safety net hospital" would mean a Medicaid DSH-eligible hospital; a rural hospital, including a small and rural hospital and a critical access hospital, as specified; or a sole community hospital, as classified by the federal Centers for Medicare and Medicaid Services and in accordance with certain federal provisions.
SB 1290 **Roth (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Health care coverage: essential health benefits** **Summary:** 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 1300 **Cortese (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Health facility closure: public notice: inpatient psychiatric and maternity services** **Summary:** This bill would change the notice period required before proposed closure or elimination of a supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. Before a health facility may provide notice of a proposed closure or elimination of an inpatient psychiatric service or maternity service, this bill would require the facility to provide an impact analysis report, as specified, regarding the impact on the health of the community resulting from the proposed elimination of the services. The bill would require the health facility to provide the impact analysis report to the Department of Health Care Access and Information for review and certification. The bill would require, after certification, that the impact analysis report be delivered to the local county board of supervisors and to the department. The bill also would require the cost of preparing the impact analysis report to be borne by the hospital. The bill would strongly encourage the board of supervisors to hold a public hearing within 15 days of receipt of the report, as specified, and to post the impact analysis report on its internet website. The bill would require, if the loss of beds will have an impact to on the health of the community, that the State Department of Public Health prioritize and expedite the licensing of additional beds for up to 18 months to replace the number of lost beds.
SB 1339 **Allen (D)** **Status:** Active Bill - In Committee Process Referred to Com. on RLS, 2/29/24.	**Health and care facilities** **Summary:** This bill would state the intent of the Legislature to enact legislation to ensure that licensed facilities that receive referred behavioral health patients have their licenses checked to ensure that these licensed facilities are capable of providing the appropriate level of care.
SB 1354 **Wahab (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Health facilities: payment source** **Summary:** This bill would require a long-term health care that participates as a provider under the Medi-Cal program to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.
SB 1355 **Wahab (D)** **Status:** Active Bill - Pending Referral Introduced 2/16/24.	**Medi-Cal: in-home supportive services: redetermination** **Summary:** This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions.
SB 1397 **Eggman (D)** **Status:** Active Bill - In Committee Process	**Behavioral health crisis services: reporting** **Summary:** This bill would authorize a county to report to the Department of Managed Health Care or the Department of Insurance a complaint about a health care service plan's or a health insurer's failure to make a good faith effort to contract or enter into an agreement with the county to obtain reimbursement for behavioral health crisis services, or to timely reimburse the county for services the plan or insurer is required to cover by state

Referred to Com. on HEALTH, 2/29/24.	or federal law, and would require the respective department to timely investigate the complaint.
SB 1423 **Dahle (R)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Medi-Cal: critical access hospitals** **Summary:** This bill would remove the provisions relating to supplemental payments to critical access hospitals, as defined, and would instead require the reimbursement to a critical access hospital for Medi-Cal covered outpatient services at a rate equal to the actual cost to the hospital of providing the services or the amount charged by the hospital for the services, whichever is less. The bill would also require reimbursement to those hospitals, under the same terms, for swing-bed services, relating to beds licensed for general acute care that may be used as skilled nursing beds. Existing law sets forth various Medi-Cal payment reductions by specified percentages for certain providers, including rural swing-bed facilities. This bill would make an exception to those payment reductions for rural-swing bed facilities in the case of critical access hospitals under the above-described reimbursement provisions.
SB 1492 **Menjivar (D)** **Status:** Active Bill - In Committee Process Referred to Com. on HEALTH, 2/29/24.	**Medi-Cal reimbursement rates: private duty nursing** **Summary:** This bill would provide that, for reimbursement purposes related to the MCO tax, private duty nursing services provided to a child under 21 years of age by a home health agency are considered specialty care services.

DATE: March 27, 2024

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the First Month Ending January 31, 2024

For the month ending January 31, 2024, the Alliance reported an Operating Income of $14.6M with a Medical Loss Ratio (MLR) of 86.1% and an Administrative Loss Ratio (ALR) of 4.9%. The Net Income is $18.4M after accounting for Non-Operating Income/Expenses.

The budget expected a $10.5M Operating Income for January. The actual result is favorable to budget by $4.1M or 39.3%, driven primarily by rate variance and membership favorability.

Jan-24 (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*456,002*	*440,590*	*15,412*	*3.5%*
Revenue	$162,944	$149,796	$13,148	8.8%
Medical Expenses	140,320	130,464	(9,856)	-7.6%
Administrative Expenses	8,027	8,850	823	9.3%
Operating Income/(Loss)	14,598	10,482	4,116	39.3%
Net Income/(Loss)	$18,360	$12,091	$6,269	51.8%
PMPM				
Revenue	$357.33	$339.99	$17.34	5.1%
Medical Expenses	307.72	296.11	(11.61)	-3.9%
Administrative Expenses	17.60	20.09	2.48	12.4%
Operating Income/(Loss)	$32.01	$23.79	$8.22	34.6%
MLR %	86.1%	87.1%	1.0%	
ALR %	4.9%	5.9%	1.0%	
Operating Income %	9.0%	7.0%	2.0%	
Net Income %	11.3%	8.1%	3.2%	

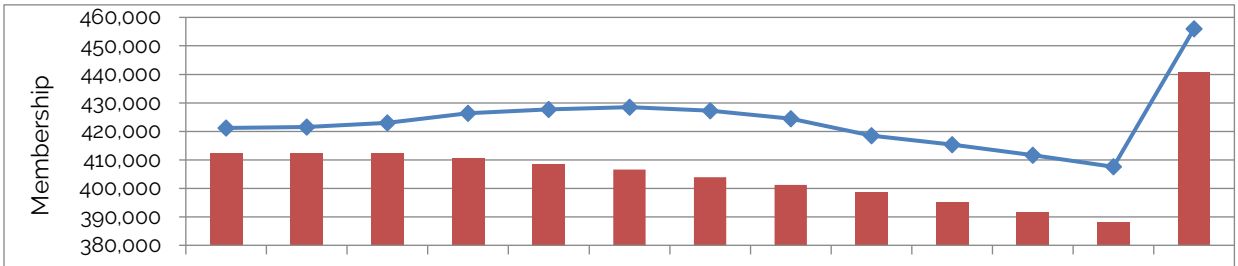
Per Member Per Month (PMPM). Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not usually correspond with enrollment and should be evaluated at the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

At a PMPM level, the January revenue is $357.33, which is favorable to budget by $17.34 or 5.1%. Medical cost PMPM is $307.72, which is unfavorable by $11.61 or 3.9%. Overall, this results in a favorable gross margin of $5.74, or 13.1%, compared to the budget. The operating income PMPM is $32.01, which is favorable to the budget by $8.22 or 34.6%.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Membership. January 2024 membership is favorable to budget by 3.5%. January includes Mariposa and San Benito counties. Mariposa membership is 6k, and San Benito is 21k. 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.

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



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Budget	412,231	412,231	412,231	410,347	408,481	406,635	403,892	401,191	398,530	395,036	391,611	388,255	440,590
Actual	421,212	421,478	423,002	426,328	427,656	428,448	427,275	424,399	418,442	415,304	411,670	407,542	456,002
Variance	8,981	9,247	10,771	15,981	19,175	21,813	23,383	23,208	19,912	20,268	20,059	19,287	15,412
Variance %	2.2%	2.2%	2.6%	3.9%	4.7%	5.4%	5.8%	5.8%	5.0%	5.1%	5.1%	5.0%	3.5%

Revenue. The 2024 revenue budget was based on the current Department of Health Care Services (DHCS) 2024 draft rate package, and this does not include Targeted Rate Increase (TRI). Furthermore, the budget assumed breakeven performances for San Benito Region. The prospective CY 2024 draft rates from DHCS (dated 12/5/2023, including Maternity) are favorable to the rates assumed in the CY 2024 budget by 2.1%, excluding TRI.

January 2024 operating revenue of $162.5M is favorable to budget by $13.1M or 8.8%. Of this amount, $4.6M is from boosted enrollment, and $8.5M is due to rate variance.

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).

Jan-24 Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	122,393	111,810	10,583	4,519	6,064
CEC UIS	32,871	32,260	611	(390)	1,001
SBN SIS	6,212	4,455	1,757	396	1,361
SBN UIS	1,070	927	143	55	88
Total*	**162,545**	**149,452**	**13,093**	**4,579**	**8,514**

*Excludes Jan-24 In-Home Supportive Services (IHSS) premiums revenue of $0.4M.

Medical Expenses. The 2024 budget assumed a 3.7% increase in utilization over the base data that spanned from 2018 through June 2023 and 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).

January 2024 Medical Expenses of $140.3M are over budget by $9.9M or 7.6%. Of this amount, $4.6M is due to higher enrollment, and $5.3M is due to rate variances.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - Hospital	45,816	47,829	2,013	(1,668)	3,681
Inpatient Services - LTC	19,506	11,224	(8,282)	(389)	(7,892)
Physician Services	32,467	27,803	(4,664)	(976)	(3,687)
Outpatient Facility	16,636	16,228	(408)	(567)	159
Other Medical*	25,895	27,380	1,485	(965)	2,449
State Incentive Programs	-	-	-	-	-
TOTAL COST	**140,320**	**130,464**	**(9,856)**	**(4,565)**	**(5,291)**

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

At a PMPM level, the January Medical Expenses are $307.72, unfavorable by $11.61 or 3.9% compared to the budget. The main variances are from the rate variance of LTC and Physician Services.

The unfavorable impact on LTC arises from the budget's assumption that the 10% LTC rate increase, prompted by COVID-19, would cease in 2024. However, due to a significant lag in payments under LTC and the onset of the new year, payments from 2023, which include the 10% rate increase, are still ongoing. Other drivers contributing to the variance impact include additional reserve for anticipated DHCS fee increase to occur in September/October ($500K/month) and additional reserve for higher acuity of new Age 26-49 UIS enrollments ($600K).

The negative impact on Physician Services arises from higher incurred but not reported (IBNR), which came in at 15% or $3 million higher than prior years' monthly average. This is due to increased upward pressure to prior months for paid PMPM, and increased reserves due to new 26-49 UIS enrollments.

Jan-24 YTD Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	100.47	108.56	8.08	7.4%
Inpatient Services - LTC	42.78	25.48	(17.30)	-67.9%
Physician Services	71.20	63.10	(8.09)	-12.8%
Outpatient Facility	36.48	36.83	0.35	1.0%
Other Medical	56.79	62.14	5.36	8.6%
State Incentive Programs	-	-	-	0.0%
TOTAL MEDICAL COST	**307.72**	**296.11**	**(11.61)**	**-3.9%**

Administrative Expenses. January Administrative Expenses are favorable to budget by $0.8M or 9.3% with a 4.9% ALR. Salaries are slightly favorable by $0.3M, driven by savings from vacant positions, benefits, temporary services, and PTO. Non-Salary Administrative Expenses are favorable by $0.5M or 19.3% due to the timing of the actual spend versus budget.

Non-Operating Revenue/Expenses. January Net Non-Operating income is $3.8M, which is favorable to the budget. Total Non-Operating Revenue is favorable to budget by $1.3M, attributed to $1.0M interest income and $0.3M in unrealized investment gain. Non-Operating Expenses are favorable by $0.8M due to lower grant expenses.

Summary of Results. Overall, the Alliance generated a Net Income of $18.4M, with an MLR of 86.1% and an ALR of 4.9%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The First Month Ending January 31, 2024
(In $000s)

Assets	
Cash	$214,890
Restricted Cash	300
Short Term Investments	849,437
Receivables	572,494
Prepaid Expenses	4,692
Other Current Assets	5,888
Total Current Assets	**$1,647,701**
Building, Land, Furniture & Equipment	
Capital Assets	$79,417
Accumulated Depreciation	(44,466)
CIP	1,413
Lease Receivable	3,084
Total Non-Current Assets	**39,448**
Total Assets	**$1,687,149**
Liabilities	
Accounts Payable	$445,311
IBNR/Claims Payable	317,664
Provider Incentives Payable	44,203
Other Current Liabilities	10,365
Due to State	10,574
Total Current Liabilities	**$828,117**
Deferred Inflow of Resources	2,933
Total Long-Term Liabilities	**$2,933**
Fund Balance	
Fund Balance - Prior	$837,738
Retained Earnings - CY	18,360
Total Fund Balance	**856,098**
Total Liabilities & Fund Balance	**$1,687,149**
Additional Information	
Total Fund Balance	**$856,098**
Board Designated Reserves Target	419,792
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	165,802
Value Based Payments	46,100
Total Reserves	**688,394**
Total Operating Reserve	**$167,704**

* MCGP includes Additional Contribution of $48.6M

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The First Month Ending January 31, 2024
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*456,002*	*440,590*	*15,412*	*3.5%*	*456,002*	*440,590*	*15,412*	*3.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$162,545	$149,452	$13,093	8.8%	$162,545	$149,452	$13,093	8.8%
State Incentive Programs	-	-	-	0.0%	-	-	$0	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	$0	0.0%
Premiums Commercial	399	344	55	15.9%	399	344	55	15.9%
Total Operating Revenue	**$162,944**	**$149,796**	**$13,148**	**8.8%**	**$162,944**	**$149,796**	**$13,148**	**8.8%**
Medical Expenses								
Inpatient Services (Hospital)	$45,816	$47,829	$2,013	4.2%	$45,816	$47,829	$2,013	4.2%
Inpatient Services (LTC)	19,506	11,224	(8,282)	-73.8%	19,506	11,224	(8,282)	-73.8%
Physician Services	32,467	27,803	(4,664)	-16.8%	32,467	27,803	(4,664)	-16.8%
Outpatient Facility	16,636	16,228	(408)	-2.5%	16,636	16,228	(408)	-2.5%
Other Medical**	25,895	27,380	1,485	5.4%	25,895	27,380	1,485	5.4%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$140,320**	**$130,464**	**($9,856)**	**-7.6%**	**$140,320**	**$130,464**	**($9,856)**	**-7.6%**
Gross Margin	**$22,625**	**$19,332**	**$3,292**	**17.0%**	**$22,625**	**$19,332**	**$3,292**	**17.0%**
Administrative Expenses								
Salaries	$5,798	$6,087	$289	4.8%	$5,798	$6,087	$289	4.8%
Professional Fees	135	284	149	52.5%	135	284	149	52.5%
Purchased Services	1,067	1,177	109	9.3%	1,067	1,177	109	9.3%
Supplies & Other	621	904	283	31.3%	621	904	283	31.3%
Occupancy	148	134	(14)	-10.7%	148	134	(14)	-10.7%
Depreciation/Amortization	258	265	7	2.6%	258	265	7	2.6%
Total Administrative Expenses	**$8,027**	**$8,850**	**$823**	**9.3%**	**$8,027**	**$8,850**	**$823**	**9.3%**
Operating Income	**$14,598**	**$10,482**	**$4,116**	**39.3%**	**$14,598**	**$10,482**	**$4,116**	**39.3%**
Non-Op Income/(Expense)								
Interest	$3,933	$2,912	$1,021	35.1%	$3,933	$2,912	$1,021	35.1%
Gain/(Loss) on Investments	286	(36)	323	100.0%	286	(36)	323	100.0%
Other Revenues	183	197	(14)	-7.0%	183	197	(14)	-7.0%
Grants	(640)	(1,463)	823	56.2%	(640)	(1,463)	823	56.2%
Total Non-Op Income/(Expense)	**3,762**	**1,609**	**2,153**	**100.0%**	**$3,762**	**$1,609**	**$2,153**	**100.0%**
Net Income/(Loss)	**$18,360**	**$12,091**	**$6,269**	**51.8%**	**$18,360**	**$12,091**	**$6,269**	**51.8%**
MLR	*86.1%*	*87.1%*			*86.1%*	*87.1%*		
ALR	*4.9%*	*5.9%*			*4.9%*	*5.9%*		
Operating Income	*9.0%*	*7.0%*			*9.0%*	*7.0%*		
Net Income %	*11.3%*	*8.1%*			*11.3%*	*8.1%*		

*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 First Month Ending January 31, 2024
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*456,002*	*440,590*	*15,412*	*3.5%*	*456,002*	*440,590*	*15,412*	*3.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$356.46	$339.21	$17.25	5.1%	$356.46	$339.21	$17.25	5.1%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	0.87	0.78	0.09	12.0%	0.87	0.78	0.09	12.0%
Total Operating Revenue	**$357.33**	**$339.99**	**$17.34**	**5.1%**	**$357.33**	**$339.99**	**$17.34**	**5.1%**
Medical Expenses								
Inpatient Services (Hospital)	$100.47	$108.56	$8.08	7.4%	$100.47	$108.56	$8.08	7.4%
Inpatient Services (LTC)	42.78	25.48	(17.30)	-67.9%	42.78	25.48	(17.30)	-67.9%
Physician Services	71.20	63.10	(8.09)	-12.8%	71.20	63.10	(8.09)	-12.8%
Outpatient Facility	36.48	36.83	0.35	1.0%	36.48	36.83	0.35	1.0%
Other Medical**	56.79	62.14	5.36	8.6%	56.79	62.14	5.36	8.6%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$307.72**	**$296.11**	**($11.61)**	**-3.9%**	**$307.72**	**$296.11**	**($11.61)**	**-3.9%**
Gross Margin	**$49.62**	**$43.88**	**$5.74**	**13.1%**	**$49.62**	**$43.88**	**$5.74**	**13.1%**
Administrative Expenses								
Salaries	$12.71	$13.82	$1.10	8.0%	$12.71	$13.82	$1.10	8.0%
Professional Fees	0.30	0.64	0.35	54.1%	0.30	0.64	0.35	54.1%
Purchased Services	2.34	2.67	0.33	12.4%	2.34	2.67	0.33	12.4%
Supplies & Other	1.36	2.05	0.69	33.7%	1.36	2.05	0.69	33.7%
Occupancy	0.32	0.30	(0.02)	-7.0%	0.32	0.30	(0.02)	-7.0%
Depreciation/Amortization	0.57	0.60	0.04	5.9%	0.57	0.60	0.04	5.9%
Total Administrative Expenses	**$17.60**	**$20.09**	**$2.48**	**12.4%**	**$17.60**	**$20.09**	**$2.48**	**12.4%**
Operating Income	**$32.01**	**$23.79**	**$8.22**	**34.6%**	**$32.01**	**$23.79**	**$8.22**	**34.6%**

*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 First Month Ending January 31, 2024
(In $000s)

	MTD	YTD
Net Income	$18,360	$18,360
Items not requiring the use of cash: Depreciation	258	258
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	(80,906)	(80,906)
Prepaid Expenses	(829)	(829)
Current Assets	(282)	(282)
Net Changes to Assets	**(82,017)**	**(82,017)**
Changes to Payables:		
Accounts Payable	39,436	39,436
Other Current Liabilities	1,173	1,173
Incurred But Not Reported Claims/Claims Payable	32,444	32,444
Provider Incentives Payable	4,203	4,203
Due to State	(127)	(127)
Net Changes to Payables	**77,130**	**77,130**
Net Cash Provided by (Used in) Operating Activities	**13,731**	**13,731**
Change in Investments	(3,605)	(3,605)
Other Equipment Acquisitions	(319)	(319)
Net Cash Provided by (Used in) Investing Activities	**(3,923)**	**(3,923)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**9,807**	**9,807**
Cash & Cash Equivalents at Beginning of Period	**205,083**	**205,083**
Cash & Cash Equivalents at January 31, 2024	**$214,890**	**$214,890**

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

Meeting Minutes

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

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

Commissioners Present:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Tracey Belton	County Health and Human Services Agency Director
Ms. Dorothy Bizzini	Public Representative
Ms. Janna Espinoza	Public Representative
Supervisor Zach Friend	County Board of Supervisors
Ms. Elsa Jimenez	County Director of Health Services
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	County Public Health Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Health Care Provider Representative
Dr. Allen Radner	At Large Health Care Provider Representative
Dr. Eric Sergienko	County Public Health Officer

Commissioners Absent:

Dr. Maximiliano Cuevas	Health Care Provider Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Ms. Mónica Morales	County Health Services Agency Director

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Dr. Omar Guzmán	Chief Health Equity Officer
Dr. Dennis Hsieh	Chief Medical Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Ms. Jessica Finney	Community Grants Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

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

Ms. Alicia Rodriguez, CEO, GoldenPACE Health, spoke in support for a Program of All-Inclusive Care for the Elderly (PACE) center to serve Santa Cruz, Monterey and San Benito counties.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Schrader introduced and welcomed Dr. Omar Guzmán the Alliance's new Chief Health Equity Officer. Dr. Guzmán will be working together with providers to improve health equity for our members by addressing disparities.

Negotiations with CommonSpirit were completed on February 27, 2024 for a three-year renewal. Staff await CommonSpirit's decision to accept or terminate, either of which will be effective February 29, 2024 at midnight when the existing agreements expire. In the event of a termination, staff have been coordinating with the Department of Health Care Services (DHCS) on a continuity of care and member transition plan.

On February 27, 2024, Local Health Plans of California (LHPC) held its annual legislative briefing in Sacramento. CEO's and Government Affairs staff from local plans convened with invited guests from key legislative offices and administration staff. LHPC staff provided an overview of the work of the local plans. Mr. Schrader participated on a CEO roundtable discussion on community investments in which the Board has made through the Alliance's Medi-Cal Capacity Grant Program. This briefing was an opportunity to highlight the work of local plans with key lawmakers, policymakers and decision makers in Sacramento.

In addition, Mr. Schrader and Ms. Danita Carlson, Government Relations Director, met with several of the local elected representatives and their staff including Senator Anna Caballero, Assemblymember Esmeralda Soria, Senator John Laird, Assemblymember Gail Pellerin and the Health Advisor for Speaker Rivas. An update was provided on the work of the Alliance including the expansion of services to Mariposa and San Benito counties and the expansion of membership to 26-49 year old individuals regardless of immigration status. Issues related to hospital solvency and how the Alliance supports its hospital providers were also discussed.

Staff are working to develop an allocation and methodology for Alliance supplemental payments for certain provider types for Board consideration. The purpose of which would be to use reserves to support providers to improve access, quality and equity for members. The Alliance supplemental payments would augment or be in addition to existing provider payments. The supplemental payments would not impact current provider contract rates, the Managed Care Organization tax and state directed supplemental provider payments. Staff plan to return to the Board in June for approval to set aside all or part of the CY 2023 operating surplus for the provider supplemental payments. Staff plan to return to the Board in the fall for Board approval for the methodology and timing for the provider supplemental payments.

Earlier this month DHCS completed its annual audit of the Alliance. There was only a single preliminary finding related to timely claims payments for emergency room and family planning services. The Alliance can expect to receive a preliminary report for review and response from DHCS in late April to early May 2024.

Notable on consent is staff's recommendation authorizing the Chairperson to sign an amendment to the Medi-Cal contract; staff's recommendation to approve the Alliance's 2024 Policy Priorities; and staff's recommendation to approve an advance on Payment 4 and 5 of the DHCS CalAIM Incentive Payment Program for Enhanced Care Management providers in 2024.

On the regular agenda, Ms. Jessica Finney, Community Grants Director, will discuss recommendations around the Medi-Cal Capacity Grant Program.

Consent Agenda Items: (5. – 10K.): 3:28 p.m.

Chair Jimenez reminded the Board that in order to manage any risk of conflict, consent would be taken in two separate motions due to potential conflicts of interest on item 10K, approval of an advance on Payment 4 and 5 for the Department of Health Care Services CalAIM Incentive Payment Program (IPP) in order to fund Enhanced Care Management providers in 2024. Items 5 – 10J, which all Board members may discuss and vote on; and item 10K that is affiliated with Board members which may have a potential conflict.

Chair Jimenez opened the floor for approval of Consent Agenda items 5 through 10J.

MOTION: Commissioner Bizzini moved to approve Consent Agenda items 5 – 10J, seconded by Vice Chair Pedrozo.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Askew, Belton, Bizzini, Espinoza, Friend, Jimenez, Molesky, Nanyonjo, Pedrozo, Rabago, Radner and Sergienko.

Noes: None.

Absent: Commissioners Cuevas, Hernandez and Morales.

Abstain: None.

Chair Jimenez opened the floor for approval of Consent Agenda item 10K.

MOTION: Commissioner Sergienko moved to approve Consent Agenda item 10K, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Cuevas, Hernandez and Morales.

Abstain: Commissioners Abasta-Cummings, Armstrong, Belton, Jimenez, Nanyonjo, Rabago and Radner.

Regular Agenda Item: (11. – 12.): 3:33 p.m.

11. Discuss Alliance state of Technology, Data and Security Report and consider approving a Data Sharing Incentive Program. (3:33 – 4:08 p.m.)

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

Cecil Newton, Chief Information Officer & Information Security Officer, discussed the Alliance's state of technology, data and security. In December 2022 an Alliance Data Management Strategy was created. The Data Management Strategy is that of a Health Information Exchange (HIE) centric model where most of the healthcare data in and out of the Alliance is via the HIEs. The strategy calls for provider data sharing incentive programs to increase provider willingness and capacity to share data. The strategy requires the HIE's to provide real-time bi-directional data to and from the Alliance and to and from the providers. The Alliance will also partner with providers to acquire infrastructure funding so that their systems are capable of providing real time healthcare data and effectively participate in data sharing. The development and implementation of a comprehensive Data Management Strategy is a multi-year effort that will take time to implement.

The next steps in the data sharing incentive program include identifying target providers and developing a DSI provider agreement. Beginning April 1, 2024, providers sign Alliance DSI agreements, CALHHS Data Sharing Agreement, HIE Participation Agreement and HIE connectivity activities, with incentive payments beginning June 30, 2024.

MOTION: Commissioner Friend moved to approve ratifying to January 1, 2024, a Data Sharing Incentive Program to begin on April 1, 2024, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Belton, Espinoza, Friend, Molesky, Nanyonjo, Pedrozo, and Sergienko.

Noes: None.

Absent: Commissioners Cuevas, Hernandez and Morales.

Abstain: Commissioners Abasta-Cummings, Armstrong, Bizzini, Jimenez, Rabago and Radner.

12. Consider approving Medi-Cal Capacity Grant Program governance policy recommendations; consider approving Medi-Cal Capacity Grant Program County Allocation Methodology and Redistribution recommendations; and discuss 2024 Medi-Cal Capacity Grant Program Investment Plan. (4:08 – 4:57 p.m.)

Ms. Jessica Finney, Community Grants Director, discussed the key factors that prompted the need for changes to the administration and governance structure of the Medi-Cal Capacity Grant Program (MCGP) and proposed governance policy changes.

The strategic direction of funding goals, priorities and allocations of the MCGP would remain under the Board's purview. The Board would have strategic direction over the MCGP framework, the annual MCGP investment plan, funding allocations to the MCGP per the Health Care Reserve Policy, and County allocation methodology.

Implementation of programmatic details of funding opportunities and grant awards would fall under staff's purview. Staff would provide biannual reporting in the Board packet of all grantmaking activities and grants awarded under funding opportunities.

MOTION: Commissioner Molesky moved to approve establishing an annual Medi-Cal Capacity Grant Program investment planning process for funding allocations to Board approved focus areas and strategies; and to direct staff to implement grantmaking activities and award decisions per the Board approved Medi-Cal Capacity Grant Program framework, funding goals and annual investment plan, seconded by Commissioner Sergienko.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Askew, Belton, Espinoza, Friend, Jimenez, Molesky, Nanyonjo, Pedrozo, Radner and Sergienko.

Noes: None.

Absent: Commissioners Cuevas, Hernandez and Morales.

Abstain: Commissioners Armstrong, Bizzini and Rabago.

Ms. Finney presented proposed changes for MCGP unallocated budget distribution: 1) adoption of a revised methodology for allocating reserves to the MCGP based on member volume by county; and 2) redistribute $105.5M in MCGP unallocated budget to facilitate grantmaking in all five Alliance counties and adjusting the allocations for health equity. MCGP allocations from Alliance strategic reserves are currently distributed using a 50% split across three counties and 50% based on member value.

[Commissioner Radner departed at this time: 4:28 p.m.]

Staff recommended changing to a member volume only methodology and reallocating funds across all five counties to integrate San Benito and Mariposa counties into the MCGP to build capacity in the new counties and to introduce equity adjustment for the counties that have quality metrics below the MPL.

MOTION: Commissioner Askew moved to adopt a revised methodology for allocating reserves to the Medi-Cal Capacity Grant Program based on member volume by county; and redistribute $105.5M in Medi-Cal Capacity Grant Program unallocated budget to facilitate grantmaking in all five Alliance counties, seconded by Commissioner Espinoza.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Belton, Espinoza, Friend, Jimenez, Molesky, Nanyonjo, Pedrozo and Sergienko.

Noes: None.

Absent: Commissioners Cuevas, Hernandez, Morales and Radner.

Abstain: Commissioners Abasta-Cummings, Armstrong, Bizzini and Rabago.

Ms. Finney discussed Board approved MCGP funding goals and strategies and a proposed plan for new allocations from the MCGP unallocated budget to address these goals and strategies through new and existing funding opportunities.

[Commissioner Friend departed at this time: 4:43 p.m.]

Staff plan to return with a final 2024 MCGP Investment Plan for Board consideration in March 2024. Once the plan is approved by the Board, new funding opportunities would be developed to fund awards starting in 2024 and continue based on remaining funding.

[Commissioner Nanyonjo departed at this time: 4:55 p.m.]

Commissioners discussed and expressed the need for housing, shelter, homeless response services and access to care.

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

The Commission adjourned its regular meeting of February 28, 2024 at 4:57 p.m. to the regular meeting of March 27, 2024 at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, December 20, 2023
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
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
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
Maya Heinert	Medical Director
Michael Schrader	Chief Executive Officer
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley	Compliance Director (Chair)
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shaina Zurlin	Behavioral Health Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Dianna Diallo	Medical Director
Marwan Kanafani	Health Services Officer
Michael Wang	Medical Director

Committee Members Excused:

Bryan Smith	Claims Director
Dennis Hseih	Deputy Chief Medical Officer
Jennifer Mandella	Chief Compliance Officer
Jessica Finney	Grants Director
Kate Knutson	Compliance Manager
Megan Sims	Health Services Operations Manager
Tammy Brass	Utilization Management Director

Ad-Hoc Attendees:

Kat Reddell	Compliance Specialist II
Ka Vang	Compliance Specialist II
Margarita Shull	Compliance Specialist
Rebecca Seligman	Compliance Manager
Rachel Siwajek	Program Integrity Specialist
Paige Harris	Regulatory Affairs Specialist
Sara Halward	Compliance Specialist III
Stephanie Vue	Regulatory Affairs Specialist

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

   Chairperson Ryan Markley called the meeting to order at 9:03 a.m.

2. **Review and Approval of October 18, 2023 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of October 18, 2023 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **2024 Contract Gap Analysis**
   4. **Updated Notice of Privacy Practices**
   5. **Updates to Compliance Plan**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. HIPAA Privacy and Security Update

Seligman, Compliance Supervisor, and McMurray, Information Security Analyst, presented the Q3 2023 HIPAA Privacy & Security Report. Seligman reported on recent updates to the HIPAA Program with audit of staff email for compliance with policy on printing PHI (Protected Health Information) from home.

Seligman reviewed HIPAA disclosure notifications received in Q323, noting that of the 40 referrals received, 15 were determined to be incidents requiring report to the state, 25 were determined to be non-events and 0 were determined to be breaches. Highest ranking incident root causes for HIPAA disclosures in the quarter were incorrect selection/entry, incorrect contact information and other.

Seligman reviewed HIPAA program metrics included on the Alliance Dashboard for Q323 reporting that the quality metric met the targeted performance threshold while the efficiency metric was just shy of meeting the target.

McMurray reported assessment of cybersecurity measures related to phishing attacks for the quarter noting a decrease in delivered messages and a rising trend of the overall Phish Prone Percentage (PPP) from .09% to 1.8% and a decrease in reporting messages from the phishing campaign from 51.6% to 47.9%.

McMurray provided an update on HIPAA/NIST (National Institute of Standards and Technology) incident remediation noting that 25 incidents were remediated, 2 were in progress, 4 were accepted and 3 were deferred in Q323.

McMurray reviewed Q323 outcomes of the annual Cybersecurity Assessment noting that 5 critical/high findings were identified and resolved and 3 were in process of being resolved. McMurray advised the Committee that completion for all critical and high findings will be completed by end of Q423.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2023 HIPAA Privacy & Security Quarterly Report.

2. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q3 2023 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Siwajek reported that 34 concerns were referred to Program Integrity in Q3 2023, 26 of which resulted in the opening of a MUI. There were 57 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting that 5 were Provider specific, 1 was member related, 2 were State Requests, 1 was waste related and 17 were categorized as Other.

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

Siwajek reviewed 2 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation. This included monitored investigation of a 2021 MUI related to a provider with a pattern of claims billed by multiple rendering providers and identified as duplicate services and investigation of two MUIs related to concerns related to delegation of member communications.

Siwajek reviewed Q323 Program Integrity Financial Reporting noting the total requested recoupment was $7,946.17 and completed recoupment was $464.42.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2023 Program Integrity Report.

3. Internal A&M Quarterly Report and DHCS/DMHC Audit Updates

Halward, Compliance Specialist III, presented the Q3 2023 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 6 internal audits were conducted, and 3 received a passing score. Halward reviewed one exemplar internal audit, the purpose of which is to ensure that confidential communications requests are reviewed and determinations made appropriately and in alignment with requirements.

Halward reviewed Q3 2023 Targeted Audits Dashboard metrics related to internal audits, noting that the efficiency metric was met and that the quality metric was not applicable as it is an annual metric.

Halward then reviewed outcomes of the monitoring of 31 Alliance Dashboard metrics related to regulatory requirements, noting that 30 metrics met their established thresholds during the review period of Q1 2023 - Q2 2023.

Halward reviewed the Q4 2023 Internal Audit Workplan identifying focus areas for high, medium and low risk levels and planned activities for corrective action plans.

Finally, Halward informed the Committee of the outcomes of 2024 DHCS Medical Audit, noting that mock audits will take place in January and the remote audit will begin January 29th 2024. Halward informed the Committee of the outcomes of 2024 DMHC Medical Survey pre-audit deliverables, noting that mock audits will take place in February and the in-person audit will begin on March 11th 2024.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2023 Internal A&M Quarterly Report.

4. 2024 Legislation

Carlson, Government Relations Director, reviewed 2023 Legislative Session outcomes and identified the following areas of policy focus for staff:

- Access to Care
- Local Innovation

- Eligibility and Benefits
- Financing and Rates
- Health Equity
- Person-Centered Delivery System Transformation

Carlson noted that Government Relations actively tracked 68 bills, 3 of which the Board took position on. Government Relations staff reviewed 23 Chaptered bills Chaptered (signed into law) and advised Alliance staff of impact. 13 bills require implementation and 10 were informational only. Carlson advised that Compliance staff will be developing and executing an implementation work plan.

The meeting adjourned at 9:59 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

Meeting Minutes

Monday, November 6, 2023

Teleconference Meeting

Members Present:

Janna Espinoza	Monterey County – CCS WCM Family Member, WCMFAC Chair
Manuel López Mejia	Monterey County – CCS WCM Family Member
Michael Molesky	Santa Cruz County – Alliance Commissioner
Paloma Barraza	Monterey County – CCS WCM Family Member

Members Absent:

Frances Wong	Monterey County – CCS WCM Family Member
Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Heloisa Junqueira, MD	Monterey County – Provider
Irma Espinoza	Merced County – CCS WCM Family Member
Kim Pierce	Monterey County – Local Consumer Advocate
Susan Skotzke	Santa Cruz County – CCS WCM Family Member

Staff Present:

Dianna Diallo, MD	Medical Director
Jenna Stromsoe, RN	Complex Case Management Supervisor - Pediatric
Kayla Zoliniak	Community Engagement Administrative Specialist
Kelsey Riggs, RN	Complex Case Management Supervisor
Kevin Lopez	Member Services Supervisor
Lilia Chagolla	Community Engagement Director
Ronita Margain	Community Engagement Director
Tammy Brass, RN	Utilization Management Director

Guest:

Anna Rubalcava	Merced County
Denise Sanford	Santa Cruz County
Kevin Low	Monterey County
Susan Paradise	Santa Cruz County

1. **Call to Order by Chairperson Espinoza.**
   Lilia Chagolla welcomed the group. Chairperson Espinoza called the meeting to order.

   WCMFAC Mission Statement read in English and Spanish.

   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**
   Chairperson Espinoza opened the floor for approval of the meeting minutes of the previous meeting on September 11, 2023. Minutes were approved with no further edits.

Regular Agenda Items:

4. **CCS Advisory Group Representative Report**
   Chairperson Espinoza provided an update on behalf of S. Skotzke.

   Key topics of discussion from the meeting included Whole Child Model readiness, monitoring CCS performance, Enhanced Care Management, transition of Child Health and Disability Prevention program, and Kaiser care entering the Alliance service area.

5. **Feedback, New Issues, and Impact on Members – Open Forum**
   M. Lopez Mejia requested information about how the Alliance prepares and educates parents on the transition of children from pediatric to adult services and care. K. Riggs stated the Alliance begins outreach when the child is 16 or 17 years of age, mails letters with information, conducts an assessment, and individualizes the approach. The Pediatric Complex Care Management team makes a warm handoff to the Adult Complex Care Management team to ensure a smooth transition. K. Riggs will follow up with M. Lopez Mejia to further discuss the need and opportunities to prepare and educate parents.

   There was discussion around the age out process and timeline.

   Commissioner Molesky shared SPIN Santa Cruz is interested in providing comment to WCMFAC and will provide K. Zoliniak their contact information.

   Chairperson Espinoza inquired about the legislation regarding qualifying conditions expanding on an annual basis. K. Low shared the legislation is SB 424 and is in the Senate Health Committee. Chairperson Espinoza will bring SB 424 to WCMFAC at a future meeting.

   The Alliance is expanding to Mariposa and San Benito counties; however, the Whole Child Model will not transition to the Alliance until 2025. Individuals in Mariposa and San Benito may attend and observe WCMFAC meetings as they are open to the public. The Alliance is in conversation with community-based organizations and providers in Mariposa and San Benito counties.

Chairperson Espinoza inquired about a new assessment similar to the UCSF assessment conducted in 2019. K. Riggs is not aware of a new assessment but will inform WCMFAC if she hears of one.

6. WCMFAC Roadmap and Documents

L. Chagolla reviewed the 2023 Roadmap and accomplishments.

L. Chagolla reviewed and solicited feedback on the Mission Statement. No feedback or objection was received.

L. Chagolla presented and solicited feedback on the proposed 2024 Roadmap. Two members expressed approval and no objection was received. Chairperson Espinoza will work with Alliance staff to finalize 2024 Roadmap and present at the next meeting.

L. Chagolla stated the WCMFAC Resource Flyer is in the process of being updated and solicited input. Chairperson Espinoza recommended including Mariposa and San Benito resources as members do not need to be CCS members to utilize many of the resources.

Chairperson Espinoza shared Family Voices of California is a resource to families. She will be reaching out to learn more about legislative news in advance of the legislative news tracker process development in Q2 2024.

Commissioner Molesky will connect with Chairperson Espinoza regarding representation of families with persons with disabilities through their lifetime in Santa Cruz Master Plan on Aging questionnaire.

7. Review Action Items

K. Zoliniak reviewed the actions items.

8. Future Agenda Items

2024 Roadmap (Q1)
Legislative News Process Development (Q2)

Adjourn:

The meeting adjourned at 2:50 p.m.

The meeting minutes are respectfully submitted by Kayla Zoliniak, Administrative Specialist
Next Meeting: Monday, January 8, 2024, at 1:30p.m.

DATE: March 27, 2024

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: 2024 Medi-Cal Capacity Grant Program Investment Plan

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Recommendation. Staff recommend the Board approve the 2024 Medi-Cal Capacity Grant Program (MCGP) Investment Plan in this report.

Summary. The proposed 2024 MCGP Investment Plan was presented for the Board's strategic input on February 28, 2024 prior to approving the final plan. The final 2024 MCGP Investment Plan proposed in this report incorporates feedback from the February Board meeting and includes the proposed funding allocation by county, based on the Board's approval of the new five-county allocation methodology. This report also includes background on Board-approved MCGP focus areas and funding strategies.

Board approval of the 2024 MCGP Investment Plan is supported by the MCGP governance policies approved by the Board on February 28, 2024. The Board provides strategic direction for the MCGP through an annual investment plan, by which the Board provides input on community needs and grantmaking priorities in the Alliance's service areas, makes funding allocations for Board-directed strategies, and reviews progress from previous allocations to make adjustments as needed. The Board directs staff to manage program-level implementation and county budgets based on allocated funding.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through investment of a portion of the Alliance's reserves, the MCGP provides grants to local health care and community organizations in the Alliance's service areas to increase the availability, quality and access of health care and supportive services for Medi-Cal members and to address social drivers that influence health and wellness in our communities. The Board approved three allocations to the MCGP in 2014, 2016 and 2022 totaling $266.6M. Since 2015, the Alliance has awarded 742 grants totaling $153M to 178 organizations in the Alliance's service areas.

In August 2022, the Board adopted three new investment focus areas for the MCGP: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. These new focus areas were the result of significant Board and community input and consideration of the Alliance's strategic planning elements, including an assessment of the current health care landscape, community needs and organizational priorities. These new focus areas address unmet and emerging Medi-Cal needs and opportunities, align with organizational and State priorities and increase investments upstream towards root causes and prevention. The focus areas direct resources in areas outside of core health plan responsibility where other funds are not available.

In 2023, the Board approved new funding allocations for funding opportunities that advance the goals of the three MCGP focus areas. The Alliance awarded $23.5M in Merced, Monterey and Santa Cruz counties in 2023 under the new focus areas across 12 funding opportunities.

Discussion. The MCGP has $105.5M remaining of the total $266.6M allocated since 2014 that has not yet been directed by the Board for specific use. Staff recommend allocating $91.98M of the $105.5M unallocated budget to the 2024 MCGP Investment Plan to continue to meet community need through Board-directed strategies. The 2024 MCGP Investment Plan aims to advance funding goals through new funding opportunities in the Alliance's service areas to strengthen the Medi-Cal delivery system, with a strategic focus on health equity. The proposed allocation for each strategy is a composite of budget estimates for specific funding opportunities under each strategy described later in this report. The plan reflects the prioritized need for new investments in healthcare workforce and infrastructure under the Access to Care focus area.

Proposed Funding Allocations. An allocation of $91.98M would be used for grant awards starting in 2024 and continuing over the next several years. Based on the available funding, the variety of funding opportunities, and the anticipated community response, staff expect to increase the annual spending amount above the historical average of $18M per year and award grants from this new allocation over approximately the next four years.

2024 MCGP Investment Plan Allocations			
Focus Area	**Strategy**	**Proposed Allocation**	**Percent of Total Proposed Allocation**
Access to Care	Healthcare Workforce	$52.38M	57%
	Healthcare Infrastructure	$26M	28%
Healthy Beginnings	Parent/Child Health & Wellness	$0	0%
	Parent Education & Engagement	$0	0%
Healthy Communities	Community Resources/Engagement	$1.1M	1%
	Social Drivers of Health	$10M	11%
Any Focus Area	Any Strategy	$2.5M	3%
	Total	**$91.98M**	**100%**

In addition to the recommended $91.98M allocation in the 2024 MCGP Investment Plan, there is $23.46M remaining from previous Board-approved allocations in Merced, Monterey and Santa Cruz counties for existing funding opportunities which are currently accepting grant applications (see attached). Further, funding for Enhanced Care Management and Community Supports capacity building for San Benito and Mariposa counties will be funded through the existing $5M approved by the Board in June 2023 for grantmaking in these two new counties. Both amounts from previous allocations ($23.46M and $5M) are in addition to, and not allocated from, the recommended $91.98M allocation. After approval of the 2024 MCGP Investment Plan, the total funding available for new grant awards under the MCGP portfolio of funding opportunities in the five counties would be $120.45M.

MCGP Funding Available for New Grant Awards						
	Merced	**Monterey**	**Santa Cruz**	**San Benito**	**Mariposa**	**Total**
Proposed Allocation	$39.81M	$31.70M	$13.28M	$5.52M	$1.64M	$91.98M
Existing Allocation	$11.85M	$7.75M	$3.85M	$3.90M	$1.09M	$28.46M
Total Available	$51.67M	$39.45M	$17.14M	$9.43M	$2.73M	$120.45M

Proposed Funding Opportunities. The 2024 MCGP Investment Plan includes expansion of three of the eight existing programs as well as seven new funding opportunities under Board-approved strategies (see table below). The plan also includes brief descriptions of these funding opportunities (see below) designed to meet the prioritized needs for building Medi-Cal delivery system capacity in the Alliance's service areas. These descriptions provide a high-level description of the approach that would be developed and implemented by staff to make funding available in the community to achieve MCGP funding goals.

Strategy	Existing Programs	Proposed New in 2024
Healthcare Workforce	• Workforce Recruitment (expand) • Workforce Development (expand) • Equity Learning	• Workforce Retention • Workforce Support for Care Gap Closure
Healthcare Infrastructure	• Healthcare Technology (expand)	• Data Sharing Support • Capital
Parent/Child Health & Wellness	• Home Visiting	-
Parent Education & Engagement	• Parent Education and Support	-
Community Resources & Engagement	• Community Health Champions • Partners for Active Living	• Population Needs Assessment Support
Social Drivers of Health	-	• Permanent Supportive Housing
All Strategies	-	• Innovation Fund

Healthcare Workforce

1. *Workforce Recruitment:* Expand existing support for recruitment of providers that serve Medi-Cal members, including allied, behavioral health, primary care, specialty care and certified substance use disorder service providers, and community health workers, doulas and medical assistants.
2. *Workforce Retention*: Support to retain the healthcare workforce within the Alliance's provider network.
3. *Workforce Development*: Expand opportunities to support training and higher education to grow the healthcare workforce in the Alliance service area.
4. *Workforce Support for Care Gap Closure*: Support for a targeted workforce intervention to close specific Managed Care Accountability Sets (MCAS) care gaps, increase quality scores and improve members' overall health.

Healthcare Infrastructure

5. *Healthcare Technology Program:* Expand existing program to also fund clinical equipment to improve performance of specific quality measures.
6. *Data Sharing Support*: Support capacity building to meet Medi-Cal data sharing requirements and connect to a heath information exchange.

7. *Capital*: Clinical capacity building, community and school-based resource/wellness centers and large equipment projects.

Community Resources/Engagement

8. *Population Needs Assessment Support*: Initial support for county planning and coordination efforts to enable the Alliance's meaningful participation in the Community Health Assessment and the Community Health Improvement Plan in each county.

Social Drivers of Health

9. *Permanent Supportive Housing (PSH)*: Blend additional funding with Housing and Homelessness Incentive Program (HHIP) funds to support PSH projects identified by local Continuum of Care partners through HHIP planning efforts.

All Strategies

10, *Innovation Fund*: Emerging opportunities to expand Medi-Cal capacity aligned with MCGP funding goals that do not fit under an existing funding opportunity.

Conclusion. After approval of the 2024 MCGP Investment Plan, staff will implement new funding opportunities for local health care providers and community partners in the Alliance's five counties. The planning for 2025 and beyond will include aligning the annual MCGP investment planning with the Department of Health Care Services' new Community Reinvestments requirement for Medi-Cal managed care plans.

Fiscal Impact. This recommendation would allocate a total of $91,982,752 from the MCGP unallocated budget to fund grant programs in each county developed under the Board-approved focus areas and strategies.

Attachments.

1. MCGP Current Funding Opportunities

Medi-Cal Capacity Grant Program

CURRENT FUNDING OPPORTUNITIES

PURPOSE

The Alliance makes investments to health care and community organizations in Merced, Monterey and Santa Cruz counties through the Medi-Cal Capacity Grant Program 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 and address social drivers that influence health and wellness in our communities.

FUNDING PRIORITIES

The Alliance invests in developing Medi-Cal capacity in three priority funding focus areas:

1) Access to Care
2) Healthy Beginnings
3) Healthy Communities

CURRENT FUNDING OPPORTUNITIES

Focus Area: *Access to Care*

Workforce Recruitment Programs provide funding to support health care and community organizations in their efforts to recruit and hire personnel to provide culturally and linguistically competent care to the Medi-Cal population in Merced, Monterey and Santa Cruz counties.

Community Health Worker (CHW) Recruitment
Grants for CHWs who become credentialed to provide the Medi-Cal CHW Benefit.

Doula Recruitment
Grants for doulas who become qualified to provide the Medi-Cal Doula Service Benefit.

Medical Assistant (MA) Recruitment
Grants for MAs in primary care practices.

Provider Recruitment
Grants for high need priority provider types including allied, behavioral health, primary care and specialty care.

The Alliance offers an additional Linguistic Competence Provider Incentive for grantees who hire bilingual providers.

Equity Learning for Health Professionals
Grants to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care.

Healthcare Technology
Grants to support the purchase and implementation of specific types of technology and infrastructure that improves Medi-Cal member access to high quality health care.

Focus Area: *Healthy Beginnings*

Home Visiting
Grants to support the implementation or expansion of home visiting programs that use evidence-based models with trained professionals for pregnant women and parents of children up to age 5.

Parent Education and Support
Grants to increase access to childhood development education, parenting skills and supportive resources for parents of children up to age 5.

Focus Area: *Healthy Communities*

Community Health Champions
Grants for organizing, training and supporting youth and adults to promote individual and community health and wellness and to advocate for equity in health care access.

Partners for Active Living
Grants to support community-based projects that provide children, adults and families opportunities to engage in physical activity and recreation programs in the community and engage health care providers in partnering on program coordination and referral of Medi-Cal members to these resources.

APPLICATION PROCESS

- Visit our website for program descriptions, eligibility criteria and link to the online application process.
- Grant applications for Workforce Recruitment grants will be considered four times per year.
- Grant applications for all other funding opportunities will be considered by the Alliance Board two times per year.
- Applications will be accepted on a rolling basis if funds are still available. Visit the website for upcoming application deadlines and award dates.

FOR MORE INFORMATION

For questions, email **grants@ccah-alliance.org** or contact staff at **(831) 430-5784**.

For more information about the Medi-Cal Capacity Grant Program, please visit
www.thealliance.health/grants

DATE: March 27, 2024

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

FROM: Jenifer Mandella, Chief Compliance Officer

SUBJECT: 2023 Compliance Program Report

Recommendation. Staff recommend the Board approve the Compliance Program Report for 2023.

Summary. This report summarizes the Alliance's Compliance Program activities for 2023 and includes a recommendation to approve the Compliance Program Report.

Background. The Alliance maintains a Compliance Program, which takes a systematic and strategic approach to decreasing risk posed by non-compliance with the numerous and complex laws that govern Alliance business practices. The Compliance Program, articulated in the Alliance's Compliance Plan, is modeled after the United States Federal Sentencing Guidelines' seven elements of an effective compliance program. These include having written standards of conduct, a designated compliance officer, an education and training program for staff, effective lines of communication throughout the organization, monitoring and auditing protocols in place to evaluate compliance problem areas, appropriate disciplinary mechanisms to enforce standards, and the ability to initiate corrective action to detected offenses.

The Alliance Governing Board (Board) is responsible for oversight of the Compliance Program. In April 2008, the Board delegated authority for overseeing the Compliance Program to the Compliance Committee. The Compliance Committee is chaired by the Compliance Director and consists of Alliance Division Chiefs and Department Directors. The Compliance Committee met routinely in 2023 to receive reports on key Compliance Program functions, information on risk evaluation, compliance monitoring, legislation and All Plan Letter (APL) implementation, and developed resolutions to identified concerns. Committee members discuss the issues and make recommendations to direct Compliance Department staff activities. Compliance Program activities are reported to the Board through the routine submission of Compliance Committee minutes and the inclusion of key Compliance Program metrics in the Alliance Dashboard.

This report serves to inform the Board of the Alliance's Compliance Program activities for 2023.

Discussion. The Compliance Program monitors several areas to ensure the plan's adherence to the Alliance's Compliance Plan. Key areas of focus include:

- General compliance inquiries (policies, regulations, regulatory requests, contractual requirements, etc.)
- Confidential employee hotline referrals
- Oversight of subcontracted entities
- Health plan audits (regulatory audits and internal auditing and monitoring)
- Recoveries of overpayments
- Monitoring of plan activities to prevent fraud, waste and/or abuse (FWA)

- Investigations of suspected/actual FWA
- Investigations of Health Insurance Portability and Accountability Act (HIPAA) incidents
- Staff training

Please refer to the attached Compliance Program Dashboards for detailed 2023 Compliance Program statistics.

Key Program Accomplishments

- Implemented a Compliance Division with subordinate Compliance and Legal Services Departments, which provides adequate Compliance leadership resources to integrate compliance review into strategic planning and enable the Alliance to meet increasing compliance obligations. This includes the creation of a new Regulatory Affairs Unit within the Compliance Department, with focus on streamlining regulatory reporting and filings, timely implementation of new regulatory requirements across the organization, and enhancing the Alliance's partnership with its regulators, trade associations, and other local health plans.
- Executed its implementation plan for the revised Department of Health Care Services (DHCS) model agreement to ensure organizational compliance with the terms of the agreement by the 2024 effective date. Compliance staff worked collaboratively with business units to ensure timely and complete implementation of the DHCS model agreement, with 96% of the new requirements fully implemented by end of year, and the remaining requirements having adequate implementation plans under way. Compliance staff also submitted 203 operational readiness deliverables to DHCS and received approval of 197 submitted documents; the remaining deliverables were either recently submitted and remain under review or are items the Plan is actively working with DHCS on.
- Commenced organizational project towards National Committee for Quality Assurance (NCQA) health plan and health equity accreditations, which must be obtained by 2026. As NCQA project leadership, Compliance established a project completion date of July 31, 2024 to ensure readiness for its NCQA Survey date of April 1, 2025 and continues to work closely with all impacted business units to drive implementation efforts across the organization to include development of new and revised policies and procedures, expanded member and provider data collection, and more targeted data reporting methodologies.
- Assessed the Compliance Program's readiness to operate under Medicare program requirements, both through participation in the organizational vendor-led operational gap analysis, and through a supplemental in-depth analysis by Compliance staff. Staff developed a preliminary plan to close gaps and operate a CMS compliance program by 2026.
- Assessed organizational engagement in Compliance Program processes and acted on opportunities for improvement in delegate oversight process, the process for implementation of new requirements (as detailed below), and the Virtual Policy Hub process.
- Implemented the new Mandates Hub, a cross-functional forum that meets bi-weekly, to ensure all new regulatory requirements are disseminated, assigned ownership, and implemented timely and completely across the organization. Since the inception of Mandates Hub in July 2023, the timely and successful implementation of new requirements has improved from ~80% to ~95%.

- Continued the electronic management of the Alliance's policy review process. During 2023, 265 policies and attachments were reviewed to ensure alignment with contract provisions, regulation, legislation, and DHCS and Department of Managed Health Care (DMHC) APLs, and revised policies were submitted to DMHC and/or DHCS for review and approval, as appropriate.
- Program Integrity collaborated with the Alliance's Advanced Analytics Unit to develop quarterly reporting to leverage data in furtherance of FWA prevention activities. The two new reports include the ability to 1) examine, by provider, trends in paid claims amounts quarter over quarter, and 2) billing for specific CPT codes and spikes in use compared to the rest of the Alliance provider network. Engagement with the Advanced Analytics Unit remains ongoing to optimize reporting.
- Adjusted the frequency of the Internal Audit and Monitoring (IA&M) Work Plan from annual to quarterly. Performed quarterly compliance risk assessment focusing on Alliance audit findings, newly implemented requirements, and ad hoc concerns. which directs IA&M activities.
- Performed monitoring and evaluation of the performance of Alliance delegated entities through the annual and ongoing review of delegates' reporting at Compliance Committee.
- Reviewed new requirements, including 18 bills passed during calendar year (CY) 2023, six government contract amendments, one Data Use Agreement with the DHCS, and 70 new or revised APLs issued by DHCS and DMHC for applicability to Alliance operations and ensured all such requirements were implemented by operational departments.

Regulatory Audit Activity:
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 CY 2023, including the auditing entity and a description of the audit or review.

- DHCS Medical Audit – which is a routine review of the Alliance's regulatory and health services operations for the Medi-Cal line of business. DHCS conducted a limited-scope audit covering the areas of utilization management (UM), case management and coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. The audit resulted in no findings issued to the Plan.
- DMHC Follow Up Survey – which is a follow up review of the deficiencies deemed uncorrected from the 2020 DMHC Medical Survey. The results of the audit identified that four of thirteen deficiencies remained uncorrected. Uncorrected deficiencies related to processing appeals and grievances, member grievance resolution letters, and notice of action letters for UM denials, including pharmacy denials. The Plan provided an Append Letter to the Department's final report to demonstrate the Plan's commitment to correcting the deficiencies and describes actions the Plan has taken to ensure correction.
- Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit – which is a review of Medi-Cal quality of care measures by an External Quality Review Organization on behalf of DHCS, covering measurement year 2022. The audit was managed by Quality Improvement staff. The results of the audit identified no issues and no required corrective action.
- Independent Financial Audit – which is an independent audit of the Alliance's financial position and operations. The audit was managed by Finance staff. In CY 2023, Moss Adams, LLP audited the Alliance's financial performance for CY 2022. Moss Adams did

not identify any material deficiencies in internal controls. The audit results were presented at the May 24, 2023 Board meeting.

In October 2023, DMHC notified the Alliance of their intent to conduct a Medical Survey, which occurs every three years. The medical survey is a routine review of the Alliance's performance in providing health care benefits and meeting the health care needs of subscribers and enrollees for the Alliance's Alliance Care In-Home Supportive Services (IHSS) line of business in the areas of grievances and appeals, prescription drugs, UM, quality management, language assistance, continuity of care, access and availability, and access to emergency services and payment. The onsite audit occurred the week of March 11, 2024, with preparations for pre-audit deliverable production beginning in 2023. Staff expect to receive preliminary audit results in June of 2024.

In late 2023, DHCS also provided notification to the Plan regarding the 2024 DHCS Medical Audit, which occurred at the end of January 2024, into the beginning of February 2024. The audit was a limited scope audit of the Medi-Cal line of business covering the areas of 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 one preliminary finding related to timely claims payments for Emergency Room, Family Planning and State Supported Services. DHCS is still in the process of reviewing follow-up submissions from the Alliance related to claims data. A draft preliminary report from DHCS is anticipated to be provided to the Alliance for review and response in late April to early May of 2024.

For the second year in a row, DHCS announced that they intend to sanction plans for Medi-Cal Accountability Set (MCAS) scores below the minimum performance levels. The Alliance had eight measures below the DHCS-defined minimum performance level, and DHCS imposed the minimum sanction amount of $25,000. Plan staff have developed a responsive action plan focused on improving MCAS scores in Merced County.

Health Insurance Portability and Accountability Act:
The Alliance continually identifies and implements opportunities to strengthen HIPAA compliance. In 2023, Compliance and Information Technology Services (ITS) staff continued to integrate privacy and security topics in training materials. In addition to incorporating security-related topics into new hire and annual refresher training materials, a focus was placed on providing more education to Alliance staff via Pulse articles, All-Staff Meeting presentations, focused content at Chiefs' Coffee Talks offering live question and answer opportunities, and ad-hoc trainings requested by departments to enhance staff knowledge in safeguarding protected health information and timely reporting of HIPAA events to Compliance.

In 2023, the Alliance experienced an increase in referrals of suspected HIPAA events, from 91 in 2022 to 117 in 2023 (22.6% increase). There were 47 events requiring DHCS notification pursuant to the DHCS Medi-Cal contract, which is an increase from 38 in 2022 (23.7% increase). Compliance staff fully investigated all reports and worked with operational departments to mitigate risk and prevent further disclosure of Alliance member protected health information. As an outcome, 11 of the 47 reported events were reclassified as a non-events or non-reportable events. There were no events determined to be a breach in 2023, which is a decrease from one breach that occurred in 2022.

Additionally, ITS staff enlisted Moss Adams to conduct a comprehensive assessment of the Plan's alignment of HIPAA/NIST standards with an emphasis on assessing the effectiveness of the 2022 remediation efforts. Engagement with the vendor has been completed including the delivery of a report and recommended action items to relevant stakeholders. Additionally, to proactively identify any vulnerabilities and weaknesses, simulated attack of the Alliance's infrastructure, applications, and security measures was performed by Praetorian. ITS staff engagement with the vendor was completed and all deliverables have been met including an assessment of Web Applications, Internal and External networks, Social Engineering tactics, and Wireless security. Q4 2023 marked the finalization of the 2023 HIPAA/NIST Gap and Security Assessments for which ITS staff is currently reviewing the final reports and assessing the resulting findings, placing priority on those considered to be a higher risk.

Compliance and ITS staff continue to monitor HIPAA incidents and ensure HIPAA compliance remains an area of focus for the organization in 2024. Of specific focus will be continued efforts towards staff education and awareness, responding to the opportunities identified in the 2023 HIPAA/NIST Gap and Security Assessment, and developing a vendor oversight program.

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 2023, the Alliance experienced a significant increase in referrals of potential FWA, from 89 in 2022 to 160 in 2023 (80% increase in referrals) as well as an increase in the number of newly opened investigations, from 62 in 2022 to 113 in 2023 (82% increase in opened investigations). The increase in referral volume and newly opened investigations can be attributed to continued impacts of the resumption of care following the COVID-19 public health emergency as well as an increase in potential Medi-Cal ID theft referrals related to members who had reported stolen/lost wallets. Further, Program Integrity staff initiated a process for referral monitoring and targeted internal trainings (noted below) which also attributes to the increase in referrals. Member-related matters were primarily the result of allegations of false eligibility and the potential abuse of the Alliance transportation benefit. Provider-related matters were primarily related to over-utilization, upcoding, irregular billing behavior, and billing for services not rendered.

As noted above, the Program Integrity Unit identified an increased trend in reports related to stolen and lost Alliance member identification cards (Alliance ID). In response to this, Program Integrity staff coordinated with Member Services on new member content to be mailed to members along with their Alliance ID that provides information on best practices to safeguard their medical identity.

Program Integrity staff developed a process for the monitoring of FWA referral volume by various Alliance departments to ensure reasonable engagement with Program Integrity. On an annual basis, Program Integrity will analyze an aggregate of FWA referrals to identify 1) any fluctuation in reporting compared to years prior, and 2) whether changes in referral volume can be correlated with some identifiable and impacting factor. As a result of this monitoring, Program Integrity staff developed and conducted targeted FWA trainings to multiple internal departments in order to increase staff awareness of potential FWA concerns and ensure appropriate referral volume.

Finally, Program Integrity staff attended each of the California Department of Justice (DOJ) quarterly and statewide meetings. The meetings enhance collaboration and data sharing with Program Integrity staff from other health plans, as well as investigators from DHCS and the DOJ. At this year's statewide DOJ meeting, a Program Integrity Specialist presented an investigation summary related to non-emergency transportation (NEMT) provider billing trends and audit findings in order to educate other health plans and regulators on observed billing patterns and FWA schemes. Program Integrity staff also attended the Health Care Fraud Task Force meeting hosted by the DOJ for the Eastern District of California in Sacramento in furtherance of the above.

Internal Audit & Monitoring Program:
The Alliance's 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.

In 2023, Compliance staff increased its review frequency of the IA&M Work Plan from annually to quarterly. This increased review frequency allowed staff to intake and assess new concerns and to prioritize and re-focus on higher risk concerns to the Plan. Each quarter, the IA&M Work Plan is revised to identify and/or re-prioritize operational areas to audit. As in previous years, compliance risk was assessed according to established criteria which consider complexity, level of cross-departmental work and potential impacts on members and providers, with the higher risk items receiving the most frequent review. The 2023 IA&M Work Plan included 21 planned reviews of 16 operational areas. In total, Compliance staff completed 17 of its planned reviews for the year. Four of its completed audits were initiated in 2022, and 13 were initiated in 2023. An additional two reviews were conducted by Compliance staff during Q4 2023; however, the audits were not closed prior to the end of the quarter which resulted in these reviews being omitted from 2023 outcomes. Audits completed in the last quarter of the year will generally be counted in the following year's audit statistics.

A total of nine departments were audited in 2023, with the biggest review impact in UM (four reviews) and Member Services (seven reviews). Of the total completed reviews in 2023, 67% received a passing score, reflecting a slight improvement in passing scores from 62% in 2022. Where gaps were identified, Compliance staff oversaw the implementation of Corrective Action Plans (CAPs) and/or provided recommendations around process improvement.

Compliance staff monitor timely response to internal audit findings and adequate correction of issues identified in previous internal audits, which is reported to the organization and Board through the Alliance Dashboard. Compliance staff met threshold performance for receipt of timely responses to audit findings three of the four quarters in 2023. Adequate correction of deficiencies identified in internal audit is measured annually; if review areas have consecutive failing results, they are considered uncorrected. No review areas were found to have repeat fails during the year.

Compliance staff also developed the Q1 2024 IA&M Work Plan, reviewing recent Alliance audit findings, newly implemented APLs and legislation, and other ad hod concerns. In Q1 2024, Compliance staff will focus on completing existing assigned reviews, as development of the Work Plan will shift in Q2 2024 at the direction of the Compliance Director. IA&M will focus on areas foreseeably prevalent in upcoming external, regulatory audits. This is a timely shift considering new and revised requirements from 2024 DHCS model agreement, which will

undoubtedly be an audit focus going forward. In addition, Compliance staff will conduct a quarterly review of the 31 metrics on the Alliance Dashboard that were derived from regulatory requirements.

Delegate Oversight:
The Alliance's Delegate Oversight Program ensures that delegates meet all Alliance standards through a pre-delegation assessment and approval process for new delegates; ongoing annual verification of delegation; and continuous oversight, monitoring and evaluation of delegated activities. During 2023, Alliance staff conducted routine oversight, including annual and quarterly reviews of eight delegated functions for 13 delegates.

During 2023, Compliance staff facilitated the pre-delegation review of one function newly delegated to an existing vendor. Specifically, the credentialing function was delegated to Dignity Health Medical Foundation.

Where delegate performance does not meet the Alliance's expectations, the Plan imposes corrective actions upon the delegate, which can include the issuing of a Warning Letter or direct escalation to a formal CAP commensurate with the delegate's performance deficiency or compliance violation. In 2023, the Alliance issued two CAPs against Carelon: one specific to deficient provider support and network management, and the other resulting from Carelon's failure to meet its telephone access and triage services performance metric. For the latter, the Plan also withheld a penalty of 1.5% per member per month from administrative payments to Carelon, per the delegation agreement. In addition to these new CAPs, the Plan continued to support Carelon in their efforts to correct deficiencies relative to the delegated credentialing function through a CAP issued in 2022. Also in 2023, the Alliance imposed a CAP on its non-medical transportation (NMT) delegate, Call the Car, following identification of non-compliance with member connection requirements outlined in its General Services Agreement with the Plan. Specifically, the Alliance identified that Call the Car was inappropriately billing the Plan for phone calls including those which did not meet contractual criteria for billing, resulting in repayment of approximately $39,000. The CAP also addressed data deficiencies in Call the Car's invoicing and a decline in the utilization of public transit as an NMT method. Compliance remains closely involved in monitoring Call the Car's ongoing performance and compliance with both contractual and regulatory obligations.

Outside of standard delegate oversight program operations, substantial efforts were made to ensure compliance with the 2024 DHCS model agreement specific to delegate oversight. Noteworthy accomplishments include expansion of the Plan's annual review process to encompass 2024 contractual requirements, the inclusion of downstream subcontractors into the purview of the delegate oversight program, the development of a high level, public facing Delegation Model, a Delegation Plan which provides an overview of the Plan's approach to delegate oversight, and collaborating with internal Alliance departments as well as delegates to complete the DHCS' new, comprehensive Delegation and Reporting Plan. Compliance expects DHCS to significantly increase its focus on the Alliance's oversight of delegate performance, pursuant to the 2024 DHCS model agreement.

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.

In 2023, the Alliance saw a return to pre-pandemic levels of reporting via the hotline, although the rate of reports remained below the industry standard of one report per 1,000 employee per month. Ten reports were received through the hotline during the year, with seven unique concerns reported. Six of the reported concerns were employee-related concerns and one concern contained both employee relations and compliance concerns.

Compliance staff continued to promote the use of the hotline with staff. That the reporting rate remains low despite these efforts signals that Alliance staff are comfortable reporting concerns directly to their leadership, Compliance staff, and/or Human Resources staff.

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 2023, 684 training sessions were completed, including 104 web-based trainings for new hires, supplemental web-based compliance training for 99 new hires, and 481 web-based trainings for existing staff. Additionally, Program Integrity completed targeted training for Quality Improvement and Population Health, Provider Services, Claims and Complex Care Coordination/Enhanced Case Management. Additionally, Compliance staff provided targeted HIPAA training to Member Services responsive to an increase in HIPAA related concerns from that department. Learning and Development reports indicate that all required new hire trainings were completed timely. Compliance-specific trainings not completed timely are escalated to Compliance leadership for follow-up and delays are typically related to staff who are on extended leaves of absence.

Compliance Program Activities for 2024:
The Alliance continuously works to develop and strengthen the plan's Compliance Program. Areas of focus for 2024 include:

- Through its revised approach to the IA&M program, ensuring complete and compliant implementation of the revised 2024 DHCS model agreement which took effect on January 1, 2024.
- Leading organizational efforts to bring the Alliance into compliance with NCQA requirements. This is an intensive, multi-year effort, with significant focus on readiness for health plan and health equity accreditations occurring in 2024. The goal is to complete implementation efforts by July of 2024 to enable the Alliance to obtain NCQA accreditations in Q2 2025. Further, Compliance will focus on developing and implementing a new NCQA oversight and monitoring program to ensure ongoing

readiness for its recurring NCQA surveys as part of maintaining accreditation in good standing.

- Supporting organizational efforts towards D-SNP implementation with particular focus on revising its current processes and developing new processes to ensure alignment with CMS mandates for an effective compliance program, successful acquisition of Knox Keene licensure, a timely Notice of Intent to Apply submission, and ultimately, succeeding in the CMS' bidding process.
- Assessing ongoing opportunities to modify the Compliance program's processes to ensure efficacy and increasing organizational engagement, with a particular focus on processes used to oversee delegated activities considering 1) reasonably foreseeable scrutiny from the DHCS in the area of delegate oversight, and 2) required development of new processes stemming from D-SNP implementation.
- Identifying opportunities to automate Compliance core functions to improve data accuracy and reporting to thereby allow the team to better focus its efforts on proactive engagement and value-adding activities throughout the organization.
- Providing extensive support towards the Alliance's Behavioral Health Integration project. Compliance will oversee and execute the comprehensive regulatory filing process and provide substantial guidance to the organization on behavioral health network development, operational, and reporting requirements.
- Implementing Business Associate oversight process to confirm Business Associates comply with HIPAA requirements prior to entering into agreements and on an ongoing basis.
- Supporting 2024 organizational objectives, with a particular focus on supporting departments in the operational objective related to achieving all regulatory, contractual, and core program requirements.

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

Attachments.

1. 2023 Annual Internal A&M Dashboard
2. 2023 Annual HIPAA Dashboard
3. 2023 Annual Program Integrity Dashboard

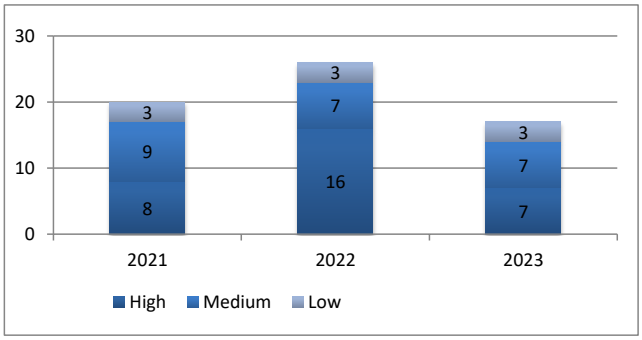
Compliance

Internal Audit Dashboard - 2023 Annual Report

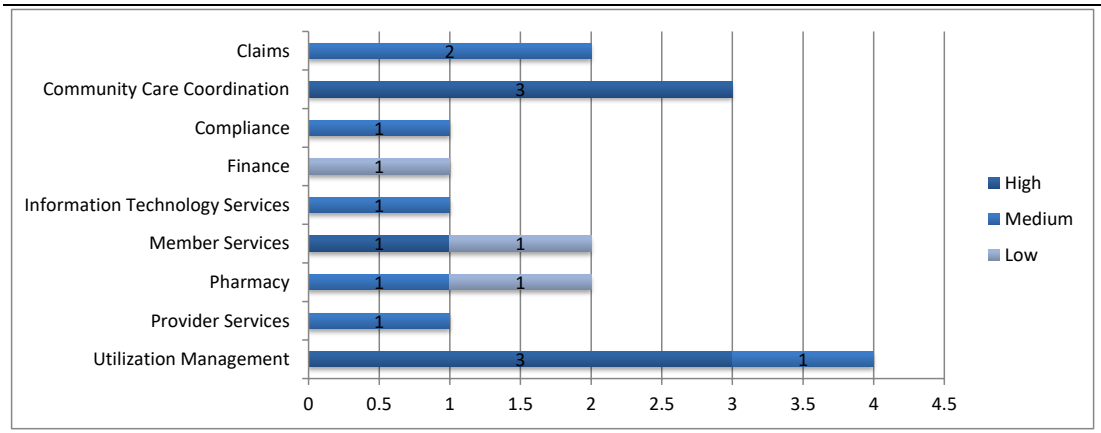
Prepared for the Alliance Board

Reviews Completed by Risk Level

Compliance completed a total of 17 internal audits in 2023. Items were selected for the work plan by prior year's audit findings, new requirements, and other ad hoc concerns.



17 Total Reviews Completed in 2023

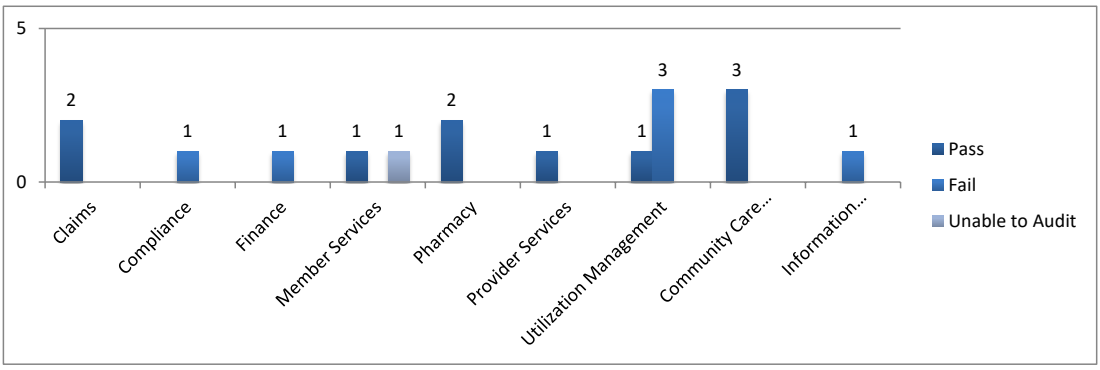


Reviews by Operational Area & Risk Level

Each review is assigned a SME department who has oversight responsibility of the requirement. The chart shows the number of reviews conducted by department within each risk level.

Review Results by Operational Area

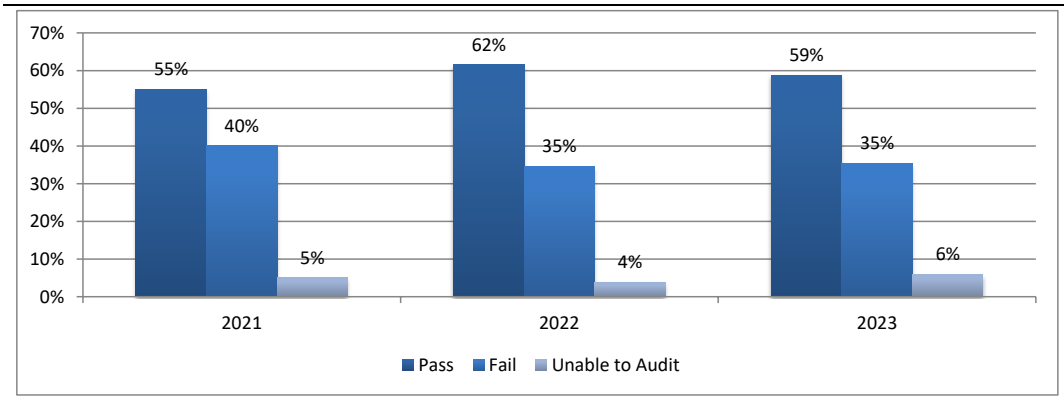
10 of 17 completed reviews received a passing score
6 of 17 completed reviews received a failing score
1 of 17 reviews was unable to be audited



Mitigation for Failed Reviews

Compliance partners with departments to ensure deficiencies are corrected through the following:

- Recommending process improvements
- Requesting action plans from departments to cure the deficiency
- Re-auditing to ensure correction



Trending and Annual Review Results by Risk Level

Information presented here depicts where Compliance has issued findings based on risk level.

2023 Outcomes

High Risk Areas: 71% Passed
Medium Risk Areas: 57% Passed
Low Risk Areas: 33% Passed
Overall Result: 59% Passed

Compliance

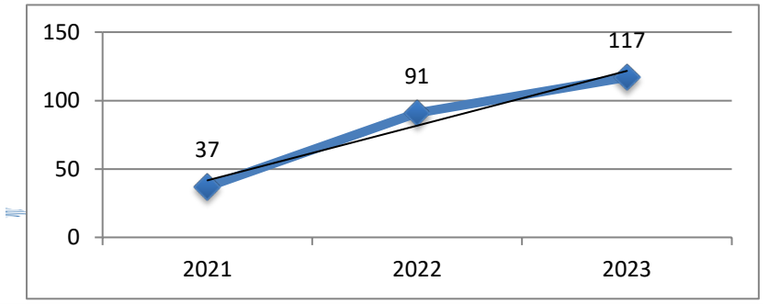
HIPAA Dashboard - 2023 Annual Report

Prepared for the Alliance Board

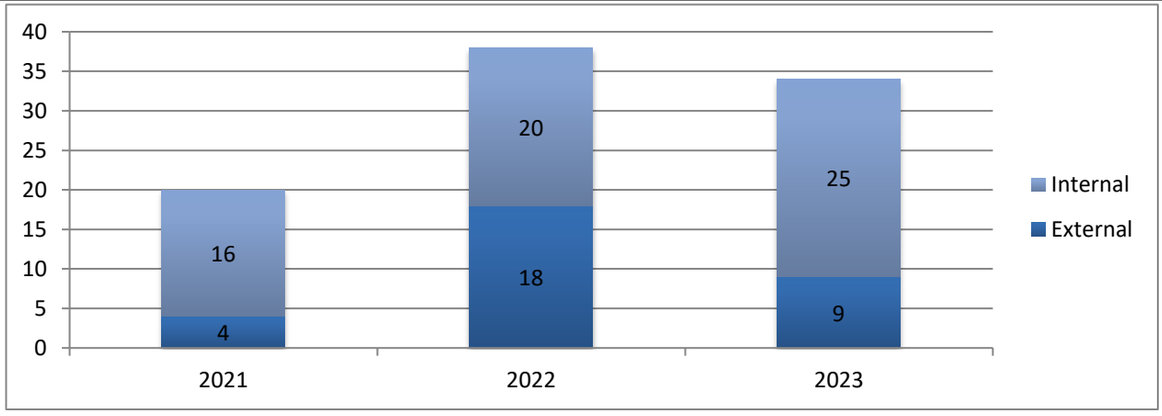
Reports of Suspected Disclosures by Year

Compliance received a total of 117 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during 2023

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



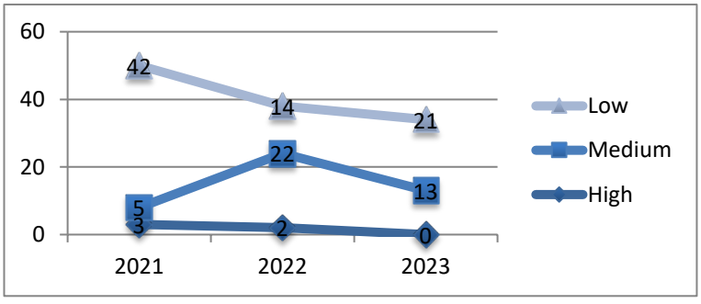
117 Total HIPAA Reports in 2023



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 delegates.

**Excludes Non-Events and Duplicates*



Impact of Reportable Events

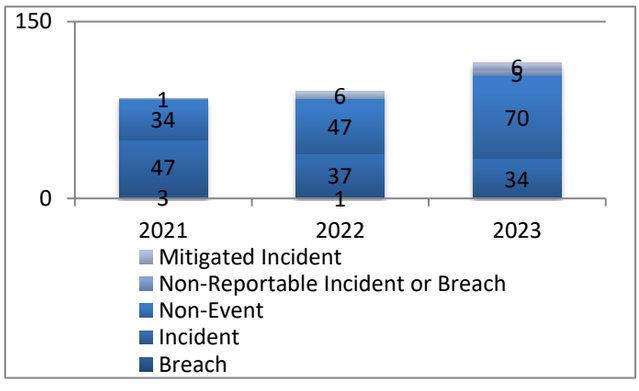
(excludes Non-Events and Duplicates)

21 of 34 reportable events had an impact of low
13 of 34 had an impact of of medium
0 of 34 had an impact of high

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

Final Classification

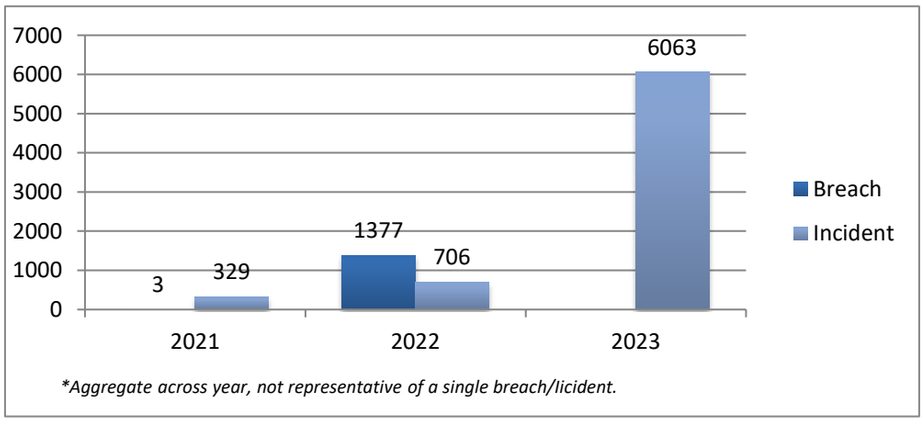
Breaches are unauthorized disclosures of PHI to a non-covered entity; incidents are unauthorized disclosures to covered entities; mitigated incidents occur when PHI was disclosed to a covered entity but recovered; non-events are when the investigation reveals that no unauthorized disclosure of PHI occured.



Member Impact

6063 members were impacted by HIPAA events in 2023;
6063 were due to Incidents and 0 were due to Breaches.

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



**Aggregate across year, not representative of a single breach/licident.*

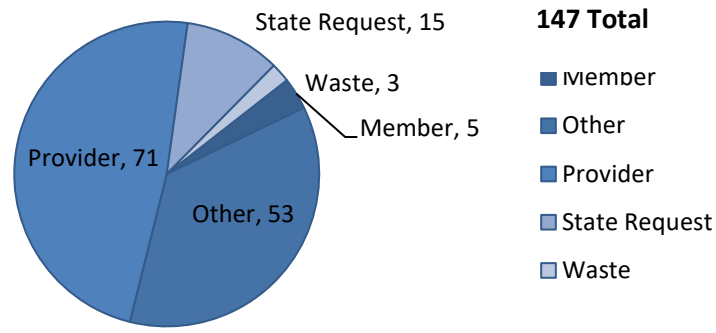
Compliance
Program Integrity Dashboard - 2023 Annual Report

Prepared for the Alliance Board

Matters Under Investigation (MUIs)

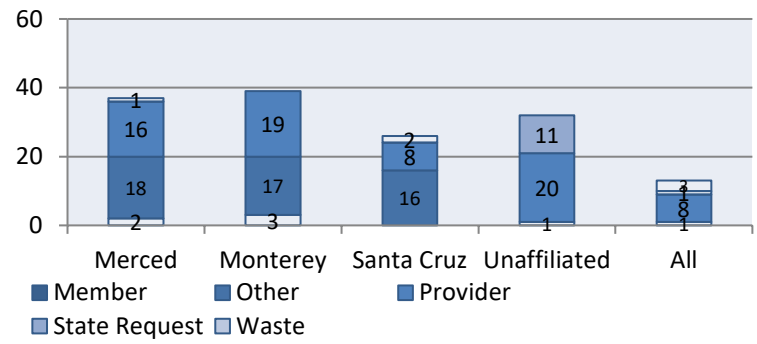
In CY-2023 there were 147 total MUIs investigated by the Program Integrity Unit.

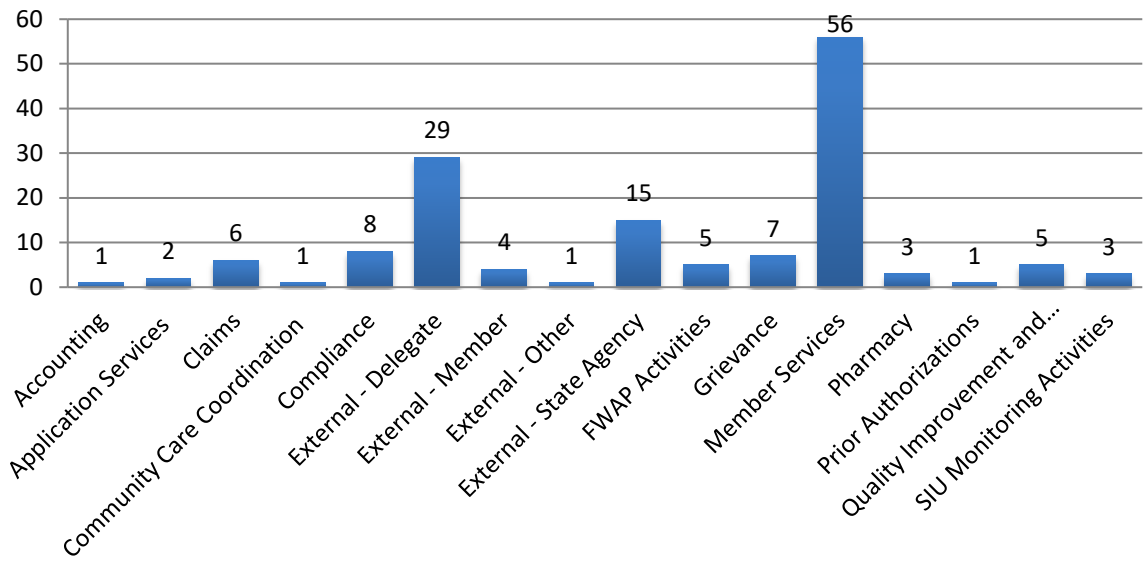
MUIs are classified by the target of the allegation/concern ("Other" example: If a member alleged a non-Alliance member used their Alliance ID card to fraudulently obtain prescription medications).



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 address, respectively.



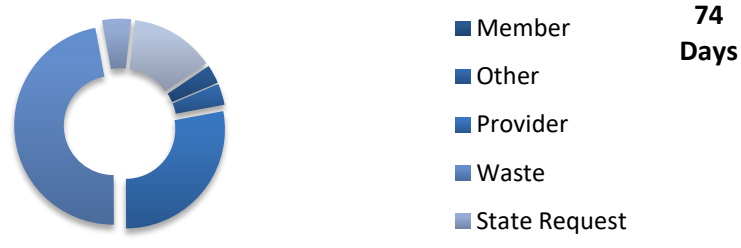


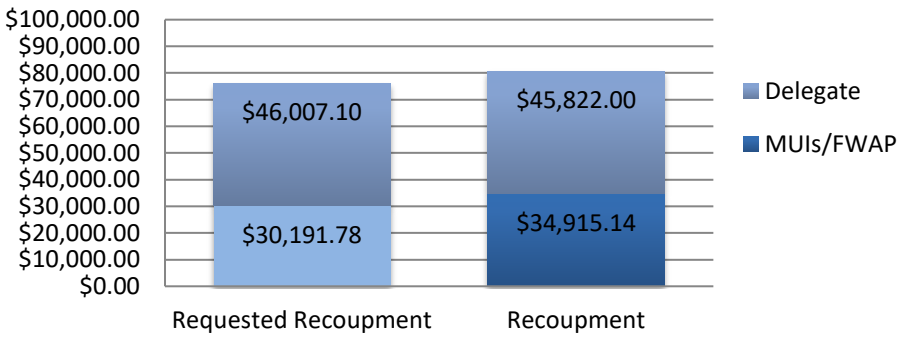
MUI Reporting Staff Department

The referral source represents the origin of the referral, not the nature of the allegation/concern (anonymous referrals included as "other" in summary).

Investigation Duration Average

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





Financial Reporting

MUIs and FWAP: represent claims requested for recovery 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.

Requested Recoupment:
- MUI/FWAP: $30,191.81
- Delegate: $46,007.10

Completed Recoupment:
- MUI/FWAP: $34,915.14
- Delegate: $45,822.00

Back to Agenda

DATE: March 27, 2024

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

FROM: Kay Lor, Payment Strategy Director

SUBJECT: Medicare Dual Eligible Special Needs Plan Primary Care Provider Rate Recommendation

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Recommendation. Staff recommend the Board approve payment for Primary Care Providers at 100% of Medicare rates as part of the Medicare Dual Eligible Special Needs Plan (D-SNP) expansion, effective January 1, 2026.

Background. D-SNPs are Medicare Advantage plans that provide specialized care for dually eligible beneficiaries. The Alliance will launch a Medicare D-SNP product effective January 1, 2026, as part of the Department of Health Care Services (DHCS) policies to promote integrated care for beneficiaries dually eligible for Medicare and Medi-Cal benefits as a component of the CalAIM initiative. In preparation to contract with the provider network, staff are bringing the rates approval request to begin building the network in Q2 2024.

Discussion. With a Medicare line of business (LOB), staff will align with Medicare payment methodology for the D-SNP product, which is inclusive of specialty and facility providers, and a payment model that includes fee-for-service and pay-for-performance (P4P) for primary care services. This approach enables the Alliance to earn additional revenue by improving or maintaining Health Care Effectiveness Data and Information Set (HEDIS) performance. HEDIS is a tool used by DHCS and the Centers for Medicare and Medicaid Services (CMS) to measure performance on important dimensions of care and services.

The P4P component of the model will be included in the annual Care-Based-Incentive (CBI) program that is shared with the Board each year. Since most of the HEDIS measures mirror the current CBI program, staff plan to include the Medicare LOB.

Additionally, reimbursement for specialty and facility providers will be aligned with our current payment policy for the Medi-Cal line of business and does not require Board approval. Currently, we already pay specialty providers at the Medicare rate and Medicare methodology. When a health plan moves to a Medicare product, CMS requires that the plan aligns with Medicare payment methodology for facility providers. As part of the implementation plan to move to a Medicare LOB, staff will transition to paying facility providers using the Medicare Severity Diagnosis Related Group and Outpatient Prospective Payment Systems payment methodology.

Fiscal Impact. There is no impact on the 2024 financials. The 2026 D-SNP budget will incorporate this payment methodology.

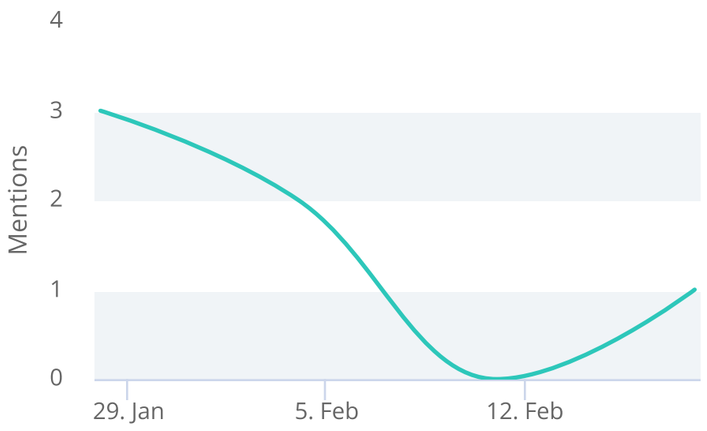
Attachments. N/A

Information Items: (11A. – 11E.)

March 2024 Board Report

Mention Analytics

Mentions by Media Type and Time



Audience by Media Type

Publicity by Media Type

Total Online + Print Audience
5,500,048

Total Online + Print Publicity
USD $83,032

Total Number of Clips 6

(Requires Critical Mention login)

Santa Cruz; Sobering center open after four-year hiatus

1

Powered by LexisNexis

Date Collected Feb 5, 2024 7:32 AM EST
Category Print
Source Santa Cruz Sentinel (California)
Author PK Hattis ; pkhattis @santacruzsentinel.com

Est. Audience 14,664
Est. Publicity Value USD $149
Market Santa Cruz, CA
Language English

SANTA CRUZ >> After halting services for about four years, a sobering center that county leaders say is a critical boon to the community, local health care providers and law enforcement is back online in Santa Cruz.

The new Santa Cruz County Sheriff's Office Sobering Center at 265 Water St., symbolically situated between the county jail and the courthouse across the street, is meant to steer publicly intoxicated people away from jails or local emergency rooms and into an alternative facility that not only offers more appropriate care, but also frees up time for law enforcement that can be ...

Santa Cruz sobering center reopens after four-year hiatus

2

Date Collected Feb 4, 2024 3:30 PM EST
Category Digital News
Source Santa Cruz Sentinel
Author PK Hattis

Est. Audience 28,259
Est. Publicity Value USD $290
Market Santa Cruz, CA
Language English

SANTA CRUZ — After halting services for about four years, a sobering center that county leaders say is a critical boon to the community, local health care providers and law enforcement is back online in Santa Cruz.

The new Santa Cruz County Sheriff's Office Sobering Center at 265 Water St., symbolically situated between the county jail and the courthouse across the street, is meant to steer publicly intoxicated people away from jails or local emergency rooms and into an alternative facility that not only offers more appropriate care, but also frees up time for law enforcement that can be ...

Back to Agenda

King City Chamber Awards honor Sun Street Centers, residents for their contributions to the community

3

Date Collected Feb 21, 2024 2:21 PM EST
Category Digital News
Source King City Rustler
Author Ryan Cronk

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

... abuse in the community. One outcome was to invite Sun Street Centers, an addiction treatment center based in Salinas, to open programs in King City.

Two years later, in 2018, the organization partnered with Monterey County Behavioral Health, California Board of State and Community Corrections and **Central California Alliance for Health** to buy and renovate the King City property at 641 Broadway St. for a new South Monterey County location. The City of King and Four Cities for Peace initiative provided additional support.

The Broadway site included a run-down motel that was gutted and remodeled into residential treatment units; an ...

Dignity Health leaders call on state officials to negotiate a fair Medi-Cal contract | Opinion

4

Date Collected Jan 28, 2024 12:20 PM EST
Category Print
Source The Merced Sun-Star (California)
Author Dale Johns and Dr. Robert Quinn; The Merced Sun-Star

Est. Audience 15,952
Est. Publicity Value USD $185
Market Merced, CA
Language English

... t happen without strong health plan partnerships. As the largest Medi-Cal provider in California, three out of every four patients who come to a Dignity Health hospital are covered by either Medi-Cal or Medicare.

Since September we have been in contract negotiations with the local Medi-Cal payer, **Central California Alliance for Health**; to date, we have been unable to negotiate an agreeable equitable contract. If **CCAH** does not agree to a new contract with Dignity Health, **CCAH** will no longer consider Dignity Health Medical Group physicians and Mercy Medical Center Merced as "in-network" ... beginning Feb. 16.

It is anticipated that **CCAH** will begin to reassign our Dignity Health Medical Group Primary Care patients to a new physician prior to this date. **CCAH** may direct their members to use providers in other cities.

It is important for the community to understand why we are in contract negotiations with **CCAH**. Contrary to popular belief, hospitals do not set their own prices for services. We contract with health plans like ... **CCAH** so we can be "in-network" for you. The details of the contract govern the amount we are reimbursed for the care we provide, the way claims get processed, and how referrals and authorizations are handled.

It is unfair for an insurer to pay us less than the cost of care; we lose money for every ... Medi-Cal patient we treat. Our Dignity Health network has faced a considerable financial impact with this contract, and we have not received a rate increase from **CCAH** in several years.

Opinion label

In Merced County, one of every two residents is covered by **CCAH**, and Mercy Medical Center Merced provides the highest volume of care to **CCAH** members with approximately 3,900 admissions annually. Mercy Medical Center Merced provides more than 30,000 emergency room visits per year to **CCAH** patients -- about 90 patients per day. ... Based on this information and the complexity of **CCAH** patients, our current reimbursement is not sustainable.

Our physicians are relied upon heavily in Merced County. There are an insufficient number of local primary or specialty care physicians to care for our population. Dignity Health has provided approximately 15,000 primary care, specialty care ...

Dignity Health leaders call on state officials to negotiate a fair Medi-Cal contract | Opinion

5

Date Collected Jan 28, 2024 10:07 AM EST
Category Digital News
Source AOL.com

Est. Audience 5,428,903
Est. Publicity Value USD $82,256
Market United States
Language English

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Dignity Health leaders call on state officials to negotiate a fair Medi-Cal contract | Opinion

6

Date Collected Jan 28, 2024 9:22 AM EST
Category Digital News
Source Merced Sun-Star
Author Dale Johns and Dr. Robert Quinn

Est. Audience 12,053
Est. Publicity Value USD $150
Market Merced, CA
Language English

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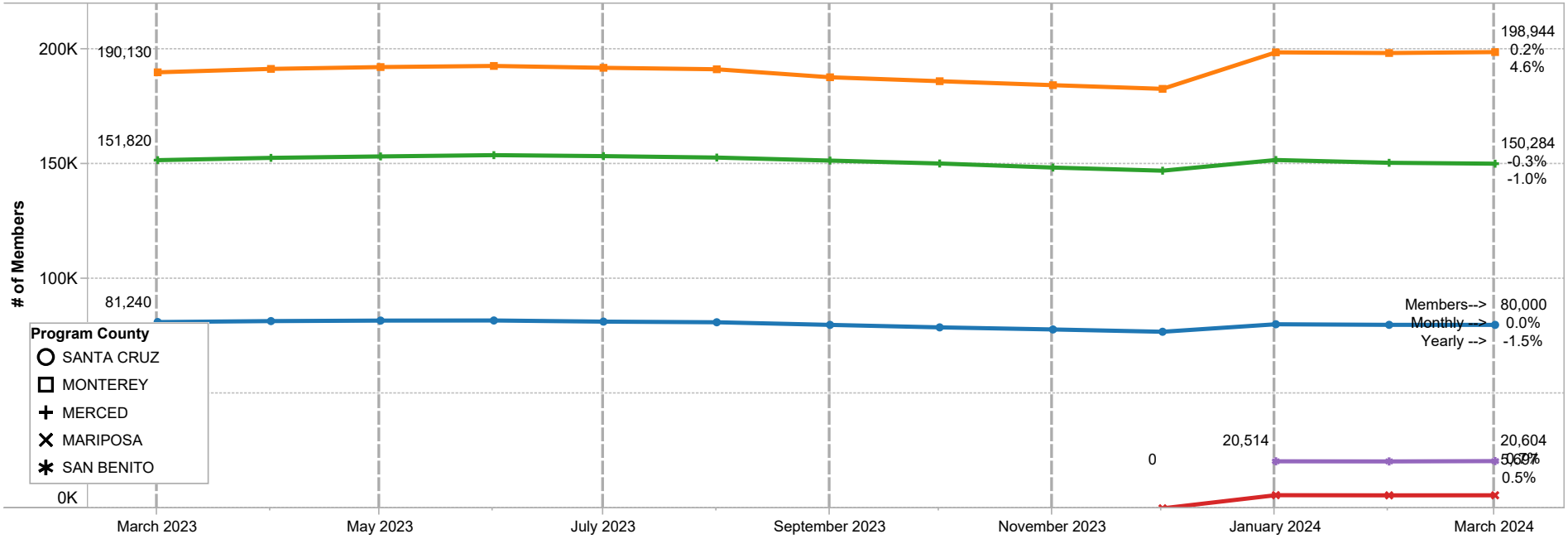
Enrollment Report

Year: *2023 & 2024* **County:** *All* **Program:** *AIM, IHSS, Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *3/5/2024*

StaticDate
3/1/2023 12:00:00 AM to 3/31/2024 11:59:59 PM

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



Program..	ProgramCo..	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Medi-Cal	SANTA CRUZ	81,240	81,653	81,870	81,915	81,419	81,140	79,998	78,913	78,002	76,998	80,268	80,017	80,000
	MONTEREY	189,484	190,969	191,760	192,232	191,418	190,772	187,285	185,570	183,833	182,215	198,135	197,839	198,239
	MERCED	151,820	152,829	153,451	154,011	153,582	152,956	151,636	150,369	148,599	147,232	151,886	150,677	150,284
	MARIPOSA										0	5,739	5,671	5,697
	SAN BENITO											20,514	20,462	20,604
IHSS	MONTEREY	646	648	656	670	674	681	682	683	691	697	700	700	705
Total Members		**423,190**	**426,099**	**427,737**	**428,828**	**427,093**	**425,549**	**419,601**	**415,535**	**411,125**	**407,142**	**457,242**	**455,366**	**455,529**