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

Meeting Agenda

Wednesday, June 26, 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: 561 958 75#

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, June 25, 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.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

1. Call to Order by Chairperson Jimenez. 3:00 p.m.

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome Dr. Kristina Keheley, Mariposa County Health Department Representative, to the Board.

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.

<u>Consent Agenda Items</u>: (5. – 9C.): 3:25 p.m.

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

- Reference materials: Executive Summary from the CEO; Letter to Honorable Jesse Gabriel: Reinstate MCO Tax Agreement; and Central California Alliance for Health 2024 Bill List.

Pages 5-01 to 5-51

6. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the fourth month ending April 30, 2024.

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

<u>Appointments</u>: (7A.)

7A. Approve appointment of Dr. Camille Guzel to the Whole Child Model Clinical Advisory Committee.

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

Page 7A-01

<u>Minutes</u>: (8A. – 8C.)

8A. Approve Commission regular meeting minutes of May 22, 2024 and special meeting minutes of May 22, 2024.

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-09

8B. Accept Physicians Advisory Group meeting minutes of March 7, 2024.

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-05

8C. Accept Whole Child Model Clinical Advisory Committee meeting minutes of March 21, 2024.

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-03

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Reports: (9A. – 9C.)

9A. Authorize the Board to ratify the execution by the Chairperson of Medi-Cal Contract 23-30241 A-02.

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

Page 9A-01

9B. Authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority to provide Covered Services to eligible and enrolled In-Home Supportive Services providers for the period July 1, 2024 through June 30, 2025.

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

Page 9B-01

9C. Authorize the Chairperson to sign an amendment to the Medi-Cal contract to incorporate updated Capitation Payment Rates for Calendar Year 2023.

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

Page 9C-01

Regular Agenda Items: (10. – 12.): 3:30 p.m.

10. Consider approving proposed 2025 Behavioral Health Service Incentive. (3:30 – 4:00 p.m.)

A. Ms. Kay Lor, Payment Strategy Director, will review and Board will consider approving proposed Behavioral Health Services Incentive Program effective July 1, 2025.

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

Pages 10-01 to 10-02

11. Consider approving Strategic Allocation of Reserve. (4:00 – 4:40 p.m.)

A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will consider approving a one-time strategic allocation for provider supplemental payment over multiple years.

B. Ms. Lisa Ba, Chief Financial Officer, will review and Board will consider authorizing staff to develop a supplemental payment methodology.

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

Pages 11-01 to 11-02

12. Consider approving Medi-Cal Capacity Grant Program Allocation for Mariposa County. (4:40 – 5:00 p.m.)

A. Ms. Jessica Finney, Community Grants Director, will review and Board will consider approving Medi-Cal Capacity Grant Program allocation for Mariposa County.

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

Pages 12-01 to 12-03

Information Items: (13A. – 13F.)

A. Alliance in the News — Page 13A-01
B. Member Appeals and Grievance Report – Q1 2024 — Page 13B-01
C. Membership Enrollment Report — Page 13C-01
D. Member Newsletter (English) – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Member-June2024-ENG.pdf
E. Member Newsletter (Spanish) – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Member-June2024-SPA.pdf
F. Provider Bulletin – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Provider-June2024-high-res-FINAL.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, June 26, 2024; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, August 8, 2024; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, September 12, 2024; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, September 19, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, July 8, 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 June 26, 2024 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
  Wednesday, August 28, 2024; 3:00 – 5:00 p.m.

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

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

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

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

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

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

Members of the public interested in attending should call the Alliance at (831) 430-5523 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: June 26, 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

2024-25 State Budget. As previously reported, the budget for the upcoming State Fiscal Year beginning July 1, 2024 through June 30, 2025 includes substantial deficits. Budget projections worsened with the release of the May Revise despite the legislature having taken early action on several budget items. While there remain no substantial reductions in eligibility or benefits, the proposed budget eliminates adult acupuncture as a benefit and funding for the Equity and Transformation grants is significantly reduced. Other reductions include eliminating In-Home Supportive Services coverage for individuals with unsatisfactory immigration status. The Legislature met the June 15, 2024 deadline to send a budget to the Governor in order to continue to receive a paycheck. Meanwhile, negotiations between Leadership and the Governor will continue so that the parties may reach agreement by the June 30, 2024 deadline.

Managed Care Organization (MCO) Tax. The most significant proposed Medi-Cal budget revision is to the previously proposed allocation of the $2.6B MCO tax dollars to providers in 2025 and beyond. The May Revise proposes to, instead, allocate those funds as a general fund backfill. However, the 2024 MCO tax funded Target Rate Increases to providers for primary care, behavioral health, and maternity care, remain. MCO Tax discussions and deliberations remain ongoing. Attachment 1 to this report is a coalition letter to the Assembly Budget Chair urging the legislature to uphold the previous agreement on how to spend the MCO tax revenues, which is critical to advance the goals of universal, equitable and quality access to health care. While the Legislature did send a budget bill to the Governor in order to meet their constitutional deadline and to continue to receive pay, negotiations on the between legislative leaders and the Administration continue regarding the MCO tax and the budget generally. More will be known with the upcoming budget deadlines including the June 30, 2024 deadline for the Governor to sign the budget. Staff will continue to update your Board as information is available.

2024 Legislation. Staff continue to monitor and advocate for legislation in alignment with the Board's adopted 2024 Policy Principles. Included as Attachment 2 to this report, you will find the 2024 bill list that includes one-hundred twenty-two (122) bills that staff are tracking with the status of each bill indicated. Staff will continue to monitor these bills to assess potential impact and consider necessary planning and implementation steps should bills be enacted and signed into law by the Governor.

Community Involvement. On June 12, 2024, I attended the virtual Department of Health Care Services All Plan CEO June 2024 meeting and the virtual California Association of Health Plans Board meeting. I attended the virtual Health Improvement Partnership of Santa Cruz County Executive Committee meeting on June 20, 2024 and the groundbreaking of the Sí Se Puede Behavioral Health Center in Watsonville on June 21, 2024.

Health Services

Health Services is pleased to be fully staffed among the directorate this month. With the addition of Ms. Tammy Hoeffel, Director of Enhanced Health Services, and Ms. Elizabeth Leary, Director of Care Management, we now have the leadership team that will help drive National Committee for Quality Assurance (NCQA) accreditation, Enhanced Care Management/Community Supports (ECM/CS), and Care Transitions to successful completion. Ms. Hoeffel has direct responsibility over leading the ECM/CS team as well as building the Alliance's inaugural Transitional Care Unit.

The Pharmacy team has been hard at work finalizing our Part D PBM strategy while increasing focus on drug utilization review programs aimed at addressing opioid use disorder. Their site of care efforts has also been gaining traction helping meet member needs in the home-infusion space. Utilization Management (UM) has recently increased its partnership with Enhanced Health Services by providing additional leadership and training support for ECM/CS authorizations to support our efforts to increase appropriate activation of those benefits.

The Behavioral Health (BH) team continues to ensure that care provided by Carelon meets our highest standards while also working on the critical integration efforts. Their most recent accomplishment includes finalizing the supplemental and value-base payment package that our contracting team will use to build our BH network.

Please see the below for more details by the Health Services department.

Quality Improvement and Population Health

Healthcare Effectiveness Data and Information Set/Managed Care Accountability Sets (MCAS) Report 2024. Finalized measurement year 2023 MCAS audit rates will be submitted to NCQA and DHCS by the June 14, 2024 deadline. Additional collaboration efforts were made this year with the county BH departments in Merced, Monterey, and Santa Cruz County to share carve out BH outpatient services for health plan reporting.

Comprehensive Quality Improvement and Health Equity Process. The Alliance completed the first submission to DHCS for the Comprehensive Quality Improvement and Health Equity process for Merced County. Medi-Cal Managed Care Plans whose reporting unit(s)/county(ies) performed below the state or region median in two or more of the four domains. This included submitting a fishbone diagram of the Children Domain and Women's Reproductive and Cancer Prevention Domain. The second submission will occur at the end of June to include initial strategies and action Items.

Children's Domain Measures of Focus:

- Child and Adolescent Well-Care Visits
- Childhood Immunization Status: Combination 10
- Immunizations for Adolescents: Combination 2
- Lead screening in Children
- Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months
- Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30

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Women's Reproductive and Cancer Prevention Domain Measures of focus:

- Chlamydia Screening in Women
- Breast Cancer Screening in Women.

Utilization Management

Work continues in the transition from Essette to the ZeOmega (Jiva) care management system replacement platform, with the go-live date scheduled for July 15, 2024, at which time systems will switch over from Essette to ZeOmega (Jiva). End to end testing is in progress as are Train the Trainer activities across all modules within the platform (Provider Portal, UM, Case Management, Appeals and Grievances). Mission critical, regulatory required elements are under final development prior to go-live with tracking in place for post go-live system enhancements. To further prepare for the changes ahead, the Alliance has partnered with an external vendor for development and delivery of a robust training program that is supporting both Alliance staff and external providers in orientation to the ZeOmega (Jiva) system. Training includes creation of video modules to support both internal teams as well as external providers who are also orienting to the new provider portal functions.

National 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. UM teams are optimizing annual UM Program Evaluation processes for successful completion of deliverables in advance of the October 2024 NCQA lookback period. UM criteria review processes have been increased to include routine external independent medical reviews, with external experts additionally assessing policies both at initial creation and upon annual review as part of NCQA readiness. Processes for sharing Alliance criteria and policy guidelines with external stakeholders have been enhanced as part of UM NCQA process improvement.

BH UM integration processes are well underway in advance of the July 2025 implementation date, with recruitment in process for a BH UM Manager to oversee internal BH UM program development and authorization activity. Development of the Alliance's BH authorization framework is underway with code sets and utilization patterns under review. Policy development and recruitment for prior authorization staff to support utilization oversight of the plan's BH requests will progress over the next two months.

<u>Inpatient and Emergency Department (ED)</u>. Collaborative work continues across teams towards the person-centered strategic goal to improve the system of care for members with complex medical social needs. The goal is a 5% change downward year over year for 30-day all-cause readmissions and ED visits (per 1K/PMPY) for high-risk members. A new report has been developed to support assessment of this metric, with readmission rates specifically for high-risk members assessed across the five counties. Total 30-day readmissions (quarter one) for this high-risk metric came in ranging from a low of 2% (Mariposa) to a high of 17% (Merced). Total overall average for 30-day high risk readmissions for all counties came in at 9% for quarter one.

Work to reduce readmission rates, reduce avoidable emergency department utilization, and improve transitions of care (TCS) for Alliance members continues through a focused and collaborative multidisciplinary approach. Interdisciplinary team (IDT) meetings continue to expand with internal/external stakeholders, reflecting over 400 IDT meetings held in the first quarter. The Alliance's additional TCS pilot work continues to identify members with diabetes and cardiac

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disease as a population of focus. Identification of members for outreach while inpatient support, in the acute setting and then post discharge to ensure connection to resources and to support successful transitions across care settings.

New LTC admission reflects a 59% decrease over Q4, which may reflect both claims' lags and increases in alternative residential care facilities for the elderly (RCFE) placements. There was a 24% increase in short term rehab (STR) bed days over Q4 2024, though total number of STR stays remains stable quarter over quarter. The increase in STR bed days will be monitored and further assessed for any new emerging or sustained patterns, though initial review indicates increases related to more complex member needs. Readmission rates after STR discharge remain stable at about 20% and indicate an opportunity for ongoing TCS support.

Prior Authorization. The Prior Authorization team continues to increase team efficiencies, with authorization activity advanced to day three turnaround time (versus five) and the majority of the UM team now additionally engaged in ZeOmega (Jiva) testing and training. The Alliance has seen an increase in authorization volumes compared to last year, a reflection of county expansion and increased membership totals. Overall utilization activity reflects consistent trends with successful redirection for in network specialty referrals, decreased denial activity and improved member access to care.

The UM team has moved all ECM/CS authorizations to the UM department as part of ongoing process improvement for ECM/CS UM. Collaboration continues across Alliance teams to increase member connection to authorized ECM and CS services. Policy development and provider education continues for ECM and CS with additional internal workflow development related to medically tailored meals.

Pharmacy

Drug Utilization Review (DUR) Program. Staff are working with Advanced Analytics to create a DUR report in which the data analysis is automated to identify members with opioid use disorder, who might benefit from additional interventions and coordination of care. Staff hope to use this as a template for future DURs in identifying high risk members with various disease states requiring therapeutic and/or care coordination interventions. For example, a report can be created to identify members with opioid overdose related admissions, and these members could be referred to transition care teams for initiation of buprenorphine and naloxone therapies. Additionally, the same report will help identify primary care providers who would benefit from educational interventions regarding buprenorphine and naloxone prescribing. Lastly, staff are working on including demographic data in the report to identify any gaps in access for opioid use disorder care (buprenorphine and naloxone) based on their age, ethnicity, spoken language or residency.

Pharmacist-Led Academic Detailing (PLAD) Program. Diabetes: During May, the Alliance pharmacist continued working with two clinics (a total of two providers) divided into two separate groups. Both providers are scheduled to complete the program by July 2024.

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 session conducted over the course of two weeks. We have one clinic scheduled to begin at the end of June and one more clinic pending scheduling for the end of June.

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Site of Care: The Alliance pharmacist has been working to expand the drug list offered as home infusion with contracted home infusion providers. Additionally, the Alliance has been working to expand the home infusion network. The Alliance Pharmacy Department will potentially be conducting a pilot with a care coordination provider to help shift the administrative tasks to the provider while increasing home infusion access.

Care Management

Care Management has continued efforts to assist hard-to-place members with long hospital stays with placements in RCFE. These members require close monitoring and collaboration between our Complex Care Management (CCM) team and our UM department. This collaboration has been successful in reducing unnecessary hospitalizations and acute utilization for our high-risk members with complex conditions.

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

In preparation for NCQA accreditation staff are also strengthening our member outreach efforts to engage high-risk complex patients for the survey. As part of our patient engagement efforts, we are convening a work group to initiate hospital visits for high-risk members to better coordinate their care and prevent acute utilization. Staff are also streamlining workflows and processes in preparation for NCQA accreditation.

Whole Child Model/Pediatric Complex Care Management. The Pediatric CCM team continues work on the Essette system replacement ZeOmega (Jiva). Work in the platform is in full swing across all teams. Optimization for both 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. Staff are currently in the end-to-end testing phase. This current phase includes full engagement of Pediatrics team members to explore and validate system functionality as well as test critical business workflows.

The Pediatrics CCM team is successfully managing the increased volume of pediatric cases for Mariposa and San Benito members and working closing with our county CCS partners. The Whole Child Model (WCM) expansion project work for San Benito and Mariposa counties continues to be a priority. WCM will be implemented in these two counties in January 2025. This project spans multiple departments and divisions and will build off the work that has been initiated for county expansion. Collaborative meetings with both our new counties and DHCS continue. DHCS has provided multiple deliverable requests to implement this expansion. Impacted departments include (but are not limited to) Pediatrics CCM, UM, and Provider Services. In the three existing WCM counties, we continue to monitor and observe steady CCS referrals and enrollment rates.

Enhanced Care Management/Community Supports. Focus remains on increased enrollment in ECM services. There are ongoing engagement efforts to support awareness of the benefits through community contacts. The Providing Access and Transforming Health collaborative groups are working with the ECM team to focus on 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. A cohort of new providers have been onboarded as of the beginning of Q2.

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Behavioral Health

The Behavioral Health Integration Planning (BHIP) work has continued moving forward at a rapid pace. This month the team worked to refine a supplemental payment and value-based payment package using data-driven strategies to motivate providers in key areas such as place of service, language of service and service hours. The package is prepared for presentation to the Board at the June Board meeting. The clinical strategy has been finalized, articulating the importance of an approach that is integrated, high quality, high value, low barrier, equitable and community responsive. The BH team has further been collaborating on building workflows for cross-functional areas, such as the intersection between Member Services and Care Management when members call the Alliance to request new BH services. To continue supporting agencywide work in BH integration, the BH Director has conducted the first of a series of open office hours, where staff from all areas can bring questions, thoughts, and concerns about integration for discussion.

In addition to BHIP work, the team has been active in moving CalAIM objectives further through intra- and inter-agency collaboration. For example, the BH team met with Dr. Omar Guzman, Chief Health Equity Officer, for a session to share the equity work being done in the department and hear how it fits with his overall strategy. Key areas of discussion were designing community responsive service opportunities in various geographic areas and increasing utilization in our most underserved counties. The BH Director partnered with the Santa Cruz County Office of Education Superintendent and the Health Services Agency Director to conduct a presentation for the Santa Cruz Board of Supervisors regarding the full BH continuum in the county. This was an opportunity for the Alliance to highlight our role in BH services as well as the intersections with schools, health services, and other key local collaborators. The BH Director also collaborated with leadership from OpEx, Program Development and Data Analytics on drafting the charter for a new Data Optimization project, ensuring that BH-specific data needs are being included for current and future bi-directional information exchange.

The BH Department continues to monitor Carelon with daily engagement, weekly executive meetings, and ad hoc discussion. Carelon has been communicating their intent to resolve the Corrective Action Plan from the Alliance regarding delays in care access for specialized services for Autism Spectrum and Developmental Disorders issued April 17, 2024. The team meets regularly to ensure that the gap in care has been addressed and that members impacted have received outreach to ensure they have access to appropriate services.

Program Development

Housing as Health. In May 2024, the Alliance launched the Alliance Housing Fund to provide capital funds to build, purchase, renovate and/or furnish permanent housing units, recuperative care facilities and short- (one) term post-hospitalization housing units. The Alliance Housing Fund will help expand temporary and permanent housing opportunities for Medi-Cal members across the Alliance service area.

Letters of intent are currently being accepted through June 30, 2024, for projects planned in Mariposa, Merced, Monterey, San Benito, and Santa Cruz counties. Funded projects must designate at minimum 80% of units developed to Medi-Cal beneficiaries. The Alliance will award no more than 50% of total project costs. Project requests must be for non-renewable funding that can be sustained through earned revenue or other sources without dependence on further

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Alliance investment or grant contributions. Projects that allow for incorporation of ECM and CS service provision directly on-site will be prioritized.

In addition to the Alliance Housing Fund general funding opportunity, in Santa Cruz County, the Alliance is planning to allocate $5,000,000 from the Alliance Housing Fund budget to pilot a revolving loan fund for housing to be administered by a third-party Community Development Financial Institution (CDFI). Proposals are currently being accepted from CDFIs interested in managing the revolving loan fund for site-specific projects in Santa Cruz County. CDFI proposals are also due to the Alliance by June, 30, 2024,

Learn more at https://thealliance.health/for-communities/funding-opportunities/alliance-housing-fund/

CalAIM Incentive Payment Program (IPP). Alliance staff is awaiting receipt of a report on the amount of IPP funds earned from Submission 4; the Alliance has the potential to earn $10.8M based upon it March 15, 2024 submission to DHCS for the measurement period of July 1, 2023 – December 31, 2023. This submission covered only Merced, Monterey, and Santa Cruz counties. 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, submitted to DHCS on May 15, 2024. 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. To date, 54 IPP LOAs have been executed, for a total of $29.2M.

Student Behavioral Health Incentive Program (SBHIP). Staff have received third reports from all participating school districts, covering the time frame of January 1 - June 30, 2024. The reports encompass updates on each targeted intervention project (21 total, across seven districts in all five counties), and are being reviewed for June 30, 2024, submission to DHCS. These reports are associated with 12.5% of allocation funding (~$1.5M) and will be the first time the Alliance serves as the MCP for report submission for San Benito and Mariposa. Upon this submission, there will be just one reporting period remaining, with SBHIP completing December 31, 2024.

Equity and Practice Transformation (EPT). The Alliance is supporting 15 providers in the EPT pass-through payment program. May 10, 2024, Governor Newsom released a Revised Budget Proposal for California's fiscal year 2024-2025 that proposed cuts to multiple health and human services programs, including the Equity and Practice Transformation directed payment program. The revised budget proposal reduces the EPT program from $700 million over five years ($350M from CA General Fund and a $350 match from CMS), to $140 million ($70M from CA General Fund, $70M CMS match). If approved, it will reduce payments available to the 200+ EPT practices by about 80%. While the EPT program is not being eliminated, the reduction in funding, if it remains at the proposed levels, will significantly impact the program structure. As a result, CMA asked LHPC to sign on to a letter opposing the funding reductions of the EPT Directed Payment Program in the May Revise. The Alliance signed on to this advocacy effort via our LHPC association. Regardless of the decision, the Alliance has decided to continue the hiring process of four new FTEs to provide practice coaching to our awarded EPT practices.

Medical Directors

Enhanced Care Management. The Medical Department team has been doing deep dives with the ECM team to automate ECM provider assignment both for patients who are identified ad hoc during operational care of Alliance patients as well as monthly eligibility lists. This should greatly reduce the burden of manual assignment being done by the ECM team while also allowing rapid assignment of members in real time when they are identified as ECM patients.

Community Supports. The Medical Directors are working closely with UM, Transitions of Care, and multiple other departments to firm up eligibility criteria for CS. This has been a very collaborative effort and will bring clarity to ordering providers as well as internal staff around what patients qualify for what CS services.

Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse of Dependence (FUA)/Follow-up After Emergency Department Visit for Mental Illness (FUM) Collaboration with County Behavioral Health Services. In collaboration with BH and Quality Improvement, Dr. Wang has been involved in regular meetings with county BH services, Santa Cruz Health Information Exchange (SCHIO), and other providers to ensure that we have smooth data flow from the emergency departments discharging patients with FUA/FUM qualifying conditions to either county behavior health services or Carelon. We are making significant progress now that counties are agreeable to send data to the Alliance.

Alliance Clinical Data Warehouse. Dr. Wang is working with ITS to evaluate multiple IT architecture options for storing clinical data. He is making sure that the selected solution will adequately serve all of Health Service's use cases.

SCHIO Collaboration. Dr. Wang is working with SCHIO to perform data validation of incoming clinical data to ensure that data is cleaned well and meaningfully consumed by the Alliance for operational use cases.

Employee Services and Communications

Alliance Workforce. As of June 3, 2024, the Alliance has 620.4 budgeted positions of which our active workforce number is 576.2 (active FTE and temporary workers covering LOAs and vacancies). Additionally, the Alliance has 42.5 budgeted temporary workers, of which 16.5 are filled. Overall, the Alliance is 90.7% staffed. Additionally, there are 54 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.

Mid-Year Check-in. The Alliance provides leadership and staff two formal opportunities a year to meet and discuss current performance, goal status, career development and other performance related topics. This year, Human Resources updated and introduced new competencies across the organization, and this will be the first formal discussion on these new competencies. Self-evaluations will commence June 24, 2024, supervisors will write check-ins in July, and deliver to staff no later than August 2, 2024.

Employee Engagement Survey. The Alliance encourages staff to participate in the Annual Employee Engagement Survey to gauge their level of engagement in both the work we do, and

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with the organization itself. The survey provides staff with the opportunity to share feedback so that the Alliance understands what is important to them, what we are getting right, and where there are opportunities for growth. Human Resources will share this information with Directors on June 20, 2024 followed by staff Info-Sessions the week of June 24, 2024.

Facilities and Administrative Services

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 December 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

Community Investment Communications Plan. Communications staff is partnering with Community Grants and Program Development on a communications plan to support and promote the Alliance's community investment efforts across our five counties. The purpose is to enhance overall awareness of our local investments that align to our mission and strategic priorities in order to grow positive brand share. While the plan is currently being finalized, tactics will include communication tactics targeted at community partners, provider network and media partners. This work will be a multi-year effort; however, we expect to begin formally executing tactics in Q3.

Member Texting and Engagement. The member texting and engagement project is on schedule. Initial campaigns and scripting have been identified and we have revised the project scope to include execution of a digital member ID card, delivered securely through the platform. We are currently working on the texting application and digital ID submissions to DHCS. We have tentative plans to launch full-scale texting by early fall and the digital ID solution in mid-fall, pending DHCS approvals.

Q3 2024 Communications. Staff is working on developing tactics for our Q3 media campaign. This campaign will target Merced families with kids under 13, urging them to schedule their appointments for vaccines. The bi-lingual campaign is scheduled to run July 22 through September 15, 2024 and includes radio advertisements and interviews, radio weather sponsorships, DMV ads, and social media ads. We are testing new hyperlocal ad tactics called "mobile conquesting", which shows ads to users within identified geotargeted locations where our members frequent, and "social mirroring", which surfaces our Facebook ad video on other mobile platforms our members may visit. We will be tracking the conversion rate of these ads to determine if they net a positive ROI. The campaign slogan is: "Kids grow up fast. Give them a healthier future."

Merced County Well-Checks for School Communications. Our first co-branded media campaign wraps up mid-June. The campaign targets Merced families with school-aged children, aiming to raise awareness of the importance of well-checks for school. Campaign partners include Merced County of Education (MCOE) and Mercy Health. Campaign tactics include a billboard (provided by MCOE), flyers, newsletter articles, website content, social media content, Spanish and English

terrestrial radio, radio interviews with SMEs, YouTube and Snapchat ads. We will include campaign metrics in next month's report.

Operations

Community and Member Engagement. In May, the Community Engagement team focused on Mental Health Awareness and attended several BH community events, including the Alisal Integrated Health Resource Fair (Monterey County) and the Mental Health Awareness Month Resource Fair (Merced County). Field visits were also conducted to community partners focusing on supportive mental health services including, Encompass (Santa Cruz County), Heritage House (Mariposa County) and the Navigation Center (Merced County) to discuss services and benefits available to members. We also recognized Asian American and Pacific Islander Heritage month by participating in the first Merced Hmong American Day with the Hlub Hmong Center and engaged with our members at the Trip Around the World event at Farmdale Elementary School in Merced. Both events featured a rich array of cultural experiences.

In June, the team will continue to engage with our community to remind members to get in for summer well checks, through participation of Celebration of Fatherhood (Merced County), Kid's Day (Santa Cruz County), and Kids at the Park (San Benito County). We will also be celebrating Pride Month and Juneteenth.

Enrollment Trends. Membership has stayed consistent across all counties. Membership in May was slightly under 450K at 449,666, over 10% higher membership than projected for this time of the year. This is in part due to the Alliance continuing to see strong month over month new enrollment numbers in 2024. Our new members have been active, seeking information and education around the benefits and services the Alliance provides. Our call volume reflects the enrollment numbers and we have been able to assist all members effectively over the phone and in person. We continue to receive an increased call volume with May totaling 15,000 calls with a 98.5% success rate of answering and addressing member needs.

Member walk-ins continue to be high with 528 total walk-ins for all sites in May. Members in Merced and Monterey County had the most walk-ins with 320 for Merced and 136 for Monterey. During the walk-ins, members seek information around housing support, soliciting a new member ID, and getting transportation services. Specifically, our adult expansion population tend to seek services in-person as they learn to navigate the health care system.

Top Initiatives in Operations. *Dual Eligible Special Needs Plans (D-SNP) Implementation:* In June, the Alliance is focused on beginning the D-SNP provider network development for primary care providers, specialists, and facilities and drafting our Model of Care. We are also focusing on system add-ons and enhancements that will allow our workflow to be efficient and compliant.

Printer Services Vendor Replacement: Print vendor replacement work has begun with finalization on the scope of work and initializing the RFP documentation. The request for bids will be sent out in the next several weeks to potential vendors.

Paper Claims Optimization: The Paper Claims Optimization project is on schedule. We are currently involved in UAT testing, as we test batch files.

Provider Network Development and Trends. In May, the Alliance added many new providers to the network including non-traditional and allied providers. A new community health worker provider, Health Projects Center, was added and will provide services in Santa Curz, San Benito and Monterey counties. A component of DHCS's Long Term Support Services, program requires Medi-Cal plans to expand additional Long Term Care networks to locations outside county lines. As a result, the plan credentialed five new Long Term Care facilities in May. Four physical therapists were added to the network in Merced County. Monterey County added two new speech therapists and a new Doula to the network. Santa Cruz County added in a new acupuncturist. Serving our Mariposa membership, a new surgeon was added to Mariposa County, a new plastic surgeon was added in Fresno and a new podiatrist was added in Sonora.

Board Level Measures from the Alliance Dashboard. In 2019, the Board selected 27 metrics from the Alliance Dashboard to report specifically, in addition to the roll-up of the overall Alliance Dashboard by key processes. These 27 metrics are largely operational (e.g., calls answered within 30 seconds, timely resolution of member complaints, facility site reviews, claims processed timely, employee turnover). Some of the metrics were more strategic in nature (e.g., All Cause Readmissions, Avoidable Emergency Department visits, Consumer Assessment of Healthcare Providers and Systems Member rating of health plan).

To focus on reporting more strategic information to the Board, the Alliance will replace these 27 specific metrics with a quarterly update on the strategic plan metrics starting August 2024. Measures from the Strategic Plan include Healthcare Effectiveness Data and Information Set Pediatric Measures for which there is a large disparity, Emergency Department Visits and All Cause Readmissions for High-Risk Members, and BH Insourcing. Note that the specific metrics, while no longer reported in detail, remains a part of the aggregated Alliance Dashboard by key processes.

Attachment.

1. Letter to Honorable Jesse Gabriel; Reinstate MCO Tax Agreement
2. Central California Alliance for Health 2024 Bill List

Back to Agenda

Attachment 1

May 22, 2024

The Honorable Jesse Gabriel
Chair, Assembly Budget Committee
1020 O Street, Room 8230
Sacramento, CA 95814

RE: Reinstate MCO Tax Agreement

Dear Chairman Gabriel:

On behalf of a broad coalition of healthcare providers, workers and health plans in California, we urge you to maintain California's commitment to work toward universal coverage for all and to address ongoing health disparities in our state. That means upholding last year's budget agreement that dedicated revenues from the state's largest-ever Managed Care Organization (MCO) tax to expand access to care for low-income patients.

Medi-Cal is the largest Medicaid program in the country and provides critical health care coverage to approximately one-third of our state's population, including half of California's children. Our coalition is a broad and diverse group of providers, employees,
and health plans that collectively support the needs of these low-income and vulnerable patients.

Upholding the previous agreement on how to spend the state's Managed Care Organization (MCO) tax revenues, is critical to advance California's goals of universal, equitable and quality access to care.

California's last several MCO taxes have supported the state's General Fund. The agreement reached last year provides approximately $12 billion in general funds, while also providing dedicated revenues to increase provider rates for those that serve low-income patients. Those provider-rate increases will help keep hospitals, physician offices and community health centers open, while making it possible for more providers to see more Medi-Cal patients. The Administration's proposal sweeps all of this funding to use it for general state costs.

Dedicating a large portion of the current MCO tax – the largest in the state's history – to healthcare, as it was originally intended, is critical to making health coverage more meaningful for millions of low-income Californians.

We cannot continue to raid healthcare dollars and expect our system to absorb the millions more Medi-Cal patients we have seen over the last several years. While the number of patients on Medi-Cal continues to grow, the last series of broad Medi-Cal rate increases occurred in 1998. Increasing eligibility and benefits, while not increasing provider rates has left Medi-Cal patients in a delivery system that is chronically underfunded, overcrowded and increasingly failing to fulfill our state's goal of providing equitable, accessible and quality care.

We strongly believe that revenue generated by the reinstatement of the MCO tax must be directly dedicated to supplementing and enhancing the core areas of the Medi-Cal program such as primary and specialty care, community clinics, emergency department access, hospital services, family planning, mental health and workforce needs, to provide the funds necessary to stabilize California's healthcare system.

*We respectfully request you **reinstate the MCO Tax Agreement**.*

CALIFORNIA MEDICAL ASSOCIATION
CALIFORNIA HOSPITAL ASSOCIATION
PLANNED PARENTHOOD AFFLIATES OF CALIFORNIA
SEIU CALIFORNIA STATE COUNCIL
AFSCME
CALIFORNIA PRIMARY CARE ASSOCIATION
CALIFORNIA ASSOCIATION OF HEALTH PLANS
CALIFORNIA STATE ASSOCIATION OF PSYCHIATRISTS
CALIFORNIA SOCIETY OF PLASTIC SURGEONS
CALIFORNIA OPTOMETRIC ASSOCIATION
AMERICA'S PHYSICIAN GROUPS
CALIFORNIA RHEUMATOLOGY ALLIANCE
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNEOCOLOGISTS
CALIFORNIA ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
CALIFORNIA PODIATRIC MEDICAL ASSOCIATION
LOCAL HEALTH PLANS OF CALIFORNIA

cc: The Honorable Dr. Akilah Weber, M.D., Chair of Assembly Subcommittee #3 Health
Members, Assembly Budget Committee
Christian Griffith, Chief Consultant, Assembly Budget Committee
Casey Dunn, Consultant, Assembly Republican Caucus

Central California Alliance for Health
2024 Bill List

Priority Bills	
AB 1379 **Papan (D)** **Status:** Dead **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:** 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 (D)** **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:** 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:** 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:** Referred to Com. on HEALTH, 5/1/24.	**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 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:** Senate Inactive File – Asm. Bills, File Date 6/5/24.	**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:** 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:** 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:** 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:** Re-referred to the Com. on APPR, 7/5/2023.	**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.
AB 564 **Villapudua (D)**	**Medi-Cal: claim or remittance forms: signature**

Status: Referred to Com. on HEALTH, 6/14/23.	**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:** 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:** In Coms. On L. GOV. and JUD., first hearing canceled by author, 5/21/24.	**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:** 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)** **Status:** Held under submission, 9/1/23.	**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 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:** Held under submission, 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:** 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:** Held under submission, 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:** Senate Inactive File – Asm. Bills, File Date 6/5/24.	**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:** Amended and re-referred to Com. on HEALTH, 5/20/24.	**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. The bill would require coverage for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, as specified. The bill would require a Medi-Cal managed care plan, as defined, to be responsible for covering, and reimbursing providers for furnishing, those emergency services and care, as specified.
AB 1331 **Wood (D)** **Status:** Held under submission, 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 **Papan (D)** **Status:** Amended, re-referred to Com. on RLS, 5/30/24.	**California Environmental Quality Act: geothermal exploratory projects: lead agency** **Summary:** The California Environmental Quality Act (CEQA) requires a lead agency, as defined, to prepare, or cause to be prepared, and certify the completion of an environmental impact report on a project that it proposes to carry out or approve that may have a significant effect on the environment or to adopt a negative declaration if the lead agency finds that the project will not have that effect. CEQA also requires a lead agency to prepare a mitigated negative declaration for a project that may have a significant effect on the environment if revisions in the project would avoid or mitigate that effect and there is no substantial evidence that the project, as revised, would have a significant effect on the environment. Existing law establishes the Geologic Energy Management Division in the Department of Conservation, under the direction of the State Oil and Gas Supervisor, who is required to supervise the drilling, operation, maintenance, and abandonment of wells so as to permit the owners or operators of those wells to utilize all methods and practices known to the industry for the purpose of increasing the ultimate recovery of geothermal resources, as provided. Existing law requires the division to be the lead agency for all geothermal exploratory projects for purposes of CEQA, as specified. This bill would repeal the requirement that the division be the lead agency for all geothermal exploratory projects for purposes of CEQA.This bill would declare that it is to take effect immediately as an urgency statute.

AB 1537 **Wood (D)** **Status:** Senate Inactive File – Asm. Bills, File Date 6/5/24.	**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:** 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:** Re-referred to Com. on APPR., 5/29/24.	**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:** Referred to Com. on APPR., 5/29/24.	**Public health: maternity ward closures** **Summary:** This bill would require an acute care hospital that offers maternity services, when those services are at risk of closure, as defined, in the next 12 months to provide specified information to the Department of Health Care Access and Information as well as the State Department of Public Health, including, but not limited to, the number of medical staff and employees working in the maternity ward and the hospital's prior and projected performance on financial metrics. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 6 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health, to conduct a community impact assessment to determine the 3 closest hospitals offering maternity services in the geographic area and their distance from the at-risk facility. The bill would require the hospital to provide public notice of the potential closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the proposed closure. The bill would require the public to be permitted to comment on the potential closure for 60 days after the notice is given, and would require at least one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program.
AB 1926 **Connolly (D)** **Status:** Referred to Com. on APPR., 5/29/24.	**Health care coverage: regional enteritis** **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 dietary enteral formulas, as defined, for the treatment regional enteritis, 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)**	**Medi-Cal: telehealth** **Summary:** This bill would require the department to produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would

Status: Referred to Com. on HEALTH, 5/22/24.	authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.
AB 1970 **Jackson (D)** **Status:** In Senate, to Com. on RLS for assignment, 5/22/24.	**Mental Health: Black Mental Health Navigator Certification Pilot Program** **Summary:** This bill would require the department to develop criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, as specified. The bill would require the department to collect and regularly publish data, not less than annually, including, but not limited to, the number of individuals certified, including those who complete a specialty certificate program, as specified, and the number of individuals who are actively employed in a community health worker role.
AB 1975 **Bonta (D)** **Status:** Referred to Com. on HEALTH., 5/29/24.	**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:** Read second time, amended, and re-referred to Com. on APPR., 5/30/24.	**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. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.
AB 1995 **Essayli (R)** **Status:** 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:** Hearing cancelled at request of author, in committee, 4/18/24.	**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.

AB 2031 **Jones-Sawyer (D)** **Status:** Hearing cancelled at request of author, in committee, 3/12/24	**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:** Referred to Com. on HEALTH, 5/29/24.	**Medi-Cal: nonmedical and nonemergency medical transportation** **Summary:** This bill would require the department to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026.
AB 2063 **Maienschein (D)** **Status:** Referred to Com. on HEALTH, 5/29/24.	**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:** Referred to Com. on HEALTH, 5/29/24.	**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 and is medically necessary, as specified. 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:** In committee: Held under submission, 5/16/24.	**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	**Controlled substances: clinics**

Haney (D) **Status:** In Senate, read first time, to Com. on RLS. for assignment, 5/23/24.	**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. This bill would specify that medical evaluation may be conducted by any health care provider, if it is verified by a narcotic treatment program practitioner, would authorize a program to allow patients to refuse or delay laboratory tests for disease, and would state that a patient receiving maintenance treatment is not precluded from receiving medication by a refusal to participate in counseling. The bill would revise the criteria to be considered prior to providing a patient with take-home medication privileges to include the absence of active substance use disorders and known recent diversion activity and the regularity of attendance for supervised medication administration, among others. The bill would state that a practitioner is not required to restrict a patient's take-home medication privileges if the patient tests positive for an illicit substance as described above and a practitioner is not required to establish a specified number of negative tests to restore those privileges to a patient. The bill would authorize a program to allow a patient to be absent from the program for up to 30 days without contact before requiring that they be terminated from the program.
AB 2129 **Petrie-Norris (D)** **Status:** Referred to Com. on HEALTH, 5/15/24.	**Immediate postpartum contraception** **Summary:** This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a acute care hospital or accredited birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure.
AB 2132 **Low (D)** **Status:** Set for first hearing in Coms. On HEALTH and JUD., hearing canceled at request of author, 6/4/24.	**Health care services** **Summary:** This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient's health insurance, unless the health care provider reasonably believes certain conditions apply. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive, as specified. The bill would prohibit a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure. The bill would make related findings and declarations.
AB 2198 **Flora (R)** **Status:** Amended and re-referred to Com. on HEALTH, 6/3/24.	**Health information** **Summary:** This bill would, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from application programming interfaces (API) requirements, and would instead require that the specialized plan or insurer that meets specified enrollment requirements comply with API requirements beginning January 1, 2027, or when final federal rules are implemented, whichever is later.
AB 2200 **Kalra (D)**	**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

Status: In committee: Held under submission, 5/16/24.	universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Under the bill, CalCare would be a health care service plan subject to Knox-Keene. 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 third-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:** Referred to Coms. On HEALTH and G.O., 5/29/24.	**Children and youth: transfer of specialty mental health services** **Summary:** This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health–services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department's Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified. By increasing duties of counties administering the Medi-Cal program, the bill would impose a state-mandated local program.
AB 2246 **Ramos (D)** **Status:** Referred to Com. on B., P. & E. D., 5/22/24.	**Medical Practice Act: health care providers: qualified autism service paraprofessionals** **Summary:** Existing law, the Medical Practice Act, establishes the Medical Board of California and charges it with administrative and enforcement duties related to the provision of medical services under the act. Existing law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program.
AB 2250 **Weber (D)** **Status:** Referred to Coms. On HEALTH, 5/29/24.	**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:** Referred to Coms. On HEALTH and JUD., 5/29/24.	**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 prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies, but would authorize the hospital to consider a health savings account, as specified. 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:** Second hearing cancelled at request of author, 4/11/24.	**Health and care facilities: prospective payment system rate increase** **Summary:** This bill would, upon appropriation, require the State Department of Health Care. Services to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment for specified health care facilities to account for the costs of complying with the minimum wage schedules described above. The bill would require that the alternative methodology be applied retroactively to January 1, 2025, until those costs are included in the prospective payment system rate. The bill would require the department to seek all necessary federal approvals or amendments to the state Medi-Cal plan to implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services.
AB 2319 **Wilson (D)** **Status:** In Senate, read first time, to Com. on RLS. for assignment, 5/24/24.	**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 bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal 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 specified facilities to document each employee's implicit bias training in accordance with regulations adopted

	by the department for documenting staff development programs. The bill would require the department to assess each hospital's compliance with this requirement during periodic inspections. 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 have been issued administrative penalties. 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. The bill would make the provisions of the act severable.
AB 2332 **Connolly (D)** **Status:** In committee: Held under submission, 5/16/24.	**Corrections: health care** **Summary:** This bill would require the Department of Corrections and Rehabilitation (CDCR) to take specific actions in the provision of substance use treatment, such as ensuring uniform application of the California Correctional Health Care Services Care Guide and retaining at least one full-time addiction medicine physician and surgeon at each facility to be assigned medication-assisted treatment patients exclusively. The bill would require the CDCR to provide physicians and surgeons clear guidance on interpretation of certain toxicology tests, the misuse, abuse, and illegal distribution of substances, and access to alternative medication. The bill would require the CDCR to provide physicians and surgeons training consisting of at least 8 hours of integrated substance use disorder treatment didactic training, 3 days of shadowing an integrated substance use disorder treatment practice, and an annual training of at least 8 hours covering specified topics. The bill would require the CDCR to form a working group consisting of 6 members of the Union of American Physicians and Dentists and integrated substance use disorder treatment program departmental representation with the authority to make decisions for the purpose of identifying program areas for improvement or additional training that could be offered to certain employees, in order to enhance program success. Existing regulations establish a process for the CDCR to verify licenses and credentials of newly hired health care providers. This bill would require that process to include addiction medicine as an additional qualification.
AB 2339 **Aguiar-Curry (D)** **Status:** Referred to Coms. On HEALTH, 5/29/24.	**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:** Referred to Coms. On HEALTH, 5/29/24.	**Medi-Cal: EPSDT services: informational materials** **Summary:** This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is 12 years of age or older but under 21 years of age.

	The bill would authorize the department to standardize the materials, as specified, and would require the department to regularly review the materials to ensure that they are up to date. The bill would require the department to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries, in order to ensure that the materials use clear and nontechnical language that effectively informs beneficiaries. The bill would require the department or a Medi-Cal managed care plan, depending on the delivery system, to provide to a beneficiary who is eligible for EPSDT services, or to the parent or other authorized representative of that beneficiary, as applicable, the informational materials within 60 calendar days after that beneficiary's initial Medi-Cal eligibility determination and annually thereafter.
AB 2342 **Lowenthal (D)** **Status:** Referred to Com. on HEALTH, 2/26/24.	**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 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:** Referred to Coms. on JUD. and HEALTH, 5/29/24.	**Mental health and psychiatric advance directives** **Summary:** This bill would extend advance health care directive provisions to psychiatric advance directives and would make conforming changes. The bill would specify that a psychiatric advance directive is a legal written or digital document, executed as specified, that allows a person with behavioral health illness to document their preferences for treatment and identify a health care advocate in advance of a behavioral health crisis. Under the bill, a written or digital psychiatric advance directive may include the individual's nomination of a health care advocate who is in agreement to uphold the person's preferences for treatment in the case of a behavioral health crisis. If the health care advocate is informed of the directive's revocation, the bill would require them to promptly communicate that fact to the supervising health care provider and any health care institution where the patient is receiving care. The bill would specify that a psychiatric advance directive is legally sufficient if it contains the date of its execution and is signed by the individual, their health care advocate or another adult in the individual's presence and at the individual's direction, and one additional, unrelated witness. This bill would specify that a person's current and possible supports to be considered by a court in a conservatorship determination include psychiatric advance directives and health care advocates. The bill would specify that less restrictive alternatives to conservatorship include psychiatric advance directives for purposes of the conservatorship alternatives program. This bill would require a designated facility evaluating if a patient is in need of involuntary mental health services to keep a record that includes if the person detained has an advance health care directive or a psychiatric advance directive. If a person who is the subject of a petition for involuntary treatment has a psychiatric advance directive, the bill would require directions in that directive to be considered in formulating their written treatment plan. This bill would authorize a health care advocate to be a supporter in the CARE process. The bill would authorize a supporter to provide information to the respondent about advance health care directives or psychiatric advance directives and would authorize the supporter to

	be present in a meeting, proceeding, or communication relating to interacting or communicating with the chosen health care advocate. The bill would prohibit a supporter from creating a psychiatric advance directive without explicit authorization by the respondent with capacity. This bill would require the Behavioral Health Services Oversight and Accountability Commission, at least annually from 2025 to 2030, inclusive, to assess the extent to which digital psychiatric advance directives have been implemented and submit recommendations on ways to improve the adoption and effectiveness of digital psychiatric advance directives to specified committees of the Legislature. This bill would specify that the 90-day transition plan required for youth or nonminor dependents transitioning out of the statewide system of child welfare services and foster care, may include options for creating a psychiatric advance directive and choosing a health care advocate, as well as information regarding the psychiatric advance directive written or digital form. The bill would require a county welfare department to provide a dependent child with an advance health care directive or psychiatric advance directive written or digital form. By increasing the duties of county welfare departments, this bill would impose a state-mandated local program.
AB 2356 **Wallis (R)** **Status:** In committee: held under submission, 5/16/24.	**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:** In Senate, read first time, to Com. on RLS. for assignment, 5/23/24.	**Chemical dependency recovery hospitals** **Summary:** This bill would expand the definition of "chemical dependency recovery services" to include medications for addiction treatment and medically managed voluntary inpatient detoxification. The bill would delete the requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital or acute psychiatric hospital, and instead would authorize those facilities to provide chemical dependency recovery services as a supplemental service within the same building or in a separate building on campus that meets specified structural requirements of a freestanding chemical dependency recovery hospital. The bill would delete the requirements for chemical dependency services to be provided in a hospital building that provides only chemical dependency recovery services, or has been removed from general acute care use.
AB 2428 **Calderon (D)** **Status:** Referred to Com. on HEALTH, 5/29/24.	**Medi-Cal: Community-Based Adult Services** **Summary:** This bill, for purposes of a mutual agreement between a Medi-Cal managed care plan and a network provider, would require that the reimbursement be in an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system. Under the bill, no later than January 1, 2025, for payments commencing on July 1, 2019, a Medi-Cal managed care plan that has not reimbursed a network provider furnishing CBAS according to those provisions would be required to reimburse the network provider the difference between the amount required and the amount that has been paid. Existing law requires that capitation rates paid by the department to an applicable Medi-Cal managed care plan be actuarially sound and account for the payment levels in the above-described provisions as applicable. This bill would prohibit the changes made by the bill to the above-described reimbursement from being construed as requiring the department to retroactively

	recalculate the capitation rates for purposes of any reimbursement of the difference between the amount required and the amount that has been paid.
AB 2435 **Maienschein (D)** **Status:** Re-referred to Com. on G.O., 5/29/24.	**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:** Referred to Com. on HEALTH, 5/29/24.	**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 diseases of the skin. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. The bill would require the department to seek any necessary federal approval to implement this section.
AB 2449 **Ta (R)** **Status:** Re-referred to Com. on APPR., 6/4/24.	**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 another national accrediting entity approved by the Secretary of California Health and Human Services.
AB 2466 **Carrillo (D)** **Status:** In committee: Held under submission, 5/16/24.	**Medi-Cal managed care: network adequacy standards** **Summary:** Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above. This bill would require a plan that has a previously approved alternative access standard to submit a renewal request on an annual basis, explaining which efforts the plan has made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard, as specified. The bill would require the department to consider the reasonableness and effectiveness of the mitigating efforts as part of the renewal decision. This bill would, effective for contract periods commencing on or after July 1, 2025, require the plan's and department's reports to include certain information and require the department's evaluation to be performed using a direct testing method, as specified. Under the bill, failure to comply with these provisions may result in contract termination or the issuance of sanctions. Existing law, as part of the federally required external quality review organization (EQRO) review of Medi-Cal managed care plans, requires the EQRO designated by the department to compile certain data, by plan and by county, for the purpose of informing the status of implementation of the above-described standards.

	This bill would require that the data include, effective for contract periods commencing on or after July 1, 2025, the number of requests for alternative access standards, categorized by new and returning patients, and the number of allowable exceptions for the appointment time standards, categorized by urgent and nonurgent appointment types and by new and returning patients. This bill would require the department to monitor any plan of correction imposed by the director, with progress reported publicly no less than annually for the duration of the plan of correction. Existing law authorizes the director to impose monetary sanctions based on any of specified circumstances, including, among others, failure to submit timely and accurate network provider data. This bill would, for purposes of the particular circumstance described above, set forth definitions for the terms of "timely" and "accurate network provider data."
AB 2467 **Bauer-Kahan (D)** **Status:** In Senate, read first time, to Com. on RLS. for assignment, 5/24/24.	**Health care coverage for menopause** **Summary:** This bill would require a health care service plan contract or health insurance policy, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for treatment of perimenopause and menopause.
AB 2556 **Jackson (D)** **Status:** Amended, read second time, amended, and re-referred to Com. on HEALTH, 5/28/24.	**Behavioral health and wellness screenings: notice** **Summary:** This bill would require a health care service plan, except as specified, or health insurer to provide to each subscriber or policyholder of a contract or policy that covers 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 on an annual basis.
AB 2668 **Berman (D)** **Status:** In committee: Held under submission, 5/16/24.	**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:** In committee: Held under submission, 5/16/24.	**Hazardous materials: reporting: civil liability** **Summary:** This bill would require the California Environmental Protection Agency to adopt new regulations regarding reporting of handling hazardous materials, amongst other changes.
AB 2701	**Medi-Cal: dental cleanings and examinations**

Villapudua (D) **Status:** Referred to Com. on HEALTH, 5/29/24.	**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:** In Senate, read first time, to Com. on RLS. for assignment, 5/23/24.	**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:** In committee: Held under submission, 5/16/24.	**Specialty care networks: telehealth and other virtual services** **Summary:** This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a grant program. Under the bill, the grant program would be aimed at facilitating a telehealth and other virtual services specialty care network or networks that are designed to serve patients of safety-net providers consisting of qualifying providers, as defined. Under the bill, the purpose of the demonstration project would be to improve access to specialty care for Medi-Cal beneficiaries through development of a financially sustainable specialty care network or networks that are focused on serving the needs of the health care safety net. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency. The bill would state the intent of the Legislature that implementation of the demonstration project would facilitate compliance with any applicable network adequacy standards. The bill would require the agency to administer the grant program to award grant funds to one or more grantees based on an application process and by meeting specified conditions. The bill would require a grantee to use the funds to develop a network or networks by, among other things, providing health information technology and technical assistance to support both the specialists and any primary care provider care coordination, referral, or electronic consultations. The bill would require the agency to arrange an independent evaluation of the demonstration project. The bill would require the evaluation to examine the extent to which the project was successful in achieving certain objectives, including, among others, reducing structural barriers to access experienced by patients. The bill would require a grantee to report data and information to allow for monitoring and evaluation of the project. The bill would require the agency to ensure that lessons learned, recommendations, and best practices from the project are publicly disseminated to inform the development of a telehealth and specialty care network or networks to serve the needs of the health care safety net.
AB 2753 **Ortega (D)** **Status:** In committee: Held under submission, 5/16/24.	**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:** Referred to Com. on HEALTH, 5/29/24.	**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 2860 **Garcia (D)** **Status:** In committee, set for first hearing; hearing canceled at request of author, 6/3/24. **Position:** Support	**Licensed Physicians and Dentists from Mexico programs** **Summary:** This bill would repeal the provisions regarding the Licensed Physicians and Dentists from Mexico Pilot Program, and would instead establish two bifurcated programs, the Licensed Physicians from Mexico Program and the Licensed Dentists from Mexico Pilot Program. Within these 2 programs, the bill would generally revise and recast certain requirements pertaining to the Licensed Physicians and Dentists from Mexico Pilot Program, including deleting the above-described requirement that Mexican physicians participating in the program enroll in adult English as a second language classes. The bill would instead require those physicians to have satisfactorily completed the Test of English as a Foreign Language or the Occupational English Test, as specified. The bill would remove the requirement that the orientation program be 6 months, and would further require the orientation program to include electronic medical records systems utilized by federally qualified health centers and standards for medical chart notations. The bill would also delete the requirement that the physicians participate in a 6-month externship. The bill would further delete provisions requiring an evaluation of the pilot program to be undertaken with funds provided from philanthropic foundations, and would make various other related changes to the program. Commencing January 1, 2025, the bill would authorize the board to issue a limited number of active licenses to eligible applicants to participate in the program, as specified. Under the bill, each additional physician selected for the program would not be eligible to renew their 3-year license. The bill would require the federally qualified health centers employing physicians pursuant to the program to continue specified peer review protocols and procedures and to work with an approved medical school or medical institution with an approved residency program, as provided. The bill would also require specified entities to be the points of contact involved in securing required documents, recruiting and vetting candidates, assisting candidates to meet all program requirements, selecting appropriate federally qualified health centers throughout California, ensuring compliance with program provisions, developing policy and clinical workshops, monitoring productivity and increased access to medical care, and assessing the necessity of policy and programmatic improvements. The bill would impose fees in connection with the program, as specified.
AB 2956 **Boerner (D)** **Status:** In committee: Held under submission, 5/16/24.	**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 above 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 the above-described 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 prompt 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. For purposes of the income verification process only, when a renewal is received without a reasonable explanation or other income verification, the bill would require a county to accept self-attested information, as specified. 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. The bill would make conforming changes to related provisions. 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. 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:** 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 3059 **Weber (D)** **Status:** In Senate, read first time, to Com. on RLS. for assignment, 5/23/24.	**Human milk** **Summary:** This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized human milk that was obtained from a mothers' milk bank. Existing law requires health care service plans and health insurers, as specified, to provide certain health benefits and services, including, among others, maternity hospital stays, inpatient hospital and ambulatory maternity services, and maternal mental health programs. This bill would require a health care service plan contract or health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2025, to cover the same health benefits for human milk and human milk derivatives covered under the Medi-Cal program as of 1988.
AB 3129 **Wood (D)** **Status:** Referred to	**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

Coms. On HEALTH and JUD., 5/29/24.	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 consent to, give conditional consent to, or not consent 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 does not 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:** In committee: Held under submission, 5/16/24.	**Promotores and Promotoras Advisory and Oversight Workgroup** **Summary:** This bill would require the department, by no later than January 1, 2025, and until December 31, 2026, to convene the Promotores and Promotoras Advisory and Oversight Workgroup to provide perspective and guidance to changes in the health and human services delivery system, including, but not limited to, the Medi-Cal program. The bill would require the secretary to appoint no fewer than 9 individuals to the workgroup who have at least ten years experience working in California as, or with, Promotores or Promotoras. The bill would require the workgroup to be comprised of no less than 51% Promotores or Promotoras, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the departments under the agency to ensure that services provided by Promotores or Promotoras are available and accessible to all eligible populations. The bill would also require the workgroup to advise the agency to ensure that Promotores and Promotoras training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores or Promotoras services and the Medi-Cal program. The bill would also make findings and declarations related to the inclusion of Promotoras.

AB 3156 **Patterson (R)** **Status:** In Senate, read first time, to Com. on RLS. for assignment, 5/24/24.	**Medi-Cal: managed care plans: beneficiaries with other primary coverage** **Summary:** Under this bill, in the case of an enrollee of a Medi-Cal managed care plan who has other health care coverage and for whom the Medi-Cal program is a secondary payer, the department would be required to ensure that a provider billing the managed care plan for allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. The bill, in the case of an enrollee of a Medi-Cal managed care plan who has coverage under the federal Medicare Program or another primary form of health care coverage and for whom the Medi-Cal program is a secondary payer, would prohibit a provider participating in the Medi-Cal fee-for-service delivery system or in the federal Medicare Program from being required to contract with the Medi-Cal managed care plan in order to provide services to that enrollee and to bill the managed care plan. The bill would require a Medi-Cal managed care plan to provide assistance to Medi-Cal providers and beneficiaries, upon request, on options for maintaining health care relationships between beneficiaries and existing providers that are contracted with, or have agreements with, a beneficiary's primary form of health care coverage, if the beneficiary transitions from receiving services under the Medi-Cal fee-for-service delivery system to being an enrollee of the managed care plan. The bill would require the department, at least annually from 2025 through 2028, to report to the legislative health committees on the effectiveness of implementing these provisions. The bill would authorize the department to implement these provisions through plan letters or similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.
AB 3215 **Soria (D)** **Status:** 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:** Referred to Com. on HEALTH, 5/22/24.	**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 require records, books, and papers to be preserved until furnished, if requested by the department. 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. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program. Existing law requires the department to conduct periodically an onsite medical survey of the health delivery system of each plan. Existing law requires the director to publicly report survey results no later than 180 days following the completion of the survey, and requires a final report to be issued after public review of the survey. Existing law requires the department to conduct a followup review to determine and report on the status of the plan's efforts to correct deficiencies no later than 18 months following release of the final report. This bill would state that nothing in those provisions prohibits the director from taking any action permitted or required under the act in response to the survey results before

	the followup review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations. Existing law enumerates acts or omissions by a health care service plan that constitute grounds for disciplinary action by the director. This bill would add to those enumerated acts or omissions the failure by a health care service plan to respond fully or timely, or both, to a duly authorized request for production of records.
AB 3245 **Patterson (R)** **Status:** Referred to Coms. On HEALTH and APPR., 5/15/24.	**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 of A or a grade of B, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency, in addition to the United States Preventive Services Task Force.
AB 3260 **Pellerin (D)** **Status:** Referred to Com. on HEALTH, 5/29/24.	**Health care coverage: reviews and grievances** **Summary:** This bill would require that utilization review decisions be made within 72 hours from the health care service plan's receipt of the clinical information reasonably necessary to make the determination when the enrollee's condition is urgent, and would make a determination of urgency by the enrollee's health care provider binding on the health care service plan. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced. This bill would require a plan's grievance system to include expedited review of urgent grievances, as specified, and would make a determination of urgency by the enrollee's health care provider binding on the health care service plan. The bill would require a plan to communicate its final grievance determination within 72 hours of receipt if urgent and 30 days if nonurgent, except as specified. If a plan fails to make a utilization review decision within the applicable timelines, the bill would require a grievance to be automatically resolved in favor of the enrollee. This bill would extend the deadline under existing law to 12 months beyond the specified qualifying periods. The bill would require the plan to provide specified correspondence and documents to an enrollee and their representative, if applicable, if the enrollee has submitted a grievance for review under the Independent Medical Review System. The bill would require the department to provide an enrollee and their representative a reasonable opportunity to respond to communications between the department and the plan or the independent review organization before the grievance is resolved. The bill would prohibit the department and its independent medical review organization from engaging in ex parte communication with a plan, enrollee, or their representatives during the grievance process, except as specified. If a grievance is filed internally with an insurer, this bill would require an insurer to communicate its final grievance determination within 72 hours of receipt if urgent and 30 days if nonurgent. Upon notice from the department to a disability insurer that an insured has submitted a grievance to the department, the bill would require an insurer to respond within 24 hours, if directed by the department, regarding an urgent grievance or within 5 calendar days regarding a nonurgent grievance. This bill would require the department to determine whether or not a grievance is urgent, as specified, unless the insured's referring or treating provider has already designated the

	grievance as urgent. The bill would require the department to provide specified correspondence and documents to an insured and their representative, if applicable, if the insured has submitted a grievance for review under the Independent Medical Review System. The bill would require the department to provide an insured and their representative a reasonable opportunity to respond to communications between the department and the insurer or the independent review organization before the grievance is adjudicated. The bill would prohibit the department and its independent medical review organization from engaging in ex parte communication with an insurer, insured, or their representatives during the grievance process, except as specified.
AB 3275 **Soria (D) and Rivas (D)** **Status:** Referred to Com. on HEALTH, 5/29/24.	**Health care coverage: claim reimbursement** **Summary:** Under existing law, if a claim is not reimbursed, contested, or denied pursuant to existing timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate for a health insurer to 15% per annum. The bill would delete the provisions that extend the timelines for a health maintenance organization. The bill would require a health care service plan or health insurer to reimburse a claim within 15 working days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 15 working days that the claim is contested or denied. Under the bill, if a claim for reimbursement is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 working days after receipt of the additional information to complete reconsideration of the claim. The bill would require the departments to develop respective lists for categories of claims that, commencing January 1, 2026, would be required to be paid by a health insurer or health care service plan no later than 5 days after receipt of the claim, as specified. This bill would also require a health insurer to automatically include all interest accrued in its payment of a claim. Existing law requires a health care service plan that fails to comply with the requirement to include all interest in its payment of a claim to pay the claimant a $10 fee. This bill would instead require a health insurer or health care service plan that fails to comply with that requirement to pay the claimant a fee of no less than 10% of the interest accrued.
Senate Bills	
SB 70 **Wiener (D)** **Status:** 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:** 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:** Amended and re-referred to Com. on HUM. S., 5/30/24.	**California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program** **Summary:** This bill would, among other things, require the Treasurer to verify the cause of death of the parent, Indian custodian, or legal guardian and to verify the minor's family household income prior to the death of the parent, Indian custodian, or legal guardian once the Treasurer receives government-issued documents or a statement signed by a person who is eligible to do so under penalty of perjury that establishes the identity of the child and that the person whose death certificate was provided was the child's parent, Indian custodian, or legal guardian. By expanding the crime of perjury, this bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all eligible children will be automatically enrolled for a HOPE trust account to the extent possible, and would require the Treasurer to, in order to achieve this goal, collaborate with the State Department of Social Services and any other relevant governmental agencies to gather deidentified data to maximize participation in the HOPE trust account program for eligible youth, as specified. 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 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 also require a one-time lump sum payment made from a HOPE trust account to be automatically exempt from a garnishment order, as specified. The bill would make these provisions operative on July 1, 2025, or on the date that the State Department of Social Services notifies the Legislature that the Statewide Automated Welfare System or the California Automated Response and Engagement System (CARES) can perform the necessary automation to implement these provisions, whichever date is later. To the extent this bill would expand county duties, the bill would impose a state-mandated local program. The bill would also authorize a program enrollee who is also an eligible youth to withdraw or transfer funds from their HOPE trust account on and after their 18th birthday, and would require the Treasurer to assist an eligible youth in transferring funds from their HOPE trust account to other specified accounts. The bill would require the Treasurer to design and disseminate information for parents, Indian custodians, and legal guardians of children and youth who are potentially eligible for the HOPE Trust Account Program to facilitate their enrollment in the program and the transfer of funds, as specified, and to annually submit an audited financial report on the operations of the program by August 1 to the Governor, the Controller, the California State Auditor, and the Legislature, as specified. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect.
SB 294	**Health care coverage: independent medical review**

Wiener (D) **Status:** Amended and re-referred to Com. on HEALTH, 5/24/24.	**Summary:** This bill, commencing January 1, 2026, 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 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. This bill, commencing January 1, 2026, would require a health care service plan or disability insurer that provides treatment for mental health or substance use disorders to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured. The bill would require a plan or insurer to provide a written acknowledgment of a grievance that is automatically generated and would specify the circumstances under which that grievance is required to be submitted automatically to independent medical review. 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 Director of Managed Health Care and the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill, and to issue interim guidance, as specified.
SB 324 **Limón (D)** **Status:** 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:** 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:** 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 (D)** **Status:** 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:** Asm. 3rd Reading File – Senate Bills, 6/5/24.	**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:** 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:** 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:** 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:** On Asm. Inactive File, 6/5/24.	**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:** 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 (D)** **Status:** Held in committee and under submission, 5/16/24.	**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:** Referred to Coms. On HEALTH and JUD., 6/3/24.	**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 on and after January 1, 2026. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Fund to be available to the department for use, upon appropriation by the Legislature, for costs related to licensing and regulating pharmacy benefit managers. This bill would require a pharmacy benefit manager to file with the department at specified annual intervals 2 reports, one of which discloses product benefits specific to the purchaser, and the other of which includes information about categories of drugs and the pharmacy benefit manager's contracts and revenues. The bill would specify that the contents of the reports are not to be disclosed to the public. The bill would require the department, at specified annual intervals, to submit 2 reports to the Legislature based on the reports submitted by pharmacy benefit managers, and would require the board to post the reports on the board's internet website. This bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including prohibiting a pharmacy benefit manager from deriving income from pharmacy benefit management services, except as specified. The bill would make a violation of the above-specified provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Fund, into which fines and administrative penalties would be deposited. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides prescription drug coverage from calculating an enrollee or insured's cost sharing at an amount that exceeds the actual rate paid for the prescription drug. The bill, for a preexisting contract between a pharmacy benefit manager and a health care service plan or health insurer authorizing spread pricing, would prohibit an amendment or renewal of the contract from authorizing spread pricing. The bill would prohibit a contract between a pharmacy benefit manager and a health care service plan or health insurer that is executed on or after January 1, 2025, from authorizing spread pricing. The bill would require a plan or insurer to include additional information in its annual prescription drug data reporting, including the aggregate amount of rebates received by the pharmacy benefit manager for each drug. By expanding the scope of a crime under the Knox-Keene Act, the bill would impose a state-mandated local program. This bill would declare that it shall not narrow, abrogate, or otherwise alter the authority of the Attorney General to maintain or restore competitive markets and prosecute state and federal antitrust and unfair competition violations, and would declare that the provisions of this bill are severable.

SB 975 **Ashby (D)** **Status:** 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:** Referred to Com. on HEALTH, 6/3/24.	**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, when medically necessary to restore a tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill would remove the condition that the tooth be posterior, as written in existing law. This bill would also add, as a covered Medi-Cal benefit for persons of any age, subject to prior authorization, a dental implant if tooth extraction or removal is medically necessary or if the corresponding tooth is missing. The bill would condition this coverage on there being no other covered functional alternatives for prosthetic replacement to correct the person's dental condition, as specified, on the person being without medical conditions for which dental implant surgery would be contraindicated, on receipt of any necessary federal approvals, and on the availability of federal financial participation. Under the bill, the above-described provisions would not be construed to exclude Medi-Cal coverage for laboratory-processed crowns on teeth or dental implants if otherwise required under EPSDT services.
SB 999 **Cortese (D)** **Status:** Referred to Com. on HEALTH, 5/28/24.	**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:** Held in committee and under submission, 5/16/24.	**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 specified coverage for the treatment of obesity, including coverage for least one FDA-approved antiobesity medication.
SB 1017 **Eggman (D)** **Status:** Held in committee and under submission, 5/16/24	**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:** Referred to Coms. On HEALTH and HUM. S., 6/3/24.	**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 develop a model memorandum of understanding (MOU), and would require the department to authorize Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model. 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 informing and directing the family of a child who is eligible but not a beneficiary of the Medi-Cal program on how to enroll the child and on referring a child who is 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:** Referred to Coms. On HEALTH and P. & C.P., 6/3/24.	**Health care coverage: utilization review** **Summary:** This bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.
SB 1131 **Gonzalez (D)** **Status:** Referred to Com. on HEALTH, 5/28/24.	**Medi-Cal providers: family planning** **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 a minimum of 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to 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, including, among others, being offered through a virtual platform and being offered at least once per month. For purposes of both of the above-described programs, existing law requires the program to disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, that is otherwise lost, or that is surrendered while a disciplinary hearing is pending, as specified. This bill would authorize the department to elect to not disenroll an individual or entity as a program provider if the revocation, suspension, loss, or disciplinary hearing in another state is based solely on conduct that is not deemed to be unprofessional conduct under California law. Under existing law, a provider is subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive reimbursement from one of the above-described programs or from the Medi-Cal program and the individual has previously been on one of certain lists, as specified. Under this bill, a provider would not be subject to disenrollment under that provision if the sole basis for an individual's listing is conduct that is not deemed to be unprofessional conduct under California law. The bill would condition implementation of the disenrollment exceptions described in the 2 provisions above on receipt of any necessary federal approvals and the availability of federal financial participation.
SB 1180 **Ashby (D)** **Status:** Referred to Com. on HEALTH, 5/28/24.	**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 establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined. The bill would require those contracts 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 that 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. The bill would condition this Medi-Cal coverage on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.
SB 1213 **Atkins (D)** **Status:** Referred to Com. on HEALTH, 5/28/24.	**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)** **Status:** Held in committee and under submission, 5/16/24	**Medicare supplement coverage: open enrollment periods** **Summary:** This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The 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:** Referred to Com. on HEALTH, 6/3/24.	**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:** First hearing set and canceled at request of author, 4/24/24.	**Medi-Cal managed care plans: contracts with safety net providers** **Summary:** This bill would require a Medi-Cal managed care plan to offer a network provider contract to, and maintain a network provider contract with, each safety net provider, as defined, operating within the plan's contracted geographic service areas if the safety net provider agrees to provide its applicable scope of services in accordance with the same terms and conditions that the Medi-Cal managed care plan requires of other similar providers. The bill would set forth exceptions to that requirement in the case of a safety net provider no longer being willing to accept those terms and conditions, its license being revoked or suspended, or the department determining that the health or welfare of a Medi-Cal enrollee is threatened by the provider. The bill would require the plan to follow certain notification procedures if it terminates the network provider contract. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.
SB 1269 **Padilla (D)** **Status:** Second hearing set and canceled at request of author, 4/15/24.	**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:** Referred to Com. on HEALTH, 5/28/24.	**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)**	**Health facility closure: public notice: inpatient psychiatric and maternity services**

Status: Referred to Com. on HEALTH, 6/3/24.	**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. The bill would authorize the hospital to close the inpatient psychiatric service or maternity service 90 days after providing public notice of the closure if the department determines that the use of resources to keep the inpatient psychiatric services or maternity services open for the full 120 days threatens the stability of the hospital or if the department cites the hospital for unsafe staffing practices related to these services. 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. By changing the requirements on a health care facility, the violation of which is a crime, this bill would impose a state-mandated local program. The bill would require 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 on the health of the community, that the State Department of Public Health prioritize and expedite the licensing of additional beds to replace the number of lost beds necessary to mitigate the negative impacts identified in the impact analysis report.
SB 1339 **Allen (D)** **Status:** Referred to Com. on HEALTH, 6/3/24.	**Supportive community residences** **Summary:** This bill would require the State Department of Health Care Services (department), by January 1, 2027, and in consultation with relevant public agencies and stakeholders, to establish, and provide for the administration of, a voluntary certification program for supportive community residences. The bill would define a "supportive community residence" as specified residential dwellings providing housing for adults with a substance use disorder, mental health diagnosis, or dual diagnosis seeking a cooperative living arrangement that does not provide medical care or a level of support for activities of daily living that require state licensing. The bill would require the certification program to include standards and procedures for operation, such as types of certifications needed and services navigation, and procedures and penalties for enforcing laws and regulations governing supportive community residences. The bill also would require the department to create and maintain a searchable online database of certified facilities, which would include specified contact and complaint information for those residences. The bill would require the department to adopt or amend regulations to require referring entities to provide information relating to the license or certification status of community care facilities and supportive community residences to individuals with a substance use disorder, mental health diagnosis, or dual diagnosis, and to report any suspected fraudulent license or certification identified during verification to the department. The bill would define "referring entity" to include a state or local entity, or a state-regulated entity that provides adults with substance use disorders or mental health diagnoses with referrals to, or that authorizes health care coverage for, services provided by supportive community residences or licensed community care residential facilities. The bill also would require the regulations to include enforcement methods for willful and repeated violations of those requirements by referring entities. The bill would prohibit a supportive community residence from providing any licensed services onsite, including, but not limited to, incidental medical services. The bill would authorize the department to charge a fee for certification of supportive community

	residences in an amount not to exceed the reasonable cost of administering the program, not to exceed $2,000, and would establish the Supportive Community Residence Program Fund for collection of the fee. Under the bill, a certification would be valid for a period of 2 years and the bill would authorize the department to charge a recertification fee not to exceed $500.
SB 1354 **Wahab (D)** **Status:** Referred to Com. on HEALTH, 6/3/24.	**Long-term health care facilities: payment source and resident census** **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. This bill would require a long-term health care facility that participates as a provider under the Medi-Cal program to make publicly available its current daily resident census, as defined. The bill would require the facility to make the information available either by posting it on the facility's internet website or by providing the information to a requester within 24 hours of a request, as specified. The bill would exempt these requirements from the above-described and other related criminal penalties. This bill would require that the notice also include a specified statement relating to, among other things, restrictions on discharge from the facility or transfer within the facility solely as a result of changing the manner of purchasing services from private payment or Medicare to Medi-Cal payment, and certain resource information about facilities participating in Medi-Cal.
SB 1355 **Wahab (D)** **Status:** Held in committee and under submission, 5/16/24.	**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:** Referred to Com. on HEALTH, 6/3/24.	**Behavioral health services coverage** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after July 1, 2025, that covers medically necessary mental health and substance use disorder services to comply with rate and timely reimbursement requirements for services delivered by a county behavioral health agency, as specified. The bill would require in-network cost sharing, capped at the in-network deductible and in-network out-of-pocket maximum, to apply to these services. Unless an enrollee or insured is referred or authorized by the plan or insurer, the bill would require a county behavioral health agency to contact a plan or insurer before initiating services. The bill would authorize a plan or insurer to conduct a postclaim review to determine appropriate payment of a claim, and would authorize the use of prior authorization as permitted by the regulating department. The bill would require the departments to issue guidance to plans and insurers regarding compliance with these provisions no later than April 1, 2025.
SB 1423 **Dahle (R)**	**Medi-Cal: critical access hospitals** **Summary:** This bill would require that each critical access hospital that elects to participate receive a base reimbursement at 100% of the hospital's projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of

Status: Referred to Com. on HEALTH, 6/3/24.	service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies, or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the cost-based payment levels. The bill would set forth a timeline and a procedure for the department to notify each critical access hospital of the ability to elect to participate in those methodologies, and for a critical access hospital to inform the department of its election to participate, its discontinuance, or its later participation. The bill would require a critical access hospital that elects to participate to make available to the department relevant financial information upon request by the department. Under the bill, these provisions would not be construed to preclude a participating critical access hospital from receiving any other Medi-Cal payment for which it is eligible, including, but not limited to, supplemental payments, with specified exceptions. The bill would require the department to determine the projected reasonable and allowable Medi-Cal costs prior to each applicable calendar year, as specified. The bill would require the department to require each applicable Medi-Cal managed care plan to reimburse a participating hospital for covered services, and would require the department to develop and pay actuarially sound capitation rates to each applicable managed care plan, as specified. The bill would require the department to promptly seek any federal approvals that it deems necessary to implement these provisions, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation. The bill would authorize the department to modify the requirements described in these provisions under certain conditions for federal purposes.
SB 1428 **Atkins (D)** **Status:** Referred to Com. on HEALTH, 4/29/24.	**Health care coverage: triggering events** **Summary:** This bill would allow an individual 60 days before and after the date of a triggering event to apply for subsequent coverage, to the extent no conflicts with the availability and length of specified special enrollment periods exist.
SB 1492 **Menjivar (D)** **Status:** Held in committee and under submission, 5/16/24.	**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 included as an eligible category for Medi-Cal reimbursement.

DATE: June 26, 2024

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Fourth Month Ending April 30, 2024

For the month ending April 30, 2024, the Alliance reported an Operating Income of $27.1M. The Year-to-Date (YTD) Operating Income is $79.7M, with a Medical Loss Ratio (MLR) of 83.9% and an Administrative Loss Ratio (ALR) of 4.7%. The Net Income is $80.8M after accounting for Non-Operating Income/Expenses.

The budget expected a $36.4M Operating Income for YTD April. The actual result is favorable to budget by $43.3M or 100.0%, driven primarily by rate variance and membership favorability.

Apr-24 MTD ($ In 000s)				
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*455,001*	*415,884*	*39,117*	*9.4%*
Revenue	$196,058	$140,898	$55,160	39.1%
Medical Expenses	160,617	122,910	(37,706)	-30.7%
Administrative Expenses	8,374	8,766	391	4.5%
Operating Income	27,067	9,222	17,845	100.0%
Net Income	$21,613	$10,646	$10,967	100.0%
MLR %	81.9%	87.2%	5.3%	
ALR %	4.3%	6.2%	1.9%	
Operating Income %	13.8%	6.5%	7.3%	
Net Income %	11.0%	7.6%	3.5%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Apr-24 (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,826,071*	*1,712,947*	*113,124*	*6.6%*
Revenue	$700,937	$580,466	$120,472	20.8%
Medical Expenses	588,085	509,671	(78,414)	-15.4%
Administrative Expenses	33,148	34,434	1,286	3.7%
Operating Income/(Loss)	79,704	36,361	(43,343)	-100.0%
Net Income/(Loss)	$80,784	$42,417	$(38,367)	-90.5%
PMPM				
Revenue	$383.85	$338.87	$44.98	13.3%
Medical Expenses	322.05	297.54	(24.51)	-8.2%
Administrative Expenses	18.15	20.10	1.95	9.7%
Operating Income/(Loss)	$43.65	$21.23	$22.42	100.0%
MLR %	83.9%	87.8%	3.9%	
ALR %	4.7%	5.9%	1.2%	
Operating Income %	11.4%	6.3%	5.1%	
Net Income %	11.5%	7.3%	4.2%	

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

At a PMPM level, YTD revenue is $383.85, which is favorable to budget by $44.98 or 13.3%. Medical cost PMPM is $322.05, which is unfavorable by $24.51 or 8.2%. Overall, this results in a favorable gross margin of $20.47, or 49.5%, compared to the budget. The operating income PMPM is $43.65, which is favorable to the budget by $22.42 or 100.0%.

Membership. April 2024 membership is favorable to budget by 9.4%. The 2024 budget assumed a 17% decrease over the course of redetermination (July 2023 to June 2024) based on Mercer projections. Mercer later updated their projections to be less impactful than originally estimated and now only assumes an 11% decrease. The actual decrease from July 2023 to June 2024, is approximately 5.9%, excluding the new counties/new Unsatisfactory Immigration Status (UIS) members.

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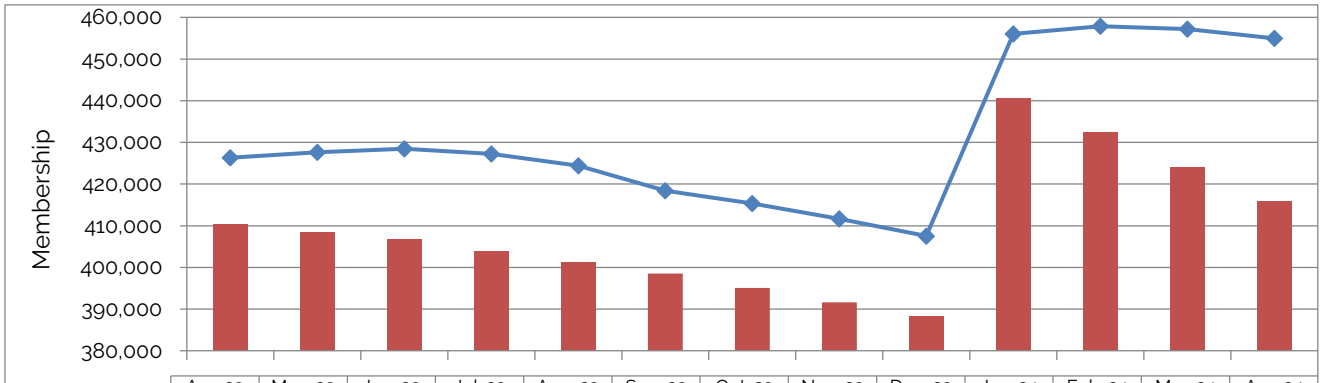
Membership. Actual vs. Budget (based on actual enrollment trend for Apr-24 rolling 13 months)



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Budget	410,347	408,481	406,635	403,892	401,191	398,530	395,036	391,611	388,255	440,590	432,354	424,119	415,884
Actual	426,328	427,656	428,448	427,275	424,399	418,442	415,304	411,670	407,542	456,002	457,871	457,197	455,001
Variance	15,981	19,175	21,813	23,383	23,208	19,912	20,268	20,059	19,287	15,412	25,517	33,078	39,117
Variance %	3.9%	4.7%	5.4%	5.8%	5.8%	5.0%	5.1%	5.1%	5.0%	3.5%	5.9%	7.8%	9.4%

Revenue. The 2024 revenue budget was based on the Department of Health Care Services (DHCS) 2024 draft rate package (dated 10/13/2023), which reflected a 0.4% rate increase, not including the Targeted Rate Increase (TRI). Furthermore, the budget assumed breakeven performances for the San Benito region. The CY 2024 Prospective rates from DHCS (dated 12/5/2023, including Maternity) represented a 2.1.% increase over CY 2023 Rates excluding TRI.

April 2024 operating revenue of $196.1M is favorable to budget by $55.2M or 39.1%. Of this amount, $13.5M is from boosted enrollment, and $41.6M is due to rate variances and State Incentives.

The rate variance of $41.6M is due to $17.8M from rate adjustments and $23.8M from State Incentives Programs. The incentives are broken down as follows: $21.5M the Housing and Homeless Incentive Program (HHIP), $1.4M for Student Behavioral Health Incentive Program (SBHIP), and $0.8M for Equity and Practice Transformation Incentive Payment Program (EPT) and offset the State Incentive Programs expense. These incentives are assumed to be budget neutral.

April 2024 YTD operating revenue of $700.9M is favorable to budget by $120.5M or 20.8%. Of this amount, $37.6M is from boosted enrollment and $82.9M is due to rate variances and State Incentives. The rate variance of $82.9M is due to $59.1M from rate adjustments and $23.8M from State Incentives Programs.

The State Incentive Programs consist of $21.5M for HHIP, $1.4M for SBHIP, and $0.8M for EPT and are offset by the State Incentive Programs expense. These incentives are assumed to be budget neutral.

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

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

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	506,940	434,562	72,378	28,489	43,889
CEC UIS	138,872	123,616	15,256	6,400	8,856
SBN SIS	25,467	17,301	8,166	2,083	6,084
SBN UIS	4,240	3,611	629	377	252
Total*	**675,519**	**579,089**	**96,429**	**37,348**	**59,081**

*Excludes Apr-24 In-Home Supportive Services (IHSS) premiums revenue of $1.6M and State Incentive Programs revenue of $23.8M.

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).

April 2024 Medical Expenses of $160.6M are $37.7M or 30.7% unfavorable to budget. April 2024 YTD Medical Expenses of $588.1M are above budget by $78.4M or 15.4%. Of this amount, $33.6M is due to higher enrollment and $44.8M due to rate variances which include $23.8M for State Incentive Programs. YTD, we are seeing increases in spending on LTC, Physician Services and Outpatient Facility.

The State Incentive Programs consist of $21.5M for HHIP, $1.4M for SBHIP, and $0.8M for EPT. These are also included under revenue and assumed to be budget neutral.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - Hospital	192,058	186,725	(5,333)	(12,297)	6,964
Inpatient Services - LTC	66,013	43,819	(22,195)	(2,878)	(19,316)
Physician Services	128,134	108,549	(19,585)	(7,170)	(12,414)
Outpatient Facility	79,669	63,354	(16,315)	(4,175)	(12,140)
Other Medical*	98,405	107,224	8,819	(7,091)	15,910
State Incentive Programs	23,806	-	(23,806)	-	(23,806)
TOTAL COST	**588,085**	**509,671**	**(78,414)**	**(33,610)**	**(44,803)**

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

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At a PMPM level, YTD Medical Expenses are $322.05, unfavorable by $24.51 or 8.2% compared to the budget. More than half of this negative variance is due to budget neutral State Incentive Programs.

Inpatient Services – LTC. LTC's unfavorability is primarily driven by unit cost. The budget underestimated the baseline cost and did not consider the continuation of the 10% COVID-19 add-on for certain codes or the 3% annual fee schedule increase. Furthermore, in San Benito, LTC utilization primarily occurs in hospital-based subacute facilities compared to CC counties, primarily accessing freestanding nursing facilities. While costs in hospital-based facilities are twice those of freestanding facilities, the financial risk, if any, will be mitigated through the risk corridor provision for San Benito. And possibly leverage redirection to freestanding nursing facilities if it is feasible. We expect the unfavorable variance to budget will continue.

Physician Services. The budget assumed utilization would increase by 3% compared to 2023. However, it has increased by 14%, driven by the new UIS 26-49 age group at Federally Qualified Health Center (FQHC) clinics.

Outpatient Facility. High ER utilization continues to drive the outpatient category, offset by lower outpatient costs. A shift in the methodology of our Incurred But Not Paid (IBNP) process caused dollars to move from other medical into OP that were not budgeted for.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	105.18	109.01	3.83	3.5%
Inpatient Services - LTC	36.15	25.58	(10.57)	-41.3%
Physician Services	70.17	63.37	(6.80)	-10.7%
Outpatient Facility	43.63	36.99	(6.64)	-18.0%
Other Medical	53.89	62.60	8.71	13.9%
State Incentive Programs	13.04	-	(13.04)	-100.0%
TOTAL MEDICAL COST	**322.05**	**297.54**	**(24.51)**	**-8.2%**

Administrative Expenses. April YTD Administrative Expenses are favorable to budget by $1.3M or 3.7% with a 4.7% ALR. Salaries are slightly favorable by $0.7M, driven by savings from vacant positions, benefits, and PTO. Non-Salary Administrative Expenses are favorable by $0.6M or 5.7% due to the timing of the actual spending versus the budget.

Non-Operating Revenue/Expenses. April YTD Net Non-Operating income is $1.1M, which is unfavorable to the budget. Total Non-Operating Revenue is unfavorable to budget by $4.2M, attributed to a $9.2M unrealized investment loss offsetting $5.1M in interest income. Non-Operating Expenses are unfavorable by $0.8M due to higher grant expenses.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $80.8M, with an MLR of 83.9% and an ALR of 4.7%.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Fourth Month Ending April 30, 2024
(In $000s)

Assets	
Cash	$448,865
Restricted Cash	300
Short Term Investments	788,076
Receivables	347,015
Prepaid Expenses	3,286
Other Current Assets	4,998
Total Current Assets	**$1,592,540**
Building, Land, Furniture & Equipment	
Capital Assets	$79,417
Accumulated Depreciation	(45,240)
CIP	2,989
Lease Receivable	3,084
Subscription Asset net Accum Depr	10,510
Total Non-Current Assets	**50,761**
Total Assets	**$1,643,301**
Liabilities	
Accounts Payable	$193,626
IBNR/Claims Payable	464,755
Provider Incentives Payable	41,347
Other Current Liabilities	9,941
Due to State	6,456
Total Current Liabilities	**$716,125**
Subscription Liabilities	8,687
Deferred Inflow of Resources	2,933
Total Long-Term Liabilities	**$11,620**
Fund Balance	
Fund Balance - Prior	$834,772
Retained Earnings - CY	80,784
Total Fund Balance	**915,556**
Total Liabilities & Fund Balance	**$1,643,301**
Additional Information	
Total Fund Balance	**$915,556**
Board Designated Reserves Target	447,056
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	159,856
Value Based Payments	46,100
Total Reserves	**709,713**
Total Operating Reserve	**$205,843**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2024
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*455,001*	*415,884*	*39,117*	*9.4%*	*1,826,071*	*1,712,947*	*113,124*	*6.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$171,836	$140,554	$31,282	22.3%	$675,519	$579,089	$96,429	16.7%
State Incentive Programs	23,806	-	23,806	100.0%	23,806	-	$23,806	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	$0	0.0%
Premiums Commercial	415	344	71	20.6%	1,612	1,376	236	17.1%
Total Operating Revenue	**$196,058**	**$140,898**	**$55,160**	**39.1%**	**$700,937**	**$580,466**	**$120,472**	**20.8%**
Medical Expenses								
Inpatient Services (Hospital)	$46,832	$44,955	($1,878)	-4.2%	$192,058	$186,725	($5,333)	-2.9%
Inpatient Services (LTC)	15,170	10,549	(4,622)	-43.8%	66,013	43,819	(22,195)	-50.7%
Physician Services	28,537	26,135	(2,402)	-9.2%	128,134	108,549	(19,585)	-18.0%
Outpatient Facility	18,677	15,253	(3,424)	-22.4%	79,669	63,354	(16,315)	-25.8%
Other Medical**	27,593	26,019	(1,575)	-6.1%	98,405	107,224	8,819	8.2%
State Incentive Programs	23,806	-	(23,806)	-100.0%	23,806	-	(23,806)	-100.0%
Total Medical Expenses	**$160,617**	**$122,910**	**($37,706)**	**-30.7%**	**$588,085**	**$509,671**	**($78,414)**	**-15.4%**
Gross Margin	**$35,441**	**$17,988**	**$17,453**	**97.0%**	**$112,852**	**$70,795**	**$42,058**	**59.4%**
Administrative Expenses								
Salaries	$5,620	$6,068	$447	7.4%	$22,986	$23,661	$675	2.9%
Professional Fees	336	276	(60)	-21.8%	895	1,140	245	21.5%
Purchased Services	1,065	1,021	(44)	-4.4%	4,206	4,198	(8)	-0.2%
Supplies & Other	994	959	(35)	-3.6%	3,549	3,769	220	5.8%
Occupancy	101	120	19	15.7%	480	515	36	6.9%
Depreciation/Amortization	258	323	65	20.1%	1,031	1,150	118	10.3%
Total Administrative Expenses	**$8,374**	**$8,766**	**$391**	**4.5%**	**$33,148**	**$34,434**	**$1,286**	**3.7%**
Operating Income	**$27,067**	**$9,222**	**$17,845**	**100.0%**	**$79,704**	**$36,361**	**$43,343**	**100.0%**
Non-Op Income/(Expense)								
Interest	$4,675	$2,576	$2,099	81.5%	$16,064	$10,966	$5,098	46.5%
Gain/(Loss) on Investments	(5,648)	150	(5,798)	-100.0%	(8,874)	300	(9,174)	-100.0%
Bank & Investment Fees	(73)	(36)	(37)	-100.0%	(205)	(145)	(60)	-41.0%
Other Revenues	207	197	10	5.3%	679	787	(107)	-13.7%
Grants	(4,616)	(1,463)	(3,153)	-100.0%	(6,586)	(5,851)	(734)	-12.5%
Total Non-Op Income/(Expense)	**(5,454)**	**1,424**	**(6,878)**	**-100.0%**	**$1,079**	**$6,056**	**($4,977)**	**-82.2%**
Net Income/(Loss)	**$21,613**	**$10,646**	**$10,967**	**100.0%**	**$80,784**	**$42,417**	**$38,367**	**90.5%**
MLR	*81.9%*	*87.2%*			*83.9%*	*87.8%*		
ALR	*4.3%*	*6.2%*			*4.7%*	*5.9%*		
Operating Income	*13.8%*	*6.5%*			*11.4%*	*6.3%*		
Net Income %	*11.0%*	*7.6%*			*11.5%*	*7.3%*		

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

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2024
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*455,001*	*415,884*	*39,117*	*9.4%*	*1,826,071*	*1,712,947*	*113,124*	*6.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$377.66	$337.97	$39.70	11.7%	$369.93	$338.07	$31.86	9.4%
State Incentive Programs	52.32	-	52.32	100.0%	13.04	-	13.04	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	0.91	0.83	0.08	10.2%	0.88	0.80	0.08	9.9%
Total Operating Revenue	**$430.90**	**$338.79**	**$92.10**	**27.2%**	**$383.85**	**$338.87**	**$44.98**	**13.3%**
Medical Expenses								
Inpatient Services (Hospital)	$102.93	$108.09	$5.17	4.8%	$105.18	$109.01	$3.83	3.5%
Inpatient Services (LTC)	33.34	25.36	(7.98)	-31.4%	36.15	25.58	(10.57)	-41.3%
Physician Services	62.72	62.84	0.12	0.2%	70.17	63.37	(6.80)	-10.7%
Outpatient Facility	41.05	36.68	(4.37)	-11.9%	43.63	36.99	(6.64)	-18.0%
Other Medical**	60.64	62.56	1.92	3.1%	53.89	62.60	8.71	13.9%
State Incentive Programs	52.32	-	(52.32)	-100.0%	13.04	-	(13.04)	-100.0%
Total Medical Expenses	**$353.00**	**$295.54**	**($57.46)**	**-19.4%**	**$322.05**	**$297.54**	**($24.51)**	**-8.2%**
Gross Margin	**$77.89**	**$43.25**	**$34.64**	**80.1%**	**$61.80**	**$41.33**	**$20.47**	**49.5%**
Administrative Expenses								
Salaries	$12.35	$14.59	$2.24	15.3%	$12.59	$13.81	$1.23	8.9%
Professional Fees	0.74	0.66	(0.08)	-11.3%	0.49	0.67	0.18	26.4%
Purchased Services	2.34	2.45	0.11	4.6%	2.30	2.45	0.15	6.0%
Supplies & Other	2.18	2.31	0.12	5.3%	1.94	2.20	0.26	11.7%
Occupancy	0.22	0.29	0.07	22.9%	0.26	0.30	0.04	12.7%
Depreciation/Amortization	0.57	0.78	0.21	27.0%	0.56	0.67	0.11	15.9%
Total Administrative Expenses	**$18.40**	**$21.08**	**$2.67**	**12.7%**	**$18.15**	**$20.10**	**$1.95**	**9.7%**
Operating Income	**$59.49**	**$22.18**	**$37.31**	**100.0%**	**$43.65**	**$21.23**	**$22.42**	**100.0%**

*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
Statement of Cash Flow
For The Fourth Month Ending April 30, 2024
(In $000s)

	MTD	YTD
Net Income	$21,613	$80,784
Items not requiring the use of cash: Depreciation	258	1,031
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	(51,414)	144,573
Prepaid Expenses	(269)	(1,058)
Current Assets	(182)	608
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(51,865)**	**144,123**
Changes to Payables:		
Accounts Payable	(84,322)	(212,249)
Other Current Liabilities	677	749
Incurred But Not Reported Claims/Claims Payable	(48,388)	176,382
Provider Incentives Payable	(11,034)	1,347
Due to State	(1,582)	(4,246)
Subscription Liabilities	0	0
Net Changes to Payables	**(144,648)**	**(38,016)**
Net Cash Provided by (Used in) Operating Activities	**(174,643)**	**187,921**
Change in Investments	2,560	57,756
Other Equipment Acquisitions	(1,022)	(1,895)
Net Cash Provided by (Used in) Investing Activities	**1,538**	**55,861**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**(173,105)**	**243,782**
Cash & Cash Equivalents at Beginning of Period	**621,971**	**205,083**
Cash & Cash Equivalents at April 30, 2024	**$448,865**	**$448,865**

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DATE: June 26, 2024

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

FROM: Dr. Dennis Hsieh, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

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

Background. The Board established the WCMCAC pursuant to Welfare and Institutions Code §14094.17(a) (SB 586 – Statutes 2015).

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

Name	Affiliation	County
Camille Guzel, MD	Provider Representative	Santa Cruz

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

Meeting Minutes

Wednesday, May 22, 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
Ms. Anita Aguirre	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Tracey Belton	County Health and Human Services Agency Director
Ms. Dorothy Bizzini	Public Representative
Dr. Maximiliano Cuevas	Health Care Provider Representative
Ms. Janna Espinoza	Public Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	County Public Health Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. Allen Radner	At Large Health Care Provider Representative

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Commissioners Absent:

Supervisor Zach Friend	County Board of Supervisors
Ms. Elsa Jimenez	County Director of Health Services
Ms. Mónica Morales	County Health Services Agency Director
Dr. James Rabago	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial 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
Mr. Marwan Kanafani	Health Services Officer
Ms. Anne Brereton	Deputy County Counsel, Monterey County
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Vice Chair Pedrozo.

Commission Vice Chair Pedrozo called the meeting to order at 3:04 p.m.

Roll call was taken and a quorum was present.

Mr. Michael Schrader, Chief Executive Officer, informed the Board that regular agenda item 12, was being removed from the regular meeting and added to the special meeting agenda scheduled to follow this meeting at 4:30 p.m. The special meeting was called ahead of the 24 hour public notification upon advice of County Counsel. Staff had been advised to revise the agenda item language for regular item 12 in order for the Board to take action on this item. Counsel's opinion was that the agenda item language should be revised to ensure full compliance with the Brown Act. In order to remain fully compliant, this item was heard in a special meeting for the Board to review, consider and take action on a request for a letter of support from GoldenPACE Health to develop Program for All Inclusive Care for the Elderly (PACE) to serve Santa Cruz, Monterey and San Benito counties.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Vice Chair Pedrozo opened the floor for Commissioners to make comments.

Commissioner Espinoza spoke on Daybreak Health which provides personalized, accessible youth mental health services partnering with school districts in Monterey County.

Commissioner Molesky reported that on May 1, 2024, the Department of Health and Human Services finalized a rule that prohibits discrimination on the basis of disability under Section 504.

Commissioner Armstrong informed the Board that there are currently two entities who wish to purchase or manage Hazel Hawkins Hospital.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Schrader introduced Ms. Anne Brereton, from the Monterey County Counsel office. He informed the Board that beginning with today's meeting and going forward Monterey County Counsel staff will attend Alliance Board meetings. County Counsel will provide support by addressing Brown Act and conflict of interest questions that may arise during the meetings. Commissioners will continue to receive confidential attorney-client privileged conflict of interest memos from Mr. Dave McDonough, Alliance Legal Services Director, prior to each meeting.

The Governor's office followed its January proposed budget for fiscal year 2024-25 with the May revision to the budget. The May revision outlines additional cuts, funding shifts, delays and deferrals in an attempt to balance the budget. There are significant impacts to the Medi-Cal program related to Medi-Cal managed care plans. Using Managed Care Organization (MCO) tax revenue, the May revision proposes to maintain the January 1, 2024 targeted rate increases for primary care, non-specialty mental health services and obstetric care, including doulas, to at least 87.5% of Medicare. However, it proposes to eliminate the January 1, 2025 targeted rate increases that would have brought many providers up to 100% of Medicare and to eliminate funding for graduate medical education and the Medi-Cal labor workforce. Instead the May revision proses to shift the $6.7B of MCO tax revenue to backfill the general fund and support the Medi-Cal program in other ways, including developing a new directed payment for children's hospitals and replenishing the Proposition 56 (tobacco tax) funding shortfall. For the Equity and Practice Transformation Program, the May revision proposes to reduce funding for Cohort 1 and otherwise proposes to eliminate funding for the program over multiple years. Additionally, the May revise proposes to eliminate funding for various healthcare workforce initiatives such as community health workers, nursing and social work, eliminate the optional adult acupuncture benefit, the expansion in coverage of In-Home Supportive Services for undocumented for all ages, but to increase direct payments to public hospitals. There is also draft trailer bill language that is related to the Children and Youth Behavioral Health Initiative which would impose a fee on plans, including the Alliance, to pay for the State's new contract with Carelon. Carelon will serve local education agencies, including managing a network of school-linked behavioral health providers, serving as a claims clearinghouse and maintaining a statewide multi-payer fee schedule. The next steps in the budget process include that legislative budget committees continue meeting to review the Governor's proposed budget solutions. The legislature is required to pass the budget by June 15, 2024 and the Governor needs to sign the budget by the beginning of the new fiscal year which begins on July 1, 2025.

[Commissioner Hernandez arrived at this time: 3:12 p.m.]

The Alliance received a contract amendment from the Department of Health Care Services (DHCS). It was received subsequent to the publishing of this month's Board packet. DHCS is requesting a short turn-around and requesting signature by May 30, 2024. This is a routine amendment consisting of clarification language to align with existing state and federal requirements, regulations and policies. Staff have requested that the Chair sign the amendment and bring it back to the Board for ratification of the Chair's signature at the June meeting.

Consent Agenda Items: (5. – 9l.): 3:20 p.m.

Vice Chair Pedrozo opened the floor for approval of Consent Agenda items 5 through 9l.

MOTION: Commissioner Molesky moved to approve Consent Agenda items 5 through 9l, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Aguirre, Armstrong, Askew, Belton, Bizzini, Cuevas, Espinoza, Hernandez, Molesky, Pedrozo and Radner.

Noes: None.

Absent: Commissioners Friend, Jimenez, Morales, Nanyonjo and Rabago.

Abstain: None.

Regular Agenda Items: (10. – 11.): 3:22 p.m.

10. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2023 from Moss Adams LLP, independent auditors. (3:22 – 3:39 p.m.)

Mr. Chris Pritchard, Partner, and Ms. Rianne Suico, Partner, from Moss Adams LLP, reported to the Board the outcomes of the annual independent financial audit. Mr. Pritchard indicated the audit process was completed and a non-modified audit opinion was issued acknowledging the financial statements are fairly presented in accordance with generally accepted accounting principles.

The asset composition included information derived from the statement of net position. Part of the audit included obtaining third party confirmation of bank balances and management prepared reconciliations, to ensure those balances agree and were prepared accurately. There were no issues with Management's ability to reconcile the cash account. Capitation receivables from the State of California were reviewed.

The short-term and Board designated investments were presented. Part of the audit procedure included obtaining third party financial statements or financial institution confirmations to ensure the amounts stated in the balance sheet were presented at fair market value in accordance with Governmental accounting standards basis. No discrepancies were found on the confirmed amount and investments and related disclosures are complete, accurate and in compliance.

Capitation receivable from the state shows a significant increase from the prior year due to the premium tax receivable dollars that were not yet received at year end. Short term and Board designated investments of the organization investment balances were tested to insure that they are recorded at fair market value.

Capital assets and other assets remained fairly consistent from the prior year and are properly capitalized and in accordance with management's capitalization policy. Other Assets balance remains fairly consistent with the prior year and are property supported.

Composition of liabilities and net positions of the financial statements were discussed. Medical claims liability was one of the largest estimates in the financial statements and included both known claims and those that were incurred but not reported medical claims liability. Directed payments payable related to pass-through payment to providers subsequent to year end were found to be effectively paid out to the related providers. A new account, Subscription Liabilities, has been added related to the new accounting pronouncement in effect in 2023, whereby the Alliance is required to include this account on the financial statements. Provider incentives payable showed a significant increase over the prior year balance due to provider incentive payments. Accounts payable and accrued liabilities consists mainly of premium tax payable in Q4 2023. The increase in net positions from the prior year is due mainly to positive operating results in 2023.

Operating Revenues in 2023 increased slightly over 2022. Capitation and claims expenses remain the largest expense to the organization. The historic estimated claims liability and historic actual claims liability, and tangible net equity were reviewed.

The year-to-year comparisons of revenue and the accounting that is being applied is fairly consistent with general accounting principles. There has been no significant change in the way the organization has been doing business and found management to be collaborative and very straightforward with providing the requested information to complete the audit. There were no audit adjustments as a result of audit procedures. The plan's accounting policies are reviewed annually to ensure compliance with known accounting standards.

MOTION: Commissioner Bizzini moved to accept the audited financial statements and management letter for Alliance's fiscal year ending December 31, 2023 from Moss Adams LLP, independent auditors, seconded by Commissioner Espinoza.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Aguirre, Armstrong, Askew, Belton, Bizzini, Cuevas, Espinoza, Hernandez, Molesky, Pedrozo and Radner.

Noes: None.

Absent: Commissioners Friend, Jimenez, Morales, Nanyonjo and Rabago.

Abstain: None.

11. Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2025. (3:39 – 4:16 p.m.)

Vice Chair Pedrozo 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.

[Commissioner Nanyonjo arrived at this time: 3:51 p.m.]

Dr. Dennis Hsieh, Chief Medical Officer, summarized the proposed changes to CBI for 2025.

Staff recommended the following changes to CBI for 2025.

1. Programmatic Measures
   - Add Colorectal Cancer Screening
   - Add Well-Child Visits for Age 15 Months - 30 Months
   - Add Chlamydia Screening in Women
2. Health Equity
   - Retire Child and Adolescent Well-Care Visit (Duplicative)
3. Performance Threshold
   - Retire Performance Improvement

MOTION: Commissioner Molesky moved to approve proposed changes to Alliance's Care-Based Incentives for 2025, seconded by Commissioner Belton.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Friend, Jimenez, Morales and Rabago.

Abstain: Commissioners Abasta-Cummings, Aguirre, Armstrong, Cuevas, Hernandez and Radner.

The Commission adjourned its regular meeting of May 22, 2024 at 4:16 p.m. to the special meeting of May 22, 2024 at 4:30 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

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

Special Meeting Minutes

Wednesday, May 22, 2024
4:30 p.m. – 5:00 p.m.

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

Commissioners Present:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Ms. Anita Aguirre	At Large Health Care Provider Representative
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
Dr. Maximiliano Cuevas	Health Care Provider Representative
Ms. Janna Espinoza	Public Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	County Public Health Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. Allen Radner	At Large Health Care Provider Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Commissioners Absent:

Supervisor Zach Friend	County Board of Supervisors
Ms. Elsa Jimenez	County Director of Health Services
Ms. Mónica Morales	County Health Services Agency Director
Dr. James Rabago	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Finance 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
Mr. Marwan Kanafani	Health Services Officer
Ms. Anne Brereton	Deputy County Counsel, Monterey County
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Vice Chair Pedrozo.

Commission Vice Chair Pedrozo called the special meeting to order at 4:30 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Special Agenda Item: (2.): 4:30 p.m.

2. Consider and take action on request for Letter of Support for Program of All-Inclusive Care for the Elderly (PACE). (4:30 – 5:18 p.m.)

Mr. Marwan Kanafani, Health Services Officer, reviewed staff's evaluation regarding GoldenPACE Health's proposal to open a PACE center to serve residents of Santa Cruz, Monterey, and San Benito counties.

As part of GoldenPACE Health's process to establish a PACE Center, a letter of support is required from the Board. The criteria was based on six categories: 1) established history of providing services; 2) description of member experience; 3) current standing with the Alliance; 4) willingness to establish an MOU with the Alliance; 5) market feasibility; and 6) letters of support and identification of any objection. GoldenPACE Health received a score of 22 out of a total of 40 points attainable.

Vice Chair Pedrozo opened the floor for public comment. The following people spoke:

1. Ms. Teresa Acosta, GoldenPACE Health, spoke in support for GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey and San Benito counties.
2. Ms. Lois Sones, Community Bridges/Elderday, expressed concern for GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey and San Benito counties.
3. Ms. Alicia Rodriguez, GoldenPACE Health, spoke in support for GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey and San Benito counties.

[Commissioner Bizzini departed at this time: 5:01 p.m.]

Commissioners discussed options with respect to the request for a letter of support for PACE.

MOTION: Commissioner Molesky moved to approve no letter of support for GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey and San Benito counties at this time, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Aguirre, Armstrong, Askew, Belton, Espinoza, Molesky, Nanyonjo and Pedrozo.

Noes: Commissioner Radner.

Absent: Commissioners Bizzini, Friend, Jimenez, Morales and Rabago.

Abstain: Commissioners Cuevas and Hernandez.

The Commission adjourned its special meeting of May 22, 2024 at 5:18 p.m. to the regular meeting of June 26, 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

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Physicians Advisory Group

Meeting Minutes

Thursday, March 7
12:00 - 1:30 p.m.

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

Group Members Present:

Dr. Cristina Mercado	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Cheryl Scott	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Mai-Khanh Bui-Duy	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. Donaldo Hernandez	Board Member

Group Members Absent:

Dr. James Rabago	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr, Mimi Carter	Provider Representative
Dr. Charles Harris	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Ralph Armstrong	Board Member
Dr. Eric Sergienko	Board Member

Staff Present:

Dr. Mike Wang	Medical Director
Dr. Dianna Diallo	Medical Director
Ms. Jessie Dybdahl	Provider Services Director
Ms. Kelsey Riggs	Complex Case Management Manager
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Kristen Rohlf	Quality & Population Health Manager

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Ms. Suzie Vargas-Tombs	Sr. Provider Relations Representative
Mr. Juan Velarde	Quality Improvement Advisor
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Provider Representative

1. Call to Order by Dr. Mike Wang.

Group Chairperson Wang called the meeting to order at 12:00 p.m.
Roll call was taken.

No supplements or deletions were made to the agenda.

2. Oral Communications.

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

No members of the public addressed the Group.

Consent Agenda

A. The Group reviewed the December 7, 2023 Physicians Advisory Group (PAG) minutes.

Action: Minutes approved.

3. **New Business**

A. Care Based Incentives 2025
Kristen Rohlf presented on Care Based Incentives (CBI) 2025.
Care Coordination Measures include:
Hospital & Outpatient Measures
- Ambulatory Care Sensitive Conditions
  - Point Reduction from 7 points to 5 points.
- Preventable Emergency Visits
  - Point Reduction from 8 points to 5 points.
- Plan All-Cause Readmission
  - Point Reduction from 10.5 points to 7 points.

Regarding the Ambulatory Care Sensitive Conditions and Preventable Emergency Visits., the Alliance is not proposing any changes. Staff have reviewed how to transition the measures to a more outpatient and outreach measure, but at this time, there are no codes that support the transition. It is still a high priority to make more functional hospital and outpatient measures for primary care providers (PCPs) because the Alliance received feedback that these hospital diagnosis are not in the scope of the PCP and that the conditions are being managed by specialists. The Alliance will continue to review opportunities to update these measures.

Dr. Diallo noted the Alliance looked at providing incentives for outreach after hospitalization and emergency department (ED) visits but experienced some barriers. Dr. Diallo asked if this would be something that would be helpful. A provider noted it would be a good idea. It was noted, there is a current draft all plan letter (APL) for Community

Health Workers (CHWs) specific to hospital outreach but there is not enough information to make a change at this time. Another provider expressed challenges with readmission rates. Having data for those individuals regarding barriers and how they can be managed would be effective. Another suggestion would be to look at high utilizer data and barriers. Currently there are no medical homes in some populations.

Another provider noted that when she had extended office hours and weekend appointments, it made a difference, and prevented patients from ending up in the ED. This measure was ended, and incentivizing clinics for extended hours would be helpful. Another provider noted Enhanced Care Management (ECM) is available for high utilizers. Payment for outreach and communication would be beneficial for all patients. Possibly incentivize clinic to hospital, and clinic to specialist coordination.

Access Measures

- Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
- Application of Dental Fluoride Varnish
- Developmental Screening in the First 3 Years
- Initial Health Appointment
- Post-Discharge Care
  - Allow specialty visits.
  - Add DST submission.

The Alliance is looking to make changes in the post-discharge care measures to expand the measure to allow specialty visits as a compliant follow-up visit within 14 days of a hospital admission and add the Provider Portal Data Submission Tool (DST) submission for providers. If patient is seen by the specialist it still counts towards the PCP. Kristen asked the Group if they had any conditions they felt should be removed from this measure. It was noted to have newborns as an exclusion. There was a question regarding the measure and psychiatric hospital admissions. **Action:** The Alliance will follow-up on psychiatric visits.

CBI Quality of Care and Performance Measures

Proposed additions:

- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Well-Child Visits for Age 15 Months–30 Months

The measures come from NCQA and are part of MCAS measures reported to the state. A provider noted regarding the chlamydia screening, that patients are on birth control for several medical conditions. Currently, the measure is identifying members if they are through pharmacy data for contraceptive medications, and billed pregnancy test, sexual activity, and pregnancy codes. Provider noted chlamydia screening should not be based on pregnancy test or birth control. A provider asked how the data is going to be obtained for sexually active patients. A provider stated she does not want the measure added for her organization because of barriers with EHR and other issues. Also noted, some pediatricians will not screen as it is not written in evidence based medicine (not medically indicated). **Action:** The Alliance will take back the comments/concerns regarding chlamydia screening and provide an email with clarification. The measure is to surpass the 50th percentile for the national Medicaid benchmark. Screening for the measure is for 16-24 years of age, billed under a chlamydia screening test code, with some exceptions. Members are excluded from the measure if they are identified for the measure based on

a pregnancy test alone, and they have a pregnancy test and a prescription for isotretinoin on the date of the pregnancy test or 6 days after the pregnancy test, or a pregnancy test and a x-ray on the date of the pregnancy test or 6 days after the pregnancy test. A provider noted they collect urine for all 16+ years of age and it makes screening easier.

It was suggested, the Combo 10 has changed since the pandemic, and decreasing the thresholds would be helpful. If a patient comes in from another clinic, they miss some vaccinations. There are no changes to CBI fee-for-service measures.

Health Equity Measure

- Health Equity: Child and Adolescent Well-Care Visit – to be retired.

Exploratory Measures

- Controlling High Blood Pressure

The health equity measure to be removed as there are other projects/opportunities the Alliance is engaging in regarding health equity. In April or May, there will be a Board presentation on CBI 2025.

Provider asked about food for members, and if there could be an opportunity to incentivize for prescribing fresh fruits and vegetables. The provider noted that BMI improvements were seen with individuals that had access to fruits and vegetables from the farmer's market. The provider will share information with the Alliance. Another provider noted she connects members with the food banks and offers a $20 framer's market voucher to patients with diabetes. Dr. Diallo suggested providing education around food insecurity and opportunities. Jessie noted members in ECM qualify for the tailored medical meals program and this is also an opportunity**. Action:** Quality Improvement/ECM can look into any gaps where changes can be made to assist with meals. Another provider noted she works with Park Rx. Health Programs offers incentives through the Healthy Weight for Life program for attendance of classes.
Link to the member incentives website:
https://thealliance.health/for-members/health-and-wellness-rewards/

Action: The Alliance to provide information/discussion regarding Medically Tailored Meals and Population Health in a future meeting.

B. Challenges with Ancillary Services
Dr. Wang asked the Group about challenges with ancillary services, specifically, physical therapy (PT), occupational Therapy (OT) and durable medical equipment (DME). It was noted there are few local providers. Many patients do not want to drive further away for services and the few providers available are booked. PCPs do not have providers to send patients to and some need to go to Stanford for autism services. There are access issues for those with special needs and for OT.

There are no issues for adults. In Monterey, patients with developmental issues can only go to Stanford or San Francisco. Merced lacks pediatric specialists and patients are sent out of area to Valley Children's, Stanford, or Lucille Packard with long wait times. It was noted, all counties are experiencing the same issues, and pediatricians need assistance. Jessie noted the importance of assessing if issues are Medi-Cal or statewide regarding lack of pediatric specialty services. The Group expressed that there are local issues with Medi-Cal and commercial plans with a lack of providers for both. Dr. Diallo noted the local Regional Centers are another resource. The Alliance's Merced office is partnering

with Valley Children's partnering for children to discuss referral patterns and solutions. Jessie noted if this is If successful in Merced, it can be offered in the additional counties.

C. Transitions of Care
Dr. Wang asked the Group the best way for the Alliance to get discharge information back to the primary care provider (PCP). What are the barriers to getting members in within 14 days of discharge.

A provider noted she receives ACT feeds from the hospitals, and logs into those that have EPIC. Another provider asks patients if they have been in the ED and then logs into system to retrieve the information. It was noted information is received from Natividad, and Salinas Valley Memorial Hospital (SVMH). A provider noted she receives a list in the morning of patients seen in the ED. Providers noted, Lucille Packard and Community Hospital of the Monterey Peninsula (CHOMP) are good about sending discharge summaries. Lucille Packard will call providers when a patient is discharged. Dominican and Watsonville Hospitals are slow at getting discharge summaries completed in a timely manner. One of the metrics for Dominican is to have discharge summaries completed within 72 hours.

A provider indicated there is contrary information given to the patient and provider. There are also issues with the quality of the discharge summaries. **Action**: The Alliance will follow-up on how to get discharge summaries to providers. In Merced, information is mostly received when a patient comes in for a visit. Also noted, some patients are discharged from hospitals that are not in the county/portal and the provider is unaware. Regarding barriers to getting members in within 14 days, it was noted access is an issue. Some confusion exists in figuring out who will get the open slots for appointments. One of the clinics is having medical assistants (MAs) conduct outreach and this has helped. The Group noted, the Alliance website does not have the discharge information in a timely manner, information shows up after 7 days. Jessie noted the Alliance is working with all of the hospital EDs to become ECM providers. The ECM provider would then communicate information back to the provider.

4. Open Discussion

Jessie noted the Alliance's payment vendor experienced a cyber-attack and the Alliance has been unable to pay providers for 2 weeks. The Alliance is hoping to pay providers early next week. Information is posted on the Alliance website and providers can call Provider Services with questions.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

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

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, March 21, 2024
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Cal Gordon, MD	Provider Representative
Devon Francis, MD	Provider Representative
Allyson Garcia, MD	Provider Representative
Salvador Sandoval, MD	Provider Representative
John Mark, MD	Provider Representative
Lena Malik, MD	Provider Representative
Allyson Garcia, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
Nicole Shelton, PA	Provider Representative
James Rabago, MD	Board Representative
Ibraheem Al Shareef, MD	Provider Representative

Committee Members Absent:

Sarah Smith, MD	Provider Representative
Jennifer Yu, MD	Provider Representative

Staff Present:

Dennis Hsieh, MD	Chief Medical Officer
Mike Wang, MD	Medical Director
Omar Guzman, MD	Chief Health Equity Officer
Tammy Brass, RN	Utilization Management Director
Shaina Zurlin, LCSW, PsyD	Behavioral Health Director
Kristynn Sullivan, PhD	Program Development Director
Minerva Galvan	Provider Services Representative
Cynthia Bali	Provider Relations Supervisor
Kelsey Riggs, RN	Pediatric Complex Case Mgmt. Manager
Jenna Stromsoe, RN	Complex Case Management Supervisor
Ashley McEowen, RN	Complex Case Management Supervisor
Jacqueline Morales	Provider Relations Representative
Sarah Sanders	Grievance & Quality Manager

Other Representatives Present:

Janna Espinoza	Member Representative

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

   Welcome new members Dr. Hue Nguyen & Nicole Shelton, PA from Hollister Pediatrics.

2. **Oral Communications.**

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

Jana Espinoza addressed the Committee and noted there have been issues with the WCM recently with members aging out and not receiving nursing care and medical therapy referrals. There was a miscommunication with Stanford, and her daughter did not receive treatment as a result (no valid referral). The Alliance was able to resolve the issue however, she believes a considerable number of other members are impacted.. Dr. Hsieh noted there are two system issues and an opportunity for education with Stanford, Also, the clinicians are not sending the appropriate information which has also been a contributing factor, and the Alliance is following up. **Action:** Tracy will schedule a meeting with the Alliance team and Janna for further discussion to understand the issues.. It was noted there is a backlog with the state with those members aging out. Dr. Hsieh asked to be included in future cases that have issues, and noted the Alliance can escalate these issues to the legislative level.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the December 13, 2023 meeting were reviewed.

B. Grievance Update
Grievance data was reviewed and provided to the Committee.

M/S/A Consent agenda items approved.

4. Regular Business.

A Whole Child Model California Children's Services (CCS) Referral Updates
Jenna Stromsoe shared CCS referral data from Q4, Total referral approval rates by county for Q4 includes Merced – 72%, Monterey – 73.1% and Santa Cruz – 74.5%. Average approval rate is 73.2%. Referral trends were also presented to the Committee.

CCS Referral Counts Rates by County:
Merced: 143
Monterey: 134
Santa Cruz: 47
Total Referrals: 324

As of February, total WCM volume was 7,519 and age-out was 68. total WCM enrollment
Action: Dr. Hsieh noted that a presentation on historical trends would be helpful.

B. Enhanced Care Management /Community Supports (ECM/CS) Update & Discussion.
Dr. Hsieh asked the Committee for suggestions how the Alliance can improve ECM/CS numbers as numbers are not where we would like them. In the past, one of the barriers was a lack of providers. The Alliance has onboarded quite a few new providers but would like to see more engagement. It was noted in Santa Cruz, numbers are quite low considering eligible candidates, possibly a matter of understanding what the services are and finding targeted communities. This is building slowly but an outbound campaign may help. Other than CCS, maybe possible outreach to the medical therapy program as a target group. In addition, outreach to general providers and specialists that are seeing patients would be of value. Outreach is happening at Joint Operating Committee (JOC) meetings but targeted outreach to high volume specialists is a good idea.
Dr Malik noted having someone from the Alliance come to the clinics for an in-service meeting would be beneficial. **Action:** Tracy will follow-up with Dr. Malik to schedule an in-person meeting and will ask Jessica Hampton for ECM numbers after the meeting to send to the Committee.

Dr. Hsieh provided an overview of ECM. Enhanced Care Management is a way for high risk individuals to obtain comprehensive case management. There are 6 components to ECM; provider outreach to the member, enrolling the member in the program, engagement in case management with the member's support network, member education on complex challenges, ensure the member is connected with providers and making it to appointments (possibly accompany member to appointments), follow-up after hospitalization and ED transitions and looping the member into CCC or specialist, and assistance with social determinants of health. The ECM program is envisioned to help eligible members receive the services they need. Referrals can be sent through the provider portal, and members can self-refer.

It was noted it is difficult in busy clinics to have someone screen patients. It was suggested, it would be helpful for information to be given to providers regarding eligible members. Another suggestion was to educate physicians in addition to medical assistants (MAs) and front desk staff. **Action:** The Alliance will take back this information and work on approaches to additional staff and report back on outreach efforts. It was noted there is a no wrong door approach and information is being shared in IDT and JOC meetings The Alliance is working to decrease the administrative burden and appreciates the feedback. A reminder to providers that case managers are available to assist. A provider suggested text message reminders and a checklist of diagnoses sent to providers, mail campaign, etc.,

C. Provider Feedback & Challenges
Dr. Hsieh asked the Committee for feedback regarding any challenges they are experiencing. A provider noted when he sees newborns at 1 month, there is a transition period when they need to be enrolled in Medi-Cal and this causes stress to his schedule. Sometimes this holds up the patient's office visit. Dr. Hsieh asked how the Alliance can assist with this process. **Action:** Tammy provided her contact information and will take this issue back to the Member Services team. It was noted the baby has the mother's ID and then receives their own. Another provider noted sometimes the baby is linked to another clinic and then needs to be put on administrative status so they can be seen.

D. Paneling Specialist Providers for California Children's Services (CCS)
Dr. Hsieh asked the Committee about best approaches, or barriers they are aware of regarding the CCS paneling process.. A provider noted in her clinic they needed a signature from a CCS paneled provider and became aware not all pediatricians are CCS providers. The provider suggested the Alliance make this part of the credentialing process. **Action**: Tammy and Kelsey will take back the suggestion to include CCS paneling in the credentialing process to the Provider Services Director.

5. Open Discussion.
Chairperson Hsieh opened the floor for the Committee to have an open discussion.
No further discussion.

Respectfully submitted.

Ms. Tracy Neves
Clerk of the Advisory Committee

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

DATE: June 26, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract 23-30421 A 02

Recommendation. Staff recommend the Board ratify the execution by the Chairperson of Medi-Cal Contract 23-30241 A-02 incorporating updated contract requirements as described below.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance entered into the primary Agreement 23-03421 with DHCS on January 1, 2024. The agreement has subsequently been amended via written amendment A 01.

Discussion. DHCS prepared A 02, an amendment to the Alliance's State Medi-Cal contract to incorporate changes and new requirements for Medical Loss Ratio, Network Provider Agreements, Enhanced Care Management, Population Needs Assessment, Justice Involved Reentry and Coordination, Transitional Care Services, FQHC Alternative Payment Model Risk Corridor, Unsatisfactory Immigration Status Risk Corridor, and Data Sharing.

Staff have reviewed the language and are assessing for operational impact and any necessary implementation steps to ensure compliance.

Fiscal Impact. There is no financial impact.

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: June 26, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Contract with Monterey County In Home Supportive Services Program

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Recommendation. Staff recommend the Board authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority (Public Authority) to provide Covered Services to eligible and enrolled In-Home Supportive Services (IHSS) providers for the period July 1, 2024 through June 30, 2025.

Background. The Alliance has offered the Alliance Care IHSS product under an agreement with the Public Authority since July 1, 2005. Alliance Care IHSS provides comprehensive health coverage, including hospital, outpatient, primary and specialty care prescription drug and mental health services to providers of IHSS services in Monterey County who meet the county's eligibility criteria and are enrolled by the county into coverage. Alliance staff communicate with County representatives at least annually to determine if contract terms, conditions or monthly premiums require adjustment.

Discussion. The benefit year covered under the current agreement with the Public Authority ends June 30, 2024 and the contract must be renewed to support the ongoing provision of services. Staff and County representatives have reviewed contract provisions, program performance and medical costs and utilization and have determined that no changes are needed to the contract terms and conditions. An increase to the per member per month premiums is necessary to ensure that premiums cover expected costs based on historical utilization.

Fiscal Impact. The premium is set to achieve a minimum breakeven performance based on the available information.

Attachments. N/A

DATE: June 26, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract CY 23 Rate Amendment

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Recommendation. Staff recommend the Board authorize the Chairperson to sign an Amendment to the Medi-Cal contract to incorporate updated Capitation Payment rates for Calendar Year 2023.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties. The Alliance entered into the primary Agreement 23-30241 and the secondary (State-Only) Agreement 23-30273 with DHCS on January 1, 2024.

Discussion. DHCS is preparing an amendment to the Alliance's State Medi-Cal contract to incorporate final Capitation Payment rates for CY 2023. The CY 2023 rates have been revised to reflect a negative acuity adjustment of $27M due to the delay in redetermination.

Fiscal Impact. There is no financial impact as staff have already accrued this adjustment in the 2023 audited financial statement.

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: June 26, 2024

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

FROM: Kay Lor, Payment Strategy Director

SUBJECT: Proposed 2025 Behavioral Health Services Incentive

Recommendation. Staff recommend the Board approve the proposed Behavioral Health Services Incentive Program as part of the Behavioral Health "in-sourcing" of the benefit, effective July 1, 2025.

Summary. In alignment with the Strategic Plan goal to improve behavioral health services and systems to be person-centered and equitable, an incentive program is intended to increase access to care that helps better manage member mental health, increase quality of lives, provide timely treatment of mental and behavioral conditions, and advance value-based payments.

Background. In 2014, the Department of Health Care Services (DHCS) allocated responsibility for non-specialty mental health services to the managed care plans. This includes member servicing, network development and credentialing, claims processing, utilization management, care coordination, and appeals and grievances. The Alliance met this responsibility by selecting Carelon Behavioral Health (formerly Beacon Health Options) as the Managed Behavioral Healthcare Organization to execute the non-specialty mental health services on its behalf. With some challenges with the management of the benefit, the Board approved to "in-source" the benefit. As part of the network strategy, staff developed an incentive program that offers financial incentives for our behavioral health providers and promotes timely, high-quality care for members.

Discussion.

Participation Requirements: Contracted providers are eligible to participate in the program.

Program Duration: Effective July 1, 2025, and ending December 31, 2026.

The 18-month program allows additional time for our providers to learn, develop an action plan to earn the incentives, and enable the Alliance team to socialize and engage the providers to ensure the program's success.

Measurements: The selected measures focus on areas to improve overall quality and access for members needing the service. There are a total of eight measures, as shown in the table below.

Behavioral Health Quality Measurements

Measurement	Goal
Primary Care Provider Coordination	Encourage coordination between primary care and behavioral health providers
Increase Provider Satisfaction Survey Completion	Encourage providers to complete the survey
Complete Health Equity Training	Alignment with DHCS and National Committee for Quality Assurance requirements of training
Increase access	Increase access and availability for members to be seen timely
Adverse Childhood Experience Screening (ACE) Training	Provider completion of ACEs Aware Training
ABA Therapy Access - After hours and weekends	Increase access through additional payment for after-hours and weekends
Access - Community Setting	Encourage providers to see members in more convenient community-based settings (such as streets, homes, libraries, or churches) by offering additional payment for visits.
Reduce Emergency Department (ED) Utilization	Provider to see members within 7 or 30 days of ED discharge for those presenting with mental health or substance use disorder concerns
Provider Retention Bonus	$500 per provider
Provider Bilingual Bonus	$250 per provider
Bilingual Visit Add-On	Per visit add-on to encourage bilingual visits in the member's preferred language

Fiscal Impact. The incentive may cost up to $9M for the 18-month period, and staff will include the appropriate amount in the 2025 and 2026 budgets.

Attachments. N/A

Back to Agenda

DATE: June 26, 2024

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Strategic Allocation of Reserve

Recommendation. Staff recommend the Board:

1. Make a one-time strategic allocation of $152.4M to be used for provider supplemental payment over multiple years.
2. Authorize staff to develop a supplemental payment methodology that addresses:
    a. Realized network access.
    b. Health equity.

Summary. This action item proposes strategic allocations that will enhance our provider payment to improve network access and promote health equity.

Background. On June 22, 2022, the Alliance's Board approved an updated Health Care Expense Reserve Policy recognizing the Board designated reserve target at three times the average monthly premium capitation. The Reserve Target is a component of the Alliance's financial plan, which provides that surplus funds are used to expand access, improve benefits, or augment provider reimbursement. The policy indicates that annually, following the acceptance of the annual independent financial audit, the Alliance Board may strategically allocate a fund balance that exceeds the Reserve Target to enable the implementation of future programs and/or to the Medi-Cal Capacity Grant Program (MCGP) to strengthen the local delivery system for the future.

Discussion. On May 22, 2024, the Board approved the audited financials for CY 2023, recognizing a net income of $168.0 million. Our fund balance was at $834.8 million. Of this amount, our Board already set aside $413.1M, or three months capitation for emergencies, $166.4 million for the MCGP, $56.7 million to cover the potential loss from the implementation of a Dual Special Need Plan (D-SNP), and $46.1 million to guarantee the distribution of existing Value-based Payment (VBP). This leaves $152.4 million available for strategic allocation.

The Governor's proposed May revision to the State Fiscal Year 2024-25 budget would reduce by $6.7B over multiple years the planned Medi-Cal provider increase set for January 1, 2025. Should the Governor's proposal be adopted, the highly anticipated Target Rate Increase (TRI) from the Managed Care Organization (MCO) Tax will not expand to broader provider types or enhance Medi-Cal payment beyond 87.5% of Medicare.

Because the Alliance has achieved a healthy reserve and does not need to accumulate a higher balance, our reserve policy allows us to use the surplus amount to expand network access and augment provider payments. Therefore, staff recommends using the entire excess amount for provider supplemental payments over multiple years.

The Alliance's strategic priorities are to advance health equity and promote person-centered system transformation, both of which require staff partnering with our providers. In addition,

during the April 24, 2024 Board meeting, the Board reviewed the Alliance access framework, including the concept of realized access. Additionally, Omar Guzman, MD, Chief Health Equity Officer, led the discussion on opportunities to improve health equity. To continue advancing these two bodies of work, we ask the Board to authorize staff to develop a supplemental payment methodology addressing 1) realized network access and 2) health equity.

Staff will present the methodology at a later Board meeting and begin implementing the provider supplemental payment in 2025.

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

Attachments. N/A

Back to Agenda

DATE: June 26, 2024

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program (MCGP) Allocation for Mariposa County

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Recommendation. Staff recommend the Board approve an allocation of $5M from the Medi-Cal Capacity Grant Program (MCGP) Unallocated Budget to the available funds for grantmaking in Mariposa County.

Summary. This report includes background on the revised MCGP county allocation methodology adopted by the Board in February 2024 and proposes an additional $5M allocation to Mariposa County as an interim step toward equity in grantmaking in the Alliance service area to meet current Medi-Cal capacity building needs.

Background. Per MCGP governance policies adopted by the Board in February 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.

In February 2024, after Mariposa and San Benito counties joined the Alliance service areas in January 2024, the Board approved a revised five-county allocation methodology for distributing funds committed to the MCGP. The revised allocation methodology was primarily based on member volume in each county with a one-time equity adjustment which shifted 20% of existing allocations from Santa Cruz and Monterey counties to Mariposa, Merced and San Benito counties. The equity adjustment recognized the need for more significant capacity investment to improve access to quality health care in Merced, San Benito and Mariposa counties and served as an initial shift toward an equity-based grantmaking model.

In March 2024, the Board approved the 2024 MCGP Investment Plan which allocated $92M from the MCGP Unallocated Budget remaining balance to invest in new and existing funding opportunities under Board approved focus areas and strategies. The MCGP Unallocated Budget are funds that have not yet been awarded or allocated to a specific use and are available to develop new funding opportunities. After the approval of the 2024 Plan, there was a remaining balance of $13.5M in the MCGP Unallocated Budget. The next potential opportunity for a recommended allocation from the Alliance's reserves into the MCGP Unallocated Budget will be June 2025.

Since March 2024, per the 2024 MCGP Investment Plan, there has been: 1) one round of Workforce Recruitment grant award approvals; 2) the distribution of $1.75M to blend funds with CalAIM Incentive Payment Program to support capacity building for Enhanced Care Management and Community Supports providers in Mariposa and San Benito counties; 3) the distribution of $10M across five counties to blend funds to implement the Alliance Housing

Fund; and 4) the launch of two new funding opportunities, Capital and Data Sharing Support, now open for application in all five counties by the July 16, 2024 deadline.

Discussion. The first round of Workforce Recruitment grants available for application in Mariposa County resulted in the award of seven Workforce Recruitment grants totaling $1,059,486, which reduced Mariposa County's MCGP remaining available funds by nearly 50% just in this first round. The Alliance' grant program has received significant interest from Mariposa County providers for capacity building funding as evidenced by participation in recent informational webinars, discussions with Alliance staff and email inquiries. The existing MCGP allocation cannot foreseeably support the demand in Mariposa County through the remainder of 2024. While the initial equity adjustment approved in February 2024 was a positive step to support Mariposa County's Medi-Cal providers, the experience and stakeholder input to date in 2024 is indicating that a greater allocation will be needed to sustain grantmaking into 2025.

The remaining funds allocated for award across all funding opportunities in each county are as follows:

MCGP Funding Available for New Grant Awards					
Mariposa	**Merced**	**Monterey**	**San Benito**	**Santa Cruz**	**Total**
$1,113,506	$45,873,957	$34,410,839	$7,125,001	$14,814,030	$103,337,332

Staff recommend that an additional $5M be allocated from the $13.5M MCGP Unallocated remaining budget to bring Mariposa County up to the level of the current San Benito County allocation to recognize the need to support capacity building costs for workforce recruitment and infrastructure (per majority allocation of funds to these strategies under the Access to Care focus area in the 2024 MCGP Investment Plan) that have fixed costs that do not vary greatly by county. This allocation would be a second, interim step toward evolving the MCGP allocation methodology to be equity-based within the five-county service area.

Proposed MCGP Funding Available for New Grant Awards with Additional Allocation for Mariposa County					
Mariposa	**Merced**	**Monterey**	**San Benito**	**Santa Cruz**	**Total**
$6,113,506	$45,873,957	$34,410,839	$7,125,001	$14,814,030	$108,337,332

The Alliance has been sanctioned for quality performance in Merced County. Mariposa is now included in the same region for revenue and quality rates as Merced, Monterey and Santa Cruz, so it is critical that an additional investment be made at this time to bring Mariposa County closer to the level of investment of at least San Benito's MCGP allocation. The Alliance received sanctions for eight MCAS quality metrics below the minimum performance level (MPL) in Merced County for measurement year 2022 (MY22). While under other managed care plans in MY22, San Benito County had three metrics below the MPL and Region 2, which includes Mariposa County, had ten metrics below the MPL. For Santa Cruz and Monterey counties, there were no metrics below the MPL in MY22. MCAS scores are one key indicator for a more equitable distribution of funds across the service area in each county's performance on the Medi-Cal Managed Care Accountability Set (MCAS) quality metrics.

Conclusion. The MCGP has undergone an evolution in its governance policies and funding allocation methodology to adapt to a new five-county service area. The Board will have the opportunity at the September 2024 retreat to reflect on the impact of these changes to date and the current structure for MCGP funding allocations within the Alliance service area and explore options for a long-term approach to equitable allocation and grantmaking within the service area. The outcome from this discussion will be incorporated into the 2025 MCGP Investment Plan recommendations which will be presented to the Board in January 2025. The planning for 2025 will also align 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 $5M from the MCGP Unallocated Budget to fund grant awards in Mariposa County developed under the Board-approved focus areas and strategies. There would be $8.5M remaining in the MCGP Unallocated Budget available for a Board-directed specific use in the future.

Attachments. N/A

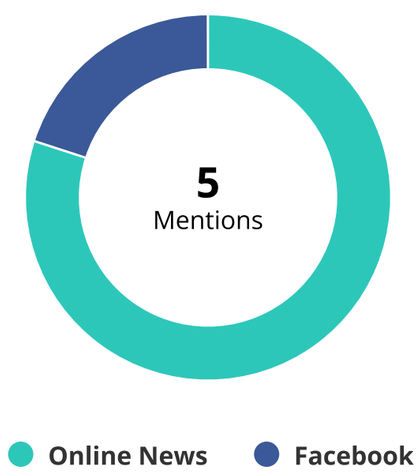
Information Items: (13A. – 13F.)

A. Alliance in the News — Page 13A-01
B. Member Appeals and Grievance Report – Q1 2024 — Page 13B-01
C. Membership Enrollment Report — Page 13C-01
D. Member Newsletter (English) – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Member-June2024-ENG.pdf
E. Member Newsletter (Spanish) – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Member-June2024-SPA.pdf
F. Provider Bulletin – June 2024
https://thealliance.health/wp-content/uploads/CCAH-Provider-June2024-high-res-FINAL.pdf

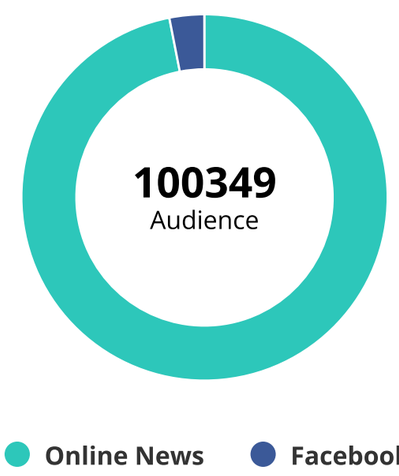
June 2024 Board Report

Mention Analytics

Mentions by Media Type



Audience by Media Type



Publicity by Media Type

Total Online + Print Audience
97,267

Total Online + Print Publicity
USD $1,581

Total Social Followers
3,082

Total Number of Clips 5

Santa Cruz Sentinel

(Requires Critical Mention login)

Santa Cruz County; Food Bank offers help with CalFresh applications

1

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Date Collected May 27, 2024 7:35 AM EDT
Category Print
Source Santa Cruz Sentinel (California)

Est. Audience 14,664
Est. Publicity Value USD $88
Market Santa Cruz, CA
Language English

... says Padilla-Chavez. "When we work with local agency partners, state programs like CalFresh, and others, our ability to nourish our community increases exponentially."

This year's forum, held on May 3 at Twin Lakes Church, brought together 65 individuals from 25 Food Bank partner agencies such as **Central California Alliance for Health**, Santa Cruz Human Services, Community Bridges, Grey Bears, and Santa Cruz County Office of Education. Topics discussed included nutrition education and community engagement. "The forum allows community partners to come together and not only find out about CalFresh updates and the services we ...

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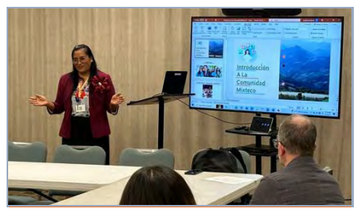

Second Harvest Food Bank Santa Cruz County offers help with CalFresh applications

2

Date Collected May 26, 2024 5:07 PM EDT
Category Digital News
Source Santa Cruz Sentinel
Author Tara Fatemi Walker

Est. Audience 28,259
Est. Publicity Value USD $183
Market Santa Cruz, CA
Language English

... says Padilla-Chavez. "When we work with local agency partners, state programs like CalFresh, and others, our ability to nourish our community increases exponentially."

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Salinas Valley Health opens cardiology office in Hollister

3

Date Collected May 17, 2024 1:53 PM EDT
Category Digital News
Source Benito Link
Author Camille Mattish

Est. Audience 1,087
Est. Publicity Value USD $29
Market Hollister, CA
Language English

... offices in three other locations. Two are in Salinas and one is in Monterey.

The company accepts the following insurance plans:

Aetna–Commercial, Medicare, Medi-Cal

Anthem Blue Cross

Aspire–Medicare Advantage

Blue Shield of California—Commercial—TRIO, non-TRIO, Covered California/Exchange

Central California Alliance for Health (**CCAH**)—Medi-Cal

Cigna—Commercial

Coastal Health Administrators—Commercial

First Health—Commercial

Health Smart/InterPlan—Commercial

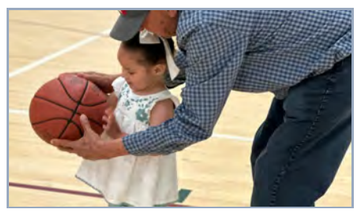
Humana Choice Care—Commercial

Health Net—Commercial

Multiplan—Commercial

Pacific Health Alliance—Commercial

Private Healthcare Systems, Inc ...



Boys & Girls Clubs of Monterey County

4

Time May 17, 2024 1:00 PM EDT
Type Post
Language English

Followers 3.1K

Thanks to everyone who joined us for our Triple Play Family Night in Seaside and Salinas. It was wonderful to see so many families come together to enjoy exciting games and create their own tasty, healthy snacks.

A big shoutout to the Central California Alliance for Health for their invaluable support of our Triple Play program. Your commitment to fostering healthier communities is truly inspiring!
Stay tuned for more events like this. #TriplePlay #HealthyFamilies #CommunityHealth #BGCMC

Golden Valley Health Centers offers new 'Enhanced Care Management' program

5

Date Collected May 2, 2024 8:16 PM EDT
Category Digital News
Source ABC30 News
Author Amanda Aguilar

Est. Audience 53,257
Est. Publicity Value USD $1,281
Market Fresno, CA
Language English

FRESNO, Calif. (KFSN) -- Golden Valley Health Centers is taking action to help patients who need extra care live healthier lives.

Through a grant from the California Department of Health Care Services, in partnership with **Central California Alliance for Health**, the organization just launched its Enhanced Care Management program in Merced and Stanislaus counties.

It's a statewide Medi-Cal benefit available to select members with complex needs.

Thousands of people in the Central Valley need services beyond the four walls of a health clinic.

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GVHC vice- ...

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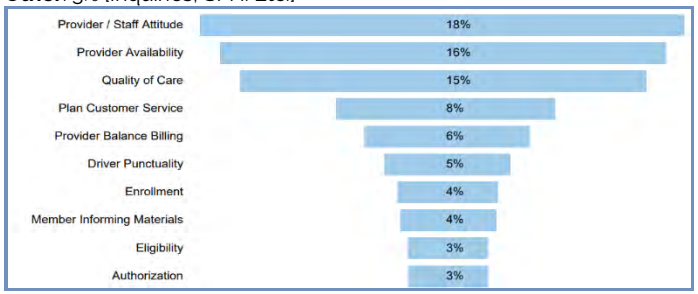
Member Appeals and Grievance Report

Q1, 2024

Q1 2024 Appeals and Grievances: 1,156* including Carelon.

Appeals: 5% [80% in favor of Plan; 20% in favor of Member]
Exempt: 48%
Grievances: 44%
Other: 3% [Inquiries, SFH. Etc.]



Analysis and Trends

- Access issues regarding provider availability in MRY improved.

Highest Grievances Filed by County

1. **Monterey**: 39%
2. Merced: 26%
3. Santa Cruz: 25%
4. San Benito: 6%
5. Mariposa: 4%

Behavioral Health Carelon Grievances: #31

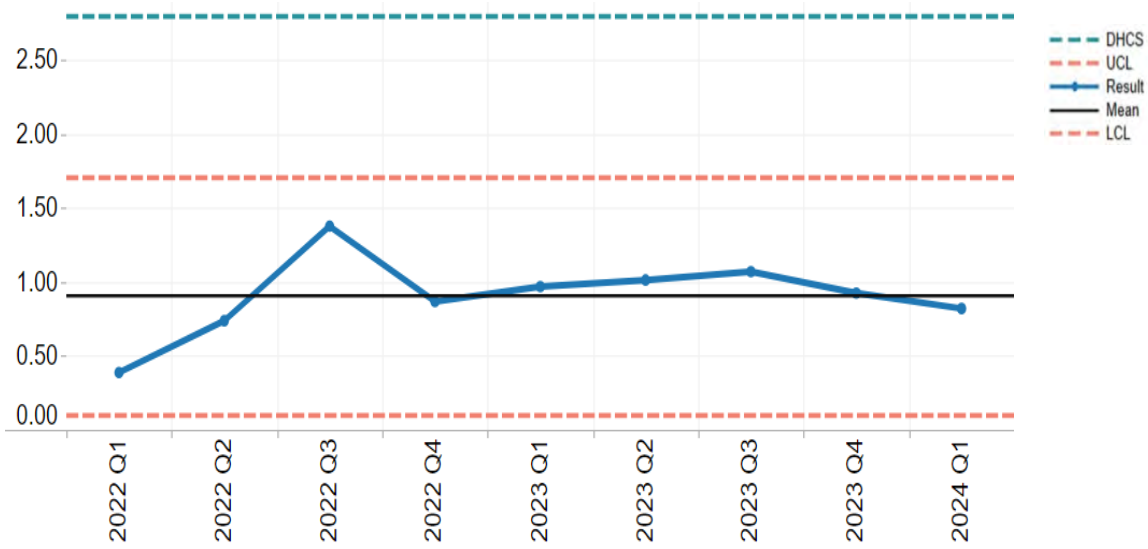
- **Monterey**: 20
- Santa Cruz: 5
- Merced: 6

IHSS Summary: #10

- Member Grievances: 7
- Exempt Complaints: 3

☒ **In Control**
☐ **Not in Control**

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



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	MemberMonths	420,221	421,742	423,195	426,113	427,756	428,853	427,127	425,589	419,667	415,634	411,325	407,472
	Case Count	321	425	480	376	488	436	448	459	455	479	369	295
	Case Count Per 1000 MM	0.76	1.01	1.13	0.88	1.14	1.02	1.05	1.08	1.08	1.15	0.90	0.72
2024	MemberMonths	458,015	456,585	456,194									
	Case Count	394	385	346									
	Case Count Per 1000 MM	0.86	0.84	0.76									

*Grievances Per 1,000 Member Month

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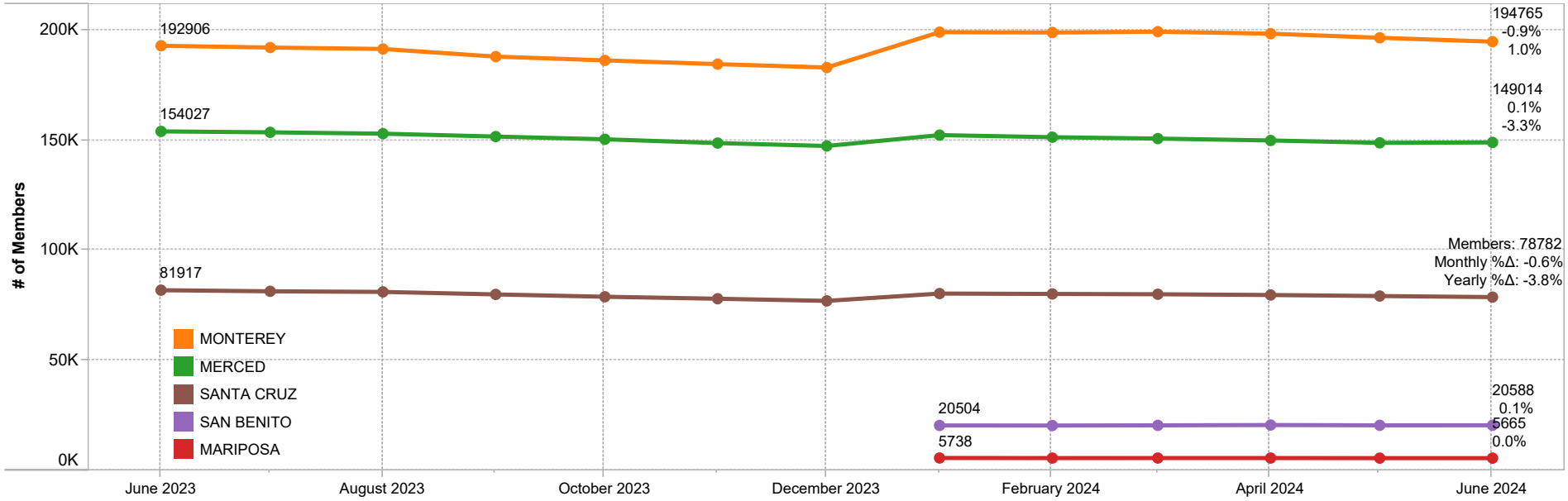
Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *6/5/2024 6:14:31 AM*

Enrollment Month
6/1/2023 to 6/30/2024

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



LOB	County	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024
Medi-Cal	SANTA CRUZ	81,917	81,419	81,142	80,008	78,940	78,045	77,068	80,389	80,217	80,079	79,733	79,272	78,782
	MONTEREY	192,236	191,427	190,772	187,299	185,580	183,877	182,325	198,390	198,228	198,585	197,682	195,802	194,033
	MERCED	154,027	153,600	152,989	151,680	150,442	148,720	147,407	152,338	151,389	150,762	149,906	148,836	149,014
	MARIPOSA								5,738	5,684	5,703	5,702	5,665	5,665
	SAN BENITO								20,504	20,472	20,551	20,693	20,564	20,588
IHSS	MONTEREY	670	674	681	682	683	691	697	700	700	705	720	726	732
Total Members		**428,850**	**427,120**	**425,584**	**419,669**	**415,645**	**411,333**	**407,497**	**458,059**	**456,690**	**456,385**	**454,436**	**450,865**	**448,814**

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