

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



## Meeting Agenda

**Wednesday, December 4, 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 16<sup>th</sup> 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: 872 372 565#
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, December 3, 2024, to the Clerk of the Board at [clerkoftheboard@ccah-alliance.org](mailto: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.
2. **Oral Communications. 3:05 p.m.**
  - A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed three minutes in length, and any individuals may speak only once during Oral Communications.
  - B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to three minutes per item.
3. **Comments and announcements by Commission members.**
  - A. Board members may provide comments and announcements.
4. **Comments and announcements by Chief Executive Officer.**
  - A. The Chief Executive Officer (CEO) may provide comments and announcements.

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

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

Pages 5-01 to 5-07
6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the ninth month ending September 30, 2024.**
  - Reference materials: Financial Statements as above.

Pages 6-01 to 6-10
7. **Approving technical revisions to 2025 Supplemental Payment Methodology.**
  - Reference materials: Staff report and recommendations on above topic.

Pages 7-01 to 7-02
8. **Accept Alliance Dashboard for Q3 2024.**
  - Reference materials: Alliance Dashboard – Q3 2023.

Page 8-01

**Appointments: (9A – 9C.)**

- 9A. **Approve appointment renewals of Carolina Meraz, Alma Mandujano-Orta, and Mimi Park to the Member Services Advisory Group.**
  - Reference materials: Staff report and recommendation on above topic.

Page 9A-01
- 9B. **Approve appointment of Michelle Perez, MD to the Whole Child Model Clinical Advisory Committee.**
  - Reference materials: Staff report and recommendation on above topic.

Page 9B-01
- 9C. **Approve appointment of Janell White to the Whole Child Model Family Advisory Committee.**
  - Reference materials: Staff report and recommendation on above topic.

Page 9C-01

**Minutes: (10A. – 10D.)**

**10A. Approve Commission regular meeting minutes of November 6, 2024.**

- Reference materials: Minutes as above.

Pages 10A-01 to 10A-05

**10B. Accept Finance Committee meeting minutes of August 28, 2024.**

- Reference materials: Minutes as above.

Pages 10B-01 to 10B-04

**10C. Accept Compliance Committee meeting minutes of October 16, 2024.**

- Reference materials: Minutes as above.

Pages 10C-01 to 10C-04

**10D. Accept Whole Child Model Family Advisory Committee meeting minutes of July 15, 2024.**

- Reference materials: Minutes as above.

Pages 10D-01 to 10D-03

**Reports: (11A. – 11D.)**

**11A. Authorize the Chairperson to sign an Amendment to the primary and secondary agreements (23-30241 and 23-30273 A02) between the Department of Health Care Services and the Alliance to incorporate final Capitation Payment rates for Calendar Year 2024.**

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

Page 11A-01

**11B. Accept report on 2024 Legislative Session Wrap-Up.**

- Reference materials: Staff report on above topic; and 2024 Legislation – Final

Pages 11B-01 to 11B-40

**11C. Approve Board meeting schedule and schedule of Board member participation in Committees and Advisory Groups for 2025.**

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

Pages 11C-01 to 11C-04

**11D. Accept the report from September 11, 2024, meeting of the Peer Review and Credentialing Committee.**

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

Page 11D-01

**Regular Agenda Items: (12. – 13.): 3:45 p.m.**

**12. Consider approving: 1) Medical Budget and 2) Administrative Budget for Alliance Calendar Year (CY) 2025. (3:45 – 4:05 p.m.)**

Ms. Lisa Ba, Chief Financial Officer (CFO), will review and Board will consider approving proposed Medical Budget for CY 2025.

Ms. Ba, CFO, will review and Board will consider approving proposed Administrative Budget for CY 2025.

- Reference materials: Staff report and recommendation on above topic; Proposed Medical and Administrative Budget for CY 2025; and Capital Budget and Depreciation Expense for CY 2025.

Pages 12-01 to 12-04

**13. Consider approving the Alliance's legal and regulatory Compliance Program Report for Q1-2 2024 (4:05 – 4:35 p.m.)**

Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider approving the Alliance's Compliance Program Report for Q1-2 2024.

- Reference materials: Staff report and recommendation on above topic; Q1-2 2024 Internal A&M Dashboard; Q1-2 2024 HIPAA Dashboard; and Q1-2 2024 Program Integrity Dashboard.

Pages 13-01 to 13-11

**Adjourn to Closed Session: (4:35 – 4:55 p.m.)**

**14. Conference with legal counsel – anticipated litigation (Gov. Code sections 54956.9(d)(2) and (e)(3)): Government Claims Act claim dated October 30, 2024, from Aggrigator, Inc.**

- A. Closed session agenda item.
- Reference materials: Government Claims Act claim dated October 30, 2024. (Confidential)

**15. Conference with legal counsel – pending litigation (Gov. Code section 54956.9(d)(1)): THC – Orange County, LLC dba Kindred Hospital – San Francisco Bay Area v. Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Centra California Alliance for Health; Santa Cruz County Superior Court case number 23CV00978.**

- A. Closed session agenda item.

**Return to Open Session: (4:55 – 5:00 p.m.)**

**16. Report Board action regarding [Agenda 13] Conference with legal counsel – anticipated litigation (Gov. Code sections 54956.9(d)(2) and (e)(3)): Government Claims Act claim dated October 30, 2024, from Aggrigator, Inc.**

- A. Board will report on action taken in closed session.

**Information Items: (17A. – 17G.)**

- A.** Alliance in the News Pages 17A-01 to 17A-04
- B.** Membership Enrollment Report Page 17B-01
- C.** Letter of Support Page 17C-01
- D.** Member Newsletter (English) – September 2024  
<https://thealliance.health/wp-content/uploads/MSNewsletter-202409-E-highres.pdf> Pages 17D-01 to 17D-12
- E.** Member Newsletter (Spanish) – September 2024  
<https://thealliance.health/wp-content/uploads/MSNewsletter-202409-S-highres.pdf> Pages 17D-01 to 17D-08
- F.** Provider Bulletin – September 2024  
<https://thealliance.health/wp-content/uploads/CCAH-Provider-September2024.pdf> Pages 17F-01 to 17F-12
- G.** Alliance Fact Sheet Pages 17G-01 to 17G-02

**Announcements:**

**Meetings of Advisory Groups and Committees of the Commission**

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

- Finance Committee  
\*Wednesday, March 26, 2025 1:30-2:45 p.m.

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## Member Services Advisory Group

\*Thursday, February 13, 2025; 10:00 – 11:30 a.m.

- Physicians Advisory Group  
Thursday, December 5, 2024; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [*Remote teleconference only*]  
Thursday, December 19, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [*Remote teleconference only*]  
\*Monday, February 3, 2025

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

\*Subject to Board approval

### **The next regular meeting of the Commission, after this December 4, 2024 meeting, unless otherwise noticed:**

- Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
Wednesday, January 22, 2025; 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 16<sup>th</sup> 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) 430-2568 to verify meeting date and location prior to the meeting.

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The complete agenda packet is available for review on the Alliance website at

<https://thealliance.health/about-the-alliance/public-meetings/>. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-2568. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.



**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Michael Schrader, Chief Executive Officer  
**SUBJECT:** CEO Report

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

- November 5<sup>th</sup> Presidential Election. As we convene in the wake of the recent federal elections, it is important to acknowledge the significance of the election results and the potential implications for healthcare policy at both the national and state levels. With the re-election of Donald J. Trump to become the 47<sup>th</sup> President of the United States and the Republican party securing majorities in both the Senate and the House of Representatives, we can anticipate potential changes in direction from the federal level.

While transition plans are underway and key leadership positions remain under consideration, the full scope of shift in leadership and priorities is yet to be known. However, clearly, changes in congressional composition could influence federal healthcare priorities including Medicaid funding, public health investments and the future of the Affordable Care Act.

And, while the direction of the health policy under a new administration is yet to be determined, it is possible that there may be a renewed focus on Medicaid expansion or eligibility and program funding may be revisited or scrutinized.

The Alliance will leverage existing relationships to develop strategies and action plans to address potential impacts. We will remain ready to respond to shifts in federal funding or policy changes while continuing to advocate for the needs of our members and our communities. Regardless of federal changes, the results of the election reinforce the need for robust state and local collaboration to sustain programs like Medi-Cal and meet the needs of our vulnerable populations. As a local plan our ability to provide high quality care does not rest solely on federal policy but also on the strength of our local partnerships and the commitment of this board. The need for comprehensive, accessible, quality, equitable healthcare remains, and the Alliance is positioned to continue our mission through strategic initiatives and efficient use of resources.

- Special Legislative Session. Governor Newsom has called a special legislative session beginning December 2, 2024, to address potential challenges posed by the incoming federal administration. The session will focus on safeguarding California values including civil rights, reproductive freedoms, and environmental protections. This includes resources to defend against potential federal action that could undermine California policies including those affecting Medi-Cal programs.

**HEALTHY PEOPLE. HEALTHY COMMUNITIES.**

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

- Community Collaboration. In November, we kicked off our in-person collaboration effort with Mercy Medical Center's Street Medicine Unit. In addition to the Unit providing direct patient care in the community, our team was able to connect members to Alliance resources and benefits and answer health plan questions. Services were provided at a local park, the Rescue Mission and the D Street Shelter in Merced County. In Santa Cruz County, we were invited by Blue Path Wellness and Omatochi to take part in the Senior Well Fair where staff participated on the CalAIM Q&A panel and provided resources for participants. In Monterey County, we continued to participate in cultural events including Dia De Los Muertos at Hartnell College and engage with youth at the Fall into STEAM Fun Day at Monte Bella Elementary School. To continue developing relationships with expansion counties, we met with the Seniors Council, toured the Community Foundation of San Benito's Epicenter and engaged with new Alliance members at the Mariposa Family Resource Center's Family Fun Day.
- Media. Our final media campaign of the year ran from mid-October through the end of November. The paid campaign ran in Merced and focused on encouraging community members to call their doctor before the end of the year to make their annual appointment. The bi-lingual ad campaign included social media ads, radio advertisements, digital display and physical ads in convenience stores, dollar stores, grocery stores and other areas our members visit. In addition to this campaign, we also secured a fourth ad in DMV locations. These ads will change out quarterly and appear in DMV offices in Watsonville, Merced, Los Banos and Hollister.
- Digital ID and texting. In mid-November, we began promoting the availability of our digital ID card more broadly to members and providers and provided provider offices with messaging points. In September and October, we delivered nearly 900 digital ID cards to members. In September, we launched our broad text messaging campaign for all members (beyond redetermination). In September and October, we sent nearly 400,000 texts to member households on topics including redetermination, adult and infant flu reminders, and Well Child visit reminders.

#### Alliance Six Priority Initiatives.

- Medicare Dual Special Needs Plan (D-SNP). Staff are preparing to launch a D-SNP product by January 1, 2026. This product will allow the Alliance to serve as the single plan for members eligible for both Medi-Cal and Medicare, streamlining their healthcare experience. The Alliance submitted our Notice of Intent to Apply (NOIA) for the Medicare D-SNP product to the Centers for Medicare and Medicaid Services (CMS) in October 2024.

The Alliance team has been working towards a key milestone, which is to have the provider network in place by February 2025. Accomplishment to date includes the



execution of D-SNP amendments with 69 percent of our current Medi-Cal provider network, as shown in the table below. As a supplement, we are pursuing non-binding Letters of Intent (LOIs) with key providers that need more time before signing D-SNP amendments. In addition to the existing Medi-Cal network, an additional fifty (50) providers have been identified as needed for recruitment, and staff have begun to engage with them.

D-SNP Amendment	PCPs	Specialists	Hospitals
Providers	57	342	10
Fully Executed	42	249	4
Declined Amendment	3	10	0

We are proposing that the D-SNP plan name be *TotalCare HMO D-SNP* and are currently in the process of securing trademark designations for the name, as well as creating branding elements.

- National Center for Quality Assurance (NCQA) Accreditation. The NCQA standards represent a commitment to quality, excellence, and health equity. Our efforts continue to obtain two separate accreditations from NCQA: Health Plan Accreditation and Health Equity Accreditation. We needed to complete work by October 2024 since the NCQA survey of the Alliance will take place on April 1, 2025, for which the lookback period is six months. Prior to October 2024, staff modified our policies and procedures to align Alliance operations with NCQA standards. Now, staff are implementing those modified policies and procedures in advance of our NCQA survey. For accreditation, a minimum of 80% of the NCQA standards must be achieved and all must-pass elements must be met. We are closing out this initiative in December 2024 and transitioning to ongoing operations.
- JIVA Care Management System. The Alliance went live with the new Jiva Care Management System in July and completed the remaining integration work through the end of October. The Jiva Care Management System is necessary for meeting operational requirements related to our future Medicare D-SNP program and NCQA accreditations. The system is used for prior authorizations, case management, and appeals and grievances. We are closing out this initiative and transitioning any enhancements and optimization of Jiva usage to ongoing operations.
- Behavioral Health Insourcing. In June 2025, the Alliance formally notified Carelon that we will not renew the contract when it expires on June 30, 2025. Effective July 1, 2025, the Alliance will internally manage the behavioral health benefit, including non-specialty mental health (i.e., mild to moderate mental health) and behavioral health therapy. Bringing behavioral health inhouse will give us direct control and better opportunity to improve access for members, support providers, and collaborate with counties and schools. The Alliance team has been working diligently to build relationships with behavioral health providers and have outreached to those providers with historically high utilization and/or operate in the



Alliance service areas. To date, we have outreached over 360 providers to begin the contracting process. One identified challenge is that many behavioral health providers are not enrolled with Medi-Cal, a DHCS requirement for our Alliance network, and staff have been supporting them with the enrollment process. Other work efforts include redesigning internal workflows and developing future workflows to ensure that the Alliance complies with regulatory requirements related to behavioral health. Staff also completed the initial regulatory filings to DHCS and DMHC.

- Enhanced Care Management and Community Supports. The purpose of this initiative is to connect our most vulnerable members to needed clinical and non-clinical support in the community. Our objectives have been multifactorial: to increase ECM enrollment, to ensure that our capitated ECM providers are delivering services and submitting complete and timely encounter data to the Alliance, and to show DHCS that the rate it pays to the Alliance is supported by the encounter data.

To increase ECM enrollment, the Alliance team has actively conducted outreach and education to enroll new ECM providers and generate referrals of members to ECM providers. The result has been that our ECM enrollment has increased from 2,900 to 14,144 members in a twelve-month period,

To ensure that our capitated ECM providers are delivering services to their assigned members and submitting complete and timely encounter data, the Alliance team has been actively conducting focused outreach. Staff have been educating ECM providers about the need to submit complete encounter data, as required per their Alliance contracts, and helping them overcome operational and technical challenges. The result of these focused efforts is that we've experienced a 160 percent increase in monthly ECM encounter submissions over the past 3 months.

The Alliance team has also been sharing the encounter data with DHCS. We must demonstrate to DHCS that our ECM utilization, as reflected by the encounter data, supports the capitation rate that it pays the Alliance. Without sufficient encounter data, DHCS said it will lower the ECM capitation rate that it pays to the Alliance, from which the Alliance derives the capitation rate for our downstream ECM providers.

- Quality and Health Equity in Merced and Mariposa Counties. We want to close the geographic health disparity across our 5-county service area that disproportionately impacts children in Merced and Mariposa Counties. The Alliance recognizes that not all children and youth experience the same opportunities to reach their full health potential. Therefore, your board approved a strategic plan that mobilized resources in Merced to include grants targeted to increasing access for our members. Evaluation of the impact of our grants targeted at workforce support has shown large gap closures in HEDIS measures for the clinics that participated. \$3.8M was distributed among 15 clinics in Merced so that clinics could pay overtime to their staff and use locum physicians to increase capacity for care gap clinics. As a result of

these efforts, it is projected that 6 of the 8 HEDIS measures are now at or above 50th percentile (MPL). The grants were part of a multifaceted strategy operationalized by a cross functional team that exhibits the Alliance's commitment to addressing health disparities to move toward health equity.

Whole Child Model (WCM) Program Expansion. The Alliance is preparing to implement the WCM program in San Benito and Mariposa counties and has been working in collaboration with the counties and DHCS to ensure a seamless transition of services including case management, utilization management, provider contracting and claims payment for services provided to children eligible for California Children Services (CCS) providers.

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights.

- Regulatory Affairs. The Alliance's Regulatory Affairs team is responsible for analyzing new laws and regulations, identifying impacts they might have on the Alliance's operations, and for managing our organizational efforts to implement these new requirements. Accordingly, California's 2024 Legislative Session produced 21 pieces of legislation the Alliance must implement. Currently, Regulatory Affairs does not foresee any barriers toward timely implementation of 2024 legislation, which will carry into 2025.
- Regulatory Audits. Like all Medi-Cal Managed Care Plans, the Alliance is in a constant state of preparing for routine audits, experiencing them, or following up.

Under preparation:

- 2025 DHCS Medi-Cal Audit. We received official notice of our annual 2025 DHCS Medi-Cal Audit. Scheduled for January 21-31, the DHCS' areas of focus will be utilization management, case management and coordination of care, access and availability, members rights, quality improvement, and administrative and organizational capacity.
- 2025 DMHC Financial Examination. We are currently reviewing and finalizing pre-Audit Deliverables for our 2025 DMHC Financial Examination. It is a routine Examination that occurs every three years.

Under follow up:

- 2023 DHCS Focused Audit of Behavioral Health and Transportation. DHCS issued a final report from its 2023 DHCS Focused Audit of Behavioral Health and Transportation, and the Alliance team is remediating the identified deficiencies.
- 2024 DMHC Medical Survey. We continue to await DMHC's preliminary report from its 2024 Medical Survey of the Alliance that took place in March 2024.

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

- All Staff and Town Hall meetings. The most recent Town Hall was held on November 12, 2024, via Zoom. We have quarterly All Staff meetings, two in-person and two via Zoom. The next All Staff meeting will be in-person at the Cocoanut Grove on the Santa Cruz Beach Boardwalk on December 12, 2024.
- Staffing Numbers. As of November 4, 2024, the Alliance has 647.7 budgeted positions, of which 595.5 are filled. Moreover, the Alliance has 42 temporary employees supporting our workforce needs. In total, the organization is 93.3% staffed. Talent Acquisition is currently managing 83 regular and temporary recruitments.
- Year End Performance Evaluations. Supervisors will begin the year-end performance evaluations by attending Training and Info Sessions in December. 2024 Evaluations are due to Human Resources in January.
- Engagement Survey Results and Trends: Annually in May, the Alliance conducts our Annual Employee Engagement Survey designed to gather insights into overall job satisfaction, engagement levels and areas of improvement. The survey was conducted among all regular employees, with a 79% participation rate. Compared to our 2023 score, we saw a slight decrease in overall engagement at 80% favorable over 82% favorable in 2023, yet still a strong, overall score. HR held Info Sessions with staff in June, sharing the outcomes of the survey. Directors were asked to share department specific outcomes with their teams and select areas of focus for improvement efforts over the course of the next year.

The Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to health care and community organizations to realize the Alliance's vision of healthy people, healthy communities. These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members, as well as to address social drivers that influence health and wellness.

- MCGP Annual Investment Plan. The Board will consider and take action at the January 22, 2025, Board meeting on staff recommendations for the MCGP 2025 Investment Plan. The Board reviewed and provided input on staff's November 6, 2024, report on stakeholder inputs and emerging priorities for funding strategies.
- Trends in the Number of MCGP Awards and Total Spend. Both MCGP grant awards and annual spending have increased in 2024. MCGP has paid out \$21.4M year to date 2024 compared to \$13M for all of 2023. New MCGP awards year to date 2024 total \$41M. Additionally, there is one more round of Workforce Recruitment grant applications in 2024, with 46 applications currently under review for the December 13, 2024, awards. Details of all awards in 2024 will be included in the end of year report in the January 2025 Board packet.

Cybersecurity. The Alliance uses a collection of technologies, practices, and policies to safeguard our members' protected health information (PHI). Two measures that took place in the third quarter of 2024 are described below.

- Email Security Trends. Email Gateway Effectiveness: The email gateway continues to block malicious emails effectively, with a noticeable decrease in rejections due to fewer IP addresses being listed in the Real-Time Blackhole List (RBL).

Inbound Email Volume: There was a substantial increase in inbound email traffic, reaching nearly 2.42 million emails in Q3 2024.

Email Rejection Statistics: The rejection rate decreased from 6.94% at the beginning of the quarter to 4.77% by the end of September, indicating improved email quality.

- Phishing Campaign Effectiveness. Phishing Susceptibility: The internal phishing campaign shows a slight increase in employee susceptibility to phishing, rising from 0.93% in July to 1.09% by September, suggesting the potential for a need to renew focus on awareness and training.

Phishing Reporting and Engagement: Reporting rates declined slightly, from 44.24% in July to 42.97% in September, indicating potential hesitation in reporting phishing attempts. Read rates fluctuated, peaking at 91.15% in September, reflecting changes in employee behavior and engagement.

**DATE:** December 4, 2024

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

**FROM:** Lisa Ba, Chief Financial Officer

**SUBJECT:** Financial Highlights for the Ninth Month Ending September 30, 2024

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For the month ending September 30, 2024, the Alliance reported an Operating Loss of \$15.9M. The Year-to-Date (YTD) Operating Income is \$33.8M, with a Medical Loss Ratio (MLR) of 92.5% and an Administrative Loss Ratio (ALR) of 5.2%. The Net Income is \$70.2M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Income of \$40.5M for the YTD September. However, actual performance fell short of the budget by \$6.7M or 16.5%. This unfavorable variance was primarily driven by increased utilization due to higher enrollment and elevated unit costs. Key service categories contributing to the variance include Inpatient LTC, Emergency Room (ER), and ECM/CS services. It's important to note that the significant ramp-up of Enhanced Care Management (ECM) and Community Supports (CS) services led to higher-than-expected expenses. While the risk corridor will mitigate ECM expenses, CS revenue is trailing significantly, nearly nine times below the current experience. The DHCS has been informed of the financial sustainability concerns related to the CS expansion.

<b>Sep-24 MTD (\$ In 000s)</b>				
<u>Key Indicators</u>	Current Actual	Current Budget	Current Variance	% Variance to Budget
<i>Membership</i>	445,356	398,242	47,114	11.8%
Revenue	\$149,708	\$134,608	\$15,100	11.2%
Medical Expenses	156,858	124,946	(31,912)	-25.5%
Administrative Expenses	8,726	8,764	39	0.4%
<b>Operating Income</b>	<b>(15,876)</b>	<b>898</b>	<b>(16,774)</b>	<b>-100.0%</b>
Net Income	(\$10,581)	\$2,097	(\$12,677)	-100.0%
<i>MLR %</i>	104.8%	92.8%	-12.0%	
<i>ALR %</i>	5.8%	6.5%	0.7%	
<i>Operating Income %</i>	-10.6%	0.7%	-11.3%	
<i>Net Income %</i>	-7.1%	1.6%	-8.6%	

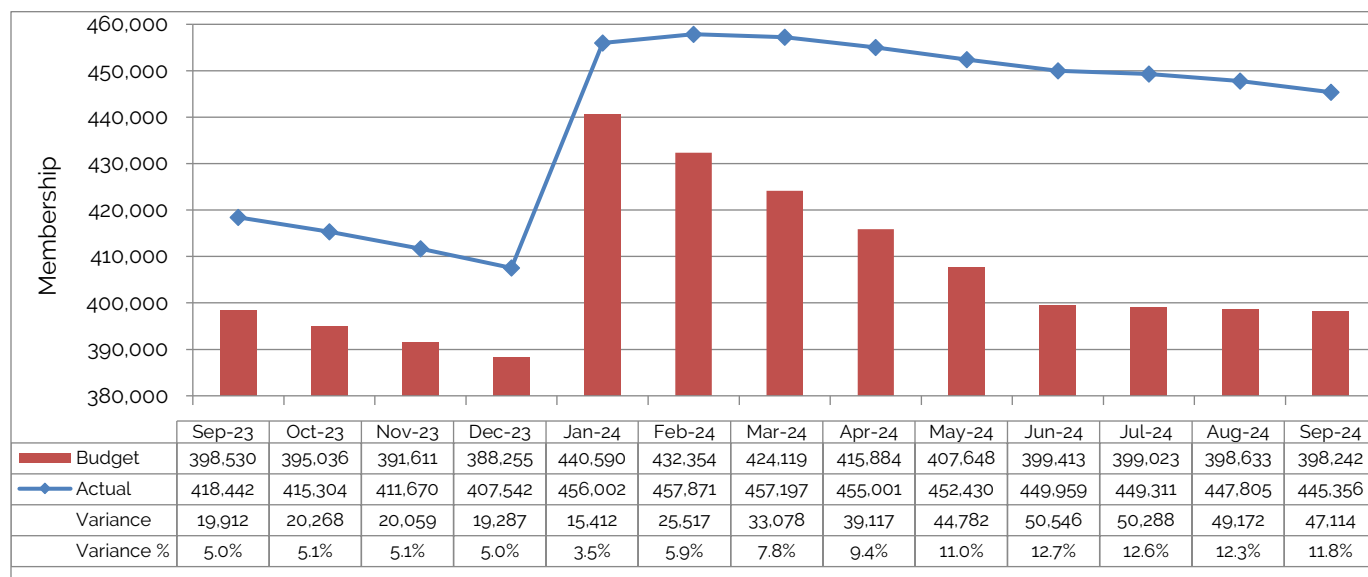
<b>Sep-24 (In \$000s)</b>				
<u>Key Indicators</u>	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
<i>Member Months</i>	4,070,932	3,715,905	355,027	9.6%
Revenue	\$1,454,504	\$1,257,297	\$197,207	15.7%
Medical Expenses	1,345,083	1,138,326	(206,757)	-18.2%
Administrative Expenses	75,627	78,514	2,888	3.7%
<b>Operating Income</b>	<b>33,794</b>	<b>40,457</b>	<b>(6,662)</b>	<b>-16.5%</b>
Net Income/(Loss)	\$70,173	\$52,918	\$17,255	32.6%
<b>PMPM</b>				
Revenue	\$357.29	\$338.36	\$18.93	5.6%
Medical Expenses	330.41	306.34	(24.07)	-7.9%
Administrative Expenses	18.58	21.13	2.55	12.1%
Operating Income/(Loss)	\$8.30	\$10.89	(\$2.59)	-23.8%
<i>MLR %</i>	92.5%	90.5%	-1.9%	
<i>ALR %</i>	5.2%	6.2%	1.0%	
<i>Operating Income %</i>	2.3%	3.2%	-0.9%	
<i>Net Income %</i>	4.8%	4.2%	0.6%	

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 \$357.29, which is favorable to budget by \$18.93 or 5.6%. Medical cost PMPM is \$330.41, which is unfavorable by \$24.07 or 7.9%. This results in an unfavorable gross margin of \$5.14 or 16.0% compared to the budget. The operating income PMPM is \$8.30, unfavorable to the budget by \$2.59 or 23.8%.

Membership: September 2024 membership is favorable to budget by 11.8%. 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 decrease from July 2023 to June 2024 is approximately 7.6% during the unwinding period, excluding the new counties / new Unsatisfactory Immigration Status (UIS) members. Redetermination losses continued in September, and the total loss between July 2023 and September 2024 was 8.9%.

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



**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. The final rate package was received for CY 2024 (dated 9/24/2024), which now represents a 1.6% increase over CY 2023 Rates excluding TRI. Overall, actual revenue is favorable due to higher enrollment, a favorable category of aid (COA) mix, and an increase in final rates.

Before diving into the September financial details, it's important to recall the August Board Finance Report. The August entry included the initial adjustment for the UIS risk corridor payable, which will be trued up monthly for the remainder of the year. This adjustment reflected an \$18M reduction in revenue to align with the risk corridor threshold, which was reconciled through August. In addition, an additional \$8.4M adjustment was made, bringing the total YTD net adjustment to 26.4M through September.

As of September MTD, actuals are favorable to budget by \$15.1M or 11.2%. This positive variance is primarily driven by favorable enrollment, which contributed \$17.3M, offsetting rate variances of \$2.2M. The rate variance includes an \$8.4M reduction for the UIS Adult and Adult Expansion Risk Corridor and a \$10.0M gain from the ECM Risk Corridor. Additionally, the final CY2024 rates were applied to reconcile the revenue previously accrued using the estimated prospective rates, resulting in a \$5.4M reduction in revenue. As of September 2024, the YTD operating revenue is \$1,454.5M, surpassing the budget by \$197.2M or 15.7%. This favorable variance includes \$124.5M from increased enrollment and \$72.7M from favorable rate variances, state incentives, and prior-year revenue. The rate variance of \$72.7M comprises \$27.6M from favorable final rates, \$24.4M from State Incentive Programs, and \$20.4M from prior year revenue due to MCO tax liability relief for CY 2021 and CY 2022.



The State Incentive Programs consist of \$22.1M for HHIP, \$1.4M for SBHIP, and \$0.8M for EPT, 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).

<b>Sep-24 YTD Capitation Revenue Summary (In \$000s)</b>					
Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	1,046,516	945,626	100,890	80,219	20,671
CEC UIS	295,571	263,051	32,520	36,355	(3,835)
SBN SIS	53,773	37,617	16,156	5,922	10,234
SBN UIS	9,810	7,906	1,904	1,362	542
<b>Total*</b>	<b>1,405,670</b>	<b>1,254,200</b>	<b>151,470</b>	<b>123,858</b>	<b>27,612</b>

\*Excludes Sep-24 In-Home Supportive Services (IHSS) premiums revenue of \$4.0M, State Incentive Programs revenue of \$24.4M, and Prior Year Revenue of \$20.4M.

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

September 2024 Medical Expenses of \$156.9M are \$31.9M or 25.5% unfavorable to budget. September 2024 YTD Medical Expenses of \$1,345.1M are above budget by \$206.8M or 18.2%. Of this amount, \$108.4M is due to higher enrollment and \$98.4M due to rate variances, including \$24.4M for State Incentive Programs. The YTD September unfavorability is primarily driven by LTC, ER, ECM, and Community Supports.

The State Incentive Programs consist of \$22.1M for HHIP, \$1.4M for SBHIP, and \$0.8M for EPT. These are also included under revenue and assumed to be budget-neutral.

Sep-24 YTD Medical Expense Summary (\$ In 000s)					
Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient - Hospital	417,122	416,499	(623)	(39,793)	39,170
Inpatient - LTC	156,091	97,738	(58,353)	(9,338)	(49,015)
Physician Services	261,253	242,128	(19,125)	(23,133)	4,008
ECM/CS	72,364	13,402	(58,962)	(1,280)	(57,682)
Outpatient Facility	191,330	141,314	(50,016)	(13,502)	(36,514)
Other Medical*	222,531	227,245	4,714	(21,711)	26,425
State Incentive Programs	24,392	-	(24,392)	-	(24,392)
<b>TOTAL COST</b>	<b>1,345,083</b>	<b>1,138,326</b>	<b>(206,757)</b>	<b>(108,758)</b>	<b>(97,999)</b>

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

At a PMPM level, YTD Medical Expenses are \$330.41, which is unfavorable by \$24.07 or 7.9% compared to the budget.

Inpatient Services: Inpatient Services continues to be favorable to budget due to lower utilization than budgeted. Inpatient was budgeted to have a utilization of 344 days per 1,000 members but actual utilization is closer to 307 days per 1,000 members. Unit costs are comparable between budget and actuals, resulting in a 10.4% PMPM variance between budget and actual. This is expected to continue for the rest of the year.

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

Outpatient Facility: The Outpatient Facility consists of both Outpatient and Emergency Rooms. ER continues to trend upwards for utilization per 1k, and unit cost significantly and is unfavorable to budget for both utilization and unit cost by 15% and 15%, respectively, partially offset by favorable other Outpatient to budget both in utilization and unit cost.

Physician Services: Utilization has risen by 14% compared to the previous year across SIS and UIS populations, driven by increased utilization at Federally Qualified Health Center (FQHC) clinics and Primary Care Physicians (PCP) and overall growth at ACA expansion and whole Child model enrollments, which utilize Specialty Clinics. The budget underestimated FFS unit cost in PCP and FQHC, and we expect this unfavorable variance to continue.

ECM/CS: ECM enrollments have grown nearly five-fold since the beginning of the year as of September YTD and continue to grow at 11% month-over-month. As ECM is a newer program, the risk corridor will help offset the higher expenses from this growth. Another factor contributing to the unfavorable variance is the upward trend in Community Supports

(CS) expenses, driven by the ramp-up of CS benefits, while revenue streams are lagging significantly, with a nearly nine-fold shortfall through September. We have communicated these ongoing increases to DHCS for consideration in rate adjustments.

Other Medical: Other medical costs are favorable to budget by \$4.7M, primarily driven by non-claims health care costs being \$6.9M lower than budgeted. However, this favorable variance is partially offset by an unfavorable \$2.2M variance in Other Medical costs, driven by increased expenses in Allied Health, Behavioral Health, Transportation, and Durable Medical Equipment.

<b>Sep-24 YTD Medical Expense by Category of Service (In PMPM)</b>				
Category	Actual	Budget	Variance	Variance %
Inpatient - Hospital	\$102.46	\$112.09	\$9.62	8.6%
Inpatient - LTC	38.34	26.30	(12.04)	-45.8%
Physician Services	64.18	65.16	0.98	1.5%
ECM/CS	17.78	3.61	(14.17)	-100.0%
Outpatient Facility	47.00	38.03	(8.97)	-23.6%
Other Medical	54.66	61.15	6.49	10.6%
State Incentive Programs	5.99	-	(5.99)	-100.0%
<b>TOTAL MEDICAL COST</b>	<b>\$330.41</b>	<b>\$306.34</b>	<b>\$(24.07)</b>	<b>-7.9%</b>

Administrative Expenses: September YTD Administrative Expenses are favorable to budget by \$2.9M or 3.7% with a 5.2% ALR. Salaries are favorable by \$2.0M, driven by savings from vacant positions, employment taxes, benefits, and PTO. Non-Salary Administrative Expenses are favorable by \$0.9M or 3.6% due to savings and unspent budgets.

Non-Operating Revenue/Expenses: September YTD Net Non-Operating Income is \$36.4M, which is favorable to budget by \$23.9M. The favorability is from the YTD Investment Income of \$50.1M, which is favorable to budget by \$26.3M due to the higher interest rates. The YTD Other Revenue is \$1.7M and is on target to budget. The YTD Non-Operating Expense is \$15.5M and is unfavorable to budget by \$2.3M due to higher Grant disbursements.

Summary of Results: Overall, the Alliance generated a YTD Net Income of \$70.2M, with an MLR of 92.5% and an ALR of 5.2%.



**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**  
**Balance Sheet**  
**For The Ninth Month Ending September 30, 2024**  
**(In \$000s)**

<b>Assets</b>	
Cash	\$326,122
Restricted Cash	300
Short Term Investments	1,040,982
Receivables	178,544
Prepaid Expenses	4,535
Other Current Assets	4,262
<b>Total Current Assets</b>	<b>\$1,554,743</b>
Building, Land, Furniture & Equipment	
Capital Assets	\$82,651
Accumulated Depreciation	(46,649)
CIP	285
Lease Receivable	3,084
Subscription Asset net Accum Depr	10,510
<b>Total Non-Current Assets</b>	<b>49,881</b>
<b>Total Assets</b>	<b>\$1,604,625</b>
<b>Liabilities</b>	
Accounts Payable	\$167,356
IBNR/Claims Payable	456,781
Provider Incentives Payable	33,143
Other Current Liabilities	8,670
Due to State	22,110
<b>Total Current Liabilities</b>	<b>\$688,059</b>
Subscription Liabilities	8,687
Deferred Inflow of Resources	2,933
<b>Total Long-Term Liabilities</b>	<b>\$11,620</b>
<b>Fund Balance</b>	
Fund Balance - Prior	\$834,772
Retained Earnings - CY	70,173
<b>Total Fund Balance</b>	<b>904,945</b>
<b>Total Liabilities &amp; Fund Balance</b>	<b>\$1,604,625</b>
<b>Additional Information</b>	
<b>Total Fund Balance</b>	<b>\$904,945</b>
Board Designated Reserves Target	456,951
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	150,989
Value Based Payments	46,100
Provider Supplemental Payments	152,410
<b>Total Reserves</b>	<b>863,149</b>
<b>Total Operating Reserve</b>	<b>\$41,796</b>



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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
<b>Member Months</b>	445,356	398,242	47,114	11.8%	4,070,932	3,715,905	355,027	9.6%
<b>Capitation Revenue</b>								
Capitation Revenue Medi-Cal	\$149,185	\$134,264	\$14,921	11.1%	\$1,405,670	\$1,254,200	\$151,470	12.1%
State Incentive Programs	-	-	-	0.0%	24,392	-	\$24,392	100.0%
Prior Year Revenue*	27	-	27	100.0%	20,405	-	\$20,405	100.0%
Premiums Commercial	496	344	151	44.0%	4,037	3,097	940	30.4%
<b>Total Operating Revenue</b>	<b>\$149,708</b>	<b>\$134,608</b>	<b>\$15,100</b>	<b>11.2%</b>	<b>\$1,454,504</b>	<b>\$1,257,297</b>	<b>\$197,207</b>	<b>15.7%</b>
<b>Medical Expenses</b>								
Inpatient Services (Hospital)	\$45,902	\$45,634	(\$268)	-0.6%	\$417,122	\$416,499	(\$623)	-0.1%
Inpatient Services (LTC)	17,443	10,708	(6,735)	-62.9%	156,091	97,738	(58,353)	-59.7%
Physician Services	39,227	26,530	(12,697)	-47.9%	312,816	242,128	(70,688)	-29.2%
Outpatient Facility	25,451	15,483	(9,968)	-64.4%	191,330	141,314	(50,016)	-35.4%
Other Medical**	28,835	26,591	(2,244)	-8.4%	243,332	240,647	(2,685)	-1.1%
State Incentive Programs	-	-	-	0.0%	24,392	-	(24,392)	-100.0%
<b>Total Medical Expenses</b>	<b>\$156,858</b>	<b>\$124,946</b>	<b>(\$31,912)</b>	<b>-25.5%</b>	<b>\$1,345,083</b>	<b>\$1,138,326</b>	<b>(\$206,757)</b>	<b>-18.2%</b>
<b>Gross Margin</b>	<b>(\$7,150)</b>	<b>\$9,662</b>	<b>(\$16,812)</b>	<b>-100.0%</b>	<b>\$109,421</b>	<b>\$118,971</b>	<b>(\$9,550)</b>	<b>-8.0%</b>
<b>Administrative Expenses</b>								
Salaries	\$5,869	\$5,829	(\$40)	-0.7%	\$51,763	\$53,761	\$1,998	3.7%
Professional Fees	224	406	182	44.8%	2,667	2,835	168	5.9%
Purchased Services	1,216	916	(301)	-32.8%	9,430	9,024	(407)	-4.5%
Supplies & Other	1,041	1,133	92	8.1%	8,381	8,960	579	6.5%
Occupancy	99	137	38	27.5%	986	1,136	150	13.2%
Depreciation/Amortization	276	343	68	19.7%	2,400	2,798	399	14.2%
<b>Total Administrative Expenses</b>	<b>\$8,726</b>	<b>\$8,764</b>	<b>\$39</b>	<b>0.4%</b>	<b>\$75,627</b>	<b>\$78,514</b>	<b>\$2,888</b>	<b>3.7%</b>
<b>Operating Income</b>	<b>(\$15,876)</b>	<b>\$898</b>	<b>(\$16,774)</b>	<b>-100.0%</b>	<b>\$33,794</b>	<b>\$40,457</b>	<b>(\$6,662)</b>	<b>-16.5%</b>
<b>Non-Op Income/(Expense)</b>								
Interest	\$4,967	\$2,100	\$2,866	100.0%	\$38,883	\$22,380	\$16,504	73.7%
Gain/(Loss) on Investments	4,417	400	4,017	100.0%	11,725	1,800	9,925	100.0%
Bank & Investment Fees	(47)	(36)	(11)	-29.6%	(468)	(327)	(141)	-43.1%
Other Revenues	217	198	19	9.4%	1,691	1,774	(83)	-4.7%
Grants	(4,258)	(1,463)	(2,795)	-100.0%	(15,453)	(13,166)	(2,287)	-17.4%
<b>Total Non-Op Income/(Expense)</b>	<b>5,295</b>	<b>1,199</b>	<b>4,096</b>	<b>100.0%</b>	<b>\$36,378</b>	<b>\$12,461</b>	<b>\$23,917</b>	<b>100.0%</b>
<b>Net Income/(Loss)</b>	<b>(\$10,581)</b>	<b>\$2,097</b>	<b>(\$12,677)</b>	<b>-100.0%</b>	<b>\$70,173</b>	<b>\$52,918</b>	<b>\$17,255</b>	<b>32.6%</b>
<b>MLR</b>	<b>104.8%</b>	<b>92.8%</b>			<b>92.5%</b>	<b>90.5%</b>		
<b>ALR</b>	<b>5.8%</b>	<b>6.5%</b>			<b>5.2%</b>	<b>6.2%</b>		
<b>Operating Income</b>	<b>-10.6%</b>	<b>0.7%</b>			<b>2.3%</b>	<b>3.2%</b>		
<b>Net Income %</b>	<b>-7.1%</b>	<b>1.6%</b>			<b>4.8%</b>	<b>4.2%</b>		

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

\*\*Other Medical includes Pharmacy and IHSS.



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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
<b>Member Months</b>	445,356	398,242	47,114	11.8%	4,070,932	3,715,905	355,027	9.6%
<b>Capitation Revenue</b>								
Capitation Revenue Medi-Cal	\$334.98	\$337.14	(\$2.16)	-0.6%	\$345.29	\$337.52	\$7.77	2.3%
State Incentive Programs	-	-	-	0.0%	5.99	-	5.99	100.0%
Prior Year Revenue*	0.06	-	0.06	100.0%	5.01	-	5.01	100.0%
Premiums Commercial	1.11	0.86	0.25	28.8%	0.99	0.83	0.16	19.0%
<b>Total Operating Revenue</b>	<b>\$336.15</b>	<b>\$338.01</b>	<b>(\$1.85)</b>	<b>-0.5%</b>	<b>\$357.29</b>	<b>\$338.36</b>	<b>\$18.93</b>	<b>5.6%</b>
<b>Medical Expenses</b>								
Inpatient Services (Hospital)	\$103.07	\$114.59	\$11.52	10.1%	\$102.46	\$112.09	\$9.62	8.6%
Inpatient Services (LTC)	39.17	26.89	(12.28)	-45.7%	38.34	26.30	(12.04)	-45.8%
Physician Services	88.08	66.62	(21.46)	-32.2%	76.84	65.16	(11.68)	-17.9%
Outpatient Facility	57.15	38.88	(18.27)	-47.0%	47.00	38.03	(8.97)	-23.6%
Other Medical**	64.75	66.77	2.02	3.0%	59.77	64.76	4.99	7.7%
State Incentive Programs	-	-	-	0.0%	5.99	-	(5.99)	-100.0%
<b>Total Medical Expenses</b>	<b>\$352.21</b>	<b>\$313.74</b>	<b>(\$38.46)</b>	<b>-12.3%</b>	<b>\$330.41</b>	<b>\$306.34</b>	<b>(\$24.07)</b>	<b>-7.9%</b>
<b>Gross Margin</b>	<b>(\$16.06)</b>	<b>\$24.26</b>	<b>(\$40.32)</b>	<b>-100.0%</b>	<b>\$26.88</b>	<b>\$32.02</b>	<b>(\$5.14)</b>	<b>-16.0%</b>
<b>Administrative Expenses</b>								
Salaries	\$13.18	\$14.64	\$1.46	10.0%	\$12.72	\$14.47	\$1.75	12.1%
Professional Fees	0.50	1.02	0.52	50.7%	0.66	0.76	0.11	14.1%
Purchased Services	2.73	2.30	(0.43)	-18.8%	2.32	2.43	0.11	4.6%
Supplies & Other	2.34	2.84	0.51	17.8%	2.06	2.41	0.35	14.6%
Occupancy	0.22	0.34	0.12	35.1%	0.24	0.31	0.06	20.8%
Depreciation/Amortization	0.62	0.86	0.24	28.2%	0.59	0.75	0.16	21.7%
<b>Total Administrative Expenses</b>	<b>\$19.59</b>	<b>\$22.01</b>	<b>\$2.42</b>	<b>11.0%</b>	<b>\$18.58</b>	<b>\$21.13</b>	<b>\$2.55</b>	<b>12.1%</b>
<b>Operating Income</b>	<b>(\$35.65)</b>	<b>\$2.25</b>	<b>(\$37.90)</b>	<b>-100.0%</b>	<b>\$8.30</b>	<b>\$10.89</b>	<b>(\$2.59)</b>	<b>-23.8%</b>

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

\*\*Other Medical includes Pharmacy and IHSS.



**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**  
**Statement of Cash Flow**  
**For The Ninth Month Ending September 30, 2024**  
**(In \$000s)**

	<u>MTD</u>	<u>YTD</u>
Net Income	(\$10,581)	\$70,173
Items not requiring the use of cash: Depreciation	296	2,441
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	16,470	313,044
Prepaid Expenses	1,397	(2,307)
Current Assets	(204)	1,344
Subscription Asset net Accum Depr	0	0
<b>Net Changes to Assets</b>	<b>17,663</b>	<b>312,082</b>
Changes to Payables:		
Accounts Payable	48,031	(238,519)
Other Current Liabilities	644	(521)
Incurred But Not Reported Claims/Claims Payable	81,564	168,407
Provider Incentives Payable	2,507	(6,857)
Due to State	(6,603)	11,408
Subscription Liabilities	0	0
<b>Net Changes to Payables</b>	<b>126,142</b>	<b>(66,082)</b>
<b>Net Cash Provided by (Used in) Operating Activities</b>	<b>133,521</b>	<b>318,614</b>
Change in Investments	(7,932)	(195,150)
Other Equipment Acquisitions	(123)	(2,425)
<b>Net Cash Provided by (Used in) Investing Activities</b>	<b>(8,056)</b>	<b>(197,575)</b>
Deferred Inflow of Resources	0	0
<b>Net Cash Provided by (Used in) Financing Activities</b>	<b>0</b>	<b>0</b>
<b>Net Increase (Decrease) in Cash &amp; Cash Equivalents</b>	<b>125,465</b>	<b>121,039</b>
<b>Cash &amp; Cash Equivalents at Beginning of Period</b>	<b>200,657</b>	<b>205,083</b>
<b>Cash &amp; Cash Equivalents at September 30, 2024</b>	<b>\$326,122</b>	<b>\$326,122</b>





**DATE:** December 4, 2024  
**TO:** Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission  
**FROM:** Kay Lor, Payment Strategy Director  
**SUBJECT:** 2025 Supplemental Payment Methodology Revisions

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Recommendation. Staff recommend the Board approve technical changes to the 2025 Supplemental Payment Methodology previously approved by the Board to allow efficiencies in operations while complying with the overall direction and intent of the program as approved by the Board.

Summary. The Alliance will execute revisions to the 2025 Supplemental Payment Methodology approved in August 2024 using the supplemental payment to increase realized network access and advance health equity.

Background. As a result of regular agenda item 12 at the August 28, 2024 Board Meeting, the Board approved the 2025 Supplemental Payment Methodology for our contracted providers to address realized network access and advance health equity. At a high level, to improve realized network access, the 2025 Supplemental Payment Methodology approved adjusting upwards the payment for certain providers from a percentage of the Medi-Cal fee schedule that they are currently receiving, to 90 percent of the Medicare fee schedule.

Discussion. Following the August 2024 Board meeting, Alliance staff began the process of configuring the Alliance's claims payment systems to comport with the 2025 Supplemental Payment Methodology, including moving non-specialists, such as stand-alone dialysis centers, community-based adult services centers, home health, non-emergency transportation, durable medical equipment, and various allied health providers (physical therapy, speech therapy, acupuncture, chiropractic, and audiology) from a percentage of the Medi-Cal fee schedule that they are currently receiving, to 90 percent of the Medicare fee schedule.

During implementation, the systems configuration process uncovered technical limitations to the Alliance's systems and incompatibility of the Medicare fee schedule to certain Medi-Cal-specific services. The result of these issues is that for certain eligible provider types, moving them to 90 percent of the Medicare fee schedule is impractical or impossible. To overcome these issues, while preserving the goal of improving realized network access and advancing health equity, staff recommend the Board approve revisions to the 2025 Supplemental Payment Methodology.

The 2025 Revised Supplemental Payment Methodology provides that where it is impractical or impossible to implement the 2025 Supplemental Payment Methodology as approved in August, Alliance staff may use their discretion to substitute a payment methodology that, in the best judgment of staff, approximates what was approved by the Board in August 2024.

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To use the example discussed above, where, for certain non-specialists, it is impractical or impossible to pay them 90 percent of the Medicare fee schedule, Alliance staff may elect to increase their current payment rates by 10 percent in lieu of paying them 90 percent of the Medicare fee schedule. The remainder of the 2025 Supplemental Payment Methodology is unchanged.

Fiscal Impact. There is no anticipated fiscal impact to using the 2025 Revised Supplemental Payment methodology in lieu of the 2025 Supplemental Payment methodology.

Attachments. N/A.

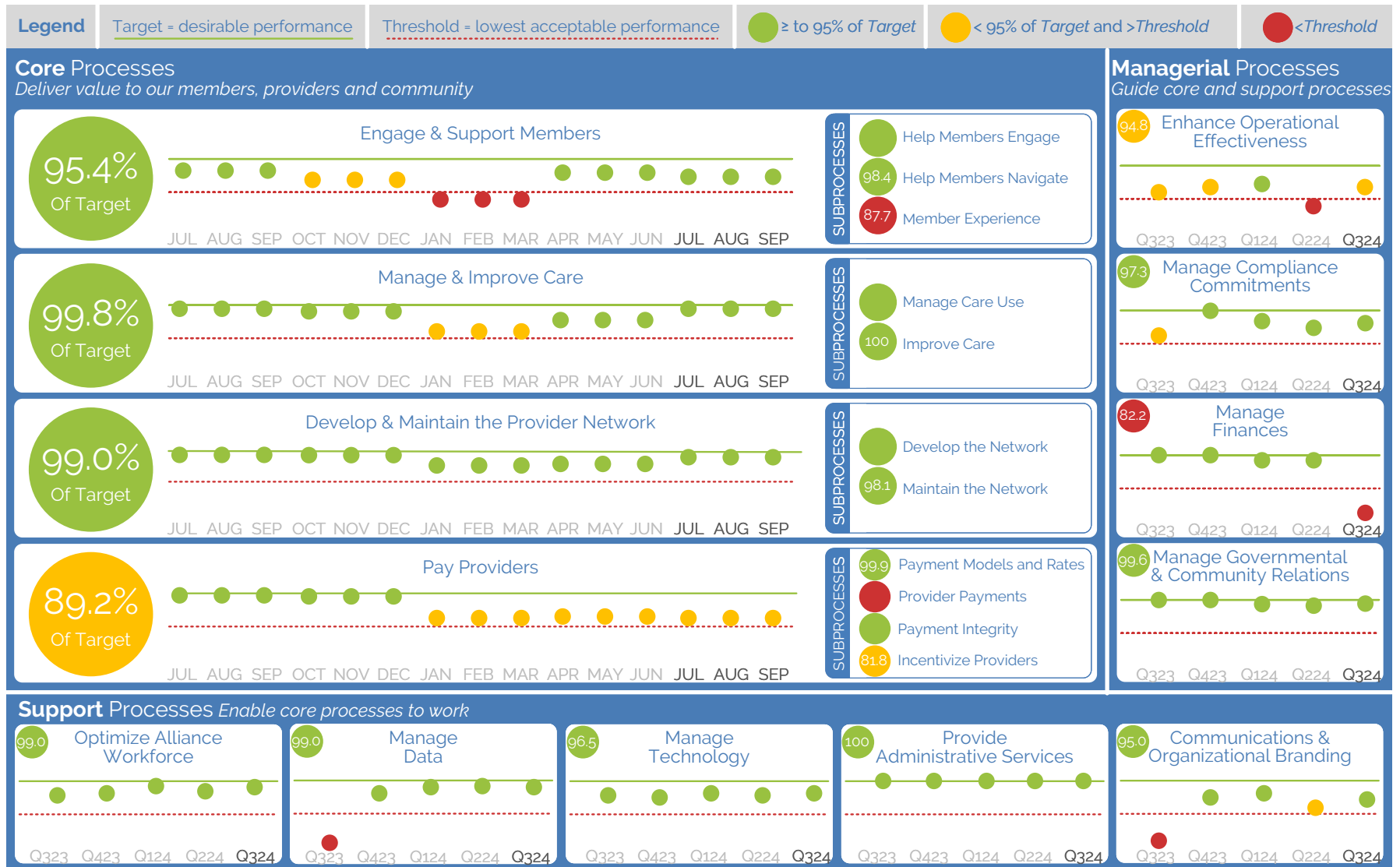
# Alliance Dashboard

## Quarter 3, 2024



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

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





**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Ronita Margain, Community Engagement Director  
**SUBJECT:** Member Services Advisory Group: Member Appointment

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

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

Discussion. The following individuals have indicated interest in participating on MSAG.

Name	Affiliation	County
Carolina Meraz	Consumer	Merced
Alma Mandujano-Orta	Community Advocate	Monterey
Mimi Park	Consumer	Monterey

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

Attachments. N/A



**DATE:** December 4, 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
Michelle Perez, MD	Provider Representative	Mariposa

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

Attachments. N/A

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**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Ronita Margain, Community Engagement Director  
**SUBJECT:** Whole Child Model Family Advisory Committee: Member Appointment

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

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

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

Name	Affiliation	County
Janell White	Parent/Guardian of Consumer	San Benito

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

Attachments. N/A

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



## **Meeting Minutes**

**Wednesday, November 6, 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 16<sup>th</sup> 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. Anita Aguirre,  
Dr. Ralph Armstrong,  
Supervisor Wendy Root Askew,  
Ms. Tracey Belton,  
Ms. Dorothy Bizzini,  
Dr. Maximiliano Cuevas,  
Ms. Janna Espinoza,  
Supervisor Zach Friend,  
Dr. Donald Hernandez,  
Ms. Elsa Jimenez,  
Dr. Kristina Keheley,  
Mr. Michael Molesky,  
Supervisor Josh Pedrozo,  
Dr. James Rabago,

At Large Health Care Provider Representative  
At Large Health Care Provider Representative  
County Board of Supervisors  
County Health and Human Services Agency Director  
Public Representative  
Health Care Provider Representative  
Public Representative  
County Board of Supervisors  
Health Care Provider Representative  
County Director of Health Services  
Interim Health and Human Services Agency Director  
Public Representative  
County Board of Supervisors  
Health Care Provider Representative

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Dr. Allen Radner,

At Large Health Care Provider Representative

**Commissioners Absent:**

Ms. Leslie Abasta-Cummings,  
Ms. Mónica Morales,

At Large Health Care Provider Representative  
County Health Services Agency Director

**Staff Present:**

Mr. Michael Schrader,  
Mr. Scott Fortner,  
Dr. Omar Guzman,  
Dr. Dennis Hsieh,  
Ms. Jenifer Mandella,  
Mr. Cecil Newton,  
Ms. Van Wong,  
Ms. Danita Carlson,  
Ms. Anne Brereton,  
Ms. Dulcie San Paolo,  
Ms. Hayley Tut,

Chief Executive Officer  
Chief Administrative Officer  
Chief Health Equity Officer  
Chief Medical Officer  
Chief Compliance Officer  
Chief Information Officer  
Chief Operating Officer  
Government Relations Director  
Deputy County Counsel, Monterey County  
Administrative Specialist  
Administrative Specialist

**1. Call to Order by Chair Jimenez.**

Commission Chairperson Jimenez called the meeting to order at 3:00 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

**2. Oral Communications.**

Chair Jimenez opened the floor for any members of the public to address the Commission on items not listed on the agenda. The following person spoke:

1. Mr. Doug Peterson of Aggrigator, Inc. provided comment from Monterey County. He spoke on how Aggrigator's services reach over 4,000 CCAH members and reduce medical costs by approximately \$2,000 per person. He shared that he hopes these figures highlight the importance of the partnership between CCAH and Aggrigator and its positive impact on members.

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

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

Chair Jimenez opened the floor for Commissioners to make comments.

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

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

Mr. Schrader spoke on the new format to the CEO report that aims to improve readability. He highlighted a recent health fair that was hosted at the CCAH Merced office, which had an estimated attendance of 1,000 people. It included immunizations, mobile medicine, food

distribution, and community partner booths. He additionally highlighted CCAH's Merced quality scores. Since the 4<sup>th</sup> quarter of 2023, the Alliance started a pilot program with local clinics, and this year the program expanded to all Merced clinics, with the goal of improving access to pediatric and women's care in the area. He noted the messaging campaigns the Alliance sponsored to encourage immunizations in the area. He added that since this pilot program was introduced, 5 of 8 of the quality cores have improved to exceed the 50<sup>th</sup> percentile with another 2 measures that have also improved significantly, but not at the 50<sup>th</sup> percentile yet. Michael thanked the Merced clinics and CCAH partners for this improvement.

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

**Consent Agenda Items: (5. – 9B.): 3:09 p.m.**

Chair Jimenez opened the floor for approval of Consent Agenda items 5 through 9B.

**MOTION:** Commissioner Rabago moved to approve Consent Agenda items 5 through 9B, seconded by Commissioner Friend.

**ACTION:** The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Askew, Belton, Bizzini, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Keheley, Molesky, Pedrozo, Rabago and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Morales

Abstain: None.

**Regular Agenda Items: (10. – 12.): 3:11 p.m.**

**10. Election of Officers of the Commission (3:11 – 3:15 p.m.)**

The bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission require an annual election of the Chair and Vice Chair in October. Immediately following the election, the newly elected Chairperson facilitates the remainder of the meeting.

Vice Chair Pedrozo nominated Chair Jimenez to serve as Chairperson and Commissioner Abasta-Cummings to serve as Vice Chairperson for a successive year.

**MOTION:** Commissioner Pedrozo moved to approve the nomination of Chair Jimenez as the Chairperson of the Commission and Commissioner Abasta-Cummings as the Vice Chairperson of the Commission, seconded by Commissioner Askew

**ACTION:** The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Askew, Belton, Bizzini, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Keheley, Molesky, Pedrozo, Rabago, and Radner.

Noes: None

Absent: Commissioners Abasta-Cummings, and Morales.

Abstain: None.

**11. Consider and take action on request for Letter of Support for Program of All-Inclusive Care for the Elderly (PACE) (3:15 – 4:23 p.m.)**

Ms. Danita Carlson, Government Relations Director at the Alliance introduced the item and noted that PACE is a federal Medicare and Medicaid program. She explained the program's purpose, which is to consolidate care for the elderly into singular locations, and well as outlined the programs enrollment requirements. She added there are 27 PACE locations serving around 20,000 members across California. She further explained that Golden Pace had previously requested a letter of support from the board, which they voted on but did not pass. Golden PACE has since requested reconsideration. Golden PACE has since provided additional supplemental information including updated partnerships, added alternative care sites, an updated market viewability study, and additional letters of support from community members and entities.

Ms. Alicia Rodriguez, CEO of Golden PACE provided a presentation on their program and request for a letter of support. Ms. Rodriguez detailed California's aging population and noted its goals to support the elderly community. She explained their provider panels and how their small provider to patient ratio benefits member care. She explained the most common conditions they treat in the PACE program and reiterated their mission to make healthcare accessible and equitable. Ms. Rodriguez went on to add the partnerships and backing they have locally and across the state, as well as how PACE fits into the Governor's strategy for aging. Ms. Rodriguez described the multiple studies they completed to decide on their Salinas location which covers the most seniors in the t area. She also detailed the degree of care that seniors need and explained how the PACE program helps to fill that need.

Commissioners discussed merits and concerns with this request.

[Commissioner Friend departed at this time: 3:45 p.m.]

Chair Jimenez opened the floor for public comment. The following person spoke:

1. Rio Herrera provided comment from Santa Cruz County and expressed support for the PACE program.

**MOTION:** Commissioner Radner moved to approve the Alliance providing a Letter of Support for a Program of All-Inclusive Care for the Elderly (PACE), seconded by Commissioner Espinoza.

**ACTION:** The motion failed to pass with the following vote:

Ayes: Commissioners Armstrong, Belton, Bizzini, Espinoza, Keheley, and Radner

Noes: Commissioners Askew, Cuevas, Molesky, Pedrozo, and Rabago

Absent: Commissioners Abasta-Cummings, and Morales

Abstain: Commissioners Aguirre, Hernandez, and Jimenez

[Vice-Chair Pedrozo departed at this time: 4:22 p.m.]

[Commissioner Rabago departed at this time: 4:23 p.m.]

[Chair Jimenez departed at this time: 4:23 p.m.]

**12. Medi-Cal Capacity Grant Program 2025 Annual Investment Plan. (4:23 – 4:59 p.m.)**

Ms. Jessica Finney, Community Grants Director at the Alliance, provided an overview of the 2024 MCGP Investment Plan and the current funding opportunities.

Jessica Finney provided a detailed overview of the 2025 Annual Investment plan. She noted that in 2022, the board established three focus areas and goals for grants, funding opportunities, and investments that have dictated the awards of 2023 and 2024. These areas were access to care, healthy beginnings, and healthy communities. With the 91 million dollars of funding opportunities, 85% has been directed toward access to care. Jessica noted that as of October of this year, the Alliance has awarded 180 total grants totaling 40.4 million dollars to 117 organizations. She went on to describe the inputs that help the organization make funding decisions. She went to explain the community health assessment and community health improvement plans which report on county-specific health needs and issues. Jessica detailed some specifics and commonalities among the five counties in regard to these inputs. She explained the results of the grantee survey which revealed positive impacts and deep understanding of community needs. She then described grantee interviews and the processes for gathering feedback. Jessica then provided an overview of the parallels between areas of critical need, the Alliance Strategic Plan, and funding priorities.

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

[Commissioner Keheley departed at this time: 4:50 p.m.]

Commissioner Molesky opened the floor for public comment.

1. Staff read an email containing public comment from Oscar Flores of First 5 Monterey County.

**The Commission adjourned its regular meeting of November 6, 2024, at 4:59 p.m. to the regular meeting of December 4, 2024, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister, and Mariposa. unless otherwise noted.**

Respectfully submitted,

Ms. Dulcie San Paolo  
Administrative Specialist

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



## Meeting Minutes

**Wednesday, August 28, 2024**

**Commissioners Present:**

Ms. Anita Aguirre,  
Ralph Armstrong, DO,  
Ms. Elsa Jiménez,  
Mr. Michael Molesky,  
Supervisor Josh Pedrozo,  
Allen Radner, MD,

At Large Health Care Provider Representative  
At Large Health Care Provider Representative  
County Health Director  
Public Representative  
County Board of Supervisors  
At Large Health Care Provider Representative

**Commissioners Absent:**

**Staff Present:**

Ms. Lisa Ba,  
Mr. Michael Schrader,  
Ms. Danita Carlson,  
Mr. Jimmy Ho,  
Ms. Dulcie San Paolo,

Chief Financial Officer  
Chief Executive Officer  
Government Relations Director  
Accounting Director  
Finance Administrative Specialist

**1. Call to Order. (1:32 - 1:33 p.m.)**

Chairperson Molesky called the meeting to order at 1:32 p.m. Roll call was taken. A quorum was present.

**2. Oral Communications. (1:33 – 1:34 p.m.)**

[Commissioner Pedrozo arrived at this time: 1:33 p.m.]

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

No members of the public addressed the Committee.

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**Consent Agenda Items:****3. Approve minutes of the June 26, 2024 meeting of the Finance Committee. (1:34 – 1:35 p.m.)**

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the June 26, 2024 meeting.

**MOTION:** Commissioner Jiménez moved to approve the minutes, seconded by Commissioner Radner

**ACTION:** The motion passed with the following vote:

Ayes: Commissioners Aguirre, Jiménez, Molesky, Pedrozo, Radner

Noes: None

Absent: Commissioner Armstrong

Abstain: None

**Regular Agenda Items:****4. Discuss the Annual Election of Officers of the Finance Committee. (1:35 – 1:38 p.m.)**

Chair Molesky introduced the topic of holding an annual election for the Chairperson and Vice Chairperson of the Finance Committee for discussion. Ms. Lisa Ba, Chief Financial Officer (CFO), provided background information. The Finance Committee, as part of the Alliance's Board, should adhere to the same rules for the annual election of officers. At the upcoming November meeting, the committee will nominate and elect a Chairperson and Vice Chairperson for a one-year term.

**5. 2024 YTD June Financial Results. (1:38 - 1:51 p.m.)**

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financial performance for the six months ending on June 30, 2024. Year-to-date (YTD) Operating Income was \$82.1M, with a Medical Loss Ratio (MLR) of 86.9% and an Administrative Loss Ratio (ALR) of 4.9%.

Ms. Ba provided an overview of the per member per month (PMPM) June 2024 YTD Medical Expenses by Category of Service. She mentioned that the Inpatient Services (LTC) category exceeded the budget. She explained that this was because the category had been underbudgeted, as it did not account for the continuation of the 10% COVID add-on for certain codes in 2024, as well as the annual fee schedule increase. The unfavorable variance is anticipated to continue.

Chair Molesky noted the importance of having long-term care services available in the counties where Alliance members reside and requested that information on access to these

services and facilities in the Alliance's service area be provided at the November 2024 Finance Committee meeting.

**6. 2024 Forecast #1 based on YTD June Financials. (1:51 - 2:18 p.m.)**

Ms. Ba presented the commissioners with an overview of the forecast based on the YTD June financials including a summarized view of the 2024 forecast as compared to the actual financial results for 2022 through 2023 and the 2024 budget.

The current enrollment is higher than was budgeted, and this, combined with a favorable Category of Aid (COA) mix and a favorable rate of 0.7%, is expected to generate \$260M more in revenue compared to the budget. Medical expenses are projected to increase by \$200M primarily due to the higher-than-budgeted enrollment. The 2024 forecast expects an MLR of 89.3%, equivalent to \$1.7B for medical costs, and an ALR of 5.4%, which is \$105.4M, towards administrative expenses. An operating income of \$102.3M or 5.3% is projected for 2024. The predicted 2024 Administrative cost is \$105.4M or 5.4% ALR and includes \$8.5M for Behavioral Health insourcing and \$4.0M for Medicare D-SNP. Ms. Ba reminded the commissioners that the Board allocates the excess operating reserve from the previous year-end balance every June for strategic use. As of June 2024, the operating reserve amounted to \$69.2M, with an expected balance of \$105.8M at the year-end. The Board will allocate this amount for strategic use in June 2025.

**7. Q2 2024 Investment Update. (2:18 – 2:39 p.m.)**

Ms. Ba introduced Mr. Jimmy Ho, the Accounting Director, who provided an economic and investment update.

In his economic update, Mr. Ho mentioned that the Federal Fund Rate is currently at 5.33% as of June 2024. The last increase in the federal rate happened in July 2023, and the Fed has not raised the rates since then. If inflation continues to decrease towards the Fed's 2% target, it is expected that there will be three rate cuts in the second half of the year, with the first one anticipated to occur in September 2024.

Next, Mr. Ho reviewed the Investment Policy and explained the Alliance's investment strategies. He gave an overview of the Pooled Money Investment Accounts (PMIA) that the Alliance is qualified to participate in. Additionally, Mr. Ho advised that the Alliance aims to have 95% of its total holdings invested in core short to medium-term investments, with no more than 5% in available cash. The benchmark targets are set to achieve a diversified investment portfolio, with 75% of investment holdings in PMIAs and a combined 25% in self-managed investment institutions.

Mr. Ho provided an overview of the Alliance's investment portfolio as of June 2024. He explained that due to the higher interest rates, cash was reinvested at a higher return rate than before the pandemic. As of June 2024, the investments show a 4.36% annual rate of return.

[Commissioner Armstrong arrived at this time: 2:32 p.m.]



Commissioner Radner suggested that future investment updates should include not only the percentage yield on the fund balance but also the absolute dollar amount so that the Finance Committee can better understand the impact of investments compared to operating income.

Additionally, Commissioner Radner asked if the staff could consider exploring the possibility of investing in partnerships and joint ventures, such as the construction of healthcare properties for Federally Qualified Health Centers (FQHCs). He suggested that taking advantage of these opportunities would result in more healthcare facilities and improved access, as well as potentially offering a higher rate of return compared to the Alliance's current investments. Mr. Michael Schrader, Chief Executive Officer, stated that investing the reserve funds for the above purposes would involve using funds already allocated for specific purposes, such as the Medi-Cal Capacity Grant, value-based payment programs, and provider supplemental payments.

In closing, Chairperson Molesky noted the newly eligible Unsatisfactory Immigration Status (UIS) population and suggested discussing its impact on future enrollment in upcoming meetings. Ms. Ba mentioned that this change is projected to add approximately 29,000 new members across the five counties.

**The Commission adjourned its meeting of August 28, 2024, at 2:39 p.m.**

Respectfully submitted,

Ms. Dulcie San Paolo  
Finance Administrative Specialist

# COMPLIANCE COMMITTEE



**Meeting Minutes**  
**Wednesday, October 16, 2024**  
9:00 – 10:00 a.m.

## **Via Videoconference**

### **Committee Members Present:**

<b>Andrea Swan</b>	Quality Improvement and Population Health Director
<b>Anne Lee</b>	Financial Planning and Analysis Director
<b>Arti Sinha</b>	Application Services Director
<b>Bob Trinh</b>	Technology Services Director
<b>Bryan Smith</b>	Claims Director
<b>Cecil Newton</b>	Chief Information Officer
<b>Danita Carlson</b>	Government Relations Director
<b>Dennis Hseih</b>	Deputy Chief Medical Officer
<b>Dianna Myers</b>	Medical Director
<b>Elizabeth Leary</b>	Care Management Director
<b>Fabian Licerio</b>	Risk Adjustment Director
<b>Jenifer Mandella</b>	Chief Compliance Officer
<b>Jimmy Ho</b>	Accounting Director
<b>Kay Lor</b>	Payment Strategy Director
<b>Krishan Patel</b>	Data Analytics Services Director
<b>Kristynn Sullivan</b>	Program Development Director
<b>Lilia Chagolla</b>	Community Engagement Director
<b>Linda Gorman</b>	Communications Director
<b>Lisa Artana</b>	Human Resources Director
<b>Lisa Ba</b>	Chief Financial Officer
<b>Marwan Kanafani</b>	Health Services Officer
<b>Michael Schrader</b>	Chief Executive Officer
<b>Nicole Krupp</b>	Regulatory Affairs Manager (Chair)
<b>Omar Guzman</b>	Chief Health Equity Officer
<b>Ronita Margain</b>	Community Engagement Director, Merced County
<b>Ryan Inlow</b>	Facilities & Administrative Services Director
<b>Scott Crawford</b>	Medicare Program Executive Director
<b>Scott Fortner</b>	Chief Administrative Officer
<b>Shelly Papadopoulos</b>	Operations Management Director
<b>Tammy Brass</b>	Utilization Management Director
<b>Tammy Hoeffel</b>	Enhanced Health Services Director
<b>Van Wong</b>	Chief Operating Officer

### **Committee Members Absent:**

<b>Adam Sharma</b>	Operational Excellence Director
<b>Dave McDonough</b>	Legal Services Director

<b>Jessica Finney</b>	Community Grants Director
<b>Jessie Dybdahl</b>	Provider Services Director
<b>Michael Wang</b>	Medical Director

**Committee Members Excused:**

<b>Kate Knutson</b>	Compliance Manager
<b>Navneet Sachdeva</b>	Pharmacy Director
<b>Ryan Markley</b>	Compliance Director

**Ad-Hoc Attendees:**

<b>Anita Guevin</b>	Medicare Compliance Program Manager
<b>Daisy Gomez</b>	Compliance Specialist (Temp)
<b>Ka Vang</b>	Compliance Specialist
<b>Margarita Shull</b>	Program Integrity Specialist
<b>Paige Harris</b>	Regulatory Affairs Specialist
<b>Rachel Siwajek</b>	Program Integrity Specialist
<b>Rebecca Seligman</b>	Compliance Supervisor
<b>Sara Halward</b>	Compliance Specialist
<b>Stephanie Vue</b>	Regulatory Affairs Specialist
<b>Vanessa Paz</b>	Health Equity Program Manager

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

Chairperson Nicole Krupp called the meeting to order at 9:04 a.m.

**2. Review and Approval of August 21, 2024 Minutes.**

COMMITTEE ACTION: Committee reviewed and approved minutes of August 21, 2024 meeting.

**3. Consent Agenda.**

- 1. Policy Hub Approvals**
- 2. Regulatory and All Plan Letter Updates**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

**4. Regular Agenda****1. Program Integrity Quarterly Report**

Siwajek, Program Integrity Specialist III, presented the Q2 2024 Program Integrity Activity Report. Siwajek reported that 36 concerns were referred to Program Integrity in the quarter, 25 of which resulted in the opening of a matter under investigation (MUI). There were 81 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting the following:

- 17 provider related
- 2 subcontractor related

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

Siwajek reported performance of the Program Integrity metrics from the Q2 2024 Alliance Dashboard noting that efficiency metrics failed to meet target performance and quality metrics met target performance.

Siwajek reviewed 1 exemplar case, highlighting investigative measures taken and next steps for completion of MUI investigation. This included investigation of an MUI related to a provider improperly sourcing referrals from Alliance providers for the medically tailored meals program.

Siwajek reviewed Q224 Program Integrity Financials reporting the total requested recoupment was \$464,833.82 and completed recoupment was \$399,685.95.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2024 Program Integrity Report.

## **2. Internal Audit & Monitoring Quarterly Report**

Halward, Compliance Specialist III, presented the Q2 2024 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 10 internal audits were conducted, 6 of which received a passing score.

Halward reported Q2 2024 Targeted Audits Dashboard metrics related to internal audits noting that efficiency metrics met the targeted performance threshold for the quarter.

Halward reviewed one exemplar internal audit, the purpose of which is to ensure that HIPAA events and breaches are documented correctly, reported timely, and classified accurately according to regulatory and contractual requirements.

Halward informed the Committee of updates CAP process for failed Targeted Audits.

Halward reviewed outcomes of the monitoring of 35 Alliance Dashboard metrics related to regulatory requirements, noting that all 35 metrics met their established thresholds during the review period of Q4 2023 – Q1 2024.

Halward reviewed the Q3 2024 Internal Audit Workplan identifying upcoming planned audit activity.

Halward reported updates of the 2023 DHCS Focused Audit – Behavioral Health and Transportation and the 2024 DHCS Medical audit and advised the Committee on collaboration with impacted departments to develop responses to the findings.

Finally, Halward reviewed Corrective Action Plan (CAP) activities for Q2 2024 reporting on activities related to the internal CAPs for Provider Payment Accuracy and Provider Preventable Conditions.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2024 Internal A&M Quarterly Report.

### **3. CAPs Review**

Seligman, Compliance Supervisor, reported updates to new and previously reported Corrective Action Plans (CAPs) as follows:

DHCS 2024 Medical Survey CAP – DHCS accepted all action items completed by the plan including staff education, workflow revisions, system updates and implementation of pre-check run audits and closed the CAP.

PCP to FTE Ratio CAP – The plan continues to discuss this CAP with DHCS, focusing on inconsistencies in reporting methodology between DHCS and the Alliance. In addition, the Committee suggested that Provider Services explore network development in Monterey County.

### **4. 2024 Legislation**

Carlson, Government Relations Director, reviewed 2024 Legislative Session outcomes and identified the following areas of policy focus for staff:

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

Carlson noted that during the 2024 legislative session, Government Relations tracked 114 bills, 12 of which the Board took position on. Government Relations staff reviewed 29 Chaptered bills and advised Alliance staff of impact. 13 bills require implementation and 10 were informational only. Carlson advised that Regulatory Affairs staff will be developing and executing an implementation work plan.

The meeting adjourned at 9:51 a.m.

Respectfully submitted,  
Robin Sihler  
Compliance Administrative and Data Reporting Assistant



## Meeting Minutes

Monday, July 15, 2024

### Teleconference Meeting

#### **Members Present:**

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

#### **Members Absent:**

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

#### **Staff Present:**

Kelsey Riggs, RN	Complex Case Management Manager - Pediatric
Lilia Chagolla	Member Services Director
Linda Gorma	Marketing and Communications Director
Maura Middleton	Member Services Administrative Assistant
Ronita Margain	Community Engagement Director
Dianna Myers, MD	Medical Director

#### **Guest:**

Susan Paradise	Santa Cruz County
Christine Betts	Monterey County
Fanta Nelson	County of Merced

### 1. Call to Order by Chairperson Espinoza.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Chairperson Espinoza called the meeting to order.

Committee introductions and roll call was taken.

## **2. Oral Communications.**

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

### **Consent Agenda Items:**

## **3. Accept WCMFAC Meeting Minutes from Previous Meeting**

J. Espinoza opened the floor for approval of the meeting minutes of the previous meeting on May 13, 2024. Minutes were approved with no further edits.

### **Regular Agenda Items:**

## **4. CCS Advisory Group Representative Report**

S. Skotzke provided updates on topics of concern for the CCS population. Dr. Dianna Myers has become a new member of the CCS State Advisory Board. The recent meeting covered the mission statement, introduced new board members, discussed program expansion and compliance monitoring, and announced a new caregiver advocacy group called. The group is a collaboration with Children Now and the Lucille Packard Foundation. Their focus will be on caregiver advocacy, policy change and support. The next meeting is set for October 9th.

## **5. ECM / CS Overview**

T. Hoeffel, the new Enhanced Care Services Director gave an overview of the Enhanced Care Management program (ECM). ECM has been active for about two years, addressing medical, mental health, and social needs. It is aimed at coordinating care for CCAH members in managed plans through comprehensive case management. Collaboration with community providers, hospitals, and behavioral health units. The target populations is:

- Homeless individuals (adults and youth)
- Individuals with mental health issues, medical issues, or substance use disorders.
- High utilizers of hospital and emergency rooms.
- Individuals transitioning from incarceration.
- Adults in long-term care facilities transitioning back to the community.
- Children and youth in CCS or involved in child welfare.
- Focus on birth equity and addressing social determinants of health.

ECM serves as the coordinator, connecting members to various services. Services include housing navigation, security deposits, tenancy support, post-hospitalization housing, recuperative care, respite services, day habilitation programs, nursing facility

transitions, personal care, homemaker services, home modifications, medically supported food programs, sobering centers, and asthma remediation.

ECM is focused on a holistic approach, covering physical, mental, and social needs. The program aims to support vulnerable populations through various transitions and improve overall health outcomes. Community supports are available to help members integrate back into the community and maintain stability.

### **Review Action Items**

R. Margain reviewed the actions items.

### **Future Agenda Items**

Committee member requested more discussion around ADA challenges that they face.

Communications department efforts.

### **Adjourn:**

The meeting adjourned at 2:58 p.m.

The meeting minutes are respectfully submitted by Maura Middleton, Administrative Assistant. Member Services

*Next Meeting: Monday, September 9, 2024, at 1:30 p.m.*





**DATE:** December 4, 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 Amendment: CY 24 Final Rates

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Recommendation. Staff recommend the Board authorize the Chairperson to sign contract Amendments 23-30241 A04 and 23-30273 A02 to the Alliance's primary and secondary Medi-Cal contracts to incorporate updated and final Capitation Payment rates for Calendar Year 2024.

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. The primary agreement has subsequently been amended via written amendments A01 – A03.

Discussion. DHCS has issued amendments to the Alliance's primary and secondary State Medi-Cal contracts to incorporate final Capitation Payment rates for CY 24. The CY 24 rates have been revised from the prospective rates received due to a negative acuity adjustment of 1.1% for the Central rating region and 1.5% for the San Benito rating region.

Fiscal Impact. Final CY 2024 rates reflect a 1.6% increase over CY 2023 rates and represent a 1.2% increase over budget.

Attachments. N/A

**HEALTHY PEOPLE. HEALTHY COMMUNITIES.**

**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Danita Carlson, Government Relations Director  
**SUBJECT:** 2024 Legislative Session Wrap-Up

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

Summary: Staff provides a summary of the 2024 legislative session, including the outcomes of bills on which the Board took a position of advocacy. In addition, attached for your Board's information is a final list of bills that staff tracked throughout the legislative session.

Background: The official end of the 2024 legislative session came on September 30, 2024, with the deadline for Governor Newsom to sign or veto bills passed by the legislature prior to recessing for the year.

Throughout the legislative session, staff, in conjunction with the Local Health Plans of California and our Sacramento representatives—Edelstein, Gilbert, Robson and Smith—identified, tracked, and monitored bills in the six areas of focus of the Alliance's Board-approved Policy Priorities:

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

Discussion: The Alliance tracked 114 bills in these areas of focus, including 12 priority bills on which the Alliance and/or LHPC took an official position of support or opposition. Of the 114 bills tracked, 29 were signed into law.

The Alliance/LHPC held support positions on seven bills, an oppose position on two bills, and an "Oppose Unless Amended" position on one bill. The following provides a report on the outcome of each of these bills:

### **Support Bills**

- AB 2703 (Aguiar-Curry) – Federally Qualified Health Centers and Rural Health Clinics: psychological associates. Allows FQHC and RHCs to bill for an encounter between a patient and a psychological associate.

Final Disposition. SIGNED by the Governor.

- SB 2860 (Garcia) Licensed Physicians and Dentists from Mexico Programs. Authorizes the Medical Board of California to allow a specified number of licensed physicians specializing in family medicine, internal medicine, pediatrics, and obstetrics and gynecology to practice medicine in California with a three-year, non-renewable license.

Final Disposition. SIGNED by the Governor.

- AB 1895 (Weber) – Public Health: Maternity Ward Closures. Requires an acute care hospital that operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services to report specified information to the Department of Health Care Access Information

Final Disposition. VETOED by the Governor.

- AB 1975 (Bonta) Medi-Cal: Medically Supportive Food and Nutrition Interventions. Makes medically supportive food and nutrition interventions a covered benefit under the Medi-Cal program.

Final Disposition. VETOED by the Governor.

- AB 2250 (Weber) Social Determinants of Health: Screening and Outreach. Makes social determinants of health screenings a covered benefit for Medi-Cal beneficiaries.

Final Disposition. VETOED by the Governor

- AB 1379 (Papan) – Open Meetings: Local Agencies: Teleconferences. Allows additional flexibilities to Brown Act meetings for local agencies utilizing teleconferencing from multiple teleconferencing locations.

Final Disposition. Failed passage.

- SB 282 (Eggman, McGuire) Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics. Authorizes additional flexibilities to ensure reimbursement for a maximum of 2 visits that take place on the same day at the same site and adds other related changes.

Final Disposition. Failed passage.

## **Oppose Bills**

- AB 3275 (Soria/Rivas) – Health care coverage: claim reimbursement. Reduces turnaround time for health plans to reimburse a clean claim and assesses an administrative fee on plans for violations. .

Final Disposition. SIGNED by the Governor.

- AB 236 (Holden) – Health care coverage: provider directories. Implements standards for provider directory listings and assesses administrative penalties for failure to meet prescribed benchmarks.

Final Disposition. Failed passage.

- AB 3260 (Pellerin) – Health care coverage: reviews and grievances. Revises standards for utilization review decisions and complaints and grievances.

Final Disposition. Failed passage.

- SB 516 (Skinner) – Health care coverage: prior authorization. Revises standards for prior authorization and requires plans to create a process for exemptions

Final Disposition. Failed passage.

### **Oppose Unless Amended**

- AB 815 (Wood) – Health care coverage: provider credentials. Creates a provider credentialing board 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.

Final Disposition. Failed passage.

Staff continue to review all applicable bills that were signed into law by the Governor to identify implementation issues and potential impact on the plan, members, providers and other key stakeholders and will report to the Board on any significant concern on items that may arise from this review that warrant Board attention.

Attached is the final bill list indicating those bills that staff were tracking based on the Board's established areas of focus. The status of each bill is indicated.

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

### **Attachments**:

1. 2024 Legislation - Final

## Central California Alliance for Health 2024 Bill List

Priority Bills	
<a href="#"><u>AB 2703</u></a> <b>Aguiar-Curry (D)</b> <b>Status: CHAPTERED</b>  <b>Position:</b> Support <i>(LHPC)</i>	<b>Federally qualified health centers and rural health clinics: psychological associates</b> <b>Summary:</b> 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.
<a href="#"><u>AB 2860</u></a> <b>Garcia (D)</b>  <b>Status: CHAPTERED</b>  <b>Position:</b> Support <i>(CCAH/LHPC)</i>	<b>Licensed Physicians and Dentists from Mexico programs</b> <b>Summary:</b> 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.
<a href="#"><u>AB 3275</u></a> <b>Soria (D) and Rivas (D)</b>  <b>Status: CHAPTERED</b>	<b>Health care coverage: claim reimbursement</b> <b>Summary:</b> Commencing January 1, 2026, this bill would require a health care service plan or health insurer to reimburse a clean claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim does not meet the criteria for a clean claim, to notify the claimant within 30 calendar days that the claim is contested or denied.

<p><b>Position:</b> Oppose (LHPC)</p>	<p>The bill would require the Department of Managed Health Care and the Department of Insurance to determine the criteria for a clean claim, as specified, no later than July 31, 2025. The bill would authorize the departments to issue guidance and amend regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.</p> <p>This bill would require a complaint or inquiry made by an enrollee to a health care service plan about a delay or denial of a payment of a claim to be treated as a grievance subject to that grievance process.</p> <p>This bill would require that an administrative fee assessed upon a health care service plan for a violation of the above-describe provisions related to clean claim reimbursement be deposited into the fund.</p> <p>The bill would require those moneys to be retained in the fund to assist enrollees and providers impacted by a violation, upon appropriation by the Legislature.</p>
<b>Assembly Bills</b>	
<p><a href="#"><u>AB 869</u></a> <b>Wood (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Hospitals: seismic safety compliance</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1282</u></a> <b>Lowenthal (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Mental health: impacts of social media</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1316</u></a> <b>Irwin (D) and Ward (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Emergency services: psychiatric emergency medical conditions</b> <b>Summary:</b> 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.</p>

	<p>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.</p>
<p><a href="#">AB 1842</a>  <b>Reyes (D)</b>  <b>Status: CHAPTERED.</b></p>	<p><b>Health care coverage: Medication-assisted treatment</b>  <b>Summary:</b> 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.</p>
<p>AB 1936  <b>Cervantes (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Maternal mental health screenings.</b>  <b>Summary:</b> Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified.</p> <p>This bill would require the program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider.</p>
<p><a href="#">AB 2105</a>  <b>Lowenthal (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Coverage for PANDAS and PANS</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2115</a>  <b>Haney (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Controlled substances: clinics</b>  <b>Summary:</b> 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. The bill would require clinics with a supply of narcotic drugs being dispensed pursuant to these provisions to establish policies or procedures for dispensing the narcotics, as specified.</p> <p>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</p>

	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.
<a href="#">AB 2129</a> <b>Petrie-Norris (D)</b>  <b>Status: CHAPTERED</b>	<b>Immediate postpartum contraception</b> <b>Summary:</b> 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 licensed birth 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.
<a href="#">AB 2132</a> <b>Low (D)</b>  <b>Status: CHAPTERED</b>	<b>Health care services</b> <b>Summary:</b> This bill would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting where primary care services are provided, to be offered the 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 care coverage, except as specified. 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. The bill would prohibit a health care provider that 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 require the State Department of Public Health to work with stakeholders to implement these provisions, and to notify primary care facilities about these provisions. This bill would require a Medi-Cal managed care plan to ensure access to care for latent TB infection and active TB disease and coordination with local health department TB control programs for plan enrollees with active TB disease, as specified.
<a href="#">AB 2198</a> <b>Flora (R)</b>  <b>Status: CHAPTERED</b>	<b>Health information</b> <b>Summary:</b> 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 the final federal rules for impacted payers are implemented, whichever is later.
AB 2258 <b>Zbur (D)</b>  <b>Status: CHAPTERED</b>	<b>Health care coverage: cost sharing</b> <b>Summary:</b> This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings.
<a href="#">AB 2297</a> <b>Friedman (D)</b>  <b>Status: CHAPTERED</b>	<b>Hospital and Emergency Physician Fair Pricing Policies</b> <b>Summary:</b> 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



	<p>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, among other things, 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.</p>
<p><a href="#">AB 2319</a>  <b>Wilson (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>California Dignity in Pregnancy and Childbirth Act</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2340</a>  <b>Bonta (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Medi-Cal: EPSDT services: informational materials</b>  <b>Summary:</b> 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.</p> <p>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</p>

	<p>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.</p> <p>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.</p>
<a href="#">AB 2376</a> <b>Bains (D)</b>  <b>Status: CHAPTERED</b>	<p><b>Chemical dependency recovery hospitals</b>  <b>Summary:</b> 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 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 require a general acute care hospital, acute psychiatric hospital, or distinct unit thereof, providing chemical dependency recovery services that meet specified federal program requirements, to provide the confidentiality protections required by specified federal regulations to the hospital's or unit's patients with a substance use disorder. 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.</p>
<a href="#">AB 2435</a> <b>Maienschein (D)</b>  <b>Status: CHAPTERED</b>	<p><b>California Health Benefit Exchange</b>  <b>Summary:</b> 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.</p>
<a href="#">AB 2556</a> <b>Jackson (D)</b>  <b>Status: CHAPTERED</b>	<p><b>Behavioral health and wellness screenings: notice</b>  <b>Summary:</b> 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 annually.</p>
<a href="#">AB 2843</a> <b>Petrie-Norris (D)</b>  <b>Status: CHAPTERED</b>	<p><b>Health care coverage: rape and sexual assault</b>  <b>Summary:</b> 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.</p>
<a href="#">AB 3059</a> <b>Weber (D)</b>  <b>Status: CHAPTERED</b>	<p><b>Human milk</b>  <b>Summary:</b> 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 donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health. This bill would require a health care service plan contract or health insurance policy that is issued,</p>

	amended, delivered, or renewed on or after January 1, 2025, to cover medically necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health..
<a href="#"><u>AB 3221</u></a> <b>Pellerin (D)</b>  <b>Status: CHAPTERED</b>	<b>Department of Managed Health Care: review of records</b> <b>Summary:</b> 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.
<b>Senate Bills</b>	
<a href="#"><u>SB 242</u></a> <b>Skinner (D)</b>  <b>Status: CHAPTERED</b>	<b>California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program</b> <b>Summary:</b> 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.

	<p>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.</p>
<p>SB 339 Weiner (D)  Status: CHAPTERED</p>	<p><b>HIV preexposure prophylaxis and postexposure prophylaxis</b>  <b>Summary:</b> This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including the pharmacist's services and related testing ordered by the pharmacist, and to pay or reimburse for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan or health insurer has an out-of-network pharmacy benefit, except as specified. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits.</p>
<p><a href="#">SB 729</a> Menjivar (D)  Status: CHAPTERED</p>	<p><b>Health care coverage: treatment for infertility and fertility services</b>  <b>Summary:</b> 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 contract holders 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.</p>
<p><a href="#">SB 819</a> Eggman (D)  Status: CHAPTERED.</p>	<p><b>Medi-Cal: certification</b>  <b>Summary:</b> 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.</p>
<p><a href="#">SB 1120</a> Becker (D)  Status: CHAPTERED</p>	<p><b>Health care coverage: utilization review</b>  <b>Summary:</b> This bill would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including</p>

	that the tool bases its determination on specified information and is 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.
<a href="#">SB 1131</a> <b>Gonzalez (D)</b> <b>Status:</b> Enrolled <b>CHAPTERED.</b>	<p><b>Medi-Cal providers: family planning</b>  <b>Summary:</b> 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.</p> <p>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.</p>
<a href="#">SB 1180</a> <b>Ashby (D)</b> <b>Status:</b> CHAPTERED	<p><b>Health care coverage: emergency medical services</b>  <b>Summary:</b> This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 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 prohibit reimbursement rates adopted pursuant to this provision from exceeding the health care service plan's or health insurer's usual and customary charges for services provided.</p>



	<p>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.</p>
<p><b>SB 1300</b>  <b>Cortese (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Health facility closure: public notice: inpatient psychiatric and maternity services</b>  <b>Summary:</b> 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 determines the hospital cannot maintain required staffing levels due to employee attrition.</p> <p>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.</p> <p>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.</p>
<p><b>SB 1320</b>  <b>Wahab (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Mental health and substance use disorder treatment</b>  <b>Summary:</b> Existing law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.</p> <p>This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025.</p>
<p><b>SB 1354</b>  <b>Wahab (D)</b>  <b>Status: CHAPTERED</b></p>	<p><b>Long-term health care facilities: payment source and resident census</b>  <b>Summary:</b> 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.</p> <p>This bill would require a skilled nursing facility that participates as a provider under the Medi-Cal program to make publicly available its current daily resident census and nurse staffing data, as defined. The bill would require the facility to make the information</p>

	<p>available either by posting it on the facility's internet website or by providing the information to a requester by telephone or e-mail, as specified. The bill would exempt these requirements from the above-described and other related criminal penalties.</p> <p>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.</p>
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## Vetoed

<p><a href="#">AB 1895</a> <b>Weber (D)</b></p> <p><b>Status: VETOED</b></p> <p><b>Position:</b> Support (LHPC)</p>	<p>This bill would require an acute care hospital that operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services, to report specified information to the Department of Health Care Access Information, including, but not limited to, the number of medical staff and employees working in the perinatal unit and the hospital's prior performance on financial metrics. The bill would require the Department of Health Care Access and Information to forward the provided information to the State Department of Health Care Services and the State Department of Public Health. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within- 3 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 and the State Department of Health Care Services, to conduct a community impact assessment to identify the 3 closest hospitals operating a perinatal unit, their distance from the challenged facility, and whether those hospitals have any restrictions on their reproductive health services. The bill would require the Department of Health Care Access and Information to provide the community impact assessment to specified entities and would require these entities to keep the community impact assessment confidential. If the hospital plans to close its perinatal unit, the bill would require the hospital to provide public notice of the proposed 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 closure. The bill would require the public to be permitted to comment on the closure for 60 days after the notice is given and would require one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment.</p>
<p><a href="#">AB 1975</a> <b>Bonta (D)</b></p> <p><b>Status: VETOED</b></p> <p><b>Position:</b> Support (LHPC)</p>	<p><b>Medi-Cal: medically supportive food and nutrition interventions</b> <b>Summary:</b> 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, no sooner than July 1, 2026, upon appropriate and 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.</p> <p>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</p>

	<p>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, upon appropriation, to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items.</p>
<p><a href="#"><u>AB 2250</u></a> Weber (D)</p> <p><b>Status: VETOED</b></p> <p><b>Position:</b> Support (LHPC)</p>	<p><b>Social determinants of health: screening and outreach</b>  <b>Summary:</b> 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 until regulations are adopted, and would require the departments to coordinate in the development of guidance and regulations. 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.</p>
<p><a href="#"><u>AB 1977</u></a> Ta (R)</p> <p><b>Status: VETOED</b></p>	<p><b>Health care coverage: behavioral diagnoses</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2237</u></a> Aguiar-Curry (D)</p> <p><b>Status: VETOED</b></p>	<p><b>Children and youth: transfer of specialty mental health services</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2339</u></a> Aguiar-Curry (D)</p> <p><b>Status: VETOED</b></p>	<p><b>Medi-Cal: telehealth</b>  <b>Summary:</b> 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,</p>



	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.
<a href="#">AB 2428</a> <b>Calderon (D)</b> <b>Status: VETOED</b>	<b>Medi-Cal: Community-Based Adult Services</b> <b>Summary:</b> 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.
<a href="#">AB 2446</a> <b>Ortega (D)</b> <b>Status: VETOED</b>	<b>Medi-Cal: diapers</b> <b>Summary:</b> 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.
<a href="#">AB 2467</a> <b>Bauer-Kahan (D)</b> <b>Status: VETOED</b>	<b>Health care coverage for menopause</b> <b>Summary:</b> 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 evaluation and treatment options for of perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause.
<a href="#">AB 3129</a> <b>Wood (D)</b> <b>Status: VETOED</b>	<p>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 before a transaction between the private equity group or hedge fund and a health care facility, provider, or provider group, as those terms are defined, and any of those entities under common control or affiliated with a payor, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the transaction. 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 before a transaction between a private equity group or hedge fund and a nonphysician provider or a provider, with specified gross annual revenue.</p> <p>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 health care facility's, provider group's, or provider'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 transaction will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 45 days, as prescribed.</p> <p>The bill would authorize the Attorney General to consent to, give conditional consent to, or not consent to a transaction between a private equity group or hedge fund and a health care facility, provider group, or provider if the transaction 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</p>

	<p>bill would authorize the private equity group or hedge fund to elect to participate in an evidentiary hearing before an administrative law judge assigned to the Office of Administrative Hearings and would set forth the requirements for that hearing.- The bill would require the administrative law judge to issue a statement of decision after the close of the hearing and would require the Attorney General to issue a final determination accepting or rejecting the statement of decision, as specified. The bill would authorize the private equity group or hedge fund to seek subsequent judicial review, as specified, of the Attorney General's final determination if the Attorney General does not consent or gives conditional consent to a transaction.</p> <p>The bill would prohibit a private equity group or hedge fund involved in any manner with a physician, psychiatric, or dental practice doing business in this state from interfering with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions, among other things The bill would authorize the Attorney General to adopt regulations to implement its requirements, as specified. This bill would exempt transactions involving private equity groups or hedge funds that are subject to Attorney General review pursuant to the bill from this notice requirement.</p>
<p><a href="#"><u>AB 3156</u></a> Patterson (R)  Status: VETOED</p>	<p><b>Medi-Cal: managed care plans: beneficiaries with other primary coverage</b> <b>Summary:</b> Under the bill, in the case of a Medi-Cal managed care plan enrollee who has other health coverage, as specified, 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.</p> <p>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 also prohibit a Medi-Cal fee-for-service provider from being required to contract with a Medi-Cal managed care plan in order to provide services to an enrollee who fits the above-described criteria and to bill the Medi-Cal managed care plan.</p> <p>The bill would require the department to solicit input from specified stakeholders regarding the coordination of other commercial health coverage with Medi-Cal managed care, with a specific emphasis on Medi-Cal recipients receiving regional center services. The bill would require the department to include an item on the agenda of the first meeting of the Medi-Cal Managed Care Advisory Committee of 2025 to discuss this topic and, within 12 months of the advisory committee meeting, take the actions it deems necessary to ensure to ensure that Medi-Cal managed care enrollees who have other health coverage, including those receiving regional center services, are able to coordinate their care as seamlessly as possible. 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.</p>
<p><a href="#"><u>AB 3245</u></a> Patterson (R)  Status: VETOED</p>	<p><b>Coverage for colorectal cancer screening</b> <b>Summary:</b> 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 approved by the California Health and Human Services Agency.</p>

<p><a href="#"><u>SB 966</u></a>  <b>Wiener (D)</b></p> <p><b>Status: VETOED</b></p>	<p><b>Pharmacy benefits</b>  <b>Summary:</b> 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.</p> <p>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 establish various filing and service requirements when a proceeding is brought for a violation of specified requirements by a pharmacy benefit manager. The bill would create the Pharmacy Benefit Manager Fines and Penalties Fund, into which fines and administrative penalties would be deposited.</p> <p>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.</p>
<p><a href="#"><u>SB 1213</u></a>  <b>Atkins (D)</b></p> <p><b>Status: VETOED</b></p>	<p><b>Health care programs: cancer</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>SB 1423</u></a>  <b>Dahle (R)</b></p> <p><b>Status: VETOED</b></p>	<p><b>Rural Hospital Technical Advisory Group.</b>  <b>Summary.</b> This bill would require the department to convene a Rural Hospital Technical Advisory Group, with a certain composition of stakeholders, at least bimonthly during the 2025 calendar year. The bill would set forth the purposes of the advisory group, including, among other things, analyzing the continued ability of small, rural, or critical access hospitals, as defined, to remain financially viable under existing Medi-Cal reimbursement methodologies, to provide related recommendations, and to identify key contributors to the financial challenges of those hospitals, as specified.</p>

	The bill would require, by March 31, 2026, the department, in consultation with the advisory group, to report to the Legislature on the findings and recommendations arising out of the convenings, as specified.
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## Failed Passage

<a href="#">AB 236</a> <b>Holden (D)</b>  <b>Status:</b> Suspense File 8/5/24  <b>Position:</b> Oppose (LHPC)	<b>Health care coverage: provider directories</b> <b>Summary:</b> 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.
<a href="#">AB 815</a> <b>Wood (D)</b>  <b>Status:</b> Suspense File 8/5/24 <b>Position:</b> Oppose Unless Amended (LHPC)	<b>Health care coverage: provider credentials</b> <b>Summary:</b> 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.
<a href="#">AB 1379</a> <b>Papan (D)</b>  <b>Status:</b> Dead  <b>Position:</b> Support	<b>Open meetings: local agencies: teleconferences</b> <b>Summary:</b> 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

	<p>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.</p> <p>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.</p>
<p><b><a href="#">AB 3260</a></b>  <b>Pellerin (D)</b></p> <p><b>Status:</b> Suspense File  8/5/24</p> <p><b>Position:</b> Oppose  (LHPC)</p>	<p><b>Health care coverage: reviews and grievances</b></p> <p><b>Summary.</b> 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 urgent. 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, if the plan has received the information necessary to make a decision.</p>



	<p>This bill would require a plan's grievance system to include expedited review of urgent grievances, as—specified. 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, except in specified circumstances.</p> <p>This bill would extend the above deadline 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-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.</p> <p>This bill would limit the applicability of the above-described provisions to health insurers. The bill would require a decision to approve, modify, or deny a request by a provider before the provision of health care services to be communicated no more than 5 business days from the health insurer's receipt of the request. If the insurer lacks information reasonably necessary to make the decision, the bill would require the insurer to notify the insured and provider within 5 business days from receipt of request and to afford the insured and provider at least 45 days from receipt of that notice to provide the information. If the insured's condition is urgent, as defined, the bill would require a decision to approve, modify, or deny a request by a provider before, or concurrent with, the provision of health care services to be communicated no more than 72 hours from the insurer's receipt of the request. If the insurer lacks information reasonably necessary to make the decision, the bill would require the insurer to notify the insured and provider no later than 24 hours from receipt of request and to afford the insured and provider at least 48 hours from receipt of that notice to provide the information. The bill would require an insurer to communicate a decision to modify or deny a concurrent care request, as specified, within 24 hours from the insurer's receipt of the request. If an insurer fails to provide notice of a decision, the bill would require an insurer to treat the request as a grievance and immediately notify the insured and provider that a grievance has <del>commenced</del> commenced, if the insurer has received the information necessary to make a decision.</p> <p>This bill would require the department to determine whether or not a complaint is urgent, as specified, unless the insured's provider has already designated the complaint as urgent. The bill would require the insurer to offer to provide specified correspondence and documents to an insured and their representative, if applicable, if the insured has submitted a complaint or independent medical review case to the department. 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 insurerbefore the grievance isresolved. The bill would prohibit an insurer from engaging in ex parte communication with the independent medical review organization deciding a case.</p>
<p><a href="#"><b>SB 282</b></a>  <b>Eggman (D)</b>  <b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Medi-Cal: federally qualified health centers and rural health clinics</b>  <b>Summary:</b> 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</p>

<p><b>Position:</b> Support</p>	<p>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.</p>
<p><a href="#"><u>SB 516</u></a>  <b>Skinner (D)</b></p> <p><b>Status:</b> Hearing cancelled at request of author 8/27/24</p> <p><b>Position:</b> Oppose (LHPC)</p>	<p><b>Health care coverage: prior authorization</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1092</u></a>  <b>Wood (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Health care service plans: consolidation</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1110</u></a>  <b>Arambula (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Public health: adverse childhood experiences</b>  <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 4</u></a>  <b>Arambula (D)</b></p>	<p><b>Covered California: expansion</b>  <b>Summary:</b> 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</p>

<p><b>Status:</b> Held under submission 8/15/24</p>	<p>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.</p>
<p><a href="#"><u>AB 365</u></a> <b>Aguiar-Curry (D)</b></p> <p><b>Status:</b> Ordered to Inactive File 8/30/24</p>	<p><b>Medi-Cal: diabetes management</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 412</u></a> <b>Soria (D)</b></p> <p><b>Status:</b> Referred to Com. on HEALTH, 6/14/23.</p>	<p><b>Distressed Hospital Loan Program</b> <b>Summary:</b> 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</p>



	provide hard copies of hospital data reports. This bill would declare that it is to take effect immediately as an urgency statute.
<a href="#"><b>AB 492</b></a> <b>Pellerin (D)</b>  <b>Status:</b> Referred to Com. on HEALTH, 6/14/23.	<b>Medi-Cal: reproductive and behavioral health integration pilot programs</b> <b>Summary:</b> 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.
<a href="#"><b>AB 564</b></a> <b>Villapudua (D)</b>  <b>Status:</b> Referred to Com. on HEALTH, 6/14/23.	<b>Medi-Cal: claim or remittance forms: signature</b> <b>Summary:</b> 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.
<a href="#"><b>AB 817</b></a> <b>Pacheco (D)</b>  <b>Status:</b> In Com. on L. GOV. Set second hearing. Failed passage. Reconsideration granted.	<b>Open meetings: teleconferencing: subsidiary body</b> <b>Summary:</b> 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.
<a href="#"><b>AB 1117</b></a> <b>Irwin (D)</b>  <b>Status:</b> Referred to Com. on HEALTH, 6/7/23.	<b>Hospice agency licensure</b> <b>Summary:</b> 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.
<a href="#"><b>AB 1157</b></a> <b>Ortega (D)</b>  <b>Status:</b> Held under submission, 9/1/23.	<b>Rehabilitative and habilitative services: durable medical equipment and services</b> <b>Summary:</b> 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

	<p>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.</p>
<p><a href="#"><u>AB 1331</u></a> <b>Wood (D)</b></p> <p><b>Status:</b> Held under submission, 8/15/24.</p>	<p><b>California Health and Human Services Data Exchange Framework</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1537</u></a> <b>Wood (D)</b></p> <p><b>Status:</b> Ordered to Inactive File 8/29/24</p>	<p><b>Skilled nursing facilities: direct care spending requirement</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1783</u></a> <b>Essayli (R)</b></p> <p><b>Status:</b> Introduced 1/3/24.</p>	<p><b>Health care: immigration</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 1926</u></a> <b>Connolly (D)</b></p> <p><b>Status:</b> Referred to suspense file. 6/24/24.</p>	<p><b>Health care coverage: regional enteritis</b> <b>Summary:</b> 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.</p>

<a href="#"><u>AB 1943</u></a> <b>Weber (D)</b> <b>Status:</b> Referred to suspense file. 6/17/24.	<b>Medi-Cal: telehealth</b> <b>Summary:</b> This bill would require the department to, by October 1, 2025, 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 authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.
<a href="#"><u>AB 1970</u></a> <b>Jackson (D)</b>  <b>Status:</b> Held under submission 8/15/24	<b>Mental Health: Black Mental Health Navigator Certification Pilot Program</b> <b>Summary:</b> 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.
<a href="#"><u>AB 1995</u></a> <b>Essayli (R)</b>  <b>Status:</b> Introduced 1/30/24.	<b>Health care facilities: small and rural hospitals</b> <b>Summary:</b> This bill would make technical, nonsubstantive changes to the definition of small and rural hospital.
<a href="#"><u>AB 2028</u></a> <b>Ortega (D)</b>  <b>Status:</b> Hearing cancelled at request of author, in committee, 4/18/24.	<b>Medical loss ratios</b> <b>Summary:</b> 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.
<a href="#"><u>AB 2031</u></a> <b>Jones-Sawyer (D)</b>  <b>Status:</b> Hearing cancelled at request of author, in committee, 3/12/24	<b>One California program</b> <b>Summary:</b> 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.
<a href="#"><u>AB 2043</u></a> <b>Boerner (D)</b>  <b>Status:</b> Held under submission 8/14/24	<b>Medi-Cal: nonmedical and nonemergency medical transportation</b> <b>Summary:</b> 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.
<a href="#"><u>AB 2110</u></a> <b>Arambula (D)</b>  <b>Status:</b> In committee: Held	<b>Medi-Cal: Adverse Childhood Experiences trauma screenings: providers</b> <b>Summary:</b> 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

<p>under submission, 5/16/24.</p>	<p>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.</p>
<p><a href="#"><u>AB 2200</u></a> <b>Kalra (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Guaranteed Health Care for All</b> <b>Summary:</b> This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. 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.</p> <p>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.</p> <p>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.</p>

	<p>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.</p> <p>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.</p> <p>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.</p>
<p><a href="#">AB 2246</a> <b>Ramos (D)</b></p> <p><b>Status:</b> Held under submission 8/15/24.</p>	<p><b>Medical Practice Act: health care providers: qualified autism service paraprofessionals</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2303</a> <b>Carrillo (D)</b></p> <p><b>Status:</b> Second hearing cancelled at request of author, 4/11/24.</p>	<p><b>Health and care facilities: prospective payment system rate increase</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2332</a> <b>Connolly (D)</b></p> <p><b>Status:</b> In committee: Held</p>	<p><b>Corrections: health care</b>  <b>Summary:</b> 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</p>



<p>under submission, 5/16/24.</p>	<p>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.</p> <p>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.</p>
<p><a href="#"><u>AB 2342</u></a> <b>Lowenthal (D)</b></p> <p><b>Status:</b> Referred to Com. on HEALTH, 2/26/24.</p>	<p><b>Medi-Cal: critical access hospitals: islands</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2352</u></a> <b>Irwin (D)</b></p> <p><b>Status:</b> In committee. Hearing postponed by committee. 6/11/24.</p>	<p><b>Mental health and psychiatric advance directives</b> <b>Summary:</b> 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.</p> <p>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.</p> <p>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.</p>

	<p>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.</p> <p>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.</p> <p>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.</p>
<p><a href="#"><u>AB 2356</u></a> <b>Wallis (R)</b></p> <p><b>Status:</b> In committee: held under submission, 5/16/24.</p>	<p><b>Medi-Cal: monthly maintenance amount: personal and incidental needs</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2449</u></a> <b>Ta (R)</b></p> <p><b>Status:</b> Held under submission 8/15/24</p>	<p><b>Health care coverage: qualified autism service providers</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2466</u></a> <b>Carrillo (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Medi-Cal managed care: network adequacy standards</b> <b>Summary:</b> 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.</p> <p>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.</p>

	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This bill would, for purposes of the particular circumstance described above, set forth definitions for the terms of "timely" and "accurate network provider data."</p>
<p><a href="#"><u>AB 2668</u></a> <b>Berman (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Coverage for cranial prostheses</b> <b>Summary:</b> 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.</p>
<p><a href="#"><u>AB 2699</u></a> <b>Carrillo (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Hazardous materials: reporting: civil liability</b> <b>Summary:</b> This bill would require the California Environmental Protection Agency to adopt new regulations regarding reporting of handling hazardous materials, amongst other changes.</p>
<p><a href="#"><u>AB 2701</u></a> <b>Villapudua (D)</b></p> <p><b>Status:</b> Held under submission 81524</p>	<p><b>Medi-Cal: dental cleanings and examinations</b> <b>Summary:</b> This bill would restructure existing provisions so that at least 2 dental prophylaxis cleanings and at least 2 periodic dental examinations per year, as specified, would be covered Medi-Cal benefits for all beneficiaries, regardless of age. The bill would, for purposes of these provisions, include an individual's inability to maintain daily oral hygiene habits,</p>



	<p>susceptibility to oral health disease or decay, preoperative dental care, or as required by other specified provisions of law, in the definition of “medically necessary,” and require the department to update the Medi-Cal Dental Manual of Criteria to conform with this inclusion.</p>
<p><a href="#">AB 2726</a> <b>Flora (R)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Specialty care networks: telehealth and other virtual services</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2753</a> <b>Ortega (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Rehabilitative and habilitative services: durable medical equipment and services</b>  <b>Summary:</b> 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.</p>
<p><a href="#">AB 2956</a> <b>Boerner (D)</b></p> <p><b>Status:</b> In committee: Held</p>	<p><b>Medi-Cal eligibility: redetermination</b>  <b>Summary:</b> 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</p>

<p>under submission, 5/16/24.</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p><a href="#"><u>AB 2976</u></a> <b>Jackson (D)</b></p> <p><b>Status:</b> Introduced 2/16/24.</p>	<p><b>Mental health care</b> <b>Summary:</b> This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.</p>
<p><a href="#"><u>AB 3149</u></a> <b>Garcia (D)</b></p> <p><b>Status:</b> In committee: Held under submission, 5/16/24.</p>	<p><b>Promotores and Promotoras Advisory and Oversight Workgroup</b> <b>Summary:</b> 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</p>

	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.
<a href="#"><u>AB 3215</u></a> <b>Soria (D)</b>  <b>Status:</b> Introduced 2/16/24.	<b>Medi-Cal: mental health services for children</b> <b>Summary:</b> 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.
<a href="#"><u>SB 70</u></a> <b>Wiener (D)</b>  <b>Status:</b> Held under submission, 9/1/23.	<b>Prescription drug coverage</b> <b>Summary:</b> 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.
<a href="#"><u>SB 238</u></a> <b>Wiener (D)</b>  <b>Status:</b> Held under submission, 9/1/23.	<b>Health care coverage: independent medical review</b> <b>Summary:</b> 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.
<a href="#"><u>SB 294</u></a> <b>Wiener (D)</b>  <b>Status:</b> Held under submission 8/15/24	<b>Health care coverage: independent medical review</b> <b>Summary:</b> 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

	<p>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.</p> <p>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.</p>
<p><a href="#">SB 324</a> <b>Limón (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Health care coverage: endometriosis</b> <b>Summary:</b> 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.</p>
<p><a href="#">SB 340</a> <b>Eggman (D)</b></p> <p><b>Status:</b> 6/27/23 first hearing cancelled at request of author.</p>	<p><b>Medi-Cal: eyeglasses: Prison Industry Authority</b> <b>Summary:</b> 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.</p>
<p><a href="#">SB 363</a> <b>Eggman (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Facilities for inpatient and residential mental health and substance use disorder: database</b> <b>Summary:</b> 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.</p>

<p><b><a href="#">SB 589</a></b>  <b>Alvarado-Gil (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Foster youth: disaster aid assistance</b>  <b>Summary:</b> 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.</p>
<p><b><a href="#">SB 598</a></b>  <b>Skinner (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Health care coverage: prior authorization</b>  <b>Summary:</b> 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.</p>
<p><b><a href="#">SB 873</a></b>  <b>Bradford (D)</b></p> <p><b>Status:</b> Held under submission, 9/1/23.</p>	<p><b>Prescription drugs: cost sharing</b>  <b>Summary:</b> 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.</p>
<p><b><a href="#">SB 953</a></b>  <b>Menjivar (D)</b></p> <p><b>Status:</b> Held in committee and under submission, 5/16/24.</p>	<p><b>Medi-Cal: menstrual products</b>  <b>Summary:</b> 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.</p>



<p><a href="#"><b>SB 975</b></a> <b>Ashby (D)</b></p> <p><b>Status:</b> Referred to Senate Com. on RLS, 2/14/24.</p>	<p><b>Emergency medical services: community paramedicine</b> <b>Summary:</b> 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.</p>
<p><a href="#"><b>SB 980</b></a> <b>Wahab (D)</b></p> <p><b>Status:</b> Held under submission 8/15/24.</p>	<p><b>Medi-Cal: dental crowns and implants</b> <b>Summary:</b> 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.</p>
<p><a href="#"><b>SB 999</b></a> <b>Cortese (D)</b></p> <p><b>Status:</b> Held under submission 8/15/24</p>	<p><b>Health coverage: mental health and substance use disorders</b> <b>Summary:</b> 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.</p>
<p><a href="#"><b>SB 1008</b></a> <b>Bradford (D)</b></p> <p><b>Status:</b> Held in committee and under submission, 5/16/24.</p>	<p><b>Obesity Treatment Parity Act</b> <b>Summary:</b> 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.</p>
<p><a href="#"><b>SB 1017</b></a> <b>Eggman (D)</b></p> <p><b>Status:</b> Held in committee and under submission, 5/16/24</p>	<p><b>Available facilities for inpatient and residential mental health or substance use disorder treatment</b> <b>Summary:</b> 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</p>

	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.
<a href="#"><b>SB 1236</b></a> <b>Blakespear (D)</b>  <b>Status:</b> Held in committee and under submission, 5/16/24	<b>Medicare supplement coverage: open enrollment periods</b> <b>Summary:</b> 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.
<a href="#"><b>SB 1258</b></a> <b>Dahle (R)</b>  <b>Status:</b> Held under submission 8/15/24	<b>Medi-Cal: unrecovered payments: interest rate</b> <b>Summary:</b> 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.
<a href="#"><b>SB 1268</b></a> <b>Nguyen (R)</b>  <b>Status:</b> First hearing set and canceled at request of author, 4/24/24.	<b>Medi-Cal managed care plans: contracts with safety net providers</b> <b>Summary:</b> 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.
<a href="#"><u>SB 1269</u></a> <b>Padilla (D)</b>  <b>Status:</b> Second hearing set and canceled at request of author, 4/15/24.	<b>Safety net hospitals</b> <b>Summary:</b> 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.
<a href="#"><u>SB 1290</u></a> <b>Roth (D)</b>  <b>Status:</b> Ordered to Inactive File 8/28/24	<b>Health care coverage: essential health benefits</b> <b>Summary:</b> 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.
<a href="#"><u>SB 1339</u></a> <b>Allen (D)</b>  <b>Status:</b> In committee. Hearing postponed by committee. 6/17/24.	<b>Supportive community residences</b> <b>Summary:</b> 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 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.  The bill would require a referring entity, as defined, to provide information relating to the license or certification status of a step-down care facility when informing an individual with a substance use disorder, mental health diagnosis, or dual diagnosis of options for step-down care covered by the individual’s health insurance. The bill would require a referring entity to verify the license or certification of a step-down care facility if a particular step-down care facility is not covered by an individual’s insurance. The bill would define a “step-down care



	facility” to include a supportive community residence, a community care facility, or other residential treatment or detox facility. The bill would require a referring entity to report any suspected fraudulent license or certification to the appropriate state agency.
<a href="#">SB 1355</a> <b>Wahab (D)</b>  <b>Status:</b> Held in committee and under submission, 5/16/24.	<b>Medi-Cal: in-home supportive services: redetermination</b> <b>Summary:</b> 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.
<a href="#">SB 1397</a> <b>Eggman (D)</b>  <b>Status:</b> Held under submission 8/15/24	<b>Behavioral health services coverage</b> <b>Summary:</b> 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.
<a href="#">SB 1428</a> <b>Atkins (D)</b>  <b>Status:</b> First hearing cancelled at request of the author. 6/19/24.	<b>Health care coverage: triggering events</b> <b>Summary:</b> Under the bill, a person, in exercising their individual rights under the above-described constitutional provision and the Reproductive Privacy Act, would not be subject to civil or criminal liability or penalty, or otherwise deprived of their rights, for using, receiving, possessing, or storing brand or generic mifepristone or any drug used for medication abortion. Under the bill, a person who aids or assists a pregnant person in exercising their rights under those provisions would not be subject to liability or penalty or deprivation of rights based solely on their actions to aid or assist a pregnant person in accessing any of those drugs. The bill would declare those actions as being lawful under the laws of California.  This bill would state the intent of the Legislature to protect reproductive health-access. The bill would authorize CHHSA or its departments to enter into partnerships resulting in the production, procurement, or distribution of mifepristone.  In the event of a change in the approval status of mifepristone by the FDA, or a change in conditions for use or in the accessibility of mifepristone, the bill would authorize CHHSA or its departments to develop a process to allow continued access to mifepristone, such as clinical trials or approval for use through the State Department of Public Health.
<a href="#">SB 1492</a> <b>Menjivar (D)</b>  <b>Status:</b> Held in committee and under submission, 5/16/24.	<b>Medi-Cal reimbursement rates: private duty nursing</b> <b>Summary:</b> 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:** December 4, 2024  
**TO:** Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission  
**FROM:** Michael Schrader, Chief Executive Officer  
**SUBJECT:** Schedule of Alliance Board Meetings and Board Member Committee Participation 2025

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Recommendation. Staff recommend the Board approve the 2025 schedule of Alliance Board Meetings and Board member Committee and Advisory Group participation.

Discussion. The schedule for meetings of the Alliance Board, Board Committees and Advisory Group are set by the Board at the final meeting of each calendar year for the following year. In addition, Advisory Group and Committee members serve a one-year term at the end of which Commissioners vote on membership. Meetings are held at the following locations via videoconference unless otherwise noticed and are open to the public.

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

### Board Meetings

Alliance Board Meetings are held from 3:00 to 5:00 p.m. (fourth Wednesday) via videoconferencing at each of the Alliance's three offices in Scotts Valley, Salinas and Merced and in public meeting rooms in San Benito and Mariposa counties. Board members are required to attend the meetings in person at one of the five locations. Members of the public will be allowed access to each meeting location and to provide public comment from each location.

### Schedule of Alliance Board Meetings for 2025

January 22, 2025	In-person Alliance Offices and Meeting Rooms
February 26, 2025	In-person Alliance Offices and Meeting Rooms
March 26, 2025	In-person Alliance Offices and Meeting Rooms

**HEALTHY PEOPLE. HEALTHY COMMUNITIES.**

April 23, 2025	<i>In person Merced County; 10:00 a.m. – 3:00 p.m.</i>
May 28, 2025	In-person Alliance Offices and Meeting Rooms
June 25, 2025	In-person Alliance Offices and Meeting Rooms
July 2025	No meeting scheduled
August 27, 2025	In-person Alliance Offices and Meeting Rooms
September 24, 2025	In-person Alliance Offices and Meeting Rooms
October 22, 2025	In-person Alliance Offices and Meeting Rooms
November 2025	No meeting scheduled
December 3, 2025	In-person Alliance Offices and Meeting Rooms

### Finance Committee

Finance Committee meets quarterly in March, June, August and October immediately preceding the Board meeting.

Wednesday, March 26, 2025, 1:30 – 2:45 p.m.

Wednesday, June 25, 2025, 1:30 – 2:45 p.m.

Wednesday, August 27, 2025, 1:30-2:45 p.m.

Wednesday, October 22, 2025, 1:30 – 2:45 p.m.

Finance Committee members:

- Michael Molesky (Committee Chair)
- Alan Radner, MD (Committee Vice Chari)
- Anita Aguirre
- Ralph Armstrong, DO
- Elsa Jimenez
- Josh Pedrozo

### Member Services Advisory Group (MSAG)

MSAG meets quarterly in February, May, August and November. Meetings will be held in person in Alliance Scotts Valley, Salinas and Merced offices and in public meeting rooms in San Benito and Mariposa counties 10:00 – 11:30 a.m. unless otherwise noticed.

Thursday, February 13, 2025:

Thursday, May 8, 2025

Thursday August 14, 2025

Thursday, November 6, 2025

Board member participants on MSAG:

- Janna Espinoza

- Michael Molesky

#### Member Services Advisory Group Selection Committee (MSAGSC)

MSAGSC meets quarterly in February, May, August and November. Meetings will be held in person in Alliance Scotts Valley, Salinas and Merced offices and in public meeting rooms in San Benito and Mariposa counties 9:30am – 9:45 a.m. unless otherwise noticed.

Thursday, February 13, 2025  
Thursday, May 8, 2025  
Thursday, August 14, 2025  
Thursday, November 6, 2025

Board member participants on MSAGSC:

- Janna Espinoza

#### Physicians Advisory Group (PAG)

PAG meets quarterly in March, June, September and December. Meetings will be held in person in Alliance Scotts Valley, Salinas and Merced offices and in public meeting rooms in San Benito and Mariposa counties from 12:00 – 1:30 p.m. unless otherwise noticed

Thursday, March 6, 2025  
Thursday, June 12, 2025  
Thursday, September 4, 2025  
Thursday, December 4, 2025

Board member participants on PAG:

- Ralph Armstrong, DO
- Donaldo Hernandez, MD
- James Rabago, MD

#### Whole Child Model Clinical Advisory Committee (WCMCAC)

WCMCAC meets quarterly in March, June, September, and December. Meetings will be held by remote videoconference from 12:00 – 1:00 p.m. unless otherwise noticed with a 2025 meeting schedule as follows.

Thursday, March 20, 2025, 12:00 – 1:00 p.m.  
Thursday, June 26, 2025, 12:00 – 1:00 p.m.  
Thursday, September 18, 2025, 12:00 – 1:00 p.m.  
Thursday, December 18, 2025, 12:00 – 1:00 p.m.

Board member participants on WCMCAC::

- James Rabago, MD

### Whole Child Model Family Advisory Committee (WCMFAC)

WCMFAC meets every other month. Meetings will be held by remote videoconference from 1:30 – 3:00 p.m. unless otherwise noticed with a 2025 meeting schedule as follows.

Monday, February 3, 2025; 1:30 – 3:00 p.m.

Monday, May 5, 2025; 1:30 – 3:00 p.m.

Monday, August 4, 2025; 1:30 – 3:00 p.m.

Monday, November 3, 2025; 1:30 – 3:00 p.m.

Board member participants on WCMFAC::

- Janna Espinoza
- Michael Molesky

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

Attachments. N/A



**DATE:** December 4, 2024  
**TO:** Santa Cruz-Monterey-Merced Managed Medical Care Commission  
**FROM:** Dr. Dennis Hsieh, Medical Director  
**SUBJECT:** Peer Review and Credentialing Committee Report of September 2024

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Recommendation. Staff recommend the Board accept the decisions from the September 11 meeting of the Peer Review and Credentialing Committee (PRCC).

Background. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) is accountable for all provider credentialing activities. The Board has delegated to the PRCC the authority to oversee the credentialing program for the Central California Alliance for Health (the Alliance).

Discussion. The PRCC is currently a seven-member committee comprised of Alliance-contracted physicians who make recommendations to approve, defer, or deny network participation for new and existing providers based on established credentialing criteria. The committee meets quarterly. The PRCC also conducts peer review of network providers and offers advice and expertise when making credentialing decisions. Provider credential verification and review ensures that network providers possess the legal authority, relevant training and experience, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards. The Alliance credentialing standards are aligned with applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care and, as appropriate, the National Committee for Quality Assurance.

#### September 2024 Meeting

- New Providers:
  - 76 Physician Providers (MD, DO, DPM)
  - 54 Non-Physician Medical Practitioners
  - 34 Allied Providers
  - 25 Organizations
- Recredentialed Providers:
  - 124 Physician Providers (MD, DO, DPM)
  - 29 Non-Physician Medical Practitioners
  - 13 Allied Providers
  - 8 Organizations

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

Attachments. N/A

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**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Lisa Ba, Chief Financial Officer  
**SUBJECT:** Proposed Medical and Administrative Budget for Calendar Year (CY) 2025

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Recommendation. Staff recommend the Board approve the following 2025 budgets:

1. Medical Budget of \$2,041,559,444
2. Administrative Budget of \$119,575,753

Summary. The Alliance is committed to putting forward a budget that ensures adequate funds for efficient and effective operations and demonstrates fiscal responsibility for long-term sustainability. This shall be achieved through:

- Maintaining access to and ensuring quality of care for members.
- Aligning payment rate with revenue rate, utilization trends, and industry benchmarks.
- Improving provider reimbursement through value-based payment (VBP).
- Sustaining operational efficiency while adequately funding administrative resources to execute regulatory requirements,

Background. During the COVID-19 public health emergency (PHE), many Medi-Cal enrollees were given continuous coverage, but with the end of PHE, the redetermination process began in July 2023 and was expected to conclude by June 2024. Despite this timeline, we are still seeing redetermination extending beyond June, leading to a further decline in membership. Additionally, those who have remained enrolled are seeing higher acuity levels and increased medical costs. As a result, these factors are placing increased pressure on both membership and cost management, requiring ongoing adjustments to our financial and operational strategies.

The medical cost budget accounts for the decline in membership, higher utilization, and increased unit costs. It also includes the first year of the board-approved provider supplemental payment (PSP), or \$52.4M.

The administrative budget incorporates the resources needed to bring behavioral health services in-house, implement the Dual Eligible Special Needs Plan (D-SNP), and expand ECM and Community Supports.

Overall, the Alliance will spend 95.4% or 97.9% (including PSP) of its revenue on medical and 5.7% on administrative costs, resulting in an operating loss of \$79.4M or 3.8%

Discussion. Staff developed the 2025 Medical Budget based on claims data from January 2022 through September 2024, paid through September 30, 2024. The 2025 medical cost budget reflects adjustments for utilization and unit cost trends plus Targeted Rate Increases (TRI), the continuous expansion of Enhanced Care Management (ECM) and Community Supports (CS) programs, in-sourcing of Behavioral Health services by July 2025, applicable risk corridors,

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changes in provider contracts and fee schedules, and cost-of-care savings initiatives, with further opportunities to enhance managed care efficiency, as described in the revenue section. Should any unforeseen program or funding changes materially impact the 2025 budget, these variations will be addressed in the 2025 financial forecast.

*Enrollment:* The 2025 budgeted enrollment will remain flat due to uncertainty about Medi-Cal's post-redetermination landscape. The IHSS members will reduce by 4% due to the potential increase in premiums. Staff expect the membership to be 438,649 by December 2025, a 0.03% decrease from the projected December 2024 enrollment.

*Revenue:* The budget is based on the CY 2025 draft rates released on October 21, 2024. The rate is based on our Rate Development Template crosswalk provided to DHCS in December 2023 and on the State fiscal year 2022-23 cost experience. The CY 2025 draft rates represent a 0.6% increase over CY 2024, excluding ECM and TRI. Overall, the budget revenue totals \$2.1 billion.

DHCS implemented a Targeted Rate Increase (TRI) in CY 2024 rates, which was continued into 2025 with a 7.2% increase for a PMPM of \$23.02 or \$118.3M. This increase will be recognized as revenue in CY 2025. Furthermore, staff assume the TRI is budget neutral, meaning the total amount will be distributed to providers. It is important to note that the TRI rate does not reflect the impact of Prop 35, passed in the November 2024 election, and staff anticipate the final rates will reflect the proposition.

There is a positive acuity adjustment of \$28.4M, offset by a negative managed care efficiency adjustment of \$29.1M. These adjustments include potentially preventable hospital admissions (PPAs), low acuity non-emergent visits (LANE), and the Healthcare Common Procedures Coding System (HCPCS) efficiency adjustment for physician-administered drugs.

DHCS also increased the quality withhold to 1% in the draft rates, up from 0.5% in 2024. The budget assumes that we can earn back 75%.

While a slight acuity adjustment has been applied, the current draft rate does not fully address the increased utilization and associated costs resulting from changes in acuity following redeterminations and shifts in population. These factors are critical to accurately capturing the financial impact. Additionally, rates for Community Supports (CS) expenses have not kept pace with the rising cost trends driven by the ramp-up of CS benefits. The rate for the Central region is further discounted from benchmarking the former plan in Mariposa despite the Alliance leveraging its network and payment methodology across all counties. Furthermore, the draft rate does not adequately cover essential administrative costs, particularly fixed expenses, which must be allocated across a smaller member base while still meeting quality standards. All concerns regarding the draft rate have been formally communicated to DHCS as of 11/7/2024.

The budget assumes the three risk corridors remain in effect for ECM, Unsatisfactory Immigration Status (UIS) members, and San Benito. This means that we have breakeven performances in these areas.

*Medical Expenses:* The Alliance budget spends 97.9% (including \$52.4M in PSP) of its revenue on medical expenses. The medical expense budget for 2025 totals \$2.04 billion, including \$52.4M PSP.



The main categories of services are Inpatient/Outpatient services (Hospital) at 39.5%, Physician Services at 25.8%, with 5.9% for TRI, Other medical services at 13.1%, Long-Term Care at 10.3%, ECM/CS at 7.5% and Behavioral Health at 3.9%.

The medical cost budget is based on historical trends in utilization and unit costs from recent years, including a 3.3% increase in utilization and a 4.7% rise in unit costs compared to the 2024 forecast, driven by the ramp-up of ECM and Community Supports services, case mix adjustments, and costs associated with in-sourcing Behavioral Health services in the second half of 2025. The budget also incorporates the Targeted Rate Increase (TRI), which will help maintain the funding levels supported by Proposition 56.

The budget assumes continued ramp-up of ECM and Community Supports (CS) through 2025, but both will be impacted if DHCS does not align with current experience levels; while ECM is mitigated through risk corridors, ECM cash flow and CS sustainability will be at risk if rates remain inadequate.

As the State continues to develop actuarially sound rates, seek cost efficiencies, and enhance the quality of care, staff remain committed to the payment policy, ensuring provider rates align with the revenue rates, utilization trends, and industry benchmarks while offering Value-Based Payment (VBP) opportunities to enhance provider reimbursement. As such, the 2025 budget includes a \$56.2M investment in various incentive programs to improve quality and member outcomes. This includes a \$20M Hospital Quality Incentive Program, a \$15M Care-Based Incentive, a \$12.5M Specialist Care Incentive, a \$4M Data Sharing Incentive, a \$3.7M Behavioral Health Valued Based Payment Incentive, and a \$1M Risk Adjustment Incentive. The budget is \$9.2M or 20% over the 2024 budget.

*Administrative Expense:* The administrative budget totals \$119.6M, or 5.7% of revenue. This reflects an increase of \$14.2M, or 13.5%, from the 2024 budget. The budget invests administrative resources to bring Behavioral Health Insourcing by July 2025, continue Medicare D-SNP implementation for a Go-Live date of January 2026, and continue expanding ECM Enrollment and CS programs. The administrative budget aims to maintain organizational efficiency through department assessment, technology, and process improvement to achieve long-term financial sustainability and stewardship.

*Non-Operating Income/(Expense):* The net non-operating income totals \$13.9M, primarily from the \$45.9M investment income offset by an estimated \$32M grant distribution.

Fiscal Impact. Overall, the proposed medical and administrative budgets yield an Operating Loss of \$75.2M with a medical loss ratio of 97.9% and an administrative loss ratio of 5.7%. Please note that excluding the provider supplemental payment, the operating loss is \$22.8M, or 1.1%. Including the non-operating income, the net loss will be \$61.3M, or 2.9%.

#### Attachments.

1. Proposed Medical and Administrative Budget for CY 2025
2. Capital Budget and Depreciation Expense for CY 2025



## Central California Alliance For Health

### Proposed Medical and Administrative Budget for Calendar Year 2025 (In \$000's)

	2022 ACTUAL	2023 ACTUAL	2024 BUDGET	2024 FORECAST	2025 BUDGET
Total Member Months	4,852,922	5,052,756	4,908,292	5,389,365	5,265,613
Total Operating Revenue	\$1,546,914	\$1,709,505	\$1,660,129	\$1,915,603	\$2,085,968
Total Medical Expenses	1,358,876	1,483,504	1,532,466	1,780,482	2,041,559
<b>Gross Margin</b>	<b>\$188,038</b>	<b>\$226,001</b>	<b>\$127,663</b>	<b>\$135,121</b>	<b>\$44,409</b>
Administrative Expenses					
Salaries	56,342	63,405	72,420	70,422	80,806
Professional Fees	3,491	3,233	3,945	4,116	5,210
Purchased Services	8,492	10,713	11,791	13,296	13,555
Supplies & Other	9,505	5,605	12,004	12,454	9,458
Occupancy	1,099	1,348	1,511	1,483	1,576
Depreciation/Amortization	3,333	6,467	3,704	3,604	8,971
Total Administrative Expenses	82,262	90,771	105,376	105,376	119,576
<b>Operating Income/(Loss)</b>	<b>\$105,775</b>	<b>\$135,230</b>	<b>\$22,288</b>	<b>\$29,745</b>	<b>(\$75,167)</b>
Non-Op Income/(Expense)					
Interest	12,645	36,253	28,190	51,844	39,716
Gain/(Loss) on Investments	(25,291)	8,356	3,300	11,725	4,500
Bank & Investment Fees		(488)	(436)	(623)	(740)
Other Revenues	1,639	1,877	2,540	2,254	2,376
Grants	(10,834)	(13,182)	(17,554)	(32,816)	(32,000)
Total Non-Op Income/(Expenses)	(21,842)	32,815	16,040	32,384	13,853
<b>Net Income/(Loss)</b>	<b>\$83,934</b>	<b>\$168,045</b>	<b>\$38,328</b>	<b>\$62,129</b>	<b>(\$61,314)</b>
MLR	87.8%	86.8%	92.3%	92.9%	97.9%
ALR	5.3%	5.3%	6.3%	5.5%	5.7%
Operating Income	6.8%	7.9%	1.3%	1.6%	-3.6%
Net Income %	5.4%	9.8%	2.3%	3.2%	-2.9%



**DATE:** December 4, 2024  
**TO:** Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission  
**FROM:** Jenifer Mandella, Chief Compliance Officer  
**SUBJECT:** Q1 – 2 2024 Compliance Program Reporting

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Recommendation. Staff recommend the Board approve the Compliance Program Report for Q1-2 2024.

Summary. This report summarizes the Alliance's Compliance Program activities for Q1-2 2024 and includes a recommendation to approve the Compliance Program Report.

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

The Alliance Board is required to exercise reasonable oversight with respect to the implementation and effectiveness of the program. The Board has delegated authority for overseeing the Compliance Program to the Compliance Committee and receives updates on the efficacy of the Compliance Program through the routine submission of Compliance Committee minutes, the inclusion of key Compliance Program metrics in the Alliance Dashboard, and the receipt of bi-annual reporting from the Chief Compliance Officer.

Discussion. This report serves to inform the Board of the Alliance's Compliance Program activities for Q1-2 2024.

### *Legal and Regulatory Updates*

Compliance staff track and manage a process to ensure the implementation of new requirements, including legislation, contract changes, and sub-regulatory guidance. A brief description of significant changes that have not been addressed elsewhere with the Board are included below for Board awareness.

- Following an organization-wide project to implement all provisions, the Alliance began operating under the 2024-DHCS Medi-Cal contract, which imposes significantly new requirements on plans related to health equity, community engagement, transparency and oversight.
- The Centers for Medicare and Medicaid Services published a final rule on Managed Care Access, Finance, and Quality. The rule intends to increase access through establishing national appointment wait time standards, annual secret shopper surveys, and public reporting of results. As related to quality, the rule makes changes to state development of value-based purchasing agreements and provides certain limitations to those arrangements. To ensure appropriate financing of Medi-Cal services the rule limits expenditures on in lieu of services, provides specificity on

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MLR reporting, and outlines requirements around provider incentive payments. Additional guidance is expected from DHCS in the coming months.

- Changes were made to rules governing the confidentiality of substance use disorder (SUD) records (Part 2 Rule) which allow some flexibility in the sharing of SUD records to support care coordination.
- As a result of the latest election and administration change, staff are monitoring for potential impacts. These may include efforts to eliminate the Affordable Care Act's Medicaid expansion, cuts to federal funding through block grants or per-capita grants, changes to Medicaid eligibility criteria, and the introduction of new requirements for approving waiver requests from states.
- The Supreme Court's overturn of the Chevron doctrine also introduces uncertainty into the environment. The Chevron doctrine is a legal principle that says that where laws were ambiguous, courts should defer to the interpretation of that rule made by the agency that enforces it. Going forward, staff expect increased scrutiny of federal regulations and more litigation as courts, agencies, and Congress adapt to this new framework.

### *Regulatory Audits*

The Alliance undergoes routine audits and examinations of its finances and operations by its regulatory oversight agencies, as well as by independent auditing firms. Following is a list of audits and examinations that the Alliance was involved in during Q1-2 2024, including the auditing entity and a description of the audit or review.

- 2024 DHCS Medical Audit – which is a routine review of the Alliance's regulatory and health services operations for the Medi-Cal line of business. DHCS conducted a limited-scope audit covering the areas of utilization management (UM), case management and coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. The audit resulted in 2 findings related to payment of claims for family planning and abortion services. The Alliance has since remediated the findings through implementing new audit procedures and DHCS has closed the CAP.
- DHCS Targeted Behavioral Health and Transportation Audit – which is a statewide review conducted in 2022 to ensure that members are receiving support in coordinating care between the various systems responsible for providing mental health and substance use disorder services as well as a review of plan processes for ensuring transportation is provided to enable members to access covered services. The Alliance received 8 findings; 6 findings related to coordination of care between the Alliance, its managed behavioral health organization Carelon and the County Mental Health Plan (MHP) for members accessing specialty mental health, non-specialty mental health, and substance use disorder services. Two findings related to the provision of transportation services with particular emphasis on ensuring the availability of services and provision of services that align with member need for support. The Alliance has resolved the two transportation findings and is awaiting confirmation of resolution from DHCS. The remaining 6 care coordination findings are being resolved through developing collaborative procedures with the county MHPs, with resolution anticipated at the end of 2024.
- DMHC Medical Audit – which is a routine review of the Alliance's performance in providing health care benefits and meeting the health care needs of subscribers and

enrollees for the Alliance's Alliance Care In-Home Supportive Services (IHSS) line of business in the areas of: grievances and appeals, prescription drugs, utilization management (UM), quality management, language assistance, continuity of care, access and availability, and access to emergency services and payment. The Alliance has not yet received the results of this survey.

- Health Services Advisory Group Network Adequacy Validation Audit – which is a review conducted by a DHCS-contracted organization to confirm the validity of the data, systems, and methods used by the Alliance to calculate results for its Annual Network Certification filing. The Alliance has not yet received the results of this survey.

### *Regulatory Notices of Non-Compliance*

In addition to conducting audits, the Alliance's regulators routinely monitor plan activities to confirm compliance with requirements. Where regulators have found the Alliance to be non-compliant, they may issue warning letters or notices of non-compliance, may implement corrective action plans (CAPs), and may impose sanctions (collectively referred to in this report as "notices of non-compliance"). Following is a list of notices of non-compliance received during Q1-2 2024.

- DMHC audit sanctions – DMHC imposed an Enforcement Action regarding four findings from the 2020 DMHC Medical Survey which remained uncorrected during the 2022 Follow-Up Survey. The results uncorrected deficiencies related to processing appeals and grievances, pharmacy denial notices, and communications to members regarding grievance resolution and utilization management denials. Notably, the latter two findings were issued because the Alliance erroneously underlined the DMHC's website in our member letters. The Department indicated a willingness to resolve the matter with the payment of a \$100,000 administrative penalty. The Alliance has not accepted the compromise and has communicated its concern that the magnitude of the penalty does not align with the minimal nature of the findings with DMHC. We are awaiting DMHC's response.
- DHCS Primary Care Provider ratio CAP – DHCS issued a CAP indicating that the Alliance had failed to meet the requirement to ensure the full-time equivalent (FTE) ratio of one PCP to every 2,000 members in Monterey and Merced counties. Staff revised network reporting procedures, which addressed the deficiency in Merced County. Staff continue to work collaboratively with DHCS to resolve the ratios in Monterey County as there appears to be a discrepancy in the network data DHCS is reviewing and internal reporting sources.
- Enhanced Care Management (ECM) Justice Involved Population of Focus pre-CAP – DHCS noted that the Alliance was lacking an ECM provider in Mariposa County with experience with the justice involved population and indicated the Plan's capacity assessment did not consider recent membership and provider data. The Alliance described its efforts to recruit and train ECM providers, which resulted in DHCS closing the pre-CAP.

### *HIPAA*

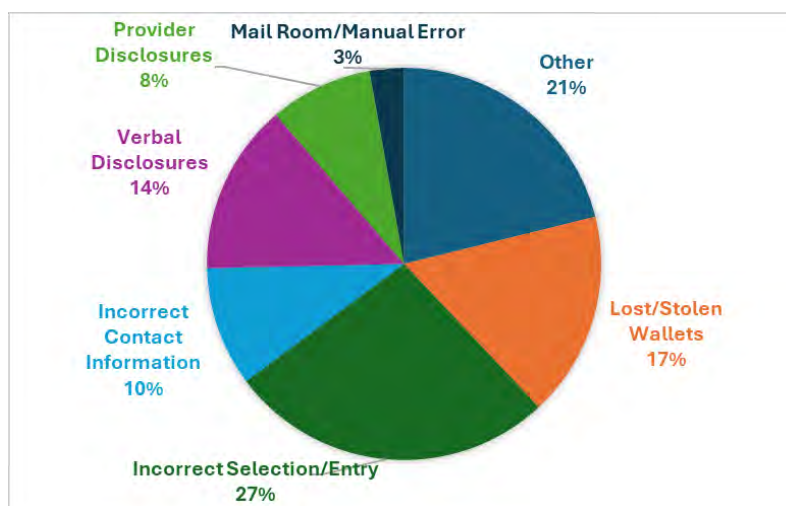
The Alliance maintains a comprehensive process to investigate suspected disclosures of protected health information (PHI) and report disclosures to relevant oversight bodies. The table below summarizes HIPAA Program activity for Q1-2 2024.

Q1 2024		Q2 2024
Referrals Received		31
Investigation Outcome	Breach	0
	Incident	10
	Non-reportable	21
	Pending	0
Members Impacted		59

In the first half of 2024, the Alliance continued to experience slightly higher than average referral volume with 41 referrals in Q1 and 31 referrals in Q2, as compared with the 29 referrals per quarter in 2023. 34% of referrals required DHCS notification pursuant to the DHCS Medi-Cal contract. Zero referrals were deemed breaches.

78 members were impacted by incidents, meaning that their PHI was disclosed to a covered entity that they did not have a treating relationship with. The majority of the incidents reported to DHCS were the result of a mis-selection during claims processing or service authorization and impacted only a single member. Two incidents impacted multiple members; one was the result of a remittance advice being mailed to the incorrect address and the other was the result of using live PHI during a training session. For all incidents, corrective action was put in place to ensure correction and prevent recurrence. Compliance's reporting indicates these corrective actions were effective as there were minimal repeat concerns during the reporting period.

Compliance staff conduct root cause analysis on all referrals, whether a disclosure occurred or not. The chart below shows the root causes of suspected disclosures of PHI during Q1-2 2024.



Incorrect selection/entry, lost/stolen wallets, and verbal disclosures are typically the main drivers of HIPAA referrals, and that trend has continued during the reporting period. Compliance provides ongoing training on how to prevent inadvertent disclosure of PHI to mitigate disclosures resulting from incorrect selection/entry or verbal disclosure. Lost/stolen wallets are not reportable to DHCS as they are disclosures not resulting from Plan actions.

A newer trend is the increase in security incidents that impact our providers and/or vendors, with Change Healthcare's data breach being a well-known example. The Alliance has taken a proactive approach to educating staff and ensuring protections are in place to minimize risk of security incidents. Information Technology Services (ITS) staff have implemented a cyclical process to assess, remediate, and re-assess our systems for vulnerabilities.

#### *FWA Prevention, Detection, and Investigation*

The Alliance Program Integrity function is responsible for ensuring the Plan has controls in place to prevent and detect fraud, waste and abuse (FWA), and to investigate, report, and resolve suspected and/or actual FWA. In limited instances, Alliance delegates may conduct some FWA-related activities at the Plan's direction. These activities are represented in this report. The table below summarizes Program Integrity activity for Q1-2 2024,

	Q1 2024	Q2 2024
Referred	76	36
Opened	43	25
Reported	36	24

Referral and case volume continues to remain high, with Q1 2024 volume a record. Staff received 76 referrals in Q1 and 36 referrals in Q2, compared with an average of 40 referrals per quarter in 2023. In addition to receiving reports from staff, Program Integrity receives and, as appropriate, investigates and/or responds to data requests and fraud referrals from DHCS. During the reporting period, 54% of referrals met the threshold for DHCS reporting pursuant to the DHCS Medi-Cal contract.

Where FWA is suspected, Plan staff prevents recurrence of the identified behavior by providing education, issuing CAPs, and/or implementing internal controls. Compliance's reporting indicates these corrective actions are effective as there were minimal repeat concerns during the reporting period. Where the Alliance identifies overpayments as a result of its investigations, it will pursue those recoupments in accordance with DHCS and CMS requirements. The table below includes the Program Integrity-related claim recoveries for Q1-2 2024.

Recoupment	Alliance initiated	Delegate initiated
Requested Recoupment	\$491,751.10	\$12,974.72
Completed Recoupment	\$399,781.15	

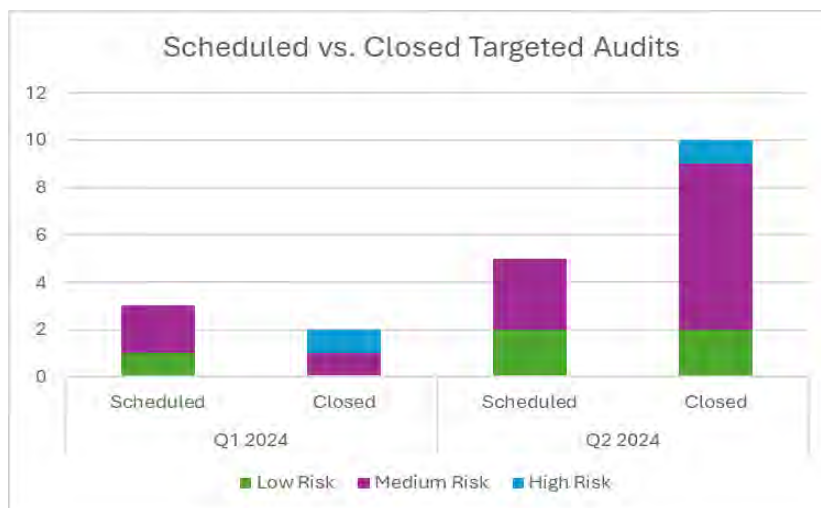
Provider-related concerns typically make up the the bulk of Program Integrity investigations, with concerns related to over-utilization, upcoding, irregular billing behavior, and billing for services not rendered. In the first half of 2024, staff observed a slight increase in member-related concerns and state requests. Member-related matters were the result of allegations of abuse of the Alliance's transportation and Community Supports (CS) benefits. There was no clear trend in the state requests for data and DHCS rarely shares the rationale for their data requests. One notable trend during the period was the increase in investigations related to ECM and CS, with concerns that include member misuse of the benefit and concerns with the adequacy, frequency, and quality of services provided. This has garnered DHCS' attention, and they are working to develop additional guidance for these programs.

Program Integrity staff attended 2 California Department of Justice (DOJ) meetings. The meetings enhance collaboration and data sharing with Program Integrity staff from other health plans, as well as investigators from DHCS and the DOJ. During these meetings, Plan staff received training on the California and Federal False Claims Acts from DOJ personnel and engaged in collaborative discussion with other plans regarding challenges with overseeing ECM service delivery.

#### *Internal A&M Program*

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

As shown in the table below, staff are able completing planned audits, although closure may lag as a result of the time needed to obtain corrective action from business units and because audit staff are also supporting regulatory audit activities. High-risk areas scheduled for audit included grievance identification and processing and UM regulatory notices; medium-risk areas include provider screening and enrollment and HIPAA reporting; and low-risk areas include non-medical transportation requests and translation requests.





During the first half of 2024, staff closed 13 targeted audits, including 2 audits of high-risk areas, 9 audits of medium-risk areas and 2 audits of low-risk areas.

		Q1 2024	Q2 2024
Total		3	10
Risk Level	High	1	1
	Medium	2	7
	Low	0	2
Result	Pass	3	6
	Fail	0	4
	Unable to Audit	0	0

4 audits received a failed result, with details as follows.

- Utilization Management regulatory notices – which reviewed UM notices to members and providers to ensure timeliness and required content. Results indicate that all notices are sent timely, but that the underlined DMHC website had not yet been corrected and the content of deferral notices lacked certain elements.
- HIPAA reporting – which reviewed the timelines and content of required HIPAA reports to DHCS. Findings related to missing elements in the submitted report and not submitting reports by the approved extension date.
- Claims Accuracy Self-Audit – which reviewed whether Claims staff are sufficiently conducting claims accuracy audits. The audit revealed that Claims is conducting these audits and following up to fix identified concerns. Compliance staff noted that there were no established procedures to ensure the auditing is conducted consistently and that results are documented and shared with leadership and staff.
- Employee Permissions – which ensures that procedures are in place to suspend or terminate access to Alliance systems when staff are on leave or separate from the organization. Permissions for separations were processed timely but timeliness of permission changes for letters of absence fell below threshold.

For all aforementioned areas, Compliance staff ensured the implementation of CAPs and will assess the need to re-audit to confirm full CAP implementation.

Routine monitoring of compliance-related metrics on the Alliance Dashboard did not identify any deficiencies.

		Q1 YEAR	Q2 YEAR
Total Metrics Monitored		31	35
Result	Pass	31	35
	Fail	0	0

### *Confidential Reporting*

In support of the requirement to ensure effective lines of communication from staff to the Compliance Officer, the Alliance maintains a confidential hotline, which Alliance staff may use to report compliance issues anonymously. During Q1-2 2024, 5 reports were received through the hotline; 4 of the reported concerns were employee-related concerns and 1 concern was compliance-related.

### *Training and Education*

All Alliance staff receive web-based compliance training, which reviews FWA prevention, HIPAA policies and procedures, the Alliance's Compliance Plan and Code of Conduct, the Alliance's DHCS Medi-Cal contract, and mechanisms for reporting non-compliance. New hires must complete training within two weeks for staff-level positions, or four weeks for supervisory-level positions. Existing staff are enrolled in the web-based module annually as a refresher. New hires also receive supplemental training which provides a high-level overview of the content and structure of the Alliance's Medi-Cal Contract, regulatory audits, the Internal A&M Program, and HIPAA and FWA processes and reporting mechanisms.

In Q1-2 2024, 106 of staff were due to complete this training and all trainings were completed timely.

During the reporting period, Compliance staff conducted a routine review of our new hire and annual training content to ensure the content remains relevant and current. In addition, staff developed standalone trainings covering the use of artificial intelligence and DHCS expectations regarding entering into memoranda of understanding (MOUs) with county entities and maintaining ongoing relationships with those entities.

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

### Attachments.

1. Q1-2 2024 Internal A&M Dashboard
2. Q1-2 2024 HIPAA Dashboard
3. Q1-2 2024 Program Integrity Dashboard

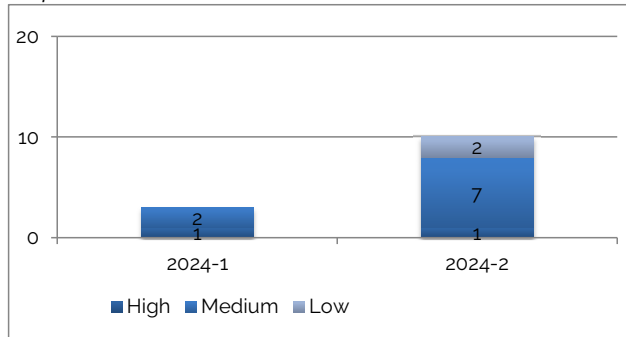


## Compliance Internal Audit Dashboard - Q1-Q2 2024

Prepared for the Alliance Board

### Reviews Closed by Risk Level

Compliance closed a total of 13 risk-based internal reviews during Q1-Q2 2024. The internal audit program assesses and mitigates risk to ensure Plan readiness for regulatory audits and forthcoming accreditations. Items were selected for the work plan based on recent audit findings, new requirements, and regulatory sanctions.



**13 Total  
Reviews  
Closed  
in Q1-Q2  
2024**

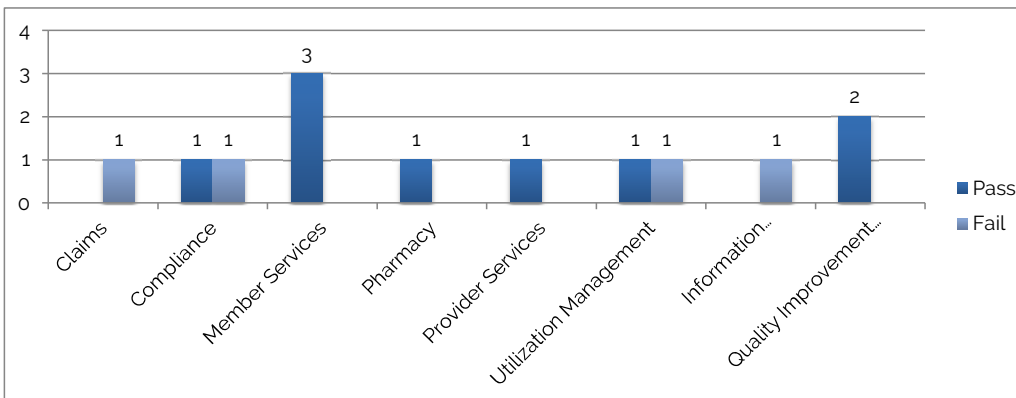


### Q2 Reviews by Operational Area & Risk Level

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

### Q1-Q2 2024 Review Results by Operational Area

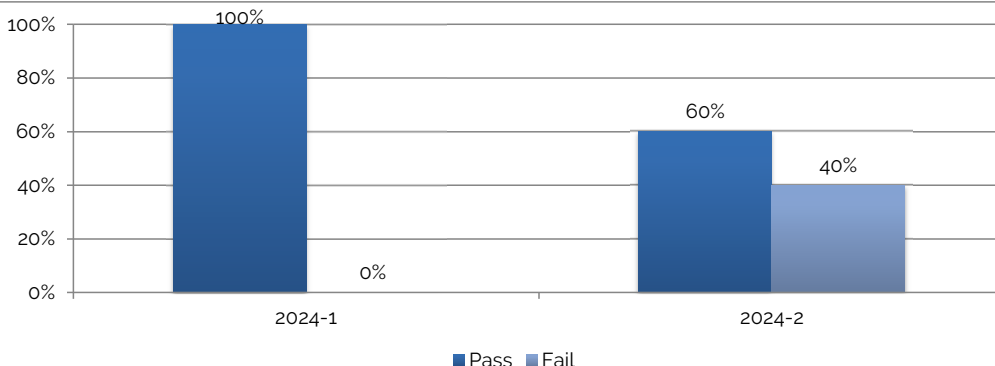
9 of 13 closed reviews received a passing score  
4 of 13 closed reviews received a failing score



### Mitigation for Failed Reviews

In response to failed reviews, Compliance partners with SME departments to ensure deficiencies are corrected through the following:

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



### Trending and Quarterly Review Results by Risk Level

Information presented here depicts Compliance-issued findings for audits conducted over the past 4 quarters.

#### Q1-Q2 2024 Outcomes

High Risk Areas: 50% passed  
Medium Risk Areas: 67% passed  
Low Risk Areas: 100% passed  
**Overall Result: 69% Passed**



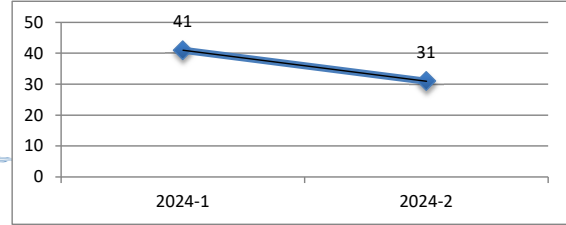
# Compliance

## HIPAA Dashboard - Q1-Q2 2024

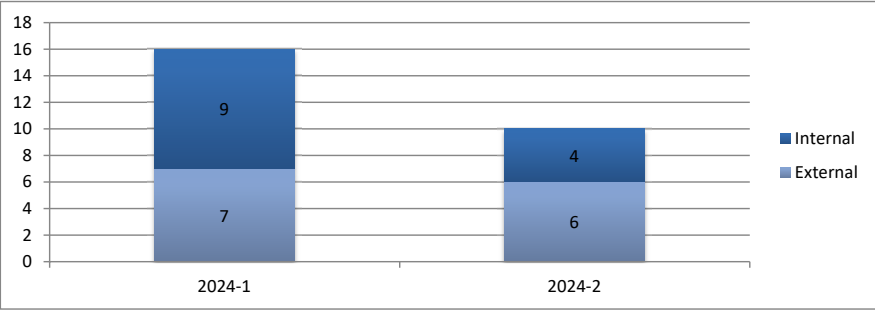
Prepared for the Alliance Board

### Reports of Suspected Disclosures

Compliance received a total of 72 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q1-Q2 2024. (This is all suspected events, whether or not they were deemed reportable upon investigation)

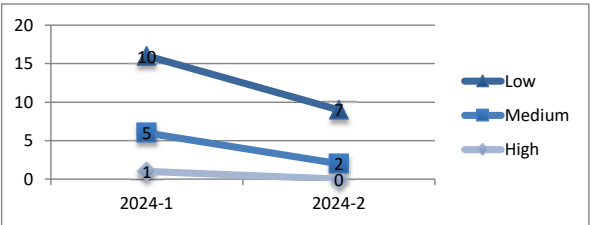


72 Total HIPAA Reports in Q1-Q2 2024



**Sources of Disclosures:**  
**Internal (Alliance) & External (Non-Alliance)**  
Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegates.

*\*Excludes Non-Events, Duplicates and Non-Reportable Incidents*

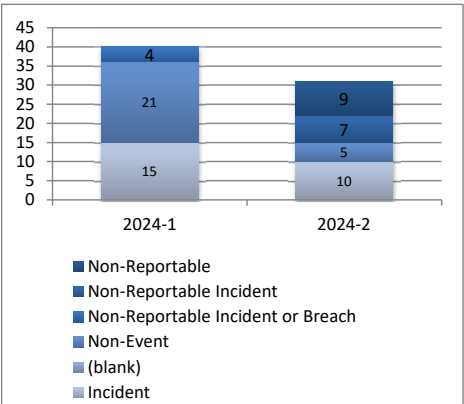


**Impact of Events**  
(excludes Non-Events and Events Pending Investigation)  
17 of 25 events had an impact of low;  
7 of 25 had an impact of medium;  
1 of 25 had an impact of high.

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

### Final Classification

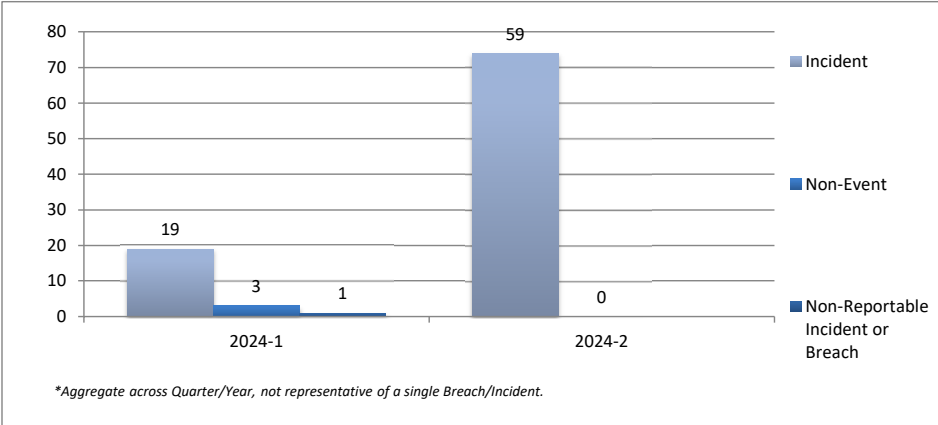
Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; Non-events are when the investigation reveals that no unauthorized disclosure of PHI occurred; Mitigated incidents are when the Plan is able to mitigate the disclosure within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



### Member Impact

97 members were impacted by HIPAA events in Q1-Q2 2024;  
0 were impacted due to breaches, 93 were due to incidents, 4 were classified as non-events or non-reportable

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

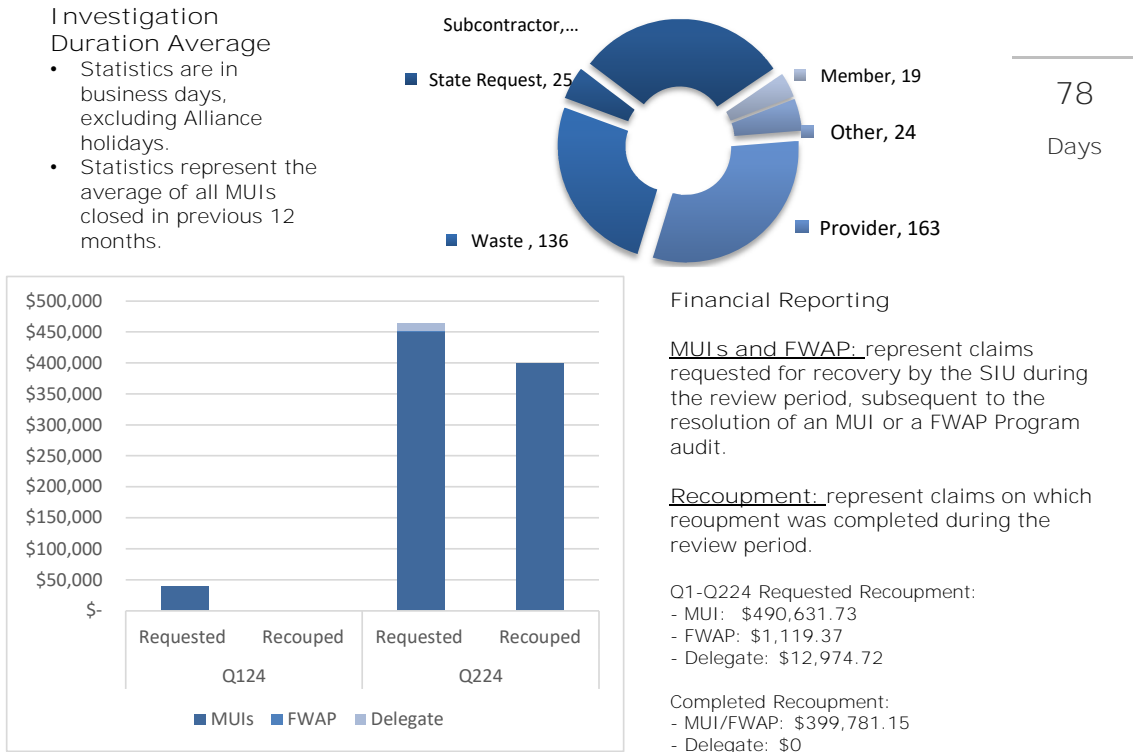
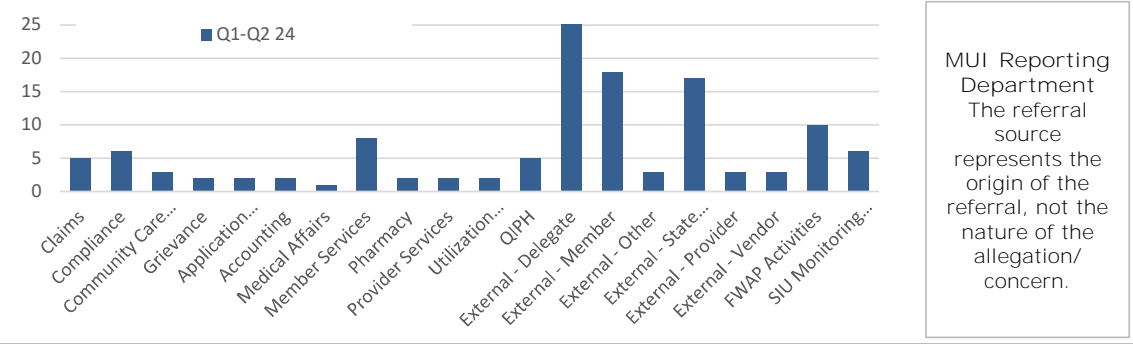
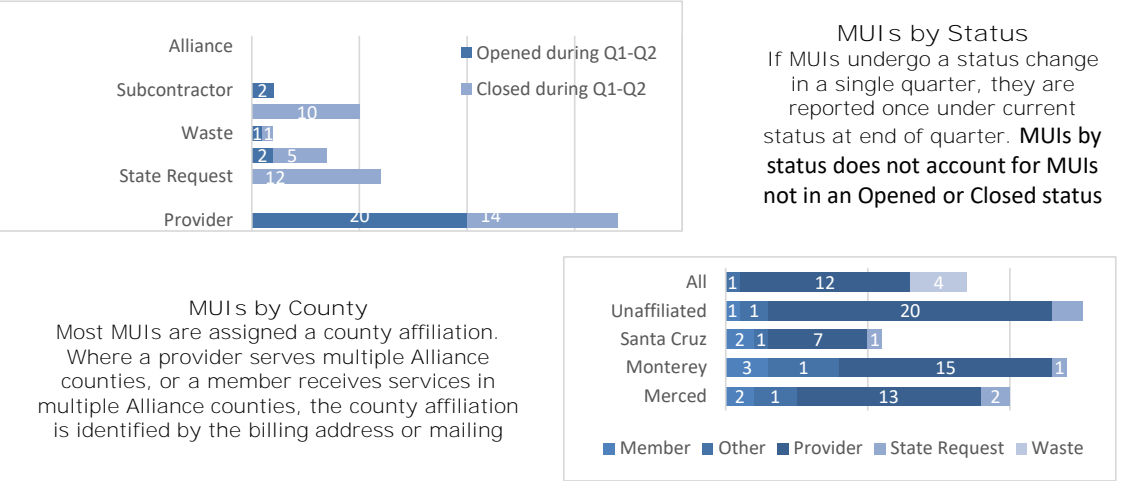
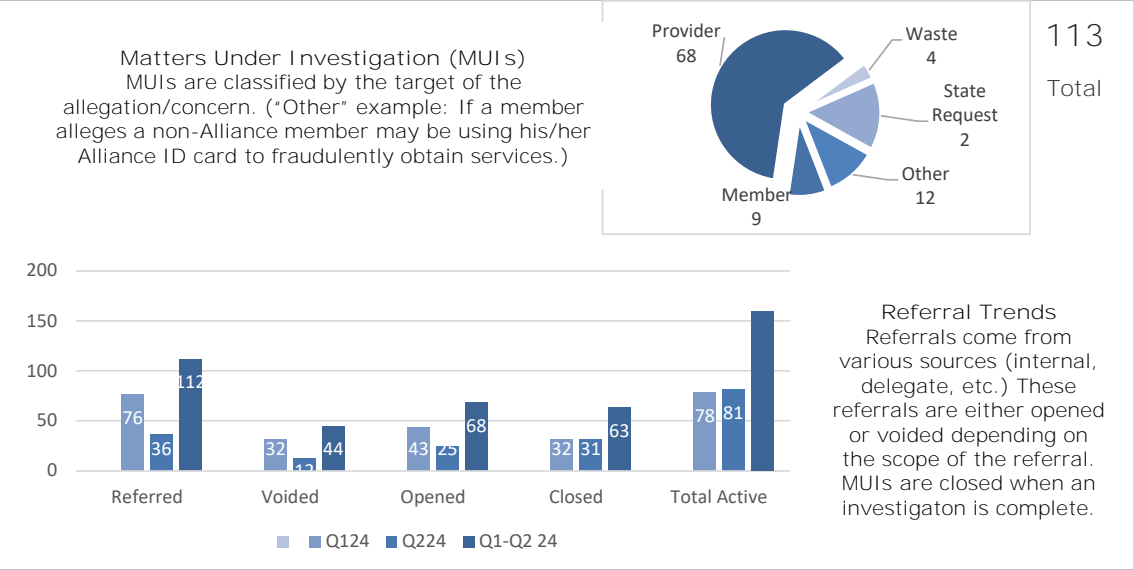


*\*Aggregate across Quarter/Year, not representative of a single Breach/Incident.*



Program Integrity  
Special Investigations Unit Dashboard - Q1-Q2 2024  
Prepared for the Alliance Board

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





## Information Items: (17A. – 17G.)

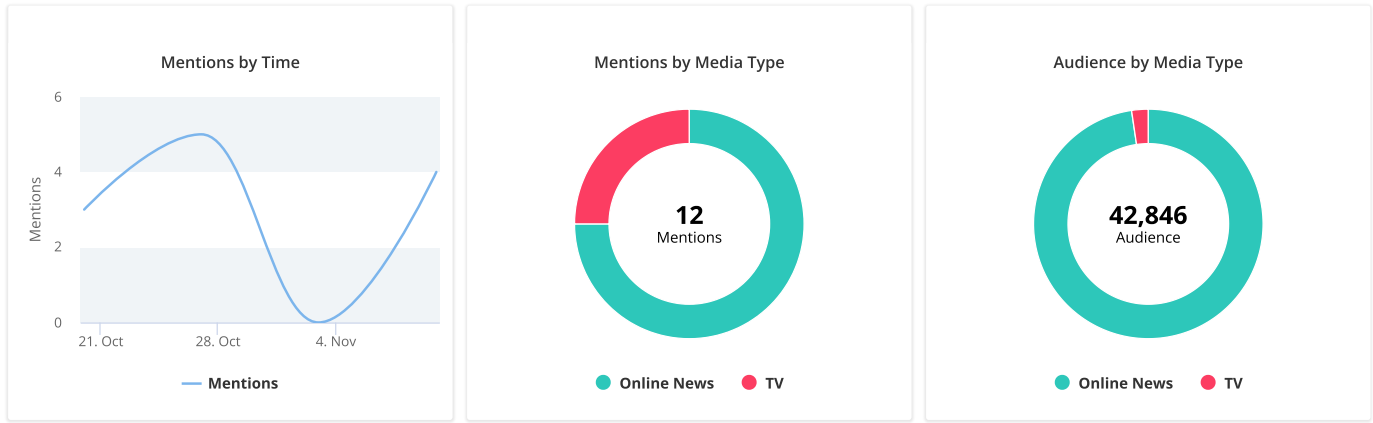
A. Alliance in the News	Page 17A-01 to 17A04
B. Membership Enrollment Report	Page 17B-01
C. Letter of Support	Page 17C-01
D. Member Newsletter (English) 09-2024	Page 17D-01 to 17D-12
E. Member Newsletter (Spanish) 09-2024	Page 17E-01 to 17D-08
F. Provider Bulletin 09-2024	Page 17F-01 to 17F-12
G. Alliance Fact Sheet	Page 17G-01 to 17G-02

**HEALTHY PEOPLE. HEALTHY COMMUNITIES.**

# December 2024 Board Report



## Mention Analytics



<b>Total National TV Audience</b> 1,001	<b>Total National TV Publicity</b> USD \$434	<b>Total Local TV Audience</b> 1,001	<b>Total Local TV Publicity</b> USD \$434
<b>Total Online + Print Audience</b> 41,845	<b>Total Online + Print Publicity</b> USD \$1,041		

Total Number of Clips 12 ⚡ Collapse All Clips

### New mental health clinic opening its doors in Hollister

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Powered by LexisNexis

**Date Collected** Nov 12, 2024 2:05 AM EST  
**Category** Digital News  
**Source** [BenitoLink \(CA\)](#)  
**Author** Ashlyn Manninen

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$20  
**Market** Hollister, CA  
**Language** English

... cognitive, behavioral, solution-based, and attachment-based therapies. They offer a narrative approach, as well as psychodynamic and dialectical behavioral therapy. Online therapy is also available through HomePsych, a division of NAMHS.

### Free falls prevention training for older adults launches in San Benito County

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Powered by LexisNexis

**Date Collected** Nov 12, 2024 2:05 AM EST  
**Category** Digital News  
**Source** [BenitoLink \(CA\)](#)  
**Author** BenitoLink Sta

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$16  
**Market** Hollister, CA  
**Language** English

... provided by Volunteer Center of Santa Cruz County. Lea este artículo en español aquí.

The Volunteer Center of Santa Cruz County's Empowered Aging Division announced today that it is expanding the "A Matter of Balance" falls prevention

### New mental health clinic opening its doors in Hollister

SCMMSBMMMCC Meeting Packet | December 4, 2024 | Page 17A-01

Back to Agenda



Full Article

**Date Collected** Nov 11, 2024 8:44 AM EST  
**Category** Digital News  
**Source** [Benito Link](#)  
**Author** Eric Johnson, Ashlyn Manninen

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$25  
**Market** Hollister, CA  
**Language** English

... cognitive, behavioral, solution-based, and attachment-based therapies. They offer a narrative approach, as well as psychodynamic and dialectical behavioral therapy. Online therapy is also available through HomePsych, a division of NAMHS.

NAMHS currently accepts patients with coverage from the **Central California Alliance for Health**, Medicare, Medi-Cal, and commercial insurance plans. The company has clinics in Eureka, Fairfield, Monterey, Redding, Salinas, Woodland, and other Northern California towns and cities.

Providers and therapists with NAMHS in the Salinas and Monterey areas will begin seeing patients starting in ...



Full Article

### [Free falls prevention training for older adults launches in San Benito County](#)



4

**Date Collected** Nov 11, 2024 3:55 PM EST  
**Category** Digital News  
**Source** [Benito Link](#)

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$18  
**Market** Hollister, CA  
**Language** English

... español aquí.

We're listening! Take our survey to help us bring you the news you need!

The Volunteer Center of Santa Cruz County's Empowered Aging Division announced today that it is expanding the "A Matter of Balance" falls prevention program to San Benito County, supported by a grant from the **Central California Alliance for Health**. The award-winning, evidence-based program,

[Read More](#)



View Full Text

(Requires Critical Mention login)

### [Vida Y Salud health fair brings resources to downtown Hollister](#)



5

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 **LexisNexis**

**Date Collected** Oct 31, 2024 12:30 PM EDT  
**Category** Digital News  
**Source** [BenitoLink \(CA\)](#)  
**Author** Jenny Mendolla Arbizu

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$13  
**Market** Hollister, CA  
**Language** English

Lea este artículo en español aquí.

The Hollister Farmers Market brought health and wellness awareness to downtown Hollister on Oct. 9 with Vida Y Salud, a health fair sponsored by the



Full Article

### [34th Annual Red Ribbon Run winners](#)



6

**Date Collected** Oct 30, 2024 3:55 PM EDT  
**Category** Digital News  
**Source** [Benito Link](#)

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$16  
**Market** Hollister, CA  
**Language** English

... would like to acknowledge and thank all the local agencies, volunteers, and businesses for their support:

City of Hollister Parks & Recreation

San Benito County Government

[Read More](#)



Full Article

### [San Benito Health Foundation steps into the health-culture intersection](#)



7

**Date Collected** Oct 28, 2024 2:53 PM EDT  
**Category** Digital News  
**Source** [Benito Link](#)  
**Author** Noe Magaña

**Est. Audience** 1,087  
**Est. Publicity Value** USD \$8  
**Market** Hollister, CA  
**Language** English

... Alejandra Maria Gabriela Bologna, Congresswoman Zoe Lofgren and Andres Rodriguez from the office of Assemblymember Robert Rivas.

Community members joined the celebration and heard live music and had the opportunity to visit informational tables featuring organizations such as Youth Alliance, **Central California Alliance for Health**, YMCA, and Suicide Prevention Service of the Central Coast.

We need your help. Support local, nonprofit news! BenitoLink is a nonprofit news website that reports on San Benito County. Our team is committed to this community and providing essential, accurate information to our fellow residents. ...





Play

### KSBW Action News 8 Weekend Sunrise

**Time** Oct 27, 2024 11:15 AM EDT  
**Local Broadcast Time** 8:15 AM PDT  
**Category** News  
**Call Sign** KSBWDT2 (ABC)  
**Market** DMA: 127 Monterey, CA  
**Language** English

landings designed to accommodate larger vessels like whale watching cruises and fishing charters...**central california alliance for health** announced they will award nine million dollars in grants to help create more affordable housing in santa cruz county... the goal is to address the critical issue of homelessness and housing insecurity among santa cruz county residents who are on medi-cal... by providing them opportunities to build,

Read More



Play

### KSBW Action News 8 Weekend Sunrise

**Time** Oct 27, 2024 10:14 AM EDT  
**Local Broadcast Time** 7:14 AM PDT  
**Category** News  
**Call Sign** KSBWDT2 (ABC)  
**Market** DMA: 127 Monterey, CA  
**Language** English

boardwalk the dolphin restaurant on the santa cruz wharf was demolished . the iconic restaurant had been serving customers since 19-63 but was forced to close in december 20- 23 due to storm damage... strong waves knocked out some of the pilings that support the wharf... some of them directly underneath the restaurant... crews are set to start replacing those damaged pilings after the demolition. ...# the restaurant's demolition will allow the city to make some big changes to the santa cruz wharf.. the current plan is to build a new promenade along the east side of the wharf as well

Read More



Play

### KSBW Action News 8 at 11

**Time** Oct 24, 2024 2:10 AM EDT  
**Local Broadcast Time** 11:10 PM PDT  
**Category** News  
**Call Sign** KSBWDT2 (ABC)  
**Market** DMA: 127 Monterey, CA  
**Language** English

**Est. National Audience** 1,001  
**Est. National Publicity Value** USD \$434  
**Est. Local Audience** 1,001  
**Est. Local Publicity Value** USD \$434

hitler... harris was asked whether she thinks trump is a fascist...<"do you think donald trump is a fascist?" harris: "yes, i do. yes, i do. and i, and i also believe that the people who know him best on this subject should be trusted."" tonight... trump defending himself by going after john kelly in a post on truth social writing in part, "thank you for your support against a total degenerate named john kelly, who made up a story out of pure trump derangement syndrome hatred!"...**central california alliance for health** announced today they will award nine million dollars in grants to help

Read More



Full Article

### Over \$9 million granted to Santa Cruz County for Medi-Cal housing projects

**Date Collected** Oct 23, 2024 5:42 PM EDT  
**Category** Digital News  
**Source** [KSBW Channel.com](https://www.ksbw.com)  
**Author** Ricardo Tovar  
Advertisement Updated: 2:36 PM PDT Oct 23, 2024

**Est. Audience** 34,236  
**Est. Publicity Value** USD \$925  
**Market** Salinas, CA  
**Language** English

Digital Content Manager

**Central California Alliance for Health** announced that it is awarding \$9 million to make more housing in Santa Cruz County. In addition to funding, 9 housing projects have created 359 beds across the county. These grants were awarded through the Housing Fund initiative, which aims to provide

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Full Article

### Over \$9 million granted to Santa Cruz County for Medi-Cal housing projects

**Date Collected** Oct 23, 2024 5:36 PM EDT  
**Category** Digital News  
**Source** [KSBW 8](https://www.ksbw.com)  
**Author** Ricardo Tovar, <https://www.facebook.com>, Digital Content Manager

**Market** United States  
**Language** English

**Central California Alliance for Health** announced that it is awarding \$9 million to make more housing in Santa Cruz County. In addition to funding, 9 housing projects have created 359 beds across the county. These grants were awarded through the Housing Fund initiative, which aims to provide temporary and permanent housing opportunities ... like these address critical social drivers of health, like housing and safe environments. A safe place to sleep helps individuals with complex medical and social needs achieve positive health outcomes. This initiative helps bring us closer to our vision of 'healthy people, healthy communities'."

Read More

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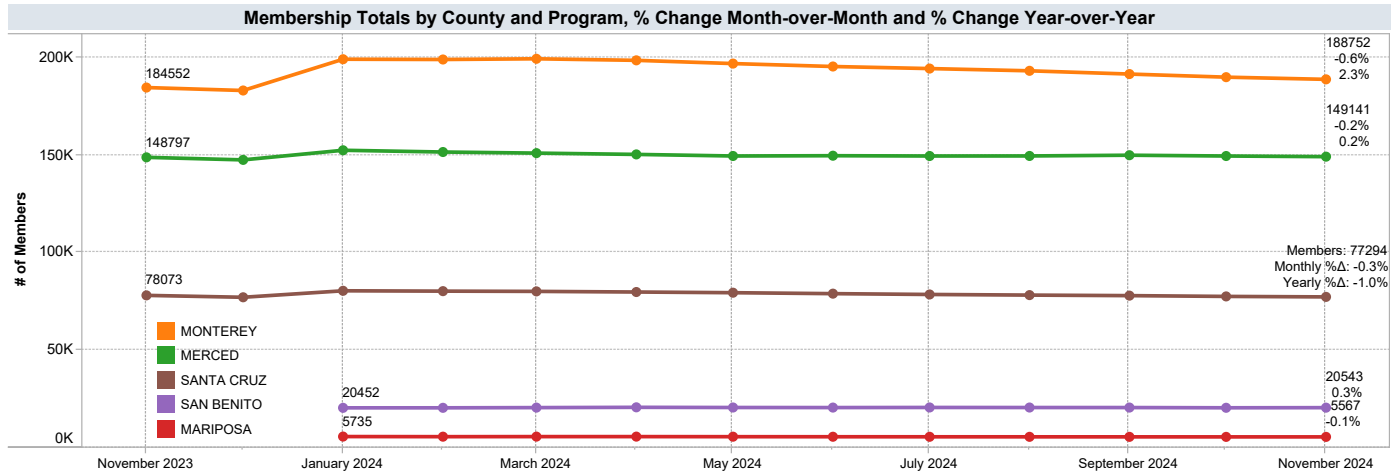
Visit us at  
[www.criticalmention.com](http://www.criticalmention.com)



## Enrollment Report

County: **None** Program: **None** Aid Cat Roll Up: **None** Data Refresh Date: **11/12/2024 6:08:52 AM**

Enrollment Month  
11/1/2023 to 11/30/2024



LOB	County	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024
Medi-Cal	SANTA CRUZ	78,073	77,097	80,420	80,242	80,116	79,792	79,440	78,956	78,539	78,215	77,939	77,540	77,294
	MONTEREY	183,863	182,345	198,368	198,227	198,578	197,775	196,109	194,603	193,545	192,405	190,749	189,165	188,050
	MERCED	148,797	147,490	152,416	151,520	150,957	150,296	149,486	149,628	149,479	149,507	149,885	149,474	149,141
	MARIPOSA			5,735	5,679	5,710	5,708	5,671	5,641	5,618	5,602	5,588	5,572	5,567
	SAN BENITO			20,452	20,462	20,569	20,719	20,625	20,589	20,646	20,614	20,598	20,481	20,543
IHSS	MONTEREY	689	695	698	698	704	719	725	731	729	723	717	709	702
Total Members		411,422	407,627	458,089	456,828	456,634	455,009	452,056	450,148	448,556	447,066	445,476	442,941	441,297



November 11, 2024

*RE: Letter of Support for Health Projects Center and Cabrillo College for Highroad Training Partnership Healthcare Grant*

Dear California Workforce Development Board:

We write to support Health Projects Center and Cabrillo College in their efforts to implement the *Advancing Community Health Worker (CHW) Workforce Development* project with funding through the Highroad Training Partnership Healthcare Grant.

Central California Alliance for Health (the Alliance) is a regional Medi-Cal managed care health plan established in 1996 to improve access to health care for over 456,000 members in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. As an award-winning managed care health plan with a vision of "healthy people, healthy communities," the Alliance remains focused on efforts to improve access to quality health care for its members.

The *Advancing CHW Workforce Development* project is a collaborative effort between the Health Projects Center's Central Coast Area Health Education Center and Cabrillo College and will address critical workforce needs by enhancing training for CHWs who are enrolled in Cabrillo's CHW training program. This initiative focuses on filling skill gaps, creating career advancement pathways, and enhancing job quality for CHWs to meet the healthcare demands of underserved communities. Health Projects Center presently supports community-based education for RN students at Cabrillo and will expand such collaboration to CHW students.

The Alliance supports this initiative by Health Projects Center and Cabrillo College to further develop the CHW workforce in Santa Cruz County. The Alliance support ongoing development of our contracted network of CHWs to deliver community-based health care services by connecting members with providers that deliver timely services and care, focused on prevention, early detection and effective treatment. The Alliance has supported Health Projects Center's efforts to recruit CHWs to provide services to Alliance members and to become an Enhanced Care Management provider.

The California Workforce Development Board's support for this local workforce initiative will strengthen the local health care system and expand local collaboration between key service and education leaders in our community.

Sincerely,

A handwritten signature in blue ink that reads "Michael Schrader".

Michael Schrader  
Chief Executive Officer



# Living Healthy

A newsletter for the members of  
Central California Alliance for Health



September 2024 | VOLUME 30, ISSUE 3

## Protect yourself and your family this flu season

Flu season is September through May. The best way to protect yourself and your family is to get your flu vaccine early, before the flu starts to spread in your community.

The flu vaccine can help stop serious illness from the flu. People who are at higher risk of having serious flu complications are:

- Young children.
- People who are pregnant.
- People with certain chronic health conditions like asthma, diabetes, and heart or lung disease.
- People who are ages 65 and older.

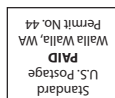
Getting the flu vaccine is free and easy. Everyone ages 6 months and older can get it every year. Children can get the flu vaccine from their doctor. Adults have the option to get the flu vaccine at a pharmacy without a referral.



For more information, visit [www.thealliance.health/flu](http://www.thealliance.health/flu).

Alliance members ages 7 to 24 months who get their two flu vaccine doses between September 2024 and May 2025 will

be entered into a monthly raffle for a chance to win a **\$100 Target gift card!**



Central California Alliance for Health  
1600 Green Hills Road, Suite 101  
Scotts Valley, CA 95066

# Ask the doctor

## What to know about vaccines for children

Dr. Omar Guzmán is the Chief Health Equity Officer at Central California Alliance for Health. He is a board-certified emergency medicine physician, born and raised in the Central Valley.

### Are vaccines safe for my child?

**Yes, they are safe.** Millions of children safely receive vaccines each year. As an emergency room doctor, I see more serious illnesses in children who were not vaccinated than in children who had rare reactions to a vaccine. It saddens me when a sick baby comes into the emergency room in the middle of the night. It's even scarier when the child is not protected by vaccines. Vaccines protect kids from many diseases. Some of those diseases

can be especially dangerous for young kids.

### What are the side effects of vaccines?

**The usual side effects we see are minor**, like low-grade fever, fussiness or soreness where the vaccine was given. These side effects usually last a few days and go away on their own.

### Can vaccines overload my baby's immune system?

**No.** Babies are exposed to thousands of germs every day after they are born. The germs

have antigens that cause a baby's immune system to start protecting them. Vaccines also have antigens, but only a tiny amount. Babies are exposed to more antigens in their everyday environment, so vaccines could never overload a baby's immune system.

### Why do vaccines start so early?

**The youngest children have the highest risk for complications**, hospitalizations or death from preventable diseases. Kids can develop strong immune systems from vaccines and be protected from serious illnesses. At work, when a sick kid comes in, I try to do what is best for them as a doctor. But at home, I'm Dad, and hearing my kids cry breaks my heart. My six kids at home have all been vaccinated, so I understand how hard it can be on parents to take their babies to get vaccines so early in life, but I also understand why it is so important.







### What do you think of delaying some vaccines or following a nonstandard schedule?

It can feel like a lot of vaccines, but vaccines are scheduled this way for a reason.

The schedule of vaccines gives your baby the most protection when they are most at risk. Delaying vaccines leaves your baby unprotected.



The Alliance has created an Infant Wellness Map to help you remember your baby's appointments. You can view it at **[www.thealliance.health/infantwellnessmap](http://www.thealliance.health/infantwellnessmap)**. You can request a printed copy of the Infant Wellness Map by calling **800-700-3874, ext. 5580**.

We also have rewards for keeping up with your baby's checkups. Learn more at **[www.thealliance.health/healthrewards](http://www.thealliance.health/healthrewards)**.



## What to know about prescription drugs

If you are a Medi-Cal member, your prescription drugs that are filled at a pharmacy are covered by Medi-Cal Rx, not the Alliance. To find out if a drug is covered, call **800-977-2273** (TTY: Dial **711**) or go to **[www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov)**.

If you are an IHSS member, pharmacy services are managed by MedImpact. You can view the list of covered drugs at **[www.thealliance.health/prescriptions](http://www.thealliance.health/prescriptions)**. You can also request a mailed copy by calling Member Services at **800-700-3874** (TTY: Dial **711**). You can also call Member Services if you have questions about a medication.

### Drugs given in a doctor's office or clinic

These are considered physician-administered drugs (PAD). You can view the list of covered drugs and any changes to the list at **[www.thealliance.health/prescriptions](http://www.thealliance.health/prescriptions)**. If you would like a mailed copy, please contact Member Services at **800-700-3874** (TTY: Dial **711**).

# Healthy Moms and Healthy Babies Program

## Benefit spotlight

The Alliance's *Healthy Moms and Healthy Babies* (HMHB) Program helps pregnant women get early prenatal and postpartum care. HMHB also provides education to support you in having a healthy pregnancy.

Members enrolled in the HMHB Program are contacted by Alliance health educators. Health educators provide information on a variety of topics, including prenatal and postpartum health, breastfeeding, pediatric care and parenting.

### Get health rewards!

The Alliance offers members health rewards for seeing the doctor for prenatal and postpartum care. Alliance members who see their doctor within the first 13 weeks of being pregnant are entered into a raffle for a chance to win a **\$50 Target gift card**. Members who see their doctor 1 to 12 weeks after having a baby will receive a **\$25 Target gift card**.

Once your baby is born, the Alliance also offers health rewards for taking

your baby to the doctor for regular checkups. For more information about health rewards available for you and your baby, visit **[www.thealliance.health/healthrewards](http://www.thealliance.health/healthrewards)** or call the Health Education Line at **800-700-3874, ext. 5580**. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

### Community resources

The Alliance also provides pregnant and postpartum members with information about community resources, including the Women, Infants and Children Program (WIC). WIC is a nutrition education program that helps individuals who are pregnant or just had a baby and children up to age 5. For more information on the WIC program, visit **[www.myfamily.wic.ca.gov](http://www.myfamily.wic.ca.gov)** or call **800-852-5770**.

Our Your Health Matters (YHM) outreach team will be coming to community events in your area! Alliance staff can help you learn about Medi-Cal benefits, Alliance services and your local organizations in person. See our calendar of events at **[www.thealliance.health/communityevents](http://www.thealliance.health/communityevents)**.



# Heart health and statins

Statins are a type of medicine that treats high cholesterol levels. Statins also reduce the risk of a heart attack and stroke. Some examples of statins include atorvastatin (Lipitor), rosuvastatin (Crestor) and simvastatin (Zocor).

Statins can help people who have:

- Been diagnosed with heart disease.
- Had a heart attack or stroke.
- A stent.
- Plaque in their body.

Statins are also recommended for people who may be at risk for other conditions. Examples include a family history of high cholesterol, heart disease or diabetes.

The most common side effects of taking statins are muscle pain and weakness. But statins are not always the reason behind muscle pains. If you are experiencing muscle pain and weakness, tell your doctor. Your doctor may have you stop taking the statin for a month to see if the pain goes away. Or your doctor may switch you to another statin or change your dose.

**Ask your doctor first before making any changes to your medication.** Do not stop taking your medicine unless your doctor tells you to stop. It is important to take your statin medicine as prescribed by your doctor.

**Pay attention to any warnings that come with your medication.** Certain medicines, and even grapefruit juice, can affect how well statins work. Always let your doctor know when you start a new medication.



## The Alliance's American Sign Language (ASL) interpretation services

Did you know the Alliance offers American Sign Language (ASL) services for Alliance members who are deaf or hard of hearing?

We work hard to ensure that all Alliance members can communicate with their primary care provider (PCP) about their health care needs. We can help schedule an ASL interpreter to be present at your medical visits.

To learn more about the Alliance ASL interpretation services, please call the Health Education Line at **800-700-3874, ext. 5580**. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial 711).

# Living healthy with diabetes

Diabetes is a chronic health condition that affects how well your body turns food into energy. With diabetes, your body either does not make enough insulin or cannot use it as well as it should.

Diabetes is not something that goes away by itself. You can live a healthy life with diabetes. Here are some things you can do.

**See your doctor regularly.** You will need to have checkups with your doctor on a regular basis. Your doctor will review your progress and adjust your care if needed. Make sure to keep your appointments.

We have transportation services for you to use if you need help getting to your doctor visits. Call us at least five business days before your appointment at **800-700-3874, ext. 5577**, Monday through Friday from 8 a.m. to 5:30 p.m.

**Follow the instructions your doctor gives you to manage diabetes.** This includes taking medicine your doctor prescribes for your diabetes care.

**Adopt a healthy lifestyle.**

These habits can help you live a healthy lifestyle:

- Maintain a healthy weight.
- Eat healthy food.
- Be active.

**Learn about how to manage your diabetes and get support.** Our Care Management services can

help you make sure you understand your diagnosis and have everything you need to start managing it. Call **800-700-3874, ext. 5512**.

We offer the *Live Better with Diabetes* Program, where you will

learn about healthy eating, staying active, improving your quality of life and more! To join or learn more about our six-week workshop, call our Health Education Line at **800-700-3874, ext. 5580**.



HEALTHY PEOPLE. HEALTHY COMMUNITIES.





## Women: Get screened for breast cancer

A breast cancer screening is also called a mammogram. Doctors have studied how often a woman should get screened for breast cancer. These studies show that women between the ages of 40 and 74 should get a screening every two years.

If you are younger than 40 or older than 75, please talk with your doctor about what they would recommend.

### Why screening is important

Getting a breast cancer screening is really important because breast cancer can show up very quickly. Breast cancer can be treated if found early. Getting a screening less than every two years could result in missing breast cancer if it shows up. This makes the cancer harder to treat.

If you have had a breast cancer screening in the last two years but feel a lump in your breast or have any other concerns, please talk to your doctor immediately. They will let you know if you should get screened again.

Talk to your doctor today about getting a breast cancer screening. If you are having trouble getting in to see your doctor or getting a screening, please call our Member Services department at **800-700-3874**. We can help you get scheduled for your breast cancer screening.

For more information on how breast cancer screening saves lives, visit [www.thealliance.health/breast-cancer-screening-saves-lives](http://www.thealliance.health/breast-cancer-screening-saves-lives).

# Help your child have a healthy weight

## September is National Childhood Obesity Awareness Month

One in five children in the United States is obese. Childhood obesity puts kids at risk for health problems like type 2 diabetes, high blood pressure and heart disease.

The good news is that childhood obesity can be prevented. In honor of National Childhood Obesity Awareness Month, the Alliance encourages your family to make healthy changes together.

### Ways to be healthier

Taking small steps as a family can help your child stay at a healthy weight. Below are some ideas for your family to be healthier, together.

- **Get active.** Walk around the neighborhood, go on a bike ride or play outside.
- **Limit screen time.** Keep extra screen time (such as playing video games or watching TV) to two hours a day or less.
- **Make healthy meals.** Buy and serve more vegetables, fruits and whole-grain foods.

### Rewards and programs

The Alliance offers the *Healthy Weight for Life* Program. This program is for children and teens ages 2 to 18 who want to reach a healthy weight. The *Healthy Weight for Life* Program can help your child learn how to eat healthy and be more active. You can also learn tools to support your child with lifestyle changes.



Talk to your child's doctor about this program. The doctor can refer your child to the program if they think your child needs it.

We also have support for adults who want to reach a healthy weight! Members 19 years of age and older can join our adult weight management program.

**Questions?** For information on our health programs, call the Alliance Health Education Line at **800-700-3874, ext. 5580** or visit [www.thealliance.health/health-and-wellness](http://www.thealliance.health/health-and-wellness).



**The Alliance is texting members when it is time to renew their Medi-Cal!**  
You might get a text message from us.



At every life stage.  
For any health condition.

Trusted, no cost Medi-Cal  
health care from a local team  
that understands you.

**The Alliance—your ally in  
being your healthiest self.**

LIVING HEALTHY is published for the members and community partners of CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, telephone 831-430-5500 or 800-700-3874, ext. 5505, website [www.thealliance.health](http://www.thealliance.health).

Information in LIVING HEALTHY comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider.

Models may be used in photos and illustrations.

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[www.thealliance.health](http://www.thealliance.health)

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## Nondiscrimination Notice

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

The Alliance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Alliance between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. If you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

**Central California Alliance for Health**  
**1600 Green Hills Road, Suite 101**  
**Scotts Valley, CA 95066**  
**800-700-3874**  
**800-735-2929** (TTY: Dial **711**)

### HOW TO FILE A GRIEVANCE

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the

Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact the Alliance's Senior Grievance Specialist between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**).
- **In writing:** Fill out a complaint form or write a letter and send it to:  
**Central California Alliance for Health**  
**Attn: Senior Grievance Specialist**  
**1600 Green Hills Road, Suite 101**  
**Scotts Valley, CA 95066**
- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.
- **Electronically:** Visit the Alliance's website at **[www.thealliance.health](http://www.thealliance.health)**.

### OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:  
**Deputy Director, Office of Civil Rights**  
**Department of Health Care Services**  
**Office of Civil Rights**  
**P.O. Box 997413, MS 0009**  
**Sacramento, CA 95899-7413**

Complaint forms are available at

**[www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)**.

- **Electronically:** Send an email to **[CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov)**.



This newsletter is also available in large print and audio formats at **[www.thealliance.health/otherformats](http://www.thealliance.health/otherformats)**.

## OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **800-368-1019**. If you cannot speak or hear well, please call TTY/TDD **800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services**  
**200 Independence Avenue, SW**  
**Room 509F, HHH Building**  
**Washington, D.C. 20201**

Complaint forms are available at [www.hhs.gov/civil-rights/filing-a-complaint/index.html](http://www.hhs.gov/civil-rights/filing-a-complaint/index.html).

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Daim ntawv tshaj xo no los kuj muaj ua ntawv luam loj thiab kaw ua suab nyob ntawm [thealliance.health/hmn/tag/alternative-access](http://thealliance.health/hmn/tag/alternative-access).

Este boletín también está disponible en formato de letra grande y audio en [thealliance.health/es/tag/alternative-access](http://thealliance.health/es/tag/alternative-access).

### English Tagline

ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge.

### الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير. اتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

### Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված կրթեր: Չանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

### ស្មាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

### 简体中文标语 (Simplified Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 1-800-700-3874 (TTY: 1-800-735-2929)。这些服务都是免费的。

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**مطلب به زبان فارسی (Farsi)**

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

**हिंदी टैगलाइन (Hindi)**

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

**Nqe Lus Hmoob Cob (Hmong)**

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

**日本語表記 (Japanese)**

注意日本語での対応が必要な場合は 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

**한국어 태그라인 (Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

**ແທກໄລພາສາລາວ (Laotian)**

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໃບທາດບີ 1-800-700-3874 (TTY: 1-800-735-2929). ອັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕເລີມໃຫຍ່ໃຫ້ໃບທາດບີ 1-800-700-3874 (TTY: 1-800-735-2929). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

**Mien Tagline (Mien)**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hlou mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

**ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

**Русский слоган (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

**Mensaje en español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000). Estos servicios son gratuitos.

**Tagalog Tagline (Tagalog)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Libre ang mga serbisyonang ito.

**แท็กไลน์ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

**Примітка українською (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

**Khẩu hiệu tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.





# La Vida **Saludable**

Un boletín informativo para los miembros  
de Central California Alliance for Health



Septiembre 2024 | VOLUMEN 30, NÚMERO 3

## Protéjase y proteja a su familia esta temporada de la gripe

La temporada de la gripe abarca desde septiembre hasta mayo. La mejor manera de protegerse y proteger a su familia es vacunarse contra la gripe temprano, antes de que la gripe comience a propagarse en su comunidad.

La vacuna contra la gripe puede ayudar a prevenir enfermedades graves que se producen a partir de la gripe. Las personas con mayor riesgo de sufrir complicaciones graves de la gripe son:

- Niños pequeños.
- Personas embarazadas.
- Personas con ciertas condiciones crónicas de salud, como asma, diabetes y enfermedades del corazón o pulmonares.
- Personas de 65 años o más.

Vacunarse contra la gripe es gratis y fácil. Cualquier persona a partir de los 6 meses de vida puede recibir esta vacuna todos los años. Los niños pueden recibirla de su doctor. Los adultos tienen la opción de recibir la vacuna contra la gripe en una farmacia sin necesidad de una referencia.



Para obtener más información, visite  
[www.thealliance.health/es/flu](http://www.thealliance.health/es/flu).

¡Los miembros de la Alianza de 7 a 24 meses de vida que reciban sus dos dosis de la vacuna contra la gripe entre septiembre del 2024 y mayo del 2025

participarán en un sorteo mensual para poder ganar una **tarjeta de regalo de Target de \$100!**

# Consulte al **doctor**

## Lo que debe saber sobre las vacunas para niños

El Dr. Omar Guzmán es el Director de Equidad en Salud de Central California Alliance for Health. Nació y se crió en el Valle Central, y está certificado por la junta como doctor especialista en casos de emergencia.

### ¿Son seguras las vacunas para mi hijo?

**Sí, son seguras.** Cada año millones de niños reciben vacunas de manera segura. Como doctor de servicio de emergencias, veo enfermedades más graves en los niños que no recibieron vacunas que en los que tuvieron reacciones raras a una vacuna. Me

entristece cuando un bebé enfermo llega a la sala de emergencias en medio de la noche. Pero es mucho peor cuando el niño no está protegido por las vacunas. Las vacunas protegen a los niños de muchas enfermedades. Algunas de ellas pueden ser especialmente peligrosas para los niños pequeños.

tienen antígenos, pero solo una pequeña cantidad. Los bebés están expuestos a más antígenos en su entorno diario. Por lo tanto, las vacunas nunca podrían sobrecargar el sistema inmunitario del bebé.

### ¿Por qué las vacunas se empiezan a administrar a una edad tan temprana?

**Los niños más pequeños tienen el mayor riesgo de sufrir complicaciones,** ser hospitalizados o morir a causa de enfermedades prevenibles. Los niños pueden desarrollar sistemas inmunitarios fuertes a partir de las vacunas y estar protegidos de enfermedades graves. En el trabajo, cuando llega un niño enfermo, trato de hacer lo que es mejor para él como doctor. Sin embargo, en casa, soy papá y escuchar a mis hijos llorar me rompe el corazón. Todos mis seis hijos recibieron sus vacunas, así que entiendo lo difícil que puede ser como padre llevar a un bebé a vacunarse tan temprano en la vida, pero también entiendo por qué es tan importante.

### ¿Cuáles son los efectos secundarios de las vacunas?

**Los efectos secundarios habituales que vemos son leves,** como fiebre baja, irritabilidad o dolor en el lugar de administración de la vacuna. Estos efectos secundarios suelen durar unos días y desaparecen por sí solos.

### ¿Las vacunas pueden sobrecargar el sistema inmunitario de mi bebé?

**No.** Los bebés están expuestos a miles de gérmenes todos los días después de nacer. Los gérmenes contienen antígenos que hacen que el sistema inmunitario del bebé comience a protegerlos. Las vacunas también





### ¿Qué piensa de postergar algunas vacunas o de seguir un calendario de vacunación no estándar?

Puede parecer que son muchas las vacunas, pero el calendario de vacuna es así por un motivo.

Este le brinda a su bebé la mayor protección cuando está expuesto al mayor riesgo. Postergar las vacunas deja a su bebé sin protección.



La Alianza creó un Mapa de Bienestar Infantil para ayudarle a recordar las citas de su bebé. Puede consultarlo en **[www.thealliance.health/es/infant-wellness-map](http://www.thealliance.health/es/infant-wellness-map)**. Para solicitar una copia impresa del Mapa de Bienestar Infantil, puede llamar al **800-700-3874, ext. 5580**.

También tenemos recompensas por seguir el cronograma de chequeos de su bebé. Obtenga más información en **[www.thealliance.health/es/healthrewards/](http://www.thealliance.health/es/healthrewards/)**.



## Qué debe saber sobre las medicinas recetadas

Si es miembro de Medi-Cal, las medicinas recetadas que surta en una farmacia están cubiertas por Medi-Cal Rx, no por la Alianza. Para averiguar si una medicina está cubierta, llame al **800-977-2273** (TTY: Marque **711**) o visite **[www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov)**.

Si es miembro de IHSS, los servicios de farmacia están a cargo de MedImpact. Puede consultar la lista de medicinas cubiertas en **[www.thealliance.health/es/prescriptions](http://www.thealliance.health/es/prescriptions)**. Para pedir una copia por correo, llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**). También puede llamar a Servicios para Miembros si tiene preguntas sobre un medicamento.

### Medicinas administradas en un consultorio médico o clínica

Se consideran medicamentos administrados por el doctor (physician-administered drugs; PAD, por sus siglas en inglés). Puede consultar la lista de medicamentos cubiertos y cualquier cambio en la lista en **[www.thealliance.health/es/prescriptions](http://www.thealliance.health/es/prescriptions)**. Si desea recibir una copia por correo, comuníquese con Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).



# Programa Mamás Saludables y Bebés Sanos

## Beneficios destacados

El Programa *Mamás Saludables y Bebés Sanos* (*Healthy Moms and Healthy Babies Program*; HMHB, por sus siglas en inglés) de la Alianza ayuda a las mujeres embarazadas a recibir cuidado prenatal y de posparto a tiempo. El Programa HMHB también le brinda educación para ayudarle a tener un embarazo saludable.

Los educadores de salud de la Alianza se comunican con las miembros inscritas en el Programa HMHB. Estos brindan información sobre una variedad de temas, que incluyen la salud prenatal y posparto, la lactancia materna, el cuidado pediátrico y la crianza.

### ¡Obtenga recompensas de salud!

La Alianza ofrece a las miembros recompensas de salud por visitar al doctor para recibir cuidado prenatal y de postparto. Las miembros de la Alianza que visiten a su doctor en las primeras 13 semanas de embarazo participan en un sorteo en el que pueden ganar una **tarjeta de regalo de Target de \$50**. Las

miembros que visiten a su doctor entre la primera y la doceava semana después de tener a su bebé recibirán una **tarjeta de regalo de Target de \$25**.

Una vez que nace su bebé, la Alianza también ofrece recompensas de salud por llevar a su bebé al doctor para los chequeos regulares. Para obtener más información sobre las recompensas de salud disponibles para usted y su bebé, visite [www.thealliance.health/es/healthrewards/](http://www.thealliance.health/es/healthrewards/) o llame a la Línea de Educación de Salud al **800-700-3874, ext. 5580**. Para la Línea de Asistencia de Audición o del Habla, llame al **800-735-2929** (TTY: Marque **711**).

### Recursos comunitarios

La Alianza también ofrece a las personas embarazadas y en el período posparto, que son miembros, información sobre recursos de la comunidad, incluido el Programa para Mujeres, Bebés y Niños (*Women, Infants and Children*; WIC, por sus siglas en inglés). El objetivo del Programa WIC es brindar educación sobre nutrición para ayudar a las personas embarazadas o que acaban de tener un bebé y niños de hasta 5 años. Para obtener más información sobre el Programa WIC, visite [www.myfamily.wic.ca.gov](http://www.myfamily.wic.ca.gov) o llame al **800-852-5770**.

¡Nuestro equipo de extensión de Su Salud Importa (*Your Health Matters*; YHM, por sus siglas en inglés) asistirá a eventos comunitarios en su área! El personal de la Alianza puede ayudarle a conocer los beneficios de Medi-Cal, los servicios de la Alianza y sus organizaciones locales en persona. Consulte nuestro calendario de eventos en [www.thealliance.health/es/communityevents](http://www.thealliance.health/es/communityevents).

# Salud del corazón y estatinas

Las estatinas son un tipo de medicamento que trata los niveles altos de colesterol. Estas también reducen el riesgo de sufrir un ataque al corazón y un accidente cerebrovascular. Algunos ejemplos de estatinas son atorvastatina (Lipitor), rosuvastatina (Crestor) y simvastatina (Zocor).

Las estatinas pueden ayudar a las personas que:

- Tienen diagnosticada una enfermedad cardíaca.
- Tuvieron un ataque al corazón o un accidente cerebrovascular.
- Tienen un stent.
- Tienen placa en el cuerpo.

Las estatinas también se recomiendan para personas que pueden estar en riesgo de padecer otras condiciones. Algunos ejemplos son los antecedentes familiares de colesterol alto, las enfermedades cardíacas o la diabetes.

Los efectos secundarios más comunes de tomar estatinas son dolor y debilidad muscular. Sin embargo, las estatinas no siempre son el motivo detrás del dolor muscular. Si siente dolor y debilidad muscular, informe a su doctor. Este podría pedirle que deje de tomar el medicamento durante un mes para ver si el dolor desaparece. O podría cambiarle a otra estatina o modificar la dosis.

**Consulte primero a su doctor antes de hacer cualquier cambio en su medicamento.** No deje de tomar su medicamento a menos que el doctor se lo indique. Es importante que tome el medicamento con estatina según las indicaciones de su doctor.

**Preste atención a las advertencias que acompañan el medicamento.** Ciertos medicamentos, e incluso el jugo de toronja, pueden afectar al funcionamiento de las estatinas. Informe siempre a su doctor si empieza a tomar un medicamento nuevo.



## Servicios de interpretación del Lenguaje de Señas Americano de la Alianza

¿Sabía que la Alianza ofrece servicios de Lenguaje de Señas Americano (American Sign Language; ASL, por sus siglas en inglés) a los miembros que son sordos o tienen problemas auditivos?

Trabajamos mucho para garantizar que los miembros de la Alianza puedan comunicarse con su proveedor de cuidado primario (primary care provider; PCP, por sus siglas en inglés) sobre sus necesidades de cuidado de la salud. Podemos ayudar a coordinar sus citas médicas de modo que haya un intérprete de ASL presente.

Para obtener más información sobre los servicios de interpretación del ASL de la Alianza, llame a la Línea de Educación de Salud al **800-700-3874, ext. 5580**. Para la Línea de Asistencia de Audición o del Habla, llame al **800-735-2929** (TTY: Marque **711**).



# Vida sana con diabetes

La diabetes es una condición crónica que afecta la manera en que el cuerpo transforma los alimentos en energía. Con la diabetes, el cuerpo no produce suficiente insulina o no puede utilizarla tan bien como debería.

La diabetes no es algo que desaparezca por sí sola. Puede llevar una vida saludable con diabetes. Estas son algunas de las cosas que puede hacer.

**Vea a su doctor regularmente.** Tendrá que hacerse chequeos con su doctor de forma regular. El doctor revisará su progreso y ajustará el cuidado si es necesario. Asegúrese de asistir a las citas.

Tenemos servicios de transporte para que los utilice si necesita ayuda para ir a sus citas médicas. Llámenos al menos cinco días hábiles antes de su cita al **800-700-3874, ext. 5577**, de lunes a viernes, de 8 a.m. a 5:30 p.m.

**Siga las instrucciones que le dé su doctor para controlar la diabetes.** Esto incluye tomar medicamentos que el doctor le recete para el control de la diabetes.

**Adopte un estilo de vida saludable.** Estos hábitos pueden ayudarle a llevar un estilo de vida saludable:

- Mantener un peso saludable.
- Coma alimentos saludables.
- Manténgase activo.

**Aprenda a manejar la diabetes y obtenga apoyo.** Nuestros servicios de Manejo de Cuidado pueden ayudarle a asegurarse de que comprenda su

diagnóstico y tenga todo lo que necesita para comenzar a manejarlo. Llame al **800-700-3874, ext. 5512**.

Ofrecemos el Programa *Viva Mejor con Diabetes* (*Live Better with Diabetes Program*; LBD, por sus siglas en inglés),

en el cual aprenderá sobre alimentación saludable, cómo mantenerse activo, mejorar su calidad de vida y más. Para inscribirse u obtener más información sobre nuestro taller de seis semanas, llame a la Línea de Educación de Salud al **800-700-3874, ext. 5580**.





# Mujeres: Háganse exámenes de detección del cáncer de mama

La prueba para la detección del cáncer de mama también se denomina mamografía. Los doctores han estudiado con qué frecuencia la mujer debe hacerse pruebas para la detección del cáncer de mama. Estos estudios muestran que las mujeres que tienen entre 40 y 74 años deben realizarse una prueba de detección cada dos años.

Si es menor de 40 años o mayor de 75, hable con su doctor y pregúntele cuál es su recomendación.

## Por qué son importantes las pruebas de detección

Hacerse una prueba para la detección del cáncer de mama es muy importante porque el cáncer puede aparecer con mucha rapidez. Este tipo de cáncer se puede tratar si se detecta temprano. Hacerse una prueba de detección con una frecuencia menor a cada dos años podría hacer que no se detecte el cáncer de mama si aparece. Esto hace que sea más difícil tratarlo.

Si se hizo una prueba para la detección del cáncer de mama en los últimos dos años, pero siente un bulto en la mama o tiene alguna otra inquietud, hable con su doctor de inmediato. Este le indicará si debe hacerse la prueba de detección nuevamente.

Hable hoy mismo con su doctor sobre la prueba para la detección del cáncer de mama. Si tiene dificultades para ver a su doctor o hacerse una prueba de detección, llame a nuestro departamento de Servicios para Miembros al **800-700-3874**. Podemos ayudarle a programar su prueba para la detección del cáncer de mama.

Para obtener más información sobre cómo la prueba para la detección del cáncer de mama salva vidas, visite [www.thealliance.health/es/breast-cancer-screening-saves-lives](http://www.thealliance.health/es/breast-cancer-screening-saves-lives).



# Ayude a su hijo a tener un peso saludable

## Septiembre es el Mes Nacional de Concientización sobre la Obesidad Infantil

Uno de cada cinco niños en los Estados Unidos es obeso. La obesidad infantil pone a los niños en riesgo de sufrir problemas de salud, como diabetes tipo 2, presión arterial alta y enfermedad del corazón.

La buena noticia es que la obesidad infantil se puede prevenir. En honor al Mes Nacional de Concientización sobre la Obesidad Infantil, la Alianza alienta a su familia a hacer cambios saludables juntos.

### Formas de estar más saludable

Dar pequeños pasos como familia puede ayudar a su hijo a mantener un peso saludable. A continuación, encontrará algunas ideas para que su familia, esto incluye a todos los miembros, esté más saludable.

- **Manténgase activo.** Camine por el vecindario, dé un paseo en bicicleta o juegue en el exterior.
- **Limite el tiempo frente a la pantalla.** Limite el tiempo adicional frente a las pantallas (como jugar a videojuegos o ver televisión) a dos horas por día o menos.
- **Prepare comidas saludables.** Compre y sirva más verduras, frutas y alimentos integrales.

### Recompensas y programas

La Alianza ofrece el Programa *Peso Sano de por Vida* (Healthy Weight for Life Program; HWL, por sus siglas en inglés). Este programa es para niños y adolescentes de 2 a 18 años que desean alcanzar un peso saludable. El Programa *Peso Sano de por Vida* puede ayudar a su hijo a aprender a comer bien y estar



más activo. Usted también puede conocer herramientas para apoyar a su hijo con cambios en el estilo de vida.

Hable con el doctor de su hijo sobre este programa. El doctor puede referir a su hijo al programa si cree que lo necesita.

¡También ofrecemos apoyo a los adultos que desean alcanzar un peso saludable! Los miembros de 19 años o más pueden unirse a nuestro programa de control del peso para adultos.

**¿Tiene preguntas?** Para obtener información sobre nuestros programas de salud, llame a la Línea de Educación de Salud de la Alianza al **800-700-3874, ext. 5580** o visite **[www.thealliance.health/es/health-and-wellness](http://www.thealliance.health/es/health-and-wellness)**.



**¡La Alianza envía mensajes de texto a los miembros cuando es momento de renovar su Medi-Cal!** Es posible que reciba un mensaje de texto de nuestra parte.



En todas las etapas de la vida.  
Para cualquier condición médica.

De confianza; cuidado de salud de Medi-Cal sin costo ofrecido por un equipo local que le entiende.

**The Alliance: su aliado en ser su versión más saludable.**

LA VIDA SALUDABLE se publica para los miembros y socios comunitarios de CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, teléfono 831-430-5500 o 800-700-3874, ext. 5508, sitio web [www.thealliance.health/es](http://www.thealliance.health/es).

La información de LA VIDA SALUDABLE proviene de una gran variedad de expertos médicos. Si tiene alguna inquietud o pregunta sobre el contenido específico que pueda afectar su salud, sírvase comunicarse con su proveedor de cuidado médico.

Se pueden usar modelos en fotos e ilustraciones.

Communications Project Specialist  
Quality and Health Programs Supervisor

Randi Motson  
Ivonne Muñoz

[www.thealliance.health/es](http://www.thealliance.health/es)

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September 2024



# Provider Bulletin

A **quarterly** publication for providers.



## Raising the bar to increase access

As a mission-driven organization, a top priority is ensuring our members maintain access to quality care. We achieve this by maintaining a robust network of providers who share in this mission. I am pleased to report that, on average, we partner with over 99% of primary care providers (PCPs), 98% of specialty care providers, and all hospitals in our five-county service area.

Despite these figures, we recognize that provider shortages remain a reality. Affected PCPs may limit their panel sizes, and affected specialists may limit the referrals that they will accept. As a result, members may have difficulty scheduling timely appointments with their doctors or must drive

longer distances to reach their provider for necessary care.

We're making significant efforts to improve our members' access to the care they need. For starters, we continue to offer more than \$8 million in annual grants for providers to recruit a wide variety of medical professionals. We continue to offer competitive reimbursement with rates that are closer to Medicare than Medi-Cal.

A primary focus of our incentives and value-based programs is to close gaps in care, especially for children. The Alliance is making concerted efforts to expand our network of enhanced care management providers to take some of the load off PCPs.

### Alliance Board Meetings

**Wednesday, Sept. 25, 2024**

Board Retreat, 10 a.m. to 3:30 p.m.

**Wednesday, Nov. 6, 2024**

3 p.m. to 5 p.m.

**Wednesday, Dec. 4, 2024**

3 p.m. to 5 p.m.

### Physicians Advisory Group (PAG) Meeting

**Thursday, Dec. 5, 2024**

Noon to 1:30 p.m.

### Whole Child Model Clinical Advisory Committee Meetings

**Thursday, Sept. 19, 2024**

Noon to 1 p.m.

**Thursday, Dec. 19, 2024**

Noon to 1 p.m.

We understand that by taking care of our providers, our providers can better care for our members. Thank you for partnering with us in continuing to serve our community.



*Michael Schrader*

Michael Schrader, CEO

# HEDIS report

## Key highlights and improvements

The Alliance's Quality Improvement and Population Health team completed the Healthcare Effectiveness Data Information Set (HEDIS) audit for measurement year 2023 (MY2023) under the Managed Care Accountability Set (MCAS). Below are highlights of county Plan-level results.

### Merced County

- Achieved high performance in Timeliness of Prenatal Visits, Postpartum Follow-Up, and Lead Screening in Children.
- Sustained gains in 10 MCAS measures.

- Significant improvements in Well-Child Visits, Adolescent Well-Care Visits, Childhood Immunizations, HbA1c Poor Control, and Breast Cancer Screening, with a combined 33% improvement.

### Monterey and Santa Cruz counties

- Demonstrated strong HEDIS performance in MY2023.
- Achieved 11 high performance levels out of 18 measures.
- Over 5% improvement in Child & Adolescent Well-Care Visits and Well-Child Visits in the First 15 Months – 6+ Visits.

### MY2024 MCAS\* measures released

Here is the list of measures held to minimum performance level (MPL) for MY2024.

#	Measure required of MCP	Measure steward	Measure type methodology
<b>Behavioral health</b>			
1	Follow-up after ED visit for mental illness – 30 days	NCQA	Administrative
2	Follow-up after ED visit for substance abuse – 30 days	NCQA	Administrative
<b>Children's health</b>			
3	Child and Adolescent Well-Care Visits	NCQA	Administrative
4	Childhood immunization status – Combination 10	NCQA	Hybrid/Admin
5	Developmental screening in the first 3 years of life	CMS	Administrative
6	Immunization for adolescents – Combination 2	NCQA	Hybrid/Admin
7	Lead screening in children	NCQA	Hybrid/Admin
8	Topical fluoride for children	DQA	Administrative
9	Well-Child Visits in the first 30 months of life – 0 to 15 months – six or more Well-Child Visits	NCQA	Administrative
10	Well-Child visits in the first 30 months of life – 15 to 30 months – two or more Well-Child Visits	NCQA	Administrative
<b>Chronic disease management</b>			
11	Asthma medication ratio	NCQA	Administrative
12	Controlling high blood pressure	NCQA	Hybrid/Admin
13	Glycemic status assessment for patients with diabetes (>9%)	NCQA	Hybrid/Admin

To get a copy of your site's performance, email [QI@ccah-alliance.org](mailto:QI@ccah-alliance.org) with the subject line: HEDIS Report.



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

## PROVIDER NEWS

Reproductive health			
14	Chlamydia screening - women	NCQA	Administrative
15	Prenatal and postpartum care: Postpartum care	NCQA	Hybrid/Admin
16	Prenatal and postpartum care: Timeliness of prenatal care	NCQA	Hybrid/Admin
Cancer prevention			
17	Breast cancer screening	NCQA	Administrative
18	Cervical cancer screening	NCQA	Hybrid/Admin

\*MCAS measures are selected by the Department of Health Care Services (DHCS) and include multiple rate calculation stewards, presently limited to NCQA, DQA and CMS for held to MPL measures.



## The Alliance's Capital Program

The Alliance's **Medi-Cal Capacity Grant Program (MCGP)** invests in health care and community organizations in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. Funding opportunities are available to health care providers and community organizations who serve Medi-Cal members in our five counties.

Launched in June 2024, the Capital Program provides funding to 501(c)(3) nonprofits and government entities to support the construction, renovation and acquisition of medical facilities, mobile medical clinics, and community-based and school-based wellness centers that will

serve a significant volume of Medi-Cal members in the Alliance service areas. Funding is also available for fixed-asset equipment projects for medical facilities.

The Capital Program belongs to a diverse portfolio of funding opportunities available through the MCGP, which makes community investments to increase the availability, quality and access of health care and supportive resources

for Medi-Cal members and address social drivers that influence health and wellness in our communities.

**The next application deadline for Workforce Recruitment Programs is October 15, 2024.**

Beginning in 2025, all grant programs will be on the same application cycles three times per year, starting with the first application deadline of the year on Jan. 21, 2025.

Visit [www.thealliance.health/mcgp](http://www.thealliance.health/mcgp) for more information about our funding priorities, current opportunities and how to apply.

# Statewide data sharing requirements for providers

Has your organization completed the necessary steps to meet statewide data sharing requirements?

California providers are required to meet California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF) requirements. This means that providers must be able to respond to requests from other health care entities in real time via Health Information Exchange (HIE).

The DxF addresses areas including but not limited to:

- Health information creation, including the use of national standards in clinical documentation, health plan records and social services data.
- Translation, mapping, controlled vocabularies, coding and data classification.
- Storage, maintenance and management of health information.
- Linking, sharing, exchanging and providing access to health information.

DxF participants must send health and social services information to other participants in a timely manner, or risk violation of the California Information Blocking Prohibitions Policy and Procedure ([www.thealliance.health/realtimeexchange](http://www.thealliance.health/realtimeexchange)).

For more information, see APL 23-013: Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework.



## What Alliance providers will need to do

**Sign the CalHHS Data Sharing Agreement.** California providers are required to sign this agreement to share patient information safely.

If your organization has not signed this agreement yet, please do so at [www.thealliance.health/signthedsa](http://www.thealliance.health/signthedsa). Please check the DSA Signatory List to ensure that your organization has signed: [www.thealliance.health/dsa-list](http://www.thealliance.health/dsa-list).

**Participate with a Qualified Health Information Organization (QHIO).** Providers must exchange information via an intermediary QHIO, a nationwide network or framework, or a point-to-point connection. You can find out more about these requirements at [www.thealliance.health/dxf-tech-requirements](http://www.thealliance.health/dxf-tech-requirements).

**Explore Alliance incentive/funding opportunities for data sharing.** The Alliance is providing financial assistance to our provider

network to help them participate in active data sharing via our QHIO partner, Serving Communities Health Information Organization (SCHIO). Funding of up to \$40,000 per organization is available through our Data Sharing Incentive (DSI) program.

To learn more, visit [www.thealliance.health/dsi](http://www.thealliance.health/dsi).

## Not ready for data sharing?

Funding for capacity is also available through the Data Sharing Support Program, which is part of our Medi-Cal Capacity Grant Program. Data Sharing Support provides funding to eligible Medi-Cal provider types for infrastructure, operational solutions and technical assistance to build capacity to meet Medi-Cal requirements by sharing real-time health care data and connecting to a health information exchange (HIE).

More information is available at [www.thealliance.health/data-sharing-support](http://www.thealliance.health/data-sharing-support).







## Healthy Moms and Healthy Babies program



The Alliance's *Healthy Moms and Healthy Babies* (HMHB) program helps pregnant women get early prenatal and postpartum care. HMHB also provides education to support members in having a healthy pregnancy.

Members enrolled in the HMHB program are contacted by Alliance health educators. Health educators provide information on various topics, including prenatal and postpartum health, breastfeeding, pediatric care, and parenting.

### Health rewards

The Alliance provides members with health rewards for seeing a doctor for prenatal and postpartum care. Alliance members who visit their doctor within the first 13 weeks of being pregnant are entered into a raffle for a chance to win a \$50 Target gift card. Members who see their doctor 1 - 12 weeks after having a baby will receive a \$25 Target gift card.

Once the baby is born, the Alliance also offers health rewards for members who take their baby to the doctor for regular checkups.

### Referrals

Providers can refer members to any of the Alliance's Health Education and Disease Management programs using the referral form found on our website at [www.thealliance.health/health-programs-referral](http://www.thealliance.health/health-programs-referral). Once the referral form is received, the Health Education team will conduct telephonic outreach to offer education services to members. For more information, providers can call the Health Education Line at **800-700-3874, ext. 5580**.

### Community resources

The Alliance also provides pregnant and postpartum members with information about community resources, including the Women, Infants, and Children Program (WIC). WIC is a nutrition education program that helps individuals who are pregnant or just had a baby, as well as children up to age 5. For additional information about the WIC program and how the services can help members, visit [www.myfamily.wic.ca.gov](http://www.myfamily.wic.ca.gov) or call **888 WIC-WORKS (888-942-9675)**.



## Live Better with Diabetes program

The Alliance offers the *Live Better with Diabetes* program for Alliance members diagnosed with diabetes or prediabetes. The program provides workshops in group settings for members to learn self-management skills and understand ways to cope with diabetes symptoms. Program topics include weekly action planning, healthy eating, exercise, and how to work effectively with health care providers with a diabetes or prediabetes diagnosis. Workshops are available in English and Spanish throughout the year.

Workshops are offered in three different modalities:

- Over the phone.
- Virtually with online meetings.
- In person.

Providers can refer members to the *Live Better with Diabetes* program by completing the Health Programs Referral Form found on the Alliance website: [www.thealliance.health/health-programs-referral-form](http://www.thealliance.health/health-programs-referral-form).

Providers can also call the Alliance Health Education Line at **800-700-3874, ext. 5580**, if assistance is needed for referring members.

## Are you registered for the Naloxone Distribution Project?



DHCS has a program called Naloxone Distribution Project (NDP) to increase access to no-cost naloxone. The eligible entities include schools, universities, tribal entities, substance-use recovery facilities, FQHCs, community clinics and many other organizations.

Educational resources and videos for naloxone use may be accessed at [www.narcan.com](http://www.narcan.com).

DHCS recently announced the distribution of free, all-in-one fentanyl test strip kits through the NDP. These free fentanyl test strip kits aim to protect California communities that are at risk of fentanyl exposure and to prevent overdoses. These all-in-one kits help simplify the process of testing drugs for the presence of fentanyl.

Organizations eligible to receive naloxone through the NDP can apply to receive free fentanyl test strip kits through the same application form via the NDP at [www.thealliance.health/NDP-application](http://www.thealliance.health/NDP-application).

If your organization has not yet registered to receive free naloxone through NDP or is interested in free fentanyl test strip kits through NDP, please visit their website at [www.thealliance.health/NDP](http://www.thealliance.health/NDP) to determine if your organization qualifies and what documentation your organization will be required to submit with the application.

Reference:

[www.dhcs.ca.gov/individuals/Pages/Naloxone\\_Distribution\\_Project.aspx](http://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx)

## Pharmacist-Led Academic Detailing (PLAD) Program:

Alliance pharmacists offer an interactive, nonbiased, evidence-based, and individualized educational program. Our goal is to promote evidence-based practices, provide support, build relationships with health care teams, and ultimately improve patient health outcomes.

**The following topics are currently available:**

Diabetes

Asthma

Hypertension

To learn more about the program and to enroll, please email [pharmacy@ccah-alliance.org](mailto:pharmacy@ccah-alliance.org) and include the phrase "Pharmacist-Led Academic Detailing" in the subject line.

### Alliance's Physician-Administered Drug List and Procedures

Alliance's Physician-Administered Drug List, restrictions, prior authorization criteria, policies, and their updates are available on the Pharmacy page: [www.thealliance.health/pharmacy-services](http://www.thealliance.health/pharmacy-services). If you would like to request physical copies, please contact the Pharmacy Department at **831 430-5507**.



## Vaccine hesitancy: Bridging the gap

The wealth of information on vaccines has heightened structural barriers to vaccine uptake, especially in under-resourced communities and historically marginalized groups. Overcoming these challenges requires a nuanced approach and may not be swift.

Health care professionals must understand vaccine hesitancy's nuances, possess tools to address concerns, overcome mistrust and provide accurate information to help individuals make informed vaccine decisions.

### Provide community education through trusted messengers

Building trust between health care providers and patients is crucial in addressing vaccine hesitancy. Community education by trusted messengers can significantly increase vaccinations. Meeting people where they live, work, learn and play is vital. Door-to-door canvassing or partnering with trusted community locations, such as churches or barber shops, can foster deeper relationships and acceptance of vaccines.

Trusted messengers are effective because they are part of the community. They understand the daily challenges and realities people face.

### Address basic needs and meet patients where they are

Social needs, like unemployment, food insecurity, transportation and unstable housing, can hinder individuals from prioritizing health and immunizations. Shifting from vaccine hesitancy to acceptance requires meeting individuals where they are and making vaccine access convenient.

### Recognize the conversation type

The book *Supercommunicators* highlights aligning with others to make them feel heard and validated, which is crucial when dealing with vaccine hesitancy. Physicians can use these strategies to enhance their communication with hesitant patients:

1. **Identify the conversation type:** Assess whether the patient's concerns are based on data and



statistics or on personal experiences and emotional fears. Tailor your educational approach accordingly, using studies and supportive data for those focused on facts or sharing examples of family and community members who have benefited from vaccines for those influenced by personal stories.

2. **Recognize the patient's emotional state:** If a patient expresses anger or fear about vaccines, acknowledge their emotions before presenting facts. This can diffuse tension and open the door to a more productive dialogue.
3. **Active listening:** Listen to the patient's concerns without judgment. Reflect what you've heard to show understanding and build trust.
4. **Storytelling:** Share stories of positive vaccine outcomes. Personal narratives can be more persuasive than statistics alone.
5. **Empathy and intuition:** Use empathy to connect with the patient on a human level and intuition to sense and address unspoken concerns proactively.

Physicians can transform vaccine discussions into opportunities for connection and education. It's about empowering patients with the confidence to make informed health decisions, not just convincing them to vaccinate.

Reference:

[www.cdc.gov/vaccines/partners/vaccinate-with-confidence.html](https://www.cdc.gov/vaccines/partners/vaccinate-with-confidence.html)

# The state of Enhanced Care Management (ECM)

ECM holds the promise of transforming health care for our most vulnerable members. The concept makes perfect sense – treating each member like family, understanding their unique needs and advocating for them across complex systems.

But after 2.5 years, it's clear there's still confusion about ECM's purpose and implementation.

## What is ECM?

Simply put, ECM is the care you'd want for your loved ones. It involves understanding each member's needs, advocating for them, and coordinating care across health care, social services and other systems. It's designed for members facing difficult circumstances like homelessness, justice involvement, severe mental illness, substance use disorder, medical complexity, long-term care risk, foster care or pregnancy.

## How are we doing with ECM?

With approximately 7,600 members currently served, we're thrilled to announce that we've climbed into the top 10 for all health plans in the last 12 months. While we're seeing the incredible value this approach offers, ECM hasn't reached its full potential for several reasons:

- 1. The COVID-19 pandemic** caused delays and disruptions to the rollout and implementation of ECM, hindering the engagement and focus needed from health care providers, the Alliance and members to fully realize its potential.
- 2. Unclear guidance** from DHCS on ECM implementation as a standard benefit led to confusion and the creation of unnecessary processes.
- 3. Inclusion of new nontraditional providers** in the ECM program has presented challenges, as these providers have had to adapt to new billing procedures, navigate the complex health care system and learn how to effectively reach hospitalized patients.



- 4. Not enough providers**, despite efforts to contract all willing CBOs and increase reimbursement rates. There continues to be a shortage of ECM providers due to hiring challenges faced by county partners.

## How do we achieve ECM's vision?

To increase enrollment, we are:

- 1. Educating staff, providers, CBOs and members** about ECM.
- 2. Identifying vulnerable members** and referring them to ECM services.
- 3. Supporting local partners** to increase capacity.
- 4. Bringing in new partners** with a local presence.

To ensure high-quality care, we are:

- 1. Standardizing ECM processes** as we would with any other benefit.
- 2. Focusing on quality assurance, improvement and technical assistance** for providers through case reviews, interdisciplinary rounds, audits, training and relationship building.

Through these strategies, we hope to increase ECM utilization and ensure that every member receives the high-quality, compassionate care they need and deserve.

For more information and resources, please visit [www.thealliance.health/ecm](http://www.thealliance.health/ecm).





# The Alliance offers language assistance services

The Alliance offers a variety of language assistance services that our provider network can utilize to communicate with our members, including:

- Telephonic interpreting services.
- Face-to-face interpreting services.

The Alliance's Cultural and Linguistics team can provide training and support for our provider network to ensure providers and staff are aware of how to use the interpretation services available for Alliance members.

The Alliance can also provide resources such as language assistance flyers and materials for office staff to utilize when working with members.

For additional information on the Alliance language assistance services, please visit our website at **[www.thealliance.health/cultural-and-linguistic-services](http://www.thealliance.health/cultural-and-linguistic-services)** or call the Alliance Health Education Line at **800-700-3874, ext. 5580**.

Providers can also reach out to their Alliance Provider Relations Representative for any language assistance training needs.



# Top 3 denials for long-term care crossover billing

Effective Feb. 1, 2024, long-term care (LTC) claims must be submitted on a UB-04 claim form. Local accommodation codes are obsolete. Claims must be submitted using national uniform billing revenue codes, value codes and value amount codes.

As a reminder:

- Box 44 is not a required field and should be left blank. Claims submitted with procedure codes or HCPCSs will be denied with explain reason code: 87-procedure code/HCPCS code/rev code invalid, bill with correct LTC revenue codes.
- Box 39-41 value codes and value code amounts are required fields. Claims submitted with missing value codes and value amounts will be denied with explain reason code: 4N6-value code is not valid or missing for LTC pricing.
- Box 50 is a required field, and OHC payers must be listed. When OHC is Medicare, Type A or Type B must be listed. Claims submitted with missing information will be denied with explain reason code: 5Q-the submitted documentation was not adequate.



Please refer to "LTC Code and Claim Conversion: Forthcoming Crossover Claims Changes" at [www.thealliance.health/crossover-changes](http://www.thealliance.health/crossover-changes) for more information.

## Inquiries and disputes for post-service authorization requests

The Alliance would like to remind providers that post-service (retrospective) authorization requests can be obtained by submitting the request directly to Health Services. For questions related to authorizations, please contact Health Services at **831-430-5506**.

Any provider of service may submit inquiries and disputes regarding the authorization or denial of a service, the processing of a payment or non-payment of a claim, the timeliness of the reimbursement on an uncontested clean claim, and any interest required to pay on claims.



## Urinalysis unbundling

The Alliance has identified a recent pattern of unbundling of CPT code 81003 (*urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, ph, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy*) when billed with HCPCS codes Z1032 (*initial antepartum office visit*) or Z1034 (*antepartum follow-up office visit*).

The Alliance would like to remind providers that reimbursement for individual antepartum visits and global obstetric service includes reimbursement for routine urinalysis. According to the Medi-Cal manual, claims for routine urinalysis tests will be denied if they are submitted with a diagnosis related to pregnancy. Providers are encouraged to review the DHCS Medi-Cal manual: "Pregnancy Early Care and Diagnostic Services" as a guide when billing antepartum services with urinalysis.



## Welcome, new providers

### New ECM/CS Providers

- Livingston Community Health. ECM Services. Merced County.
- Front Street. ECM Services. Santa Cruz and Monterey.
- Step Up on Second Street. ECM and CS Housing Services. Santa Cruz and Monterey.
- 18 reasons: CS Nutritional Assessments, Grocery/Produce Delivery. All counties.
- Imperium Care Home Aid: ECM/CS Respite Services, PC & HS. Santa Cruz and Monterey.
- Merced County Food Bank: CS Nutritional Assessments, Produce/Grocery Delivery. Merced and Mariposa.
- Stepping Up Santa Cruz: ECM/CS Housing Services. Respite Services, PC & HS. Santa Cruz and Monterey.
- Universal Health Net: ECM/CS Recuperative Care, Short-term post-hospitalization, Respite Services, PC & HS. Santa Cruz, Monterey and San Benito.
- Cope Health Solutions: ECM Services. Monterey County.
- Dragonfly Forward: ECM Services. Monterey County.
- Everyone's Harvest: CS Nutritional Assessments, Grocery/Produce Delivery. Monterey County.
- Salud Para La Gente: CS Housing Services. Santa Cruz County.
- Umoja Supply Chain Solutions: CS Medically Tailored Meals, Nutritional Assessments, Grocery/Produce Delivery. All counties.

#### Santa Cruz County

##### Primary Care

- Timothy Brennan, MD, Family Medicine

- Jessica Wall, MD, Family Medicine

##### Referral Physician/Specialist

- Joshua Babad, MD, Ophthalmology
- Misty Eleryan, MD, Dermatology
- Agustina Garzon-Lopez, MD, Family Medicine
- Yuxi Guan, MD, Podiatric Medicine
- Reema Syed, MD, Ophthalmology

#### Monterey County

##### Primary Care

- Inga Bates, MD, Family Medicine
- Elizabeth Beal, DO, Family Medicine
- Maura Becerra, MD, Family Medicine
- Kawajleet Bhatia, MD, Pediatrics
- Forrest Mealey, DO, Internal Medicine
- Jose Pauda, MD, Family Medicine
- Doloras Pena, MD, Family Medicine

– Continued on back page

## Important phone numbers

Provider Services . . . . .	<b>831-430-5504</b>
Claims. . . . .	<b>831-430-5503</b>
Authorizations . . . . .	<b>831-430-5506</b>
Status (non-pharmacy) . . . . .	<b>831-430-5511</b>
Member Services. . . . .	<b>831-430-5505</b>
Web and EDI . . . . .	<b>831-430-5510</b>
Cultural & Linguistic Services. . . . .	<b>831-430-5580</b>
Health Education Line. . . . .	<b>831-430-5580</b>

Partnering with local doctors and specialists  
to ensure that Alliance members get access  
to the right care, at the right time.



Standard  
U.S. Postage  
**PAID**  
Walla Walla, WA  
Permit No. 44

# Welcome, new providers

– Continued from page 11

- Francis Rangel Ventura, MD,  
Family Medicine

## Referral Physician/Specialist

- Christopher Bird, MD, Neurology
- Lauren Farac, MD, Anesthesiology
- Ronald Friedman, MD,  
Ophthalmology
- Noah Hawthorne, MD,  
Emergency Medicine
- Gurvinder Kaur, MD,  
Neurological Surgery
- Yang Liu, MD, Hematology
- Mario Roldan, DO, Surgery
- John Shumway, MD, Radiology
- Sky Vanderburg, MD,  
Pulmonary Disease
- Christopher Way, DO, Neurology

## Merced County

### Primary Care

- Shruti Agarwal, MD,  
Internal Medicine
- Tejaswini Bandaru, MD, Pediatrics
- Preethi Conjeevaram Selvakumar,  
MD, Pediatrics
- Vijay Devireddy, MD,  
Internal Medicine
- Simrit Dyal, MD, Family Medicine
- Ladan Modallel, MD, Pediatrics
- Karen Ann Rayos, MD,  
Family Medicine



- Ramanjeet Singh, MD,  
Internal Medicine
- Elaine Joy Soriano, MD,  
Internal Medicine
- Chaithra Sreenath, MD, Pediatrics
- Dheera Tamvada, MD,  
Internal Medicine

## Referral Physician/Specialist

- Kwame Adjepong, MD, Neurology
- Sai Santosh Kumar Bhuvanagiri,  
MD, Endocrinology, Diabetes  
and Metabolism
- Zachary Brewer, MD, Thoracic  
Surgery (Cardiothoracic  
Vascular Surgery)
- Dipal Chatterjee-Berfroid, MD,  
Orthopaedic Surgery
- Michael Flannery, DO, Neurology
- Mihoko Fujita, MD,  
Radiation Oncology
- Carrie Grouse, MD, Neurology
- Drew Lewis, DO, Pain Medicine
- Lauren Patrick, MD, Neurology

- Pritikanta Paul, MD, Neurology
- Homayoon Shahidi, MD,  
Hematology

## San Benito County

### Referral Physician/Specialist

- Joseph Fabry, DO, Surgery

## Mariposa County

### Primary Care

- Felix Conte, MD, Pediatrics  
(Tuolumne)
- Shayna Murdock, MD, Family  
Medicine (Tuolumne/Sonora)

## Referral Physician/Specialist

- Michael Flannery, DO, Neurology
- Carrie Grouse, MD, Neurology
- Steve Jensen, DPM,  
Podiatric Medicine
- Lauren Patrick, MD, Neurology
- Surinder Sandhu, MD,  
Cardiovascular Disease



# Alliance Fact Sheet

## Q4 2024



### About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **442,007 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.



### Quick Facts

**1996**

Year  
Established

**598**

Number of  
Employees

**\$1.66B<sup>1</sup>**

Annual  
Revenue

**6.3%<sup>1</sup>**

Administrative  
Overhead

**\$23.5M<sup>2</sup>**

Community Grants

### VISION

HEALTHY PEOPLE.  
HEALTHY COMMUNITIES.

### MISSION

Accessible, quality health care  
guided by local innovation.

### VALUES



#### Collaboration:

Working together toward solutions  
and results.



#### Equity:

Eliminating disparity through  
inclusion and justice.



#### Improvement:

Continuous pursuit of quality  
through learning and growth.



#### Integrity:

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

### What We Do

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

### Who We Serve

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

### Provider Partnerships

The Alliance partners with 100% of hospitals in our services areas and a network of approximately 13,400 providers (98% of primary care physicians and 98% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 4,600 providers to deliver behavioral health and vision services.

## Our Members<sup>4</sup>

**1 out of every 3**  
Mariposa County residents.



**1 out of every 2**  
Merced County residents.



**1 out of every 2**  
Monterey County residents.



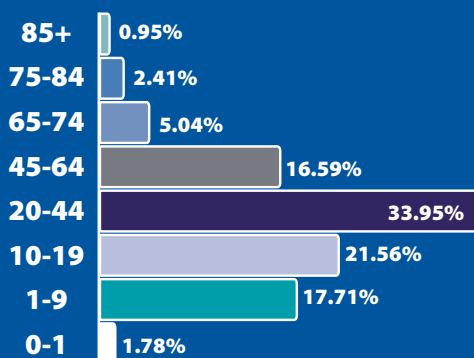
**1 out of every 3**  
San Benito County residents.



**1 out of every 3**  
Santa Cruz County residents.

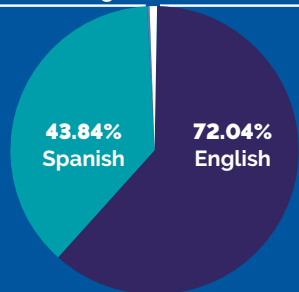


## Membership by Age Group

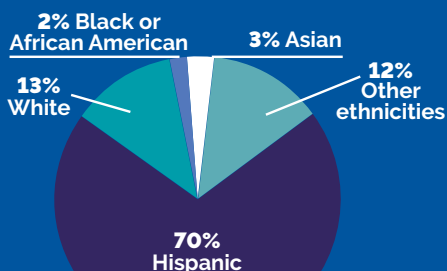


## Preferred Language

0.44% Hmong 1.07% Other languages



## Race/Ethnicity



## Executive Leadership



**Michael Schrader**  
Chief Executive Officer



**Dennis Hsieh, MD**  
Chief Medical Officer



**Lisa Ba**  
Chief Financial Officer



**Jenifer Mandella**  
Chief Compliance Officer



**Scott Fortner**  
Chief Administrative Officer



**Cecil Newton**  
Chief Information Officer



**Omar Guzmán, MD**  
Chief Health Equity Officer



**Van Wong**  
Chief Operating Officer

## Governing Board

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

In alphabetical order, current Board members are:

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

Unless otherwise stated, Fact Sheet data as of October 1, 2024.

<sup>1</sup>Amounts based on 2024 annual budget.

<sup>2</sup>Represents 2023 investments through the Alliance's [Medi-Cal Capacity Grant Program](#).

<sup>3</sup>County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).

<sup>4</sup>Represents an approximate visual representation. Membership percentage by county: Mariposa (33 percent) Merced (51 percent); Monterey (44 percent); San Benito (30 percent); Santa Cruz (30 percent).