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**SENATE COMMITTEE ON HEALTH**  
**Senator Dr. Richard Pan, Chair**

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**BILL NO:** AB 2724  
**AUTHOR:** Arambula  
**VERSION:** June 20, 2022 Amended  
**HEARING DATE:** June 22, 2022  
**CONSULTANT:** Jen Flory

**SUBJECT:** Medi-Cal: alternate health care service plan

**SUMMARY:** Authorizes the Department of Health Care Services (DHCS) to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSPP) to serve as the primary Medi-Cal managed care plan for specified eligible beneficiaries in specified geographic regions, so long as the AHCSPP also provides commercial coverage in that market. Requires the AHCSPP to enter into a memorandum of understanding with DHCS, which would include specified standards or requirements and the AHCSPP's commitment to increase enrollment of new Medi-Cal members and any requirements related to the AHCSPP's collaboration with and support of applicable safety net providers. Requires the AHCSPP to work with federally qualified health centers (FQHCs) in AHCSPP service areas, as specified and at the request of the FQHC, to provide assistance with population health management and clinical transformation.

**Existing law:**

- 1) Establishes the Medi-Cal program, which is administered by the Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. [WIC §14000, et seq.]
- 2) Authorizes the DHCS Director to contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries and establishes managed care models that DHCS contracts with in each county. [WIC §14087.3, §14087.5, §14087.967, §14087.98, and §14089]
- 3) Authorizes DHCS to negotiate exclusive contracts with counties that seek to provide Medi-Cal services, known as the county organized health systems (COHSs). Authorizes county boards of supervisors to establish a commission to negotiate the exclusive contract and to arrange for the provision of Medi-Cal services, and permits the commission to subcontract with providers or health plans or other entities. [WIC §14087.5, §14087.55, and §14087.6]
- 4) Authorizes DHCS, under state Two-Plan Model Medi-Cal regulation, to contract with an AHCSPP to promote continuity of care, preserve access to providers, and maintain physician-patient relationships. Authorizes DHCS, to the extent allowable under the law to enter into either one contract for all geographic areas where the AHCSPP operates or enter into multiple contracts to serve the different geographic areas. Permits the following beneficiaries enrolling in Medi-Cal managed care (MCMC) to enroll in the AHCSPP:
  - a) An existing member of the AHCSPP transitioning into Medi-Cal managed care;
  - b) A beneficiary who has been enrolled in the AHCSPP at any time during the 12 months immediately prior to the beneficiary's Medi-Cal eligibility; or
  - c) A beneficiary with an AHCSPP family member linkage. [22 CCR §53800]

**This bill:**

- 1) Permits DHCS to enter into one or more comprehensive risk contracts with an AHCSF to serve as a primary MCMC plan for specified eligible beneficiaries in geographic regions in which the AHSCP also provides commercial coverage in the individual, small group, or large group market.
- 2) Defines an “AHSCP” as a nonprofit health care service plan with at least 4,000,000 enrollees statewide that owns or operates pharmacies and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed pursuant to the Knox-Keene Health Care Service Plan Act (Knox-Keene Act). Requires the AHCSF, if it cannot comply with any terms of the Knox-Keene Act, to request a modification of its license or an exemption from the Department of Managed Health Care (DMHC).
- 3) Permits the enrollment of the following beneficiary groups in an AHCSF:
  - a) A beneficiary who was previously a member of the AHCSF as their MCMC plan at any point from January 1, 2023, to December 31, 2023;
  - b) An existing member of the AHCSF who is transitioning into MCMC;
  - c) A beneficiary who was a member of the AHCSF at any time during the 12 months preceding the effective date of the beneficiary’s Medi-Cal eligibility;
  - d) A beneficiary with an AHCSF family linkage. Defines “AHCSF family linkage” to include when any of the following individuals are current AHCSF members on the effective date of the beneficiary’s Medi-Cal eligibility:
    - i) A beneficiary’s spouse or domestic partner;
    - ii) A beneficiary’s dependent child, foster child, or stepchild under 26 years of age;
    - iii) A beneficiary’s dependent who is disabled and over 21 years of age;
    - iv) A parent or stepparent of a beneficiary under 26 years of age; or
    - v) A beneficiary’s grandparent, guardian, foster parent, or other relative of a beneficiary under 26 years of age with appropriate documentation of familial relationship, as determined by the department.
  - e) A beneficiary who was previously enrolled in a primary MCMC plan other than the AHCSF at any point from January 1, 2023, to December 31, 2023, but who was assigned to, and made the responsibility of, the AHCSF under a subcontract with the MCMC plan;
  - f) A dual eligible beneficiary residing in a geographic region approved by DHCS for purposes of this subdivision and for which DHCS has contracted with the AHCSF for services to this population;
  - g) A beneficiary who is eligible on the basis of their receipt of services through a state foster care program or a former foster youth, as defined in statute, residing in a geographic region approved by DHCS and for which DHCS has contracted with the AHCSF for services to this population. A beneficiary who is in foster care in this state or is otherwise eligible on the basis of their receipt of services through a child welfare agency or a former foster youth eligible residing in a geographic region for which DHCS has contracted with the AHCSF. Permits beneficiary who was previously enrolled in the AHCSF as their primary MCMC plan to remain in the AHCSF even if the beneficiary is no longer receiving services through a child welfare agency; and,
  - h) A beneficiary not listed in a)-g) who resides in a geographic region for which DHCS has contracted with the AHCSF and is assigned to the AHCSF according to DHCS’s default enrollment process for beneficiaries that fail to elect a MCMC plan. Requires DHCS to annually determine the rate of default enrollment for beneficiaries into the AHCSF in

each applicable county or geographic region based on the AHCSPP's projected capacity. If the default enrollment into the AHCSPP described results in a default rate of 20 percent or higher for two consecutive months in an applicable county or counties, exempts DHCS from the requirement of surveying beneficiaries as to why they are not choosing a plan.

- 4) Permits DHCS to contract with an AHCSPP as a MCMC plan in any geographic region of the state for which federal approval is available and for which the AHCSPP maintains appropriate licensure or an approved exemption from DMHC and in which the AHCSPP also provides commercial coverage in the individual, small group, or large group market. Permits DHCS to enter into either a single comprehensive risk contract for all geographic areas where the AHCSPP is approved to operate as a MCMC plan or multiple contracts to serve the different geographic areas to the extent permissible under federal law.
- 5) Prohibits the AHCSPP from denying enrollment to any eligible individual eligible unless the DHCS or DMHC has ordered the AHCSPP to cease enrollment in an applicable service area.
- 6) Prohibits the AHCSPP from disenrolling any eligible beneficiary. Requires the Health Care Options program (the entity that coordinates managed care plan choice within DHCS) to disenroll members of the AHCSPP who meet a reason for disenrollment specified in existing regulation according to the process specified in regulation.
- 7) Requires the comprehensive risk contract or contracts with the AHCSPP to include the same standards and requirements as those for other MCMC plans, including any requirements imposed by the CalAIM Terms and Conditions and any terms and conditions imposed by a successor federal waiver or demonstration project except for those standards and requirements relating to beneficiary enrollment that DHCS determines are inapplicable to the AHCSPP.
- 8) Requires DHCS and the AHCSPP to enter into a memorandum of understanding (MOU) to memorialize any standards or requirements that are in addition to, or different than, those imposed on other MCMC plans. Requires DHCS, upon execution, to post the MOU on its website.
- 9) Requires the MOU to include the AHCSPP's commitment to increase enrollment of new Medi-Cal members over the course of the relevant contract terms and any requirements related to the AHCSPP's collaboration with, and support of, applicable safety net providers, including FQHCs as follows:
  - a) Requires the AHCSPP to work with FQHCs in AHCSPP service areas selected by the AHCSPP and DHCS, at the request of the FQHC, to provide assistance with population health management and clinical transformation; and,
  - b) Requires DHCS and the AHCSPP to identify the highest need specialties and geographic areas where the AHCSPP will provide, using the AHCSPP's physicians, outpatient specialty care and services to address related needs, including diagnostic testing and outpatient procedures for Medi-Cal beneficiaries who are not enrollees of the AHCSPP.
- 10) Requires DHCS to publish a report describing the implementation of the standards and requirements imposed by the MOU for the applicable rating period and post the report on its website within six months after the end of each applicable rating period for which DHCS contracts with the AHCSPP, commencing with the 2024 calendar year.

- 11) Requires the AHSCP to periodically consult with counties and other affected local stakeholders in those geographic regions in which the AHSCP operates, as specified.
- 12) Requires contracts entered into pursuant to this bill to be effective no sooner than January 1, 2024, except when an AHSCP was already contracted with DHCS as a MCMC plan as of January 1, 2022.
- 13) Requires DHCS to seek any federal approvals it deems necessary to implement this bill. Requires it be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.
- 14) Requires the capitation rates established for contracts entered into pursuant to this bill to be set in accordance with existing law on MCMC plan capitation rates.
- 15) Permits the DHCS to implement, interpret, or make specific this bill by means of plan letters or other similar instructions, without taking any further regulatory action.
- 16) Exempts contracts made under this bill from the review or approval of any division of the Department of General Services.
- 17) Makes conforming changes for the inclusion of the AHSCP with other types of MCMC plans.

**FISCAL EFFECT:** According to the Assembly Appropriations Committee, this bill has unknown costs (GF and federal funds) to DHCS beginning January 1, 2024 (the 2023-24 fiscal year (FY), assuming implementation of one or more comprehensive risk contracts with Kaiser to serve as a primary MCMC plan for eligible beneficiaries. DHCS released its proposed trailer bill language and proposal for a statewide contract with Kaiser in February 2022 but has not released fiscal estimates of how implementation of such a contract would affect existing plan payment rates or other fiscal details. Costs will likely increase as a result of DHCS directly overseeing an expanded directed plan contract with Kaiser of approximately 600,000 to 700,000 beneficiaries, offset in whole or in part by reducing DHCS workload overseeing existing direct MCMC plan contacts.

This bill could also result in cost pressure to increase MCMC rates paid to COHS plans and local initiatives that currently contract with Kaiser which would no longer receive an administrative fee on the subcontracted beneficiaries from Kaiser, and the development of a plan selection process in COHS counties where such a process does not currently exist.

**PRIOR VOTES:**

Assembly Floor:	41 - 18
Assembly Appropriations Committee:	12 - 3
Assembly Health Committee:	10 - 2

**COMMENTS:**

- 1) *Author's statement.* According to the author, this bill will improve affordability, access, quality, and equity for some of our most vulnerable populations by making it easier for low-income Californians to go directly to providers for health care. In doing so, this bill eliminates confusing bureaucracy that is difficult for consumers to navigate. Through Medi-

Cal, low-income Californians receive preventive care, doctor visits, hospital stays, medications, and other vital medical services. CalAIM is moving Medi-Cal towards a population health approach that prioritizes prevention and whole person care. As part of that process, DHCS is asking certain health plans to do more for the Medi-Cal program. This bill will allow DHCS to enter into a direct contract with AHCSPs that operate as a health plan, a provider network, and that owns or operates their own pharmacies. At this time, Kaiser Permanente (Kaiser) is the only such plan that meets all of these requirements. By creating a direct contract with Kaiser as an AHCSP, the state will have direct oversight of Kaiser as they step up to provide more care for Medi-Cal enrollees. Just as important, consumers will have a direct link to Kaiser services, without the need to divert funds intended for health care services toward administrative purposes, which happens under current subcontracting practices.

- 2) *Medi-Cal managed care plan models.* The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox Keene Act. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, over 12 million Medi-Cal beneficiaries are enrolled in a MCMC and receive services through one of six managed care models:
  - a) County Organized Health Systems. In 1982, the Legislature authorized the creation of three COHS, which are county-administered MCMCs. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the Knox-Keene Act, though they are specifically exempted from requiring a license under the Knox-Keene Act. There are currently 22 counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties implemented in 2012. Beneficiaries in these counties receive services through Partnership Health Plan of California. In March 2022, there were just under 2.5 million enrollees in COHS plans.
  - b) Geographic Managed Care. In 1992, DHCS designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to be Knox-Keene licensed. Sacramento and San Diego remain the only two GMC counties in the state. In March 2022, there were just under 1.4 million enrollees in GMC plans.
  - c) Two Plan Model. In 1995, as part of a significant expansion of MCMC, 12 counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a

commercial plan. Both plans are required to be Knox-Keene licensed. There are currently 14 Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other managed care plans to provide services to Medi-Cal beneficiaries. In March 2022, there were just under eight million managed care enrollees in the Two Plan models, with six million of those enrollees in the local initiative plan, though as mentioned, many of those enrollees in Los Angeles receive services through a subcontracted commercial plan.

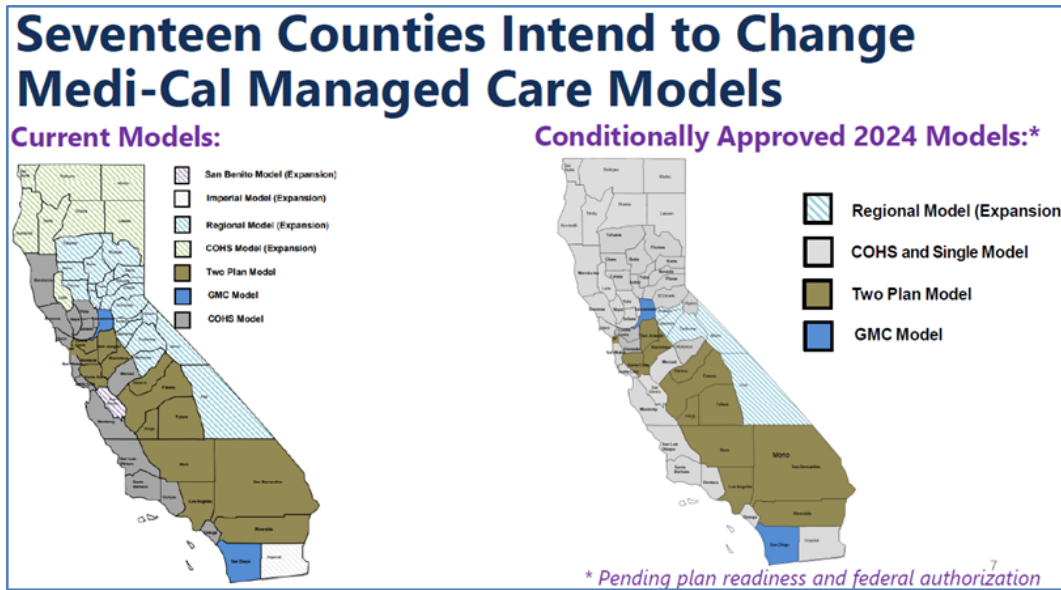
- d) Regional Model. AB 1467 (Committee on Budget, Chapter 23, Statutes of 2012) authorized the expansion of MCMC into 28 rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. Eight counties transitioned into the COHS model, while 18 counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties receive services through either Anthem Blue Cross or California Health and Wellness. In March 2022, there were approximately 354,000 enrollees in regional model plans.
  - e) Imperial Model. Imperial County was one of the 28 county counties in the rural county expansion. Rather than join the 18 counties under the regional model or transition into a COHS, Imperial County established a Local Health Authority Commission (Commission) that provides oversight over the MCMC program in the county. Beneficiaries in the Imperial County receive services through two commercial MCMC plans. The Commission selects one commercial MCMC plan, which, in addition to the contract with DHCS, must also meet local contract provisions established by the Commission, and DHCS selects the other. In March 2022, there were approximately 87,000 enrollees in Imperial model plans.
  - f) San Benito Model. The rural county expansion also brought managed care to San Benito County. Unlike the rest of the state, beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal. In March 2022, there were just over 10,400 enrollees in San Benito model plans.
- 2) *Current role of Kaiser in MCMC*. Currently, there are close to 900,000 Medi-Cal enrollees in Kaiser, which participates as a subcontractor with 12 local MCMC plans in 17 counties and has a direct contract in five counties, including the two GMC counties and three of the regional model counties. Kaiser participates in Medi-Cal primarily through a continuity of care model, serving Medi-Cal beneficiaries who had Kaiser coverage through a commercial plan or Medicare, or who have family members with Kaiser coverage. Medi-Cal enrollees without a pre-existing linkage to Kaiser cannot choose or are not defaulted into Kaiser. The following chart shows in the enrollment as reported by Kaiser in January 2022:

**Current Kaiser Medi-Cal Enrollment**

County	Plan Model	Enrollment	% of Medi-Cal Enrollment
<i>Direct Enrollment</i>		<b>184,192</b>	
<b>Sacramento</b>	GMC	107,775	21.26%
<b>Placer</b>	Regional, changing to COHS	11,284	19.11%
<b>San Diego</b>	GMC	62,054	7.27%
<b>El Dorado</b>	Regional, changing to 2-plan	2,869	8.24%
<b>Amador</b>	Regional	210	2.82%
<i>Subcontract</i>		<b>712,030</b>	
<b>Solano</b>	COHS	37,315	29.38%
<b>Napa</b>	COHS	8,447	25.93%
<b>Sonoma</b>	COHS	26,153	21.59%
<b>Marin</b>	COHS	7,873	17.38%
<b>Alameda</b>	2-plan, changing to single	44,727	12.08%
<b>Contra Costa</b>	2-plan, changing to single	40,474	15.94%
<b>Yolo</b>	COHS	6,415	10.96%
<b>Santa Clara</b>	2-plan	34,246	9.46%
<b>San Bernardino</b>	2-plan	77,182	9.32%
<b>San Mateo</b>	COHS	11,563	9.31%
<b>Riverside</b>	2-plan	67,979	8.13%
<b>San Francisco</b>	2-plan	14,281	8.05%
<b>Los Angeles</b>	2-plan	243,673	7.22%
<b>Orange</b>	COHS	55,384	6.43%
<b>San Joaquin</b>	2-plan	16,803	6.27%
<b>Kern</b>	2-plan	12,840	3.20%
<b>Ventura</b>	COHS	6,675	2.90%

The plans that Kaiser subcontracts with do not pass through the entire premium they receive to Kaiser. Kaiser describes this as an administrative fee, while local plans argue it covers the cost of overseeing the contract with Kaiser and for benefits they provide that Kaiser does not. The amounts are propriety and determined via contract between Kaiser and each Local Initiative and COHS and vary by plan, but DHCS indicates they average 5%. DHCS’s managed care performance dashboard measures the number of primary care physicians per 2,000 plan enrollees and all physicians per 1,200 plan enrollees. Kaiser had the second highest number of primary care physicians compared to other plans, and the third highest physicians per 1,200 members compared to other plans.

3) *Medi-Cal managed care plan reprocurement.* In 2021, DHCS began a statewide procurement process of commercial MCMC plans for the new managed care contract effective January 1, 2024. Prior to the actual plan reprocurement, DHCS allowed counties to submit a letter of intent if they wanted to switch plan models. DHCS also announced it would limit the number of plans in GMC model counties. In order for Kaiser to participate in the GMC model, it would have to agree to a significant enrollment increase. DHCS provided conditional approval to 17 counties to change the type of managed care plan model in which they participate as demonstrated in the graphic below:



On February 9, 2022, DHCS released a Request for Proposal (RFP) for its commercial managed care plan contracts. While the RFP is only for commercial plans, DHCS indicates the updated contract released with the RFP will be executed with all MCMC plans, including local initiatives and COHS, as of January 1, 2024. Plans turned in their proposals by April 11 and DHCS expects to announce the awarded contracts in August of this year, giving plans the rest of 2022 and 2023 to prepare for the new contracts starting January 1, 2024. The chart below shows which counties are involved in reprocurement and under what models:

Plan Model	Counties Being Procured	Intended Number of Awards
<b>Two Plan Commercial</b>	14 counties: Alpine, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, Santa Clara, San Francisco, San Joaquin, Stanislaus, and Tulare.	One award for a commercial health plan for each county identified in this RFP.
<b>Geographic Managed Care</b>	2 counties (no change): Sacramento and San Diego.	Two awards for commercial health plans per county.
<b>Regional</b>	5 counties: Amador, Calaveras, Inyo, Mono, and Tuolumne.	Two awards for commercial health plans per county.



- 4) *New contract requirements in reprocurement.* According to DHCS, the current MCMC reprocurement process reflects DHCS' intention to hold all plan partners and their subcontractors more accountable for high-quality, accessible, and comprehensive care across all settings, reducing health disparities, and improving health outcomes. MCMC plans will now be required to publicly report on financial performance information as well as access, quality improvement, and health equity activities. They will be expected to exceed quality improvement benchmarks or face sanctions. Plans will report on what proportion of their spending is on primary and integrated care and tied to alternative primary care payment models. Additionally, plans will be held accountable for the quality of care at all levels of delegation, and for the first time, the contract mandates that plans report information on delegated functions.

Plans will be required to partner with local agencies (e.g., local health departments, county behavioral health plans, continuums of care, community-based organizations) to ensure that they understand and meet community needs. Plans will also be required to facilitate warm hand-offs and closed-loop referrals of members to community resources and follow-up to ensure services are rendered. Plans and their fully delegated subcontractors with positive net income will also be required to allocate 5% to 7.5% of these profits (depending on the level of their profit) to local community activities that develop community infrastructure to support Medi-Cal members. Plans will be newly required to provide medically necessary health and behavioral health services in schools and other settings (i.e., at home and in the community) and implement interventions by school-affiliated providers that increase access to preventive, early intervention, and behavioral health services. Plans will also be required to expand access to evidence-based behavioral health services focused on earlier identification and engagement in treatment for children, youth, and adults and integrated with physical health care, including establishment of No Wrong Door policies to support access to diagnoses and treatment.

With regards to quality and addressing social drivers of health, plans and their subcontractors are expected to achieve National Committee for Quality Assurance (NCQA) Health Plan Accreditation by 2026. They will also be required to achieve NCQA Health Equity Accreditation, a new standards program focused on the delivery of more equitable and culturally and linguistically appropriate services. Plans will be required to identify physical and behavioral health disparities and inequities in access, utilization, and outcomes by race, ethnicity, language, and sexual orientation, and to have focused efforts to improve health outcomes within the most impacted groups and communities. Plans are also required to implement new population health management and care management strategies to address the unmet social needs of members, such as food security and housing, and document members' needs and services. All MCMC plans contracting with DHCS, including the AHCS, would be subject to these requirements beginning January 1, 2024.

- 5) *DHCS's proposed direct contract with Kaiser.* In this context, DHCS has proposed to allow it to enter into a direct contract with Kaiser as a MCMC plan within new geographic regions of the state, effective January 1, 2024, for a five-year contract term, with the potential for contract extensions. Under the new contract, Kaiser would operate as a full-risk, full-scope MCMC plan, consistent with other MCMC plans and without specific exceptions or alternative standards. This includes the additional contract requirements described above. However, Kaiser would not be open to beneficiaries through the traditional Medi-Cal plan choice methods, but would only be available to existing Kaiser members in both Medi-Cal and commercial lines of business, members with family

linkage, dually eligible Medicare and Medi-Cal enrollees, foster and former foster youth, and via default enrollment for Medi-Cal beneficiaries that have not chosen a plan. According to DHCS, Kaiser would commit to growth of its Medi-Cal members by 25% by the end of the five-year term, though that is not specified in this bill.

- 6) *DHCS's rationale for the direct contract.* In 2021, DHCS announced it would limit the number of plans in GMC model counties. However, due to limitations in Kaiser's integrated model, physical capacity as well as fixed geographic locations, Kaiser is not in a position to be listed on Medi-Cal enrollment choice forms for all Medi-Cal beneficiaries. DHCS states if Kaiser is unable to participate in the RFP due to its network's physical capacity, the Medi-Cal program would lose its highest quality plan, its integrated model and clinical expertise. In addition, Kaiser's enrollees in at least the GMC and direct contract counties (Sacramento, San Diego, Amador, El Dorado, and Placer) would need to change health plans. Finally, DHCS states that growth commitment from Kaiser in the DHCS proposal will mean that Medi-Cal growth will be at a faster rate than Kaiser's projected growth for commercial (CalPERS, Covered CA, etc.) and Medicare. While Kaiser is open to all comers on these lines of business, it is at a manageable rate that aligns with their available capacity. If Kaiser were to take all comers in Medi-Cal, the growth rate would far outpace their physical capacity, especially since DHCS' default algorithm favors quality and Kaiser has high quality scores in all the counties it participates in. DHCS states Kaiser consistently scores above 90% in the Aggregated Quality Factor Score, which is a quality score that accounts for plan performance on DHCS-selected Healthcare Effectiveness Data and Information Set indicators. In comparison, the weighted average of other MCMC plans is 65%. Further, in 41 of 48 quality measures Kaiser (either Northern California and/or Southern California) exceed the weighted average for all MCMC plan and in 37/48 measures significantly better than the weighted average.

DHCS also points to the following arrangements of this proposal:

- a) Kaiser will implement CalAIM Enhanced Care Management (ECM) and Community Supports in a manner consistent with other MCMC plans. Kaiser will leverage more community presence with other providers (e.g., county departments, public hospitals and health systems, and community health centers) and not solely provide all ECM and Community Supports internally. Kaiser will also commit to broad uptake of Community Supports, consistent with other MCMC plans and will implement at least the same number of Community Supports as other Medi-Cal managed care plans in the area;
- b) Kaiser will support FQHCs across the state to implement a robust portfolio of population health management and practice transformation solutions to augment clinical outcomes for patients cared for in this vital community-based system. This bolsters the strengths of two systems: The breadth of community presence and cultural and equity excellence of the FQHCs and the practice transformation and approach to quality care of Kaiser; and,
- c) DHCS and Kaiser will identify the highest need specialties and geographic areas where Kaiser will provide, by Kaiser physicians, a limited number of in person, ambulatory based, outpatient specialty care visits, and associated needs such as diagnostic testing and outpatient procedures for non-Kaiser members. These services may be provided at locations other than Kaiser facilities (for example at FQHCs). Similar to above, this would leverage Kaiser's clinical expertise and integrated model to support underserved areas and would test out models and partnerships to deliver specialty care.

- 7) *Previous legislation.* AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) included the CalAIM proposal which authorized DHCS to standardize populations required to enroll in a MCMC across aid codes and MCMC models, subject to a MCMC plan readiness, and a transition developed in consultation with stakeholders. AB 133 also requires DHCS, commencing January 1, 2023, to require each MCMC plan operating in the seven Coordinated Care Initiative (CCI) counties to operate, or continue to operate, a Dual Eligible Special Needs Plan (D-SNP), and permits DHCS, commencing January 1, 2026 in the 51 non-CCI counties, to require each MCMC plan to operate, or continue to operate, a D-SNP in accordance with the CalAIM terms and conditions and in accordance with federal requirements.

SB 226 (Pan, Chapter 446, Statutes of 2020) authorized Sacramento County, by ordinance, to establish a health authority, defined as a separate public entity established by the Sacramento County Board of Supervisors. SB 226 authorized the health authority to designate a number of Knox-Keene licensed health plans for purposes of MCMC plan procurement for GMC as the only MCMC plans authorized to operate within the county. Authorizes the county to seek and obtain Knox-Keene health plan licensure in order to serve as the county-sponsored Local Initiative health plan contracted with DHCS for MCMC, or to negotiate and enter into a contract with a Knox-Keene licensed plan to be the designated Local Initiative plan for the purpose of contracting with DHCS, instead of the current GMC model in the county.

SB 260 (Monning of 2015) would have deleted the exemption that allows COHS to provide health care services to Medi-Cal beneficiaries without a Knox-Keene license, which, among other things, would have required COHS plans to provide independent medical reviews. *SB 260 died on the Assembly floor.*

AB 1467 (Committee on Budget, Chapter 23, Statutes of 2012) authorized DHCS to enter into exclusive or nonexclusive contracts with one or more managed health care plans to provide a comprehensive program of MCMC plan services to Medi-Cal recipients residing in 28 smaller counties under the regional model.

- 8) *Support.* This bill is supported by Kaiser and a number of consumer advocacy groups. Kaiser states that a single contract will create a more consumer-friendly experience as members enroll in Kaiser coverage. The current subcontracting arrangement adds unnecessary layers and costs in the program that create barriers and confusion for patients. Eligible members will have the ability to access Kaiser in ten new counties to allow for continuity of care in Kaiser's entire commercial footprint. In addition, members will not face barriers to accessing Kaiser for Medi-Cal where arbitrary enrollment caps have been imposed by Plan Partners. Its single contract will be the same as other MCMC plan contracts on January 1, 2024, except with controls on growth to ensure there are no adverse impacts on other MCMC plans, the safety net, or Kaiser's integrated delivery system. Kaiser is committed to meeting all the requirements in the new contract, including without limitation, having a community presence for the new enhanced care management benefit and broad uptake of Community Supports, consistent with other Medi-Cal managed care plans.

Western Center and National Health Law Program both write that the proposal provides more plan choices to Medi-Cal beneficiaries, particularly those in counties with a COHS. They also point out that enrolling in Kaiser will give them the opportunity to enroll in a Knox-Keene licensed plan and to gain important consumer protections. All of the consumer groups write that the arrangement will give DHCS more oversight over Kaiser and offer more opportunity for continuity of care for consumers losing their Kaiser commercial coverage. Health Access writes Kaiser will do more of its fair share in Medi-Cal and potentially improve the capacity, quality, and accountability of this program that serves over 13 million Californians. Kaiser will serve additional vulnerable populations with complex needs, those being foster children and dual-eligible Medi-Cal and Medicare seniors and people with disabilities.

- 9) *Opposition.* This bill is opposed by a number of plans, clinics, counties, and one consumer group. The Local Health Plans of California write that the proposal undercuts the public plan model which has existed in California for nearly 40 years, makes changes to the Medi-Cal delivery system that are inequitable for Medi-Cal enrollees, and harms the local safety net while advancing the growth and interests of a single commercial health plan. Several counties and plans write in opposition to allowing Kaiser to contract in COHS counties, arguing that it undercuts a model based on local control. They, and many of the plans counties, and clinics seek a number of amendments including excluding the COHS counties entirely, requiring legislative approval to expand Kaiser contracts to new areas, assurances that Kaiser does not exceed the proposed 25% enrollment, a requirement that Kaiser enrollees be assigned to a Kaiser primary care provider, specifically limiting the counties where DHCS may contract with Kaiser, limiting the contract period and requiring legislative review for any renewal, and requiring increased reporting to the legislature. A number of plans also express concern that neither the Kaiser rates nor their own rates will be adequately specific so as to account for the actual risk of their patient populations. They also argue that the proposal allows Kaiser to enroll healthier Medi-Cal members based on which populations are allowed to enroll in Kaiser and express skepticism that the rates will accurately reflect the higher acuity populations that they serve. Some clinics also note that they have linguistic and cultural proficiency for the Medi-Cal population that exceeds Kaiser's. Finally, several stakeholders express concerns if Kaiser moves into new regions without they do not have sufficient infrastructure as they be relying on other safety net providers, thus not increasing health care access. Some counties and plans also want more clarity about which counties are or are not included in the proposal.
- 10) *Oppose unless amended.* The National Union of Healthcare Workers write that any expansion of Medi-Cal contracting with Kaiser should wait until the health plan implements – or at minimum enters into binding agreements with the state to implement – concrete steps to remedy its egregious, multifold, documented failures to provide timely and appropriate behavioral health services to its more than nine million current enrollees. Over the past decade, the DMHC repeatedly has found Kaiser to have failed in its obligation to provide patients with timely and appropriate behavioral health care to which they are entitled under the law, and has found in each successive instance that Kaiser has failed to remedy multiple deficiencies that had been noted previously. As a result of Kaiser's failures, in many parts of the state, enrollees are currently waiting as long as three months between therapeutic visits, in contradiction of their providers' clinical judgment, and in violation of generally accepted standards of care for their conditions.

Many other plans and community health centers also wrote in opposition unless the COHS counties are excluded from this bill.

11) *Concerns.* Other stakeholder write expressing concerns with how it has been presented and with potential outcomes. For example, the Community Clinic Association of Los Angeles County writes that the touting of Kaiser's quality scores by DHCS fails to acknowledge that Kaiser currently has a healthier population and fails to acknowledge the differences in financial resources and operational structures between different entities serving Medi-Cal.

12) *Policy Comments.*

- a) *Concerns about Kaiser's behavioral health record.* In 2013, Kaiser was fined \$4 million by DMHC for creating barriers to its enrollees in obtaining mental health services. In 2017, Kaiser entered into an agreement with DMHC to resolve deficiencies regarding access to behavioral health services that included multiple required corrective actions. Last month DMHC announced it would be conducting a non-routine survey based on complaints received from enrollees, providers, and other stakeholders concerning the plan's behavioral health operations. Although this committee hesitates to recommend that Kaiser be subject to different rules than other MCMC plans, particularly as other MCMC plans are failing in other areas of health care access and quality, this history does warrant additional scrutiny. Current Medi-Cal law already requires that DHCS evaluate plan readiness prior to expanding managed care to a new geographic area. DHCS could follow this model prior to allowing an AHCSPP to enter a new area with particular focus on the provisions regarding an adequate provider network and the ability of the plan to meet timely access standards. The author should consider incorporating such notion of plan readiness into this bill with a particular focus on behavioral health services and a report to the Legislature prior to the commencement of the contract.
- b) *Concerns about where the AHCSPP may or may not operate.* The most recent amendments attempted to alleviate this concern by limiting the new contract with the AHCSPP to areas where it also has a commercial presence. The use of the word "already" instead of "also" would clarify the intent that the AHCSPP must first establish a presence in the commercial health plan markets before moving into Medi-Cal. This could also alleviate concerns that Kaiser would be relying on safety net rather than using Kaiser providers, which would undermine the goal of bringing more providers into the Medi-Cal system.
- c) *Concerns about whether the AHCSPP will use safety net providers.* Local plans have requested language requiring the AHCSPP to assign enrollees to a primary care provider exclusively contracted in the AHCSPP's network. DHCS indicates that this violates the federal requirement that all MCMC plans contract with FQHCs. However, if this is the intent of this bill, language could be included subject to federal approval or including a *de minimus* exception to meet federal requirements.
- d) *Concerns about plan rate and risk mix.* The bill in its current form includes language subjecting it to the same rate setting process as is used by the other MCMC plans. Questions as to whether this process is fair still remain, though are likely outside of the scope of this bill. However, if the AHCSPP has a statewide blended rate due to a singular contract rather than rates for each region it serves, there could be incentive to increase enrollment in some regions over others.

- e) *Concerns about the AHCSF's local participation, particularly in COHS counties.* The COHS model is not without controversy as Medi-Cal recipients have no choice in who they receive their care through and the majority of COHS plans do not have a Knox Keene license. COHS plans are not required to offer Medi-Cal beneficiaries independent medical reviews when services are denied as other MCMC plans are. Nonetheless, COHS plans do maintain close ties with their county partners given the space they occupy in the Medi-Cal field. The latest contract requirements currently included in the plan procurement process, as described in detail above, require all plans to form local partnerships, invest profits back in the community, and facilitate warm hand-offs to community providers. The author should consider whether any of these requirements should also be included in this bill. One particular issue to consider is that if the AHCSF has a statewide contract, would any profits be invested in each of the communities that the AHCSF serves or any of the communities?

**SUPPORT AND OPPOSITION:**

**Support:** California Pan-Ethnic Health Network  
Health Access California  
Kaiser Permanente  
National Health Law Program  
Western Center on Law & Poverty

**Oppose:** Big Sur Health Center  
California Advocates for Nursing Home Reform  
California Partnership for Health  
California State Association of Counties  
CalOptima (unless amended)  
Central California Alliance for Health  
Clinicas Del Valle De Salinas  
Colusa County Department of Health and Human Services  
CommuniCare Health Centers (unless amended)  
Community Medical Centers (unless amended)  
County of Glenn  
County of Humboldt  
County of Santa Clara  
County of Solano (unless amended)  
Health Alliance of Northern California (unless amended)  
Inland Empire Health Plan  
LA Care Health Plan  
Local Health Plans of California  
Marin Community Clinics (unless amended)  
Mariposa County Board of Supervisors  
Mendocino Coast Clinics (unless amended)  
Merced County Board of Supervisors  
Monterey County Board of Supervisors  
Mountain Valley Health Centers (unless amended)  
National Union of Healthcare Workers (unless amended)  
Natividad Medical Center  
Newman Medical Clinic  
OLE Health (unless amended)

Open Door Community Health Centers (unless amended)  
Partnership Health Plan of California (unless amended)  
Petaluma Health Center (unless amended)  
Salud Para La Gente  
San Benito County Board of Supervisors  
San Mateo County Board of Supervisors  
San Luis Obispo County Board of Supervisors  
Santa Barbara County Board of Supervisors  
Santa Barbara Neighborhood Clinics  
Santa Clara Family Health Plan  
Santa Cruz County Board of Supervisors  
Santa Cruz Community Health  
Shasta Community Health Center (unless amended)  
Sonoma County Board of Supervisors  
Ventura County Board of Supervisors  
West County Health Centers (unless amended)  
Winters Healthcare Foundation (unless amended)  
Women's Health Specialists (unless amended)  
Yolo County Board of Supervisors  
Humboldt County Board of Supervisors

**-- END --**