April 12, 2022

The Honorable Jim Wood
Chair, Assembly Health Committee
1020 N St., Room 390
Sacramento, CA 95814

Re: AB 2724 (Alternative Health Care Service Plan) – OPPOSE

Dear Chair Wood:

On behalf of the Boards of Supervisors of Ventura, San Mateo, Santa Barbara, Monterey, Santa Cruz, Sonoma, Mariposa, Merced, San Luis Obispo, and Yolo counties, we are writing to express our opposition to AB 2724 (Alternative Health Care Service Plan) by Assemblyman Arambula. We request the Committee's reconsideration of the bill, based on our considerations of the harms it could cause to the safety net health systems in our counties, and the Medi-Cal beneficiaries we serve.

A County Organized Health System (COHS) plan and local initiative plans (LI) are publicly governed, Medi-Cal managed care plans authorized under federal and state law and created under local ordinance. As such, COHS and LI models, which has been operational in California for almost forty (40) years, is a unique and time-tested model of publicly accountable managed care. Pursuant to federal, state, and local authority, the COHS and LI plans organize the local delivery system, complies with all requirements set forth in the DHCS contract, and is governed by a public commission operating pursuant to the requirements of California's Brown Act. The COHS and LI model has been so effective that 14 additional counties passed county ordinances last year to join an existing COHS or LI in 2024. **COHS and LI plans and their partner counties exemplify transparent and accountable governance that directly leads to optimal outcomes for the vulnerable populations they serve.**

Currently, Medi-Cal recipients in our counties receive their services through COHS or LI plans, which is a local public health plan. We believe the proposed bill proposed will be disruptive to local safety net networks and potentially harmful to our critical county health systems. If Kaiser or any other entity contracts directly with the State, the local public plans would have no oversight of care delivered to members served by that entity. If one integrated system contracts directly with the State, it sets a precedent for further fracturing of community collaborations. Our local plans have spent years building strong and trusted community partnerships, working with local community-based organizations to respond directly to emerging needs at the neighborhood level, and plan with the community for solutions that meet the unique needs of diverse residents. We are concerned that a contract brokered directly between the State and a national health plan will not bring the local solutions that our communities have engendered over decades and that our communities need to achieve wellness as we come out of a global pandemic. **A closed system that excludes vulnerable populations is inequitable, where any reinvestment of net earnings would not inure to the benefit of the members excluded from the closed system, especially those who have higher needs and require that additional investment.**

It is unclear how the proposal will impact current patients served by our counties, but we presume some portion of the patients we serve may choose Kaiser if they meet the criteria outlined in the draft trailer bill language. Our counties also have concerns with how enrollment into Kaiser will be effectuated. **How will the enrollment process work so that Kaiser is assigned patients with higher acuity levels and more complex physical, behavioral, and socio-economic needs versus giving the existing safety net**

system and local plans, who do not exclude populations, a disproportionate share of complex and costly patients? The State should reevaluate how to measure quality scores and equity across systems serving vastly different acuity levels. A system serving mostly working and healthy beneficiaries is quite different than a system serving historically underserved members experiencing complex physical health, mental health, and social conditions including individuals experiencing homelessness, individuals with serious mental health conditions, individuals with multiple co-morbidities and complex care needs, and individuals and families involved with the justice system.

The value of the COHS and LI models are that they understand their members and know how to coordinate care for the entire Medi-Cal population. Introducing multiple entities will lead to duplicative contracting, member and provider confusion, and runs counter to the State's integration and standardization goals through the California Advancing Innovation in Medi-Cal (CalAIM) transformation. Our local plans have spent decades cultivating strong and trusted relationships with our community-based organizations that serve our most vulnerable Medi-Cal members. Kaiser would not be able to do this quickly, so new Kaiser members would not have access to these critical services when they need it. **Further, the intention of the legislature has been to support models that can best meet member needs locally in a health plan that is publicly governed and directly accountable to the communities it serves.** We continue to support such models and believe these networks are crucial to the success of CalAIM.

Additionally, as enrollment is diverted away from COHS and LI plans, it will reduce the Medi-Cal supplemental payments that public providers receive – thereby impacting future funding for public hospitals, clinics, and public health departments necessary to sustain critical public health systems that responded so well to the pandemic. Currently, Medi-Cal supplemental payments are used to bolster low Medi-Cal rates for public providers and are based on enrollment in COHS and LI plans. We anticipate that our county systems could lose millions of dollars in supplemental funding if this proposal was to be implemented.

For the reasons described above, Ventura, San Mateo, Santa Barbara, Monterey, Santa Cruz, Sonoma, Merced, San Luis Obispo, Mariposa, and Yolo counties must oppose the Alternative Health Care Service Plan proposal and uphold the integrity of the COHS model. We request the State's reconsideration of the proposal, based on our considerations of the harms it could cause to the safety net health systems in our counties, and the Medi-Cal beneficiaries we serve. Thank you for your time and attention to this matter.

County Descriptions

Ventura County operates a Level II Trauma Center with 180 bed acute care hospital. The county also operates a 49-bed campus in Santa Paula and 18 Federally Qualified Health Centers (FQHCs), 7 urgent care centers for a total of 35 clinic locations including specialty clinics. San Mateo County operates a 105-bed acute hospital with an additional 32 skilled nursing beds along with five FQHC sites. Santa Barbara County operates 5 FQHCs and clinics at 3 homeless shelters. Monterey County operates a Level II Trauma Center with a 172-bed acute care hospital. The County operates 10 FQHCs, the D'Arrigo Family Specialty Clinic with over 15 specialties, and Natividad Medical Group. Santa Cruz County operates three FQHCs, and through the County Behavioral Health Division, provides the Specialty Mental Health care for Medi-Cal and other beneficiaries. The County is also home to the newly-formed Pajaro Valley Health Care District, which is the court-approved buyer for the Watsonville Community Hospital.

Approximately 6,000 Medi-Cal enrollees in Ventura are Kaiser members through a subcontract with Gold Coast. The Ventura County health system currently serves 40-45% of Medi-Cal enrollees and 100% of foster youth. San Mateo serves about 50% of the Medi-Cal enrollees in the county where Health Plan of San Mateo has delegated about 11,000 of their 150,000 Medi-Cal beneficiaries to Kaiser. CenCal Health in Santa Barbara County is responsible for 146,243, or 88% of the total Medi-Cal Population in the county. The Monterey County health system currently serves 40-45% of the County's Medi-Cal managed care enrollees and 100% of foster care youth. The Federally Qualified Health Centers operated by the County of Santa Cruz serve 13,100 Medi-Cal beneficiaries or 18% of the county's Medi-Cal managed care enrollees. Partnership HealthPlan in Sonoma covers 122,373 Medi-Cal beneficiaries with 26,088 delegated to Kaiser. Merced County operates two acute care hospitals with 226 beds between them. The County operates 2 FQHCs and one look alike clinic, and through the County Behavioral Health Division, provides the acute psychiatric care in a 16-bed inpatient facility. 1 in 2 Merced County residents are enrolled in Medi-Cal managed plans, and 39% are served by the 3 County community health centers. Mariposa County has 6,221 Medi-Cal beneficiaries with 4,418 being adults and 1,802 being children under 21.

Sincerely,

Carmen Ramirez, Chair Ventura County Board of Supervisors	DocuSigned by: Mary Adams 3473B0F0E2D645F... Mary L. Adams, Chair Monterey County Board of Supervisors
Don Horsley, President San Mateo County Board of Supervisors	DocuSigned by: Manu Koenig 43369812764640D... Manu Koenig, Chair Santa Cruz County Board of Supervisors
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Angel Barajas, Chair Yolo County Board of Supervisors	DocuSigned by: Rosemarie Smallcombe EEE9F94B55214DC... Rosemarie Smallcombe, Chair Mariposa County Board of Supervisors
Bruce Gibson, Chair San Luis Obispo Board of Supervisors	Lloyd Pareira, Chairman Merced County Board of Supervisors

cc: The Honorable Joaquin Arambula, Author
Members, Assembly Health Committee
Scott Bain, Consultant – Assembly Health Committee
Consultant, Assembly Republican Caucus