Chief Executive Office.

COUNTY OF LOS ANGELES
CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

HEALTH AND MENTAL HEALTH CLUSTER AGENDA REVIEW MEETING

DATE: Wednesday, December 13, 2023
TIME: 11:30 A.M.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY AS PERMITTED UNDER THE BOARD OF SUPERVISORS AUGUST 8, 2023, ORDER SUSPENDING THE APPLICATION OF BOARD POLICY 3.055 UNTIL MARCH 31, 2024

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:
DIAL-IN NUMBER: 1 (323) 776-6996
CONFERENCE ID: 322130288#
MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

11:00 A.M NOTICE OF CLOSED SESSION
CS-1 CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION
Government Code Section 54956.9(a)
Taren Moody v. County of Los Angeles
LA Superior Court Case No. 22STCV14273
Department of Health Services

I. Call to order

II. **Discussion Item(s):**

a. **DMH/DPH:** Implementing Lanterman-Petris-Short Act Reform

III. **Information Item(s) (Any Information Item is subject to discussion and/or presentation at the request of two or more Board offices)**:

a. **DPH:** Authorization to Accept and Implement a Forthcoming Award and Future Awards and/or Amendments from the Centers for Disease Control and

Prevention for the Emerging Infections Program for the Period of January 1, 2024 to December 31, 2028 (#07260)

IV. **Presentation Item(s):**

a. DHS: Health Services Fiscal Outlook

b. DPH: Approval to Execute an Amendment to the Provider Participation Agreement with Health Net of California, Inc. to Include Medi-Cal Doula Services (#07204)

c. DPH: Authorization to Accept and Implement Notice of Award Number 1 NH28CE003543-01-00 and Accept Future Awards and/or Amendments from the Centers for Disease Control and Prevention and other Federal, State, and Local Entities (#07281)

V. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting

VI. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda.

VII. Public Comment

VIII. Adjournment

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	12/13/2023
BOARD MEETING DATE	1/9/2024
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Public Health
SUBJECT	Authorization to accept and implement a forthcoming award and future awards and/or amendments from the Centers for Disease Control and Prevention for the Emerging Infections Program for the period of January 1, 2024 to December 31, 2028
PROGRAM	Acute Communicable Disease Control Program (ACDC)
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No If Yes, please explain why:
DEADLINES/ TIME CONSTRAINTS	Contract award expected December 2023; if awarded, program start date is January 1, 2024.
COST & FUNDING	Total cost: $37,850,345 estimate ($7,570,069 annually for five years) Funding source: Centers for Disease Control and Prevention (CDC) Emerging Infections Program (EIP) Grant TERMS (if applicable): Grant term January 1, 2024 – December 31, 2028 Explanation: Amount subject to change based on anticipated award amount.
PURPOSE OF REQUEST	Delegate authority to accept forthcoming award and future awards and/or amendments from the CDC to conduct active disease surveillance, epidemiologic and laboratory activities, evaluation of prevention/intervention projects, and respond to emerging infectious disease issues and other public health emergencies in Los Angeles County (LAC).
BACKGROUND (include internal/external issues that may exist including any related motions)	On April 22, 2023, CDC released a Notice of Funding Opportunity Announcement Number: CDC-RFA-CK24-2401, Assistance Listing Number 93.317 soliciting applications to enhance their EIP network which collaborates with local, state, and national agencies to help prevent, control, and monitor infectious diseases. If awarded, CDC funding will support 1) Investment in basic infrastructure to support EIP activities including administrative capacities, 2) Enhance public health surveillance to increase response efforts of emerging or re-emerging infectious disease(s) or public health threats, 3) Research and evaluate prevention strategies for ABC pathogens, 4) Active surveillance of infections commonly transmitted through food, and 5) Evaluate the effectiveness and durability of Monkeypox vaccine.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: ACDC conducts disease surveillance, disaggregates data and analyzes it for different racial/ethnic and demographic subgroups in order to determine the patterns of mortality and morbidity. Based on the results, ACDC makes

	recommendations on interventions and policies to prevent diseases and eradicate racial disparities in LAC. ACDC's work adheres to the equity principles for its program work.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☐ Yes ☒ No If Yes, please state which one(s) and explain how:
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: 1. Joshua Bobrowsky, Director, Government Affairs, Public Health (213) 288-7871, jbobrowsky@ph.lacounty.gov 2. Sharon Balter, MD – Director, ACDC Program, 213-288-8865, sbalter@ph.lacounty.gov 3. Blaine McPhillips, Senior Deputy County Counsel (213) 974-1920, bmcphillips@counsel.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

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DRAFT

January 9, 2024

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

AUTHORIZATION TO ACCEPT AND IMPLEMENT A FORTHCOMING AWARD AND FUTURE AWARDS AND/OR AMENDMENTS FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR THE EMERGING INFECTIONS PROGRAM FOR THE PERIOD OF JANUARY 1, 2024, TO DECEMBER 31, 2028 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Provide authorization to accept and implement a forthcoming award and/or future awards and/or amendments from the Centers for Disease Control and Prevention for the Emerging Infections Program.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of the Department of Public Health (Public Health), or designee, to accept and implement a forthcoming award from the Centers for Disease Control and Prevention (CDC), Assistance Listing Number 93.317, to support the Emerging Infections Program (EIP), for the period of January 1, 2024, through December 31, 2028, at an amount estimated not to exceed $7,570,069 annually, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

2. Delegate authority to the Director of Public Health, or designee, to accept future award(s) and/or amendment(s) that are consistent with the requirements of the CDC award referenced above that extend the funding periods at amounts determined by CDC; and/or an increase or decrease in funding, subject to review and approval by County Counsel, and notification to your Board and the CEO.

3. Delegate authority to the Director of Public Health, or designee, to accept future amendments that are consistent with the requirements of the CDC award referenced above that reflect non-material and/or ministerial revisions to the award's terms and conditions and allow for the rollover of unspent funds and/or redirection of funds, subject to review and approval by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION:

Approval of Recommendation 1 will allow Public Health to accept a forthcoming award from the CDC to support the EIP which aims to conduct active disease surveillance, epidemiologic and laboratory activities, evaluation of prevention/intervention projects, and respond to emerging infectious disease issues and other public health emergencies in Los Angeles County (LAC).

The funding will allow Public Health to: 1) expand active population-based surveillance of Active Bacterial Core (ABC) pathogens including Pertussis, group A Streptococcus, H. Influenzae, group B Streptococcus (GBS), and S. Pneumoniae while improving data collection for those ABC pathogens; 2) partner with community-based organizations to analyze and evaluate the long-term efficacy of Monkeypox (mpox) vaccine, especially in sub-populations within LAC; 3) conduct surveillance and assess risk factors of foodborne pathogens within LAC through the Foodborne Diseases Active Surveillance Network; 4) support data modernization efforts to enhance responses to emerging infections and public health emergencies through improved data infrastructure, including improvements in data visualization, data sharing, and related staff training; and 5) support surveillance and reporting efforts during emerging infectious disease outbreaks, including the ability to identify, process and analyze additional data sources, facilitate data sharing through dashboards, and improve timely communication to the public and Public Health.

Approval of Recommendation 2 will allow Public Health to accept future awards and/or amendments that are consistent with the requirements of the CDC to extend the funding periods at amounts determined by the CDC; and/or an increase or decrease in funding. This authority is being requested to enhance Public Health's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

Approval of Recommendation 3 will allow Public Health to accept future amendments that are consistent with the requirements of the CDC grant to reflect non-material or ministerial revisions to the award's terms and conditions and roll over unspent funds and/or redirect funds.

Implementation of Strategic Plan Goals

The recommended actions support Strategy I.1 – Increase Our Focus on Prevention Initiative; Strategy II.2 – Support the Wellness of Our Communities; and Strategy III.2 – Embrace digital government for the benefit of our customers and communities, of the County's Strategic Plan.

FISCAL IMPACT/FINANCIING

Public Health will accept a forthcoming award from the CDC, in the estimated annual amount of $7,570,069 for the anticipated period of January 1, 2024, through December 31, 2028. Final funding amount to be determined and approved by the CDC.

Funding was requested in Public Health's fiscal year (FY) 2023-24 Adopted Budget and will be included in future FYs, as necessary.

There is no net County cost associated with this action.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On April 22, 2023, CDC released a Notice of Funding Opportunity Announcement Number: CDC-RFA-CK24-2401, Assistance Listing Number 93.317, soliciting applications to enhance their EIP network which collaborates with local, state, and national agencies to help prevent, control, and monitor infectious diseases.

Public Health submitted an application in response to the Funding Opportunity Announcement on June 16, 2023, and anticipates receiving notification of the estimated funding award by December 1, 2023.

Applicants were allowed to submit a proposal focusing on different activities within EIP's project priority areas with varying funding levels per project activity. Public Health's application focused on the following five project priority activities: 1) investment in basic infrastructure to support EIP activities including administrative capacities; 2) enhance public health surveillance to increase response efforts of emerging or re-emerging infectious disease(s) or public health threats; 3) research and evaluate prevention strategies for ABC pathogens; 4) active surveillance of infections commonly transmitted through food; and 5) evaluate the effectiveness and durability of mpox vaccine. The total combined amount requested for the activities does not exceed $7,570,069 annually.

It is anticipated the CDC will award up to 15 local, State, and federal agencies, tribal nations, universities, nongovernmental organizations, and private entities comprised of up to $157 million per year in the total five-year grant period effective January 1, 2024, through December 31, 2028. The amount is subject to the ability of funds.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to accept forthcoming funds from the CDC to support the improvement of infrastructure, data modernization and active surveillance of infectious diseases.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:bgc
BL #07260

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

BOARD LETTER/MEMO
CLUSTER FACT SHEET

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	12/13/2023	
BOARD MEETING DATE	1/9/2024	
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th	
DEPARTMENT(S)	Public Health	
SUBJECT	Request approval to execute an amendment to Provider Participation Agreement (PPA) with Health Net of California, Inc. (Health Net) for Fee-For-Services Direct Network for Medi-Cal Managed Care Plans (MMCP) to include reimbursable doula services and delegate authority to execute future agreements and amendments	
PROGRAM	Maternal, Child, and Adolescent Health Division	
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No	
SOLE SOURCE CONTRACT	☐ Yes ☒ No	
	If Yes, please explain why:	
DEADLINES/ TIME CONSTRAINTS	NA	
COST & FUNDING	Total cost: Anticipated reimbursement TBD	Funding source: MMCP reimbursements funded by State and partial federal funding (Assistance Listing Number 93.778 through the California Department of Health Care Services (DHCS) Medi-Cal Eligibility Division
	TERMS (if applicable): Amendment to be effective upon execution	
	Explanation: Health Net will reimburse Public Health for providing Doula services for fee for service at the rate specified in the agreement.	
PURPOSE OF REQUEST	1. Approval to execute an amendment to PPA #PH-005109 with Health Net for PPA Fee-for-Services (FFS) Direct Network, to include and implement Doula Services with MMCP; 2. To execute and implement future agreements and/or amendments with MMCP for the provision of reimbursable doula services and other California Advancing and Innovating Medi-Cal (CalAIM) related services like Enhanced Care Management (ECM); and 3. To execute amendments to the PPA FFS Direct Network that: (1) extend the terms as determined by the MMCP funding availability; (2) establish new or adjust payment rates; (3) reflect other necessary modifications to the agreement to meet contractual, County, State or federal requirements; (4) terminate agreements; and (5) take any additional action required by the agreement to enable Public Health to effectuate the relevant amendments.	

BACKGROUND (include internal/external issues that may exist including any related motions)	Effective January 1, 2023, California Department of Health Care Services (DHCS) covers doula services for prenatal and postpartum visits, and during labor and delivery, miscarriage, or abortion. Doulas or Doula Group Providers who work with Medi-Cal beneficiaries are required to enter into contracts with MMCP to submit claims and receive reimbursement for services provided. The African American Infant and Maternal Mortality (AAIMM) Prevention Initiative Doula Program is an approved DHCS Group Provider of doula services. Public Health aims to reduce disparities in infant mortality and birth outcomes in Los Angeles County through the continued and expanding implementation of the AAIMM Initiative in partnership with community and clinical agencies. Through multiple interventions, including the provision of doula care, the AAIMM Initiative seeks to address racism and discrimination as the causes of elevated stress that result in adverse outcomes among Black women. Doulas are non-clinical professionals trained to provide individualized client support and education to promote a healthy and satisfying birth experience. In January 2023, the Centers for Medicare and Medicaid Services approved the Medicaid State Plan Amendment 22-0002 submitted by DHCS that proposed the addition of doula services as a covered preventive services benefit. In accordance with the State Plan Amendment, DHCS issued All Plan Letter 22-031 that announced the provision of doula services as a covered Medi-Cal benefit for pregnant and postpartum health coverage beneficiaries in fee-for-service and managed care delivery systems, effective January 1, 2023.
EQUITY INDEX OR LENS WAS UTILIZED	☒ Yes ☐ No If Yes, please explain how: AAIMM Initiative services aim to reduce racial disparities in life outcomes, implement strategies that identify, prioritize and effectively support the most disadvantage populations, and intervene early and emphasize long-term prevention.
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: Board Priority #2 Alliance for Health Integration (AHI) – In accordance with AHI's focus on reducing health inequities, the AAIMM Initiative seeks to establish a coordinated, equitable, high quality system of perinatal care for African American women to reduce disparities in infant mortality and birth outcomes.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Public Health Director Government Affairs, Joshua Bobrowsky (213) 288-7871 jbobrowsky@ph.lacounty.gov Deputy County Counsel, Craig L. Kirkwood, Jr. (213) 974-1751, CKirkwood@counsel.lacounty.gov Melissa Franklin, Director, MCAH 213-639-6400, mfranklin@ph.lacounty.gov

COUNTY OF LOS ANGELES
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January 9, 2024

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL TO EXECUTE AN AMENDMENT TO THE PROVIDER PARTICIPATION AGREEMENT WITH HEALTH NET OF CALIFORNIA, INC. TO INCLUDE MEDI-CAL DOULA SERVICES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request approval to execute an amendment to Provider Participation Agreement with Health Net of California, Inc. for Fee-For-Services Direct Network for Medi-Cal Managed Care Plans to include reimbursable doula services and delegate authority to execute future agreements and amendments.

IT IS RECOMMENDED THAT THE BOARD:

1. Approve and instruct the Director of the Department of Public Health (Public Health), or designee, to execute an amendment to Provider Participation Agreement (PPA) #PH-005109 with Health Net of California, Inc. (Health Net) for PPA Fee-for-Services (FFS) Direct Network, substantially similar to (Exhibit I) to include and implement Doula Services with Medi-Cal Managed Care Plan (MMCP), effective upon execution for a 12-month term with automatic renewals for successive one-year periods, subject to availability of funds for the provision of reimbursable doula services.

2. Delegate authority to the Director of the Public Health, or designee, to execute and implement future agreements and/or amendments with MMCPs for the provision of reimbursable doula services and other California Advancing and Innovating Medi-Cal (CalAIM) related services like Enhanced Care Management (ECM) that are consistent with the requirements of the California Department of Health Care Services (DHCS), effective upon execution, subject to availability of funding, review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director of Public Health, or designee, to execute amendments to the PPA FFS Direct Network that: (1) extend the terms as determined by the MMCP funding availability; (2) establish new or adjust payment rates; (3) reflect other necessary modifications to the agreement to meet contractual, County, State or federal requirements; (4) terminate agreements; and (5) take any additional action required by the agreements to enable Public Health to effectuate the relevant amendments. Such amendments shall be subject to review and approval by County Counsel, and notification to your Board and the CEO.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Public Health aims to reduce disparities in infant mortality and birth outcomes in Los Angeles County through the continued and expanding implementation of the African American Infant and Maternal Mortality (AAIMM) Prevention Initiative in partnership with community and clinical agencies. Through multiple interventions, including the provision of doula care, the AAIMM Initiative seeks to address racism and discrimination as the causes of elevated stress that result in adverse maternal and infant health outcomes among Black women. Doulas are non-clinical professionals trained to provide individualized client support and education to promote a healthy and satisfying birth experience.

The AAIMM Doula Program objectives include providing no-cost culturally congruent doula services to birthing people with priority for Medi-Cal eligible clients; increasing awareness around the benefits and availability of doula support among community members, partners, policymakers, and funders; and building the quantity and capacity of the Black/African American doula workforce to serve birthing families via professional development opportunities. The program trains, funds, and links Black doulas to pregnant individuals. AAIMM Doula clients receive prenatal and postpartum visits, continuous labor and delivery support, and material and educational resources including referrals to wraparound services.

In January 2023, the Centers for Medicare and Medicaid Services (CMS) approved the Medicaid State Plan Amendment 22-0002 submitted by DHCS that proposed the addition of doula services as a covered preventive services benefit. In accordance with the State Plan Amendment, DHCS issued All Plan Letter (APL) 22-031 that announced the provision of doula services as a covered Medi-Cal benefit for pregnant and postpartum health coverage beneficiaries in FFS and managed care delivery systems, effective January 1, 2023. DHCS covers doula services for prenatal and postpartum visits, and during labor/delivery, miscarriage, or abortion. Doulas or Doula Group Providers who work with Medi-Cal beneficiaries are required to enter into agreements with MMCP to submit claims and receive reimbursement for services provided.

The AAIMM Doula Program is an approved DHCS Group Provider of doula services. Public Health seeks to enter into agreements with MMCPs to coordinate the reimbursement of services provided to Medi-Cal beneficiaries.

PPA number PH-005109 was executed between Health Net and Public Health dated July 1, 2022, to arrange for Provider to participate in one or more of Health Net's networks of Participating Providers that render contracted services to beneficiaries of various benefit programs such as ECM. Public Health is the Participating Provider under this PPA receiving reimbursements for providing ECM services.

Approval of Recommendation 1 will allow Public Health to execute an amendment with Health Net for PPA FFS Direct Network to include the provision of reimbursable doula services, effective upon execution for a 12-month term with automatic renewals for successive one-year periods, subject to availability of funds. This is a revenue-generating FFS agreement, with Public Health receiving reimbursable payments for doula services provided to pregnant and postpartum Health Net beneficiaries.

Approval of Recommendation 2 will allow Public Health to execute and implement future agreements and/or amendments with MMCPs for the provision of reimbursable doula services and other related CalAIM services that are consistent with the requirements of DHCS, effective upon execution for the term defined in the agreement. These agreements will also be revenue-generating, with Public Health receiving reimbursable payments for covered services to pregnant and postpartum beneficiaries enrolled in MMCPs. Agreements may also include incentives, awards, and other payments related to reimbursable Medi-Cal doula and CalAIM services.

Approval of Recommendation 3 will allow Public Health to execute amendments to the PPA FFS Direct Network with MMCP agreements that: (1) extend the term as determined by the MMCP funding availability; (2) establish new or adjust existing payment rates; (3) reflect other necessary modifications to the agreement to meet new contractual, County, State or federal requirements; (4) terminate agreements; and (5) take any additional action required by the agreement to enable Public Health to effectuate the relevant amendments.

Implementation of Strategic Plan Goals

The recommended actions support Strategy I.1, Increase Our Focus on Prevention Initiatives, Strategy I.2.2, Enhance Our Delivery of Comprehensive Interventions: streamline Access to Integrated Health Services, and Strategy II.2, Support the Wellness of Our Communities, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Health Net will reimburse Public Health for the provision of doula services to covered beneficiaries based on the negotiated rates indicated in the agreement. Reimbursements received by Public Health will not offset the current funding for the AAIMM Doula Program.

Reimbursements will be partially comprised of Federal funds, Assistance Listing Number 93.778, through the DHCS Medi-Cal Eligibility Division.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On October 4, 2021, California Senate Bill 65 (SB 65) was enacted to improve racial disparities in maternal and infant mortality and morbidity. In addition to extending Medi-Cal postpartum coverage and easing pregnant persons' access to public assistance programs, SB 65 also included Medi-Cal coverage for doula services. DHCS subsequently amended the Medicaid State Plan filed with CMS and issued APL 22-031 to all Medi-Cal managed care health plans to announce the addition of doula services as a covered benefit effective January 1, 2023.

County Counsel has reviewed and approved Exhibit I as to form.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to provide reimbursable doula services toward implementing effective and customized perinatal care, establish and maintain partnerships with health plans, maternity hospitals, and birth centers, and expand the impact of the AAIMM Initiative.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:sp
#07204

Enclosure

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

EXHBIT I

PH-005109

FIRST AMENDMENT
to the
PROVIDER PARTICIPATION AGREEMENT
between
LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
and
HEALTH NET OF CALIFORNIA, INC.

The Provider Participation Agreement ("Agreement") dated **July 01, 2022**, as subsequently amended, between Department of Public Health and Health Net of California, Inc. and Health Net of California, Inc. on behalf of itself and the subsidiaries and affiliates of Health Net, LLC (formerly known as Health Net, Inc.), (collectively "Health Net"), is hereby further amended effective **November 01, 2023.**

RECITALS

A. **Whereas,** Provider would like to participate in Health Net's network of Doulas for Medi-Cal Beneficiaries.

B. **Whereas,** both Parties agree to amend the Enhanced Care Management Agreement to add Doula participation terms and integrate Community Supports participation terms.

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree to amend the Agreement as follows:

1. Exhibit A-1, **ENHANCED CARE MANAGEMENT** shall be deleted in its entirety and replaced with Exhibit A-1.1, **ENHANCED CARE MANAGEMENT.**

2. Exhibit A-2, **DISCLOSURE FORM**, shall be deleted in its entirety and replaced with Exhibit A-2.1, **DISCLOSURE FORM**.

3. Exhibit A-3, **DOULA SERVICES,** shall be added in its entirety as contained herein.

4. Exhibit A-4, **COMMUNITY SUPPORTS,** shall be added in its entirety as contained herein.

5. Exhibit A-5, **COMMUNITY SUPPORTS REQUIREMENTS,** shall be added in its entirety as contained herein.

6. Exhibit A-6, **MEDI-CAL BENEFIT PROGRAMS FEE-FOR-SERVICE RATE EXHIBIT,** shall be added in its entirety as contained herein.

This Amendment shall be deemed to be part of the Agreement and**,** except as modified herein, the Agreement is hereby reaffirmed and declared in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

DPH AAIMM DOULA PROGRAM **COUNTY OF LOS ANGELES**	**HEALTH NET OF CALIFORNIA, INC.**
_____ Signature	_____ Signature
Barbara Ferrer PhD, MPH, MEd Print Name	Valentina T. Shabanian Print Name
Director, Los Angeles County Department of Public Health Title	Regional Health Plan Officer Title
_____ Date	_____ Date
Tax ID: 372101937	

EXHIBIT A-1.1

ENHANCED CARE MANAGEMENT

In consideration, Provider agrees to accept reimbursement as set forth in Exhibit A-6. For the purposes of this Exhibit only, Provider shall be referred to as ECM Provider.

I. DEFINITIONS

1.1 Assigned Member. An eligible Health Net Medi-Cal Beneficiaries who meets one or more of the ECM Populations of Focus for the ECM benefit and are assigned to an ECM Provider for assessment.

1.2 Community Supports (CS). Community Supports (CS) services are medically appropriate and cost-effective alternatives to services covered under the Medi-Cal State Plan. CS services include, but are not limited to, housing transition navigation services, housing deposits, respite services, nursing facility transition, personal care and homemaker services, medically tailored meals, and asthma remediation.

1.3 CS Provider. A contracted provider of DHCS-authorized CS services. CS Providers are community-based entities with experience and expertise providing one (1) or more of the CS services authorized by DHCS to individuals with complex physical, behavioral, developmental and social needs.

1.4 ECM Provider. A provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

1.5 Engagement List. A list of Assigned Members to each ECM Provider for assessment.

1.6 Enhanced Care Management (ECM). A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.7 Enrolled Member. An Assigned Member who has accepted ECM services and is authorized by Health Net to receive ECM services from an ECM Provider.

1.8 Lead Care Manager. An Enrolled Member's designated care manager for ECM, who works for the ECM Provider (except in circumstances under which the Lead Care Manager could be on staff with Health Net, as described in the DHCS-MCPECM and CS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Enrolled Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any CS services. To the extent an Enrolled Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Enrolled Member and non-duplication of services.

1.9 Population of Focus. The following populations have been defined by DHCS to be a Population of Focus: Adult Individuals and families experiencing homelessness; high utilizers; adults with Serious Mental Illness (SMI); Substance Use Disorder (SUD); incarcerated persons and persons transitioning to the community; persons at risk for institutionalization; persons eligible for Long Term Care (LTC); nursing facility residents transitioning to the community; children/youth up to age 21 that are high utilizers; persons with Serious Emotional Disturbance (SED), identified to be at clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis; persons enrolled with CCS/CCS Whole Child Model (WCM) with additional needs beyond CCS, involved in child welfare (including those with a history of involvement; persons in foster care up to age 26); or as otherwise defined or revised by DHCS.

II. ENHANCED CARE MANAGEMENT CORE REQUIREMENTS AND SERVICES

2.1 **ECM Provider Experience and Qualifications**. ECM Provider shall:

2.1.1 Be experienced in serving the ECM Population(s) of Focus it will serve;

2.1.2 Have experience and expertise with the services it will provide;

2.1.3 Comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS MCP ECM and CS Contract associated guidance;

2.1.4 Have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Enrolled Members to critical appointments when necessary;

2.1.5 Be able to communicate to Enrolled Members in culturally and linguistically appropriate and accessible ways;

2.1.6 Have formal arrangements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including CS Providers, to coordinate care as appropriate to each Enrolled Member;

2.1.7 Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social services, and administrative data and information from other entities to support the management and maintenance of an Enrolled Member's care plan that can be shared with other Providers and organizations involved in each Enrolled Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Enrolled Member goals and goal attainment status; develop and assign care team tasks; define and support Enrolled Member care coordination and care management needs; gather information from other sources to identify Enrolled Member needs and support care team coordination and communication and support notifications regarding Enrolled Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

2.2 **Medicaid Enrollment/Vetting for ECM Providers.**

2.2.1 ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.

2.2.2 If APL 19-004 does not apply to ECM Provider, ECM Provider must comply with Health Net's vetting process, which may extend to individuals employed by or delivering services on behalf of ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

2.2.3 ECM Provider shall participate in and comply with all Health Net Policies requirements as it relates to Medicaid Enrollment and Vetting for ECM Providers. ECM Provider acknowledges that it has had the opportunity to review the Health Net Policies.

2.3 **Identifying Members for ECM.** ECM Provider is encouraged to identify potential eligible Health Net Medi-Cal Beneficiaries who would benefit from ECM and send a request to Health Net to determine if the Health Net Medi-Cal Beneficiary is eligible.

2.4 **Member Assignment to an ECM Provider.**

2.4.1 Health Net shall provide an Engagement List to ECM Provider as soon as possible, but in any event no later than ten business days after ECM referral.

2.4.2 ECM Provider shall immediately accept all Assigned Members on the Engagement List, unless ECM Provider is at its pre-determined capacity.

2.4.3 ECM Provider shall immediately alert Health Net if it does not have the capacity to accept an Assigned Member.

2.4.4 ECM Provider will assess the Assigned Member to determine the appropriate needs of the Assigned Member, and enroll the Assigned Member.

2.4.5 ECM Provider will notify Health Net of the Enrolled Member and the effective date of enrollment into ECM .

2.4.6 Upon enrollment, ECM Provider shall ensure each Enrolled Member has a Lead Care Manager who interacts directly with the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s),as appropriate, and coordinates all

covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any CS, and other servicesthat address social determinants of health (SDOH) needs, regardless of setting.

2.4.7 ECM Provider shall conduct a comprehensive assessment that identifies the Enrolled Member's physical, mental health, substance use, palliative, trauma-informed care, and social service needs. ECM Provider shall start an Enrolled Member's assessment within 30 days of the Enrolled Members enrollment in ECM and complete the assessment within 60 days of the Enrolled Member's enrollment in ECM.

2.4.8 ECM Provider shall advise the Enrolled Member on the process for changing ECM Providers, which is permitted at any time.

2.4.8.2 ECM Provider shall notify Health Net if an Enrolled Member wishes to change ECM Providers.

2.4.8.3 Health Net shall implement any requested ECM Provider changes within thirty days.

2.5 <u>ECM Provider Staffing</u>. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each Enrolled Member consistent with this Exhibit, the DHCS-MCP ECM CS Contract, and any other related DHCS guidance.

2.6 <u>ECM Provider Outreach and Member Enrollment.</u>

2.6.1 ECM Provider shall be responsible for conducting outreach to each Assigned Member on the Engagement List and enrolling each Assigned Member into ECM in accordance with Health Net Policies.

2.6.2 ECM Provider shall prioritize outreach of Assigned Members based on the highest level of risk and need for ECM.

2.6.3 ECM Provider shall conduct outreach primarily through in-person interaction where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Enrolled Member's consent.

2.6.3.1 ECM Provider shall use the following modalities, as appropriate, and as authorized by the Enrolled Member, if in-person modalities are unsuccessful or to reflect an Enrolled Member's stated contact preferences:

2.6.3.1.1 Mail
2.6.3.1.2 Email
2.6.3.1.3 Texts
2.6.3.1.4 Telephone calls
2.6.3.1.5 Telehealth

2.6.4 ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and this Agreement.

2.7 <u>Initiating Delivery of ECM.</u>

2.7.1 ECM Provider shall obtain, document and manage Enrolled Member authorization for the sharing of Personally Identifiable Information between Health Net ECM, CS, and other Providers involved in the provision of Enrolled Member care to the extent required by federal law.

2.7.2 Enrolled Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.

2.7.3 When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Enrolled Member authorization for such data sharing back to Health Net.

2.7.4 ECM Provider shall notify Health Net to discontinue ECM under the following circumstances:

2.7.4.1 The Enrolled Member has met their care plan goals for ECM;

2.7.4.2 The Enrolled Member is ready to transition to a lower level of care;

2.7.4.3 The Enrolled Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or

2.7.4.4 ECM Provider has not had any contact with the Enrolled Member despite multiple attempts.

2.7.5 When ECM is discontinued, or will be discontinued, Health Net is responsible for sending a Notice of Action (NOA) notifying the Enrolled Member of the discontinuation of the ECM benefit and ensuring the Enrolled Member is informed of their right to appeal and the appeals process. ECM Provider shall communicate to the Enrolled Member other benefits or programs that may be available to the Enrolled Member, as applicable (e.g., Complex Care Management, Basic Care Management).

2.8 <u>Comprehensive Transitional Care.</u>

2.8.1 ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

2.8.1.1 If ECM Provider subcontracts with other entities to administer ECM functions, ECM Provider shall ensure the subcontractors are bound to the terms and conditions set forth herein and the DHCS-MCP ECM CS Contract.

2.8.2 To the extent Health Net offers CS or other coordinated services, ECM Provider shall:

2.8.2.1 Ensure each Enrolled Member has a Lead Care Manager;

2.8.2.2 Coordinate across all sources of care management in the event that an Enrolled Member is receiving care management from multiple sources;

2.8.2.3 Alert Health Net to ensure non-duplication of services in the event that an Enrolled Member is receiving care management or duplication of services from multiple sources; and

2.8.2.4 Follow Health Net's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

2.8.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health providers, Specialists, dental providers, providers of services for LTSS and other associated entities, such as CS Providers, as appropriate, to coordinate Enrolled Member care.

2.8.4 ECM Provider shall provide all core service components of ECM to each Enrolled Member, in compliance with Health Net Policies as follows:

2.8.4.1 Outreach and Engagement of Health Net Medi-Cal Beneficiaries into ECM.

2.8.4.2 Comprehensive assessment and care management plan, which shall include, but is not limited to:

2.8.4.2.1 Engaging with each Enrolled Member .

2.8.4.1.2 Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Enrolled Member health status and gaps in care, and may be needed to inform the development of an individualized care plan.

2.8.4.1.3 Developing a comprehensive, individualized, person-centered care plan by working with the Enrolled Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

2.8.4.1.4 Incorporating into the Enrolled Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

2.8.4.1.5 Ensuring the care plan is reassessed at a frequency appropriate for the Enrolled Member's individual progress or changes in needs and/or as identified in the Care Management plan; and

2.8.4.5.6 Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.

2.8.4.2 Enhanced Coordination of Care, which shall include, but is not limited to:

2.8.4.2.1 Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Enrolled Member's multi-disciplinary care team, and implementing activities identified in the Enrolled Member's Care Management Plan;
2.8.4.2.2 Maintaining regular contact with all providers that are identified as being a part of the Enrolled Member's multi-disciplinary care team;
2.8.4.2.3 Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services including housing, as needed;
2.8.4.2.4 Engaging the Enrolled Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Enrolled Member engagement in treatment;
2.8.4.2.5 Communicating the Enrolled Member's needs and preferences timely to the Enrolled Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
2.8.4.2.6 Ensuring regular contact with the Enrolled Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

2.8.4.3 Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:
2.8.4.3.1 Working with Enrolled Members to identify and build on success and potential family and/or support networks;
2.8.4.3.2 Providing services to encourage and support Enrolled Members to make lifestyle choices based on healthy behavior, with the goal of supporting Enrolled Members' ability to successfully monitor and manage their health; and
2.8.4.3.3 Supporting Enrolled Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

2.8.4.4 Comprehensive Transitional Care, which shall include, but is not limited to:
2.8.4.4.1 Developing strategies to reduce avoidable Enrolled Member admissions and readmissions;
2.8.4.4.2 For Enrolled Members who are experiencing, or who are likely to experience a care transition:

i. Developing and regularly updating a transition of care plan;
ii. Evaluating medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
iii. Tracking admission and/or discharge to or from an emergency department , hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center, and communicating with the appropriate care team members;
iv. Coordinating medication review/reconciliation; and
v. Providing adherence support and referral to appropriate services.

2.8.4.5 Member and Family Support, which shall include, but are not limited to:
2.8.4.5.1 Documenting an Enrolled Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s), and ensuring all appropriate authorizations are in place to ensure effective communication among ECM Provider, the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), and Health Net, as applicable;

2.8.4.5.2 Activities to ensure the Enrolled Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Enrolled Member's condition(s) with the overall goal of improving the Enrolled Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;

2.8.4.5.3 Ensuring ECM Provider serves as the primary point of contact for the Enrolled Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

2.8.4.5.4 Identifying support needed for the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Enrolled Member's condition and assist them in accessing needed support services;

2.8.4.5.5 Providing for appropriate education of the Enrolled Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Enrolled Member; and

2.8.4.5.6 Ensuring that the Enrolled Member has a copy of their care plan and information about how to request updates.

2.8.4.6 Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:

2.8.4.6.1 Determining appropriate services to meet the needs of Enrolled Members, including services that address SDOH needs, including housing, and services offered by Health Net as CS services; and

2.8.4.6.2 Coordinating and referring Enrolled Members to available community resources and following up with Enrolled Members to ensure services were rendered (i.e., "closed loop referrals").

2.9 **Training.** ECM Provider shall participate in all mandatory, provider-focused ECM trainings and technical assistance provided by Health Net, including in-person sessions, webinars, and/or calls.

2.10 **Data Sharing to Support ECM.**

2.10.1 Health Net will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

2.10.1.1 Enrolled Member files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2.10.1.2 Encounter and/or claims data;

2.10.1.3 Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all Enrolled Members; and

2.10.1.4 Reports of performance on quality measures and/or metrics, as requested.

2.10.1.5 Engagement List to aid ECM Provider with prioritizing outreach to Assigned Members based on highest level of risk and need for ECM services.

2.10.1.6 Additional reports and/or guidance as identified by Health Net or DHCS.

2.11 **Quality and Oversight.**

2.11.1 ECM Provider acknowledges Health Net will conduct oversight of its participation in ECM to ensure the quality of services provided and ongoing compliance with benefit requirements, which may include audits and/or corrective actions.

2.11.2 ECM Provider shall respond to all Health Net requests for information and documentation to permit ongoing monitoring of ECM.

2.12 **Enhanced Care Management Benefit Costs.** In order to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs, upon request from Health Net, ECM Provider shall provide ECMs Provider's cost data as requested by Health Net or DHCS to monitor the impact of the benefit and effectiveness of the intervention in improving health outcomes from Enrolled Member and reducing overall health care costs.

III. ECM CLAIMS, PAYMENT AND REIMBURSEMENT

3.1 Claims Submission and Reporting.

3.1.1 ECM Provider shall submit claims for the provision of ECM-related services to Health Net using the national standard specifications and code sets to be defined by DHCS.

3.1.2 In the event ECM Provider is unable to submit claims to Health Net for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to Health Net with a minimum set of data elements (to be defined by DHCS) necessary for Health Net to convert the invoice to an encounter for submission to DHCS.

3.2 Payment for ECM.

3.2.1 Health Net shall pay ECM Provider for the provision of ECM services in accordance with the rates established in this Exhibit.

3.2.3 Health Net shall pay 90 percent of all clean claims within 30 days of date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Health Net receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

EXHIBIT A-2.1

DISCLOSURE FORM

(Required by California Welfare and Institutions Code Section 14452)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency;

1) the identity of all owners with a control interest of five (5) percent or greater,
2) certain business transactions as described in 42 CFR 455.105, and
3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity.

If there are any changes to the information disclosed in this form, an updated form should be completed and submitted to Health Net Community Solutions, Inc. within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity		
Name of Individual, Group Practice, or Disclosing Entity		
DBA Name		
Federal Tax Identification Number	NPI For ECM: NPI For Doula: NPI For CS:	CAQH Number

Section I

Please list the name, title address, date of birth, and Social Security Number for each individual having an ownership or control interest in this provider of five (5) percent or greater. Please list the name, Tax Identification Number, business address or each organization, corporation, or entity having an ownership or control interest of five (5) percent or greater. (42 CFR 455.104) Please attach a separate sheet if necessary.			
Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section II

Are any of the individuals listed in Section one related to each other?

- ☐ Yes
- ☐ No

If yes, list the individual's name above who are related to each other (spouse, sibling, parent, child). 42 CFR 455.104

Name	Relationship

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of five (5) percent or more?

- ☐ Yes
- ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of five (5) percent or more. 42 CFR 455.104

Name of individual or entity	DOB	Address	SSN (for individual) or TIN (for entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?

- ☐ Yes
- ☐ No

If yes, list those persons below. 42 CFR 455.106

Name and Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more of than $25,000 or any significant business transactions with any subcontractors?

- ☐ Yes
- ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve (12) month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past five (5) year period. 42 CFR 455.105

Name of Supplier or Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information) as a Disclosing Entity?

- ☐ Yes
- ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date or birth, Address, Social, Security Number, and percent of interest.

Name and Title	DOB	Address	SSN	% of Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

_____ _____

Signature Title (indicate if authorized Agent)

_____ _____

Name (please print) Date

EXHIBIT A-3

DOULA SERVICES

In consideration, Provider agrees to accept reimbursement as set forth in Exhibit A-6. Provider further agrees to meet and ensure all Doulas covered by this Agreement meet the requirements set forth in this Exhibit A-3.

I. DEFINITIONS

1.1 Doula Services. Pregnancy related services that encompass health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period. Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of Beneficiaries while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

II. DOULA RESPONSIBILITIES

2.1. Doulas for whom a State-level enrollment pathway exists shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including but not limited to Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004, or its successor.

2.2. Doulas must be at least 18 years old, possess an adult/infant CPR certification, and have completed basic HIPAA training. In addition, all Doulas must meet either the training or experience qualification pathways outlined by DHCS. All proofs of training must be maintained and available upon request by DHCS or Health Net.

2.3 Doulas must document the dates, time, and duration of Doula Services provided to Beneficiaries. Documentation must also reflect information on the service(s) provided and the length of time spent with the Beneficiary that day. Documentation should be integrated into the Beneficiary's doula service record and accessible to Health Net and DHCS upon request.

2.4. Doulas must adhere to all Doula Services requirements outlined in DHCS APL 22-031 or its successor.

III. DELIVERY OF DOULA SERVICES

3.1. Doula Services are covered for eligible Beneficiaries with a written recommendation of a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

3.2 The initial recommendation for Doula Services includes all of the following:

- One (1) initial visit.
- Up to eight (8) additional visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

The extended three-hour postpartum visits provided after the end of pregnancy do not require the beneficiary to meet additional criteria or receive a separate recommendation.

3.3 An additional second recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice is required for up to nine (9) additional postpartum visits. A recommendation for additional visits during the postpartum period cannot be established by standing order.

3.4 Non-Covered Services

3.4.1 Doula services do not include diagnosis of medical conditions, provision of medical advice,

or any type of clinical assessment, exam, or procedure.

3.4.2 The following services are not covered under Medi-Cal or as Doula Services:

- Behavioral health services
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination
- Health care services related to pregnancy, birth, and the postpartum period to be provided within 7 to 84 days after birth
- Childbirth education group classes
- Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
- Hypnotherapy (non-specialty mental health service)
- Lactation consulting, group classes, and supplies
- Nutrition services (assessment, counseling, and development of care plan)
- Transportation
- Medically appropriate Community Supports services

3.4.3 Doulas are not prohibited from teaching classes that are available at no cost to Beneficiaries to whom they are providing Doula Services.

IV. PAYMENT FOR DOULA SERVICES

4.1. Provider or Participating Doula shall record, generate, and send a claim or invoice to Health Net for Doula Services rendered.

4.1.1 Claims shall be submitted to Health Net using specifications based on national standards and code sets defined by DHCS.

4.1.2 In the event Provider or Participating Doula is unable to submit claims to Health Net using specifications based on national standards or DHCS-defined standard specifications and code sets, Provider or Participating Doula shall submit invoices with minimum necessary data elements defined by DHCS, including but not limited to information about the Member, the Doula Services rendered, and information that will allow Health Net to convert the information into DHCS-defined standard specifications and code sets for submission to DHCS.

4.2 Provider or Participating Doula must have a system in place to accept payment from Health Net for Doula Services rendered.

4.2.1 Health Net shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

4.2.2 As compensation for rendering Contracted Services to Beneficiaries covered under this Addendum, Health Net shall pay and Provider or Doula Provider shall accept as payment in full the rates set forth in Exhibit A-3, subject to the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that Health Net is solely responsible for paying Provider for Covered Services rendered to those individuals for whom Health Net provides Medi-Cal Benefit Program coverage.

EXHIBIT A-4

COMMUNITY SUPPORTS

In consideration, Provider agrees to accept reimbursement as set forth in this Addendum. Provider further agrees to meet the requirements set forth under EXHIBIT A-5, COMMUNITY SUPPORTS REQUIREMENTS, which, is incorporated herein by reference. For the purposes of this Addendum only, Provider shall be referred to as CS Provider.

II. DEFINITIONS

1.1 **ECM Provider**. A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the DHCS designated populations of focus for ECM.

1.2 **Community Supports (CS).** Community Supports (CS) services are medically appropriate and cost-effective alternatives to services covered under the Medi-Cal State Plan. CS services include, but are not limited to, housing transition navigation services, housing deposits, respite services, nursing facility transition, personal care and homemaker services, medically tailored meals, and asthma remediation.

1.3 **CS Provider.** A contracted Provider of DHCS-authorized CS services. CS Providers are community-based entities or individuals with experience and expertise providing one (1) or more of the CS services authorized by DHCS to eligible individuals with complex physical, behavioral, developmental and/or social needs.

III. CS OVERVIEW

2.1 In the event the State of California delays the CS implementation effective date for some or all of the services below in Table 1, Health Net shall use best efforts to give Provider sixty (60) days' notice of the change in effective date. The terms of this Amendment shall become effective upon the date the State's implementation has become effective.

2.2 Health Net shall notify Provider of any additional or new CS services being added to the Agreement. Provider shall have thirty (30) days after notification from Health Net to opt out of participating in such new CS service. If Provider fails to provide Health Net with such written notice of intent to not participate, Provider shall be deemed to have agreed to participate in such additional CS service under the terms outlined in the notification.

From Table 1 below, CS Provider shall offer the following DHCS-authorized CS services to Beneficiaries, and as identified in the attached Exhibit(s):

Table 1 – CS Services

SERVICE(S) DESCRIPTION					
Housing Transition Navigation Services	☐	Day Habilitation Programs	☐	Environmental Accessibility Adaptations (Home Modifications)	☐
Housing Deposits	☐	Housing Tenancy and Sustaining Services	☐	Meals/Medically Tailored Meals	☐
Nursing Facility Transition/Diversion to Assisted Living Facilities	☐	Respite Services	☐	Sobering Centers	☒
Short-Term Post-Hospitalization Housing	☐	Community Transition Services/Nursing Facility Transition to a Home	☐	Asthma Remediation	☐

SERVICE(S) DESCRIPTION					
Recuperative Care (Medical Respite)	☐	Personal Care and Homemaker Services	☐		

III. CS PROVIDER RESPONSIBILITIES

3.1. CS Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs; including but not limited to, Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.

3.1.1 If APL 19-004 does not apply to a CS Provider, the CS Provider will comply with Health Net's process for vetting CS Providers, which may extend to individuals employed by or delivering services on behalf of CS Provider, to ensure it can meet the capabilities and standards required to be a CS Provider.

3.2. Experience and training in the elected CS services.

3.2.1 CS Provider shall have experience and/or training in the provision of the CS services being offered.

3.2.2. CS Provider shall have the capacity to provide the CS services in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by Health Net.

3.3. If CS Provider subcontracts with other entities to administer its functions of CS services, the CS Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth in the Agreement.

IV. DELIVERY OF CS

4.1. CS Provider shall deliver contracted CS services in accordance with DHCS service definitions and requirements.

4.2. CS Provider shall maintain staffing that allows for timely, high-quality service delivery of the CS services that it is contracted to provide.

4.3 CS Provider shall:

4.3.1 Accept and act upon Member referrals from Health Net for authorized CS services, unless the CS Provider is at pre-determined capacity;

4.3.2. Conduct outreach to the referred Member for authorized CS services as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment;

4.3.3 Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;

4.3.4 Coordinate with other providers in the Member's care team, including ECM Providers, other CS Providers and Health Net;

4.3.5 Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in the Agreement with Health Net; and

4.3.6 Comply with non-discrimination requirements set forth in State and Federal law and the Agreement with Health Net.

4.4. When federal law requires authorization for data sharing, CS Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to Health Net.

4.4.1 Member authorization for CS-related data sharing is not required for the CS Provider to initiate delivery of CS services unless such authorization is required by federal law.

4.5 CS Provider will be reimbursed only for services that are authorized by Health Net. In the event of a Member requesting services not yet authorized by Health Net, CS Provider shall send prior

authorization request(s) to Health Net, unless a different agreement is in place (e.g., if the Health Net has given the CS Provider authority to authorize CS directly).

4.6. If CS services are discontinued for any reason, CS Provider shall support transition planning for the Member into other programs or services that meet their needs when applicable.

4.7. CS Provider is encouraged to identify additional CS services the Member may benefit from and send any additional request(s) for CS services to Health Net for authorization.

V. PAYMENT FOR CS

5.1. CS Provider shall record, generate, and send a claim or invoice to Health Net for CS services rendered.

5.1.1 If CS Provider submits claims, CS Provider shall submit claims to Health Net using specifications based on national standards and code sets to be defined by DHCS.

5.1.2 In the event CS Provider is unable to submit claims to Health Net for CS-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, CS Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the CS services rendered, and CS Providers' information to support appropriate reimbursement by Health Net, that will allow Health Net to convert CS-related services invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

5.2. CS Provider shall not receive payment from Health Net for the provision of any CS services not authorized by Health Net.

5.3 CS Provider must have a system in place to accept payment from Health Net for CS services rendered.

5.3.1 Health Net shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

5.3.2 Health Net will expedite payment for urgent CS services (e.g., recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

5.3.3 As compensation for rendering Contracted Services to Beneficiaries covered under this Addendum, Health Net shall pay and Provider shall accept as payment in full the rates set forth in Exhibit B-1, subject to the terms of this Agreement and applicable State and federal law. Notwithstanding any other provision in this Agreement, the parties acknowledge that Health Net is solely responsible for paying Provider for Covered Services rendered to those individuals for whom Health Net provides health care coverage.

VI. HEALTH NET RESPONSIBILITIES

6.1. DATA SHARING TO SUPPORT CS

6.1.1 As part of the referral process, Health Net will ensure CS Provider has access to:

6.1.1.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

6.1.1.2 Appropriate administrative, clinical, and social service information the CS Provider might need in order to effectively provide the requested service; and

6.1.1.3 Billing information necessary to support the CS Provider's ability to submit invoices to Health Net.

6.2 QUALITY AND OVERSIGHT

CS Provider acknowledges Health Net will conduct oversight of its delivery of CS services to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both the Health Net and the CS Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

EXHIBIT A-5

COMMUNITY SUPPORTS REQUIREMENTS

Type	Community Supports Description	Eligibility Criteria
Housing Transition & Navigation	Housing transition services assist beneficiaries with obtaining housing and include: 1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers. 2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal. 3. Searching for housing and presenting options. 4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). 5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset. 6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members. 7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. 8. Assisting with requests for reasonable accommodation, if necessary. 9. Landlord education and engagement 10. Ensuring that the living environment is safe and ready for move-in. 11. Communicating and advocating on behalf of the client with landlords. 12. Assisting in arranging for and supporting the details of the move. 13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. 14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day. 15. Identifying, coordinating, environmental	• Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or • Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; or • Individuals who meet the definition of an individual experiencing chronic homelessness; or • Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or • Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following: o Have one or more serious chronic conditions; o Have a Serious Mental Illness; o Are at risk of institutionalization or

Type	Community Supports Description	Eligibility Criteria
	modifications to install necessary accommodations for accessibility. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above. The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include: Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care. The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted CS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate. Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.	overdose or are requiring residential services because of a substance use disorder; ○ Have a Serious Emotional Disturbance (children and adolescents); ○ Are receiving Enhanced Care Management; or ○ Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or • Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness," which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.
Housing Deposits	Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as: 1. Security deposits required to obtain a lease on an apartment or home. 2. Set-up fees/deposits for utilities or service access and utility arrearages.	• Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services; or • Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

Type	Community Supports Description	Eligibility Criteria
	3. First month coverage of utilities, including but not limited to: telephone, gas, electricity, heating, and water. 4. First month and last month's rent as required by landlord for occupancy. 5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy. 6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home (e.g., hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc.), that are necessary to ensure access and safety for the individual upon move-in to the home. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above. The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care. Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.	disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or • Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; of • Individuals who meet the definition of an individual experiencing chronic homelessness; or • Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or • Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following: o Have one or more serious chronic conditions; o Have a Serious Mental Illness; o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder; o Have a Serious Emotional Disturbance (children and adolescents); o Are receiving Enhanced Care Management; or o Are a Transition-Age Youth with significant barriers to housing stability, such as

Type	Community Supports Description	Eligibility Criteria
		one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or • Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness," which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.
Housing Tenancy & Sustaining Services	This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include: 1. Providing early identification and intervention for behaviors that may jeopardize housing, (e.g., late rental payment, hoarding, substance use), as well as other lease violations. 2. Education and training on the role, rights and responsibilities of the tenant and landlord. 3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy. 4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability. 5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit. 6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.	• Any individual who received Housing Transition/Navigation Services CS in counties that offer Housing Transition/Navigation Services; or • Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or • Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is

Type	Community Supports Description	Eligibility Criteria
	7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset. 8. Assistance with the annual housing recertification process. 9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. 10. Continuing assistance with lease compliance, including ongoing support with activities related to household management. 11. Health and safety visits, including unit habitability inspections. 12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in). 13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources. The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above. The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care. The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Services do not include the provision of room and board or payment of rental costs. Please see housing deposits CS.	at risk of institutionalization or requiring residential services as a result of a substance use disorder; or • Individuals who meet the definition of an individual experiencing chronic homelessness; or • Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or • Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following: o Have one or more serious chronic conditions; o Have a Serious Mental Illness; o Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents); o Are receiving Enhanced Care Management; or o Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or • Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness," which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or

Type	Community Supports Description	Eligibility Criteria
		more convictions and history of foster care or involvement with the juvenile justice system.
Short-term Post-Hospitalization Housing	Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital, (either acute, psychiatric, or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. This setting provides individuals with ongoing support necessary for recuperation and recovery; such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports, (e.g., Housing Transition Navigation). This setting may include an individual or shared interim housing setting, where residents receive the services described above. Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing. The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care	• Individuals exiting recuperative care; • Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria: o Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; o Individuals who meet the definition of an individual experiencing chronic homelessness; o Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; o Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

Type	Community Supports Description	Eligibility Criteria
		○ Have one or more serious chronic conditions; ○ Have a Serious Mental Illness; ○ Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder ○ Have a Serious Emotional Disturbance (children and adolescents); ○ Are receiving Enhanced Care Management; or o Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or ○ Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system. In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, rehospitalization, or institutional readmission.

Type	Community Supports Description	Eligibility Criteria
Recuperative Care (Medical Respite)	Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include: 1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or Activities of Daily Living (ADLs). 2. Coordination of transportation to post-discharge appointments 3. Connection to any other on-going services an individual may require including mental health and substance use disorder services 4. Support in accessing benefits and housing 5. Gaining stability with case management relationships and programs. Recuperative care is primarily used for those individuals who are experiencing homelessness, or those with unstable living situations who are too ill or frail to recover from an illness, (i.e., physical or behavioral health), or injury in their usual living environment, but are not otherwise ill enough to be in a hospital. The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. The services provided should utilize best practices for clients who are experiencing homelessness and who	• Individuals who are at risk of hospitalization or are post-hospitalization, and • Individuals who live alone with no formal supports; or • Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.

Type	Community Supports Description	Eligibility Criteria
	have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.	
Respite Services	Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite services can include any of the following: 1. Services provided by the hour on an episodic basis because of the absence of, or need for relief for, those persons normally providing the care to individuals. 2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals. 3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them. The Home Respite services are provided to the participant in his or her own home or another location being used as the home. The Facility Respite services are provided in an approved out-of-home location. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.	• Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement. • Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.
Day Habilitation Programs	Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients, and to improve	Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Type	Community Supports Description	Eligibility Criteria
	overall care coordination and management. Day habilitation program services include, but are not limited to, training on: 1. The use of public transportation; 2. Personal skills development in conflict resolution; 3. Community participation; 4. Developing and maintaining interpersonal relationships; 5. Daily living skills (cooking, cleaning, shopping, money management); and, 6. Community resource awareness such as police, fire, or local services to support independence in the community. Programs may include assistance with, but not limited to: 1. Selecting and moving into a home; 2. Locating and choosing suitable housemates; 3. Locating household furnishings; 4. Settling disputes with landlords; 5. Managing personal financial affairs; 6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants; 7. Dealing with and responding appropriately to governmental agencies and personnel; 8. Asserting civil and statutory rights through self-advocacy; 9. Building and maintaining interpersonal relationships, including a circle of support; 10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;	

Type	Community Supports Description	Eligibility Criteria
	11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria; 12. Assistance with income and benefits advocacy; including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and 13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management. The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care	
Nursing Facility Transition / Diversion to ALF	Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed. For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes: 1. Assessing the participant's housing needs and presenting options. 2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.	• For Nursing Facility Transition: o Has resided 60+ days in a nursing facility; o Willing to live in an assisted living setting as an alternative to a Nursing Facility; and o Able to reside safely in an assisted living facility with appropriate and cost-effective supports. • For Nursing Facility Diversion: o Interested in remaining in the community; o Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and o Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Type	Community Supports Description	Eligibility Criteria
	3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). 4. Communicating with facility administration and coordinating the move. 5. Establishing procedures and contacts to retain facility housing. 6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.	
Community Transition Services / Nursing Facility Transition to Home	Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization. Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include: 1. Assessing the participant's housing needs and presenting options. 2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history). 3. Communicating with landlord, if applicable, and coordinating the move. 4. Establishing procedures and contacts to retain housing. 5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.	1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; 2. Has lived 60+ days in a nursing home; 3. Interested in moving back to the community; and 4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Type	Community Supports Description	Eligibility Criteria
	6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. 7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and onetime cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.	
Personal Care & Homemaker Services	Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) (e.g., bathing, dressing, toileting, ambulation, feeding, etc.). Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Services provided through the In-Home Support Services (IHSS) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired. Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes. In lieu of services can be utilized: • Above and beyond any approved county IHSS hours, when additional hours are required and if IHSS benefits are exhausted; and • As authorized during any IHSS waiting period (member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date. • For members not eligible to receive IHSS to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days). Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if	• Individuals at risk for hospitalization, or institutionalization in a nursing facility; or • Individuals with functional deficits and no other adequate support system; or. • Individuals approved for IHSS.

Type	Community Supports Description	Eligibility Criteria
	appropriate and if additional hours/supports are not authorized by IHSS .	
Environmental Accessibility Adaptations (home modification)	Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. Examples of environmental accessibility adaptions include: • Ramps and grab-bars to assist beneficiaries in accessing the home; • Doorway widening for beneficiaries who require a wheelchair; • Stair lifts; • Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower). • Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and • Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed). The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the	• Individuals at risk for institutionalization in a nursing facility.

Type	Community Supports Description	Eligibility Criteria
	equipment or service meets the needs of the individual will still be necessary. For environmental accessibility adaptations, the managed care plan must also receive and document: 1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following: A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant; B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant and reduces the risk of institutionalization. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy. 2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and 3. That a home visit has been conducted to determine the suitability of any requested equipment or service. The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.	
Meals / Medically Tailored Meals	Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their	• Individuals with chronic conditions, including but not limited to diabetes, cardiovascular disorders, congestive

Type	Community Supports Description	Eligibility Criteria
	nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction. 1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission. 2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. 3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes. 4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.	heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders; or • Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or • Individuals with extensive care coordination needs.
Sobering Centers	Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services. • When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged. • The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.	Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Type	Community Supports Description	Eligibility Criteria
	• This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care. • The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.	
Asthma Remediation	Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Examples of environmental asthma trigger remediations include: • Allergen-impermeable mattress and pillow dustcovers; • High-efficiency particulate air (HEPA) filtered vacuums; • Integrated Pest Management (IPM) services; • De-humidifiers; • Air filters; • Other moisture-controlling interventions; • Minor mold removal and remediation services; • Ventilation improvements; • Asthma-friendly cleaning products and supplies; • Other interventions identified to be medically appropriate and cost effective. The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver. When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:	Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Type	Community Supports Description	Eligibility Criteria
	1. The participant's current licensed health care provider's order specifying the requested remediation(s); 2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary. 3. That a home visit has been conducted to determine the suitability of any requested remediation(s). Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as: 1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants. 2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters. 3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.	

EXHIBIT A-6

MEDI-CAL BENEFIT PROGRAM
FEE-FOR-SERVICE RATE EXHIBIT

ENHANCED CARE MANAGEMENT (ECM)

I. **Reimbursement for ECM Services.** The following Healthcare Common Procedure Coding System (HCPCS) codes must be used for ECM services. The HCPCS code and modifier combined define the service as ECM. As an example, HCPCS code G9008 by itself does not define the service as an ECM service. The HCPCS code G9008 must be reported with modifier U1 for the care coordination service to be defined and categorizes as an ECM service. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rates
G9012	Outreach	U8	Outreach	$105.00
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services	U1	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services	$107.63
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services.	$65.51
G9012	ECM In-Person: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services	$56.53
G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services.	$34.41

DOULA FEE-FOR-SERVICE RATE EXHIBIT

II. Subject to the terms of this Agreement, including without limitation the requirements in Exhibit A-3, Health Net shall pay and Provider shall accept as payment in full for Covered Services delivered under the Medi-Cal Benefit Programs pursuant to this Addendum, the lesser of: (i) the rates listed below, or (ii) 100% of Provider's billed charges.

Category of Service	CPT, HCPC Code(s)	Modifier(s)	Compensation
Extended initial visit, 90 minutes	Z1032	XP	150% of Medi-Cal rate
Prenatal visit	Z1034	XP	150% of Medi-Cal rate
Postpartum visit	Z1038	XP	150% of Medi-Cal rate
Extended postpartum doula support, per 15 minutes	T1032	XP	150% of Medi-Cal rate
Doula support during vaginal delivery only	59409	XP	150% of Medi-Cal rate
Doula support during vaginal delivery after previous caesarian section	59612	XP	150% of Medi-Cal rate
Doula support during caesarian section	59620	XP	150% of Medi-Cal rate
Doula support during or after miscarriage	T1033	XP	150% of Medi-Cal rate
Doula support during or after abortion	59840	XP	150% of Medi-Cal rate

Compensation Conditions:

1) The extended initial visit must be for at least 90 minutes to bill with Z1032.
2) All visits are limited to one per day, per Beneficiary.
3) Only one Participating Doula may bill for a visit provided to the same Beneficiary on the same day, excluding labor and delivery.
4) One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery (including stillbirth), abortion or miscarriage support.
5) The prenatal visit or postpartum visit billed on the same calendar day as labor and delivery, abortion, or miscarriage support may be billed by a different Participating Doula.
6) For extended postpartum visits lasting at least three hours, Participating Doula may bill code T1032 (15 minutes per unit) for 12 units per visit, up to two visits (24 total units) per pregnancy per Beneficiary provided on separate days.

COMMUNITY SUPPORTS

III. The following HCPCS codes must be used for CS services. The HCPCS code and modifier combined define the service as CS services. As an example, a HCPCS code by itself does not define the CS services. The HCPCS code must be reported with a modifier for the services to be defined and categorized as CS services. If CS services are provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rate
Asthma Remediation				
S5165	Home modifications; per service	U5	Used by Managed Care with HCPCS code S5165 to indicate Community Supports Asthma Remediation	100% of Allowable Charges* Lifetime maximum of $7,500
Community Transition Services/Nursing Facility Transition to a Home				
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Nursing Facility Transition/Diversion to Assisted Living Facilities	U5	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Community Transition Services/Nursing Facility Transition to a Home	$432.49 per service
Day Habilitation Programs				
Coding Guidance Forthcoming	Day Habilitation		Used by Managed Care to indicate Community Supports Day Habilitation Programs	$6.46 per hour Not to exceed $51.68 per day
Environmental Accessibility Adaptations				
S5165	Home modifications; per services. Requires billed amount(s) to be reported on the encounter	U6, U1	Used by Managed Care with HCPCS code S5165 to indicate Community Services Accessibility Adaptations/Home Modifications	100% of Allowable Charges* Lifetime maximum of $7,500
Housing Deposits				
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization Housing	U2	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Housing Deposit	100% of Allowable Charges* Lifetime maximum of $5,000
Housing Tenancy and Sustaining Services				
T2041	Support brokerage, self-	U6	Used by Managed Care	$420.15 per

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rate
	directed		with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services	service
Housing Transition/Navigation Services				
H0043	Supported housing	U6	Used by Managed Care with HCPCS code H0043 to indicate Community Supports supported housing	$356.01 per diem
Medically-Supportive Food/Meals/Medically Tailored Meals				
S5170	Home delivered prepared meal	U6	Used by Managed Care with HCPCS code S5170 to indicate Community Supports Medically-Supportive Foods/Meals/Medically Tailored Meals	$7.00
S9470	Nutritional counseling, diet	U6	Used by Managed Care with HCPCS code S9470 to indicate Community Supports Medically-Supportive Food/Meals/Medically Tailored Meals	$33.00
S9977	Per weekly grocery box, delivered	U6	Used by Managed Care with HCPCS code S9977 to indicate Community Supports Medically-Supportive Food/Meals/Medically Tailored Meals	$52.00
Nursing Facility Transition/Diversion to Assisted Living Facilities				
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community Transition Services/Nursing Facility Transition to a Home	U4	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Nursing Facility Transition/Diversion to an Assisted Living Facility	$432.49 per service
H2022	Community wrap-around services. Requires billed amount(s) to be reported on the encounter	U5	Used by Managed Care with HCPCS code H2022 to indicate Community Supports Community Transition	$30.61per hour

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rate
			Services/Nursing Facility Transition to a Home	
Personal Care Services				
Coding Guidance Forthcoming	Personal care services		Used by Managed Care for Community Supports Personal Care Services	$30.61 per hour
Recuperative Care (Medical Respite)				
T2033	Residential care, not otherwise specified (NOS), waiver	U6	Used by Managed Care with HCPCS code T2033 to indicate Community Supports Recuperative Care (Medical Respite)	$188.74 per diem
Respite Services				
H0045	Respite care services, not in the home	U6	Used by Managed Care with HCPCS code H0045 to indicate Community Supports Respite Services	$30.61 per hour
S5151	Unskilled respite care, not hospice	U6	Used by Managed Care with HCPCS code S5151 to indicate Community Supports Respite Services	
S9125	Respite care, in the home	U6	Used by Managed Care with HCPCS code S9215 to indicate Community Supports Respite Services	
Short Term Post-Hospitalization Housing				
H0044	Supported housing, per month. Modifier used to differentiate Short-Term Post Hospitalizations Housing from Housing Deposits	U3	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Short-Term Post-Hospitalization Housing	$100.48 per diem
Sobering Centers				
H0014	Alcohol and/or drug services; ambulatory detoxification	U6	Used by Managed Care with HCPCS code H0014 to indicate	$158.80 per diem

HCPCS Level II Code	HCPCS Description	Modifier	Modifier Description	Rate
			Community Supports sobering centers alcohol and/or drug services; ambulatory detoxification services	

* The Health Net authorization will determine the Allowable Charges subject to reimbursement under the Agreement, up to the lifetime maximum for the service.

BOARD LETTER/MEMO
CLUSTER FACT SHEET

DRAFT

☒ Board Letter ☐ Board Memo ☐ Other

CLUSTER AGENDA REVIEW DATE	12/13/2023
BOARD MEETING DATE	1/9/2024
SUPERVISORIAL DISTRICT AFFECTED	☒ All ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
DEPARTMENT(S)	Department of Public Health (Public Health)
SUBJECT	**AUTHORIZATION TO ACCEPT AND IMPLEMENT NOTICE OF AWARD NUMBER 1 NH28CE003543-01-00 AND ACCEPT FUTURE AWARDS AND/OR AMENDMENTS FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND OTHER FEDERAL, STATE, AND LOCAL ENTITIES**
PROGRAM	Substance Abuse Prevention and Control (SAPC) Bureau
AUTHORIZES DELEGATED AUTHORITY TO DEPT	☒ Yes ☐ No
SOLE SOURCE CONTRACT	☐ Yes ☒ No N/A
DEADLINES/ TIME CONSTRAINTS	
COST & FUNDING	Total cost: $3,217,500 — Funding source: Grant award being received, 100 percent funded by Center for Disease Control and Prevention (CDC) TERMS (if applicable): September 1, 2023 through August 31, 2024 Explanation: N/A
PURPOSE OF REQUEST	Provide authorization to accept and implement a Notice of Award and accept future awards and/or amendments from the Centers for Disease Control and Prevention to support the Overdose Data to Action: Limiting Overdose Through Collaborative Actions in Localities (OD2A:LOCAL) project and delegate authority to accept future awards from other federal, State, and local entities in support of substance use disorder prevention and harm reduction objectives in Los Angeles County (LAC).
BACKGROUND (include internal/external issues that may exist including any related motions)	The work under OD2A:LOCAL includes the following programs: (1) expanding programming that increases the initiation of low threshold medications for opioid use disorder (MOUD) and application of clinical services consistent with forthcoming American Society of Addiction Medicine (ASAM) Stimulant Use Disorder (StUD) National Practice Guideline (NPG) to improve engagement and linkage of priority populations (people experiencing homelessness and people who use drugs) within Los Angeles County (LAC) for continuity of SUD treatment and medical, mental health, and social services; (2) expanding the availability of harm reduction services to priority populations; (3) improving clinician and health systems adherence to CDC guidelines on safer prescribing of controlled substances, and adoption of best practices that include the low-threshold initiation of MOUD in accordance with established national guidelines, and management of StUD in accordance with the forthcoming ASAM StUD NPG, specifically including naloxone prescription and distribution and referral to community harm reduction services; (4) launching a harm reduction focused anti-stigma media campaign involving the community, health care systems, first responders, and people who use drugs that lifts their voices, increases the

	acceptability of harm reduction policies, services, and practices, and that reduces said stigma; (5) enhancing Public Health's overdose surveillance infrastructure to perform data abstraction to inform timely and actionable overdose response initiatives; and (6) conducting toxicology testing of drug products and/or paraphernalia at LAC contracted and certified harm reduction syringe services programs.
EQUITY INDEX OR LENS WAS UTILIZED	☐ Yes ☒ No If Yes, please explain how:
SUPPORTS ONE OF THE NINE BOARD PRIORITIES	☒ Yes ☐ No If Yes, please state which one(s) and explain how: Sustainability - Public Health will implement and support a number of overdose prevention and harm reduction activities in collaboration with community partnerships via the OD2A:LOCAL project in LAC.
DEPARTMENTAL CONTACTS	Name, Title, Phone # & Email: Joshua Bobrowsky, Public Health Director Government Affairs, (213) 288-7871 jbobrowsky@ph.lacounty.gov Emily Issa, Senior Deputy County Counsel (213) 974-1827 eissa@counsel.lacounty.gov Gary Tsai, Public Health Substance Abuse Prevention and Control (626) 299-3504 GTsai@ph.lacounty.gov

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

ANISH P. MAHAJAN, M.D., M.S., M.P.H.
Chief Deputy Director

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www.publichealth.lacounty.gov

DRAFT

January 9, 2024

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

AUTHORIZATION TO ACCEPT AND IMPLEMENT NOTICE OF AWARD NUMBER 1 NH28CE003543-01-00 AND ACCEPT FUTURE AWARDS AND/OR AMENDMENTS FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND OTHER FEDERAL, STATE, AND LOCAL ENTITIES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Provide authorization to accept and implement a Notice of Award and future awards and/or amendments from the Centers for Disease Control and Prevention to support the expansion of vitally needed harm reduction and overdose prevention services as part of the Overdose Data to Action: Limiting Overdose Through Collaborative Actions in Localities and delegate authority to accept and sign future awards from other federal, State, and local entities in support of prevention and harm reduction programs in Los Angeles County.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize and instruct the Director of the Department of Public Health (Public Health), or designee, to accept and implement award number 1 NH28CE003543-01-00 (Exhibit I) from the Centers for Disease Control and Prevention (CDC), Assistance Listing Number 93.136, for the Overdose Data to Action: Limiting Overdose Through Collaborative Actions in Localities (OD2A:LOCAL) project in the

amount of $3,217,500 for the Year 1 budget period of September 1, 2023 through August 31, 2024.

2. Delegate authority to the Director of Public Health, or designee, to accept grants or awards from Substance Abuse and Mental Health Services Administration (SAMHSA) and/or other federal, State or local entities that provide additional support for substance use disorder (SUD) prevention and harm reduction objectives, subject to review and approval by County Counsel and notification to the Board and the Chief Executive Office (CEO).

3. Delegate authority to the Director of Public Health, or designee, to accept future award(s) and/or amendment(s) that are consistent with the requirements of the CDC award referenced in Recommendation 1 and/or the grants and awards referenced in Recommendation 2, that extend the funding period at amounts to be determined by the funder; allow for the rollover of unspent funds; and/or provide an increase or decrease in funding, subject to review and approval by County Counsel and notification to the Board and the CEO.

4. Authorize the Director of Public Health, or designee, to accept future amendments that are consistent with the requirements of the CDC award referenced in Recommendation 1 and the grants and awards referenced in Recommendation 2, that allow changes to the budget where there is no net change in funding, to provide administrative changes, or changes that reflect non-material or ministerial revisions to the terms and conditions, subject to review and approval by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of Recommendation 1 will allow Public Health to accept and implement award Number 1 NH28CE003543-01-00 from the CDC for the OD2A:LOCAL project, which supports the expansion of vitally needed harm reduction and overdose prevention services.

The work under OD2A:LOCAL includes the following programs: (1) expanding programming that increases the initiation of low threshold medications for opioid use disorder (MOUD) and application of clinical services consistent with forthcoming American Society of Addiction Medicine (ASAM) Stimulant Use Disorder (StUD) National Practice Guideline (NPG) to improve engagement and linkage of priority populations (people experiencing homelessness and people who use drugs) within Los Angeles County (LAC) for continuity of SUD treatment and medical, mental health, and social services; (2) expanding the availability of harm reduction services to priority populations; (3) improving clinician and health systems adherence to CDC guidelines on safer prescribing of controlled substances, and adoption of best practices that include the low-threshold initiation of MOUD in accordance with established national guidelines, and management of StUD in accordance with the forthcoming ASAM StUD NPG, specifically including naloxone prescription and distribution and referral to community

harm reduction services; (4) launching a harm reduction focused anti-stigma media campaign involving the community, health care systems, first responders, and people who use drugs that lifts their voices, increases the acceptability of harm reduction policies, services, and practices, and that reduces said stigma; (5) enhancing Public Health's overdose surveillance infrastructure to perform data abstraction to inform timely and actionable overdose response initiatives; and (6) conducting toxicology testing of drug products and/or paraphernalia at LAC contracted and certified harm reduction syringe services programs.

Approval of Recommendation 2 will allow Public Health to accept grants or awards from SAMHSA and other federal, State or local entities that support SUD prevention and harm reduction objectives.

Approval of Recommendation 3 will allow Public Health to accept and implement future awards and/or amendments that are consistent with the requirements of the CDC award referenced in Recommendation 1 and the grants or awards referenced in Recommendation 2, that extend the funding period at amounts to be determined by the funder, allow for the rollover of unspent funds, and/or an increase or decrease in funding.

Approval of Recommendation 4 will allow Public Health to accept future amendments from CDC award referenced in Recommendation 1 and the grants and awards referenced in Recommendation 2 that allow for changes to the budget where there is no net change in funding; provide administrative changes; and changes that reflect non-material or ministerial revisions to the terms and conditions.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2 – Support Wellness of our Communities; Objective II.2.4 – Promote Active and Healthy Lifestyles, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Award Number 1 NH28CE003543-01-00 from the CDC provides funding in the amount of $3,217,500, for the Year 1 budget period of September 1, 2023, through August 31, 2024.

Funding for the CDC award is included in Public Health's fiscal year (FY) 2023-24 Adopted Budget, and future funding for related to this award or other to be accepted by Public Health under this authority will be included in future FYs, as necessary.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On May 8, 2023, Public Health submitted an application to the CDC for award Number 1 NH28CE003543-01-00. On August 3, 2023, Public Health received notification from the CDC indicating that the application was accepted and advanced for final approval.

Exhibit I, Notice of Award number 1 NH28CE003543-01-00 has been reviewed and approved by County Counsel.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will allow Public Health to implement and support a number of overdose prevention and harm reduction activities in collaboration with community partnerships via the OD2A:LOCAL project and to accept future federal, state, and local awards or grants in support of prevention and harm reduction in Los Angeles County.

Respectfully submitted,

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

BF:jt
#07281

Enclosure

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 1 NH28CE003543-01-00
FAIN# NH28CE003543
Federal Award Date: 08/23/2023

Recipient Information

1. Recipient Name
COUNTY OF LOS ANGELES
313 N Figueroa St RM 806
Chronic Disease & Injury Prev
Los Angeles, CA 90012-2602

2. Congressional District of Recipient
34

3. Payment System Identifier (ID)
1956000927A1

4. Employer Identification Number (EIN)
956000927

5. Data Universal Numbering System (DUNS)
624882309

6. Recipient's Unique Entity Identifier (UEI)
DN3NGS58SMT9

7. Project Director or Principal Investigator
Dr. Brian Hurley M.D.
bhurley@ph.lacounty.gov
3234573675

8. Authorized Official
Dr. Heather Frank
hguentzelfrank@ph.lacounty.gov
3239142253

Federal Agency Information
CDC Office of Financial Resources

9. Awarding Agency Contact Information
Darryl Mitchell
dvm1@cdc.gov
770-488-2747

10.Program Official Contact Information
Sherry Bolden
Program Officer
skb2@cdc.gov
4044980341

Federal Award Information

11. Award Number
1 NH28CE003543-01-00

12. Unique Federal Award Identification Number (FAIN)
NH28CE003543

13. Statutory Authority
Section 311(c)(1) of the PHS Act (42 USC § 243(c)(1))

14. Federal Award Project Title
Limiting Overdose through Collaborative Actions in LA County

15. Assistance Listing Number
93.136

16. Assistance Listing Program Title
Injury Prevention and Control Research and State and Community Based Programs

17. Award Action Type
New

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 09/01/2023 **- End Date** 08/31/2024	
20.	**Total Amount of Federal Funds Obligated by this Action**	$3,217,500.00
	20a. Direct Cost Amount	$3,217,500.00
	20b. Indirect Cost Amount	$0.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$3,217,500.00
26.	**Period of Perfomance Start Date** 09/01/2023 **- End Date** 08/31/2028	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$3,217,500.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
Ms. Tajsha LaShore

30. Remarks

Recipient Information

Recipient Name
COUNTY OF LOS ANGELES
313 N Figueroa St RM 806
Chronic Disease & Injury Prev
Los Angeles, CA 90012-2602

Congressional District of Recipient
34
Payment Account Number and Type
1956000927A1
Employer Identification Number (EIN) Data
956000927
Universal Numbering System (DUNS)
624882309
Recipient's Unique Entity Identifier (UEI)
DN3NGS58SMT9

31. Assistance Type
Cooperative Agreement
32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$200,000.00
b. Fringe Benefits	$0.00
c. Total Personnel Costs	$200,000.00
d. Equipment	$12,500.00
e. Supplies	$13,500.00
f. Travel	$10,000.00
g. Construction	$0.00
h. Other	$112,000.00
i. Contractual	$2,869,500.00
j. TOTAL DIRECT COSTS	**$3,217,500.00**
k. INDIRECT COSTS	**$0.00**
l. TOTAL APPROVED BUDGET	**$3,217,500.00**
m. Federal Share	$3,217,500.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	CFDA NO.	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
3-9390BX6	23NH28CE003543OPCE	CE	410Q	93.136	$3,217,500.00	75-23-0952

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

COUNTY OF LOS ANGELES 1 NH28CE003543-01-00

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federal-regulations-policies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number CDC-RFA-CE-23-0003, entitled Overdose Data to Action: Limiting Overdose through Collaborative Actions in Localities (OD2A: LOCAL), and application dated May 8, 2023, as may be amended, which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NoA).

Approved Funding: Funding in the amount of $3,217,500 is approved for the Year 01 budget period, which is September 1, 2023 through August 31, 2024. All future year funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third-party in-kind contribution when applicable.

Note: Refer to the Payment Information section for Payment Management System (PMS) subaccount information.

Component/Project Funding: The NOFO provides for the funding of multiple components under this award. The approved component funding levels for this notice of award are:

NOFO Component	Amount
Component A	$ 2,892,500
Component B	$ 325,000
Component C	$ 0

Financial Assistance Mechanism: Cooperative Agreement

Substantial Involvement by CDC: This is a cooperative agreement and CDC will have substantial programmatic involvement after the award is made. Substantial involvement is in addition to all post-award monitoring, technical assistance, and performance reviews undertaken in the normal course of stewardship of federal funds.

CDC program staff will assist, coordinate, or participate in carrying out effort under the award, and recipients agree to the responsibilities therein, as detailed in the NOFO. Across all components, CDC will provide substantial involvement beyond regular performance and financial monitoring during the period of performance. Substantial involvement means that recipients can expect federal programmatic partnership in carrying out the effort under the award. CDC's Division of Overdose Prevention (DOP), with support from the DOP Technical Assistance Center (TAC), will work in partnership with recipients to ensure the success of the cooperative agreement by:

- Assisting in advancing program activities to achieve project outcomes
- Providing technical assistance on data management plans

- Collaborating with recipients to develop evaluation plans that align with CDC evaluation activities
- Providing technical assistance on recipient's Evaluation and Performance Measurement Plan
- Providing technical assistance on recipient's Targeted Evaluation Projects
- Providing technical assistance to define and operationalize performance measures
- Facilitating the sharing of information among recipients
- Participating in relevant meetings, committees, conference calls, and working groups related to the cooperative agreement requirements
- Coordinating communication and program linkages with other CDC programs and Federal agencies, such as Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration (FDA), the National Institutes of Health (NIH), Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Justice (DOJ), and the HHS Office of the National Coordinator for Health Information Technology (ONC)
- Translating and disseminating lessons learned and best practices through publications, meetings, surveillance measures, and other means to expand the evidence base
- Identifying and awarding a partner organization to expand and strengthen recipients' capacity to implement surveillance and prevention activities through jurisdiction-level staffing support

Additionally, technical assistance for Component A around the funding announcement's guiding principles will be available to ensure that all recipients are able to:

- Collect data around community characteristics, including racial and ethnic composition, and conduct analyses with a health equity focus
- Use data to inform and tailor prevention programs, with emphasis on reaching groups disproportionately affected by the overdose epidemic
- Ensure implementation of culturally relevant interventions and equitable delivery of prevention services

The Technical Assistance Center (TAC) will leverage various modes of technical assistance, including group trainings, webinars, communities of practice, individualized one-on-one assistance, peer-to-peer interactions, and asynchronous learning to increase recipient capacity to implement evidence-based interventions. DOP staff and DOP TAC subject matter experts will work with the recipients to provide scientific subject matter expertise and resources by:

- Providing guidance on using data to inform jurisdiction-level populations of focus, on selecting evidence-based overdose prevention interventions, and on implementation of best practices across all prevention strategies
- Providing support and technical assistance for implementation of all components (A, B & C)

Component B: The following additional support will be provided to Component B recipients:

- Guidance on the drugs that should be included in standard toxicologic testing. This guidance will be updated periodically or as needed in response to emerging trends. This will be done in consultations with recipients
- Guidance for sharing toxicologic results with CDC in a standardized fashion to meet Component B reporting requirements
- Provide support on collecting and analyzing the data through drug product and/or drug

paraphernalia workgroup meetings that will be held at least quarterly. This may include presentations by CDC and external experts on topics of interest

Component C: The following additional support will be provided to Component C recipients:

- Guidance on the required and optional standardized indicators for linkage to and retention in care surveillance. This guidance may be updated periodically or as needed in consultations with recipients
- Guidance for sharing linkage to and retention in care surveillance indicators with CDC in a standardized format to meet Component C reporting requirements, including providing a data submission template
- Provide support on collecting and analyzing data through the linkage to and retention in care surveillance workgroup meetings that will be held at least quarterly. This may include presentations by CDC, external experts, and recipients on topics of interest

Budget Revision Requirement: By October 2, 2023 the recipient must submit a revised budget with a narrative justification for the following cost:

- Funding reduced to align with the approved funding amount
- **Salaries and Fringe:** Any vacant staff positions must be filled in a timely manner. The recipient must provide a detailed job description of each position along with the percentage of time and effort. In addition, notify CDC upon hiring of these positions (Component A) - $200,000
- **Supplies:** Detailed justification and itemizations missing (Component B) - $13,500
- **Travel:** In accordance with the CDC Budget Preparation Guidelines, the recipient must identify the position(s) traveling and provide a detailed narrative justification describing the travel personnel will perform. Dollars requested in the travel category should be recipient staff travel only. (Component A) - $10,000
- **Other:** Justification and itemization required to support allocation (Component A)
- **Equipment**: Itemization and justification is required to determine if items are reasonable and allowable- (Component B) - $12,500

Failure to submit the required information in a timely manner may adversely affect the future funding of this project. If the information cannot be provided by the due date, you are required to contact the GMS/GMO identified in the CDC Staff Contacts section of this notice before the due date.

Expanded Authority: The recipient is permitted the following expanded authority in the administration of the award.

☒ Carryover of unobligated balances from one budget period to a subsequent budget period. Unobligated funds may be used for purposes within the scope of the project as originally approved. Recipients will report use, or intended use, of unobligated funds in Section 12 "Remarks" of the annual Federal Financial Report. If the GMO determines that some or all of the unobligated funds are not necessary to complete the project, the GMO may restrict the recipient's authority to automatically carry over unobligated balances in the future, use the balance to reduce or offset CDC funding for a subsequent budget period, or use a combination of these actions.

FUNDING RESTRICTIONS AND LIMITATIONS

Indirect Costs: Indirect costs are not approved for this award, because indirect costs were not requested, or an approved Indirect Cost Rate Agreement has not been established. To have indirect costs approved for this grant, submit an approved indirect cost rate agreement to the grants management specialist no later than October 2, 2023.

Missing Contractual Elements – The contracts listed below are **not** approved and the recipient may not begin the contract until detailed itemizations, are provided via GrantSolutions as a Notification of a Contractor or Consultant and GMO approval is provided via Notice of Award.

Contractor 1: LA County + USC Medical Center Foundation, Inc (Component A)
Contractor 2: DPH-SAPC CENS Network (Component A)
Contractor 3: DPH-SAPC Harm Reduction Syringe Services Program Staffing (Component A)
Contractor 4: DHS-HRD Overdose Education Naloxone Distribution Program(Component A)
Contractor 5: TBD Media Vendor-Missing contractual elements (Component A)
Contractor 6: USC Institute for Addiction Sciences (Component A)
Contractor 7: DPH-SAPC (Component A)
Contractor 8: University of California, Los Angeles (Component B)

REPORTING REQUIREMENTS

Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses:

CDC, Office of Grants Services
Darry V. Mitchell, Grants Management Officer/Specialist
Centers for Disease Control and Prevention
Branch 5 Supporting Chronic Diseases and Injury Prevention
2960 Brandywine Road
Atlanta, Georgia 30341
Email: dvm1@cdc.gov (Include “Mandatory Grant Disclosures” in subject line)

AND

U.S. Department of Health and Human Services
Office of the Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW

Cohen Building, Room 5527
Washington, DC 20201

Fax: (202)-205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Recipients must include this mandatory disclosure requirement in all subawards and contracts under this award.

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

CDC is required to report any termination of a federal award prior to the end of the period of performance due to material failure to comply with the terms and conditions of this award in the OMB-designated integrity and performance system accessible through SAM (currently FAPIIS). (45 CFR 75.372(b)) CDC must also notify the recipient if the federal award is terminated for failure to comply with the federal statutes, regulations, or terms and conditions of the federal award. (45 CFR 75.373(b))

PAYMENT INFORMATION

The HHS Office of the Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous.

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified beginning on the bottom of Page 2 of the Notice of Award must be known in order to draw down funds.

Health Services
LOS ANGELES COUNTY

December 19, 2023

Christina R. Ghaly, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Deputy Director, Clinical Affairs

Nina J. Park, M.D.
Chief Deputy Director, Population Health

Elizabeth M. Jacobi, J.D.
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"To advance the health of our patients and our communities by providing extraordinary care"

TO: Supervisor Lindsey P. Horvath, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Janice K. Hahn
Supervisor Kathryn Barger

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES' (DHS) FISCAL OUTLOOK**

This is to provide an update to DHS' fiscal forecast for Fiscal Years (FY) 2023-24 through 2026-27 (Attachment I-A). DHS (excluding DHS Community Programs [CP] and Correctional Health Services [CHS]) is forecasting an available fund balance of $1.53 billion in FY 2023-24, $1.72 billion in FY 2024-25, $1.37 billion in FY 2025-26, and $528.6 million in FY 2026-27.

In this report, DHS is presenting a revised fiscal forecast format for informational purposes: Attachment I-A provides details for DHS' department-wide operations (excluding DHS CP and CHS); Attachment I-B provides details for DHS CP; Attachment I-C provides details for CHS; and Attachment I-D provides a Department-wide summary including DHS CP and CHS.

Available Fund Balance

The significant decrease in DHS' available fund balance over the four-year fiscal forecast period demonstrates the continuing structural deficit. The root cause of the ongoing structural deficit is the fact that the current financial system for financing public hospitals does not provide sufficient funding in Medi-Cal managed care and fee-for-service (FFS) to cover costs. Public hospitals in California must self-finance (i.e., provide the non-federal share) for a large portion of their budgets, leaving public hospitals without sufficient revenue to cover their costs. DHS has been working with the other public hospitals experiencing revenue shortfalls to request that the Department of Health Care Services (DHCS) and California's Medi-Cal Managed

Care plans address the managed care funding shortfalls. The discussions with DHCS and health plans are expected to be protracted as the current financing system for the public hospitals is complicated. The FFS shortfalls are also being discussed with DHCS. Any potential changes that may be forthcoming will still not guarantee a resolution to DHS' structural deficit.

There continues to be a significant imbalance between DHS' estimated expenditures and revenues resulting in ongoing structural deficits. One-time positive adjustments made in earlier years, as discussed below, increase the available fund balance offsetting the existing annual structural deficit.

For FY 2024-25 DHS is forecasting an adjustment that will have a positive impact on the available fund balance due to the resolution of our Long-Term Receivables with DHCS which is expected to increase the value of DHS' available fund balance by more than $700.0 million.

For FY 2025-26 DHS is expecting the completion of the audit of the Provider Relief Fund. DHS is expecting the audit to be completed by FY 2025-26 which will increase the value of our available fund balance by $325.0 million.

Updates to Major Fiscal Issues

Current Year Surplus/(Deficit)

Due to one-time adjustments for prior year revenues, DHS is forecasting an operating surplus of $153.8 million in FY 2023-24 (see Attachment I-A, Line 48). These prior years' adjustments are mainly due to 1) Centers for Medicare and Medicaid Services' (CMS) approval of changes to Medi-Cal funding programs related to COVID-19, and 2) timing issues related to revenue recognition. Without these one-time adjustments, DHS would have experienced an operating deficit (which would be resolved by utilizing available fund balance). These adjustments will not occur in future years.

Proposed Managed Care Rules

On April 27, 2023, CMS issued proposed rules governing managed care delivery systems related to, among other things, directed payments, quality rating systems, and other policy and reporting changes. DHS has concerns regarding some of the proposed rules. For example, the rules propose to set limits on the amount of directed payments that can be made to a managed care provider. Such limits could potentially impact DHS' Enhanced Payment Program and Quality Incentive Program. Another example is that the rules propose a definition of "academic medical center" which, as currently written, could potentially exclude DHS' teaching hospitals. On these and other

issues, DHS submitted comments on the proposed regulations to CMS on July 3, 2023. A response from CMS is expected sometime during the first quarter of 2024. Depending on the specifics of the finalized rule, the fiscal impact could range from material to minor. Since the rule is still pending, the fiscal forecast does not include the impact of any potential rule changes.

Managed Care Organization (MCO) Tax

California has proposed a new MCO tax that, if approved by CMS, would be effective April 1, 2023 through December 31, 2026. The proposed MCO tax would make available additional funding that would be used to increase Medi-Cal managed care rates, with a potential value of up to $19.0 billion statewide, paid out over a period of 4-9 years. If approved by CMS, there is likely to be a potential benefit to DHS, though specific amounts cannot be determined at this time. In addition, a November 2024 ballot initiative called "Protect Access to Healthcare Act of 2024" would permanently authorize the MCO tax in California's constitution and in state law, allowing the fiscal benefit to be ongoing. The majority of revenues generated would go toward improving Medi-Cal provider payments for targeted service categories. Given that the specific benefit to DHS is not able to be quantified at this time, the impact of the MCO Tax is not included in the current fiscal forecast.

Managed Care Contracting

DHCS concluded its first-ever competitive procurement process to select commercial plans for Medi-Cal managed care beginning in January 2024. In Los Angeles County, Health Net was awarded the commercial plan. The contract with DHCS provides that Health Net will continue its subcontracting agreement with Molina Healthcare (Molina) but increase Molina's member assignments from 15% to 50% of Health Net's market share. DHS has finalized contracts for base rates with Molina and Health Net for Calendar Year (CY) 2024; negotiations with L.A. Care for CY 2024 base rates are currently ongoing. The fiscal forecast does not include the impact of any negotiated rate changes with LA Care.

Disproportionate Share Hospital (DSH) Funding

Under the Affordable Care Act, reductions in DSH funding were to begin in 2014. Since that time, Congress has approved multiple delays and no DSH reductions have occurred. On November 16, 2023, President Biden signed a Continuing Resolution which, among other things, includes a delay in DSH cuts until January 19, 2024. Beyond this date, further action will be required by Congress. DHS is closely following this situation with other California

counties and our legislative advocates. If DSH cuts were to occur, DHS estimates an annual loss to the Global Payment Program (a combination of funding for DSH and Safety Net Care Pool) of $300.0 million. DHS anticipates another delay will be approved by Congress and so has not included DSH cuts in the forecast.

Updates to Major Revenue Categories

Medi-Cal Redetermination

As reported previously, because of the COVID-19 pandemic and the issuance of a public health emergency (PHE) order, the annual Medi-Cal requirement to redetermine a beneficiary's eligibility was suspended and large numbers of beneficiaries retained continuous Medi-Cal coverage throughout the pandemic. This resulted in a significant increase in the number of beneficiaries assigned to DHS.

The Consolidated Appropriations Act of 2023 passed by Congress decoupled the Medicaid continuous enrollment provision from the PHE and terminated this provision effective March 31, 2023. Accordingly, the redetermination process in California resumed in July 2023 on a phased-in basis and is expected to be fully phased in by June 2024. As the redetermination process returns to normal, DHS estimates a loss of 115,000 members (due to those individuals either not completing the redetermination process or no longer being eligible for Medi-Cal) over the phase-in period and a decrease of approximately $175.0 million annually in net capitation revenue. Reduced membership will also decrease the annual value of the Rate Range program by approximately $77.8 million. Overall, the impact of the redetermination process is expected to result in an annual reduction in Medi-Cal managed care revenues of approximately $252.8 million.

Expanded Medi-Cal Coverage

Effective May 1, 2022, DHCS implemented the Older Adult Expansion (OAE) Medi-Cal program. The OAE program is a state-only funded program that expands eligibility for full-scope Medi-Cal benefits to individuals who are 50 years of age or older, regardless of their citizenship or immigration status. Previously, these individuals were only eligible to receive limited scope benefits. Under the OAE program, those with limited benefits are automatically transitioned into full scope Medi-Cal managed care. DHS estimates approximately 40,000 of its assignments are in the OAE program.

Beginning in January 2024, the State will expand full Medi-Cal eligibility to the remaining group of income-eligible Californians, aged 26-49, regardless

of their citizenship or immigration status. These coverage expansions may result in increased DHS member assignments; however, any potential increase is likely to be reduced to some extent, depending on the rate at which current beneficiaries fail to complete the redetermination process and ultimately lose their Medi-Cal coverage.

California Advancing & Innovating Medi-Cal (CalAIM)

Through a combination of 1915(b) and 1115 waivers, CMS approved the CalAIM initiative effective January 1, 2022. CalAIM's goal is to improve health outcomes through intensely coordinated care management, mitigation of social determinants of health, and reduction of health disparities. CalAIM is an umbrella term for a multitude of initiatives that span the entire Medi-Cal delivery system; funding streams and rules vary for different programs. DHS leverages certain CalAIM funding streams to support services for some of the county's most vulnerable populations, including individuals experiencing homelessness and justice-involved individuals.

CalAIM's Enhanced Care Management (ECM) program is a care coordination benefit for the highest need cases that became effective for most eligible populations on January 1, 2022, with additional populations added in January 2023. Individuals with this managed care benefit will receive several months of support to help stabilize and coordinate various aspects of their medical and social care needs.

CalAIM's Community Supports programs allow Medi-Cal managed care plans the option to provide 14 different health-related social services including housing navigation, tenancy supports, recuperative care, and others. DHS has contracted with managed care plans for some of these services, previously covered under the Whole Person Care (WPC) and Health Homes programs. Implementation of CalAIM has been challenging. It has required new operations and procedures across multiple services and health plans at the same time, with sometimes incomplete state guidance. Plans have limited eligibility and require significant documentation for each individual service. As a result, rollout has continued to be uneven, with difficulties including delayed implementation and data alignment challenges with health plans. DHS' revenue projections are subject to change once these challenges have been resolved.

Also, under CalAIM, the Providing Access and Transforming Health (PATH) Program is providing $1.85 billion one-time in gross statewide funding over the five-year Waiver period that supports:

a) existing WPC pilot services until they can be implemented under CalAIM as Community Supports;

b) technical assistance and collaborative planning support to help implement and expand ECM and Community Supports;
c) capacity expansion of ECM and Community Support services beyond what was offered under WPC; and
d) Medi-Cal pre-release enrollment and suspension processes, as well as the delivery of Medi-Cal services in the 90 days prior to a justice-involved individual's release.

DHS has been approved for more than $20.0 million funding under categories a), c), and d) above for FY 2023-24.

Through a separate approval on January 4, 2022, CMS granted authority for the Home and Community-Based Services Spending Plan, which includes two major CalAIM initiatives that could benefit DHS through March 31, 2024: a) $1.3 billion gross statewide one-time funding for Medi-Cal managed care plans to earn incentives for making investments that address homelessness under the Housing and Homelessness Incentive Program (HHIP) program, and b) $298.0 million gross statewide one-time funding for Community Based Residential Continuum Pilots to provide medical and supportive services in various non-hospital settings designed to avoid unnecessary health care costs, including emergency services and future long-term care placement in a nursing home. The Chief Executive Office (CEO) Homeless Initiative and DHS worked with L.A. Care and Health Net regarding implementation of certain services using HHIP that is estimated to be worth $15.0 million for FY 2023-24.

AB 85 Realignment

AB 85 establishes a formula to redirect a certain portion of "excess" state health realignment funds to social services programs based on a sharing ratio of 80% State and 20% County. Based on current estimates, DHS is projecting AB 85 redirection amounts to be $0 for FYs 2023-24 through 2026-27.

In-Home Supportive Services (IHSS) Provider Health Plan

The cost for DHS to provide healthcare services to the IHSS providers enrolled in the health plan exceeds the net capitation revenue that DHS receives annually by approximately $85.0 million. This is primarily due to cost escalations over the last decade without any corresponding increases in the capitation rate DHS receives per member to provide health care services. DHS has evaluated the need to increase the health plan capitation rate to cover DHS' financial losses and to provide an investment in the IHSS network. L.A. Care has proposed a rate increase for the IHSS program and

DHS is currently evaluating the proposal and its impact on the finances of this program.

Specialty Mental Health Services

Earlier this year, DHS and the Department of Mental Health (DMH) finalized negotiations on the terms of a new Memorandum of Agreement (MOA) for the administration and funding of specialty mental health services. The new MOA replaces the FY 1990-91 Interagency Agreement between the two departments and provides an additional $37.0 million in funding annually to DHS under the new Behavioral Health Payment Reform effective July 1, 2023. DHS and DMH will continue to work collaboratively together to reduce any remaining fiscal issues DHS experiences as a provider of specialty mental health services as contracted with DMH.

Summary of Major Revenue Categories

Until the time at which DHS can fully resolve any shortfalls related to these revenue updates with additional revenue or implement cost reduction strategies, DHS will need to continue to use fund balance to close the Department's annual funding gap.

DHS Community Programs (Attachment I-B)

DHS CP includes the Housing for Health program and the Office of Diversion and Reentry, including Harm Reduction activities. Housing for Health provides housing, intensive case management and health care to individuals experiencing homelessness. The Office of Diversion and Reentry diverts people with mental illness and substance use disorder from the LA County jails and places them in permanent supportive housing. Harm Reduction activities include conducting overdose prevention work and other community programs that serve individuals who use drugs. In addition, the DHS CP unit also manages Community Supports under the CalAIM Medi-Cal waiver and includes programs such as My Health LA and the Medical-Legal Community Partnership.

DHS CP is projecting replacement funding will need to be identified starting in FY 2024-25 at $9.6 million up to $96.3 million in FY 2026-27. This is primarily due to the loss of CalAIM funding, American Rescue Plan Act-enabled funding, and Housing for a Healthy California Grand funding, with no ability to reduce associated program costs without cutting services and/or housing placements. Replacement funding sources are still to be determined; DHS will work closely with the CEO Homeless Initiative to identify potential alternative funding sources.

Correctional Health Services (Attachment I-C)

While DHS manages CHS operations, CHS is primarily funded with net County cost and DHS requests additional funding, as needed, through the County's budget process. At this time, DHS is estimating a balanced budget for CHS through FY 2026-27; however, DHS continues to work with the CEO and the Sheriff to address various Department of Justice-related operational and staffing issues, and it is likely additional funding will be needed to support these efforts in the future. DHS will continue to discuss any supplemental funding needs with the CEO.

Updates to Major Cost Categories

Salary & Employee Benefits (S&EB) Increases

DHS is required to fund any increases in its S&EB that result from increased labor costs, including those due to new or revised labor agreements with our majority represented workforce. The forecast includes the additional S&EB costs for those bargaining tables that have been closed and approved by the Board, estimated to exceed $120.0 million annually.

The County is currently in negotiations with the Union of American Physicians and Dentists (UAPD). Any additional costs negotiated with UAPD and approved by the Board that are beyond the standard County COLA are not included in this forecast.

SB 525, enacted on October 13, 2023, is a new minimum wage law for health care workers. SB 525 provides that for the twelve largest hospital systems in the state, i.e., those with more than 10,000 full-time equivalent workers, the healthcare worker minimum hourly wage will be phased in on an expedited timeframe listed below:

- $23.00 in June 2024
- $24.00 in June 2025
- $25.00 in June 2026
- minimum wage after 2026 will be indexed to the lower of inflation or 3.5%.

DHS must comply with the wage schedule noted above with the exception that SB 525 extends the start date for the wage increases to January 2025 for hospital systems that are county-owned or operated. Accordingly, DHS will be required to comply with the new minimum wage requirements

beginning in January 2025. In addition to the hourly minimum wage provisions, the bill requires that salaried health care employees earn a monthly salary equivalent to no less than 150% of the health care worker minimum wage or 200% of the applicable minimum wage, whichever is greater. DHS has included the projected impact of both provisions of SB 525 to its S&EB in the DHS fiscal forecast as follows:

- FY 2024-25: $45.0 million
- FY 2025-26: $95.0 million
- FY 2026-27: $100.0 million

Harbor-UCLA Medical Center Replacement Project (H-UCLA Replacement Project)

In February 2022, the Board approved the design-build contract with Hensel-Phelps for the construction of the H-UCLA Replacement Project. The long-term debt service costs for the H-UCLA Replacement Project will be shared based on the total project cost split between DHS (89.4%), and the Department of Mental Health (10.6%), whose share of cost will fund the construction of psychiatric emergency services and psychiatric inpatient beds. Working with DMH, these percentages will be revised to account for DHS paying down a portion of the replacement costs.

Since the Board's approval, a series of meetings have been held with clinical users to develop the design for the hospital, clinic, lab, and support service buildings and parking structure. The plans for the Clinic and Hospital buildings are currently going through jurisdictional approvals. Construction of the Support Services Building, which will house the Facilities Management, Information Technology, and Safety programs, will be completed in early 2024. The 1,500-space parking structure will be completed by late Spring 2024. Construction began in Spring 2023 on the Clinic Building and is ongoing. Demolition and site preparation for the Hospital will begin in early 2024. The H-UCLA Replacement Project is expected to be completed by 2028.

DHS used its fund balance to pay a total of $377.0 million in FYs 2021-22 and 2022-23 for the planning, design, and construction costs for the H-UCLA Replacement Project and other projects as they occurred. Latest estimates are predicting a project cost overrun. As firm numbers are available, we will update our estimated debt service payments. DHS will continue to work with CEO and Public Works on this matter.

Implementation of Cost Accounting System

DHS has completed the implementation of the new Cost Accounting Decision Support System. Multiple labor-intensive activities related to data capture, data quality, and data accuracy are ongoing. DHS is in the process of closely evaluating and analyzing the cost of primary care and urgent care services provided across DHS facilities. The detailed analysis is expected to assist in operational and strategic planning decisions.

Implementation of Patient Accounting System

DHS currently uses the Affinity Revenue Cycle Only (RCO) patient accounting system. DHS is planning to request Board approval to purchase the Cerner patient accounting system in fall 2024 to replace the RCO system. The Cerner system will be integrated with DHS' electronic health record system (ORCHID) which will result in new billing protocols. In the existing RCO system, data is transferred to the billing vendor who then prepares and submits the claims through their own system. Under the new Cerner system, the data will reside in DHS' system and the billing vendors will submit claims through the DHS system.

DHS Finance has met with DHS' Contracts and Grants regarding the development of the Statement of Work for a Request for Proposals to select vendors for DHS' billing and recovery services for billing claims from the Cerner Patient Accounting System. We anticipated a phased implementation timeline starting with CHS by December 2025. Once implementation of the Cerner Patient Accounting System begins, DHS will be operating dual billing systems, i.e., services provided after the new system's start date will be billed in the new Cerner system, while services provided before that date will be billed using the old RCO system. We estimate the termination of the dual systems will occur in January 2028.

If you have any questions or need additional information, please let me know, or you may contact Allan Wecker, Chief Financial Officer, at (626) 525-6100.

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Attachments (4)

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT I-A

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FORECAST

FISCAL YEARS 2023-24 THROUGH 2026-27

($ IN MILLIONS)

DHS
(Excluding Community Programs and Correctional Health Services)

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2023-24 Forecast	Adjustments	FY 2024-25 Forecast	Adjustments	FY 2025-26 Forecast	Adjustments	FY 2026-27 Forecast	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 3,632.924	$ 310.229	$ 3,943.153	$ 207.576	$ 4,150.729	$ 167.810	$ 4,318.539	(2)
(3)	Net Services & Supplies	2,571.812	18.260	2,590.072	97.142	2,687.214	95.416	2,782.630	(3)
(4)	Debt Service - Harbor Master Plan	5.439	35.787	41.226	23.327	64.553	25.822	90.375	(4)
(5)	Debt Service - Other	61.424	(0.626)	60.798	0.962	61.760	(0.034)	61.726	(5)
(6)	Other Charges	1,553.628	(144.525)	1,409.103	44.973	1,454.076	37.455	1,491.531	(6)
(7)	Capital Assets	51.301	-	51.301	-	51.301	-	51.301	(7)
(8)	Capital Projects & Deferred Maintenance	72.117	21.515	93.632	(1.354)	92.278	(0.002)	92.276	(8)
(9)	Operating Transfers Out	30.344	1.214	31.558	1.262	32.820	1.313	34.133	(9)
(10)	Intrafund Transfer	(95.119)	-	(95.119)	-	(95.119)	-	(95.119)	(10)
(11)	**Total Expenses**	$ 7,883.870	$ 241.854	$ 8,125.724	$ 373.888	$ 8,499.612	$ 327.780	$ 8,827.392	(11)
(12)	**Revenues**								(12)
(13)	Managed Care	1,183.286	(109.251)	1,074.035	(7.023)	1,067.012	(9.663)	1,057.349	(13)
(14)	Enhanced Payment Program (EPP)	914.312	137.128	1,051.440	157.717	1,209.157	116.696	1,325.853	(14)
(15)	Quality Incentive Program (QIP)	365.610	4.727	370.337	4.758	375.095	4.906	380.001	(15)
(16)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	6.700	(0.751)	5.949	-	5.949	(2.973)	2.976	(16)
(17)	Providing Access & Transforming Health (PATH)	19.298	(19.298)	-	-	-	-	-	(17)
(18)	Global Payment Program (GPP)	1,278.646	105.385	1,384.031	23.597	1,407.628	24.067	1,431.695	(18)
(19)	Medi-Cal Inpatient	472.772	13.436	486.208	16.854	503.062	17.457	520.519	(19)
(20)	Medi-Cal Outpatient - E/R	104.395	1.427	105.822	1.818	107.640	1.883	109.523	(20)
(21)	Medi-Cal CBRC	226.722	13.409	240.131	18.217	258.348	9.242	267.590	(21)
(22)	Medi-Cal SB 1732	11.128	-	11.128	-	11.128	-	11.128	(22)
(23)	Specialty Mental Health Services (SMHS)	197.882	-	197.882	-	197.882	-	197.882	(23)
(24)	Managed Care Graduate Medical Education (GME)	180.660	-	180.660	-	180.660	-	180.660	(24)
(25)	Hospital Provider Fee	25.350	-	25.350	0.781	26.131	-	26.131	(25)
(26)	Medicare	377.747	-	377.747	-	377.747	-	377.747	(26)
(27)	Hospital Insurance Collection	111.303	-	111.303	-	111.303	-	111.303	(27)
(28)	Self-Pay	2.857	-	2.857	-	2.857	-	2.857	(28)
(29)	In-Home Supportive Services (IHSS)	94.358	52.471	146.829	-	146.829	-	146.829	(29)
(30)	Federal & State - Other	113.152	-	113.152	-	113.152	-	113.152	(30)
(31)	Measure H	-	-	-	-	-	-	-	(31)
(32)	Other County Department (OCD)	524.645	-	524.645	-	524.645	-	524.645	(32)
(33)	American Rescue Plan Act (ARPA) Revenue	-	-	-	-	-	-	-	(33)
(34)	Other	108.936	-	108.936	-	108.936	-	108.936	(34)
(35)	**Total Revenues**	$ 6,319.759	$ 198.683	$ 6,518.442	$ 216.719	$ 6,735.161	$ 161.615	$ 6,896.776	(35)
(36)	**Net Cost - Before PY**	$ 1,564.111	$ 43.171	$ 1,607.282	$ 157.169	$ 1,764.451	$ 166.165	$ 1,930.616	(36)
(37)	AB 85 Redirection	-	-	-	-	-	-	-	(37)
(38)	Prior-Year Surplus / (Deficit)	648.615	(648.615)	-	-	-	-	-	(38)
(39)	**Net Cost - After PY & AB 85 Redirection**	$ 915.496	$ 691.786	$ 1,607.282	$ 157.169	$ 1,764.451	$ 166.165	$ 1,930.616	(39)
(40)	**Operating Subsidies**								(40)
(41)	Sales Tax & VLF	412.001	-	412.001	-	412.001	-	412.001	(41)
(42)	County Contribution	360.631	8.108	368.739	9.820	378.559	5.397	383.956	(42)
(43)	Tobacco Settlement	52.159	-	52.159	-	52.159	-	52.159	(43)
(44)	Measure B	244.464	-	244.464	-	244.464	-	244.464	(44)
(45)	**Total Operating Subsidies**	$ 1,069.255	$ 8.108	$ 1,077.363	$ 9.820	$ 1,087.183	$ 5.397	$ 1,092.580	(45)
(46)	**Surplus / (Deficit) = (45) - (39)**	**$ 153.759**	$ (683.678)	**$ (529.919)**	$ (147.349)	**$ (677.268)**	$ (160.768)	**$ (838.036)**	(46)
(47)	Replacement Funding Needed	-	-	-	-	-	-	-	(47)
(48)	**Adjusted Surplus / (Deficit)**	**$ 153.759**	$ (683.678)	**$ (529.919)**	$ (147.349)	**$ (677.268)**	$ (160.768)	**$ (838.036)**	(48)
(49)	**Beginning Fund Balance**	**$ 1,791.644**	$ 64.664	**$ 1,856.308**	$ 192.322	**$ 2,048.630**	$ (679.597)	**$ 1,369.033**	(49)
(50)	Surplus / (Deficit)	153.759	(683.678)	(529.919)	(147.349)	(677.268)	(160.768)	(838.036)	(50)
(51)	Long Term Receivables	(89.095)	811.336	722.241	(724.570)	(2.329)	(0.073)	(2.402)	(51)
(52)	**Ending Fund Balance**	**1,856.308**	192.322	**2,048.630**	(679.597)	**1,369.033**	(840.438)	**528.595**	(52)
(53)	Restricted - Provider Relief Fund	(325.274)	-	(325.274)	325.274	-	-	-	(53)
(54)	**Available Fund Balance**	**$ 1,531.034**	$ 192.322	**$ 1,723.356**	$ (354.323)	**$ 1,369.033**	$ (840.438)	**$ 528.595**	(54)

ATTACHMENT I-B

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FORECAST

FISCAL YEARS 2023-24 THROUGH 2026-27

($ IN MILLIONS)

B

Community Programs

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2023-24 Forecast	Adjustments	FY 2024-25 Forecast	Adjustments	FY 2025-26 Forecast	Adjustments	FY 2026-27 Forecast	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 52.402	$ 2.733	$ 55.135	$ 2.745	$ 57.880	$ 2.856	$ 60.736	(2)
(3)	Net Services & Supplies	883.686	(0.093)	883.593	(14.411)	869.182	(6.195)	862.987	(3)
(4)	Debt Service - Harbor Master Plan	-	-	-	-	-	-	-	(4)
(5)	Debt Service - Other	2.382	-	2.382	-	2.382	-	2.382	(5)
(6)	Other Charges	40.556	7.771	48.327	(28.154)	20.173	(17.375)	2.798	(6)
(7)	Capital Assets	0.682	(0.682)	-	-	-	-	-	(7)
(8)	Capital Projects & Deferred Maintenance	-	-	-	-	-	-	-	(8)
(9)	Operating Transfers Out	-	-	-	-	-	-	-	(9)
(10)	Intrafund Transfer	(266.424)	9.120	(257.304)	11.979	(245.325)	3.023	(242.302)	(10)
(11)	**Total Expenses**	$ 713.284	$ 18.849	$ 732.133	$ (27.841)	$ 704.292	$ (17.691)	$ 686.601	(11)
(12)	**Revenues**								(12)
(13)	Managed Care	0.532	(0.021)	0.511	(0.006)	0.505	(0.007)	0.498	(13)
(14)	Enhanced Payment Program (EPP)	0.443	0.084	0.527	0.080	0.607	0.058	0.665	(14)
(15)	Quality Incentive Program (QIP)	-	-	-	-	-	-	-	(15)
(16)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	58.684	(6.378)	52.306	(26.684)	25.622	(12.767)	12.855	(16)
(17)	Providing Access & Transforming Health (PATH)	-	-	-	-	-	-	-	(17)
(18)	Global Payment Program (GPP)	-	-	-	-	-	-	-	(18)
(19)	Medi-Cal Inpatient	-	-	-	-	-	-	-	(19)
(20)	Medi-Cal Outpatient - E/R	-	-	-	-	-	-	-	(20)
(21)	Medi-Cal CBRC	-	-	-	-	-	-	-	(21)
(22)	Medi-Cal SB 1732	-	-	-	-	-	-	-	(22)
(23)	Specialty Mental Health Services (SMHS)	-	-	-	-	-	-	-	(23)
(24)	Managed Care Graduate Medical Education (GME)	-	-	-	-	-	-	-	(24)
(25)	Hospital Provider Fee	-	-	-	-	-	-	-	(25)
(26)	Medicare	-	-	-	-	-	-	-	(26)
(27)	Hospital Insurance Collection	-	-	-	-	-	-	-	(27)
(28)	Self-Pay	-	-	-	-	-	-	-	(28)
(29)	In-Home Supportive Services (IHSS)	-	-	-	-	-	-	-	(29)
(30)	Federal & State - Other	274.367	20.458	294.825	(27.755)	267.070	(3.704)	263.366	(30)
(31)	Measure H	196.610	0.017	196.627	4.510	201.137	(5.773)	195.364	(31)
(32)	Other County Department (OCD)	0.159	0.005	0.164	0.005	0.169	0.005	0.174	(32)
(33)	American Rescue Plan Act (ARPA) Revenue	-	-	-	-	-	-	-	(33)
(34)	Other	24.567	(3.461)	21.106	-	21.106	(1.700)	19.406	(34)
(35)	**Total Revenues**	$ 555.362	$ 10.704	$ 566.066	$ (49.850)	$ 516.216	$ (23.888)	$ 492.328	(35)
(36)	**Net Cost - Before PY**	$ 157.922	$ 8.145	$ 166.067	$ 22.009	$ 188.076	$ 6.197	$ 194.273	(36)
(37)	AB 85 Redirection	-	-	-	-	-	-	-	(37)
(38)	Prior-Year Surplus / (Deficit)	-	-	-	-	-	-	-	(38)
(39)	**Net Cost - After PY & AB 85 Redirection**	$ 157.922	$ 8.145	$ 166.067	$ 22.009	$ 188.076	$ 6.197	$ 194.273	(39)
(40)	**Operating Subsidies**								(40)
(41)	Sales Tax & VLF	20.979	-	20.979	-	20.979	-	20.979	(41)
(42)	County Contribution	134.143	(1.478)	132.665	(6.809)	125.856	(51.706)	74.150	(42)
(43)	Tobacco Settlement	2.800	-	2.800	-	2.800	-	2.800	(43)
(44)	Measure B	-	-	-	-	-	-	-	(44)
(45)	**Total Operating Subsidies**	$ 157.922	$ (1.478)	$ 156.444	$ (6.809)	$ 149.635	$ (51.706)	$ 97.929	(45)
(46)	**Surplus / (Deficit) = (45) - (39)**	**$ -**	$ (9.623)	**$ (9.623)**	$ (28.818)	**$ (38.441)**	$ (57.903)	**$ (96.344)**	(46)
(47)	Replacement Funding Needed	-	9.623	9.623	28.818	38.441	57.903	96.344	(47)
(48)	**Adjusted Surplus / (Deficit)**	**$ -**	$ -	**$ -**	$ -	**$ -**	$ -	**$ -**	(48)

ATTACHMENT I-C

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FORECAST

FISCAL YEARS 2023-24 THROUGH 2026-27

($ IN MILLIONS)

C

Correctional Health Services

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2023-24 Forecast	Adjustments	FY 2024-25 Forecast	Adjustments	FY 2025-26 Forecast	Adjustments	FY 2026-27 Forecast	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 365.299	$ 15.352	$ 380.651	$ 15.365	$ 396.016	$ 16.012	$ 412.028	(2)
(3)	Net Services & Supplies	134.555	2.147	136.702	3.565	140.267	4.682	144.949	(3)
(4)	Debt Service - Harbor Master Plan	-	-	-	-	-	-	-	(4)
(5)	Debt Service - Other	-	-	-	-	-	-	-	(5)
(6)	Other Charges	1.792	-	1.792	-	1.792	-	1.792	(6)
(7)	Capital Assets	9.623	-	9.623	-	9.623	-	9.623	(7)
(8)	Capital Projects & Deferred Maintenance	-	-	-	-	-	-	-	(8)
(9)	Operating Transfers Out	-	-	-	-	-	-	-	(9)
(10)	Intrafund Transfer	(3.337)	-	(3.337)	-	(3.337)	-	(3.337)	(10)
(11)	**Total Expenses**	$ 507.932	$ 17.499	$ 525.431	$ 18.930	$ 544.361	$ 20.694	$ 565.055	(11)
(12)	**Revenues**								(12)
(13)	Managed Care	-	-	-	-	-	-	-	(13)
(14)	Enhanced Payment Program (EPP)	-	-	-	-	-	-	-	(14)
(15)	Quality Incentive Program (QIP)	-	-	-	-	-	-	-	(15)
(16)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	-	-	-	-	-	-	-	(16)
(17)	Providing Access & Transforming Health (PATH)	-	-	-	-	-	-	-	(17)
(18)	Global Payment Program (GPP)	-	-	-	-	-	-	-	(18)
(19)	Medi-Cal Inpatient	-	-	-	-	-	-	-	(19)
(20)	Medi-Cal Outpatient - E/R	-	-	-	-	-	-	-	(20)
(21)	Medi-Cal CBRC	-	-	-	-	-	-	-	(21)
(22)	Medi-Cal SB 1732	-	-	-	-	-	-	-	(22)
(23)	Specialty Mental Health Services (SMHS)	-	-	-	-	-	-	-	(23)
(24)	Managed Care Graduate Medical Education (GME)	-	-	-	-	-	-	-	(24)
(25)	Hospital Provider Fee	-	-	-	-	-	-	-	(25)
(26)	Medicare	-	-	-	-	-	-	-	(26)
(27)	Hospital Insurance Collection	-	-	-	-	-	-	-	(27)
(28)	Self-Pay	-	-	-	-	-	-	-	(28)
(29)	In-Home Supportive Services (IHSS)	-	-	-	-	-	-	-	(29)
(30)	Federal & State - Other	41.714	-	41.714	-	41.714	-	41.714	(30)
(31)	Measure H	2.049	-	2.049	-	2.049	-	2.049	(31)
(32)	Other County Department (OCD)	-	-	-	-	-	-	-	(32)
(33)	American Rescue Plan Act (ARPA) Revenue	2.818	(1.879)	0.939	(0.939)	-	-	-	(33)
(34)	Other	0.014	-	0.014	-	0.014	-	0.014	(34)
(35)	**Total Revenues**	$ 46.595	$ (1.879)	$ 44.716	$ (0.939)	$ 43.777	$ -	$ 43.777	(35)
(36)	**Net Cost - Before PY**	$ 461.337	$ 19.378	$ 480.715	$ 19.869	$ 500.584	$ 20.694	$ 521.278	(36)
(37)	AB 85 Redirection	-	-	-	-	-	-	-	(37)
(38)	Prior-Year Surplus / (Deficit)	1.324	(1.324)	-	-	-	-	-	(38)
(39)	**Net Cost - After PY & AB 85 Redirection**	$ 460.013	$ 20.702	$ 480.715	$ 19.869	$ 500.584	$ 20.694	$ 521.278	(39)
(40)	**Operating Subsidies**								(40)
(41)	Sales Tax & VLF	-	-	-	-	-	-	-	(41)
(42)	County Contribution	460.013	20.702	480.715	19.869	500.584	20.694	521.278	(42)
(43)	Tobacco Settlement	-	-	-	-	-	-	-	(43)
(44)	Measure B	-	-	-	-	-	-	-	(44)
(45)	**Total Operating Subsidies**	$ 460.013	$ 20.702	$ 480.715	$ 19.869	$ 500.584	$ 20.694	$ 521.278	(45)
(46)	**Surplus / (Deficit) = (45) - (39)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	(46)
(47)	Replacement Funding Needed	-	-	-	-	-	-	-	(47)
(48)	**Adjusted Surplus / (Deficit)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	(48)

ATTACHMENT I-D

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

FORECAST

FISCAL YEARS 2023-24 THROUGH 2026-27

($ IN MILLIONS)

D = A + B + C

DHS Total

		Year 1		Year 2		Year 3		Year 4	
		A	B	C	D	E	F	G	
		FY 2023-24 Forecast	Adjustments	FY 2024-25 Forecast	Adjustments	FY 2025-26 Forecast	Adjustments	FY 2026-27 Forecast	
(1)	**Expenses**								(1)
(2)	Salaries & Employee Benefits	$ 4,050.625	$ 328.314	4,378.939	$ 225.686	$ 4,604.625	$ 186.678	$ 4,791.303	(2)
(3)	Net Services & Supplies	3,590.053	20.314	3,610.367	86.296	3,696.663	93.903	3,790.566	(3)
(4)	Debt Service - Harbor Master Plan	5.439	35.787	41.226	23.327	64.553	25.822	90.375	(4)
(5)	Debt Service - Other	63.806	(0.626)	63.180	0.962	64.142	(0.034)	64.108	(5)
(6)	Other Charges	1,595.976	(136.754)	1,459.222	16.819	1,476.041	20.080	1,496.121	(6)
(7)	Capital Assets	61.606	(0.682)	60.924	-	60.924	-	60.924	(7)
(8)	Capital Projects & Deferred Maintenance	72.117	21.515	93.632	(1.354)	92.278	(0.002)	92.276	(8)
(9)	Operating Transfers Out	30.344	1.214	31.558	1.262	32.820	1.313	34.133	(9)
(10)	Intrafund Transfer	(364.880)	9.120	(355.760)	11.979	(343.781)	3.023	(340.758)	(10)
(11)	**Total Expenses**	$ 9,105.086	$ 278.202	$ 9,383.288	$ 364.977	$ 9,748.265	$ 330.783	$ 10,079.048	(11)
(12)	**Revenues**								(12)
(13)	Managed Care	1,183.818	(109.272)	1,074.546	(7.029)	1,067.517	(9.670)	1,057.847	(13)
(14)	Enhanced Payment Program (EPP)	914.755	137.212	1,051.967	157.797	1,209.764	116.754	1,326.518	(14)
(15)	Quality Incentive Program (QIP)	365.610	4.727	370.337	4.758	375.095	4.906	380.001	(15)
(16)	Cali. Advancing & Innovating Medi-Cal (CalAIM)	65.384	(7.129)	58.255	(26.684)	31.571	(15.740)	15.831	(16)
(17)	Providing Access & Transforming Health (PATH)	19.298	(19.298)	-	-	-	-	-	(17)
(18)	Global Payment Program (GPP)	1,278.646	105.385	1,384.031	23.597	1,407.628	24.067	1,431.695	(18)
(19)	Medi-Cal Inpatient	472.772	13.436	486.208	16.854	503.062	17.457	520.519	(19)
(20)	Medi-Cal Outpatient - E/R	104.395	1.427	105.822	1.818	107.640	1.883	109.523	(20)
(21)	Medi-Cal CBRC	226.722	13.409	240.131	18.217	258.348	9.242	267.590	(21)
(22)	Medi-Cal SB 1732	11.128	-	11.128	-	11.128	-	11.128	(22)
(23)	Specialty Mental Health Services (SMHS)	197.882	-	197.882	-	197.882	-	197.882	(23)
(24)	Managed Care Graduate Medical Education (GME)	180.660	-	180.660	-	180.660	-	180.660	(24)
(25)	Hospital Provider Fee	25.350	-	25.350	0.781	26.131	-	26.131	(25)
(26)	Medicare	377.747	-	377.747	-	377.747	-	377.747	(26)
(27)	Hospital Insurance Collection	111.303	-	111.303	-	111.303	-	111.303	(27)
(28)	Self-Pay	2.857	-	2.857	-	2.857	-	2.857	(28)
(29)	In-Home Supportive Services (IHSS)	94.358	52.471	146.829	-	146.829	-	146.829	(29)
(30)	Federal & State - Other	429.233	20.458	449.691	(27.755)	421.936	(3.704)	418.232	(30)
(31)	Measure H	198.659	0.017	198.676	4.510	203.186	(5.773)	197.413	(31)
(32)	Other County Department (OCD)	524.804	0.005	524.809	0.005	524.814	0.005	524.819	(32)
(33)	American Rescue Plan Act (ARPA) Revenue	2.818	(1.879)	0.939	(0.939)	-	-	-	(33)
(34)	Other	133.517	(3.461)	130.056	-	130.056	(1.700)	128.356	(34)
(35)	**Total Revenues**	$ 6,921.716	$ 207.508	$ 7,129.224	$ 165.930	$ 7,295.154	$ 137.727	$ 7,432.881	(35)
(36)	**Net Cost - Before PY**	$ 2,183.370	$ 70.694	$ 2,254.064	$ 199.047	$ 2,453.111	$ 193.056	$ 2,646.167	(36)
(37)	AB 85 Redirection	-	-	-	-	-	-	-	(37)
(38)	Prior-Year Surplus / (Deficit)	649.939	(649.939)	-	-	-	-	-	(38)
(39)	**Net Cost - After PY & AB 85 Redirection**	$ 1,533.431	$ 720.633	$ 2,254.064	$ 199.047	$ 2,453.111	$ 193.056	$ 2,646.167	(39)
(40)	**Operating Subsidies**								(40)
(41)	Sales Tax & VLF	432.980	-	432.980	-	432.980	-	432.980	(41)
(42)	County Contribution	954.787	27.332	982.119	22.880	1,004.999	(25.615)	979.384	(42)
(43)	Tobacco Settlement	54.959	-	54.959	-	54.959	-	54.959	(43)
(44)	Measure B	244.464	-	244.464	-	244.464	-	244.464	(44)
(45)	**Total Operating Subsidies**	$ 1,687.190	$ 27.332	$ 1,714.522	$ 22.880	$ 1,737.402	$ (25.615)	$ 1,711.787	(45)
(46)	**Surplus / (Deficit) = (45) - (39)**	**$ 153.759**	$ (693.301)	**$ (539.542)**	$ (176.167)	**$ (715.709)**	$ (218.671)	**$ (934.380)**	(46)
(47)	Replacement Funding Needed	-	9.623	9.623	28.818	38.441	57.903	96.344	(47)
(48)	**Adjusted Surplus / (Deficit)**	**$ 153.759**	$ (683.678)	**$ (529.919)**	$ (147.349)	**$ (677.268)**	$ (160.768)	**$ (838.036)**	(48)
(49)	**Beginning Fund Balance**	**$ 1,791.644**	$ 64.664	**$ 1,856.308**	$ 192.322	**$ 2,048.630**	$ (679.597)	**$ 1,369.033**	(49)
(50)	Surplus / (Deficit)	153.759	(683.678)	(529.919)	(147.349)	(677.268)	(160.768)	(838.036)	(50)
(51)	Long Term Receivables	(89.095)	811.336	722.241	(724.570)	(2.329)	(0.073)	(2.402)	(51)
(52)	**Ending Fund Balance**	**1,856.308**	192.322	**2,048.630**	(679.597)	**1,369.033**	(840.438)	**528.595**	(52)
(53)	Restricted - Provider Relief Fund	(325.274)	-	(325.274)	325.274	-	-	-	(53)
(54)	**Available Fund Balance**	**$ 1,531.034**	$ 192.322	**$ 1,723.356**	$ (354.323)	**$ 1,369.033**	$ (840.438)	**$ 528.595**	(54)

SB 43 – New Definition of Grave Disability

DMH – Elan Shultz, Director Policy and Strategy

DMH - Connie D. Draxler, Acting Chief Deputy

DPH – Dr. Gary Tsai, SAPC Bureau Director

DHS – Jaqueline Yu, Specialty Mental Health Services Director

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SB 43 – Grave Disability Definitions

- Current definition:
  - A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.
- New definition:
  - A condition in which a person, as result of a mental health disorder, severe substance use disorder or a co-occurring mental health disorder and severe substance use disorder, is unable to provide for their basic needs of food, clothing, shelter, personal safety or necessary medical care.

SB 43 Changes

- Expanding the grave disability criteria to allow for involuntary detention and conservatorship on the basis of a standalone severe substance use disorder and co-occurring mental health disorder and severe substance use disorder.
- Expanding the definition of grave disability to include individuals who are unable to provide for their basic personal need for personal safety or necessary medical care.
- Defining “necessary medical care” to mean care that a licensed health care practitioner determines to be necessary to prevent serious deterioration of an existing medical condition which is likely to result in serious bodily injury if left untreated.
- Changes to hearsay evidence in conservatorship hearings.
- Requiring counties consider less restrictive alternatives such as assisted outpatient treatment (AOT) and CARE Court in conducting conservatorship investigations.

Implications on Capacity & Other Considerations

- **Capacity challenges expected throughout the LPS system**
  - **Expectation for more people to be placed on involuntary holds:**

As a result of the expanded definition of grave disability, SB 43 is anticipated to result in increases in the numbers of people placed on 5150 holds (up to 72 hours) that will result in capacity needs at LPS facilities where 5150s are placed (e.g., emergency rooms, psychiatric emergency rooms, crisis stabilization units).

  - **Expectation for more people to be placed on longer holds:**

A portion of those 5150s is anticipated to result in longer term involuntary holds such as 5250s (up to 14 days) all the way to conservatorships, resulting in the need for additional bed capacity needs in longer term LPS designated facilities (e.g., inpatient psychiatric hospitals) and other Institutions for Mental Disease beds.

  - **Safety Concerns:**

Implementation of SB 43 will increase safety concerns for DHS hospital staff and patients in already overcrowded psychiatric emergency rooms.

  - **Increase DHS inpatient length of stays:**

LPS conservatorship processes will increase inpatient length of stays resulting in a lack of flow from DHS hospital inpatient beds to community resources, thereby negatively impacting DHS capacity for treating acute patients in need of this level of care.

Implications on Capacity & Other Considerations

- **Capacity challenges expected throughout the LPS system**
  - **Expectation that lack of capacity for involuntary SUD care will increase strain on LPS settings:**
    - Given current LPS facility constraints and the fact that there are no LPS designated facilities within the specialty SUD system in California, as well as the specialized needs related to severe SUD and medical care, there will be capacity constraints in LPS settings.
- **Involuntary SUD Care**
  - Involuntary SUD treatment is poorly studied and there are significant risks of pushing people with SUD further into the shadows; implementation of SB 43 will need to be carefully executed.
  - Will need to work with SUD treatment providers to explore the establishment of LPS facilities within the specialty SUD system and service models to engage people who may be on involuntary holds
  - Will need to work with DMH to enhance SUD treatment capabilities within the current LPS facility network.

Operational Areas to be Addressed Before Implementation of SB 43

- Client Flow, System Mapping and System Guidelines
- Designation and Training
- Treatment and Care Planning
- Management of Individuals Ineligible for New Criteria
- Court Processes/Adherence to Court Orders
- Community Education and Collaboration
- Staffing and Budgetary
- Managed Care Plan Coordination

Client Flow, System Mapping and System Guidelines

- DPH-SAPC, in consultation with DMH, hospitals, designated clinicians, County Counsel and other partners must establish parameters that illustrate and define severe substance use disorder.
- DMH and DPH-SAPC, in consultation with DHS, hospitals, designated clinicians, County Counsel and other partners, establish parameters that illustrate and define “necessary medical care” and “personal safety” as referenced within SB 43.
- DMH and DPH-SAPC, in consultation with DHS, hospitals, designated clinicians, County Counsel, local law enforcement agencies and other partners must develop policies regarding client flow and explaining where clients are intended to be taken upon a determination of grave disability by front-line provider or law enforcement.
- DMH and DPH-SAPC, in consultation with DHS, hospitals, designated clinicians, County Counsel and other partners must determine workflows and service delivery models for clients who are referred under SB 43, have behavioral health service needs, but do not meet grave disability criteria

Designation and Training

- Develop training materials based upon the new parameters/criteria for grave disability.
- Coordinate and conduct the trainings and re-designation process for more 4,200 individuals designated by DMH to initiate involuntary holds.
- Coordinate with the local hospitals, County Counsel, Public Guardian, Superior Court, and local law enforcement agencies to retrain their staff on the updated grave disability criteria and parameters. Retrain DMH and DPH-SAPC staff as well.

Determining and Developing Appropriate Treatment Options

- DMH and DPH-SAPC, along with DMH's Fee-for-Service, Short Doyle, and DHS (County) hospitals will need to strategize solutions for managing the increase in involuntary detentions while safeguarding emergency department and psychiatric inpatient unit capacity.
- DMH and DPH-SAPC, along with medical partners, will develop a service delivery and facility model that will provide for the addition of physical health conditions to the definition of grave disability.
- DMH and DPH-SAPC will develop the service delivery, financing, and facility models to increase capacity to serve with DPH-SAPC's specialty SUD treatment system and DMH's specialty mental health treatment system. The departments will also determine if new financing and contracting models are required.

Coordinating Services and Appropriate Placement with the Courts

- DMH and DPH-SAPC to collaborate with Justice Partners regarding the development of new conservatorship court orders, develop a common understanding regarding placement options and funding limitations, etc.

Community Education and Collaboration

- Once DMH, DPH-SAPC and their partners have developed the new criteria for the grave disability definition and have developed client workflows, then the departments can start educating our community partners about how the County will be implementing SB 43
  - Town Halls and briefings for cities, fellow County departments, local hospitals, legal entity providers, community-based organizations, and families of individuals suffering from serious mental illness and severe substance use

Determining Staffing and Budgetary Needs

- SB 43 requires counties to implement new mandates but received no additional funding for the implementation.
  - DMH and DPH-SAPC will need to evaluate staffing needs and work with CEO on funding for increased staffing.

Managed Care Plan Coordination

- SB 43 implementation will require close coordination between DMH, DPH-SAPC and the managed care plans (who are responsible for ensuring physical/medical healthcare access for Medi-Cal members) to ensure that a client's comprehensive care needs are properly addressed, as specified under the expanded grave disability definition under SB 43.

Questions?

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